

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

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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

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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

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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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 It didn't.

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1 is when I trusted the hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 And he said, "Well, can we wait another four hours?"
4 I said, "I don't want to wait". But we still had to
5 wait. And then, when he came back, and because I said,
6 "Why would I wait?" And he said, well -- he went into
7 the technical and he said, "I'll exam, I'll do the
8 exam". And he said, "You're not dilating."

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

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

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

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

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

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

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

19 **Q.** Let me ask you another question.

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

24 **A.** So not straight away.

25 **Q.** When were you told that?

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1 A. Well, I ordered them to take her, because -- so they
 2 brought her back to the room, and they put her for skin
 3 to skin on me, and she didn't feel right, she didn't
 4 feel lively or with me. And I could see I wasn't
 5 connecting with her; I could feel she wasn't there, and
 6 was asking, I could see there was plenty of nurse coming
 7 in and out and I was saying, "Can you please come and
 8 check?" And they were saying, "Oh no, she's fine, can
 9 you try to feed her?" And she was not interested in
 10 feeding. I said, "She seems very floppy and she's doing
 11 that noise". I didn't know what it was called but she
 12 said, "Yes, it's grunting. She's come three weeks early
 13 so the lungs sometimes don't quite work as well as
 14 a full-time baby and you've given birth through
 15 C-section so, you know, she's a bit shaken, that's
 16 nothing to worry about".
 17 And I said: "Well, she does not look right so can
 18 you please ask the doctor to check on her"? A doctor
 19 came and I was very annoyed because he had that smirk on
 20 his face, and very dismissive, and he's just like, "Oh,
 21 no, the baby's fine, there's just nothing odd here".
 22 And I wasn't happy and I said, "I want a second opinion.
 23 I want you to go and ask another doctor because this is
 24 not right. She's not responding like she should".
 25 Q. You say in your statement at paragraphs 42 and 43 that

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1 first time to Dr Brunton and he came to us, and he
 2 reassured us he said, "Listen, everything's fine, she's
 3 much better. She's come off the light therapy. She's
 4 picking up. She seems to be more lively". She seemed
 5 to react as she should react. All the obs and the
 6 readings were going better. And they said: if all
 7 carries on, continue expressing milk, and if all carries
 8 on, tomorrow morning you can breast feed her and you can
 9 have a cuddle and that's that. She's on her way to
 10 recovery. She's -- full recovery".
 11 Q. You say that the about 2 am in the morning you
 12 understand Dr Newby was called urgently to see Child D
 13 because of an unusual area of mottling. How do you --
 14 were you told about that first time --
 15 A. No.
 16 Q. -- that Dr Newby was called? No. So you know that from
 17 the notes?
 18 A. Yeah.
 19 Q. You say:
 20 "I found out afterwards this was across Child D's
 21 abdomen and was said to be because of sepsis, something
 22 I could not understand."
 23 Then you say:
 24 "At 3.15 am, a second call was made because Child D
 25 was very upset and crying and at 3.45 am her alarm

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1 after you had first been able to visit her, you say
 2 there:
 3 "Child D looked better and was a better colour.
 4 Father D took me back to my room and Dr Brunton went to
 5 see Child D. She was doing much better. I was told to
 6 continue to express milk. At about 7 pm, I understood
 7 that Child D was doing well and she was improving and
 8 was responsive on handling."
 9 You say here:
 10 "I know that ventilation was removed and she seemed
 11 to be making a good recovery. I was told if everything
 12 continued to improve I'd be able to hold her the next
 13 day."
 14 Do you remember being told that?
 15 A. Yes, very clearly. So that time between when she went
 16 to intensive care and then, there was, at first they
 17 weren't so sure of her condition or how she will do, and
 18 but there was never a concern for her life. They just
 19 say, you know, she's just born, and it was a bit of
 20 a shaken start so she just needs a bit of care, she's
 21 a bit vulnerable, but she'll be fine. They said that
 22 they started the treatment, just watching her obs and
 23 that was that throughout the day, and my husband has
 24 been with her most of the time.
 25 And during that day, that was when we spoke the

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1 sounded."
 2 And you say it was at 4 am that you were woken up by
 3 one of the nurses?
 4 A. Yes.
 5 Q. So tell us about how you were woken up and what was said
 6 to you?
 7 A. It was the first night since my water broke that I let
 8 go, and I thought, "I will rest, because things are
 9 okay. She's going to be okay, and we can rest". The
 10 same for my husband. We were together in the same room,
 11 yes, we were sleeping. Someone came to the room,
 12 a nurse, and she said, "You need to come now, your
 13 daughter is very poorly" and we just said -- and she
 14 said, "You need to come now". And I couldn't get out of
 15 the bed on my own so my husband got me on the wheelchair
 16 and she was rushing us, and when we arrived, that's when
 17 there was the scene. I couldn't see my daughter.
 18 I could see Dr Brunton holding her, and trying to save
 19 her. There was a lot of people. One that was doing
 20 nothing useful, that was Lucy Letby. And she was just
 21 looking at us crumbling and crying and Dr Brunton was
 22 trying to save my daughter, and he was trying really
 23 hard. He was just -- someone -- well, Letby was holding
 24 the phone to his head and I was saying "What's going on?
 25 Why has he got -- he's busy, why is there a phone?" And

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

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

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

20 **A.** Yes.

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

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

21

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

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

20 **A.** Yes, she did. Yes.

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

22 **A.** Yes.

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

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

23

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

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

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

11 **A.** She was upset.

12 **Q.** And you say it was all so unexpected?

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

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

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

22

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

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

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

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

24

1 with your baby and one stays with you. And I mean maybe
 2 if your baby has been alive for a little while you might
 3 have some memories, but there wasn't any. I did ask,
 4 when my daughter was born, they give the babies a hat
 5 and a blanket and I did ask to have these two. They
 6 brought a blanket that was not hers. It made me very
 7 upset, and they said, "That is hers". And I said, "I'm
 8 telling you I know what her blanket was and that was not
 9 her blanket". I don't know where the blanket ended up
 10 but the box had nothing in it. They gave the bracelet
 11 with her name on it. That was that. An empty box.
 12 **Q.** I'm going to come now to the questions you were asking
 13 and the cause of her death and deteriorations and we
 14 know you had a meeting with Dr Joanne Davies and you
 15 said Joanne Davies and nursing staff on 24 June 2015.
 16 Do you know what nursing staff or who was there or not?
 17 **A.** Sorry, can you repeat?
 18 **Q.** You say in your statement at paragraph 59:
 19 "We had a meeting with Dr Joanne Davies and nursing
 20 staff on 24 June 2015."
 21 **A.** Yes. That was more to do with my -- although I had
 22 questions about what happened, it was more about my
 23 condition, because I wasn't recovering as expected.
 24 This is why I had an MRI and --
 25 **Q.** Don't worry about that. We don't need to go into that.
 25

1 policy below 37 weeks. I apologised for this missed
 2 opportunity."
 3 It goes on:
 4 "I explained that when she was initially seen at
 5 36+6 weeks, the decision was made to induce her the
 6 following day and therefore manage her as a term rupture
 7 of membranes. The main difference in this management is
 8 that oral antibiotics are not started, intravenous
 9 antibiotics in labour are only started if there is
 10 evidence in a change in maternal observations or fetal
 11 observations. Neither of these occurred in Mother D's
 12 labour and therefore she was never given intravenous
 13 antibiotics. I apologise for this.
 14 "We had a long discussion about the possible
 15 implications of not having these antibiotics. I have
 16 explained to her that we can never know that if she had
 17 got these antibiotics we would not have had the same
 18 outcome. We also had a long discussion about NICE and
 19 college guidelines around premature rupture of membranes
 20 and term rupture of membranes and the arbitrary cut-off
 21 of 37 weeks, and if Mother D had been only one day
 22 further on in her pregnancy and had followed the term
 23 rupture of membranes guideline, this management would
 24 have been correct."
 25 Over the page at the top:
 27

