

12 October 2022
Prosecution Opening Speech (continued)

Wednesday, 12 October 2022
(10.30 am)

(In the presence of the jury)

Opening by MR JOHNSON (continued)

MR JUSTICE GOSS: Yes, Mr Johnson.

MR JOHNSON: Good morning, ladies and gentlemen. We're moving on to counts 9 and 10, please. You'll find them in the indictment at page 4. They both concern [Baby H].

[Baby H] was born on 22 September. So you'll remember what I told you, I think yesterday, about the way the medics count the days of life. Day 1 is the day of birth and so on. So count 10 was day 5 of [Baby H]'s life and count 11 -- I said counts 9 and 10, didn't I? I meant counts 10 and 11, I'm sorry.

So count 10, day 5, a day of [Baby H]'s life, and count 11, day 6. So two allegations of attempted murder.

[Baby H] had been born on 22 September at a gestational age of 34 weeks and 4 days to [Parents of Baby H]. She was delivered by C-section. She weighed 2.33 kilos, which is just over 5 pounds. Soon after birth she had breathing difficulties and she was transferred into nursery 1 at the neonatal unit. She was put on CPAP, which is one of the less invasive forms of breathing assistance.

This is a case or [Baby H]'s is a case which is complicated to a degree by the sub-optimal treatment she received at the beginning of her life because there was what the independent experts have characterised as an unacceptable delay in intubating her, in other words putting an EG tube -- I can't even say the right term -- an ET tube -- you'll find it in the glossary; I think it's endotracheal tube -- down her throat and connecting her to a ventilator.

There was also an unacceptable delay in administering surfactant. Do you remember me telling you about that protein that is put into a baby's lungs to help -- to loosen the lungs, in effect, to make them less brittle and to help the baby's breathing?

Additionally, when [Baby H] was put on to a ventilator initially, she wasn't paralysed and she was also, at a later stage of her treatment, left with butterfly needles in her chest

for prolonged periods of time, which may have punctured her lung tissues and contributed to her having -- "punctured lungs" is the phrase that you and I would use generally speaking. The phrase the medics use, and you will find it under P in the glossary, is pneumothoraces. Pneumothorax is a punctured lung, more than one, pneumothoraces.

So you can see from the indictment that we allege there are two occasions when Lucy Letby tried to kill [Baby H]. The first occasion, the one in count 10, was at about 3.25 or so in the morning of 26 September. And the second occasion was at about 00.59 in the morning of 27 September. So two consecutive night shifts is what we're talking about in general terms.

Going back to the beginning now, following [Baby H]'s birth on 22 September, [Baby H] still hadn't stabilised by the 23rd. The breathing support she was given was made more invasive from CPAP to BiPAP. We'll show you videos of all these things in due course, but just so you understand, the degree of breathing support was being increased. Then it was reduced again back to CPAP.

The important thing to recognise, really, in [Baby H]'s case, and in all the cases where this occurs, is that any form of breathing support -- or the more invasive the form of breathing support, the greater the risk of a punctured lung, a pneumothorax.

On the night shift of 23 to 24 September Lucy Letby was [Baby H]'s designated nurse. [Baby H] had saturation problems through the night, in other words her blood oxygen wasn't as high as it should have been, and at 6 o'clock in the morning on the 24th [Baby H] suddenly deteriorated significantly. This isn't one of the allegations that we are making in the indictment.

[Baby H] required ventilating by means of handbagging, and that's a process that involves the use of literally a medical practitioner or a nurse squeezing a bag to force air into the lungs and was placed back on to BiPAP, which is the slightly more invasive form of breathing support. She didn't improve and so an ET tube was put down her throat and she was put on to a ventilator at 7.45, which will be -- you will remember the change in shifts in the morning. Lucy Letby, in the normal course of events, would have been expected to go off duty at 8 o'clock.

So we're still dealing with the 24th. [Baby H] deteriorated further, she required bagging further and the use of 100% oxygen to support her saturations, and the pressure of the ventilator was increased and a chest X-ray taken at 8.40 on the 24th showed

a left-sided pneumothorax, so a punctured lung, a punctured left lung.

The medics have concluded that it's likely that the increased pressure of the ventilator probably caused that punctured lung, so air or oxygen going in under too much pressure into the lungs causing in effect a punctured lung.

Following a further deterioration of [Baby H] later that morning, the registrar put a needle into her chest between the chest wall and the lung, so that space between the outer part of the lung and the inner part of the chest wall, and the point of that was to withdraw air that had got trapped between the inner aspect, the inner side of the chest wall, and the outer aspect, the outer side of the lung, because that compresses the lung. So that's the danger, in effect, of a punctured lung.

That needle into the chest is called a thoracocentesis. Once that air had been removed, a chest drain was put in, which had the purpose of preventing a further build-up of air between the outer side of the lung and the inner side of the chest wall.

Once that had been done, over the next few days, [Baby H] continued frequently to desaturate and significantly desaturate, but in all but two cases there was an obvious medical cause for that. The causes were variously: the punctured lung, the pneumothorax; the fact that the ET tube, the tube going down her throat, was blocked, secretions blocking the tube; suction of the ET tube; or merely handling a child can, if a child is vulnerable, cause a child, a small baby, to desaturate.

Interestingly, whilst there were two events which couldn't be explained by any of those means, the same two events also proved -- or the same two events didn't prove responsive to routine resuscitation. So these two events which are inexplicable also needed more than routine resuscitation.

Those two significant and what I'll call uncharacteristic events were the two that I've told you about, the one in the early hours of the 26th and the other one in the early hours of 27 September. And both those resuscitations required a full CPR, cardiopulmonary resuscitation, with the use of adrenaline. I'm sure probably most of you know, adrenaline is a drug that's used in extreme CPR to boost blood pressure and heart rate, to bring someone back.

So dealing with the two incidents individually, ladies and gentlemen, starting with the first, the night shift of 25 into 26 September. [Baby H]'s designated nurse was Lucy Letby. Also on duty that night were the registrar, Alison Ventress, the senior house officer Jessica Scott, nurses [Nurse A], Yvonne

Griffiths and the nursery nurses Valerie Thomas and Elizabeth Marshall. And when [Baby H] needed the full resuscitation, Dr Gibbs, the senior consultant, had to be called in as well.

Throughout the shift, Lucy Letby undertook and recorded on the charts, some of which you've seen examples of now, the observations for [Baby H]. So her breathing rate, respiration, blood pressure, heart rate, all those sorts of things which are habitually recorded in hospital.

[Baby H]'s condition was such that at the beginning of the shift, those observations were being recorded every hour, but that then, because of her deteriorating condition, moved to 15-minute intervals until midnight, and then back to hourly intervals from 1 o'clock in the morning.

[Baby H]'s heart rate had risen from about 140 beats per minute, which is within the normal range for a child of her age, at 11 pm, up to 170 beats per minute at 1 o'clock and 2 o'clock. And between just after 11 pm and 2 am, she was given a blood transfusion.

At 3 o'clock in the morning, her pulse had fallen back to 150 beats per minute from 170. Her respiratory rate, her breathing rate in that period, was between 45 and 55 a minute, her temperature was constant, and at 2.15 the medical notes made by Dr Gibbs, the consultant, record the fact that [Baby H]'s chest X-ray showed a re-accumulation of her left-sided pneumothorax, so that air between the inner chest wall and the outside of the left lung. So a further chest drain was inserted to relieve that pressure.

The ICU chart shows that Lucy Letby recorded having given [Baby H] a dose of morphine at 1.25 in the morning and a dose of saline at 2.50. That dose of saline was set to run for 20 minutes and therefore would have ended at 3.10. Lucy Letby, of course, therefore would have had the cover of legitimate treatment for accessing the intravenous lines for [Baby H] just before she collapsed.

At 3.22, [Baby H] suffered a profound collapse and needed a full resuscitation. At the time, Dr Gibbs, the senior consultant, concluded that the cause of the collapse was unclear by contrast to what had gone before. So this time, no explanation.

At the time he concluded that the episode was caused by a shortage of oxygen, which in turn caused a profound lowering of [Baby H]'s heart rate and blood pressure.

When the registrar, Dr Ventress, arrived in response to the emergency, she found [Baby H] being bagged via the ET tube,

[Baby H] had good chest movement, in other words if you're inserting using a bag, a bit like a pair of bellows for people who know what bellows are, if you're pushing air in with a bag down the tube, the ET tube, and the chest is rising, it shows that -- it's obvious, isn't it? It shows that what you're pushing in is having an effect.

So that meant -- the conclusion that the doctors draw from that is that the tube was in the right position. So the tube -- the end of the tube, which is somewhere down here at the top of the lungs (indicating), was in a position that enabled air to come in and go in both sides of the lungs.

There's also a device on the end of the tube, so the end of the tube that's sort of here (indicating) in relation to the patient's mouth, called a capnograph. And a capnograph will react, its colour will change, if carbon dioxide is coming out from the lungs. As I'm sure everybody knows, you breathe in, you absorb oxygen and you breathe out less oxygen and more carbon dioxide. So the point of the capnograph is it shows that the air coming out has less oxygen than the air going in and more carbon dioxide, so it's an easy ready reckoner, if you like, a visual indication for the doctors, to show that things are working properly. So that was a positive sign.

Lucy Letby made notes in the nursing records at 4.14. She recorded a bradycardia, so a lowering of the heart rate, at 11.30, which had required Neopuffing. She recorded the attendance of Dr Gibbs, which I have just told you about, to insert the additional chest drain. She recorded the blood transfusion that I have also told you about, at 2 o'clock, and the fact that [Baby H]'s observations were within normal range, but that [Baby H] was desaturating, so her oxygen levels were decreasing when she was handled.

Of the collapse at 3.22 she made the following record:

"Profound desaturation and colour loss to 30%."

Which means [Baby H]'s saturations, which should have been in the high 90s, had gone down to 30%, which is a life-threatening level:

"Good chest movement and air entry, colour change on CO2 indicator."

So the carbon dioxide indicator, the capnograph I just told you about:

"Neopuff commenced in 100% oxygen and help requested. Serous fluid+++ from all three drains."

That meant there was fluid coming out of the chest drains:

"Became bradycardic. Doctors crash called and resus commenced as documented."

At 5.21, Lucy Letby recorded a conversation between herself, Dr Gibbs and [Baby H]'s parents. So that's the first incident.

The second incident, the one in count 11. Before that night shift of the 26th into the 27th, there had of course been a day shift, so Lucy Letby would have gone off duty at about 8 o'clock on the morning of the 26th. And during the day shift [Baby H] was relatively stable. So she'd had this life-threatening event on the night shift, and then the day shift where she was relatively stable, and the following night shift of the 26th into the 27th. And on this shift, Shelley Tomlins was the designated nurse for [Baby H].

The staff were registrar Dr Matthew Neame, senior house officer Dr Jessica Scott. The nurses were Chris Booth, who was shift leader, Shelley Tomlins, Lucy Letby, [Nurse B], and a nursery nurse, Elizabeth Marshall. So you'll see immediately the only two nurses who'd been working the previous night were Lucy Letby and the nursery nurse, Elizabeth Marshall. So almost a complete change of staff.

[Baby H] was still in room number 1.

In her witness statement, Nurse Tomlins said that she couldn't recall whether she'd taken a break during the shift and couldn't remember whether she'd been with [Baby H] throughout the shift. She confirmed that there would have been times when she went out of the room to get a drink or to get something from a cupboard. And the review of other children's medical records who were on the ward, on the unit that evening show that Lucy Letby had responsibility, was the designated nurse, for a child in room number 2. So [Baby H] in room 1, the other child in room 2.

There are electronic records for [Baby H], which show that Lucy Letby co-signed for some of [Baby H]'s treatments with Nurse Tomlins at just after 10 o'clock, at 10.13 and 10.38 pm, so relatively early in shift.

[Baby H] suffered two sudden and unexpected episodes of profound desaturation at 00.55 and 03.30. The registrar, Dr Neame, responded to the emergency call on both occasions. On one occasion, one of those two occasions, which he thought was probably the later of the two, on arrival he saw Lucy Letby activating the Neopuff and assumed that she was actually the baby's designated nurse.

Dr Neame took the history of what had happened from Lucy Letby, not from the designated nurse, from Lucy Letby. We suggest that this is a pretty good indicator of who it was that discovered that [Baby H] was having problems. You'll remember some of the cases I told you about, one specifically, behind the curtain where Lucy Letby discovered the problem. Well, this, we suggest, is another similar event.

Nurse Tomlins noticed that there were pink-tinged secretions around [Baby H]'s mouth. You'll remember what I told you yesterday about the swollen vocal cords of [Baby C], the bleeding round the mouth of [Baby E] when [Baby E]'s mum went to visit him at feeding time, at 9 pm, and the case of [Baby G].

