Tuesday, 24 September 2024

(10.07 am)

LADY JUSTICE THIRLWALL: Good morning, Mr Skelton. I understand we've got Father L&M on the line --

MR SKELTON: Yes, my Lady.

LADY JUSTICE THIRLWALL: -- listening and I understand that he can see us, so thank you very much indeed for being here, Father L&M. I understand Mr Skelton is going to read a statement on your and Mother L&M's behalf.

MR SKELTON: Thank you.

MS LANGDALE: My Lady, before we do that --

LADY JUSTICE THIRLWALL: Thank you. Sorry, Ms Langdale.

MS LANGDALE: -- and before we turn to today's evidence, we understand from the solicitors representing Mother and Father J that Mother and Father J would like to correct something they said in evidence yesterday.

Their meeting to raise concerns about Baby J was with Dr Saladi and a nurse, but that nurse was not Eirian Powell as stated. We will explore in oral evidence, my Lady, which nurse it was in due course.

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

Mr Skelton.

FATHER L&M statement read

MR SKELTON: Thank you. Witness statement of Father L&M dated 17 July 2024.

"I, Father L&M, will say as follows.

"I am the father of Child L and Child M. I make this statement on behalf of myself and my wife, Mother L&M.

"I make this statement in relation to the Inquiry into the events on the neonatal unit at the Countess of Chester Hospital. As the Inquiry knows, Lucy Letby has been found guilty of causing harm to and the death of several children at [the hospital]. She was found guilty of attempting to murder both of our children in April 2016.

"The contents of my statement are accurate and derive from my own knowledge. Where the contents are not from my own knowledge, I have specified where the information came from. This statement has been prepared following discussions with my solicitor taking place on the telephone. I have also relied on information contained in the statements my wife and I prepared in the criminal proceedings.

"Impact.

"As stated, Lucy Letby was found guilty of attempting to murder both Child L and Child M. The

babies were born [in April] 2016. Lucy Letby tried to murder Child M on 9 April 2016 and Child L from 9 April 2016.

"We are asked by the Inquiry about the impact of events at the [hospital] and subsequently on our family. My wife and I have already provided statements to the police and a victim impact statement. My wife's statements are dated 27 March 2019; and dated 17 April 2023. My statements are dated 5 March 2019; and 17 April 2023. I would ask that the Inquiry read those documents alongside this statement, but also here set out below are some extracts from these statements.

"In my wife's police statement she wrote:

"'Being involved in this case has taken its toll on our family and seeing my husband suffer throughout the last five years has been heartbreaking for me to witness. The doctors told us that the whole events that took place in 2016 surrounding my children were normal for premature babies and we believed what the doctors were telling us at the time. Little did we know that a year or so after their birth the Police would come knocking on the door and break the news that this could be an attempted murder case.

"'I was second on the scene when Child M had his collapse as I was still on the ward at the time. My

mental health has suffered as a consequence of this case and I have some good days and some bad, especially as the trial was about to begin and anxiety levels increased.

"'The boys had to witness their dad suffer a seizure for the first time in their life which was traumatic for them and I believe this would never have happened without the enormous amount of stress and anxiety this has placed on us as a family and I have also suffered from restless sleepless nights throughout this five-year ordeal waiting for the case to come to court'.

"To be clear, the reference above to being told by doctors that the events in 2016 were normal for premature babies refers only to Child M. As I explain below, at the time we were not made aware of any concerns about Child L's condition.

"In my statement to the police, I wrote:

"'The whole event surrounding this case has taken its toll on me both physically and mentally ...

"'I was first on the scene when Child M had his collapse, and that image has been forever etched in my mind and this case has been going on for five plus years (it is obviously longer now). The stress and strain has been unbearable at times and my mental health has

suffered as a consequence of this case.

"'I had to take time out of work and seek counselling. I have also had to take a course of anti-depressants to help me cope with this. Even though they have helped they can never take away the feelings I have as a parent knowing now what truly happened at the Countess of Chester in 2016 and it doesn't make it any easier to cope with over time ...'

"I had a seizure for the first time in my life as we approached the criminal trial. This happened in front of my children and was very distressing for them. The doctors attributed this to the stress and the pressure of what had happened to our children.

"I cannot get the image of the doctors and nurses trying to do CPR on Child M out of my mind or being told we needed to come quickly to the neonatal unit. Even to this day I get flashbacks to what I saw on the unit. I get chest pain, have trouble sleeping and struggle to manage my diabetes sometimes. I used to think I was a very happy-go-lucky guy but now I find myself struggling with my patience which has naturally affected my relationship with my children.

"Child L is very clingy to his mother and neither Child L nor Child M would sleep in their own beds. We had some concerns about Child L's behaviour as he grew

up but now we know it is just his personality. Child L also had some minor speech problems but we have been reassured by the doctors that he is fine.

"I explain below that Child M had a brain scan after his collapse. This was reported as normal but we still have concerns that there may be a problem as he grows up but for now we are happy the twins are fine and healthy. In the evidence at the criminal trial Professor Stivoros noted that there is damage to Child M's brain which will not rectify itself and, over time, Child M may deviate from his peers in terms of attainment and cognitive and motor function. It still haunts me to this day that we do not know what the future might hold.

"Experience at the Countess of Chester Hospital.

"Delivery of our Babies.

"Our twins were born by caesarean section [in] April 2016 at 33 plus 2 weeks gestation at [the hospital].

"We knew early on that we were having twins and, up until March 2016, my wife had a routine pregnancy and the due date was *(redacted)* May 2016. In March, I took the day off work to take my wife to the hospital because she was not feeling well. Her doctor explained that she would need to be admitted straight away and I understood

this to be because of the position of the babies in the womb. She had to be kept in hospital to be monitored for about two weeks. The plan, which my wife agreed with, was to deliver the twins with a caesarean section.

"[In] April 2016, I was at work and my wife rang me to tell me that the doctors at [the hospital] wanted to deliver the twins the following day due to the position they were both in inside the womb. My wife had remained in hospital until this time. I went home and packed a bag for her, taking it to the hospital that night so that everything was ready for the next day.

"The twins were delivered the next morning at 33 weeks and 2 days, by caesarean section. ... I was with their mother when they were born and I was allowed to see them both straight away. Lucy Letby and a nurse called Laura were present and took the babies to the neonatal unit. We were told they were fine and healthy. My wife was taken to a ward upstairs.

"I was able to go to the neonatal unit to see them again a few hours later and they both seemed fine, they just seemed like babies. They were in Nursery 1. I cannot recall who was looking after them when I went to the neonatal unit but they both seemed fine.

"I understood they were on the unit because they were small and they did not weigh very much - they each

weighed just over 3lbs. I understood that we would be able to take them home within a few weeks.

"I have since learned that Child L had periods of low blood sugar which required treatment, but we were not aware of this at the time.

"Child M.

"... the rest of our family came to see the babies. We all went together down to the neonatal unit, as did the mother of Child L&M. We were very happy and proud parents. All seemed well and no one spoke to us about any concerns.

"We had been back on the maternity ward for about ten minutes (having left the neonatal unit) when a nurse came rushing in to tell us we needed to come back to the neonatal unit immediately because something was wrong. I do not remember this nurse's name or what she looked like. However, in my wife's statement to the police she said that she thought the nurse was called Yvonne but we cannot be sure. This nurse did not give more detail at this time about what was wrong. I am advised by my solicitor that Nurse Belinda Simcock's police statement says that she sent a nurse called Ashleigh Hudson to get us.

"I arrived on the neonatal unit before my wife as she was in a wheelchair and needed to be pushed. When

I got there, I remember seeing one of the doctors doing chest compressions on Child M. It was such a horrible image and has stuck with me forever.

"My wife arrived shortly after I did. She remembers that the nurse said that they would explain what was wrong when we got to the neonatal unit.

"In my wife's statement to the police she recalled that Lucy Letby was there, with the nurse called Laura, and another nurse wearing glasses and with a bob haircut, as well as a doctor.

"I do not remember much about what we were told or who was there on the unit. My head was just spinning at the time and my focus was only on Child M. I was just crying and crying and could not speak.

"In my wife's police statement she said:

"'When we got there one of the doctors was just pressing Child M's chest. People were saying the boys were healthy yesterday and they didn't know what had happened today. One of the nurses with glasses and a bob haircut said she had done everything with him and he was absolutely good and she didn't know what had happened. I don't know her name but it sounded like she was the nurse in charge of his care. She was short and fair'.

