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Thursday, 19 September 2024

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2	(10.30 am)
3	LADY JUSTICE THIRLWALL: Good morning, Mother H.
4	Thank you very much for being online to give your
5	evidence this morning, I know it won't have been easy to
6	arrange and I'll very grateful to you. You'll be
7	wanting to get started so I'm going to invite
8	Ms Langdale to do that.
9	MS LANGDALE: Thank you, my Lady. May the witness be swo
10	MOTHER H (affirmed)

(By videolink)

Questioned by MS LANGDALE

MS LANGDALE: Mother H, we're doing this over a link, and if at any point you can't hear me, raise your hand, I'll do the same if I can't hear you, and we'll see that if we can't see each other or hear each other saying it.

You provided a statement on 16 July 2024 to the Inquiry. Can you confirm the contents are true and accurate, as far as you're concerned?

20 A. Yes.

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21 Q. I'm going to begin by asking you about your experience 22 at the Countess of Chester Hospital and your experience 23 through pregnancy and any treatment that you were having 24 there. Can you tell us about that?

25 Α. Yes. So Child H was my firstborn child. I didn't know

explained things to you and you felt that was good and clear care? Α. Yes, I had no concerns during that pregnancy at all in

3 4 terms of the Countess of Chester in terms of the 5 diabetes care and the antenatal appointments there.

6 Q. In the antenatal phase was there any discussion or not 7 about whether Child H would need some extra care when 8 she was born or not? What did you think the position 9 was?

10 A. At the time of sort of when it was just a case of 11 planning during pregnancy and all the scans and things, 12 there was no indication that she would need extra care, 13 but I was told that if she came earlier, there is always 14 a chance that, you know, she could have been born 15 earlier and therefore then that runs the risk of needing 16 some extra assistance. But they said that can vary 17 greatly and it depends on how early it is that the 18 pregnancy goes to.

19 You were induced, weren't you, at 34 weeks and four Q. 20 davs?

Yes. Yeah. 21 Α.

22 Q. Tell us about your experience of that and the C-section?

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23 So I was ... I'm trying to think how to word this.

24 I was not having a good end to the pregnancy at this

25 point in that I was having a lot of low sugars and it what to expect in terms of hospital care throughout pregnancy or birth because I had no experience so I didn't know what was to be considered normal. And I am a diabetic so I had a lot of hospital involvement with my pregnancy journey at the Countess of Chester Hospital, which is where I received my diabetes care and --

Q. What was that care like?

The diabetes care was good because they had regular appointments, regular scans, and, you know, just making sure that everything was okay. So the before birth appointments seemed to all be quite intense in that, you know, you had to go regularly, there was a lot of tests and checks and things like that, but it showed that they were monitoring things, and I was told what the plan would be for a diabetic mother that they always aimed to induce you early, but the plan is to get to 38 weeks because there is a risk of the placenta not working at the end of the pregnancy if you go to full term.

So it was always expected, I suppose, that she would be born earlier, but the aim was to not have a premature baby and to try to have a have as healthy a pregnancy as possible. And they provided a good care and at that point it seemed to have been good care --

25 Q. So the antenatal team dealt with your diabetic issue and

had got to the point then when I was having to go in a lot more regularly for checks and there were some concerns. Everything from the scans I suppose seemed to be okay but at this particular point in time when I got to 34 weeks and four days it got to a point where it was really guite bad so I had to phone and go in sort of as an emergency. At that point they had decided to give me steroids to try and help control blood sugars and to help develop the baby's lungs because it was earlier than the 38 weeks that we planned for, and I was admitted to hospital and given another dose of steroids the next day and told that at this point she could be delivered earlier. But there was no indication that she would need a lot of extra care or that she would be particularly poorly. And in fact from the day she was delivered there was -- they told me there was a chance she might not even need to go to the neonatal unit and it was just a case of seeing how she is when she's born.

The next day after I'd had the second dose of steroids, they decided that because the blood sugars hadn't improved there were concerns that maybe the placenta was failing and so the safest option was to deliver her and not run the risk. So I was told that they'd perform a caesarean. However, then it came to my attention that there was actually a shortage -- they

said because she is early, she would need -- she may need some checks from the neonatal care team and we need to make sure there's a bed if she needs to go there.

And they said it's exceptionally busy and there were no beds available in the Countess.

They explained to me that they couldn't move me because I wasn't well enough, but that if it came to the case where they'd have to deliver her, it may be that she would have to be transferred to another hospital and I would have to follow.

11 Q. How did that make you feel, the thought of that, that
 12 your baby would be taken to another hospital but you
 13 were effectively confined to the one you were in?

A. Terrified. I didn't want that to happen at all, and at this point I was really beside myself thinking no, no, I don't want that to happen, I thought being separated at all from your baby when they're born was enough. Everybody goes on about, you know, this golden hour and have this golden hour, you know, with the baby afterwards, and you have these visions of how it would be and then to be told that actually she could be taken completely away to another hospital. And it got more complicated than that because then they said there was no beds in the near vicinity and, you know, it could be as far as Birmingham that she could be transferred to

situation with the beds and with the hospitals and what was available and, you know, what was going to happen in terms of that. So from that side of things, yes, the only issue was that it was a busy time, it seemed to be, but that was a case of that was something that obviously couldn't be helped.

Q. How was Child H when she was born?

A. She was in really good condition. I remember them saying she had like an Apgar score of 9, she came out and she was crying, she was pink. She was slightly smaller but she was still a good weight. And they were really pleased, and they let us hold her sort of straight away, as much as you can when you're having a caesarean but they placed her on my chest and my husband was able to hold her, and, you know, we could have that bit of time with her.

However, after a little bit of time holding her I noticed that she started to sort of grunt a little bit and the doctors said they would just take her to check her over. And at that point they said, "Because she is early, I think it's best if we take her for some monitoring on the neonatal unit".

So they took her to the neonatal unit, and my mother was in the hospital at the same time so she went down with her, as did my husband. I asked him to go there

and they were even contacted to try and find an available bed, and that brought a lot of panic just before her birth as to what was going to happen.

They had decided then at 6 o'clock that evening or around about then that they were going to do the caesarean and it wasn't until I was on the operating table that they came over to say that it was good news, and a bed had become available, there'd been a discharge, and a bed had become available in the Countess on the neonatal unit, and at that point I thought: great. Yeah, that means that at least, you know, we can be in the same hospital. With hindsight it would have been far better if she'd been transferred to another hospital, but at the time, I thought that it was really good because we could be together.

16 Q. In terms of --

17 A. I didn't have --

18 Q. Sorry.

19 A. I was just going to say I didn't have any issues,20 though, with the caesarean or anything.

Q. So the obstetric care you received was good. You feltthat you were looked after?

23 A. Yes.

24 Q. And communication was good?

25 A. Yes. Yeah, because they kept me informed over the

1 also.

Q. Where were you? Which ward were you on? Where were youstaying?

4 A. I was on the -- still on the Labour Ward at this point,
5 in the recovery. They told me because it was quite late
6 at this point that, you know, obviously I wanted to go
7 straight away to go and be able to see her, and I didn't
8 know what the expectations were in terms of the set-up
9 with neonatal units and how that worked, it was
10 something I had no experience of at that time.

So I really wanted to go and they said it would probably be the next morning before I could go and I said no, I really wanted to go and they said, "Well, if you're able to get up and get dressed and walk, as long as you've got somebody with you, a nurse with you, or somebody, then you can go to the neonatal unit."

17 So I did that, so that I was able to go and see her 18 that evening. But it was much later in the evening at 19 this point.

Q. Were you able to walk to get there or did you need to bein a wheelchair? What happened?

A. I had to go in a wheelchair because I'd had the
 anaesthetic so I had to go in a wheelchair but I was
 able to go with a nurse from that ward and my husband.

25 And when I got to the unit she was on CPAP, and I was

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- 1 told that she was struggling a bit with her breathing 2 and needed a little bit of extra support and --3
 - Q. What's CPAP?

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- 4 A. It's a positive airway pressure just to provide some 5 extra air. I think it forces sort of like the oxygen 6 through to sort of keep the airways open, because they 7 said, you know, even after a C-section and when a baby 8 is early, you know, the lungs can be a bit sticky. So 9 it's to keep that, the -- everything open.
- 10 Q. Was that explained to you?
 - A. It was explained why she needed it, but there was sort of a very vague then explanation of: but it's normal, she probably won't need it for long, it's okay. At this point I said, you know, it was quite a shock to see her like that. I didn't know what this was beforehand. I'd never seen CPAP or had any experience with it. But she said, "It's okay, you know, you can still hold her," and the nurse at that time had arranged for us to be able to hold her while she was on the CPAP for a little while. and we stayed there for as long as we could.