Dr Saladi, the consultant paediatrician, came in at 2.40 and no cause at the time was identified for this profound collapse either. Earlier in the shift, at just before 11 pm, the designated nurse, Shelley Tomlins, had made a note recording a profound desaturation at about 8.30, but in that case the air wasn't going through the ET tube, so that's -- there was a blockage. So that is an obvious cause. And when that was remedied, [Baby H] immediately recovered.

At 9.45 in the morning there'd been a similar event which was attributed to thick secretions which were blocking the tube again. The first of the two desaturations in the shift, the one that's particularised in the indictment at 00.55, was recorded by Shelley Tomlins at 2.52 in the notes, in the nursing notes. You remember, I showed you some examples of the nursing notes yesterday. These are all documents that you will see in due course.

Shelley Tomlins noted the following. She said there had been:

"A profound desaturation to 40% despite equal bilateral entry and positive capnography."

Putting that into language that I can understand, a severe drop, profound drop, in oxygen in [Baby H]'s blood, despite the fact that there was air going down the tube into both lungs and coming out was carbon dioxide, as detected by the capnograph. So [Baby H] was desaturating, losing oxygen, despite the fact that there was unimpeded air going in and out of the ET tube.

It was also noted in the notes by Shelley Tomlins that when they suctioned the ET tube, there had been no secretions in the tube. So I suppose it's obvious, the fact that air was going in and coming out that there were no blockages, but they also checked by suctioning the tube and nothing came out. So that cannot have been the cause.

So, ladies and gentlemen, it means that, unlike the previous desaturations on this particular shift, there was no reason for what was going on.

The second of the desaturations on the shift at 3.30 also had no obvious cause, but that isn't noted in the medical records. In the context of this case it's important to differentiate between the medical records, which are the -- you or I would probably think of our medical records as including anything to do with our medical history. In the context of this case medical records are the notes made by the doctors and are divided from the nursing records which are made by, obviously, the nurses.

Dr Neame, the registrar, made similar notes to those which had been made by Shelley Tomlins and he recorded the removal and replacement of the ET tube at about 1.05. So it's a precaution, even though it wasn't blocked, even though all the tests suggested that air was passing in and out of the lungs, they took the precaution of replacing the tube.

[Baby H], following this second profound desaturation, was transferred to Arrowe Park Hospital on the Wirral, you'll remember the tertiary centre, the more -- the hospital that's used to dealing with more extreme cases or has the capacity to deal with more extreme cases, and she was transferred out a few hours later at 5.25 the same morning.

She actually stabilised in the ambulance that was taking her from one hospital to the other. So she improved even in the ambulance. Her mother, who was with her, speaks of her dramatic improvement as soon as she got to Arrowe Park, and the medical records bear out that improvement. She returned to the Countess of Chester 3 days later and the remainder of her time at the Countess of Chester was uneventful and she was, happily, discharged on 8 October.

Mercifully, [Baby H] has not suffered any permanent consequences from these two events in the first 2 weeks of her life. But we say, ladies and gentlemen, that it is a notable fact in [Baby H]'s case, as with others, that as soon as children were removed from the Countess of Chester and the sphere of influence of Lucy Letby, they often suddenly and remarkably recovered.

These two incidents, and indeed the general treatment of [Baby H], have been reviewed by the independent medical experts. Dr Dewi Evans concluded that it is probable that [Baby H]'s pneumothorax, punctured lung, was a complication of her clinical condition. It was treated appropriately by the chest drain, but that there was no obvious explanation for [Baby H]'s deterioration in either the early hours of 26 or 27 September.

Dr Sandie Bohin agreed that the punctured lungs were a combination of either prematurity, something called respiratory distress syndrome, or a combination of both, and deemed the clinical care provided as "satisfactory". She too expressed concern at the two events that we allege were attempts by Lucy Letby to kill [Baby H]. Because unlike earlier events, no clear cause was identified for the collapse and so profound or so extreme were the collapses that they required CPR and the use of adrenaline.

Dr Bohin's view was those facts, the necessity for both CPR and adrenaline, showed that those collapses were more significant than the others, for which there are obvious, clear medical explanations. But Dr Bohin concluded that whilst infection almost certainly played a part in [Baby H]'s illness, it could not explain the two profound collapses because [Baby H] recovered so quickly from them. Once she was brought back, she in effect recovered.

To be fair, Dr Bohin was critical of the way the chest drains were inserted and managed, and you'll, I dare say, be hearing a bit of evidence about that in due course.

Lucy Letby was interviewed. In the first set of interviews in July 2018 she was asked about the incidents identified by Dr Evans on 26 and 27 September. She confirmed that she'd been [Baby H]'s designated nurse on the 26th, she remembered [Baby H] because [Baby H] had had chest drains, which are a fairly rare thing these days, and she said she had no recollection that was independent of what was in the notes.

In relation to the incident on 27 September, she said that she had not been the designated nurse and therefore assumed that she had not been caring for [Baby H]. But she did confirm her signature on the administration of some drugs to [Baby H] at 3.41 and some sucrose that was administered to [Baby H] at 3.44, and you'll remember what I've just told you of the fact that when Dr Neame arrived, there she was as the person giving the history to the attending registrar, which we would suggest shows that she was the person that was there when things happened.

In June 2019 Lucy Letby identified her signatures on more medical records. In particular, she confirmed that she'd been involved in the administration of saline to [Baby H] at 2.50. That, you'll remember, ended at 3.10 and was therefore just before her collapse at 3.22.

Although having looked at the documentation, she suggested that perhaps it was [Nurse A] who had administered the saline, albeit, she, Lucy Letby, was the designated nurse on the 26th.

On 27 September, or of 27 September, she confirmed that although she'd not been [Baby H]'s designated nurse, she had been giving her treatment at about the time [Baby H] collapsed. So yet again at the time a child collapsed inexplicably Lucy Letby was recorded as giving her treatment.

From Lucy Letby's home address were recovered five handover sheets referring to [Baby H], two of which were for the relevant shifts that are particularised in those counts in the indictment.

It's yet another case where there are some interesting Facebook searches by Lucy Letby. On 5 October 2015, so about a week after [Baby H]'s second collapse, at about 1.15 in the morning and within an overall period of 3 minutes, she searched for [Mother of Baby H], [Father of Babies E & F], and [Mother of Baby I], the mother of [Baby I], whose case is the next in the list. That day was her day off, 5 November. So on her day off, 1.15 in the morning, searching for three sets of parents, the parents of three children whose names appear in this indictment, all in a 3-minute period.

So I'm well aware that I'm starting to sound like a broken record now, ladies and gentlemen. We say this is a case that has to be looked at in the context of everything else. It fits with the pattern of unexplained collapses when Lucy Letby was there and we say it's more than an innocent coincidence that once [Baby H] was moved out of the Countess of Chester, she dramatically improved and had no further problems.

Other features that we suggest are significant are that in relation to the first incident she was the designated nurse and in relation to the second incident the collapse happened when the designated nurse was out of the room and there was Lucy Letby to explain what had happened to the registrar who attended. All things that you've heard before in previous cases. So those are the -- that's an outline of the case relating to [Baby H].

Next, [Baby I]. On the indictment, you will find [Baby I]'s name in count 12. [Baby I] was born on 7 August. She died on 23 October 2015 and this is an allegation of murder.

[Baby I] was born in Liverpool Women's Hospital. Her gestational age was 27 weeks and her mum and dad are [Parents of Baby I]. She was born at 20.47 on 7 August. She was transferred to the Countess of Chester on the 18th. [Baby I]'s case is an extreme example, even by the standards of this overall case.

You'll remember me saying to you at the beginning that Lucy Letby made repeated attempts to kill some of these children. This is a case where we allege Lucy Letby tried four times and succeeded on the fourth attempt.

[Baby I] was resilient, but ultimately at the fourth attempt Lucy Letby succeeded in killing her. [Baby I] weighed 970 grams at birth, 2 pounds and 2 ounces. Although she was small, she was born in good condition, and despite the fact that she was so premature she did very well from the very beginning.

She was intubated and ventilated for the first 10 hours of her life, but then taken off the ventilator and supported with CPAP, which is one of the less invasive ways of supporting breathing. She didn't have any significant lung disease and she was being fed initially through the nasogastric tube.

In the first few weeks of her life she did have a few problems, but, as you will see in other cases, these all had obvious causes and were all resolved. So it was almost 2 months later, 29 September, when she was 8 weeks old, that the ongoing clinical concerns that had existed had diminished. [Baby I] had no breathing problems, she was in air -- in other words she wasn't having any supplemental oxygen to improve her saturations -- she was gaining weight, and she was being fed using bottles and through the NGT.

29 September was a couple of days, 2 days after Lucy Letby's second attempt to kill [Baby H]. And lest you have forgotten, it was a week or so after events 2 and 3 for [Baby G].

So the first attempt by Lucy Letby to kill [Baby I].

On 30 September Lucy Letby worked a long day and that's a day shift that lasts 8 until 8 and she was [Baby I]'s designated nurse. [Baby I] was doing so well that she was in room number 3, with two other children, and Lucy Letby was the designated nurse for all three of the children in room 3.

Despite the fact that she had three babies to care for, Lucy Letby was also involved that shift with both [Baby H] and [Baby G]. Other staff on duty were the consultant Dr Gibbs, John Gibbs, the registrar [Dr A], two -- I think three -- SHOs on that day shift, Doctors Peter Fielding, Charlotte Newton and Dr Lucy Hunt. The nurses were [Nurse B], who was the shift leader, Lucy Letby, Laura Eagles, Melanie Taylor, Ashleigh Hudson, Kate Bissell and Bernadette Butterworth, and the nursery nurses Jean Peers and Lisa Walker. You can see already there were generally more staff on during the day than would be on at night.

According to [Baby I]'s mum, [Mother of Baby I], Lucy Letby expressed some concern about [Baby I] to her and indicated that [Baby I] would need to be reviewed by a doctor. When she made the notes in the nursing notes though, Lucy Letby reversed this concern and said that it had been [Mother of Baby I] who had expressed concern about [Baby I] to her. And what Lucy Letby wrote in the notes was -- this is of [Mother of Baby I]'s abdomen:

"Mum feels it's more distended [swollen] to yesterday and that [Baby I] is quiet. Not on monitor but nil increased work of breathing."

So it's a point you might want to bear in mind when we get to [Baby I]'s case. Who was raising the concern here? Was it Lucy Letby to cover what she planned to do? [Mother of Baby I] says it was Lucy Letby. Or was it as Lucy Letby recorded in the notes? You know what we say about Lucy Letby's notes from some of the other cases.

Can I just show you the feeding chart, please, which is J14457. It's not the feeding chart, it's the nursing notes, I beg your pardon.

You'll be very used to these by the time we finish, ladies and gentlemen, I'm sure you already know from what you've seen previously that these are the nursing notes. It says at the top "Patient notes: nurse notes".

You can see this is a note made on 30 September at 13.36 and perhaps ending at 13.48. LL of course Lucy Letby:

"Written for care given from 8 to present."

So this is covering a period from the start of the shift:

"Emergency equipment checked, fluids calculated. [Baby I] nursed on a hot cot, initially set at 36.5 degrees."

Then sets out her temperature. Then a bit further down:

"Abdomen appears full and slightly distended, soft to touch."

That's a good sign, soft on touch:

"[Baby I] straining++. Bowels have been opened. Mum feels it is more distended to yesterday and that [Baby I] is quiet. Appears generally pale. Not on monitor but nil increased work of breathing. Handling well and waking for feeds. Doctors asked to review to continue with current plan."

"Handling well and waking for feeds", a good sign, isn't it?

A review took place at 3 pm, so an hour and 20 minutes or so after these notes were made. By then, [Baby I] appeared mottled in colour with a distended abdomen and prominent veins, but she was still breathing unassisted in air.

We can move on to the feeding chart now, please, at 14780. I'm going to tell you what they say first of all and then I'll point out the bit -- here we are, perfect.

So feeding chart. If you look at the far right-hand column, ladies and gentlemen, you can see Lucy Letby's signature and underneath that her initials. If we go back towards the left-hand side of the chart, in the second column we've got the times, 00.30, 3.30, 7 o'clock, 10 o'clock, 1 o'clock, 4 o'clock.

We can see in the next column what [Baby I] was being fed:

"EBM [which means expressed breast milk]/fort [or fortifier]..."

And that's a thickener that is put into the breast milk. I'll let the doctors explain why that's done.

In the next column, the amount, 35 millilitres, 35. Then the route. What we see is B for bottle, NGT for nasogastric tube. Then in the next column:

"Vomit ASP."