"I remember the doctors trying to help Child M for

about 30 minutes. They told us afterwards that his heart had stopped. I recall there was a conversation with me about withdrawing treatment for Child M because they had been working on him for so long and he was not coming back, but then he managed to recover.

"During this time one of the male doctors, who I now understand to be Dr Ravi Jayaram, took me and my mum into a side room on the unit. My wife was not present. He explained to us that these things can happen with premature babies. I understood that he was referring to Child M's collapse and the need for resuscitation. I saw no reason to question that at all, it seemed to make sense.

"At the criminal trial into Lucy Letby's actions, Dr Jayaram explained that he had been involved in the resuscitation of Child M and had seen weird patches and discolouration on Child M's skin when they were trying to resuscitate him. I also understand now that this would have been very rare and highly unusual. At no point was this mentioned to us as parents. We had no idea that anyone thought anything about Child M's condition or presentation was unusual or suspicious. We were first time parents and had been told that this could happen with premature babies and so we had no reason to question anything or raise any concerns.

Essentially we were given a reason for it which we accepted at the time. Child M was then not unwell again, so the explanation made sense to us in the circumstances.

"The Inquiry has referred me to the police statement of Dr Jayaram, dated 7 March 2019. I am informed by my solicitor that in this statement Dr Jayaram says that, during the resuscitation, he saw patches of pink flitting on Child M's abdomen, which appeared to come and go a little bit. He says he remembers the patches being quite clear as Child M has quite dark skin and it was 'very unusual' to see these patterns. He then says that he saw very similar observations with Child A and that, as a result of his observations with Child M and Child A and conversations with colleagues, he carried out some research.

"Dr Jayaram's statement to the police also says that Child M's resuscitation was done correctly but he did not respond as expected, but then suddenly and quickly recovered. He writes, 'these facts, combined with the pink blotches I saw, later made me question whether an air embolism was involved after reading the paper I found on the subject'. The statement also says '[i]f Child M's collapse had been a one-off, even in view of all I have stated above, I may not have thought

anything more of it, however, this happened at a time when other incidents were occurring, a time when realisation was beginning to dawn on me and so I added Child M to my list of suspicious incidents'.

"The Inquiry has asked us what Dr Jayaram told us about Child M's collapse. I have explained this above. We were not given more information about his collapse or the reasons for it until the police spoke with us in 2019. Blotches on Child M were not mentioned to us by Dr Jayaram or others at the [hospital]. We were not made aware by Dr Jayaram or others at the hospital that Child M's collapse was being viewed as suspicious. The information set out above from Dr Jayaram's statement was not discussed with us by the doctor or others at the [hospital].

"The Inquiry has also provided the police statement of nurse Laura Eagles dated 27 February 2018. I am informed by my solicitor that in that statement Nurse Eagles says that she was made designated nurse for Child M on the day shift on 10 April 2016, starting at 07.30. Her statement refers to the handover notes stating that Child M had suffered a collapse the day before and was being treated for necrotising enterocolitis. We did not know that Child M was being treated for necrotising enterocolitis.

"My wife stayed in hospital for a further two weeks. She would visit Child L and Child M on the neonatal unit during the day, she would stay with them for a good few hours each morning and then when I finished work at about 4 pm I would go and spend the evening with them along with her. Once she was discharged, she would go every day to spend time with them just as before. The boys seemed perfectly well and, as far as we were aware, there were no incidents in that time or concerns about their condition. We were aware that Child M had a brain scan to make sure there had been no damage from his collapse. We were told that came back fine so we were really happy.

"Child L.

"The Inquiry has referred us to our police witness statements in which we both recalled only Child M had issues early on. We are then asked if anyone at [the hospital] told us there were concerns about Child L's condition while he was in the neonatal unit.

"The answer is no, no one told us there were concerns about Child L's condition while he was in the neonatal unit.

"No one told us that Child L's blood results had been abnormal and had shown there was far too much insulin in his blood stream. It was never mentioned to

either of us as parents. In fact, my wife's statement to the police says that, after Saturday 9 April 2016, the boys were really stable and there were not any other problems. That was our understanding of the position. My wife was there every day. My statement to the police says there were not any other issues with the boys and 'it was actually only Child M who had the problem early on'.

"The Inquiry has asked us about evidence from Nurse Belinda Simcock has contained in her police statement dated 16 February 2018. I am informed by my solicitor that in this statement it says 'I would say that I was surprised that Child M suffered such a collapse as it was Child M's brother [ie Child L] who had been more of a concern to us than Child M'. We were asked whether anyone said anything to us to indicate concern about Child L and whether we knew if there were any concerns about Child L at the time. As indicated above, the answer is no. We were not told about any concerns about Child L.

"The Inquiry has also referred us to the police statement of Dr Stephen Brearey dated 16 April 2019. I am informed by my solicitor that this statement sets out when he first became aware of the possible administration of insulin to Child L. That statement

refers to Child L's hospital discharge letter, which stated: 'in his first 72 hours of life Child L did have notable hypoglycaemia requiring high concentration dextrose (up to 15%) via UVC. A hypoglycaemia screen at this time revealed normal cortisol and appropriately low insulin/C-peptide supporting a diagnosis of hypoglycaemia secondary to small size and prematurity rather than [any] other underlying pathology'.

"At the time, we were not informed that Child L had notable hypoglycaemia requiring high concentration dextrose.

"Dr Brearey's statement also says that in February 2018 he was asked to review the care of a number of babies, including Child L. He read the discharge letter referred to above and says 'I took this statement at face value which I recognise as an error of judgment'. He then says that in August 2018, the laboratory was asked to send insulin and C-peptide results and, on reviewing Child L's results, it became clear his insulin and C-peptide results were abnormal and 'suggestive of exogenous insulin administration'.

"We were not told about this by staff at the [hospital] at any time. It was the police that first informed us in 2019 that they thought insulin had been used to harm Child L. It was not until we heard the

evidence at the criminal trial that it was first explained about how this was likely done. The suggestion was that this excess insulin had been added to a number of fluid infusion bags for him.

"We were able to take the twins home after about three to four weeks.

"Causes of collapse or deterioration.

"The Inquiry has asked us a series of questions going to what we knew about concerns or investigations at [the hospital] and how we became aware that investigations were being undertaken in relation to neonatal services there in respect of neonatal deaths and unexpected collapses.

"We are specifically asked what, if any, investigations into Child M's sudden deterioration we understood were going to take place at the time and whether we thought there was any investigation in relation to Child L. We did not know that [the hospital] was doing or going to do any investigation into Child M's collapse. As explained above, we did not know there were concerns about Child L and so did not think there was any investigation into him.

"We heard nothing from [the hospital] about the events on the neonatal unit once we took the twins home. The first we ever heard about anything of concern was

when the police knocked on our front door in 2019 telling us they wanted to speak to us about an attempted murder case.

"We are asked if we were aware that the Royal College of Paediatrics and Child Health undertook a review into neonatal deaths and the neonatal unit at [the hospital]. I am informed by my solicitor that this review is dated November 2016. We were not aware of that. We are also asked if we were aware of an Advisory Medical report prepared by Dr Hawdon dated 1 October 2016 in relation to babies who died or had cardiorespiratory collapses in the neonatal period at [the hospital]. We were not aware of that. I do not recall receiving any copies of the report from the Royal College of Paediatrics and Child Health.

"Suspicions and Concerns Regarding Lucy Letby.

"The Inquiry has asked if we had any dealings with Lucy Letby. I have already explained above that Lucy Letby was present at the delivery [in] April 2016. My wife recalls her being present after Child M's collapse on 9 April 2016.

"My wife also recalls one occasion where she went into the unit, Lucy was in the room with Child L&M. This was after my wife had been discharged from hospital. Child M was being monitored by a machine that

showed his heartbeat. It stopped working and my wife said 'Lucy, something is wrong with your machine?' Lucy could hear her but she did not respond, she was just looking at the machine and then she went outside. There was a loose wire on the machine but there was no alarm sounding, it was just showing all zeros. Then after a few minutes she came back in the room and she checked the wire, and said 'Now it's okay'. Then it started making the noise it made when it worked properly.

"Lucy Letby took a real shine to Child L. She would feed him while my wife was feeding Child M. She would talk to us about him all the time and she said he was her favourite. When it came for us to take the babies home, Lucy asked if she could get Child L ready. We have been asked by the Inquiry whether we had any suspicions or concerns about her. We did not.

