1 **Wednesday, 18 September 2024**
2 **(10.00 am)**
3 **LADY JUSTICE THIRLWALL:** Is the shorthand writer ready?
4 Thank you very much.
5 I'll just mention one thing which I did yesterday.
6 I know that everyone who is listening online and who is
7 a member of the media is aware of the reporting
8 restrictions which arise out of the Crown Court orders,
9 and this is really by way of a reminder that if there's
10 any inadvertent breach of the order by anyone, it is not
11 to be reported, and obviously it will be removed from
12 the transcript in due course.
13 Ms Langdale.
14 **MS LANGDALE:** Good morning, my Lady.
15 **MOTHER E&F (sworn)**
16 Questioned by MS LANGDALE
17 **MS LANGDALE:** Mother E&F, you provided a statement to the
18 Inquiry dated 16 July 2024. Can you confirm the
19 contents are true and accurate as far as you're
20 concerned?
21 **A.** Yes.
22 **Q.** We all know of course that Child E was murdered on 4
23 August and Child F attempted murder by insulin
24 poisoning.
25 Could you tell my Lady the impact that has had on

1 you?
2 **A.** The impact that that has had on us has been enormous.
3 It changed the course of our life completely and we've
4 had to try and grieve in so many different ways. We
5 tried to grieve at the time, and then we had to endure
6 what was going to be happening when that report arrived
7 on our doorstep, and then that brought everything back
8 up. We had to grieve for the life that we thought we
9 were going to have with Child F, with his learning
10 difficulties. So it was a real mixture of emotions and
11 ups and downs, and it felt like over the course of
12 nine years, a lot of things that have been good and
13 meaningful to us have been very overshadowed by the
14 actions of the Countess of Chester.
15 **Q.** We'll come on to reports and what you did and didn't
16 receive later.
17 One of the matters you comment at the outset in your
18 statement about is being robbed of expectations of
19 family life and tormenting yourself with thoughts of
20 Child E buried in the clothes that Letby picked out and
21 dressed him in. And we have seen a note you have
22 written about that where you say:
23 "She dressed him in a little woollen gown with blue
24 ribbon around the waist. We buried him in that. She
25 put a small teddy next to him."

1 Did she have a discussion with you about those
2 clothes or what was being done? Can you remember?
3 **A.** No, so there was no discussion about those clothes. He
4 was bathed by Lucy Letby and he was placed in that
5 woollen gown in his incubator, and when I asked where it
6 had come from, she said that it had come from the unit
7 and she'd picked it out and chosen it for him.
8 **Q.** And you also made notes that she gave you a memory box
9 with his hand and feet prints in it, and taken some
10 pictures and put them on a card, and all his belongings
11 were in that memory box?
12 **A.** Yes.
13 **Q.** Did you know that was being put together?
14 **A.** I did not know that was put together.
15 **Q.** And how do you feel now about having the memory box
16 being put together by her?
17 **A.** I think if that memory box was put together in the way
18 it's meant to be put together by somebody who was, you
19 know, a caring professional who hadn't done harm to our
20 child, it would be meaningful, but everything in that
21 box, absolutely everything, has been created by her.
22 All his belongings were touched by her. His blankets
23 that had the blood on are in the box. His hand and
24 footprints were taken by her. His hair was cut by her,
25 and it's painful. Even one of the pictures that she

1 took of him has got part of her hand in it and for me
2 that hurts because I don't know if it was intentional
3 but it felt intentional, once we knew what had happened.
4 **Q.** You say in your statement you listened to your boy's
5 final hours during the trial. So what did you learn in
6 the criminal trial that you didn't know before?
7 **A.** Everything. We didn't know any information, because the
8 criminal trial was, you know, it was quite rightly so it
9 was protected and, you know, that was important. But
10 the information, you know, about the falsifying of
11 records and the way things were done, and --
12 **Q.** You gave evidence in the criminal trial, didn't you?
13 **A.** I did.
14 **Q.** And just touching upon that, when you knew you had to
15 give evidence, were you able to speak to anyone about
16 the rest of the case or anything like that until you'd
17 given your evidence?
18 **A.** No. So I wasn't able to attend court up until after
19 I had given evidence. So I had to stay away from the
20 media and everything until I'd given evidence. So
21 I couldn't know anything about what was happening in the
22 trial, which was really, really difficult because again,
23 everything felt out of my control.
24 **Q.** We'll come on to that evidence later but for now can
25 I ask you about your experiences at the Countess of

1 Chester Hospital in the run-up to giving birth and when
2 you were pregnant, and you start at paragraph 19 in your
3 statement.
4 A. Okay, so I was under the care of Liverpool Women's
5 Hospital. I was there as an inpatient, there'd been
6 a problem at one of my last appointments, and the
7 Consultant thought it was best that I stayed in
8 hospital. They were trying to get the pregnancy to 30
9 weeks and they thought that was going to be possible and
10 I was being scanned every day. It was suggested that
11 Child E was significantly smaller than Child F, and
12 there was a problem with the blood flows to the boys.
13 We knew there was a problem with the neonatal unit
14 at the Liverpool Women's as in capacity and we knew
15 a few days before that it was actually at capacity. And
16 it was suggested that we -- you know, we be transferred
17 to different units and I think one of them was actually
18 Cardiff, and I was quite upset at the prospect of being
19 sent to Cardiff, which is quite --
20 Q. Yes. So you ended up having a C-section, didn't you, at
21 the Countess of Chester?
22 A. I did.
23 Q. And how was that experience?
24 A. It was okay. So I arrived in an ambulance and I was
25 taken to a room, and albeit it was -- it wasn't like the

1 Tertiary Centre of Liverpool Women's, it was quite
2 a stark contrast to that. But I was treated well and
3 things were explained to me. And I was about to go into
4 theatre and an emergency came in so they -- the
5 emergency went in and I waited and then I went in and
6 had -- had the boys.
7 Q. And you were told there was going to be a team for each
8 of the boys?
9 A. Yes.
10 Q. And one for you, in the theatre?
11 A. Yes.
12 Q. You had an epidural?
13 A. Yes.
14 Q. All of this was explained and went well from your
15 perspective.
16 A. (Witness nodded)
17 Q. And when were they both born, did they cry on delivery?
18 How was it?
19 A. Yeah, so it was explained to me before, before I had my
20 section, that because they were so premature, that they
21 may not cry, but actually both boys did at birth, which
22 was really lovely to hear.
23 Q. Where were you taken when you came out of theatre?
24 A. I was taken back to the room where I had come from and
25 then, after an hour or so, I was taken up to a ward with

1 other mums and babies. My husband was able to go and
2 visit the boys briefly. I didn't want him to go on his
3 own so my mum actually went with him. They didn't want
4 her to but I insisted that he must have my mum with him.
5 Q. So you were effectively on a ward watching other mothers
6 with their babies but you couldn't see yours?
7 A. Yes.
8 Q. Did you or your husband have to insist that he could see
9 them or how was that or was it just offered? What was
10 the position?
11 A. I think it was offered that he could go and see the
12 boys, but that was to take some pictures for me. So
13 I essentially had two pictures of my boys, and, you
14 know, it was really, really difficult when there's lots
15 of other mums on a ward around me with babies, and
16 babies crying, and it -- it all just felt really, really
17 sad and I felt lost.
18 Q. Would it have been helpful for you to have a camera in
19 the incubator so you could have at least seen them from
20 where you were even though you were in a different part
21 of the hospital and view them in the way parents
22 sometimes do when they can't be with their children?
23 A. Absolutely. I think that would have been really helpful
24 for me at that time.
25 Q. You say in your statement you were told you should wait

1 until the morning to see the twins but you insisted you
2 wanted to see them sooner and eventually, at 11 pm, six
3 hours after giving birth, you were able to do so?
4 A. Yes. My husband said he wouldn't leave the hospital
5 until I'd seen them and he took me down to the neonatal
6 unit to see them.
7 Q. And when you saw them, what impression did you get about
8 how they were and what was happening?
9 A. I was actually in shock when I seen the babies because
10 they were so small and Child F was actually wrapped in
11 a plastic bag, and it took me by surprise. And
12 I actually said to one of the nurses, "I don't think
13 that these are my babies, they're just so small". And
14 she said they were, "They are, I was here when they came
15 through".
16 Q. And at any stage or other, were you led to have any
17 concern that they weren't progressing, getting stronger
18 and doing as they should?
19 A. Everybody that we came into contact with said how well
20 they were doing and they were doing way better than
21 what, you know, they were meant to be doing for their
22 gestation that they were born at. Child E was actually
23 breathing for himself, he was on no support. Child F,
24 he needed a little bit of extra support but that was
25 explained to us. It was because Child E was ready to be

1 born and Child F would have been quite happy to stay
2 in utero a bit longer.
3 **Q.** Child E. On the night of 3 August 2015 tell us when you
4 were called to go to the NNU what happened?
5 **A.** Sorry, can you repeat that?
6 **Q.** On 3 August, if you look at your statement from
7 paragraph 46 onwards --
8 **A.** Yes.
9 **Q.** -- you visited Child E, that evening, didn't you on the
10 ward?
11 **A.** Yes.
12 **Q.** Can you tell us about that now?
13 **A.** In the evening?
14 **Q.** Yeah, in the evening when you went down, what --
15 **A.** So in the evening I went to take some expressed milk.
16 I'd been with him. I'd have been with both of the boys
17 all day. My husband had done skin to skin with Child E
18 in the morning and I had done skin to skin in the
19 afternoon with him. He was thriving. He was --
20 **Q.** Tell us what that means, skin to skin?
21 **A.** So it's when baby is placed on mum or dad's chest and
22 then wrapped in a blanket to keep all the heat in, and,
23 you know, the baby can feel our heartbeat and we can
24 feel theirs, and it's just a really beautiful thing to
25 be able to do.

1 **Q.** So you'd been doing that in the day. In the evening,
2 what happened when you took the milk down?
3 **A.** So I went in the evening, I took the milk and as
4 I was -- I was -- I'd come in to the unit in the
5 corridor, I could hear screaming and crying, and it was
6 a shock, because I'd never really heard -- I mean, I'd
7 been on that unit six days and I'd never heard a baby
8 cry like that. And then I walked into the room and
9 I realised it was my baby. And I went to him, and he
10 had blood around his mouth and I was just shocked and
11 I tried to -- I put my hands in the incubator and
12 I tried to do a containment exercise that they'd
13 explained to us, that that makes the baby feel like
14 they're still in your tummy, you put your hand on their
15 stomach and hand on the head, and that is meant to calm
16 the baby down so it feels like it's secure and safe.
17 And that didn't work.
18 And I asked Lucy Letby why there was blood around
19 his mouth, why he was bleeding. She was quite
20 dismissive and said, "It'll be the feed tube rubbing the
21 back of his throat, and that's where the blood will have
22 come from. But I've contacted the registrar, and, you
23 know, he's on his way. Go back -- you know, you go back
24 to the ward and if there's any problems I'll ring for
25 you".

1 And I didn't have my phone with me and I wanted to
2 speak to my husband because I knew there was something
3 not right. So I left.
4 **Q.** And did you phone your husband?
5 **A.** I did and he told me that there was nothing to worry
6 about because he's in the best place: he's in a hospital
7 with people that know what they're doing, and if there
8 was a problem, that we would know about it. But I know.
9 **Q.** When you went back, did you get a call later that night
10 to go back to the NNU?
11 **A.** Yes, yes. So I'd had a conversation with a midwife and
12 I was upset, and I told her what I'd found, and I think
13 she checked on me throughout the couple of hours, and
14 she then asked me to -- she'd come in to the room and
15 asked me to contact my husband, and ring him. And at
16 that point I knew something really bad was happening,
17 and she asked to speak to him and she didn't -- she
18 wanted to speak to him and she told him to come to the
19 hospital straight away and not to drive. To get
20 somebody else to drive him.
21 So at that point, I knew something really awful was
22 happening, but I never for a million years did I think
23 that my boy was going to die. It never entered my head
24 that he was going to die.
25 **Q.** So you go down with the midwife again that evening?

1 **A.** Yes.
2 **Q.** How long after when you first went down are we talking
3 about? Do you remember the timings or not?
4 **A.** A couple of hours. About two hours, I think.
5 **Q.** So you go down, and what situation confronted you?
6 Where were you when you went down?
7 **A.** Sorry?
8 **Q.** Where were you when you went down, where were you taken?
9 **A.** So when I went down I was sat in that same corridor
10 where I could first hear them crying and there were some
11 chairs and the midwife was sat next to me and I think
12 she was trying to talk to me, and I was -- I don't
13 really know what she was saying because I was watching
14 what was happening through the window because I could
15 see his incubator straight from where I was sat. And
16 I could see -- or I couldn't really see -- I couldn't
17 see Child E, but I could see the team around him working
18 and it looked busy and it looked serious.
19 **Q.** You say in your statement you had to sit outside in the
20 corridor for approximately 15 minutes?
21 **A.** Yes.
22 **Q.** And then:
23 "A member of staff came out and asked if I wanted
24 Child E to be christened and asked where my husband
25 was."

