I have been asked about a senior nurse from the children's ward who made comment to me about Lucy LETBY not being good in her third year as a student. I can confirm that this senior nurse was Sister Nicky LIGHTFOOT.

I have been shown a statement I made to the Coroner regarding Child A b. PD 06/2015. The statement is dated 24/07/2015 and I have been given opportunity to read it. I can confirm that the statement is correct and describes events as I remember them. The statement is now reproduced below to form part of my evidence to police:

I am Dr Ravi Jayaram. My GMC number is I&S My qualifications are MBBS(1990 Newcastle Upon Tyne) MRCP (UK), FRCPCH.

I have been asked to provide a statement detailing my involvement in the care of Child A I have had access to a copy of the clinical records to assist me.

I have been employed at the Countess of Chester Hospital NHS Foundation Trust since 13th December 2004 as a Consultant Paediatrician. I took over consultant responsibility for Child A on the early afternoon of Monday 8th June when I took over as consultant on call from my colleague Dr Murthy Saladi. Child A had been born PD He was one of a pair of twins born at 31+2 weeks gestation whose mother was known I&S. At the time he was handed over to me it was reported that he was stable from a respiratory point of view with respiratory support provided by continuous positive airways pressure (CPAP). He was due to have an umbilical venous catheter (UVC) inserted by the junior paediatric doctors.

I was undertaking an Outpatient clinic during the afternoon. Dr Sally Ogden, paediatric ST3, came to talk to me in the Outpatient clinic to discuss the x-ray that had been done after the UVC had been inserted by Dr Teresa McCarrick. paediatric ST1. The x-ray suggested that the tip of the catheter had entered the portal vein which is a recognised complication of UVC insertion. I suggested that this should be removed and a new catheter placed. The new catheter was inserted by Dr Mccarrick and an x-ray was performed that was reviewed at 16.30 hours Again it appeared that the UVC had gone into the portal vein rather

than into the inferior vena cava. This x-ray was discussed with me by Dr Ogden in the outpatient clinic and I suggested that this should be removed. The purpose of siting a long line was to give intravenous fluids and Total Parenteral Nutrition (TPN). I suggested that as it was likely that Child A would need intravenous feeds for a few days that a percutaneous intravenous long line should be inserted instead. On looking at the notes Dr Ogden documented on the x-ray review sticker that UVC had been removed.

Dr Ogden handed over to Dr David Harkness, Paediatrrc ST4, who was the on duty registrar. He inserted a percutaneous long line in the left antecubital fossa (left elbow). This was x-rayed and the x ray was reviewed at 1909 hours by Dr Harkness The long line had been inserted to 12cm but on the x-ray this had crossed the midline and the tip of the long line was visible just to the right side of the trachea on the x-ray. It was also noted on the X-ray that the UVC was still in place. The plan was for the long line to be pulled back so that it sat in the left subclavian vein. Throughout this time Child A had remained stable in terms of his respiratory status on CPAP and there had been no clinical concerns in terms of his cardiorespiratory status Dr Harkness commented in the notes that at the time he reviewed the x-ray he was scrubbed and was placing a long line in another patient so although the intention was to pull the long line back and to remove the UVC at that time, he could not action this.

At 2026 hours Child A suddenly deteriorated. He initially stopped breathing although his heart rate was maintained at 90-100 beats per minute Dr Harkness and Dr Chris Wood GPST were in attendance together with the neonatal nursing staff. At that time l was on the Children's Ward and I received a call to attend the Neonatal Unit. Dr Rachel Lambie Paediatric ST6 was also present as she had arrived to take over from Dr Harkness as the on duty registrar. Resuscitation was commenced immediately. Artificial ventilation breaths were given via the neopuff system. Dr Harkness commented that good chest movement was seen Dr Harkness removed the long line at 2027 hours as he was concerned that Child A's deterioration may have been due to the long line causing a cardiac arrhythmia. Dr Harkness passed an endotracheal tube at 2028 and he documented that he visualised this going through the vocal cords. Artificial respirations were continued down this tube. However Child A's heart rate dropped to 60 beats per minute and so chest compressions were commenced. On-going cardiopulmonary resuscitation (CPR) was on-going. He was given a 10mg/kg bolus of normal saline intravenously at 2031 and intravenous adrenaline at 2033.

I arrived at 2033 hours. At that time cardiopulmonary resuscitation was on-going. Child A had no spontaneous respiratory effort and had no heart sounds audible or no palpable pulse. Looking at the

monitor there was evidence of electrical activity at a rate of around 40 beats per minute with low voltage complexes. The only venous access was the UVC. This was pulled back to ensure that it was in the inferior vena cava rather than the portal vein as it was the only available venous access. Resuscitation continued and 7 doses of adrenaline, a further bolus of normal saline, a bolus of 4.2% sodium bicarbonate and a bolus of 10% dextrose were all given during resuscitation. At 20 50 hours, 24 minutes after Child A had deteriorated a heart rate was heard of around 50 beats per minute but by 20.55 this was absent again. At the time that heart sounds were heard, no pulse was palpable.

I spoke with Child A's parents and grandmother at 15 minutes into the resuscitation and at 28 minutes into the resuscitation. I explained that Child A's prognosis for survival was extremely poor and a decision was made to withdraw treatment at 20.58 hours, 32 minutes after resuscitation had commenced I explained to Child A's family that I would need to inform the Coroner and I spoke with Mr Rheinberg later that evening. That was my last involvement with Child A

It is clear from the above statement to the Coroner that I did not mention within it any observations related to blotches and discolouration on Child A's body, whereas I have done in my statement to the police. My explanation for this is that, at the time my statement to the Coroner was written, I did not believe the blotches to be relevant. The above statement was written before I had any suspicions, before any pattern had developed or been recognised, and a long time before we approached police. It was only later during conversations with colleagues who had seen similar things that I began to realise the relevance of the blotches. It is also the case that I did not describe these blotches in the medical notes. This is simply because there was so much else going on, e.g. CPR and talking to parents. I thought it was a bit odd but I really didn't see the significance at the time as compared to everything else we were doing to try and save Child A

On 14th July 2016 I attended a board meeting at the hospital. Police are in possession of the minutes from this meeting and I am reminded of an occasion during the meeting when I said that what I was about to say was confidential and not to be minuted. I have been asked to recount what I said to the meeting and which has not been recorded. I have absolutely no idea what I said, it was over two years ago now and I have no memory of it, I can't think of anything that it may have been or anything I would have said that