1 **A.** Yes, okay.
 2 **Q.** If you go to page 45 of the bundle, we see there
 3 a letter from Dr Joanne Davies to, I assume, a GP. You
 4 don't need to give a name of the GP. But I want to look
 5 at some of what she is saying in this letter, at this
 6 time. She says:
 7 "I saw Mother and Father D today in the Pregnancy
 8 Risk Clinic following the sad loss of Baby D. As you
 9 know, Mother D had spontaneous rupture of the membranes
 10 at 36+6 weeks gestation and after an emergency caesarean
 11 section for failed induction of labour.
 12 "Baby Child D became unwell and subsequently died on
 13 the neonatal unit hours later. Since then, we have had
 14 the post-mortem back which essentially has shown acute
 15 pneumonia."
 16 It says at paragraph 2:
 17 "We had a very long and detailed discussion about
 18 her antenatal and intrapartum care. I explained there
 19 had been an obstetrics secondary review and also
 20 a multi-disciplinary perinatal mortality review to
 21 discuss the case.
 22 "Following these case reviews, I explained to them
 23 that the findings were that we had missed an opportunity
 24 in giving Mother D both oral antibiotics and IV
 25 antibiotics as per the premature rupture of membranes
 26

1 "This was obviously very difficult for them to take,
 2 and I agreed with them, if the guideline is in place
 3 then it should be followed. In this case it was not
 4 done so."
 5 And at the end of the letter the same page it says:
 6 "They were both keen to know the processes that had
 7 taken place after the review in this meeting.
 8 I explained to them the reviews have produced an action
 9 plan. The main actions are around learning for the
 10 individual members of staff involved in the team but
 11 also review of the term 'Premature Rupture of Membranes
 12 guidance' and the timing of induction. I reassured them
 13 that all members of the team, both obstetrics and
 14 paediatrics, took any poor outcome very seriously and at
 15 all times wanted to learn to improve practice.
 16 "As far as what happened from now for them
 17 I explained to them the complaints process and if they
 18 wanted to go forward with that."
 19 So discussion there around antibiotics, and we know
 20 you had another meeting on 17 August when you asked
 21 Dr Newby lots of questions. And if we turn to page 23
 22 in the bundle, we see that letter. It's page 23.
 23 A letter to Mother and Father D, and Dr Newby is
 24 thanking you for coming in and she summarises the
 25 details of the discussions.
 28

1 At the first point she says:
 2 "We discussed that paediatric involvement started
 3 from the time of Child D's birth and therefore these are
 4 the aspects of care which we discussed at the meeting.
 5 We discussed that a Neonatal Morbidity and Mortality
 6 Meeting had taken place on 29 July 2015, at which we
 7 discussed in detail Child D's care as a department.
 8 Present at that meeting were myself and my consultant
 9 colleagues including our Neonatal Lead, Junior Doctors,
 10 some of whom were involved in Child D's care and our
 11 governance facilitator."
 12 Did you know at the time those meetings were
 13 happening and did anyone ever ask your view or thoughts
 14 in respect of that meeting?
 15 **A.** No, which I commented on that.
 16 **Q.** Over the page at paragraph 4, page 24, paragraph 4:
 17 "We discussed that unfortunately the post-mortem
 18 results are as yet unavailable but we felt as
 19 a department that the most likely diagnosis was one of
 20 sepsis, ie overwhelming infection, and we discussed the
 21 signs that led us to this diagnosis."
 22 And at bullet point 6 on the next page, 25:
 23 "We discussed the aetiology of the rash which is
 24 documented to have appeared during Child D's first
 25 episodes of deterioration. This appeared to look like
 29

1 reasoning. It doesn't add up or doesn't explain, and
 2 you have to do better than that".
 3 **Q.** We know you wrote to the Coroner on 23 September 2015.
 4 That letter, my Lady, is at page 48 of the bundle.
 5 Page 48 to 50, Mother D.
 6 You say to the Coroner:
 7 "As discussed over the phone with Yvonne Williams,
 8 my husband and I would like you to start a complete
 9 inquest following our daughter Child D's death."
 10 You set out a number of matters. You set out how
 11 you were induced. You set out how handover and
 12 communication failed, as you were induced as being full
 13 term where in fact the membranes ruptured prematurely,
 14 this being a high factor for infection.
 15 You set out over the following page:
 16 "Taking into consideration all of the above,
 17 Child D, a greater risk for infection should have been
 18 taken straight to Neonatal Intensive Care."
 19 You set out Apgar scores. The last but one
 20 paragraph, you say:
 21 "Post-mortem confirmed pneumonia. I believe it is
 22 known by the doctors that early onset pneumonia in
 23 newborn are due to bacteria, most commonly Strep B, that
 24 same bacteria being the most common reason for Premature
 25 Rupture of Membrane. Placenta could have provided more
 31

1 bruising under the skin and we discussed that this was
 2 likely a sign of the effects the infection was having
 3 upon Child D's circulation."
 4 Do you remember the post-mortem results and sepsis
 5 being discussed with you at this time?
 6 **A.** No, and I -- as much as she was a doctor, I clearly
 7 said, "I disagree". And I asked -- so at the meeting
 8 I said you had -- so when my daughter was born and
 9 started on antibiotics they said, "We will run the tests
 10 but it takes a few days". She passed before the test
 11 results. But when the test results -- and when we left
 12 the hospital we still didn't know. When we finally got
 13 to meet with the doctors, I said, "What were the test
 14 results? Did she have an infection?" She said, "No,
 15 she did not".
 16 And I said, "Well, you explain this to me because if
 17 an infection is that overwhelming that it will kill
 18 a baby but doesn't show on the reading, this does not
 19 make sense. She was getting better. Not getting worse.
 20 Again, explain". She couldn't explain.
 21 They had to write a report. They had to put
 22 something together because that's what they do; they
 23 can't leave things unresolved and that's what they did.
 24 But that was unsatisfactory for me. I said, "I'm not
 25 accepting your finding. I'm not accepting your
 30

1 accurate data."
 2 Were you all looking all these things up for
 3 yourself? How were you questioning these things that --
 4 **A.** That's when I felt there was half of me that stayed sane
 5 to try to understand and get clued up with what needs
 6 questioning. When I requested the notes, I knew nothing
 7 I was getting myself into. So nothing was in order.
 8 Everything was a mess. So I tried to put it in an order
 9 that made sense. And then there were lots of words and
 10 initials and things noted so I had to understand what
 11 they mean. I had to understand the NICE Guidelines, the
 12 College of London, the protocols, and what should have
 13 been done, in my case whether my daughter was fine or
 14 not. At birth she should have automatically gone to
 15 Intensive Care just to be watched, because of all the
 16 prebirth, which is another massive failure. And they
 17 should have kept the placenta because of all the
 18 labour's situation. They didn't.
 19 **Q.** And you say at the end of the letter at page 50:
 20 "Could you please look into the post-mortem
 21 conclusions, following notes, reports and statements and
 22 review whether Child D's death was of natural causes or
 23 not."
 24 You say in your statement going back to
 25 paragraph 71, you carried out your own research,
 32

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

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

19 **Q.** Why did you want an inquest?

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

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

33

1 list a full inquest hearing as soon as possible."

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

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

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

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

35

1 **A.** Yeah.

2 **Q.** -- asking for an inquest, and making submissions what
3 the family say and what you were saying about the
4 circumstances, including NICE Guidelines, how they were
5 identified, how they weren't followed, not prescribed
6 antibiotics, et cetera. A list of issues relating to
7 your treatment. And then we see at page 54,
8 11 January 2016 the response from Mr Rheinberg who says:

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

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

34

1 not to.

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

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

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

10 **A.** Yes.

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

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

36

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

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

8 "Further to previous correspondence and the
9 completed review of the Neonatal Unit carried out by the
10 Royal College of Paediatrics and Child Health at the
11 Countess of Chester Hospital, I'm writing to appraise
12 you of our current progress. You will have seen within
13 the review that one of the recommendations was that
14 a separate independent review of the care of each of the
15 babies should be carried out. This review has now been
16 completed but has in turn indicated a small number of
17 areas of investigation are required and I aim to
18 undertake this as quickly as possible. I will in due
19 course be sharing the findings of this further review in
20 relation to Child D with you and will be offering to
21 meet with you to discuss any concerns or issues you may
22 have arising from both the College review and the
23 consequent review.

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

37

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

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

13 Did you receive that letter?

14 **A.** Yes.

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

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

39

1 we've carried out the whole review process. I want to
2 make sure I can confidently respond to any concerns you
3 have in an open and transparent manner. Unfortunately
4 due to the depth of investigation, I am not in
5 a position to give you a definitive date for any meeting
6 but will be endeavouring to make this as soon as
7 possible and will certainly aim for this to be within
8 the next six weeks."

9 Did you receive that letter?

10 **A.** Yes.

11 **Q.** And what did you make of that?

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

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

22 "Dear Mother D,

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

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

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

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

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

13 **A.** Yes.

