

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.

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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

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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

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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

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

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

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

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

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

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

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

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

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

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

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

15 "Experience at the Countess of Chester Hospital.

16 "Delivery of our Babies.

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

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

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

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

6 "Child M.

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

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

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

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

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

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

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

15 "In my wife's police statement she said:

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

25 "I remember the doctors trying to help Child M for

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

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

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

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

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

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

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

5 "The Inquiry has asked us what Dr Jayaram told us  
6 about Child M's collapse. I have explained this above.  
7 We were not given more information about his collapse or  
8 the reasons for it until the police spoke with us in  
9 2019. Blotches on Child M were not mentioned to us by  
10 Dr Jayaram or others at the [hospital]. We were not  
11 made aware by Dr Jayaram or others at the hospital that  
12 Child M's collapse was being viewed as suspicious. The  
13 information set out above from Dr Jayaram's statement  
14 was not discussed with us by the doctor or others at the  
15 [hospital].

16 "The Inquiry has also provided the police statement  
17 of nurse Laura Eagles dated 27 February 2018. I am  
18 informed by my solicitor that in that statement  
19 Nurse Eagles says that she was made designated nurse for  
20 Child M on the day shift on 10 April 2016, starting at  
21 07.30. Her statement refers to the handover notes  
22 stating that Child M had suffered a collapse the day  
23 before and was being treated for necrotising  
24 enterocolitis. We did not know that Child M was being  
25 treated for necrotising enterocolitis.

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

14 "Child L.

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

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

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

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

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

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

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

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

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

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

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

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

7 "Causes of collapse or deterioration.

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

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

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

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

4 "We are asked if we were aware that the Royal  
5 College of Paediatrics and Child Health undertook  
6 a review into neonatal deaths and the neonatal unit at  
7 [the hospital]. I am informed by my solicitor that this  
8 review is dated November 2016. We were not aware of  
9 that. We are also asked if we were aware of an Advisory  
10 Medical report prepared by Dr Hawdon dated  
11 1 October 2016 in relation to babies who died or had  
12 cardiorespiratory collapses in the neonatal period at  
13 [the hospital]. We were not aware of that. I do not  
14 recall receiving any copies of the report from the Royal  
15 College of Paediatrics and Child Health.

16 "Suspensions and Concerns Regarding Lucy Letby.

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

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

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

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

10 "Suggestions and Recommendations.

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

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

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

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

17 "Raising Concerns and Getting Answers.

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

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

18

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

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

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

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

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

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

18 My Lady, that concludes the statement.

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

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

21

1 are some difficulties with it.

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

5 (10.37 am)

(Short Break)

7 (11.03 am)

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

13 Mr Skelton.

14 **MOTHER N statement read**

15 **MR SKELTON:** Thank you, my Lady.

16 Witness statement of Mother N, dated 17 July 2024.

17 "I, Mother N, will say as follows:

18 "I am the mother of Child N.

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

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

23

1 take account of that at all times.

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

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

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

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

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

22

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

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

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

15 "Impact.

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

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

24 **MOTHER N:** I can, yes, thank you.

25 **LADY JUSTICE THIRLWALL:** Thank you. Sorry, do

24

1 continue.

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

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

25

1 has been broken.

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

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

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

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

27

1 felt guilty leaving our other children at home.

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

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

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

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

26

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

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

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

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

28

1 poorly and having to see me and Father N upset.  
 2 "We have discussed having another baby since  
 3 Child N was born but the fear of witnessing what  
 4 happened repeat itself and having to go back into the  
 5 hospital setting and the possibility of going back into  
 6 the neonatal unit has stopped us from doing so.  
 7 "The worst part of going to [the criminal] court  
 8 is being away from Child N and the other children. It  
 9 disrupts their routine and their home life - everything  
 10 that we try our hardest to protect and preserve, having  
 11 to listen to what she did to the other babies weighs  
 12 heavy on the mind because you know exactly the hurt each  
 13 of those parents felt you carry that also ...'  
 14 "Experience at [Countess of Chester Hospital].  
 15 "Child N's antenatal care and delivery.  
 16 "I had my antenatal care at [the hospital] and had  
 17 a normal pregnancy with Child N up until about 24 weeks.  
 18 At that point I attended for a scan and to check on his  
 19 growth as there was a concern that Child N was not  
 20 growing properly.  
 21 "I recall that the plan was that I delivered at 32  
 22 weeks by a caesarean section because he was small and  
 23 the consultants wanted him delivered as soon as possible  
 24 in order to make sure the placenta did not fail.  
 25 "I have a blood clotting disorder. We knew Child N  
 29

