

Monday, 23 September 2024

(10.05 am)

LADY JUSTICE THIRLWALL: Just before we start, I will remind those people listening online that the feed is going out live. If there are any breaches -- probably inadvertent breaches -- of any of the restriction orders, they must not be reported and any references will be deleted from the transcript before it is issued. Thank you.

Can I just say thank you very much for coming today to see me. I know that you will be nervous, so rather than keep you waiting any longer, I'm going to ask Ms Langdale to begin.

MS LANGDALE: Thank you, my Lady.

Mother J and Father J have provided to the Inquiry a joint written statement. They are both going to give oral evidence. I'm going to invite Mr Suter to have both witnesses sworn and I'll direct questions to Mother J and Father J as appropriate and occasionally they may defer or Mother J may defer for an answer to some questions. So if that meets with your approval, that's the way we propose to deal with the evidence.

LADY JUSTICE THIRLWALL: That seems very sensible. Thank you, Ms Langdale.

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meant that when things were changing, the nurses didn't see -- the same nurses weren't seeing those changes and picking up on those changes.

Q. Let's look now, if we may, at your background before having Child J. How was your antenatal care and treatment generally at that point?

MOTHER J: We had very good antenatal care with the Countess of Chester Hospital and also Liverpool Women's Hospital. We were cared for by their Fetal Medicine Team. I think it's -- which section is it in the -- I just refer back to the statement. Yes, number 10. We felt that we were in very good hands with the Fetal Medicine Team. They communicated the various concerns with the pregnancy and looked after us incredibly well.

Q. You refer there to Mr McCormack. He is of course the Consultant Obstetrician and Jill Ellis, is that a senior midwife?

MOTHER J: Yes, it's the late Jill Ellis, sadly. She was present with the majority of the scans with Mr McCormack.

Q. So you were very satisfied with that care?

MOTHER J: Yes, absolutely. It was a difficult pregnancy but we were well informed and when things were changing in the pregnancy. The team -- the people around us acted quickly and communicated really well

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MOTHER J (affirmed)

FATHER J (affirmed)

Questioned by MS LANGDALE

MS LANGDALE: Mother J, can you confirm that the statement provided to the Inquiry is true and accurate as far as you are concerned?

MOTHER J: It is.

MS LANGDALE: Father J, can you confirm likewise?

FATHER J: Yes, I can.

MS LANGDALE: Mother J, you provide various observations about the care provided to your child, Child J, both at the Countess of Chester and at Alder Hey Hospital. As a preliminary question, how did experience of both hospitals inform your understanding of the level of care that she was provided in each hospital?

MOTHER J: Sorry, can you repeat the question?

MS LANGDALE: If you look at paragraph 7, when you set out your experiences of the one hospital, how did experience in another hospital assist you in doing that?

MOTHER J: So we saw different standards in the care that the two hospitals -- Alder Hey Hospital had a very consistent team of nurses that looked after our daughter and at the Countess there were quite a different number of nurses involved in her care which

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with us, so we understood the decisions that we had to take and we felt informed and we were making them based on their experience and scope.

Q. You had to have laser ablation surgery, didn't you?

MOTHER J: Yes, I did.

Q. Would you like to tell us what that was about?

MOTHER J: Yes, so with twin-to-twin transfusion syndrome there was an issue with the blood supply to the two babies, so one baby gets far more blood than the other and then that obviously has an impact on the growth and survival, so it was picked up quite early by Mr McCormack and Jill Ellis and they had suspicions around week 13 that that could be something in the pregnancy and it did deteriorate really quite quickly.

They were keeping a close monitor on it and we were sent over to Liverpool Women's Hospital to the expert Surabhi Nandha to review us and they said that we would need to have the laser ablation at King's College Hospital in London which was a laser treatment to divide the blood vessels and to resupply the blood to both babies.

Q. Moving forward in time, you had a caesarian section, didn't you, in October?

MOTHER J: Yes.

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1 Q. Tell us how that came about and from your
2 perspective how that all went?

3 MOTHER J: Yes, the plan from Mr McCormack was to
4 try and get us to 34 weeks with a caesarian section
5 because of the complexities in the pregnancy. So we
6 knew that that was what we were aiming towards but
7 unfortunately that didn't happen and we got, you know,
8 32 weeks and two days so fairly close.

9 Q. How was Child J when she was born?

10 MOTHER J: Yes, she was -- she was breathing. They
11 showed her to us. There didn't seem a great deal of
12 concern and, yes, she seemed fine after the delivery.
13 We knew that she would go to the neonatal department
14 because of her prematurity but there didn't seem any
15 alarm bells going off immediately after the birth.

16 Q. Were you prepared for what happened with her
17 twin at that point?

18 MOTHER J: Not really. I think on reflection the
19 pregnancy had been so difficult, with lots of
20 uncertainty on whether my daughter would survive, that
21 it was very difficult to think about already carrying
22 a child that had died in the pregnancy.

23 Q. The initial neonatal care. Child J we know
24 was taken to Nursery 1 in an incubator on the neonatal
25 unit. When did you first get to go and see her and how

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1 fluid coming out of her mouth" and I was handed a tissue
2 or something and just -- I think I wiped her mouth, or
3 I think one of the nurses perhaps wiped her mouth and
4 that was the first sign that something wasn't quite
5 right.

6 Q. You said you had been told about necrotising
7 enterocolitis, "and we knew it was potentially very bad
8 but the neonatal team did not know for sure" if she had
9 that, and in fact she didn't turn out to have that, did
10 she?

11 MOTHER J: Difficult one to answer that, really,
12 because I think they had mixed views on it maybe.

13 Q. At the time was that being expressed to you,
14 mixed views about whether she did or didn't? Don't
15 worry if you don't know the answer.

16 MOTHER J: Maybe Father J could answer that
17 question.

18 Q. Do you remember that, Father J?

19 FATHER J: Yes, because I was up and down to the
20 unit between my wife and our daughter. Initially they
21 weren't sure whether it was NEC. However, that did come
22 up as a possibility when they looked at x-rays and I can
23 remember them showing me the x-rays. They were also
24 concerned that if it was NEC they wouldn't be able to
25 deal with it, so they worked on the assumption that it

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1 easy was it to do that?

2 MOTHER J: So I think we can refer to
3 paragraph 16 ... yes, we -- we went to see her. I think
4 it was around about 6 o'clock in the evening that we
5 actually got to see her in the incubator and that
6 process was quite easy. I think I went off to the
7 maternity ward and then came back down to see her once
8 I had had my things in there.

9 Q. Sorry, I didn't quite catch -- once you had
10 had --

11 MOTHER J: My things in the room. So I think
12 I went up to the room for a short period of time and
13 then came down to see her in the neonatal unit.

14 Q. You went together to do that?

15 MOTHER J: Yes, yes.

16 Q. What were you told about her when you got
17 there, if anything?

18 MOTHER J: I don't recall having a conversation.

19 Q. You make reference to her bringing up some
20 brown fluid. Was the conversation about that?

21 MOTHER J: Yes, so we had a conversation about
22 that. So I just remember that not long after I arrived
23 and saw her in the incubator, she just all of a sudden
24 started to bring up some brown fluid and I called the
25 nurse or my husband and said "Oh, she has got some brown

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1 could be NEC and therefore they referred to Alder Hey at
2 that point. It was already quite late in the evening so
3 I remember there was a lot of phone calls and activity
4 and they did keep us updated and then the decision was
5 to take our daughter to Alder Hey, which they said was
6 a precaution but if there was a problem, Alder Hey was
7 the right place to be. So it seemed like -- so it was
8 extremely stressful. It felt like the right decision to
9 us and turned out to be the right decision.

10 Q. Mother J, you say:

11 "A little later ... a neonatal nurse visited me on
12 the ward and asked what we would be calling Child J's
13 sibling on her death certificate."

14 You say that hadn't been discussed with you before
15 and you think it probably should have been, looking
16 back.

17 MOTHER J: Yes, we weren't aware that -- because
18 our other daughter had been born into the world that she
19 would be given a name and I think the only way that
20 I could deal with the situation the day after the
21 surgery was to think of it like a miscarriage because it
22 was incredibly painful to carry on a pregnancy whilst
23 carrying a child that had died, so I wasn't really
24 prepared for that situation, which, you know, you can
25 look at things in hindsight, can't you, and perhaps we

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1 could have asked some questions around the births, but
2 we were so concerned that our other daughter really
3 wasn't going to make it into the world that we felt it
4 quite difficult to be dealing with that as well.

5 **Q.** In fact you say you were asked if you would
6 like a priest to visit so you could have Child J
7 christened prior to transfer and surgery?

8 **MOTHER J:** Yes.

9 **Q.** You say "well-meaning", but that was quite
10 stressful?

11 **MOTHER J:** Yes, because I think when you're in that
12 stressed state and, you know, our daughter was going to
13 surgery, that you're into a world that is very unknown,
14 uncertain situation and probably your mind goes to the
15 worst case scenarios and, you know, at that point I was
16 thinking that she probably wouldn't make it through the
17 surgery and that's why they were asking whether we would
18 like to get her christened. So that made me feel very
19 stressed and worried then that the outcome wasn't going
20 to be a positive one.

21 **Q.** You say at paragraph 18:

22 "We are sharing this information in case it helps
23 the NHS to prepare parents going through a similar
24 pregnancy to ours so parents can make some decisions
25 earlier in the pregnancy to remove making important

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1 with -- neither of us really had any sleep, I didn't
2 have any sleep for a couple of days, but they were --
3 they were extremely professional when we got to
4 Alder Hey as well so that was very comforting, that
5 aspect of it.

6 **Q.** How did you feel, Mother J, that you weren't
7 able to go to Alder Hey with your daughter?

8 **MOTHER J:** Well, incredibly upset and isolated and
9 just removed from something that was so serious and our
10 daughter is so precious that I felt pretty helpless.

11 **Q.** What did you hear about how her operation had
12 gone?

13 **FATHER J:** If it's okay for me to answer. I was
14 staying in a room at Alder Hey, so the surgeon -- I was
15 getting some information back but of course during
16 surgery I didn't get any information back so it was just
17 a case of waiting. The only way we could get
18 information is I was contacting my wife to update her
19 which was quite a difficult experience because I was in
20 a hospital setting at Alder Hey that was -- I wasn't
21 really getting a great deal of information because of
22 the nature of the fact that we were in surgery. So
23 I think neither of us really knew what was going on but
24 we understand that that's probably part of the process
25 that you have to go through, but it was quite difficult

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1 decisions so soon after giving birth when they could be
2 experiencing extremely stressful circumstances and
3 uncertainty."

4 The transfer team then, so we know Child J was
5 transferred to Alder Hey in the early hours. Who is
6 best able to say how it was with the transfer team?

7 **MOTHER J:** I think Father J.

8 **Q.** Father J, how did that work?

9 **FATHER J:** The transfer team, if I remember
10 correctly was a regional transfer team who came with
11 their own equipment and then our daughter was prepared
12 for the transfer which takes some time. The transfer
13 team seemed extremely professional and -- but it's quite
14 a daunting experience because they come with -- they
15 come with a special incubator which just -- even now we
16 struggle to look at the photographs, but they were
17 supremely professional and they took their time, they
18 were very calm and our daughter was finally transferred.

19 It's quite a stressful experience and especially in
20 the situation that we were in as parents in that I had
21 to leave my wife in the Countess of Chester and follow
22 the ambulance to Alder Hey and try and collect some
23 clothes and we had other things that we needed to
24 organise at home and that you're not prepared for in
25 these situations, so I followed the ambulance on my own

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1 to contact each other.

2 **Q.** You -- we know that Child J was in Alder Hey
3 for ten days at that time. At paragraph 24 you set out
4 some examples of excellent care or positives that you
5 noticed about Alder Hey. Would you like to tell us what
6 those were?

7 **FATHER J:** Yes. I will refer to my statement and
8 read some of them, if that's acceptable.

9 **LADY JUSTICE THIRLWALL:** Yes, of course.

10 **FATHER J:** So the main positives that we noticed,
11 they had the meticulous record-keeping, attention to
12 detail. They were happy to explain what was happening
13 and answer questions. They were very willing to
14 communicate with us and understood we felt more at ease
15 when we understood the detail, and we felt like they
16 were very good at adapting their communication style
17 based on the parents' style of communication. So just
18 to elaborate there they treated us quite
19 collaboratively. They realised that we liked to know
20 what was happening and the Consultant -- the surgeon,
21 the Consultant Surgeon and the nursing staff would hold
22 their discussions in front of us, which was extremely
23 helpful so we could understand the flow of information
24 between them and it was clear that the nurses that were
25 very, very skilled and knowledgeable as well which gave

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1 us comfort.

2 **Q.** Sometimes they describe it as "a huddle" when
3 they are all grouped together. Was that the kind of
4 situation and you could be part of it or what?

5 **FATHER J:** Yes and one feature of the new Alder Hey
6 was that you had a relatively large room for each baby,
7 which had a sliding door which could be shut, so the
8 people who needed to be in there would come in there and
9 you would -- you were all involved in the same
10 discussion, which was -- which seemed very -- a great
11 way of dealing with parents, to us.

12 They also had -- as my wife mentioned before -- the
13 same staff care for the same baby, so they knew the
14 patient history, so they tried quite hard to keep -- to
15 keep the same nurses on whilst not -- whilst -- hard to
16 explain. They would make sure that other nurses were
17 involved so there wasn't just single nurses who knew
18 what was going on but they tried to keep the main nurse
19 the same all night, for example.

20 They also recognised that we had lost our
21 daughter's twin and they were extremely empathetic about
22 that and very sensitive around it.

23 They encouraged us to take breaks and stressed the
24 importance of looking after ourselves so we were fit and
25 healthy to look after Child J because that's something

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1 were taking the right steps and doing the right things.

2 **Q.** How difficult did you find it emotionally and
3 physically, the first time doing it?

4 **MOTHER J:** Yes, the first time we did it, it was
5 incredibly emotional. We were obviously parents and
6 we're not nurses and the process of putting a small tube
7 into her bowel and being concerned it might hurt or
8 damage -- hurt the child or damage the stoma was
9 incredibly stressful and I think we were obviously quite
10 anxious at that time because we had just been through so
11 much during and then after the pregnancy.

12 **Q.** At this time we understand from paragraph 28
13 the plan was to try and get you back to the Countess of
14 Chester to be nearer home. Was there any indication
15 that there was concern at Alder Hey that, for example,
16 there wouldn't be an ability to manage the stoma or the
17 care required for your daughter at that point?

18 **MOTHER J:** No, no concern. Alder Hey said they
19 would contact Chester and check that they could do the
20 recycling which is quite an important part of the
21 process, so they made the contact and Chester said that
22 they could do that and they were comfortable with that
23 decision, so plans were made to return to Chester.

24 **Q.** Did you understand they had a stoma team at
25 the Countess of Chester who would be responsible for her

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1 that as scared and worried parents, it's very easy to
2 not look after your own health in those situations, for
3 example, not eating, not sleeping, not wanting to go to
4 sleep because you're worried about what might happen.

5 They gave us reassurance it was okay to go and
6 leave Child J and rest and that we felt she was safe
7 with them. They also made sure that we knew when the
8 consultant or surgeon was coming round so we could ask
9 questions so that was quite a formalised process and the
10 consultants and nurses, as I said before, openly
11 discussed things in front of us and included us in the
12 conversations.

13 **Q.** Training of care.

14 So you had to have some stoma care training,
15 didn't you, in readiness for transfer back to a district
16 hospital and then ultimately to home? Can you tell us
17 about that, how you received that training and how you
18 were facilitated in that process of care for your
19 daughter?

20 **MOTHER J:** So the nurses at Alder Hey took us
21 through the process and we watched them and then we
22 would take part in the process and they would then check
23 what we were doing and they were just very patient and
24 encouraging and recognised that it wasn't an easy
25 process to do to a child but they reassured us that we

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1 care, effectively?

2 **MOTHER J:** That wasn't shared with us.

3 **FATHER J:** Shall I answer that?

4 **Q.** Sorry, can you say that again?

5 **FATHER J:** Is it okay if I answer that question?

6 **Q.** Yes.

7 **FATHER J:** Yes, they told us that they -- my
8 understanding was that they did have a stoma team and
9 that there were nurses who were sufficiently trained in
10 stoma care and we didn't discover what that meant until
11 the trial in fact in terms of what level of staff and
12 according to the NICE guidelines who should and
13 shouldn't be able to look after stomas. That wasn't
14 explained to us at the time but we learned that later.

15 **LADY JUSTICE THIRLWALL:** Sorry, Ms Langdale, just
16 for clarification, you say they told us that they did
17 have a stoma team. Was that Alder Hey or the Countess?

18 **FATHER J:** At the Countess. So at Alder Hey, the
19 process was that Alder Hey had called the Countess of
20 Chester. They had confirmed to them and then they
21 subsequently confirmed to us that they had a stoma team.
22 It wasn't clear to us at the time that it was an adult
23 stoma team, however, and that they didn't have
24 a specialist neonatal stoma care team but the nurses
25 were supposedly trained at stoma.

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1 Q. When you were still at Alder Hey discussing
2 the transfer back to the Countess of Chester, what was
3 the overall plan? What were they telling you in terms
4 of how much weight she needed to gain, whether you would
5 get to the stoma reversal point, what was the big
6 picture thinking at that point?

7 FATHER J: There was a plan for her to gain around
8 a kilo in weight and the reason for that was it makes
9 the reversal operation easier and there was a number of
10 other aspects, one of those was that the stoma recycling
11 from the bag was a key component in this, make sure
12 there's a regularity of feeds and that the volume was
13 increased over time and this was explained to us that by
14 transferring from one stoma to another it allowed the
15 lower part of her intestine to also grow which would
16 help later on when we reconnected. They gave us an
17 indication of around 9 to 12 weeks although they did say
18 that was something they would have to review depending
19 on progress.

20 Q. How much did they want her to put on weight
21 per week?

22 FATHER J: Yes --

23 MOTHER J: A pound a week.

24 Q. So the expectation was a pound a week, milk
25 volumes presumably having to increase for those

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1 involved so that then puts us in a little bit of
2 a difficult situation then because we didn't want to
3 reach out to the Alder Hey dietician based on that
4 information.

5 Q. No. So you go back to the Countess of Chester
6 on 10 November, Baby J goes back. Did you have any
7 discussions with the dietician there subsequently?

8 MOTHER J: No.

9 Q. They didn't identify themselves to you or you
10 didn't --

11 MOTHER J: We didn't -- we requested to see the
12 dietician on a couple of occasions and that never
13 happened.

14 Q. You say in your statement, at paragraph 36,
15 that the physical infrastructure was very different when
16 you got back to the Countess. Baby J had come back in
17 an ambulance. You are there, you say, standing at
18 a desk in front of two nurses. What was obviously
19 different about the two places?

20 MOTHER J: I think the style of communication was
21 very different to what we had experienced at Alder Hey,
22 so Alder Hey was very professional, but very empathetic,
23 just -- I feel like they put themselves in the shoes of
24 the parents. I think they understood that being in
25 hospital is a stressful experience and an unknown

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1 purposes?

2 FATHER J: Yes. I mean the correlation between
3 pound a week and the total amount that they said was the
4 minimum amount they needed was significantly different,
5 so we weren't concerned at that point that we wouldn't
6 achieve the minimum weight gain.

7 Q. Did you speak with a dietician at Alder Hey,
8 and whichever one of you did answer the question
9 perhaps?

10 MOTHER J: Yes, we did speak to the dietician.

11 Q. What was the dietician's advice?

12 MOTHER J: The dietician said it was really
13 important to monitor the output from the stoma because
14 the consistency -- any changes in consistency should be
15 reported, colour should be reported, and yes, she was --
16 I think she did refer to the weight gain side of things
17 as well. If our daughter wasn't putting on weight that
18 should also be a red flag and raised.

19 Q. Did the dietician say you could get in touch
20 with her if you needed follow-up or information?

21 MOTHER J: She did.

22 Q. Did you ever do that?

23 MOTHER J: We didn't because we mentioned that to
24 the team at the Countess and they said they had their
25 own dietician and they would get their own dietician

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1 environment to go into. It felt like they were very
2 sensitive, whereas I felt like when we arrived at the
3 neonatal unit at the Countess it wasn't such a warm
4 reception, but it was a professional reception, so
5 I guess it's -- when you're going from one place to
6 another and transitioning it's about making everybody
7 feel at ease and familiar because we knew that our
8 journey with them was going to be for some time.
9 Q. Paragraph 41 you say in the statement:
10 "We tried to let them know what Child J's routine
11 had been whilst at Alder Hey and reiterated the things
12 that had been stressed to us as important before we left
13 but they seemed quite disinterested in this information.
14 The feeling we got from the nursing team was that there
15 was a Countess of Chester way of doing things and that
16 was the way it would be done regardless of what had been
17 said to us at Alder Hey."

18 Can you elaborate on that?

19 MOTHER J: Sure. So it felt like when we left
20 Alder Hey we were in a very positive position, with
21 a good plan that was clear. Our daughter had been --
22 she made excellent progress despite the adversity
23 against her, surgery, stomas, all of those things, but
24 she was progressing really, really well, so we felt
25 comfortable with the information that they had given to

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1 us and that we were planning on following that because
2 we knew that we would be doing this process at home,
3 that had been the expectation that had been clearly set
4 to us, so when we started to share that it wasn't really
5 taken in the way that we expected, which was that would
6 just continue. It was very much "Well, you're here now
7 so" --

8 **Q.** So when you arrived, did they do more of the
9 stoma care initially than you had been allowed to be
10 part of at Alder Hey, or how did it work?

11 **MOTHER J:** Yes. There was a 48-hour period of
12 infection control where our daughter remained in an
13 incubator so they were involved in the care then. We
14 didn't get involved in the care for the first 48 hours
15 but we were monitoring what -- closely what was
16 happening because we had seen what had happened at
17 Alder Hey and seeing how they measured everything that
18 was going on and --

19 **Q.** Do you mean the measured outputs and inputs?

20 **MOTHER J:** Yes, outputs, inputs, consistency,
21 colour, of the stools, you know, everything that was
22 done there wasn't immediately done at the Countess and
23 that straight away made us concerned because we had left
24 with having a conversation with the dietician saying
25 that these are the things that should be closely

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1 journey with them, we were monitoring carefully feeds,
2 we were giving a lot of the feeds ourselves and one of
3 the things they did at Alder Hey would be for example
4 measure fluids in, weigh nappies out and then we would
5 know how much had been recycled of the stoma so it was
6 a fairly simple concept, but they weren't following it
7 with the same -- with the same attention to detail.

8 **Q.** Paragraph 43 you say:

9 "Although Child J was recovering well she wasn't
10 gaining weight at the rate we were told to expect by the
11 Alder Hey specialist. We know retrospectively from the
12 records that they were noting that weight needed to be
13 reviewed and there was suboptimal weight gain, but we
14 didn't see any positive actions to address this. We
15 couldn't access the donor milk to top up feeds for
16 Child J feed her ourselves on time. We could only
17 access our own milk from the communal fridge which
18 contained boxes labelled with the child's name."

