Tuesday, 17 September 2024.

(10.00 am)

LADY JUSTICE THIRLWALL: Just before we start, there's something I just want to say because it's so important. These proceedings are being linked on an audio link, and they are of course subject to the orders of the court that were made by the Crown Court some months ago.

The link is a live link, and it means if anyone inadvertently breaches the order, it is absolutely essential that no reporting is made of any breach. I'm sorry to repeat that, I know I said it at great length yesterday and I'll probably say it again tomorrow, but it's important to understand that nothing must be reported which would be a breach of the order. Thank you.

Now, good morning, Mother D, very good to see you and thank you very much indeed for coming to give your evidence today. I know you'll be feeling nervous so rather than say anything else, I think it's probably best if we just get started. Ms Langdale.

MS LANGDALE: May Mother D be sworn?

LADY JUSTICE THIRLWALL: Thank you.

MOTHER D (sworn)

Questioned by MS LANGDALE

MS LANGDALE: Mother D, you have prepared a statement dated

30 August 2024 for the Inquiry. Can you confirm the contents are true and accurate, as far as you're concerned?

A. Everything is true and accurate, yes.

Q. You begin your statement by saying this:

"Child D died on 22 June at 4.25 am in the neonatal unit at the Countess. She was attacked three times during the night and died after the third attack. She was murdered by Lucy Letby."

A. Yes, that's correct.

Q. Can I ask you firstly broadly about the impact that has had on you: first of all the loss of your child; and secondly, learning that she was murdered by Letby?

A. Immediately, I could not stay in the room, so my husband wheeled me out of the room where she passed away and everything crumbled in. It was just a whirlwind of emotion and disaster, and I had loads of questions straight away.

It's not until the police called us at 6 am to tell us that they were about to arrest someone that has murdered Child D and other babies that it hit us, yes.

MS LANGDALE: When the police called you that morning, what did they say to you? Can you remember?

A. Richard, the detective, called us, and I was with my husband. That woke us up, and we -- he just said, "I'm

letting you know, this is the Police, Cheshire Police, I'm letting you know that we're about to arrest a person that has allegedly murdered your daughter and other babies. I can't go into it too much now. I know it's very abrupt, but we will call you back". And this left us in shock because we'd just never expected something of that nature.

As much as I had questions, and I was questioning people at the Countess and wanted the police to get involved, I did not expect this to turn out this way. So we were just shocked, and we were trying to understand what was going on. And until we were getting a callback, because we didn't have any way of contacting anyone, we were just questioning things starting to try to understand: how does that work? What happened? There's more people? Just more and more and more questions. I already had thousands and now we were just confused how serious this was turning out to be.

Q. We're going to go through this morning some of the questions you had at the time, but just focusing now on after you'd been called by the police, did you attend the criminal trial? Did you listen to the evidence of the criminal trial?

A. Not until I was called as a witness. So until I gave my evidence, I did not listen, hear or know about anything

that was being said. If anything, during the investigation, I had many questions, and the police were just very firm in not sharing any information, any contact with the parents, I've never met anyone. I only knew what I knew of my story. So when the trial started, my husband did attend every day. But I was clear that I was going to stay in a bubble. I didn't -- I wanted to be integral and I wanted to make sure that I didn't get impacted or influenced by anything I hear, and I knew absolutely nothing. I just knew my husband coming home upset. Sometimes he came home he was whitewashed, but I didn't know how to support because I didn't know what he's heard.

On the morning of giving my evidence, I was still isolated, you just go through a different entrance. You're kept in that bubble I'd been keeping myself in. So I gave my evidence and then I got 10, 15-minutes' break and it all started then. I was listening about everything to do with my daughter and my case, and I was trying to catch up every evening on what's been said the past weeks, how much I-- everything was a surprise and a shock because I knew nothing about all that was revealed.

Q. What did you learn when you caught up with what had happened in the criminal trial and what had been said

about your daughter? What did you learn that you did not know before in that process?

A. So much. Well, first, that everything I knew was not the reality. There's a lot of things that happened before the birth, my daughter's birth, that I wasn't aware of. Because all throughout my searches for the truth, I was never told there was anything suspicious with anyone else before, after. So going to the trial, I knew there was going to be things coming out but I didn't know the nature and what I didn't start convinced that Lucy Letby was guilty, because -- not that I didn't want to accept, but I just didn't know what they had on her. I just needed to hear for myself, I needed to understand. It needed to make sense.

And so yes. I went thinking: let me find out what's the truth, what you've got on her, why this is the reality of what's happened, and then learn what I need to do with this. I understand that it was a lot of failings, and some I understood already because I requested my notes, but I didn't know all the meetings that took place. I didn't know all the times they failed. On top of the ones I've already identified, there was other times, other conversation, all the messages and the interest Lucy Letby had in our family, I didn't know.

Q. Just pausing there, so you say in your statement one of the things you found hard to digest in the criminal trial was how Letby could say she didn't remember your daughter. What did you find out -- first of all, how did you find that, and what did you find out in terms of her conducting searches on you and your husband?

A. I ... I didn't realise how much of a mess this was. I -- in my head, I could picture her in my story. But I didn't know everything else that was happening. I found out that she looked us up, both my husband and I, which I clearly know the mother's name does not appear where she would be looking at a baby's notes. So she would have had to consciously go and look for the notes. Even more, for my husband. She -- I never spoke with her in conversation to know her name. I -- she shouldn't have known about us and she should have had no reason to go and look us up. And the conversations she had by text message with colleagues about my daughter and how she called this "fate", and that "sometimes things happen", this I found shocking, because after what she's done, this is disgusting. I don't know if that answered the question. Sorry.

Q. You say at the beginning of your statement you continue to struggle psychologically. How difficult has it been for you dealing with all of this?

A. There's not many words to explain, because not only this situation is thankfully not common, you start ... I first found -- I thought, during labour, for things to go okay, and they didn't. And then she was fighting for her life. She was doing it well. I was promised that I would be okay to go to sleep that night, and I will wake up and I'll be able to feed her and hold her. And we got woken up in the morning to be told: no, this is not happening. And things turned around. I did not pick myself up and I still haven't picked myself up, because everything just crumbled. Everything -- nothing made sense. I mean, there is the grief side of things, but you're having to completely turn things around so you're going home without your baby. But you know things aren't right. There's accepting things sometimes happen and but nothing made sense. So to try to get myself together and move on, it was impossible. So psychologically, it was hard to have people understand what I was trying to do. Because clearly, I think my husband and I were each other's rock because we could not allow anyone else in that little unit, only our daughter and she wasn't there, so we were the only people in each other's life but we weren't dealing with things the same way so it was extremely difficult. I know my husband was worried because I was asking too

many questions, and I was requesting notes and I was talking about -- I'm investigating and going to the police, and I thought maybe I was losing my mind and I didn't think people understood why I was pushing and everything that I identified, no one seemed to have paid attention to.

So it was hard to keep saying, because I -- I just didn't know if what I was doing was right but I kept thinking: this is my -- I can't -- this is my daughter's voice. I can't give up here. So I will carry on even if I'm on my own. And I did. So throughout doing that, any energy and strength I had was going into pushing, reading the notes, getting clued up, and anything else was getting drained in my emotions. I was just losing myself, I was no longer a friend or a daughter or a wife. I know I was losing myself, but that was my sacrifice.

Q. Let me ask you now, under "Experiences at the Countess of Chester Hospital" from paragraph 16, you talk about when you were pregnant, when you learnt you were having your daughter, tell us about that period.

A. Well, that was happy. I mean, we never tried. That was pretty straightforward. We ... I mean, we met, we fell in love, we enjoyed life and then when we decided to try for a baby, it happened naturally, in love, and all

sounded perfect. My pregnancy was smooth, apart from the odd pain that people get. There was no concern, no issues. I was towards the end of my pregnancy just over three weeks, so my daughter was a good size baby. She was pretty much -- I was almost full term so everything for me was in place. Everything was ready. The nursery was sorted. I crafted everything in the room. I painted, I decorated, I made everything. Only we knew the name, so we had like a little reveal ready. Everything was ready in the house. So we were just on the little cloud nine.

And then when my water went, I -- I can't say I felt concerned, but obviously you're anxious because you're not sure what's going on, but that's when things changed. But up to then, everything was fine. No complication, no issues.

Q. And when your waters had gone, you tell us that you were told to go into the hospital, and what about the delivery? Tell us about the delivery.

A. So it's not a straight delivery because there's the pre -- should I go into this? Because when the water went, I knew it was a water, but when I called the hospital they said, "Well, just wait a bit, see how it goes." And then a few hours later, I called again and they said, "Well come in, you know, we'll check". And that

is when I trusted the hospital.

And the midwife checked everything she needed to check and I said, "But the water went and now it's been a little while, what's the protocol? What are we doing?" And she said, "Well, you know, you have -- labour hasn't clearly started so you're going to have to go home and wait", and I thought this was risky. But she sent me on my way, so I went home. I think we were more excited at that stage because we thought that's it, she's -- because they did tell us, "We will induce you tomorrow if it hasn't started on its own" and there was nothing to worry about, unless labour started clearly, had come early, otherwise I was coming the next day.

I came the next day, and when we arrived it was a really quiet place and we were the first in the waiting room, and we waited in a waiting room, and then another couple arrived, and they went before us, and that's when I started to feel uncomfortable because I thought: okay, this has been over 24 hours now, I'm still losing water. Is there any water left? I didn't understand enough and I didn't have anyone to ask questions to. So I was concerned. At that stage I was clearly tired already because I haven't slept through the night. And when we first got put into a room, we were waiting for more hours, and they said, "Well, we

won't start just yet, you know, we're still observing what's going on, is the baby moving?" And I thought: everything seems okay. I'm still not comfortable; I feel this is all open to infection. And they just dismissed my concern.

And a day went by, and still no one really pushing for the next stage. And this built up to a second day, and then a third day. I was all that time in hospital and all throughout. We went through so many different shifts and handovers and every time I said, "Have you paid attention that I am not" -- they made a mistake on the notes on the gestation age and I said, "This is relevant, you need to pay attention." "Yeah, don't worry, we know what we're doing" and I said, "Okay, but, you know, this doesn't seem right, and you're saying this is still not progressing, and you induced me now, still no progress. When are we talking the next stage?"

And I kept being dismissed because they were busy and they weren't worried. It came to a point when I -- all this time I didn't rest, pretty much, and I went to the bathroom and I have seen a bit of blood but they said this is not concerning, we'll just move you on to the next stage of induction now, and they said, "Now things will go a lot faster".

It didn't.

Q. Did there come a time when you were asking for a caesarean section?

A. So that's when, when we got moved to another room which -- that's what they called the Labour Ward and that's where things will get started. That's when I was seeing more of the consultant, and I felt there was a bit more attention given to me. I was no longer very patient and maybe I was a bit abrupt. My husband was saying, "You know, you're tired, they know what they're doing". And I said, "I think they don't and they think because I'm a first time mum they don't know what's going on but I said I feel things aren't going well, and my body is clearly not wanting to do this like that so I'd like a C-section".

The consultant said, "Well, we need to review because, you know, you're still fairly early in the labour process."

And I said, "It's not early, it's over two days. My water has gone".

I wasn't full term, I was past. I mean, I'd just made it to 37 but when my water went, I wasn't. This is not correct. I still -- "What about the risk of infection? What about this?"

And they just -- I felt dismissed, and so I waited and the consultants were generally coming every four

hours-ish, and there seemed to be always a delay, because they were very busy. Then another person came, and that's the doctor that delivered my daughter.

When he came, I mention that I wanted a section a bit more firmly, and he smiled and he said, "That's what people tend to think these days, this is the easy option". I said, "This is not the easy option. I'm petrified of scars." And I know that's not -- but the after -- the healing part, I'm scared of. So this is not my option. That's not my first choice, that's my last option, and I'm not doing it for me, I'm doing it for the baby because at this stage I don't -- I can't tell that I'm feeling the baby or not. I'm completely exhausted. I haven't slept for three days. And all this -- because one of the midwifes was lovely but probably a bit too soft. She just kept coming to me and giving me a hug and saying, "Oh it's going to be fine". "It's not going to be fine. I want you to listen. I want you to pay attention to what I am saying. I want C-section and I want it now".

Because by that time they've turned the monitors away from me and I couldn't see any more what was going on with the movements. They tried to give me gas and air. Nothing was working. I was starting to panic, clearly. And I said, "I want someone to listen". I was

getting very upset and a bit rude, probably. But I said, "I'm sorry but I need you to listen".

And he said, "Well, can we wait another four hours?"

I said, "I don't want to wait". But we still had to wait. And then, when he came back, and because I said, "Why would I wait?" And he said, well -- he went into the technical and he said, "I'll exam, I'll do the exam". And he said, "You're not dilating."

And I said, "Exactly. I've been here for almost three days now. We need to do something, get the baby out".

And when -- "How do we know the baby is fine? Because I can't see the monitor and there seems to be a lot of activity. What's going on?"

He went anyway, and I was just told to just try to keep calm and deep breath and all that. I just felt completely dismissed and not cared for and not looked after, and I was just dismissed, I felt. And I was getting very scared. And then he came back for the four hours check, he did the exam, and he said, "Actually, it's gone back. There was a one centimetre thing" and he said, "It's gone back now".

And I said, "That's it. I'm not asking you; I'm telling you. C-section now".

And he said, "Okay, just one sec" or whatever.

He went outside speaking with people. They came back, and it seemed like an urgency then. Everything turned round. They got my husband to scrub up and they say, "Okay, we're going to take you to theatre now". And it's as if all of a sudden they realised that there's a rush.

I've read the notes and it doesn't say that it's a rush, but it felt like a rush and a panic. And they obviously had to top my epidural up and the -- the spinal, sorry, and do everything they needed to do to prep me for theatre. And I was warned that it would be overwhelming because there's a lot of people for an operation, and it was overwhelming.

Q. When your daughter was born, you and your husband were there. How was she?

A. So when -- so that was obviously my first time. I didn't really know. There's a sheet in front of -- between me and the delivery part so I can't see a thing. I was just crying and upset and the baby came and I couldn't hear the baby. And I thought: what's going on? And my husband was also upset. And then the nurse had my daughter in her arms and she took her to the side and you can't really see because of the way it's set up. So [redacted] went straight there and she was probably weighing the baby and doing the check they need to do.

There was still no sound and the room was very quiet. So I just was not -- I didn't understand what was going on.

And then they said, "She's fine" and they put her on my husband's chest and he came next to me, and I looked, and I thought: she does not look fine. I mean, she's very quiet and she looked a bit purple. And they took her back and then they sort of, they came and speak to me then. So I couldn't see what was going on. And I know they called my husband to be with the nurse and my daughter. But I was just -- I didn't really know what was going on. There was a whole rush and they were talking to me and they were, "How are you feeling?" And this and that and checking on me. So there was one part looking after the baby, one part looking after the mum and that was it. And then they finished the C-section. I don't know what was happening in the background. Took me back to the room, and then that's when --

Q. Let me ask you another question.

Eventually she was taken, wasn't she -- your daughter was taken to the neonatal unit and you were told she required antibiotics and she required some ventilation --

A. So not straight away.

Q. When were you told that?

A. Well, I ordered them to take her, because -- so they brought her back to the room, and they put her for skin to skin on me, and she didn't feel right, she didn't feel lively or with me. And I could see I wasn't connecting with her; I could feel she wasn't there, and was asking, I could see there was plenty of nurse coming in and out and I was saying, "Can you please come and check?" And they were saying, "Oh no, she's fine, can you try to feed her?" And she was not interested in feeding. I said, "She seems very floppy and she's doing that noise". I didn't know what it was called but she said, "Yes, it's grunting. She's come three weeks early so the lungs sometimes don't quite work as well as a full-time baby and you've given birth through C-section so, you know, she's a bit shaken, that's nothing to worry about".

And I said: "Well, she does not look right so can you please ask the doctor to check on her"? A doctor came and I was very annoyed because he had that smirk on his face, and very dismissive, and he's just like, "Oh, no, the baby's fine, there's just nothing odd here". And I wasn't happy and I said, "I want a second opinion. I want you to go and ask another doctor because this is not right. She's not responding like she should".

Q. You say in your statement at paragraphs 42 and 43 that

after you had first been able to visit her, you say there:

"Child D looked better and was a better colour. Father D took me back to my room and Dr Brunton went to see Child D. She was doing much better. I was told to continue to express milk. At about 7 pm, I understood that Child D was doing well and she was improving and was responsive on handling."

You say here:

"I know that ventilation was removed and she seemed to be making a good recovery. I was told if everything continued to improve I'd be able to hold her the next day."

Do you remember being told that?