But I wasn't given any indication that her health was going to get worse and they didn't seem to have any concerns at all. It was like this is fairly normal, you know, and it can happen, and they need a little bit of this, a little bit of extra support, and, you know, it

hospital is the ward I was on after I'd come from the Labour Ward is upstairs, the sort of maternity ward, and the neonatal unit is downstairs. So you have to go up the ward and go down the stairs and it's along the corridor and then out the back.

So I wasn't allowed to go on my own and I always had to let the midwives know if I was leaving, and there were certain times I had to be back as well for doctors and nurses and checks and things like that to do things and you didn't always know when that was going to be so sometimes you'd end up waiting longer for that. So on that morning I was very eager to go down and see her.

I was finding it very hard being on the ward which was a ward full of people with their babies with them, and I was on the ward, and I'd asked to go down early in the morning to see her. I was told there were no midwives available because again, it was a very, very busy time and the ward was exceptionally busy at that time. They were helping people as well with their babies and I felt at that point like I wasn't really a priority because it was just me, you know, waiting, and I was at this point sort of just trying to get in the process of getting discharged, and it was a case of I had to wait, you know, I wasn't, you know, they had other things that they had to deal with, and it kind of

tends to, you know, just be a case of they have that bit of support and then everything's okay. You know, there was no concerns and no indication that this could get worse or any extra support might be needed.

We had a lot of questions at the time because this was all completely new to us and very unexpected --

Q. Can I just pause there.

I'm going to ask you now about some deteriorations of Baby H on September 24 and 25 September.

To be clear, my Lady, these are not deteriorations Letby was charged in respect of.

I'm going to ask you about the care and what happened and what you saw. So you say at paragraph 28 of your statement:

"On the morning of the 24th, I wanted to go back down from the maternity ward to see Child H ... there were no midwives available and I was not allowed to go on my own as I was in a wheelchair."

That's what happened on the 24th, was it? A. Yes, because I was still an inpatient I had to stay for a bit longer to make sure that my sugars were stabilised, post-birth, and because of the C-section there was a time limit, and it was sort of like the ward -- I wasn't allowed to just get up and go on my own to go down the stairs because the way it is in the

- 1 felt like it was a bit of an inconvenience for me to ask 2 somebody.
- 3 Q. So was it Father H who came in and took you down that 4 morning?
- 5 A. Yes, yes.
- 6 Q. So tell us about that?
- 7 A. So he was on his way in, and it's -- a little bit of 8 a drive to the hospital, so it's not quite as easy as 9 getting there, getting back and things like that.
- 10 Q. Yes.

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A. And I'd come in that morning, then and he took me down to the unit and we went to go and see our daughter. When we got there, I noticed that she'd been put on a different machine. She was in the first room as you sort of walked through the door from the corridors. I asked the doctor what was going on and I was told that she had been put on a ventilator. I really couldn't understand why I'd not been informed of this earlier because we were told that she was okay. You know, I'd always check and would always ask how she was, and we were told that she was okay, you know, that she was okay.

I was only upstairs. I knew they were busy but if it was something that significant to me, a ventilator sounds like a really scary and a really big change and

there was no indication that that was going to happen that we were told of. You know, they never said, "Oh she's going to need maybe, you know, more breathing support or to need extra care".

Q. What did the ventilator look like when you walked in?
What does that --

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- 7 A. It's -- it was sort of like she had sort of almost like 8 tape or screens around her mouth with a big breathing 9 machine and the machine itself was on the outside of the 10 incubator. That was big. But you could tell it was --11 it's different, and you could tell it was more intense, 12 and there was quite a lot ongoing there. But I was very 13 distressed at the situation, and I was also just really 14 upset that I had not been informed considering I was 15 upstairs. But regardless of that even if I wouldn't 16 have been upstairs and I would have been discharged, if
- I wouldn't have been able to have been there because
 they were always telling me to take breaks, you couldn't
- 19 come in at handover, you'd always have to avoid handover
- 20 time. You were not allowed to be there at times of
- 21 handover. Then, you know, the --
- Q. Who told you that, that you couldn't be there at timesof handover?
- A. The nurses. It was sort of the rules, that you weren't
 allowed to be there at handover times. And, you know,
 - know, and it's a case of why could nobody have done that? And what had happened? Why did she all of a sudden, I was told that she'd need the CPAP, and that she'd be on that for a bit, and a bit of extra support and that this was another step now which meant that obviously she had deteriorated and I don't remember anyone giving me a clear explanation as to why she had deteriorated. It was a case of, "Sometimes they just need a little extra support, that her breathing had got worse and we needed to give her some extra, more intense, breathing support". We weren't happy about the situation so we spoke with PALS.
- 13 Q. Just pausing there, what is PALS and how did you know4 what PALS was?
- 15 A. It's the Patient Advice Liaison Service. I knew what16 PALS was.
- 17 **Q**. So you knew of the service generally?
- 18 **A.** Yes.
- 19 Q. So what did you do in terms of communicating with them?
- A. So we made a complaint to say that we weren't happy
 about the situation because it worried me then, you
 know, if something else happened, were we going to be
 informed? And what did this mean? You know, I felt
- 24 like we'd not been given a proper explanation, and it
- 25 was really -- everybody had been really reassuring that

- 1 and the people would always tell you to go and take
- 2 a break, you know, and go and -- so I spent an awful lot
- 3 of my time sat by the incubator and being told "Go and
- 4 take a break, go and take a break." But I didn't ever
- 5 want to. I didn't ever want to leave her for as much as
- 6 possible and I was very keen to get discharged from the
- 7 hospital in one way so that I didn't feel like I had to
- keep going back there to have things, but then inanother way I was worried about being separated from her
- and being at home and not able to get in as much.
- Q. When you saw her with the ventilator, did you askdoctors and nurses about it, and --
- 13 **A.** Yeah.
- 14 Q. And what were you told?
- A. So I asked them what had happened, how had this
 happened, and, you know, why weren't we told? And we
 were told -- their response is that they need to deal
- 18 with what's happening at the time and to look after the
- 19 child. And I said okay, I get that and of course I want
- you to deal with the situation and look after my child
- first but there are other nurses, there were other midwives upstairs, there were other doctors, could
- somebody not have phoned simply or phoned my mobile, you
- 24 know, even just to say, especially considering that
- 25 she'd been checked on and I was told she was fine, you 14
- 1 "This is fine, this is normal, it's all just going to,
- 2 you know, be a bit of time and it will, you know, sort
- 3 of get better". And at this point now I was really
- 4 starting to worry, is something more going to happen?
- 5 And we told them that we weren't happy, you know, and
- 6 that especially that we'd not been informed, because we
- 7 didn't know then and we couldn't have been there.
- 8 And --
- 9 Q. So you spoke to -- the Inquiry has seen a record so you
 spoke to a woman from PALS on the same day, on the 24th,
 when that had happened when you saw the ventilator?
- A. I believe it was the same day, yes. I'm sure, from my
 memory, I'm sure it was later on, on the same day.
- 14 Q. And how was the person who received the complaint? Was
- she helpful? Did she record it? What was your view?
- 16 **A.** She said she would speak with Dr Gibbs because it was
- 17 Dr Gibbs who was the doctor who was there at the time
- for the care. She said she would speak to Dr Gibbs and
- then we were told that Dr Gibbs would come and speak
- 20 with us. So we went into -- there's another room on the
- 21 ward where the parents sort of -- or a meeting room, and
- we had a meeting with Dr Gibbs, and he apologised about
- the delays and he just reiterated that, you know, there
- 24 was a need to deal with the situation at the time, and
- 25 that it had happened at handover, so there just hadn't

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been the time before we got down there ourselves to be able to inform us. He said they would have informed us, but it happened and that we were there basically at the point that they'd managed to stabilise her and therefore it was just a case of they hadn't had time to be able to inform us as of yet but their intention would be that they would try to keep us informed in the future and there was discussion there over if I got discharged, over us staying on the unit in the parents room at the back of the ward.

The parents room however was full for that night, so they said to us about another room which was connected with the children's ward where we could potentially stay, looking into some options over how we could be near, especially with her, because at the point then that the baby was on a ventilator, they said then they tried to make that also a priority.

- 18 Q. Were you satisfied with Dr Gibbs' response and his
 19 apology to you? Did you think that was an appropriate
 20 response?
- A. I was upset. I was very upset still and I was very
 worried. I think it certainly made me a lot more
 worried of what was going to happen and I realised that
 it wasn't going to be a case of this journey was going
 to be quite how it was portrayed to us in terms of, you

neonatal unit, as I say, during handover times, which were set times. I can't remember what they were off the top of my head now but I know that they were morning and evening. You know, the morning shift handover and the evening shift handover. So you couldn't be there during those times.

