

11 October 2022
Prosecution Opening Speech (continued)

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Housekeeping

Tuesday, 11 October 2022
(10.30 am)

(In the absence of the jury)

Housekeeping

MR JUSTICE GOSS: Sorry we're a few minutes late, Mr Johnson.

MR JOHNSON: My Lord, we have paginated versions of the glossary now which, if your Lordship approves, we can ask the jury to replace before we go any further.

MR JUSTICE GOSS: Certainly. What I suggest we do is, when the jury comes in, ask them to remove the current contents of section 2, pass them all up before they get the new ones.

MR JOHNSON: Yes.

MR JUSTICE GOSS: We'll do that. Thank you.

Jury in, please.

(In the presence of the jury)

MR JUSTICE GOSS: Good morning, members of the jury.

There's going to be a bit of paperwork moving now.

Mr Johnson is going to explain it to you. Do you remember I said the glossary should be paginated? We'll deal with that first.

MR JOHNSON: We'll deal with that first if we can, please.

Because these bundles are yours, ladies and gentlemen, sometimes the court staff may change things, but we, as in the lawyers, will never touch them or never see what you write. So any notes you make are always yours and are always confidential to you.

Can we ask you to remove -- unless you've made notes on a specific page, can we ask you to remove just the pages behind section 2? So this document (indicating).

So not the tabs themselves, but simply the pages. If they could be passed down to the end of the row.

(Pause)

As everything in court, it takes a long time, so we're now going to give you the replacements.

You're now getting a practical demonstration of why most of the documents in this case are going to be on iPads. Imagine if we were doing this with piles and piles of lever arch files. You'd never escape!

(Pause)

Opening by MR JOHNSON (continued)

MR JOHNSON: As we go through, ladies and gentlemen, I'll be repeating quite a lot of things in terms of the terminology. It's not because I think you're daft, it's because I'm well aware from personal experience that a lot of the terminology in this case are things that people who are not medics just don't know. Sometimes a bit of repetition helps to reinforce some of the important points, so when you get to hear the evidence about the children, you already have a reasonable working knowledge of what people are talking about.

The witnesses will explain as we go along, but sometimes repetition of the important terms at an early stage can help us all, not least me.

So if we can just open the glossary at page 2 because there's something I'm going to come to in a second, just while you've got it there. I'll direct you to it in a minute. But I'm going to move on now to the third child, who is [Baby C].

The charge, the count, relating to [Baby C] is count 3 and the allegation is that Lucy Letby murdered [Baby C] on 14 June 2015.

[Baby C] was born on 10 June 2015. He, like so many other of the children in this case, was premature. His gestational age was 30 weeks and 1 day. You'll remember, I told you yesterday, 40 weeks is the standard, if there is such a thing, length of pregnancy. Anything 37 weeks plus is regarded by the medics as a full term baby. So significantly premature at 30 weeks and a day.

He was born to [Parents of Baby C], his parents, and [Baby C]'s growth in the womb had been restricted because of a problem with the placenta. The placenta, you all know without me telling you, I'm sure, is sometimes referred to as the afterbirth.

[Baby C] weighed 800 grams when he was born, so that's less than 2 pounds in imperial measurements. But despite that, he was born in good condition. He didn't require any resuscitation at birth and he had high Apgar scores.

You can see on that second page that I have just asked you to keep open in the glossary that the Apgar test is a scoring system that evaluates the physical condition of the newborn child at 1 minute after birth, 5 minutes after birth and also 10 minutes after birth. You'll hear these scores being given in evidence in due course, but for present purposes all you need to know is that his scores were good. So premature, but in good condition.

He, that is [Baby C], was admitted into nursery 1 of the neonatal unit. He began to show signs of breathing distress and so was intubated. Intubated means a tube was put down his throat to help him breathe. So put on to a ventilator to help him breathe.

He was also given a drug or a substance which is called surfactant, and this is something that you will hear mentioned in many of these cases. If you go to page 22 of the glossary:

"Surfactant is a naturally occurring protein that helps to reduce surface tension in the lungs, thereby keeping the lungs open and closed [I think it should say]. It is missing in premature babies, therefore artificial surfactant is given to prevent babies developing stiff lungs."

So putting it in more straightforward language, it's a protein that helps the lungs and therefore helps the baby to breathe.

The following day after his birth, so 11 June, the tube was taken out -- the doctors would say he was extubated -- so "ex", as in out, "tube" -- and put on a form of breathing support called CPAP.

He had a line, a catheter, in through his belly button, which was designed to give him fluids and medicines. That fell out at about 6 o'clock in the morning on 12 June -- so this is now day 3 for [Baby C] -- and that caused him a brief period of hypoglycaemia, low blood sugar. You'll find all these terms in the glossary, so hypo, low, glycaemia, low blood sugar. Hyperglycaemia, high blood sugar.

So a long line, so another intravenous line, was fitted to [Baby C], and he was X-rayed, his abdomen was X-rayed, and the point of the X-ray was to check that the line was in the correct position. That X-ray showed that he had an abnormal build-up of

gas in his abdomen and his stomach was swollen and the loops of his small bowel, remember the intestines that go almost like a winding river down through the abdomen from the stomach to the rectum, there was gas in the small bowel. That can be -- this is a theme that you'll hear being developed in the evidence -- a feature of the sort of breathing support that [Baby C] was on.

The breathing support that [Baby C] was given was reduced and, having managed a period of independent breathing, so breathing without any support at all, he was placed on something called Optiflow, which is the least invasive form of breathing support. And that was by noon on 13 June. So day 1, when he was born, the 10th. Then 11th, 12th, 13th, so day 4 for [Baby C].

You'll remember me telling you yesterday that when nurses feed very small premature babies, they use the nasogastric tube, the tube that goes up the nose and down into the stomach. Before they feed, they'll draw it back, they'll suck the stomach contents out to see if there's any undigested food in the stomach. So for reasons that you'll hear explained in the evidence, very important. You'll hear me coming back and back and back to this point as I develop this explanation.

When they did this, when they -- they call it aspiration -- so when they sucked out the stomach contents, the nurse found some bile, traces of bile. If there are traces of bile in the stomach, that can be an early sign of something called necrotising enterocolitis.

If we just go to that in here in page 16 of the glossary, please. You'll see necrotising enterocolitis, often referred to as NEC, for obvious reasons, listening to me trying to say it, it's a serious gastrointestinal disorder where a portion of the bowel becomes inflamed and may die. It typically occurs in newborns that are either premature or otherwise unwell. Symptoms of NEC may include food intolerance, abdominal distension -- so swelling of the abdomen -- abdominal pain, blood in the stool, vomiting or bile aspirate, so what I have just said, bile being sucked up through the NEC (sic) before the feed. And it gives a number of other potential symptoms there.

Then the definition goes on to say it's:

"The most common gastrointestinal emergency occurring in neonates and affected infants will not tolerate their feeds or have progressive symptoms including aspirates [milk from the stomach after a feed because it's not been digested], abdominal distension... pain... and other evidence of (inaudible: coughing)."

Then at the end:

"It's a serious gastrointestinal emergency."

So any signs of NEC are taken very seriously.

[Baby C] was given treatment for that potential problem -- I say potential problem because it hadn't been confirmed -- and part of that treatment was to stop his feeds. Obviously, you don't want to be putting more food into an infant that's got a bowel problem for reasons that are probably so obvious they don't need me to explain them.

But by the evening of the same day, so we've gone from noon to the evening, [Baby C] was fine and the decision was taken to start milk feeds again and he was doing well.

The night shift of the 13th into the 14th, so 8 pm to 8 am, you will remember, is one of the few shifts in this case that we don't have records of which child was in which of the four nurseries. So this is -- there's a gap in the records for this particular shift.

A nurse called Sophie Ellis was allocated responsibility for caring for [Baby C] in room number 1, so she was the designated nurse. And Sophie Ellis was less qualified than Lucy Letby. Do you remember me telling you about the hierarchical structure yesterday? Number 6 at the top, 4 in the middle, and the sub-division of 5s, the 5 with the ICU training, which Lucy Letby was one of those, and the 5s without that qualification.

But Sophie Ellis, albeit she wasn't as well qualified as Lucy Letby, was given the care of [Baby C] because he was stable. So it's not simply a question of looking at where a child is in terms of which room they're in, but there is an assessment by the medical staff of whether a child is stable or unstable. Again, this is something we'll come back to as we go through the explanation.

Lucy Letby was the designated nurse for another child and I'll use this child's initials for the reasons I told you yesterday. We'll call him JE. JE was in room 3. So if you were to look at this simplistically, you'd say [Baby C] in room 1 is in a worse condition than JE, who's in room 3. But as a matter of fact, on this occasion, that wasn't the view of the medical staff. Because although JE was in room number 3, [Nurse B], who was the shift leader, who was the senior nurse on duty, had assigned him to Lucy Letby because, in [Nurse B]'s opinion, [Baby C] was of more concern and he appeared to be deteriorating at the start of the shift.

Did I say [Baby C]? I meant JE was deteriorating, sorry. So JE in room number 3. Lucy Letby looking after/designated to JE. He is deteriorating and the sign of deterioration in his case was that he was grunting. In this context, grunting means that there are breathing difficulties. Okay? With these very small babies, if they make grunting sounds, that's a red flag for potential breathing problems.

So Lucy Letby was told that she needed to keep a really close eye on him because that was not normal behaviour for JE. That was a message that [Nurse B] had to reinforce later in the shift when it became apparent to [Nurse B] that Lucy Letby was ignoring what she'd been told.

[Baby C], on the other hand, was first fed milk that night at 23.00 hours, so 11 o'clock on 13 June. He was being given really tiny quantities. Sophie Ellis put half a millilitre of milk into his nasogastric tube, a tiny, tiny quantity. It goes into the tube and it passes down in a sort of syphon effect under the force of gravity -- the baby there, end of tube here, (indicating). It goes in and goes down under the force of gravity.

And 15 minutes after Sophie Ellis had given [Baby C] this tiny quantity of milk, she checked that he was stable and she left nursery number 1 to go to the nurses' station, which is just outside the room.

When she was there at the nurses' station, she heard the monitor alarm, the monitor that was connected to [Baby C]. She heard it alarm. And when she went back into nursery 1, there was Lucy Letby standing next to [Baby C]'s incubator. So Lucy Letby, who should have been in room number 3 and had been told off by [Nurse B] for not looking after JE who was grunting, had no business, we would say, with [Baby C], and yet when the alarm went off, there was Lucy Letby.

Lucy Letby said to Sophie Ellis, "He's just dropped his heart rate and saturations", so his heart rate had gone down, what the medics call bradycardia, so that's a low heart rate. Tachycardia, it's a phrase some people know probably, means a fast heart rate. So a brady or a bradycardia, low heart rate, "He's just dropped his heart rate and saturations."

So here we have, ladies and gentlemen, the third baby who had suffered a serious deterioration in that neonatal unit in a matter of less than a week and there again, at the bedside or at the incubator side, was Lucy Letby.

Nurse Taylor remembers being called over by Sophie Ellis about half an hour later. [Baby C] was desaturating, his heart rate

was dropping, and she used what's called a Neopuff device to try and help him with his breathing. I'm just going to show you part of a video, you'll see the full video in due course, but just to give you an idea of what I'm talking about by a Neopuff.

(Video played to the court)

There is sound that goes with this, but I'm just going to play you the video for now so you can visualise what it is I'm talking about.

So the working end, so to speak, or the important end is that little cup in the nurse's hand that goes over the mouth of the child. This gives oxygen to the child to help with resuscitation. So it's a non-invasive form of resuscitation that's used by the nurses to keep a child who is in crisis going until the doctors arrive because it's the doctors that are qualified to put in the breathing tubes, put the tube down the throat, and hook up the child to a ventilator.

When the Neopuff was used, [Baby C] quickly recovered, but within a short time again he had prolonged desaturation, so his oxygen content in his blood was falling and his heart was slowing again, and this time a crash call was put out.

Ladies and gentlemen, you might get the impression from what you've heard from me since 2 o'clock yesterday afternoon that babies collapsing in this way was a common event in a neonatal unit because this was the third that I've told you about in a few days. But this was the first time Sophie Ellis had ever seen a collapse and resuscitation. So one of the nurses who was there, this was the first time she'd ever seen it. That's how uncommon these events were in that unit, and yet three in a matter of days.

As [Baby C] collapsed for what proved to be the final time, Lucy Letby said to Sophie Ellis, "He's going, he's going", and she was right.

Now, evidence that the police subsequently obtained from a mobile phone that had been seized from Lucy Letby gives us and you an insight into what Lucy Letby was actually doing immediately before [Baby C] collapsed, as does material from the medical records of other children who were in the unit at the time.