1 **A.** Yes, yes. I've reflected on that. I think it was
2 a nurse. It wasn't Lucy Letby and it wasn't the nurse
3 in charge. It was the other nurse. But in that time,
4 I actually don't believe that I would have -- I don't
5 think I would have been with Child E if it hadn't have
6 been for the midwife, because I heard her talking to the
7 staff, saying, "It's not fair, it's not right. She's
8 his mum. She should be there with him. This isn't
9 right. She's sat in a corridor".
10 **Q.** We have, my Lady, the statement from that midwife.
11 We've seen the statement from the midwife, who says
12 she had taken the decision to take you down to the NNU
13 and indeed she thought you should be there.
14 **A.** Yes.
15 **Q.** Is that what you're telling us?
16 **A.** Yes.
17 **Q.** You remember her saying that?
18 **A.** Yes.
19 **Q.** Were you allowed to go in to be with Child E or to hold
20 his hand at any point?
21 **A.** I did, yes. I did, after I was -- I think I was sat
22 outside for a about 15, 20 minutes, and again, a nurse
23 came out and said for me to go in, and to hold him. So
24 I had to kind of go around the back of where they were
25 working and hold his hand, and I was told to talk to him

1 because he could hear me, and I was just talking to him,
2 telling him everything was going to be okay and all the
3 fun that we were going to have when we got home.
4 **Q.** We know at paragraph 60 of your statement you tell us
5 Child E was christened and Doctor ZA had said to you
6 they wanted to stop working on him as they couldn't save
7 him.
8 **A.** Yes.
9 **Q.** Did you witness and see how hard they were trying to
10 save him?
11 **A.** I did. I did. I believe that Doctor ZA and Dr Harkness
12 tried everything that they could, and that, you know,
13 I could see their expressions on their face, that, you
14 know, it's -- they were really upset by what was
15 happening, and I think they tried everything they could
16 to bring him back, and I think trying for 45 minutes on
17 a baby that's so small is -- it's testament to how much
18 they wanted to save him.
19 **Q.** What were you told straight afterwards? What can you
20 remember being told about it?
21 **A.** So I had -- we had a conversation with Doctor ZA, and
22 she told us that she believes he had died from NEC,
23 which is --
24 **Q.** Necrotising enterocolitis?
25 **A.** Yes, yes. Which is quite common in premature babies and

1 small premature babies albeit, you know, Child E was,
2 from what we were told, he was, you know, a really good
3 weight for his gestation. And she mentioned
4 a post-mortem, and I think it was my husband who asked
5 what would that be able to tell us? And she said well,
6 she didn't think that that would -- she wouldn't be able
7 to tell us anything, because, you know, she believed
8 he'd died from NEC.
9 **Q.** You were asked whether there should be a post-mortem,
10 and Doctor ZA in effect said you weren't going to learn
11 anything different from it.
12 **A.** Yes.
13 **Q.** What do you think about parents' input at that time as
14 to whether there's a post-mortem or not? Do you think
15 it's important you have a say in that? Do you think it
16 should be a final say? What do you think about the role
17 of the parent in that situation, deciding whether there
18 should be a post-mortem?
19 **A.** I think in our situation, I think that decision should
20 have been taken out of our hands, I think. From
21 everything that I've learnt from the criminal trial, it
22 was so unusual for Child E to die in that way, that was
23 expressed by all the doctors. I think trying to make an
24 informed decision when you've got your child that's died
25 in your arms on whether you want him to have

1 a post-mortem is -- it's an impossible decision to have
2 to make and I couldn't -- I couldn't make an informed
3 decision at that time. So I feel that it's unfair to
4 ask a bereaved parent whether they want that to happen
5 for their child, because of course you don't.
6 **Q.** You decided, you say, not to have a post-mortem, and
7 Doctor ZA later apologised for her advice on that point
8 during the criminal trial. So tell us about that?
9 **A.** So in the criminal trial, she spoke about not giving
10 enough weight to the X-ray that he'd had that showed no
11 signs of NEC whatsoever, and it was a real emotional
12 moment because it's the first time that anybody from the
13 Countess of Chester has apologised for their, you know,
14 part in what happened, and I think it was extremely
15 brave of her to do so. She actually wrote to us as well
16 back in September 2023 to apologise, which I thought was
17 a really kind gesture from her.
18 **Q.** You then set out in your statement, you touched upon it
19 earlier, that Lucy Letby bathed Child E. And you say:
20 "He was all purple and bruised. It hurt even more
21 seeing him in that state."
22 **A.** Yes.
23 **Q.** So you could see that -- you've described what you see
24 there?
25 **A.** Yes. So at that time, Lucy Letby asked if I would like

1 to bathe Child E. And the boys are my first babies and
2 I've never bathed a baby before. I've never bathed
3 a baby that small and I'd never bathed a baby that had
4 died and I just -- I couldn't do it. And she bathed him
5 in front of me.
6 **Q.** Did you get any private time to spend with Child E, you
7 and your husband, at this point?
8 **A.** We had no private time with Child E at all. We had to
9 grieve in Nursery 1 and spend time with him in Nursery 1
10 with other members of staff.
11 Mine and my husband's family came that same night
12 after Child E died and they had to go and spend time
13 with him in his incubator in Nursery 1, so there was no
14 space to spend any time with him at all, which at the
15 time I didn't question, because I didn't know, I didn't
16 know any better, so to speak. It was -- and that's the
17 thing. It's giving parents choice, because in that
18 moment they don't know what's right, because, you know,
19 it's the first time that that had ever happened for us,
20 and we couldn't even think straight because a couple of
21 hours earlier we had two thriving little boys, and in
22 the space of a couple of hours, it had all been taken.
23 And our world had just spinned upside down and nothing
24 felt right. So it, you know, should be for
25 professionals to guide.

1 **Q.** And you say:
2 "Myself and Father E&F grieved the loss of our baby
3 in full view of the staff in Nursery 1."
4 **A.** Yes, yes.
5 **Q.** We know that a Datix report was produced in relation to
6 the death of Child E. They are reports used by
7 hospitals or made by hospitals surrounding incidents,
8 concerns or risks, deaths.
9 **A.** **(Witness nodded)**
10 **Q.** If we look at page 63 in the bundle you've got there,
11 there's a handwritten number in the right-hand corner.
12 If you go to 63, this is the Datix form surrounding
13 Child E and his death. If you look at page 64, it looks
14 as though people enter information at different times in
15 this reporting system and we see on 2 August 2017:
16 "Unexpected neonatal death of twin. Baby had
17 a gastric bleed followed by another, but the cause was
18 unknown. The baby had a sudden deterioration after
19 this. The baby suffered cardiac arrest and
20 CPR/resuscitation was attempted. The baby's parents
21 were consulted and the decision was made to stop
22 resuscitation."
23 Sorry, I should have said the date was
24 2 August 2017.
25 Was that information in that way communicated to you

1 around the time or subsequently of his death?
2 **A.** No.
3 **Q.** If we look at the top of the same page, there's an entry
4 by Debbie Peacock, 16 December 2015.
5 "Summary of Neonatal Review.
6 "Baby was a 29 week gestation infant at high risk of
7 NEC. His initial condition was good but he showed signs
8 of stress and maladaption to extrauterine life,
9 persistent high blood sugars. He is likely to have died
10 from a perforated bowel secondary to NEC. Neonatal care
11 was appropriate and record-keeping of a high standard.
12 Possible learning points from the case are described but
13 is unlikely any changes in management would have
14 prevented this sad outcome."
15 So that's the entry for December 2015. Was that
16 what you understood was the position, what was stated in
17 the summary above?
18 **A.** Part of it. I wasn't aware he had persistent high blood
19 sugars, I was told he had high blood sugar at I think it
20 was day (redacted) of life, and with a small amount of
21 insulin -- it rectified itself.
22 **Q.** Sorry, you're talking about Baby F now. You're talking
23 about Baby F, yes?
24 **A.** No, E.
25 **Q.** E, sorry, yes, with the insulin, yes, sorry, carry on?

1 **A.** So it says here, doesn't it, with Child E, he had had
2 persistent high blood sugars?
3 **Q.** Yes.
4 **A.** That was rectified with a very, very small amount and
5 that was, I think, I think that was -- he'd come off
6 that by the time *(redacted)* August had arrived so it
7 wasn't persistent, it was -- I think it was a one-off.
8 **Q.** Right, and they'd told you that at the time?
9 **A.** Yes, but we were also told with that it's so common with
10 neonates, and it's them adjusting to being, you know,
11 born.
12 **Q.** When Child E had died, how did you feel about being in
13 the same hospital with Child F?
14 **A.** We wanted to leave but we were waiting on transport. So
15 every day it was waiting to see if the transport team
16 could have two ambulances available for the boys to move
17 them, and unfortunately for us, that never happened. So
18 after Child E died, we were very, very keen to move.
19 **Q.** If you go back to your statement at paragraph 73,
20 following Child E's death, almost exactly 24 hours later
21 Child F collapsed.
22 **A.** Yes.
23 **Q.** Can you tell us about that?
24 **A.** So we were in bed in the accommodation on the neonatal
25 unit, because I discharged myself from the Countess of

1 Chester Maternity Services, and me and my husband were
2 staying on the unit until we were able to get Child F
3 moved, and we were in bed, and Nurse T come and knocked
4 on the door, and said, "I think you need to come in to
5 Nursery 2, Child F is experiencing really rapid, fast
6 heart rate", and in that moment I just thought: not
7 again. This simply cannot be happening to us again.
8 And I went in there, and I sat in the chair, and
9 I was just willing that his heart rate would come down
10 and he was going to be okay. And I sat all night, and
11 the heart rate didn't come down, and I think it was --
12 I was told to go back to bed by a nurse. But
13 I wouldn't. There was no way I was leaving him. No
14 way. Not after leaving Child E the night before.
15 **Q.** We know that Dr Gibbs came to review Child F and what
16 did he tell you about Child F's position?
17 **A.** He told me that Child F had an infection in the long
18 line of his leg, and moving the long line in his leg,
19 and setting him on a course of antibiotics would rectify
20 things.
21 **Q.** You now know the day that you left the Countess of
22 Chester Hospital, insulin test results came in for
23 Child F?
24 **A.** Yes.
25 **Q.** Did you know about those results at the time and what

1 they showed?
2 **A.** I didn't even know he'd been tested for insulin.
3 Insulin was never mentioned to us at the time. We were
4 simply told he had an infection in the long line of his
5 leg.
6 **Q.** Did you ever know that there were ever any issues with
7 his blood sugar?
8 **A.** No.
9 **Q.** What were you told about any infection or antibiotics?
10 Did you know about anything?
11 **A.** Yeah, so we were told he would be started on a course of
12 antibiotics. I think it was precautionary, because they
13 thought that they had an infection in the tip of the
14 long line of his leg, and they removed that long line,
15 and put him on a course of antibiotics.
16 **Q.** When did you find out about insulin having been given to
17 Child F?
18 **A.** So I -- as part of the police investigation, Child F was
19 asked to go for an MRI scan, and again, the police did
20 not inform us what that was looking for, but I asked
21 a medical professional who told me what the test was
22 looking for. So with that, I had actually obtained
23 Child F's medical records from our solicitor, and for
24 many, many weeks I combed through all those the best
25 I could with no medical knowledge whatsoever and found

1 the readings, and researched what those meant, and came
2 up with my own conclusions that, you know, they were
3 suggesting that, you know, he'd been given a lot of
4 insulin when he shouldn't have. And I think a month
5 before the criminal trial, the Family Liaison Officers
6 provided us with like a paragraph which set out what the
7 case against Lucy Letby was. Again, it was very brief,
8 and there was no real information behind it but I think
9 that was done so there was no -- I want to say shock but
10 "shock" isn't the right word because the whole thing was
11 shocking. So we knew before we went into the room what
12 was --
13 **Q.** Going to be said about your child?
14 **A.** Yes.
15 **Q.** Were you, in terms of the hospital, ever told about any
16 meetings or investigations into Child E's death and
17 Child F's sudden deterioration? For example, we've seen
18 on that Datix a neonatal unit discussion or meeting.
19 **A.** Yeah.
20 **Q.** Anything like that or a serious incident discussion?
21 **A.** Yes.
22 **Q.** Nothing like that?
23 **A.** No. And I think I never questioned anything, because
24 quite a few people on the unit at that time had actually
25 said to us, "You know, we're never going to forget

1 Child E because we don't lose children on this unit. It
2 just doesn't happen", and that was said to us quite
3 a few times. So for us, it wasn't something that
4 usually happened there.
5 **Q.** When did you find out at the time there would not be
6 a post-mortem? There seemed to be no need for one?
7 **A.** That was the next day. So -- well, not the next day.
8 In the day of the 4th --
9 **Q.** 4 August.
10 **A.** -- we were in the family room and I was there with my
11 mum and my husband's mum, and I think it was Doctor ZA
12 came in and said that she'd spoken to the Coroner and
13 the Coroner had said that we don't need to have
14 a post-mortem and they actually arranged for the
15 registrar to actually come to the hospital to register
16 both the boys' births and Child E's death at the same
17 time.
18 **Q.** You -- it's understood you received a letter from the
19 Medical Director, Mr Harvey. If you go to page 73 in
20 the bundle we see a letter dated 8 February 2017.
21 **A.** Yes.
22 **Q.** "Dear Mother E&F,
23 "You may be aware the hospital asked for an external
24 assessment of its Neonatal Unit from the Royal College
25 of Paediatrics and Child Health and the Royal College of

1 Nursing. This step was taken because we wanted to
2 better understand why there had been a greater number of
3 deaths than we would normally expect on our Neonatal
4 Unit between January 2015 and July 2016.
5 "On Friday last week we tried to contact you to let
6 you know this report was ready and we are keen to share
7 it with you. You will be able to access this report via
8 the News section on our hospital website from 12 noon on
9 Wednesday 8th February.
10 "Once you have read the report we would be happy to
11 meet with you. Please contact [number given] between
12 the hours of 9am and 5pm so we can arrange for us to
13 speak with you directly and for the report to be
14 delivered. We are desperately sorry for any distress or
15 upset that news of this review will have caused. We
16 know you will have been thorough so much already."
17 Did you receive that letter?
18 **A.** I did. I received that letter by a black taxi knocking
19 on my door about 30 minutes before that report was due
20 to go live online.
21 **Q.** And was the report sent with it?
22 **A.** No, the report was online, so I was having to access
23 that report on their website.
24 **Q.** Had you any warning that was coming or what it was
25 about?

1 **A.** I had absolutely no warning whatsoever. I was
2 absolutely mortified. I was panicking. I didn't know
3 what was going on. I was at home with my son, Child F,
4 and my daughter, who was a couple of months old at that
5 time, and it beggars belief that a black taxi could turn
6 up at my door with a letter about something that I had
7 no idea about, I had no knowledge that there was any
8 assessment or anything that was going on.
9 **Q.** You say in your statement:
10 "Prior to this, the only time Countess of Chester
11 contacted me was to ask for a breast pump back. In fact
12 it had already been returned to them on the day we left
13 the NNU."
14 **A.** Yes.
15 **Q.** Were they able to contact you to ask you about that --
16 **A.** (Witness nodded)
17 **Q.** -- and how did they contact you? Don't give --
18 **A.** So I -- the neonatal team loaned me a breast pump for
19 Child E's funeral so I could pump milk whilst I was
20 there.
21 **Q.** Of course.
22 **A.** And I had already taken that straight back because we
23 were actually living on the unit. So I'd given it back
24 on the day. And they actually telephoned me to ask me
25 for it back and I said, "Well, I gave it back".

1 **Q.** So they had a number for you?
2 **A.** Absolutely, yeah, they had a number. They rung me twice
3 for that same breast pump.
4 **Q.** You tell us you called Debbie Dodd, which was the number
5 supplied to you on that letter that was brought to you
6 in that cab?
7 **A.** Yes.
8 **Q.** And you wanted to read the report and try to understand
9 what it meant?
10 **A.** Yes.
11 **Q.** When you phoned Debbie Dodd what did you ask and what
12 happened?
13 **A.** I asked to speak to Ian Harvey, because he'd signed the
14 letter. And she said he wasn't available, and that she
15 would pass any messages on and I said I was concerned
16 because I had no idea that there was ever any issue,
17 and, you know, why was this the first time that I'm
18 hearing about this? And in my mind, I thought it was
19 because we were out of the area, and I felt like we'd
20 kind of been forgotten. And then Ian Harvey never rung
21 me back. And I actually had a conversation, I said,
22 "This letter states that you've tried to ring me".
23 I said, "Nobody's tried to ring me". I said, "I'm at
24 home with my two children. If somebody rings, I answer
25 it".