And the same, they had ward rounds upstairs, and you had to wait to see the doctors because, you know, the doctors couldn't always come back to see you at other times. So the practicalities of actually getting downstairs after having had a caesarean, there is lifts and things like that, but it was still a fair walk. And you had to have somebody with you, because I was an inpatient with diabetes issues, you know, and sugars issues, so it wasn't safe as such for me to just be able to wander around the ward on my own. And I had asked to have been discharged so it could have made it easier for me to get there, because my priority at that time was getting to my daughter. And they said, "Well, you can discharge yourself but we'd rather wait for you to do this". So I followed the doctor's advice -- my diabetes doctor, that is -- to give it "at least this amount of time for the recovery, let's get in a situation where me feel that you're more stable, and then we'll go with discussion". And they tried to put it from the point of

know, a simple and short stay. And I was concerned. Which is why, then, at this point we said we don't want to be too far away. We don't want to leave. And I made sure as well from that point onwards that even if they were telling us to go and take breaks, that I stayed as much as I possibly could by her side, and I was a lot more cautious over things.

I still, however, did not have any prior experience or any, you know, medical knowledge so I didn't always know the questions to ask or what things meant, and it was very hard to get an understanding of that. I don't think that it was well explained to us, and it was very hard. So we weren't entirely satisfied with Dr Gibbs' response at the time, and we appreciate that they were busy, but to us it's our child that, you know, this is all completely new to us. This might be everyday to them to some degree, but it's not for us. And, yeah, we felt more could have been done.

- 19 Q. Just so I'm clear, Mother H, in terms of you getting
 20 down to the unit and seeing your baby, and how long it
 21 took you to do that, can you just clarify what the
 22 practical difficulties were about getting there?
- A. Yeah. So because I was an inpatient on the ward, they
 have doctors around up there on the morning, as they do
 as well in the neonatal unit. So you couldn't go to the

view of at least you're closer being up here, but then in some ways I felt like I had less freedom and less ability.

Obviously parents or mums who have had a baby or have got their baby there can come and go a bit more freely because there's other things there and I know every situation is different but that was the situation for myself at that time so it felt very restrictive. So I had to wait. Most of the time I just had to wait for my husband to be able to get in to come to take me --

- 11 Q. And did you have a mobile phone with you?
- 12 A. I did, yes.
- 13 Q. Is that a number that you were happy to leave? Would14 the hospital have that number or wards have that number?
- 15 A. Yes, they did.
- Q. On the maternity ward as far as you're aware is there
 a landline, calls at the nurses stations that can be
 taken?
- A. Yeah, I'd asked a few times if, you know, it could be
 phoned to check. But especially to begin with, when we
 didn't have access to be able to get to things as easily
 when I was -- at that very first night I'd asked in the
 night, you know, to phone to check on her, but they were
 always just too busy, was the response, you know, a lot
 of the times. So I had my mobile, which I did use to be

able to check if I couldn't get down there, because your thoughts are constantly on your child and how they're doing, and it's really heartbreaking to know that they're downstairs, they don't feel like your child because they're in a completely separate room and you can't be there with them and especially when you're in a ward where it's full of people who have just had their babies to the most part, and you can't be doing those things. It's very, very hard. So I would always check in by phoning, if I couldn't be there.

And my husband would do the same, or he would check with me, "Have you checked, you know, to see how things are?"

Q. Paragraph 38, you tell us, you were told:

"... Child H had pneumothoraxes ... hospital staff had told me that this was due to her being on breathing support as it can sometimes cause damage."

Can you just tell us what your understanding was at that time? You've already covered that a bit, but just set out what you thought was happening.

- A. So they told us initially that because she was on the
 ventilator, they were going to put something called
 surfactant which is to help the lungs with that
 stickiness, which they do give to babies that are
 premature and it helps them give them a bit of a break,
 - 21
- 1 **A.** Yes.

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- 2 Q. When did you first see this Datix report?
- 3 A. I saw this only during the Inquiry. Oh sorry, this --4 sorry, this one.
- 5 Q. 25 September. Take your time.
- A. Sorry, which Datix, this one is, because I know there's
 a couple of Datix --
- 8 Q. Yes, there's a couple. This one is 25 --
- 9 A. -- I'd seen this during the criminal trial.
- 10 Q. Yes. So we see here 25 September:

"1.30: infant required emergency needle aspiration of a large tension pneumothorax. Required x3 further needle aspirations. X2 butterfly needles used from Resus trolley. No further needles available on the unit leading to a delay in treatment of approx 10 mins.

"Action taken: Butterfly needles obtained from Children's Unit because no stock items available on Unit for use."

So there looks as though there has been some delay in treatment there. Were you aware of that at the time or of any issue?

- 22 $\,$ **A.** No. We were not told anything about that whatsoever.
- We were not told that there were no needles available.
- 24 We were not told that there had been a delay. As I say,
- 25 this was something that was all completely new to us.

it's something that is naturally produced usually but

they said they'd give it manually or synthetically,

I suppose, when a baby is early because sometimes theydon't produce enough of it when they've been born early

4 don't produce enough of it when they we been bonn early

5 and we knew that she'd gone quite quickly from being

fine to having deteriorated at that point and needing
 a ventilator, and they said because of the pressure of

8 the air that's being forced through the ventilator, it

the all that's being lorded throught the ventulator, it

9 can be quite a common problem that the air pressure can

sometimes cause leaks in the lung. But there was no

indication that the incident had a classification of,you know, particular seriousness in terms of the fact

that -- they didn't say there were more of these events

that could happen, they didn't say that she was going to

15 become seriously ill or that, you know, she could be at

16 risk of dying or needing, you know, resuscitation and

17 things like that. There was no indication of that

18 whatsoever. We were just told that it was due to her

19 being on breathing support and it can sometimes --

20 whilst it's needed to help, it can sometimes cause

21 damage because of the pressure of the air going through

22 the lungs.

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Q. If you look at page 22 of the documents you have with
 your statement, you will see a Datix incident report for

25 September?

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- 1 The first time we saw this particular incident was in
 - the courtroom during the criminal trial and it really,

3 really made us very upset that we had not been told

4 this. Especially as it said that the risk grading was

5 that there was a high potential, you know, for harm from

6 that, I feel that it's something that should have been

7 informed to us, even if it was a case of, you know, it

8 was a mistake and, you know, we didn't expect this, it

9 still should have been -- we still should have been told

that, you know, there's been a report made to say that

11 this was an issue and an error, and we weren't told

12 about it at any point from the hospital.

13 Q. Turning to your statement at paragraph 48, we to move
 14 additional collapses in early hours of the 26 September
 15 and 27 September.

My Lady, to be clear about these, the prosecution didn't specify a precise mechanism but said there was no obvious explanation for these deteriorations in the early hours of the 26th or on the 27th and cardiac compressions and adrenaline was required to resuscitate Baby H. Letby was found not guilty on 26 September of attempted murder and the jury could not agree in relation to 27 September.

- 24 LADY JUSTICE THIRLWALL: Thank you.
- 25 MS LANGDALE: Mother H, tell us about -- at paragraph 48 you

begin -- the first collapse, the one on the 26th, what happened and how you came across that? A. So at this point I was still up on the ward. I'd been moved to a side room because I was finding it quite hard and upsetting, especially with the fact that she had deteriorated, and we were now concerned, getting concerned about her care and about us being informed of things, and the situation was getting (unclear). So they'd moved me into a side room. I did feel that the midwives were still very busy, because the ward -- it was a busy time. And I remember it being late in the night, because I'd not long, really, left the ward because as I say, I was spending as much time as I possibly could down there and I'd had to go back up to the ward to get my nighttime medication, which was already late at this point.

I'd gone back up and I remember it being early on, and I'd only really just got back into bed. And I'd -- when I'd got into the bed, I just remember hearing like a knock on the door because, as say, I was in room at this point, so I just remember hearing a knock on the door, and one of the midwives had come in, and she'd come in and she'd said, "You need to come quickly" and I remember being in quite a shock and thinking: what do you mean? And she told me just to get my slippers and

up to, in terms of being able to get there.