19 Would you like to expand on that, Mother J?

20 **MOTHER J:** Sorry, I think ...

21 **Q.** Don't worry, paragraph 43.

22 **LADY JUSTICE THIRLWALL:** Just take a minute to have
23 a look. There's no rush.

24 *(Pause)*

25 **MOTHER J:** Yes, so there was a weekly weigh-in. It

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1 monitored.

2 **Q.** So were they measuring fluid in and fluid out
3 or --

4 **MOTHER J:** It will probably be best that my husband
5 answers that question because that was a conversation
6 that took place.

7 **FATHER J:** They weren't measuring in the same way
8 that Alder Hey was, that's for certain. There was
9 a later interaction that I had with one of the
10 Registrars where we had a basic disagreement which was
11 slightly later in our journey about that specific lack
12 of measurement and not following the same procedure
13 where I questioned why it wasn't standard procedure and
14 didn't -- and felt brushed off and quite honestly
15 slightly condescended, in a case of "You just don't
16 understand", which is frustrating when it's your child
17 because --

18 **Q.** What was it suggested you didn't understand?

19 **FATHER J:** Just -- the actual phrase -- I remember
20 the phrase being used: "that's not how babies work".
21 I distinctly remember the phrase because it really stuck
22 with me because I was quite irritated by it. What was
23 happening is we were finding there was -- the weight
24 gain wasn't at the rate we were expecting and it
25 started -- this is slightly later, a few weeks into the

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1 was on a Thursday and for us that was a particularly
2 important day of the week because you're doing all of
3 these things to make -- really the goal is to take your
4 child home and at the right time, but as quickly as
5 possible because a hospital setting is not a home
6 setting and we were really keen to be able to get her
7 home as quickly as possible, so I just remember being
8 quite disappointed when we had had that weigh-in and it
9 would be, you know, tiny, tiny weight gains that we were
10 seeing which was frustrating but also it felt like going
11 home was being pushed further away from us and then
12 surgery, reversal surgery, you know, who knew how long
13 that was going to be then. So I think there's quite
14 a focus on the weight gain because we knew really that
15 that would get us to a point where we could have the
16 reversal surgery and hopefully life would be a little
17 bit different after that, so it was frustrating that
18 when there were busy times on the ward that we were
19 waiting to get the donor milk and then -- I recognise
20 that every place of work gets busy and it can be very
21 challenging at times and people are trying their best to
22 split their time and manage their priorities, but for us
23 I think it's just -- it was quite frustrating because we
24 knew that the weight gain was such -- would change,
25 you know, the time we would be in hospital and getting

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1 our child home.

2 **Q.** You say in that paragraph:

3 "There were days when the feeds and medication
4 would be so delayed she essentially missed that feed.
5 We were monitoring this in the daytime and trying to
6 keep her on track but could not influence this at
7 night."

8 So what were you doing in the day? Either or both
9 of you can comment on that.

10 **MOTHER J:** So I would arrive on the ward about
11 8 o'clock in the morning and stay there until 6 to
12 8 o'clock at night.

13 **Q.** Were her feeds late when you were there in the
14 day?

15 **MOTHER J:** Yes, on occasions the feeds were late.

16 **Q.** Why was that?

17 **MOTHER J:** I think pressure on resource, is what
18 I was hearing at the time.

19 **Q.** You say:

20 "Whilst this was unlikely to be endangering her
21 health it was slowing down her weight gain."

22 **MOTHER J:** Yes, well, you know, when a child is
23 hungry, they want their food now and, you know, waiting
24 5, 10, 15 minutes is probably acceptable. An hour on
25 a child that's very premature is not an acceptable time

25

1 skill to cut it so that no skin was exposed because the
2 output from the stoma was actually -- very easily
3 irritates the skin so it was necessary to make sure that
4 the stoma bag was cut in such a way that only the stoma
5 trickled through, and as you can probably imagine on
6 a busy ward with babies crying, needing feeding and,
7 you know, pressures on the staff constantly, we were
8 making templates for the bags such that when we weren't
9 there the nurses didn't have to necessarily think about
10 what they were doing in terms of cutting the bags, they
11 could just cut them to a template and stick them on
12 which was intended to save them some time.

13 **Q.** So it was fair to say that you were both very
14 involved in the feeds and care of Baby J at this time?

15 **FATHER J:** In the daytime we were extremely
16 involved, yes.

17 **Q.** You say at paragraph 47 on 23 November Baby J
18 was moved to Room 4, the room requiring the least
19 observations, and you were told to prepare to go home
20 and how this would work.

21 Mother J, what was your expectation around this
22 time?

23 **MOTHER J:** That there was a process that was in
24 place for actions that would be taken in order for us to
25 complete the discharge process.

27

1 to wait.

2 **Q.** Father J, you were working with nurses to
3 create templates to get a better fit underneath the
4 stoma bag. Tell us what you were doing?

5 **FATHER J:** Yes, we -- because there were a lot of
6 aspects to both the feeds and stoma care which were --
7 the feeds not being particularly unusual, but important
8 and the stoma care being, you know, quite challenging,
9 we were basically monitoring everything and trying to
10 help where we could, not only because we wanted to help
11 but because we knew this was something we would have to
12 do at home, or was likely to be something we would have
13 to do at home. The original plan was that our daughter
14 would gain sufficient weight and be stable such that we
15 could take her home. That was expected to happen within
16 weeks, not months, so we were conscious that we needed
17 to know exactly what we were doing as well.

18 So we were monitoring the feeds, which at that
19 point -- were two hours originally and we were also
20 helping with the stoma care and to do that we were
21 making templates for the stoma bags. The stoma bags
22 were probably not at that time appropriate for neonatals
23 because they just weren't small enough, so you had
24 a stoma bag that was probably too large and it took
25 quite some skill to make it stay on, it took quite some

26

1 **Q.** How was she at this time, how well did she
2 seem?

3 **MOTHER J:** Yes, she was incredibly well. I was
4 very keen to breast feed so we had had one of the nurses
5 from the Breast Feeding Team come down to see us, try to
6 breast feed which was a little bit of a challenge
7 because of the situation with the stoma but she was,
8 you know, feeding well. There were -- yes, just seemed
9 to be quite happy, just the challenge of the weight gain
10 really but still, you know ...

11 **Q.** You say in this paragraph:

12 "Child J had been taken off the monitor and we were
13 told she would not be put back on it. However, the
14 notes collected by our solicitors say the staff put her
15 on the monitor at night on 23rd to 24th. On the evening
16 of the 24th I stayed over and did cares and feeds to
17 practice for being at home and to prepare Child J for
18 this also."

19 Do you remember whether she was on a monitor at any
20 point at this time? Would you have been told whether
21 she was or not?

22 **FATHER J:** I think --

23 **Q.** Father J?

24 **FATHER J:** Yes. We were told that she wouldn't be
25 on a monitor but we did know that other babies were

28

1 sometimes put on monitors. Why that was -- and this is
 2 probably just pure speculation -- was that the Room 4 --
 3 they would often leave the babies in Room 4 and it would
 4 be lights off and, you know, they -- because they were
 5 essentially on their way home, they were kind of left on
 6 occasions at nighttime and I suspect that sometimes they
 7 put them back on monitors if they were leaving for
 8 a long time. I don't know if that's the case, however,
 9 and we only know that we were told our daughter wasn't
 10 going to be on a monitor because we had some anxiety
 11 over that initially because when you have had a child
 12 that's been on a monitor for weeks and weeks and
 13 suddenly isn't, that gives you some --

14 **Q.** What kind of monitors -- I suppose we should
 15 be clear what kind of monitor?

16 **FATHER J:** This is a sats monitor and heart rate
 17 monitor. Yes, so we were told she wouldn't be on
 18 a monitor at night but the notes have told us that she
 19 was on the monitor on occasion.

20 **Q.** You say at paragraph 49:

21 "By 25th November she had been increased to larger
 22 four hourly feeds and her stoma was healthy, and she had
 23 a soft abdomen which was a healthy sign."

24 Thursday 26 November you have pictures of her
 25 looking well and taking full bottle feeds and you had

29

1 **Q.** Does she have one?

2 **MOTHER J:** She did have a bath in the end but the
 3 nursing assistant said to me at the time that she wasn't
 4 any different to any other babies on the ward and that,
 5 you know, she should have a bath because that's part of
 6 the process. I still didn't feel comfortable with the
 7 way that that was put across and one of the more senior
 8 nurses got involved and she did bathe her, but I just
 9 feel that that could have been handled a lot
 10 differently.

11 **Q.** That night and over the early hours of Friday
 12 27 November 2015 you now know that that's when Child J
 13 collapsed on a number of occasions. We know, of course,
 14 my Lady, Letby was charged with an attempted murder of
 15 Child J but the jury could not agree on that count.
 16 What and who first heard about Child J collapsing that
 17 night? Who is best able to tell us about that?

18 **MOTHER J:** My husband can probably answer that
 19 question.

20 **FATHER J:** Yes, so we were planning on going in as
 21 normal because at this stage we were expecting to take
 22 our daughter home imminently. We had basically
 23 performed most of the tasks and procedures that they
 24 wanted us to do before we took our daughter home, so we
 25 got a call in the morning and one feature of the calls

31

1 messaged friends and family saying her NG tube had been
 2 removed as she no longer needed it. What were these
 3 things all being done in preparation for?

4 **MOTHER J:** For taking her home.

5 **Q.** At that time did she seem stable and ready
 6 enough to go home?

7 **MOTHER J:** Very, yes.

8 **Q.** You say one of the discharge readiness check
 9 items, Mother J, was for the baby to be bathed. How was
 10 that handled? Obviously she had her line, she had her
 11 stoma, Broviac line in situ, wearing the stoma bag. How
 12 was that handled?

13 **MOTHER J:** Yes, there was a lot going on with her,
 14 with the Broviac line and the stomas, so I was a bit
 15 concerned about her having -- or being bathed and the
 16 nursing assistant at the time didn't really -- couldn't
 17 really see that I was feeling quite stressed about that
 18 because we were informed all along the way that
 19 infection was the biggest threat to these neonates.

20 **Q.** To be clear, did she ever get an infection?

21 **MOTHER J:** On the -- later on in the journey,
 22 before we left the Countess, when she was very poorly.

23 **Q.** At this point -- carry on, at this point you
 24 have the bath, you have the conversation about the bath?

25 **MOTHER J:** Mm-hm.

30

1 from the hospital was that they often came from
 2 a withheld number, so I answered the call. It wasn't
 3 a long discussion. They said we had to come straight in
 4 because our daughter had been resuscitated. It was --
 5 it wasn't a long discussion. We just got straight in
 6 the car and left. We later discovered that actually
 7 they didn't tell us at the time the full details. They
 8 told us that she had had a collapse and been
 9 resuscitated. There was a series of collapses, we
 10 discovered later in the court case, so obviously we had
 11 been called at the end of that process and not at the
 12 start -- and not nearer the start of that process.

13 **Q.** Just dealing with what you were told at the
 14 time, not what you learned subsequently, so you go to
 15 the hospital, do you see any medical records at that
 16 point?

17 **FATHER J:** No.

18 **Q.** So you're having a conversation with a doctor,
 19 a nurse, who tells you about it?

20 **FATHER J:** I don't remember specifically which
 21 doctor or nurse told us at the time when we arrived.
 22 I think there was quite -- it was quite a stressful
 23 situation, there was quite a lot of people running
 24 around. There was a conversation later on with
 25 Dr Gibbs. It wasn't a formal debrief as such. He told

32

1 us what had happened. I understand there were some
2 other things happening on the unit as well at the same
3 time which was causing quite a bit of stress for the
4 staff which had happened after our daughter's collapse,
5 so it was understandable that -- they were clearly quite
6 busy.

7 **Q.** Paragraph 62, if I can take you to that,
8 Father J. This is a record of messaging friends about
9 the discussion, so, first of all, are these notes here
10 what you said at the time in messages? Can you see?

11 **FATHER J:** Yes, so --

12 **Q.** So see what you told -- what you said about
13 that.

14 **FATHER J:** Yes, so I had messages to friends and
15 family describing the conversation with Mr Gibbs and he
16 had said that they were investigating the possibility
17 that it could be sepsis, it could be an epileptic
18 seizure or it could be sleep apnoea and those were the
19 three primary areas that they were going to investigate.

20 He explained that when he attended for the -- he
21 had attended personally for the desats at 06.56 and
22 07.24 where our daughter -- you will have to excuse me.
23 It is quite difficult, this.

24 **Q.** Shall I read the message?

25 **FATHER J:** No, it's fine. She went stiff and her
33

1 earlier records and notes about --

2 **FATHER J:** Yes, and we discovered about the --
3 there was actually a series of collapses and not just
4 the collapse that we were told about. We learned
5 a little bit more about the type of collapse. We also
6 learned that, by listening to the other cases, that the
7 length and duration of a collapse like that had
8 resulted -- the description had been very similar to the
9 collapse of other children who had very sadly had been
10 left with permanent disabilities, so that was quite
11 a shocking and distressing thing to hear.

12 We also never -- Dr Gibbs -- Dr Gibbs was always
13 somebody who we found to be very easy to communicate
14 with and extremely professional. Even by his own
15 admission later on when we had contact with him he was
16 never able to explain the collapse to us and his -- the
17 subsequent investigations had ruled out pretty much all
18 the things that he suggested it could be.

19 **Q.** You say at paragraph 64:

20 "They gave Child J a blood transfusion and
21 antibiotics in case there was an infection but after
22 tests they ruled out sepsis and the records show there
23 was no sign of infections in bloods as the CRP was zero
24 and so they stopped the antibiotics."

25 **FATHER J:** Yes, so they were adamant that it wasn't
35

1 eyes rolled back and she was clenching, I remember that
2 description, and once they brought her back she took
3 a very long time to settle. He -- that's why Dr Gibbs
4 said he thought potentially seizure and Dr Gibbs had
5 a specialty in epilepsy and he said it looked very
6 similar.

7 He seemed quite distressed but we knew also there
8 was an emergency with twins on the ward that morning, so
9 we put that down to having a difficult morning.
10 Dr Gibbs was usually very calm and collected so we were
11 actually very concerned at this stage that he couldn't
12 explain what had happened but they did then go on to
13 perform a number of tests on our daughter to try and get
14 to the bottom of what had happened.

15 **Q.** So just -- I can pick up, if I may, Father J,
16 paragraph 62 Dr Gibbs had said:

17 "... he didn't really know what the problem was and
18 why Child J had collapsed but he had said they were
19 investigating" -- you have already set that out -- "the
20 possibility it could be sepsis, an epileptic seizure or
21 sleep apnoea."

22 So he wasn't sure why she collapsed. You learned
23 in the trial further details about the final -- or the
24 collapse, the muscle spasms and the collapse. Is that
25 when you also found out the records that there were,
34

1 an infection. That was one thing which was clear which
2 is why we were very concerned for years afterwards that
3 our daughter had -- would potentially have another
4 seizure at some point because they said it wasn't -- it
5 absolutely wasn't sepsis, that was clear, and it wasn't
6 just a generalised infection, they made that quite
7 clear, from the tests.

8 **Q.** Was there any formal debrief later on, so not
9 just on the morning, but later on with you or any of the
10 nurses and doctors about that collapse or what had
11 happened or not?

12 **FATHER J:** There wasn't. We didn't ever have
13 a formal debrief and, as I understand it, I don't think
14 there was ever a formalised review or record made or we
15 have yet to be made aware of one.

16 **Q.** Child J was moved from Room 4 back to Room 2
17 for closer monitoring, you say at paragraph 68 and Child
18 J's father and you, Mother J, stayed in the parents'
19 room on the ward that night and the next day. How did
20 Child J do then?

21 **MOTHER J:** Yes, she made quite a quick recovery,
22 was keen to start her feeds, we could tell that she was
23 very hungry and that process was always quite slow
24 because they were being cautious but she -- from seeing
25 her in one situation 24 hours earlier where she looked
36

1 dreadful, she came back to how she was before really
2 quickly.

3 **Q.** We see from paragraph 70 Letby writing up
4 Child J's notes that night along with Child J's
5 observation, says:

6 "Parents had Child J out for cuddles and pleased
7 that she is starting feeds. Appeared happy this evening
8 and understands care being given to Child J resident on
9 the unit overnight."

10 In terms of the night before, you make an
11 observation about CCTV at paragraph 65, going back in
12 your statement, and say:

13 "We will never know the truth. It is for this
14 reason we believe babies should be monitored using
15 technology such as CCTV."

16 What's your view about that?

17 **FATHER J:** Yes, I believe that generally in this
18 period CCTV would have answered a number of questions
19 and that that probably will remain unanswered forever
20 for a number of parents. I think one thing that's
21 become clear is that note-taking I personally believe
22 wasn't as accurate as it could or should have been.
23 There are a number of areas where CCTV could have
24 helped, for example, even where nurses -- who is
25 covering who during the breaks, because that didn't seem

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1 We just really couldn't understand how a child could go
2 from being so well to then not breathing and requiring
3 resuscitation. It just didn't sit well with us at all.

4 **Q.** By 8 December, you record here that she was
5 weighing 5 lbs 1 oz, which was increasing but not at the
6 weight you were told to expect and it's at this time,
7 Father J, that you have the conversation about the
8 meticulous or not recording of fluid in and out. Were
9 you worried about that at this time?

10 **FATHER J:** I was, mainly because we had become --
11 we had become hypervigilant at this point because we
12 had -- we had an unexplained collapse. We were
13 concerned that something wasn't going right and probably
14 quite naturally we were looking at everything that could
15 be improved upon to try and help our daughter's journey.

16 One thing that had happened at this point was we
17 were expecting to go home and we had had a sudden
18 unexplained collapse and we were obviously at this point
19 I think scared is a fair phrase to use. We were scared
20 that we would take our child home and she would have
21 a collapse at home and we would be unable to deal with
22 it, knowing what they had had to do to keep her alive,
23 you know, we were really frightened of taking her home
24 and her not surviving being at home with us.

25 One -- I think this is the type of scenario where

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1 to be noted. It would have been much easier to know who
2 was where when.

3 I think there's -- there's a concern generally in
4 society about the amount of CCTV we have but this is the
5 most vulnerable members of our society, our babies and
6 the elderly, and in those cases I personally believe
7 they deserve the right to be protected in any way that
8 is necessary and people who are working in those
9 settings, that should be part of that -- they should
10 accept that as part of them wanting to do the right
11 thing and be in an environment that is 100% dedicated to
12 the patients and their safety.

13 **Q.** You say -- going back to 71 -- this is how she
14 is at the end of November. You say: Child J underwent
15 tests on her heart, brain and bowel to check for
16 underlying conditions, chest, abdominal x-rays, cranial
17 ultrasound, ultrasound scans of her abdomen and a blood
18 transfusion. You message friends on 30 November saying
19 she was fine and handling well, pictures of her out of
20 her cot with no NG tube and yet here she was being put
21 back in a cot and taking full feeds again.

22 At that stage what did you think that had been, the
23 collapse on 27th or -- did you think it was a blip or
24 a condition, what were you thinking?

25 **MOTHER J:** It just never really made sense to us.

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1 you feel quite helpless and do everything that you can
2 to try and -- in your power to try and improve things,
3 so we were asking questions about why -- you know, why
4 certain methodologies weren't being followed, we were
5 monitoring, we kept a notebook of the times of feeds, we
6 kept a notebook of the times of supplements being
7 delivered. We noted that some nurses had missed some
8 supplements and again whilst these weren't in any way
9 life-threatening actions, to us it demonstrated a lack
10 of attention to detail which perhaps not only affected
11 care but could have been helpful in highlighting issues
12 for other parents later.

13 **Q.** You say in the statement at paragraph 78 that,
14 Mother J, you knew you could contact PALS but despite
15 you having these concerns, both of you, you didn't
16 contact PALS. You were aware of who they were but you
17 didn't pass your concerns about the inattention to
18 detail around feeding to them. Why was that? Why
19 didn't you choose to do that?

20 **MOTHER J:** I think we felt at the time that if we
21 had shared our concerns with PALS that with being on the
22 ward for such long periods of time that we were working
23 with the nurses and if they felt criticised then we
24 thought that that would damage the relationships further
25 and we didn't really want to do that, so we were trying

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1 our best to maintain relationships and work with them
2 but there seemed to be a bit of an uneasy atmosphere, is
3 the only way I can describe it at the time.

4 **Q.** You say here:

5 "It just wasn't that type of environment that you
6 risked criticising the nursing care."

7 **MOTHER J:** Yes, and what I mean by that is I think
8 if you shared an observation or you weren't happy with
9 something then there was a defensive response to that
10 rather than a "we're invested in our daughter's care and
11 we're trying to help you here, we can see that you are
12 busy", so it was the response to the communication and
13 we were trying to communicate in a way which was
14 respectful to their priorities and the needs of the
15 other babies on the ward.

16 **Q.** If you were asking for swabs or care kits or
17 anything like that, what kind of reaction would you get
18 to those requests?

19 **MOTHER J:** I would generally ask my husband a lot
20 of the time to communicate with the nurses with those
21 things.

22 **Q.** Pausing there, that speaks for itself, really.
23 Why would you ask him to do it and not feel able to ask
24 for yourself?

25 **MOTHER J:** Because it just felt like it was met
41

1 between the Countess of Chester and Alder Hey in
2 relation to the appearance of the stoma at one point and
3 getting assistance from Alder Hey about whether anything
4 needed to be done. Who can address that? Father J,
5 thank you.

6 **FATHER J:** Yes, well, the stoma -- the stoma
7 started -- one stoma started to protrude slightly more
8 and have what is called a fistula in it, which is
9 a small hole inside.

10 Alder Hey were not particularly concerned about it,
11 however it was something that needed to be monitored and
12 it was information that Alder Hey needed in order to
13 help them assess when surgery would need to take place
14 because, as with everything, they had surgical lists
15 which only occurred every so many weeks so it was
16 a question of which list our daughter would get on for
17 reversal surgery. This was obviously an important piece
18 of information that may mean she needed to go in
19 earlier, get on an earlier list.

20 The -- we were more concerned in that this fistula
21 was causing the bags to wash off and that made changing
22 the bags even more frequent than they were already which
23 made the whole care for our daughter even more
24 challenging which meant for us we knew that we were
25 going to have an even -- a more difficult time, let's
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1 with -- I don't know what the right word is, reluctance
2 or just another thing to do perhaps is the better way to
3 describe it really --

4 **Q.** And Father --

5 **MOTHER J:** -- they were a busy team but, you know,
6 the response was like a roll of the eyes, you know.

7 **Q.** So Father J, how did you find it when you
8 asked for those kinds of routine kits?

9 **FATHER J:** I think we were both very focused on
10 making sure that what was supposed to happen did happen
11 and I was -- as time had gone on, my approach had
12 certainly changed and I was much more prepared to
13 challenge and I think we made -- whether it was
14 a conscious or unconscious decision that I would
15 challenge when necessary any staff actions and, for
16 example, I would ask -- if they were late with cares or
17 we had asked for the equipment -- there was a kind of
18 care pack that you needed and if they weren't giving
19 that to us I would just simply ask "Can I go and get it
20 myself?"