"Raising Concerns and Getting Answers.

"The Inquiry has referred us to the statement of DC Griffiths, a police Family Liaison Officer in the criminal proceedings, dated 16 December 2021. In this statement DC Griffiths sets out some of the families' concerns about the provision of information and about hearing things for the first time at court. We are asked if we have these concerns.

"The answer is yes. There are two parts to this.

First, we did not receive anything from the Countess of Chester Hospital about concerns on the unit, or concerns about what had happened to our children. It fell to the police to have to relay that information to us. Secondly, we heard abundance of information and evidence at the criminal [trial] and much of this was new.

"We certainly did not make any use of the Patient Advice and Liaison Service (PALS) as we were new parents and did not think anything unusual had happened.

"Suggestions and Recommendations.

"Lucy Letby is responsible for giving Child L excess insulin. We understand that if small amounts of insulin were being used, this would not be noticed, eg if adding insulin to a dextrose infusion bag then 1% of a bottle would not be noticed. However, healthcare professionals at [the hospital] had Child L's blood results on *(redacted)* April which showed excessive insulin. We think that this should have raised - including with us -- and investigated further. Perhaps Child L's lines and equipment could have been changed and then the insulin prepared by a Consultant to ensure it was correct. Maybe the contents of the bags should be checked with some kind of test before they are administered?

"It is not for me to advise a hospital as to how

this should be managed. That is a recommendation for those in practice who know how to implement proper safety and monitoring system but, for us, without doubt, it is a drug that needs tighter control and supervision given the harm it can cause.

"I believe that the whole management team, above the consultants, need to be held accountable for their actions. From our perspective, they allowed a nurse who was causing harm to babies to continue working after concerns were raised by Consultants about her potential involvement in babies dying or deteriorating. If they had listened sooner, fewer babies would have died or been harmed. Fewer families would have been bereaved and damaged. It is not enough to just say sorry to the families now.

"I understand a rash, similar to that seen on Child M, had been seen before in another baby on the unit. However, it was extremely rare and very unusual. Dr Jayaram said that he had done some private research about the cause maybe being an air embolism but that his concerns were not taken seriously. Given the rarity of skin discolouration, I do not understand why more steps were not taken to consider the cause, or a discussion about it amongst the doctors, or with other doctors on a wider scale. If it had been, there may have been more

weight to the suspicion that it had been purposefully caused. Given how unusual it was, I really do not understand why it was not taken further by the clinical staff.

"Unusual, rare or unexplained symptoms in a baby should be discussed openly with all the team on the unit and research taken further if the cause remains unexplained. At the criminal trial, Dr Jayaram gave evidence that he had emailed a medical paper he had found about air embolism to his colleagues. But was this ever taken any further?

"I am aware of a book which the BBC are planning to release in the autumn titled 'Unmasking Lucy Letby'. I do not think it is fair that this book and other publications are allowed to be released without first consulting the families. This will further add to the pain each family is suffering."

My Lady, that concludes the statement.

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

Father L&M, thank you very much for providing your statement. You will have heard me say to other parents that I do know that underneath the letters L&M there are two boys and I know that under Mother L and Father L and Father M and Mother M there are real people and I do

take account of that at all times.

The statements are enormously helpful, firstly about the facts and your experience, and I will be referring to them as I go on to consider what is going to go into my report, but I do recall that it was very early on, before the Inquiry had been set up, that you raised the suggestion that there should be CCTV on neonatal units and you will know that others have agreed with you and it is for that reason that we were able to ask the corporate witnesses to deal with that suggestion and we will have in due course evidence from them about using CCTV in hospital wards.

The same applies to your observations which we heard in your statement about the need to scrutinise access to insulin, so thank you for the whole of your evidence and in particular what you have said in respect of recommendations.

I am grateful to you for being here today and for listening to Mr Skelton read out your statement. Would you be kind enough to pass on all of what I have just said to the mother of the children, your wife. Thank her very much too.

THE WITNESS: Thank you, very much, and to Peter.

MS LANGDALE: My Lady, may we now rise, not least to check the quality of the audio link, I think there

are some difficulties with it.

LADY JUSTICE THIRLWALL: Okay, I'm sorry to hear that. I will rise briefly and will someone just say when we are ready.

(10.37 am)

(Short Break)

(11.03 am)

LADY JUSTICE THIRLWALL: Mother N, I understand that you are online with your camera turned off, which is of course absolutely fine. Thank you very much for being with us this morning and I understand Mr Skelton is going to read your statement on your behalf.

Mr Skelton.

MOTHER N statement read

MR SKELTON: Thank you, my Lady.

Witness statement of Mother N, dated 17 July 2024.

"I, Mother N, will say as follows:

"I am the mother of Child N.

"I make this statement in relation to the Inquiry into the events on the neonatal unit at the Countess of Chester Hospital ... for which Lucy Letby has been found guilty of the murder and attempted murder of several children.

"Child N was born [in] June 2016. Lucy Letby was found guilty of attempting to murder him on *(redacted)*

June 2016. She was charged with two further counts of attempting to murder him on *(redacted)* June 2016 but the jury was unable to reach a verdict in relation to those counts.

"The contents of my statement are accurate and derive from my own knowledge. Where the contents are not from my own knowledge, I have specified where the information came from. This statement has been prepared following discussions taking place on the telephone.

"I have previously made a statement to the police in relation to these events, dated 19 December 2018 and would ask that this be read in conjunction with this statement. I have also included some information from that statement in this document.

"Impact.

"I prepared a victim impact statement for use in the criminal proceedings, dated 21 June 2023. Again I ask for that impact statement to be read alongside this statement but I have also included extracts here ..."

LADY JUSTICE THIRLWALL: Mr Skelton, just before you continue, may I just check, Mother N, that you can see Mr Skelton?

MOTHER N: I can, yes, thank you.

LADY JUSTICE THIRLWALL: Thank you. Sorry, do

continue.

MR SKELTON: "'When we received the phone call (on *(redacted)* June 2016) to say that Child N was poorly and that he wouldn't be coming home as expected, it just didn't feel real. The day we were called to the neonatal unit was the worst day of our lives, from waking up that morning being prepared to take home our son to the utter catastrophic scene we arrived at has left a lasting imprint on us, seeing our tiny baby fighting for his life, medics doing CPR on his tiny body and not knowing if he was going to live or die with no obvious cause. We have often heard of people dying from a broken heart, this is how we can describe how we felt that day the pain was immeasurable and we didn't want to leave that hospital without our son, we both relive this every day because not a day goes by without thinking about that day. Then he was transferred to Alder Hey which was even further away from home and we were often doing a two-hour round trip twice a day to see our son in-between looking after two other children, we did this for a month after his transfer.

"'Financially this was difficult as Father N was self-employed, we were exhausted both emotionally and physically and the additional driving didn't help. We felt guilty leaving Child N in hospital, but we also

felt guilty leaving our other children at home.

"'I honestly knew [that] Child N had been deliberately harmed. I felt like there wasn't a natural explanation but that someone was responsible for Child N being poorly. I don't know whether this was common sense, or a mother's instinct but I just knew and I said this to Father N at the time. I just kept questioning why our healthy baby boy was fine one minute and then bleeding from the mouth and needing CPR the next.

"'This caused massive trust issues which have remained with us to this day and we don't think will ever leave us. I only trusted Father N and me to be there and I didn't want Child N to be left alone and Father N agreed, so this created additional pressure for us all.

"'When Child N eventually came home, I only wanted it to be me or Father N who took him for his medical appointments. This makes life difficult if I am ever poorly, as I am the only person trained to provide Child N with his medication in respect of his blood disorder.

"'My mum used to care for our two eldest children overnight, but I can count on one hand the number of times I've allowed Child N to stay at his grandmother's. My mum is completely capable but it is our trust that

has been broken.

"'I think there has only been one occasion when me and Father N have been out, just the two of us, since Child N was born. As that would involve asking someone to look after Child N for what I would say was social but not essential.

"'Child N slept in with me and Father N until he was two and a half, as we wanted to be able to hear him breathing and feel his presence. We had an 'Angel' monitor in Child N's bedroom which was an alarmed mat. This was meant for babies but he actually slept on it until he was four/five years old.