This relates to -- do you remember me telling you yesterday that before feeding a child, a baby, particularly a premature baby, the nurse would draw up through the tube using a syringe -- the other end of the tube sitting in the stomach, would draw up from the stomach to see what comes up. And if there is a large quantity of undigested milk before you're about to feed a child then that's a bad sign, so the child would not be fed.

What you see here at -- well, there are no entries at all in the first few, in the first four lines. In the line at 1 pm we see 5 millilitres were aspirated and a pH of 5, so that's a measure of -- anyone who knows anything about chemistry, pH gives you the acidity or alkalinity of something, and you can see in the 4 o'clock feed 3 millilitres were drawn up before the feed. But that wasn't a concern and so [Baby I] was fed, hence the figures in the column two to the left, 35 and 35.

What Lucy Letby recorded there at 4 o'clock, therefore, is that she fed [Baby I] 35 millilitres of expressed breast milk at 4 o'clock and that she fed it to [Baby I] down the NG tube

because, if you look in the comments column that's just to the left of her initials, [Baby I] was asleep.

An emergency crash call was put out for [Baby I] at 4.30 because [Baby I] had vomited, desaturated, her heart rate dropped, and she was struggling to breathe. You can see a note in Lucy Letby's handwriting, 4.30:

"Large vomit+ [so emphasis] and apnoea [in other words not breathing] NBM."

"NBM" means nil by mouth.

[Baby I]'s airway had to be cleared, she was given breathing support, and she was moved into room number 1. An X-ray, taken at about 5.30/5.40, revealed a massive amount of gas in her stomach and in her bowel, and her lungs appeared squashed. You remember me telling you yesterday about the diaphragm? If you overfill the stomach, like a balloon it expands, pushes up on the diaphragm and the diaphragm in turn squashes the lungs, so reduces the capacity for a small child to breathe.

So the effect of this gas that we say had been injected into [Baby I] through the nasogastric tube, into her stomach, was to in effect splint her diaphragm and impede her capacity to breathe.

Dr Harkness, the registrar, recorded having seen [Baby I] at 4.30, and [Baby I] had suffered a respiratory arrest, she'd stopped breathing. She was pale, she was distressed, her abdomen was described as "distended and hard". Her heart rate was low, she was struggling to breathe, and what he wrote in the notes was that the NGT was aspirated, in other words out again -- remember this is only half an hour after she'd been fed -- and produced air+++ -- so in half an hour, air+++ had got in there -- and 2 millilitres of milk. So if 35 went in, there was a vomit, leaving 2. This is an interesting comparison to one of the cases I told you about yesterday, isn't it?

As soon as that air was removed from [Baby I], the crisis passed. You'll remember, won't you, [Baby C], [Baby E], [Baby G]? [Baby G] was the projectile vomit on to the chair, do you remember?

Lucy Letby's shift ended at 8 pm and the handover to the nurse for the night shift took place between 7.30 and 8.00, and at 7.30, at the beginning of the handover, the notes record that Lucy Letby adjusted [Baby I]'s glucose infusion and gave her an injection of saline; and within moments you know what happens, don't you? [Baby I] deteriorated again.

But as I've already said, [Baby I] was resilient and overnight, once removed from the orbit of Lucy Letby, [Baby I]'s condition improved. In the period after that shift, she enjoyed a period of stability and so stable was [Baby I] that by 11 October, she wasn't even on a monitor for her heart rate or her respiration rate. She was doing so well that she didn't need to be monitored.

Incident 2 was on the night shift beginning 12 October. Nurse Ashleigh Hudson was [Baby I]'s designated nurse on this shift, [Baby I] was in nursery 2, she was with two other babies, and Lucy Letby had a baby in nursery 1. There were two other babies in nursery 1 being looked after by Laura Eagles. So putting that a different -- this is important in this case. Three babies in nursery 1, two being looked after by Laura Eagles, one by Lucy Letby. Three babies in nursery 2, all being looked after by Ashleigh Hudson.

The staff on duty that shift were registrar Dr Matthew Neame, the senior house officer was Dr Ekaterina Clegg. The nurses, the shift leader was Caroline Oakley. Together with Lucy Letby, the other two nurses were Ashleigh Hudson and Laura Eagles, who I have already mentioned, and the nursery nurse was Janet Cox.

[Baby I] was well at the beginning of the shift. She was being fed by bottle every 4 hours and at 1.30 in the morning she took a 55-millilitre bottle of breast milk. At about 3 o'clock on 13 October, Ashleigh Hudson left the nursery temporarily. So she's got the three in nursery 2, including [Baby I]. She leaves. What she remembers is that she asked either Lucy Letby or Caroline Oakley to listen out for [Baby I]. Does that remind you of things I've already told you about?

Nurse Hudson, the records show, went into room number 1, into nursery 1, where Lucy Letby had her child. What Nurse Hudson did, the records show, is she helped Laura Eagles with one of the children in room number 1. So when you're wondering who it would have been that Nurse Hudson asked to help out by supervising [Baby I] and the other two in room 2, it's a fairly obvious inference to draw, isn't it, given that Lucy Letby was already in room 1? "Do you mind just going into room 2 to keep an eye on the babies while I help here in your room?"

Whether or not that's right, whether or not the inference that I'm inviting you to consider is right, Ashleigh Hudson remembers that when she returned to room 2 at about 3.20, Lucy Letby was standing in the doorway of the room. The room was darkened, because it was night, and as soon as Ashleigh Hudson appeared, Lucy Letby said to her that [Baby I] looked pale.

Nurse Hudson then turned on the light and saw that [Baby I] appeared to be at the point of death and wasn't breathing.

When she reconsidered it later, months, years later, she thought possibly [Baby I] was breathing at least once every 20 seconds, and it may be that that's what she thinks because, if she hadn't been breathing once every 20 seconds, the apnoea alarm would have gone off and there was no alarm sounding. Of course, the alternative might be somebody had silenced or turned off the alarm. You may want to consider that as a possibility.

You might also want to wonder how it is that Lucy Letby, from the doorway of a darkened room, could see into a cot and that [Baby I] looked pale. This is yet another feature of the case that will repeat.

MR JUSTICE GOSS: Sorry, Mr Johnson.

(Pause)

DARTS has just gone off. It's the digital recording system.

MR JOHNSON: Sometimes the clock stops but the system...

MR JUSTICE GOSS: It's rebooting or trying to reboot.

(Pause)

MR JOHNSON: Maybe we could take an early break.

(Pause)

MR JUSTICE GOSS: In terms of a break, we will have a break: you choose an appropriate moment from now on.

MR JOHNSON: Thank you.

Well, ladies and gentlemen, what Ashleigh Hudson remembers is certainly right. It's right because Lucy Letby made a note at 8 o'clock at the end of the shift -- 8.10, actually, at the end of the shift. I'll just show you that now, please. It's 14504.

She wasn't [Baby I]'s designated nurse, you will remember, but here she is making a note. To be fair, I think care was transferred to Lucy Letby at a later stage. Anyway. Here's the note made at between 07.59 and 8.10:

"[Baby I] noted to be pale in cot by myself at 03.20. Nurse Hudson present. Apnoea alarm in situ and had not sounded. On examination [Baby I] centrally white, minimal shallow breaths followed by gasping observed. Ventilation breaths."

Dr Neame, the registrar, was beeped at 3.23. When he got to [Baby I] he saw that the nurses were giving her full CPR. He repositioned [Baby I]'s ET tube, [redacted]. The consultant, Dr Newby, arrived a few minutes later and gave [Baby I] adrenaline, intubated her and ventilated her. And an X-ray showed gross gas swelling throughout her bowel and signs of something called chronic lung disease of prematurity.

So in other words, [Baby I] had, on this occasion, the same problem that she'd had back on 30 September when Lucy Letby had fed her and there was Lucy Letby again when it recurred out of the ether. And yet in the intervening 2 weeks, [Baby I] had been absolutely fine.

The medical team at the time felt that the swelling of [Baby I]'s abdomen, her stomach, had affected her ability to expand her chest and that was the cause of the deterioration. What they appeared not to have considered so much is how the stomach got distended or swollen in the first place. And both the nursing and the medical staff commented on a bruise-like discolouration to the right of the sternum, the breastbone, and assumed that was a result of the chest compressions that had been given to [Baby I].

The category of nursing care was raised a level and ironically, Lucy Letby then became [Baby I]'s designated nurse because she was the more qualified.

Dr Neame's medical notes record that not only had the ET tube been displaced at the time [Baby I] had collapsed but also, at 4.25 in the morning, the nasogastric tube had curled in her oesophagus, so that was misplaced as well, and that happening to the NG tube would mean that that would stop any pressure in the stomach from the gas coming out through the tube: that gas that we say Lucy Letby had put in there couldn't come out because the tube was curled.

So that's incident 2. [Baby I] survived.

Incident 3. The night shift of 13 to 14 October. Lucy Letby was [Baby I]'s designated nurse and [Baby I] was her only responsibility that night, she had no other children to care for. The other staff on duty were the registrar Dr Neame, Dr Clegg was the house officer, Nurse Caroline Oakley the shift leader, Lucy Letby working with Joanne Williams and Laura Eagles, and the nursery nurse Janet Cox. You'll get all these in lists, ladies and gentlemen. You don't need to write them down if you feel you don't want to.

[Baby I] was in room number 1 with at least a couple of other babies. On 14 October both Lucy Letby and Dr Neame recorded that [Baby I] had increasing abdominal distension. She had discolouration to the right and she was sensitive to touch between 5 am and 5.55. In other words, coming up towards the end of the shift. An X-ray taken at 6.05 shows that she had widespread gas, which was swelling her stomach, and it was sufficient to splint the diaphragm. So the same problem happening again. This prevented [Baby I] breathing properly, it led to her desaturating again, and yet again she had to be resuscitated.

So same nurse, same problem. A problem that didn't occur when Lucy Letby wasn't about.

At 7 am, [Baby I] had a significant desaturation with a lowered heart rate, which required full resuscitation, so CPR, adrenaline. At 7.10 Dr Neame recorded this in the notes:

"... then desaturating again despite good [air entry]..."

Do you remember me telling you about air entry before? So sats crashing but air coming in and out. So:

"... despite good [air entry], chest wall movement and negative cold light."

We'll hear about a thing called a cold light test. It's a test they do to see if there's a punctured lung, a pneumothorax, so negative means there's no evidence of a punctured lung.

At 7.45, so right at the end of the shift:

"Heart rate below 60. CPR initiated. Capnography positive."

So carbon dioxide was coming out of [Baby I], so there was the gas exchange within the lungs, but despite that, still in a life-threatening situation:

"Chest wall movement and equal..."

And [Baby I] was bought back from the brink of death right at the end of the shift at 7.58.

Lucy Letby's notes were made at about 8.45. She recorded this:

"At 5 o'clock abdomen noted to be more [distended] and firmer in appearance with areas of discolouration spread on right-hand side. Veins more prominent, gradually requiring 100% oxygen. Blood gases poor as charted. Nil obtained from NG tube throughout. Continued to decline. Re-intubated at approximately

7 am. Initially responded well. Resuscitation commenced as documented in medical notes. Night and day staff members present."

So that was the third attempt that Lucy Letby made to kill [Baby I]. [Baby I] experienced a transient, a temporary desaturation, at just after 9 o'clock that night, and respiratory difficulties on the morning of 15 October. And she was transferred to Arrowe Park Hospital, the tertiary centre.

She had an episode where her heart rate dropped and she desaturated, but after that she quickly stabilised. So as before, here we have another child suffering life-threatening problems and a speedy recovery once removed from Chester, and in due course was then returned back to Chester and on 17 October, and [Baby I] had, when she came back to Chester on the 17th, had 5 good days of progress, a period that coincided with the absence from work of Lucy Letby.

The night shift of 22 to 23 October. Ashleigh Hudson was the designated nurse for [Baby I]. [Baby I] was in room 1 with at least one other child. Lucy Letby had a child in room number 3. Other staff on duty that night were on-call consultant Dr Gibbs, registrar was Dr Chang, the SHO was Dr Laddie, the nurses were Ashleigh Hudson, Melanie Taylor and Christopher Booth, obviously with Lucy Letby, and also the nursery nurse Val Thomas.

Between 8 o'clock that evening and [Baby I]'s collapse, the only entry Lucy Letby made in any child's records in that unit that night were those of her designated infant in room number 3. And she recorded having fed that child, who I'll call MCA, and taking the child's observations at 9 pm. It therefore appears from the records she made at least that it was a slow night for Lucy Letby.

So far as [Baby I] was concerned, at 11 pm [Baby I]'s fluid balance chart was noted by her designated nurse, Ashleigh Hudson. At just before midnight [Baby I] became unsettled and Nurse Hudson and Lucy Letby attended to her, but [Baby I] collapsed and required cardiac compressions.