You already know she was supposed, Lucy Letby was supposed, to be looking after JE in room number 3, but she didn't want that. Do you remember me telling you that [Nurse B] had told her off? Lucy Letby didn't want to be looking after JE in room number 3 because she texted an off-duty colleague saying that she, Lucy

Letby, wanted to be in room number 1, because it would be cathartic for her. In other words, it would help her well-being, she was saying, to see a living baby in the space that had previously been occupied by a dead baby, [Baby A], the baby that had died a few days earlier under her care. But [Nurse B] had put her in room 3, so she didn't like it.

In the records of JE, Lucy Letby recorded herself as having checked in on him at 10 pm, 22.00 hours. One of the observations that she recorded in JE's notes was that he was grunting. Do you remember me telling you, that's a problem? You might expect that in all the circumstances, and particularly after the death of [Baby A] and the near fatal collapse of [Baby B] a few days earlier, that would have caused her some concern and that she would have stayed with this child, who was exhibiting breathing problems, JE. But she didn't.

Between 10 pm and 11 pm she's recorded as having checked the medication for other babies, three other babies. They were in another room. But the medicines were stored in room number 1, where [Baby C] was, and at 10.21, she co-signed with [Nurse B] in the notes of yet another child.

Although she had no specifically allocated responsibilities in room number 1, Lucy Letby texted her friend at 10.34, 22.34, and she said:

"I've done a couple of meds in 1 [ie room 1], I'll be fine."

At 10.53 she texted:

"Just a shame I was on with Mel and [Nurse B]. Sophie in 1 so I haven't got her to talk to either."

At 11 pm, she was back in room number 3 with JE, and she took some observations from another child at the same time, who I'll refer to as PE.

At 11.09 she sent a text referring to the image of [Baby A], the dead [Baby A], that she had in her head from the week before and then texted her friend, "Sleep well", followed by two kisses.

[Baby C]'s collapse was documented in the notes and timed 7 minutes later, at 23.15, just before she uttered the line, "He's going".

Now, when the crash call went out, the senior house officer and the registrar responded promptly. They used what is called, what I'll probably mispronounce as a Guedel airway to help [Baby C] breathe. The registrar was a Dr Katherine Davis. She made efforts to intubate, to put a tube down [Baby C]'s throat, but

she didn't succeed, and the reason she didn't succeed was that [Baby C]'s vocal cords were swollen. When she looked -- the doctors look down the throat of the patient before they put the tube in. When she looked down she saw that [Baby C]'s vocal cords were swollen. This is another feature that we'll return to in other cases.

The consultant, Dr Gibbs, who was the senior, the most experienced consultant, attended. He successfully intubated [Baby C] and took over a prolonged effort to resuscitate him, but he did not succeed. Tragically, he did not succeed, and [Baby C] was pronounced dead after a long effort at resuscitation at 5.58 on the morning of 14 June 2015.

A post-mortem examination was conducted 2 days later. A Dr Kokai gave the cause of death as:

"Widespread hypoxic ischaemic damage to the heart/myocardium due to lung disease."

He gave some other contributing factors as well. But the important thing here, ladies and gentlemen, is [Baby C] did not have NEC. In isolation, you'll be wondering why I'm emphasising that. As we go through, you'll understand why that becomes an important fact.

The independent medical experts who reviewed these cases gave their opinions. Dr Dewi Evans thought that infection was a significant factor in [Baby C]'s collapse but did not adequately explain it and he expressed concerns about the cause of [Baby C]'s sudden deterioration. He concluded that the swelling to the gastric area that I told you about could be the consequence of using the breathing support, but he also thought it could be suspicious in the context of all the other cases that you are going to hear about. And importantly, he was of the view that the damage to [Baby C]'s heart was the result of rather than the cause of his collapse. So he was looking at the pathologist at the time's findings about hypoxic ischaemic damage to the heart -- in simple terms, lack of oxygen damage -- and he said that wasn't what caused him to collapse, that was the result of the collapse.

Dr Bohin, Sandie Bohin's view was that although [Baby C] had pneumonia at the time of his death she believed that was not the cause of death. She agreed with Dr Evans that infection was a contributory factor in the sense that it made [Baby C] less responsive to resuscitation and she agreed with Dr Evans that the damage noted to [Baby C]'s heart had occurred after he had collapsed and therefore did not cause it.

She couldn't identify any pathological process or condition to account for the inflation of [Baby C]'s gastric area. She thought it was too gross to be the consequence of CPAP.

She both agreed and disagreed with Dr Evans over the cause of that abdominal gas and thought that it could be a case of someone having deliberately inserted air into the nasogastric tube, into the stomach, but that wasn't the only possibility. And because Dr Bohin thought that this was very concerning and had no clear cause, she conducted a full review of the notes to determine whether or not the NGT, the tube, the nasogastric tube, had been on free drainage, what they call free drainage, at the time of or before the swelling that had been noted on 12 June.

Free drainage, in a very short explanation, and you'll get the proper explanation from the witnesses, not from me, but free drainage means almost what it says: if there's air in there, if the tube is on free drainage, if it's uncapped, the air can escape back through the tube. Okay? And if a tube's on free drainage, it means that if you get a build-up of air in the stomach then, rather than having to go through the intestines and out of the bottom end, it can come out through the tube.

Dr Bohin's close examination of the notes found a nursing record on 13 June, so the day before [Baby C]'s death, showing that the tube had been on free drainage and, more importantly, the nurses were aspirating the tube every 3 or 4 hours. In other words, they were deliberately pulling out the stomach contents every 3 or 4 hours up the tube to check that there was no excess gas or liquid. And when that was done every 3 or 4 hours, the aspiration, pulling up of the contents, yielded only small volumes, half of 1 millilitre.

So it follows from that, ladies and gentlemen, from the fact that this exercise was being undertaken every 3 or 4 hours, that any suggestion that the build-up of gas when [Baby C] collapsed had started with CPAP, with the breathing support, it doesn't work because if that was the cause, it would have been pulled out.

Therefore, a rather long run-up to the wicket, leads to the conclusion of Dr Bohin that the only feasible mechanism for the excessive air in [Baby C]'s gastrointestinal system, his stomach and his bowel, the only feasible explanation or mechanism for that at the time of his collapse was because someone had deliberately put air into [Baby C] down the nasogastric tube. In other words, [Baby C] was killed by air injected into his stomach through the nasogastric tube. So this isn't a case of injecting air into the bloodstream, this is a case of air going in through the NGT.

So it was a variation or a refinement of a theme that Lucy Letby had started with the [Babies A & B] twins. We will see, as we go through the balance of the 17 cases, this method being replicated on other children.

A radiologist, a doctor with expertise in interpreting X-rays and scans, Dr Owen Arthurs, looked at the scans of [Baby C] and he thought that what you could see was consistent with, not necessarily diagnostic of but consistent with, air being inserted into [Baby C] in this way down the nasogastric tube.

Dr Marnerides, who is the independent pathologist, concluded that the ischaemic changes to [Baby C]'s heart -- and "ischaemic" means changes caused by a lack of blood flow and a lack of oxygen -- were most likely caused by the prolonged unsuccessful resuscitation. So in other words, he agreed with Dr Bohin and Dr Evans that the heart problem was the result of the resuscitation; it's not the cause of the need for resuscitation. So the collapse was nothing to do with the heart problem.

He noted that the microscopic histological examination of the lungs confirmed that [Baby C] had pneumonia, but he concluded from all the findings that [Baby C] had died as a result of having an excessive quantity of air injected into his stomach, down the nasogastric tube, the NGT.

The effect of that, ladies and gentlemen, I don't know if you can visualise now -- in fact, if we can put it on the screen, please. It's the NGT video, please.

(Video played to the court)

This is subject to the expert evidence, okay, ladies and gentlemen? So health warning: a barrister telling you about the human body is not a reliable source. Okay?

You can see the stomach in green and you can see directly above the stomach, the heart. Thank you. Then to either side of the heart you can see the lungs. Between the lungs and the stomach is a sort of slightly crescentic muscle, which is the diaphragm, so it's under the heart -- that's it, so across there (indicating), running the full width almost of the body. Can you see what I'm talking about? It sort of goes like that (indicating) under the heart.

If you inflate the stomach with air, it expands like a balloon and it puts pressure on the diaphragm and it splints, we'll call it, the diaphragm. And it's the diaphragm that -- it's the use of the diaphragm that enables you to breathe. If you splint the diaphragm, you either reduce or eliminate its effectiveness and

it means you can't breathe. It's in effect putting pressure on the lungs. We'll get a proper explanation of this from the doctors, but that's the mechanism, if you like, of how inflating a baby's stomach with either air or milk or a combination of those two things will stop a baby breathing.

You can also put pressure on something called the vagus nerve, which also can slow the heart rate. It was that -- it was that inflation of the stomach that led to [Baby C]'s breathing being compromised and him then suffering a cardiac arrest. So if you're trying to murder a child in a neonatal unit, it's a fairly effective way of doing it. It doesn't really leave much of a trace.

The staff on duty in the unit at the time of [Baby C]'s collapse, or just after, were the consultant, Dr Gibbs -- I suppose he's a physician, not a surgeon. So Dr Gibbs, registrar Dr Katherine Davis, senior house officer Jian Minh Hor, the nurses [Nurse B], Lucy Letby, Sophie Ellis, Melanie Taylor and Nicola Dennison.

And even if you can't remember the names, ladies and gentlemen, you'll remember what I showed you yesterday, the correlation between these events and who is on duty. I think we're either -- I think Lucy Letby, by the third episode, is the only person who was present at this and the preceding two events. You can imagine how -- and you have seen in that table -- although she's there every time, the next highest number of times anyone else was there is much, much lower.

Lucy Letby was interviewed in July 2018. She confirmed that JE, the boy that she was looking after, had been in room 3. She denied that she'd had anything to do with [Baby C] other than during the resuscitation. She said that she'd not been the person who discovered the problem with [Baby C], although we say her texts put her in the room. She associated [Baby C]'s problem with his first feed, the implication being that she believed that this was a case of NEC. And she couldn't remember how it was that she had ended up in room number 1.

In an interview a year later, she said again that JE had been in room 3, she'd been his nurse, and then she said that she might have been in room number 1 because she was getting drugs from the cupboard or checking the resuscitation trolley, which was kept in room number 1.

She was then asked about the text messages, which by then the police had recovered from her phone. She said that she might have been sending them from the nurses' station and then gone into room number 1 "to do something else".

She then agreed in this second interview in 2019 that she'd been the only person in the room when [Baby C] had collapsed.

On 14 June, back to 2015 now, ladies and gentlemen, at 15.52, Lucy Letby had searched on Facebook for [Baby C]'s parents. That was the first of her days off, having come off duty at about 8 o'clock that morning. The timing may well suggest that having just done a night shift, it was one of the first things she did when she woke up.

So again, ladies and gentlemen, it's important always, we suggest, to keep a sense of perspective in this case. It's very easy to get dragged in by the detail. But there was and there is a pattern emerging, we suggest. So far as the nursing staff were concerned, Lucy Letby was the only person that was working when [Baby C] collapsed who had also been working when [Baby A] and [Baby B] had died and collapsed.

She was the only person in the room when [Baby C] collapsed, just as she had been by the side of [Baby A] when he collapsed and had been one of two in the room when [Baby B] collapsed. Not only did she have no reason to be in the room when [Baby C] collapsed, but she should have been in room number 3, keeping an eye on JE, having already been told off for failing to do so.

As I said earlier, we'll come back to the issue of the swollen vocal cords in [Baby C] that were seen by the doctor, who was trying to -- was it Dr Davis -- who tried to intubate [Baby C] when he first collapsed.

What we're going to see as we progress, ladies and gentlemen, is that Lucy Letby's method of attacking these children in the NNU was beginning to develop. She had injected air into the bloodstream of the [Babies A & B] twins. She'd varied that approach by injecting air down the nasogastric tube of [Baby C] and, as I said earlier, the method she used on [Baby C] was one she replicated in some of the later cases.

I'm going to move on now to [Baby D]. [Baby D] was born just less than a week after [Baby C] died. You will find reference to [Baby D] in count 4 on the indictment. This also is an allegation of murder. It's on page 2 of the indictment. The date of the offence, as you can see, is 22 June.

[Baby D] was a baby that would be classified as full term because she was born to [Parents of Baby D] at a gestational age of 37 weeks and 1 day. And she was delivered by C-section. The risk factor so far as [Baby D] was concerned, albeit she was full term, was that her mum [Mother of Baby C]'s waters had broken early and [Mother of Baby C] should have been given

antibiotics to stave off infection, but she was not. That failure is a legitimate target of criticism in her care.

But despite that fact, [Baby D] was born in good condition. She had a normal birth weight, but 12 minutes after she had been born, she needed some help because she lost colour and became floppy in her father's arms. She was put under observation because of the issue with her mum's waters breaking early and she began to show signs of respiratory distress, grunting. Do you remember JE in room 3? Exactly the same problem. And [Baby D]'s temperature dropped.

