

10 October 2022 (Day 4)

The charges, Jury directions, Prosecution Opening Speech

Monday, 10 October 2022

(10.30 am)

[Redacted]

(Jury sworn in)

CLERK OF THE COURT: Members of the jury, the defendant Lucy Letby stands charged on an indictment which contains 22 counts.

On count 1 she is charged with murder. The particulars are that she, on 8 June 2015, murdered [Baby A].

On count 2 she is charged with attempted murder.

The particulars are that she, between 8 June 2015 and 11 June 2015, attempted to murder [Baby B].

On count 3 she is charged with murder. The particulars are that she on, 14 June 2015, murdered [Baby C].

On count 4 she is charged with murder. The particulars are that she, on 22 June 2015, murdered [Baby D].

On count 5 she is charged with murder. The particulars are that she, on 4 August 2015, murdered [Baby E].

On count 6 she is charged with attempted murder.

The particulars are that she on 5 August 2015 attempted to murder [Baby F].

On count 7 she is charged with attempted murder. The particulars are that she, on 7 September 2015, attempted to murder [Baby G].

On count 8 she is charged with attempted murder. The particulars are that she, on 21 September 2015 at about 10.15 hours, attempted to murder [Baby G].

On count 9 she is charged with attempted murder. The particulars are that she, on 21 September 2015 at about 15.30 hours, attempted to murder [Baby G].

On count 10 she is charged with attempted murder. The particulars are that she, on 26 September 2015, attempted to murder [Baby H].

On count 11 she is charged with attempted murder. The particulars are that she, on 27 September 2015, attempted to murder [Baby H].

On count 12 she is charged with murder. The particulars are that she, on 23 October 2015, murdered [Baby I].

On count 13 she is charged with attempted murder. The particulars are that she, on 27 November 2015, attempted to murder [Baby J].

On count 14 she is charged with attempted murder. The particulars are that she, on 17 February 2016, attempted to murder [Baby K].

On count 15 she is charged with attempted murder. The particulars are that she, on 9 April 2016, attempted to murder [Baby L].

On count 16 she is charged with attempted murder. The particulars are that she, on 9 April 2016, attempted to murder [Baby M].

On count 17 she is charged with attempted murder. The particulars are that she, on 3 June 2016, attempted to murder [Baby N].

On count 18 she is charged with attempted murder. The particulars are that she, on 15 June 2016 at about 7.15 to 7.30 hours, attempted to murder [Baby N].

On count 19 she is charged with attempted murder. The particulars are that she, on 15 June 2016 at about 15.00 hours, attempted to murder [Baby N].

On count 20 she is charged with murder. The particulars are that she, on 23 June 2016, murdered [Baby O], also known as [Baby O].

On count 21 she is charged with murder. The particulars are that she, on 24 June 2016, murdered [Baby P], also known as [Baby P].

On count 22 she is charged with attempted murder. The particulars are that she, on 25 June 2016, attempted to murder [Baby Q].

To this indictment she has pleaded not guilty. It is your charge to say, having heard the evidence, whether she is guilty or not.

Will any witnesses in this trial please leave court.

JURY DIRECTIONS

MR JUSTICE GOSS: Members of the jury, you have now heard the 22 charges, alleged offences, upon which you are to try the defendant in this case. They will, I suspect, have become something of a blur to you as they were read out, but there was, as you will appreciate, a common theme. They were offences, and only offences, of murder and attempted murder: seven alleged murders, 15 alleged acts of attempted murders. They all relate to babies.

You will hear, when Mr Johnson King's Counsel on behalf of the prosecution begins to open the case to you, the facts that give rise to these allegations.

Before that happens, it is very important that I explain to you your role and duties as jurors in this case. In your plastic packs in front of you, there should be a document which is entitled "Your legal responsibilities as a juror". Would you please take it out from the pack? Do you each have one of those? Yes?

Good, thank you very much.

I'm going to ask that you are also given a one-and-a-half page document, which I have drawn up, entitled "Jury directions", which goes with this document and with the narrative that I am about to deliver in relation to this document. All right? There's more than sufficient there. There are more than 14.
(Handed)

(Pause)

You each have that document as well. For the moment, please, just listen to what I'm about to say and I will draw your attention to these documents at the appropriate points.

The first thing I wanted to try and do is alleviate, insofar as I'm able to, any anxiety or apprehension you may have about your role as jurors in this case. As I've already said, it may well be that as the counts on the indictment were put to you, you were losing focus and concentration and things were becoming a bit of a blur. That is because your anxiety state will have been heightened by the fact that you've been selected to serve as jurors in this case and you will have apprehension about what is to follow, both in relation to the nature of the case and as your duties in relation to being jurors in this case.

I want to reassure you that juries up and down the country are trying very serious cases, so there are many people who are, unhappily, given the task of performing jury service and trying

very serious cases, and what I am about to say to you is said in various forms to all jurors.

Do not be anxious. You will find, as this case proceeds, you soon become acquainted with all the material that you need to be acquainted with, all that is put in front of you, what the issues in the case are and what decisions you have to make.

Ultimately, it can be distilled into two simple propositions: I am the judge of the law, you are the judges of the facts. I deal with all questions of law, I ensure that the trial is conducted according to law and I rule on any issues of law that have to be decided.

You, on the other hand, are the sole judges of the facts. You will decide on the evidence that's placed before you what you accept as being truthful and reliable evidence and what you reject as being untruthful or unreliable, and the conclusions that you draw from all the evidence at the end of the case. So you don't approach this case with any sense of pre-judgment about it: you keep open minds and reach conclusions when you have heard all the evidence and the arguments in relation to the evidence.

That is the sort of process that we all undertake in our daily lives when we have to make decisions. We assess the evidence, the reasons, and then come to a conclusion. All right? So there's no actual mystique and then, applying the directions of law that I will give you, I will tell you what law you need to know, you will reach verdicts in this case. So that will be 22 verdicts, a verdict of guilty or not guilty on each of the charges on the indictment. All right?

So that essentially is direction 1 that you have in your sheet of paper that I have handed you, "Jury directions". You are the sole judges of the facts in the case. I, as the judge of the law, will give you written directions as to the law you need to know in relation to the offences and other legal matters at the end of all the evidence. The law is not complicated in this case, it's very straightforward; it's the facts that are going to require analysis and decisions. All right?

You will try this case -- well, I'll come on to written direction 2 next. Offences of this nature, the alleged murder of babies and attempting to murder babies, is bound to provoke an instinctive reaction of horror. We all have emotions, it is part of our characteristics as a human being. Whilst retaining your knowledge and understanding of human behaviour, you must put your emotions to one side and consider and judge the evidence calmly, rationally, fairly and dispassionately. I am sure you

would do that anyway, but you must bear that in mind at all times.

3. You will try this case on all the evidence placed before you during the trial and your assessment of the evidence and nothing else. The case will inevitably attract a lot of media attention. If you read or hear any reports of the case in the media or from any other source, remember that any report is but a selective part of the proceedings.

You may also read comments made by others about the case over social media forums. I am not saying you are prohibited from using social media, but beware: pay no attention to the reports that you read of the case or the views of others that may be expressed to you. You hear and consider all the evidence in this case and you decide what is relevant and what importance to attach to any piece of evidence and you, of course, and you alone are the only people that have to make any decisions in relation to this case.

4. Do not seek any information from any source or conduct any research over the internet or in any other way about anything or anyone involved in the case. You come to this case, through the process that you've seen undertaken, completely detached from everyone and everything associated with this case. That must remain the situation for the whole of the trial. So you do not conduct any research, nor indeed must you conduct any research about the law or the trial procedures in this case or any of the personalities involved in the case.

As I've said to you, I will give you directions of the law that you need to know and apply in this case -- I reassure you again, it's not complex -- and you will decide this case on, and only on, all the evidence placed before you in this courtroom and nothing else.

5. Do not talk or communicate in any way, for example by social media or texting, to anyone, including a family member or a friend, who is not a fellow juror in this case about the case or anything to do with it until it is all over.

That is of vital importance because obviously when you are not sitting in this courtroom hearing this case, you will be mixing with family members and friends. This is going to be a long case so there will be very many opportunities for you to talk to people about this case, particularly when they know, and close family members obviously will know, you're performing jury service in this case.

You must simply say, if they ask to talk to you about it, "I must not talk about this case or anything to do with it". In

that way you will not engage in a conversation, nothing will be said to you that may consciously or sub-consciously affect your view about something to do with this case, and you'll appreciate that will be wholly wrong. That person hasn't been here, hearing every word of the evidence like you, has no responsibility in relation to the case, has no part in the case. They're curious, obviously, but you must not satisfy their curiosity, you must simply be very firm and say to them, "I must not talk about this case or anything to do with it".

Now, this is also set out in this document, which I'm not going to ask you to look at now and refer to now, but it sets out these rules as well and the consequences of your breaking the rules. If you break the rule and talk to someone about this case or you conduct any research, then you have actually committed an offence and will be punished, and more to the point the integrity of the case is obviously lost and you could not continue to serve as a juror in this case, indeed the whole trial may be brought to an end and have to be restarted.

I don't want to sound heavy or threatening, but I really want to reinforce, as you will see from this, the importance of your obeying the rules. We pride ourselves in this country on having a fair and just system; it depends upon jurors following the rules. All right?