Dr Chang, the on-call registrar, attended, followed by Dr Gibbs, the consultant. Dr Gibbs arrived at about 00.15 on 23 October, and noted that CPR was underway, [Baby I] had a mottled blue appearance of the trunk and her peripheries and, as on previous occasions, the contemporaneous medical notes record that when [Baby I] was intubated there was good colour change of the capnograph, the carbon dioxide detector. After 5 minutes of CPR [Baby I]'s saturations picked up to 100%, she was then ventilated when Dr Gibbs arrived, and once again the X-ray showed a massive dilation of her bowel, which was noted as a

"large stomach bubble", and [Baby I] was successfully resuscitated at that stage and recovered to the extent that she was rooting -- rooting in this context means that she wants to be fed, sucking, pouting as if she wants some milk -- and she was fighting the ventilator, in other words had sufficient about her to be breathing not in sync with the ventilator but breathing for herself and against the ventilator.

So because of that, at 00.45, the ET tube was removed. At 1.06, Nurse Hudson left the nursery, and you know what I'm going to say next, don't you? She responded to [Baby I]'s alarm and Lucy Letby was standing by the incubator. [Baby I] was very distressed and Nurse Hudson wanted to intervene, but Lucy Letby said that they'd be able to sort it out. "Don't worry, we'll sort it out, we'll settle her." I'm not saying that's a direct quotation of what she said, but what she said was, "We will settle the baby".

[Baby I] then collapsed. This, if you sort of park this exchange, mirrors what will happen in one of the later cases, a lad called [Baby O], about 6 months later.

Dr Chang arrived at 1.12, he led the attempts to resuscitate [Baby I] -- sorry, she led the attempts to resuscitate [Baby I]. She was joined by Dr Gibbs at 1.25, who noted purple and white mottling. As before, the capnograph, the CO2, detector, on the ET tube, suggested that air was getting in and out of [Baby I]'s lungs, but all resuscitative efforts were unsuccessful, and at 2.10 treatment was withdrawn.

[Baby I] was pronounced dead at 2.30 and in the immediate aftermath of her death, her parents were taken into a private room. Ashleigh Hudson and Lucy Letby asked if [Mother of Baby I] wanted to bathe her daughter. As [Mother of Baby I] bathed her recently departed child, Lucy Letby came into the room, and in the words of [Mother of Baby I], "was smiling and kept going on about how she was present at [Baby I]'s first bath and how much [Baby I] had loved it".

This case was referred to the coroner. A post-mortem examination was carried out by Dr Kokai on 26 October. The cause of death was recorded as:

"Hypoxic ischaemic damage of brain and chronic lung due to prematurity and extreme prematurity."

One of the findings at the post-mortem examination was that all the loops of [Baby I]'s bowel showed what the medics call "significantly dilated lumen due to increased air content". In layman's terms that means expanded, like a partially inflated balloon.

There were no signs of NEC, that bowel disorder, or any other bowel problem, and an examination of [Baby I]'s brain showed signs of earlier hypoxic ischaemic damage, in other words brain damage from oxygen starvation, and in other words the earlier attempts to kill [Baby I] had caused brain damage resulting from a shortage of oxygen. And testing for a battery of viruses proved negative.

The independent experts. Dr Evans, he acknowledges this is a highly complicated case, but was of the view that [Baby I]'s deteriorations on 30 September, on 13 October, when he thought the apnoea monitor must have been switched off or tampered with, on 22 and 23 October are all consistent with the deliberate administration of a large amount of air into [Baby I]'s stomach through the NG tube.

Dr Evans also believes that [Baby I] was given an amount of air injected into her bloodstream on or just before and after midnight on 22 to 23 October, and in support of that opinion he refers to [Baby I] screaming, quickly followed by her collapse.

Dr Bohin agreed with Dr Evans and made the point that the findings at post-mortem excluded NEC, this bowel disease, as being the problem.

Dr Marnerides, the independent pathologist, concluded that the constellation of findings would strongly indicate that [Baby I] died due to unnatural causes, having been submitted to repeated, separate episodes of excessive injection of air into her stomach and intestines.

Lucy Letby, having been arrested, was interviewed. In July 2018 she confirmed that she had been [Baby I]'s designated nurse on 30 September. She confirmed that she'd given [Baby I] a feed via her NG tube at 4 o'clock and said she couldn't remember the circumstances in which the crash call had been put out at 4.30. You remember that's the chart I showed you.

Lucy Letby confirmed that on the night shift of 12 to 13 October she had taken over the care of [Baby I] at 3.20, after [Baby I] had had an "episode". With regards to the events of 14 October, she said she had no independent recollection. She said she had no recollection of the events surrounding [Baby I]'s death and she said her view was that Arrowe Park had brought or sent back [Baby I] too quickly to the Countess of Chester.

In June 2019 she was asked about a sympathy card that she had sent to [Baby I]'s parents. She said that to send a card -- for a nurse to send a card was not normal. Indeed, this was the only time she said she had ever done it. But it was not often that

the nurses got to know a family as well as they had known [Baby I]'s family. She accepted that she had kept an image of that card on her phone.

She denied giving [Baby I] air through her NGT. She was asked about the occasion on 13 October when [Baby I] had desaturated in the dark and she said that the first time she had realised was when the lights were illuminated but couldn't remember why she and Ashleigh had gone into the room and you'll remember what was in the note I showed you.

She challenged Ashleigh Hudson's account, so she didn't agree with what Ashleigh Hudson said, and continued by saying:

"Maybe I spotted something that Ashleigh wasn't able to spot."

Because, as she said, she was "more experienced than Ashleigh".

She denied that Ashleigh Hudson had left her with the responsibility for caring for [Baby I] on that night. You'll remember what I've said about that.

In the interview of November 2020 she was asked about the text messages she'd sent to [Nurse A] on 14 October in which she had asked to be assigned to [Baby I]'s care on the following shift. She said that she didn't recall the detail of those messages. And as with other cases, she was asked why she had taken an interest in [Baby I]'s parents on Facebook. Her response was that she didn't recall doing it.

Well, you will remember what I said to you earlier this morning, ladies and gentlemen, about that 3-minute period in the early hours of one of her days off when she searched for [Baby I]'s parents, [Baby H]'s parents and [Babies E & F]'s parents.

So ladies and gentlemen, in summary, [Baby I] was born very early and very small, but she survived for 2 months, for the first 2 months of her life, and was doing well by the time Lucy Letby got her hands on her.

What happened to [Baby I] following the pattern -- or followed the pattern of what had happened to others before and what was yet to happen to others that I'll be telling you about later.

All of a sudden, out of nowhere, came vomiting, breathing problems and critical desaturations.

Incident 1, a vomit followed by lots of air and some milk. Incident 2, the designated nurse fed [Baby I], left her and returned to find Lucy Letby coolly watching [Baby I], who was in crisis. Incident 3, similar to incident 1 but without the vomit,

[Baby I] pumped up with air. And finally, the fatal incident, incident 4, [Baby I] pumped up with air when the designated nurse was away from her and the designated nurse returning in response to the alarm and finding Lucy Letby standing over her.

It was persistent, it was calculated and it was cold-blooded.

That may be a good point.

MR JUSTICE GOSS: Certainly. We'll have a 15-minute break then, members of the jury. Thank you very much.

(In the absence of the jury)

Thank you.

(12.05 pm)

(A short break)

(12.20 pm)

(In the presence of the jury)

MR JUSTICE GOSS: Mr Johnson.

MR JOHNSON: Back to the indictment, please, ladies and gentlemen. Would you go to page 5 and count 13?

Eight days after the death of [Baby I], was born [Baby J] on 31 October 2015. [Baby J] was 32 weeks plus 2 days gestation. Once she started to breathe regularly, she was initially stable. However, it was discovered that she had a necrotic and perforated bowel.

She was a child, and the only child in this case, who really did have NEC, that bowel disorder.

The following day, she was transferred to Alder Hey Children's Hospital in Liverpool and there she had what's called a bowel resection and ileostomy with an external stoma and bag. What that means is, ladies and gentlemen, that they opened her up, found the bit of dead bowel, cut the dead bit out and then created a stoma, which is an exit for the bowel in the wall of the abdomen, which is where you would have the bag to collect the faeces. But they don't do that in the sense -- what they tend to do is they also have an entry point from the healthy end of the bowel and they do what they call recycling the stools. So stools will be produced by the digestive process, will come out of the exit point and will then be put into the entry point to come out the normal way. Once that has been established then

they tend to have a further operation in which the child is re-opened and the two healthy ends of bowel are stitched together, which means that the child will live a normal life -- normal in the sense of not having to have a bag. So that's the mechanical explanation which no doubt will be given in much better and more accurate terms by the expert witnesses in due course.

Having had that operation, [Baby J] recovered well and she was returned to the Countess of Chester on 10 November and her clinical condition was stable. She had to help with her nutrition a line called a Broviac line, which I won't try to explain, but it's an unusual type of line that is inserted under surgery. So that was done at the same time that [Baby J] had the bowel operation.

The issue of the stoma and that in combination with a Broviac line was something that was unusual and many of the staff in the Countess of Chester were not familiar with that sort of thing.

On 16 November, so the birth plus 17 days, the medical notes reflect that [Baby J] was well, she was breathing in air, her saturations, her oxygen saturations, were 100%, her temperature was normal, her heart rate and breathing rate were healthy. But she suffered an unexplained collapse in the early hours of 27 November.

That night shift, the nurses on duty were Mary Griffith, Lucy Letby, Caroline Oakley, Nicola Dennison, Laura Eagles and Vicky Blamire, and this was now 5 weeks after the death of [Baby I].

Before she went to work for that shift, Lucy Letby exchanged text messages with one of her colleagues, and it seems that she wasn't happy with her working conditions and she referred to the difficulties of looking after babies who'd only needed feeding support. So in other words, the babies in room 3 and room 4. She wasn't happy about that. [Baby J] was one of those and it appears, we suggest, that working in nurseries 3 and 4 was not sufficiently stimulating for Lucy Letby.

On this particular night shift, Nurse Dennison was the designated nurse for [Baby J], who by this stage was in room 4, ready to go home. Lucy Letby's charge was in a different room and although she wasn't designated to [Baby J], the notes suggest that Lucy Letby got herself involved with [Baby J]. She co-signed for the administration of medication, just after midnight, and to be fair it may well be that because Nurse Dennison was a band 4 nurse and therefore not sufficiently qualified to give intravenous medication to [Baby J], that may be the reason why Lucy Letby got involved. But whether or not that is the reason, [Baby J] was well and she was on 4-hourly observations. We've seen some cases, haven't we, with 15

minutes? So to give you a contrast, here was [Baby J] on 4-hourly observations.

[Baby J] was well, but after a feed at about 4.40 that morning, Nurse Dennison thought that [Baby J] became pale and mottled. And shortly after, she left the room for a short time and, when she returned, Nurse Griffiths (sic) was helping [Baby J] with [Baby J]'s breathing. Nurse Griffiths can't remember the incident or how her involvement came about, and an examination of the records of all the other children on the unit at the time showed the last thing Lucy Letby recorded herself doing before the collapse of [Baby J] was at about 3 o'clock, and there's data from the door fob system, the security pass system that the staff use, which suggests that following that event at 3 o'clock, Lucy Letby had come back into the neonatal unit at 3.47. So it may well be that she'd had a break between 3 o'clock and 3.47.

So I've told you about her desaturation. It was just after 5 o'clock, 5 am, that [Baby J] suffered a further desaturation and the decision was made to move her to the high dependency part of the unit in room number 2.

At that point Mary Griffith took over [Baby J]'s care and began to monitor her condition. Dr Verghese, one of the registrars, was called and she examined [Baby J] -- he examined [Baby J]. Dr Verghese was told that [Baby J] had suffered two profound desaturations which had required breathing support from the nursing staff and he examined [Baby J] and found that she was working hard to breathe, although otherwise she had recovered well and she was screened for infection and her feeds were stopped.

At 6.56, so coming up to the end of the shift, [Baby J]'s alarm activated and she suffered another episode. Nurse Griffith responded and was joined quickly by Lucy Letby. [Baby J]'s saturation and heart rate had both dropped and she required help. Dr Gibbs was present on the unit by this time and he took control and describes [Baby J]'s oxygen levels as "dropping to unrecordable levels" and her circulation as "poor". And he noticed also symptoms of a seizure in that [Baby J]'s arms were stiff, her fists were clenched and her eyes were deviating to the left.

At 7.20 Lucy Letby signed a chart for the administration of a 10% glucose infusion and the co-signer for that was Mary Griffith. If we just look at this, please, it's page 16244.