21 In the end, actually, a number of times I was given
22 permission to go and collect it myself which in itself
23 is slightly strange, but we were very focused on making
24 sure that what needed to happen, happened on time.

25 **Q.** Paragraph 79, we see there was communication
42

1 say, on the ward.

2 We were getting to the point where we didn't feel
3 like the communication levels between Alder Hey and the
4 Countess were sufficient and that perhaps information
5 wasn't getting passed through quickly enough, or at all,
6 and we never -- we don't know yet whether all the things
7 we brought up were passed on to Alder Hey, but certainly
8 it was getting to the point where we had the surgeon's
9 mobile phone number, again unusually, and we were
10 considering --

11 **Q.** The surgeon from which hospital?

12 **FATHER J:** Alder Hey, yes. Considering contacting
13 directly, which again was probably outside protocol.

14 **Q.** Then the stoma bags were getting more
15 difficult, you say that clearly. What did you come to
16 find in December, on 14 December, 15 December, with the
17 stoma bag? Paragraph 81. Who was the one who came
18 in --

19 **MOTHER J:** Oh, so that was me.

20 **Q.** Right, so tell us what you found when you came
21 in on the 15th?

22 **MOTHER J:** Yes, so I walked into Room 2 and our
23 daughter was in her hot cot at the time and she was just
24 in a small towel, just put across her bottom area, and
25 just over the stoma so the stoma bag wasn't on there and
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1 just sort of loosely covered is the way I would describe
 2 it and she has a Broviac line in place, so I just took
 3 one look at her and was just -- well, I was just
 4 disgusted really to see her in that situation and also
 5 incredibly saddened being a mum and thinking: what's
 6 happened here, and there were two nurses in the room at
 7 the time and they could see that she was in that
 8 situation and I just said, you know -- I think one of
 9 them was pregnant and I knew the other one had children
 10 and I said "You are mums, what would you do in this
 11 situation? Why has she been left like this?" They
 12 didn't really engage in discussion and we made
 13 a complaint on that day. I think my husband then came
 14 in shortly afterwards, saw her in that situation as well
 15 and then we took the address they gave us --

16 **Q.** When you say made a complaint, Father J, who
 17 did you complain to or speak to about it or was it you,
 18 Mother J?

19 **MOTHER J:** I spoke to one of the nurses and said
 20 that we wanted to see one of the Consultants about that
 21 situation and that it was just unacceptable.

22 **Q.** Did you speak to a Consultant?

23 **MOTHER J:** Yes.

24 **Q.** Who did you speak with?

25 **MOTHER J:** Dr Saladi.

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1 after your baby yourself, are you, so how was this put
 2 to you?

3 **FATHER J:** Yes, I will answer that if that's okay.
 4 Yes, Eirian Powell* -- in fact Eirian Powell and Saladi
 5 both agreed that we should have some rest, however it
 6 was Eirian Powell's suggestion that we should go home
 7 initially. It was very frustrating and again quite
 8 condescending that we were making a complaint about
 9 finding our child with a Broviac line under a towel
 10 covered in her own faeces and the conclusion was that we
 11 should have some rest and it wasn't the conclusion that
 12 I was expecting to hear and certainly I was quite
 13 annoyed by the answer, I remember.

14 **MOTHER J:** I think as well, on reflection, we
 15 weren't informed who left her in that situation and that
 16 I think would be the first thing that you would share
 17 with somebody and then -- so you could address that with
 18 that person and take the appropriate actions. We
 19 understand that there are emergencies that happen in
 20 these neonatal wards, but, you know, on reflection now
 21 it's only recently come to light who was caring for her
 22 and that wasn't shared at the time and at that meeting
 23 we were saying -- you know, we were really concerned
 24 that she was -- we had already had one collapse and we
 25 were -- which was unexplained, so we were really

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1 **Q.** When did you speak to him?

2 **MOTHER J:** I think that was in the afternoon on the
 3 same day.

4 **Q.** Did you both speak with Dr Saladi?

5 **MOTHER J:** Yes, one of the nurses, Eirian --

6 **Q.** Eirian Powell*?

7 **MOTHER J:** Yes.

8 **Q.** So who wants to tell us about that meeting?

9 Who is best able to tell us about that?

10 **MOTHER J:** Probably me again. So we were just in
 11 a small side room and explaining that seeing our
 12 daughter in that situation was very upsetting and just
 13 couldn't understand how that could happen really, but
 14 the conversation quickly sort of turned towards
 15 ourselves and more about they were seeing that we were
 16 tired and stressed and that we should perhaps consider
 17 going home, spending some time recovering and that,
 18 you know, sort of didn't really address what had
 19 happened so that's quite frustrating really that it got
 20 turned that it was us that were the challenge.

21 **Q.** Can you just expand for me? Who said
 22 something to the effect that if you were tired you
 23 should just go home and rest and was it expressed like
 24 that or in a different way? Because of course if you go
 25 home and rest, you're not there to monitor and look

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1 concerned that she was going to get poorly again
 2 without -- you know, with the same situation and we were
 3 trying our best to obviously make sure her care was at
 4 the highest level, so I kept saying to them "I'm really
 5 concerned that she is going to get poorly, we're going
 6 to be in the same situation again" and literally
 7 24 hours later we were.

8 **Q.** You say on the same day of that experience,
 9 Father J, you had messaged the Alder Hey surgeon asking
 10 about the surgical date, saying there were some bag
 11 issues and trying to see if she could get an earlier
 12 surgical date and you received a reply that they had
 13 a list for January 14 and Child J was on it although
 14 also they would try to get an earlier list if possible.

15 **FATHER J:** Yes.

16 **Q.** What was your view about her being in the
 17 Countess of Chester at this point?

18 **FATHER J:** At this point we were already extremely
 19 anxious. We wanted to be out of the Countess and it's
 20 hard to describe the stress of any parent on a neonatal
 21 unit when they've got a sick child and when things
 22 aren't quite happening in the way you expect them to
 23 happen and then you have an unexplained collapse, that
 24 stress is almost incomprehensible.

25 We sensed things weren't right. We felt the

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1 culture was a difficult one and we were taking it upon
2 ourselves to try and basically kick-start the
3 communication that should have been happening anyway.
4 Fortunately the surgeon was extremely approachable and
5 very helpful which was our general experience of
6 Alder Hey and she started to communicate with us
7 directly about her surgical lists and telling us when we
8 could get on that list.

9 **Q.** You also had been told that a Consultant from
10 Alder Hey held a stoma day clinic at the Countess of
11 Chester where she would come and see children who had
12 had bowel surgery. Did you ever ask for Baby J to be
13 seen in that day clinic at any point? Did that ever
14 happen?

15 **FATHER J:** Yes. We weren't initially aware that
16 this stoma clinic occurred. We found out that the
17 surgeon would come. We assumed, possibly wrongly, that
18 as the only neonatal stoma baby in the Countess of
19 Chester we would automatically be on this list for
20 review. However, it was clear that wasn't the case and
21 we were very surprised by that and when we requested to
22 go on the list we were told they would see what they
23 could do, which seemed almost incomprehensible to me at
24 the time.

25 We did -- because we had a -- because of our

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1 **LADY JUSTICE THIRLWALL:** So we will break for about
2 15 minutes unless you would like any longer, in which
3 case just say.

4 **MOTHER J:** Thank you.

5 **LADY JUSTICE THIRLWALL:** So quarter of an hour.
6 (11.29 am)

7 (Short Break)

8 (11.48 am)

9 **MS LANGDALE:** So we were in mid-December 2015. You
10 have just told us, Father J, that Baby J was seen by
11 a Consultant who recommended progressing to reversal of
12 stoma. On 17 December one of you received a call
13 heading to the hospital. Who is best able to deal with
14 that?

15 **MOTHER J:** That's me.

16 **Q.** Would you like to tell us what happened on the
17 17th?

18 **MOTHER J:** So I was in the car and the phone rang
19 and it was a withheld number and at that time the only
20 withheld numbers that were calling were from the
21 hospital, so I knew it was the hospital that would be
22 calling as the other call that we had had was -- the
23 emergency call was from the hospital, and I just recall
24 that the nurse said that our daughter had had another
25 collapse.

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1 daughter's fistula, particularly we knew that it was
2 important for her to get reviewed to see which surgical
3 list she would go on and we were having problems with
4 the bags coming off. It seemed obvious to us that the
5 best -- the best outcome would be for her to have
6 a stoma reversal as quickly as possible and we did get
7 seen eventually, once the -- once Alder Hey were aware
8 that we were wanting to be seen, they said of course we
9 can be seen and when the Consultant saw her daughter she
10 said, "Well, yes, you should be on the next list".

11 **Q.** So you did finally see that Consultant at the
12 Countess of Chester on the day clinic --

13 **FATHER J:** Yes.

14 **Q.** -- having requested that and when she saw
15 Child J you, I understand, have messaged a friend to
16 say:

17 "The Consultant took about 10 seconds to come to
18 the conclusion the quicker Child J has her stomas
19 closed, the better for everyone."

20 **FATHER J:** Yes. That was a text message to
21 a friend.

22 **MS LANGDALE:** My Lady, I think that's a good point
23 to stop. The stenographer will need a break. I'm sure
24 you both do as well. If you can avoid talking about the
25 evidence in the break.

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1 **Q.** Did you go into the hospital? Paragraph 92
2 and 93 in your statement.

3 **MOTHER J:** Yes, so I -- yes, the nurse on the phone
4 said that she had had a collapse and to come quickly to
5 the hospital and she did say at the time that she had
6 let out a big scream and then suddenly collapsed, so
7 I carried on with the journey, got to the hospital as
8 soon as possible and she was in the intensive care room
9 when I arrived.

10 **Q.** Were you given any cause or reason for the
11 collapse?

12 **FATHER J:** I will address that, if that's okay. At
13 that point, no, we weren't. Again, there was -- as they
14 tended to do in these cases, we understood the risk
15 perhaps that there could be for example an infection, so
16 they tended to have a kind of clear checklist of things
17 that they would go to, first infection being one of
18 them, so they would have needed to take bloods and
19 measure things like CRP, and even basic things like
20 pressing her abdomen, simple tests, in order to try and
21 understand what was going on. So at that point they
22 said they wouldn't rule out infection, they wouldn't
23 rule out sepsis and they wouldn't rule out an issue with
24 her bowel, so those were the three things that they were
25 looking at.

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1 Q. Was there a plan to transfer her to Alder Hey
2 then?

3 **FATHER J:** Dr Brearey was involved and he decided
4 as a precaution it was best to transfer her to
5 a surgical hospital, either -- they said it would --
6 primarily they would try and get her back to Alder Hey
7 but if not we would go to St Mary's, depending on who
8 had a bed available.

9 Q. You got -- we see at paragraph 99 --
10 confirmation from Alder Hey that Child J could go on
11 a surgical list for 30 December and you, Father J, told
12 the Consultant that Child J was seriously ill?

13 **FATHER J:** Yes.

14 Q. You say you both sat next to Child J's
15 incubator during the time after the collapse until the
16 early hours when transfer to St Mary's Hospital arose?

17 **MOTHER J:** So I was so concerned and obviously
18 upset seeing her in such a severe situation that
19 I couldn't leave her, so I just sat next to the
20 incubator and I think maybe, you know, took a few
21 comfort breaks, five-minute comfort breaks, and just
22 waited for the team to come and transfer her.

23 Q. You tell us she was given broad spectrum
24 antibiotics at this time:

25 "They couldn't explain with any certainty what had
53

1 had had there.

2 Q. So did you in fact stay at St Mary's until the
3 transfer to Alder Hey?

4 **MOTHER J:** Yes, we refused to go back to the
5 Countess of Chester and were quite firm in saying that
6 we either have the surgery at St Mary's Hospital or it
7 would need to be Alder Hey but we couldn't return back
8 to Chester because at that point we had lost confidence
9 really.

10 Q. It says -- you say:

11 "We know now from records St Mary's noted our
12 concerns with regards to Countess of Chester's stoma
13 care and we didn't want Child J to go back there."

14 So you go to Alder Hey Hospital on 23 December and
15 you describe the reception when you arrived there from
16 the nursing team. What was that like?

17 **MOTHER J:** Like stepping back into a warm family,
18 familiar faces, they knew us, they knew Child J.

19 Q. Sorry, you might have to speak up slightly.

20 **MOTHER J:** They knew us, they knew our daughter and
21 we felt we were in the right place then for the path to
22 recovery.

23 Q. You say:

24 "... the nursing team hugged us ... We felt at ease
25 and safe again."

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1 happened."

2 She had been doing so well and it was unexpected.

3 In the early hours of 18 December you left the
4 Countess of Chester to go to St Mary's Hospital in
5 Manchester. Did you have any other further discussion
6 about that second collapse or not with the Countess of
7 Chester or anywhere else at the time?

8 **FATHER J:** We -- at that time we didn't and because
9 we had left the Countess by the time it would have come
10 to having a discussion because we weren't there any
11 more. St Mary's -- obviously we then had discussions
12 with St Mary's about what they believed it was. As we
13 understand, our daughter had some infection markers and
14 it was assumed that she had had an infection, although
15 we never had -- we never had a full debrief. We
16 certainly didn't have anything written and there was no
17 formalised meeting afterwards, so everything that we
18 learned pretty much on the whole of our daughter's
19 journey, in fact, was verbal.

20 Q. There came a time she had a cranial ultrasound
21 on 21 December which appeared normal and St Mary's told
22 you that she was well enough to be discharged back to
23 Chester. What did you think about that?

24 **MOTHER J:** So we were both deeply concerned about
25 returning back to Chester given the experiences that we
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1 **MOTHER J:** Yes. That's exactly how I felt.

2 Q. She had her surgery on 30 December and you say
3 made a quick recovery and by early January you had
4 returned home with her.

5 **MOTHER J:** Yes.

6 Q. In the immediate aftermath obviously she was
7 recovering well, you say that, but were you left --
8 physically she was recovering well. Were you worried
9 about any aspects, or that there might be anything else
10 that lay ahead given what had happened?

11 **MOTHER J:** Yes, just having those experiences of
12 the collapses and not having any explanation of why they
13 happened, it was always there at the back of our minds
14 that at some point that could reoccur.

15 Q. You also had experience, didn't you, of the
16 Countess of Chester children's ward, as you had an issue
17 with milk intolerance as you moved forward. What was
18 your experience of the children's ward and the staff
19 that you dealt with there at the Countess of Chester?

20 **FATHER J:** We were dealt with by Dr Gibbs and he
21 remembered our daughter from the NNU and they diagnosed
22 us -- they had diagnosed the issue really quickly. They
23 switched our daughter to a non-dairy milk supplement and
24 resolved the issue really quickly and we felt we had
25 been given really great care, which -- again our

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1 experience of the Countess of Chester was that we had
2 had really fantastic care by the Fetal Medicine Team.
3 We had a great experience in the children's ward and it
4 seemed to not fit with our experience with the NNU.

5 I think I would like to point out as well that
6 Dr Gibbs -- we had a lot of contact with Dr Gibbs and
7 Dr Brearey and both of them came across as extremely
8 knowledgeable and professional and caring and empathetic
9 towards us as parents. The main issues seemed to be
10 that they were just overstretched in their roles.

11 **Q.** When you received discharge letters --
12 presumably you received discharge letters from the
13 hospital relating to your daughter's care. Did they
14 mention the collapses you have told us about?

15 **MOTHER J:** No. I have looked back at those letters
16 because I kept them over the years and none of them
17 mention anything about the collapse. It was almost like
18 it didn't happen. Other things are documented there but
19 none of the collapses.

20 **Q.** You tell us you were invited to a workshop at
21 Alder Hey to help them understand the experience of
22 babies and parents moving from a specialist surgical
23 hospital to a district hospital. What were your
24 contributions to that? What's your thinking about that?

25 **MOTHER J:** So -- I will just refer to my statement
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1 **FATHER J:** We didn't see any records until we had
2 appointed a solicitor. As I say, apart from the
3 discharge letter I don't think we received any other
4 letters about specific things such as collapses, or --
5 and nor was it recorded that we had made a complaint
6 about finding our daughter in a towel -- faeces covered
7 towel, so those were things we would have expected would
8 have been recorded but in fact as far as we know at this
9 time there were some notes made but there was never any
10 formalised response to much of our feedback.

11 **Q.** Back in paragraph 81 of your statement, in
12 relation to your daughter being found in the towel, you
13 say:

14 "There was no record of Letby or other staff having
15 issues with bags on the shift, however, on 15 December,
16 at the handover from Letby's shifts, when I came in at
17 around 8 am and found Child J in her cot ..."

18 That's when you have given the evidence earlier
19 about what you found.

20 So when you saw the records was that the first time
21 you could see whether there had been any issues or who
22 was there on the shift before you found her?

23 **FATHER J:** The first time we asked who had left our
24 daughter in a towel, this faeces covered towel with
25 nothing else on her. We never got an answer at the
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1 there, so:

2 "We were invited to a workshop at Alder Hey to help
3 them understand the experience of babies and parents
4 moving from a specialist surgical hospital to a district
5 hospital. They were aware of potential challenges when
6 babies transfer to district hospitals and wanted to try
7 to ensure continuity of care. There were lots of
8 suggestions from families who had been negatively
9 affected by these moves and not just the Countess of
10 Chester Hospital. Alder Hey were keen to use the
11 parents' experiences to find a solution on how to
12 monitor the progress of babies after surgery within the
13 district hospitals, they were considering ideas such as
14 a trained Alder Hey nurse would visit once a week. It
15 was clear at this meeting that the other parents had
16 challenging experiences at other district hospitals. It
17 left us feeling that the care at Countess of Chester
18 Hospital was similar to the care given at these other
19 district hospitals across the region and none of them
20 were able to reach the level of care of a specialist
21 surgical hospital. Despite comparable experiences
22 across the region, no other hospitals had the same
23 problem of deaths and collapses."

24 **Q.** Medical records. When did you first see
25 Child J's medical records?
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1 time. We never got an answer afterwards. It wasn't
2 until our solicitor looked at the records that she
3 discovered that the designated nurse on that shift was
4 in fact Lucy Letby who was responsible for looking after
5 our daughter when she was left in this particular state,
6 so that was a big shock to us. It is something we have
7 only found out recently.

8 **Q.** You also at paragraph 91, describing the
9 second collapse, make the point that Letby was on duty
10 again that evening, the 16th through to the 17th. Is
11 that something you asked about at the time, who was
12 around, or would it not have occurred to you to ask
13 about that?

14 **FATHER J:** At the time it didn't occur to us to ask
15 and again it wasn't something that we discovered until
16 the police involvement with the case and I'm not sure of
17 the exact time that we found that out but it had been
18 investigated by the police and not taken to -- not taken
19 to trial, so at that point they were able to give us
20 further information.

21 **MOTHER J:** However, what I would like to just add
22 there was the nursing staff at the nighttime -- we
23 didn't know who the nurses were at the nighttime looking
24 after our daughter at the Countess of Chester. At
25 Alder Hey we were told who was responsible for their
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1 care, so I would say in the daytime it was very clear
2 but at the nighttime not so clear and consistently
3 shared with us.

4 **Q.** So how many years after these events and your
5 daughter's time there do you feel you got further
6 knowledge around who was looking after her and where and
7 what happened potentially?

8 **FATHER J:** It's been in the region of probably --
9 some information had been eight years almost before we
10 discovered what is actually quite important information
11 to us.

12 **Q.** In terms of impact what would you like to say
13 about impact? You say a couple of things at
14 paragraphs 116 and 117.

15 **MOTHER J:** I will refer to my statement.

16 **Q.** Yes.

17 **MOTHER J:** "I cannot emphasise enough the impact of
18 this on our whole family. Who we are as people,
19 parents, work life, spouses, children. We went through
20 this at the time with minimal written explanation. We
21 then discovered about the investigation into deaths and
22 collapses via the newspaper and read that the hospital
23 and Police had supposedly contacted all parents
24 involved. My husband contacted the Police to check if
25 they had looked into Child J's collapse and they said

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1 I don't know, Father J, shall I ask you first to deal
2 with some of these points?

3 Point one, as far as Baby J is concerned you say
4 missed opportunities to intervene and protect Baby J.
5 What would you seek to highlight?

6 **FATHER J:** We -- I believe here that we're talking
7 about potentially not -- about protecting all the
8 children on the neonatal unit and I believe in terms of
9 our daughter there were some opportunities missed, for
10 example immediately after Baby J's collapses there
11 appeared to be no investigation which seems to be
12 a missed opportunity. On discovering Baby J's mother's
13 milk was missing, which is a topic we haven't --

14 **Q.** Actually we haven't, perhaps we should pause
15 there and Mother J, would you like to tell us about
16 that? So there was an occasion, wasn't there --

17 **MOTHER J:** Yes.

18 **Q.** Set that out for us.

19 **MOTHER J:** So it happened on the first collapse.
20 We -- the milk was obviously an important part of the
21 journey in helping our daughter recover, so when we
22 received the call at home we just took the expressed
23 breast milk from our fridge but we didn't have any
24 labels at the time because we were obviously just
25 rushing to get into the hospital as fast as possible, so

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1 the hospital had not passed on our records despite us
2 never getting an explanation as to the reason for the
3 collapse and Letby being the designated nurse. We then
4 quickly found ourselves part of the investigation once
5 the police had looked at our records. For nearly ten
6 years we have been on a challenging journey. The last
7 five years have been especially difficult, enduring the
8 investigation and trial and hearing new information in
9 terrible detail about the other children on the same
10 ward. This has cast a shadow of sadness over every part
11 of our lives."

12 **FATHER J:** I would like to read 117, if that's
13 okay:

14 "By the time Child J was on the ward I now know
15 that the consultants had already reported their concerns
16 about Letby and an independent report had potentially
17 told the Executive Team to investigate it further.
18 I don't understand how in the light of this more action
19 wasn't taken. It is almost inconceivable that, even
20 when they did move her for a short period, they moved
21 her to a patient safety admin role. When someone is
22 accused of causing harm to patients, to move them into a
23 role focused on safety seems ludicrous and
24 inconceivable."

25 **Q.** I'm going to move now to recommendations and

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1 when we arrived on the ward my husband -- I went
2 straight to our daughter in the HDU and my husband said
3 "You need to -- we've got some milk here but it is
4 unlabelled. Do you have any labels?" and they didn't
5 have any labels at the time so he said, "Well, I will
6 place it in the box of our daughter in the communal
7 fridge" which was just for expressed breast milk and
8 "Could you please get us some labels so we can label
9 it?" because we knew that that was the process that we
10 had to follow.