"'We knew the alarm would activate if Child N stopped breathing, we still have a camera so we can watch him whilst he sleeps and check he's okay even though he has just turned seven years old, we are both extremely over-protective, making sure everything is perfect and everything is done right. It made me feel good, but looking back I don't know whether we functioned on adrenaline because we certainly didn't sleep. I wanted to be the one who did everything.

"'Now as Child N gets older, he is a free spirit. We wanted him to be home schooled as we didn't want anyone else looking after him as our trust in people in a position of trust has been completely broken. All the

other impacts; emotional, financial, anything else doesn't matter much to us [as] our son being here today is more important than anything else and outweighs the burden of all other impacts. We couldn't keep Child N safe in hospital, as a parent it's your duty to protect your children and this was taken away from us when he was in a place where he should have been at his safest, so we do everything possible to keep him safe now and if that means wrapping him up in cotton wool, then that is what we will do.

"'We know he that we smother Child N with love and affection ... after everything that has happened in his early life we don't give him boundaries, as we never want him to feel sad.

"'When we were informed that Child N was a part of the police investigation, we weren't sad - we were happy and relieved. We would describe it as a feeling of a mixture of emotions, both shock and it being surreal. We felt like we were being listened to and that finally we would receive some answers as to why and what happened to Child N that day happened.

"'We didn't want to burden our eldest children with all of the information and the police investigation as all we ever want is for our children to be happy and content. They had been through enough when Child N was

poorly and having to see me and Father N upset.

"'We have discussed having another baby since Child N was born but the fear of witnessing what happened repeat itself and having to go back into the hospital setting and the possibility of going back into the neonatal unit has stopped us from doing so.

"'The worst part of going to [the criminal] court is being away from Child N and the other children. It disrupts their routine and their home life - everything that we try our hardest to protect and preserve, having to listen to what she did to the other babies weighs heavy on the mind because you know exactly the hurt each of those parents felt you carry that also ...'

"Experience at [Countess of Chester Hospital].

"Child N's antenatal care and delivery.

"I had my antenatal care at [the hospital] and had a normal pregnancy with Child N up until about 24 weeks. At that point I attended for a scan and to check on his growth as there was a concern that Child N was not growing properly.

"I recall that the plan was that I delivered at 32 weeks by a caesarean section because he was small and the consultants wanted him delivered as soon as possible in order to make sure the placenta did not fail.

"I have a blood clotting disorder. We knew Child N

was a boy and were aware there was a 50% chance he would be born with a blood disorder. We understood that, because of this, extra staff would need to be present in theatre for safety and to check Child N over once he was born. I initially expected Child N would be on the maternity unit with me, but once he was delivered we were told he would need to be admitted to the neonatal unit for a few weeks before we could take him home. I recall finding this out on the evening of his birth.

"The Inquiry has referred me to the police statement of Dr Sudeshna Bhowmik, who was a trainee paediatrician. In this she describes meeting me on the morning of *(redacted)* June 2016, before Child N was born. She says she explained various things about his delivery and that Child N would be admitted to the neonatal unit for observation, respiratory support and feeding support as needed. I am asked if this accords with my memory but I do not recall a tour of the unit and in my original police statement made in December 2018, I stated that 'No one actually sat us down and told us anything about Child N and I felt there was a lack of information throughout the whole process in the neonatal unit. We actually ended up having a few words with one of the nurses about this and the fact that there were parents who had come onto the unit after

us who had been given booklets on premature babies whereas we didn't get given anything until we raised the issue'.

"Child N was born at [the hospital] in June 2016 by caesarean section. He did not have a bleed during the delivery but he was small, only 3 lbs 11 oz and he was also jaundiced. He was taken to the neonatal unit straight away.

"It was not until very late that night that I got to go and see him on the neonatal unit. One of the midwives took me down there. He was in Nursery 2 and I was surprised that he was just in the incubator on his own.

"While I was there, I was not introduced to any staff on the unit and no one came to introduce him or herself. The first time I interacted with the nursing staff and they spoke to me was when I needed to ask questions about Child N. Nobody from the neonatal unit proactively came to speak to us about him, about his condition, or his treatment. No one gave us information about caring for a premature baby.

"We did see parents come onto the neonatal unit who were given booklets about premature babies, but we were given nothing.

"I also did not get daily updates from the nurses

on the unit. I would take it upon myself to look at Child N's charts and try to speak with the consultant who I recall was there each day. I was trying to get more information and find out how Child N was doing (I explained this in my police statement). I understand that staff were working with Alder Hey Hospital on a plan in case Child N had a bleed while he was so young.

"As far as I was concerned, Child N was only on the neonatal unit because he was premature. It was not until *(redacted)* June, so *(redacted)* days after he was born that I was made aware there had been problems with Child N. I was informed that doctors had been trying to keep his temperature stable and also that he had a feeding tube in, but they were trying to establish a feeding regime for him. There had been nothing to make me think his condition was not normal.

"However, even at this point I was not made aware there had been any problems with Child N's condition in the early hours on *(redacted)* June 2016.

"The Inquiry has asked me for my views on the adequacy of the information on the neonatal unit at [the hospital]. It should be clear from what I have said above that I considered the information to be inadequate, in terms of the processes on the neonatal

unit, how to care for a baby there, and also information about Child N's condition. I thought that was the case both at the time and after.

"In the first days of Child N's life, I remember Lucy Letby, along with nurses called Catherine and Bernie, helped to look after him.

"Child N's Collapses.

"The Inquiry has asked me about Child N's deterioration in the early hours of the morning of *(redacted)* June 2016 and what I was told about this deterioration and its cause. I am now aware that Child N's oxygen saturations dropped very low overnight on *(redacted)* June to 40%. I heard about this profound desaturation around a month before the criminal trial. Lucy Letby was convicted of attempting to murder him on this date, but I knew nothing about this deterioration at the time. I was not told that a crash call had been put out or that Child N's oxygen saturations had dropped to 40%. I was not even told Child N had had problems that night until shortly before the trial.

"On *(redacted)* June 2016, I was told that Child N would be able to come home the following day. By this point he was in Nursery 4.

"However, at around 8 am on *(redacted)* June I got a phone call from Child N's father. He said there had

been an issue at the hospital and that Child N had a bleed but there was nothing to worry about. I then rang [the hospital] to ask them if I should bring the car seat in with me to take Child N home that day. However, I was told by a lady called Grace that Child N was in fact really poorly and be had been since 4 am that morning. She said that they had caused the bleed. By this I understood she meant healthcare professionals had caused a bleed. She told me I had to get in there as soon as possible.

"I do not know why I had not been contacted earlier, if the bleed or the problem had happened during the night and several hours earlier.

"I got to the hospital at about 9 am. Father N met me at the hospital. Child N was now in the intensive care nursery. I had never been in that nursery before. I saw lots of people gathered around him. It was a very emotional time and I just remember consultants trying to keep him stable at this point. I remember being told he had some apnoeas since the morning but they did not know why.

"I recall that Lucy Letby was there and another nurse, possibly called Mina.

"I was told that the doctors had tried to intubate him at some time between 4-8 am and that he had had

a bleed when they were trying to do it. Dr Saladi said he had let a registrar try to intubate Child N which had resulted in a bleed (or that was our understanding). We did not really get an answer as to what had happened or why and were just told that it was essential to intubate Child N at the time.

"They carried on trying to intubate him while we were there. I believe an anaesthetist tried and could not, and Dr Saladi also tried and could not. It was a long, drawn out process. During this time he had two further collapses.

"During the day on *(redacted)* June, Lucy Letby was our main point of contact as she was tending to Child N in between the doctors being with him. She recommended that we have Child N baptised, and for some reason we did. I think we just wanted anything that might possibly help. It was a spur of the moment decision. It was only that evening that they managed to intubate Child N, when doctors from Alder Hey arrived.

"On the evening of *(redacted)* June, Father N and I were sitting outside the intensive care nursery when the night duty shift nurses arrived on the neonatal unit. One of the nurses ... came to speak to us. She had been looking after Child N overnight on *(redacted)* to *(redacted)* June. She said she had been caring for

him when he became ill. We found her to be cold and dismissive. I also felt like everyone was staring at Father N and me. In hindsight I think this is probably because Child N was yet another child who had collapsed in the neonatal unit. I felt like it was so inconsiderate of the nurse to think that this was the right time to talk to us about the fact that she had been looking after Child N given all the events that had happened that day.