Whilst you are a jury of 14, which you are at the moment, 12 plus 2, do not even talk to each other about this case. All right? So you will be tempted to talk, particularly when you're waiting to come into court, for argument's sake, about the case and saying, well, that was interesting or that wasn't interesting or something else. Do not talk to anyone else who is a juror on this case while you remain a jury of 14.

When you become a jury of 12, then you will be able to talk to fellow jurors about the case but only when all other jury members of present, in other words, you are together as a group of 12, and if someone talks about the case everyone else can hear what that juror is saying about it. Do you understand? It's so that you don't form into little groups and that sort of thing, talking about the case. Again it's all to preserve fairness in relation to your role as the decision-makers on the facts in this case.

When the trial is over, number 6, you will know this, I anticipate, from the video -- when the trial is over you may discuss the case with anyone except you must never discuss or reveal what was said or done by you or any jury member when you were engaged in your room deliberating on your verdicts. You carry that with you as long as you are alive. It's a lifetime prohibition on you discussing anything about the discussions

that took place in relation to the decisions that you reach or have reached in the case. All right?

I'm taking this slowly and simply and that's why you've got it in writing, so that you can refer to it at any time during the course of this case.

If anyone tries to speak to you during the trial about the case or to seek to influence you, you must tell the court immediately. You will find that the court ushers are your route to me. So anything that crops up, if someone does try to speak to you or seeks to influence you, report it immediately. And if you are not at court you should call the police and, furthermore, do not talk to another juror about what has happened to you. All right? If it happens, you simply tell the usher. Don't tell anyone else.

8. You act as a collective group and ensure that each of you obeys the rules. If, for example, one of you came in, in the morning, and said, "I've just looked up such-and-such on the internet and what we've heard isn't right", that clearly would be a breach of the rules. And if that were to happen, I sincerely hope it doesn't happen, but if it were to happen that must be reported immediately to me. All right? So you're responsible as a group for ensuring you all stick to the rules.

So the court must be told immediately and you don't discuss the matter with anyone else, including fellow jurors. All right?

Now, we know that life goes on outside the courtroom. We all have our private lives and other matters to attend to and no one knows exactly what is going to happen. Sometimes unexpected events during the course of people's lives -- sometimes someone is taken ill, you may fall ill, we've just had a pandemic where people have been falling ill and we are entering the flu season now where people are likely to succumb to influenza.

If any of you are unwell or something untoward takes place, please don't suffer and come into court and therefore spread the virus or whatever it is that you have. Just alert the jury officer and ring in. Keep the court informed. Because we will expect each of you to be here, just as I have to be here each day, ready to start when the court starts to sit. So do you. Because if you're not here we can't start if any one of you is not here. So if something occurs, either personal illness or a family member is taken ill, there's an emergency at home, or something untoward takes place which means you have to give that higher priority than performing jury service and you can't provide cover or make arrangements to cover the situation, then please inform the court. Don't -- and you will have been told

this by the jury officer, I'm sure -- fail to turn up and simply say why you're not here.

The court sitting times will normally be between 10.30 and finishing no later than, I hope, 4.15 in the afternoon. That is a long day. It may not seem long to you, but I do assure you if you've been sitting here concentrating literally on every word -- there will be a break for lunch -- you will have found you've had a full working day.

There may be some days when we will finish earlier, there may be some days when we finish a little later, but it would have to be very exceptional to go beyond 4.15 in the afternoon for a number of reasons. All right? So plan around that, make arrangements around that commitment, Monday to Friday, being here to deal with the case. If there's going to be a day or a time when we're going to finish early or only going to sit a half day I will let you know as soon as I know about it so that you can fill that gap in and know that you're not here and can do other things. All right?

But the main thing is that there's communication between you and me, each telling the other about any difficulty that anyone may have. But otherwise, here for the trial to proceed according to those court times.

All right?

Finally, number 9. If anything is said or happens that is a cause of real concern to one of your number, which is outside those matters I have already indicated, someone approaching you and saying something to you about the case or someone who is a fellow juror saying something they shouldn't be saying because it's contrary to the rules that are set out, then send me a note as soon as possible.

Bring any other problems to the attention of the court usher as soon as possible, who will pass them on to me, and I will address them. Do not wait, if something arises, until the case is over and say such-and-such happened, or, so-and-so said something and it really worried me, what that person said, because obviously it's too late, the trial is over and I won't be able to deal with it. If it's brought to my attention at the time, I can deal with it and I do deal with problems as they go on and solve them by whatever means are appropriate. All right? But don't leave it until it's all over and then raise it. It's no more that common sense. A great deal, you will find, of what takes place is common sense. That's it.

Now then, "Your legal responsibilities as a juror".

This sets out a lot of what I have said. What I'm going to do is, when we break off shortly for the conventional lunch break, which is between 1.00 and shortly after 2 o'clock, I'm going to ask each of you to read through this document before we resume this afternoon and try and absorb the information. But you should keep these two documents together with you at all times and refer to them. It can be quite useful because if you have a strong family members who says, "You can tell me what the case is about and talk to me", you can show them this, what'll happen to you if you do. You may be parting company from them if you do. You know what I mean by that. All right?

So it is very important that you read those and assimilate the information and refer to it if you need to. As I say, you're going to receive a lot of information and it's helpful for you to have that.

In front of you are screens. Mr Johnson will, when he begins his address, explain to you, as I've said, what this case is about. Again, don't be concerned that you have to retain every piece of information you've been given. Unless you have actually got a form of recording memory or photographic memory, you wouldn't be able to do that. There are very few people who actually do have completely photographic memories. But don't be alarmed about that because the issues will become clear and the evidence will become focused for you. Just listen, assimilate as much as you can. A lot of the evidence is going to be put up on the screen. You will be having some paper copies, is that right, Mr Johnson, of some documents?

MR JOHNSON: A few paper documents of few documents and iPads.

MR JUSTICE GOSS: Exactly. You're going to get iPads.

I don't know whether any of you use iPads. There are very few people who don't use some form of electronic device now. Mobile phones are essentially computers now that you carry around in your pocket anyway. But this will all be explained to you. Don't be alarmed if you're not very tech savvy. Don't be alarmed that you are going to struggle with it. You won't, I can assure you. We will make sure that everyone is following and understanding what is going on.

So a lot of the -- it's digital, in other words, rather than paper. It used to be the case that jurors would have lever arch files in front of them and in this case you'd have very many lever arch files, but it's all going to be digital and you will be taken through that.

If you want to make notes on anything, you should have a pen and paper available to you. It's entirely up to you, note taking, whether you want to or not.

I would suggest to you that if there is something that you think is really important that emerges in the course of the evidence, make a headline note of it, just to remind yourself, because you're going to be involved in a lot of events over a prolonged period and at least then you've got a note of it to remind yourself, a form of aide-memoire for when you want to recall it or cross-reference back to it. But do not seek to write down the word of every witness that is put in front of you because it would be impossible and you wouldn't be concentrating on the evidence and absorbing it in the holistic sense, which is very important, you would simply just be trying to make sure you were writing down everything that was said, and you would realise that wouldn't be a fruitful way of approaching your task, or you may not think it would be a fruitful way of approaching your task, and, as the issues become more defined, then some evidence becomes less relevant than other pieces of evidence.

At the end of the case, you will hear addresses from counsel, putting forward their cases and the evidence upon which they rely in their submissions as to how you should resolve the issues in this case. Then I will summarise the evidence, I will go through it again, identifying points and I'll be able to reference you to points in the evidence as well, but make your own references as well because you're the judges of the facts, I'm not. All right? I will just try to help you in that respect, but I don't help you with the decision-making. That's entirely for you. I help you facilitate it, but I don't influence the decisions.

Now, I think, Mr Johnson, unless you want to make a start now, it's entirely up to you, you may want to use the 10 minutes that we've got available.

MR JOHNSON: Yes, I'm happy to make a start.

MR JUSTICE GOSS: It will be nice for the jury to hear a different voice as opposed to mine. We'll break off at a convenient moment at around 1 o'clock. I'll let Mr Johnson choose when that is. Then I'll send you away for the lunch break and then we'll continue with his address this afternoon.

Thank you.

Opening by MR JOHNSON

MR JOHNSON: Thank you, my Lord.

Hello, ladies and gentlemen. I'm sure you all know the city of Chester. And on the edge of the city of Chester is a hospital called the Countess of Chester Hospital. It's a busy general hospital and included within the facilities that it provides is a maternity unit. And within the maternity unit is a neonatal unit.

The neonatal unit cares for premature and sick babies. In that sense, it's a hospital like so many others in the UK. But unlike many other hospitals in the UK, and unlike many other neonatal units in the UK, within the neonatal unit at the Countess of Chester, a poisoner was at work.

Prior to January 2015, the statistics for the mortality of the babies in the neonatal unit at the Countess of Chester Hospital were comparable to other like units. However, over the next 18 months or so, there was a significant rise in the number of babies who were dying and in the number of serious catastrophic collapses. And this rise was noticed by the consultants working at the Countess of Chester and they searched for a cause.

Their concern was that babies who were dying had deteriorated unexpectedly. Not only that, but when babies seriously collapsed, they didn't respond to appropriate and timely resuscitation. Some other babies who didn't die collapsed dramatically, but then equally dramatically recovered, and their collapses and their recoveries defied the normal experience of the treating doctors.