Those two factors should have prompted an immediate medical review as those two signs together are indicative of infection, which is the sort of problem you would expect or you would anticipate at least when a mother's waters break far in advance of giving birth. A review eventually took place when [Baby D] refused to feed and had poor colour. And because of these problems, [Baby D] was admitted into nursery number 1 at the neonatal unit and she was put into an incubator. She was given supplemental oxygen through that Neopuff machine that I showed you earlier, and she was fed by fluids and given antibiotics to stave off infection.

She developed a very high temperature and also had a high heart rate. And because of that, she was -- a tube was put down her throat, so she was intubated, and put on to a ventilator. In order to do that, the doctors essentially paralyse you so that you don't fight against the -- so that the child doesn't fight against the ventilator.

After that treatment was given, [Baby D] improved significantly, but was still affected by her infection, and although X-rays that were taken showed no obvious signs of infection, the clinical picture, what the doctors were seeing in the patient, in the sense of looking at the patient and how she was behaving, suggested that she had an infection. So that, ladies and gentlemen, was 20 June.

The following day, the 21st, [Baby D] was breathing for herself, so no tube, no supplemental oxygen, and what -- the doctors use a shorthand SVIA, self-ventilating in air. So doesn't need any extra oxygen, doesn't need any support in terms of a machine or anything like that.

So she managed that, which obviously is a good sign, she was then given a bit of extra support using the CPAP machine, but air -- so no extra oxygen, just the machine to help with the breathing.

Catheters were put into [Baby D]'s umbilical cord, so to get access, get a line in through the umbilical cord into [Baby D]'s vein system and her arterial system, so blood coming out and blood going back to the heart. And the test for infection showed a decrease in the markers for infection, signs of infection, to a low level, and other tests and observations were normal, and [Baby D] was started on feeds. So all good signs on 21 June.

The general picture was that although she was ill, [Baby D] was responding well to treatment and was not expected to deteriorate.

During the night shift of the 21st into the 22nd June, which was a Sunday, nurse Caroline Oakley was given -- was made the designated nurse for [Baby D], who was one of three children in room number 1. Nurse Oakley also had a child for whom she was the designated nurse in room number 2, a child who I'll refer to by the initials GC.

[Baby D] in room number 1, GC in room number 2, Caroline Oakley designated nurse for both. There were two other children in room number 1 with [Baby D]. The designated nurse for the other two was Lucy Letby. They were JE, who was the boy who had had the grunting issue when in room number 3 when [Baby C], we say, was murdered by Lucy Letby, and another child, ME. So JE and ME.

On that night shift, [Baby D] collapsed three separate times. The first at about 1.30 in the morning, the second at 3 o'clock, and finally at 3.45 on Monday, 22 June. On each occasion that [Baby D] collapsed, those who attended, the medics who attended, were struck by the sight of mottling and poor perfusion and brown/black discolouration to her skin, mainly over her trunk. We've heard that sort of thing before, haven't we?

The prosecution say this was another case of injecting a child with air into the bloodstream. So intravenous -- into the venous system -- embolus. Intravenous embolus, the same mode of attack that had been deployed with the [Babies A & B] twins.

Just coming back slightly, first collapse at 1.30. At 1.15, 15 minutes before [Baby D]'s first collapse, Caroline Oakley checked [Baby D]. At 1.25, 5 minutes before [Baby D]'s first collapse, the notes say that Caroline Oakley and Lucy Letby started an infusion for [Baby D]. In other words, a liquid going in through a line into [Baby D]'s bloodstream.

Remember [Baby A]? There is also a note in the feeding chart of an aspirate at 1.30, so this drawing-up of liquid through the nasogastric tube.

So Lucy Letby hands-on with [Baby D] in the minutes before she collapsed through an air embolus, we say.

Dr Emily Thomas, who made a note of 1.29 had noted an unusual rash, what she noted in the notes as "a spreading, non-blanching rash". When that was first noticed, Caroline Oakley, who you will remember was the designated nurse, and was responsible with Lucy Letby for starting the infusion at 1.25, when that was noted, Caroline Oakley was away from [Baby D]. So the designated nurse, out of the room. Because there is a record in the notes that Caroline Oakley made, saying that she was called back by Lucy Letby, and a nurse with the surname Percival-Ward.

There's a suggestion that the shift leader, [Nurse C], noticed that [Baby D] was stiff and had an odd discolouration of the skin. There's a note made by Lucy Letby in JE's records, one of the other children in room number 1, that she was engaged with him at the time everyone else was responding to the emergency with [Baby D].

Well, if Lucy Letby's note is right, how could she have been the person that called back the designated nurse? Unless of course what she wrote in somebody else's notes isn't true. We'll come back to that in the context of other cases. Unless she was setting herself up with an alibi in somebody else's notes: it couldn't have been me because at that time I was doing this with another patient.

We know what time the crash team arrived, the doctors arrived, because, as you would expect, you have to use a pass to get in and there is an electronic record. It's not an invariable record, it has to be said there are holes in the records, but we know on this occasion when the three doctors arrived because their security passes have registered on the system. And in that first episode, [Baby D] was successfully resuscitated. She settled back to normal with normal sats, normal saturations, the oxygen content of the blood, and normal blood gas results. But as I said, a further episode at 3 o'clock.

About 20 minutes before that, Lucy Letby and Caroline Oakley had administered some medication to [Baby D] and Caroline Oakley then updated the computer records for [Baby D] before going to another baby in room number 2, the baby ME. So Caroline Oakley again leaves the room. Lucy Letby, the designated nurse for the other two children in room number 1. So again immediately before the collapse, the second collapse of [Baby D] that night, the designated nurse leaves the room, leaving a single person in room. As always, we suggest Lucy Letby.

The medical team was called again when [Baby D] collapsed for the second time and they saw similar discolouration to what

they'd seen the first time, the signs, we suggest, of the air embolus, the air into the bloodstream, although it was said it was less severe than it had been on the first occasion.

This time, [Baby D] was distressed and crying. As you will hear from the experts, that can be a sign consistent with air embolus. Once again, [Baby D] was resuscitated, but Lucy Letby didn't leave it there. [Baby D]'s records show that at 3.20, Lucy Letby started another infusion for [Baby D]. We know that she remained in the room, if her records are accurate, because there's a record in JE's notes that she did something at 3.30 for him.

At 3.45, [Baby D]'s monitor alarmed again, and this was [Baby D]'s third and final collapse. When the medical staff arrived, when the doctors arrived, CPR was in progress, all resuscitative efforts were unsuccessful and, sadly, treatment was withdrawn at 4.21. [Baby D] was pronounced dead at 4.25 on 22 June. Her death was reported to the coroner and at the time the cause of death was given as pneumonia with acute lung injury.

So, ladies and gentlemen, in a two-week period, three children had died and one had had a life-threatening episode in the neonatal unit at the Countess of Chester Hospital, and Lucy Letby was the only constant presence.

These events and the records were again reviewed by independent experts. Dr Dewi Evans observed that [Baby D]'s clinical course, exhibiting a window of near recovery on two occasions followed by a third collapse, was not consistent with the fatal evolution of pneumonia.

If a child dies from pneumonia, ladies and gentlemen, where the symptoms are present at birth, the child tends to show a clinical course that's unrelenting and progressive, despite medical intervention. So in other words, a decline to death which isn't helped by doctors intervening. And that is patently obviously not the case with [Baby D]. And Dr Evans concluded that the discolouration, this fleeting rash observed by the treating medics was indicative of another case of air embolism.

Dr Sandie Bohin, the other independent paediatrician, noted that whilst there was clear evidence of infection, [Baby D] had improved after the first two interventions. In her view, in Dr Bohin's view, [Baby D]'s clinical status at 7 pm on 21 June was not that of a deteriorating baby who would be dead a few hours later.

Dr Bohin thought that this skin rash, this moving rash, was abnormal. She excluded the possibility of it being bruising because it disappeared and we all know, you don't have to be

doctors, we all know that bruising doesn't just disappear. And she thought that findings or observations at the time, findings on X-rays after death, were all consistent with Dr Evans' view that this was a case of intravenous air embolus.

In case it's a question that's occurring to you, ladies and gentlemen, Dr Bohin's view was that injecting a child of this size with as little as 3 to 5 millilitres per kilo of air is sufficient to kill. It doesn't take much. And Dr Bohin refers to published medical texts about air embolus, in which on very, very rare occasions there are documented cases of accidental air embolus, but the subject of air embolus often exhibits signs of extreme terror, it's a physiological response. She thought that was consistent with what was being described about [Baby D].

Ladies and gentlemen, this isn't just looking at one case this isolation. We say you have to, and you should, look at what happened to [Baby D] in the context of what had gone before and what was to follow.

Dr Marnerides, the pathologist, phrased it this way: that [Baby D] died with pneumonia, not from pneumonia. It's a bit like the heart issue with [Baby C]. He was of the view that this was a case of deliberate injection of air into what he refers to as a vascular access line. In other words, a line that gives access to the vascular system, to the bloodstream. That sort of thing just doesn't happen by mistake.

Dr Arthurs, the radiologist who looked at the scans or the X-rays taken of [Baby D] after her death, saw gas in the bloodstream. He was of the view that what he could see was compatible with, consistent with air embolus, but there were other possible explanations. But he did say that he'd not ever come across a baby with this amount of gas in one of the great vessels of the body for which no cause was found.

None of the medical staff on duty that night had been on duty when the [Babies A & B] twins had suffered death and collapse or when [Baby C] collapsed and died. As for the nursing staff, the only nurse other than Lucy Letby who'd been on duty on any of the previous three cases was Kathryn Percival-Ward, who'd been working the night [Baby B] collapsed, and Elizabeth Marshall, the nursery nurse who'd been on when [Baby C] had collapsed. So two of the other staff had been working one each of the other three incidents.

In the aftermath of [Baby D]'s death there were many messages sent by Lucy Letby to her friends. [Nurse A], one of the other nurses, had queried what had happened to [Baby D] in the context of what had happened before to [Baby C] and to the [Babies A &

B] twins. And Lucy Letby suggested that they were all clearly explicable by natural causes.

When she was interviewed by the police, Lucy Letby accepted that her signature was on some of the documents in [Baby D]'s records in the early hours of 22 June. She said that she didn't remember where she'd been at 1.30 that morning when [Baby D] had first collapsed and said, "I cannot remember how I got involved". But she did confirm that she would have had to use a syringe in the intravenous port to do what she had signed as having done. So she had access to [Baby D]'s bloodstream at the time that we say somebody injected [Baby D] with air.

She seemed to accept in interview that she'd administered medication with a syringe at 5 minutes before the first collapse when [Baby D]'s designated nurse was absent.

In the June 2019 interview she said she couldn't remember calling Caroline Oakley back when [Baby D] had collapsed, Caroline Oakley was the designated nurse, but it was possible that she had. She said she had no recollection of [Baby D] independently of the medical records, and the police were showing her the records when they were interviewing her, just so you understand. She ended that interview by saying that if [Nurse C] said that she, Lucy Letby, was in room 1 alone with [Baby D] at the time of the collapse then she must have been. So she seemed to accept that she was in the room alone at the critical time.

In November 2020 it was put to Lucy Letby that she had searched Facebook for [Baby D]'s parents in the aftermath of [Baby D]'s death. She said that she couldn't remember doing that, but she accepted that she had done and she could not explain why she had done it. Ladies and gentlemen, we suggest that if, as a nurse, you searched for the family of a baby that you had seen die, you would know and remember why you'd done it.

She was asked about messages she'd had with one of her colleagues on 22 June, the day [Baby D] died, in which she described:

"A weird rash looking like overwhelming sepsis."

And she said she couldn't remember having formed that opinion.

She was asked about other messages or another message in which she'd referred to "an element of fate [an element of fate] being involved". She said that it was fate that babies get unwell sometimes, but she would have liked -- sorry, she would have to know the context.

Well, we say that, tragically for [Baby D], her bad luck or fate was the fact that Lucy Letby was working in the neonatal unit that night.

So again, just taking a step back, back from the detail of [Baby D]'s case, [Baby D] is case number 4. So far we have three allegations of injecting small babies with air into their bloodstream and one of injecting air into the stomach. The [Babies A & B] twins, [Baby C] and [Baby D] were all children who deteriorated catastrophically, yet none was expected to have serious problems. Only [Baby B] survived and only Lucy Letby was the constant presence.

We suggest that you'll have to assess all that in the light of -- for the reasons we will see we are suggesting that Lucy Letby was the insulin poisoner as well.

MR JUSTICE GOSS: Mr Johnson, I think we'll have a short break because it's approaching midday and we've got another hour in the conventional morning session. We'll have just a 15-minute break for people who wish to make themselves comfortable if they wish to. You know what I mean by that, and just stretch your legs before we move on to the next count. All right? I'm told that you can be taken somewhere nearer to this court for this time where there will be facilities if you need them.