And Dr Gibbs was doing chest compressions, and asking the nurses to get medicine. And I remember one of the nurses saying to me, just because I was stood in the corner of the doorway because I didn't want to get in the way, because there was a lot going on, I remember them saying to me, "It's okay, you can go in". And I remember walking in, and I remember Lucy Letby was there during the resuscitation. I don't remember anybody actually telling me, "She's being resuscitated" but there was a lot happening at the time and as I say, I could sense the urgency, and I didn't want to stop them from taking care of our daughter.

I remember one of the nurses telling me to go over and hold her hand and talk to her. And I remember just going over and holding her hand, and just talking to her. And the nurse just said, "Just talk to her about anything. Anything at all", she said, "Just let her know that you're here, let her know that she can hear your voice".

And I remember talking to her and, you know, making promises, you know, that all the things that she was going to do, and then I heard Dr Gibbs mention something about Atropine, and I didn't know specifically what that was, but it sort of made it an alarm bell go off in my

my dressing gown and I needed to come to the neonatal unit urgently. She didn't say why and she didn't say what and I remember feeling in a panic and feeling, you know, do I need to let my husband know? And I remember rushing and she said, "Phone him on the way". So I remember grabbing my phone and trying to phone him on the way and just saying, "Just come, just come quickly".

The midwife took me through -- the normal way you'd go out is to walk all the way through the ward, to get to the main entrance doors and go down the lift, as I say, and round that way, but she took me an opposite way out here and there was a little door at the back of the ward which I had no idea what that was for, but it had stairs, and those stairs went directly down into the neonatal unit. So she took me down those. We ran down those stairs out the back of the ward upstairs to get into the neonatal unit. She said it was a shortcut that they had for emergencies.

When I got there, towards the room, I could see the lights were on, and the lid was off her incubator, and that was like one of the first times that I'd really seen that. And I remember thinking: what is going on, because at this point still nobody had told me. And I was also panicking that this situation was not looking good, and I did not know where my husband, you know, was

head, and I remember thinking: that doesn't sound good. And so I asked him, I said, "How long has this been going on for?" And he told me that it had been 20 minutes, and that to me felt like a long time.

And I was looking up at the doors and the entrance to the neonatal unit at this time thinking: is my husband going to be able to get here? And I remember he then came running through the doors, and just sort as he came back through the doors I was still speaking to her at this point. I was holding her hand, and I was talking to her and I remember him coming through the doors and then sort of as he got to her cot-side, I just remember coming back all of a sudden, and everybody seemed to just sort of step back a little bit, and the other drugs which Dr Gibbs had in his hand at that time, he didn't, you know, put through and he didn't do and, you know, she seemed to be starting to improve. And after they'd sort of stabilised her again at this point because you could see her heartbeat and everything had come back up, I remember speaking with Dr Gibbs as to why it had happened, and we asked why she needed to be resuscitated, because, you know, that's a major thing. And I just remember him saying to us he didn't know. And, you know, why weren't we told that this could potentially happen? And he said he didn't know, and

they didn't anticipate it to happen. And I remember him telling me he didn't anticipate it to happen again, but we were worried obviously then about the situation.

He also asked us, though, if we -- of our religious beliefs and if we wanted to have her christened, and I felt almost like the urgency to get her christened implied that she might die. So even though she's stable now and they're, like, "She's doing perfectly fine on the ventilator, she seems to have come back through this, we don't know why it's happened, we don't anticipate that it will happen again, she seems to be good again now, but because we don't know why it happened, you know, if that is something that you'd like to do, it may be worth getting her christened while she's still in hospital".

So we arranged that and that happen on the morning of the 26th.

- 18 Q. And that night again there was another collapse, wasn'tthere?
- 20 A. (Witness nodded)

- 21 Q. Tell us what happened?
- A. So we stayed with her all of that day and other family
 had been allowed to come in as well, because normally
 you're only allowed a certain limit of people at the
 cot-side but other family had been allowed to come in

pillow to maybe get some sleep, again, there was a knock on the door and it was the same situation again and this time we were a lot closer to get there a lot quicker so we literally just had to come out of the parents room and round to the room where she was and the lid was off the incubator and the doctor was giving her chest compressions again.

And it was what -- like watching a replay of the first incident. I asked how long they'd been doing the chest compressions this time, and they said it had only been for a couple of minutes and I went over to hold her hand again, and this time she came around a lot more quickly, but we were very concerned at the fact that this had happened again, and at this point my main concern was: was she going to make it? And I remember she just -- she didn't look a good colour at all, and it's a very scary situation when you see your child, we didn't know to question that, you know, because I don't know what somebody looks like after they've been resuscitated, but both me and my husband remember that she was, you know, not looking good, and we were really concerned at this time.

They decided as well then that they were going to transfer her then at this point to Arrowe Park who they had been keeping in touch with throughout her care.

for the christening and between us all we all spent a long time at her cot-side, and she was perfectly, you know -- she was on the ventilator still and obviously not perfect, but there was no issues, no deteriorations, no -- she seemed stable for being on the ventilator, and it was just a normal course of care throughout that day. But we weren't given any explanation as to why it had happened, and we were just sort of told that "She's come round, she's okay now, and we don't anticipate it to happen again".

But we were really reluctant to leave her so they'd arranged for both me and my husband to stay in the family room, and a nurse on the shift that day told us she was having a good day, she was stable, and she said it was difficult to believe that she'd just been resuscitated a few hours earlier. And her nurse then for that night, by the time we'd got to the night point, because we'd stayed again until very, very late in the evening at her cot-side told us she'd had a really good day considering, and we should go and get some rest and that there were no issues and no concerns. This is the nurse that was caring for her on that night.

However, then it felt like basically minutes after we'd got back or when we'd only just got back, really, to the parents' room, again just putting head on the

Q. We know she was transferred on the 27th to Arrowe Park
 so how did you think -- how had that decision been
 arrived at? What did you know about the transfer or
 reasons for transfer?

A. As I say, once she'd been on the ventilator, they said they had to have contact with a higher level unit. So there was doctors in Arrowe Park that they would speak to after each of the ward rounds and things like that, or any changes to sort of relay or ask about her care. That was apparently normal practice when a baby is on a ventilator. So they were in touch with Arrowe Park anyway about her care, and they'd said they felt it best to transfer her over there because it had been the second collapse and they didn't know why it had

There, was, however, concerns with the difficulties of transferring a baby on a ventilator, and they'd said that it was something that is quite intense, especially if a baby is very vulnerable, and it was set out as we couldn't go with her because of all the equipment that needed to be done, there was a team that would have to come to arrange all the equipment and transfer her over and that we would have to follow behind, but they would phone us if during the journey there were any issues, and it was very much a case of sort of saying goodbye to 32

1 her before she goes and, you know, all of this, and, you 2 know, have some time with her as well, you know, before 3 she's going on her journey but "We will keep you 4 informed throughout". And it was very, very hard to 5 have that situation. It took a little bit of time as 6 well, but a doctor came over first of all from Arrowe 7 Park, he checked her over and again at this point she 8 was stable again, as stable as she could be on 9 a ventilator, and they were asking lots of questions 10 about things, trying to work out as to maybe why this 11 had happened, talking about tests, talking about all 12 kinds of weird and wonderful conditions, talking about 13 what had happened, talking about what they might be 14 doing, their own checks and their own observations and 15 things, and when she was ready to be transferred, they 16 moved her over into the transfer incubator, and we were 17 told to give her a few minutes and then to follow 18 behind.

19 Q. And was there a handover? Did you see doctors and 20 nurses from the Countess talking to Arrowe Park Hospital 21 doctors?

22 Α. (Witness nodded)

23 Q. You've described that, but did you see that?

24 A. I remembered the doctor there, yes. Yes, they were 25 involved with asking because they were asking questions.

1 sitting at that desk at one point with her head in her 2 hands and she seemed quite shocked, and to me, 3 I thought -- I just remember that image of her sitting 4 there and thinking why, you know, if this is something 5 that you deal with, why is -- I thought maybe she's 6 tired and obviously it's very distressing, but I felt 7 almost like I had to reassure her a bit, in terms of, 8 you know, things. And she said, "Oh, you know, it's the 9 right thing for her". But I remember just feeling that 10 sort of atmosphere of her being quite shocked that it 11 had happened, the same shock as I think what it was for 12 us. And that sort of stuck with me, then, as to why. 13 Why did this happen? And the doctor was the same, 14 because this was obviously the second time it had 15 happened now and we were told they didn't anticipate it 16 would happen again, and we were sort of just trying to 17 ask why? Why has this happened again? What is it? And 18 is this going to happen again? You know, are we going 19 to lose her?

20 Q. When you -- Child H was taken into the ambulance, you 21 say Letby handed you a red box. Can you tell us about 22 that?