Usually, a baby's collapse is the unhappy end-point to a process, and it's usually secondary to problems with the heart, with infection, or with dehydration.

Usually, when an intervention is undertaken by the medics, a positive response can be expected. But many of the cases you are going to hear about defied those expectations and norms.

Babies who had not been unstable at all suddenly severely deteriorated. Sometimes babies who had been sick but had then been on the mend suddenly deteriorated for no apparent reason. And having searched for a cause, which they were unable to find, the consultants noticed that the inexplicable collapses and deaths did have one common denominator: the presence of one of the neonatal nurses. That nurse was Lucy Letby.

In the time that you'll be looking at, ladies and gentlemen, the total nursing staff on the books at the Countess of Chester Hospital numbered anything between about 25 and 30 nurses and about 15 nursery nurses in the neonatal unit. I'm not talking about the hospital in general, I'm talking about the nurses in the neonatal unit.

As a general proposition, the nurses worked either a day shift or a night shift or a combination of the two. As a general rule of thumb, more nurses worked on the day shift on a specific day than would work on the corresponding night shift and therefore there were fewer people around at night.

Parents tended to visit their sick children during the day, not so much at night, and many of the events in this case occurred on the night shifts, although when Lucy Letby was moved on to day shifts at a late stage of the time period, the collapses and deaths moved to the day shifts.

Because of the inability of the doctors to find what they believed were genuine medical reasons for the deaths and collapses, the police were called in, and the police commissioned a painstaking review by experienced doctors with no connection to the Countess of Chester Hospital. That review suggests that in that period, between the middle of 2015 and the middle of 2016, somebody in the neonatal unit poisoned two children with insulin.

The prosecution say that the only reasonable conclusion to draw from the evidence you will hear is that somebody poisoned those babies deliberately with insulin. These were no accidents. And if we are right about that -- and it will be for you to say whether we are -- the fact that there were two deliberate poisonings with insulin will help you when you are assessing whether the collapses and the deaths of other children on the neonatal unit were because somebody was sabotaging them or whether these were just tragic coincidences.

We say that the collapses and deaths of the 17 children named in the indictment were not naturally occurring tragedies, they were the work -- they were all the work, we say -- of the woman in the dock, who we say was the constant, malevolent presence when things took a turn for the worst for these 17 children.

The babies or the names of the babies who we allege were poisoned with insulin are [Baby F] and [Baby L]. [Baby F] was a twin. He was poisoned in August 2015, a couple of days after he and his twin had been born.

[Baby L] was a twin. He was poisoned in April 2016, a couple of days after he and his twin had been born.

Lucy Letby was on duty when both were poisoned and we allege she was the poisoner. And it won't surprise you to know, ladies and gentlemen, that there is a very restricted number of people who could have been the poisoner because entry to a neonatal unit is closely restricted.

I see it's 1 o'clock. I'll leave it there for now, with his Lordship's leave, and give you some more detail once you've had a break.

MR JUSTICE GOSS: Certainly, Mr Johnson.

All right. There is a start. You'll appreciate there's a lot more to come from Mr Johnson. We'll break off now. Could you be ready, please, to come into court at 2.05, which is just over an hour? It takes time for people to come and go. I'm not suggesting you need that long to take any refreshment you want to take, but it just enables people to have a proper break. All right?

So ready to resume at 2.05. In the meantime, please do read this (indicating) and you'll probably want to read it tonight when you get home, just so you've absorbed all of the information.

Thank you very much.

(In the absence of the jury)

Thank you very much.

(1.00 pm)

(The short adjournment)

(2.05 pm)

MR JUSTICE GOSS: Yes, jury, please.

(In the presence of the jury)

MR JUSTICE GOSS: Before I ask Mr Johnson to continue, I apologise that we're slightly late coming in. It in fact transpired that we did need slightly longer than the hour and 5 minutes. I'll ensure sufficient time is allowed and you are not unduly inconvenienced in any breaks so far as I'm able to.

Can I just confirm that you have all read "Your legal responsibilities as a juror", that document? If you haven't, please do read it tonight, and even if you have, it's probably worth going over it again in the calm of the environment away from this court building.

But as I say, keep that with you and follow it.

Thank you very much.

Yes, Mr Johnson.

MR JOHNSON: Thank you, my Lord.

Welcome back, ladies and gentlemen. In the time you've been away, the court staff have put some lever arch files on the desks in front of you. At the moment it only contains two documents: one is the indictment, which is the charge sheet, the list of charges and that you will recall was read out to you once you had been sworn. The other is a medical glossary, a medical dictionary, if you like, which has a list of all the -- we hope all, if we have got it right, the medical terms that are going to be used in this case. That's, I can assure you, as much for our benefit as it is for yours because we are all together going on a journey into a world that most of us at least have very little experience of.

You will remember that just before we parted for the break, I mentioned two babies to you. One was [Baby F] and the other was [Baby L]. Although those young men were born many months apart, they shared one thing in common -- two things or three things even. Both born at the Countess of Chester, both were twins, and both were poisoned with insulin.

I'm going to move on to why we say they were poisoned, because you will remember that what the prosecution allege is that not only were they poisoned by Lucy Letby, but also the very fact that they were poisoned helps you to interpret what happened to other children when Lucy Letby was there or thereabouts.

Just going back to [Baby F] and [Baby L], both boys' blood sugar dropped to dangerous levels, the sort of levels that can result in all sorts of medical problems and ultimately in death if not rapidly rectified.

Both babies survived because of the skill of the medical staff in the neonatal unit. The doctors realised at the time that [Baby F] and [Baby L]'s blood sugar level was dropping that there was a problem, but these problems can sometimes occur for natural causes. What the medical staff didn't realise at the time was that the reason, in the cases of [Baby F] and [Baby L], was that it was because somebody was poisoning them both with insulin and it took a long time after these events for that fact to emerge.

I'll come to the details of the cases of [Baby F] and [Baby L] in a while and why it is that we say there can be no doubt that both young children were poisoned. But the prosecution say, and I'm sure this may already have occurred to you, the prosecution say that one of the reasons that the cause of [Baby F] and [Baby L]'s problems was not identified and at the time was attributed

to a naturally occurring phenomenon was that it simply didn't occur to the doctors, or anyone else in that hospital, that someone in the neonatal unit would have poisoned them with insulin, because nobody would think, would they, ladies and gentlemen, that in a neonatal unit of a hospital somebody was trying to kill babies?

I think I said to you before we parted that both [Baby F] and [Baby L] had a twin brother: [Baby F]'s brother was called [Baby E]; [Baby L]'s brother was called [Baby M]. And [Baby E] and [Baby M] were also attacked by Lucy Letby. [Baby E] did not survive; mercifully, [Baby M] did.

Just as the cases of [Baby F] and [Baby L] are similar in the sense that they were both poisoned with insulin, so are the cases of their twins, [Baby E] and [Baby M].

One of the means by which [Baby E] was killed and [Baby M] was harmed was by having air injected into their bloodstream. That's what the doctors refer to as an air embolus. Air was injected into the circulations of these very small babies.

Ladies and gentlemen, as we go through this introduction of the case to you, we will see that similar events repeated themselves time and time again. The means by which the children in this case were harmed and killed varied. Sometimes they were injected with air, both intravenously, in other words into their bloodstream, but also through what's called a nasogastric tube. I just want to show you a picture of what I'm talking about.

This is an animation of a nasogastric tube. If we move on to the video now -- is this all coming up on the screens in front of you? Good.

(Pause)

(Video played to the court)

As you can see, they're often referred to by the witnesses as NGTs or nasogastric tubes. They go up the nose -- they use them with adults as well in hospitals, you may have seen them. They go up the nose through the oesophagus, down the throat, through the oesophagus, and as we'll see, into the stomach.

Ignore the words for now, because we're going to come to all this in the evidence. I just want you to understand what it is I am talking about first of all.

You'll understand, ladies and gentlemen, I'm sure, that the stomach of a newborn baby is very small, the stomach of a

premature baby even smaller, and many of the babies that you will be hearing about were premature to varying degrees.

If you inject down one of those nasogastric tubes milk -- or, I should say, too much milk -- or some other fluid or air, that can have catastrophic effects on the baby. So sometimes babies injected with air, either down the tube, into the circulation, sometimes insulin into the circulation through a feeding bag, and sometimes too much milk or air down the nasogastric tube.

So varying means by which these babies were attacked, but the constant presence, when they were fatally attacked or collapsed catastrophically, as I've said, was Lucy Letby.

There are many events that you're going to hear about, primarily the 22 that mirror the counts in the indictment, and there is a chart, ladies and gentlemen, a grid in effect, that shows all the staff that worked in the neonatal unit over the period of time that we're talking about, all the babies that are concerned in this case with the events when they were unlawfully attacked.

I'm going to show it to you now. I'll have to put my glasses on to see this one. What you can see here, ladies and gentlemen, is what's called a "nurses present summary". That's the top left-hand corner of the screen. Above that it says Operation Hummingbird, which is -- that's something you may see time and time again in this case. It's the name given to the investigation.

The exhibit reference is at the top in the centre of the screen. That's just an individual reference that identifies the document. Then in the top right-hand corner of the screen, "Staff presence report".

So listed down the left-hand column and numbered 1 to 24 we have the events that will primarily concern the evidence, with the children named in the same order as they appear in the indictment.