We can see there highlighted in yellow are the signatures, Lucy Letby's signature above and Mary Griffith's rather smaller signature in the same box below and those two signatures

replicated in the following line, which contains another prescription that has been stricken through.

Four minutes later, 7.24, [Baby J] again collapsed. So within minutes of an infusion started by Lucy Letby, [Baby J] collapsed and it was handover time and so there were numerous members of staff on the unit. Two shifts' worth of staff on the unit at this stage. Dr Gibbs had again helped to resuscitate [Baby J]. Again on this occasion [Baby J]'s fists were clenched, her eyes were rolling to the left and mercifully [Baby J] recovered satisfactorily from that collapse. But Dr Gibbs could offer no explanation for what had happened from the results of various tests that were undertaken and he considered the incidents unexplained.

These episodes or this episode was reviewed by the independent experts. Dr Evans described the collapse at 7.11 as unexpected, without any straightforward explanation, and said that it was:

"Of concern and consistent with some form of obstruction of her airways, such as smothering."

[Baby J] was well beforehand, there was no evidence of infection and she recovered soon after.

The symptoms of a seizure or a fit, this clenching of the fists, stiffening of arms and eyes deviating to the left, suggests that the brain was deprived of oxygen and raised the prospect therefore that [Baby J]'s airway had been obstructed. Ever since [Baby J] has never suffered a seizure. In a later statement Dr Evans said:

"Whilst I have concerns regarding the suddenness of [Baby J]'s deterioration on 27 November, one cannot rule out the presence of infection, despite the normal inflammatory markers at the time of the collapse episode."

And noted also the presence of the stoma, this exit and entry of the bowel, which could have been a source for organisms that caused a systemic infection.

Dr Evans reviewed the case later, [Baby J]'s case later, and persisted in the view that airway obstruction was the most likely cause of [Baby J]'s collapse and concluded that that couldn't be because a tube was blocked because [Baby J] hadn't been intubated at this stage, she was getting no ventilatory support at all. He excluded the possibility of [Baby J] having inhaled milk, because [Baby J] had been on normal feeds for some time, had coped well and if that had been the source of the problem then her airways would have required clearing, which

they didn't. Also he made the point that if [Baby J] had inhaled milk she wouldn't have recovered so quickly.

Dr Bohin also considered the issue of infection in relation to this occasion. She concluded that the issue could not have been infection because there had been no, what she categorised as, soft signs. By that, she's referring to a sort of gradual deterioration which you would expect if this collapse had been the result of infection.

By contrast, she made the point this was a sudden collapse and it was so sudden that whatever happened caused her brain to be starved of oxygen, which in turn had caused the seizures. She then recovered quickly and the inflammatory markers, in other words the things that they look for in your blood to see if you have an infection, were low.

Lucy Letby was interviewed about this. She said she had little recollection of [Baby J] but did remember the Broviac line, and she said that the level of interest in [Baby J]'s treatment was unusual. She confirmed contact with [Baby J] on the occasions that had been recorded in the medical records but denied doing anything to cause her any harm.

In 2020, when she was interviewed, Lucy Letby was asked why it was she'd searched Facebook for [Baby J]'s parents on 17 December 2015. She said, "I don't remember doing that".

Well, ladies and gentlemen, our case is straightforward here. We suggest that it is highly significant that children within the orbit of Lucy Letby persistently and consistently suffered unexplained collapses. Sometimes the evidence of her hand at work is more obvious than others and it's remarkable that on many occasions when children who'd suffered unexpected spectacular and life-threatening collapses were removed from her orbit, they had exceptional recoveries. [Baby J]'s case is one where, we suggest, that its parallels with other cases tell you what happened and who was responsible.

[Redacted] My Lord, that may be a convenient moment.

MR JUSTICE GOSS: Yes, it certainly is.

So we'll have our lunch break, members of the jury.

I said to you yesterday that we were going to have a full day. We will finish actually at or shortly before 4 o'clock this afternoon, but it's basically a full day.

I'm going to say now, could you please be ready to come into court for quarter past? I'll aim to recommence completely at

2.15. So you've got an hour and 10 minutes. Thank you very much.
2.15 that is, obviously.

(1.03 pm)

(The short adjournment)

(2.13 pm)

MR JUSTICE GOSS: Mr Johnson.

MR JOHNSON: My Lord.

Welcome back, ladies and gentlemen. Can we go to the indictment again, please, at page 6, counts 15 and 16. You'll see named [Babies L & M], two twins, [Babies L & M]. I'll deal with [Baby L]'s case first.

Both [Babies L & M] were born on 8 April 2016.

In the days before they were born, Lucy Letby moved into her new house at 41 Westbourne Road in Chester.

[Baby L] was born at 10.13 in the morning of 8 April. He and his brother were 33 weeks and 2 days gestation. [Baby L] was the first born and it's the prosecution case that Lucy Letby attacked [Baby L] first with insulin -- and you'll remember [Baby F] is the other insulin baby -- and then, whilst the attack on [Baby L] was underway, she also attacked [Baby M].

As with all neonates, so children just born, [Baby L]'s blood glucose levels were tested at regular intervals. Between 34 minutes of age and 6 hours and 20 minutes of age, [Baby L]'s blood glucose level was noted to be low, so hypoglycaemia. That deficiency, that low reading, was marginal and considered to be naturally occurring given his prematurity and small size.

He was treated for it with a sugar infusion, a dextrose infusion. It's in a clear plastic bag and hangs from a thing by the side of the bed and runs through a tube into the body. That was signed for by Nurse Lucy Letby and Nurse Davies at 11 o'clock. His condition improved and by the night shift that ended at breakfast time on Saturday, 9 April, [Baby L] was stable.

On the Saturday day shift, so this is the day after Lucy Letby had hooked up the sugar or the glucose infusion, the Saturday day shift Lucy Letby came on duty at 7.30 in the morning. The other staff on duty or the other nursing staff on duty, I should say, were [Nurse B], who was the shift leader, Mary Griffith,

Belinda Simcock and Ashleigh Hudson with the nursery nurse Angela McShane.

So it follows that on duty on this day shift on 9 April were only two people who were on duty when [Baby F] was poisoned with insulin. Lucy Letby was one and the other was Belinda Simcock.

Mary Griffith was the designated nurse for [Baby L] and [Baby M], who were both in room number 1, and the designated nurse for the other two babies in room number 1 that Saturday morning was Lucy Letby. By this time Lucy Letby was supposed only to be working day shifts because the consultants were concerned about the correlation between her presence and unexplained deaths and life-threatening episodes on the night shifts.

In the hours that followed Lucy Letby's arrival that morning, [Baby L]'s glucose levels fell to abnormally low levels and throughout the day he was given additional doses of glucose in an attempt to correct that low blood sugar, but they proved ineffective.

The reason for [Baby L]'s hypoglycaemia, low blood sugar, was found in a test performed on his blood sample, which was taken mid-afternoon at 3.45 that Saturday, 9 April. The sample had to be sent to a laboratory at the Royal Liverpool teaching hospital and, because of that, there was a delay in the doctors at the Countess of Chester receiving the results until some time after [Baby L]'s condition had improved. So [Baby L] -- by the time they got the results back, the problem had been sorted.

It seems that although the results of the test were grossly abnormal, nothing was done about it because by the stage the report came back, [Baby L] was well.

As with the case of [Baby F] before him, the results revealed a very high level of insulin in [Baby L]'s blood and the reading was so high that it was actually at the limits of the reading that the machinery was capable of delivering.

There was no correspondingly high level of C-peptide. You'll remember what I told you yesterday about there should be a correlation between C-peptide and insulin. It's natural that when you are producing your own insulin, you will also be producing C-peptide, and if your insulin level is high, your C-peptide level will be high, if your insulin level is low, your C-peptide level will be low, but the C-peptide level was within the normal range. So off the scale or at the limit of the scale for insulin, normal C-peptide.

The only explanation for that anomaly is that what was being measured was synthetic insulin, so somebody poisoned [Baby L]

with insulin. He was not being prescribed it, but it is a drug that's readily available in the locked fridge in the neonatal unit and it happens to be in the same fridge as the total parenteral nutrition bags, those liquid feed bags. Do you remember, I showed you an animation of one of those bags yesterday? It was yellow coloured.

So it follows that somebody certainly gave unauthorised insulin to [Baby L]. There is an infusion therapy prescription sheet in [Baby L]'s medical records. I'm just going to show you that. It is page 17948 as you can see.

This is a written record of the dextrose bag being fed to [Baby L]. What it shows is that the -- on this shift, the bag was running from 11 o'clock on 8 April when it had been set up by Lucy Letby.

You can see at the top there, there are two prescriptions that have been written for 10% dextrose at 11 o'clock -- or even three, actually. In the doctor's signature column you can see the same doctor has signed, it's Dr Bhowmick(?). And you can see that the difference is the calculation. Duration of infusion: in the top line it says 4.2mls per hour, middle 3.6, and then settling on 4.4.

It was set up by Lucy Letby and Nurse Davies. I think I said -- 11 o'clock is the time of the prescription, the infusion is timed as having been started at midday and you can see it in that far right column.

We say that Lucy Letby added insulin to that bag of dextrose. She did it deliberately to kill [Baby L]. She had failed to kill [Baby F], and so she increased the dose. You'll remember, I gave you the level of insulin that was measured in [Baby F]'s blood sample, and in round terms, I don't remember off the top of my head the precise figure, but it's about half what was found in [Baby L]'s blood. That was 4,000 and something; this was 9,999.

Well, Lucy Letby had been present at [Baby L]'s birth and she cared for him during the first day of his life on 8 April. She would have been aware of his mild hypoglycaemia and volunteered later that day to complete an additional day shift on 9 April. We say that, in effect, she saw the opportunity to complete what she had attempted with [Baby F]. So on the day of his birth, we've just seen the prescription, dextrose.

[Baby L]'s blood sugar remained dangerously low through the day shift on 9 April, despite further infusions of what in effect is sugar. At 4.30 that afternoon, the supplement required reached 12.5% and that necessitated a new replacement infusion bag because these bags are all specific concentrations.

Nurses Griffith and Letby were in the process of completing that task at 4.30 when [Baby L]'s twin, [Baby M], was suddenly taken ill, and Nurse Belinda Simcock took over so that they could both attend to [Baby M] and Belinda Simcock confirms that she actually connected the new bag for [Baby L].

So far as the expert evidence is concerned, the essence of the expert evidence is that this was a case of insulin poisoning and that it must have been administered intravenously to [Baby L] through his liquid feed. As I said before, the level of insulin was probably greater than the range that the machinery could measure, either that or it's a coincidence that it just happened to be the maximum that the machine could measure. And we suggest that the evidence will leave only the possibility that someone put insulin directly into the liquid feed.

If we're right about that, the issue will be who did it. And in answering that question, then you may care to look at what happened in all the other cases.

During her police interview, Lucy Letby agreed that she was aware of [Baby L]'s low blood sugar levels. She confirmed that she knew that prolonged low blood sugar could cause severe brain damage or even death. She confirmed that insulin on the unit was kept in a locked fridge, together with a variety of other drugs, and that the keys to the lock were passed among staff as and when needed. There was no specific keyholder, nor was a record kept of who had the keys at any given time.

She agreed that the insulin could not have been administered accidentally. She denied being responsible. Her only explanation was that it must have already been in one of the bags that [Baby L] was receiving. Well, for reasons we'll explore in evidence, ladies and gentlemen, we say that is not a credible suggestion.

[Baby M], count 16. [Baby M], born just after [Baby L]. He was born in good condition and there were no concerns. He didn't need any assistance with his breathing and there was no evidence of infection. He was classified as a special care baby as opposed to a high dependency baby within the neonatal unit. The reason he was in the higher level of room was because he was with his brother, which I'm sure you'll understand is something that will be arranged if at all possible.

[Baby M] suffered an unexpected life-threatening event at about 4 pm on 9 April at the time his brother's blood sugar was dangerously low. Without warning, [Baby M]'s heart rate and breathing dropped dramatically and he required full resuscitation by the medical staff. He came close to death. Yet 4 hours later, having been resuscitated, he was breathing

unsupported in air. So you'll remember, I'm sure, when I introduced the case to you just before lunch on Monday, I was telling you that one of the notable features of this case isn't just the speed of collapse but the speed of recovery, which defies the normal experience of the doctors.

During the day shift in notes that she wrote up at the end of the shift, Mary Griffith wrote that at 11 o'clock [Baby M] had had a small posset, which those of you with kids will be familiar with, even if you're not familiar with the term, you'll be familiar with what it is. It's almost like a mouth vomit, just a little bit of sick, the sort of thing that you tend to get on the shoulder of your best dress or your best suit jacket. It doesn't happen at other times, of course, but you'll be familiar with what I'm talking about.