But it's just nice to stretch your legs and refresh yourselves before we continue.

(In the absence of the jury)

I think from what happened yesterday, would it be possible for the defendant to remain up here rather than be taken down? There will be facilities if necessary for any of you that need them. Good. Thank you very much indeed.

(11.57 am)

(A short break)

(12.13 pm)

MR JUSTICE GOSS: Yes, thank you.

(In the presence of the jury)

Mr Johnson.

MR JOHNSON: [Baby E], please, ladies and gentlemen. If you look on the indictment you'll find his name on page 2.

Count 5, the allegation of murder on 4 August. So moving on about 5 or 6 weeks from the case of [Baby D].

[Baby E] was born on 29 July, so he lived for about a week. He was a gestational age of 29 weeks and 5 days when he was born to [Parents of Babies E & F]. [Baby E] was one of twins. You'll remember his twin [Baby F], I told you about yesterday, was one of the two that were poisoned with insulin, so this is [Baby E].

[Baby E] weighed 1,327 grams, so just under a kilo and a half. To old people like me, that's just less than 3 pounds. He cried at birth, which you'll know is a good thing. He had a good heart rate. His saturations then dropped a bit and he was given some oxygen, but his Apgar score at 5 minutes was good and he was quickly weaned to air and transferred to nursery 1. So breathing in air, which you now know is a good sign.

He was at risk of NEC, this bowel issue, and because of that he was started on antibiotics. He was given intravenous fluids and he was given caffeine as a stimulant. A nasogastric tube, NGT, was put in on 29 July, and a long line was put in, through which he was given fluids successfully on 30 July.

He was breathing independently by 30 July, but on that day he experienced a mild transient, temporary high blood sugar, so hyperglycaemia, which was corrected with a very, very low dose of insulin.

He was started on milk on 31 July, being given tiny quantities, like you've heard before, half a millilitre every 2 hours. If you think of a teaspoon of medicine, most of you who have kids will remember the Calpol dose of 5 millilitres. Well, a tenth of that is what he was being given every 2 hours.

On the night of 1 August he had two small vomits and lots of air was aspirated, brought back from his nasogastric tube, but otherwise his feeds were well tolerated and they were increased step by step to 2 millilitres every 2 hours. And that was by 3 pm on 3 August, so the day before he died.

The entries in the nursing notes show that he was stable, despite being on that tiny dose of insulin to correct his high blood sugar.

The night shift of the 3rd to the 4th of August. He and his brother [Baby F] were the only children in nursery 1. And until 11 pm, Lucy Letby was the designated nurse for both. At about 9 pm on 3 August, the twins' mum, [Mother of Babies E & F], decided to visit the boys in the neonatal unit. We say that [Mother of Babies E & F] interrupted Lucy Letby, who was attacking [Baby E]. She didn't realise it at the time, but I'm

going to explain why we suggest you can be confident that is what happened.

When [Mother of Babies E & F] arrived, [Baby E] was acutely distressed and he was bleeding from his mouth. Remember the swollen vocal cords of [Baby C]? [Baby E] was bleeding from the mouth. [Mother of Babies E & F] remembers that Lucy Letby tried to reassure her, telling her that the blood from the mouth was because the nasogastric tube was irritating [Baby E]'s throat. "Trust me, I'm a nurse." That's what she told [Mother of Babies E & F].

Lucy Letby told [Mother of Babies E & F] that the registrar -- remember what I said about consultants aren't on the ward at night? -- the registrar, so the senior doctor on duty, would be down to review [Baby E] before urging [Mother of Babies E & F] to return to the postnatal ward because [Mother of Babies E & F] was still an inpatient herself on the maternity ward. And [Mother of Babies E & F] did as she was told. [Mother of Babies E & F] was so worried about what she'd seen that she phoned her husband, and her phone records prove that she made the call at 11 minutes past 9, 21.11.

The call lasted 4 minutes and 25 seconds, we know, because it's in the phone records. Whilst that call was going on, back in room number 1 at the neonatal unit, Lucy Letby made a note in [Baby F]'s records. So not [Baby E], [Baby F]. She timed that at 21.13, so this is after she'd got rid of [Mother of Babies E & F].

We say that the presence of blood round the mouth of [Baby E] and the timing of this event are important because the next time [Mother of Babies E & F] remembers seeing [Baby E] was when he was in terminal decline later that night. And you may think she'd have a pretty good reason to remember.

Now, two separate records, nursing records, were made by Lucy Letby, both timed at 4.51 the following morning. So we're moving on in the timeline, if you like, about 8 hours or so. This was after [Baby E] had died. I'm going to tie this all up in a minute.

The later nursing note records the following -- and I'm just going to show it to you so you can get an idea of what we're talking about. Let's look at it. It says:

"Patient notes. Family communication. Created on 4 August at 4.51. LL [Lucy Letby]. 4 August 15."

And the time 4.58. No doubt we'll hear some evidence about this, but that might suggest that the note is created at 4.51 and in

fact entered into the system at 4.58. Anyway, it's about that time, whatever.

What it says is this -- so just remember what I've just told you about what [Mother of Babies E & F] remembers, okay? She went down at 9 pm, found her son with blood, very upset and, we suggest, was fobbed off by Lucy Letby.

Do you remember me saying to you earlier in relation to one of the other children that what Lucy Letby writes in the notes isn't always necessarily true? Let's see what she wrote in the notes here:

"Mummy was present at the start of shift, attending to care."

So that's 7.50 or 8 o'clock, that's the start of the shift:

"Visited again approx 22.00 hours. Aware that we had obtained blood from his NG tube..."

This isn't blood round the mouth, is it, this is blood coming up from the tube according to the note:

"... and were starting some different medications to treat this. She [that's mummy] was updated by Registrar Harkness..."

Registrar Harkness was never seen by [Mother of Babies E & F] at that stage:

"... and contained [Baby E]."

That's a reference to containment, holding, to calm a baby down:

"Informed her that we would contact her if any changes. Once [Baby E] began to deteriorate, midwifery staff were contacted. Both parents present during the resus."

So the note made by Lucy Letby suggests that [Mother of Babies E & F] was there between about 7.30 and 8 pm and that she returned at 10 pm. Neither is true. There's no mention in the notes, is there, of blood round [Baby E]'s mouth at 9 o'clock? And no mention in the notes of the visit by [Mother of Babies E & F] at 9 o'clock. But this was no figment of [Mother of Babies E & F]'s imagination because what you don't know, and what you're about to find out, is that 9 o'clock was a very important time in the life of [Baby E] because it was the time he was due to be fed and he was being fed by his mother's expressed breast milk.

[Mother of Babies E & F] says that that is the reason that she went down at 9 o'clock because her son was to be fed and she was providing the milk. The fact that [Mother of Babies E & F]

called her husband at 9.11 fits with that timeline as well, doesn't it? It fits with [Mother of Babies E & F]'s timeline. It doesn't fit with Lucy Letby's fraudulent timeline.

But in the other part of Lucy Letby's notes following [Baby E]'s death, she wrote this. It's at page 2592:

"Prior to 21.00 hours feed..."

Can you see that in the second line there?

"... 16mls mucky, slightly bile-stained aspirate..."

So this is something coming up the NG tube, do you remember?:

"... obtained and discarded. Abdo soft, not distended. SHO [senior house officer] informed to omit feed."

So that's the order given by the senior house officer.

Again, we say this is a fraudulent note. It is false, it is misleading and it is designed to cover her tracks because it fails to mention that [Baby E] was bleeding at 9 o'clock and it mentions a meeting between Dr Harkness and [Mother of Babies E & F] that neither Dr Harkness nor [Mother of Babies E & F] remembers.

If we look at the feeding chart next, please, ladies and gentlemen. This is a handwritten chart that records information at 9 o'clock.

Can you see -- you can see [Baby E] at the top is his name. Then towards the bottom that's highlighted in yellow, "Feeds". NGT, you can see nasogastric tube is the means by which [Baby E] is being fed. In the bottom line, the signature line, we've got the signatures or the initials of the nurses who are doing various things.

If we go along the top line, which is next to the date, you can see the times running from 1 in the morning through to midnight on the far right-hand side. If we go across to 21.00 hours, please -- and can you highlight that column? Thank you.

You can see the shift change is noted in the sense that the nurse's initials at 7 o'clock are different to the nurse's initials at what's been manually altered from 20.00 hours to 20.15 at the top. So in other words, Lucy Letby taking over from 8 o'clock, which is when the night shift starts.

What you can see is the volume of feeds that was being given to -- sorry, the volume of fluids that was being given to [Baby

E] via the line. Can you see where it says Babiven, the top left? Can you highlight -- thank you:

"Babiven via LL."

Via long line in this context. Okay?

So we can see if you look in the total volume -- well, actually, underneath where it says Babiven you can see 7.5:

"7.5 millilitres per hour of Babiven."

Then if we go to the line below that, it's total volume, which is the volume through the day, it's a running total. We can see that by 21.00 hours, 156mls of Babiven had been received by [Baby E] through his long line.

Where it says the 21.00 hours feed, it says "omitted" just by where the cross is. Can you see that? So this fits with [Mother of Babies E & F], doesn't it? She was there for the 9 o'clock feed, she was fobbed off. That's why [Baby E] didn't get his milk.

Then underneath that, you can see "discarded 16 ml mucky"; do you see that? Then in the 10 o'clock column next to it, "15ml fresh blood", all in Lucy Letby's handwriting.

The SHO, senior house officer, that Lucy Letby says advised her to omit the 9 o'clock feed, was a Dr Wood, who has no recollection of giving advice to omit the 9 o'clock feed. He, Dr Wood, was on the paediatric ward, not on the neonatal unit, for most of the night until [Baby E] entered his terminal decline and he believes that the only time he, Dr Wood, would have had anything to do with [Baby E] before the emergency was in a secondary role to Dr Harkness, the registrar, who conducted an examination of what Dr Wood remembers being at about 10 o'clock.

Dr Harkness, the registrar, he didn't come on duty until 9 o'clock, the time when the feed should have been taking place, the time when [Baby E] had the blood round his mouth. He reviewed [Baby E] at 10.10 and he made a note. What Dr Harkness noted was:

"Large, very slightly bile-stained aspirate 30 minutes ago."

So that would be 9.40, not what Lucy Letby is writing in her -- what I've characterised as a fraudulent note:

"Sudden large vomit of fresh blood [is what Dr Harkness wrote at 10.10] plus 14ml aspirate."

[Dr C], the on-call consultant, says that Dr Harkness told her in a phone call at the time that some blood and bile-stained fluid had come up [Baby E]'s NGT, and Dr Harkness recalls being told that [Baby E] had suffered a blood-flecked vomit and he recalls the review as having been between 10 pm and 10.30.

Dr Harkness doesn't remember any blood on [Baby E]'s face but regarded what he saw initially as undramatic. But about half an hour later, Dr Harkness remembers that there was a large amount of fresh blood which had come up [Baby E]'s NGT tube, or NG tube, I should say, different to Lucy Letby's entry on the feeding chart there. And this was the first indication of a serious problem so far as the medical staff were concerned.

There was a further loss of 13 millilitres of fresh blood at 11 o'clock. It doesn't sound a lot, does it? But in a small baby, we're talking of huge amounts here. Dr Harkness had never seen -- an experienced registrar had never seen a baby bleed like this, a small baby bleed like this.

Subsequent expert evidence establishes that adding the quantities of blood together that are recorded, this would have represented a combined loss of over 25% of [Baby E]'s circulating blood, and that figure is probably an underestimate because it doesn't include, doesn't take into account that not all the blood could have been brought up the NGT.

At 11.40, [Baby E] suffered a sudden desaturation to 60%. His heart rate went down to 80 to 90 beats per minute. Over his abdomen, what do you think they saw?

"Striking discolouration with flitting white and purple patches."

Dr Harkness had seen [Baby A] as he died. What he saw reminded him of what he had seen.

Medical staff started full CPR. At that stage there was no output at all from [Baby E]'s heart. His saturations were dropping inevitably and he continued to bleed during resuscitation. Interestingly, and although she was participating in the resuscitation of [Baby E], at the same time Lucy Letby co-signed for medication being given to a child in nursery number 4. That's at 00.38, 2 minutes after full CPR started for [Baby E].

[Dr C] came in, the on-call consultant. She did her best, but all efforts to revive [Baby E] were unsuccessful. Treatment was withdrawn at 1.23 and [Baby E] was pronounced dead at 1.40 on 4 August.

[Dr C], the consultant at the time, regarded [Baby E] as high risk, who had shown signs of NEC, that's necrotising enterocolitis, bowel disorder, and the cause of death was certified as NEC and prematurity. The parents, for perhaps understandable reasons, didn't want to have a post-mortem and the consultant, [Dr C], didn't deem one necessary and the coroner's office agreed. Subsequent reviews have established that was a big mistake, no PM.