A. Yes, very clearly. So that time between when she went to intensive care and then, there was, at first they weren't so sure of her condition or how she will do, and but there was never a concern for her life. They just say, you know, she's just born, and it was a bit of a shaken start so she just needs a bit of care, she's a bit vulnerable, but she'll be fine. They said that they started the treatment, just watching her obs and that was that throughout the day, and my husband has been with her most of the time.

And during that day, that was when we spoke the

first time to Dr Brunton and he came to us, and he reassured us he said, "Listen, everything's fine, she's much better. She's come off the light therapy. She's picking up. She seems to be more lively". She seemed to react as she should react. All the obs and the readings were going better. And they said: if all carries on, continue expressing milk, and if all carries on, tomorrow morning you can breast feed her and you can have a cuddle and that's that. She's on her way to recovery. She's -- full recovery".

Q. You say that the about 2 am in the morning you understand Dr Newby was called urgently to see Child D because of an unusual area of mottling. How do you -- were you told about that first time --

A. No.

Q. -- that Dr Newby was called? No. So you know that from the notes?

A. Yeah.

Q. You say:

"I found out afterwards this was across Child D's abdomen and was said to be because of sepsis, something I could not understand."

Then you say:

"At 3.15 am, a second call was made because Child D was very upset and crying and at 3.45 am her alarm

sounded."

And you say it was at 4 am that you were woken up by one of the nurses?

A. Yes.

Q. So tell us about how you were woken up and what was said to you?

A. It was the first night since my water broke that I let go, and I thought, "I will rest, because things are okay. She's going to be okay, and we can rest". The same for my husband. We were together in the same room, yes, we were sleeping. Someone came to the room, a nurse, and she said, "You need to come now, your daughter is very poorly" and we just said -- and she said, "You need to come now". And I couldn't get out of the bed on my own so my husband got me on the wheelchair and she was rushing us, and when we arrived, that's when there was the scene. I couldn't see my daughter. I could see Dr Brunton holding her, and trying to save her. There was a lot of people. One that was doing nothing useful, that was Lucy Letby. And she was just looking at us crumbling and crying and Dr Brunton was trying to save my daughter, and he was trying really hard. He was just -- someone -- well, Letby was holding the phone to his head and I was saying "What's going on? Why has he got -- he's busy, why is there a phone?" And

he kept shouting, "No, this is" -- and he was saying my daughter's name and he was saying, "This is not someone else, this is this baby", and shouting, and then Dr Newby tap on his shoulder and she said, "You need to let her go. She's gone".

So he didn't want to let her go. But then as soon as she said that, they said the time of death, and that -- I couldn't stay in the room. We completely broke down and I said, "Get me out, I can't believe this". He was still holding my daughter; I couldn't even see her. And we were rushed out. We went back to the room. The door closed, and it was just us crying, thinking: what just happened? We didn't even know what time it was until they said the time, and then that just kept going over in my head. And I -- yeah. That just -- that's how ...

Q. Pausing there on the phone call, you found out later there'd been a mix-up and it was the parents of Baby B that Dr Brunton was talking to --

A. Yes.

Q. -- when the phone had been put to his ear so talking about your baby to a different parent?

A. Not only this, I found that out later by piecing things together that that was the first time the parents of Baby B left her after what she's gone through and her

brother died and they got a call in the middle of the night to say that their baby was not going to make it but really in fact it was my daughter.

I don't know how; to me this is not just a mistake. It's malicious. And I don't know how it was allowed, but -- and why would you need to put a phone on to someone who is trying to save a baby? It's completely ridiculous.

Q. Yes. You say in your statement Dr Newby was there and she was clearly upset.

A. She was upset.

Q. And you say it was all so unexpected?

A. And shocked. I can't say how long, but pretty quick after we went back to the room she came to see us, and she just was upset and she said, "I don't know what to say. I don't know what happened. I don't know why it happened. I can't explain it. We're going to speak to the Coroner we always have a briefing so we'll speak. I will tell you what I can when I can but at the time now, I don't know what's happened. I can't explain it".

Q. You say she told you that they'd need to inform the Coroner.

A. Before that, they asked us if my daughter would be an organ donor, which is something I did not think about. But we were pretty much put on the spot, and I said,

"Yes, if this is going to save another baby". And the nurse said, "Well, there's a baby that need a heart" and that just made us even more upset, because -- and I said, "Yes, if her heart can" -- but it was very rushed but I understand the medical reason, it needs to be rushed in this situation. But within a matter of minutes someone came back and they said, "Well, actually, your daughter -- there's going to be a post-mortem so she can't be an organ donor" and then I felt guilty. And because I thought: what if the other parents have just found out that they've got someone to save their baby and now they haven't and why does my daughter need a post-mortem? And that's when we were told that's because they don't understand what happened, and why it happened. So they need to investigate.

Q. You were asked if you wanted hand and footprints taken, and you say you did, but you couldn't do it, but fortunately your husband's mother had the strength to do so?

A. Yes, she did. Yes.

Q. You say you were then sent for an MRI scan; yes?

A. Yes.

Q. Then you were moved to the Lavender Suite. Can you tell us about that?

A. That's very -- another shocking way of dealing with

grieving parents. Once it was -- after my daughter passed, they offered us to come back and see her. So we went to see her, and then they said, "We're going to move your room now, it's a better room, you're going to have more space, more privacy". It turns out that room is in Labour Ward so you go past people who are giving birth in good or bad situation. You -- they are seeing you completely destroyed and you're seeing them smiling and there's balloons around and it's very bad taste, the way it's located. And when you are in that room you can hear everything that's going on outside. It's very traumatising. Very traumatising. You feel you're stuck because if you get out, you're just going to be facing all this, and it's just feel like you're stuck in time because this is you two days ago and you just keep thinking: this is torture. What should I have done? What's happened? What's going on and why are we here?

And I also felt for the other parents because I would be very distressed if I seen someone like they would have seen me. Yes, it's bad.

Q. You were given a memory box when you left. What did you have when you left?

A. Ha. Well, nothing. I know it comes from a good place, but they give you a box and it's got two little teddy bears in it. The idea of the two teddies is one goes

with your baby and one stays with you. And I mean maybe if your baby has been alive for a little while you might have some memories, but there wasn't any. I did ask, when my daughter was born, they give the babies a hat and a blanket and I did ask to have these two. They brought a blanket that was not hers. It made me very upset, and they said, "That is hers". And I said, "I'm telling you I know what her blanket was and that was not her blanket". I don't know where the blanket ended up but the box had nothing in it. They gave the bracelet with her name on it. That was that. An empty box.

Q. I'm going to come now to the questions you were asking and the cause of her death and deteriorations and we know you had a meeting with Dr Joanne Davies and you said Joanne Davies and nursing staff on 24 June 2015. Do you know what nursing staff or who was there or not?

A. Sorry, can you repeat?

Q. You say in your statement at paragraph 59:

"We had a meeting with Dr Joanne Davies and nursing staff on 24 June 2015."

A. Yes. That was more to do with my -- although I had questions about what happened, it was more about my condition, because I wasn't recovering as expected. This is why I had an MRI and --

Q. Don't worry about that. We don't need to go into that.

A. Yes, okay.

Q. If you go to page 45 of the bundle, we see there a letter from Dr Joanne Davies to, I assume, a GP. You don't need to give a name of the GP. But I want to look at some of what she is saying in this letter, at this time. She says:

"I saw Mother and Father D today in the Pregnancy Risk Clinic following the sad loss of Baby D. As you know, Mother D had spontaneous rupture of the membranes at 36+6 weeks gestation and after an emergency caesarean section for failed induction of labour.

"Baby Child D became unwell and subsequently died on the neonatal unit hours later. Since then, we have had the post-mortem back which essentially has shown acute pneumonia."

It says at paragraph 2:

"We had a very long and detailed discussion about her antenatal and intrapartum care. I explained there had been an obstetrics secondary review and also a multi-disciplinary perinatal mortality review to discuss the case.

"Following these case reviews, I explained to them that the findings were that we had missed an opportunity in giving Mother D both oral antibiotics and IV antibiotics as per the premature rupture of membranes

policy below 37 weeks. I apologised for this missed opportunity."

It goes on:

"I explained that when she was initially seen at 36+6 weeks, the decision was made to induce her the following day and therefore manage her as a term rupture of membranes. The main difference in this management is that oral antibiotics are not started, intravenous antibiotics in labour are only started if there is evidence in a change in maternal observations or fetal observations. Neither of these occurred in Mother D's labour and therefore she was never given intravenous antibiotics. I apologise for this.

"We had a long discussion about the possible implications of not having these antibiotics. I have explained to her that we can never know that if she had got these antibiotics we would not have had the same outcome. We also had a long discussion about NICE and college guidelines around premature rupture of membranes and term rupture of membranes and the arbitrary cut-off of 37 weeks, and if Mother D had been only one day further on in her pregnancy and had followed the term rupture of membranes guideline, this management would have been correct."

Over the page at the top:

"This was obviously very difficult for them to take, and I agreed with them, if the guideline is in place then it should be followed. In this case it was not done so."

And at the end of the letter the same page it says:

"They were both keen to know the processes that had taken place after the review in this meeting. I explained to them the reviews have produced an action plan. The main actions are around learning for the individual members of staff involved in the team but also review of the term 'Premature Rupture of Membranes guidance" and the timing of induction. I reassured them that all members of the team, both obstetrics and paediatrics, took any poor outcome very seriously and at all times wanted to learn to improve practice.

"As far as what happened from now for them I explained to them the complaints process and if they wanted to go forward with that."

So discussion there around antibiotics, and we know you had another meeting on 17 August when you asked Dr Newby lots of questions. And if we turn to page 23 in the bundle, we see that letter. It's page 23.

A letter to Mother and Father D, and Dr Newby is thanking you for coming in and she summarises the details of the discussions.

At the first point she says:

"We discussed that paediatric involvement started from the time of Child D's birth and therefore these are the aspects of care which we discussed at the meeting. We discussed that a Neonatal Morbidity and Mortality Meeting had taken place on 29 July 2015, at which we discussed in detail Child D's care as a department. Present at that meeting were myself and my consultant colleagues including our Neonatal Lead, Junior Doctors, some of whom were involved in Child D's care and our governance facilitator."

Did you know at the time those meetings were happening and did anyone ever ask your view or thoughts in respect of that meeting?

A. No, which I commented on that.

Q. Over the page at paragraph 4, page 24, paragraph 4:

"We discussed that unfortunately the post-mortem results are as yet unavailable but we felt as a department that the most likely diagnosis was one of sepsis, ie overwhelming infection, and we discussed the signs that led us to this diagnosis."

And at bullet point 6 on the next page, 25:

"We discussed the aetiology of the rash which is documented to have appeared during Child D's first episodes of deterioration. This appeared to look like

bruising under the skin and we discussed that this was likely a sign of the effects the infection was having upon Child D's circulation."

Do you remember the post-mortem results and sepsis being discussed with you at this time?

A. No, and I -- as much as she was a doctor, I clearly said, "I disagree". And I asked -- so at the meeting I said you had -- so when my daughter was born and started on antibiotics they said, "We will run the tests but it takes a few days". She passed before the test results. But when the test results -- and when we left the hospital we still didn't know. When we finally got to meet with the doctors, I said, "What were the test results? Did she have an infection?" She said, "No, she did not".

And I said, "Well, you explain this to me because if an infection is that overwhelming that it will kill a baby but doesn't show on the reading, this does not make sense. She was getting better. Not getting worse. Again, explain". She couldn't explain.

They had to write a report. They had to put something together because that's what they do; they can't leave things unresolved and that's what they did. But that was unsatisfactory for me. I said, "I'm not accepting your finding. I'm not accepting your

reasoning. It doesn't add up or doesn't explain, and you have to do better than that".

Q. We know you wrote to the Coroner on 23 September 2015. That letter, my Lady, is at page 48 of the bundle. Page 48 to 50, Mother D.

You say to the Coroner:

"As discussed over the phone with Yvonne Williams, my husband and I would like you to start a complete inquest following our daughter Child D's death."

You set out a number of matters. You set out how you were induced. You set out how handover and communication failed, as you were induced as being full term where in fact the membranes ruptured prematurely, this being a high factor for infection.

You set out over the following page:

"Taking into consideration all of the above, Child D, a greater risk for infection should have been taken straight to Neonatal Intensive Care."

You set out Apgar scores. The last but one paragraph, you say:

"Post-mortem confirmed pneumonia. I believe it is known by the doctors that early onset pneumonia in newborn are due to bacteria, most commonly Strep B, that same bacteria being the most common reason for Premature Rupture of Membrane. Placenta could have provided more

accurate data."

Were you all looking all these things up for yourself? How were you questioning these things that --

A. That's when I felt there was half of me that stayed sane to try to understand and get clued up with what needs questioning. When I requested the notes, I knew nothing I was getting myself into. So nothing was in order. Everything was a mess. So I tried to put it in an order that made sense. And then there were lots of words and initials and things noted so I had to understand what they mean. I had to understand the NICE Guidelines, the College of London, the protocols, and what should have been done, in my case whether my daughter was fine or not. At birth she should have automatically gone to Intensive Care just to be watched, because of all the prebirth, which is another massive failure. And they should have kept the placenta because of all the labour's situation. They didn't.

Q. And you say at the end of the letter at page 50:

"Could you please look into the post-mortem conclusions, following notes, reports and statements and review whether Child D's death was of natural causes or not."

You say in your statement going back to paragraph 71, you carried out your own research,

considered data on cases. And you carried on having an exchange of correspondence, didn't you, between -- I don't want to take us to it all -- September and October between the Coroner and the Coroner's Office, and asking for certain things to be addressed?

A. Yes. By then I have contacted a solicitor and I had someone supporting my actions. The first decision of the Coroner was not to have an inquest and to just draw things as whatever they seemed to be. I asked for the post-mortem to be reviewed and I asked for an inquest but I had to point out to him why what it was saying did not add up with what happened. There was clearly -- the Countess has not provided all the information. For what they proved, it was half a lie, half, I don't know how to describe the other half. It was clearly not -- they weren't giving all the information and what they were giving wasn't true or accurate. So it was upsetting that I had to do their job for me.

Q. Why did you want an inquest?

A. To find out the truth because nothing that's said added up with what they were saying. Nothing -- it didn't match up.

Q. Let's look at two pieces of correspondence briefly. At page 51 that's your solicitor's letter, Gamlins Law, to the Coroner --

A. Yeah.

Q. -- asking for an inquest, and making submissions what the family say and what you were saying about the circumstances, including NICE Guidelines, how they were identified, how they weren't followed, not prescribed antibiotics, et cetera. A list of issues relating to your treatment. And then we see at page 54, 11 January 2016 the response from Mr Rheinberg who says:

"Thank you for your letter of 23 December 2015. Your further submissions have been very helpful and I have decided on reflection not to discontinue the investigation but to hold a full inquest into the death of Child D. During the course of your letter you submit that the evidence suggests that had different courses of treatment been employed, Child D's death would probably have been avoided. That in my view overstates the existing evidence which only suggests that death might have been avoided.

"However, I am now satisfied that this is an area that needs to be explored in detail at a full inquest and my intention is to instruct an independent gynaecologist and an independent paediatrician. The gynaecologist will be able to give expert evidence as regards the treatment of Mother D. I'm afraid it will take a little time to obtain expert reports but I will

list a full inquest hearing as soon as possible."

How did you feel when you knew that was going to take place?

A. At that stage, finally because they weren't joining the dots, they were just taking things out of context and just taking things to fit whatever they were trying to, to just -- it felt like they were just trying to file my case, and I was not having it. So for me, I kept saying, "You can't just look at the treatment in intensive care or look at the pre birth -- both sides are related and are important and failings happened with me and my daughter". So that, for me, was going to be thorough and I was being heard.

Q. One of the reports obtained of course was from the consultant paediatrician, Dr Mecrow, and he concluded that your daughter's death was disturbing because the collapse was so sudden and unexpected. When do you remember seeing that report from Dr Mecrow? When did you first see that?

A. I don't remember the date. I do remember that when I got it, I got on the phone with my solicitor and I thought: this is more -- again, more evidence. There's -- now when people are actually looking into things, we need to do more. And I mean, I wanted to complain against the Countess, but I was obviously told

not to.

Q. The Coroner sent -- you say at paragraph 81 of your statement:

"The Coroner sent us the service review that was completed by the Royal College of Paediatrics and Child Health in 2016. I think we received it in about April 2017."

So you remember receiving that before the Inquiry. We saw it back in April 2017, around then?

A. Yes.

Q. What did you make of that report insofar as your child was concerned? Did it help you understand anything about --

A. I did. It didn't seem to. It seemed like an overview. It seemed like just a tick in the box, no, they haven't actually looked into -- that was just a tick in the box. They did call someone, or a team of people. They reviewed some things. They identified. They didn't identify anything to me. It was just very vague and we still weren't talking about my case in particular. At that time I was only aware and interested in my case but I also did mention the fact that what happened if the mistakes happen again? If you're not allowing me to report this, how do we know this doctor or this nurse or anyone who makes a mistake won't get away with it again?