14 **Q.** "We write further in respect of the inquest touching
15 upon the death of Child D due to take place on 25 May.
16 We enclose copies of letters sent to our client from
17 Mr Ian Harvey, Medical Director, dated 3 March and
18 21 April, regarding independent reviews to be undertaken
19 by the Trust on each of the babies identified within the
20 Royal College of Gynaecologists and Obstetricians'
21 Review. The letters indicate that the review upon
22 Child D's death have been undertaken but a small number
23 of areas of investigation are required and in the most
24 recent letter that a consultation was needed with the
25 Pan Cheshire Child Death Overview Panel.

40

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

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

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

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

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

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

41

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

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

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

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

17 **A.** No.

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

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

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

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

13 **Q.** At paragraph 89 of your statement you say:

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

18 That's the Royal College review.

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

23 **A.** No, there was not. No.

24 **Q.** So have you seen them since and --

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

42

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

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

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

9 So, Mother D, we are going to take a break now. So
10 if we can be back ready to start, if you're ready, at
11 11.30. If you're not, we'll wait for you.

12 **THE WITNESS:** Thank you.

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

15 **THE WITNESS:** Okay.

16 (11.14 am)

(A short break)

18 (11.30 am)

19 **MS LANGDALE:** We're going to pick up from paragraph 95 in
20 your statement, "Suspicious and concerns regarding
21 Letby".

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

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

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

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

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

45

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

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

14 **A.** Yes.

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

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

21 So, um ...

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

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

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

19 **A.** Yes.

20 **Q.** Medical records.

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

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1 **A.** Yes.

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

4 "This report is made following review of the
 5 clinical notes by each speciality in relation to care
 6 provided to Mother and Baby."
 7 And this relates to you and your daughter.
 8 Is this part of the notes that you got at an earlier
 9 stage or do you know when you got this?

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

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

14 "Actual effect on patient and/or service."
 15 It says:
 16 "A term baby has died within the first week of life.
 17 This will have a severe impact on the parents and
 18 family."
 19 Then it says:
 20 "The Trust also recognises the potential
 21 psychological impact to the staff directly involved, and
 22 this, in conjunction with the potential impact to the
 23 reputation of the Trust, is considered severe harm."

24 **A.** Yes.

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

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1 the way that is described, the second sentence I've read
 2 out?
 3 **A.** That troubled me. I didn't understand why this is what
 4 was concerned -- this -- it was out of order for me to
 5 mention anything to do with the reputation and that's
 6 one of my concerns because that's when exactly I was
 7 trying to push and ask questions, where I felt there was
 8 resistance, where things were trying to be played down
 9 and clearly I know by the reports and everything I read,
 10 that things weren't -- if I didn't request the notes and
 11 get clued up as much as I did, I would never have got
 12 the Coroner to get involved. I would have never known
 13 everything that was missed, and everything it shows not
 14 to share with the Coroner. So it was clear they were
 15 trying to hide things.
 16 **Q.** When you looked at the detail of this case review you
 17 were also concerned to the reference to you as being
 18 a PRoM case, ie, a Premature Rupture of Membranes when
 19 in fact you were a Pre-term Premature Rupture of
 20 Membranes?
 21 **A.** Yes.
 22 **Q.** So you were looking at all of the details, weren't you,
 23 and seeing whether there were inconsistencies? Whatever
 24 they did or didn't mean, you were looking and seeing
 25 them?

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1 it was just inappropriate that someone would come
 2 straight away. I mean, we knew if we wanted to go and
 3 ask for someone we could ring a bell, we could ask, we
 4 wanted just some space and to gather our thoughts and
 5 some privacy. We weren't given that. And I told the
 6 lady I wasn't being rude but she could leave now because
 7 she wasn't really welcome and I will contact her when
 8 I need -- yeah, I just think it's a bit inappropriate to
 9 push the service on to someone who doesn't want it.
 10 **Q.** You say:
 11 "Sometime later [you] were referred to the
 12 hospital's Bereavement Counsellor, Jo Gwinn", and you
 13 undertook bereavement sessions with her.
 14 Did you find that helpful?
 15 **A.** Very. She was exceptional. She was brilliant. But
 16 from her own -- my understanding, she pushed for me to
 17 have more sessions, otherwise I was only going to get
 18 given a few, maybe four or six, but I came to a point
 19 where I begged for more. And she said, "Well, no, the
 20 people above me believe that you've had more than enough
 21 and now it's time, you know, to go about your life, or
 22 whatever", and I was highly disappointed, and especially
 23 since by that time I still haven't had answers. I still
 24 was asking around, yeah. But for what -- for the job
 25 she did, she did a brilliant job. She was very

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1 **A.** But this is to my point. They were dismissing exactly
 2 what I was pointing out, and it was not innocent,
 3 I don't believe, because it just added up with what was
 4 being shared with the Coroner, what was being shared
 5 with the information in the review of the conversation.
 6 Any meetings they were having, they kept dismissing the
 7 details, which is -- I mean even the mottling on my
 8 daughter, you -- they told me clearly they don't
 9 understand, they've never seen this, they don't know
 10 what's going on. So then, look for answers. Don't tell
 11 me this and then leave it at that. This is not good
 12 enough. I need to understand. I can't accept when
 13 I don't understand what happened and why it happened.
 14 And they didn't either, so I don't understand why they
 15 wouldn't push more.
 16 **Q.** Bereavement counselling and support.
 17 You tell us at paragraph 117: "Shortly after Baby
 18 D's death, a lady from the Bereavement Department came
 19 to see us."
 20 **A.** Yes.
 21 **Q.** What did she offer and tell us about that service?
 22 **A.** In all honesty, from my experience, she came far too
 23 early. I haven't yet wrapped up my head around the fact
 24 that my daughter has passed. I just -- things were
 25 going far too fast, and when she came and I just felt --

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1 supportive.
 2 **Q.** And you had a number of sessions, roughly how many, did
 3 you have?
 4 **A.** It was 24.
 5 **Q.** And they stopped at that point?
 6 **A.** Yeah, because she was told that's it, she can't -- she
 7 kept pushing but she was told that's it, no more.
 8 **Q.** Raising concerns and getting answers.
 9 You told us that in September 2015 you made the
 10 decision to instruct a solicitor and pushing for the
 11 things that you had been asking for and that solicitor
 12 contacted both the Trust, we know, and the Coroner's
 13 Office, don't we?
 14 During that process -- and this isn't obviously
 15 a reflection on the lawyers -- how frustrating was that
 16 in terms of trying to push for the Trust and also with
 17 the Coroner for answers, from your perspective?
 18 **A.** Well, there was two aspects. There's the emotional one,
 19 because I didn't feel I was supported around by people.
 20 I think people just thought because I was grieving,
 21 I was transferring my sadness on to other avenues and
 22 that I needed to just accept what happened.
 23 So there was my heart and then there was my head
 24 that told me: no, there are things that need
 25 investigating and I need answers. And thankfully, the

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

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

8 **A.** Okay.

9 **Q.** I don't need to ask that.

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

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

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

18 **A.** No.

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

25 When you got to the hospital, did that meeting take
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1 more worrying and more serious. But I thought, even
 2 though this is happening, we'll still be able to have
 3 some answers, and when that got cancelled, it was very
 4 upsetting because we weren't going to get any answers
 5 and with now the police being involved it was going to
 6 be years before anyone tells us anything.

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

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

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

25 **Q.** Did you know when Serious Incident Meetings or any other
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1 place or not? Or what happened when you were there?

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

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

21 **A.** Yes.

22 **Q.** How did you feel about that?

23 **A.** Very upset. It was upsetting that Ian Harvey was not
 24 answering any question at all. So that's -- that was
 25 worrying and then the police being involved made things
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1 meetings were taking place in respect of your daughter?

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

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

4 **A.** Yes.

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

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

19 **Q.** Moving to suggestions and recommendations.