The medical experts, the independent medical experts, have reviewed this case and they disagree fundamentally with the treating doctors' diagnosis of NEC.

Dr Evans. In his opinion, [Baby E]'s sudden death was the result of a combination of air embolus and bleeding and the bleeding was indicative of trauma. Remember [Baby C]'s swollen vocal cords, which we are going to see again as we go through more of these cases. Dr Evans concluded that the air embolus was most likely intentionally introduced to [Baby E]'s bloodstream through an intravenous line. And because there hadn't been a post-mortem, no one could say from an examination whether [Baby E] -- or from physical signs within [Baby E] where any trauma might have been or exclude NEC.

Dr Bohin also disagreed with the suggestion that [Baby E]'s was a case of NEC and she agreed that the cause of death was air embolus and bleeding. She concluded that the cause of the bleeding was unknown but acknowledged that there were fleetingly rare possible natural causes, which in the absence of a post-mortem couldn't be excluded. She discounted trauma secondary to forceful insertion of the nasogastric tube as a potential cause for any gastric haemorrhage and she concentrated, this is Dr Bohin, on this discolouration to the abdomen and concluded that this was a clear case of air being introduced to [Baby E]'s circulation.

Dr Marnerides, the pathologist, couldn't contribute to the debate due to the absence of a post-mortem examination. In other words, there were no findings that a pathologist had made at the time which could be reviewed and he, in a rather understated way, thought that the absence of an autopsy was "most unfortunate". He too remarked on the description of purple discolouration around the time of [Baby E]'s deterioration, and he said from his specialist pathologist's point of view he could not identify, in the materials he had been given, any other findings which would justify a view that the death of this baby may have been due to unnatural causes and therefore he says from his point of view all he can say is unascertained.

Dr Arthurs, the radiologist, reviewed two X-rays taken before [Baby E]'s death and said he has concluded that they show no

specific abnormality and do not show features of NEC and that they neither support nor refute the hypothesis of a gastrointestinal bleed.

You have to look at it in the context of all the other cases, don't you, ladies and gentlemen? The staff on duty at the time of [Baby E]'s collapse and death, the consultant [Dr C], the registrar Dr Harkness, the house officer Dr Wood, nurses Belinda Simcock, Caroline Oakley and Lucy Letby and two nursery nurses, Lisa Walker and Valerie Thomas. And of them, those nurses, ladies and gentlemen, Caroline Oakley had been on the shift where [Baby D] had died and Lisa Walker had been working when the [Babies A & B] twins had been attacked. As always, Lucy Letby was the constant presence.

Lucy Letby was interviewed, of course. She said she could remember [Baby E]. She said that on the night shift of 3 and 4 August, [Baby E] had been stable when she had taken over his care. She said there had been nothing of concern before the large bile aspirate that she had noted in the records. Well, you know what we say about her records.

She said that she and Belinda Simcock had disposed of the aspirate and the advice had been to omit the feed. So no one else, any doctors, had seen it. She said that [Baby E]'s abdomen was becoming fuller and, minutes later, there was a purple discolouration, so she'd asked Dr Harkness to review [Baby E]. That's not the way [Mother of Babies E & F] tells it, is it? She said that she'd got blood from the NG tube too, she was asked specifically about the retrospective notes that she made that I have shown you a few minutes ago, and said that if there'd been any blood before 10 o'clock she would have made a note of it. Contrast that to what [Baby E]'s mum saw, what concerned her so much that she rang her husband.

She thought that it had been Dr Harkness that had spoken to [Mother of Babies E & F]. She said that had the bile aspirate -- sorry, she said that she had the bile aspirate first and that had been prior to the 9 o'clock feed which had been omitted. And she said it was after 9 o'clock that the senior house officer had reviewed [Baby E], but she couldn't recall whether the review had been face to face or over the phone.

She said that she could remember [Mother of Babies E & F] leaving after the visit that she said was at 10 o'clock, the visit that [Mother of Babies E & F] puts at 9 o'clock.

In the interview of June 2019 she was pressed about the conversation that she was saying she'd had with the senior house officer, Dr Wood. Do you remember? "Omit the feed", that conversation that she said she had. She said that she had no

independent memory of it but that she wouldn't have put it in the notes if it hadn't really happened, a note that was made after [Baby E] had died at 4.31 in the morning.

She said that she couldn't remember [Mother of Babies E & F] coming into the room at 9 o'clock with milk, nor [Baby E] being upset with blood coming from his mouth. She said she didn't know why she would have said that [Baby E]'s problems were anything to do with a nasogastric tube and that she wouldn't have told [Mother of Babies E & F] to go back upstairs.

On being pressed, she said that if she had seen blood in or around [Baby E]'s mouth she would have suctioned it and escalated it to the more senior nursing staff and/or to a doctor.

So ladies and gentlemen, this is why we say [Mother of Babies E & F] interrupted Lucy Letby attacking [Baby E]. You have a stark contrast, don't you, between what mum says, what [Mother of Babies E & F] says, and what Lucy Letby says? You know [Baby E] was due to be fed. You know he was due to be fed expressed breast milk. You know that the milk was coming from [Mother of Babies E & F] and you know, we say, that that was the reason [Mother of Babies E & F] was there at 9 o'clock. A visit that has been wiped out of the records, didn't happen so far as Lucy Letby is concerned, because she knows, we say she knows, the consequences of [Mother of Babies E & F] being right about this.

The night her son died, she wouldn't (inaudible). The phone call doesn't prove it necessarily but it's consistent with it. Why else was she calling her husband at that time? Was she simply (inaudible). Why was Lucy Letby saying, I wouldn't have sent her away?

In November 2020, another issue. She was asked about Dr Harkness' statement in which he'd said he'd been shown what's classified as a dirty aspirate, a blood-flecked aspirate that had come out through the NGT at 10 o'clock. She confirmed that Dr Harkness was right. She was asked why it was she'd sent a text referring to [Baby E] that queried whether he had Down's syndrome, to one of her colleagues about [Baby E], whether he had Down's syndrome. And she said that she couldn't remember whether anyone had ever mentioned something like that in the notes.

Lucy Letby took a very unusual interest in the [Babies E & F] family and she did social media searches on [Mother of Babies E & F] and her husband on 6 August 2015, 2 days after [Baby E] had died, on 23 August, on 14 September, on 5 October, on 5 November, on 7 December and even on Christmas Day 2015.

There were further searches in January 2016. And whilst her interest in [parents of Babies E & F] was limited to social media, we suggest her interest in [Baby E]'s twin [Baby F] was more sinister and it may be that I can deal with that after the short adjournment.

MR JUSTICE GOSS: Yes. That's the next count on the indictment. We'll move on to that. It is shortly before 1 o'clock, but it's obviously appropriate to break at that particular point rather than start and take that up again after the break.

I'm going to say -- and you'll remember that this afternoon we're going to finish by 3.45 at the latest, it's a slightly shorter day. I'm going to see whether -- and I'll say this, that we'll start again, can you be ready, please, to start again at 2.05? We'll see whether we'll have a break in the afternoon or not.

It's an hour and 35/40 minutes to the end of the session, if we go as far as that time. But I'll see if it's necessary to have a break or not, but we'll see how Mr Johnson is.

How you are, all right? If we finish slightly earlier but don't have a break then that's another way of doing it. We'll just see how you go. Thank you very much.

Please remember -- this is going to be the first significant break since yesterday evening when you're going to be out and about. Please remember, I take it you all still have with you "Your responsibilities" or "Your obligations as a juror" and that printed note I gave you of the important instructions that you must obey? In particular no discussion, even with each other, about this case and certainly no research into anything to do with this case or anyone involved in this case. Thank you very much.

(12.56 pm)

(The short adjournment)

(2.05 pm)

(Delay in proceedings)

(2.17 pm)

(In the absence of the jury)

MR JUSTICE GOSS: I'm not going to spend time now enquiring as to why we're nearly 15 minutes late sitting. I'll investigate that at the end of the day. All right, thank you.

I did receive an email from a representative of a well-known media organisation, are you aware of this, apologising?

MR JOHNSON: I heard about something to do with Sky News.

MR JUSTICE GOSS: Yes, a live blog and inadvertent reference to -- I'll deal with it later.

(In the presence of the jury)

MR JUSTICE GOSS: I'm sorry you've been kept waiting, members of the jury. The consequence is we will sit through the afternoon, we won't have a break, and we'll go on to a convenient point up to 3.45.

MR JOHNSON: Welcome back, ladies and gentlemen. We're on to count 6 now, please, which you'll find on page 3 of the indictment. This relates to [Baby F], who is of course the twin of [Baby E], about whose case I gave you an introduction just before we separated.

[Baby F] is one of the two insulin cases, so important in the overall context. It's an allegation, as you can see, of attempted murder on 5 August, and by reference to count 5, concerning [Baby E], this was the day after [Baby E] had been killed, murdered we say, by Lucy Letby.

Of course, being a twin, [Baby F] was born at about the same time as [Baby E]. He was marginally the younger of the twins. He required some resuscitation at birth. He was later put on to a ventilator and given that protein, surfactant, which you'll remember is the thing that's given to premature babies to help with their lungs. You remember us looking at that this morning in the glossary.

But his initial blood gas readings were within normal range. The breathing tube was taken out on 29 July, so the same day that he was born, at about 10 pm. But he had continuing breathing problems, so the medics re-intubated him. But he was in reasonable shape, his blood sugars were recorded as stable. But then between 3.40 and 6.20 on the morning of 31 July, so 2 days after his birth, he had high blood sugar readings and was prescribed a tiny dose of insulin to help correct it.

By the time his breathing tube was removed -- sorry, at about that time his breathing tube was removed, but he was given some breathing support, and thereafter he tolerated small amounts of breast milk and he was given fluid nutrients, it's called total parenteral nutrition, TPN for short, also known as Babiven, and

that comes out of a bag via a tube into the body, so that was a supplement for his nutrition.

If it's known in advance, so if the medics have some warning that a particular baby can't take milk for whatever reason and needs to be fed through fluids, then the TPN bag is prepared in the pharmacy unit of the hospital. The system is that a doctor has to write a prescription for TPN, the prescription goes to the pharmacy, the pharmacy prepares the bag and sends the bag back on a daily delivery up to the ward. The bag is individualised, it's a bespoke bag prepared for an individual patient. Okay?

If for whatever reason the medics don't know that there is going to be a need for total parenteral nutrition to be used for a specific baby, they do have a couple of stock bags on the ward. They're non-specific, they've not been -- nothing's been added to in the pharmacy, or shouldn't have been added to in the pharmacy, and they are kept in reserve.

Just to give you an idea of what we're talking about, I'm going to show you a little representation of what it is we're talking about. This is what a TPN bag looks like. You can see underneath that there are in effect three separate ports. Convention dictates that nothing is added to any of these bags on the ward. Okay? So it absolutely shouldn't happen. If anything is added to one of these bags, it must be done in the pharmacy in the hospital.

But despite the fact that that is the convention, one of the ports -- and I think it's the one in the middle of the three -- is a port that you can, as a matter of fact, if you wanted to, insert a syringe with a needle. So the needle goes through the port into the bag, and you can inject medicine or whatever into these bags, but it doesn't happen on the wards. If anything has to be added, it has to be added in the pharmacy.

As a matter of practice in the hospital, insulin is never added to a TPN bag. So not only not added on the wards, because nothing should be added on the wards, but even within the pharmacy the pharmacist would never put insulin in a TPN bag. Because insulin, when it is prescribed for a baby, has to be given via its own infusion and it's usually put into a syringe on a syringe driver which delivers an automatic dose over a period of time.

One of the primary reasons that insulin is never added to a TPN bag is because of the chemical make-up of insulin and the chemical make-up of the plastic that is used in the bags and in the tubes and in the delivery hardware that actually goes into the baby. Insulin can stick to the plastic or bind to the

plastic, so that makes it more difficult to calculate precisely what dose you're giving and that in turn makes it unreliable, which in turn defeats the object of giving insulin in the first place. All right? So insulin never goes into a TPN bag.

You know from what I told you this morning that on 4 August, [Baby E] had died. Later that morning, on the 4th, the pharmacy unit received a prescription for a TPN bag for [Baby F]. As you can imagine, in a hospital, there are very heavily regulated protocols as to how things are dealt with. Records are kept, sterile atmosphere, all that sort of business.

And a confirmation -- on 4 August at 12.32, a confirmation document was printed relating to the production of a TPN bag for [Baby F] and the pharmacist made a handwritten correction to the label to go on the bag that that bag was to be used within 48 hours of 23.30 that day, so on the late evening of 4 August.