1 **Q.** Can you go to page 74 in the bundle, and it's another
2 letter from Mr Ian Harvey, 3 March 2017.
3 "Dear Mother E&F,
4 "Further to previous correspondence and the
5 completed review of the Neo Natal Unit carried out by
6 the Royal College of Paediatrics and Child Health at the
7 Countess of Chester Hospital, I am writing to appraise
8 you of our current progress. You will have seen within
9 the review that one of the recommendations was that
10 a separate independent review of the care of each of the
11 babies should be carried out. This review has now been
12 completed but has in turn indicated that a small number
13 of areas of investigation are required and I aim to
14 undertake this as quickly as possible. I will, in due
15 course, be sharing the findings of this further review
16 in relation to Child E with you and will be offering to
17 meet with you to discuss any concerns or issues that you
18 may have arising from both the College Review and the
19 subsequent review.
20 "I apologise for the length of time this whole
21 process has taken. This reflects the depths to which we
22 have carried out the whole Review process. I want to
23 make sure I can confidently respond to any concerns you
24 have in an open and transparent manner. Unfortunately,
25 due to the depth of investigation I am not in a position

1 to give you a definitive date for any meeting but will
2 be endeavouring to make this as soon as possible and
3 will certainly aim to make this in the next six weeks."
4 First of all, did you receive that letter?
5 **A.** Yes.
6 **Q.** What did you make of that?
7 **A.** I -- at the time, it made me panic and it made me
8 worried, because again, up until this point, I had no
9 idea or any clue that there was, you know, an elevated
10 death rate on the unit and I was thinking all sorts of
11 things. I didn't know what had happened. I actually
12 didn't know what happened. I was in the dark. I had no
13 information to go off, and to be honest, it's just a lot
14 of words, isn't it? It doesn't actually mean anything,
15 that letter.
16 **Q.** Did you try and phone Debbie Dodd again or what did you
17 do when you --
18 **A.** I think I contacted Debbie Dodd and I think at that time
19 we contacted a solicitor as well, which ...
20 **Q.** When did you finally receive, first of all, the RCPCH
21 report? Do you know which one I'm referring to then?
22 The external report was by Dr Hawdon, and then there was
23 an RCPCH report?
24 **A.** Yes.
25 **Q.** The first one that was --

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1 **A.** So the first one, that was the one that went online,
2 wasn't it?
3 **Q.** Yes.
4 **A.** So we accessed that on 8 February and I had accessed
5 that online.
6 **Q.** Was that -- was that something that was publicly
7 available to anyone who accessed it?
8 **A.** It was.
9 **Q.** Or a few people? So it was a publicly available version
10 of the report?
11 **A.** Yes, but from my phone call with Debbie Dodd on that
12 date, she sent me a hard copy of that as well.
13 **Q.** The Inquiry is aware there are two different versions:
14 a confidential version of that report and one that was
15 disseminated more publicly?
16 **A.** Yes.
17 **Q.** Have you now seen the two different versions of the
18 report?
19 **A.** I have.
20 **Q.** Where there's one with more information about Nurse LL
21 and one with no information about Nurse LL?
22 **A.** Yes.
23 **Q.** So which one did you see at the time?
24 **A.** The redacted version.
25 **Q.** So you didn't see anything about the concerns about LL?

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1 **A.** No.
2 **Q.** Or what was said in that section 4 of the RCPCH report?
3 **A.** No.
4 **Q.** Would you like to have seen that at the time?
5 **A.** Yes.
6 **Q.** And what impact, if any, do you think that would have
7 had upon you at the time, to see that section?
8 **A.** I think the Countess of Chester being transparent and
9 open with what they were investigating would have given
10 me peace of mind of, you know, not thinking that I've
11 missed something, and, you know, I blamed myself for
12 a lot of things that happened in that time, and I think,
13 you know, that's my son. I think any information that
14 they have about him should have been shared openly with
15 us. I don't think it should have been held back.
16 I think to do that is, I think it's quite hideous, to be
17 honest.
18 **Q.** If you look at page 75 of the bundle in front of you
19 there's another letter, 21 April 2017, addressed to
20 Mother E&F.
21 **A.** Yes.
22 **Q.** "Further to the letter of 3 March I would like to thank
23 you for your continued patience. I can confirm that
24 further investigation work has been undertaken, however,
25 we have been advised by the independent external case

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1 reviewer to consult with the Pan Cheshire Child Death
2 Overview Panel (CDOP) which has been arranged for next
3 week.
4 "It is important we take this step to complete the
5 reviews so that we conclude this matter as soon as
6 possible. Once this consultation has taken place I will
7 make arrangements as soon as possible to meet you to
8 discuss all the review findings.
9 "I appreciate this provides for a further delay for
10 which we are sorry and recognise it is a really
11 distressing time for you but it is important that we
12 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 what it did or what that meant?
17 **A.** No, I didn't know anything about that.
18 **Q.** Did that communicate anything effectively to you? What
19 did you take from that?
20 **A.** I took from that that something had gone very, very
21 wrong, and we still had no idea, and I was essentially
22 waiting on other people to tell us what happened to our
23 son.
24 **Q.** If you look at page 76, the next page, another letter,
25 28 April 2017 to you from Mr Harvey.

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1 "Dear Mother E&F,
2 "Further to my letter of 21 April I am writing to
3 you again to pass on the results of the independent
4 external review regarding the care of your baby.
5 I appreciate that by its nature this report will contain
6 some technical terms but I felt it was important that
7 you saw the original report. Once you have had the
8 opportunity to read and consider the contents of this
9 latest document, together with the previously sent copy
10 of the Royal College of Paediatricians [sic] and Child
11 Health report, please contact me if you wish to meet to
12 discuss these documents and any other issues you might
13 have in greater detail. We will then also be in
14 a position to explain any of the terminology that might
15 be unclear."
16 And if we turn over the page, there's two pages of
17 typed notes, medical notes, in respect of Child E from
18 this external review. Just looking at those notes, were
19 they sent to you at the time?
20 **A.** Yes.
21 **Q.** What did you make of those notes in relation to Child E?
22 **A.** I was absolutely furious when this arrived. It was --
23 it's just not meaningful at all. And, you know, I felt
24 the times were wrong on this document. I now know that
25 the times were falsified. But that the timings was

1 wrong, and the letter itself is -- why on earth would
2 you sent bereaved parents a letter with documentation in
3 about their child from a medical perspective when the
4 parents have no medical training or any medical
5 background? What was earth was I meant to do with that
6 piece of paper? You know, to say I was furious was an
7 absolute understatement, because the letter, it's
8 careless. It's not mindful of bereaved parents and I'd
9 go as far as to say it's quite sloppy, to be honest.
10 **Q.** Tell us why you challenged the timings and why you say
11 at the time you thought it was sloppy?
12 **A.** So I challenged the timings because it stated that on
13 03/08, Child E had a gastro bleed at 2210 when in fact
14 I know that that was an hour earlier.
15 **Q.** You knew he was bleeding an hour earlier?
16 **A.** I knew he was bleeding just before 9 o'clock and
17 I pointed that out, and that was the time that I was
18 that furious I contacted my mobile phone provider
19 because I knew that I'd had a conversation with my
20 husband as soon as I'd come back up, and I almost
21 thought that I was losing my mind and I was wrong. So
22 I wanted that proof that I was right, and I got that
23 proof. I was right, and I knew what time it was.
24 **Q.** So the time here had been incorrectly stated in the
25 records?

1 **A.** Yes.
2 **Q.** So when you read that letter from Mr Harvey and saw
3 those two pages, what do you think was happening then?
4 This was in April 2017.
5 **A.** I thought that the hospital was really incompetent.
6 That was my overarching thought. I just thought that
7 they just haven't been able to get anything right. And
8 then, for page 79 that we have here, but it was 21 on
9 the report, you know, again I had to take to the
10 Internet to try and decipher what any of that actually
11 meant. But I think the Countess of Chester are dealing
12 with people and to send that report with nothing to back
13 it up or any conversation, or anything, it was actually
14 sent on sample paper.
15 **Q.** On?
16 **A.** Sample paper, so it wasn't -- it was just like it had
17 been -- there's just been no care, I think. And --
18 **Q.** Each letter that we have gone to stated that you could
19 make an appointment to meet with Mr Harvey?
20 **A.** Yes.
21 **Q.** Would you have welcomed that? Did you want --
22 **A.** I tried to, yes. I tried to make an appointment with
23 him and was -- I think I rung quite a few times -- so
24 I know I rung after every letter arrived, and maybe
25 more, more than once. And on one occasion I was told he

1 was on annual leave and I was told that, you know, he
2 would get back in contact with me, and -- and I was
3 actually really upset with Debbie Dodd on the phone at
4 one point. I wasn't upset with her, I was upset on the
5 phone and, you know, she was kind and she was nice and
6 she empathised. But essentially she was just
7 Ian Harvey's shield. And that's how I feel about it.
8 **Q.** And you say in your statement after the commencement of
9 the police investigation you never tried to contact
10 Mr Harvey again?
11 **A.** No.
12 **Q.** You were going to be a witness and your position you've
13 set out earlier?
14 **A.** Yes.
15 **Q.** Moving now to suspicions and concerns regarding
16 Lucy Letby. At the time or subsequently, have you had
17 concerns when you look back about her?
18 **A.** When I look back?
19 **Q.** Yeah, when you look back.
20 **A.** I think her behaviour towards me was very different to
21 other nurses, and that's something that I've reflected
22 on. She was very attentive of me. Whenever she used to
23 see me she would hug me. She was just as upset as me,
24 which, reflecting back on it now, it's very odd, odd
25 behaviour, when none of the other nurses were really

1 like that. They were very professional and cared for
2 Child F in the correct way, whereas she was very
3 emotional, and I thought she was being kind.
4 **Q.** This was when the bathing and the dressing of Child E,
5 you mean, she was upset and tearful?
6 **A.** No.
7 **Q.** No?
8 **A.** No, right up until we actually left the unit she looked
9 like every time she was speaking to me she was on the
10 verge of tears, and very upset.
11 **Q.** When you look back now, the evidence you gave at the
12 criminal trial and now about being sent away when you
13 were concerned about any blood on his mouth, what do you
14 make of that now?
15 **A.** I -- well I blame myself for leaving, and I shouldn't
16 have left him, but I can't turn that clock back, because
17 I did leave him, and that's something that I have to
18 live with. But I think that, you know, she was doing
19 something to him in that moment, and I've -- you know,
20 it's been nine years and I've reflected quite a lot on
21 it, and her behaviour in that moment when I went in, and
22 where she was stood and what she was doing and the lack
23 of eye contact, which was very, very different to what
24 I had known her to be, and that was something
25 that I grappled with for quite some time, in that moment

1 it was -- our interactions were very, very different to
2 what they had been.
3 **Q.** When did you first learn there was going to be an
4 investigation by the police?
5 **A.** So I think it was -- I want to say 17 May. It was
6 definitely in mid-May, and we'd had a phone call off of
7 Family Liaison saying they wanted to come and have
8 a chat with us, and, you know, there was an
9 investigation going to happening with regard to the
10 hospital. But in that moment, and right up until her
11 arrest, I never believed that somebody has maliciously
12 gone out of their way to hurt my baby. Never. I never
13 thought that.
14 **Q.** Standing back now, do you think that the hospital were
15 open, honest, as candid as they could be with you
16 throughout this process of them having investigations,
17 having to conduct them? Do you think more information
18 should have been given to you?
19 **A.** I think more information should have been given. I know
20 it's a fine line of what they, you know, they can and
21 can't give. I think the way things were presented was
22 really, really poor. And I think they had a duty of
23 care, and -- you know, and that candour and openness.
24 I think it just fell short of the mark, didn't it,
25 really? I mean, when we look at and reflect on the

1 letters that were sent, it's just really, really poor.
2 **Q.** Medical records.
3 When were you given access to your babies' medical
4 records, and did you have to ask for them and do you
5 know when they were --
6 **A.** I never asked for them from the hospital. I obtained
7 both boys' medical records via our solicitor.
8 **Q.** Bereavement counselling and support.
9 After Child E's death were you offered any
10 bereavement support or care?
11 **A.** No, we weren't offered anything. We were given a SANDS
12 leaflet, but that was whilst I still had Child E in my
13 arms. I don't actually know what happened to that
14 leaflet, but in that moment, I wasn't able to think
15 about bereavement support. It was -- I was very much in
16 that moment, and I was in shock, and I don't think that
17 that was quite the right time to be delivering a leaflet
18 to a parent.
19 **Q.** You tell us in your statement that you took a hamper to
20 the hospital to the unit later on. Tell us about that,
21 and how that was received?
22 **A.** Yes. So I believe that was in October. We took
23 a hamper to the Countess of Chester and we went to the
24 ward, and we buzzed the door. And it looked like they
25 were doing some decorating inside in Nursery 1. And two

1 nurses come out that we didn't recognise and they took
2 the hamper from us and then they went back in, and that
3 was the last time that we ever stepped foot in the
4 Countess of Chester.
5 And we took that hamper because we were so grateful
6 to have a child that was still with us, and from our
7 experiences there, we actually thought at one point that
8 we weren't going to have our family to come home. So we
9 were very grateful. And, you know, I think for me,
10 I mistook people's kindness and, you know, I thought
11 because people were kind and they seemed caring that
12 they had, you know, our best interests at heart, and it
13 turned out that one person didn't, and they betrayed
14 everything and done the most unimaginable thing
15 possible. And for me, my children are not left with
16 anybody. They don't get left in any medical settings
17 with anybody: myself or my husband are always with them.
18 There's just -- the worst thing happened to us once, it
19 happened to us twice. It wasn't going to happen a third
20 time. It just wasn't happening. And we protect those
21 children with everything. And I ask questions and
22 I don't take people at face value and I think that was
23 part of my naivety at the Countess of Chester. I took
24 people at face value. I took what the consultants said
25 and I took what Lucy Letby said at face value, and

1 I took it for what it was. But a lot of it was lies.
2 **Q.** So your trust has been affected?
3 **A.** Yes, yes. Thankfully, we've never really had many
4 occasions with our children where we have had to leave
5 them unattended in a hospital setting, but again, the
6 one time that we did have to was when Child F had to
7 have his MRI scan as part of the investigation and that,
8 for both myself and my husband, felt like torture
9 waiting at the other side of that door because the last
10 time we'd left a child with somebody, something really,
11 really dreadful happened for us. So the children don't
12 get left with anybody.
13 **Q.** You say in your statement you have no experience or
14 didn't experience the Patient Advice and Liaison
15 Service, PALS, and you didn't raise concerns with any
16 external organisations, that's presumably because you
17 told us at the time that you didn't have any concerns
18 that something terrible had happened?
19 **A.** No, no.
20 **Q.** The Inquiry has seen a witness statement from the Family
21 Liaison Officer in the criminal proceedings, and she
22 sets out some of the family's concerns about the
23 provision of information, about hearing things for the
24 first time at court. Was there material you heard when
25 you were able to listen to the evidence for the first