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

23 **A.** My recommendation would be that it is different to an
 24 adult having CCTV in the rooms or in the corridors,
 25 because the babies, every parent that can't be at the
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1 hospital want to know what's happening to the baby, to
 2 the babies, to their baby. It should be -- there should
 3 be no reason why this is not safeguarding. There's
 4 no -- there's nothing that could be bad about this. All
 5 this is watching someone caring for the baby. So --
 6 **Q.** Would it have helped you the first night when you
 7 couldn't be with her, would it have been nice just to be
 8 able to see her in the incubator that if there is a
 9 little camera --
 10 **A.** If I knew she had one collapse I would have stayed there
 11 all night. If I had access because there was a CCTV or
 12 because we were being kept aware of what was going on,
 13 she wouldn't have died. I would have been there. So it
 14 wouldn't have happened. So yes.
 15 **Q.** Communication.
 16 What did you think the level of communication was
 17 and what change do you think there should be around
 18 communication with parents?
 19 **A.** So I understand they don't -- communication is poor.
 20 I appreciate there's a level of information they can
 21 share sometimes or they choose not to because they don't
 22 want to worry. Maybe we are not as informed or
 23 understanding, but there should be no second-guessing.
 24 No parents don't want to know. If there is any risk,
 25 any problem, anything, we want to know. We want to know

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1 mottling, whether it's anything that's unusual or
 2 whether parents keep reporting the same issues, there
 3 should be a unit just for that, investigating. Because
 4 whether it's someone that is harming babies or it's
 5 a virus that's just broke out from nowhere, how are they
 6 going to join the dots when they decide not to?
 7 **Q.** Accountability.
 8 You say:
 9 "Throughout the years I've come to appreciate that
 10 what we were told may not in fact be correct or
 11 accurate. For example, Mr Harvey's false reassurance to
 12 the media when in fact he would not disclose the
 13 investigation findings to us. How do we hold board
 14 members to account?"
 15 Why do you think that's important to hold them to
 16 account?
 17 **A.** That's their role, safeguarding, that's their role to
 18 communicate. That's -- they should have -- they lied to
 19 the public, they made it sound like they did their job
 20 and they communicated right, and they didn't. So
 21 they're all -- every single one is responsible. It's
 22 not just one person; it's all of them.
 23 **Q.** And you say:
 24 "It would urge consideration of independent
 25 oversight and regulation for management teams at

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1 for all the reasons that could exist. We need to know.
 2 For understanding what happened, for understanding how
 3 to address the future, anything, it's -- the
 4 communication is power.
 5 **Q.** You also speak in your statement about the need for
 6 investigations into deaths when they unexpectedly die,
 7 when babies die. And you say you question and don't
 8 understand why the investigation process is not carried
 9 out by independent investigators. Do you want to say
 10 a bit more about that?
 11 **A.** Well, why they don't go into it further? Is it because
 12 no one takes accountability, and no one thinks it's
 13 their job to pick up or point out anything that seems
 14 unusual is beyond my understanding. The fact that me,
 15 I'm not trained, I could identify a few failings and
 16 they did not is shocking. So I imagine anyone that's
 17 outside that has no interest in defending or the
 18 opposite would be the right person. They don't join the
 19 dots between shifts and between what happened to one
 20 baby the day before, anything. There's no -- there's
 21 nothing to lose to say something wasn't right, we need
 22 to report this. There should be one place where it's
 23 clear, it's spotted as a separate way of looking at
 24 things. Is there a pattern here? Is there a train that
 25 it keeps -- something keeps happening? Whether it's the

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1 hospitals."
 2 **A.** Yes.
 3 **Q.** What about the role of the Coroner in that? You were
 4 pushing and you got an inquest was going to be held,
 5 until the police became involved. Do you think that is
 6 a process that gives an independent overview?
 7 **A.** Over the years I think I understand that they don't --
 8 when -- in the process of that, the post-mortem
 9 involvement, the Coroner won't be looking at something
 10 suspicious. That for me is a failing in the first
 11 place, because you're here to identify what's happened.
 12 But at the same time, if they're not fed all the
 13 information, or the correct information, they can't do
 14 the correct job. So in my case and in my daughter's
 15 case, it's ... the Coroner was responsible to review the
 16 case, and for me, I don't understand how I had access
 17 and the knowledge, he didn't. Is it a failing on his
 18 part because he didn't dig enough or his team didn't
 19 look for more? Or is it all on the Countess because
 20 they didn't share all the information? I think it's on
 21 both sides.
 22 **Q.** You finish your statement with an area for
 23 recommendation heading "Compassion". What do you think
 24 is important for other bereaved parents, as you were in
 25 the Countess of Chester, to understand in providing an

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

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1 **LADY JUSTICE THIRLWALL:** Very well. Let me know when you're
 2 ready.

3 (12.01 pm)

4 (A short break)

5 (12.10 pm)

6 Questioned by MR BAKER

7 **LADY JUSTICE THIRLWALL:** Mr Baker.

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

9 Mother D, you gave evidence describing how unwell
 10 Child D was when she was first born, and how she was
 11 then taken to the neonatal unit.

12 **A.** Yes.

13 **Q.** Did her condition improve after she was taken there?

14 **A.** Yes.

15 **Q.** If you look at your witness statement, please, at
 16 paragraph 107, you can see there you're describing in
 17 this witness statement extracts that you subsequently
 18 read in the clinical notes; is that correct?

19 **A.** Yes.

20 **Q.** And you say:

21 "At 9.25 on 21 June 2015 Dr Newby reviewed Child D
 22 and noted good condition and improvement. Dr Rylance
 23 reviewed Child D at 7 o'clock [7pm], noting that she was
 24 much improved but that her breathing still needed
 25 assistance but I expected that for a newborn three weeks

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1 the parents should be allowed to review and be made
 2 aware and be part of -- when there's the reviews that
 3 happen after death, where they review mortality, they
 4 review actions, what happened then? Even when you ask,
 5 you don't get the answer. I still don't know what was
 6 said. I still don't know what they decided. The only
 7 thing I got told is: well, I think we will retrain some
 8 of the staff. They don't all know about the NICE
 9 Guidelines. That's not just the NICE Guidelines.
 10 That's everything. There's dozens. I mean, I'm not
 11 working with them day-to-day, and I can name many. So
 12 they should, for working there, know what should be
 13 done.

14 **Q.** Mother D, those are all the questions I have for you.
 15 Is there anything you'd like to add or state
 16 that I haven't asked you about that you think is
 17 relevant to do so?

18 **A.** No, I trust in the process. I just want the truth to
 19 come out. So no, that's it for me. Thank you.

20 **MS LANGDALE:** Thank you.

21 My Lady, this might be a good moment to break again
 22 so Mr Baker can consider if he has any further questions
 23 to ask.

24 **MR BAKER:** I have a couple of questions. I just need to
 25 take instructions.

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1 early born by caesarean section."

2 First of all, those entries that you read in the
 3 notes, are they consistent with what you were told by
 4 members of medical staff?

5 **A.** Yes.

6 **Q.** And are they also consistent with what you observed when
 7 you visited Child D?

8 **A.** Yes. She was good colour, she looked full size baby.
 9 Yes.

10 **Q.** And the time of the second entry is described, the
 11 Dr Rylance entry is 7 pm. And you have given evidence
 12 that you visited the neonatal unit around 7 pm?

13 **A.** Mm-hm.

14 **Q.** So presumably a little bit more or after this point?

15 **A.** Yes.

16 **Q.** And that was a point where you saw Letby?

17 **A.** Yes.

18 **Q.** And you described how she made you feel uncomfortable?

19 **A.** Yes.

20 **Q.** Was that the same night, and I appreciate it was the
 21 early hours of morning that you were called back, but
 22 was that the same night that you were called back
 23 unexpectedly because Child D had collapsed?

24 **A.** Yes.