23 A. Yes. So literally as we're leaving the door, they gave 24 us a box. It was just like a red box, and it had 25 a teddy bear on the top and inside the box was a cot 35

1 Arrowe Park were asking questions to them. They were 2 letting them know of certain -- handing over certain like documents and things, and they did a discharge sort

3 4 of summary to hand over to them to take with her because

5 then we'd be under the care of Arrowe Park, so it was

6 like we'd been discharged from the Countess to go to

7 Arrowe Park and at that point they just -- they'd said 8 that they didn't know, this was the second in two

9 nights, and they didn't know why it had happened so even

10 though she was stable again now, they felt it was for 11 the best.

12 Q. So the plan was, Child H went in the ambulance and you 13 and your husband were going to follow in a car?

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15 Q. Or something like that?

16 **A.** And the nurse that was her nurse for that night before, 17 I remember telling us that her being transferred was the 18 right thing for her, and I remember the doctor who 19 resuscitated her was also keen for that to happen.

20 Q. Why was the nurse keen for that to happen?

21 A. I don't know. I do remember that that particular nurse, 22 when we had come in, because she had come back into the 23 room later on in the resuscitation, I don't remember

24 when. I just remember her being there at the end and

25 there was a desk with a chair on it and I remember her

card and her wristband from the Countess of Chester but then there was also in a plastic bag with a white sticky label on the front that said, "For my Mummy and Daddy, xxx" and it had her CPAP hat in it, the CPAP hat and things. To me it almost seemed a bit like a memory box. I remember thinking that it was guite morbid. You know, because she was not dead, and yeah, I did ask about that during the criminal trial and I was told it wasn't a memory box as such, that was something that they did, but I remember not feeling entirely comfortable about that. And especially the fact that the writing on that label of the CPAP hat says, "For my Mummy and Daddy" with a "xxx" on it from Lucy Letby, you know, and the fact that she handed that over to us, yeah. I do struggle with that.

Q. When Baby H was at Arrowe Park, you say they'd taken 16 17 a detailed family history and did tests. Did you see 18 her being treated at Arrowe Park when you got there?

19 (Witness nodded). When we arrived there we saw that Α. they were doing, yeah, lots of tests that they did so 20 21 heart, checks on her heart. They asked again really 22 like detailed family histories, loads of blood tests, 23 they did a lumbar puncture, you know, for concerns maybe

24 over infection, they did ECG,s they did x-rays, they did

25 ask, you know, about incidences of what happened at the

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time. They did lots of tests. And we were there for many of them.

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The unit itself was a very different set-up in that it was a very busy room, and there was lots of incubators in this room, whereas our daughter had been in a room on her own at the point of these two resuscitations in -- and the room was completely separate. It's off to the side. So very isolated, really, in the Countess. So this -- and almost very quiet. And it was very busy in Arrowe Park so it was harder to almost sit there with her more often, but there was a lot of tests and it was a very different atmosphere.

But they did a lot of thorough checks, and we watched the doctors remove the chest drains within hours from [Child H] because she'd stabilised that much and they said that, actually, she'd stabilised in the ambulance, you know, and they said that that was not usually what happens. They said she's had a really, really good journey, they said. Usually it puts them through a lot of extra pressure because they're so unwell and so unstable but they said, actually, she'd done really well on the ambulance journey, and so then by the time she'd got there within a few hours, after doing the tests and they'd removed the chest drains, and

- 1 Q. So tell us about when she went back, and what ward and 2 cot she was in when she went back?
 - A. So when she went back, we were put back into that same first room to begin with, and I remember not feeling -they said, "That's normal process, when you come back in, you go back into that first room for the first few hours and we do some observations and then we move her over to one of nurseries which is less intense because she doesn't need to be in this intensive care room now, but we've put her in here for monitoring to begin with".

And I remember them saying, "But we'll put her in this cot this time because we don't want to put her into the --" and I remember thinking it was a really strange thing to say -- "We don't want to put her back into the cot of doom". And I thought that was just such a really odd thing to say, and just put it down to the fact that she'd been resuscitated in there, and they didn't want to put us back in the same place.

We were in there for a few hours and then we moved into one of the other nurseries which was the first time that we'd been in those nurseries, and she was able to just to concentrate on being fed, had less intense monitoring but still a little bit of monitoring and checking that she was gaining weight.

And how many days or how long did she have to be there Q. 39

she was like a completely different baby.

We spent just two nights at Arrowe Park and during that time she had the chest drains removed, she'd come off the breathing support, she was able to go back on to feeds, because she'd been on parenteral nutrition before through a drip because she was so unwell so she was able to go back on to starting to have feeds through an NG tube, but, you know, she was starting to be able to have that. You could hold her. You could pick her up. She was a completely different baby.

However, they couldn't give us an answer still as to why it had happened. We had to just sort to leave it there, and have that concern still in the back of our head as: was it going to happen again? Could she have some really, you know -- condition that, you know, could cause something to happen again, or could she have problems? And also, the concern over whether the length of time of the resuscitation would have any impact on her. They did do brain scans but they said it wouldn't be something that they would know until she grew, because of the lack of oxygen. So it would be --So she had two nights at Arrowe Park and then went back

- 22 23 to the Countess of Chester to make sure, you say, she 24 was able to feed properly?

25 A. And put weight on, yeah.

1 before discharge, roughly?

A. We left -- in total, we were there for 21 nights. In 3 total. That was the length of stay from when she was 4 born until when we got to go home. She made very quick 5 improvements after that. It was just a case of the 6 normal checking she was gaining weight and feeding, 7 which took a little bit of time but not very long and 8 then it was just checks to be able to go home. And 9 yeah, we were able to go home then but still we'd no 10 explanation as to what had happened.

- 11 Q. Medical records. Did you ever have access to her 12 medical records at the time?
- 13 A.
- 14 Q. Or when did you first see them?
- 15 A. No. During the court case.
- So during the criminal trial, you saw her records? 16 Q.
- 17 A. (Witness nodded)
- 18 Q. Had you ever asked for them or did you not do that 19 earlier?
- 20 A. No. We always still felt uneasy with the fact that 21 obviously this had happened and we didn't know why, but 22 we'd kind of taken it as a miracle that she'd come
- 23 through this. Nobody anticipated that it would happen
- 24 again. They couldn't find the reason for it. They had
- 25 done a good job and she seemed to be doing so much

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better that by the time we'd got home with her and we were busy with her, concentrating on her, and as she grew, you know, she seemed to be reaching her milestones, there was less concern as well over there being any other issues which could be going on. We didn't feel it was worth going through that trauma again of bringing it all back up again, or trying to find out what had happened, and we just sort of took it as a miracle as that she survived this and she's a miracle that she's here, you know, kind of thing. So we didn't ever go back. We considered making a complaint or trying to dig further but we felt at the time that it was better to concentrate our energy on her.

So we didn't go back into that but the thought was always there still in the back of my mind as to why did this happen? And for a long time, I was still worried, could it happen again? You know, I was still concerned over things, and protective of her. But we didn't -there was nothing to indicate that there was anything wrong and -- with her. She was doing great, and we didn't feel it was worth going through the pain of going through it all to try and find out why or what had happened. And we didn't know that there were things that could have been done differently, because that was our first experience. So we didn't, at the time.

that to happen. I mean, you don't, you just can't imagine that somebody would do that. So we just didn't for a second think that but we did think, you know, we never knew why these collapses happened.

- 5 Q. Did you get a telephone call before she was arrested 6 from the police?
- 7 A. Yes, yes.

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- Q. What were you told then? 8
- 9 A. So we were told then that they were going to be making 10 an arrest, because prior to that, we were told that they 11 had -- were going along the route of that somebody that 12 caused harm, and that was quite a shock to take. They 13 couldn't tell us who it was until they were making the 14 arrest, and I remember them saying -- phoning to say 15 they were going to be arresting Lucy Letby. And 16 I remember thinking: how could this -- you know, how 17 could this have happened? It didn't feel real. But at 18 the point that we were told that somebody had caused 19 harm, and there was a high probability, they said that 20 somebody would have caused harm and that's what they 21 were looking into now, the police said. At that stage 22 I didn't know that Lucy Letby was under suspicion. So 23 to get that phone call and say that it was her was 24 definitely a shock, and it was very hard. I remember it 25 being very early in the morning.

Q. In terms of Letby, did you have any suspicions or 1 2 concerns about her while you were at the Countess of 3 Chester? Did you have many dealings with her?