Because we don't know where the mistakes are or why they happened. Clearly, we don't. So this is -- this didn't -- that was just brushing the problem away, but it wasn't -- it didn't address the issues.

Q. There's a letter at page 55 of the bundle, if you could have a look at that, please, 3 March 2017, addressed to "Mother D", from Mr Harvey.

"Further to previous correspondence and the completed review of the Neonatal Unit carried out by the Royal College of Paediatrics and Child Health at the Countess of Chester Hospital, I'm 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 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 D with you and will be offering to meet with you to discuss any concerns or issues you may have arising from both the College review and the consequent review.

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

we've carried out the whole review process. I want to make sure 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 will certainly aim for this to be within the next six weeks."

Did you receive that letter?

A. Yes.

Q. And what did you make of that?

A. That was a cop-out. It was just not good enough. That was just again trying to say, "Well, we've addressed the situation". I wasn't -- they weren't getting rid of me then. For me, I've had many exchanges, and every time, it was just trying to keep me at bay. That just doesn't address anything. It doesn't answer any of my questions. It doesn't go any of the specifics of what I was pointing out. It was just not good enough.

Q. If we turn over the page at 56, there's another letter from Mr Harvey dated 21 April to you:

"Dear Mother D,

"I write further to our letter of 3 March and would like to thank you for your continued patience in this matter. I can confirm that further investigation work

has been undertaken, however, we have been advised by the independent external case reviewer to consult with the Pan Cheshire Child Death Overview Panel, CDOP, which has been arranged for next week. It is important we take this step to complete the reviews so that we can conclude this matter as soon as possible.

"Once this consultation has taken place, I'll make arrangements as soon as possible to meet you to discuss all the review findings. I appreciate this provides for a further delay for which we are sorry and recognise it is a really distressing time for you but it is important we complete our reviews."

Did you receive that letter?

A. Yes.

Q. Did you know what the Pan Cheshire Child Death Overview Panel was or did?

A. No, and that's another frustrating part of the process, because it was really hard to communicate with anyone and get answers to any question, because I was just always told "They will get in touch, someone will get in touch, and we will answer to you as soon as we can". But there was never -- I am being told something is being done, okay, but that is after something else was done. What happened to the something else? What was the finding? What's relevant to my story, to my

circumstances? Nothing. This is just a lot of rubbish. There is nothing in this letter that answers any of my questions or my concerns.

Q. You comment that you read a news article on the BBC website on 8 February 2017 in which Mr Harvey had said the Trust had acted swiftly and reviews had been completed. You say that at paragraph 85 of your statement. Do you remember what you read at the time?

A. Yes, yes, I do. Well, what was being said did not match with what was being said to us.

Q. And your solicitors -- at page 57 of the bundle, my Lady -- sent a letter to the Coroner on your behalf.

A. Yes.

Q. "We write further in respect of the inquest touching upon the death of Child D due to take place on 25 May. We enclose copies of letters sent to our client from Mr Ian Harvey, Medical Director, dated 3 March and 21 April, regarding independent reviews to be undertaken by the Trust on each of the babies identified within the Royal College of Gynaecologists and Obstetricians' Review. The letters indicate that the review upon Child D's death have been undertaken but a small number of areas of investigation are required and in the most recent letter that a consultation was needed with the Pan Cheshire Child Death Overview Panel.

"However, in a news article published on the BBC website, Mr Harvey indicated to the BBC that the Trust had 'acted swiftly' and that the reviews had been completed. Furthermore, he indicated to the BBC that 'When we speak with parents we can now share full and accurate information on an individual basis and we are now able to share everything that we understand about what has happened here'.

"Mother and Father D [the letter continues] are concerned that despite indicating to the BBC that all information was available and ready to share with the parents in February 2017, that it is still not the case now. Furthermore, Mother and Father D are extremely eager for the review and its findings to be released to them in advance of the inquest."

And then the letter continues with observations about witness statements, and it says also:

"We confirm we have sent a copy of this letter to the solicitors acting for the Trust."

You were asking for all of the information about your child that was available by then, weren't you, very clearly?

A. I was very specific and still they wouldn't comply. I remember calling because when I got the notes I was asked: 'is that because you've got something, are you

not something that existed. It wasn't. No. At no point when I spoke to people face-to-face, Ian Harvey and all the doctors, no one ever mentioned anything. It was just "We're sorry what happened", you know, nothing. Nothing else. No transparency. I was very precise and direct with my question. I was straight to the point and I was getting no answers.

Q. How often did you -- you say you spoke with Mr Harvey. Did you meet him how often?

A. Face-to-face, once. But I think we had about five exchanges. And with people from the Countess, many, over a dozen between everyone I spoke to. Even over 20.

Q. Have you now read the full version of the Royal College report with the paragraphs about Letby and the need for an investigation or an HR processes? Have you read that?

A. No.

Q. If you had been aware that there were concerns about a member of staff being present at a number of deaths, what would your response have been to that around this time?

A. I think I would have gone to the police myself regardless of what anyone advised or -- I mean, when I first mentioned involving the police, everyone thought -- this is bonkers. There's nothing to do --

bringing a claim against the Countess'? And at the time I was not. I just wanted to understand for myself what there was to understand. Then when there was more reports and reviews and I was asking, they said at the time, "You're not allowed to have access to these".

So I don't know what was being discussed, what was being answered. I kept asking, every time I could, and I'd speak to someone at the Countess, no transparency. I don't know what was being done, when it was being done, what came of those conversations, what improvements were -- nothing. Nothing was -- it was very blasé and no information was shared. Nothing.

Q. At paragraph 89 of your statement you say:

"It was clear that the Trust was not being open and honest with us. It seemed to me they were trying to cover something up. We finally received a copy of the review on 29 April 2017."

That's the Royal College review.

Do you remember now when you got that report, did you see a section in the report with comments about Letby, a Nurse L, described as "Nurse L"? You know there's two copies of the --

A. No, there was not. No.

Q. So have you seen them since and --

A. And it was not mentioned, it was not written. It was

it's not criminal. There's nothing more to it. It's sad, but your baby passed because she was poorly but if I knew everything there was to it, I would have gone myself.

MS LANGDALE: My Lady, I'm moving to a different topic and I wonder if that's a good point for a morning break?

LADY JUSTICE THIRLWALL: Thank you very much indeed Ms Langdale.

So, Mother D, we are going to take a break now. So if we can be back ready to start, if you're ready, at 11.30. If you're not, we'll wait for you.

THE WITNESS: Thank you.

MS LANGDALE: And you must not discuss your evidence with anyone in the break.

THE WITNESS: Okay.

(11.14 am)

(A short break)

(11.30 am)

MS LANGDALE: We're going to pick up from paragraph 95 in your statement, "Suspicions and concerns regarding Letby".

Did you have any concerns about Letby at the time or with the benefit of hindsight? If you have any recollections of your dealings with her, then tell us.

A. With the benefit of hindsight and what I know, I had

what someone would call instinct. I felt very uneasy in her presence. When I went to visit my daughter, she was there, I did not know her name, Lucy Letby, and she was just there in the room, and she had no reason to be there because she didn't clearly do something. She was just around waiting, and I told my husband: why is she here? Can we tell her to go? And he was just trying to keep me nice and sweet but I was uncomfortable. She just was watching us, and there was no reason for her to be there. So I did question her presence. I did question why she was there and I remember seeing that same person again at the time of death so as soon as I could I mentioned that person again because I did think -- I don't know why she stood out. I didn't catch her doing anything in particular. I just remember thinking: this person does not belong in those situation, why is she here? Yes.

Q. You tell us at paragraph 98 you didn't know of her involvement at all until you were informed by the police. Did the hospital at any time let you know whether there were concerns at all about her?

A. No, in fact no one has ever made a relation between what I was saying and what they knew. So at no point had anyone ever asked: is there anything I've noted? Is there anything on a particular person? It's only when

I spoke to the police that I made a point -- not knowing who they were referring to, I made a point that there was a nurse who stood out to me and I explained why, and they took note, obviously, and they weren't aware. They went back asking me more and if there was anything in particular and I said I can't explain this feeling, I just -- sometimes you can't exactly understand, about things don't add -- don't -- seem odd, or doesn't -- an odd presence, and especially, I think it stood out even more because at the time of death, it was -- I don't know, it seemed maybe ten people, and that's one person stood out for me as odd. I wouldn't know why, because I didn't see her in other situation to think. I didn't -- I never exchanged conversation or any other moments with her. So yeah, that person did stand out to me.

Q. And when you say at the time of death, was that when she was holding the phone for Dr Brunton?

A. Yes.

Q. Medical records.

From paragraph 100, we ask you about medical records, and when you requested them. Can you tell us about that, when you asked for them, when you got them? I don't need to ask you about the details of them, we've gone into that already.

A. Well, when I requested them it wasn't straightforward. But when I got to the right person I was sent a form that I needed to fill in to explain why I wanted the records and I questioned that because I said I shouldn't have to exactly justify it, but I did. I said I wasn't understanding the circumstances and I needed to go over now that I have -- I wasn't -- at the time, I was obviously tired and sad and everything. So I just thought: let me go back. Maybe now I'm calm, I've slept, maybe I will read through and maybe things will make more sense. But yeah, this is why I wanted the notes. I got the notes, but it wasn't easy.

Q. But it was in 2015, was it, that you got them?

A. Yes.

Q. So you asked for them and there's a process to go through, but you did get the records to go through?

A. Yes, and not long after, I required something else. I can't remember exactly, but I asked for some other notes, and they said, "Well, you shouldn't have actually had access to those notes in the first place".

So, um ...

Q. But you had the notes that enabled you to go off and consult the NICE Guidelines and look for the other information around prescription of antibiotics and you did that when you got them?

A. Yes.

Q. You also saw a case review, if we turn to page 28. It begins at page 27, Case Review Admission to NNU.

"This report is made following review of the clinical notes by each speciality in relation to care provided to Mother and Baby."

And this relates to you and your daughter.

Is this part of the notes that you got at an earlier stage or do you know when you got this?

A. No, there was -- I don't believe that was part of the original notes, no.

Q. At some point you've obtained this and look at what it says on page 28 at the top:

"Actual effect on patient and/or service."

It says:

"A term baby has died within the first week of life. This will have a severe impact on the parents and family."

Then it says:

"The Trust also recognises the potential psychological impact to the staff directly involved, and this, in conjunction with the potential impact to the reputation of the Trust, is considered severe harm."

A. Yes.

Q. You comment on that in your statement. How do you view

the way that is described, the second sentence I've read out?

A. That troubled me. I didn't understand why this is what was concerned -- this -- it was out of order for me to mention anything to do with the reputation and that's one of my concerns because that's when exactly I was trying to push and ask questions, where I felt there was resistance, where things were trying to be played down and clearly I know by the reports and everything I read, that things weren't -- if I didn't request the notes and get clued up as much as I did, I would never have got the Coroner to get involved. I would have never known everything that was missed, and everything it shows not to share with the Coroner. So it was clear they were trying to hide things.

Q. When you looked at the detail of this case review you were also concerned to the reference to you as being a PRoM case, ie, a Premature Rupture of Membranes when in fact you were a Pre-term Premature Rupture of Membranes?

A. Yes.

Q. So you were looking at all of the details, weren't you, and seeing whether there were inconsistencies? Whatever they did or didn't mean, you were looking and seeing them?

A. But this is to my point. They were dismissing exactly what I was pointing out, and it was not innocent, I don't believe, because it just added up with what was being shared with the Coroner, what was being shared with the information in the review of the conversation. Any meetings they were having, they kept dismissing the details, which is -- I mean even the mottling on my daughter, you -- they told me clearly they don't understand, they've never seen this, they don't know what's going on. So then, look for answers. Don't tell me this and then leave it at that. This is not good enough. I need to understand. I can't accept when I don't understand what happened and why it happened. And they didn't either, so I don't understand why they wouldn't push more.

Q. Bereavement counselling and support.

You tell us at paragraph 117: "Shortly after Baby D's death, a lady from the Bereavement Department came to see us."

A. Yes.

Q. What did she offer and tell us about that service?

A. In all honesty, from my experience, she came far too early. I haven't yet wrapped up my head around the fact that my daughter has passed. I just -- things were going far too fast, and when she came and I just felt --

it was just inappropriate that someone would come straight away. I mean, we knew if we wanted to go and ask for someone we could ring a bell, we could ask, we wanted just some space and to gather our thoughts and some privacy. We weren't given that. And I told the lady I wasn't being rude but she could leave now because she wasn't really welcome and I will contact her when I need -- yeah, I just think it's a bit inappropriate to push the service on to someone who doesn't want it.

Q. You say:

"Sometime later [you] were referred to the hospital's Bereavement Counsellor, Jo Gwinn", and you undertook bereavement sessions with her.

Did you find that helpful?

A. Very. She was exceptional. She was brilliant. But from her own -- my understanding, she pushed for me to have more sessions, otherwise I was only going to get given a few, maybe four or six, but I came to a point where I begged for more. And she said, "Well, no, the people above me believe that you've had more than enough and now it's time, you know, to go about your life, or whatever", and I was highly disappointed, and especially since by that time I still haven't had answers. I still was asking around, yeah. But for what -- for the job she did, she did a brilliant job. She was very

supportive.

Q. And you had a number of sessions, roughly how many, did you have?

A. It was 24.

Q. And they stopped at that point?

A. Yeah, because she was told that's it, she can't -- she kept pushing but she was told that's it, no more.

Q. Raising concerns and getting answers.

You told us that in September 2015 you made the decision to instruct a solicitor and pushing for the things that you had been asking for and that solicitor contacted both the Trust, we know, and the Coroner's Office, don't we?

During that process -- and this isn't obviously a reflection on the lawyers -- how frustrating was that in terms of trying to push for the Trust and also with the Coroner for answers, from your perspective?

A. Well, there was two aspects. There's the emotional one, because I didn't feel I was supported around by people. I think people just thought because I was grieving, I was transferring my sadness on to other avenues and that I needed to just accept what happened.

So there was my heart and then there was my head that told me: no, there are things that need investigating and I need answers. And thankfully, the

solicitor was supporting me, but it wasn't straightforward either because it was the neglect side of things where I thought there was more to it, which was not easy. She said, you know, you're not up against --

Q. Don't worry, you don't have to tell us what your solicitor said to you.

A. Okay.

Q. I don't need to ask that.

So you were still looking for answers and it wasn't easy because you weren't getting any, is that --

A. No, because you can't just put a complaint against a nurse or a doctor or -- yeah, it's not that straightforward at all.

Q. You had no involvement with PALS, you say in the statement. Did you know what they were, this Patient Advisory Liaison Service?

A. No.

Q. Okay. You tell us that you travelled on 16 May with your husband to have a meeting, on 16 May 2017 you were supposed to be having a meeting with Mr Harvey and your solicitor but you received a telephone call earlier that day from the police telling you that the investigation was taking place. So those two things coincided.

When you got to the hospital, did that meeting take

place or not? Or what happened when you were there?

A. So when we arrived, as far as we knew, it was still happening. We'd been waiting for a while and the secretary, there seemed to have been a mix-up because she said, "You should have been contacted because this has now been cancelled". And I didn't care. I said, "I'm still here, and Ian Harvey is still here and I want to see him. I came here today and he can speak to me, he can tell me to my face that he won't answer my question or he will. He promised me he will give me answers. There's no reason, if there's nothing to hide, nothing to worry about. He can speak to me face-to-face". I wasn't going away until she was getting him so I did see him but he didn't want to speak. He didn't have anything to say. He said it wasn't up to him to speak any more. So ...

Q. Your solicitor in this period also received a telephone call from the Coroner's Office to say the inquest hearing had been adjourned due to the police involvement.

A. Yes.

Q. How did you feel about that?

A. Very upset. It was upsetting that Ian Harvey was not answering any question at all. So that's -- that was worrying and then the police being involved made things

more worrying and more serious. But I thought, even though this is happening, we'll still be able to have some answers, and when that got cancelled, it was very upsetting because we weren't going to get any answers and with now the police being involved it was going to be years before anyone tells us anything.

So everything got put on hold, and I then decided to give up the notes because it was making me very poorly, and I was just constantly knocking on doors and asking people and I just thought now I've got the police doing that job I have to stop and they're going to take over and I have to trust that they will do a thorough job and I mean I passed on all the questions I had, all the notes I had. I had hundreds, thousands of pages and letters and exchanges. So I had to trust that they were going to do everything and then I had to accept that I was going to stay in limbo for a while because now we -- we were very close to getting answers and it was all stopped again. So very hard.