"After this approach from the nurse I immediately said to Father N that she had harmed Child N. In retrospect I was wrong that she had been responsible, but I just knew there was something not right about him being so well and then suddenly becoming so ill. A child does not go from being fine and healthy to being gravely unwell.

"In addition, [the hospital] had no Factor VIII in stock to give to Child N so a haematology nurse from Alder Hey Hospital had to bring this over to [the hospital] in a taxi. I found this extremely upsetting as they had known there was a risk Child N had *(redacted)*. I am informed by my solicitor that Child N's medical records at 1.45 am on *(redacted)* June 2016 state 'presumed *(redacted)*'.

"That night Child N was transferred to Alder Hey

Hospital where they stabilised him. After he was transferred, we were approached by a nurse in the intensive care unit there who told us that, after reviewing Child N's notes, there were discrepancies. I do not recall the nurse explaining what discrepancies these were.

"No one, either at Alder Hey Hospital or from [the Countess of Chester Hospital], expanded on this further. We just had that little bit of information and nothing else. We have never been told what the discrepancies in the notes were.

"Causes of Collapses.

"Once Child N had left the care of [the hospital], we did not hear anything from the hospital about the causes of the collapses or any investigation into them. When Child N was a few months old we attended a paediatric appointment at [the hospital]. I saw Dr Murthy Saladi, a consultant paediatrician, and began to question him on what had happened to Child N on *(redacted)* June 2016 and what had caused it. Initially, Dr Saladi began to speak about the registrar who attempted to intubate Child N, but upon further questioning was unable to give a reason for why the collapses had occurred. This is the conversation with Dr Saladi that I refer to in my police statement.

"I think it is ingrained into you that, when you go to hospital and something happens, the doctors always provide a medical reason, but they seemed not to be able to provide a reason to me.

"The Inquiry has asked me what, if any, investigations into Child N's sudden collapses I understood were taking place at [the hospital] at the time or were going to take place. I was not told about any investigations that were being done or would be done. As I explained above, when I tried to understand more about what had happened and why, it seemed that Dr Saladi did not have any answers, but no one suggested to me that an investigation could or would be done.

"Suspicions and Concerns Regarding Lucy Letby.

"The Inquiry has asked me about any dealings I had with Lucy Letby. I have set this out above.

"I am also asked what, if any, information I was given by [the hospital] about concerns about Lucy Letby's conduct; and if I was given information, when and how that was provided. I am also asked what I was told [the hospital] were doing about any concerns about Lucy Letby. [the hospital] did not inform me of any concerns about her conduct or that it was doing anything about such concerns. I learned from the police that a nurse at [the hospital] had been arrested, as

I explain below.

"The first I heard about the police investigation into unexplained collapses on the neonatal unit was on a phone call with the father of Child N in or around mid-2018. He told me that he had received a phone call from the police and passed my details over to them. I received a call from Cheshire Police not long after in which I was informed that they were investigating some of the unexplained collapses at [the hospital]. When the police came to visit me at home, they told me that the hospital had referred itself to the police regarding unexplained collapses and the police believed Child N may be one of the suspicious or concerning collapses.

"Shortly before Lucy Letby was arrested I received a phone call from Cheshire Police informing me that they would be making an arrest. I was not told if this person was employed by [the hospital], or whether this particular person had any part in Child N's care.

"I am informed by my solicitor that Lucy Letby was arrested on 3 July 2018. Around 6 am on the morning of her arrest, I received a call from the police to say that they had arrested a nurse who had worked at the [hospital]. I cannot recall when I was told it was Lucy Letby.

"Counselling.

"The Inquiry has asked about any help and support I was offered by the [hospital], the Trust or any other organisation.

"I received the offer of counselling during the criminal trial. I had just one session and hated the awkward silences in which I was expected to speak so I did not go back. My counselling session was with the therapists provided by the Police Service. It was held by Microsoft Teams. I would consider now having more counselling if it would be face-to-face.

"Raising Concerns and Getting Answers.

"The Inquiry has asked me a series of questions going to my knowledge of investigations at [the hospital], the police investigation, communication from [the hospital], and the adequacy of information provided by [the hospital]. I did not think to request Child N's medical records. Some of the evidence I have given above is relevant to this topic.

"I am asked if I was aware that the Royal College of Paediatrics and Child Health undertook a review into neonatal services at [the hospital]. I am informed that this review is dated November 2016. I was not made aware of this report and was not provided with a copy of it.

"I am also asked if I was aware of an Advisory

Medical Report prepared by Dr J Hawdon, dated 1 October 2016, in relation to some babies who had died or had cardiorespiratory collapses, in the neonatal period at [the hospital]. I was not made aware of this either.

"I have explained that I tried to have a conversation with Dr Saladi about what had happened to Child N on *(redacted)* June. This was when he was a few months old and I took Child N to a paediatric appointment at [the hospital]. But I was not invited to a meeting at [the hospital] to discuss his care or any investigations.

"As I have explained above, Lucy Letby was charged and tried for three counts of attempting to murder Child N. The first attempt was in the early hours of *(redacted)* June 2016. As is clear from this statement, I had no idea there had been an issue with Child N prior to *(redacted)* June other than he had experienced some episodes of apnoea. I was not aware of anything significant or sinister that had occurred prior to *(redacted)* June. We were essentially kept in the dark about this. It is in relation to this attempt on Child N's life, that we knew nothing about, that Lucy Letby was found guilty.

"We were aware there had been collapses on

(redacted) June 2016 but were told that the cause was uncertain. Although Lucy Letby was charged with two counts of attempted murder in relation to events on *(redacted)* June, the jury was unable to reach a verdict on either count. Therefore, it remains the case that we have no clear explanation for Child N's collapses on this date.

"At the criminal trial we heard evidence that Doctor U had tried to look into Child N's throat when his desaturations occurred on the morning of *(redacted)* June and thought he had seen blood in Child N's throat. But we also heard that there was swelling and Doctor U could not see where the blood had come from. I still don't understand the sequence of events. Did Child N have blood in his throat before he needed to be intubated, or was the bleeding caused by the numerous attempts to intubate him? If the blood was there first, what caused it? Child N's medical records describe it as being already there when Doctor U looked in his throat but elsewhere the records seem to state it was intubation that caused the bleeding. I still do not think I know for certain why Child N needed to be intubated, all we were told when we arrived at the hospital on *(redacted)* June was that Child N had a bleed and that was why they needed to intubate him. They were

very vague about what was happening, like no one really knew.

"In my police statement I referred to three concerns I had with the neonatal unit at [the hospital]. These were the staffing levels, the nurse that looked after Child N the night he fell ill and the discrepancies in his notes regarding the reason for him deteriorating on *(redacted)* June. These are concerns I had at the time, and still have today. I did not raise these concerns with anyone at [the hospital] as I had already left their care and was under the care of Alder Hey Hospital.

"On staffing, the whole time that Child N was in the neonatal unit at [the hospital], they seemed very understaffed. There was a board on the wall that said how many staff should be on duty, and how many staff were actually on duty. The board said that five or six should be working, but there were usually three or sometimes four.

"I lodged a complaint against Doctor U. I made this complaint when it was revealed at the criminal trial that he had discussed Child N with Lucy Letby on Facebook and by private text message, even referring to Child N by their surname. There were several grounds to my complaint. One was his disregard for, and blatant

breaches of, patient confidentiality. In addition, he shared emails that had been exchanged between Consultants in regard to Lucy Letby's conduct with her, and should not have done that. I made this complaint as the evidence was heard at trial but was asked by the police to put the complaint on hold due to the reporting restrictions. I made the complaint formally at the end of the trial. I raised the complaint with PALS and received a response from (redacted), explaining they would be overseeing the complaint response. This acknowledgement was received about a month after the trial finished in 2023.

"I have had a number of meetings about this complaint. At a recent meeting I was told by an anaesthetist that consultants now use an encrypted 'chat' service such as WhatsApp to communicate outside work. I am yet to receive the formal outcome of the investigation.

"I know that the evidence presented at the criminal trial showed that a number of nurses on the neonatal unit did the same thing as Doctor U. They would share and discuss the medical conditions of patients on their private mobile phones. No record of those conversations would have been available unless there was police involvement. Though I do not object to nurses and

doctors discussing patients, it is the method of communication by insecure means, and the risk of a breach of confidentiality, that was so willfully ignored and commonly used by a number of staff.