A. No, she -- some of the nurses you could that have like 4 5 a chat with or a laugh and, you know, you'd get to know 6 them because you're there a lot, and you're there for 7 quite a while. But I don't -- Lucy Letby didn't really 8 register much with me. She was pretty unmemorable, to 9 be perfectly honest. I do remember her being present 10 during that first collapse, but on the whole there was 11 very little conversation between us. She was very quiet 12 in terms of that, and there was no particular dealings 13 or connection that I recall us having with her. So

14 other than knowing that she was there, no. 15 Q. When did you learn that there were suspicions and 16 concerns about her and her conduct?

17 A. May 2017. I got a phone call from the police. We'd 18 seen the newspaper articles at the time that said there 19 were investigations into baby deaths and collapses on 20 the neonatal unit, and they would determine if it was 21 medical negligence or somebody, you know, could have 22 caused harm. But at that point when we were told by the 23 police, we were sort of given the impression that the 24 fact that somebody could have caused deliberate harm was 25 very much a worst-case scenario. And we didn't expect

When were you and how were you told that Letby was suspected of causing injury to your child, Child H?

Well, during that call, because we knew -- well, we knew that somebody -- that there was a high probability that somebody was causing harm because at the first point it was a case of looking at all the options and then we were told that it was a case of -- it was a high probability that they were -- somebody had caused the harm was the reason that they were now looking into. So 10 we knew that there was a potential that somebody had 11 caused the harm. But it still didn't seem definite at 12 that point. And then it was the point that, "We're 13 arresting somebody because -- we have Lucy Letby, who we 14 believe has caused the harm."

And it was that morning of the --

16 Q. Did you ever have any dealings with the hospital 17 management or anyone from the hospital about your child 18 and her treatment and what was by then suspected?

19 A. No. Nothing at all. Absolutely nothing from the 20 Countess. And we were told obviously because of the 21 investigations that we couldn't do anything at that 22 time; we had to wait for the criminal proceedings to 23 take its course. And so we couldn't contact the 24 hospital at that point to ask or to see anything 25 further. But we had nothing at all from them. And, you

- 1 know, she was cared for under the paediatric -- the same 2 neonatal doctors, but the paediatric team until she was 3 nearly two because that's the normal process when you 4 have premature babies, they like to monitor to make sure 5 they're developing and regular checks, you know, and 6 things like that. So we were at the hospital still for 7 outpatient appointments and we saw, you know, the 8 doctors still as an outpatient, and at no point were we 9 told anything, you know, about these other meetings and 10 things that -- reports that had been done. Nothing at 11
- 12 So the Royal College report, you didn't know about that Q. 13
- 14 Α. No --
- Q. And there was a report from Dr Hawdon -- so that's been 15 16 through the Inquiry.
- 17 A. (Witness nodded)
- Did you listen to the criminal trial? 18 Q.
- 19 A.

- 20 Q. Parts of it? What did you hear? Did you hear material 21 for the first time in that trial that you'd like to have
- 22 known before?
- 23 A. Yes, a lot. There was basically nothing from, in terms 24 of the medical side or things like that that we knew 25 beforehand, because we hadn't gone down the route of

1 complaint and our concerns and said that they would try, 2 you know, to better keep us informed. So yes, yes 3

- 4 **Q.** And were they easy to find in the hospital, the person 5 you needed to speak to? Did you know where to find 6 them, or just ask somebody to know where to find them?
- 7 A. It was an email that was sent, because there was 8 a number. There are leaflets as well with it on. 9 I can't remember where exactly I got the email address 10 from at this point or whether I phoned the office on the 11 number and was given the email address or whether I got 12 it off a leaflet. I can't recall exactly, but I don't 13 remember -- I don't remember particularly it being 14 a case of being hard to find or to get hold of. But 15 I suppose we had the advantage of knowing that that
- service was there. So we were looking for it. 17 Q. You tell us with a subsequent child you didn't want to 18 go to the Countess of Chester Hospital?
- 19 A. Yes. Yes, I think it was the memories of what had 20 happened and also at this point we knew there was an 21 investigation happening. We had not really planned on 22 having another child and I struggled with it a lot
- 23 because of what happened with our firstborn and I was 24 terrified throughout the whole pregnancy. The whole
- 25 pregnancy was completely different. It was an awful lot

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1 making a complaint, or asking for further information 2 after we'd been discharged, because as I say, we were 3 concentrating on her. But nobody told us, still, about 4 this. You know, if we'd have been told this, then we'd have known that actually, there was something there that 5 6 could have been looked into further. And I suppose we 7 were just clinging to the fact that she was a miracle, 8 that she pulled through. And I was also dealing with 9 the fact that I was feeling the guilt over the fact that 10 because I'm a diabetic, that was essentially the reason 11 why she was born early. And, you know, and I was thinking: is this a normal course for a premature baby? 12 13 I didn't know any differently at the time because, 14 again, it's not something you often hear of.

15 Q. More generally in your statement dealing with PALS, you 16 say:

"On this occasion [ie, in relation to Child H] PALS did what they were supposed to do and informed the doctors so they could answer my questions."

20 A. (Witness nodded).

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- Q. Did you feel that it was a route for raising your 21 22 concerns and the questions were answered and you had 23 a meeting with Dr Gibbs?
- 24 A. Yes, yeah, because he came to meet us, as I say, and 25 talked us through, and acknowledged, you know, our

1 of tests, and I didn't want to go back to the Countess 2 and I especially didn't want to go back to the neonatal 3 unit. But all my diabetes care was there, and I needed 4 their input from that team for both the safety of the 5 baby and for me, and I needed something that was close 6 by. So the plan was always going to be that I'd have 7 the diabetes care there during this pregnancy and then 8 I would be transferred to another hospital for her 9 birth.

> But it came to -- we also had a meeting with Dr Brearey to discuss my feelings of going back to the Countess of Chester, and what had happened with our firstborn, and I remember him saying to us that sometimes the safest place to be is the warzone after a war. And also trying to reassure us that there had been no incidences of anything since, and that, you know, they would do anything possible, if we decided that that's what we wanted. It was completely understandable if we didn't, but if that's what we wanted, to go back there, then they would do everything possible to make it as comfortable for us as they could.

And obviously the hope was at that point that that wouldn't even need to happen, and that she wouldn't need to go to a neonatal unit. However, it was the case again, unfortunately, that she had to arrive early, and

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because of the situation at that time, it was again an emergency situation and she did have to be born in the Countess, and at this point I was very clear in the fact that she was never to be left alone, you know, without one of us there. I couldn't -- I couldn't do that. And I made sure that there was somebody who was going to be there with her as much as physically possible.

8 Q. I don't want to ask you any more about your other child 9 unless you want to share that information. You've set 10 out your position there.

Shall we move on to suggestions and recommendations?

12 A. Yes. Yeah.

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13 Q. What, in your view, would have assisted in preventing 14 the crimes of Letby? You set out a number of things. 15 Would you like to expand on any of them? You say, 16 "A clear contract between parents and staff". What are 17 you thinking about there?

18 A. Well, I think it's important to be able to have an input 19 on the child's care, and to know exactly what's 20 happening with her condition so that you can feel like 21 they are your baby, that they are yours, and you have 22 the ability to be able to make the most important 23 decisions, that you don't have to hand everything over 24 to them. The communication should certainly be a lot 25 better. There should be ways in which, you know -- in

> So people who maybe work, you know, that might have -- nobody ever wants to suspect, I suppose, that somebody that they work with is doing something wrong. I suppose it was just not in your nature, but if you have any concerns whatsoever, there should be a way for that to be reported and reported without any consequences.

8 **Q.** You say there should be respect between managers and 9 senior medical staff?

A. Yes, because they're the ones who are there on the wards, the senior medical staff, and the managers are people who aren't involved in that. So they should be able to take on board what they're saying without there being a case of: well, this is protocol, this is how it works, you know, kind of thing. There should be a case of, "This is what's happening, we need you to do something more about that."

You know, it should be a case of there should be more safety measures in place to prevent things like this happening, and if somebody is saying they've got issues, then they should be listened to and dealt with. Even if the outcome is that's not the case, then great. There shouldn't be a case of: well, we'll, you know, we'll ignore that until we know for sure.

25 Q. You say: no other situation, you know, after a baby is in the neonatal unit, you know, if you had a baby that was born and was only, you know, a few weeks old and had to go back into the hospital, you'd have to be there with them all the time. The same for a child. You know, kind of thing. They're your responsibility. But that's sort of taken away from you a bit when you're in the neonatal setting because you have to rely on other people to care for them and you can't physically be there all the time. You can't sleep by their -- the cot-side. You can't be there. So there needs to be the way to keep fully informed and to have so that access and that ability to be able to know that they are being cared for and clearly

15 Q. You say there should have been staff training around 16 dealing with concerns and a protocol for reporting 17 concerns, and transparent systems.