Now, as a matter of practice, they tend to hang the bags at midnight, but because midnight can cause confusion about which day it is if you put a date on, is it midnight at the end of the day or the beginning of the day, they put 23.30. So as a matter of practice they do it at midnight, but they write on the bag 23.30 for the time so there's no mistake as to how long the bag should last.

This particular bag, having been produced this afternoon, went up to the ward on a delivery run at about 4 pm. So the bag goes up to the ward, 4 pm on 4 August. And it was that night, so the night of the 4th into 5 August that [Baby F] was on the ward and his designated nurse was [Nurse A]. [Baby F] was being cared for in room number 2 and he'd been moved out of room number 1 where [Baby E] had died into room number 2.

Lucy Letby had a single baby to look after that night, so the night of the 4th to the 5th, and I'll refer to that baby by the initials ME. That baby was also in room 2, so [Baby F] had come out of room 1 into room 2. ME in room 2, designated nurse Lucy Letby. That particular night, the records suggest that there were seven babies in the unit and five nurses working.

Lucy Letby and [Nurse A] signed the prescription chart to record the fact that the TPN bag that had come up from the ward at 4 o'clock was started and administered via a long line at 00.25 on 5 August. And that, as I say, would have been the bag that had come up in the afternoon from the pharmacy.

I'm just going to show you the chart now on the screen, so you've got an idea of what I'm talking about. If we can just make it slightly bigger, please. Can we have the whole thing just a bit bigger if possible?

So this is my highlighting, ladies and gentlemen. The original doesn't have the highlighting on. In the top right-hand corner you can see it says:

"[Babies E & F] twin 2."

Which is a reference to [Baby F].

Day 6, you can see, was 3 August. And a child's life -- day 1 is the day they're born and so on.

Then you can see how much TPN was prescribed to [Baby F] per day: 74.7 millilitres per kilo per day. The rate was 4.46 millilitres per hour. The doctor prescribing the TPN was Dr Ventress. Underneath the TPN line you can see "lipid". Lipid is a substance that's given to babies who are not on milk, so it gives them -- essentially, in layman's terms, it gives them the fats that you'd get from milk that you need, which aren't in TPN. So that goes separately.

You can see that that has been zeroed off by Dr Ventress as not required because, as I have already told you, [Baby F] was getting some milk, so he was getting his fats, but he needed more nutrition, hence the TPN bag.

Just going back to the top line where it has Dr Ventress' signature, we can see that at midnight on the 4th, in other words the 3rd into the 4th, Lucy Letby signed for "continuing 48-hour bag". That tells us that the normal practice is for one of these bags to last 48 hours. Okay?

Then go down the page, please, to day 7, which is those two. There's actually one that's been -- can we have them both, please?

Day 7. We can see two prescriptions this time. What we see in the top half is a prescription -- sorry, it was Dr Ventress before, this time it's Dr Gail Beech. We can see the rates. We can see no lipids required and Dr Beech has also written in "not required". Underneath we see a second prescription at a different rate this time and this one signed by Dr Wood. Dr Wood is the same senior house officer that Lucy Letby said she spoke to about [Baby E]'s problems. Do you remember me telling you Dr Wood didn't remember a conversation with Lucy Letby about [Baby E]?

What we see there looks unusual, we suggest, because we can see that towards the right-hand side of the page, after Dr Beech's signature, we can see that on 5/8/15 at 00.25, Lucy Letby -- and the other signature is [Nurse A]'s signature -- they sign at

00.25 for putting up this bag. But underneath, a different prescription, written apparently by Dr Wood, where that's also been signed for at 00.25. But the difference between the prescriptions here is no lipids on the first but lipids on the second. Can you see Dr Wood has prescribed the lipids underneath the Babiven?

It looks like Dr Wood's signature is timed at -- you can be the judges of what it actually says -- at 01.00, or is it 03.00, there on the far right-hand corner of that orange box, which would be 2.5 hours or so after the bag had been hung.

Whatever was going on with this bag, at 01.54 which, if the timings on the time the bag was hung are correct, in other words if the bag was hung at 00.25, an hour and a half later, at 01.54, [Baby F]'s heart rate surged, it went up, and his blood sugar went down. And although she wasn't [Baby F]'s designated nurse, because she had the other baby in room 2, Lucy Letby signed the observation charts at 5.00 in the morning on 5 August, and her shift ended at 8 o'clock that morning.

On the day shift, on the morning ward round, the consultant, Dr Saladi, instructed the nursing staff to stop this bag and to provide [Baby F] with dextrose, which is essentially a sugar solution. The purpose of giving him a sugar solution was to counteract this steep drop in [Baby F]'s blood sugar. He told the nursing staff to move the TPN bag to a different line, what they call a peripheral line, whilst a new long line was put in. So Dr Saladi realised there was a problem, he realised that he needed to correct the drop in blood sugar, told the nursing staff to put in a new line and he gave or he commissioned others to give dextrose to [Baby F].

At about 11 o'clock that morning, fluids were stopped for [Baby F]. The nurses who did that at 11 o'clock -- so the day shift had been well on by this stage, on since 8 -- were [Nurse C] and Shelley Tomlins. They believe that a new -- not only was a new line put in, but they also would have hung a new TPN bag. So this bag that I'm going to suggest was the bag that someone had put insulin in was taken off and a new bag was put on. The reason for that is that it is the practice in the neonatal unit that if ever a new line is put in, then a correspondingly new bag is put in as well.

Other than the handwritten note, so far as the new bag was concerned, there's no contemporaneous note of precisely what did happen, although the convention appears to be in the records that if a new bag is hung -- sorry, there is silence if it's a new bag and the fact that it's a continuing bag would be noted. So there is silence as to whether or not there's a new bag, but

that silence appears, on the conventions that applied at the time, to indicate that it was a new bag.

Anyway, the new bag was hung, and thereafter [Baby F]'s blood glucose increased before falling back at 2 o'clock and 4 o'clock.

Whilst that was all going on, another prescription had been written. That had been sent down to the pharmacy and that was for a further TPN bag made specifically for [Baby F]. Once again they put a label on it. There was the correction that I have told you about before to eliminate the risk of misunderstanding about the times, and that second bag would have gone back up to the ward at 4 o'clock on the 5th.

Given that that bag didn't come up until that time, it follows that that bag that came out of the pharmacy cannot be the bag that was fitted on to the line at 11 o'clock. Okay? It's not straightforward. You're going to hear a lot of evidence about this. I hope I'm making sense. So bag 1, hung at midnight, taken off at 11.00, either that bag or a stock bag put on. Second bag, prescription sent down, that bag doesn't come until 4 o'clock.

So you've got a drop in blood sugar after bag 1 goes up. New line, new bag. Blood sugar continues to go down. Then there's a third bag coming up at a later stage.

So the point here, ladies and gentlemen, just to make it clear, is that the blood sugar started to drop calamitously while Lucy Letby was there, but continued after she'd gone. So the question is how did that happen?

It could happen in a number of ways and I'll come to that, but the blood sample that was taken -- a blood sample was taken from [Baby F] at just before 6 o'clock that evening. In other words, about 16 hours or so after that bag was hung, into which we say Lucy Letby put insulin. And that blood sample taken at about 6 o'clock returned a blood glucose level which was very low, very low. So low that if it had remained untreated, it may have caused convulsions, coma, a cessation in breathing, irreversible brain damage and death.

Once that level of blood sugar returned the analysis, which is virtually immediate, a bag of sugar water, dextrose, was put up. So taken off the TPN altogether, put on to dextrose. By 7.30 pm, [Baby F]'s blood sugar levels were virtually normal. So disconnected from the TPN, on to dextrose, within a short period of time virtually normal blood sugar. And he had no further episodes of hypoglycaemia at all.

These events were sufficiently concerning to the medical staff that they ordered a check of what's called his plasma insulin level and the level of another hormone called C-peptide. In most people, if you're not diabetic, your healthy blood glucose levels, your blood sugar levels, are maintained naturally by the body's production of the hormone insulin. You probably all know that already.

But what you may not know is that when your body produces insulin, it also produces another hormone called C-peptide, and once produced, both insulin and C-peptide break down in the body at similar rates and so the proportion of insulin in your blood is directly proportional to the proportion of C-peptide. The amount of insulin is directly proportionate to the amount of C-peptide.

If you're diabetic and you don't produce your own insulin, then your blood glucose levels may be managed by taking synthetic insulin, by injecting insulin, and synthetic insulin or exogenous insulin, insulin coming from outside, doesn't come with C-peptide. Okay? So it follows from that slightly complicated explanation that if your blood is analysed for insulin, the analysis can tell whether your insulin is natural or if it's synthetic or from the outside, exogenous insulin.

So if somebody has an abnormally high insulin level in their blood, together with a very low level of C-peptide, it must be that they have been given or have taken synthetic insulin. Okay? So high insulin with low C-peptide, only conclusion is it's synthetic insulin.

The blood sample taken from [Baby F] at just before 6 o'clock returned a very high insulin measurement of 4,657 and a very low C-peptide of less than 169. And that, we say, and we don't anticipate that anybody's going to dispute this, at least, means that somebody gave [Baby F] synthetic insulin, somebody poisoned him.

All experienced medical and nursing members of staff would know the dangers of introducing insulin into any individual whose glucose levels are within the normal range and they would know that hypoglycaemia, low blood sugar, over a prolonged period of time, carries life-threatening risks. No other baby on the neonatal unit at that time was being prescribed insulin. [Baby F] therefore couldn't have received the insulin that was intended for somebody else by negligence. And as I have already told you wouldn't have had it put, even if it was a negligent but well-intentioned act, it wouldn't have gone into the TPN bag anyway.

To give insulin to [Baby F], whoever did it would have had to access the locked fridge on the ward. They would have to use a needle and syringe to remove some insulin from the ampoule in the fridge and either inject it into the TPN bag, that yellow bag that we saw on the screen -- and the stock TPN bags, as a matter of interest, are kept in the same fridge as the insulin. Or, if they didn't do it that way, they'd have to go to the cot side and inject the insulin directly into the infant, either through a IV line or an intramuscular injection or, and this is what we say happened in this case, inject it into the TPN bag so that it went with the nutrition through the line on a regular basis into the baby.

Both prosecution independent paediatricians concluded that the combination of this grossly elevated insulin level, together with the low C-peptide level and the very low glucose level, was consistent with [Baby F] having received synthetic insulin from the TPN bag, just prior to the discovery of his low blood sugar. It can't have been an accident. And you know who was in the room and you know from the records who hung the bag.

One of the questions may be whether it went into one bag or two bags, whether it went into the bag that was hung at midnight and whether it also went into the stock bag in the fridge, so if the bag was changed, the stock bag also had insulin in it. We'll see how the evidence emerges on that issue.

But the fact that this was synthetic insulin, the prosecution say, is conclusively proved by the evidence of a doctor called Professor Peter Hindmarsh. Summarising what Professor Hindmarsh says, he identifies first of all this disparity between the high level of insulin and the low level of C-peptide and says, well, that means that this must be a case of synthetic insulin. But Professor Hindmarsh takes it a bit further because he says it has to have gone in through the TPN bag rather than through the other possibilities because the low blood sugar, the hypoglycaemia, went on for such a long period of time and it went on for such a long period of time despite the fact that [Baby F] was given five separate injections of 10% dextrose and he was on a dextrose or glucose bag as well to up his blood sugar.

Professor Hindmarsh put his mind to the issue of how it could be that if the original bag had been changed, how could it be that the problem, the hypoglycaemia continued, despite the fact that the original bag had been changed. He comes up with a number of possibilities. The first is that the original bag wasn't replaced, it was simply carried on. The second is that the stock bag in the fridge, which happens to be where the insulin is kept, had already been contaminated with insulin. And the third possibility is that some part of the giving set, which is the

bit that goes into the patient, was contaminated by insulin from the first bag and that insulin had bound to the plastic in the giving set and therefore continued to leech out of the plastic, even though the bag was changed and the second bag didn't have insulin in it. So it's all a bit of a headache, but it's this point about the binding of insulin to plastic that introduces the third possibility.

But the bottom line, ladies and gentlemen, we say, is that there can be no doubt that somebody contaminated that original bag with insulin and that because of that, and because of the possibility that the stock bag was contaminated as well, the problem continued through the day.

This case, [Baby F]'s case, will have to be considered, and I will consider it, tomorrow in conjunction with [Baby L]'s case, because [Baby L], you will remember from what I told you yesterday, is the other baby who was poisoned with insulin and you'll remember that only two people that were on the [Baby F] shift were on the [Baby L] shift and one of them is sitting in the dock. Okay?

So moving on to the interviews, Lucy Letby was, in July 2018, asked about this particular night shift of 4 into 5 August. She confirmed that she remembered [Baby F]. She said she had no recollection of the incident other than looking at the notes there. She said she'd not been [Baby F]'s designated nurse and had not been involved in his care other than as shown by the notes.