In the next column across it says "Date shift started". And you can see that the first event with which you'll be concerned was 8 June 2015 and the final, 25 June 2016.

We see what I mentioned to you earlier, there is a preponderance of night shifts over day shifts.

So taking [Baby A], who is the first baby with whom you'll be concerned, if we read across that line, so row number 1, we can see that an event happened on the night shift that started on 8 June. So a shift that started at 8 pm on 8 June and ended at 8 am on the 9th.

If you look for the crosses in the boxes, you will see that on duty during that shift, of the nurses, were Caroline Bennion, Elizabeth Marshall, Lisa Walker, Lucy Letby, Mary Griffiths and Melanie Taylor and [Nurse A].

So when whatever it was that the prosecution say caused the death of [Baby A] happened, the people that were there, or the nurses that were there, were those who are marked with a cross. And so on.

So if we expand that box to include rows 1 and 2, please. So [Baby A] and his twin, [Baby B]. We can see that of the people that were working when the prosecution say that [Baby A] was attacked, when his sister was attacked the following night, the people that were common to the two shifts were Lisa Walker, Lucy Letby, Mary Griffiths and [Nurse A].

If we expand it again to include line 3, [Baby C], we say he was attacked 4 days after [Baby B], and you can see that the only person that was present on all three occasions was Lucy Letby.

If you look at the table overall, the picture is, we suggest, self-evidently obvious. It's a process of elimination.

If we just get rid of the screen, please.

Thank you.

Every criminal case starts with an introduction by the prosecution. When we have introduced you to the case, you will get an introduction from Mr Ben Myers, King's Counsel, who sits on the front row next to me, and he will give you an explanation from the point of view of Lucy Letby. You'll be glad to know that you're not -- during the prosecution case at least, you're not only going to have to listen to me. I will present the case with my learned friends Mr Simon Driver, who's sitting directly behind me, and Mr Philip Astbury, who's sitting slightly closer to you. And as I do that, Mr Myers will be assisted by Mr Michael Maher, who sits closer to you in the second row, and Ms Fiona Clancy, who sits slightly further away.

It's important, ladies and gentlemen, to remember that what I'm saying at the moment isn't the evidence in the case, okay? It's an introduction to the evidence. My job, if you like, is to give you an explanation of what the case is about so that as we call the evidence, you've got an idea of where it's going to fit into the overall picture. Okay?

As his Lordship said to you, nobody would expect you -- if you were asked context questions when I sit down, no one would

expect you to be able to remember the detail, okay? But we will live this case together in this courtroom and you'd be amazed at how you will pick up the detail.

It's a complicated case by any measure. As his Lordship said, it concerns seven allegations of murder and allegations of the attempted murder of 10 other children. We allege that sometimes Lucy Letby tried to kill the same baby more than once. Sometimes a baby that she succeeded in killing, she didn't manage to kill the first time she tried or even the second time. And in one case, even the third time.

To help you follow the evidence, we'll give you some documents. His Lordship has already explained this to you, you'll be glad to know we've moved on from the days when jurors were given huge boxes of files. In the olden days, as I'll call them, you'd have had loads of files like this (indicating) crammed full of documents. The files would start to fall apart on the second day of the trial and the holes would rip out, you'd have bits of paper on the floor and the whole thing would end up as a bit of a mess. Well, people say the law never develops. It has at least in this respect.

As his Lordship has said to you, you'll get iPads and we will all get a little tutorial from somebody that can explain these things a lot better than I can when I have finished talking to you as to how to use them, but you'd be amazed -- well, you probably won't be amazed. Old-timers like me are amazed at how quickly it is to get to grips with things like that.

The point of what I'm saying, really, is just for you to understand the shape of the case. Okay? What we've got in this jury bundle -- and these are for you in the sense that nobody else will ever get to look at these. Okay? At the moment you can see that there are 21 dividers in there. It will be filled in due course, as we go through the evidence, but can we just look at what's actually in here first of all, please.

Behind divider 1 is the indictment -- "indictment" is just an old word for charge sheet. You can see that this particular indictment runs to eight pages. It runs to 22 counts -- "count" being another word for charge. If you go to page 3 of the indictment, count 6, you'll see that there appears the allegation relating to [Baby F], who is the first of the two babies that the prosecution allege was poisoned with insulin.

If you move on to page 6, count 15, you'll see the name [Baby L], who is the second of the two young boys the prosecution say was poisoned with insulin.

What this indictment does is not only set out the allegations made by the prosecution, but it also gives you a very simple chronology of the case. So it starts with the first incident, which the prosecution allege, which is the murder of [Baby A] on count 1. That, as you can see, was 8 June 2015.

If you go to page 8, and you look at count 22, you can see the final event, which is the attempted murder of [Baby Q] on 25 June 2016.

Just taking another example as an explanation, can we go back to page 6, which was the page on which [Baby L]'s and indeed his brother [Baby M]'s names appear. You can see at count 17 an allegation of attempted murder on 3 June 2016 relating to a small baby called [Baby N]. So that's 3 June.

If you turn the page, counts 18 and 19, you can see are two more allegations of attempted murder made against Lucy Letby, both also relating to the same child. These two happened on the same day as each other, but on a different day to the one in count 17. The first occurred at between 7.15 and 7.30 on the morning of 15 June 2016, and the second at about 3 pm on 15 June 2016.

So what I will do in a moment, I'll come to the individual cases and give you a summary of the prosecution allegations, but these allegations can all be referenced back to this document, the indictment. So this document, a list of charges, is what we, the prosecution, set out to prove. Okay?

The glossary appears behind divider 2. It's alphabetical. In dark letters are various medical terms. Following those medical terms is a definition.

If ever there is a medical term used, if we've done our jobs right it should be in here. Okay?

If you go to -- I'm afraid it's not paginated and it may be we can get a version of this that's got pagination. If you go to N, the first N that you will find in the alphabet is nasogastric tube. It's right at the bottom of the page.

MR JUSTICE GOSS: I'll say this now, Mr Johnson, pagination.

MR JOHNSON: Yes, I know.

MR JUSTICE GOSS: I already spotted it, I was going to raise it in any event.

MR JOHNSON: So was I, but we didn't have time to...

MR JUSTICE GOSS: It's all right. These will be replaced with another version that'll have page numbers on them because otherwise we waste time trying to flick through to find the page.

MR JOHNSON: Yes. I'm not going to get hung up on this document during this explanation. But for example, nasogastric tube, NG tube, NGT are all the way that this thing that you've already seen a video representation of is described. Then a definition:

"A narrow-bore tube passed into the stomach via the nose used for short or medium-term nutritional support and the administration of drugs. In certain circumstances it may be used to aspirate the contents of the stomach."

What that means, and this is important in the context of this case, but when people talk about stomach contents being aspirated, that means sucked out, literally, not like that, but with a syringe. And when these very small children were being fed through the tube, before they were fed the nurse would habitually aspirate the tube to see if there was any undigested milk in the stomach of the baby. All right? That is the way it works as a rule.

Can we put these away now, please?

MR JUSTICE GOSS: I'm not asking you to do it now, but if you go back to page 2, you'll see "aspirate" and "aspiration" defined for you. As I say, you will soon become familiar with all of this. There will be a lot of information that you'll have access to at any time.

MR JOHNSON: Now, Lucy Letby was born on 4 January 1990.

She is therefore now 32 years old. She comes originally from Hereford and she studied for her nursing degree at the University of Chester.

At the time of the events leading to these charges she was a nurse at the Countess of Chester Hospital and had been so since she had qualified a few years earlier.

She worked throughout the period --

MR JUSTICE GOSS: I'm sorry, there's been a breakdown in the connection. Just pause. Sorry, Mr Johnson. Just by way of explanation, this is a small courtroom. A lot of other people want to be able to see and hear what is going on in this courtroom, who are connected with the case, and so it is being, to use a simpler, readily understandable expression, beamed into other courtrooms, other buildings, transmitted, so that they can

see. You can't see a screen there, but behind you there's a screen with the courtroom on it so they can see and hear what's going on. They're back again. You'll be familiar with the internet dropping out. It's what happens, it drops out intermittently. When that happens, I am alerted to it and I have to stop them.

Sorry, Mr Johnson. I should imagine we'll get quite a lot of this, so we just have to be patient, I'm sorry.

MR JOHNSON: Throughout the period that you'll be considering, Lucy Letby was working in the neonatal unit at the Countess of Chester. Prior to her arrest, she was living at an address at 41 Westbourne Road in Chester.

As I think I may have said to you earlier, the doctors and nurses at the Countess of Chester worked on a shift system and inevitably the shifts were different, just to complicate things. But so far as the nurses were concerned, at least, there were nurses both on the neonatal unit but also on the children's ward. And it was the general rule that nurses in those two locations didn't mix on a specific shift. So if a nurse started the shift in the neonatal unit, the norm was that that was where the nurse remained for the shift.

Generally speaking for the nurses, on any given day the day shift started at 7.30 in the morning and the night shift ended at 8 o'clock in the morning. So there was a 30-minute period of time where you had the end of the night shift and the beginning of the day shift, working side by side.

During that 30-minute period there would be a short general briefing for the day shift coming in, which was then followed by specific handovers of individual patients between specific nurses. So the nurse going off would hand over the patient to the nurse coming on.