11 So shortly afterwards -- I can't remember, I think
12 maybe my husband went to get the breast milk because we
13 were allowed to start giving small feeds and the milk
14 wasn't in the box so we asked the question "Where is the
15 milk?" and I remember there was quite a few nurses
16 around the area and I think my husband was asking pretty
17 much everybody, you know, "Where has this milk gone?"
18 you know and there wasn't any explanation, nobody owned
19 up to removing the milk from the box in the fridge,
20 disposing of it. The milk never turned up. We never
21 had an explanation as to who had taken it and, you know,
22 what had happened really and I remember my husband at
23 the time was just really -- just perplexed that this
24 could happen and there didn't seem to be too much
25 seriousness attached to that.

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1 Q. The importance of it?

2 MOTHER J: Yes, absolutely, the importance of it
3 and we -- you know, we didn't ever get an explanation of
4 what had happened, so yes, that just remained as is.

5 Q. So you make the point there then, Father J,
6 that in terms of recommendations, picking up on that and
7 the importance of that, for the child, for the mother,
8 for the safety generally of children being fed on the
9 units, did you ask anybody about that at the time, any
10 of the nurses?

11 FATHER J: Yes. It's one event that still stands
12 out quite clearly in my mind. I was adamant at the
13 time, despite the fact that that was the day of one of
14 the collapses, that I went around to all nursing staff
15 and to the nursing station and said "Look, we're going
16 to have to put some milk in the fridge that's
17 unlabelled. As soon as you get labels, we need a label
18 to put on it. Don't throw it away". Then when
19 I returned and then it was missing I then asked
20 everybody again "Where is it?" My concern at that point
21 was that it's a -- you know, it's expressed milk and
22 shouldn't be given to anybody else. Certainly I was
23 quite shocked that they didn't take it particularly
24 seriously and my question was "Well, if somebody has
25 thrown it away, that's fine, we just need to know that

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1 appears to be a reluctance to accept the seriousness of
2 incidents and an omission in recording them or
3 follow-ups to them. You refer to the unrecorded meeting
4 with Eirian Powell* and Dr Gibbs, is that the one you
5 mean?

6 FATHER J: Dr Saladi.

7 Q. Sorry, Dr Saladi.

8 FATHER J: Yes, so that meeting was effectively
9 a complaint and whilst we didn't formalise a complaint
10 I'm not even sure that we knew how to make a formal
11 complaint. I think we had made a verbal complaint and
12 one would have assumed at the time that that would be
13 recorded as such as followed up as such. We didn't have
14 any formal or written review after the collapses. In
15 fact, we don't know what level of review, if any,
16 occurred internally, even if there was kind of
17 a stand-up discussion anywhere. We didn't get -- we
18 didn't get all of the details in any case ourselves
19 until after the police investigation and the solicitor
20 review and in fact the police investigation information
21 didn't come until the trial.

22 There were also, I would highlight, facts that
23 recorded events were only recorded -- for example when
24 feeds were missed that wasn't recorded, so they only
25 recorded times when feeds were given rather than -- they

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1 it has been thrown away and not given to somebody else",
2 because whilst my wife wasn't taking any kind of
3 medication, you know, she could have been, so that was
4 quite concerning and they didn't treat it very seriously
5 at all and the reason I referred to it in the missed
6 opportunities was that again Letby was on duty and to me
7 it seems as if there was some concerns going on, these
8 types of events were opportunities to, for example, do
9 a little bit more investigation and perhaps start to
10 manage situations and ask questions, so if I may, if
11 I return back to those recommendations, and immediately
12 after Baby J's collapses and immediately after
13 discovering that my wife's milk were missing, they were
14 opportunities to start asking questions.

15 Even things like minor care errors such as missing
16 feeds and supplements, I would have thought there would
17 be generalised questions asked about why things weren't
18 happening in the way they should be. That in itself is
19 an opportunity to look into any individual's activities
20 and certainly after finding our daughter wrapped in
21 a towel with her stoma bag off and then now that we know
22 that the nurse at the time was Letby, that was most
23 certainly a missed opportunity to investigate or begin
24 an investigation into opportunities.

25 Q. You also say there was a reluctance, or

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1 didn't record what was essentially a failure to feed on
2 time and I would have thought those were opportunities
3 for just basic improvement in their own processes.

4 There were incomplete records of when our daughter
5 was put on and off monitors which were discovered by our
6 solicitor and I think those things personally should be
7 basic, basic data recording, and those things would have
8 helped actually in the ensuing investigations.

9 It also wasn't recorded when we as parents were
10 performing stoma care and giving feeds versus nurses
11 doing stoma care and feeds, which again I would have
12 expected to have happened.

13 We didn't get any follow up at any points about any
14 of the collapses even though for the first collapse we
15 had no explanation whatsoever and for the second
16 collapse we had an incomplete explanation.

17 Q. You make a point around attitudes and
18 behaviours of some nursing staff and a cultural issue.
19 Would you like to tell us what you raise there?

20 FATHER J: Yes. One of the -- one of the questions
21 which is still being answered now by the records is we
22 didn't know if any of our messages or questions were
23 passed to Consultants, so where we had queries about
24 care we never knew to what level that was referred to
25 because we never got any full feedback.

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1 We had a perception that some of the nursing
2 staff -- and this was perhaps a perception because we
3 didn't know their individual levels of training, but
4 some of the nursing staff and Registrars seemed to us
5 overconfident about their competency, particularly
6 around issues like stoma care, but that was based on our
7 experience of Alder Hey who were extremely competent and
8 I think it's fair to say that as Alder Hey are
9 a surgical hospital it's probably unfair to compare
10 directly.

11 We did, however, find that we did get some
12 dismissive responses by some nursing staff and
13 Registrars. When we questioned their approach and their
14 answer was "This is the way we do it here" rather than
15 addressing our concerns and there was a reluctance, we
16 noticed, to defer to Alder Hey surgical hospital when
17 the care didn't align with the plan that had been
18 explained to us.

19 **Q.** How did that manifest itself?

20 **FATHER J:** We were asking -- we thought initially
21 the appropriate way to deal with issues was to deal with
22 the Countess of Chester staff and that they would
23 escalate when requested or when appropriate. That
24 didn't seem to happen and that became a growing
25 frustration and -- which ultimately -- which ultimately

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1 the journey, we were informed and it helped us to relax
2 and feel that things were happening as they should be
3 happening and at the Countess it was a -- it was more of
4 a kind of reactive communication as opposed to proactive
5 communication, so we would sort of hear, you know, the
6 Consultants would be coming along to do their review,
7 but we wouldn't know when that was happening. It was
8 sort of by chance if you were there or not there and
9 I think for us and the way we were as parents, we would
10 like to be included because we needed to know what was
11 happening and how our daughter was progressing, so that
12 may not be perceived by the hospital as an important
13 thing to have the parents involved because the care is
14 in their hands, but actually for us to be present and so
15 heavily involved I think it would have helped if
16 everybody, the nurses and doctors, were there at the
17 time.

18 **Q.** Were you offered any counselling or support at
19 any stage in this journey of care with Baby J? You're
20 shaking your head --

21 **MOTHER J:** Sorry, yes. So the first offer of
22 counselling came from the police when I first met with
23 the detective and he suggested that we had been on quite
24 a journey and perhaps I should seek out some
25 counselling, but prior to that we hadn't had anything.

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1 resulted in us dealing directly with Alder Hey which I'm
2 pretty sure was not the accepted protocol, but in this
3 situation our main focus was to make sure our daughter
4 (a) survived and (b) thrived and when we didn't -- when
5 we finally realised we weren't getting the progress that
6 we needed, we took that into our own hands.

7 We only discovered the level to which information
8 has or hasn't been between Alder Hey and the Countess of
9 Chester very recently in the last probably 6 to
10 12 months.

11 **Q.** In terms of communication in its various forms
12 but particularly staff communicating with you as
13 parents, how would you assess that and how could that
14 have been improved?

15 **MOTHER J:** At the Countess?

16 **Q.** (Nods)

17 **MOTHER J:** So the style of communication in
18 Alder Hey worked really well for us where their nurses
19 were present and the Consultant would be present,
20 perhaps the surgeon and the parents and we would have
21 just a quick review of what had happened today, what
22 happened that week, any significant things that needed
23 to be focused on and then there was sort of like
24 a collective agreement on next steps and that worked
25 really well because it just felt like we were part of

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1 **Q.** When did you first become aware that there was
2 an investigation being undertaken in relation to the
3 neonatal services at the Countess of Chester in respect
4 of deaths and unexpected collapses?

5 **FATHER J:** It was actually I read an article in the
6 newspaper, in the local newspaper. Prior to that we
7 weren't aware of any of the reports. We hadn't been
8 copied any report and in fact we have recently
9 discovered that there was no informal notes made about
10 the collapses anyway.

11 **Q.** So you weren't aware of the Royal College
12 report, Dr Hawdon's report or anything like that?

13 **FATHER J:** No.

14 **Q.** Until the police told you or --

15 **FATHER J:** None of it and in fact we didn't -- the
16 police didn't give us very much information at all.
17 That was understandable because they were talking about
18 a murder trial, couldn't tell us anything and that was
19 again a difficult situation -- yes, so we were unaware
20 of all -- and in fact we are still learning about the
21 reports at this time, what reports -- in fact the
22 opening statements of the Inquiry enlightened us further
23 about what reports were written and when.

24 **Q.** So you have never been invited to any meetings
25 or discussions at the Countess of Chester Hospital about

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1 Baby J at the time or subsequently?

2 **FATHER J:** No.

3 **Q.** PALS. Have you had any experience of PALS,
4 the Patient Advice and Liaison Service, ever tried to
5 use it, thought of using it? You said earlier why you
6 didn't actively want to make a complaint, but did you
7 ever actively think about PALS?

8 **MOTHER J:** We thought about PALS but we didn't make
9 contact with them because we were concerned then about
10 what impact that would have on the relationship with the
11 nurses and the doctors.

12 **Q.** So it wasn't that you had a lack of confidence
13 in the service, it was that you didn't want the effect
14 of it to be transmitted to the nurses?

15 **MOTHER J:** Yes, yes.

16 **Q.** Did you ever raise any concerns with any
17 external organisation about your experiences at the
18 time?

19 **FATHER J:** If I may answer that?

20 **Q.** Yes, please.

21 **FATHER J:** We didn't raise any concerns. However,
22 we did raise concerns when we were part of a working
23 group set up by Alder Hey, so it wasn't something that
24 we actively pursued. Our main focus was to get our
25 daughter home. I think there was a huge amount of

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1 knowledge and understanding of what those requirements
2 are, such that they cannot (a) hide behind ignorance or
3 (b) pretend that it's not something that they have
4 a duty to make sure they have all the information about.
5 So in this case having already seen the initial
6 submissions to the Inquiry, listened to the opening, it
7 does seem clear to me that this type of annual fitness
8 to manage test would have resolved at least some of the
9 problems that have been discussed.

10 **Q.** Reporting of deaths and collapses you say
11 should immediately go to a centralised reporting system
12 with a strict set of guidelines, meaning Executives
13 can't influence the reporting or under-report. What do
14 you think the issue might be if there's under-reporting?
15 Why might that be the case?

16 **FATHER J:** Well, it seems clear that in order to
17 compare performance you have to have all of the
18 information and if that information isn't presented in
19 the correct way in a formalised manner and understood by
20 the people receiving that information, it's almost
21 impossible for them to see things such as outlying
22 statistics. There's a lot of talk about statistics
23 around this case so it's not a word I want to
24 particularly use in this case, but it is very important
25 that the people who understand what they are looking at

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1 relief to get home and our main focus after that was to
2 look after her.

3 **Q.** That was parents such as yourselves trying to
4 help understand where improvements could be made to help
5 babies recover from surgery in district hospitals?

6 **FATHER J:** Yes, we realised we had been on quite
7 a journey and also potentially had some useful feedback
8 for that group and wanted to be part of trying to
9 improve things.

10 **Q.** In terms of suggestions and recommendations,
11 one of the issues you raise is an annual "Fitness to
12 Manage" test for Executives to ensure they understand
13 duties in key areas such as patient safety,
14 safeguarding, response to complaints and accusations of
15 wrongdoing, whistle-blowing, both legal and moral
16 aspects. Would you like to expand on that a bit?

17 **FATHER J:** Yes, I don't claim to understand what
18 tests or qualifications are required to be an Executive
19 at the Trust. However, it does seem clear to me that
20 there should be a standard below which nobody sitting in
21 one of these positions should fall and that should be
22 something which is tested and checked on a regular basis
23 to understand that those people -- to make sure that
24 they understand their duties, that they are regularly
25 reminded of their duties and that they have the

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1 get all of the information and there should be no way
2 that any Executive Team in any Trust should be able to
3 influence what is reported. The facts should be
4 reported and nothing else.

5 **Q.** You say when collapses and deaths occur there
6 should be:

7 "Immediate review straight after [an] incident
8 including witness statements taking a true account at
9 the time ... in the same way accident reporting occurs
10 in the workplace."

11 **FATHER J:** Yes, it seems -- and I understand that
12 the Datix system, I assume, is actually that appropriate
13 system, but it appears to me that this hasn't happened
14 and certainly in our case that didn't happen and of
15 course we have contact with other parents and we know
16 that that hasn't happened in their case. It seems to me
17 that this type of process is one that's extremely
18 well-known, well understood in many walks of life and
19 industries and it just doesn't seem to be working, or
20 certainly was not working at the time that we were at
21 the Countess of Chester and that's something that if it
22 isn't working now then it needs to be immediately
23 addressed.

24 **Q.** You say:

25 "Technology for Automatic incident data analysis

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1 flagging up data such as staff/team attendance v
2 incidents over a time period."

3 **FATHER J:** Yes, it seems to me that technology has
4 significantly moved on since even this time and it would
5 appear to me that it should be relatively easy for
6 information to be automated such as, you know, if
7 a child is put on a monitor in a crash situation,
8 a button can be pressed and that data sent somewhere to
9 be recorded and, you know, for example with recording --
10 there was a tendency in crash situations to write things
11 on the nearest piece of paper like a towel, like a paper
12 towel. To me that just seems so archaic. Why -- for
13 example, police have an open channel they can press in
14 an emergency situation. Why that couldn't be simply
15 implemented in the case of hospital crashes, I would
16 think these types of use of technology should be more
17 than achievable now.

18 **Q.** You have covered, both of you, CCTV earlier
19 on, saying it should be there for each cot space or
20 incubator. You also suggest here areas such as the drug
21 store, storage areas and milk fridge and monitoring of
22 drugs such as insulin with either swipe card systems or
23 facial imaging systems?

24 **FATHER J:** Yes, again it seems remarkable that even
25 the basic things like the milk fridge were accessible to

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1 **FATHER J:** An audio recording of what is being
2 said, yes, yes, you could even make notes of
3 observations at the time. For example, skin
4 discolourations seems a very relevant observation that
5 could be made by an audio note.

6 **Q.** You go on to set out in the same part of your
7 statement where you think the information was not shared
8 with you adequately. We have covered most of those
9 points in evidence already, but one point you make is
10 Consultants' and Registrars' rounds times were not
11 readily transmitted to parents and you say later "We
12 never knew if requests to speak with Consultants were
13 transmitted to them by the nursing staff." And you
14 referred earlier to Alder Hey and the "huddle" and being
15 there and set times, so what was different about the
16 Countess of Chester in terms of not knowing when you
17 could speak to a doctor or being able to speak to one?

18 **MOTHER J:** I think the nurses at Alder Hey were
19 aware of the timings of when the Consultants were going
20 to visit and they were -- they would just come to us and
21 say "Such Consultant will be here around about this time
22 if you would like to be present for the discussion",
23 whereas at the Countess that just didn't happen. It was
24 more that, you know, we were hanging around and making
25 sure that we were there to try and be involved in that

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1 anybody who came onto the ward. We know about the
2 insulin cases and it seems fairly clear again that CCTV
3 and the use of swipe cards, or even facial recognition
4 systems which are commonplace in a lot of workplaces,
5 would allow -- or would prevent the misuse of drugs,
6 either accidentally or intentionally.

7 **Q.** You have already referred to monitor readings
8 being transmitted to an independent body with the press
9 of a button, but you refer here also to automatic audio
10 recording being available to staff so they can make
11 voice notes rather than writing on paper towels to get
12 a realtime record of actions.

13 **FATHER J:** Yes. I think it's quite important that
14 realtime records -- realtime records are much better
15 than retrospective records. One thing that became clear
16 in the criminal trial was that there were a number of
17 retrospective records made which may or may not have
18 been wholly accurate and in the case of being able to
19 make verbal notes whilst also in this case if you're
20 attending to a crash, it would seem quite sensible that
21 somebody who needs to use their hands could also make
22 voice notes at the same time.

23 **LADY JUSTICE THIRLWALL:** Would do you mean, like
24 sort of recording what they're saying to each other
25 while they're doing it?

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1 discussion and sometimes we just missed that
2 opportunity, you know, we popped to the kitchen to have
3 a quick cup of tea and then, you know, that had happened
4 and we weren't there then.

5 **Q.** Frustrating?

6 **MOTHER J:** Yeah, it was frustrating and, you know,
7 disappointing because things were happening that we
8 wanted to discuss directly and we couldn't, we missed
9 the opportunity. We understood that, you know, their
10 time is very precious but we just felt like that
11 communication could have been a lot better.

12 **LADY JUSTICE THIRLWALL:** Can I just ask
13 a supplementary about that. I understand the point you
14 make about not knowing when they were coming but when
15 you were there and they came, what was that like? Were
16 you involved in the discussion then?

17 **FATHER J:** Can I answer that? It was very specific
18 to whichever Consultant or Registrar came.

19 **LADY JUSTICE THIRLWALL:** Right.

20 **FATHER J:** So both Brearey and Gibbs we had contact
21 with and they were very -- quite communicative with us
22 and quite helpful. The Registrars, they changed quite
23 frequently and so it was very difficult to build any
24 kind of relationship with them, so they tended to just
25 be in and out and gone, so it was very much dependent on

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1 which Consultant or Registrar did the particular round.

2 **LADY JUSTICE THIRLWALL:** I follow.

3 **FATHER J:** As opposed to Alder Hey which was much
4 more structured and it was the same surgeon who was your
5 Consultant who came to see you every time.

6 **MS LANGDALE:** One of the recommendations you think
7 the Inquiry should make surrounds continuity of care and
8 you say limiting the number of nurses that look after
9 a child over a period of day-to-day or over a longer
10 period presumably.

11 **FATHER J:** Mm-hm.

12 **Q.** Was that -- you gave evidence about that
13 earlier, but was that frustrating for you as parents
14 that it did change so much?

15 **MOTHER J:** Yes, it was frustrating. I think that
16 when the nurses are dealing with your child on a daily
17 basis they get to know the small signs of -- and get to
18 know the -- you know, the way that they are behaving.
19 They just get to know them.

20 **Q.** To know the patient?

21 **MOTHER J:** Yes, absolutely, and because she had
22 complex needs with the stoma care you sort of -- the
23 more a nurse worked with her, the easier it was then to
24 make her comfortable and know if she was in any kind of
25 discomfort and at Alder Hey they did that very, very

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1 proficiency, skill and training looks like in this case,
2 ie somebody can be trained but not have the proficiency
3 because they haven't had the practice or experience and
4 others could have -- not be trained to the same level
5 but actually have had quite a lot of experience. I'm
6 not sure how that's measured. I'm not sure how it was
7 measured then and certainly we're not sure how either of
8 those things, both the competency and skill level, were
9 checked. We know there was a telephone conversation but
10 we don't know if there was either the passing of
11 training records, for example, to demonstrate that
12 certain members of staff were able to perform stoma care
13 and I think that's something generally -- we're talking
14 about stoma care here, but generally should be more
15 formally checked, if it isn't.

16 **Q.** You say:

17 "Weekly review with surgical hospital of the
18 progress of surgical babies at district hospitals" would
19 be a good idea "in order that they are fully aware of
20 progress and what's happening."

21 **FATHER J:** Yes. I mean I think perhaps -- we're
22 talking about nearly years ago now. Things like video
23 calls were obviously not as prevalent, but certainly now
24 I would think that would be quite an easy thing to
25 perform, to have a weekly review, even if it's only

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1 well. It was just a small number of nurses that were
2 caring for her, whereas at the Countess it sort of went
3 in -- how to describe it, like -- one period of time it
4 could be the same nurses and then a couple of weeks
5 later it might be different nurses and if they were
6 short-staffed -- I remember somebody came on -- they had
7 like a bank nurse and I don't think that bank nurse had
8 any experience of stoma care but then the next time was
9 a bank nurse from Alder Hey which was reassuring, so it
10 was just that inconsistency that made you feel a little
11 uneasy really because she was being dealt with by so
12 many different people.

13 **Q.** You have raised the need for stoma care at
14 both hospitals and you say here:

15 "Alder Hey spoke to the Countess of Chester about
16 Child J's complex needs and were told the Countess of
17 Chester had the necessary experience in recycling bowel
18 contents and neonatal stoma care."

19 You say:

20 "I am not sure how this was checked [though],
21 whether it was just a question on the telephone or by
22 email or some more formal means of checking."

23 Father J, would you like to expand upon that?

24 **FATHER J:** Yes, I would. We still don't really
25 understand how the process worked in terms of what

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1 a remote one, in order to allow the surgical hospitals
2 to have more involvement with the local hospitals.
3 Certainly at the time there was definitely a feeling
4 when we had these feedback meetings with Alder Hey that
5 this wasn't an issue specific to the Countess of
6 Chester, it was an issue that was quite well-known
7 around local hospitals and integrating surgical babies
8 back into local hospitals and we didn't feel as though
9 the involvement from Alder Hey was great enough and
10 whether they even knew really what was going on, and
11 I think by formalising some kind of weekly, that that
12 would have helped them to understand what was going on
13 and would have taken a huge amount of stress off us as
14 parents.

15 **Q.** You say also:

16 "Consider an additional ward at Alder Hey for
17 babies recovering from surgery rather than local
18 hospitals. This may help speed up the time taken to get
19 babies home." With that level of expertise.

20 **FATHER J:** Yes, one of the things that was a big
21 focus was to get babies well enough to go home because
22 there was two aspects: one, they thrived better at home.
23 Certainly our daughter did when she got home. She put
24 on a huge amount of weight when she came home. So there
25 is one aspect which is, you know, blocking beds and the

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1 other aspect is that they seem to improve when they got
2 them home. However, if the local hospitals just aren't
3 able to handle certain types of surgical babies it seems
4 sensible to us that some other method is used in order
5 to help them get home.

6 **Q.** Finally from me, you say, in terms of
7 recommendations that this Inquiry should consider,
8 parent liaison support but not only of a religious
9 nature. I don't know if you would like to expand upon
10 that, Mother J, or whether you would like to --

11 **MOTHER J:** I think it's important to check in with
12 the parents on how they are mentally when they're going
13 through such a process of change. Some of the things
14 that you see are not things that you are prepared to see
15 and just having someone that can maybe sit down and just
16 ask that question of "Are you okay?" to then open up
17 a conversation, may just help people to, you know, to
18 just be open about what they're experiencing.

19 I think when you're involved in the care of a child
20 that's had surgery it really does touch every part of
21 your life and it's important that the parents feel
22 physically, but also mentally, strong to deal with the
23 things that they're seeing.