"Recommendations.

"The Inquiry has asked me if I have any recommendations or suggestions to help prevent crimes like Lucy Letby's in the future and keep babies safe on neonatal units. While I include some information in this statement, it may be that I have further thoughts and wish to say more as the Inquiry continues, possibly through my lawyers.

"Firstly, I would like CCTV to be mandatory when vulnerable patients are being cared for.

"I would hope that the managers of the Trust are held accountable for failing to investigate the whistleblowing allegations. A lot of the harm that Lucy Letby caused could have been avoided if a thorough and prompt investigation had taken place after the whistleblowers raised concerns. The managers should be listening to what is reported to them. Ignoring these allegations, or not giving them proper weight, makes these people complicit in the harm that was caused. I feel that they should be held accountable, they should not be able to continue in their roles and should face

criminal action.

"I do not think that the NHS is fit for purpose as it stands. There have been many issues in the past, such as Harold Shipman and Beverley Allitt, and nothing effective has been done to prevent this from happening again. It should start with the people at the top, they should listen to the Consultants who work, day-in day-out, in the wards as those who experience and know about the day-to-day running of the NHS. It should not be someone sitting in an office making decisions.

"Reflecting on what has happened, I find that the staff were too involved with each other, and had too much of a focus on their friendship rather than their job and what was going on in the unit and with the babies. I now know that they were texting each other outside of work about the babies. I feel that they need to be more professional and there should be a clear line set in place to prevent this in future. If they paid more attention to their patients, rather than gossiping, things might have been different."

My Lady, that concludes the statement.

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

Mother N, thank you very much indeed for providing us with your statement and allowing Mr Skelton to read

it. It is a very helpful and a very focused statement which sets out very clearly what your experiences were and will undoubtedly be of great assistance to me when dealing with the issues raised in the Terms of Reference.

Thank you also for your observations on what would be good recommendations and your other views on other aspects of the care that you received in the hospital and also your general observations about other matters. Thank you very much indeed.

MOTHER N: Thank you.

Thank you, Peter.

MS LANGDALE: My Lady, may I ask that we resume at midday.

LADY JUSTICE THIRLWALL: Thank you. So 12 o'clock.

(11.34 am)

(Short Break)

(12.03 pm)

LADY JUSTICE THIRLWALL: Mr Skelton, I understand that Father N is not dialling in, or has not dialled in?

MR SKELTON: I think that's right, my Lady. I understand he is self-employed and it was always a possibility he wouldn't be able to attend today.

LADY JUSTICE THIRLWALL: Very well, but you are content and you have instructions to continue to read

his statement?

MR SKELTON: I do, thank you.

LADY JUSTICE THIRLWALL: Thank you. I will invite you to do that now then, please.

FATHER N statement read

MR SKELTON: Thank you.

Witness statement of Father N, dated 17 July 2024.

"I, Father N, will say as follows:

"I am the father of Child N.

"I make this statement in relation to the Public Inquiry into the events at Countess of Chester Hospital for which Lucy Letby has been found guilty of murder and the attempted murder of a number of children.

"Child N was born in June 2016. Lucy Letby was found guilty of attempting to murder him on *(redacted)* June 2016. She was charged with two further counts of attempting to murder him on *(redacted)* June 2016 but the jury was unable to reach a verdict in relation to those counts.

"The contents of my statement are accurate and derive from my own knowledge. Where the contents are not from my own knowledge, I have specified where the information came from. This statement has been prepared following discussions taking place on the telephone.

"Impact.

"The Mother of Child N has already prepared an impact statement, dated 21 June 2023 and I would request that this be read alongside my statement.

"In particular her statement describes '(We) ... kept questioning why our healthy baby boy was fine one minute and then bleeding from the mouth and needing CPR the next. This has caused us massive trust issues which have remained with us to this day and we don't think will ever leave us'.

"Both myself and Child N's mother have made previous statements surrounding the events on the neonatal unit at [the hospital]. My statement is dated 14 November 2019 and Child N's mother's statement is dated 19 December 2018. I ask that those police statements are read in conjunction with this statement, but have also included here some information from my police statement:

"'Since Child N was born, Mother N and I went to see Child N in the neonatal unit every day. Mother N stayed in hospital for about a week after the caesarean. She was initially in a private room, upstairs on the ward. Once Mother N came home we both went to see Child N every day. We usually went along in the morning at about 9 o'clock after the other kids went off school. At the weekend we also took Mother N's children in to

see him. I never went to see Child N by myself. I was a bit scared to be honest. We tended to stay with Child N for a couple of hours then we would go home for a while and go back later. Sometimes Mother N would go back later by herself and I would look after the other kids. As I said, I was self-employed and we were juggling the other kids, Child N and my work. There was plenty of time that neither Mother N nor I were able to be with Child N on the neonatal unit.

"' ... when I went to visit Child N I remember looking at the staffing board on the wall of the neonatal unit. It seemed to me that a lot of the time there were less nurses on duty than there should have been. When we were in the neonatal unit at [the hospital] I got the impression from the nurses that it was like Child N wasn't our son. I didn't get a good vibe. I felt like I should not be touching him. We were not encouraged to handle him by the nurses. I didn't hold him until he went to Alder Hey when he was about three weeks old.

"'Every time you went into the unit it was someone else looking after him. You might have the same nurse for two days and then someone else. It was a weird situation in the neonatal unit. I felt like we were not entitled to hold our own kid. You did not feel welcome.

One of the nurses, Mina, was all right. She interacted with people. It might be that they were old school, I don't know.

"' ... on the day Child N was due to come home from the Countess of Chester Hospital (I am not sure of the day or date but Child N was *(redacted)* or *(redacted)* days old), I was at work ... first thing in the morning. I then received a phone call from Child N's nurse, Lucy. Lucy said that Child N had been a bit unwell in the night but she said he's okay now. About ten minutes later Mother N rang me crying her eyes out as she had had a phone call from another nurse who had said that Child N was really not well and we needed to go to the hospital. I can't remember who Mother N said it was that phoned her but I remember that it was not Lucy. Mother N told me that the nurse said he had a bleed.

"' ... during the first day we were at Alder Hey we were trying to get answers about why he was there and what had happened. We spoke to a nurse and she said that she would have a look in Child N's transfer notes. She told us that there was a conflict in the notes as to what had happened. I think one set of notes said that they had caused the bleed and another set said he had had a bleed. I found it really hard to come to terms with what had happened or make sense of it. I thought

that something usually happens for a reason. We could not get an answer from anywhere we looked what had actually happened or why'.

"Experience at the CoCH.

"Child N's Antenatal Care and Delivery.

"I was self-employed when Mother N was pregnant so I could not attend all the scans with her at the [hospital]. I am not sure of the date but at one appointment Mother N informed me that the doctors were concerned that Child N was not growing normally so he would have to have steroids to help develop his lungs.

"As a result of these concerns about his growth, the plan was that he would be delivered by caesarean section several weeks earlier than normal. We were both aware of this and the reasons for it.

"As Child N's mother has *(redacted)*, we knew that the delivery would require a number of extra people in the operating theatre in case there was excess bleeding. Everyone was very aware of this from the beginning of the pregnancy.

"I do not recall although I am almost certain that we did not meet with Dr Bhowmik or Dr Jankee for a tour of the unit. I have no recollection of Dr Bhowmik talking to me about Child N being on the unit. Across all the statements I have given in relation to Child N's

time on the neonatal unit, I have always said that we were given no introduction to the unit but we did see that some other parents were.

"The caesarean was planned for June 2016 and I was there when Child N was delivered in June at 13.42. He was just over 34 weeks. I remember he was very small and weighed only 3 lbs 11 oz.

"We knew there was a risk he would need Factor VIII at birth but learned later on, due to the subsequent events on the neonatal unit, that [the hospital] did not have any in stock for him. This was a surprise as the caesarean had been booked in advance, the date set and the doctors had warned that he might need it. Luckily, there were no issues with Child N bleeding on the day he was born.

"Events Post Child N's birth - Neonatal Care.

"Child N needed oxygen when he was born and this was a bit scary. I knew he would need to be cared for on the neonatal unit because he was premature. Other than that, we were told he was fine and there were no issues.

"Mother N was not allowed to go and see him after he was born as she needed to wait for the epidural to wear off. I sat with her before going to see Child N alone.

"I was only able to stay for five minutes as I had to get home to collect our other two children from school.