25 **Q.** If you could then go on to a slightly different topic,

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1 it's at paragraph 81. Here you say that you received
 2 a service review completed by the Royal College of
 3 Paediatrics and Child Health. You think you received it
 4 in about April 2017 from the Coroner?
 5 **A.** Yes.
 6 **Q.** Did you receive a copy of that report from the Trust?
 7 **A.** I believe, through my solicitor.
 8 **Q.** When you received the copy from the Coroner in or about
 9 April 2017, was that the first time that you had seen
 10 that report?
 11 **A.** Yes.
 12 **Q.** And the version of the report that you received, did
 13 that refer to suspicions regarding Letby?
 14 **A.** No.
 15 **Q.** You also gave evidence that you had one conversation
 16 with Ian Harvey. Did he or anyone from the Trust say to
 17 you at any time that there had been failings in the care
 18 provided to Child D?
 19 **A.** Yes. He knew there was failings.
 20 **Q.** Did he communicate those failings to you?
 21 **A.** No.
 22 **Q.** Did anyone from the Trust communicate to you there had
 23 been failings in the care provided to Child D?
 24 **A.** Well, Dr Davies, in her conversation with colleagues,
 25 she said that I was treated as PROM, but being so close
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1 parents of the victims and she only had one word:
 2 'unimaginable'. Her wicked sense of entitlement and
 3 abuse of her role as a trusted nurse is truly a scandal.
 4 Lucy Letby, you failed God and the plans he had for
 5 Child D. You even called it fate. You were clearly
 6 disconnected with God. After today, I hope to be free
 7 of this limbo state I've been stuck in. The heavy load
 8 constantly on my mind has deeply changed me. My heart
 9 broke into a million pieces the second Child D lost her
 10 battle against evil and that is when hell broke loose
 11 for us. Those lives were not yours to take, and
 12 although I am torn with sadness, anger and unanswered
 13 questions, I cannot forgive you. There is no forgiving,
 14 not now, not ever. After Child D passed, we were asked
 15 if we would like her to be an organ donor. This was
 16 a very difficult question to answer but we thought if
 17 she could be a baby's saviour, as painful as it felt, it
 18 felt right to say yes. We were told the baby needed
 19 a heart. I can't explain how I felt then, but very
 20 soon, they came back to us and said that a post-mortem
 21 has been ordered as they couldn't explain why she
 22 collapsed and died, therefore she could not be an organ
 23 donor, which broke my heart even more.
 24 "I stayed a few more days in hospital to recover,
 25 then Father D and I went home, just the two of us,
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1 to being PPROM, they did fail in doing the right --
 2 taking the right action. But I was very close so it's
 3 almost as if it wasn't so much of a failing.
 4 **Q.** When did you first discover that there were suspicions
 5 regarding a nurse?
 6 **A.** The police contacting us.
 7 **Q.** That was on the day of Letby's arrest?
 8 **A.** Yes, yeah.
 9 **Q.** You prepared a Victim Impact Statement for the Crown
 10 Court trial, and it appears at page 59 of the bundle
 11 that you have. You may feel that you've already said
 12 everything that you want to say about impact so there's
 13 no obligation to read it, but if you would like to read
 14 it, it's there to be read out. Don't feel you should
 15 have to.
 16 **A.** I would like it to be read, but not by me.
 17 **Q.** Would you like me to read it?
 18 **A.** If that's okay, please.
 19 **MR BAKER:** Is that okay?
 20 **LADY JUSTICE THIRLWALL:** Of course.
 21 **MR BAKER:** It says:
 22 "Victim Impact Statement dated 5 July 2023
 23 anonymised but signed by Mother D.
 24 "My name is Mother D. I am Child D's mum.
 25 Lucy Letby had a chance to say something to us all
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1 instead of a family of three. We were given Child D's
 2 hand and footprints and also a memory box with two tiny
 3 teddy bears, one to go with Child D and one for us to
 4 keep. Our family cleared all traces of baby stuff
 5 around the house, removed the baby seat from the car,
 6 took Child D's hospital bag home. All was stored inside
 7 her bedroom and the door remained closed for many
 8 months. We had to organise her funeral. You don't
 9 choose the date. The service took place the day before
 10 her due date and her ashes were buried in a tiny box on
 11 her actual due date.
 12 "Those weeks were particularly difficult. I
 13 couldn't rest or stop thinking about all the little
 14 things I should be doing instead. My arms, my heart, my
 15 life, all felt so painfully empty. I miss Child D so
 16 much. I was desperate to feel her, smell her, cuddle
 17 her. I needed to be her mum in every way to look after
 18 her and keep her safe. I felt so guilty and questioned
 19 if any of this was my fault. Did I miss something? Did
 20 I do something wrong? Did I fail my daughter?
 21 "When I left the hospital, I requested Child D's
 22 medical notes and mine. I got clued up on medical
 23 terms, neonatal death statistics, guidelines protocols.
 24 I was knocking on doors asking questions, meeting with
 25 doctors from the Countess and even the Management Team.
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1 We got a solicitor and I wanted the police involved. At
2 that stage, I was told that this was not a criminal
3 matter so the police were out of question.

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

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

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

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

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

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

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

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

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

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

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

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

13 Thank you, my Lady.

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

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

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1 about recommendations.

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

6 **THE WITNESS:** Thank you.

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

9 (12.26 pm)

10 (The short adjournment)

11 (2.00 pm)

12 **MOTHER I (read)**

13 **LADY JUSTICE THIRLWALL:** Good afternoon. Welcome.

14 I understand Mr Sharghy is going to read your statement
15 for you. You don't need to answer, if you just nod if
16 you hear what I said, all right?

17 (The witness nodded)

18 **LADY JUSTICE THIRLWALL:** Mr Sharghy.

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

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

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

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

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

25 This resulted in me being transferred that night to the

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

3 "My experience at the Countess of Chester Hospital:

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

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

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

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

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

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

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

16 "My waters breaking so early was completely
17 unexpected. I had expected to walk in and walk out with
18 my new baby a few hours later. I had just had my
19 20 week scan and everything was fine so I hadn't even
20 seen anyone since when my waters broke. My other
21 children did not need special or intensive care so it
22 was never something I had ever considered.

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

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1 every two to three days for blood tests.
 2 "I only got to the first appointment which was on
 3 the following Wednesday 05/08/2015 because when the
 4 nurse took my bloods, she informed me that I'd have to
 5 stay in as my blood levels were slightly abnormal and
 6 that they'd like to keep an eye on me. Plus, they were
 7 waiting for my blood test results from Manchester Royal
 8 Hospital to be sent through so they could compare them
 9 and see how much they'd risen.
 10 "I'd asked if I could go home and collect some
 11 things as they'd wanted me to stay. Initially I was
 12 told 'Yes' but prior to me leaving, the results from
 13 Manchester Royal Hospital were received. After they'd
 14 compared my two sets of results, I was told I couldn't
 15 leave and my levels appeared to have significantly
 16 increased. I believe these results referred to my
 17 infection levels and there was concerned that an
 18 infection had developed, even though my temperature was
 19 okay, and I didn't have any other symptoms.
 20 "The Countess of Chester Hospital then transferred
 21 me that day via ambulance to the Liverpool Women's
 22 Hospital. On arrival I was booked in and given a room
 23 on their maternity ward, whilst my bloods were checked
 24 again. Over the next few days, I was continuously
 25 monitored.

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1 "When I got back onto the Maternity Ward a midwife
 2 came and I was attached to a monitor. She informed me
 3 that I wasn't in labour and then left. I told my
 4 husband that I thought I was having contractions, go and
 5 get the midwife. She returned and gave me a couple of
 6 paracetamols and left again saying I wasn't in labour.
 7 As I wasn't happy, I spoke with a friend of mine, who is
 8 a midwife at the same hospital; she went to get a male
 9 doctor (name unknown). This doctor instructed the staff
 10 to remove me from the monitor and he physically checked
 11 me. After his examination he said for me to go straight
 12 to the Labour Ward as I was 6cm dilated.
 13 "When I got to the Labour Ward, I was told
 14 that I needed to be connected to a drip which would help
 15 my baby's brain to which I told them it was too late.
 16 I asked the midwife 'How important is it that the team
 17 are here', to which she said it was very important. So
 18 I said 'Get them in here then' and she buzzed down.
 19 "A further midwife and the neonatal team arrived
 20 shortly afterwards. During this time, my contractions
 21 just stopped (I think it was out of fear as I was too
 22 scared to push) so the staff checked the monitors and
 23 from there they were able to see my contractions and
 24 they'd tell me when I needed to push. At some point
 25 they informed me that my baby was becoming distressed,

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1 "By (redacted) August 2015, I was still leaking
 2 amniotic fluid, however, my waters had started to change
 3 colour. Usually amniotic fluid is clear, but it had
 4 started to turn a yellowy/greeny colour so everyone was
 5 worried about infection. Due to this change in colour,
 6 I had a further scan. After I was informed by a female
 7 doctor (name unknown) that there was still some fluid
 8 left and that my baby was still safer in than out.
 9 "The doctor continued to say that I would become
 10 poorly before my baby did, so my blood pressure and
 11 temperature were continuously monitored. I remember
 12 telling them that I don't really show signs, I just
 13 crash, but they were adamant that I would show signs of
 14 an infection before it affected my baby. They
 15 instructed me that if I had any pain I should say so
 16 immediately, as I wouldn't have a normal delivery and
 17 that she may come very quickly.