24 **MS LANGDALE:** Thank you. Those are all my
25 questions.

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1 **MOTHER J:** Just a lack of care and humanity really,
2 towards a child that was recovering from surgery and
3 here was at a high risk of catching an infection because
4 she had a Broviac line.

5 **Q.** What is a Broviac line?

6 **MOTHER J:** It's a line that goes into the -- so
7 it's a quick access point into the aorta, the main
8 artery into the heart.

9 **Q.** So it's a central line?

10 **MOTHER J:** A central line.

11 **Q.** What had you been told about managing the
12 Broviac line?

13 **MOTHER J:** That it needed to be flushed every
14 seven days to keep it sterile and to make sure that it
15 was clean and free of infection.

16 **Q.** Did it concern you then, with regard to
17 infection, that the stoma bag had been left leaking?

18 **MOTHER J:** Well, the stoma bag was off, so yes, it
19 was very concerning.

20 **Q.** When you spoke to Mr Saladi and
21 Eirian Powell*, did you raise that issue with them,
22 about the risk of infection?

23 **MOTHER J:** Yes. I mentioned the risk of infection
24 quite a few times and that I was concerned that she was
25 going to, in my words, "get poorly", which was my way of

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1 Is there anything either of you would like to say
2 that I haven't asked you about, or would like to bring
3 to the Chair's attention? Your counsel will have
4 an opportunity in the next ten minutes to have a look if
5 there's anything else that he would like to ask you
6 after a short break.

7 **MR BAKER:** The short break is not necessary from my
8 point of view, I'm ready to start now, but if the
9 witnesses would prefer to have ten minutes then I'm
10 happy to --

11 **FATHER J:** No.

12 **LADY JUSTICE THIRLWALL:** I think they're probably
13 ready to continue. Very well.

14 **Questioned by MR BAKER**

15 **MR BAKER:** I just want to go back, first of all, to
16 15 December. It's dealt with at paragraph 81 of your
17 witness statement and that's the date when you went in
18 and found Child J without her nappy on.

19 Now, your evidence was that that it was first thing in
20 the morning, it was -- Lucy Letby had been the nurse
21 over the course of the preceding night, so it was the
22 end of the shift.

23 What was it that particularly concerned you about
24 finding Baby J wrapped in a towel without a stoma bag
25 on?

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1 saying that she was, you know, at high risk of infection
2 and we still hadn't had an answer on why she had
3 collapsed the first time and I was just so afraid that
4 that was then going to happen again. It was trying our
5 best to mitigate against that, even though it was an
6 unknown -- unknown collapse.

7 **Q.** Do you think they took that seriously, that
8 complaint or concern?

9 **MOTHER J:** Not as -- not as seriously as I would
10 have expected. I think they listened to us, but
11 I didn't see any actions after that conversation.

12 **Q.** But you weren't aware at that time that
13 Lucy Letby was the nurse?

14 **MOTHER J:** No, we weren't aware at that time.

15 **Q.** Finally, on page 32 of the bundle, which is
16 also page 32 of your statement, you have a concluding
17 comment. First of all, how is Child J doing now?

18 **MOTHER J:** Yes, she is doing very well now, very
19 healthy.

20 **Q.** I don't know if you want me to ask you
21 questions about the concluding comment section, or if
22 you would just --

23 **MOTHER J:** I would like to read that out:

24 "This journey has severely impacted our lives even
25 though we have a healthy and happy child. We recognise

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1 that we haven't suffered the terrible loss and sadness
2 and ongoing lifelong challenges of many of the other
3 families. They have lost babies who would normally have
4 gone on to live happy lives in loving families. Having
5 a healthy child has given us the strength to keep moving
6 forwards during many of the dark days, and in particular
7 during the trial. Despite our involvement, we can only
8 imagine the strength, courage and dignity the other
9 parents needed to summon to function over the last
10 ten years. We have given this statement to stand in
11 solidarity with them. At the end of this process there
12 must be accountability and there must be permanent
13 change."

14 **MR BAKER:** Thank you, my Lady. Those are all my
15 questions.

16 **LADY JUSTICE THIRLWALL:** Thank you, both of you,
17 and, Mother J, thank you in particular for your remarks
18 which I know you wrote together at the end.

19 You mentioned a number of times during the course
20 of your evidence how important it is to be empathetic
21 and to walk in the shoes of someone else. You mentioned
22 it principally in relation to the care you had at
23 Alder Hey, in fact, but what you have demonstrated and
24 I think will be very important to the other parents is
25 your willingness to do this for them, as well as for

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1 **FATHER J:** Thank you.

2 *CORECTION: During the hearing on 24 September
3 2024, Ms Langdale KC stated: "we understand from the
4 solicitors representing Mother and Father J that Mother
5 and Father J would like to correct something they said
6 in evidence yesterday. Their meeting to raise concerns
7 about Baby J was with Dr Saladi and a nurse, but that
8 nurse was not Eirian Powell as stated. We will explore
9 in oral evidence, my Lady, which nurse it was in due
10 course".

11 (12.52 pm)

12 (The luncheon adjournment)

13 (2.00 pm)

14 **LADY JUSTICE THIRLWALL:** Mr and Mrs K, thank you
15 very much for coming to give evidence. It's very good
16 to see you. I know that you will be nervous, so we will
17 crack on. Ms Langdale.

18 **MS LANGDALE:** Mother K, may you take the
19 affirmation?

20 **MOTHER K (affirmed)**

21 **MS LANGDALE:** You have provided the Inquiry with
22 a statement.

23 **MOTHER K:** Yes.

24 **Q.** Can you confirm that the contents are true and
25 accurate as far as you are concerned?

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1 yourselves, and I'm very grateful to you for doing that.
2 I also know that it's much harder to do than you think
3 it's going to be because it brings back a lot of
4 memories.

5 Your evidence was thoughtful and detailed, some of
6 it very personal, but all of it very helpful for me in
7 looking at Part A of the Terms of Reference and a little
8 bit about Part C also.

9 I was struck by your comparison between different
10 hospitals, but also between different wards of the same
11 hospital and the difference that individuals make to how
12 a ward feels and how you felt as parents, so thank you
13 for that.

14 Finally, the thought that you have put in to the
15 recommendations is very striking and you have given
16 a number of suggestions which will be considered and
17 tested against the views of others, but I am grateful to
18 you for all of that. Thank you very much indeed for
19 coming.

20 **MOTHER J:** Thank you.

21 **FATHER J:** Thank you.

22 **LADY JUSTICE THIRLWALL:** So that concludes the
23 proceedings for this morning. We will start again at 2
24 and you are free to go whenever you want.

25 **MOTHER J:** Thank you.

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1 **MOTHER K:** Yes, I can.

2 **Q.** You tell us about your pregnancy with Child K.
3 Can you tell us something first about your expectations
4 for family life and moving into your pregnancy with
5 Child K?

6 **A.** Yes. So obviously my husband and I had met,
7 we had moved out, got a house and things, careers were
8 going well and we found ourselves in that space where we
9 were wanting to start a family. It was a little bit of
10 a long road to get there but we did, and we found
11 ourselves pregnant in 2015 and we were obviously
12 thrilled and happy and over the moon with it.

13 We generally didn't foresee any issues with the
14 pregnancy or anything like that. I kept myself very fit
15 and well, but yes, we went, you know, to the 12-week
16 scan --

17 **Q.** Before we get to the scan, can I just ask you
18 this: was your care shared between the community midwife
19 based at your GP surgery and with the Countess of
20 Chester?

21 **A.** It was, yes. Obviously the normal process is
22 you contact your doctor locally and that then kind of
23 kicks in the process to arrange scans and things like
24 that.

25 **Q.** And you both attended all appointments at the

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1 Countess of Chester Hospital?
 2 **A.** We did, yes.
 3 **Q.** And you would go to the midwife appointments?
 4 **A.** That's right, yes.
 5 **Q.** So you had your first scan. Tell us about
 6 that. I think you were going to move on to that?
 7 **A.** So yes, we had the first 12-week scan booked
 8 in at the Countess. Both of us attended and during the
 9 scan you could tell that they started to look a little
 10 bit concerned as they were obviously working through the
 11 scan and the details. At the end of the scan the
 12 midwife did say "Right, I'm going to go and have
 13 a conversation with one of my colleagues" and then came
 14 back into the room and advised us about the little
 15 pocket of fluid around the back of our daughter's neck.
 16 From that we went into a separate room where more
 17 discussions were had around what does that mean for my
 18 daughter and mean for us and decisions that we would
 19 have to make. They alluded to the fact that this could
 20 be a potential sign of Down's syndrome and a couple of
 21 other conditions as well.
 22 So obviously we were pretty devastated. They gave
 23 us some options of what we could do next and one of
 24 those was the amniocentesis. We did have to wait
 25 a couple of weeks so we were at the right gestation for

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1 **A.** Yes, so once we had the results back that
 2 actually everything was okay with our daughter, the
 3 pregnancy was continuing but now they needed to monitor
 4 the fluid, so pretty much every two weeks we were in for
 5 a scan. These were carried out by Jill Edwards. She
 6 was a senior midwife there and she was fantastic. We
 7 built up a really good relationship. You could tell the
 8 amount of experience she had but also just on a personal
 9 level she was very connective. Mr McCormack would then
 10 obviously review the results. He would have
 11 conversations with us that the fluid was starting to
 12 clear on its own and that that was a good sign and that
 13 by the time baby arrives, fluid should all be cleared up
 14 and no issues and they were happy with the development
 15 of the baby.
 16 **Q.** I think at this time you were buying some
 17 items in preparation for your baby's birth for home?
 18 **A.** Yes.
 19 **Q.** And decorating a nursery?
 20 **A.** Yes, so because obviously we had had the great
 21 news about, you know, baby is completely fine, things
 22 are all going in the right direction with her
 23 development and things like that, we, yes, allowed
 24 ourselves to then go into the mode of preparation and
 25 purchasing some items and family wanted to get

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1 that to happen, and, again, we were told that carrying
 2 out that procedure would tell us if our daughter had
 3 a condition or not, but also it did carry a risk of
 4 miscarriage as well.
 5 **Q.** Was it Mr McCormack who was advising you?
 6 **A.** So at this point it was the lady -- the senior
 7 midwife -- that was going through the options with us
 8 and then once we decided the route that we were going to
 9 take, we then got put under the Consultant,
 10 Mr McCormack.
 11 **Q.** And how did you find that antenatal care
 12 provision or obstetric care for you generally from
 13 Mr McCormack and the senior midwife?
 14 **A.** We couldn't have faulted them. They were
 15 brilliant. They were so supportive. They spoke about
 16 all the options very clearly, precisely; you know, let
 17 us ask the questions that we wanted to ask, everything
 18 like that. They were very reassuring through the
 19 process.
 20 **Q.** And you had an amniocentesis?
 21 **A.** We did.
 22 **Q.** You had follow-up scans then, you tell us?
 23 **A.** Yes, we did.
 24 **Q.** At paragraph 17 you talk about some of the
 25 follow-up scans?

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1 involved -- they were excited as well and purchased
 2 a few things for us -- and, yes, moved naturally down
 3 that route.
 4 **Q.** Then at about 25 weeks you woke up with some
 5 niggly stomach cramps and ended up going into hospital,
 6 didn't you --
 7 **A.** That's correct, yes.
 8 **Q.** -- with those and you were examined and they
 9 thought you were in pre-term labour?
 10 **A.** Yes.
 11 **Q.** So what happened then? What were you told?
 12 Were you kept in the picture? What happened?
 13 **A.** So we arrived at the hospital, generally under
 14 the impression that we were just going to be sort of
 15 checked over, baby was going to be checked and it was
 16 going to be fine, a bit of growing pains and sent on our
 17 way. We took no preparation bags or anything like that
 18 with us. We waited in the waiting room for about half
 19 an hour or so, taken through to a side room,
 20 examination, and then they said "Well, you're in
 21 pre-term labour". Obviously we were very shocked at
 22 this point, as in "Well, what does that mean? What's
 23 going to happen?"
 24 They quickly sort of advised that really their next
 25 step would be to look into transferring us out because

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1 their unit, you know, doesn't cover that gestation.
 2 They also advised very quickly about the steroid
 3 injections that we would be receiving to boost her lung
 4 capacity and we were just then sort of obviously left
 5 while they did their investigation work, I'm assuming
 6 about the transfer.

7 **Q.** Let me just ask you for a moment about the
 8 transfer. I think you now know it was a Dr Ford and
 9 Dr Brigham that you spoke with?

10 **A.** Yes.

11 **Q.** And your medical records indicate you would
 12 need to be transferred to a Level 3 centre?

13 **A.** Yes.

14 **Q.** But you were told, were you, that you were
 15 just going to go to another hospital. Is that the
 16 position?

17 **A.** Yes, they didn't call it "Level 3". They just
 18 said "You need to be transferred out because we don't
 19 deal with babies of your gestation; you need a little
 20 bit more special care than what we can provide at the
 21 Countess".

22 **Q.** So then steroid injections were discussed and
 23 what happened then?

24 **A.** They were discussed and obviously we agreed
 25 and the first round was given and then from that point

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1 **Q.** Does that fit with your recollection now that
 2 your labour in the afternoon had progressed?

3 **A.** Yes, they had obviously continued to examine
 4 and they said "it's now progressing". I suppose the
 5 effort that they tried to slow it down didn't quite work
 6 and that, yes, this baby is coming, type thing.

7 **Q.** And at some point they discussed with you
 8 whether or not a caesarean would be necessary or a good
 9 idea. Do you remember that?

10 **A.** So yes, this was a late-night discussion. Now
 11 through the criminal trial we're aware that it was
 12 Dr Ford that had had this conversation with us and it
 13 was a conversation where it was myself and Father K and
 14 then it seemed like a team of people because quite a lot
 15 of the interns had come in to see these discussions, be
 16 part of them. We had sat down -- and his demeanour and
 17 that was great -- and, he sat on the edge of the bed and
 18 really spoke to us on quite a personal level and he just
 19 described the fact that he couldn't tell -- he couldn't
 20 give us like medical advice of which way to go because
 21 the research that's out there around the 25 week
 22 gestation was quite limited, so he could just tell us
 23 what he knew and then basically it was our decision of
 24 what we need to do.

25 He described the fact that it wouldn't be a normal

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1 they were looking to transfer us into a room then; to be
 2 fully admitted and put into a labour suite I suppose.

3 **Q.** So you were in fact admitted to the Countess
 4 of Chester. Did the issue of transfer ever come up
 5 again, either from you or from them about going
 6 somewhere else or not?

7 **A.** Not -- from memory. All we can remember is
 8 the transfer conversation. Obviously that was quite
 9 nervous for both of us to be taken out of your support
 10 area and then they came back in. They did say a name or
 11 so of a hospital. We now know it was Preston. Thinking
 12 back, we thought it was a little bit further away from
 13 that -- the first one that they mentioned to us -- just
 14 because we were aware of the surrounding areas and the
 15 timeframes it takes to get there. So when they said it
 16 the first time, it was more of a shock than of "Well,
 17 how are you going to do this? How are we going to get
 18 there?" With the one that actually came out, we knew
 19 where that was a little bit more, but actually after
 20 that point nothing else was said about the transfer.

21 **Q.** You say that you learned in the trial the
 22 reason you weren't transferred was because it was too
 23 risky to transport you and in fact your labour had
 24 progressed?

25 **A.** Yes.

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1 C-section because of obviously Baby K's gestation and
 2 that that would then affect potentially future
 3 pregnancies.

4 **MS LANGDALE:** So Father K and yourself were having
 5 that discussion with Dr Ford?

6 **A.** Yes.

7 **Q.** And you were faced with an unknown situation
 8 really and not one where there was a lot of medical
 9 expertise to back it up from what you are saying?

10 **A.** Yes.

11 **Q.** It was unclear what the route was forward?

12 **A.** Yes.

13 **Q.** You say your feeling at that point was if she
 14 could have a few more hours where she was basically to
 15 do what she needed to do in there --

16 **A.** Yes.

17 **Q.** -- was where you landed.

18 **A.** Yes.

19 **Q.** So how did that go?

20 **A.** Yes, they were very accepting of that. It was
 21 our decision to make. They were like "Fine". He was
 22 very confident in the fact that he could deliver our
 23 daughter. He made us very comfortable that if we wanted
 24 to let things progress naturally and as they should that
 25 he will be there and will be able to deliver.

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1 Q. In fact is that what happened?
 2 A. Yes, that's exactly what happened, yes, and he
 3 was very confident and delivered her.
 4 Q. You say at paragraph 35:
 5 "... other than the baby being only 25 weeks old,
 6 the doctors said there were no clinical concerns or
 7 signs that the baby was distressed. I had been
 8 monitored since my admission to the labour ward, and the
 9 baby's heart rate and all other signs were good."
 10 A. Yes.
 11 Q. Is that your recollection of it?
 12 A. Yes.
 13 Q. You say at paragraph 36:
 14 "Child K's heart rate was listened to every hour."
 15 You were scanned a few times during the delivery
 16 but there was nothing that led you to worry.
 17 A. No, no.
 18 Q. You woke up at midnight with further pains.
 19 A. Mm-hm.
 20 Q. Tell us as much as you would like about the
 21 actual delivery.
 22 A. So, yes, I had been getting niggly pains
 23 throughout the day but then it had woke me up at sort of
 24 midnight as stated. Obviously I nudged my husband just
 25 to say "Oh, kicking in a little bit now" and he pressed

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1 recorded the condition at birth.
 2 A. Yes.
 3 Q. "Dusky and floppy with no respiratory
 4 efforts." Then if we look at the APGARs at 1 minute 4,
 5 5 minutes 9 and 10 minutes 9. Do you see that?
 6 A. Yes.
 7 Q. How did you understand she was at birth and
 8 what was happening? How did you feel around that?
 9 A. To be honest, it was a bit of a blur because
 10 obviously they're still sort of working on myself. Baby
 11 was just taken straight over to the Resuscitaire and
 12 they were completely around her; you couldn't see her.
 13 You just kept sort of, you know, looking over but at the
 14 same time, I'm being asked sort of questions and things
 15 to do as well. We weren't expecting a cry or anything
 16 like that; we were prepared for the fact that they were
 17 going to have to help her so we did know that. Then it
 18 must have been maybe 20 minutes, half an hour when they
 19 sort of reverted back and said "We have stabilised her"
 20 and that's also when we learned whether it was
 21 a daughter or a son, so yes.
 22 Q. So up until that point then the antenatal care
 23 and the care on delivery, how would you describe your
 24 experience of that?
 25 A. I had no questions around it. I felt very

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1 the button on the wall. As what we were advised to do,
 2 if we felt we needed any assistance and then that's when
 3 obviously everybody entered the room, examined me,
 4 scanned me and then prepped for delivery basically.
 5 Q. Dr Ford was there?
 6 A. Yes.
 7 Q. You say he calmly stepped forward to help to
 8 deliver Child K naturally.
 9 So she is born at 2.15 am or 2.12 am in the
 10 morning?
 11 A. Yes.
 12 Q. She is immediately taken to an incubator on
 13 the other side of the labour room where the staff are
 14 with her.
 15 A. Yes.
 16 Q. So was it what you had been told to expect, in
 17 effect?
 18 A. Yes, it was, yes. We were told that the
 19 Neonatal Team had been contacted, they are aware of her
 20 delivery, that they would obviously need to be present
 21 for her delivery and that's what happened as soon as
 22 they knew that it was imminent. The Neonatal Team was
 23 also there and stood there prepped ready to take her.
 24 Q. We know she weighed 692 grams. If you look at
 25 that bundle in front of you at page 68 we can see

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1 informed. They were, as I said, very attentive. They
 2 answered our questions well. There was a plan of what
 3 was going to happen and that happened. There was no
 4 criticism from our perspective at that current time over
 5 any care that I had received and, as far as we were
 6 aware at that point, that our daughter had received.
 7 Q. About half an hour after she was born the
 8 Consultant Paediatrician -- I think you now know that
 9 was Dr Jayaram -- came over to speak to you, advised you
 10 that the baby was stable and ready to be transferred to
 11 the NNU.
 12 A. Yes.
 13 Q. And she was.
 14 A. Yes.
 15 Q. Which of you were able to go down and see her
 16 first? What happened in terms of seeing her?
 17 A. So before she was transferred obviously my
 18 husband was offered to obviously come and see her before
 19 she was transferred out of the labour ward, so my
 20 husband went to see her first. Obviously I was still
 21 being treated and then she was transferred down.
 22 My husband then had walked down before myself again
 23 that evening but the first time we had gone together was
 24 early hours in the morning when we had been told by the
 25 midwife looking after her that she was okay and due

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1 a visit.

2 **Q.** When your husband went down to see her, did he
3 come back and tell you how she was? Were you relying on
4 him to tell you how she was because you couldn't see her
5 yourself at that point?

6 **A.** Yes, very much so but at the same time more so
7 on the medical staff to be honest because while my
8 husband went down to see her I had gone off to sleep, so
9 he had left obviously to go and see her while I was
10 resting, so I didn't hear about him coming back or his
11 renditions of things until I was awake. So actually we
12 were still very much reliant on the medical team to tell
13 us how she was doing.

14 **Q.** You say that at about 4 am a nurse came in to
15 you to take you down to see her as well --

16 **A.** Yes, yes.

17 **Q.** -- with your husband. Tell us about that?

18 **A.** So the nurse came in and she just said "Hi
19 guys", you know, "I have been with your daughter, she is
20 now stable, she is doing okay, she is doing all right
21 and she is well enough for you to come and have
22 a visit", so we were like "Yeah, brilliant, we want to
23 go down." From my recollection I don't think we went
24 back with that actual nurse. I believe that -- because
25 I had to get into a wheelchair and things -- the nurse

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1 arrived that she is going to probably need that with her
2 being the gestation she is and it was tied to a little
3 bonnet and, yeah, and she had obviously all the monitors
4 on her and the monitors had little animals on them and
5 things like that, so yeah.

6 **Q.** What was the atmosphere in the unit as far as
7 you were concerned when you went in?

8 **A.** Very calm. Very, very calm. There was no
9 hustle and bustle around. To be honest I can't recall
10 any other babies at that time being in the unit.
11 I suppose you just focus on, you know, your own baby but
12 it was very calm, yes, very calm.

13 **Q.** You say you stayed for around 20 minutes and
14 you both returned to the labour room where you slept.
15 When you can't see your baby in that situation, do you
16 think it would have been comforting to see them via
17 a CCTV or --

18 **A.** Yes.

19 **Q.** -- on your phone in the way that we can see
20 images over our phones these days?

21 **A.** Yes, 100%. As you said, you were reliant on
22 a third party to come and tell you how they're doing,
23 where as if you could literally have something where you
24 could just look, you can check, she is fine, the
25 reassurance that that would give you is overwhelming

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1 left and then another midwife from the ward actually
2 wheeled us to see her but it was a very short
3 conversation. "She is doing good, come see her",
4 basically.

5 **Q.** You describe seeing her so tiny and so
6 precious.