At 12.15 it was noted by Mary Griffith that [Baby M]'s stomach was a little distended and his work of breathing was increased. At 12.30 there was an aspirate of 5 millilitres of stomach acid with partially digested milk, but he was fed, his temperature reverted to normal and he settled. And in the next feed the aspirate was 1.5 millilitres and bile-stained, which was then shown to the registrar and [Baby M] was put nil by mouth at that stage.

At 2.30, fluid with bile in was aspirated from [Baby M]'s stomach. He wasn't fed again between that time and 4 pm, and you'll remember he collapsed at just after that time, but it follows from that that he cannot have choked on his stomach contents because there was nothing in his stomach. So that cannot be the cause for his collapse.

At 3.30, so before his collapse, a fluid bag was attached to [Baby M], and at 3.45 he received intravenous antibiotics, and according to the notes, they were given to him by either Nurse Griffith or Lucy Letby. And so it is that Lucy Letby had the opportunity to interfere with [Baby M]'s well-being under the cover of legitimate care.

Digital records suggest that actually, when you're deciding who it was that dealt with [Baby M] at 3.45, digital records suggest that Mary Griffith was using a computer at that precise moment.

At 4 o'clock, according to Mary Griffith, both she and Lucy Letby were preparing the dextrose infusion for [Baby L] with their backs to [Baby M], so the hypoglycaemic [Baby L] needed more sugar, and Nurse Griffith and Lucy Letby preparing the infusion, backs to [Baby M].

According to what Mary Griffith said, they'd been doing for less than 10 minutes. The way this is done is one nurse acts as the

person doing it and the other acts as a checker and the nurse who is carrying out the infusion, the hands-on role in the infusion, has to scrub up and make themselves sterile. Okay? And it was Nurse Mary Griffith who was the sterile nurse, so Lucy Letby had the role of checker.

Whilst Nurse Griffith was making herself sterile, [Baby M]'s monitor alarmed and Lucy Letby was first to the cot. And such was the emergency that the doctors were called urgently to help.

[Nurse B] was also on duty near nursery 1 at this time. The way she remembers it is that Lucy Letby was standing with her at a computer when the alarm activated and she says that Lucy Letby was first to the cot and Lucy Letby immediately told the other nurses that [Baby M] wasn't breathing.

The way Belinda Simcock remembers it is that Lucy Letby was with Mary Griffith making up a solution at the time [Baby M] collapsed and that no one else was in the room. Well, the consultant, Dr Ravi Jayaram -- [redacted] -- he attended and he noticed unusual patches of discolouration on [Baby M]'s skin, which he thought particularly noticeable because of [Baby M]'s south Asian skin tone.

He thought the patches most unusual because normally, if a baby arrests, if they have a cardiac arrest and there's not enough oxygen moving round the body, the baby is uniformly pale, grey or blue. What he saw was what he thought was similar to what he'd seen during the resuscitations of [Babies A & B]. Do you remember the first two babies?

[Baby M] did not respond well to resuscitation. Treatment was about to be withdrawn after the injection of six doses of adrenaline -- six doses in 25 minutes -- when all of a sudden, he improved. And Dr Jayaram just couldn't find a cause for this sudden collapse, but the discolouration he'd seen caused him to suspect air embolism, an injection of air into the bloodstream.

As a result of his collapse, the shift leader, [Nurse B], transferred [Baby M]'s care to Lucy Letby, who became his designated nurse. At 9.14, Lucy Letby noticed that [Baby M] was tensing his limbs, curling his fingers and toes and rotating his hands and feet inwards. And that sort of sign or those sorts of signs are indicative of brain damage or starvation of oxygen to the brain. And you will remember, I'm sure, similar observations in the case of [Baby J].

On the night shift that followed, the nursing notes record that by 3.30 am [Baby M] was very active. He'd had a remarkably speedy recovery from his near death experience. He did suffer

further desaturations on that shift, and in particular at 7.15 as the day shift was about to start.

Again, the independent paediatricians have looked at this case. Dr Evans would not have expected such a prompt recovery had the cause been infection or some sort of lung problem. As a cause for [Baby M]'s collapse, he favoured either airway obstruction or air embolus, and it may well be that, subject to the eyewitness evidence of Nurses Griffith, Simcock and [Nurse B], air obstruction is an unlikely possibility.

Dr Bohin excluded a number of other potential causes of collapse and agreed with Dr Evans that the most likely cause of [Baby M]'s collapse was air embolus or airway obstruction.

A paediatric neurologist called Dr Stavros Stivaros reviewed a brain scan obtained from [Baby M] some time later, on 27 May 2016, and found brain damage which was in his opinion most likely caused by his cardio-respiratory collapse on 9 April.

When Lucy Letby's home was searched following her arrest 2 years after this incident, the handwritten log of drugs administered during [Baby M]'s collapse was found. Just so you understand what I'm talking about, in emergency resuscitation when drugs are being given to an infant who is potentially in terminal decline, there isn't somebody there standing, making careful notes in the medical records. The way it's done, tends to be done, is on a piece of loose paper. Someone will keep a note, so they're rough notes, and the rough notes are then taken and transposed into the medical records after the emergency has ended. Okay?

So what the police found at Lucy Letby's house was that emergency -- I won't say panicked, because it wasn't panicked, but the emergency record of how many doses of adrenaline were being given to [Baby M].

In her diary, Lucy Letby also made a note, and I'll just show you that:

"LD [long day] extra..."

Do you remember me telling you that she had volunteered for this shift?:

"... twin(s) resus."

On being interviewed, Lucy Letby said that she remembered [Baby M]'s collapse. She agreed that she had connected him to a fluid bag at 3 pm. She agreed that she'd co-signed for medication at

3.45 pm, but could not be sure whether she or Mary Griffith had administered it.

She said that she was alerted to [Baby M]'s collapse by an alarm sounding and commenced resuscitation immediately. She thought she must have taken the notes, which she accepted had been written by somebody else, so these are the emergency notes, if you like, the rough notes. Someone else wrote them, not she. She thought she had taken them home by accident and simply noted what had happened in her diary. So that was her explanation.

She denied that the notes were a souvenir and she denied deliberately trying to harm [Baby M]. She could think of no reason how [Baby M] could have suffered an air embolism.

We suggest, ladies and gentlemen, the prosecution suggest, that the cases of [Babies E & F] and [Babies L & M] are similar in that one each of those two pairs of twins suffered insulin poisoning and the other suffered an intravenous air embolism. And what are the chances of that happening innocently?

We suggest that coincidences like that simply do not happen innocently. Someone was responsible and we suggest the only credible candidate is Lucy Letby.

The 14th child, please, ladies and gentlemen. This is [Baby N]. You'll find his name in the indictment at counts 17, 18 and 19. Count 17 relates to 3 June. Counts 18 and 19 refer both to 15 June, 18 being between 7.15 and 7.30 in the morning, and 19 being at about 3 pm that afternoon.

[Baby N] was born on 2 June. He was 34 weeks and 4 days gestation and therefore was 2 weeks and 3 days short of being classified as a full term baby. He weighed 1.67 kilos and it was known that his mother was a carrier of haemophilia, which I'm sure you know is a blood-clotting disorder. So because of that, because of the knowledge of his mother's status, [Baby N] was admitted to the neonatal unit.

Following his birth, he quickly stabilised and, that evening, his clinical condition was described as excellent. The prosecution say that there are, as you can see from the indictment, three separate occasions on which Lucy Letby tried to kill him.

[Baby N]'s haemophilia is an important feature of his case. Many, if not most, people know that haemophilia makes someone more prone to bleeding for either no reason or a trivial reason. And it is clear from the medical notes that that's what the medical and the nursing staff at the Countess of Chester thought at the time. They were wrong.

Subsequent investigation has shown that [Baby N] has a mild version of haemophilia, and children with his mild level of haemophilia rarely bleed for no reason. Children of his age at the time of these events do not bleed for no reason and, most importantly, blood in the throat of a child with his level of haemophilia does not occur for no reason. It doesn't happen spontaneously.

But we allege that Lucy Letby thought that [Baby N]'s haemophilia give her cover to attack him because if she caused a bleed, it would be put down to the haemophilia. And she was right.

Count 17. The night shift of 2 to 3 June. Christopher Booth was the designated nurse for [Baby N] on that night shift, and [Baby N] was in room number 1. The nursing staff working that night, the other nursing staff, were Melanie Taylor, Lucy Letby, Sophie Ellis and the nursery nurse Valerie Thomas.

They all came on duty at 7.30. From 8 o'clock onwards Lucy Letby was texting her friends. She exhibited an interest in [Baby N], and in one text that she sent at 8 o'clock to her off-duty friend [Nurse E], she said:

"We've got a baby with haemophilia."

She then sent a further text saying:

"Everyone bit panicked by seems (sic) of things, although baby appears fine."

Four minutes later she sent a text saying that she was going to Google haemophilia. Seven minutes later, she texted [Nurse E]:

"Complex condition, yes 50:50 chance antenatally."

No doubt this is what her Google research had told her and it appears therefore that Lucy Letby thought [Baby N] was lucky to be alive.

Dr Jennifer Loughnane examined [Baby N] at 10.55 that night. He was presenting well and she had no concerns. Nurse Booth, Christopher Booth, confirmed that [Baby N] was stable until he went for his break in the early hours, at about 1 o'clock. And you know the drill now, ladies and gentlemen. The practice when a nurse goes on a break is they ask a colleague to keep an eye on the baby.

Nurse Booth cannot now remember who he asked. When asked about it, Nurse Taylor had no recollection of being asked but thought

it might have been someone already in nursery 1. Well, Lucy Letby didn't fall into that category, she'd been allotted two babies to care for in room 4. You know from one of the other cases what she thought about being in room 4.

At 1.05, so 5 minutes after Chris Booth had gone on his break, [Baby N] experienced a sudden deterioration in his oxygen saturation levels as they fell from 99% at 1 o'clock to 40%, which is a life-threatening level. More unusually, for such a small baby, he was described as crying and screaming. And Dr Loughnane responded to the emergency call, [Baby N] recovered quickly, and Dr Loughnane was then called away by another emergency bleep to go and deal with somebody else.

There's no entry in the medical or the nursing records recording who alerted the doctor to [Baby N]'s condition. But neither of the other nurses on duty that night -- we've excluded Christopher Booth because he'd gone on his break, the other two were Melanie Taylor -- they don't remember having been asked to take over and alerting Dr Loughnane that [Baby N] was unwell.

Dr Evans, Dr Dewi Evans, believes that [Baby N]'s deterioration was consistent with some kind of inflicted injury, which caused pain or severe pain/distress and destabilised him. His recovery was extremely prompt, which is not what one would expect if his deterioration was due to infection or bleeding.

Dr Evans concluded that [Baby N]'s screaming was consistent with inflicted injury or him having received an injection of air.

Dr Bohin agreed. She said such a profound desaturation followed by a rapid recovery, in the absence of any painful or uncomfortable procedure, suggested an inflicted, painful stimulus. She also said:

"This is life-threatening. He was also noted to be screaming and apparently cried for 30 minutes. This is most unusual. I have never observed a premature neonate to scream."

Lucy Letby didn't leave it there. I'll come to the other two incidents on 15 June.

Twelve days later, there were two separate incidents on that day shift. To put what happened into context, we suggest that it's important to note that Lucy Letby had been [Baby N]'s designated nurse on the previous day shift.

Just going back to the 14th for a moment, on that day shift, the 14th, [Baby N] had been doing really well. He was demanding expressed breast milk and taking more than the required volumes.

He was almost ready to go home and the only thing that was holding him back was jaundice. Overnight he was in nursery 3. At the beginning of the night shift, so this is the night shift of 14th to the 15th, just after Lucy Letby had handed him over to Jennifer Jones-Key, [Baby N] was described as being "very unsettled".

At 1 in the morning he was found to be pale, mottled and veiny, with slight abdominal distension, so swelling. The mottling persisted, he was monitored by staff through the early hours and he desaturated to the low 80s on a number of occasions but self-corrected without any intervention from the nursing staff.

He was seen on three separate occasions by the registrar, [Dr A], who saw nothing of concern: no signs of injury or blood but, as a precaution, the decision was taken to test for infection.

Lucy Letby was to be [Baby N]'s designated nurse again on 15 June. The use of her phone suggests that she was awake by 5.10 that morning. Later, [Nurse E] texted her to tell her that things on the unit were busy and "[Baby N] screened, looks like shit".

Lucy Letby was in for her day shift by 7.12. We know that because she texted the registrar, [Dr A], to tell him that she had "escaped 1", in other words escaped room 1 and was "back in 3", room 3.