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

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1 so I pushed harder and she came out.
 2 "Our baby who we named Child I was born at 9.02 pm
 3 on the evening (redacted) August 2015 weighing 2lbs 2oz.
 4 I was only in the labour room for around an hour.
 5 I didn't have any pain relief, nor did I need any
 6 intervention.
 7 "Prior to my baby's birth, I had been told that she
 8 would immediately be removed to the Neonatal Ward and
 9 I would be able to see her later. In fact, when she was
 10 born, she was doing really well and they kept her in the
 11 room with me for a short time. They brought her over to
 12 the bed for me to see her and she was put in an
 13 incubator for a while. They took her upstairs saying
 14 she needed to go to the Neonatal Unit for 'long lines'.
 15 I really appreciated I was able to see her even if it
 16 wasn't for long.
 17 "My husband was present during the birth, and
 18 I remember him saying 'She's not as small as we thought
 19 she would be'. I freshened up and went back to the
 20 Maternity Ward where we had a private room which had two
 21 beds so my husband could stay. We then just waited and
 22 waited for hours. My husband was becoming extremely
 23 anxious and frustrated and was not happy as they weren't
 24 telling us anything. I kept reassuring him saying 'If
 25 they're not saying anything she must be doing okay'.

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1 "Eventually, at around 2am or 3am, a nurse came down
2 and told us that as our baby only weighed 2lb 2oz they
3 were struggling to get her lines in. They had to scan
4 her each time to see if the line had been inserted
5 correctly and on several occasions it hadn't been. At
6 around 3am we were allowed to see her for around 10 to
7 15 minutes; she was on an incubator on a ventilator.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 near my daughter.

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

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

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

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

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

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

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

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

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

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

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

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

25 "The following day, on 06/09/2015, our baby was sent
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1 medical staff did not check our baby's stomach or bowels
2 and I think if they had just checked, it could have
3 influenced her future care and I'm not happy about that.

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

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

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1 a lady called (redacted) with her baby.
 2 "My emotions had gone from rock bottom to now being
 3 positive again. I coped by trying to forget what I'd
 4 seen and gone through, and just kept going. I just used
 5 to say 'She's just had one of her moments and she was
 6 letting us know who's boss!'

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

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

25 "Obviously she was upset because of the effort it
 93

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

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

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

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

23 "I'd describe Lucy as being around late twenties
 24 with shoulder length blonde hair, with a long slim face;
 25 her face was always on the babies' fundraising pictures.
 95

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

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

19 "Shortly afterwards, (redacted) was due to take her
 20 baby home. Nurse Nicky came in and helped bathe
 21 (redacted)'s baby. After she'd finished with
 22 (redacted)'s baby she asked me if I wanted our baby
 23 bathing, to which I remember asking, 'Are we allowed?'
 24 and she said, 'Yeah, she's doing well, I can't see why
 25 not' so I said, 'Yeah'. I was made up, but before she
 94

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

6 "Lucy came over and said that she thought our baby's
 7 stomach looked swollen, which I agreed with, but
 8 I thought that our baby looked okay in herself. Lucy
 9 informed me that she'd keep an eye on her and she'd call
 10 for the doctor to also check her out. I left at around
 11 3 pm. Our baby had been doing really well and was
 12 staying where she was safe. She had been in an
 13 incubator since her collapse on 06/09/2015 but had
 14 recently been moved to a cot so I was feeling quite
 15 relaxed at the time.

16 "I had just got home and that gone to see
 17 a neighbour when I received a phone call (around
 18 4.30 pm) from the hospital. I can't remember who
 19 I spoke to, but they told me that our baby had had
 20 another turn and I needed to make my way to the
 21 hospital. I panicked as my husband was at work and
 22 I had to ring him to let him know he had to come to the
 23 hospital now.

24 "I arrived first, and when I got there Berni, or
 25 maybe (redacted) was resuscitating our baby by
 96

1 conducting chest compressions in Room 1. I froze.
 2 I was on my own as my husband hadn't arrived yet and it
 3 was very scary. Our baby's stomach was swollen, she had
 4 been sick, and she looked really unwell.
 5 "I can't remember any of the other members of staff
 6 who were present but there were other staff there.
 7 Berni informed me that the swelling to our baby's
 8 stomach had now gone down and that she was doing better.
 9 I thought her stomach had swollen up so much that it had
 10 crushed her chest which had caused her collapse, but
 11 I wasn't told what specifically caused the collapse.
 12 I know that the doctors took samples from her spine and
 13 checked for infection. The doctors and nurses told us
 14 that she was a puzzle and weren't sure why she kept
 15 having episodes.
 16 "I now understand that a report called a 'Datix' was
 17 created on 01/10/2015 about our baby's collapse on
 18 30/09/2015. I was not told about this at the time and
 19 would not have known what a Datix report was. I had no
 20 idea there were any meetings or discussions about her
 21 collapse.
 22 "The next day, our baby was moved to Room 2. It was
 23 a quick change-around, but this time we didn't have to
 24 change hospitals as our baby started to improve within
 25 hours.

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1 "Other than these limited interactions, I didn't
 2 really have much to do with Lucy. She always appeared
 3 reserved and kept herself to herself. I thought she was
 4 a bit miserable compared to some of the other nurses.
 5 She never really interacted with the parents.
 6 "When our baby was (*redacted*) weeks old, I enquired
 7 about her getting her immunisations when she returned
 8 home but the hospital said that they had given them to
 9 her whilst she was in hospital. A female doctor (name
 10 unknown) did prepare us by saying that our baby's white
 11 blood cells would rise after she'd been immunised.
 12 "Our baby had her immunisations on 05/10/2015 but
 13 afterwards Dr Matt told us that her bloods had risen
 14 more than they'd expected and that they were going to
 15 screen her.
 16 "I understand from my medical records that on
 17 07/10/2015, our baby had a lumbar puncture and was put
 18 on antibiotics. Shortly afterwards, I remember the
 19 female doctor coming back in and asking why our baby was
 20 on antibiotics. I recall telling her that because of
 21 our baby's history and because she declined so rapidly,
 22 it was done as a precaution. I explained that our baby
 23 could go from being perfectly fine to nearly dying
 24 within seconds. There was no in between with her.
 25 I had been told all along that this was normal for

99

1 "I also remember Child G had been poorly many times
 2 around the same time as Baby I, as they were both back
 3 in Room 2 and I was trying to reassure Mother G that it
 4 would be okay. The nurses were telling me that our baby
 5 was doing well again and that it had been known for
 6 babies to be sent home from Room 2 previously.
 7 "As the days went by, I noticed that our baby was
 8 starting to be more aware. She was looking around the
 9 room taking it all in. I was able to sit her on my knee
 10 and I remember looking at her and thinking 'We're going
 11 home'. She just looked like a full-term baby. She
 12 didn't look frail or small; she just looked like she
 13 should be at home. I started to think she needed to be
 14 at home so she doesn't get an infection as I'd seen so
 15 many people not washing their hands and then touching
 16 things in the room.
 17 "I just wanted to take our baby home desperately.
 18 I had sent videos home that I'd taken on my phone and
 19 I was allowed to bath her which she loved and was
 20 smiling. I remember bathing her the first time. I was
 21 in Room 2 and Lucy Letby was on duty. I was so pleased
 22 to be able to bath our baby. Lucy helped prepare the
 23 bath and gave advice as to how to bath our baby. She
 24 even offered to take some photos using my mobile phone
 25 which I agreed.

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1 premature babies, that they get infections, that they go
 2 up and down, and that they might have to test her for
 3 lots of things.
 4 "I remember the staff at the Countess of Chester
 5 Hospital kept making a big deal about our baby's stomach
 6 swelling. They thought she had NEC, or twisted bowels.
 7 They said that she might need a dye test and that
 8 perhaps she had an intolerance to milk. At this point
 9 the medical staff told me I had to stop Googling
 10 everything. I remember a couple of the nurses telling
 11 me that sometimes these things happen. I was never led
 12 to believe that these collapses were anything to be
 13 concerned about or abnormal, or that they were worried
 14 about anything out of the ordinary.
 15 "I had been feeling positive at this point. Our
 16 baby was doing really well, I thought. I clung to the
 17 nurses saying it was fine, that it would be two steps
 18 forward, ten steps back sometimes. I know she was on
 19 antibiotics after her immunisations but this wasn't
 20 a concern as I know they were given as a precautionary
 21 measure. Dr Matt wanted to be cautious and
 22 I appreciated that.
 23 "I also remember that at some point they tested our
 24 baby for cystic fibrosis. I think it was after
 25 immunisation but before she got really sick, although

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

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

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

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

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

3 "Then, later that night whilst I was at home, we
4 received a call from the hospital telling us to come
5 immediately. This would have been the early hours of
6 13/10/2015. I don't remember much of the call or who it
7 was that rang us. When we arrived, our baby was really
8 poorly. It was the worst she'd ever been. The staff
9 had to resuscitate her at least seven to eight times.
10 She just kept flatlining. I remember the following
11 staff being present: Jo, Berni, Dr Matt and a young
12 nurse who subsequently left to go to Australia. Others
13 could have been there, but I can't remember them.