1 time at court that you felt that about?
2 **A.** Yes. All of it, to be honest. The criminal trial was
3 very in-depth and it took us through our children's
4 lives, you know, essentially hour by hour. And to find
5 out that Child E had had that significant bleed to the
6 point of it being very, very unusual, and for no
7 post-mortem to be warranted from that made me question
8 why, if it was so unusual, and so out of the blue, why
9 on earth was a post-mortem was not, you know, given any
10 weight to, if there was nothing on Child E's X-ray to
11 say there was any signs of NEC, why was the post-mortem
12 not, you know, mandatory? Why was it left for me to
13 make that decision? Again, I feel guilty for not
14 requesting that, because if that had been requested and
15 that had come back and something -- well, something
16 would have been on it, you know, there's a lot of babies
17 that could have not been involved in this case and it
18 could have stopped there. And that weighs very, very
19 heavily on me, because that decision was ultimately
20 ours, and that's painful to think about.
21 So I carry our grief, but the sadness of the other
22 families, because it should never have gone past that
23 point. And it's the same when I realised in the
24 criminal trial that the insulin reading was there and it
25 was seen and nothing was done. That could have been an

1 end to this whole horrendously sad turn of events, but
2 it wasn't. And I think, although the doctors and the
3 consultants worked really hard to save Child E, I think
4 there should have been some curiosity as to why these
5 things were happening. Why he was bleeding, why
6 Child F's insulin was -- it wasn't just a little bit
7 over, I mean it was in the 4000s, it's a lot, you know.
8 And why was it not investigated? You know, we put our
9 trust in these people. I put my trust in them to do the
10 right thing and the best thing for my children.
11 **Q.** Were you ever asked by any doctor or nurse about what
12 you had seen, the blood on the mouth when you'd gone
13 down to the unit?
14 **A.** No.
15 **Q.** So that discussion didn't happen in the grief and the
16 loss --
17 **A.** No.
18 **Q.** -- and the timings, none of that --
19 **A.** No.
20 **Q.** -- was discussed?
21 **A.** None of it was discussed, and again, I didn't bring that
22 up because I thought the team would have been
23 transparent and I thought Lucy Letby would have ...
24 **Q.** She said she was calling someone, you thought they'd
25 know?

1 **A.** She said she was calling the registrar, so I expected,
2 you know, what I'd seen and what she'd seen, because she
3 was there, to have been reported to him. And in that
4 moment, I don't -- I didn't feel strong enough to even
5 think about that moment. Unfortunately I don't have
6 that -- I don't have that anymore because nine years on,
7 I can still play that night through my mind like I'm
8 watching a film, bit by bit. And that's how I knew
9 that I had my timings right, because I can play that
10 over in my mind.
11 **Q.** I'm going to suggest we have a break now because we're
12 going to move on to suggestions and recommendations.
13 **A.** Okay.
14 **MS LANGDALE:** Is that convenient?
15 **LADY JUSTICE THIRLWALL:** Yes, thank you very much indeed,
16 Ms Langdale.
17 Mother E&F, we're going to take a break, it will be
18 15 minutes unless you want longer, in which case it will
19 be as long as you like. Thank you very much indeed.
20 **THE WITNESS:** Thank you.
21 **LADY JUSTICE THIRLWALL:** Do feel free to just go.
22 **(11.20 am)**
23 **(A short break)**
24 **(11.36 pm)**
25 **MS LANGDALE:** [No audio feed] ... into insulin levels.

1 **A.** Yes, I think I touched on that earlier on. I found it
2 really difficult to wrap my head round that that could
3 be sent back from a lab of an insulin reading that that
4 high, and absolutely nothing to be done with that,
5 whether a child has recovered or not, you know, I think
6 something should have been you know, investigated.
7 I think in light of what we now know with things that
8 happen prior to my boys being there I actually think
9 that, you know, the Consultant who looked at that should
10 have, you know, maybe been a bit more curious as to why
11 that was and maybe looked at past evidence of other
12 babies and what's been happening. Maybe there would
13 have been a trend there.
14 **Q.** Thirdly, you say hospital management should have been
15 much more responsive to concerns that were raised, both
16 to staff who were raising them, and to parents?
17 **A.** Yes. So I think ...
18 I think with that it's giving parents a full
19 picture, not half a picture, and having to scramble
20 around and look for answers themselves, and that adds
21 a whole lot of strain on somebody to then they're having
22 to do that, rather than management being upfront and
23 transparent, I think with those letters, for instance,
24 from Ian Harvey, they caused a lot of heartache for me,
25 and because they were very empty. They almost seemed to

1 pay lip service, almost, that -- he had no intention of
2 meeting us and I can really see that now. It was words,
3 almost like a tick-box exercise and I think if that had
4 been done we'd have had a bit more understanding at that
5 time.
6 But also when it comes to being more responsive,
7 I think from what I've now seen and read, I think the
8 management being dismissive of the consultants when
9 they're on the frontline and they're dealing with things
10 day in, day out, really isn't -- it's not good enough
11 and I think change needs to happen, and I'm not -- you
12 know, I don't think I'm the person to put a suggestion
13 forward for that, because I wouldn't know where to
14 start. But there's someone out there that can put that
15 change in place.
16 **Q.** CCTV. We asked you for suggestions about keeping babies
17 safe in neonatal units. What are your views about CCTV?
18 **A.** I think CCTV is a good idea. I think some people may
19 have reservations about it, with, you know,
20 confidentiality and privacy. But I also think that
21 we've been on the receiving end of the worst-case
22 scenario, and I think it's really important to keep your
23 children safe, and if you can't be there, and you can't
24 be there 24 hours a day, I think having that knowledge
25 that your child is safe is helpful. But then, that

1 being said, if a nurse is accessing a child's line or --
2 we don't know what to look for, and any parent doesn't
3 know what to look for with unusual activity. So it
4 seems like it's a good idea, but I think more so,
5 I think the CCTV is a good idea so people know where
6 members of staff are on the unit at that time so again,
7 to back up meaningful paperwork, if anything happens
8 again, you can say that this person was in such a place
9 because the paperwork suggests so because they did this,
10 this and this for this child, and also the CCTV places
11 them there, it doesn't place them anywhere else.
12 **Q.** You also refer to swipe data, to be used when accessing
13 medicines such as insulin, so it's immediately apparent
14 who has accessed particular items?
15 **A.** Yes, yes. And I would also say I think a CCTV camera
16 pointing at that fridge as well, so when you've got that
17 swipe data and also when you've got, you know, for
18 instance, with a TPN bag if somebody is going to be
19 putting something they shouldn't in a TPN bag, there's
20 CCTV there in that room that's going to cover that so it
21 will be seen.
22 **Q.** You say:
23 "... neonatal staff should have monthly/quarterly
24 supervisions with a psychologist/therapist to check
25 staff for wellbeing/warning signs."

1 **A.** Yes, yeah. I think that, you know, that happens in a
2 lot of professions in this country and I don't see why
3 nurses, especially in a neonatal unit, would be any
4 different, especially if that mortality rate is high,
5 and, you know, it's -- it must be a difficult job for
6 them if they are, you know, dealing with families and,
7 you know, children that have died, and I think checking
8 in with a psychologist or therapist to ensure that their
9 wellbeing is suitable for them to be working in that
10 kind of environment, I think that would be really,
11 really helpful.
12 **Q.** You mention post-mortems:
13 "Fourthly, post-mortems should be mandatory and not
14 done by choice."
15 Is this for neonates or babies, do you think, that
16 die? All babies or unexpected deaths? What is your
17 thinking?
18 **A.** I think all neonatal babies personally and I know that
19 may come as a controversial answer, but again, we've
20 been in that worst-case scenario, and not knowing is
21 really, really hard. It's really hard, because although
22 we have some knowledge, we don't have that full picture,
23 we don't know what happened to our son and I think
24 having that would help. I certainly don't feel that
25 asking about a post-mortem as soon as your baby has died

1 and is still in your arms is the place to be doing that,
2 really.
3 **Q.** You referred to:
4 "... a protocol should be in place to ensure no
5 staff take sensitive patient information home with them
6 ... Whilst this [might] be the law ... it needs to be
7 set out categorically so staff understand ... and with
8 disciplinary sanctions for breach."
9 **A.** Yes. I don't feel that anybody should be able to take
10 personal information home. It really upsets me that my
11 son's information was kept in somebody's house and
12 transferred from one property to another, in a carrier
13 bag. That should -- if anybody should have that, it
14 should be me.
15 **Q.** Do you want to just expand on that? When you say one
16 person carrying it around in a bag, what did you hear at
17 the trial?
18 **A.** Well, Lucy Letby at the trial, she had Child E's and
19 Child F's sensitive data stored at her home and she
20 actually moved house and actually took it with her in
21 a Morrison's carrier bag.
22 **Q.** So you query how that could ever have been at home with
23 her?
24 **A.** Yeah, yeah. Maybe there should be something in place
25 where the staff should have to maybe come in to the

1 shift in their own clothes and then change into their
2 scrubs once they get to work, and as they're leaving,
3 take their scrubs off, empty their pockets, put things
4 in the confidential waste and then put their own clothes
5 back on. That would be for me the most sensible way of
6 ensuring that nothing goes home in pockets.
7 **Q.** And you also say "No use of mobile phones by staff on
8 duty in wards, even in corridors and nurses stations".
9 Again, was this evidence that you heard in the trial
10 that you're commenting on here?
11 **A.** Yeah.
12 **Q.** So expand on that, if you will?
13 **A.** So I was really shocked at the use of mobile phones on
14 the unit throughout the whole period of the June -- to
15 June, and it wasn't just Lucy Letby; it was doctors, it
16 was other nurses, that contacting each other all the
17 time knowing that they're actually on shift, and these
18 people are tasked with looking after the most precious
19 things that we have, and for them to be distracted by
20 phones and messaging their friends about nights out or
21 messaging about babies on the unit, it just feels
22 very -- it feels wrong, and they're there to work and
23 they're there to look after and care for the babies.
24 I think for me, they need the full concentration on the
25 babies, and if phones are going to be used, have them in

1 their break rooms. They shouldn't be in their pockets.
2 They shouldn't be able to be accessed in non-clinical
3 areas such as the nurses' station because that -- you
4 don't need your phone. So, I mean, I think somebody
5 said: well, they use their calculators. Well, you know,
6 we can have a calculator that's not attached to a phone.
7 I think having a phone is a big distraction, and I think
8 that they should be left in their lockers. And I think
9 that should become common practice, because we haven't
10 always had mobile phones, have we? And ... yeah.
11 **LADY JUSTICE THIRLWALL:** What about if somebody wants to
12 contact, for example, a doctor on the ward?
13 **A.** Well, I think they have their phone that's attached to
14 the nurses' stations so they're able to contact
15 different doctors because I think they bleep them. So
16 don't actually think that comes through their personal
17 mobile phones. I think that comes through --
18 **LADY JUSTICE THIRLWALL:** It comes through a bleep, does it?
19 **A.** Yes, or I think they do have the landline.
20 **LADY JUSTICE THIRLWALL:** And what you were describing about
21 people using their phones, I think, if I've understood
22 this correctly, it's people on the ward at the time on
23 shift texting or messaging each other, but not about
24 clinical matters, but about general chit-chat.
25 **A.** Well, both. So it was of a social nature and on, you

1 know, the babies that are on the unit which, again, that
2 shouldn't really be discussed over text message with
3 somebody who is not on shift.
4 **LADY JUSTICE THIRLWALL:** Ah, so that's someone who is not on
5 the shift --
6 **A.** Yes.
7 **LADY JUSTICE THIRLWALL:** -- that they're then discussing
8 with. I see. I understand. Thank you.
9 **MS LANGDALE:** In terms of sharing information with you, you
10 say:
11 "Instead of hiding behind his secretary [Mr] Harvey
12 should have spoken to me and my husband and made clear
13 that there were unexpected deaths on the Neonatal Unit
14 and what they were doing about it. This candour was the
15 minimum we were entitled to"?
16 **A.** Yeah.
17 **Q.** When did you first learn that there were a number of
18 unexpected deaths between 2015 and 2016?
19 **A.** It was when that report arrived. And out of the blue,
20 as I said, we hadn't -- we didn't have any idea of
21 anything that was going on. We were trying to get on
22 with our life and then that arrived. And things haven't
23 quite been the same since.
24 **Q.** Moving now, if we may, to bereavement protocols and what
25 should be in place and what should be consistent

1 nationwide, in your view, you deal with it from 169
2 onwards but can you tell us how you think support should
3 be offered and what is important at the time of
4 bereavement of a child?
5 A. I think when you're in that bereavement and it's fresh,
6 and it's just happened, I think you need to be given
7 choices because you don't actually know what's right for
8 you in that moment and having choices, like, for
9 instance, we didn't know that we could -- it never even
10 entered our head to ask for anything, because we were
11 just so distraught. But, you know, having something
12 that's consistent across the whole of the UK is really
13 important.
14 So, you know, for instance, the memory boxes,
15 they're really important, but we didn't know that that
16 was happening. You know, we hadn't given any consent
17 for that to be done. We didn't have any pictures of
18 both of our boys together. You know, and one of the big
19 things for me is we didn't get to spend any private time
20 alone with our son at all. We weren't able to be with
21 him, we weren't able to hold him. In fact, we went to
22 bed and got up in the morning, and went into see
23 Child F, and Child E was still in his incubator, and
24 I was -- it took my breath away in that moment. And it
25 was actually Lucy Letby, and I said, "He's still here"

1 and she said, "You haven't told us to take him", but
2 then I didn't know that I was meant to -- I didn't know
3 what was meant to happen.
4 So being clear, I think is really, really important,
5 in that moment, often what, you know, what is happened,
6 what is in our control at that point.
7 Q. So clear information at the correct time?
8 A. Yeah, clear information at the correct time. I would
9 have really have liked the opportunity to take Child E
10 into one of those family rooms and spend some time with
11 him, and we didn't get that.
12 Q. And what level -- when you say nationwide -- of
13 bereavement counselling support do you think should be
14 offered or maybe required by people to address grief and
15 loss?
16 A. I think every neonatal unit and every maternity suite
17 should have a Bereavement Midwife in place. I think
18 that should be standard. I think they should have an
19 understanding of what it means to lose your child.
20 I also think that counselling should be offered as
21 standard to every parent, not at the moment that the
22 child is in their arms, but a conversation maybe, you
23 know, a debrief afterwards, you know, before you're
24 discharged. Have a conversation, open and honest. And,
25 you know, set out what's in place, you know, give

1 information, you know. There's so many different
2 organisations out there that provided, you know,
3 bereavement care, and I had no idea about any of them.
4 Not one. And I suppose I was made to feel like because
5 I had Child F, I had to kind of pull myself together and
6 be grateful, and I was. I was very grateful but I was
7 also very, very sad.
8 Q. What recommendations do you think this Inquiry should
9 make? You refer to the Inquiry needing to look into the
10 treatment of whistleblowers and how to hold managers
11 accountable.
12 A. I think what I mean by that is I don't feel like they
13 should be able to hide behind secretaries or, you know,
14 make decisions to make themselves look good like they've
15 got a clean sheet on their time at the hospital. I feel
16 that, you know, it's -- you know, it's life, isn't it,
17 human life that we're looking at. And I think looking
18 good is nothing compared to saving, and I can't think of
19 the word, I'm so sorry -- protecting life.
20 Q. Don't worry.
21 A. And I think if there was the slightest, even if it was
22 a hunch from consultants, a hunch should be enough to at
23 least look at what is happening, because we're dealing
24 with --
25 Q. Safety of babies?