The electronic records of the hospital on the door fob suggest that she passed through the fob-controlled security door, the first one at 7.10 and the second one at 7.12. And the other nurses working on the day shift were [Nurse B], Bernadette Butterworth, Minna Lappalainen, and the nursery nurses Vicky Blamire and Janet Pearce. [Nurse E] stayed in beyond the end of her night shift for a couple of hours.

Now, Jennifer Jones-Key, who had been the nurse to whom Lucy Letby had handed over [Baby N] the night before, was coming off as Lucy Letby came on that morning. She described some improvement in [Baby N] up until about 7.15 when Lucy Letby arrived early for her day shift.

Lucy Letby, she says, came into the room to say hello, but when she did that, Nurse Jones-Key had her back to Lucy Letby and her back to [Baby N]. And Lucy Letby said to Jennifer Jones-Key that [Baby N] had desaturated before immediately assisting with his breathing. There was no evidence of an alarm sounding or of Lucy Letby waiting to see whether he self-corrected. [Redacted].

[Dr A] was called to attend and [Baby N] was handed over to Lucy Letby as his designated nurse and transferred into nursery 1.

The medical notes that were made at 8 o'clock recorded desaturations of 48%, a dangerously low level.

During this event, an attempt was made by the registrar, [Dr A], to put an ET tube down [Baby N]'s throat. You know what I'm going to say. In his statement [Dr A] describes that he was "surprised by his anatomy more than anything else. I couldn't visualise parts of the back of his throat because of swelling."

[Baby C]. When [Dr A] looked, he saw that there was fresh blood in [Baby N]'s throat. [Baby C], [Baby E], [Baby G] and now [Baby N]. All with the same issue.

[Dr A] couldn't get the breathing tube down [Baby N]'s throat because he couldn't see the inlet to the trachea in the throat. He tried to intubate [Baby N] on three occasions.

If we look at page 19315, please. What we've got here, ladies and gentlemen, is an intensive care chart, you can see, from the Countess of Chester. We can see highlighted a number of things. 15 June, top left. This chart basically divides into two. Input and output.

So the left hand -- you can see highlighted in yellow the words input and output. So what are we putting into a baby, what's the record of what we're putting in and what's coming out of the baby?

What we see is that this record started at 9 o'clock in the morning on the 15th, so after [Baby N] had collapsed. It's about 100 minutes or so after the collapse, which coincided with Lucy Letby's arrival.

What you have there is Lucy Letby's handwriting -- or mostly Lucy Letby's handwriting, I should say. If you look at the very right-hand column, you've got LL times 5 for those entries and then for the entry at 15.00 hours you've got [initials of Nurse B], which is [Nurse B].

So at 10 o'clock, you see it's highlighted on the left-hand column, 10, and you read across, you can see in handwriting "1ml fresh blood". That's recorded in the "NG ASP/VOMIT" column. You can't see what the column is headed in the expanded part of the chart, but those of you with better eyesight than me can probably see it -- it's completely obscured again. Thank you. Yes, it's there. Thank you.

Just let's put this into context. This is a baby that Lucy Letby thinks has beaten the odds, or at least beaten the evens, 50:50, making it through to a live birth, and has -- and we know she

thought, and she was right, he had haemophilia but not to the extent she thought, as I will tell you in a moment.

The column that I have just highlighted before, the 1ml fresh blood, is intended to record the aspirates that are withdrawn from the stomach through the NG tube before a baby is fed. But the bleeding, other than that writing, which is Lucy Letby's handwriting, that bleeding isn't recorded anywhere in the medical notes, so in the doctor's notes. No doctor ever made a similar note. This was more than 2 hours after [Dr A] had tried to intubate [Baby N] following his collapse at 7.30.

Now, at 11.29, so an hour and a half after that note, if that note is correct and is timed correctly, at 11.29 Lucy Letby sent a Facebook message to [Dr A] telling him:

"Small amounts of blood from mouth and 1ml from NG."

Which would tie in with that handwritten entry:

"Looks like pulmonary bleed on X-ray."

What that means is a bleed in the lungs, which is the sort of thing that you might get if you were a premature baby with haemophilia.

"Given factor 8, wait and see."

So that's the message she sent the doctor. But other than that phone message, there's no evidence that she brought the bleeding to the attention of any of the medical staff who were on the ward, which is surprising given the problems that [Baby N] had suffered with an extreme collapse at the beginning of the shift.

In an update recorded on the computer notes at about 1.55 that afternoon, she wrote that [Baby N] was "stiff" on handling, extending his upper limbs and arching his back. And I probably need to say no more than [Baby D] and [Baby J] to you in that respect. You will remember similar observations with them.

If we just have the -- sorry, having told you to get rid of it -- thank you.

At 3 o'clock, 15.00 hours, if you read across, towards the right of the screen, what we have there, ladies and gentlemen, is "occluding" written, and then towards the right "3ml blood". That is, we say, Lucy Letby's handwriting. It's not [Nurse B]'s handwriting, although she has initialled it, and that coincides with a second collapse that day. This is the second of the two counts of the day.

Just before 3 o'clock that afternoon, the medical staff were crash bleeped because [Baby N]'s oxygen levels had fallen this time to 44%, so again life-threatening.

Dr Huw Mayberry was the first to respond. He was junior and was aware of the problem that the more senior doctor, [Dr A], had had that morning, trying to intubate [Baby N], and because of that, he crash bleeped the consultant, Dr Saladi. He did that at 1.59.

While waiting for Dr Saladi to arrive, he looked into [Baby N]'s mouth, into his airway, and saw what he describes as a large swelling at the end of his epiglottis. The epiglottis is that funny thing that hangs down from the top of the back of your throat. And he could only just see the bottom of [Baby N]'s vocal cords. He had never seen anything like this in a newborn baby.

On the other hand, Dr Saladi made notes at 4.30. He recorded this:

"Desaturated this afternoon at 2.50 pm with blood in the oropharynx [so that's the top of the throat] and blood in the NG tube. Improved with bagging, elective intubation planned following??? Unsuccessful attempts with two registrars and two consultants. Cords difficult to visualise."

So putting that into more straightforward language, various people have tried to intubate this child but because of what looked like problems in the throat, had not been able to.

The notes made by Lucy Letby towards the end of the shift at about 6.30 record this:

"At approximately 2.50 infant became apnoeic with desaturation to 44%. Heart rate 90 beats a minute. Fresh blood noted from mouth and 3mls of blood aspirated from NG tube. Doctors crash called."

Ladies and gentlemen, [Baby N] was so unwell that attempts were made to re-intubate him, to put a tube down his throat, but [Dr A] couldn't see down the throat because the view was obscured by fresh blood. Something, somebody, we say, had caused [Baby N] to bleed again. And it took a more specialist team who were called in to carry out the intubation.

[Baby N] continued to be unwell throughout that day and the difficulties with ventilating him persisted, despite the experience of the doctors involved, and eventually he had to be transferred to Alder Hey Hospital in Liverpool, where he

recovered quickly, following the pattern of [Baby H] and [Baby I].

Again, ladies and gentlemen, the independent specialists, the non-Countess of Chester specialists, have looked at [Baby N]'s case. It is Dr Evans' considered opinion that the blood seen in [Baby N]'s throat had originated in [Baby N]'s throat and hadn't come up from the stomach. In Dr Evans' opinion the bleeding was not caused by the attempts to put a tube down his throat, but instead it was something before that that had caused the collapse in the first place. He placed particular significance on the presence of blood in [Baby N]'s throat before [Dr A] had first tried to insert a tube into [Baby N] at 8 that morning.

He suggested that the bleed might have been caused by thrusting an NG tube into the back of [Baby N]'s throat because [Baby N] was otherwise a stable baby who didn't suffer any spontaneous bleeds at any time as a result of his condition.

Dr Bohin suggested only two possibilities: either inflicted trauma or a spontaneous bleed. She considered the idea of a spontaneous bleed, in other words bleeding for no reason, to be less likely because of the level of [Baby N]'s haemophilia. That is a question that has since been confronted by Professor Kinsey, whose highly specialised area is blood disorders.

Dr Bohin's view was that the likely cause of bleeding was trauma to the mouth, to the throat or to the oropharynx, this area, which was most likely from an NG tube or a suction catheter, and she thought that the injury to the epiglottis seen by the junior doctor in the afternoon supported the suggestion that there had been a further attempt to injure [Baby N].

As I have already said, Professor Kinsey considered the significance of [Baby N]'s diagnosis of moderate haemophilia in the context of the evidence relating to his collapses and reported bleeding. She describes the first collapse at the beginning of June as dramatic with no recognised medical cause. She excluded the possibility of pulmonary haemorrhage, in other words bleeding from the lungs then coming up, causing the collapse on 15 June because, in her opinion, such bleeding would not have occurred spontaneously in a child with [Baby N]'s degree of haemophilia. So it follows, we say, that the bleeding must have been caused by trauma because the blood was seen before anybody tried to put a tube down [Baby N]'s throat.

As a matter of interest, Dr Kinsey also rules out heavy-handed intubation as a potentially accidental cause.

When she was interviewed by the police, Lucy Letby said that she had difficulty remembering [Baby N] and she didn't think that he

had been named at the time and she was right about that. She did recall an occasion when doctors had difficulty intubating [Baby N]. She agreed that she'd seen blood, but she denied being responsible for causing him harm.

She couldn't explain the injury in her notes, the one I showed you earlier from 10 o'clock in the morning on 15 June, in which she recorded aspirating more fresh blood which she had not apparently brought to the attention of anybody else at that time, at 10 o'clock.

So that is the case or the cases of [Baby N], and we come now to the [Babies O & P], who are often in this case referred to by witnesses by the surname [redacted].

MR JUSTICE GOSS: Mr Johnson, I'm just going to enquire of the jury if you would like a break. The alternative to having a 10-minute break now and then doing half an hour is just to do half an hour or thereabouts now. Are you happy...? Carry on? Good, thank you. We'll do that then. If you could finish no later than 10 to, please.

MR JOHNSON: Yes, of course.

MR JUSTICE GOSS: Thank you very much.

MR JOHNSON: So we're dealing now with counts 20 and 21. So pages 7 and 8 of the indictment -- and you'll be glad to see the indictment ends at page 8, so that's a good sign.

We allege that Lucy Letby murdered two of the three brothers who were born on Tuesday, 21 June to [Parents of Babies O, P & R]. I'll deal first with the case of [Baby O], whose murder is alleged in count 20.

[Baby O] was born at 2.24 in the afternoon on Tuesday, 21 June at a gestational age of 33 weeks and 2 days. He weighed 2.02 kilos, which for a premature triplet is pretty good. He was in good condition and he made good progress. He remained stable up until the afternoon of Tuesday, 23 June, when he suffered what Dr Evans described as "a remarkable deterioration" and died.

His death was 8 days after Lucy Letby had tried to kill [Baby N]. Between trying to kill [Baby N] and her attack on the [Babies O & P], Lucy Letby had been on holiday to Ibiza, so she'd not been at work.

Overnight, on 22 to 23 June -- so he was born on the 21st. So overnight on the 22nd to 23rd, [Baby O]'s designated nurse had been Sophie Ellis and the feeding chart records that when his stomach was aspirated by the NGT, there had been some partially

digested milk. And Sophie Ellis had asked Dr Mayberry to check [Baby O] because his abdomen appeared slightly distended, slightly swollen. Dr Mayberry did so and had no cause for concern. That examination wasn't documented in the medical notes but it does appear in Sophie Ellis' nursing notes that were timed at 7.30, so the time of the handover.

When [Baby O]'s body was examined after his death, an injury to his liver was found, so the police went back to Dr Mayberry who had checked [Baby O]'s abdomen. They showed him the pathologist's report and asked whether he, Dr Mayberry, when he'd examined [Baby O] that morning he'd detected any symptoms to indicate either any liver issues or any damage and Dr Mayberry said no.

Well, Lucy Letby was working the day shift on Thursday, 23 June, and you know the form now. She came on duty at 7.30 that morning. She was the designated nurse for [Babies O & P], who were both in room 2, with another child who I will refer to as JD, for whom she was also the designated nurse. So it follows that there were three children in room 2: one was [Baby O], one was [Baby P], and the third was JD. Lucy Letby was the only nurse working in the room.

We say that gave her an open opportunity to sabotage the babies, though she did at the same time have the responsibility of supervising a student nurse called Rebecca Morgan.

Ironically, the third of the triplets, [Baby R], was in room 1, and so it appears that the doctors thought that he was the more needy of the triplets.

Other nursing staff on duty that day were Melanie Taylor, who was the shift leader, Samantha O'Brien, Christopher Booth and Yvonne Griffiths and the nursery nurse was Janet Cox.

[Baby O] was examined again at about 9.30 by Dr Katarzyna Cooke --

MR JUSTICE GOSS: I'm sorry about this, someone's obviously drilling something, I think. And now hammering.