Yes. So if there was a case of -- there should have 18 Α. 19 been enough well-trained staff because obviously we were 20 getting told quite a lot that it was busy, and there 21 wasn't enough staff. That seemed to have always been 22 a reoccurring theme or excuse. And we were -- if there 23 would have been more around suspension and things like 24 that, the minute that any concerns came in, then, you 25 know, a lot could have been prevented, I feel.

"A system of senior nursing staff having responsibility for safety, with regular spot checks to ensure staff are adhering to good practice."

A. Yeah. So if they have people who are coming in to assess, I suppose it's the same with anyone, if you've got somebody from the outside coming in to check what you're doing without it being a case of a pre-arranged check, or, you know, things like that, then you're more likely to get an accurate picture of what is happening. And information should be shared, such as the CQC, and should have been shared widely, and highlight any unusual features or statistics that were in the case. So if there was a problem concerned a trend then it was known about. Because, as I say, when you're a parent going into that, you don't know. I didn't look up statistics before I went into any hospital to see what were the average statistics of a baby being born early, how many -- how common is it for a baby to be resuscitated? You take what they're saying, you trust what they're saying and you sort of believe that's the case. But obviously they know, because they work in that situation all the time, that that wasn't usual. So if there were these unusual features and statistics, then that should have been picked up. If nobody was raising that at that point from within, because they

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- 1 just didn't want to believe that anybody did it then 2 there should have been a way for there to have been 3 checks from the outside that would know about that, and 4 have picked it up sooner.
- 5 Q. You raise CCTV, and we can see how clearly CCTV images 6 would have made crimes visible. But another aspect of 7 CCTV, for you when you had to be separated from Baby H, 8 would it have been helpful to just see in the incubator, 9 see how she was without having to ask people to take you 10 down or try and rely on others, to see for yourself?
- A. Yes, that would have been -- there was -- you almost 11 12 have this constant state of stress when you're away from 13 them. It's probably a lot of hormones as well, you 14 know, after you've had a baby, but it's like -- it's 15 a real stress, not being there with your baby. So to be 16 able to see them would be massively reassuring, you 17 know, and it would help massively for those times when 18 you couldn't be there.
- 19 Q. You also mention proper monitoring and strict security 20 on storage and use of drugs, including ensuring anyone 21 accessing storage would be identifiable afterwards, so 22 the swipe card data.
- 23 A. (Witness nodded)

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24 We asked you whether you had received any support or 25 offers of support, and you hadn't, at the time, when

> have to go back to a hospital. I just -- because I don't have the trust.

I feel that the changes as well will be lifelong. Time does heal, but I can't now un-know what I know, and I can't change what happened. I do try not to dwell on it but it's impossible not to think about it much of the time. The impact is wide as well as very deep. And it has also affected our wider family.

Another big concern for me is the fact of I'm extremely grateful that she did survive, and that I tried to focus on the positives of the fact that I have her and cherish that. But then another concern for me is, at the moment, she doesn't know. And one day, I will have to tell her. And I don't know how it will affect her when I do, if it's something I can't deal with, how is she going to deal with it?

I suppose, thankfully, not many people have to cope with something like this, but I do worry a lot of the time how I'm going to tell her and navigate that the best I can, so that she can understand. And another issue, particularly, for us, is the fact that unfortunately with the criminal trial, for that first count, they had found or come to the conclusion that they could not decide beyond reasonable doubt that she was guilty. They were -- obviously many of them did not

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your baby was in hospital? 1

- 2 A. (Witness shook head)
- 3 Q. Can you tell us now the impact of all of these events on 4 you, in so much you would like to share that?

is a limit to what I want to say here.

- 5 A. Yes. The impact has been overwhelming. What happened 6 has affected every aspect of our lives, and it really 7 isn't easy to put into words to truly convey the 8 enormity of it. It is also deeply personal, and there
- 10 LADY JUSTICE THIRLWALL: You don't need to say anything that 11 you don't want to. Please don't.
- 12 Thank you. But ultimately, it has changed me 13 fundamentally as a person. Among other things, it has 14 really affected my ability to trust people, especially 15 when it comes to anyone taking care of my children. You 16 know, they -- the people in the neonatal ward, you put 17 your whole trust into them to take care of your baby, 18 and that has been completely abused. It's affected my 19 trust in hospitals and the health service very, very 20 deeply, and unfortunately that's something that I still 21 have to have ongoing, is contact with hospitals. So 22 it's not something that I can easily walk away from, and 23 it's very, very hard to have to go back into a hospital 24 setting. I know a lot of people say, "I hate 25 hospitals", but I really do find it very traumatic to

1 feel that for the second count, and I know now, 2 throughout those trial, that beyond reasonable doubt

4 a lot more information than I knew beforehand. You 5 know, ignorance is bliss, in a way, because had I have 6 never have known any of this, then I would have just 7 been going along with the fact that she'd had these 8 awful events, there's a miracle that she survived them,

that she did do it, and I know a lot more detail and

9 and I would have just never have known the other side 10 of it. But now I do know, I can't forget that. And

11 there is still as well just the trauma of the actual 12

nights of what happened coming back, with those knocks 13 on the door and seeing your daughter being resuscitated, 14 and that, you know, they were the worst moments of my 15 life and thankfully, something that I have never had to

16 deal with before or again since.

> But how I explain that to her and obviously now she's a lot older she has a lot more questions about things. It's very hard to answer her, because I feel like I have to come up with a bit of a story. And she almost has a bit of an admiration for hospitals in a way that she goes, "Oh, you know, I'm going to go back one day and I'm going to help babies". And she said, you know, "I'd one day like to be able to be a nurse and to help people".

1	And I find that in a way very hard, because I think				
2	what will her opinions be when she knows the truth over				
3	what happened? And I suppose it's just how is she going				
4	to deal with that. You always want to protect your				
5	children, but one day I know this is something				
6	I can't keep from her forever, and I hope that I'm going				
7	to be able to deal with it the best that I can, for her,				
8	so that she knows what happened or she knows that she's				
9	safe, and that she may not have the justice for that				
10	first count, but she certainly we know, and a lot of				
11	other people know, what happened, and that Lucy Letby is				
12	in prison and will never be coming out, and that is the				
13	best outcome that can possibly be, out of all the				
14	options that are available.				
15	MS LANGDALE: There's no further questions from me,				
16	Mother H.				
17	There will be a short break and your barrister might				
18	have some questions for you after the break. Thank you.				
19	LADY JUSTICE THIRLWALL: Thank you very much. We're going				
20	to take 15 minutes to give the shorthand-writer a break.				
21	If you need any more, Mr Baker, just say.				
22	MR BAKER: Thank you.				
23	THE WITNESS: Thank you.				
24	LADY JUSTICE THIRLWALL: So we'll take a break now.				
25	(12.07 pm)				
	57				

2 a mask, a little small mask over the sort of nose and 3 mouth area. But yes, it's a machine that was doing the 4 breathing for her. Q. So --5 6 A. So it's a lot more intense ... 7 So rather than being a mask that was helping her to 8 breathe, she'd now been sedated, had a tube put down her throat, and the machine was breathing for her? 9 10 A. Yes. Q. And that's why you gave evidence to say that you found 11

outside of it on there as opposed to just a sort of

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12 this quite shocking and different?

13 Α. Mm-hm, yes. Yeah. It was a big step, and it's 14 a significant deterioration, you know, that -- I don't think you can get much more breathing support, really, 15 than a ventilator. There's nothing else that I'm aware 16 of that there is for that. 17

Q. You go on in your witness statement to describe how you 18 spoke with PALS, to Dr Gibbs, and that you raised 19 20 a complaint about not having been told about this change and having to come on to the ward to discover it. 21

22 A.

23 There is, in your bundle, an email from Eirian Powell to 24 John Gibbs. Have you seen that?

25 Yes, I have. Α.

(A short break)

2 (12.22 pm)

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LADY JUSTICE THIRLWALL: Mr Baker, thank you. 3

Questioned by MR BAKER

5 MR BAKER: Mother H, I'm just going to begin by asking you 6 to go back to paragraph 30 of your witness statement, 7 please so this is a section of your evidence where you

are dealing with finding out that Child H had been put

9 on to a different machine, a ventilator.

10 Α.

Q. Prior to that she'd been on a CPAP machine which you 11 describe --12

13 Yes. A.

Q. -- as a mask which provides positive pressure, 14 a Continuous Positive Airway Pressure. 15

16 Yes. A.

17 Q. Is CPAP. In what way was the ventilator different to 18 that?

19 A. It was doing the breathing for her. So they said that 20 in terms of to give her a break or to give her a rest, 21 but she had to be -- have medication. So to be sedated

22 to be on that, so that she didn't fight back against it.