Q. Were you involved at all in any capacity with any reviews in respect of your baby that were conducted by the hospital, or asked by anyone --

A. Not at all. And it's not for me now asking to be, but not at all, no.

Q. Did you know when Serious Incident Meetings or any other

meetings were taking place in respect of your daughter?

A. No. It was very vague. No, never.

Q. You say, "My husband and I are owed an apology"?

A. Yes.

Q. From the hospital generally? What do you mean, "owed an apology"?

A. So we had to piece the whole picture together pretty much during the trial. That's when we were finding out information. And that's when things started to make sense. But to me, if I wasn't failed in the first place by the Countess in dozens of way, and all against the protocols and the guidelines they should have followed, my daughter wouldn't have ended up in intensive care. I wouldn't have ended up poorly and destroyed, and she wouldn't have been in a place where someone is preying on babies. So they owe the strict minimum, they owe us an apology, the babies an apology, and all our family that have suffered apologies.

Q. Moving to suggestions and recommendations.

And you say you've given careful thought over the years to this. Firstly, CCTV. What do you say about that?

A. My recommendation would be that it is different to an adult having CCTV in the rooms or in the corridors, because the babies, every parent that can't be at the

hospital want to know what's happening to the baby, to the babies, to their baby. It should be -- there should be no reason why this is not safeguarding. There's no -- there's nothing that could be bad about this. All this is watching someone caring for the baby. So --

Q. Would it have helped you the first night when you couldn't be with her, would it have been nice just to be able to see her in the incubator that if there is a little camera --

A. If I knew she had one collapse I would have stayed there all night. If I had access because there was a CCTV or because we were being kept aware of what was going on, she wouldn't have died. I would have been there. So it wouldn't have happened. So yes.

Q. Communication.

What did you think the level of communication was and what change do you think there should be around communication with parents?

A. So I understand they don't -- communication is poor. I appreciate there's a level of information they can share sometimes or they choose not to because they don't want to worry. Maybe we are not as informed or understanding, but there should be no second-guessing. No parents don't want to know. If there is any risk, any problem, anything, we want to know. We want to know

for all the reasons that could exist. We need to know. For understanding what happened, for understanding how to address the future, anything, it's -- the communication is power.

Q. You also speak in your statement about the need for investigations into deaths when they unexpectedly die, when babies die. And you say you question and don't understand why the investigation process is not carried out by independent investigators. Do you want to say a bit more about that?

A. Well, why they don't go into it further? Is it because no one takes accountability, and no one thinks it's their job to pick up or point out anything that seems unusual is beyond my understanding. The fact that me, I'm not trained, I could identify a few failings and they did not is shocking. So I imagine anyone that's outside that has no interest in defending or the opposite would be the right person. They don't join the dots between shifts and between what happened to one baby the day before, anything. There's no -- there's nothing to lose to say something wasn't right, we need to report this. There should be one place where it's clear, it's spotted as a separate way of looking at things. Is there a pattern here? Is there a train that it keeps -- something keeps happening? Whether it's the

mottling, whether it's anything that's unusual or whether parents keep reporting the same issues, there should be a unit just for that, investigating. Because whether it's someone that is harming babies or it's a virus that's just broke out from nowhere, how are they going to join the dots when they decide not to?

Q. Accountability.

You say:

"Throughout the years I've come to appreciate that what we were told may not in fact be correct or accurate. For example, Mr Harvey's false reassurance to the media when in fact he would not disclose the investigation findings to us. How do we hold board members to account?"

Why do you think that's important to hold them to account?

A. That's their role, safeguarding, that's their role to communicate. That's -- they should have -- they lied to the public, they made it sound like they did their job and they communicated right, and they didn't. So they're all -- every single one is responsible. It's not just one person; it's all of them.

Q. And you say:

"It would urge consideration of independent oversight and regulation for management teams at

hospitals."

A. Yes.

Q. What about the role of the Coroner in that? You were pushing and you got an inquest was going to be held, until the police became involved. Do you think that is a process that gives an independent overview?

A. Over the years I think I understand that they don't -- when -- in the process of that, the post-mortem involvement, the Coroner won't be looking at something suspicious. That for me is a failing in the first place, because you're here to identify what's happened. But at the same time, if they're not fed all the information, or the correct information, they can't do the correct job. So in my case and in my daughter's case, it's ... the Coroner was responsible to review the case, and for me, I don't understand how I had access and the knowledge, he didn't. Is it a failing on his part because he didn't dig enough or his team didn't look for more? Or is it all on the Countess because they didn't share all the information? I think it's on both sides.

Q. You finish your statement with an area for recommendation heading "Compassion". What do you think is important for other bereaved parents, as you were in the Countess of Chester, to understand in providing an

environment for those parents after the death of a child?
A. You should not be in the same building as other families having babies once your baby has passed. That is first. It goes without saying. I don't know if that's been -- that's something I asked that should change. I don't know if it has changed but it's shocking that someone thought that was a good idea. And this should be not just one person that is ... out to help families. There should be a team of people on hand. There's not thankfully hundreds of deaths so there should be people there for the parents.
Q. And you also say that whilst you did obtain Child D's medical records, it was difficult and sometimes met with some resistance. Surely that should be offered to parents that they can see the records in their own time and see for themselves what's recorded about their child?
A. Not everyone realises that is even an option, that there is ways they can get informed if they want to. So I think some people don't realise also that they can question things. So it should be transparent. It should be clear. It shouldn't be a matter of looking to be courageous or strong and find the time or the energy, and it should be just an open and simple option where

the parents should be allowed to review and be made aware and be part of -- when there's the reviews that happen after death, where they review mortality, they review actions, what happened then? Even when you ask, you don't get the answer. I still don't know what was said. I still don't know what they decided. The only thing I got told is: well, I think we will retrain some of the staff. They don't all know about the NICE Guidelines. That's not just the NICE Guidelines. That's everything. There's dozens. I mean, I'm not working with them day-to-day, and I can name many. So they should, for working there, know what should be done.
Q. Mother D, those are all the questions I have for you. Is there anything you'd like to add or state that I haven't asked you about that you think is relevant to do so?
A. No, I trust in the process. I just want the truth to come out. So no, that's it for me. Thank you.
MS LANGDALE: Thank you.
My Lady, this might be a good moment to break again so Mr Baker can consider if he has any further questions to ask.
MR BAKER: I have a couple of questions. I just need to take instructions.

LADY JUSTICE THIRLWALL: Very well. Let me know when you're ready.
(12.01 pm)
(A short break)
(12.10 pm)
Questioned by MR BAKER
LADY JUSTICE THIRLWALL: Mr Baker.
MR BAKER: Thank you, my Lady.
Mother D, you gave evidence describing how unwell Child D was when she was first born, and how she was then taken to the neonatal unit.
A. Yes.
Q. Did her condition improve after she was taken there?
A. Yes.
Q. If you look at your witness statement, please, at paragraph 107, you can see there you're describing in this witness statement extracts that you subsequently read in the clinical notes; is that correct?
A. Yes.
Q. And you say:
"At 9.25 on 21 June 2015 Dr Newby reviewed Child D and noted good condition and improvement. Dr Rylance reviewed Child D at 7 o'clock [7pm], noting that she was much improved but that her breathing still needed assistance but I expected that for a newborn three weeks

early born by caesarean section."
First of all, those entries that you read in the notes, are they consistent with what you were told by members of medical staff?
A. Yes.
Q. And are they also consistent with what you observed when you visited Child D?
A. Yes. She was good colour, she looked full size baby. Yes.
Q. And the time of the second entry is described, the Dr Rylance entry is 7 pm. And you have given evidence that you visited the neonatal unit around 7 pm?
A. Mm-hm.
Q. So presumably a little bit more or after this point?
A. Yes.
Q. And that was a point where you saw Letby?
A. Yes.
Q. And you described how she made you feel uncomfortable?
A. Yes.
Q. Was that the same night, and I appreciate it was the early hours of morning that you were called back, but was that the same night that you were called back unexpectedly because Child D had collapsed?
A. Yes.
Q. If you could then go on to a slightly different topic,

it's at paragraph 81. Here you say that you received a service review completed by the Royal College of Paediatrics and Child Health. You think you received it in about April 2017 from the Coroner?
A. Yes.
Q. Did you receive a copy of that report from the Trust?
A. I believe, through my solicitor.
Q. When you received the copy from the Coroner in or about April 2017, was that the first time that you had seen that report?
A. Yes.
Q. And the version of the report that you received, did that refer to suspicions regarding Letby?
A. No.
Q. You also gave evidence that you had one conversation with Ian Harvey. Did he or anyone from the Trust say to you at any time that there had been failings in the care provided to Child D?
A. Yes. He knew there was failings.
Q. Did he communicate those failings to you?
A. No.
Q. Did anyone from the Trust communicate to you there had been failings in the care provided to Child D?
A. Well, Dr Davies, in her conversation with colleagues, she said that I was treated as PROM, but being so close

to being PPROM, they did fail in doing the right -- taking the right action. But I was very close so it's almost as if it wasn't so much of a failing.
Q. When did you first discover that there were suspicions regarding a nurse?
A. The police contacting us.
Q. That was on the day of Letby's arrest?
A. Yes, yeah.
Q. You prepared a Victim Impact Statement for the Crown Court trial, and it appears at page 59 of the bundle that you have. You may feel that you've already said everything that you want to say about impact so there's no obligation to read it, but if you would like to read it, it's there to be read out. Don't feel you should have to.
A. I would like it to be read, but not by me.
Q. Would you like me to read it?
A. If that's okay, please.
MR BAKER: Is that okay?
LADY JUSTICE THIRLWALL: Of course.
MR BAKER: It says:

"Victim Impact Statement dated 5 July 2023 anonymised but signed by Mother D.

"My name is Mother D. I am Child D's mum. Lucy Letby had a chance to say something to us all

parents of the victims and she only had one word: 'unimaginable'. Her wicked sense of entitlement and abuse of her role as a trusted nurse is truly a scandal. Lucy Letby, you failed God and the plans he had for Child D. You even called it fate. You were clearly disconnected with God. After today, I hope to be free of this limbo state I've been stuck in. The heavy load constantly on my mind has deeply changed me. My heart broke into a million pieces the second Child D lost her battle against evil and that is when hell broke loose for us. Those lives were not yours to take, and although I am torn with sadness, anger and unanswered questions, I cannot forgive you. There is no forgiving, not now, not ever. After Child D passed, we were asked if we would like her to be an organ donor. This was a very difficult question to answer but we thought if she could be a baby's saviour, as painful as it felt, it felt right to say yes. We were told the baby needed a heart. I can't explain how I felt then, but very soon, they came back to us and said that a post-mortem has been ordered as they couldn't explain why she collapsed and died, therefore she could not be an organ donor, which broke my heart even more.

"I stayed a few more days in hospital to recover, then Father D and I went home, just the two of us,

instead of a family of three. We were given Child D's hand and footprints and also a memory box with two tiny teddy bears, one to go with Child D and one for us to keep. Our family cleared all traces of baby stuff around the house, removed the baby seat from the car, took Child D's hospital bag home. All was stored inside her bedroom and the door remained closed for many months. We had to organise her funeral. You don't choose the date. The service took place the day before her due date and her ashes were buried in a tiny box on her actual due date.

"Those weeks were particularly difficult. I couldn't rest or stop thinking about all the little things I should be doing instead. My arms, my heart, my life, all felt so painfully empty. I miss Child D so much. I was desperate to feel her, smell her, cuddle her. I needed to be her mum in every way to look after her and keep her safe. I felt so guilty and questioned if any of this was my fault. Did I miss something? Did I do something wrong? Did I fail my daughter?

"When I left the hospital, I requested Child D's medical notes and mine. I got clued up on medical terms, neonatal death statistics, guidelines protocols. I was knocking on doors asking questions, meeting with doctors from the Countess and even the Management Team.

We got a solicitor and I wanted the police involved. At that stage, I was told that this was not a criminal matter so the police were out of question.

"We got the post-mortem report and even the Coroner ordered an inquest. Things just didn't add up. A week before we were due to go to court and face the Coroner, we got a call at 6 am from the police telling us that they were about to arrest someone on suspicion of Child D's murder and also other babies. This was something else to overcome. We knew nothing during the whole time of the investigation or what has happened to Child D.

"I became obsessed and this took over my life, fighting for Child D and justice. I wanted to know everything. I was told by someone once not to expect too much, and that it wouldn't change anything, nor bring Child D back. Thank God the police started their investigation. Now the why and never knowing will keep this wound forever open.

The following year I gave birth to Child D's brother, such a gorgeous boy, and it was all those first times. The first time we held our baby boy, the first trip in the car to come home, first bath, first cuddle, first smile, all those moments were filling my heart with happy memories. I love being a mum and at the same

time struggle with grief and depression. I have disconnected from many people around me. I lost my confidence as a friend, a woman, a mum, a wife. I never feel good enough. I felt I'd let myself go. My marriage is also scarred by all the hurdles we went through. At first, we were each other's rocks but as challenges were met, we found ourselves dealing with them in different ways, not at the same pace, and it has been hard to keep strong together at times.

"I feel not only I lost Child D, but lost all those years of my life too. Since Child D passed away I live beside my own shadow. I have had multiple therapies, panic attacks, dark thoughts plus many struggles to overcome. I used to cry every day, felt so empty, had a car accident and crashed into a wall. After a nervous breakdown I took time off work and started antidepressants. I guess it was time, but I felt so scared I would never recover.

"I gave up, then tried again but it became a rollercoaster and I was mentally exhausted. I did feel very lonely. At the time it felt I was losing my mind, my sanity, my worth, myself. I considered ending it all. I couldn't continue and didn't really want to. I was hoping so hard that maybe if I went to the other side I would see my daughter and be with her. Now

whether this is true or not, I now find comfort thinking that my prayers brought me the strength and courage to stay.

"Fast forward to the trial. This was a long time coming and I knew it would be really hard to stay in a bubble until I gave my evidence. My husband went to court every day. I listened to the opening statements and the evidence from first victims. He would come home but not allowed to speak to me about any of it. He was so strong, and I had no idea what he was taking on. I believe that part of the trial was harder on him than me.

"When I finally gave my evidence and sat on the public gallery to listen to all the facts the prosecution team had gathered, it was clearly overwhelming. It felt invasive having Child D's short life exposed to the public and sit through listening to all the babies' tragic stories. At the same time, I found comfort getting some answers, being able to ask questions and finally meet other families.

"In preparation for the trial, we also had to consider what we would tell Child D's brother about his sister. I explained that Child D died because someone hurt her. He asked where that person was, and when I said 'prison', he didn't ask any more until a while

after. Then one day he asked me who had the keys to the prison and if there was any chance the person that hurt Child D could get the keys and get out. He got upset and worried she might get out and hurt other babies, including his cousin. I had to reassure him there was no chance of that happening.

"We still have Child D's death to declare officially and this could not be done until the cause of death has been agreed. This is going to be another difficult thing do not, going to the registrar and declare our daughter's death eight years after her birth. We wanted justice for Child D and that day has come."

Thank you, my Lady.

LADY JUSTICE THIRLWALL: Thank you very much, Mr Baker.

Mother D, that's the end of your evidence. I just wanted to say that from when all this began, you looked for answers and explanations about what happened to your daughter, and we can all see and hear that at great personal cost you have never given up, and your evidence to the Inquiry this morning leaves everyone listening in no doubt of your determination and persistence on behalf of your daughter and for you and your husband. You've done everything that you could have done, and all of that evidence is of great help to the Inquiry. It's made my task easier, as do your thoughtful suggestions

about recommendations.

I do know just how hard this process has been for you and for your husband, and I would like to thank you both for all you've done for the Inquiry. Thank you very much indeed.

THE WITNESS: Thank you.

LADY JUSTICE THIRLWALL: I think that's the end of this session this morning. We'll start again at 2.00.

(12.26 pm)

(The short adjournment)

(2.00 pm)

MOTHER I (read)

LADY JUSTICE THIRLWALL: Good afternoon. Welcome. I understand Mr Sharghy is going to read your statement for you. You don't need to answer, if you just nod if you hear what I said, all right?

(The witness nodded)

LADY JUSTICE THIRLWALL: Mr Sharghy.

MR SHARGHY: "I, Mother I, the mother of Child I, will say as follows:

"I am the mother of Child I. I have (redacted) and I live with my husband, the father of Child I, in Cheshire. I've referred to Child I as 'my baby' or 'our baby' in this witness statement, rather than using her name, to protect her identity.

"This witness statement was made following several telephone discussions with my legal representatives.

"My experience at the Countess of Chester Hospital:

"In April 2015 it was confirmed that I was pregnant with my child. I was sure that I was pregnant prior to taking any test because I was really sick. Once I took an at home test, I rang the midwife and she arranged a 12 week scan. This was the first time I was seen by anyone. My sickness continued up until around 13 weeks; it was horrible. I'd never been that sick with any of my previous pregnancies. After 13 weeks the sickness and tiredness continued, it just wasn't every day. Then after 20 weeks, I felt normal again.