1 A. -- safety of babies and lives. And I don't think -- I
2 don't think anything that I have read by the management
3 is really justified in their actions of what they have
4 done.
5 Q. You finish your statement with this:
6 "I would like to know if it is standard practice to
7 give a nurse another baby straight away in a space
8 a baby has tragically died, in order to get over it. In
9 this is the case, I am horrified and this needs to
10 change."
11 A. Yeah, so again that was something that come up in the
12 criminal trial, and it was mentioned that at Liverpool
13 Women's Hospital in the neonatal unit, if a baby dies,
14 they automatically give the same neonatal nurse who has
15 been on shift and looks after a child, that child --
16 another dying child in the same cot space to get over
17 it. And I was just wondering if, you know, if there is
18 any truth to that because it has come from Lucy Letby.
19 Q. Well, let's pause there. We'll perhaps explore that.
20 But you want to know if that's the case?
21 A. Yes.
22 Q. And if it is the case, why?
23 A. Why, yeah, absolutely, because that just doesn't seem
24 acceptable.
25 Q. And you comment finally on the duty of candour and what

1 that means and you say:
2 "I believe [it should] be ... legally enforceable.
3 At the moment it's just words with no legal teeth to
4 back it up."
5 **A.** Yes.
6 **Q.** Would you like to expand on that or not?
7 **A.** Well, again it just comes back to, you know, having
8 something solid in place, and almost those rules for
9 management to follow, rather than them just going off on
10 a whim and doing things that suit them at that time.
11 And, you know, we look at those letters that were sent
12 to me, they don't actually mean anything. They're a lot
13 of words. I mean, to send bereaved parents three pages
14 of a document that have absolutely no meaning, what on
15 earth did the management think was going to -- how that
16 was going to make anybody feel or what we were meant to
17 do with that information? It created a lot of upset,
18 and panic because we had no idea what any of it meant.
19 **MS LANGDALE:** Those are all my questions. Is there anything
20 you'd like to add or say or bring to our attention
21 that I haven't asked you?
22 **A.** No.
23 **MS LANGDALE:** My Lady, may we have a short break, then, so
24 Mr Baker can consider with his team whether there are
25 any further questions for Mother E&F?

1 **LADY JUSTICE THIRLWALL:** Very well.
2 **(11.59 am)**
3 **(A short break)**
4 **(12.03 am)**
5
6 Questioned by MR BAKER
7 **LADY JUSTICE THIRLWALL:** Mr Baker?
8 **MR BAKER:** Thank you, my Lady.
9 Mother E&F, if you could turn, please, to your
10 witness statement and to paragraph 18.
11 **A.** Yes.
12 **Q.** You give some description here of your history, but say
13 that on 14 February you discovered you were pregnant and
14 that you considered this pregnancy to be a miracle?
15 **A.** Yes, yes. We'd actually found out a couple of days
16 earlier that we were pregnant on 14 February and we
17 found out we were having twins, which was -- it was
18 a miracle. To find out we were pregnant with twins on
19 14 February was just amazing. You know, we were
20 ecstatic. It didn't feel real. We were very, very
21 happy.
22 **Q.** Having asked you about a very happy time, I'm sorry I'm
23 going to have to ask you questions about a more
24 difficult time.
25 **A.** Okay.

1 **Q.** Before the early hours of the 4 August, had anyone said
2 to you that your twins were severely unwell or that they
3 might not survive?
4 **A.** No. Quite the opposite. Everybody who came into
5 contact with us said our boys were doing really, really
6 well, and that was why the transfer had been suggested,
7 because if they were unstable they wouldn't have been
8 able to travel.
9 **Q.** I think you said in response to questions from my
10 learned friend that there was a planned transfer for the
11 twins.
12 **A.** Yes.
13 **Q.** Why did you understand that that was transfer was
14 considered to be safe?
15 **A.** Because we were told that was the case. Because it
16 wouldn't be -- they wouldn't have been able to travel if
17 the boys, either of the boys were unwell. They had to
18 be in a stable condition to be able to be transported
19 because ...
20 **Q.** When were you expecting that transfer to take place?
21 **A.** That transfer was, it was mentioned, I think it was
22 mentioned to us on, I want to say on the 30th -- the
23 31 July, and we were simply just waiting on transport to
24 be available, and that was the only thing that was
25 keeping us at the Countess of Chester at that point.

1 **Q.** So coming on, then, to the evening of 3 August, you said
2 in evidence that during the day, you'd seen Child E and
3 Child F, and that they were, as far as you were
4 concerned, doing well?
5 **A.** Yes.
6 **Q.** And you went back during the course of the evening. So
7 about 9 o'clock is what you said in evidence?
8 **A.** Yes.
9 **Q.** How can you be sure it was 9 o'clock?
10 **A.** Because I was delivering breast milk for my boys' feed,
11 and because, you know, I knew that I needed to do that
12 because it was important because I wasn't able to do
13 a great deal of other things for my boys at that time.
14 I was very reliant upon other people to do things but
15 the one thing I could do was provide them with milk.
16 **Q.** Was anybody expecting you on the ward at about
17 9 o'clock?
18 **A.** I'm unsure. I was unsure if anybody was expecting me
19 but other people would have known that the boys' feeding
20 schedules. I had signed a document to say
21 that I consented to giving donor milk to my boys, but
22 the thought of that was ... it just didn't sit right
23 with me. I wanted to be able to do that for them, and
24 I made sure that that happened.
25 **Q.** And you described how, when you were walking towards the

1 room, you heard awful screaming.
2 **A.** Yes.
3 **Q.** And then you went into the nursery. Where was Lucy
4 Letby when you went into the nursery?
5 **A.** She was between his incubator and a workstation.
6 **Q.** Was she doing anything in relation to Child E?
7 **A.** No. No, she was doing something with some papers, and
8 kind of shuffling things around and moving them around
9 and she only actually came and stood by his incubator
10 when I had my hands in doing containment on Child E.
11 **Q.** And whilst she was stood there shuffling papers, what
12 was Child E doing?
13 **A.** Screaming and crying.
14 **Q.** Now, who was it who told you to leave?
15 **A.** Lucy Letby.
16 **Q.** And you said in evidence that her behaviour was
17 different. In what way was it different to how it had
18 been before?
19 **A.** She had been kind and looked at me and looked me in the
20 eye, and when I went to give milk she seemed really
21 abrasive and didn't make eye contact with me, and this
22 is on reflection, it felt very different to our other
23 interactions that we had and the interactions that we
24 had after that as well.
25 **Q.** You said you went -- you followed her instruction and

1 left the unit.
2 **A.** Yeah.
3 **Q.** And that you then telephoned your husband, Father E&F?
4 **A.** Yes.
5 **Q.** Do you know what time you telephoned him?
6 **A.** Yes, 21.11.
7 **Q.** Now you've subsequently seen medical records and you
8 attended the criminal trial?
9 **A.** Yes.
10 **Q.** What did you later find out about what had been written
11 in the notes?
12 **A.** I found out that the notes had been changed to suit
13 a different narrative of when Child E's bleed started,
14 and that's why the registrar hadn't been contacted,
15 because he didn't know I'd been there and he didn't know
16 that Child E was bleeding at just before 9 o'clock.
17 **Q.** So Lucy Letby had told you that she would contact the
18 Registrar?
19 **A.** She told me that she had, yes.
20 **Q.** That she had?
21 **A.** Yes.
22 **Q.** And then when you saw the notes subsequently you saw
23 that the times had been changed?
24 **A.** Yes.
25 **Q.** With the benefit of hindsight, what do you think you

1 witnessed on 3 August?
2 **A.** An attack on my son. An interrupted attack. I think
3 I caught her off guard. Something had happened to him
4 for him to be bleeding. Stable babies don't bleed.
5 **Q.** You were taken to a Datix report at page 63 of the
6 bundle that's in front of you. Forgive me, I am going
7 to use the internal numbering. You can see there's
8 page 1 of 9. Can you see that?
9 **A.** Yeah.
10 **Q.** This Datix, the timing of it, it's completed on 4 August
11 at 5.53 in the morning, so a few hours after Child E's
12 death?
13 **A.** Yes.
14 **Q.** If you turn on to the second page of the report, page 2
15 of 9. Can you see there that the incident reporter was
16 Lucy Letby?
17 **A.** Yes.
18 **Q.** Then if you turn on to page 4 of 9, there is a section
19 there at the bottom called "SBAR"?
20 **A.** Yes.
21 **Q.** Which is -- Situation, Background, Assessment and
22 Reporting is the acronym. If you go on to page 5 of 9
23 you can see an entry at 1930 hours?
24 **A.** Yeah.
25 **Q.** Which refers to improving oxygen requirements, and then

1 the next entry is at 2210 hours and it says ST4, I think
2 my Lady will later find out is a registrar:
3 "... has asked to review the baby as he had had
4 a gastric bleed at approximately 2140 hours."
5 **A.** Yes.
6 **Q.** Now, you've already suggested you don't regard that note
7 as being accurate?
8 **A.** It's not accurate.
9 **Q.** When did you first find out that Lucy Letby had only
10 contacted the registrar at 2210 hours?
11 **A.** At the criminal trial.
12 **Q.** So that would be about an hour after you phoned your
13 husband?
14 **A.** Yes.
15 **Q.** If you go on to the next page, 6 of 9, you can see here
16 a reference to an "SI Panel Meeting", and it's dated
17 13 August 2015. Do you know where you were on
18 13 August 2015?
19 **A.** Yes. At my son's funeral.
20 **Q.** So that's the date of Child E's funeral?
21 **A.** Yes.
22 **Q.** And were you still a patient in the hospital around that
23 time?
24 **A.** Child F was.
25 **Q.** Child F was. And it's a meeting that's attended by

1 Ian Harvey, Alison Kelly, and Sarah Harper-Lea. Were
2 you aware of that meeting taking place?
3 **A.** No.
4 **Q.** And if you were aware of that meeting and had been aware
5 that the notes were recorded that the gastric bleed had
6 occurred at 20 to 10 at night, what would you have said?
7 **A.** I would have corrected them and said that that's not
8 accurate.
9 **Q.** And finally, before we leave this form, if you look at
10 page 9, this is an entry that is dated 16 December 2015
11 relating to Child E's care and describing lessons that
12 had been learned from Child E's care?
13 **A.** Yeah.
14 **Q.** Did anybody ever tell you that the care provided to
15 Child E had been such that it was necessary to learn
16 lessons from it?
17 **A.** No.
18 **Q.** You described also a conversation that you had with
19 Doctor ZA regarding Child E, where she said that her
20 diagnosis -- that she diagnosed NEC --
21 **A.** Yes.
22 **Q.** -- and didn't recommend a post-mortem, and that she
23 subsequently apologised to you and wrote to you about
24 that. What did she apologise for?
25 **A.** In the criminal trial she apologised for not pushing and

1 suggesting for a post-mortem. In the letter to us, she
2 apologised for not being open and transparent with what
3 was happening on the unit at the time and she wasn't
4 able to be, and that is not how she works with patients.
5 And she apologised for that.
6 **Q.** And I think in her witness statement -- and of course
7 the Inquiry will hear evidence from Doctor ZA in due
8 course -- Dr ZA observes that the abdominal X-rays of
9 Child E did not show any signs of NEC prior to his
10 collapse, and whilst she notes that children with NEC
11 don't always have positive findings on X-rays,
12 particularly in the early stages of the condition.
13 "It was only with hindsight that I felt that if NEC
14 was severe enough to cause death, it should have shown
15 on the X-ray findings."
16 Is that information that she communicated to you as
17 well?
18 **A.** No.
19 **Q.** And you also were asked questions about Child F and
20 being told that he'd had an infection in his long line
21 which had caused him to deteriorate. Do you recall who
22 told you that there had been an infection in the long
23 line?
24 **A.** I believe it was Dr Gibbs.
25 **Q.** Dr Gibbs. And again, the Royal College report -- and

1 I'm sorry I'm jumping around because I'm trying to not
2 repeat all the questions you've already been asked.
3 You said that the version of the Royal College
4 report that you saw at the time, so in April 2017,
5 didn't have any references to Lucy Letby in it?
6 **A.** No, that's correct.
7 **Q.** Have you since seen a version of the Royal College
8 report that does have reference to Lucy Letby in it?
9 **A.** Yes.
10 **Q.** And when did you see that for the first time?
11 **A.** This week.
12 **Q.** This week?
13 **A.** Yes, it was shared with us this week, yes. I think it
14 was Monday.
15 **Q.** Okay. And you described the Jane Hawdon report, which
16 was sent to you in truncated form as being written on
17 sample paper. What do you mean by "sample paper"?
18 **A.** It had "sample" written right through the paper.
19 **Q.** Okay. Finally, I appreciate that you will not want to
20 say who you work for or where you work, about what is
21 your occupation now?
22 **A.** I am a bereavement counsellor working with bereaved
23 parents.
24 **Q.** And what prompted you to go into that type of work?
25 **A.** I think the lack of support given to me and way I was

1 made to feel. I didn't want any other parents to feel
2 like that. I so that was one of the reasons why
3 I decided that that was what I wanted to retrain in, and
4 do with, with my career, is to help other bereaved
5 parents, and give them a space where they can speak
6 openly and honestly, and not feel like they're a burden
7 on anybody and they can sit with their own feelings and
8 not have to take into account anybody else.
9 **MR BAKER:** Thank you, my Lady. I have no more questions.
10 **LADY JUSTICE THIRLWALL:** Thank you, Mr Baker.
11 Mother E&F, thank you. I know this was the second
12 time you've provided statements and come to give
13 evidence about what happened to your babies and to you.
14 And I do understand the enormous physical and emotional
15 effort that's been required. It's a huge public
16 service, for which I do thank you. And I'd like you to
17 know that as a result of listening to you, everyone
18 listening can all understand the joy of your pregnancy
19 which you described so well, and the joy of the delivery
20 of your two little boys, and also, the harrowing account
21 of what happened to them so soon afterwards, and the
22 lifelong consequences for you and your family.
23 I realise that this may make no difference to how
24 you feel, but I would like you to know it. I've read
25 many, many documents and I've listened to your evidence