23 And in terms of its looks, I suppose it looked a bit 24 different because it's a tube down the throat. Not that

25 you could actually see that, but you could see the

If you could just turn to it, please.

2 Yes.

3 So it begins with an email from Brenda Hooley, but the 4 Eirian Powell email is towards the bottom of the first page. And there is a reference to your complaint: 5

6 "Brenda from PALS came to speak to me this 7 lunchtime."

8 Did you formulate your complaint through PALS?

9 A. Yes, yeah.

10 Q. And there is a comment from Eirian Powell in the 11 penultimate paragraph to that email which begins: "My question as an addendum ..."; can you see that? 12

13 A. Yes, I can.

14 "... is why it had taken mum so long to come to the unit 15 when she was aware of how poorly her baby is. (just a thought) especially as she is an inpatient, or even ask 16 17 a midwife to ring/use her mobile for an update. I have

spoken to Belinda and Nurse W, and as you can imagine 18 Nurse W is upset that she had tried her best, only to 19

20 receive this complaint."

21 First of all, what sort of interactions, if any, had 22 you had with Eirian Powell prior to this point?

23 A. I don't recall many, if I'm being honest, many 24 interactions with her. So I didn't know of her and

25 I certainly don't remember her being involved in our

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1 daughter's care at any point. So I know who she is, so 2 now I know she was there and around on the wards at the 3 time, but I certainly don't remember her having any 4 involvement in the care of our daughter at that time.

- 5 Had you had any conversations with Eirian Powell before 6 you discovered that Child H was on a ventilator?
- 7 A. No.

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- 8 Q. Reading that comment now, how does that make you feel?
- 9 A. Very, very upset, and I am shocked that that is even 10 part of a conversation between the nurse and the doctor, 11 because she hasn't got the full story there at all. 12 And, you know, I am deeply offended by that. You know, 13
 - like how dare she make a comment on that at such a difficult time? Because in actual fact I was an inpatient on the ward, I had asked many a times for the people up there to phone, to phone down. I had used my mobile to ring to check that she was okay, and I was told that she was stable, and I was trying my best to get down there. I wasn't allowed to just go down on my own, so I couldn't get down there easily.

And I wasn't aware of how poorly she was because I wasn't told how poorly she was. So to have been told that she was stable only just before, to then go down and find this situation, and you think: well, what has happened, you know, in the meantime? And to then have

- 1 Q. Thank you. And just for clarification, when was the 2 first time you saw this email?
- 3 A. Yesterday.
- 4 Q. Going back to your witness statement at paragraph 72, 5 this is a section where you're describing Child H's
- 6 condition during the collapse on 26 September, which was 7

the second serious collapse that you'd witnessed, and

- 8 it's asking, actually, a question of Father H in the
- 9 bold section above about the --
- 10 A. Yes.

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11 Q. -- about the baby being very mottled during the collapse 12 on 26 September 2015. But you then describe in the 13 following paragraphs what you saw, and what Father H 14 reported that he saw, as well.

> Could you just explain what you mean by what you say at paragraph 73?

17 A. Yes. She was very, very pale, and had sort of 18 blue-purple marks, like a mottling, all over her body. 19 But we didn't know, I suppose, that that was anything 20 different, because we'd never seen anybody being 21 resuscitated on the brink, you know, of death, really, 22 before. And it is something, though, that stuck in our 23 minds, and I remember when she came back, it was almost 24 like that just disappeared. You know, she sort of came 25 back to. It's almost like, you know, when you just wake

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somebody comment on it, to say, "Why did it take so long?", when in actual fact I was trying my best to get down there, and nobody had informed me. So if somebody would have told me, I would have been able to have got down there, as well, much quicker. And if the staff weren't so busy up on the ward, then more people would have been able to helped to get down there.

There's a massive assumption, I think, being made on her behalf there, but why that even comes into a conversation with regards to a PALS complaint, or it's felt as being appropriate, is deeply upsetting, if that's the view that they're taking of parents.

And if she felt like that, as well, why didn't she come to talk to me, to say: "Look, your baby is really poorly, you know, maybe you should spend a bit more time here?" When in actual fact all the nurses were doing was telling me to take more of a break because I was spending so long next to her cot-side, you'd get the impression.

So I can't understand how they can say something like that in an email between each other, and have a very different outlook, especially for the fact that I had not spoken to her, she didn't know the situation. And that was exactly our problem: was that we weren't being communicated with to be told how poorly she was.

up from a sleep. It was like, you know, her heartbeat came back, she came back. And it was just very, very quickly, then, that she came back.

But at that point, looking at her, we thought that it doesn't look good.

- 6 Q. Shortly after this episode on 26 September there was 7 a discussion that you witnessed regarding transfer to 8 Arrowe Park Hospital.
- 9 A. Mm-hm.
- Q. And you described in evidence before the Inquiry a nurse 10 11 saying that it was the right thing for Baby H --
- 12 Child H -- to be transferred to Arrowe Park.
- 13 A. Yes.
- 14 Q. And the doctor also being keen. You give that nurse's 15 first name at paragraph 86, but I don't think -- you 16 didn't say it in evidence. Can you recall the name of 17 the nurse who was saying it was --
- 18 A. Yes.
- 19 Q. -- it was right for a transfer?
- 20 A. Sure. Sorry, I wasn't sure whether I was -- whether 21 I should say her name or not. It was Shelly. Shelly 22 Tomlins. And I remember she was actually shortly due to
- 23 be finishing at the Countess. And yeah, she was taking
- 24 care of our daughter on that night that that had
- 25 happened. And I just remember her saying, you know,

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1	that's the right thing to do, but I do remember the
2	image of her sitting at the desk behind the back of the
3	cot-side with her head in her hands. And the best
4	the interpretation I got from that was it was, like,
5	shock. And it was hard, because I do always remember
6	thinking: why is this something that you're it's
7	a hard thing to go through, but I do remember thinking:
8	why, as the nurse, do you look like you're struggling
9	with this, you know, so much? And that it was so
10	unexpected.
11	Especially for the time that I'd seen her before
12	then, you know, she was saying, "Oh she's had a really
13	good day, you know, she's been really stable." And she
14	was. We had been having a laugh, we'd had a joke and
15	a talk together, you know, because at that point our
16	daughter was doing fine. So we were sat by her bedside,
17	but we were just we were able to have a conversation
18	because there wasn't anything, you know, happening.

So we remember speaking with her and, you know, being there. And yeah, it just -- I just recall that image. It was like something that she hadn't seen, she hadn't expected to happen and, you know -- or that she hadn't seen before.

24 MR BAKER: Thank you, my Lady. I've no more questions. 25 LADY JUSTICE THIRLWALL: Thank you very much indeed,

so I'm asked to read a short statement:

"For the purposes of clarification in respect of evidence given yesterday in answer to questions from Mr Baker, I confirm the date of Child E's funeral was 12 August 2015 and the date of Child F's transfer from the Countess of Chester Hospital was 13 August 2015."

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

Ms Langdale, I think that concludes the evidence we're going to hear today.

11 MS LANGDALE: It does, my Lady.

LADY JUSTICE THIRLWALL: So we'll resume in this room next 12 13 Monday at 10.00. Thank you all very much. I'll rise

14 now.

MR BAKER: Thank you. 15

(12.41 pm) 16

> (The hearing adjourned until 10.00 am on Monday 23 September 2024)

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Mr Baker.

online to give such a clear and detailed account and a very thoughtful account of your experiences at the Countess of Chester Hospital. I hope you'll understand, in light of some of the evidence you gave towards the end of your evidence with Ms Langdale that it's not for this Inquiry to review the jury's verdict in any of the counts, and I won't be doing that in the case of Baby H. You're nodding. I'm glad you understand that. But I would like to thank you for the great assistance that you've given to me in coming to my findings and recommendations in the rest of your evidence.

Mother H, thank you very much indeed for being here

I know that it's not been easy for you to arrange to do this, because you have so many very real calls on your time, and so I'm particularly grateful to you for making yourself available and giving so generously of your evidence. Thank you. And you're free to turn us off now, if you'd like to.

20 THE WITNESS: Thank you.

21 LADY JUSTICE THIRLWALL: Now, Mr Baker, I think there's 22 something else you want to deal with.

Statement by MR BAKER

24 MR BAKER: Yes, there is indeed. It's a correction in 25 relation to the evidence of Mother E&F from yesterday,

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