1 us who had been given booklets on premature babies  
 2 whereas we didn't get given anything until we raised the  
 3 issue'.  
 4 "Child N was born at [the hospital] in June 2016 by  
 5 caesarean section. He did not have a bleed during the  
 6 delivery but he was small, only 3 lbs 11 oz and he was  
 7 also jaundiced. He was taken to the neonatal unit  
 8 straight away.  
 9 "It was not until very late that night that I got  
 10 to go and see him on the neonatal unit. One of the  
 11 midwives took me down there. He was in Nursery 2 and  
 12 I was surprised that he was just in the incubator on his  
 13 own.  
 14 "While I was there, I was not introduced to any  
 15 staff on the unit and no one came to introduce him or  
 16 herself. The first time I interacted with the nursing  
 17 staff and they spoke to me was when I needed to ask  
 18 questions about Child N. Nobody from the neonatal unit  
 19 proactively came to speak to us about him, about his  
 20 condition, or his treatment. No one gave us information  
 21 about caring for a premature baby.  
 22 "We did see parents come onto the neonatal unit who  
 23 were given booklets about premature babies, but we were  
 24 given nothing.  
 25 "I also did not get daily updates from the nurses  
 31

1 was a boy and were aware there was a 50% chance he would  
 2 be born with a blood disorder. We understood that,  
 3 because of this, extra staff would need to be present in  
 4 theatre for safety and to check Child N over once he was  
 5 born. I initially expected Child N would be on the  
 6 maternity unit with me, but once he was delivered we  
 7 were told he would need to be admitted to the neonatal  
 8 unit for a few weeks before we could take him home.  
 9 I recall finding this out on the evening of his birth.  
 10 "The Inquiry has referred me to the police  
 11 statement of Dr Sudeshna Bhowmik, who was a trainee  
 12 paediatrician. In this she describes meeting me on the  
 13 morning of (*redacted*) June 2016, before Child N was  
 14 born. She says she explained various things about his  
 15 delivery and that Child N would be admitted to the  
 16 neonatal unit for observation, respiratory support and  
 17 feeding support as needed. I am asked if this accords  
 18 with my memory but I do not recall a tour of the unit  
 19 and in my original police statement made  
 20 in December 2018, I stated that 'No one actually sat us  
 21 down and told us anything about Child N and I felt there  
 22 was a lack of information throughout the whole process  
 23 in the neonatal unit. We actually ended up having a few  
 24 words with one of the nurses about this and the fact  
 25 that there were parents who had come onto the unit after  
 30

1 on the unit. I would take it upon myself to look at  
 2 Child N's charts and try to speak with the consultant  
 3 who I recall was there each day. I was trying to get  
 4 more information and find out how Child N was doing  
 5 (I explained this in my police statement). I understand  
 6 that staff were working with Alder Hey Hospital on  
 7 a plan in case Child N had a bleed while he was so  
 8 young.  
 9 "As far as I was concerned, Child N was only on the  
 10 neonatal unit because he was premature. It was not  
 11 until (*redacted*) June, so (*redacted*) days after he was  
 12 born that I was made aware there had been problems with  
 13 Child N. I was informed that doctors had been trying to  
 14 keep his temperature stable and also that he had  
 15 a feeding tube in, but they were trying to establish  
 16 a feeding regime for him. There had been nothing to  
 17 make me think his condition was not normal.  
 18 "However, even at this point I was not made aware  
 19 there had been any problems with Child N's condition in  
 20 the early hours on (*redacted*) June 2016.  
 21 "The Inquiry has asked me for my views on the  
 22 adequacy of the information on the neonatal unit at [the  
 23 hospital]. It should be clear from what I have said  
 24 above that I considered the information to be  
 25 inadequate, in terms of the processes on the neonatal  
 32



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

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

7 "Child N's Collapses.

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

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

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

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

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

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

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

35

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

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

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

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

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

34

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

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

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

25 "That night Child N was transferred to Alder Hey

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

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

12 "Causes of Collapses.

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

37

1 I explain below.

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

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

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

25 "Counselling.

39

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

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

14 "Suspicious and Concerns Regarding Lucy Letby.

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

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

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

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

11 "Raising Concerns and Getting Answers.