7 **A.** Yes, she was just a dot, that's all she was.
8 It's such a strange feeling because the first thing you
9 obviously want to do is pick her up and give her
10 a cuddle, but at the same time you don't want to touch
11 her because you don't want to disturb her. You don't
12 want to disrupt the treatment. It's a really torn way
13 that you go about it because I can't help her so you
14 don't want to get in the way of anybody else helping
15 her, you don't want to interrupt the process that's
16 happening and, so you're very tentative with it. It's
17 a really strange, feeling but yes, she was this little
18 dot with a little white hat on, yeah.

19 **Q.** And she had a breathing tube?

20 **A.** She had a breathing tube and tubes everywhere
21 else.

22 **Q.** What did you think the breathing tube was
23 helping her with?

24 **A.** Obviously breathing and respiratory. As
25 I said, we had been told by the Consultant before she

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1 really and actually address some of your anxieties and
2 things like that and enable you probably to start that
3 recovery process as well and things like that because
4 you know she is okay, you can see her at any moment you
5 want to.

6 **Q.** You referred a moment ago to wanting to leave
7 people to do their job, the staff to do their job, and
8 that you couldn't do that job --

9 **A.** Yes.

10 **Q.** -- because at this point she needed the
11 assistance. Would it help with that if you're not
12 having to pester and ask for information, if that's how
13 it feels like when you are asking for it?

14 **A.** 100%, yes. I felt very conscious that you
15 just didn't want to get in the way. She needed their
16 100% focus and their dedication and I didn't want to
17 take any of that away, so you massively let them do
18 their job in that time. So yes, being able to see what
19 they were doing, or even the fact that actually the
20 midwives that come round and check on you, you could
21 actually ask them "What are they doing now?", so again
22 you're not taking away that concentration and dedication
23 from your baby but you can get the information you need
24 elsewhere, so it would be massively reassuring.

25 **Q.** You say that as far as you knew Child K was

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1 stable, they were good at that point?
 2 **A.** Yes.
 3 **Q.** At that point was there an expectation in your
 4 mind that there would be a transfer if she was stable?
 5 **A.** Yes.
 6 **Q.** Again, why did you think that was necessary or
 7 was going to happen?
 8 **A.** Because it had been explained pretty much from
 9 the outset -- again, from the time that we were
 10 admitted -- it would have been ideal that we were both
 11 transferred out and that if both of us weren't going to
 12 be transferred out, she would be. She needed to go to
 13 a tertiary centre and that's what would happen and when
 14 she is born that's the process that then would kick in
 15 to find that transfer, so we knew it was going to
 16 happen.
 17 **Q.** So you tell us you got some sleep and then you
 18 were ready and you went back to the NNU when the
 19 transfer team had arrived?
 20 **A.** Yes.
 21 **Q.** You also tell us that you learned subsequently
 22 that while Child K was on the NNU there were three
 23 separate incidents when the breathing tube became
 24 dislodged and she required resuscitation. Was any of
 25 that said to you at the time?

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1 You know, like, "How does this dot do that if that's
 2 what you're saying happened, that she sort of did it
 3 herself, or did it just slip?" You would ask the
 4 questions of "How has that happened?" and then for it to
 5 happen again and again, but you would hope that if we
 6 were told about the first incidents she just wouldn't
 7 have been left on her own.
 8 **Q.** To be clear: if she is not breathing as well,
 9 you would have wanted to have been there; to be with her
 10 if that was happening?
 11 **A.** Of course, yes, we should have been told;
 12 while that was happening, we should have been told that
 13 this is happening and been called to her, in my opinion,
 14 and then from that we would have understood and asked
 15 the questions "Well, how, how has that happened?",
 16 you know, that type of thing and then from that point
 17 she wouldn't have been left on her own. One of us would
 18 have been there.
 19 **Q.** You had been contacted before, hadn't you?
 20 Someone had come up to get you to come and visit her?
 21 **A.** Yes.
 22 **Q.** Did you have a mobile phone with you?
 23 **A.** Yes, we would have had our mobile phones, yes,
 24 100%.
 25 **Q.** And you were nearby in any event?

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1 **A.** No.
 2 **Q.** When did you discover that?
 3 **A.** In the criminal court proceedings.
 4 **Q.** Taking you back to the time, you go back to
 5 the NNU, the transfer team have arrived. Did you meet
 6 with any of the transfer team?
 7 **A.** Yes.
 8 **Q.** What was that experience?
 9 **A.** They came to see us first before they went
 10 down to see our daughter. They introduced themselves,
 11 where they were from and obviously the purpose is to
 12 transfer her. That they would obviously go down to the
 13 unit, they would transfer her over to a travel cot that
 14 would be suitable for the ambulance, and obviously they
 15 would make her secure and safe before they did that, and
 16 then before they left the hospital they would be back in
 17 touch with us for updates as to how that was going and
 18 let us know. So we were like "Brilliant, yeah, great".
 19 **Q.** If you had been told about desaturations at
 20 the time they were happening, or as soon as possible
 21 thereafter, what do you think you would have done?
 22 **A.** Sat there at the side of her cot. Well, my
 23 husband would have sat by the side of her cot, or we
 24 would have took it in turns, took it in shifts. You
 25 would have questioned "Well, how has that happened?"

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1 **A.** Yes.
 2 **Q.** How far away?
 3 **A.** About five minutes, if that. It's literally
 4 just through the corridor.
 5 **Q.** So around midday the transfer team tell you
 6 that Child K is stabilised and a doctor says to you the
 7 transfer is going to happen. What was his expression,
 8 what did he say to you?
 9 **A.** "It's now or never."
 10 **Q.** What did you take from that?
 11 **A.** That was one of the first times I suppose that
 12 we both had the thought of maybe this isn't as plain
 13 sailing as what it was being made out or that we were
 14 aware of because we hadn't been told any different at
 15 that point. All it was was that she was stable and she
 16 was doing okay. We had probably already maybe had the
 17 conversation about "It's taking up quite a long time"
 18 because they must have got there about 8 o'clock, 8.30
 19 or something like that, so it's now midday, but, yes,
 20 that was the first time we had that inkling of maybe
 21 this is not where she should be right now.
 22 **Q.** The transfer team are going to take her to
 23 Arrowe Park Hospital, aren't they and you say the team
 24 at Chester completely took their direction from the
 25 transfer team. In what way?

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1 A. They just took over her care. They instructed
2 what needed to happen and that's what the Countess team
3 around assisted with and helped with and so from the
4 moment they arrived, her care was under them.

5 Q. Did the team introduce themselves, who they
6 were, when they took her?

7 A. Yes, so it was the same team that came in the
8 morning and then, as I said, it was the same Consultant
9 that came back to see us to say "We're taking her now,
10 we can't do any more for her at Chester, we've got no
11 more additional facilities to help her, so we're going
12 to take her".

13 Q. At that point had you agreed a name for her?

14 A. Yes, we did. Obviously we didn't even know
15 whether it was a boy or a girl until she arrived, so
16 yes, we had the conversation and I said "I think we need
17 to give her a name before she leaves" and we, yes,
18 agreed a name.

19 Q. When she left with the transfer team, you
20 hadn't been discharged from the Countess of Chester?

21 A. No.

22 Q. What did that feel like when she was going
23 somewhere else?

24 A. Probably a little bit frustrating by now
25 because they knew this was happening and they knew that

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1 A. Again, very much like what we had seen her in
2 the Countess. The set-up was very similar. Obviously
3 she was in the incubator and the tubes and, you know,
4 all the wires hooked up to the machinery and things like
5 that, but yes, as soon as you walked in through the door
6 she was right there in front of you so yes, I remember
7 well.

8 Q. You said the transfer team had prepared
9 a certificate for her.

10 A. Yes, they had.

11 Q. Tell us about that?

12 A. Once we got there, they passed us over
13 a certificate to say congratulations on your transfer
14 from Chester to Arrowe Park and when you receive things
15 like that you just -- it's heartwarming really -- think
16 how sweet that they thought of that and obviously now
17 it's a keepsake. Because in those moments you don't
18 think about sort of collecting memories, if that makes
19 sense, but that was a lovely touch, a great touch, yes.

20 Q. You say when you arrived it said Baby K with
21 her name --

22 A. Yes.

23 Q. -- on the board?

24 A. Yes.

25 Q. So again tell us how that felt?

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1 I needed to go. I was actually quite fortunate as in
2 I had no complications so I can go -- I was physically
3 fine to go -- so it was frustrating that we're still
4 waiting now for paperwork when they knew the importance
5 of it, I suppose, and they knew that this was going to
6 happen but they obviously got the paperwork together and
7 then discharged me probably about two hours afterwards,
8 I think, once she had left.

9 Q. Did you get a telephone call when she was
10 safely there?

11 A. Yes, we did.

12 Q. Who phoned you?

13 A. The Consultant that took her phoned us and
14 said "She is here, she did great in the trip", so I'm
15 assuming by that that obviously there was no drop of her
16 condition while she was being transferred and that they
17 had managed to then obviously transfer from the travel
18 cot into the Resuscitaire within Arrowe Park and they
19 had settled her, yes.

20 Q. I think you were able to discharge yourself
21 about 2 o'clock, weren't you?

22 A. Yes, yes.

23 Q. Then you both went over to Arrowe Park?

24 A. Yes.

25 Q. How was she when you first saw her there?

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1 A. That's obviously the first time we have now
2 seen her name because she left without a name, so
3 actually we both commented on it. We were both like
4 "Oh, they wrote her name" and, again, in the normal
5 process of things, that wouldn't be something that you
6 probably would hold on to, but it means a lot in those
7 circumstances, a lot, that now she has got that identity
8 and that she is here, she is cemented, so yes, it means
9 a lot.

10 Q. You say:

11 "The feel of Arrowe Park was very different to
12 Chester. They have an open-door policy so, as a parent,
13 you can go whenever you want. There are no time
14 restrictions."

15 A. Yes, so the staff, the nurses that worked
16 there, the Consultants that worked there, encouraged you
17 to come whenever you wanted -- 24 hours, around the
18 clock -- and because of that, those initial feelings of
19 not sort of wanting to get in the way or you didn't want
20 to interrupt something that they were carrying out or
21 anything like that kind of did subside a little bit,
22 because as soon as they caught your eye they were like
23 "Oh, yeah", and they would invite you into the process
24 so yes it had a slightly different feel and you were
25 engaged a little bit more.

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1 Q. Was that the case even when it was busy?
2 Presumably that had a busy ward as well. Would it still
3 be the same?

4 A. Yes, 100%. So obviously the dedicated nurses
5 are there one-on-one with your little one but in the
6 mornings, there was always a ward round and you were
7 asked to be there on those mornings when they would
8 discuss the condition of your baby, what the treatment
9 is going to be that day, what the plan is. You were
10 part of it, which was lovely; quite hard to sometimes
11 grasp and understand exactly what they were talking
12 about in their terminology, but by the same token they
13 would -- especially the nurses -- then try and
14 re-explain it, I suppose in a little bit more layman
15 terms for us, but you were always encouraged to be part
16 of those conversations. It would be busy then where
17 they're moving everybody around, but you were, yes,
18 massively encouraged --

19 Q. If the terminology was difficult to understand
20 did you have any hesitation about asking for
21 clarification or anything?

22 A. No and they even gave you the option,
23 you know, "Do you have any questions? Do you have any
24 concerns? Do you want to ask us anything?" They gave
25 you those opportunities to do that within that meeting,

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1 so, yes, we couldn't have done it without that.

2 Q. Whilst she was at Arrowse Park she also
3 required the breathing tube, didn't she?

4 A. Yes.

5 Q. Were there any incidents with that when she
6 was there?

7 A. No, or through transfer.

8 Q. You tell us at paragraph 68 that there was
9 a change within the 24-hour window and that she looked
10 different?

11 A. Yes.

12 Q. Again, only sharing as much as you would like
13 to, but how did she start to appear?

14 A. She just become very swollen; very swollen,
15 very bruised. She just looked very tight, her skin had
16 gone very tight and, yes, she looked full. You would
17 just look at her and you would think -- all I kept
18 thinking was "How much more can you pump into her",
19 because that was the impression that she gave you when
20 you're looking at her, is how much they had put into her
21 that caused it, so yeah, she was very swollen.

22 Q. You say at paragraph 73:

23 "Outside of the huddles information was passed on
24 at the cot-side. Some mornings we would walk in and
25 a nurse may be changing the lines and they would tell us

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1 but not obviously solely within that meeting. As
2 I said, once you came down and the nurses were about
3 they would explain what they were doing and why they
4 were doing it and answer any questions that you had.

5 Q. You say you were told about the room at
6 Ronald McDonald House when you first arrived at
7 Arrowse Park.

8 A. Yes.

9 Q. Tell us about that accommodation and how
10 supportive that is or can be for parents in your
11 situation?

12 A. I don't think we could have done it without
13 that support and without that option. They had already
14 set that up for us. We weren't aware that that was
15 something that was available and when we got there they
16 said "We have already set you up to meet with one of the
17 ladies that run Ronald McDonald" and they had already
18 put a room aside, so again very proactive, you know,
19 with what they knew that we would need but yes, again it
20 also allowed you to sort of be with your baby as much as
21 you wanted to be and then also have that breathing space
22 of being able to go and change, shower, food, or even as
23 well when you have family you've got somewhere to sit
24 with your family and have discussions with your family
25 and things and it hasn't got to be all around the cot,

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1 that Child K had had a good morning. At one point
2 Child K had her first wee and everyone was pleased. It
3 was a good sign as it meant that everything was working
4 as it should. A positive step."

5 So they were telling you along the way how she was?

6 A. Yes.

7 Q. But you also say at paragraph 74:

8 "The team had started to explain what the meanings
9 on the monitors were and I knew they were having
10 difficulty keeping Child K's sats within the range that
11 they would like."

12 A. Yes.

13 Q. So was that being explained to you as well as
14 seeing the sats? What did you think the issue was?

15 A. Yes, so they were struggling obviously to try
16 and keep her oxygen levels up and she would fluctuate so
17 much through the day; within one hour they would all be
18 sat within the good range and then the next hour they
19 would have all dropped again. As I said, they would
20 explain as much as what they could around everything and
21 where they would like them to be and that they were
22 trying -- they tried everything to help her. They
23 transferred her to a different ventilator that increased
24 the rapidness of her breathing because some babies
25 preferred that. She didn't like that, so she went back

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1 to the other ventilator.

2 There was a young doctor -- I don't think
3 I actually mentioned it in here -- but there was a young
4 doctor there and she had been sat there for hours
5 working out this next medication that they were going to
6 try and again you could tell that it was kind of like
7 the last chance but they literally were trying
8 everything that they could come up with and every single
9 person in that unit tried as much as they could to do
10 what they could for her.

11 **Q.** The day before she passed away, you say it's
12 the first time you realised just how poorly she was.
13 Was it something that someone said to you or something
14 else that made you realise that?

15 **A.** I think, again, I don't know whether it's just
16 a parent thing, you sort of grab on to the little things
17 like she has had a wee and that's kind of what you focus
18 on so you're like "Okay, so it's all working and it's
19 good and". But obviously alongside that, there's other
20 things that you can see that they're fighting with and
21 it was just you could start to see it in their demeanour
22 as well, I suppose a little bit and how it came across
23 and, as I said, the change in her body and you just got
24 a sense of it. It wasn't necessarily what somebody
25 actually said. It was the collective feeling.

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1 a bit naive and hold on to the hope, I suppose.

2 **Q.** So the following day you say you had an
3 overwhelming feeling in the early hours that you needed
4 to go and see her.

5 **A.** Yes. I've never felt anything like that
6 before or since. I just woke up and I was just like
7 "I need to go", just needed to go, and obviously nudged
8 my husband and he was half awake and I was like "Can we
9 just go see her" and he was like "Yeah", I was like
10 "okay", in our pyjamas and we went and, as I said, you
11 turn the corner and she was right in front of door and
12 I knew. I just knew without even anybody saying
13 anything.

14 **Q.** Shall we take a break? Would you like
15 a break?

16 **A.** I'm sorry.

17 **LADY JUSTICE THIRLWALL:** We will leave the room.
18 The shorthand writer will stop making notes and we will
19 come back when you are ready.

20 **(2.46 pm)**

(Short Break)

22 **(3.00 pm)**

23 **LADY JUSTICE THIRLWALL:** Ready to start?

24 **THE WITNESS:** Yes.

25 **MS LANGDALE:** Mother K, we know you and your

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1 **Q.** Did somebody raise with you whether you would
2 like her to be baptised or advise that?

3 **A.** Yes, they did. So they asked us if she would
4 like to be baptised and we said yes, we would, so
5 a couple of family members also came in and she was
6 baptised and again I suppose just you're holding on to
7 hope, I think, that's what you do and everything else
8 might be pushed to one side a little bit to sort of get
9 you through the next couple of steps. Looking back now
10 and learning what we have learned, normally they ask you
11 that question if things aren't going great but when
12 you're in that situation and we were obviously first
13 time parents, we had never been in this situation
14 before, we just thought "Oh, that's a lovely thing to
15 do". Naivety and, as I said, maybe a bit of hope, but
16 now we're aware of the fact that they actually did it
17 because they probably knew what was coming and the
18 person that carried it out and the words and the reading
19 of how they did it was not so positive.

20 **Q.** Do you mean the experience wasn't positive?

21 **A.** Not the experience, the words that he was
22 using as in like this was her last way out, if you know
23 what I mean, rather than the celebration, it was
24 a goodbye. But the experience of it and the process of
25 it 100% we would do it again, but yeah, you are just

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1 husband were shown to a family room with your baby and
2 you set out in your statement what happened next, and
3 you say here that the staff gave Child K dignity with
4 the way they handled her.

5 **A.** Yes.

6 **Q.** Can you just expand upon that, the care or the
7 assistance you got with that difficult time?

8 **A.** Yes, so as we walked into the room, there was
9 a Consultant -- which we now know is Dr Gardner -- and
10 she was sat at the bottom of Child K's cot. That was
11 the Consultant that we had a conversation with and she
12 had actually said that she had been debating about
13 phoning us for a couple of hours during that night
14 because of how much Child K was struggling. So we had
15 that conversation and frankly sort of said, "She's not
16 going to get better"? To which the response was, "No,
17 she's not going to get better, it's a matter of time",
18 and we said, "Well, we want time with her, quality time
19 with her. We don't want the machines to be telling us
20 that it's over". She had gone through enough by this
21 point. There was no more that they could do so we
22 requested to have that time with her, so, as you said,
23 we got taken to a family room literally just outside the
24 unit, and they said that then they would fetch our
25 daughter into us once we were in the family room and

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1 they did, and they wrapped her up in a blanket, fetched
2 her in with a NeoPuff and handed her over to my husband
3 first and then explained that obviously they would take
4 the NeoPuff away when we had enough time to spend with
5 her and they would come back and check within
6 ten minutes or so on her and that's what they did. It
7 was very peaceful, it was very calm and, as I said, they
8 were just very gentle on how they handled her and how
9 they handled us.

10 **Q.** You say,, on reflection, that in the back of
11 your mind at the time there was concern about what you
12 should be doing in that situation.

13 **A.** Yes.

14 **Q.** Because obviously you had never dealt with
15 that situation.

16 **A.** Yes.

17 **Q.** So what would your advice be to people dealing
18 with that situation? I don't mean the parents, I mean
19 the people -- nurses, doctors -- who may not have had
20 that experience advising on what to do in that
21 situation.

22 **A.** Emphasise that time is on your side; that you
23 haven't got a time limit with your baby. There's no
24 pre-conceptions of what you should be doing. There's no
25 right thing; there's not a wrong thing. Every family is

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1 and we got a knock on the door of the family room and it
2 was the Consultant that had transferred her and he said
3 "I had obviously just started my shift and I have just
4 learned that she has passed and I just wanted to come
5 and pass on my condolences", which we thought was
6 lovely. He didn't have to do that, you know, he had
7 sort of moved on with his day, but he didn't, he took
8 the time to come and just say "I'm sorry and I hope
9 you're all okay". It was just a really nice gesture in
10 that moment.

11 **Q.** When you first arrived at Arrowe Park you say
12 they had given you contact details and a little booklet
13 about Bliss, the charity for premature babies.

14 **A.** Yes.

15 **Q.** Did you ever look at that?

16 **A.** Yes, I had flicked through it. I can't say
17 I sat there and read it cover to cover, but I had sort
18 of flicked through it. There were numbers in there for
19 assistance and help and it explained a little bit about
20 the process and the procedure of taking care of a prem
21 baby and sort of what's to be expected, so yes, you had
22 a little bit of a reference material to look at.

23 **Q.** So did you feel you were given some
24 information at least about bereavement counselling, if
25 you to wanted to obtain it then?

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1 different. The time that they spend is different.

2 There's not going to be a knock on the door and that's
3 it, you've got to leave, or --

4 **Q.** Did you find yourself worrying about that "Am
5 I supposed to be here for a long time?" or not?

6 **A.** Yes, 100%. You're sat there and then you just
7 don't know what to do, which was a very strange feeling
8 for myself and for my husband. We are in careers where
9 we do make decisions, we manage people and we're very
10 capable of that but we just weren't at that point. It
11 had just gone and I needed somebody to do that for me
12 and I think some parents would be still fully, you know,
13 "This is what I want to do and this is how it's going to
14 be" and that's perfectly fine and I think other parents
15 need a little bit of coaxing and help and reassurance
16 that it's okay to sit for hours with your little one
17 and, you know, little things like taking pictures and
18 things like that would never have crossed my mind as
19 such. Just that type of assistance and creating that
20 environment for you to find your way a little bit.

21 **Q.** The Consultant who did the transfer did come
22 in to see you?

23 **A.** He did.

24 **Q.** Which you appreciated. Tell us about that.

25 **A.** Yes, obviously the morning shift had come on

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1 **A.** Yes, yes, it was in the back of the book.

2 **Q.** Moving forward from that time, now, we know
3 you had subsequent pregnancies, children. I'm not going
4 to ask you about the details of those, but at
5 paragraph 98 of your statement you refer to an
6 appointment you had with Mr McCormack, the Consultant
7 Obstetrician at the Countess of Chester focusing on you
8 and your obstetric history, not about Child K's
9 treatment or health.

10 Again, going to the antenatal care and then the
11 discussion of future pregnancies for you, did you feel
12 that aspect of care from the Countess of Chester was
13 a positive experience generally?

14 **A.** Yes, so again Mr McCormack and Jill Edwards,
15 who was our lead midwife through it all, we had met with
16 both of them and again it was to discuss anything that
17 they thought the reason why we would have gone into
18 premature labour and from their side of things, there
19 was nothing that would stand out to them as to why that
20 happened and no reasons why for future pregnancies it
21 would happen again, but obviously the reassurance of the
22 fact that though it has happened, future pregnancies
23 would be monitored closely. Obviously they then took
24 the time out to talk about our daughter and what had
25 happened in the weeks prior to meeting them and, yeah,

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1 they wanted to know the whole story from a personal
2 perspective so, yeah, we felt very comfortable in their
3 care and very confident in their care.

4 **Q.** You did have children under their care, the
5 same joint arrangement with your GP and the hospital?