"All of my scans came back normal. I had a 12 week scan at the Countess of Chester Hospital and then attended Eye of the Lens in Bromborough to have a 16-week scan which was to determine our baby's sex. We were told we were having a girl.

"Then at 21 weeks we had our last scan at the Countess of Chester Hospital. At no time during any of my scans were any concerns raised. Our baby was developing as I'd expected. I didn't have any antenatal appointments as I breezed through my last pregnancies and there were no areas of concern.

"I did not get to the stage of agreeing a birth plan

as my waters broke early, at around five months. As I'd had other children already, my plan was to 'go in, give birth and go home'. I'd never needed to stay overnight with my other children. The previous labours were quick, probably around 3 hours.

"My waters broke about 5 weeks after my last scan. I remember prior to them breaking I felt stressed. I was panicking over many different things. We were due to go on holiday on 28/08/2015 and I was stressing because I didn't have a hospital bag and I really needed my hospital bag to be in the car. In the end it didn't matter because my daughter arrived early.

"On 31/07/2016 I went to the Labour Ward at the Countess of Chester Hospital as I felt something wasn't right but I was reassured and sent home. That night, my pyjamas were soaked in bed. I went back to the Countess of Chester Hospital on 01/08/2015 and was admitted to the Labour Ward. Initially, they tried to tell me that I could have just leaked but I knew my waters had broken. There was water everywhere, plus it wasn't my first baby, and I knew what it felt like when your waters break. Looking back maybe the staff were just trying to calm me down. I remember they conducted some checks which confirmed my waters had indeed broken. This resulted in me being transferred that night to the

Manchester Royal Hospital by ambulance and my husband followed me by car.

"When I arrived at Manchester Royal Infirmary, they conducted blood tests, and I was regularly monitored. I was kept there over the weekend, during which time I remember a nurse from the neonatal ward giving me a tour around and they showed me where my baby would be if she was born in the near future. They told us what to expect and explained that if I didn't get an infection, they wouldn't leave me past 34 weeks so no matter what, she would be born prior to 34 weeks.

"The medical staff kept telling me that our baby was safer inside me at this time. However, if she was still inside after 34 weeks, she would then have to be delivered due to the risk of infection.

"My waters breaking so early was completely unexpected. I had expected to walk in and walk out with my new baby a few hours later. I had just had my 20 week scan and everything was fine so I hadn't even seen anyone since when my waters broke. My other children did not need special or intensive care so it was never something I had ever considered.

"By Monday 03/08/2015, due to there being no sign of infection, I was sent home, with the agreement that I would go to the Countess of Chester Hospital

every two to three days for blood tests.

"I only got to the first appointment which was on the following Wednesday 05/08/2015 because when the nurse took my bloods, she informed me that I'd have to stay in as my blood levels were slightly abnormal and that they'd like to keep an eye on me. Plus, they were waiting for my blood test results from Manchester Royal Hospital to be sent through so they could compare them and see how much they'd risen.

"I'd asked if I could go home and collect some things as they'd wanted me to stay. Initially I was told 'Yes' but prior to me leaving, the results from Manchester Royal Hospital were received. After they'd compared my two sets of results, I was told I couldn't leave and my levels appeared to have significantly increased. I believe these results referred to my infection levels and there was concerned that an infection had developed, even though my temperature was okay, and I didn't have any other symptoms.

"The Countess of Chester Hospital then transferred me that day via ambulance to the Liverpool Women's Hospital. On arrival I was booked in and given a room on their maternity ward, whilst my bloods were checked again. Over the next few days, I was continuously monitored.

"By (redacted) August 2015, I was still leaking amniotic fluid, however, my waters had started to change colour. Usually amniotic fluid is clear, but it had started to turn a yellowy/greeny colour so everyone was worried about infection. Due to this change in colour, I had a further scan. After I was informed by a female doctor (name unknown) that there was still some fluid left and that my baby was still safer in than out.

"The doctor continued to say that I would become poorly before my baby did, so my blood pressure and temperature were continuously monitored. I remember telling them that I don't really show signs, I just crash, but they were adamant that I would show signs of an infection before it affected my baby. They instructed me that if I had any pain I should say so immediately, as I wouldn't have a normal delivery and that she may come very quickly.

"Later the same day I remember my children had come to visit me and I was sat with them in the hospital canteen when my back started to ache. I recall telling my sister that she should take them home as it was getting late. I said goodbye to them and my husband asked if I was coming out to the car. I said that I thought I was in labour and that I needed to get back upstairs to the ward.

"When I got back onto the Maternity Ward a midwife came and I was attached to a monitor. She informed me that I wasn't in labour and then left. I told my husband that I thought I was having contractions, go and get the midwife. She returned and gave me a couple of paracetamols and left again saying I wasn't in labour. As I wasn't happy, I spoke with a friend of mine, who is a midwife at the same hospital; she went to get a male doctor (name unknown). This doctor instructed the staff to remove me from the monitor and he physically checked me. After his examination he said for me to go straight to the Labour Ward as I was 6cm dilated.

"When I got to the Labour Ward, I was told that I needed to be connected to a drip which would help my baby's brain to which I told them it was too late. I asked the midwife 'How important is it that the team are here', to which she said it was very important. So I said 'Get them in here then' and she buzzed down.

"A further midwife and the neonatal team arrived shortly afterwards. During this time, my contractions just stopped (I think it was out of fear as I was too scared to push) so the staff checked the monitors and from there they were able to see my contractions and they'd tell me when I needed to push. At some point they informed me that my baby was becoming distressed,

so I pushed harder and she came out.

"Our baby who we named Child I was born at 9.02 pm on the evening (redacted) August 2015 weighing 2lbs 2oz. I was only in the labour room for around an hour. I didn't have any pain relief, nor did I need any intervention.

"Prior to my baby's birth, I had been told that she would immediately be removed to the Neonatal Ward and I would be able to see her later. In fact, when she was born, she was doing really well and they kept her in the room with me for a short time. They brought her over to the bed for me to see her and she was put in an incubator for a while. They took her upstairs saying she needed to go to the Neonatal Unit for 'long lines'. I really appreciated I was able to see her even if it wasn't for long.

"My husband was present during the birth, and I remember him saying 'She's not as small as we thought she would be'. I freshened up and went back to the Maternity Ward where we had a private room which had two beds so my husband could stay. We then just waited and waited for hours. My husband was becoming extremely anxious and frustrated and was not happy as they weren't telling us anything. I kept reassuring him saying 'If they're not saying anything she must be doing okay'.

"Eventually, at around 2am or 3am, a nurse came down and told us that as our baby only weighed 2lb 2oz they were struggling to get her lines in. They had to scan her each time to see if the line had been inserted correctly and on several occasions it hadn't been. At around 3am we were allowed to see her for around 10 to 15 minutes; she was on an incubator on a ventilator.

"The ratio at Liverpool Women's Hospital was one nurse to two babies. Our baby was covered in a sterile tissue-like cover as they didn't want her to get an infection from where they'd entered/attempted to secure her lines. We then returned to the Maternity Ward, and stayed overnight.

"Later that morning around 6.30 am, Father I (my husband) and I went back up to see our baby who was still on the Neonatal Ward (Room 7) and still in an incubator. She wasn't on a ventilator; she just had a BIPAP mask. Her nurse told us this was due to the fact that our baby had fought the ventilator so they removed it and placed the BIPAP mask on instead. I was told that sometimes it can do more harm than good to use the ventilator if the baby didn't need it and not to panic.

"I was told that our baby would need to go to the Neonatal Unit because she was premature and that meant

she couldn't breathe unaided and would need constant monitoring and medication for apnoea. It was explained to me that she would be doing the growing she would normally do inside me, albeit in the incubator.

"On that first morning, (redacted*)* August 2015, one of the nurses then asked if we'd like to get her out of the incubator. At first we were reluctant, but they confirmed that it would be okay. However, as soon as she was placed onto my chest her saturation levels dropped so she was put back into the incubator where her levels improved. The nursing staff said that it might have been just a bit too soon to remove her. My baby appeared fine whilst in the incubator as she was kicking, and her hands were going everywhere. It was just us that were scared to touch her.

"During that day, Father I (my husband) and I spoke to one of the male neonatal doctors and were informed what to expect. We were told that our baby would likely be with them for a long time, but she was doing really, really well and that there were no complications, and the next weeks would indicate which way it was going to go for her. The doctors told me she was doing really well and just needed to avoid getting an infection and to keep growing. On hearing this, I was initially petrified as I didn't know if she was going to come

through, but she was fine and eventually all my fear just went away.

"Our baby was just small; the nurses kept telling me that I must have really looked after myself for her to come out as she had. I could see other babies on the ward that had been born of a similar age to our baby and they were struggling, but she wasn't.

"Our baby was then taken off CPAP. I was told she was doing fine on the machine and she wasn't being tired out, so they were going to put her on four hours of oxygen followed by four hours off. I initially raised some concerns, but they said she was healthy enough to do it the old-fashioned way. They did that for a couple of days and it was again all good news; she didn't need the oxygen all of the time. We were really positive at this point.

"Around this time, we were asked if they could run some tests on our baby for training purposes. My husband didn't want them to do the testing, but I did, so we agreed it could go ahead. How I looked at it was if people didn't get this opportunity, our baby wouldn't have had the care she'd received. If she'd been poorly or on a ventilator, I would have said 'no'. The tests only consisted of some probes on her chest, gel in her hair and checking the artery to her heart.

"All of Child I's tests results came back fine and were reassuring as expected -- we were told she was doing well. When Child I was approximately (redacted*)* days old, we were told that Child I was going to be moved into Room 2 on the NICU (Neonatal Intensive Care Unit). Babies in Room 2 do not require as much intensive care as those in Room 1; it was more like a HDU (High Dependency Unit) room, although it was still within the NICU. We thought that was brilliant news. However, the next day another doctor came in and said that our baby didn't need to be at Liverpool Women's Hospital any more, and that she was going to be transferred back to the Countess of Chester Hospital because she didn't need intensive care any longer and that all our baby needed was to keep growing, there wasn't anything wrong with her except that she was so small.

"On hearing this we initially panicked as we didn't want her to go back to the Countess of Chester Hospital. Liverpool Women's Hospital was spotless, the floor shone and our baby was settled there. The doctor again said that she didn't need to be there any more. We had been feeling really safe at Liverpool Women's Hospital, but around the same time, we'd also heard that a virus had broken out on Ward 2 there, so I agreed for my baby to

be moved back to the Countess of Chester Hospital to reduce the risk of my baby catching anything.

"On 18/08/2015, my baby was transferred back to the Countess of Chester Hospital by ambulance. My husband and I followed with our other children but when we arrived at the Neonatal Unit they wouldn't let us in. Our other children weren't allowed to enter the ward without their red books being shown; they were really strict. I didn't think badly of the hospital as I was glad that they were being so fussy.

"I remember being introduced to a lady called Berni. Berni was a senior nurse on the ward. I don't know her grade but she wore a dark blue uniform and had long dark hair. She took us aside and was very firm in telling us exactly what we could and couldn't do and that if we didn't adhere to these rules, we would be asked to leave. At first, I didn't like her. I thought she was rude. However, as time went on, I started to like her; it was what the ward needed. She was very strict and to the point.

"The Neonatal Ward was located at the rear of the hospital by the Maternity Ward. It had four separate rooms, numbered 1 to 4. Each room cared for babies who needed certain levels of care and were at different levels of health.

"Room 1 -- this was an intensive care room and it could accommodate up to eight babies with a ratio of one nurse to four babies.

"Room 2 -- this was the HDU. The room could accommodate five babies. The nurses from this room would also care for babies in either Room 3 and 4 as well.

"Room 3 -- this was the room before you go home. It could accommodate six babies; again the nurses were shared between the other rooms.

"Room 4 -- this was the nursery. It could accommodate up to six babies. This room was the room which prepared babies for going home.

"Our baby was placed in Room 1. At first, I had reservations about her care. I felt they didn't have time for our baby at Chester. Berni was looking after her, but they were so busy, I remember on one occasion we asked if we could get her out of her incubator but Berni told us 'No' as she just didn't have the time to do it. I remember ringing my mum in tears saying 'I don't want her here, they're not giving her enough time'. Room 1 was also very busy; they even had babies in the corner, and I was very concerned they would not have time for my baby.

"I also queried my baby's oxygen intake as they kept

putting her on oxygen if her saturations dropped lower than 96. I had heard previously that too much oxygen was bad for babies so I wasn't very happy. At Liverpool Women's Hospital they would alternate between having my baby on oxygen and taking her off, but they just didn't have the time to do this at the Countess of Chester Hospital.

"Then a couple of days later, Dr V came and informed us that our baby had had a scan and from this scan they could see that she had had a small bleed on her brain. The doctor then went on to say that this could have been caused by a lack of or too much oxygen. I remember thinking: 'They've caused this by putting her on the oxygen'.

"I felt that the Countess of Chester Hospital and the Liverpool Women's Hospital had different methods. The Countess of Chester Hospital was more concerned about feeding and growing as opposed to Liverpool Women's Hospital who wanted to get the babies off oxygen. They just had different methods and over time the nurses would explain why they were doing certain things.

"I also remember my baby continued to wear a CPAP mask. The problem was it was too big for her face. Staff at the hospital used cotton buds to try to pad it

out but this just caused her face to be marked. I remember going home one night and asking Jo (who was another senior nurse but I do not know her full name) if she could please just lift it or move it slightly as it was marking my baby's face. The following day when we returned my baby no longer had the CPAP mask on, and I was informed that she didn't need it anymore. I remember feeling annoyed because if she didn't need it, why hadn't they thought to remove it and prevent her face being marked without having to ask?

"When my baby was around *(*redacted*)* weeks old, she was moved to Room 2, and it was good in there. I met other families, one of them being Mother G, whose daughter, Child G, had also been born prematurely at 23 weeks but she was now *(*redacted*)* months old. When in Room 2, my baby received her first bottle.

"A nursery nurse called Nicky (I do not know her full name) came in. I remember this Nicky was sneezing and coughing whilst putting her hands in our baby's incubator.

"I was fuming, absolutely fuming, because we were doing everything to stop our baby from getting an infection. I was so annoyed that I had to go outside and phone the nursing desk. I told them that under no circumstances was anyone with a cold or cough to come

near my daughter.

"I had to phone them because if I'd seen someone in person I would have lost my temper, and to top it off whilst Nicky was in the room with a doctor, the doctor asked Nicky if she was full of cold, to which she said 'Yeah, I've been full of it for days', so even the doctors were aware and didn't do anything.

"On 5 September 2015, I helped give my baby her bottle, to which she took well. She was then placed back in the incubator. I went home to see my other children and came back just as the nursing changeover was going on.

"My husband asked if he could hold our baby which Berni agreed to but said it could only be for ten minutes as they were changing over staff, so we were made to go to the parent room. This again annoyed me because had he waited a further 30 minutes until the staff changed over to the night shift, we could have held her for a couple of hours instead of just ten minutes. This was due to the fact that that they limited our baby's movements and now that my husband had moved her we wouldn't have been able to hold her again for some time. I left the ward at this point.

"When I returned, my baby's oxygen saturation levels had dropped so either the morning or night nurses had

called the doctor. When the doctor arrived, I realised it was Dr Matt from Liverpool Women's Hospital. I was so relieved it was someone we knew. He's not actually called Dr Matt; we just called him that because we knew his first name was Matt. Dr Matt informed us that the nurses had noticed that our baby had been desaturating during changeover, so they were giving her oxygen. He said that she probably just needed a little bit of help. He then did a lumbar puncture to check her bloods just to see if she had picked up an infection.

"I was told that our baby might just be tired as she had had a big day. I had given her a bottle that day so it was a big day for her. I was learning that with a premature baby, ('premmie'), it was often a few steps forward then 100 steps back.

"As our baby's oxygen saturations had settled, Dr Matt returned to the other ward, and I felt comfortable going home for the evening -- around 10 pm or 11 pm. I thought everything was going well again. After we arrived home however, we received a phone call asking us to go back in as they'd had to put our baby onto a ventilator due to her becoming poorly again. I can't say which nurse rang me; I didn't know them too well at the time so I don't know who it was.

"The following day, on 06/09/2015, our baby was sent

back to Liverpool Women's Hospital. She was *(redacted)* weeks old, and this was the start of her becoming poorly.

"On the morning of 06/09/2015, a doctor had told us that they suspected our baby had NEC (necrotising enterocolitis) because her stomach had swelled up and her veins were visible. We were also told that she needed to go to Liverpool Women's Hospital so she was close to Alder Hey Hospital just in case her bowel ruptured and they needed to operate.

"The doctors were adamant that it was NEC and they told us that all of our baby's symptoms pointed towards this. They were working on 'worst-case scenario' to rule it out.