(Pause)

We'll carry on anyway. If you can't hear anything, just say, raise a hand.

Thank you.

MR JOHNSON: Dr Cooke, Katarzyna Cooke, at 9.30 that morning, examined [Baby O]. She recorded no nursing concern, observations

normal. So when you're considering whether [Baby O] had a liver injury at this stage, another doctor examined him and found no cause for concern.

[Baby O] was getting some breathing support through Optiflow, which is the least invasive breathing support, but he was in air, so no supplemental oxygen required, just normal air under a bit of pressure. He was breathing normally, his abdomen was noted as appearing "full", but not distended, soft, non-tender. So a good sign.

[Baby O] was being fed donated breast milk via a nasogastric tube, and there are three records of feeds made by Lucy Letby to [Baby O]: one at 8.30, one at 10.30 and one at 12.30. And all appear to be in the same writing and the latest two are signed by Lucy Letby with the earliest, in other words the 8.30 one, signed by the student Rebecca Morgan. On each occasion, there was a "trace" aspirate before the feed. That is normal.

In a note made by [Dr A] in the notes at 1.15, so in other words an hour and three-quarters after the last of the feeds at 12.30, [Dr A] noted "1 times vomit post feed" and "abdomen distended". As a precaution, [Baby O] was put on to intravenous fluids. That followed a feed given by Lucy Letby, and [Baby O]'s heart rate was elevated to 160 to 170 beats a minute and his blood gases showed a low pH and raised carbon dioxide level, which [Dr A] described as being not normal for a child who was breathing on his own. So [Dr A] decided to treat [Baby O] for suspected NEC, although --

MR JUSTICE GOSS: Sorry, could you just pause for a moment? I'm just going to find out what's going on.

(Pause)

We can't find the source of it at the moment. If you're finding it too distracting, because it is actually quite distracting to have the noise going on, please indicate, raise a hand, and we'll just finish a little bit earlier. But if you're all right to continue, we'll continue. This is all very important and you've got to concentrate and it's getting near to the end of the day.

It has stopped for a moment. Let's wait and see.

MR JOHNSON: As soon as I start talking again, it'll start inevitably. Here goes. I'll just remind you of that bit, okay?

MR JUSTICE GOSS: Please do.

MR JOHNSON: [Dr A] made a note at 1.15 in the afternoon and his note said "1 times vomit post-feed" and also "Abdomen distended" and that's why [Baby O] was put on an intravenous feed, so liquid feed, into his bloodstream rather than what they call an enteral feed, which is a traditional feed through the mouth.

That followed a feed given by Lucy Letby, that problem, and [Baby O]'s heart rate was up at between 160 and 170 beats a minute and his blood gases showed a low pH value, so acidic, and raised CO2, so raised carbon dioxide, which I told you [Dr A] described as not normal for a child who was breathing on his own. That's why [Dr A] decided to treat [Baby O] as a suspected case of NEC. So don't take any chances, assume the worst and treat for the worst.

According to what [Dr A] did note, it was thought that [Baby O]'s abdominal distension, the swelling of his belly, putting it bluntly, was because of the Optiflow, because of the breathing support he was getting, so swallowing air in effect, or that it might have been the strain of passing a stool which he had been recorded as having done earlier.

An X-ray was taken at the time. That showed a moderate amount of gas in the loops of his bowel. Do you remember that graphic of the baby yesterday that you saw with the NG tube going down into the stomach and below the diaphragm and then the stomach and the loops of bowel going down? In her note made at the end of the shift, Lucy Letby wrote this:

"Reviewed by [Dr A] at 1.15. [Baby O] had vomited undigested milk. Tachycardic [which means high heart rate] and abdomen distended. NG tube placed on free drainage."

Now, putting the NG tube on free drainage, you'll remember, enables any excess gas to come out, to vent in effect:

"10 ml/kilo saline bolus."

This is a dose of saline given as prescribed along with antibiotics. Of course saline also can -- yes:

"... given along with the antibiotics. Placed nil by mouth and abdominal X-ray performed. Observations returned to normal."

Prior to [Baby O]'s collapse, Melanie Taylor was in room 2 with [Baby O] and with Lucy Letby. While Melanie Taylor was in the room with Lucy Letby, she said to Lucy Letby of [Baby O], so figuratively if not literally pointing to [Baby O], Melanie Taylor said to Lucy Letby:

"He doesn't look as well now as he did earlier. Do you think we should move him back to room 1 to be safe?"

You've heard this before, haven't you? Lucy Letby did not agree. And that has echoes, doesn't it, of the final fatal collapse of [Baby I] and what Lucy Letby said to Ashleigh Hudson? So events repeating themselves.

Lucy Letby recorded that she had taken [Baby O]'s observations at 2.30 that afternoon. His heart and breathing rates were normal and his saturations in air, so no additional oxygen, were 100%, as good as you can get. So that's what she recorded in his notes at 2.30, but we know from her phone that at that precise moment she was sending messages over Facebook Messenger. So at the time that she was recorded as writing in the notes, actually on Facebook Messenger. The door fob entry data shows that she came into the neonatal unit at 14.39, so 9 minutes after that entry.

So whether the timing of that observation of [Baby O] is correct or accurate may be a matter that we will consider in the evidence, but whether or not there's a point there, within a few minutes of Lucy Letby coming back into the neonatal unit, as evidenced by the door entry system, [Baby O] suffered his first collapse.

Melanie Taylor responded to a call for help from Lucy Letby, who was alone with [Baby O] in room number 2. The door data suggests that the call for help must have come some time after 14.46 because that was the time that Mel Taylor came back into the unit. Anyway.

[Baby O]'s heart rate and saturations had dropped to dangerously low levels and a breathing tube was inserted by the doctors and he was successfully resuscitated and then kept on a ventilator.

Some time later, at about 3.50, [Baby O] desaturated again and [Dr B] and [Dr A] removed the ET tube and replaced it as a precaution. Lucy Letby's notes written later that day suggest that it was she who called for help, so yet again she's the one.

[Baby O] suffered yet a further collapse at 4.15, which again required resuscitation, including cardiac compressions, and tragically those efforts were unsuccessful and were withdrawn at 17.47 and [Baby O] died soon after.

During this episode, Dr Brearey, the consultant, noted that [Baby O] had an area of discoloured skin on the right side of his chest wall, which was -- the medical term he used is purpuric. That means a rash which looks like small spots of blood on the skin.

Dr Brearey, the consultant, noticed a persistent rash at 4.30, which had disappeared by 5.15, and consequently he concluded that it wasn't purpura, as he understands that to be, and was unsure what had caused it. He was particularly concerned, was Dr Brearey, about [Baby O]'s death because [Baby O] had been clinically stable before these events. His collapse was so sudden and he didn't respond as he should have done to resuscitation.

After the shift, Lucy Letby sent a variation of text messages to [Dr A], the registrar, on Facebook at just before 9 pm. She also communicated with her friend, [Nurse E]. She told [Nurse E] that [Baby O] had died and said the following. She suggested that he had:

"Had a big tummy overnight, but just ballooned after lunch and went from there."

A post-mortem examination took place and Dr Kokai, the pathologist, found free, unclotted -- in other words liquid -- blood in the peritoneal space which had come from the liver. The peritoneal space is the cavity in your abdomen. There was damage in multiple locations, both on and in [Baby O]'s liver, and the blood that was found in the peritoneal cavity had come from the liver.

Dr Kokai certified death on the basis of natural causes and intra-abdominal bleeding. He observed that the cause of the bleeding could have been asphyxia, trauma or vigorous resuscitation. Of course, it wouldn't occur to him that perhaps a nurse had assaulted a child on a neonatal unit. That, however, did occur to other experts.

Dr Evans reviewed the case and he concluded that [Baby O]'s death was the result of a combination of intravenous air embolus, in other words air into the bloodstream, and trauma. Dr Evans' view was that the liver injury was not consistent with vigorous CPR. His view was that the liver damage would have occurred before the collapse and contributed to it and was probably the reason for his symptoms through the morning. As for the air in the bowel loops, Dr Evans concluded that that was consistent with air going down the NGT.

Dr Bohin noted intravascular gas, in other words gas in the bloodstream, in the post-mortem X-rays and concluded that, together with the chest wall discolouration seen by Dr Brearey, that was indicative of air having been injected into [Baby O]'s circulation. She also thought that the swelling of the abdomen of [Baby O] was due to excess gas given down the nasogastric tube.

The reviewing pathologist, Dr Andreas Marnerides, thought that the liver injuries were most likely the result of some impact trauma, so in brutal terms an assault, not CPR. He thought that the excess air -- he thought that excess air via the nasogastric tube likely led to stimulation of the vagal (sic) nerve, which has an effect on the heart rate and would also have compromised [Baby O]'s bleeding.

He couldn't say whether it was either of those factors in isolation or in combination which had caused [Baby O]'s death and he certified the cause of death to be:

"Inflicted traumatic injury to the liver and profound gastric and intestinal distension following acute excessive injection or infusion of air via a nasogastric tube and air embolus."

So we've got a combination of three here, ladies and gentlemen: air into the bloodstream, air down the tube, and some sort of impact injury to [Baby O]'s liver causing bleeding.

In her police interviews, Lucy Letby said that she responded to [Baby O]'s alarm at 1.15 and she found that he had vomited. She said the alarm sounded again at 2.40. She was again the first to respond and, on this occasion, discovered mottling all over him, with purple blotches and a red rash, and you've heard that before, haven't you?

She said that his abdomen just kept swelling and suggested that sometimes babies can gulp air when they are receiving assistance from Optiflow, as [Baby O] was.

A year later, on the anniversary of [Baby O]'s death, Lucy Letby carried out a Facebook search for [surname of Babies O, P & R].

MR JUSTICE GOSS: Well, that's a convenient moment to end today. About how much longer? I think the jury might just want to know what tomorrow holds.

MR JOHNSON: An hour at the most, I think.

MR MYERS: As your Lordship knows, on behalf of Ms Letby, what we deal with is an introduction. It's not the same length or the same detail as the prosecution speech, but in the circumstances there has to be some detail and I anticipate it will be between about one and a half hours and 2 hours. Maybe closer to one and a half, but something like that.

MR JUSTICE GOSS: There's no pressure of time whatsoever.

MR MYERS: I'm grateful, my Lord.

MR JUSTICE GOSS: It's obviously helpful for the jury to know what is in issue in particular --

MR MYERS: Yes.

MR JUSTICE GOSS: -- so that before they start hearing the evidence, they know what's essentially not in dispute and what is in dispute.

MR MYERS: Well, we will deal with that and some other matters that we choose to do so at this early stage. We shall assist with that, but of course, as your Lordship knows, and as I will explain to the jury, it's not of the same magnitude as the prosecution opening speech, it's quite a different thing.

MR JUSTICE GOSS: You'll understand that, I'm sure, and this is all before you hear the evidence and, as you've been told more than once, it's going to be on the evidence that you are going to reach decisions in this case.

Right. Thank you very much. Could you be ready, please, to resume at 10.30 tomorrow morning? I'm going to give you notice about Monday morning now. I said I would give you notice if there was going to be any different time that we began or ended proceedings on any day. On Monday, for good reasons, we will be starting at 11 o'clock, not 10.30. So it's a slightly later start on Monday, but essentially it's almost a full day. All right? Thank you very much indeed. 10.30.

Please remember, don't talk about this case to anyone, not even a fellow juror, no research, and no communication by any means, electronic or otherwise, with anyone to do with this case. Thank you very much.

(In the absence of the jury)

Housekeeping

MR JUSTICE GOSS: Just a couple of small matters: epiglottis --

MR JOHNSON: The epiglottis.

MR JUSTICE GOSS: I think what you were indicating was the uvula. The uvula is the bit that dangles down. The epiglottis is effectively the flap that stops food going into the lungs.

MR JOHNSON: Yes. And it's not in the glossary.

MR JUSTICE GOSS: Sorry?

MR JOHNSON: It's not in the glossary.

MR JUSTICE GOSS: Neither is in the glossary, but epiglottis -- it should be. There's also -- because I was looking at the glossary this morning when you were referring to thoracocentesis. If you look at it on page 23, the sentence that begins halfway through the definition: "A cannula or hollow needle is carefully introduced into the chest between the ribs in order racks." It doesn't make sense.

MR JOHNSON: We'll print it out and we'll try and print...

MR JUSTICE GOSS: If it can be corrected manually, if it's a very small correction, you can reprint the whole page if you want, but then we'll have the business of removing and replacing. I'll leave it to you.

MR JOHNSON: Thank you.

MR JUSTICE GOSS: All right, thank you very much.

(3.46 pm)

(The hearing adjourned until 10.30 am on Thursday, 13 October 2022)