Just to make things slightly more complicated, there were two types of day shift, what was called a short day and a long day. The short day would end some time in the afternoon, the long day shift would end at 8 pm.

So it's a 12-hour or if you come on at 7.30, a 12 and a half hour shift.

When babies were handed over from one shift to the next, the system was that there was a sheet produced, which listed all the babies in the unit and their corresponding designated nurse. I'm sure you've worked it out already. The designated nurse was the nurse who was designated to look after the specific patient.

There are, and there were, different grades of nurses. Amongst the nurses who were working day to day in the neonatal unit, most fell into one of four separate bands. At the top were the band 6s. In the middle were the band 5s, although the band 5s were split into two. There were some band 5s had done special training to care for babies in the intensive care unit and some had not and Lucy Letby was a nurse that had done special training.

At the bottom of the nursing hierarchy --

MR JUSTICE GOSS: Sorry.

(Pause)

You probably heard my conversation. They've joined again, all right, we're back on again. I'm not going to spend -- I'm just going to say pause next time. I'm not a tech wizard, but I understand the basics of it, I think.

MR JOHNSON: So the band 4 nurses are at the bottom of the hierarchy and sometimes you'll hear the band 4 nurses referred to as nursery nurses.

Within the hospital records for each of the babies that you're going to hear about there is a section in which the nurses made their records and there was a different section for the doctors to make their records. And so on any specific shift, one of the nurses was designated the shift leader and he or she would inevitably be a band 6 nurse. It was the shift leader who had the responsibility of assigning specific nurses to specific babies.

So if Nurse A was assigned to Patient Z, then Nurse A was recorded as being Patient Z's designated nurse, so whenever you hear that phrase, designated nurse, that's the reason.

The consequences of that are probably so obvious that you don't really need me to explain, but what it meant was that the designated nurse had primary responsibility for the nursing care of Patient Z.

Almost always when we see the nursing records we'll see that the specific patient's records were compiled by the designated nurse, although there is the odd exception. And usually, the administration of medicine and that sort of thing, with the recording of the patient's observations, as they were called, their respiration rate, their breathing rate, their sats, saturation, how much oxygen they've got in their blood, and their heart rate are often recorded by the designated nurse.

Now, the neonatal unit itself had four separate rooms. In room 1, that was the ICU, the intensive care unit. Room 2 of the four was the high dependency unit, the HDU, so a level down from intensive care. And rooms 3 and 4 were what were classified as special care rooms, so children that weren't so sick that they needed either intensive or high dependency care. And often, though not invariably, rooms 3 and 4 were being used as, to use a fairly industrial term, I suppose, growing rooms, rooms for premature -- or babies who had been sick but who had recovered, who needed to establish a good feeding routine or regime before they could be discharged home. So babies who had had problems, had recovered, but needed -- just needed to get into a routine before they could safely be allowed home.

With one or two exceptions, the babies whose cases we'll be considering were in rooms 1 and 2. So that's the nurses and the babies.

As for the doctors, as I said, they would work different shifts to the nurses and different grades of doctor would work differently. On any given shift, the medical staff, unlike the nurses, would cover both the children's ward and the neonatal unit. So that's the first important distinction.

So it follows that doctors who were on duty didn't necessarily, and almost invariably didn't, remain within the neonatal unit throughout a shift. You will know, I'm sure, from your common sense that, broadly speaking, there are three different grades of hospital doctor. At the top of the hierarchy were the consultants, in the middle were the registrars, and at the bottom of the medical hierarchy were the doctors who are known as senior house officers or SHOs.

Sometimes the registrars and the house officers are referred to by the stage of their training that they'd reached. So often, after their name, it'll say ST and then a number. ST stands for specialty training, so if your ambition as a young doctor was to be a consultant paediatrician or neonatologist, you would start out as a senior house officer, work your way up to being a registrar, and then in due course hopefully, if your ambitions were achieved, consultant.

So after the names of the doctors, often you'll see ST plus a number, and the number is the number of years that the doctor in question had been doing the specialty training. So the higher the number, in effect, of a registrar or senior house officer, the more experienced the doctor.

As always, there may be exceptions, but generally speaking, from 9 in the morning until 5 in the evening, on any given day, there

were paediatric consultants on duty, registrars and senior house officers.

At night, the consultants were on call. Senior doctors would, generally speaking, be at home within a 10-minute journey of the hospital. So at night, generally speaking, it was the registrars who provided the senior medical cover, and a registrar could have anything up to about 11 years of postgraduate training as a paediatrician. So we're not talking about inexperienced doctors. So that's the medical background.

Just a word about how we're going to present the case. As you know, we have 22 counts, 22 charges, 17 children. In all the cases Lucy Letby was either responsible for them as their designated nurse or she got involved with them, despite not being the designated nurse.

The way we'll present the individual cases will follow a pattern. First, we'll call witnesses who were there just before, at the time of, or just after, the events that we allege were criminal actually happened.

Insofar as we can, we'll do everything in date order, but I'm sure you'll understand that some of the doctors, the independent doctors who weren't working in the hospital at the time, for their own personal or professional reasons, can't always be in court at the exact moment that we would like to call them to maintain the chronology. In a perfect world I'd be able to click my fingers and say, "I call Dr X", and Dr X would appear. I'm afraid the real world doesn't work like that and you'll understand that many of these doctors have serious professional commitments that they need to keep on a day-to-day basis. So from time to time, I'm afraid, we're going to depart from the chronology.

But when we're departing from the -- when we're not following the chronological sequence we will do our best to let you know that that's what we're doing. Okay? So hopefully it'll enable you to keep everything in the right order.

The evidence of the witnesses who were working in the unit will be put into the context of what was going on at the time, both in terms of what was actually happening in the neonatal unit, but also in the context of what was going on with some of the other children in the unit. Because sometimes, as you will see, it will be helpful for you to understand what, if anything, Lucy Letby was doing with other children in the neonatal unit at a given time or what was going on with other children in the unit at the time that we allege Lucy Letby either murdered or attempted to murder the children named in the indictment.

By and large those other children will be referred to in court by their initials because their identities aren't relevant to any issue in the case and it's what was going on with them that is relevant. Okay? So we won't use -- we will use the names in every case of every child that it is alleged Lucy Letby either murdered or attempted to murder, but in relation to what I'll call the third party children, we'll use their initials. Okay?

A lot of the information about those other children isn't disputed. The records say what they say and a lot of it appears in digital timelines or chronologies that will be on your iPads.

All the information in those timelines or chronologies -- I often refer to them as sequences of events, it all means the same thing -- it's taken from the medical records, from phone records or from other documentary sources. So in pretty much every case there is a document to back up the information that's contained in the sequence of events.

To make that all more digestible for you, rather than one of the three of us just reading it out or going through it with you, we'll call a witness to deal with it because it often helps all of us to concentrate on what's going on if there's not just one person talking at you. And by and large those witnesses are analysts who work for Cheshire Police, who were the police force that investigated these events.

Just to give you an idea of what I'm talking about, in a moment I'm just going to put on the screen one of these timelines so that you can see what it is. I'm going to start, when I do that, with the timeline for [Baby A], who is the first child. You'll be glad to know I'm not going to do this in the case of each of the 17 children because, if I did that, you'd be listening to me for a long time. Okay? That's not happening.

Once we've called the evidence about the facts of what happened with each child, and the defence have had the opportunity to ask questions of the witnesses relating to what was going on, we will call independent experts who have reviewed these cases on a case-by-case basis.

The prosecution will call two paediatricians. Their names are Dr Sandie Bohin and Dr Dewi Evans. What the expert paediatricians do, ladies and gentlemen, is they draw together the evidence of the facts of the treating physicians, the nurses and of any other experts and they will give you their opinions on the deaths or the life-threatening events that befell these 17 children named in the indictment.

From time to time other experts will give evidence as well. Examples are: a pathologist, so a doctor who specialises in the

cause of death of children who have died; experts who deal with the imaging, whether it's X-rays or CT scans, MRI scans, those sorts of things; experts who deal with blood disorders; and an expert who deals with insulin. So that's the pattern, if you like, of how we're going to present the evidence.

So that is an introduction. I'm going to turn to specific cases now and what we, the prosecution, allege Lucy Letby did to each of these 17 children.

It may help you just to go back to the indictment, if you would, please, to the first page and to count 1, so [Baby A]. As you can see, the indictment tells us that the allegation is that Lucy Letby murdered him on 8 June 2015.

[Baby A] was born on 7 June, so he died on the second day of his life. From conception to birth, a "standard", if there is such a thing, pregnancy lasts 40 weeks, and a child that is born after 37 weeks' gestation is classed by the medics as being a full-term child. So 40 weeks standard, 37 weeks full term.

[Baby A], who was a baby boy, was born at a gestational age, in other words age after conception, of 31 weeks and 2 days to his parents [Parents of Babies A & B]. He was born just after 8.30 pm on 7 June. And he was the younger of twins delivered by C section. His sister was [Baby B], who you will see is the child named in count 2.

[Baby A] and [Baby B]'s mum, [Mother of Babies A & B], had an autoimmune disease which can increase the incidence of blood clots, and the medics at the time of the twins' delivery knew about that, they knew that she had this autoimmune disease. But as it happens, although the autoimmune disease was flagged as a concern, [Mother of Babies A & B]'s blood disorder had no impact on her son's death. It is irrelevant in terms of causing her son's death.