"Child N was on the neonatal unit for about 14 days. As far as we had been aware, the only issues he had in that time were that his bilirubin levels were high and he received some light therapy for this. As I explained below, we were not made aware at the time of the significant drop in Child N's oxygen saturations overnight on *(redacted)* June 2016.

"We saw Child N every day on the unit. I never went by myself as I was a bit scared to go there alone as he was so small and vulnerable. We would stay with him for a couple of hours and I knew that Mother N would go back later in the evenings by herself to see him. I would stay at home to look after our other children. I was juggling work and the children and visiting the hospital.

"No one ever sat us down and explained anything about the neonatal unit. I had understood that Child N had to be there because he was premature but we were not given any information about why he really needed to be there and what treatments he would have or how we should be caring for him. We noticed some parents were given a booklet about premature babies but we were not.

"I got a sense from the nurses on the neonatal unit that it was like Child N was not our son. We were not encouraged to handle him and it felt like they did not want us to touch him. The Inquiry has referred me to my police statement in which I said I ' ... got the impression from the nurses that it was like Child N wasn't [our] son' and I 'didn't get a good vibe'. It felt like they were the ones looking after him and that they knew best. I felt removed from him a little bit because they were feeding him and caring for him but I was not told if I could pick him up or how to handle him. It felt like they acted like the parents and they knew best.

"It was not until he was transferred to Alder Hey Hospital at three weeks old that I got to hold him for the first time. No one told me if I was allowed to take him out of the cot or how to be safe with him. I was given no information at all.

"I remember when Child N was about 10 days old Lucy Letby said to me 'Hold him! He is your son'. She was very abrupt and short with me. I did not say anything in reply. Child N was just lying happily in his cot and he was settled and not crying. She did not hand him to me and I did not pick him up.

"Every time I went into the neonatal unit there was

a different member of nursing staff looking after him. There was a sense that you were not welcome there because they were looking after the babies and not you.

"Child N's Collapse.

"We now know that Child N's oxygen saturations dropped very low overnight to 40% on *(redacted)* June 2016. Lucy Letby was convicted of attempting to murder him on that date. The Inquiry has asked whether we were told about this deterioration at the time and how and when we were told about it. We were not told about this deterioration. We did not know Child N had had problems overnight on *(redacted)* June. I find this disgusting. As parents we have an absolute right to know what was happening to and with our son.

"Child N was due to come home from hospital on *(redacted)* June 2016. By this point he was in Nursery 4. As it turned out this was also the first day on which we were aware of any problems with his condition, other than that he had issue with his bilirubin levels and the fact that he was premature so needed support with feeding.

"On *(redacted)* June 2016 Child N had three episodes of deterioration. I am informed that the medical records show that Child N was unwell during the night on *(redacted)* June and had a mottled appearance and then

his oxygen saturations dropped around 08.00. We were not present and were only contacted in the morning as I set out below. The next deterioration was at around 14.50. We had briefly left the hospital to get something to eat. Then there was a further drop in his oxygen saturations that evening. I set out more detail below.

"On the morning of *(redacted)* June I was at work and I received a phone call from Lucy Letby. She said that Child N had been a bit unwell in the night but that he was okay now. I told her that Child N's mother would be at the hospital soon and would see him then as usual. There was no other information, no detail as to what 'a bit unwell' meant but I did not get the impression that Child N was still unwell or that I needed to be concerned.

"About ten minutes later I got a call from Child N's mother. She was very upset and explained that a different nurse had called her and told her that he was very unwell and that we had needed to go to the hospital. Mother N told me that Child N had had a bleed but I understand her police statement said I had told her that Child N had a bleed. It has been so long since these events it is difficult to remember who it was that was first told he had a bleed.

"I rushed back home and then we went straight to the hospital. It was about 9~am when we arrived at the neonatal unit.

"When we got there, Child N was now in the intensive care nursery. Lucy Letby was by Child N's cot and there was no one else around him. Occasionally a doctor would pop in and out of the unit but there was no rushing and no sense of urgency, which I didn't understand given the urgency of the phone call to Mother N.

"Lucy Letby told me he had been a bit unwell in the night but did not explain what that meant or what was wrong with him. No one did. We had not received a call in the night to alert us to any problems or that anything had happened.

"However when I saw Child N, I was shocked. He was blue in colour and had traces of blood around his lips like he had coughed up blood and it had splattered on him. The blood was dry and dark in colour. I remember feeling really confused because the machines monitoring him all looked normal but clearly something had happened. However, no one told us what had happened or why.

"Once Child N appeared settled for a bit, we decided that we should go and get some food as neither

of us had eaten all day. We felt guilty about leaving but we had nothing with us. We went to a McDonald's drive-through as it was less than five minutes away in the car. We were probably gone from the hospital for around 20-25 minutes in total.

"When we returned to the neonatal unit, the parents whose baby was also in the intensive care nursery were sitting outside the unit. They said to us 'your lad is unwell again' and I thought there was why they had been made to sit outside and I apologised to them.

"We were buzzed back into the neonatal unit and all the blinds were down which I felt meant that something serious was happening. I didn't want to go into the intensive care nursery room where Child N was because I was worried.

"A nurse came to speak to us, I think it was Beth or Kath. The nurse said that Child N was now really unwell and if we wanted we could see a priest.

"Mother N went into the ITU and the priest arrived to talk to us. I was shocked by this as I am not religious and we had not asked for him. I remember exclaiming 'what the fuck are we doing here with a priest?' It felt really inappropriate because he was a stranger and I had the impression that we were being ushered out of the way. We made chit-chat with him and

then after about ten minutes Child N's mother went back into ITU and I waited outside.

"I asked Nurse Beth if Child N would be all right and she said 'I don't know'. I stayed sitting outside on the chairs as I was struggling and very anxious.

"Lucy Letby recommended to us that we have Child N baptised so we made the decision to do that on the evening of *(redacted)* June. We did this out of desperation as we would have tried anything for him to be okay.

"I only entered the ITU room when the situation seemed to have stabilised. I was told that by the doctors very quickly that they had attempted to intubate Child N but that he had bled when they tried to do so and that this is what the problem was.

"As I remember it now, at some point we were told to go outside and get some fresh air. During this time Child N had another collapse, needing CPR again. We therefore did not see that collapse but it became clear once we were back on the unit.

"When we got there I was aware they were doing resuscitation. At this point I was also aware that a team from Alder Hey Hospital had been called and were present. I recall that a woman in a green cardigan was present and I believe she was a haemotologist. The male

doctor from Alder Hey assisted with trying again to get the breathing tube in and this time he was successful. After that Child N stabilised and everything seemed to calm down.

"The doctors then prepared him to transfer him to Alder Hey Hospital.

"After Child N had stabilised, we spoke to a haemophilia nurse, Kathy, who had come to the [Countess of Chester Hospital] from Alder Hey Hospital. In my police statement I say that she had come over in a taxi with some 'Factor'.

"I know that Alder Hey staff had to bring extra Factor VIII with them. Despite [the hospital] knowing that Child N's mother is *(redacted)* and knowing that Child N may need Factor VIII, [the hospital] did not have enough in stock.

"A nurse came to speak to us as we waited outside the intensive care nursery. She was very cold and stern. She told us she had been taking care of Child N the night before and he had been fine.

"There was no reason for her to come and speak to us like that and impart that information in that moment, particularly given our child was being resuscitated at the very same time and we did not know what was wrong with him.

"Just before we left [the hospital] to go to Alder Hey Hospital, Lucy Letby came up to us. She said that she hoped Child N would be all right and hugged Mother N. She may have even kissed her but I cannot be sure.

"Transfer to Alder Hey.

"Child N was transferred to Alder Hey in an ambulance and he went into intensive care.

"When we arrived at Alder Hey Hospital I overheard a conversation between the staff about a discrepancy in Child N's notes. I do not know if they were describing his bleeds or what happened when he had collapsed as they did not say anything else about it.

"I tried to understand from the staff at Alder Hey what had happened to Child N and why he was there. A nurse said she would look in his medical notes and she told us there was a conflict about what had happened and what had caused his bleeding. I think one record said the bleed was caused by trying to place the breathing tube but it might also have said he needed the breathing tube because he had had a bleed. It was impossible for her to tell us. I do not feel that we ever got an answer to our questions.

"Child N was at Alder Hey for about two weeks before he came home. He would occasionally have little

spasms and vomit but it was not clear why.