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

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

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

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

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

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1 resuscitated.

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

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

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

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

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

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

22 "I felt as though by christening her we were giving
23 up, but we did it. I think it was on 15/10/2015. We
24 organised for everyone to come in a rush, and our baby
25 was christened at the hospital. My medical records show
105

1 it very recently.

2 "When we arrived at Arrowe Park Hospital on
3 15/10/2015 our baby was x-rayed again, and her lungs
4 were fine. They'd blown back up, so now I had
5 Arrowe Park Hospital telling me that there was nothing
6 wrong with her. I felt as though the staff at Arrowe
7 Park Hospital were rude; they were acting as though they
8 were the better hospital. They said to me that they
9 were annoyed that our baby had even been taken there and
10 that there were other babies who were a lot sicker than
11 her and that she didn't need their care.

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

20 "I appreciate that I may have been upset at the time
21 and not making sense, but I believe the doctor should
22 have listened to my concerns. A nurse then informed me
23 that she was going to give our baby some milk to which
24 I said, 'No, she's nil by mouth'. The nurse stopped and
25 apologised, and said that she'd not read the notes.
107

1 that our baby was moved to Arrowe Park Hospital on
2 15/10/2015 so the christening was held that morning
3 before she was moved. I believe Belinda was there but
4 I can't remember any other staff being present.

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

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

23 "I now understand that a Datix report was created on
24 13/10/2015 about our baby's collapses. I was not told
25 about this at the time and have only been made aware of
106

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

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

18 "Our baby was only at Arrowe Park for two days.
19 They said she didn't need to be there and everything was
20 fine. Looking back now, it always seemed as soon as our
21 baby left the Countess of Chester Hospital, her
22 condition would improve but the journey to and from the
23 hospitals would take it out of her. When I was told she
24 could return to the Countess of Chester Hospital, I was
25 pleased and happy to return.
108

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

7 "Child I's deterioration and death.

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

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

109

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

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

19 "I heard them all counting times, so I asked
20 Dr Gibbs how long they'd been doing this, and he said
21 '20 minutes'. I could see every time they were pumping
22 her chest, her oxygen saturations levels would go up,
23 but when they stopped, she would flatline every time.
24 I remember thinking 'You can't keep doing this to her'
25 and I said to Dr Gibbs, 'You can't do it anymore'.

111

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

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

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

110

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

6 "When they eventually stopped working on our baby,
7 they passed her to me. I didn't want to let her go and
8 held her so tightly as she was our gorgeous little
9 princess. I cannot even begin to explain the pain of
10 losing her. I feel like a part of us died with her.
11 She didn't die straight away. It was around 2 am or
12 3 am in the morning on 23/10/2015 when she actually
13 went. I can't be certain as to the exact time as
14 I didn't clockwatch, as too much was going on.

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

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

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

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

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

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

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

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

115

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 "I understand that the Coroner sent another letter

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

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

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

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

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

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

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1 she only looked after our baby maybe three times.
 2 "I remember having a meeting with Dr V with the
 3 results of the post-mortem. I remember her saying that
 4 the hospital may discuss our baby in later meetings. We
 5 weren't given the impression that they were
 6 investigating anything; we thought it was for training
 7 purposes or something like that.

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

12 "I understand that a Datix report was created on
 13 23/10/2015 about our baby's death. As with the other
 14 Datix reports, I wasn't told about this at the time.
 15 This certainly wasn't discussed during my conversation
 16 with Dr V.

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

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

25 "The Royal College of Paediatrics Review.
 121

1 "I contacted the hospital on what I can see was
 2 09/02/2017 and asked if the report related to our baby's
 3 death, to which the person (I believe was probably
 4 a receptionist) said 'Not really, but I can't really go
 5 over it over the phone'. I remember telling her
 6 that I was pregnant again and unless they had a good
 7 reason, I didn't really want our baby's death raking
 8 back up and I was trying to keep things as stress free
 9 as possible.

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

24 "Police investigation and concerns over Lucy Letby.

25 "On 11/05/2017, I was contacted by Cheshire Police
 123

1 "I received a letter from the Countess of Chester
 2 Hospital asking me to contact them to make an
 3 appointment to speak to someone. I thought it was
 4 around January 2017, but I can now see it was dated
 5 08/02/2017. Apparently, they had tried to call me a few
 6 days before as well.

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

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

20 "I went onto their website and read the report.
 21 I'll be honest and say I only skim-read it. I did
 22 however recognise that our baby's death had been
 23 included even though she hadn't been named. I knew they
 24 were referring to her because she'd been the only baby
 25 who'd died on that ward on 23/10/2015.
 122

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

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

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

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

25 "Mother I Exhibit 1: plastic container containing
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1 medical equipment used by Child I on date of her death
 2 (also a separate box which is a memory box which
 3 contains clothing worn by our baby).
 4 "Mother I Exhibit 2: personal child health records.
 5 Mother I Exhibit 3: two pictures of our baby,
 6 documentation with death certificate.
 7 "Sometime after I was informed of the police
 8 investigation and I had given our baby's things to the
 9 police, I did try and contact someone at the Countess of
 10 Chester Hospital. The police were being very tight
 11 lipped about the investigation, and I wanted our baby's
 12 things back or some progress or something. I phoned
 13 them, but I was told that they could no longer give out
 14 any information as it was with the police now.
 15 I remember thinking I should have spoken to someone
 16 about the Review report earlier.
 17 "Looking back, I didn't have many dealings with
 18 Lucy Letby. I have already outlined the ones
 19 I remember. I remember thinking she was a bit quiet and
 20 a bit odd. She always seemed a bit of a loner. The
 21 most interaction I had with her was when she helped me
 22 bathe our baby. We saw her around on the odd occasion,
 23 but we didn't have much to do with her. She was always
 24 the most reserved of the nurses. I remember thinking
 25 she seemed miserable compared to the others and I never
 125

1 I tried ringing them during the police investigation and
 2 they wouldn't speak with me. I certainly was never told
 3 of any actions the Countess of Chester Hospital was
 4 taking about concerns with Lucy Letby's conduct. The
 5 first I heard of anything was when doctors and staff
 6 were giving evidence during the criminal trial.
 7 The police remained very tight lipped about what or
 8 who they were investigating. In March or April 2018
 9 I went to see Dr Brearey at the Countess of Chester
 10 Hospital. During this appointment he asked if I had
 11 heard from the police. At the time I was annoyed as
 12 I hadn't heard from them for months and I couldn't get
 13 hold of my Family Liaison Officer. He went on to talk
 14 about the nurses on the Neonatal Unit and how they were
 15 struggling and how hard it was. I told him my theory
 16 that it could have been an infection that had caused
 17 Baby I's ultimate demise. If there was an infection on
 18 the unit, those nurses should have kept the babies away
 19 as an infection could have harmed all of the babies in
 20 the Unit. I had many theories at this time as I had
 21 been told nothing by the police. Dr Brearey told me
 22 that it wasn't an infection, that everything had been
 23 tested and our baby was clear. My reaction to that was
 24 that if it wasn't an infection, it only leaves that
 25 someone tried to hurt my baby. I said 'How can I live
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1 saw her interact with parents much.
 2 "Now I have seen the medical records, I am
 3 absolutely shocked at how much 'care' she provided to
 4 our baby. She is all over her notes. I have noticed
 5 a lot of the 'care' was when I wasn't present.
 6 "I have been told that Lucy Letby sent us a card
 7 when our baby's funeral was held. I don't recall
 8 receiving one at all. I did get sent some cards, and
 9 I kept them, and I have looked through them, but
 10 I haven't found a card from her. For the funeral
 11 I specifically requested no cards, so someone else might
 12 have opened the card and thrown it away. It wasn't for
 13 anything personal that I told everyone not to buy
 14 a card -- I felt I didn't want cards for her for this.
 15 I had told everyone to buy cards when we brought her
 16 home and we weren't going to bring her home. Instead,
 17 I told people to donate to the Neonatal Unit. I didn't
 18 want sympathies for me. It was never about me, it was
 19 about our baby. Knowing what I know now, I am glad
 20 I didn't see it and that I don't recall anything about
 21 Lucy Letby's card.
 22 "I have been asked if the Countess of Chester
 23 Hospital ever said anything or provided any information
 24 about concerns over Lucy Letby's conduct. They didn't
 25 mention anything to me at all. As explained above,
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1 with myself knowing that someone would have tried to
 2 hurt my baby?'. Dr Brearey said that I would never have
 3 known. I walked out of that appointment thinking
 4 someone had deliberately killed my baby.
 5 "I was officially made aware that our baby might
 6 have been murdered and that an arrest was going to be
 7 made when the police phoned me at 6 am on the morning
 8 they were making the arrest. When they told me, my
 9 whole body started shaking and the thought of having to
 10 tell my husband was awful as he wasn't with me when
 11 I took the call. This was in July 2018. I was shocked
 12 that it was Lucy, but my husband wasn't when I did tell
 13 him. He always had suspicions that something wasn't
 14 right and now it had been confirmed, although if he had
 15 to point the finger at anyone, he had assumed it was
 16 (*redacted*). The police then came to see us later that
 17 morning. We were not given any details at all about how
 18 or why, only that an arrest was being made and how long
 19 they would be questioned before being bailed etc.
 20 "A few weeks after this, we had an appointment with
 21 Detective Superintendent Paul Hughes as he had agreed to
 22 speak with all the families. I asked if Lucy would be
 23 charged and he wouldn't confirm this, but said they were
 24 confident that our baby had been deliberately harmed.
 25 We were so broken that someone could do something so
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1 evil to our precious little girl. It has had a massive
2 effect on our family even to this day.