"When we arrived at Liverpool Women's Hospital, they immediately said that our baby didn't have NEC and within 24 hours she went from being fully ventilated (at the Countess of Chester Hospital) to no ventilation and starting back on her feeds (at Liverpool Women's Hospital).

"Our baby was still unwell and weak because she had been resuscitated and so they kept her there and put her on antibiotics just in case. She remained in Liverpool Women's Hospital for a further week but she was in the HDU not the Neonatal Unit (NICU). During this time, the

medical staff did not check our baby's stomach or bowels and I think if they had just checked, it could have influenced her future care and I'm not happy about that.

"Whilst at Liverpool Women's Hospital, I remember phoning the Countess of Chester Hospital's neonatal ward and asking the nurses to pass a message on to Child G's mum. I just wanted to tell her that our baby had turned a corner and that she was doing okay, but they informed me that they couldn't as Child G had been transferred to Arrowe Park Hospital with a similar medical condition as our baby. On hearing this, I put our baby becoming ill down to a bug that they both had picked up. I thought that it might have been Nicky's fault and that she had passed on her cold to our baby and Child G as she had been coughing on the ward just before her collapse. Staff at Liverpool Women's Hospital and the Countess of Chester Hospital said this was not the case as our baby didn't have a cold because she would have been sneezing.

"On our return to the Countess of Chester Hospital, our baby was placed in Room 3. This meant that, in a matter of a week she had gone from being critically ill on a life support machine and being rushed to Liverpool Women's Hospital, to now returning to the Countess of Chester Hospital and being placed in the room before your baby goes home. In same room was

a lady called *(*redacted*)* with her baby.

"My emotions had gone from rock bottom to now being positive again. I coped by trying to forget what I'd seen and gone through, and just kept going. I just used to say 'She's just had one of her moments and she was letting us know who's boss!'

"Whilst in Room 3, our baby was being cared for by a nurse called Janet Cox during the day, but I can't remember who it was at night. By now our constant attendance at hospital was taking its toll on our *(*redacted*)* year old daughter so my husband and I decided to split our time. I used to go to the Countess of Chester Hospital from 9 am until 3 pm and my husband would go there from 4 pm until 10 pm, as he worked during the day.

"Our baby continued to do really well and we were dressing and feeding her. Then one day I went to the Countess of Chester Hospital, and *(*redacted*)* was really upset. I asked her what had happened and initially she said 'Nothing' but eventually she told me that she'd been up all night expressing some milk and that it had been a real struggle. She said that she'd then placed the milk into the nursing fridge and someone gone in and had given it to one of the other babies.

"Obviously she was upset because of the effort it

had taken to extract it, but she was more upset due to the fact that she was on heart medication and she was worried that one of the other babies may become sick because of it. She'd asked the nurses which baby had been given it, but they declined to say due to confidentiality but said the baby would be okay because it was being fed through a feed so they could syringe it back out. They wouldn't even tell her which nurse had given it which I think is wrong because the nurse should have at least apologised.

"I also don't believe the baby's parents were told as we saw no angry parents, which I would be if my baby had been given milk containing elements of heart medication. I was concerned that it may have been our baby. I started to become obsessed with handwashing and I wouldn't take our baby out of the incubator because I was concerned that she may pick something up from the room.

"Shortly afterwards, *(*redacted*)* was due to take her baby home. Nurse Nicky came in and helped bathe *(*redacted*)*'s baby. After she'd finished with *(redacted)*'s baby she asked me if I wanted our baby bathing, to which I remember asking, "Are we allowed?' and she said, 'Yeah, she's doing well, I can't see why not' so I said, 'Yeah'. I was made up, but before she

could, Janet Cox (nursery nurse) came in and said, 'No! You can't bath her, she's not old enough, she can't regulate her own body temperature yet'. Our baby would have been around *(redacted)* weeks by this time.

"Child G returned briefly and moved to Room 4 and after that *(redacted)* and her baby went home. I recall a doctor telling me that when they were discharging her, and that our baby wasn't that far behind her and was doing really well.

"After they left, another baby was admitted to our room but I wasn't happy with this family as they didn't wash their hands; the dad would touch all of our baby's blankets. I complained to the nurses, and they told him off, which resulted in him apologising. I just explained to him that I was concerned that our baby would pick up a cold from someone which could be extremely dangerous for her.

On 30/09/2015 I was changing our baby's nappy before leaving for the day when a nurse called Lucy (at the time I didn't know her surname but now I know it to be Letby) came on duty. It would have been around 3 pm. This was the first time I met Lucy Letby.

"I'd describe Lucy as being around late twenties with shoulder length blonde hair, with a long slim face; her face was always on the babies' fundraising pictures.

I say she'd just come on duty because I hadn't seen her earlier and I thought it strange because handover is normally at 7.30 pm so I just put it down to maybe the nurse who was looking after our baby had gone home early.

"Lucy came over and said that she thought our baby's stomach looked swollen, which I agreed with, but I thought that our baby looked okay in herself. Lucy informed me that she'd keep an eye on her and she'd call for the doctor to also check her out. I left at around 3 pm. Our baby had been doing really well and was staying where she was safe. She had been in an incubator since her collapse on 06/09/2015 but had recently been moved to a cot so I was feeling quite relaxed at the time.

"I had just got home and that gone to see a neighbour when I received a phone call (around 4.30 pm) from the hospital. I can't remember who I spoke to, but they told me that our baby had had another turn and I needed to make my way to the hospital. I panicked as my husband was at work and I had to ring him to let him know he had to come to the hospital now.

"I arrived first, and when I got there Berni, or maybe *(redacted)* was resuscitating our baby by

conducting chest compressions in Room 1. I froze. I was on my own as my husband hadn't arrived yet and it was very scary. Our baby's stomach was swollen, she had been sick, and she looked really unwell.

"I can't remember any of the other members of staff who were present but there were other staff there. Berni informed me that the swelling to our baby's stomach had now gone down and that she was doing better. I thought her stomach had swollen up so much that it had crushed her chest which had caused her collapse, but I wasn't told what specifically caused the collapse. I know that the doctors took samples from her spine and checked for infection. The doctors and nurses told us that she was a puzzle and weren't sure why she kept having episodes.

"I now understand that a report called a 'Datix' was created on 01/10/2015 about our baby's collapse on 30/09/2015. I was not told about this at the time and would not have known what a Datix report was. I had no idea there were any meetings or discussions about her collapse.

"The next day, our baby was moved to Room 2. It was a quick change-around, but this time we didn't have to change hospitals as our baby started to improve within hours.

"I also remember Child G had been poorly many times around the same time as Baby I, as they were both back in Room 2 and I was trying to reassure Mother G that it would be okay. The nurses were telling me that our baby was doing well again and that it had been known for babies to be sent home from Room 2 previously.

"As the days went by, I noticed that our baby was starting to be more aware. She was looking around the room taking it all in. I was able to sit her on my knee and I remember looking at her and thinking 'We're going home'. She just looked like a full-term baby. She didn't look frail or small; she just looked like she should be at home. I started to think she needed to be at home so she doesn't get an infection as I'd seen so many people not washing their hands and then touching things in the room.

"I just wanted to take our baby home desperately. I had sent videos home that I'd taken on my phone and I was allowed to bath her which she loved and was smiling. I remember bathing her the first time. I was in Room 2 and Lucy Letby was on duty. I was so pleased to be able to bath our baby. Lucy helped prepare the bath and gave advice as to how to bath our baby. She even offered to take some photos using my mobile phone which I agreed.

"Other than these limited interactions, I didn't really have much to do with Lucy. She always appeared reserved and kept herself to herself. I thought she was a bit miserable compared to some of the other nurses. She never really interacted with the parents.

"When our baby was *(redacted)* weeks old, I enquired about her getting her immunisations when she returned home but the hospital said that they had given them to her whilst she was in hospital. A female doctor (name unknown) did prepare us by saying that our baby's white blood cells would rise after she'd been immunised.

"Our baby had her immunisations on 05/10/2015 but afterwards Dr Matt told us that her bloods had risen more than they'd expected and that they were going to screen her.

"I understand from my medical records that on 07/10/2015, our baby had a lumbar puncture and was put on antibiotics. Shortly afterwards, I remember the female doctor coming back in and asking why our baby was on antibiotics. I recall telling her that because of our baby's history and because she declined so rapidly, it was done as a precaution. I explained that our baby could go from being perfectly fine to nearly dying within seconds. There was no in between with her. I had been told all along that this was normal for

premature babies, that they get infections, that they go up and down, and that they might have to test her for lots of things.

"I remember the staff at the Countess of Chester Hospital kept making a big deal about our baby's stomach swelling. They thought she had NEC, or twisted bowels. They said that she might need a dye test and that perhaps she had an intolerance to milk. At this point the medical staff told me I had to stop Googling everything. I remember a couple of the nurses telling me that sometimes these things happen. I was never led to believe that these collapses were anything to be concerned about or abnormal, or that they were worried about anything out of the ordinary.

"I had been feeling positive at this point. Our baby was doing really well, I thought. I clung to the nurses saying it was fine, that it would be two steps forward, ten steps back sometimes. I know she was on antibiotics after her immunisations but this wasn't a concern as I know they were given as a precautionary measure. Dr Matt wanted to be cautious and I appreciated that.

"I also remember that at some point they tested our baby for cystic fibrosis. I think it was after immunisation but before she got really sick, although

I cannot be sure now. I remember being asked to leave the room and when I returned, our baby was screaming. I'd never heard her cry so loudly.

"As time went on, I felt the atmosphere within the hospital had changed. I had gone from feeling that our baby would be coming home to uncertainty. Tubes were starting to go back in, and it just felt like something was wrong. It felt like they were looking for something. I remember asking a blonde-haired nurse (name unknown, but she was in Room 2) if our baby would likely be going home any time soon. She just said, 'We'll see. She comes off her antibiotics Wednesday so we'll see what they say when she comes off'.

"Dr Dave (full name unknown) then came and checked on our baby and I again asked him how long until we could take her home. He just told me she could wake up tomorrow and not need the heated mattress or it could be six months down the line and that's just what it's like for a premature baby.

"Our baby was still feeding and was in a heated cot. She was also wired up to monitors. In the late evening of 10/11/2015, we were sitting there and I remember a nurse called Ashleigh was looking after our baby. Baby G was there with her dad and she'd been poorly too. We were all just talking when our baby's oxygen monitor

started bleeping. I turned to Ashleigh and asked if it was our baby to which she replied 'Yes, it's nothing to worry about, it's just the signal". Ashleigh then fiddled with the strap which was attached to our baby's foot saying it must be loose, but the bleeping continued. Ashleigh kept reassuring me that everything was okay, however, when I left that night, I didn't feel right. I felt as though it was the start of a pattern for our baby as her oxygen and saturation levels would always start jumping just before she became poorly.

"First thing in the morning of 11/10/2015, I phoned the hospital and spoke with Ashleigh. I asked her if she'd sorted the monitor out, to which she informed me that she'd turned it off, saying our baby didn't need it and for me to stop worrying. When I asked how our baby was, she told me that her temperature had dropped overnight and I remember thinking that's two signs: first the monitors bleeping, and then her temperature dropping. Ashleigh kept reassuring me that everything was okay and that she was fine.

"That day or the next day, which I think must have been 12/10/2015, a new baby joined our room. Again, this caused friction as they weren't adhering to the washing of hands rule and I feared that our baby would catch an infection. Mother G was telling me to calm

down, but I feared our baby getting poorly so much that I had to say something.

"Then, later that night whilst I was at home, we received a call from the hospital telling us to come immediately. This would have been the early hours of 13/10/2015. I don't remember much of the call or who it was that rang us. When we arrived, our baby was really poorly. It was the worst she'd ever been. The staff had to resuscitate her at least seven to eight times. She just kept flatlining. I remember the following staff being present: Jo, Berni, Dr Matt and a young nurse who subsequently left to go to Australia. Others could have been there, but I can't remember them.

"Eventually, they managed to stabilise our baby and the hospital staff believed that our baby had a bowel problem. On this occasion she was not found with a swollen stomach, she was found not breathing and my thoughts were had they kept the monitors on her, her condition could have been detected earlier.

"Our baby's stomach did swell in the end, and she had bruising under her left breastbone. It was blue in colour and the bruise was probably a few centimetres in size, which doesn't seem big, but due to our baby's small size, it was quite significant. Our baby continued to be poorly and she was continually being

resuscitated.

"By 14/10/2015, the hospital gave us a room to sleep in, but every time we left and started to fall asleep, we'd be woken up with banging on the door telling us to come quickly. This wasn't once, this happened several times. When I look back at it now, it feels like this went on for days but I understand from my medical records it was actually only over two days. Our baby also seemed to deteriorate when we left her alone and it was predominantly at night.

"Eventually, Dr Matt said that he was worried. He said that he didn't know if our baby was going to make it. I recall they phoned Alder Hey Hospital to seek advice. Alder Hey Hospital said that if she stayed on antibiotics for seven days and stabilised, they would be able to give her a dye test to see what the actual problem was but she would need to be on nil by mouth for this. I understand from my medical records that this conversation happened on 14/10/2015.

"I believe that the doctors there at Alder Hey thought our baby had complications or damage from an earlier episode of NEC which could have caused damage to her bowels, which would explain why she'd become poorly as she may have had a build-up in her bowels. I wasn't entirely convinced this was the cause of our baby's

problems because on this one occasion Ashleigh (nurse) said that she'd just found her blue in her cot and her stomach hadn't been bloated. I again queried why she'd been taken off her oxygen monitor if she was that poorly, as surely this would have picked up the fact that she was having breathing difficulties. I just couldn't understand why they would continue to do that.

"At this point I felt like our baby was getting worse -- things weren't improving any more. I remember standing outside the hospital and thinking what if she doesn't get home? At this point we couldn't leave hospital at any point because that was how quickly she went downhill.

"At some point between 13-14/10/2015 Belinda (surname unknown, however she was an Australian nurse) pulled me to one side and told me to sit down. She said that our baby's heart rate, even though it had picked up, was still too low and it had been like that for some time, so she suggested that we get our baby christened. She tried to reassure me that our baby could still get better but it was something for us to consider.

"I felt as though by christening her we were giving up, but we did it. I think it was on 15/10/2015. We organised for everyone to come in a rush, and our baby was christened at the hospital. My medical records show

that our baby was moved to Arrowe Park Hospital on 15/10/2015 so the christening was held that morning before she was moved. I believe Belinda was there but I can't remember any other staff being present.

"On 15/10/2015, our baby had another collapse in the morning. I was shown a scan of her lungs, and from the scan it looked as though they'd collapsed. Staff at the Countess of Chester Hospital said that our baby had to be moved as they couldn't do any more for her. We were asked where we would like her to go as there was room at Arrowe Park Hospital or Liverpool Women's Hospital. Due to Arrowe Park Hospital having a McDonald's House we decided to go there as we could all be able to go as a family. This decision was also made due to the fact that our other daughter was missing us and she'd started to have nightmares due to our absence.

"However, as our baby was being moved, her oxygen saturations dropped. I remember Belinda used an implement and sucked loads of fluid out of her lungs before she was placed in a travel incubator. Our baby was then transferred by ambulance to Arrowe Park Hospital.

"I now understand that a Datix report was created on 13/10/2015 about our baby's collapses. I was not told about this at the time and have only been made aware of

it very recently.

"When we arrived at Arrowe Park Hospital on 15/10/2015 our baby was x-rayed again, and her lungs were fine. They'd blown back up, so now I had Arrowe Park Hospital telling me that there was nothing wrong with her. I felt as though the staff at Arrowe Park Hospital were rude; they were acting as though they were the better hospital. They said to me that they were annoyed that our baby had even been taken there and that there were other babies who were a lot sicker than her and that she didn't need their care.

"I felt I had to defend the staff at the Countess of Chester Hospital. I told them that I'd seen them saving my daughter's life time and time again, but they just kept telling me that our baby was fine and for me to look at the scan. I tried to tell the nurse and the doctor that when she's moved fluid blocks her lungs which then stops her breathing, but the doctor just told me that he couldn't understand what I was saying.

"I appreciate that I may have been upset at the time and not making sense, but I believe the doctor should have listened to my concerns. A nurse then informed me that she was going to give our baby some milk to which I said, 'No, she's nil by mouth'. The nurse stopped and apologised, and said that she'd not read the notes.

I was so angry, I didn't want to be there any longer.

"I remember placing my hand on our baby's chest and I could feel her chest bubbling. I told the nurses that she wasn't well and that there was something going on. I asked the nurse to use suction to clear the lungs because I knew as soon as they moved her, she would drop like a tonne of bricks. The nurse just kept reassuring me that they had specialist doctors who were looking after our baby and that she would be okay. I again stressed my concerns saying that she was going to crash again, and she told me that Child I's lungs were fine, but when the nurse turned our baby, she crashed as I had told them she would. A doctor then came over waving his arms in the air as though he didn't know what to do, so I screamed at him to get the ventilator, to which he did. Our baby then started to pick up and her condition improved.