She was asked about that chart that I have just shown you, showing the TPN bags. She said that TPN was kept in a locked fridge next to the nurses' station in the equipment room. She said that the insulin was kept in the same fridge. She confirmed that her signature was on the TPN form with [Nurse A] and that's what we've just seen. She said she had no independent recollection of having had any involvement with administering the contents of the TPN bag to [Baby F].

She confirmed that she had given [Baby F] glucose boluses, so injections of glucose, at 3.50, 4.10 and 4.20, so even though she wasn't his designated nurse she was giving him the glucose boluses following the discovery of his hypoglycaemia.

She confirmed that at 5 o'clock that morning on that shift she'd taken observations of [Baby F] and was "hands on with him" at that time. She suggested that she must have been doing all that for someone who was on a break. She said that the blood sugar reading that she'd taken at 5 am was "a little bit low", to use her phrase, and she confirmed that it was her signature on the

fluid charts for [Baby F] at 3.50, 4.10 and 4.20, all of which reflected treatments for low blood sugar.

And later in the interview, she confirmed that she'd signed for a lipid syringe. Do you remember the syringe that sometimes goes with the liquid feed, the TPN, for a baby that isn't getting milk? That lipid syringe had been given to [Baby F] the shift before, at 01.10 in the morning on 3 August.

I just want to show you that, please. Again with my highlighting. You see at the bottom -- well, let's go down. It's prepared on 31 July, at the top, for use on 2 August. Here you can see on the next highlighted bit:

"For administration up to 48 hours commencing 23.30 hours on the 2nd."

That's the manual correction that I was talking about that is replicated on the TPN bag as well.

The hole in the page which has been photocopied should say "lipid" there:

"Lipid feed volume: 15 millilitres per kilo, supplied in a separate syringe."

And you can see at the bottom in handwriting "lipid" and then a number, "3/8/15, 0010", and that's Lucy Letby's signature. She should have got somebody else to co-sign that and she didn't.

She accepted that that signature tended to suggest that she had administered it. Interestingly, at the end of that interview, this is the 2018 interview, she asked the police whether they had access to the TPN bag that she had connected. So the TPN bag that we say someone, she, had put insulin into, she was asking the police in the interview, "Have you got the bag?"

In the June 2019 interview, she said that the order of signatures on charts, you see the double signatures, didn't necessarily identify who had administered the treatment and who was co-signing for a treatment. And she agreed that the idea that insulin had been administered accidentally could be excluded because all the nursing and medical staff knew the dangers and the idea it was happening by mistake is just not feasible.

In November 2020 she was asked why she had searched on social media for [parents of Babies E & F]. Remember me telling you about this just before we broke for lunch? She said she didn't remember doing it and thought it might be to see how [Baby F] was doing.

She was asked some texts she had sent or a text she sent to a colleague about [Baby F]'s blood sugar levels and that had been at 8 o'clock after her shift and said, "Well, I must have looked on his chart".

Ladies and gentlemen, I'm just taking a step back again. Once again a case involving a child for whom Lucy Letby was not the designated nurse, but in whom she clearly took a close interest. We say for reasons that are self-evident on the facts of this individual case, but for reasons that I'll expand on when we get to [Baby L], that there's no doubt that this is a case of insulin poisoning and that whoever did it used a method which would never be used legitimately in a hospital setting.

The fact that it was done through the TPN bag tells you that it wasn't a genuine mistake, doesn't it, and that whoever did it was trying to avoid detection? Only a few people had the opportunity and, as I've said before, taken together with what was later to happen to [Baby L], we suggest that there is really only one credible candidate for the poisoner: the same person who was present at all the unexpected collapses and deaths at the Countess of Chester neonatal unit.

So that's the case of [Baby F].

Can we move on to [Baby G], the seventh child. If we go back to the indictment, please, ladies and gentlemen. Page 3, please. You can see there are three counts: count 7, attempted murder on 7 September; count 8, attempted murder on 21 September at about 10.15 in the morning; and then count 9, also on 21 September at about 15.30 hours, attempted murder again. So we say Lucy Letby tried to kill [Baby G] on three occasions and occasions 2 and 3 were on the same shift.

[Baby G] was born on 31 May 2015, so as a matter of fact, even though she comes in midway through the chronology of the counts, she was the first born of all the children in this case.

She was born on 31 May at Arrowe Park Hospital. Arrowe Park Hospital is on the Wirral and it is what the medics refer to as a tertiary centre. In the Merseyside/Cheshire area, which is the geographical area that we're dealing with in this case, the tertiary centres that you're going to hear about are Arrowe Park Hospital and the Liverpool Women's Hospital.

In very general terms, the tertiary centres deal with the most difficult cases. Okay? So they're the level 3 centres. The Countess of Chester was a level 2. Below level 2 is level 1.

[Baby G] was born at a gestational age of 23 weeks and 6 days, so exceptionally premature given that the "standard" pregnancy is 40 weeks. Twenty-three weeks and 6 days, so at the margins of survivability.

[Baby G]'s parents are [Parents of Baby G], and when she was born [Baby G] weighed 535 grams, 1 pound and 2 ounces. Tiny. [Baby G] spent the early part of her life at Arrowe Park Hospital and she suffered various problems, including bleeding on her lungs on 29 June.

Her initial life was typical of a baby born at such an early stage. She had a number of septic or suspected septic episodes requiring antibiotics. She received nine blood transfusions, she had multiple X-rays of her chest and abdomen and underwent heart scans. She also received several brain ultrasound scans, which importantly were all reported as normal.

On 13 August, so in round terms 10 or 11 weeks after her birth, when she would have been at a gestational age of 34 weeks and 3 days, she was transferred from the tertiary centre at Arrowe Park to the Countess of Chester neonatal unit. And she was clinically stable for the first couple of weeks following her transfer to Chester and she was being fed expressed breast milk; so she was doing well.

So event 1, which is count 7. The night shift of 6 to 7 September 2015, so 3 weeks or so after she'd come from Arrowe Park to Chester. That night, [Nurse E] was the designated nurse for [Baby G] and [Baby G] was in nursery 2. There were seven babies in the unit that night and five nursing staff.

The consultant was Stephen Brearey, the registrar Alison Ventress, the SHO Charlotte Newton and the nurses on duty were Ailsa Simpson, Christopher Booth, [Nurse E] and Lucy Letby. The nursery nurse was Lisa Walker.

Lucy Letby's baby that night I'll refer to by the initials IH. IH was in nursery 1. It was a significant date, ladies and gentlemen, because 100 days had passed since [Baby G] had been born. The nurses mark these sorts of anniversaries, or milestones would be a better word, by putting up a banner and making a cake.

The feeding charts show that [Baby G] was taking bottles of 45 millilitres of milk, which, when you've heard of some of these babies being fed half a millilitre, sounds like a gargantuan amount, doesn't it? Forty-five millilitres of milk, 100 days old, and she took that from a bottle. She took that from a bottle at 11 o'clock, 11 pm, on 6 September. [Baby G] was being

fed every 3 hours, alternately by bottle and then NGT, so down the tube.

At 2 o'clock in the morning on 7 September, [Nurse E] aspirated the NGT tube, so she drew up to see if there was anything in [Baby G]'s stomach, she checked that there was no residual milk, she checked the positioning of the tube and then she fed a sleeping [Baby G] 45 millilitres of milk through the tube. So it was alternate -- bottle, tube, bottle, tube -- and this was tube.

When she had drawn up the aspirate, she found minimal aspirates of a quantity that was not sufficient to prevent feeding and meant, importantly, that before she was fed [Baby G]'s stomach had been empty, pretty much empty. So zero or pretty much zero plus 45 millilitres went down. Then [Nurse E] took her scheduled 1-hour break.

And the system was on the night shifts that all the nurses were entitled to an hour's break at some time in the shift. The way it would work would be that they would ask one of their colleagues to keep an eye on their baby while they took their break.

There's nothing recorded in the notes as to who was asked to keep an eye on [Baby G]. So [Baby G] had been fed at 2 o'clock. [Nurse E] went on her break. And at 2.15, the shift leader, Ailsa Simpson says that she was sitting with Lucy Letby at the nursing station when she heard [Baby G] vomiting, followed by the sound of [Baby G]'s alarm. Ailsa Simpson remembers jumping up and running into the nursery with Lucy Letby, and at a later stage, Ailsa Simpson marked a photograph with the location of the vomit. I just want to show you this photograph.

So [Baby G] was in a cot in that position, that type of a cot, 100 days old but still only 34.5 weeks gestation. The vomit that [Baby G] produced landed in the areas marked with the black circles.

(Photograph shown to the court)

Now, Ailsa Simpson's memory of being sitting at the nursing station in the time before [Baby G] produced that vomit, we suggest, cannot be accurate because entries in some of the other children's medical records show that it just can't be right because she and Lucy Letby are making entries in the time that she recalls that she was sitting with Lucy Letby.

But be that as it may, [Baby G], when she produced the vomit, which is denoted by those three black circles, suffered a collapse and when Ailsa Simpson and Lucy Letby went in, she

wasn't breathing. The registrar, Dr Ventress, was called urgently at 2.35, and Dr Ventress observed that [Baby G] appeared uncomfortable and her abdomen appeared purple and distended, so swollen. Her blood oxygen levels, her sats, had fallen to 80%, and she had suffered what were recorded as two projectile vomits.

And despite the fact that before she had been fed by [Nurse E], there'd been nothing or virtually nothing in [Baby G]'s stomach. When the doctor came they aspirated [Baby G]'s stomach. In other words they took out what remained in [Baby G]'s stomach, and what they took out was 45 millilitres of milk. You've got the point I'm sure: zero plus 45 equals 45. The vomit that goes in the cot on the floor and on the chair generated with a force -- imagine a tiny 34-week gestation baby producing the force to vomit on the chair next to the -- from lying in the cot, out of the cot on to the floor and on to the chair. You aspirate the contents of the baby's stomach and you find 45 millilitres of feed, but only 45 went in.

So how do we account for what came out with sufficient force to go in the cot, on the floor and on the chair? Not only was lots of -- 45 millilitres of milk taken out of [Baby G]'s stomach, but lots of air came out as well.

Prior to being fed by [Nurse E] at 2 o'clock, [Baby G] had been perfectly well. The X-rays that were taken after this episode show the air that was in her abdomen and her intestines, the stuff that hadn't been drawn out by aspirating the NGT, and also show -- she had to be intubated, show that that was correctly positioned.

Perhaps unsurprisingly, that night, [Baby G] suffered further deteriorations, leading to the fact that she had to be intubated and ventilated. And as she was being ventilated, as Dr Ventress looked down [Baby G]'s throat, the ventilator, she saw some bloodstained fluid. [Baby C], [Baby E] and now [Baby G].

At 5.30 that morning, [Baby G] desaturated despite being ventilated, and so the tube and the ventilator were changed as a precaution. At 6.05 she had a further desaturation and 100 millilitres of air were aspirated from her NG tube. When the breathing tube was removed, the registrar noted there were thick secretions in her mouth and a blood clot at the end of the breathing tube. And thereafter, [Baby G] demonstrated signs of infection.

[Baby G] was sent back to the tertiary centre at Arrowe Park in the early hours of 8 September and she made a remarkable recovery. She was then sent back to Chester on the 16th. This pattern of a child suffering a life-threatening collapse, being

transferred out of Chester, going somewhere else and making a remarkable recovery is something that we are going to see repeated in some of the cases that I have yet got to explain to you.

Before I get to the mechanism of what we're suggesting, although I'm sure you've probably worked it out already from 45 coming out and 45 going in, but having the vomit and lots of air, I'm sure you've worked out what we're saying about the first one.

But before I get to the explanation I'm going to explain to you the two incidents that happened on 21 September.

The second incident, and this is the one that's particularised or alleged in count 8, so the timing is about 10.15 in the morning. This was 21 September, which is about 5 days after [Baby G]'s return from Arrowe Park. And [Baby G] was so well by this stage that she was due to have her immunisations. As most parents probably know, you don't give immunisations to a child who isn't well. So she was that well.

At 6 that morning, she was given a 45-millilitre bottle of milk. And then there was a handover of staff from about 7.30. The team that came on at 8 o'clock was the day shift and this is the first of the day shifts that we will consider. The nurses on the day shift were Caroline Bennion, Lucy Letby, [Nurse B], Shelley Tomlins, Caroline Oakley, together with a selection of other doctors and managers. And Lucy Letby was [Baby G]'s designated nurse, as she was to the other two children who were in room 4 with [Baby G]. So by this stage [Baby G] has reached the end of the process in the neonatal unit in the sense of the furthest room from the intensive care unit.

That morning, [Baby G] was fed at 9.15 with a 40-millilitre feed of milk via the NG tube by Lucy Letby and within an hour and 5 minutes she projectile vomited twice. She was apnoeic, which means she wasn't breathing, and she suffered a brief self-resolving colour loss and her blood saturations fell to a life-threatening 30%.