1 very carefully. You have absolutely nothing to feel
2 guilty about. Nothing. And you've nothing to blame
3 yourself for. Nothing at all.
4 On the contrary, it's we who have everything to be
5 grateful to you for, including the work that you're now
6 doing for bereaved parents. Thank you for all your
7 evidence. Thank you to your husband for being here
8 throughout, and thank you for all the thought that
9 you've obviously given to the question of
10 recommendations and the need for change. I can't thank
11 you enough.
12 **THE WITNESS:** Thank you as well for giving me this
13 opportunity to voice some of the things that I have
14 today.
15 **LADY JUSTICE THIRLWALL:** As I've said before, you could not
16 be more welcome.
17 **THE WITNESS:** Thank you.
18 **LADY JUSTICE THIRLWALL:** Everyone is now free to go when
19 they want to.
20 **(12.25 pm)**
21 **(The short adjournment)**
22 **(2.00 pm)**
23 **LADY JUSTICE THIRLWALL:** Afternoon. Now, I know, I can say
24 you're very, very welcome, Mother G and Father G. I am
25 sorry to use the ciphers, I do know that there are real

1 people and real experience underneath those ciphers.
2 I'm delighted that you've both been able to come this
3 afternoon. How are we going to proceed?
4 **MS LANGDALE:** Ms Schermer-Jones is going to read Mother G's
5 statement and Father G will then read his own statement.
6 **LADY JUSTICE THIRLWALL:** Very good and thank you for
7 providing both those statements. Ms Schermer-Jones,
8 when you're ready.
9
10 **MOTHER G (read)**
11 **MS SCHERMER-JONES:** My Lady, I'll be reading the witness
12 statement of Mother G:
13 "I, Mother G, will say as follows:
14 "My date of birth is *(redacted)* January 1973 and
15 I make this statement to assist the Thirlwall Inquiry
16 into the harm caused by Lucy Letby to babies under her
17 care, which included our daughter in 2015.
18 "This statement has been drafted following meetings
19 and telephone conversations with my solicitor Ms Linda
20 Schermer-Jones from Oliver & Co. I do recall the events
21 set out in this statement but do not recall all the
22 precise dates and times of the events and this statement
23 is therefore based on my recollection and on the records
24 and notes made.
25 "Our daughter is referred to as Child G to maintain

1 her anonymity in the criminal proceedings brought
2 against Letby. We wish our daughter's anonymity to be
3 preserved, so instead of our names, my husband and
4 I will use 'Mother G' and 'Father G' for the purpose of
5 the Thirlwall Inquiry evidence.
6 "We have been sent a long list of questions by the
7 Inquiry for us to deal with in our witness statements,
8 and I have tried to answer them to the best of my
9 ability.
10 "Impact:
11 "The victim impact statement that was provided to
12 the police (Inquiry document number INQ0000387) was
13 actually a statement made on behalf of both my husband
14 and myself, even though it was signed only by my
15 husband.
16 "I feel that Lucy Letby has ruined our lives. She
17 has ruined everything. Our daughter needs 24-hour care
18 because of Letby, we don't know how long she will live
19 and it affects every single minute of all of our days.
20 "For years we thought that our daughter had suffered
21 from neonatal sepsis and aspirated her vomit, causing
22 her brain damage and making her the way she is now.
23 "Experience at the Countess of Chester Hospital.
24 "My care after falling pregnant was provided by our
25 local hospital, the Countess of Chester Hospital, and

1 the plan was for all of my care, including the delivery,
2 to be provided there.
3 "Nine weeks into my pregnancy I started bleeding,
4 but this stopped. I had further bleeding at 22 weeks
5 but otherwise the baby was fine.
6 "When I was 23 weeks pregnant, I had a further
7 bleed. When I was seen at the Countess of Chester
8 Hospital, we were told that in addition to blood, I was
9 also leaking liquor (the water that surrounded our baby
10 in my womb). It was explained that this meant I would
11 likely give birth soon. This was a shock as I knew it
12 was too early in my pregnancy to give birth and we were
13 very worried about the baby.
14 "The Countess of Chester Hospital kept me in and
15 staff told us that they weren't equipped to deal with
16 babies born before 28 weeks and so we were given the
17 choice of going to either Arrowe Park Hospital or the
18 Liverpool Women's Hospital if I gave birth prematurely.
19 We chose Arrowe Park Hospital. I prayed to God for me
20 to continue carrying our baby a little further every
21 day, to give her the best chance of living.
22 "Birth at Arrowe Park Hospital -- before transfer to
23 the Countess of Chester Hospital.
24 "I was transferred to Arrowe Park Hospital a few
25 days later having had stomach cramps for a few hours,

1 which I thought was constipation. Upon arrival on the
2 ward there, I was allocated a room. I went to the
3 toilet in my room and was shocked to find that I was in
4 the process of giving birth to our daughter while in the
5 toilet. I screamed for help and banged on the walls of
6 the toilet. When the doctors came running in, I had
7 already given birth to our baby. This was *(redacted)*
8 May 2015 and I had been pregnant for 23 weeks plus six
9 days.
10 "Our baby was taken to the intensive care part of
11 the Neonatal Unit of Arrowe Park Hospital. She was
12 ventilated and had several intravenous lines. She was
13 absolutely tiny and her skin was almost see-through, but
14 I felt so much love for her.
15 "Our daughter had a difficult first few weeks after
16 her birth and needed a lot of support, but she was
17 growing and doing well. She was able to breathe on her
18 own after a few weeks and was making good progress.
19 "Our daughter had many brain scans at Arrowe Park
20 Hospital, and we were told they were looking good.
21 I could see her growing and made sure I was present as
22 much as possible so we could bond. She was our little
23 miracle, a gift from God. We were so happy to see her
24 improving.
25 "On 13 August 2015 (at around *(redacted)* weeks of

1 age), we were told our daughter was well enough to be
2 taken to the Countess of Chester Hospital. We were told
3 that the Countess of Chester Hospital had been calling
4 up to ask the Arrowe Park doctors transfer our daughter
5 to the Countess of Chester Hospital, but until then the
6 Arrowe Park doctors didn't think she was ready. I don't
7 know why the Countess of Chester Hospital was so eager
8 for our daughter to be transferred there, especially as
9 she was doing very well at Arrowe Park Hospital.
10 I would have been more than happy for her to have stayed
11 at Arrowe Park.
12 "First admission to Countess of Chester Hospital --
13 13.08.15 to 08.09.15.
14 "Our daughter was transferred to the Countess of
15 Chester Hospital on 13 August 2015, to the High
16 Dependency Unit there from the High Dependency Unit at
17 Arrowe Park Hospital.
18 "At first, our daughter continued to improve. She
19 was doing so well. She was smiling, grabbing her dummy
20 with her hand, drinking from her bottle, recognising and
21 responding to our voices. She had a cheeky little smile
22 which I loved.
23 "We were coming up to her 100th day since birth on
24 *(redacted)* September 2015 and the nurses on the Unit had
25 prepared balloons, cake and a banner to celebrate our

1 daughter's 100th day, which was very exciting. We were
2 told that she was doing well and that it wouldn't be
3 long before we would be able to take her home.
4 "On 6 September, one of the other babies on the
5 Neonatal Unit, Baby I, as she was referred to in the
6 criminal court case against Lucy Letby, became very ill
7 and was transferred to the Liverpool Women's Hospital.
8 I had become quite friendly with Baby I's parents during
9 the time that both our babies were staying at the
10 Neonatal Unit of the Countess of Chester Hospital. We
11 chatted a lot, supported each other and shared our
12 experiences.
13 "On the evening of 7 September 2015, our daughter
14 was doing very well. My husband had given her a bottle
15 at around 22.00 and we went home for the night
16 afterwards.
17 "We then received a call in the early hours of the
18 morning from the nurse on duty, Nurse Z. She told us
19 our daughter had vomited and aspirated her vomit. She
20 said not to worry and for us to take our time to come
21 in. We jumped out of bed and set off straight away to
22 go see our daughter.
23 "When we arrived, we saw that our daughter was
24 intubated and had lines going into her body. She was
25 not moving. The doctors told us that her oxygen level

1 was low and her blood pressure was low, and that she
2 might need to be transferred back to the neonatal unit
3 of Arrowe Park Hospital if she didn't improve in the
4 next few hours.
5 "Readmission to Arrowe Park Hospital -- 08.09.15 to
6 16.09.15.
7 "Our daughter was transferred to Arrowe Park
8 Hospital on 8 September 2015, where we were told the
9 doctors were better able to look after her when she was
10 so unwell. They told us she was likely suffering from
11 neonatal sepsis, which had caused her to vomit. My
12 husband thought there might have been an infection going
13 around on the Neonatal Ward of the Countess of Chester
14 Hospital because Baby I and our daughter fell ill there
15 straight after each other. We were told that no
16 infection was found on the Neonatal Ward.
17 "Nobody referred to what happened on
18 7 September 2015 as being a 'collapse' at that time.
19 This happened later. We also only found out years later
20 that the blood tests that had been done at the time
21 showed no evidence that our daughter was suffering from
22 sepsis.
23 "Our daughter improved quite quickly at Arrowe Park
24 Hospital. She no longer needed to be ventilated and she
25 was given another brain scan while she was there.

"Second admission to Countess of Chester Hospital from 15 September 2015 to 4 November 2015.

"On around 15 September 2015 our daughter was well enough to be taken back to the Neonatal Unit of the Countess of Chester Hospital.

"We had a meeting there with the doctors who told us about the result of the brain scan that had been taken at Arrowe Park Hospital the week before. We were told that she had a small shadow on her brain. This was the first time we were told our daughter had a shadow on her brain. The doctors told us that this may cause our daughter to be a bit 'clumsy' when she grew up but that otherwise her life would not be affected by it and no treatment was needed for it.

"On 21 September 2015 I was coming in to visit my daughter on the Neonatal Unit when her nurse Lucy Letby told me to wait in the parent's room as she had to do some tests on our daughter. I had been waiting for a while when I heard our daughter screaming, so I ran back into her room to make sure she was OK.

"When I went in, I found Lucy Letby standing by our daughter's cot, looking sort of puzzled. There was another nurse in the room as well. Our daughter was screaming and looked very red and I saw vomit on her. I picked our daughter up from her cot to calm her down,

which she did. My husband had also arrived by then.

"We were told our daughter was poorly and needed to be taken to the Intensive Care Unit. We weren't told what had happened so I thought she may have become unwell due to having just received her immunisation shots, which made me feel guilty. Years later we found out that our daughter had stopped breathing twice on 21 September 2015. This was at the criminal trial of Lucy Letby. We also never knew that Letby had switched off our daughter's monitor, so the alarm wouldn't be heard.

"It was very hard for us to only find this out in court. There was a lot of stuff that happened to our daughter that we didn't know about and had not been informed.

"Our poor daughter, oh my God. Our precious little fighter, who didn't have much chance being so premature. Then when she was doing well, Lucy Letby made her collapse and caused her brain injury. Both my husband and I stayed in court when the care for our daughter was discussed but it was awful to find out the details of what happened at trial. I was upset, angry, shocked and felt sick to my stomach when we found out in open court, in front of everyone.

"Cause of Collapses and Injury.

"After her collapses on 7 and 21 September 2015, I noticed a marked change in our daughter. She didn't smile much anymore. She didn't react to us like before. She appeared more 'distant' and appeared less connected. She had less of a spark and stopped grabbing her dummy herself. Although this is hard to put into words, I knew even then (without knowing what had been done to her deliberately) that our daughter was no longer the same baby that had left Arrowe Park Hospital on 13 August 2015 and had continued to thrive up to her 100th day hallmark on *(redacted)* September 2015.

"She also seemed to have more reflux, vomited more and eventually it became clear that she wasn't safe to take oral fluids anymore because she could inhale vomited food and choke. As a result, she now only gets nutrition through a tube directly into her stomach.

"As our daughter grew, she started missing her developmental milestones. In around May 2016, she had an appointment with her regular eye doctor who noticed that she wasn't focusing or reacting to light, despite her eyes themselves appearing okay.

"The eye doctor therefore suggested that she needed another brain scan to look for a cause for this in her brain and this scan was done in around August 2016.

"My husband and I had an initial appointment about

the new brain scan with Dr Brearey at the Countess of Chester Hospital in around August 2016. Dr Brearey told us that the new brain scan showed our daughter had very severe brain damage. Dr Brearey showed us the brain scan, which looked all black. We both had tears in our eyes and were very upset. Dr Brearey said that the vomit our daughter had aspirated on 7 September 2015 had caused a lack of oxygen and the injury to our daughter's brain. We had a lot of questions about what had happened and about what this would mean for our daughter.

"Dr Brearey said he could not answer our questions about our daughter's future and said he would arrange another appointment where another specialist from Alder Hey Hospital would be present to help answer the questions we had.

"We then had an appointment with Dr Brearey and a neurology doctor from Alder Hey Hospital at the Countess of Chester Hospital. We were told our daughter had cerebral palsy, wouldn't be able to walk, wouldn't be able to talk, wouldn't be able to eat, wouldn't be aware of her surroundings. She would have spasms in her arms and legs. We were told she had a reduced life expectancy.

"It was devastating to hear how badly our daughter

would be affected by her brain injury.

"We asked how this could have happened after just one vomit? My husband was very worried she had been left to drown in her own vomit and asked how long the vomit lasted for and how long it took for the nurses to come to the help of our daughter after her vomit. Dr Brearey said he would arrange another appointment to go through this in more detail with us.

"At the next appointment with Dr Brearey, which was in around September 2016, he went through and showed us the charts that had recorded all that had happened with our daughter in the Neonatal Unit on 7 September 2015. He said that the charts all looked fine up until the moment she had her vomit and there was no reason to think that our daughter had not been helped very quickly after she vomited.

"Dr Brearey told us that our daughter had suffered neonatal sepsis and vomited, and had aspirated this vomit, the combination of which caused a lack of oxygen to her brain, leading to her brain injury. There was no mention of any 'collapse' on 21 September 2015. We weren't told that there was a concern or an investigation into what had happened at the Countess of Chester Hospital.

"At the time we trusted Dr Brearey's opinion and

believed what he said. At that point we thought our daughter's brain injury was God's will, we couldn't do anything about it and we just had to accept it.

"Suspicions and Concerns Regarding Lucy Letby.

"In around May 2017 we were informed by the police that they were starting an investigation into the Countess of Chester Hospital. We were not given any details and they didn't say anything about anybody hurting our daughter. We thought that the police were perhaps investigating a cover-up or maybe there had been a virus going round the Neonatal Ward at the Countess of Chester Hospital.