"Our baby was only at Arrowe Park for two days. They said she didn't need to be there and everything was fine. Looking back now, it always seemed as soon as our baby left the Countess of Chester Hospital, her condition would improve but the journey to and from the hospitals would take it out of her. When I was told she could return to the Countess of Chester Hospital, I was pleased and happy to return.

"I was always anxious when our baby was transferred because if she was being transferred it meant she was really poorly. I didn't have any issues with the transfers themselves, but it was always very strange that she improved straight away once at Arrowe Park Hospital or at Liverpool Women's Hospital.

"Child I's deterioration and death.

"Our baby was transferred back to the Countess of Chester Hospital by ambulance on 17/10/2015. The journey was fine and she settled back into the Room 1 on the Neonatal Ward. I understand from the medical records that our baby desaturated during the journey but soon recovered. I remember going home that night and telling my mum that our baby was awake but she just didn't look herself. It was as though she was looking right through me, like she couldn't see me.

"In my mind, it was the following day that I got a call from the hospital. However, I understand from my medical records that it must have been on 22/10/2015. Time sort of stands still when you are in the Neonatal Unit and it can feel longer and shorter. Nurse X, one of our baby's regular nurses, told me that our baby needed some clothes bringing in as she'd taken her out of the hospital clothes and had put her in a babygrow.

"The staff at the hospital continued to remain positive about our baby's condition and I started to believe them. I gained hope that we would bring her home. The staff were also talking about our baby having the dye tests, as she was still nil by mouth at this point. They said that she might be able to go and have this at Arrowe Park Hospital.

"That night we left the hospital around 10.30 pm. I remember Ashleigh was our baby's nurse that night, as was Lucy Letby. We left at this time as my mum had asked us to come home because our other children needed us. I remember leaving the hospital that night feeling lighter because our baby looked alert again, she was looking around and seemed less tired.

"Then at around 12.30 am I woke up having realised I'd slept through a phone call from the hospital. I didn't check to see if they'd left a message, I just immediately phoned the ward. The phone was answered, and I was put on to Ashleigh who informed me that our baby had just had 'a little turn' and they'd had to put her on a ventilator but she was okay now. When I put the phone down I said to my husband that we had to go to the hospital. I wasn't happy with our baby being on a ventilator after all the problems she'd had previously.

"Lots of thoughts were running through my mind. What if they had turned her and blocked her lungs? I needed to remind them, so after I rang my mum to come and look after my other children, I phoned the ward again and someone else answered the reception phone (name unknown). This person went to find Ashleigh but when they returned they told me that we needed to get to the hospital as soon as we could.

"We left home immediately and on our arrival at the hospital we saw Dr Gibbs, Ashleigh and Lucy Letby. They were working to try to resuscitate our baby. They didn't have time to tell us anything but asked me to put my hands on our baby so she could feel us. I remember standing by the incubator with my hand on her foot because there was only room for us at the bottom. I was shaking and I couldn't look at the monitors because I knew she was a lot worse than all the other times. I felt absolutely broken.

"I heard them all counting times, so I asked Dr Gibbs how long they'd been doing this, and he said '20 minutes'. I could see every time they were pumping her chest, her oxygen saturations levels would go up, but when they stopped, she would flatline every time. I remember thinking 'You can't keep doing this to her' and I said to Dr Gibbs, 'You can't do it anymore'.

"My husband couldn't watch. I don't know where he went. I think he was in one of the corridors. Whilst they were working on our baby Dr Gibbs gave her an injection. I don't know why or what was in the syringe, but it was given into her leg.

"When they eventually stopped working on our baby, they passed her to me. I didn't want to let her go and held her so tightly as she was our gorgeous little princess. I cannot even begin to explain the pain of losing her. I feel like a part of us died with her. She didn't die straight away. It was around 2 am or 3 am in the morning on 23/10/2015 when she actually went. I can't be certain as to the exact time as I didn't clockwatch, as too much was going on.

"After she passed away, we were left alone and all of the other babies were moved out from the room. This gave us some privacy. Later on, we were moved to a private room when it became visiting time.

"My husband blamed the hospital; he blamed the staff on duty that night because they'd not been the ones on duty when our baby had been successfully resuscitated before. I felt that our baby had just given up, that she just didn't have any fight left in her. I also wondered if her ventilator had blocked as that would have blocked her airways completely. I blamed Arrowe

Park Hospital. They had her nil by mouth for so long and they hadn't even done the dye test. I felt like our baby had been starved for nothing. I thought that if she hadn't been nil by mouth she might have had more energy to fight.

"Ashleigh and Lucy (Letby) asked if I wanted to bathe our baby. My husband initially said no, but I didn't want to look back and regret not doing it, so I said 'yes'. Lucy brought the bath in and said if I could get her ready she'd come in and take some pictures which we'd be able to keep.

"Then, whilst my husband and I were bathing our baby, Lucy Letby came back in. Ashleigh and Lucy would come in and out. She was smiling and kept going on about how she was present at our baby's first bath and how much our baby had loved it. I remember thinking at the time, 'What are you going on about, she's only ever had one bath and my husband never got to bath her'. I just felt so sorry for him because he hasn't got that memory and I wished Lucy would just stop talking. I remember thinking 'Will you just go away'. I was really uncomfortable and I just wanted her to leave. It was also weird that she kept smiling. I had never really seen her smiling before. Eventually, I think she realised and stopped. It wasn't something we wanted to

hear right then so I put it down to saying the wrong thing at the wrong time. However, I still thought her behaviour was strange. I mentioned it to my mum who said that maybe Lucy was trying to put a nice mood on it, but there was no nice mood. I just wished she and Ashleigh would go and swap with the next shift. I don't know if Ashleigh was there for all of it.

"I remember it was Lucy Letby who packaged up our baby's belongings for us to take home. Prior to leaving hospital, Father I (my husband) and I were spoken to by another nurse (name unknown) who had blonde hair, and by Dr Gibbs.

"Dr Gibbs said that are baby was basically a full-term baby and that these collapses shouldn't have kept happening. He mentioned about our baby having a post-mortem examination. I said I didn't want her to have one, as I just wanted her leaving alone, but he informed me that I didn't have a say and that she needed to have one as her death had been unexpected and the results would be needed to 'clear the hospital'. In response, I informed him that our baby had been fighting for her life for the past seven days, how was that unexpected and unexplained? He just said she needed to have a post-mortem and that Alder Hey Hospital wanted her there that day.

On hearing that, I lost my temper. I told him that our baby had been starved of food for the past ten days at the requests of Alder Hey Hospital so she could have a dye test to check her bowels. I questioned how she could fight anything off that she'd picked up and said something to the effect that 'now she's dead they want her'. I was fuming. I told Dr Gibbs that they were not touching her. I also remember him saying that they couldn't have kept putting our baby on a ventilator. I am still not sure what he meant by this, as Child G had been on and off a ventilator for the past three months.

"A short time later Dr Gibbs returned and said that he'd sorted it with Alder Hey Hospital and our baby wouldn't be going until Monday. I remember not liking this doctor. Looking back, I think it was just the circumstances as my mum said he had been lovely.

"We left the hospital that day with some bags which consisted of a box of our baby's belongings, handprints and leaflets, et cetera. I thought it was like a kick in the guts, as you go through all that and you come out with a couple of bags, not a baby. I was never offered any support by the hospital and there was never any follow-up welfare checks. At the time, I was really numb.

"It was my GP who supported me and gave me every test possible to show me that I wasn't at fault for our baby's death, as I wanted to know why my waters had broken early. I blamed myself for our baby's death so my GP arranged for tests just to prove to me that there was nothing I could have done. I was also having nightmares and woke terrified if anyone tried to contact me through the night.

"I really did blame myself. I remember going back to the Countess of Chester Hospital at some point and speaking to Gill Davies, an obstetrician, as I was hoping to get a hysterectomy to make sure that this could never happen again. I thought it was all my fault, that I had done something or given our baby something to make her come out too early. Gill tried to reassure me that what had happened to our baby was a random thing and she promised me that if I had another baby everything would be carefully checked.

"As time passed, my husband continued to blame the hospital for our baby's death, so in a way, I was glad that our baby had had a post-mortem as I felt that it would show if the hospital had been at fault.

"I remember my husband and I got a letter at some point from the Coroner. Looking at the Coroner's bundle, I can see it was dated 28/10/2015. I didn't

really know what it meant at the time, but I do remember talking to a family member about what an inquest was as it was mentioned in the letter.

"We had our baby's funeral in early November 2015 and I asked that people didn't buy cards or flowers, that they should donate to the Neonatal Unit at the Countess of Chester Hospital. I can't remember which day I went back to the Countess of Chester Hospital, but I popped in to bring the donations from the funeral in person. I remember bumping into Nurse X. I wasn't necessarily trying to talk to her, but I had just let the Unit I know was coming in and Nurse X happened to be the first person I saw.

"We spoke about our baby, and how shocked she was that our baby had died because she was doing so well. Nurse X had had to ring me just before she died to ask for more baby clothes. I distinctly remember Nurse X saying 'I even had to put clothes on her' during this conversation. Putting clothes on was a big deal in the Neonatal Unit. When babies are unwell or very premature, they cannot hold their body temperature so their incubator had to be set to a certain temperature to keep them warm or cool, and they have no clothes on as a doctor may need quick access to them. The babies just lie in their nappies until they start to get

better. By saying our baby needed clothes, I understood this was Nurse X saying that she had been doing well.

"I understand from Nurse X's witness statement that she doesn't remember saying this, and that she remembers me asking why she dressed our baby. I definitely didn't ask Nurse X this. I already knew why she had dressed our baby as she had called me to ask me to bring in more clothes, so I am certain that I didn't ask her anything like that.

"I also understand that Nurse X doesn't recall saying anything about prematurity. It is my recollection that Nurse X said 'I don't think it was prematurity related', as we were already discussing how shocked everyone was that our baby had died. The impression I got was that she thought our baby had some kind of underlying condition or that something had happened to cause her death.

"Around this point in the conversation I remember Dr Harkness approaching. I understand from Dr Harkness' witness statement that he says I came to the Unit a few times. I remember I wanted to drop some things off for another parent once, but I might have even done that when I was dropping the donations off, but I don't recall coming back any other time. I'm not sure where he got the impression that I did but I distinctly

remember leaving the Unit after dropping the donations off and thinking 'I can't go in there again'."

"Dr Harkness and I spoke briefly. He gave his apologies about our baby's death, and I changed the subject quickly. We spoke a little bit about how her grave was going to be a castle. In his statement I understand he says that I felt 'fobbed off' by Alder Hey Hospital. I didn't feel 'fobbed off', I felt let down by them. They made her nil by mouth and said they would do the dye test and they never followed through. I was angry at them. I felt our baby had been starved and wondered what if they had done the test and they had found an issue with her bowels? Would she still have died?

"I also understand he says I was annoyed by the transfers our baby had to endure. I was never angry at the transfers themselves, it just meant she was really poorly.

"Dr Harkness and I didn't discuss our baby's possible cause of death and he wasn't there when Nurse X and I were talking about it. Soon after he joined the conversation, I saw Ashleigh approaching and I had too many bad memories wrapped up with her, so I ended the conversation and left.

"I understand that the Coroner sent another letter

on 12/10/2016. Thinking back, I must have received the second letter although I don't remember it. It stated that the investigation into our baby's death was being discontinued and enclosed the death certificate. This is because I remember I rang the Coroner's Office when I received the death certificate to ask about a toxicology report. They told me that the hospital hadn't requested one. My thoughts were if she'd died at home, she would have had one so why not when she was in hospital? The fact a toxicology report was not performed had not been explained to us by the hospital. By the time we found out about this from the Coroner, it was too late as our baby had been buried.

"The post-mortem report came back with the cause of death as being prematurity and confirmed that there wasn't anything wrong with her bowels. I have never been happy with this conclusion, as our baby wasn't born a poorly little baby; she just became poorly. I still remember *(redacted)* telling my mum that I'd been reading our baby's monitors wrong and I put that down to two things: guilt on *(redacted)* behalf or because she'd turned them off when our baby had clearly been struggling. Had the monitor been on, I believe our baby's condition would have been detected earlier or she had got something to hide. I blamed her, even though

she only looked after our baby maybe three times.

"I remember having a meeting with Dr V with the results of the post-mortem. I remember her saying that the hospital may discuss our baby in later meetings. We weren't given the impression that they were investigating anything; we thought it was for training purposes or something like that.

"When I left, Dr V made it perfectly clear that our baby had died from prematurity and she had explained that our baby had damage to the brain, but we knew that before she died.

"I understand that a Datix report was created on 23/10/2015 about our baby's death. As with the other Datix reports, I wasn't told about this at the time. This certainly wasn't discussed during my conversation with Dr V.

"In around January 2016 I started to get nightmares again. I'd wake [up] in the middle of the night dreaming that I was back in the hospital and that the nurses were banging on my door. I also had to turn my phone off at night because if someone texted or phoned me in the evening/night I would panic.

"In April 2016, I was diagnosed with having Post Traumatic Stress Disorder.

"The Royal College of Paediatrics Review.

"I received a letter from the Countess of Chester Hospital asking me to contact them to make an appointment to speak to someone. I thought it was around January 2017, but I can now see it was dated 08/02/2017. Apparently, they had tried to call me a few days before as well.

"Included within this letter was a link to a review the Countess of Chester Hospital had conducted which related to a number of baby deaths during a specific time period. This was the first I'd heard of any review or investigation, so it was a bit shocking. I had no idea that any investigation or review was being conducted by the Countess of Chester Hospital.

"Receiving this letter was the first I'd ever heard of the Royal College of Paediatrics and Child Health Review. I also was never aware of an advisory report prepared by Dr J Hawdon. The first I'd heard of this was when my solicitor mentioned it to me while I was making this statement.

"I went onto their website and read the report. I'll be honest and say I only skim-read it. I did however recognise that our baby's death had been included even though she hadn't been named. I knew they were referring to her because she'd been the only baby who'd died on that ward on 23/10/2015.

"I contacted the hospital on what I can see was 09/02/2017 and asked if the report related to our baby's death, to which the person (I believe was probably a receptionist) said 'Not really, but I can't really go over it over the phone'. I remember telling her that I was pregnant again and unless they had a good reason, I didn't really want our baby's death raking back up and I was trying to keep things as stress free as possible.

"I have seen the note of the telephone call. It is my recollection that when I asked if the Review was important, that she told me, 'To be honest, all this is for us to improve our services, but we'll leave your baby's file open, and you can come and see us after you've had the baby if you choose to', although I see she didn't put that in her notes. I specifically remember her saying this because I rang my mum after telling her that the report was for training. I do remember talking to her about how I didn't have any concern about our baby's care, and how I was frustrated at Alder Hey Hospital. This was the only discussion I had with the Countess of Chester Hospital about the Review.

"Police investigation and concerns over Lucy Letby.

"On 11/05/2017, I was contacted by Cheshire Police

who informed me that they'd commenced an investigation into the large number of baby deaths/collapses at the Countess of Chester Hospital between 2015 and 2016. They called me to make an appointment to come and see me the following day. However before they arrived my waters broke. My mum had to wait at the house for them to arrive to tell them.

"I gave birth to my youngest daughter by emergency C-section on *(redacted)* May 2017 at the Countess of Chester Hospital. By this point the whole world knew there was a police investigation into the baby deaths at the hospital and there was press lining up at the hospital. This was a really difficult time for me. Eventually we were moved to Liverpool Women's Hospital.

"When I did finally speak to the police, I got the impression that they were investigating our baby's death and thought it might be down to hospital mistakes but that they had to look at the criminal side just in case. I was stressed about how I was going to tell my husband as he was always sure something had gone wrong and I was always telling him he was being stupid.

"According to the witness statement I gave to Cheshire Police at 1.05 pm on 20/11/2017, I handed DC Price the following items for their investigation:

"Mother I Exhibit 1: plastic container containing

medical equipment used by Child I on date of her death (also a separate box which is a memory box which contains clothing worn by our baby).

"Mother I Exhibit 2: personal child health records.

Mother I Exhibit 3: two pictures of our baby, documentation with death certificate.

"Sometime after I was informed of the police investigation and I had given our baby's things to the police, I did try and contact someone at the Countess of Chester Hospital. The police were being very tight lipped about the investigation, and I wanted our baby's things back or some progress or something. I phoned them, but I was told that they could no longer give out any information as it was with the police now. I remember thinking I should have spoken to someone about the Review report earlier.