6 **A.** Yes, we did, yes.

7 **Q.** There's just one event at paragraph 119 in
8 relation to one of your children that was delivered
9 there and when you say at paragraph 119 with this child:

10 "[You] were reviewed by the midwives before [you]
11 were discharged and the Paediatrician completed the new
12 baby check. Everything seemed to be fine and the baby
13 was feeding great. I questioned whether we needed to be
14 seen by the Neonatal Team before we were discharged
15 because the baby had been under their care with having
16 borderline oxygen levels and we had been advised that
17 the baby would need to be seen before they were
18 discharged."

19 And you were told that wasn't necessary. In the
20 next paragraph you tell us that you were in fact called
21 back. So tell us what happened there?

22 **A.** So with that pregnancy when our baby was
23 delivered, they were delivered very, very quickly and
24 his oxygen levels kept dropping so the neonatal team was
25 called in at the same time as delivery and the baby was

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1 runs the risk of them having seizures" and so the baby
2 needed to be under their care for 24 hours.

3 So obviously my next question is "Well, the baby is
4 not staying on their own, I'm coming back with them" and
5 to be fair she was like, "Don't worry, we've got you
6 a side room on the maternity ward, you will both be
7 staying". She was very apologetic "I'm sorry", so
8 obviously we changed a few things over in the bags,
9 turned round and went straight back to the hospital.

10 As soon as we got onto the ward they called down to
11 the Neonatal Unit and that Consultant came up to see us.
12 As you can appreciate, my husband was a little bit angry
13 and annoyed by this point and sort of expressed our
14 concerns over it and, to be fair, she was also very
15 frustrated that it had happened and she expressed the
16 fact that she had already been looking at the process,
17 she had already made suggestions for changes for this
18 not to happen again. It shouldn't have happened and
19 obviously my baby then had two-hourly monitoring and was
20 perfectly fine and we went home the following day.

21 I've got to say, it would have been very easy for
22 that Consultant not to have phoned. She could have very
23 easily have thought "Well, they have discharged now, any
24 issues they will come back", but she didn't, she did the
25 right thing, which would have caused her, you know,

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1 passed over to the Neonatal Team obviously to be
2 assessed because of the oxygen levels dropping.

3 They stabilised our baby. The baby didn't have to
4 go into the Neonatal Unit or anything like that. The
5 baby was fine, but because they were borderline on the
6 oxygen levels as to whether they would make a decision
7 to move into Neonatal or not, they said to us, "Before
8 you are discharged we would like to review the baby as
9 well", so the baby was, you know, perfectly fine
10 overnight and everything like that, as you said, all the
11 checks were done, the baby was fine, and we had no
12 concerns, it was just the fact that they told us that
13 the Neonatal Team needed to see the baby, so I had asked
14 the midwife that was arranging discharge. They said
15 "No, no, it's fine, the normal doctor has been round,
16 checked the baby all over, they are fine" and then she
17 came back later on and I said "Have you double-checked,
18 are you sure because we were under the impression that
19 they wanted to review the baby before we left?" "No, no,
20 you're fine, you're fine". We were like "Okay". So we
21 went home and literally it must have been within 10,
22 15 minutes of walking in through the front door the
23 phone went and it was the Neonatal Consultant who said
24 "You need to come back, we needed to monitor the baby
25 for 24 hours because they were such a borderline case it

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1 headache, workload, paperwork. She did the right thing
2 and picked up the phone and asked us to come in. It
3 shouldn't have happened. However, the implications that
4 followed were very correct.

5 **Q.** You say in your statement regardless of what
6 negative backlash might have come, she did the right
7 thing.

8 You applaud that she telephoned you and got you
9 back?

10 **A.** Yes, 100% and you could see that she was
11 pretty annoyed that it had happened, yes.

12 **Q.** Moving now to paragraph 122 and counselling
13 and support that you have received. You say you
14 received counselling support from a bereavement midwife
15 at the Countess of Chester Hospital and also received
16 occupational health support via your employer. How did
17 you find -- without going into the details of it -- the
18 value of the support from the bereavement midwife at the
19 Countess of Chester Hospital?

20 **A.** She was lovely actually and I think sometimes
21 you don't realise you need it until you're sat there.

22 It was a space that you were able just to talk about how
23 you felt, what anxieties were building up within you and
24 it was a chance just to release that pressure that sort
25 of builds and builds and builds, so it was very useful,

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1 yes.

2 **Q.** For what period of time was that offered to
3 you through the NHS service?

4 **A.** There was no time cap put on it from memory.
5 It naturally came to conclusion through having my next
6 child really and actually as we were walking out with
7 our child, our next child, we bumped into her so it kind
8 of rounded the situation off, but no, there was no time
9 cap that I was aware.

10 **Q.** The other observation you make here is one you
11 made earlier in your oral evidence, that that time with
12 Child K in the family room -- it would have helped you
13 to realise that there genuinely wasn't a timeframe and
14 you didn't have to do anything straight away,
15 practicalities can wait, just that little bit of extra
16 reassurance about that?

17 **A.** Yes, that's it, that you've got a little bit
18 of time to process and I think, you know, it depends
19 what type of person you are. We are practical people
20 and sometimes it's easier to deal with practicalities
21 than emotions -- so to have somebody maybe say "You've
22 got the time, don't rush, you haven't got to rush" would
23 help.

24 **Q.** Medical records. At paragraph 155, you say
25 you never asked for Child K's records because you had no
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1 telephone in May 2017.

2 **A.** Yes.

3 **Q.** Who took the call from the police?

4 **A.** I did.

5 **Q.** And what did they tell you?

6 **A.** So at this point -- you know, roughly a year
7 on -- I was at work and I took the call as kind of
8 scooting out of the office to a side room. Obviously
9 she introduced herself as a Family Liaison Officer with
10 the police and our daughter was part of an investigation
11 that they were carrying out at the Countess of Chester
12 Hospital as her care was within the time limits that
13 they were looking at. It very much felt at that
14 stage -- again, because we didn't really view her care
15 as Countess of Chester Hospital because she was
16 transferred out to Arrowe Park; she was only there
17 hours -- and in our mind it was a little bit of process
18 of elimination and she had just fallen inside that
19 timeframe and so they were obviously just going through
20 what they had to go through. Not for one minute did we
21 ever foresee any of this at that time.

22 **Q.** You say:

23 "We were only told that Child K's treatment
24 definitely formed part of the police investigation in
25 July 2018."
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1 reason to ask for them, so when was the first time you
2 heard and saw medical records about her?

3 **A.** At the criminal trial.

4 **Q.** You also say here:

5 "There was a moment of realisation during the
6 re-trial of shock and realisation as I just didn't know
7 how poorly Child K was when they got to Arrowe Park."

8 **A.** Yes, so, again, when you're going through the
9 emotions, as you described before, you hold on to the
10 hope aspect of things and you probably resonate with
11 that more than you do with the negativity side of things
12 and in the stark light of a trial and it being read to
13 you what medication she was on, what they tried, what
14 was actually wrong with her in their terminology, was
15 quite hard to digest. I fully appreciate that that
16 isn't what would happen at the cot-side to parents in
17 that detail, but we just didn't know. As I said,
18 I don't know whether we were just holding on to the
19 hope, but in that stark light of day, I just remember
20 sitting there thinking how poorly she was and what they
21 had done. I didn't know that at the time in Arrowe Park
22 to that level.

23 **Q.** You say, going back to paragraph 140 you only
24 became aware of any concerns regarding Child K's
25 treatment when you were contacted by the police by
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1 **A.** Yes.

2 **Q.** So did you get another telephone call or
3 a visit about that?

4 **A.** It probably would have been both. So they
5 would tend to phone to give you, I suppose, the high
6 level overview of where they were at and what was going
7 to happen and then they would come out and sort of sit
8 with you and go through it into the detail of what they
9 would be allowed to explain to you, so from how the
10 experiences go -- I can't say 100% they -- but I would
11 assume they would have done both at that time.

12 **Q.** When were you told of the mechanism of harm
13 that was alleged in respect of Baby K?

14 **A.** That was maybe a couple of months before the
15 criminal trial started. We were told by our counsel
16 team what had happened because, by the same token, we
17 had asked quite a few times for us not to learn it while
18 we're sat there in the court proceedings; that it would
19 obviously be helpful for us if we were aware of what had
20 happened and be told as much as what we could be told to
21 some extent before we were sat learning it at the same
22 time as everybody else, so we had a meeting. That was
23 worked on by the counsel teams and agreed what we were
24 able to be told and it was at that meeting that we were
25 told what had happened.
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1 Q. Did you ever have any contact with the
2 Countess of Chester Hospital about Letby's involvement
3 in Child K's care or anything about Letby?

4 A. No, nothing, no.

5 Q. One of the matters you say you learned at the
6 trial in particular was, as reflected in
7 Mr Justice Goss's summing up, the impact it might have
8 had were Baby K cared for in a tertiary centre, in
9 a better centre. Can you tell us about that? What did
10 you hear about that?

11 A. No, basically what was said and we were told
12 was that if our daughter had been born in a tertiary
13 centre she would probably still be here and that's the
14 hard sort of fact of it; that she needed that
15 specialised care and you generally just didn't
16 understand the need for that and we were aware of the
17 fact that she needed to be transferred but also aware of
18 the fact that she -- they were equipped to stabilise
19 her -- in Chester to be transferred, but yes, it was the
20 fact that she would probably be here.

21 Q. Or with improved outcomes, I think it said,
22 with improved outcomes for her?

23 A. Yes.

24 Q. You didn't make contact with PALS or any other
25 organisation, but from what you're saying at the time

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1 hadn't gone through that and that flag would assist the
2 staff to be able to accommodate maybe, you know, that
3 little bit of extra anxiety that you might carry or that
4 little bit of extra support that you might need, or,
5 you know, little things like for example when we had our
6 daughter's eldest sibling, they had to have the same
7 glasses on as what our daughter did. They were the baby
8 didn't leave my side, the baby was there with me. But
9 just reseeing that again, you go into overload with it
10 and, you know, to be fair the midwives were a little bit
11 like -- you could see them looking at you thinking
12 "Where has this reaction come from?" I was just upset,
13 and so with that flag it might have made them look at
14 your history to sort of understand and appreciate that
15 a little bit.

16 So for me that would have helped and just
17 alleviated some of the questions and conversations.

18 Q. You also refer to the need for accurate
19 recording of information and, on transfers, CCTV which
20 we have discussed, but you say changing attitudes and
21 relationships between clinicians and management teams
22 within the NHS is a concern for you.

23 A. Yes. I think that you can put these
24 mechanisms in place that will assist and help and
25 alleviate anxieties and pressures. However, through

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1 you didn't have concerns?

2 A. We were completely oblivious. As I said, to
3 even class her care under the Countess we didn't because
4 she was there for hours; for us, she was cared by
5 Arrowe Park, so yes, we had no reason to follow up with
6 anything.

7 Q. Recommendations that you invite the Inquiry to
8 consider.

9 You say, first of all, at paragraph 166:

10 "A simple flag on medical records to alert and
11 assist medical staff quickly to your history and that
12 a baby loss has occurred ..."

13 A. Yes. So it would be very useful if people
14 were aware of your circumstances quite quickly and it
15 would alert them to the fact that maybe they need to
16 delve a little bit deeper into your medical history
17 before they have initial conversations with you. You
18 found like you were repeating yourself quite a lot
19 sometimes with whenever you were speaking to people or
20 anything like that which was unnecessary really if they
21 had actually read your medical records -- so just having
22 that quick way to recognise -- especially when you're
23 going through your next pregnancies -- you're very
24 heightened with what the outcome can be and your
25 reactions might be slightly different to, a mother that

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1 a lot of this, which I am assuming will come out later
2 down the line and conversations, my understanding is
3 there's such a disconnect between those clinicians that
4 are on the floor and the management that sit at the top.
5 They have different roles to play and I understand that,
6 but that connectivity should be there and that mutual
7 respect and understanding should be there.

8 These clinicians had raised concerns that were very
9 hard for them to understand and get their head around
10 and I don't feel like they were listened to. There's
11 actions that could have been put into place by
12 management a lot sooner to alleviate some of the next
13 steps that have happened and my biggest thing as well is
14 they need accountability. There's no accountability for
15 anybody in a senior position to make -- if they don't
16 make the decisions based on information that they're
17 given, they need to personally be accountable for it.
18 There's many organisations out there that have that in
19 place. They're not dealing with lives but they are held
20 personally accountable, they will be fined, they can be
21 put into prison, because they haven't followed processes
22 and procedures that are put in place to safeguard
23 against these issues.

24 That's exactly the same as what happened in the
25 Countess, but they're dealing with people's lives and

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1 the impact of that is forever. It doesn't stop. It
 2 doesn't stop. For myself and my husband, the ripples
 3 are unbelievable and I never appreciated that and,
 4 you know, you're around and you hear it but you don't
 5 appreciate it until you're in it and it's scarred your
 6 life, it's changed you. You look back and you don't
 7 only just grieve your daughter, you're grieving who you
 8 were. I grieve who we were as a husband and a wife.

9 It just completely destroys what's around you and
 10 you have to pick yourself up and find out who you are
 11 again in this new world and it just doesn't stop, it
 12 doesn't go away and we live with it every single day and
 13 for nobody to take accountability for that or ownership
 14 for that is not right. It can't continue to be like
 15 that because this will happen again because what's the
 16 reason to stop them? There is no reason. They just
 17 protect themselves.

18 **Q.** You conclude your statement, Mother K, at
 19 paragraph 173, with some acknowledgement of the people
 20 that have helped you along the way in all that you have
 21 experienced. I don't know if you want to reflect some
 22 of that now, read that, or parts of that; however you
 23 choose to complete your evidence, or at least your
 24 questions from me.

25 **A.** "Finally, I would like to say that along with
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1 **(3.32 pm)**

2 **(Short Break)**

3 **(3.57 pm)**

4 **FATHER K statement read**

5 **MS STANGER:** "I, Father of Child K will say as
 6 follows:

7 "My personal details are duly removed from this
 8 witness statement to protect my identity and I can be
 9 identified as the father of Child K who died aged
 10 *(redacted)* days old.

11 "I make this statement at the request of and to
 12 assist with the Public Inquiry to examine the events at
 13 the Countess of Chester Hospital and the implications
 14 following the trial and subsequent convictions of former
 15 neonatal nurse Lucy Letby of murder and attempted murder
 16 of babies at the hospital, of which my child was one.

17 "My wife, Mother of Child K, and I have spent many
 18 years involved with the investigation into the actions
 19 of Letby and the subsequent criminal trial. At the
 20 criminal trial which took place between October 2022 and
 21 August 2023, the jury were unable to reach a verdict in
 22 respect of Child K and as such, a re-trial specific to
 23 our baby took place commencing on 10 June 2024.

24 "As part of the initial police investigation named
 25 'Operation Hummingbird', my wife and I both provided our
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1 this unthinkable and stressful process I have met some
 2 of the most amazing and caring people which I'm so
 3 thankful for. They have touched my life in many ways
 4 and somewhat restored my faith in humanity that was not
 5 present at the start of this ordeal. We have all been
 6 fighting our own battles but have also managed to
 7 support and care for each other along the way.
 8 I believe this has enabled some healing to take place as
 9 you've discussed your thoughts and feelings with people
 10 that have been going through the same as you. We have
 11 a long road to go but evil will not prevail. I hold on
 12 to the faith that we will make it, our children will
 13 make it and know that life can be good and filled with
 14 adventure and surrounded by people that will care,
 15 support and love you each and every day."

16 **MS LANGDALE:** That concludes my questions, my Lady.

17 **LADY JUSTICE THIRLWALL:** Thank you, Ms Langdale.
 18 Mr Baker.

19 **MR BAKER:** I don't have any questions.

20 **LADY JUSTICE THIRLWALL:** No, thank you.

21 **MR BAKER:** If we could have a short break so we can
 22 just review Mr K's witness statement before it is read
 23 out.

24 **LADY JUSTICE THIRLWALL:** Of course. There is no
 25 need for you to leave the room, we can leave the room.
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1 witness statements. However, since that date further
 2 evidence has come to light through our involvement in
 3 the Inquiry and more recently the re-trial has alerted
 4 us to the full extent of Letby's actions and the
 5 concerns that had been raised as to her involvement in
 6 the deaths of a number of babies.

7 "I take this opportunity to provide my statement to
 8 the Inquiry as to my own experiences and my concerns
 9 regarding the care afforded to my baby at the Countess
 10 of Chester Hospital.

11 "With the exception of the statement I provided to
 12 the police and one session of counselling in around 2022
 13 this is the first occasion that I have discussed the
 14 events surrounding Child K.

15 "Background.

16 "I grew up with my mum, my dad and sisters. My dad
 17 worked whilst my mum stayed at home. After I left
 18 school, I went straight into employment. My sisters
 19 both have their own children with my eldest sister being
 20 very young when she first had children. I've got
 21 a large extended family and I see a lot of my cousin as
 22 we have children of a similar age.

23 "I first met my wife at a local pub when I was
 24 a teenager. Although we were young, we wanted to start
 25 our life together. We bought our first house when we
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1 were in our early 20s. We both worked full-time in
 2 demanding jobs.
 3 "After a few years, we decided that it was time to
 4 start our family. My wife always wanted four kids.
 5 I was happy with one of each but welcomed more.
 6 I always knew when we first got married that we would
 7 have children and that, when we did, they would come
 8 first.
 9 "I wanted to have children before my wife.
 10 I always wanted to have them young and be an engaged
 11 dad. All I want to be is out and about with the
 12 children. I love being with them.
 13 "I knew as soon as I had any children, girl or boy,
 14 that I wanted them to learn to swim early as I love the
 15 water. I wanted that to be our thing that we did
 16 together along with teaching them to ride a bike once
 17 they could walk.
 18 "In 2015 my wife found out that she was pregnant
 19 with Child K. We were delighted but it was massively
 20 tempered due to (redacted). I can't remember now when
 21 we told people, but I think we held back a little
 22 because my wife wanted to wait a while.
 23 "I went to all of the appointments with my wife at
 24 the Countess of Chester. After the first scan we were
 25 told that there was some fluid on Child K's neck and we

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1 needed to call the midwife and let's just go in to be
 2 checked.
 3 "After some calls, we went to the Countess of
 4 Chester Hospital just after 9 am. I had contacted my
 5 employers to tell them that I would be late. When we
 6 arrived, we were taken to a side room and my wife was
 7 examined. We were told she was progressing with labour.
 8 I didn't have a clue what was going on. I had to ask my
 9 wife what was happening and she told me it meant that
 10 the baby was starting now. We had only gone in to get
 11 checked over and the next minute we were having the
 12 baby.
 13 "My wife was admitted onto the labour ward and we
 14 were told that they would try to slow it down. One of
 15 the injections was for Child K's lungs to try and bring
 16 them on a bit. I was concerned for my wife because she
 17 was lying there uncomfortable and I felt so useless.
 18 I didn't know what to do or say. At that time, I wasn't
 19 concerned about my wife or Child K's care. They know
 20 best. Child K was the first child we had. I had never
 21 been in that process before so I didn't know what was
 22 happening.
 23 "All we were told was that they were going to
 24 transfer my wife. We didn't know why. I know now as
 25 part of the lengthy investigation process that Preston

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1 had some tests done. We had tests for Down's syndrome
 2 and they came back clear. My wife's midwife, Jill
 3 Edwards, has passed away now but she was a fantastic
 4 woman. It was a bit of a worry because I didn't know
 5 what was going to happen but the more and more scans we
 6 had, we believed it was getting smaller. I was starting
 7 to think that it was going to be okay. As the weeks
 8 went on, I started to get more excited. I could see on
 9 the scans that the baby was getting bigger, the fluid is
 10 getting smaller and I was happy.
 11 "Jill and my wife's obstetrician, Mr McCormack,
 12 seemed to be very good friends. She always referred to
 13 Mr McCormack if there was anything. We didn't find out
 14 if we were having a boy or a girl. I wanted to but my
 15 wife didn't.
 16 "I went with my mum and we bought the Moses basket
 17 in preparation for baby's arrival.
 18 "We were told that there was a little bit of fluid
 19 on Child K's lungs but no one seemed to be concerned.
 20 Everybody was telling us that the baby was okay.
 21 "A few weeks later in the morning my wife said to
 22 me that she felt a bit off. To start with it didn't
 23 seem too bad, but she had a shower and was getting ready
 24 for work and it hadn't gone away. She seemed a bit
 25 uncomfortable and she had had some spotting. I said she

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1 was mentioned but I don't think that Preston was
 2 mentioned at that time because I knew where that was.
 3 I believe it was somewhere else that was mentioned
 4 first.
 5 "It could have been Bristol or Stoke that was
 6 mentioned. I cannot be sure now.
 7 "Our view at that time was that we would do what we
 8 had to do. We would go wherever we needed to go and
 9 I would have got there. Eventually we were told that my
 10 wife couldn't travel because it wasn't safe any more.
 11 At that point I thought, 'why are we staying here now?
 12 You told us that you were looking for another bed in
 13 a hospital because that was a better hospital.'
 14 "We were expecting Child K to arrive soon and at
 15 one point a youngish male came down to speak to us.
 16 This is Dr Ford, who also provided a statement to
 17 the police. He said that Child K was going to be
 18 breach, they were premature and that they were
 19 monitoring the baby. I wasn't sure at that time whether
 20 he was an Obstetrician or from the Neonatal Team. I was
 21 just focusing on my wife and my baby and I understood
 22 that the labour was moving.
 23 "I remember that there was a conversation about
 24 a caesarean section but all I remember is that it was an
 25 option. I don't really remember much more because it

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1 was such a blur. Everyone was in the room with us.

2 "I knew that there would be a Paediatrician when
3 Child K was born and they said that we wouldn't be able
4 to have a cuddle. They wanted to get Child K to the cot
5 and stabilise them as quickly as possible.

6 "My wife was given a second dose of steroids and
7 during another ward round in the morning Child K had
8 turned round again. I think that my wife wanted
9 a natural birth but I don't think that we ever refused
10 a caesarean section. There was just too much going on
11 in there to listen and take it all in. My focus was on
12 my wife. I didn't need to worry because the doctors
13 were doing what they needed to do. I just had to make
14 sure that my wife was okay. I was just holding my
15 wife's hand and letting the midwives and doctors get on
16 with it.

17 "My wife was the active one in the discussions with
18 the doctors and midwives. We were having the injections
19 for Child K's lungs to try and push them along. Again,
20 if Child K needed it, they needed it.

21 "I thought that we were in the safest place and
22 I was relieved that we didn't need to travel but would
23 have done it if that was the best thing for Child K.
24 They explained that it wasn't a good thing to move my
25 wife because it was a lot safer to have the baby born in

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1 doctor.

2 "When Child K was born, she was a reddy purply
3 colour. They asked whether I wanted to have a quick
4 look at Child K. To be honest I wanted to see Child K
5 with my wife but she said to go and have a quick look.
6 I wanted to know she was really here.