"Eventually we were asked to provide a witness statement to the police which took us a while to arrange as our daughter was in and out of hospital for treatment all the time.

"The police did come to our house to take our statements, but they didn't mention Lucy Letby by name or any involvement of nurses in their investigation. I still thought this was an investigation into a cover-up of a bad virus on the Neonatal Ward.

"In around July 2018, my husband got a call from the police to say they were coming to the house that morning to speak with us about an arrest that had been made, which they wanted to tell us about as it would be all

over the news soon. My husband was in work and was told to come home to meet with the police.

"The police came to our house and told us they had arrested Lucy Letby as they had some evidence that Lucy Letby had attacked our daughter. They did not mention more than one attack on our daughter and they didn't mention any other babies being involved. The police told us they couldn't comment any further as it was an active investigation and it might jeopardise the court case against Lucy Letby.

"I couldn't breathe and was in shock. It was extremely hard to hear this, and it broke my heart. I had to leave the house and just walked outside. This was the first time we became aware that someone may have hurt our daughter.

"I received a further call from the police shortly thereafter, to tell me that Lucy Letby had been released on bail.

"Because I was visiting our daughter daily, spending as many hours as possible with her on the Neonatal Ward, I did interact with Lucy Letby a few times but she didn't really talk to me much: less than other nurses.

"While I didn't particularly like Lucy Letby, I had no inkling that she was hurting our daughter on purpose. To me, she looked miserable; like she didn't enjoy her

job. I just thought she wasn't very good at her job but never thought she would intentionally harm our daughter.

"I thought I could trust all the hospital staff to look after our daughter. Of course, my views have changed since then and it is fair to say that I now have bad trust issues and I find it very hard to talk about what happened. At the same time, I can't forget what happened.

"The Countess of Chester Hospital never once told us they had any concerns about Lucy Letby and we didn't find out until we were informed by the police in 2018 -- but even then, we knew no details of what precisely Lucy Letby was accused of having done to our daughter. We only found this out just before the criminal trial of Lucy Letby, which was harrowing.

"I feel that the Countess of Chester Hospital have covered up what happened to our daughter for years, telling us all this time that our daughter suffered neonatal sepsis, despite there not even being a marker for sepsis in her blood tests at the time.

"Medical Records.

"We didn't get the medical records ourselves. The police requested them with our permission. Later on, our solicitors also got a copy of the medical records.

"Counselling and Support.

1 "We were not offered any help or support by the
2 Countess of Chester Hospital or by anyone else, and
3 I didn't request any myself.
4 "I did go to see my GP. I was hoping to be referred
5 to a specialist, but this didn't happen.
6 "Reinforcing Concerns and Getting Answers.
7 "The Royal College of Paediatric and Child Health
8 review into neonatal services at the Countess of Chester
9 Hospital and the advisory medical report prepared by
10 Dr Hawdon are things I first heard about at the criminal
11 trial of Lucy Letby. We have never received a copy of
12 either report.
13 "Dr Brearey never said anything about an
14 investigation at the Countess of Chester or about
15 concerns over Lucy Letby's care of our daughter. It
16 really upset me to think that he might have helped cover
17 it all up. Our daughter continues to be treated by him,
18 even now.
19 "I did receive a call from Dr Brearey on the day
20 when the police came to see us in July 2018. He
21 apologised and said he had been unable to tell us about
22 any of the concerns while the police were investigating.
23 "As set out before, we only became aware of a police
24 investigation in around May 2017 when we were told this
25 by the police themselves, albeit without providing us

1 with any detail of what happened.
2 "We were also not given any opportunity to meet with
3 anyone at the Countess of Chester Hospital to discuss
4 our daughter's care in 2015 or any investigations.
5 "I feel the information given to us by the Countess
6 of Chester Hospital is totally inadequate. We only ever
7 had clinical meetings with the Countess of Chester
8 Hospital staff about ongoing care for our daughter but
9 concerns about Lucy Letby were never mentioned at all.
10 "As we did not have any idea about our daughter
11 being hurt, we didn't raise any concerns with the
12 Countess of Chester Hospital, with PALS or with any
13 external organisations. We have also not been asked nor
14 have taken part in any wider review into the safety of
15 babies under the hospital's care.
16 "Suggestions and Recommendations.
17 "After four babies had already died on the Neonatal
18 Unit of the Countess of Chester Hospital, they still
19 wanted our daughter to be transferred there from Arrowe
20 Park Hospital. She was doing well at Arrowe Park
21 Hospital and was developing and growing stronger there.
22 "In my view, the Countess of Chester Hospital should
23 have taken Lucy Letby off the ward and investigated her
24 much sooner. Concerns had been raised by Dr Brearey,
25 which the Countess of Chester Hospital just left be.

1 "The number of babies dying on the Neonatal Unit at
2 the Countess of Chester Hospital was higher than at the
3 Neonatal Unit at Arrowe Park Hospital where babies were
4 more premature and more ill. This was another reason to
5 start an investigation.
6 "An investigation should have been carried out by an
7 external body, independent of the Countess of Chester
8 Hospital, and a full report prepared.
9 "During the investigation, no further babies should
10 have been admitted to the Neonatal Unit. This would
11 have saved more babies' lives. To my mind, the Countess
12 of Chester Hospital was more concerned about their
13 reputation than about our daughter's life.
14 "I think this Inquiry should recommend that there
15 should be increased protection for whistleblowers.
16 Also, I feel there should be a recommendation that
17 hospital leaders should be held personally responsible
18 when things go wrong after they have had a report about
19 problems and did nothing about it."
20 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,
21 Ms Schermer-Jones and Mother G.
22 Now, Mr G, when you're ready, please start.
23 **FATHER G (read)**
24 **FATHER G:** I, Father G, will say as follows:
25 "My date of birth is *(redacted)* December 1978 and

1 I make this statement to assist the Thirlwall Inquiry
2 into the harm caused by Lucy Letby to babies under her
3 care which included our daughter in 2015.
4 "This statement has been drafted following meetings
5 and telephone conversations with my solicitor, Ms Linda
6 Schermer-Jones from Oliver & Co. I do recall the events
7 set out in this statement, but do not recall all the
8 precise dates and times of the events and this statement
9 is therefore based on my recollection and on the records
10 and notes made.
11 "Our daughter is referred to as 'Child G' to
12 maintain her anonymity in the criminal proceedings
13 bought against Letby. My wife and I wish our daughter's
14 anonymity to be preserved, so, instead of our names, my
15 wife and I will use 'Mother G' and 'Father G' for the
16 purpose of the Thirlwall Inquiry evidence.
17 "We have been sent a long list of questions by the
18 Thirlwall Inquiry for us to deal with in our witness
19 statements, and I have tried to answer them to the best
20 of my ability.
21 "Impact.
22 "The Victim Impact Statement I provided to police
23 (Inquiry document number INQ0000387) was actually
24 a statement on behalf of both my wife and myself. I do
25 not wish to add anything to it.

"Experience at the Countess of Chester.

"Birth at Arrowe Park Hospital -- before first transfer to the Countess of Chester Hospital.

"Our daughter was born on *(redacted)* May 2015 at Arrowe Park Hospital because my wife had gone into labour prematurely. Our daughter was conceived using IVF and antenatal care was provided at the Countess of Chester and we were expecting all care to be provided by the Countess of Chester, including the birth of our daughter.

"At 23 weeks of pregnancy, when it came apparent that our daughter might be born prematurely, my wife was transferred from the Countess of Chester Hospital to Arrowe Park Hospital. We understood that, while the Countess of Chester did have a Neonatal Intensive Care Unit, they were not capable of providing the very specialist care needed by babies who were born at less than 28 weeks, while Arrowe Park was capable of doing this. Our daughter was born at Arrowe Park Hospital after only 23 weeks plus six days of pregnancy.

"We were happy with the care given to our daughter at the Neonatal Intensive Care Unit of Arrowe Park Hospital, and while she was there, she had a rocky start and needed a lot of support being ventilated for the first few weeks of her life. Our daughter is clearly

a fighter and we could see her growing and improving week upon week.

"My wife was at the hospital every day, for most of the day, to be with our daughter and she expressed breast milk to feed our daughter through a tube via her nose into her stomach. I went back to work after a few weeks after her birth and would visit when I was not in work.

"Doctors and nurses at Arrowe Park told us that the staff at the Countess of Chester Hospital were always ringing them to push for our daughter to be transferred to the Countess of Chester. I got the impression this was a financial issue, with the cost of looking after our daughter at Arrowe Park Hospital coming out of the budget of the Countess of Chester Hospital.

"At that time, our preference was for our daughter to stay at Arrowe Park Hospital as we could see her improving there. She had regular brain scans and we were told that her brain looked good and was developing well.

"Initially the doctors at Arrowe Park Hospital didn't think she was well enough for our daughter to be transferred to the Countess of Chester Hospital, but on 13 August 2015 she was transferred to the Countess of Chester Hospital.

"First admission to the Countess of Chester Hospital -- 13.08.15 to 08.09.15.

"The Neonatal Unit at the Countess of Chester Hospital had three parts: namely, the Intensive Care Unit (ICU) for the babies needing the most support; the High Dependency Unit (HDU); and the Nursery. In total there were approximately 16 cots. Our daughter went from HDU at Arrowe Park Hospital to HDU in the Countess of Chester Hospital on 13 August 2015.

"At that point, she had improved enough to only need a little bit of oxygen (via nasal prongs) and was in an open cot. She did not need any of the intravenous lines anymore. She recognised my voice and turned her head to me and smiled whenever I talked to her.

"On 26 August 2015, our daughter was strong enough to drink her first bottle, even if it was only a small amount to start with. She continued to improve and was able to grab hold of the bottle with her tiny hands when being fed. We were told by staff on the Unit that our daughter just needed to grow bigger and then we would be allowed to take her home.

"Because my wife spent most days on the Neonatal Unit, we got to know some of the parents of the other babies there and on around 6 September 2015, we became aware that Baby I ('I' referred to the cipher given to

her as part of the criminal trial against Letby), who had been on the Unit for *(redacted)* weeks, had suddenly become very unwell. She was transferred to Liverpool Women's Hospital Neonatal Unit.

"In the early hours of 7 September 2015, I received a phone call from Nurse Z on my mobile. She told me that our daughter had had a vomit and had aspirated the vomit, meaning the vomit had gone into her lungs, and that she would need to be put on the ventilator.

"Nurse Z said not to worry, she wanted to let us know. While we were told to take our time to come in, my wife and I jumped in our car and raced to the Countess of Chester Hospital. We arrived at the Neonatal Unit within 20 minutes of receiving the call.

"When we arrived, we went straight to the Intensive Care Unit and saw doctors working on her. She had been intubated and looked very still. Multiple lines had been inserted into her little body and it was awful.

"When we spoke to doctors, they told us again that our daughter had had a vomit and she had aspirated it. She required ventilation to help her to breathe and to get her sats (the oxygen levels in her blood) up.

"Readmission to Arrowe Park Hospital -- 08.09.15 to 16.09.15.

"All that day and into the next morning, the doctors

tried to get our daughter's sats up and to get her blood pressure up, which was also low. From what we were told, the Countess of Chester could only provide intensive care to our daughter for 24 hours, after which she would need to go to a more specialist unit, and so on 8 September 2015 she was transferred to Arrowe Park Hospital again.

"We were happy she was taken to Arrowe Park Hospital as the doctors there had made our daughter better before, and we thought their care of her was very good.

"At Arrowe Park Hospital, the doctors said it was suspected that our daughter was suffering from sepsis caused by some sort of virus.

"At Arrowe Park Hospital, our daughter had an MRI scan of her brain on around 15 September. We didn't get the result from this scan until after she was taken back to the Countess of Chester Neonatal Unit once more.

"Second admission to the Countess of Chester Hospital -- 15.09.15 to 04.11.15.

"Our daughter was taken from Arrowe Park Hospital to the Countess of Chester Hospital on around 15 September 2015. We were told that she was fine to go back, she was off the ventilator and didn't need much oxygen at all.

"My wife and I then had a meeting with a consultant

and a nurse (whose names I don't remember) on the Neonatal Unit of the Countess of Chester Hospital to discuss the outcome of the brain scan of 15 September 2015. They said that they could see some small amount of damage to our daughter's brain on the scan.

"They said these might cause her to be a bit 'clumsy' when she grew up, but that was all. The consultant said she had seen worse scans and those babies grew up to be okay, so we felt positive for our daughter.

"I did ask the consultant about a potential virus going around the Unit. I asked her about it because Baby I had also fallen ill, just a day before our daughter became very ill on 7 September 2015, and so I thought a virus might have caused both babies to have become very ill in quick succession. The consultant told me there had been no virus.

"On 21 September 2015, I arrived at the Neonatal Unit for a normal visit of our daughter after work. I had not received a phone call about her being unwell, and when I went in, I found that she had been taken to the intensive care room and was being worked on by doctors. Our daughter was screaming and clearly in pain.

"I asked what was going on and was told again she had a viral infection and was poorly. Eventually, they let my wife hold our daughter, upon which she calmed down and then the doctors were able to put a cannula in her. We were not told that she had a collapse and not told that she had stopped breathing that day, only that she was poorly.

"Cause of Collapses and Injury.

"Nobody mentioned anything about the investigations taking place at the Countess of Chester Hospital into our daughter's illness or the care given to her at the time. We were not even told she had suffered a 'collapse' or 'collapses' on 21 September 2015. We were told she had a vomit on 7 September 2015 and was 'poorly' with neonatal sepsis. We were simply told on 21 September 2015 that she was 'poorly' with no further details of how or why our daughter became ill.

"As to the cause of our daughter being poorly on either date, we were always told by the hospitals (both the Countess of Chester Hospital and Arrowe Park Hospital) that our daughter had neonatal sepsis, nothing else, that had caused her brain damage. I had nightmares about our daughter not being attended to quickly enough by the staff after her vomit of 7 September 2015 causing her to aspirate her vomit,

which was very upsetting.

"Then a concern was raised by the ophthalmology doctor at a routine check-up of her eyes, when our daughter was around one year old, in May 2016. We had some concerns about her vision and about not meeting her milestones and we were told that her eyes appeared to be okay and that she needed another scan to check whether there was a problem with her brain. Our daughter's last brain scan had been done the year before and no scans had been done since.

"The new brain scan was done around 12 August 2016 and some weeks later we had an outpatient appointment at the Countess of Chester Hospital where the Consultant Paediatrician, Dr Brearey, had asked a neurology doctor from Alder Hey Children's Hospital (whose name I don't remember) to join the consultation we had with him and to explain the outcome of the brain scan and the extent of our daughter's brain injury. There were also two junior doctors present at this appointment.