"Looking back, I didn't have many dealings with Lucy Letby. I have already outlined the ones I remember. I remember thinking she was a bit quiet and a bit odd. She always seemed a bit of a loner. The most interaction I had with her was when she helped me bathe our baby. We saw her around on the odd occasion, but we didn't have much to do with her. She was always the most reserved of the nurses. I remember thinking she seemed miserable compared to the others and I never

saw her interact with parents much.

"Now I have seen the medical records, I am absolutely shocked at how much 'care' she provided to our baby. She is all over her notes. I have noticed a lot of the 'care' was when I wasn't present.

"I have been told that Lucy Letby sent us a card when our baby's funeral was held. I don't recall receiving one at all. I did get sent some cards, and I kept them, and I have looked through them, but I haven't found a card from her. For the funeral I specifically requested no cards, so someone else might have opened the card and thrown it away. It wasn't for anything personal that I told everyone not to buy a card -- I felt I didn't want cards for her for this. I had told everyone to buy cards when we brought her home and we weren't going to bring her home. Instead, I told people to donate to the Neonatal Unit. I didn't want sympathies for me. It was never about me, it was about our baby. Knowing what I know now, I am glad I didn't see it and that I don't recall anything about Lucy Letby's card.

"I have been asked if the Countess of Chester Hospital ever said anything or provided any information about concerns over Lucy Letby's conduct. They didn't mention anything to me at all. As explained above,

I tried ringing them during the police investigation and they wouldn't speak with me. I certainly was never told of any actions the Countess of Chester Hospital was taking about concerns with Lucy Letby's conduct. The first I heard of anything was when doctors and staff were giving evidence during the criminal trial.

The police remained very tight lipped about what or who they were investigating. In March or April 2018 I went to see Dr Brearey at the Countess of Chester Hospital. During this appointment he asked if I had heard from the police. At the time I was annoyed as I hadn't heard from them for months and I couldn't get hold of my Family Liaison Officer. He went on to talk about the nurses on the Neonatal Unit and how they were struggling and how hard it was. I told him my theory that it could have been an infection that had caused Baby I's ultimate demise. If there was an infection on the unit, those nurses should have kept the babies away as an infection could have harmed all of the babies in the Unit. I had many theories at this time as I had been told nothing by the police. Dr Brearey told me that it wasn't an infection, that everything had been tested and our baby was clear. My reaction to that was that if it wasn't an infection, it only leaves that someone tried to hurt my baby. I said 'How can I live

with myself knowing that someone would have tried to hurt my baby?'. Dr Brearey said that I would never have known. I walked out of that appointment thinking someone had deliberately killed my baby.

"I was officially made aware that our baby might have been murdered and that an arrest was going to be made when the police phoned me at 6 am on the morning they were making the arrest. When they told me, my whole body started shaking and the thought of having to tell my husband was awful as he wasn't with me when I took the call. This was in July 2018. I was shocked that it was Lucy, but my husband wasn't when I did tell him. He always had suspicions that something wasn't right and now it had been confirmed, although if he had to point the finger at anyone, he had assumed it was *(redacted)*. The police then came to see us later that morning. We were not given any details at all about how or why, only that an arrest was being made and how long they would be questioned before being bailed etc.

"A few weeks after this, we had an appointment with Detective Superintendent Paul Hughes as he had agreed to speak with all the families. I asked if Lucy would be charged and he wouldn't confirm this, but said they were confident that our baby had been deliberately harmed. We were so broken that someone could do something so

evil to our precious little girl. It has had a massive effect on our family even to this day.

"I have been asked if I consider that the Countess of Chester Hospital was 'open and honest' with me at the time and after in respect of our baby's death. At the time, I thought they were honest with me. I only had good things to say about them. This is obvious as I collected donations from my baby's funeral and said I was happy with the care our baby received when speaking to the receptionist about the Review report.

"With what I know now, I don't believe that they were being honest at all. I had doctors and staff telling us that our baby's collapses and conditions were 'normal' but it turns out it wasn't normal. Staff at the hospital already had concerns about babies being unwell and about Lucy Letby well before our baby died. I, hand on heart, believed everything they said to me at the time, and now I am so angry they were not being honest. I feel lied to and that they were just covering their own backs. Even the receptionist I spoke to about the Report downplayed it and said it wasn't important and it was basically for 'training'.

"I felt totally blinded by all their lies and cover-ups. My husband isn't surprised though, he always believed something had gone wrong and the hospital was

responsible for our baby's death.

"I had never felt the need to request our baby's medical records until I was told that someone was being arrested for her murder but by that time, I had instructed Irwin Mitchell (solicitors) and they had requested them on my behalf. Once they got them, they sent copies to me so I could review them. As I mentioned before, when I reviewed them, I was shocked by how much care was provided by Lucy Letby. She was all over the records. The only overly concerning thing was that there was a note that at some point our baby was given too many antibiotics, and even though there was no harm done, no one ever told me this.

"Knowing what is in the medical records, and after hearing evidence at the criminal trial, I truly believe that our baby was tortured. She died because she had no fight left in her as she suffered collapse after collapse, and in the end was kept nil by mouth for a test that was never done. She went through so much in her short life that was deliberately done by someone who was supposed to protect her and help her come home where she belonged.

"Bereavement counselling and support.

"When I think back, I am disappointed by the help and support offered by the Countess of Chester Hospital

after our baby died. I remember I was given a leaflet about counselling services on the day she died. I didn't have any other support. It was just left up to me. They dumped this information on us on the day our baby died, and I had these carrier bags of things that I was leaving with and not a baby. I was expected to reach out for support when we were in the worst pain and emotional state any human can imagine. No one reached out to us to offer support of any kind.

"My real lifeline was my GP. I would sometimes book an appointment to see the GP so I could offload as I was so sad. Eventually my GP booked for me to see a counsellor, but I had to wait months to get an appointment and then it was just to speak to someone to see what kind of counselling I needed. I heard nothing for months after that, and as I had started to pick myself up at that point, I didn't follow it up.

"The first year after our baby's death was a blur and I don't know how we as a family got through it. I wore sunglasses constantly to hide the pain and tears from my other kids as I didn't want to upset them as they were also struggling. I struggled in public, to eat, to sleep, and I would just relive the collapses. My emotions felt like they were happening again. I would have nightmares and night sweats and sank into

a black hole, and it was harder and harder to keep going.

"By April 2016 they'd got so bad I asked my health worker and GP for help. I didn't think it was depression, but I just couldn't snap out of it. They arranged for me to see an emergency counsellor who diagnosed me as having PTSD. Once I'd been diagnosed, my symptoms appeared to improve. I think it helped just to know what was happening to me.

"My husband struggled to be around us as a family and went to the pub to try and cope. He wished that he was dead instead of our baby. We even separated for a while as neither of us could deal with what happened. Our other kids also suffered. They gave up things they enjoyed and my older daughter stop speaking.

"Eventually we got back together and I got pregnant again. I don't remember any of the pregnancy really. I put a wall up and blocked it out as we were filled with fear. What if the same thing happened again? Scans were not happy moments -- again, just filled with fear. When our daughter was born, she was born at 34 weeks so I had to go to the NICU again and it was terrifying. We didn't leave her for a second. I couldn't bring myself to breastfeed my daughter as I had a fear that my milk had caused our baby to die.

"My GP prescribed me beta blockers, antibiotics and sleeping tablets. I was having nightmares and couldn't sleep for the first year after our baby died, and then it started all over again after I gave my police statement for the criminal proceedings. When the police got in touch, I went straight back down the black hole of depression. I started counselling in 2018 through the police and Victim Support services and I have been using this on and off ever since.

"I didn't request any additional support from the Countess of Chester Hospital as I didn't know there was anything available.

"Raising concerns.

"As I explained above, I didn't have any concerns about the Countess of Chester Hospital at the time our baby died, but my husband did and was always convinced someone was responsible for what happened. My husband has not spoken to anyone at all; he really struggles talking about anything and I do worry about him. We asked the Countess of Chester Hospital for *(redacted)* to not come to the funeral as my husband had held them responsible for our baby's death. He blamed everyone who was there for not doing enough. I didn't raise this with the hospital though and neither did he.

"After all my years of counselling, I can see it is

easier to be angry than it is to show emotion. That is how my husband goes through all of this, but in the end he was right. Throughout the years after our baby's death my husband has ranged from being convinced that a nurse had 'done something' on the night our baby died to believing our baby had died as the treating doctors hadn't done enough to save her.

"We didn't raise concerns for a few reasons. I believed that the Countess of Chester Hospital had done everything they could. I never imagined that someone would deliberately hurt our baby. I didn't know the doctors had concerns about Lucy, because they didn't tell me and instead told me everything was normal. I didn't know they had been lying at that point. Secondly, we didn't think anything would be done even if we did report our concerns and I would not have known where to report our concerns. Based on the incident mentioned above when a nurse gave milk expressed by one mother to a different baby, I would not have been confident that reporting concerns would make any difference. That incident was reported and it didn't go any further, the nurse never apologised and the other baby's parents were never informed so what was the point? When it started to become apparent that something was wrong, everyone closed ranks, and no-one

would give us any information.

"We did not speak with PALS and the only external organisation we spoke to was Irwin Mitchell (solicitors), who were first contacted in July 2018. I was not aware of any other organisations we could have contacted. I have not been involved in any other reviews concerning baby safety.

"I have seen the witness statement provided by our Family Liaison Officer, DC Griffiths. Our FLO made a statement which I have read and I totally agree with what she says. I often felt alone and completely out of the loop about what had happened to my baby. It feels like everyone else knew and I didn't. I had to find out that someone might have intentionally harmed our baby at a check-up appointment with another doctor. Even when the police did tell me, I wasn't allowed to know how my baby had been harmed. Eventually when I was given this information, I had to sign a non-disclosure agreement and I was told I could not even tell my solicitor or my counsellor. I understand why the police wanted to keep this information confidential, but it was very hard and I spiralled down that black hole again. I believe there was a real lack of transparency thorough this whole process, starting at the Countess of Chester Hospital where I was assured 'everything is normal', to being

told that the RCPCH Review was just for 'training', to everyone at the Countess of Chester Hospital closing ranks and not talking to me, to the police drip-feeding me information. I spent years digging for information, and it has taken me to some very dark places mentally. I believe it would have been easier if everyone was more open and helped a grieving family understand what went wrong, why our baby had died when she was actually progressing well despite being born prematurely, and what support was available for us to access if/once we were ready to confront the horror of losing a baby.

"I have been asked what in my view would have assisted in preventing Lucy Letby's crimes. I believe the doctors and nursing staff should have acted earlier and those in positions of authority at the hospital (ie, the management at the Countess of Chester Hospital) should have listened to them instead of trying to create their own narrative that Lucy Letby was a victim of bullying and harassment. Someone should have investigated the concerns fully at the time. This is what management are paid so handsomely to do. They shouldn't have been concentrating on saving their own skins and jobs and reputations. Babies died because someone in an office being paid hundreds of thousands of pounds didn't want the hospital to look bad if they shut

the Neonatal Unit down while they investigated why so many babies were deteriorating when they should have been thriving. Covering up failures, inadequacies and deliberate harm was valued far higher than the life of a baby whom they should have protected unconditionally.

"Even the many doctors who had concerns because they were overworked and understaffed should have spoken up earlier and louder than they did, though, given the way they saw their colleagues who did raise concerns were treated by management and the regulatory bodies, some may be forgiven for believing that speaking up was futile. However, I believe that much more should have been done after the first three babies had died within a short space of time in similar circumstances. Had prompt and effective action been taken at that time, so many other babies would have survived or not have suffered enduring life-changing harm. How many babies needed to die/be seriously harmed for action to be taken to stop Lucy Letby? Sadly, we all now know the answer.

"I understand that complaints were made about Lucy Letby far earlier than when she was suspended. If they had just had someone supervise her work, that might have saved the life of number of babies and the permanent injury of many more. Even if they weren't suspicious of Lucy Letby but they had investigated

a potential infection outbreak or faulty machine, it might have been enough to stop Lucy Letby from having the opportunity to harm my baby time after time until she succeeded in killing her.

"I think there are a lot of changes that could be made that can make any and all hospital wards safer. I have heard people mention having cameras on the medication dispensers but I don't think this is enough. In the Neonatal Unit, practically anything at all could be dangerous to premature and sick babies, not just medication, so I think there should be cameras on all the babies. I can't think of anyone that would try and claim it was an invasion of privacy to have their newborn child monitored not just medically but also, actually, to prevent any harm arising or for there to be deniability when things go wrong. If this had been available when our baby was at the Countess of Chester Hospital, Lucy Letby would never have been able to hurt our baby or indeed others.

"I also think there needs to be much more effective oversight at all levels of hospital management and overall at the Trust. People paid huge salaries allowed this to happen. They made doctors apologise to Lucy Letby when she had murdered babies and continued to harm other babies. The Countess of Chester Hospital was

totally blinded by self-preservation that they forgot why they exist -- to remain true to the Hippocratic Oath 'I will use my power to help the sick to the best of my ability and judgement. I will abstain from harming or wronging any person by it'.

"Finally, I think all hospitals and Trusts need to have a robust and fast investigation process whereby mistakes, issues with systems, personnel and the like can be looked into and any harm arising stopped as soon as reasonably practicable. The death of one baby in suspicious circumstances should be enough to result in a prompt and robust investigation as, sadly, families cannot rely on the inquest process to look into suspicious deaths as effectively as is expected. For example, the Coroner in our baby's case did not really consider the full facts and medical history to ask the simple question of 'why did this baby appear to thrive but have several serious crashes, one of which resulted in her death?'.

"I absolutely feel that the way information was shared with us was wholly inadequate. The same doctors that gave evidence at the criminal trial and said that they had suspicions of something going on before our baby had even arrived at the Neonatal Unit were the same doctors that told me that these collapses were 'normal'.

There was no way I could have made any informed choice about what the best care for my baby might have been, when the key information was being withheld from me. The staff were not telling the truth or being honest while on the ward, but appeared to discover their moral and professional obligations when giving evidence in court. This is where a lot of my anger comes from -- these people were speaking to me, and they had suspicions but told me everything was fine.

"I understand that they couldn't tell me that they had reservations without evidence, but they shouldn't have told us everything was normal. I could have made my own decisions -- I trusted them and believed everything they said, and it was not the truth. I could have made the decision that she was better placed somewhere else, or that they could have had more oversight at the time.

"The Trust could have told me about the RCPCH Review that was going on in 2017 and been honest when I asked if it was important. I had just lost my baby and I was pregnant with my youngest daughter and trying to drag myself out of the black hole of depression, so I relied on them to be honest with me and they brushed it off.

"Finally, I understand the police had to be careful about what was said so not to jeopardise the criminal

trial, but they were so closed off and unhelpful and at times it was very isolating.

"In terms of additional support, I think it would be helpful if counsellors and bereavement services reached out to you. When you lose a baby, you are numb for a long time. You are still sad but numb. It doesn't hit you properly, but when it starts to hit -- especially when you have been in a cocoon of a Neonatal Unit -- it could be months down the line and you hit rock bottom and there is no one there or anyone to offer support. When they offer support, you don't feel like accepting anything, but when you need it there is nothing.

"If I had support services ring me and offer help, I might have accepted it earlier, and if they had conducted check-up calls a few weeks or months down the line, I might have been able to access help earlier. When you're in a black hole, you can't always find the momentum to get the help you need but if someone reaches out to you, you might accept it.

"I also think there should be consideration of sanctioning (and where appropriate removing) any manager/person in a position of authority who ignores concerns raised by whistleblowers. At the present time, there appear to be no sanctions against those who lied and kept information whilst babies were being

killed/harmed by Lucy Letby. It was only when it became untenable to keep up the pretence that they finally opened up on the scale of concerns raised against her and the number of babies that she had harmed. Yet those managers/people in a position of authority were not sanctioned and continue to work unhindered by their unprofessional and morally corrupt conduct.

"I honestly believe that these people should have to explain why they didn't do something earlier, why they ignored the multitude of concerns raised about Lucy Letby's conduct, why their actions facilitated a mass murderer.

"Our baby would have turned nine this year. We should have been watching her grow and play with her siblings and friends. However, we have to somehow try to live with the fact all this has been taken away from her and us in the cruelest way possible. No parent should ever have to go through what we have been and continue to go through each and every day. To understand how easily my beautiful girl's death could have been prevented hurts even more. Forever and a day, I will continue to ask 'why?'"

Thank you very much, my Lady.

LADY JUSTICE THIRLWALL: Thank you, Mr Sharghy.

Mother I, thank you very much indeed for providing

that very frank and detailed statement, and also for inviting us to hear Mr Sharghy read it so that it would be read into the record. As a result, it's there for consideration and inclusion in our review of the Terms of Reference, and I just wanted to thank you for that. Thank you very much indeed. And also, for being here today, listening. It's very good to see you, and thank you.

(3.42 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X