So [Baby G] had the same problem that she had on 7 September, this time following a documented feed from Lucy Letby. [Baby G], who had recovered, gone back, has the same problem.

[Baby G] was well when she was seen by the doctor at 10.30, although her heart rate had increased and her temperature was low. And the nurses thought that her abdomen was more distended, more swollen than usual.

At 11.30, [Nurse B] took over [Baby G]'s care from Lucy Letby because Lucy Letby had the other two children in room 4. [Nurse

B] undertook all the necessary observations and noted that [Baby G] was connected to what's called a Masimo monitor, which is a portable device attached to the patient by a sensor that continually measures oxygen saturations and heart rate levels and we've got a picture of one of these for you.

(Photograph shown to the court)

You can see the readings are set out on the screen. There are videos which we're going to show you as part of the evidence right at the beginning so you're familiar with what all these bits of equipment look like.

These monitors should remain on and attached constantly to the baby and, of course, it probably goes out saying, I'm sure, can't be turned off by the baby.

At about 15.30 that afternoon, so we're moving on to count 9, ladies and gentlemen, Dr Gibbs, who was the consultant, was called to cannulate [Baby G], to put a line into [Baby G]. [Baby G]'s mum left the nursery whilst that was done, privacy screens were put round [Baby G]'s cot, [Baby G] was put on to a trolley, still attached to her Masimo monitor, and [Nurse B] attended to other duties whilst Dr Gibbs undertook the necessary procedure. As a matter of fact, [Nurse B] had another baby in room number 1.

Dr Gibbs, when he was asked about this, couldn't remember whether the Masimo monitor was switched off whilst he was fitting the cannula. But what he says is that it is his normal practice to transfer the sensor from one limb to another whilst he's doing a procedure or, if it is necessary to detach the monitor, he puts it back on as soon as possible. You may think that's common sense.

Dr Gibbs also says that having conducted this procedure, if [Baby G] hadn't been completely stable, he wouldn't have left her and again that's common sense, isn't it?

Well, after Dr Gibbs had gone, but [Baby G] was still behind the screen, [Nurse B] responded to Lucy Letby's shout for help. And when [Nurse B] attended she noticed that [Baby G]'s monitor had been switched off, the power was off. [Baby G] was dusky and struggling to breathe and Lucy Letby was giving her ventilation breaths.

Mercifully, [Baby G] responded to the treatment. In a text sent that evening to [Nurse A], Lucy Letby said:

"[[Baby G]] looked rubbish when I took over this morning, then she vomited at 9 and I got her screened. Mum says she hasn't been herself for a couple of days."

But as I have told you, she was due to have her immunisations and we suggest that wouldn't have been contemplated if [Baby G] had not been in good condition. There had been no significant issues with [Baby G] at all that shift until Lucy Letby got involved. [Baby G] vomited in the first part of the shift because somebody gave her excessive milk and air.

An MRI scan of [Baby G]'s brain between the first incident at the beginning of September and the second two incidents at the end of September revealed -- sorry, no, no, I'm getting confused. Sorry, I am right.

An MRI scan taken between the first incident, in other words between count 7 and between counts 8 and 9, revealed that [Baby G] had suffered brain damage. So what had happened to her in the Countess of Chester on 7 September, that projectile vomiting out of the cot on to the floor and on to the chair, had resulted in irreversible brain damage. And that was confirmed in a later scan as well.

Well, dealing with those incidents individually, starting with 7 September, both Dr Evans and Dr Bohin concluded what you have probably worked out for yourselves already, that [Baby G], when she vomited on to the chair, had received excessive milk and probably air through her NG tube at about 2 o'clock, which you'll remember is the time that [Nurse E] had fed her and gone off.

The reasoning is common sense. It's the inconsistency between the amount that she was fed and the amount that was aspirated when you add in what she vomited. Putting it simply, the milk in the vomit didn't come from nowhere, did it, and can only be accounted for by somebody feeding an excessive quantity to [Baby G]?

That doesn't happen by accident. There are parallels, aren't there, ladies and gentlemen, with what I've already told you about [Baby C]? And you are going to hear further parallels in the cases of [Baby I], [Baby P] and [Baby Q].

[Baby G]'s first deterioration on 21 September showed a similar pattern to what had happened on the 7th, didn't it? [Baby G] suffered another potentially life-threatening episode of vomiting and desaturation and produced projectile vomits.

On the second occasion, count 9, in the afternoon, when she was behind a screen, somebody switched off the monitor when [Baby G]

collapsed. Dr Gibbs didn't. [Baby G] didn't do it. And she was discovered by Lucy Letby. There is a common theme running through all these cases, isn't there?

My Lord, I'm going to go on -- sorry, I'll deal with the interviews.

Just to tell you what Lucy Letby said when she was interviewed, so we're going back to the 7th, first of all, [Nurse E] feeding, going on the break, and the projectile vomit.

Lucy Letby said that she remembered that [Nurse E] had been on her break when the incident had happened with [Baby G] in nursery 2 on 7 September. She, Lucy Letby, couldn't remember who she had been assigned to care for, she said that the notes of [Baby G] suggested that she had taken over her care at 2 o'clock that morning but she couldn't remember why that was and we say the reason is because [Nurse E] said, "Can you look after her while I go on my break?"

She said she did remember [Baby G] vomiting but she couldn't remember what had happened in the 15 minutes before the vomit, and she was asked about how it could be that [Baby G] was full of air if, before [Nurse E] had fed her 45mls, she'd aspirated the NG tube and there'd been nothing significant, how could it be that after the vomit [Baby G] was full of air? And Lucy Letby suggested that the air must have come about as a result of the vomiting or because [Baby G] had some sort of infection. So if the evidence about the aspiration is right, this is air that produced itself within -- or arrived within 15 minutes or so.

She said that she had been the person that had withdrawn the 45 millilitres of milk after that episode and that air had come with it. She said that she had seen [Baby G] vomiting and didn't remember why she'd gone in when she'd seen [Baby G] vomiting, but then that it was possible that it was a result of hearing her vomit that she'd gone in. She said that she'd noticed discolouration on [Baby G]'s abdomen at the time she was vomiting but couldn't now, in the context of the interview, describe it because she couldn't really recall it very clearly. Neither could she recall whether she'd been there when [Baby G] had desaturated later in the shift.

She was asked about events with [Baby G] on 21 September and she confirmed her writing on the documents. She said she vaguely remembered the day: [Baby G] had been in nursery 4 where she'd looked after her for a period in the morning and she accepted that at the beginning of the shift she had been [Baby G]'s designated nurse, though she had no recollection, she said, of [Baby G] vomiting at 10.15. So count 8.

Later in the interview, the first incident was revisited and she was asked about the content of a witness statement that had been made by [Nurse E]. Lucy Letby accepted that because the amount of milk aspirated after the vomit had been equal to what [Baby G] had been fed, there were really only two alternatives: either [Baby G] had been given far more than she should have been or she had not digested her earlier feed. She accepted that it was standard practice to aspirate the NG tube before feeding to check of the tube was correctly placed and that the previous feed had been digested, and if that had been done and milk had come back, in other words if [Baby G] had had milk before she was fed, she would "not necessarily" have been fed at all. And she accepted, Lucy Letby did, that the clear inference to be drawn was that [Baby G] had been given excessive milk and air via the NG tube. She denied responsibility for either of those eventualities.

With regard to the first incident on 21 September she said that the notes showed that she had aspirated 30mls of milk from [Baby G]'s stomach just before 9 o'clock but then fed [Baby G] 40mls, then had aspirated and discarded 30mls of milk from [Baby G] at 10.15, after she'd vomited. And it was suggested by the police that if there had been two milky vomits before the aspiration at 10.15 that too showed that [Baby G] must have been fed much more than had been recorded.

So two events, we say, where the records suggest [Baby G] must have received much more than she should have done. And again, Lucy Letby denied either overfeeding or injecting air into [Baby G]'s stomach via a nasogastric tube.

In November 2020 she was asked about the second of the incidents on 21 September, the incident where the monitor, the Masimo monitor, was switched off. She denied having switched it off.

She was then asked about Facebook searches that she'd done on [Baby G]'s parents, including one that she'd done on 21 September, the very same day as the final two attempts, we say, to kill [Baby G]. She had said she had no recollection of having searched for [Baby G]'s parents. We suggest that she knows very well why she did it and you can dismiss the idea that she had forgotten why she did it when she was interviewed. And the fact that she wasn't prepared to explain why she did it speaks volumes.

A remarkable feature of the interest that Lucy Letby showed in [Mother of Baby G], who is [Baby G]'s mum, was that within a minute or two of looking for [Mother of Baby G] on Facebook on 5 November, she also searched for [Mother of Babies E & F] -- do you remember the lady that saw blood round the mouth of [Baby E]? And also searched for a lady called [Mother of Baby I].

[Mother of Babies E & F], the lady that interrupted her attack on [Mother of Babies E & F]'s son. [Mother of Baby I], a case that I have yet to explain to you.

When we get to [Mother of Baby I]'s case, though -- sorry, [Baby I]'s case, you will see some similarities with [Baby G]'s case. Repeated attacks by Lucy Letby, which sadly, tragically, in [Baby I]'s case, resulted in her death. And [Baby I] too was to be injected with air.

So again, ladies and gentlemen, just taking a step back from the detail, we say that the facts really speak for themselves in [Baby G]'s case. The practice, the invariable practice -- and you will see it noted in the paperwork -- was that the nurses, before feeding a child, would check that the child's stomach was empty. That was done in [Baby G]'s case and nothing came up, which means there was nothing in her stomach. She was fed, the designated nurse went on a break, and 15 minutes later [Baby G] produced projectile vomits of such force that they left the cot and landed on a nearby chair and the floor. [Baby G] collapsed and stopped breathing and the amount of milk taken out equalled the amount that supposedly had gone in and the amount that was taken out also included lots of air. A similar episode a few weeks later, and as a result, [Baby G] has been left severely disabled.

On the second occasion, the second incident, somebody detached the monitor from [Baby G], who was behind a screen, and was discovered by Lucy Letby.

Ladies and gentlemen, these were not naturally occurring or random events, they were deliberate attempts to kill using slightly different methods by which Lucy Letby sought to give the appearance of chance events at the neonatal unit in the Countess of Chester Hospital.

My Lord, it may be that that's a good place.

MR JUSTICE GOSS: It certainly is, thank you very much, Mr Johnson. It's almost 3.45.

That's it for today then, ladies and gentlemen.

Please remember your obligations as jurors in this case, as set out in those documents that you have and still have and will have for the remainder of the trial. It's vital that you adhere to those instructions.

Can you be ready, please, to start at 10.30 tomorrow morning? Thank you very much indeed. It will be a full day tomorrow.

(In the absence of the jury)

Housekeeping

MR JUSTICE GOSS: Can I just say that there was an inadvertent identification of the first name of Child C in a blog. It was available for 7 minutes. It was only the first name.

MR JOHNSON: Yes.

MR JUSTICE GOSS: There's a profuse apology that has been forthcoming and I say no more about it, save to emphasise that in particular, in relation to blogging, because it is essentially instant, even greater care has to be taken in the reporting.

So as I say, I received the apology, I understand it was a human mistake, for which the person is very upset, obviously very upset, and apologises. So that's it.

Right.

Now then.

MR MYERS: My Lord, on the subject of profuse apologies, I think your Lordship was going to raise the question of Ms Letby's timing coming into court.

MR JUSTICE GOSS: Yes.

MR MYERS: Mr Costello, who is my instructing solicitor, tells me that Ms Letby was brought up at about a little earlier than 2.05. He's spoken with the custody officers, who asked him to knock on the door to alert them when they were to come into court. He's been occupied with various things and didn't. He's very sorry for that and he puts that apology through me. It may well be that's not the best system for summoning the defendant into court and he's wasted no time in telling me that so that your Lordship knows. Perhaps you can circumvent Mr Costello in future. I don't say that to be critical of him but it's not the best system.

MR JUSTICE GOSS: It fits with the other evidence I received about it. The indication was that the defendant and those escorting her were on their way up and then we just lost track of them and obviously they were just outside. So that accounts for the rather puzzled look on the escorting staff when I said I want an explanation of why we're 15 minutes late starting today. Again, it's just a human mistake and understandable. I agree the system needs to be improved so we don't have this again.

MR MYERS: We'll try to avoid that again, my Lord.

Apologies.

MR JUSTICE GOSS: All right. We will make sure it is a better system that you know about in relation to that.

Thank you very much.

Nothing else for today then I don't think?

MR MYERS: My Lord, no.

MR JUSTICE GOSS: Thank you very much indeed.

(3.44 pm)

(The hearing adjourned until 10.30 am on Wednesday, 12 October 2022)