7 "Even after I looked at Child K, I didn't have
8 a clue whether they were a boy or a girl. My wife asked
9 me and I couldn't tell her. Then one of the doctors
10 said, 'Oh, sorry, it's a little girl'. I was over the
11 moon. Child K was here. Child K was okay.

12 "Child K was tiny -- really, really small. I know
13 now that the medical records say Child K was floppy.
14 I didn't even hear Child K cry. I could see the cot but
15 couldn't see into it. There were too many people.

16 "It felt like a long time that the Paediatrician
17 was with Child K but it's going to seem like a long time
18 when you're waiting to hear a cry. My expectation was
19 I was meant to hear a cry but it never came. There was
20 no cry.

21 "When Child K was taken to the Neonatal Unit, I let
22 my wife go to sleep and then I phoned my mum to tell her
23 that Child K was here.

24 "Neonatal care.

25 "I went to the Unit by myself at first. I couldn't

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1 Chester. The labour room was only small and it was
2 constantly black in there. There were people in and out
3 all of the time so it was hard to know who we spoke to
4 and what was said.

5 "In the statement I gave to the police I refer to
6 a conversation I had with the midwife about fostering
7 because she was adopting the boys that she had been
8 fostering. She was a short-haired woman.

9 "Delivery.

10 "Before Child K was born, I stayed with my wife the
11 whole time. Around midnight on the day Child K was
12 born, we had fallen asleep. My wife woke me up and said
13 that she was in pain. Her mum and sister were with us.
14 I panicked and pressed the buzzer. The room was filled
15 with people as I held my wife's hand.

16 "I always refer back to the young white male
17 Consultant I refer to in my statement to the police. He
18 had short dark hair and was wearing glasses. At the
19 time I thought maybe it was a trainee, but I now know
20 him to be Dr Ford who provided a statement to
21 the police. When he was in the room everyone was doing
22 everything around him but it got to a point and he
23 stepped in. My wife screamed as he did whatever he
24 needed to with Childs K's foot, unhook it, I think, and
25 the next minute I saw him pass Child K to another

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1 sleep because I was so excited. I have a baby girl.

2 I just wanted someone to come and say that everything
3 was okay. I was over the moon. Child K had just been
4 born. I didn't feel worried because we were in the
5 hospital; we were in the right place so I thought that
6 whatever needed to be done for Child K was going to be
7 done. I wanted to know that Child K was okay.

8 "My wife was absolutely exhausted because of what
9 she had been through, so as my wife slept, I decided to
10 go and see Child K. I knew I couldn't get through the
11 double doors to get onto the Unit but walking to the
12 Unit really wasn't far and there was a window into the
13 nursery which I could look through. I can't recall the
14 exact time I went.

15 "I was looking through the window and there was
16 somebody with Child K. I couldn't say if it was
17 Lucy Letby; I couldn't say it was anyone, it has been
18 nearly nine years. But there was someone standing by
19 Child K and I felt uncomfortable. I'm not sure if
20 uncomfortable is the right word, but I didn't want to
21 get in their way. I know I couldn't be in the way
22 because I wasn't in the room but I didn't want to
23 distract them from what they were doing. I can't
24 remember if there were any other babies in the room. My
25 focus was on Child K. I was so excited. I wanted to

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1 tell people that the baby had arrived and was okay.
2 "Now, I feel guilty that I didn't stay and watch
3 for that little bit longer.

4 "We couldn't get onto the Unit without a member of
5 staff. We didn't see Child K being resuscitated and we
6 were not told that this had been needed. If I had known
7 then I would have asked why, and I never would have left
8 Child K's side. If we had known and asked questions
9 maybe Dr Jayaram would have taken it further at that
10 stage because we would have demanded answers.

11 "I now know that it was Joanne Williams that told
12 us we could go to see Child K. She came into the room
13 on the Labour Ward. I don't know now if my wife had
14 woken up or whether it was the door opening and the
15 conversation that woke her, but Joanne said that Child K
16 was stable, Child K was fine. She asked if we wanted to
17 come and see Child K. Of course I did.

18 "We jumped at the chance to go and see Child K. My
19 wife got into a wheelchair and someone took us into the
20 Unit because you had to be buzzed through the double
21 doors to get into the nursery. We sat on the left-hand
22 side of Child K. Child K had all kinds of tubes
23 attached to her which obviously needed to be there.
24 I just couldn't take my eyes off Child K. She was so
25 tiny, so small. Her whole hand sat on my thumb.

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1 first time when we were also told that the murder charge
2 would be dropped. It was only then that we were told
3 what had happened.

4 "I now know that there were three episodes when
5 Child K's breathing tube moved: at 3.50 am (which is
6 before we first visited the Neonatal Unit); at 6.30 am
7 and 7.30 am on (*redacted*) February 2016. If I had
8 known, I would have asked questions. I would have asked
9 what they were doing. Dr Jayaram would have had to
10 explain to me there and then why Child K's tube had
11 moved and how it had moved.

12 "I now know that the first episode took place
13 before we went onto the Neonatal Unit because my
14 statement to the police confirmed that the photographs
15 we took of the three of us were at 4.31 am. I can't
16 help but wonder whether I was looking through the window
17 of the Neonatal Unit around the time that this episode
18 took place but I didn't see anything that made me worry
19 for Child K. I would have been back at the hospital
20 with my wife by the time the second episode took place.
21 From what I have been told, the last episode took place
22 at the end of Letby's shift.

23 "Transfer to Arrowse Park Hospital.

24 "The transfer team arrived in the morning of
25 (*redacted*) February 2016. I expected this to happen.

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1 A photograph was taken of us while we visited.
2 I thought that they were doing their job. There was
3 nothing to make me worry. All I was told was that
4 Child K was doing okay. I knew that Child K was small
5 and we knew that Child K was going to be poorly, but she
6 was stable and here. We spent maybe 15 or 20 minutes
7 with Child K. My wife put her hand into incubator and
8 I think I did too. We knew that Child K would need to
9 be transferred to Arrowse Park but we didn't know when so
10 we should rest before the transfer.

11 "We went back to the Labour Ward and my wife got
12 back onto the bed. She needed some clothes so she told
13 me to go home, get a shower and collect our things.
14 I can't remember exactly but I think I went to my mum's
15 first just to say that Child K was here, then went home.
16 I know that we would have been told that Child K was
17 stable, as, if not, I never would have left.

18 "Child K's Breathing Tube and Desaturations.

19 "While Child K was on the Neonatal Unit there were
20 three separate incidents when the breathing tube had
21 become dislodged and Child K required resuscitation.
22 Nobody told us about these episodes whilst we were in
23 Chester. We only became aware of these facts when we
24 had a meeting with the Crown Prosecution Service at
25 Knight's Court just before we went to trial for the

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1 I remember them saying that they were struggling to
2 stabilise Child K. All that went through my mind was
3 'Why was someone stabilising Child K when these doctors
4 have already done that?' We were waiting a long time,
5 a couple of hours I think. My statement to the police
6 confirms that the transfer team arrived around 9 am.
7 They came and introduced themselves and told us what was
8 going to happen with Child K.

9 "Child K didn't look any different from their birth
10 at this stage. Child K had been moved into a transport
11 incubator. At some point whilst the transfer team were
12 with Child K, me and my wife talked about naming Child
13 K. My wife had always liked the name, and it was one of
14 the names we had, so I said to my wife that if she
15 wanted to call Child K that name, we would do.

16 "At one point Dr Kamalanathan, the specialist
17 transport Paediatrician, said "Come on, we've got to go,
18 it's now or never, we're going to go". My statement to
19 the police confirms that it got to around midday when
20 the transfer team told us that it was now or never. All
21 I can remember is saying goodbye and walking out behind
22 Child K as she went into the ambulance and the ambulance
23 left. We went back to the Labour Ward where we showered
24 and changed ready to follow once my wife was discharged.
25 Once this happened, we went straight to Arrowse Park.

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1 "Care at Arrowe Park Hospital.
 2 "We got to Arrowe Park and went straight to the
 3 Neonatal Unit. I feel like to start with Child K looked
 4 a better colour. I have photographs of Child K in both
 5 Chester and Arrowe Park. There was a certificate for
 6 Child K for making the journey. Nobody told us anything
 7 that made us worry for Child K, so we drove home and
 8 gathered more clothing as we were going to stay at the
 9 hospital. We weren't at home for long before we just
 10 wanted to be back there with Child K.
 11 "We were given a room to stay in at the
 12 Ronald McDonald House. To get to the Neonatal Unit from
 13 the room you had to come down in the lift, come out
 14 through the corridor and then went round a corner. Then
 15 you came into the Neonatal Unit and Child K was right
 16 there as soon as you walked through the door. She was
 17 in the end cot.
 18 "To start with there was nothing that looked
 19 unusual about Child K. A little bit later, Child K
 20 started to swell and she was a different colour.
 21 Towards the end, Child K looked very swollen and
 22 bruised.
 23 "At Arrowe Park, Child K dropped her oxygen support
 24 and I remember saying that it was good that they weren't
 25 on 100%, but then it went back up to 100% shortly
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1 night before. No one needed to tell us. They were too
 2 low. I knew from the look on the doctor's face, that we
 3 now know was Dr Gardner, that Child K had deteriorated
 4 and she was about to call us. My wife said 'Child K is
 5 not going to get better, is she?'
 6 "Child K had swollen up. She was a normal colour
 7 but had bruising around her chest and tummy.
 8 "We spoke to the doctor and I said that I didn't
 9 want to hear the noise of the monitors any more. I felt
 10 it was the right thing to do to turn the machines off.
 11 It wasn't fair to continue.
 12 "They took us to a little room outside the Unit.
 13 I wasn't in there long -- literally a couple of
 14 minutes -- and they brought Child K in. They brought
 15 our baby in and handed her to me as she took a breath.
 16 That was it. Child K only took one breath on her own in
 17 my arms.
 18 "My wife sat with Child K and had cuddles. The
 19 doctor came back in to check on Child K and confirmed
 20 that she had gone.
 21 "Child K had to go into a little cold bed.
 22 I couldn't understand why they had to go in there so
 23 quickly but, again, it was one of the things that if
 24 that's what needs to happen, then that's what needs to
 25 happen. I wish I could have held Child K for a little
 159

1 afterwards.
 2 "The doctors talked to us at Child K's cot every
 3 day. They always started with Child K, perhaps because
 4 she was the poorest. There was always a nurse with
 5 Child K. They were doing what they could for Child K.
 6 "My mum, dad and sisters came to visit Child K,
 7 along with my wife's family. We showered, slept and ate
 8 but the rest of the time we were with Child K. We
 9 didn't leave their side.
 10 "The night before Child K passed away, we spoke to
 11 one of the doctors, Dr Barbarao, and he said that
 12 Child K was very, very poorly. I can't remember his
 13 exact words but it frightened me and that is probably
 14 the reason why we didn't really sleep that night. It
 15 would have been late when we left Child K to get some
 16 sort of sleep.
 17 "I thought that my wife was asleep and she thought
 18 that I was asleep and I just remember her asking if
 19 I was awake. We decided to go down and sit with
 20 Child K.
 21 "Child K's Last Moments.
 22 "The doctors on the Unit had previously told us
 23 what the numbers on the machines mean and where they
 24 would like Child K's reading to be so when I walked in
 25 there I knew things weren't good, especially from the
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1 bit longer. Maybe I should have asked to hold them for
 2 a bit longer.
 3 "During the course of drafting our statements with
 4 our solicitors my wife and I have spoken. She asked me
 5 if we should have stayed with Child K for a little bit
 6 longer. Maybe we should have done but we had to leave
 7 Child K, didn't we?
 8 "The drive home was so horrible. I couldn't leave
 9 the carpark at first. I was leaving my first born.
 10 I went to drive off and my wife asked me if I was okay
 11 and I wasn't. I didn't want to leave, but at the same
 12 time I just wanted to go home. My mum wanted to come
 13 round but I said no. I didn't want to see anyone or
 14 anyone to be there. I couldn't believe that this had
 15 happened to us.
 16 "Police Investigation.
 17 "We didn't know anything about Lucy Letby or issues
 18 with Child K's treatment until my wife received a phone
 19 call from the police in May 2017. I was in work and my
 20 wife rang me very upset. She said she had had a phone
 21 call from the police and that there was an investigation
 22 on a nurse in Chester Hospital. They were looking into
 23 all the deaths within a timeframe so Child K fell into
 24 this. I was at work at the time of the call, so I went
 25 straight home.
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1 "The police came round in the evening to discuss
2 further. One of the Family Liaison Officers and a male
3 officer visited. Again, they said that they couldn't
4 say for definite that Child K was one of the babies
5 involved but they were looking into Child K because she
6 fell within the timeframe. We were just told that it
7 was an investigation into a nurse in Chester Hospital.
8 We didn't know if it was a man or a woman and we weren't
9 told Lucy Letby's name. I asked why they couldn't tell
10 us more and was just told that they can't. I can't
11 remember if we were offered any support at that stage.

12 "I was in denial at that stage. I thought Child K
13 had passed away because she was early and because she
14 was so sick. You would never think in a million years
15 that something would happen to your baby in hospital.
16 Knowing that the police can't give you any information
17 didn't make it easier for me. I was running wild in my
18 head about what might have happened to Child K.

19 "I don't remember when I first saw Lucy Letby's
20 picture, but when I first saw it I couldn't say
21 I recognised her, in the same way I wouldn't recognise
22 Joanne Williams who came and got us to visit Child K for
23 the first time. I wouldn't have noticed her because my
24 focus was on my wife and Child K. When we first saw the
25 picture I asked my wife if she recognised her but

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1 petrified seeing that again. They were kept on them for
2 a couple of days until the jaundice improved.

3 "When we had our youngest child, the Countess of
4 Chester Hospital discharged the baby before they should
5 have been seen by the Neonatal Consultant. We got back
6 home and had to take the baby back to hospital. I was
7 so angry. They discharged my baby and they should never
8 have been discharged. I told her what we had been going
9 through with Letby and she was so apologetic. I only
10 tell people occasionally what's happened because I don't
11 want to tell anyone but that time I was so angry. They
12 were not watching what they were doing.

13 "With Child K I stepped back and let the doctors
14 get on with their job, but with each of my wife's other
15 pregnancies I have asked more questions which carried on
16 when they were born. When Child K's eldest sibling
17 needed the glasses I asked why and they told me it was
18 jaundice, so I asked what jaundice was and what it
19 meant. I was involved with conversations and asked over
20 and over until I was happy.

21 "Child K's siblings never left our side whilst we
22 were in hospital. The children have had nights away
23 from us with both of our families. When my wife went
24 back to work full-time they went to our childminder who
25 was and is brilliant with all of our children. I felt

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1 neither of us could be sure. There's one picture where
2 she might have been more recognisable for my wife but
3 even then we cannot be certain. I didn't even recognise
4 Dr Jayaram and he was at the Resuscitaire with Child K.

5 "Subsequent Pregnancies and Experiences.

6 "After Child K passed away, we had an appointment
7 with Mr McCormack to discuss my wife's pregnancy and why
8 she went into premature labour. This appointment didn't
9 involve a discussion about Child K's care once born.

10 "When I found out my wife was pregnant in 2018
11 I was over the moon, but I was also petrified. We knew
12 about the investigation and that Child K might be one of
13 the babies involved whilst my wife was pregnant.
14 I remember asking my wife whether we were going to go to
15 Chester still with all that was happening. However, she
16 was happy with her midwife, Jill, and the support she
17 was receiving at this time.

18 "With all of my wife's later pregnancies we didn't
19 tell anyone for a long time. Even after the first three
20 months we didn't tell anybody or buy anything. My wife
21 had extra support from her midwife, Jill, for the
22 pregnancies with Child K's elder siblings.

23 "When Child K's eldest sibling was born the baby
24 was given the same type of little black glasses that
25 Child K had worn for her treatment for jaundice. I was

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1 okay leaving Child K's eldest sibling with the
2 childminder but only because my cousin's little girl had
3 been there too and I asked my cousin if our eldest would
4 be safe. Our childminder knows what has happened so is
5 extra thoughtful with messages and photographs
6 throughout the day.

7 "The children have stayed at their nan's house
8 a couple of times and they have been to my mum and dad's
9 caravan a few times but I can count on one hand the
10 number of times they have been.

11 "Counselling and Support.

12 "I can't talk about what happened to Child K, it
13 scares me to remember and I don't want to think about
14 it.

15 "I have been offered bereavement support and
16 counselling but I never wanted to speak to anybody.

17 "My wife spoke to the bereavement midwife but
18 I didn't want to. My wife said I should have had some
19 counselling and encouraged me so I went to one session
20 a couple of years ago. I said I didn't think I needed
21 to because I didn't want to go through it all again but
22 she said that it had really helped her. So I thought
23 I'd try it. I didn't like it, so I said at the end of
24 the session that I was going to be honest, that I didn't
25 want to do it again. I just felt uncomfortable, it was

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1 nothing to do with the counsellor, they were lovely and
 2 they made it a lot easier for me. But for me, it just
 3 made me relive it. Later down the line I might think,
 4 "Do you know what? I'm ready to speak to someone now,
 5 I'm stronger and could cope better with it", but at the
 6 moment, it's hard to say. I feel like right now I'm
 7 just putting one foot in front of the other.
 8 "Medical records.
 9 "We never asked for Child K's records because we
 10 didn't know the truth. I had no reason to ask for her
 11 records. The first time I heard about our medical
 12 records was during the criminal trial. In the re-trial
 13 they went into more detail.
 14 "Experience with the Press.
 15 "We have only been visited by a couple of people at
 16 home. One guy gave me his number and I just shut the
 17 door and on another occasion a workman called me because
 18 he had answered the door to the press.
 19 "Information sharing.
 20 "According to the witness statement I provided to
 21 the Police, the photographs we took on my phone were
 22 taken at 04.31 am on the morning of (*redacted*)
 23 February 2016. They were saying that the first time
 24 with the tube was around the 03.45 am or 03.50 am mark,
 25 that means it was before we visited. Why weren't we
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1 services and unexplained collapses until we were
 2 contacted by the police. I believe we should have known
 3 about these investigations sooner.
 4 "If we had been given this information earlier,
 5 I would have asked questions. If I had known about the
 6 first desaturation, then would the second one have been
 7 able to happen? I would have pushed for answers as to
 8 how and why they were happening. It was such a long
 9 time afterwards that we have been given this
 10 information; they should have shared it. It's obvious
 11 to me that they were hiding it and it makes me angry.
 12 "As detailed above, we have not been in contact
 13 with the Trust about Child K, which includes PALS. We
 14 didn't think that there was a problem until the police
 15 contacted us. We haven't been contacted from any other
 16 organisations about neonatal care.
 17 "The Trust haven't been open and honest with us
 18 about any suspicion of harm caused to Child K. We were
 19 never told about the desaturations.
 20 "Recommendations.
 21 "When we met for the public inquiry, one of the
 22 mums mentioned about a flag for medical records of
 23 bereaved parents. Just recently, I heard my wife on the
 24 phone trying to get a sick note and they asked why. So
 25 it feels like we have to explain what's happening again
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1 told? There were another two episodes, why weren't we
 2 told? Without a shadow of a doubt I would have stayed
 3 with Child K if I had known.
 4 "At the time I did not know that there were
 5 different levels of hospitals; I thought that one
 6 hospital was the same as any other.
 7 "We only found out about the three desaturations
 8 just before the first trial when we met with Pascale
 9 Jones and Nick Johnson at Knight's Court and heard
 10 Dr Jayaram's evidence during the re-trial. Up until
 11 this meeting, no one had sat us down to explain what had
 12 happened to Child K. I now know that her three
 13 desaturations were due to her breathing tube being
 14 moved. If we had been given this information it would
 15 have stopped all the running around in my head. Like
 16 with Child K's pictures, when I used to look at them
 17 I saw the bruise and I thought that maybe it was
 18 something Lucy Letby had done to Child K.
 19 "I did not know about the report of the Royal
 20 College of Paediatrics and Child Health into neonatal
 21 deaths and the NNU at the Countess of Chester Hospital
 22 or the Advisory Report of Dr Hawdon until my solicitors
 23 made me aware of them during the disclosure process
 24 relating to the upcoming Inquiry hearings. We had no
 25 idea about any of the investigations into neonatal
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1 and again. I don't know how everyone else feels,
 2 but for me it would help to have this flag because the
 3 doctors have to read their notes before they speak to us
 4 so they would know what's going on without me repeating
 5 myself.
 6 "If there had been CCTV that was being monitored
 7 that would have prevented some of the deaths. I think
 8 it's a good idea to put CCTV in the nursery but can't
 9 help but think it's only being looked at now because of
 10 what's happened. It's a massive cost to put it in, but
 11 it's about keeping children safe. It shouldn't just be
 12 in the Neonatal Unit, it should be for all children.
 13 "There should be one person to sign drugs in and
 14 out and confirming which baby it's for and why. It
 15 needs to be more regulated, perhaps even a swipe
 16 operation to open up these cabinets that contain
 17 medications.
 18 "Information should be given to patients or their
 19 parents there and then. Whether that's to an old-age
 20 pensioner or a baby, they should be told so they can
 21 make their own decisions about what happens next and
 22 what impact that has in their lives."
 23 **LADY JUSTICE THIRLWALL:** Thank you very much
 24 indeed, Ms Stanger.
 25 Mother K, Father K, I know that underneath those
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1 names there are real people. Thank you very much for
 2 coming today and for giving your evidence. You have
 3 absolutely perfectly communicated, both of you, your
 4 profound love for your daughter and there's a really
 5 very vivid description of inexperienced new parents
 6 dealing first with the joy and then the huge loss and
 7 how it changes everything and you, Mother K, rightly
 8 said people just don't know if they haven't experienced,
 9 so thank you for sharing that so generously with us.
 10 You have really well described what your
 11 experiences were, which, as you know, I'm looking at in
 12 Part A of the Terms of Reference and thanks also for the
 13 thoughtful observations about what helped and what
 14 didn't, and also your very frank acknowledgement of when
 15 there was good care and kindness shown to you by the
 16 many people who were involved in looking after you,
 17 Mother K, and your daughter, and it was interesting to
 18 learn of the help that you derived from the contact that
 19 you had with the bereavement midwife. I had not heard
 20 of that before, so it is particularly useful to me and
 21 thank you for your suggestions in respect of the need
 22 for accountability and much more besides.
 23 I do know how difficult the process of this Inquiry
 24 has been for you. Thank you both very much for giving
 25 your evidence today and that concludes the need for you

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1 to be here. Obviously, you can come back at any time
 2 that you wish to, but no one is going to ask you any
 3 questions any more.
 4 **THE WITNESS:** Thank you.
 5 **LADY JUSTICE THIRLWALL:** So we will finish now and
 6 we will start tomorrow morning at 10 o'clock.
 7 **MS LANGDALE:** 10 am.
 8 **LADY JUSTICE THIRLWALL:** Thank you all very much.
 9 **(4.33 pm)**
 10 **(The Inquiry adjourned until 10.00 am**
 11 **on Tuesday, 24 September 2024)**

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