So if I can just put the sequence of events up now, please, to give you -- right. So this is the timeline or the sequence of events document, ladies and gentlemen. And what you can see in the top left-hand corner in yellow, it says "[Baby A]", for obvious reasons. At the bottom you can see there's a slide bar that shows us that what we have here is a total of 397, I'll call them, tiles, which are the things you can see in the middle of the page, which effectively, almost like on a carousel, you can run your way through these items.

I'm just going to pick something -- if we can move on to [Baby A]'s birth, please. So we can see [Baby A] is the junior by a minute, junior to [Baby B], and if we click on that tile, please, for [Baby A]. What we see there, ladies and gentlemen,

is the description that's contained in the records. We can see the identity of the doctor and the nurse that were present at the birth. And then if we pull that slide bar down, please, we see "Observations".

Apgar score is something -- if any of you have heard of it, well done, but it's a way of measuring the well-being of a child immediately after birth. Rather than me attempting an explanation, I'll wait until we have an expert here to explain it to you. But it is actually one of the things in the document that we've given you behind divider 2. Just as it says, it's a scoring system that evaluates the physical condition of the newborn child at various stages, at 1 minute, at 5 minutes and at 10 minutes.

This is [Baby A]. [Baby A] was in good condition at birth. We can see that he had an Apgar score of 9 after 5 and 10 minutes. He was admitted to room number 1 in the neonatal unit, that is the intensive care unit, and he was cannulated, which means that a tube was put into him, so that he could be given fluids and medication. He was also given extra oxygen to help him breathe, which was given to him through nasal prongs. So that was his birth at 20.31 on 7 June.

And he did very well, [Baby A], because by quarter to 10 the following morning, 13 and, I think, about a half or a quarter or a half hours after he'd been born, he was breathing in air, which means he didn't need the extra oxygen.

During the afternoon of 8 June, it was noticed that the tube in his umbilical cord, the line that was potentially being used to give him medication or whatever he needed, was in the wrong position, so it wasn't used.

Some time after 5 pm, so teatime, on 8 June, one of the registrars, Dr Harkness, inserted a different type of line into [Baby A] to replace the one that was in his belly button that couldn't be used. It was intended to use that to give [Baby A] fluids.

The medical notes suggest that until a bit later no fluids were actually given to [Baby A], but he was given one millilitre of milk through the NG tube, that tube that goes up the nose and down into the stomach, and he was fed that at both 4 pm and 6 pm.

If we just look at that document, please. You'll get used to these documents, ladies and gentlemen. This is a feeding chart. In the top right-hand corner you can see it says "[Baby A]", [redacted] being his mum's surname. His date of birth appears under there, 7 June.

Can we expand or magnify what's further down the page, please? It's the bit that's highlighted, please, further down.

Can we go a bit further to the right? That's it, thank you.

So down the left-hand column, 14, 15, 16, that's the 24-hour clock that you can see. What this chart records, ladies and gentlemen, is fluids going into [Baby A] and fluids coming out of [Baby A]. You'll remember I told you that [Baby A] was given some milk, a millilitre of milk, at both 4 and 6 o'clock, and you see the yellow highlight that runs -- that's the one, thank you. You can see that there in the 4 o'clock and 6 o'clock columns.

If we look further up, what he was being given was expressed breast milk. If you look to the unexpanded portion of the page, so just -- that's it there. You see it says "EBM". That's a reference to expressed breast milk, which was what he was being fed.

That day shift -- and you'll remember the day shift runs from 8 until 8 -- that day shift, the nurse who was looking after [Baby A] was called Melanie Taylor. Melanie Taylor handed over [Baby A]'s care to Lucy Letby between 7.30 and 8 pm. You'll remember me telling you about that half an hour handover period in the evenings.

She handed over [Baby A]'s care before she, Melanie Taylor, was able to run fluids through the long line that Dr Harkness had put into [Baby A] to replace the one that was in his belly button that wasn't working. You can actually see, if you look at that highlighted page there, you see where it says, "Cannula tissued", that's a reference to the line that was going -- the cannula is the tube -- that was going into [Baby A]'s belly button. "Tissued" means it's blocked in normal everyday language. So they couldn't use that, that cannula, that line was tissued, so a new one was put in, but Melanie Taylor didn't have the opportunity to give [Baby A] fluids before the handover, before the handover between 7.30 pm and 8 pm. So the fluids were started at the time of the handover, so when Lucy Letby arrived.

[Baby A] was stable. [Baby A] was doing well when he was handed over from Melanie Taylor to Lucy Letby. At the end of her shift, Nurse Taylor went to update her notes, the nursing notes on a computer that was in the room.

Dr Harkness, the doctor that had put in the new line to [Baby A], was still in nursery 1 looking after another baby, and the fluids that were going through this new line were connected some time after 8.10. We know that because there's an X-ray that's

timed then to check that the line was in the right place. So they wouldn't run fluids through the line before its position had been checked on an X-ray.

If we look at J1103, please. This is what was being given through the line. If we start on the left, we can see the date, 8/6/15. The fluid being given was 10% dextrose, which is, in day-to-day language, water with sugar in it. The volume of the bag containing dextrose is 500 millilitres and the rate to be given is 60 millilitres per kilo, 4.15 millilitres an hour. So that's the rate that the fluid is to be given.

The route we can see, "long line" -- there on the left it does say "long line" -- prescribed by Dr Harkness and "given by", and then the second signature there is a signature that you'll become very familiar with, Lucy Letby. The time recorded on this document in handwriting, 8.05.

That's the time that the fluids started to be given to [Baby A]. When she made a note in the nursing notes -- if we go to 1082, please. This is what the nursing notes look like. If we expand the bit that's by the yellow highlight, please.

These are the nurse's notes, so you see at the top:

"Stable. 20.05 [the time, five minutes past 8], 10% glucose [what we've just seen in the handwritten prescription]. Commenced a long line with Nurse Taylor as agreed by Registrar Harkness who was present. UVC [the line going into [Baby A]'s belly button] remained in situ from day shift. Instructed line [that is the UVC, the one into the belly button] not to be used by registrar. "

[Baby A] was noted to be jittery and was due to have blood gas and blood sugar taken.

Then this:

"At 20.20 [Baby A]'s hands and feet noted to be white, centrally pale and poor perfusion. Became apnoeic."

So having problems breathing:

"Assistance called for. Glucose disconnected. [Baby A] making nil respiratory effort [ie not breathing]."

And it sets out what was done:

"Shortly after no heart rate detected. Full resuscitation commenced as per medical notes. UVC used to administer drugs.

Parents and maternal grandmother present. Dr Jayaram in attendance throughout."

Dr Jayaram was the on-call consultant who was called in, and the doctors used adrenaline to try to stimulate [Baby A]. Dr Jayaram and Dr Harkness saw an odd discolouration on the skin of [Baby A]'s abdomen, so this area (indicating). It was flitting patches of pink over blue skin that seemed to appear and then disappear, unlike the sort of rashes you'd get from an infection. Neither Dr Harkness nor the consultant, Dr Jayaram, had ever seen that sort of skin discolouration, but this proved to be the first of a series of similar presentations on the skins of babies who suddenly and catastrophically collapsed at the Countess of Chester Hospital over the succeeding months.

We allege, ladies and gentlemen, that it is, in effect, a hallmark of some of the cases in which Lucy Letby injected air into the bloodstreams of some of these small babies.

All the resuscitation techniques which would be expected to bring a baby back to life failed and [Baby A] was pronounced dead at 2 minutes to 9 that evening. He died within 90 minutes of Lucy Letby coming on duty.

Her nursing notes, you can see there on the screen. They were recorded by Lucy Letby just before she went off duty from that night shift at just before 8 am on 9 June. She was recorded in her own notes as the only staff member who witnessed the events immediately associated with [Baby A]'s collapse.

Dr Harkness, the registrar, says that he was reviewing [Baby A] just before 25 past or 26 past 8 and found that Lucy Letby was holding an oxygen mask to [Baby A]'s face. The monitors showed a normal heart rate, good oxygen saturations of 92% and a normal ECG, but [Baby A] wasn't breathing, so a non-breathing baby who had good oxygen saturations, a normal heart rate and a normal ECG. And after a number of minutes, [Baby A] then appeared pale and was turning blue and his oxygen level dropped.

What he recorded was:

"An unusual blotchy pattern of well-perfused pink skin over the whole of [Baby A]'s body, coupled with patches of white and blue skin all over his body."

Well, the case was referred to the coroner, a post-mortem examination was carried out by a pathologist, at Alder Hey Children's Hospital in Liverpool, and the cause of death was recorded as unascertained at the time.

Two independent paediatricians reviewed the records. The first was a gentleman called Dr Dewi Evans. Dr Evans concluded that [Baby A] was a well infant in a satisfactory condition immediately prior to the fatal collapse. You'll see there, noted by Lucy Letby, the top of that page on the screen, "Stable at 8.05".

Dr Evans suggested that the collapse was consistent with a deliberate injection of air or something else into [Baby A]'s bloodstream a minute or two prior to his collapse. His collapse happened when Lucy Letby was next to him. It wasn't long after the noted timing of the start of the glucose infusion, which of course is something that would have given somebody a legitimate reason to be doing something to the intravenous line going into [Baby A]. So this injection of air went in at about the noted time that Lucy Letby has recorded as giving [Baby A] the intravenous dextrose.