"The Inquiry has asked if I feel I was kept sufficiently informed about any deteriorations in Child N's condition. The answer is no. For a start, we were not informed at all about his deterioration overnight on *(redacted)* June 2016. Then when he had had his deteriorations on *(redacted)* June we did not really know what was going on, what had happened or why. This was then made worse when we were told and heard about the discrepancy in Child N's notes about what had happened.

"Cause of Collapse.

"The Inquiry has asked me what, if any, investigations into Child N's sudden collapses I understood were taking place at [the hospital] or were going to take place. Once we took Child N home from Alder Hey, and he had left the care of [the hospital] that was the end of the contact we had from, or with, the [Countess of Chester Hospital]. No one contacted us about any internal investigation into what had happened to Child N. Therefore, we did not think any investigations were being done or would be done. It was just not something that was mentioned to us.

"The Inquiry has asked me about a conversation or meeting that Mother N's mother had with Dr Saladi about the difficulties intubating Child N. This is referred

to in both Mother N's police statement and my police statement. During a routine paediatrician appointment, Mother N had asked Dr Saladi why Child N could not be intubated and why he was bleeding from his mouth. He did not know. We had tried to find out what had happened from him but never got an answer.

"The Inquiry has also asked me if we were given any further explanation by [the Countess of Chester Hospital] about Child N's collapses. Other than what I have set out above, the answer is no.

"Additionally, no one ever told us we could raise concerns about Child N's care or complain about it. It felt like once he was at Alder Hey Hospital what had happened was just brushed over.

"When I prepared my police statement (dated 14 November 2019) I included:

"'To this day I still do not know what happened to Child N at [the Countess of Chester Hospital], whether someone had tried to put a tube in him, or who that person was or whether he had had a bleed'.

"That demonstrates that even in November 2019 I had not had any proper explanation of what had happened.

"I was never comfortable with the care Child N received on the neonatal unit at the [Countess of Chester Hospital]. We felt the care was good when he

moved to Alder Hey Hospital.

"Suspicions and Concerns Regarding Lucy Letby.

"I have explained above my recollection of our contact with Lucy Letby.

"It was only after Lucy Letby had been arrested that we were informed she was being charged with the attempted murder of Child N. We were told about this by the police.

"I remember getting a call from the police around the time they had arrested Lucy Letby to let me know. Child N's mother had a knock on the door at home from the police. This was the first time we were told there was an investigation into or a suspicion about Lucy Letby. It was also the first time we were aware there was an investigation into Child N's collapses or suspicion that she had been involved.

"The Inquiry has asked what information we were given by [the hospital] about concerns about Lucy Letby's conduct. As is apparent from the above, we were not given any such information by [the hospital].

"When we were told, it actually did not come as a surprise that something untoward had happened on the neonatal unit. In my police statement (November 2019) I said, 'personally, ever since we left [the hospital] I have said something was not right in that hospital.

Something happened, the conflict in the notes, something did not add up'. I had felt that Child N was fine and healthy and then suddenly very unwell and given there was some debate about when he had a bleed, ie if it was caused by poorly intubating him or not, I suspected they were trying to cover up an error.

"However, while I thought Child N had perhaps received negligent care, I did not think anyone had intentionally or maliciously harmed or tried to harm him.

"No one contacted us about any internal investigation on a wider scale about the neonatal unit and no one mentioned to us again anything about what had happened to Child N. We were not invited to the hospital to have a meeting or to discuss what had happened to Child N.

"Raising concerns and getting answers.

"The Inquiry has asked a series of questions going to what I knew about concerns about or investigations into [the Countess of Chester Hospital], and what information was provided to us about Child N's care.

"I did not make a complaint about his care, nor was I offered any counselling or support in relation to the incidents at the time.

"I did not think to request his medical records.

"The position is quite straightforward. After Child N was discharged from hospital, no one from [the Countess of Chester Hospital] or elsewhere contacted us about an investigation into Child N's care or collapses. No one contacted us about any investigation on a wider scale into the neonatal unit. I am aware that Mother N had asked Dr Saladi to try to find out what happened but we never got an answer.

"We were not invited to any meetings with [the hospital] about any investigations into Child N's care.

"Until we were contacted by the police out of the blue, no one had mentioned anything about what had happened to Child N, or discussed any concerns with us.

"To date we still have not had an acknowledgment from [the Countess of Chester Hospital] about what happened. We have had no indication from [the hospital] that they have even reflected on what happened or taken any steps to make changes. There have been no meetings with [the hospital] to discuss what happened; nothing at all.

"The Inquiry has asked for my views about the adequacy of information and communication from [the hospital]. It follows from what I have said that the information and communication was not adequate. At the time I was angry, confused and suspicious but knowing

what I know now and after the information I heard at trial I am shocked and disgusted with [the hospital] to know that complaints and concerns had already been raised well in advance of what happened to Child N and that these were brushed under the carpet.

"We also never got to the bottom of what it was that Alder Hey thought was a discrepancy in Child N's notes. No one has ever answered this question for us when we asked the staff.

"The Inquiry has referred me to a Royal College of Paediatrics and Child Health investigation report into neonatal services at [the hospital], which I understand is dated November 2016. I am asked when and how I came aware of this investigation report and whether I received a copy of it. I was not made aware of this report and was not provided with a copy of it.

"I found out that there had been an investigation and a report when I read about it on the BBC website.

"It was not until about a month before the start of the criminal trial that I was told about the collapse on *(redacted)* June 2016. We were called into a meeting with the police and the CPS and they informed us as to what had happened because they wanted us to be aware of it before the trial started and so we did not get a shock in Court.

"The Inquiry has also asked if I was aware of an Advisory Medical Report prepared by Dr J Hawdon in relation to some babies who died or had cardiorespiratory collapses, in the neonatal period at the [Countess of Chester Hospital]. I was not made aware of this.

"Other Comments.

"I remember going to collect some of Mother N's breast milk for Child N from [the hospital] so we could have it at Alder Hey Hospital for him. The fridge where the breast milk was kept could be accessed by anyone. There was no lock on it.

"When I was there, I met one of the nurses and again she was quite dismissive of me, and cold. She just had a very brisk attitude and like I was intruding.

"I also recall being telephoned by the unit many months after Child N was discharged to tell us that there was still some breast milk there and we had to go and collect it.

"I did get the impression that things were quite understaffed at Chester. The board that showed which nurses were on duty had 5-6 slots but only ever 3-4 names.

"Recommendations for Change.

"I can only make recommendations for change at this

stage that are based on the 11 months I sat through the criminal proceedings and the things I heard in Court during that time. It may be that I have further thoughts and wish to say more as the evidence in the Inquiry is heard.

"I know that clinicians had raised concerns with their management in 2015 and that these were not taken seriously. This feels like such a kick in the teeth, those missed opportunities to take action that could protect the children who were harmed or killed after these concerns had been raised (like installing CCTV).

"I believe the use of CCTV on a neonatal unit can only be a good thing. I recognise there are privacy issues, but really, it is for the benefit of everyone: babies, parents and also staff. I believe it can protect babies from harm and protect staff from allegations of harm (if mis-founded). I do not think there is much that could be seen as inappropriate or unhelpful about having CCTV. For example, babies in cots or women breastfeeding can be seen when visiting a unit or when someone is breastfeeding outside of hospital.

"During the criminal proceedings, I was horrified to hear that staff had been using platforms like Facebook or private text messaging to send messages

about babies. It cannot be that doctors and nursing staff believe this is an appropriate thing to do and I am disappointed that no action has been taken by [the hospital] to reprimand those that did this as soon as it became evident that this had taken place.

"The general attitude and complacency to this conduct (which was part of the evidence in the criminal trial) is shocking. Staff should only talk about babies, or patients more generally, on work phones or electronic methods where it is recorded and traceable."

My Lady, that concludes the statement.

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

Would you be kind enough to convey my thanks, please, to Father N for providing the statement and for inviting you to read it on his behalf. Please explain to him that it now forms part of the evidence to the Inquiry and it will be for me to consider it in due course when preparing my report.

MR SKELTON: I am grateful.

MS LANGDALE: My Lady, we resume at 10 am tomorrow.

LADY JUSTICE THIRLWALL: Thank you very much indeed. We will rise now.

(12.30 pm)

(The Inquiry adjourned until 10.00 am

on Wednesday, 25 September 2024)

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