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

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

23 "I felt totally blinded by all their lies and
24 cover-ups. My husband isn't surprised though, he always
25 believed something had gone wrong and the hospital was
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1 after our baby died. I remember I was given a leaflet
2 about counselling services on the day she died.
3 I didn't have any other support. It was just left up to
4 me. They dumped this information on us on the day our
5 baby died, and I had these carrier bags of things that I
6 was leaving with and not a baby. I was expected to
7 reach out for support when we were in the worst pain and
8 emotional state any human can imagine. No one reached
9 out to us to offer support of any kind.

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

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

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

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

23 "Bereavement counselling and support.

24 "When I think back, I am disappointed by the help
25 and support offered by the Countess of Chester Hospital
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1 a black hole, and it was harder and harder to keep
2 going.

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

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

16 "Eventually we got back together and I got pregnant
17 again. I don't remember any of the pregnancy really.
18 I put a wall up and blocked it out as we were filled
19 with fear. What if the same thing happened again?
20 Scans were not happy moments -- again, just filled with
21 fear. When our daughter was born, she was born at 34
22 weeks so I had to go to the NICU again and it was
23 terrifying. We didn't leave her for a second.
24 I couldn't bring myself to breastfeed my daughter as
25 I had a fear that my milk had caused our baby to die.
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1 "My GP prescribed me beta blockers, antibiotics and
2 sleeping tablets. I was having nightmares and couldn't
3 sleep for the first year after our baby died, and then
4 it started all over again after I gave my police
5 statement for the criminal proceedings. When the police
6 got in touch, I went straight back down the black hole
7 of depression. I started counselling in 2018 through
8 the police and Victim Support services and I have been
9 using this on and off ever since.

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

13 "Raising concerns.

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

25 "After all my years of counselling, I can see it is
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1 would give us any information.

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

8 "I have seen the witness statement provided by our
9 Family Liaison Officer, DC Griffiths. Our FLO made
10 a statement which I have read and I totally agree with
11 what she says. I often felt alone and completely out of
12 the loop about what had happened to my baby. It feels
13 like everyone else knew and I didn't. I had to find out
14 that someone might have intentionally harmed our baby at
15 a check-up appointment with another doctor. Even when
16 the police did tell me, I wasn't allowed to know how my
17 baby had been harmed. Eventually when I was given this
18 information, I had to sign a non-disclosure agreement
19 and I was told I could not even tell my solicitor or my
20 counsellor. I understand why the police wanted to keep
21 this information confidential, but it was very hard and
22 I spiralled down that black hole again. I believe there
23 was a real lack of transparency thorough this whole
24 process, starting at the Countess of Chester Hospital
25 where I was assured 'everything is normal', to being
135

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

8 "We didn't raise concerns for a few reasons.

9 I believed that the Countess of Chester Hospital had
10 done everything they could. I never imagined that
11 someone would deliberately hurt our baby. I didn't know
12 the doctors had concerns about Lucy, because they didn't
13 tell me and instead told me everything was normal.
14 I didn't know they had been lying at that point.
15 Secondly, we didn't think anything would be done even if
16 we did report our concerns and I would not have known
17 where to report our concerns. Based on the incident
18 mentioned above when a nurse gave milk expressed by one
19 mother to a different baby, I would not have been
20 confident that reporting concerns would make any
21 difference. That incident was reported and it didn't go
22 any further, the nurse never apologised and the other
23 baby's parents were never informed so what was the
24 point? When it started to become apparent that
25 something was wrong, everyone closed ranks, and no-one
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1 told that the RCPCH Review was just for 'training', to
2 everyone at the Countess of Chester Hospital closing
3 ranks and not talking to me, to the police drip-feeding
4 me information. I spent years digging for information,
5 and it has taken me to some very dark places mentally.
6 I believe it would have been easier if everyone was more
7 open and helped a grieving family understand what went
8 wrong, why our baby had died when she was actually
9 progressing well despite being born prematurely, and
10 what support was available for us to access if/once we
11 were ready to confront the horror of losing a baby.

12 "I have been asked what in my view would have
13 assisted in preventing Lucy Letby's crimes. I believe
14 the doctors and nursing staff should have acted earlier
15 and those in positions of authority at the hospital (ie,
16 the management at the Countess of Chester Hospital)
17 should have listened to them instead of trying to create
18 their own narrative that Lucy Letby was a victim of
19 bullying and harassment. Someone should have
20 investigated the concerns fully at the time. This is
21 what management are paid so handsomely to do. They
22 shouldn't have been concentrating on saving their own
23 skins and jobs and reputations. Babies died because
24 someone in an office being paid hundreds of thousands of
25 pounds didn't want the hospital to look bad if they shut
136

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 trial, but they were so closed off and unhelpful and at
 2 times it was very isolating.
 3 "In terms of additional support, I think it would be
 4 helpful if counsellors and bereavement services reached
 5 out to you. When you lose a baby, you are numb for a
 6 long time. You are still sad but numb. It doesn't hit
 7 you properly, but when it starts to hit -- especially
 8 when you have been in a cocoon of a Neonatal Unit -- it
 9 could be months down the line and you hit rock bottom
 10 and there is no one there or anyone to offer support.
 11 When they offer support, you don't feel like accepting
 12 anything, but when you need it there is nothing.
 13 "If I had support services ring me and offer help,
 14 I might have accepted it earlier, and if they had
 15 conducted check-up calls a few weeks or months down the
 16 line, I might have been able to access help earlier.
 17 When you're in a black hole, you can't always find the
 18 momentum to get the help you need but if someone reaches
 19 out to you, you might accept it.
 20 "I also think there should be consideration of
 21 sanctioning (and where appropriate removing) any
 22 manager/person in a position of authority who ignores
 23 concerns raised by whistleblowers. At the present time,
 24 there appear to be no sanctions against those who lied
 25 and kept information whilst babies were being

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

9 **(3.42 pm)**
 10 **(The hearing adjourned until 10.00 am the following day)**

1 killed/harmed by Lucy Letby. It was only when it became
 2 untenable to keep up the pretence that they finally
 3 opened up on the scale of concerns raised against her
 4 and the number of babies that she had harmed. Yet those
 5 managers/people in a position of authority were not
 6 sanctioned and continue to work unhindered by their
 7 unprofessional and morally corrupt conduct.
 8 "I honestly believe that these people should have to
 9 explain why they didn't do something earlier, why they
 10 ignored the multitude of concerns raised about
 11 Lucy Letby's conduct, why their actions facilitated
 12 a mass murderer.
 13 "Our baby would have turned nine this year. We
 14 should have been watching her grow and play with her
 15 siblings and friends. However, we have to somehow try
 16 to live with the fact all this has been taken away from
 17 her and us in the cruelest way possible. No parent
 18 should ever have to go through what we have been and
 19 continue to go through each and every day. To
 20 understand how easily my beautiful girl's death could
 21 have been prevented hurts even more. Forever and a day,
 22 I will continue to ask 'why?'"
 23 Thank you very much, my Lady.
 24 **LADY JUSTICE THIRLWALL:** Thank you, Mr Sharghy.
 25 Mother I, thank you very much indeed for providing

I N D E X

MOTHER D (sworn)	1
Questioned by MS LANGDALE	1
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