The other prosecution paediatrician, Dr Bohin, agreed that the cause of [Baby A]'s collapse wasn't some natural disease. She too concluded that the most likely reason was a dose of air deliberately put into either the line going into [Baby A]'s belly button or the long line, the second line that was introduced by Dr Harkness, by someone who knew that it would cause significant harm.

An independent pathologist, Dr Andreas Marnerides, described the cause of death as unascertained from a pathologist's point of view, but by that he meant that there was nothing in the findings at autopsy that pointed to a reason for why [Baby A] died and he agreed with the paediatricians that it was reasonable to conclude that air in [Baby A]'s circulation was most likely caused by somebody having injected it through one of the lines.

An independent radiologist looked at X-rays of [Baby A], including images taken after he'd died, and he concluded that even allowing for post-mortem gases to develop, the pattern he could see in the X-rays was unusual and was consistent with air having been injected to [Baby A]'s bloodstream, what the medics call exogenous air administration.

There were other potential causes, he said, but he said it was consistent with that. And he suggested that in the absence of any other plausible explanation, it was reasonable to conclude that the unusual radiological findings could have been caused by somebody injecting [Baby A] with air.

Another expert called Professor Sally Kinsey is a blood expert and she ruled out as a possibility that [Mother of Babies A &

B]'s autoimmune disease could have been significant in the context of [Baby A]'s death. She said:

"The mother's autoimmune problem is associated with different sorts of problems, not this sort of problem. Also, it's not hereditary."

The staff on duty, you'll remember that table I showed you, the staff on duty at the time [Baby A] collapsed were the consultant, Dr Jayaram, registrar Doctors Lambie and Harkness, and Christopher Wood. Nurses, [Nurse A], who was the shift leader, Lucy Letby, Caroline Bennion, Mary Griffiths, with the nursery nurses Lisa Walker and Elizabeth Marshall. Nursery nurses, as a rule, would have had no business in room number 1. If they were in room number 1 that would be unusual.

It doesn't follow that as a matter of absolute fact that means they couldn't have been responsible, but as I've already shown you, as we see the staffing lists develop in succeeding cases, who was there when things happened? By the third case there was only one constant presence when these unusual life-threatening and often fatal events happened.

It was to be more than 3 years before Lucy Letby was arrested and interviewed. The first time was on 4 July 2018, then 11 June 2019, and finally 10 November 2020. She said that she and Melanie Taylor, who you'll remember was the day shift nurse, had given fluids to [Baby A] at the time of the change of shift. She said that once the fluid was connected, it had been maybe -- within maybe 5 minutes that [Baby A]'s colour had changed. And Lucy Letby described it as:

"Almost a rash appearance, like blotchy red mark on the skin."

She said first that she'd called over Dr Harkness, then that she couldn't remember whether she or Melanie Taylor had called him. When asked what she'd thought at the time, she said that she'd wondered whether the bag of fluid was "not what we thought it was". Well, you'll remember what I've already told you about the insulin poisonings of [Baby F] and [Baby L]. Whether the bag of fluid was "not what we thought it was". That's an interesting turn of phrase that we suggest you may care to carry forward as my explanation of the evidence develops because the experts in the case have concluded that whoever the poisoner was put insulin into the bags of fluid in the case of [Baby F] and [Baby L].

In the interview of 11 June 2019, Lucy Letby said that she was concerned at the time about the line and the fluid. She said that she had asked for all the fluids to be kept from the bag at the end to be checked, but there's no record of her having made

such a request. It was put to her by the police officers in the second interview that Nurse Taylor was saying that she, Lucy Letby, had been the one who had administered the fluid with the obvious implication that she was therefore the person who had the opportunity to inject [Baby A] with air.

In this interview she said that she remembered it being the other way round, and this is the first, but certainly not the last, time that there will be a factual dispute about events surrounding the death or serious collapse of a baby who was in close vicinity to Lucy Letby. And the police suggested it straight on that she had administered a dose of air.

Her answer? She said it would have been very hard to push air through the line. She said all nursing staff would be aware of the dangers of a dose of air, an air embolus.

In the November 2020 interview, so the final series of interviews, it was put to Lucy Letby that she had tracked the [family of Babies A & B] on Facebook. She said that she had no memory of having done that, but accepted that if there was evidence from her computer, which there is, it must be right.

Ladies and gentlemen, Lucy Letby's interest in the families of the children who we say she attacked is another feature of this case that we will see more of as the evidence emerges. We suggest it is an unusual interest and we will see in due course that on some occasions she searched in quick succession for several of the families whose children's names appear on this indictment.

[Baby B], the second child, the elder sister by a minute or two of [Baby A]. If we go back to the indictment, ladies and gentlemen, you'll see [Baby B] is named in count 2. This count is different in one significant respect to any other count in the indictment. You'll see it's one of many allegations of attempted murder, but the dates, you will see, are between 8 June and 11 June. The reason for that is that the events in which we allege Lucy Letby tried to kill [Baby B] happened at about midnight on the 9th into 10 June. I don't know how long ago this practice originated, but the convention when drawing dates in indictments is that you go one day before to one day after. So it's not that we're saying she's done something over a period of 4 days, it is that the event, the specific events happened at about midnight, we can't say for sure, just before or just after midnight, 9 to 10 June. So that's the only respect in which this count differs from others.

[Baby B] required some resuscitation at birth, but she recovered quickly and stabilised. She was admitted to nursery 1 in the

neonatal unit at 30 minutes of age and she was originally given breathing support by use of a ventilator.

Dr Harkness tried to fit a line into her belly button but failed and so he inserted what's called a long line, an intravenous line, through which fluids were successfully provided to [Baby B]. [Baby B] needed more help than [Baby A] with her breathing, but that help was by stages reduced and by 9 June, the day after [Baby A]'s death, she managed periods of independent breathing. All her observations were normal and she was stable.

So we come to the night shift of the 9th into 10 June, which of course is the night shift after the death of her brother. [Nurse A], who had been the shift leader the previous night, was given responsibility, she was the designated nurse for [Baby B]. Lucy Letby was the designated nurse for two babies in nursery 3, which you'll remember I referred to earlier, rather inelegantly, as the growing rooms.

Shortly before midnight, it was noted that [Baby B]'s blood oxygen levels had fallen to 75%. That's what the doctors refer to as desaturation. The nasal prongs that were giving her additional oxygen were somehow dislodged from her nostrils. So on seeing that, [Nurse A] repositioned [Baby B]'s head and the prongs and [Baby B]'s blood oxygen saturation went up to a normal level. At 5 minutes past midnight, Lucy Letby started a bag of feed called Babiven on [Baby B] with [Nurse A]. Babiven is a type of liquid feed that's given to a child through a line that goes into the circulation.

At 16 minutes past midnight, Lucy Letby, even though she wasn't [Baby B]'s designated nurse, took [Baby B]'s blood gases. About 28 hours after [Baby A] had died, at about half past midnight, 30 minutes past midnight on 10 June, the alarms on [Baby B]'s monitor started sounding and [Nurse A] was called over by Lucy Letby to [Baby B]'s incubator.

[Baby B] wasn't breathing. An emergency crash call was put out at 00.33, and [Baby B]'s saturations, the amount of oxygen in her circulation, was down to 50%. She was blue, she wasn't breathing, and she was limp. [Nurse A] began resuscitation and she noticed a rapid colour change in [Baby B]'s skin, with purple blotches and white patches all over her body. You've heard that before.

[Baby B]'s heart rate dropped. The nursing notes were made by [Nurse A], the designated nurse, and they were written up at about 7.30 the following morning at the end of the shift. In a witness statement she made about 3 years later, she said that she and Lucy Letby had been preparing antibiotics at the time

[Baby B] had collapsed and that neither she nor Lucy Letby were by [Baby B] at the time the alarm sounded.

Dr Lambie, the registrar, had attended and put a tube down [Baby B]'s throat and connected her to a ventilator. [Baby B] recovered quickly and once she'd been resuscitated her heart rate increased, her breathing resumed and she became very lively and required minimal breathing support after that. She was given some fluids, that improved her circulation, and there was a reduction in the skin discolouration by the time [Dr B], the on-call consultant, had arrived.

Subsequent routine blood tests were all normal apart from in one respect a finding which the experts suggest may not be unusual in a child of [Baby B]'s age. Other investigations were normal: the X-rays, brain scan, heart scan. But the consultant, [Dr B], noted that there were loops of gas-filled bowel. The bowel, the intestines, loop in your lower abdomen. And that's a finding that you will hear time and time again in this case.

The remainder of [Baby B]'s clinical course passed without incident apart from three episodes of self-correcting breathing problems, which didn't involve the drop in heart rate, and that was all days later.

[Baby B] improved and she was discharged on 9 July and she mercifully doesn't appear to have suffered any adverse consequences of the severe oxygen starvation that happened to her.

The independent experts examined [Baby B]'s case. Dr Evans concluded that [Baby B] was subjected to some form of sabotage before and after midnight on the night of the 9th to 10 June. He thought that [Baby B]'s airways may have been blocked and that she may have received a dose of air into her bloodstream. On balance, he favoured some form of sabotage after midnight.