"We were shown the recent MRI scan and we could see for ourselves that it looked black, which was not something that had been seen on her previous scans. Seeing this image was absolutely horrendous. We were told that our daughter would be very disabled for the rest of her life and that she would not be able to do

1 much.
2 "We were told that our daughter could choke in her
3 sleep. We were very worried about this happening and
4 kept our daughter in our bedroom to sleep at night so we
5 could keep an eye on her. In around 2021/2022, we had a
6 bedroom fitted downstairs for our daughter, including
7 a hoist, and my wife started sleeping in the downstairs
8 bedroom with our daughter to be able to look after her
9 during the night and make sure she didn't choke.
10 "Dr Brearey told us again (at that appointment in
11 2016) that the cause of our daughter's brain injury was
12 neonatal sepsis and a vomit resulting in a lack of
13 oxygen to her brain. I was very upset and said to
14 Dr Brearey that all this happened after our daughter
15 came to the Countess of Chester Hospital, that nothing
16 had been wrong with her brain until after her transfer
17 there.
18 "I didn't understand the diagnosis that Dr Brearey
19 gave us, namely that our daughter's prematurity and
20 neonatal sepsis had caused her brain injury, as her
21 brain had been developing well, and she had been
22 improving before going to the Countess of Chester
23 Hospital. I therefore raised a question that I had been
24 very concerned about, namely of our daughter vomiting on
25 7 September 2015 and asked whether she had been left to

1 drown in her vomit. At that time, and due to the
2 scarcity of information that we had been given, my wife
3 and I did not fully appreciate or understand the
4 seriousness of the two further 'collapses' that our
5 daughter suffered on 21 September 2015. In response to
6 my question, Dr Brearey said he would arrange a new
7 appointment to go through all our daughter's charts and
8 her stats (like blood pressure and oxygen levels) with
9 us.
10 "My wife and I did get another appointment with
11 Dr Brearey on 28 September 2016, where he showed us our
12 daughter's stats on a computer screen. He went through
13 all her charts and told us that he could see that all
14 our daughter's stats were fine, right up to her sudden
15 vomit on 7 September 2015 and that it didn't look like
16 there had been any delay in attending to our daughter
17 after her vomit. Dr Brearey didn't say anything about
18 investigating or reviewing why she vomited or why she
19 became unwell. He also did not mention the two
20 collapses that we now know our daughter to have suffered
21 on 21 September 2015 and how they might have affected
22 her.
23 "The doctors didn't tell us that on 7 September 2015
24 our baby daughter in fact had a projectile vomit, with
25 the milk coming out of her tiny little body with so much

1 force that it reached the chairs opposite her cot. They
2 also didn't tell us that upon aspirating the contents of
3 our daughter's stomach after her projectile vomit on
4 7 September 2015, they found she still had around
5 45 millilitres of milk in her stomach, which was an
6 enormous amount of milk and more than her feed. We only
7 found this out at the criminal trial of Letby in 2023.
8 Moreover, they didn't tell us that she had stopped
9 breathing (twice) on 21 September 2015. We were also
10 not told that there were concerns about an increasing
11 number of babies dying on the Neonatal Unit, nor that
12 they were looking at the standard of care given to our
13 daughter. It truly came as the biggest shock of my life
14 when I found this out years later.
15 "We put our trust into the doctors and believed them
16 after they told us time and again that the cause of our
17 daughter's brain injury was her prematurity and
18 subsequent neonatal sepsis, resulting in aspiration and
19 lack of oxygen to her brain on 7 September 2015. It was
20 set out in all her medical notes and in the clinic
21 letters that we received/read. I thought it had just
22 been bad luck for our little girl.
23 "It was only when the police said they were starting
24 investigations in around May 2017 that we first became
25 aware that the police were looking into the Countess of

1 Chester Hospital. However, even then, I still thought
2 that there may have been a degree of malpractice and
3 that perhaps a doctor had been useless -- it never
4 occurred to me that someone had intentionally harmed our
5 baby.
6 "In around July 2018 I had a call from the police
7 Family Liaison Officer (FLO) at 06.30 am when I was in
8 work, to tell me that they had arrested Lucy Letby. The
9 FLO said they wanted us to know before we read about it
10 in the press. The FLO asked me to go home and they
11 would come to speak to my wife and me about it and
12 explain things to us.
13 "When the police came round, they told us that Letby
14 was accused of hurting our daughter. We were both in
15 shock. We weren't told what Lucy Letby had been accused
16 of, in terms of how or when she had hurt our baby
17 daughter -- we only found this out much later, a few
18 months before the criminal trial started in 2023.
19 "Later that day, my wife told me she had also
20 received a phone call from Dr Brearey, who apologised to
21 us. He said he had been unable to tell us anything
22 about their concerns while the police investigation was
23 ongoing.
24 "We subsequently received a letter from the police
25 that set out two charges against Lucy Letby: namely, one

of attempted murder on 7 September 2015 and one of attempted murder on 21 September 2015. Then, just before the start of the criminal trial in 2023, we were told by the police that a third charge had been added to the list; namely, of a second attempted murder on 21 September 2015 and we were told what it was alleged Letby had done.

"We didn't know that our baby had stopped breathing twice on 21 September 2015 until evidence was given during the criminal trial of Lucy Letby in 2023, which made an anxious and difficult situation worse for us.

"We now know that the attacks by Lucy Letby caused a lack of oxygen to our daughter's brain resulting in a massive brain injury. Prior to the attacks, our daughter's repeated brain scans looked OK and her brain was seen to be maturing well. After the attacks, her brain scans changed and clearly showed a brain injury which had wiped out most of her brain. As a result, our daughter is severely disabled and will remain so for life.

"Our daughter cannot talk or sit up by herself. She cannot walk or swallow -- she is fed by way of a tube directly into her stomach. She is blind and can't reach to grab things on purpose with her hands. She has very little understanding and needs help with everything,

including feeding, bathing, dressing, and moving. She has a normal size body for a nine year-old so we have had to install hoists as lifting her has become more difficult. She can't be left unattended due to the risk of her choking. My wife and I provide the majority of her care and do so lovingly. She is our little girl, our fighter and our star. I have been besotted with her ever since the day she was born.

"Suspicions and Concerns Regarding Lucy Letby.

"As to my interactions with Lucy Letby, I only briefly spoke to her once or twice during our daughter's stay at the Countess of Chester Hospital. Implicitly trusting the medical and nursing professionals at the hospital, I had no concerns about Letby or her work at the time.

"We were not given any information about the concerns regarding Lucy Letby's conduct by the Countess of Chester Hospital at all. They didn't tell us about any concerns, nor did they tell us they were looking into concerns.

"We only found out about concerns regarding Lucy Letby from the police when she was arrested. We had to learn further details about the case by reading newspaper articles after Letby's arrest, which set out that concerns had been first raised as far as back as

June 2015 or thereabouts, ie, before our daughter was attacked by Lucy Letby.

"When the police said they started investigations in around May 2017, we first became aware that the police were looking into the Countess of Chester Hospital, but, even then, I thought there may have been a degree of malpractice and that perhaps a doctor had been useless -- it never occurred to me that someone had intentionally harmed our baby.

"In around July 2018 I had a call from the police Family Liaison Officer (FLO) at 6.30 am when I was in work to tell me they had arrested Lucy Letby. The FLO said they wanted us to know about it before we read about it in the press. The FLO asked me to go home and tell my wife about it, and explain things to her as well.

"When I told my wife about it, we were both in shock. We weren't told what Lucy Letby had been accused of in terms of how or when she'd hurt our baby daughter. We only found this out much later, around the time the criminal trial started in 2023.

"Medical Records.

"We didn't get the medical records ourselves. Our solicitors did.

"Counselling and Support.

"We were not offered any support by the Countess of Chester Hospital and I didn't request any myself.

"Raising Concerns and Getting Answers.

"I was not aware of the Royal College of Paediatric and Child Health review into neonatal services at the Countess of Chester Hospital until the trial, and did not receive a copy of their report.

"I was also not aware of the advisory medical report prepared by Dr J Hawdon until the criminal trial of Lucy Letby. We were also not told that the Countess of Chester Hospital was investigating or reviewing our daughter's collapse and only became aware of the police investigation in around May 2017, when we had had an email from the police to tell us that the police were investigating the Countess of Chester Hospital -- not that they were investigating Lucy Letby in particular. At that time, I didn't think anyone had intentionally harmed our daughter and I didn't think anything would come from the police investigation that would have particular impact on our family.

"Save for the meeting with Dr Brearey in September 2016, the only meetings we had with the Countess of Chester Hospital were about our daughter's ongoing care and treatment, not about concerns relating to the care given to our daughter previously. Even

1 then, the information we were given wasn't the full
2 story, as we later found out.
3 "In my view, the information given to us by the
4 Countess of Chester Hospital was completely inadequate.
5 We were never told about concerns relating to the care
6 given by Lucy Letby to our daughter. All the clinical
7 letters we received referred to her being premature and
8 suffering neonatal sepsis as the cause of her brain
9 injury.
10 "The hospital letters about our daughter have only
11 recently changed to remove the reference to neonatal
12 sepsis as a cause of her brain injury. The Consultant
13 Community Paediatrician from *(redacted)* has started
14 referring to, in their letters, the fact that our
15 daughter is a victim of Lucy Letby instead.
16 "It has been very important for us to see this in
17 writing, to have this confirmation and acknowledgement
18 in black and white. Moreover, it is important for the
19 other doctors who treat our daughter to know this,
20 because it avoids us having to explain time and again
21 how our daughter did not suffer neonatal sepsis but was
22 intentionally harmed by Lucy Letby (which is upsetting
23 to talk about) and it also avoids awkward assumptions
24 about what happened to our girl being made by those who
25 treat her.

1 "I did send an email to the Chief Executive of the
2 Countess of Chester Hospital after Lucy Letby's criminal
3 trial because the Countess of Chester was still denying
4 they had caused an injury to our daughter. In her
5 reply, she apologised to me for the delay and offered
6 a meeting, but I was then asked to go through the
7 solicitors instead of writing to the hospital directly.
8 I didn't contact any external organisations.
9 "We did have big concerns about being left in the
10 dark about what precisely happened to our daughter. It
11 was horrible to only find out these details at the
12 criminal trial of Lucy Letby, particularly so in
13 relation to our daughter's projectile vomiting on
14 7th September 2015 and her stopping breathing twice on
15 21st September 2015.
16 "I was present for part of the criminal trial of
17 Lucy Letby. During the trial, we were unexpectedly
18 shown a photo indicating the distance between our
19 daughter's cot in the Neonatal Unit and the chairs. It
20 was calculated that her projectile vomit of
21 7 September 2015 that had reached the chair in her room
22 was a distance of 3-4 feet away from her cot, indicating
23 the force of her vomit and the pain she must have felt
24 with the pressure building up in her tiny little body.
25 We had not known about this and hadn't seen it before.

1 It was an absolute shock to hear it for the first time
2 during the course of the trial.
3 "I have not taken part in any wider reviews relating
4 to the safety of neonatal babies and have not been asked
5 to do so by anyone.
6 "Suggestions and Recommendations.
7 "In relation to my views as to what could have
8 assisted in preventing Lucy Letby attacking our
9 daughter, I think Lucy Letby should have been taken off
10 her job straight away (when suspicions or concerns were
11 raised) until a full investigation had been concluded.
12 "At the time, Lucy Letby was left to continue to
13 care for (and as it turned out, harm and even kill)
14 babies who were physically vulnerable due to their
15 prematurity and medical concerns, and were unable to
16 speak up for themselves if untoward events had occurred.
17 Parents could not stay with their babies 24/7 and relied
18 implicitly and entirely on (what they thought were) the
19 best and most professional care that their babies needed
20 and deserved.
21 "The Countess of Chester Hospital should have acted
22 more quickly and taken her off the front line straight
23 away.
24 "It would also help to have CCTV cameras in each
25 baby's room and in the corridors, for the safety of

1 children and staff alike.
2 "There should be a locked door at the entrance of
3 the wards, only accessible with a personal key fob with
4 logged entry/exit times. At the criminal trial, Lucy
5 Letby admitted having been let into the Neonatal Unit
6 regularly by others on the Unit, even when she had no
7 reason to be there. 'Tailgating' should not be allowed.
8 These things stop there being an accurate report of who
9 is and who isn't on the ward at any given time. I worry
10 that Lucy Letby might have been present when more or
11 other babies had 'collapsed' because no one knew she was
12 there at the time and therefore no investigations took
13 place.
14 "Also, access to all drugs should be digitally
15 monitored by use of a personal swipe card. This way, it
16 won't be possible for anyone to get away with taking and
17 using medications without there being a record of the
18 same.
19 "Lastly, I am of the view that protection for
20 whistleblowers should be improved. Whilst there are
21 supposed to be rules in place to make sure
22 whistleblowers are taken seriously and can speak freely
23 so as to prevent harm being caused, these rules do not
24 seem to give enough protection to the whistleblowers and
25 as a result, tragedies continue to happen. It is not

1 enough to simply have written policies regarding
2 protection of whistleblowers. For the policy and
3 self-regulation/monitoring to work effectively, the
4 culture on hospital wards has to be such as to promote
5 and safeguard reporting of concerns, no matter how
6 trivial it might first appear. Any reported concerns
7 should also be investigated by an external body/person
8 who has no direct interest and/or involvement in the
9 operation of the hospital/ward. The findings of such
10 investigations should be recorded. There should also be
11 a mechanism to audit past reports of concerns and
12 subsequent investigations, such that it will be obvious
13 when a pattern starts to develop which might warrant
14 further action.
15 "About support to parents, in my view, there should
16 be more funding in the NHS for psychological assistance
17 and treatment."
18 **LADY JUSTICE THIRLWALL:** Thank you very much indeed,
19 Father G and Mother G.
20 I mentioned at the beginning, I was very pleased
21 that you felt able to come today, and I would just like
22 to repeat that. I don't underestimate -- and I've said
23 this to other parents -- how much it takes out of you to
24 write these statements and then to come and speak to
25 them, or have them read. And you've done that with

1 great courage today, and great dignity, and I am
2 grateful to you.
3 Just so you know, these statements, which give such
4 a clear and detailed picture of your long experience at
5 the Countess of Chester Hospital and then beyond, really
6 do help me answer the many questions that are set out in
7 the Terms of Reference.
8 We now have a really clear image of the 100th day
9 celebration and then of the change in your daughter
10 which I think you, Mother G, particularly noted, and
11 then learning what had happened to her and coming to
12 terms with that. But what absolutely shines through in
13 the most extraordinary fashion is your profound and
14 enduring love for your daughter, and your care for her
15 is quite extraordinary. And as you would say, it's
16 nothing more than you would have wanted to give your
17 child from the moment she was born.
18 You've done this for her, and for other parents, and
19 the Inquiry is very, very grateful to you for being so
20 generous. Thank you.
21 That concludes proceedings for today. Thank you all
22 very much.
23 **(3.01 pm)**
24 **(The hearing adjourned until 10.30 am the following day)**
25

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