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

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

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

40

1 Medical Report prepared by Dr J Hawdon, dated  
2 1 October 2016, in relation to some babies who had died  
3 or had cardiorespiratory collapses, in the neonatal  
4 period at [the hospital]. I was not made aware of this  
5 either.

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

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

25 "We were aware there had been collapses on

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

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

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

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

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

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

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

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

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

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

5 "Recommendations.

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

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

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

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

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

11 **MOTHER N:** Thank you.

12 Thank you, Peter.

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

15 **LADY JUSTICE THIRLWALL:** Thank you. So 12 o'clock.  
16 (11.34 am)

(Short Break)

17 (12.03 pm)

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

20 **MR SKELTON:** I think that's right, my Lady.

21 I understand he is self-employed and it was always  
22 a possibility he wouldn't be able to attend today.

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

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1 criminal action.

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

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

21 My Lady, that concludes the statement.

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

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

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1 his statement?

2 **MR SKELTON:** I do, thank you.

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

5 **FATHER N statement read**

6 **MR SKELTON:** Thank you.

7 Witness statement of Father N, dated 17 July 2024.

8 "I, Father N, will say as follows:

9 "I am the father of Child N.

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

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

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

25 "Impact.

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

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

10 "Both myself and Child N's mother have made  
11 previous statements surrounding the events on the  
12 neonatal unit at [the hospital]. My statement is dated  
13 14 November 2019 and Child N's mother's statement is  
14 dated 19 December 2018. I ask that those police  
15 statements are read in conjunction with this statement,  
16 but have also included here some information from my  
17 police statement:

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

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

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

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

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

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

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

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

4 "Experience at the CoCH.

5 "Child N's Antenatal Care and Delivery.

6 "I was self-employed when Mother N was pregnant so  
7 I could not attend all the scans with her at the  
8 [hospital]. I am not sure of the date but at one  
9 appointment Mother N informed me that the doctors were  
10 concerned that Child N was not growing normally so he  
11 would have to have steroids to help develop his lungs.  
12 "As a result of these concerns about his growth,  
13 the plan was that he would be delivered by caesarean  
14 section several weeks earlier than normal. We were both  
15 aware of this and the reasons for it.

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

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

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

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

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

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

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

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

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

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

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

25 "Every time I went into the neonatal unit there was

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

4 "Child N was on the neonatal unit for about  
5 14 days. As far as we had been aware, the only issues  
6 he had in that time were that his bilirubin levels were  
7 high and he received some light therapy for this. As  
8 I explained below, we were not made aware at the time of  
9 the significant drop in Child N's oxygen saturations  
10 overnight on (*redacted*) June 2016.

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

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

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

4 "Child N's Collapse.

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

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

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

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1 his oxygen saturations dropped around 08.00. We were  
2 not present and were only contacted in the morning as  
3 I set out below. The next deterioration was at around  
4 14.50. We had briefly left the hospital to get  
5 something to eat. Then there was a further drop in his  
6 oxygen saturations that evening. I set out more detail  
7 below.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 spasms and vomit but it was not clear why.

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

11 "Cause of Collapse.

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

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

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

6 "Transfer to Alder Hey.

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

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

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

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

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

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

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

15 "When I prepared my police statement (dated  
16 14 November 2019) I included:

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

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

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

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1 moved to Alder Hey Hospital.

2 "Suspensions and Concerns Regarding Lucy Letby.

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

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

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

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

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

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

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

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

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

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

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

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

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

17 "Raising concerns and getting answers.

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

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

25 "I did not think to request his medical records.

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

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

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

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

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

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

7 "Other Comments.

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

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

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

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

24 "Recommendations for Change.

25 "I can only make recommendations for change at this  
69

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

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

11 My Lady, that concludes the statement.

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

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

20 **MR SKELTON:** I am grateful.

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

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

24 (12.30 pm)

25 (The Inquiry adjourned until 10.00 am

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

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

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

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

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1 **on Wednesday, 25 September 2024)**

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<b>weigh [1]</b> 7/25	<b>while [9]</b> 13/19 13/21	39/22	22/21 23/9 23/12	
<b>weighed [2]</b> 8/1 53/7	18/11 31/14 32/7 35/7	<b>working [5]</b> 10/4 18/1	23/12 28/5 28/6 46/25	
<b>weighs [1]</b> 29/11	45/9 50/4 66/7	20/9 32/6 43/18	47/2 47/6 47/7 47/9	
	<b>whilst [1]</b> 27/15	<b>worried [1]</b> 59/15	55/20	
	<b>whistleblowers [1]</b>			