Dr Bohin thought that an obstruction of [Baby B]'s breathing would cause sudden desaturation and a reduction in heart rate but concluded that that wouldn't account for the skin changes that had been seen. She agreed with Dr Evans that whilst it was possible that [Baby B]'s airway was obstructed, that alone couldn't account for her sudden collapse, and Dr Bohin observed that the sudden onset of this discolouration to the skin, in association with a steep collapse, followed by a relatively quick recovery, is rare and only explicable by her having been given a dose of air into her bloodstream.

It's not just the speed of the collapse, ladies and gentlemen, but the speed of the recovery sometimes. And Dr Bohin noted that a bag of fluids had been connected to [Baby B]'s long line at

about 00.05 and that that would give the opportunity, or the cover, to someone for deliberate introduction of a dose of air into the bloodstream.

After all, ladies and gentlemen, the same thing had happened with [Baby A] the night before, hadn't it?

Dr Kinsey, the blood specialist, noted the account of the skin discolouration and she explained that by saying that if air was injected into a vein, it would pass through the circulation to the heart, going into the right side of the heart, which would cause problems with the blood vessels of the lungs. But in a newborn, there is a naturally occurring hole in the heart and that means that air that's injected into a vein can cross from the circulation of the veins into the circulation of the arteries, the circulation going out.

So in other words, blood returning to the heart passes straight out again without being oxygenated by the lungs. And that air going in like that would account for the changes in skin colour, as had been described by those who had seen it. But also no blood disorder would account for it, so whilst [Baby B] and [Baby A]'s mum had a blood disorder, the blood disorder could not account for what had been seen.

The staff on duty were the consultant, this time [Dr B], registrar Dr Lambie, the senior house officer Jian Minh Hor, and the nurses Kathryn Percival-Ward, who was the shift leader, [Nurse A], Lucy Letby, Mary Griffiths, with the nursery nurses Lisa Walker and Cheryl Cuthbertson-Taylor.

So we can already see, ladies and gentlemen, by incident 2, the doctors are different from the previous night. As for the nurses, three of the more senior nurses from the night [Baby A] died were working, and one of the nursery nurses.

When Lucy Letby was interviewed, she was asked about the circumstances surrounding the connection of this bag of liquid, this bag of feed, at 00.05. She looked at some paperwork for what's called a lipid syringe. A lipid syringe is a liquid that is added to the total parenteral nutrition bag. It gives you fats that you'd get from milk that you can't get from these bags of total parenteral nutritional Babiven, essentially.

She was asked about this prescription and said that it wasn't her writing, but she was the person that had signed for it and that:

"Ideally, it should have been co-signed by somebody."

The rule, ladies and gentlemen, is for things being given by nurses to little babies, two people need to sign. Nobody had co-signed for this.

It was also clear from the records, from the handwriting she accepted was hers, that she had been conducting observations on [Baby B] at 1 am, just after [Baby B] had collapsed, and yet [Nurse A] had been the designated nurse. She, Lucy Letby, told the police officers that [Baby B] had exhibited "similar mottling", was the word she used to describe it, to her brother [Baby A] the day before. So similar skin blotches to [Baby A] the day before.

And contrary to what [Nurse A] said, Lucy Letby said it was [Nurse A] who'd alerted her, Lucy Letby, to the problem with [Baby B]. This is important, isn't it, ladies and gentlemen? Because if it's always Lucy Letby that's there when things happen, you might be tempted to draw what we suggest is the obvious conclusion.

In the June 2019 interview, Lucy Letby said that it was her signature on the blood gas record at 00.15 on 10 June, just before [Baby B] collapsed. So she's hooked her up to the line at 5 past. At quarter past, the blood gas record, her signature, just before [Baby B] collapsed. So here we have an example of Lucy Letby signing the charts for a baby who wasn't her designated patient, who was in a different room to her designated patient, at a time just before the baby collapsed, a baby who had the same symptoms, albeit mercifully not the same result as her twin brother, who had been Lucy Letby's designated patient the night before. So you can see now the second case in, starting to see the coincidences between what was going on.

In November 2020, she was asked about a handover sheet relating to [Baby B] that had been found at Lucy Letby's home address during a search. When she was arrested, her home and other premises with which she had an association had been searched and in those searches, documentation connected to many of the cases that you will be considering was found.

To be fair, there was lots of documentation relating to other children as well whose name do not appear on this indictment. On this occasion, the sheet she was asked about shows that on the night of the 9th to the 10th, she had been the designated nurse for two babies in room 3. Do you remember me saying? So here we have her involved with [Baby B] just before the collapse, not the designated nurse, [Baby B] not even in the same room as the children that Lucy Letby had been designated to look after.

So ladies and gentlemen, taking a step back for a moment, it's easy to get sucked in by the detail in this case, but important

always to keep a sense of perspective. Here you can see that we have a pair of twins who were born prematurely and in pretty good condition. No one expected them to face grave problems, yet both suffered unusual symptoms within a short time of each other, which in interview Lucy Letby said were similar.

The prosecution's experts say that the collapses and skin mottling were the result of air being injected into their bloodstream. The first injection caused the death of [Baby A]. The second, the dangerous and life-threatening collapse of his sister, [Baby B]. We say that there is no plausible explanation or no plausible alternative to the explanation that this was the result of air being injected into the circulation.

The fact it happened in two cases just over 24 hours apart shows that these were not accidents. Lucy Letby was the only person with [Baby A] at the time he collapsed and she was in the room when the same thing happened to [Baby B], with the records written at the time showing her having treated [Baby B] just before she collapsed. We suggest you will be able to discount the possibility that different people were responsible for what happened to [Babies A & B] because air embolus is so rare and medical and nursing staff are all well aware of its dangers.

We also say that you are entitled to look at the evidence of what happened to [Baby A] and [Baby B] in the context, first, of what Lucy Letby did to other children and, two, most starkly, to the evidence that she was the poisoner who poisoned [Baby F] and [Baby L] with insulin.

My Lord, I'm going to move on to the third case now.

MR JUSTICE GOSS: That's a convenient point to break off because I know what's coming and the next event will take some time to get through. It's also hot in here today, this afternoon. I'm sorry about that. I plead with those who are able to control the temperature, but I think they're powerless as well to do anything about it, so it does get a bit hot. It's another reason for not going on too long in the afternoon. We'll just do the best we can.

So please do remember those instructions that I've given you in relation to your responsibilities as a juror and bear in mind we are at the very earliest of stages of this case. You have so far just heard a fraction of the prosecution opening in this case, none of the evidence at all, and it will be on the evidence that you judge this case. All right? This is just an introduction to the way the prosecution is putting its case and explaining to you the circumstances and the evidence they anticipate will be placed before you.

Remember in particular, if you do see any reports of this case, be very cautious, it's very selective, any report is very selective. I have just looked on a website during the course of the afternoon and there was a mistake in the report there, not intentional, I know how it's arisen, but you will decide this case on the evidence and not, as I say, on anything you might read. I'm not encouraging you to read anything about it, but it's entirely a matter for you. If you do, it comes with the warning that I have given you.

So take those documents with you again. I would ask you between now and when we resume again at 10.30 tomorrow just to go through them again to remind yourselves because they are so important, so you have them well in your mind.

Tomorrow we will not be sitting beyond 3.45, so we will finish by 3.45 tomorrow afternoon, because I then have two other commitments that I have to deal with, work commitments, until the early evening. So we'll finish a bit earlier tomorrow. All right? I'm just giving you that notice, I said I'd give you notice, so there we are. Thank you very much. Be ready, please, to come into court at 10.30 tomorrow.

(In the absence of the jury)

The report that I read, I'm not going to provide details of it because it's been corrected since I read it, but when it was first reported it said the case -- it referred to your opening and then said the case continues on Monday. I rather think that someone had had access to your opening note, was quoting from it, and anticipated that it had been delivered before today or someone had just not -- a sub-editor had not looked at it. But it just shows one has to be very careful and sub-editors in particular have to be very careful.

MR JOHNSON: I don't think anyone's had access to it before today.

MR JUSTICE GOSS: It's probably force of habit, "The case continues on Monday". It now says, "The case continues". So it's just that if people spot that. As I say, I'm not going to say any more about it. I know that people try hard, but sometimes those that are in court aren't actually responsible for what is actually published all the time and other people add little bits in. All right. Thank you very much.

There's nothing else, is there?

MR MYERS: My Lord, no, thank you.

MR JUSTICE GOSS: Thank you very much. Tomorrow, as you've heard me say, we won't sit beyond 3.45, so we will again have one session in the afternoon. I'll see how we go in the morning, whether we have a break in the morning.

MR JOHNSON: It's so hot in here for the jury, it's hard work.

MR JUSTICE GOSS: Maybe we'll have a slightly longer lunch break, we will just see, because of the logistics of breaking off.

All right. Thank you very much indeed.

MR MYERS: Could you ask for the dock officer to wait for one moment, please, before they leave?

MR JUSTICE GOSS: Yes.

MR MYERS: Thank you. I apologise for that.

MR JUSTICE GOSS: It's all right. It's just ensuring that you will be able to see the defendant, yes. I'll clarify that tomorrow and I say that at each break, unless a contrary indication is given, someone will want to see her.

MR MYERS: We'd be grateful. Thank you, my Lord.

MR JUSTICE GOSS: Can you remind me in the morning? I'll make a note anyway. All right. Thank you very much indeed.

(4.05 pm)

(The hearing adjourned until 10.30 am on Tuesday, 11 October 2022)