

13 October 2022 (Day 7)

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Housekeeping

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Thursday, 13 October 2022

(10.30 am)

(In the absence of the jury)

Housekeeping

MR JUSTICE GOSS: Mr Johnson, a number of matters. In relation to the iPads, that's all agreed, is it, so far as that is concerned?

MR JOHNSON: Yes. The position is going to be that following Mr Myers' address to the jury, the jury are going to be given a tutorial in open court, in effect, by Mr Murphy, who is the gentleman sitting directly behind me on the back row.

MR JUSTICE GOSS: Good, thank you.

MR JOHNSON: He will also give the lawyers and your Lordship a tutorial. Whether your Lordship chooses to have it with us or separately is plainly a matter for the court. I think it takes about 20 minutes or so, half an hour maybe. I've had it before.

MR JUSTICE GOSS: Right. Well, we can deal with that in due course, but these will need charging overnight, these iPads, so the proposal is that jurors, and indeed the defendant, who will have one for use during the course of the hearing, will simply leave it on their places, they will be charged overnight and they'll be back in their places for the next day.

These, as I understand it, are devices where all you can do is access the material on it, you can't access anything else and you can't alter anything. Am I right?

MR JOHNSON: You can make notes on them, they are individual to the user, because there is an individual password for each -- a bespoke password, so you can access your own notes.

MR JUSTICE GOSS: Right. That's fine.

MR JOHNSON: It's on a server -- a network was the word I was looking for, actually -- a network that's self-contained. It doesn't have internet access or anything.

MR JUSTICE GOSS: Fine. I'm content with that. Mr Myers, are you content?

MR MYERS: We are, my Lord, thank you.

MR JUSTICE GOSS: Thank you very much. Good.

You will have both seen, I hope, the letter from a solicitor.

MR JOHNSON: Yes. We both saw it separately, we both came to the same conclusion. The difficulty -- first of all, the problem, in inverted commas, that's identified by the letter is people who already know something may be told the same thing that they already know. Only people that know will be alerted by what has happened.

Introducing a different system at this stage of the case will insert an added level of complexity and complication, which is likely to cause significant problems in the trial because the medical records of these children form part of the neonatal reviews which, putting that into readily understandable language, is the material that relates to other children who were on the unit at the time that the prosecution say events that the jury are considering were going on.

MR JUSTICE GOSS: Well, look, what I'm going to do in relation to this -- is there going to be reference to any other children today?

MR JOHNSON: I can't remember off the top of my head, I'm afraid, but it's two or three initials. Where three initials are introduced that's simply where two people have the same initials.

MR JUSTICE GOSS: All right. We'll put it on hold for the moment. Perhaps at the moment, if you simply don't refer to any initials, you can do that just saying "another child who was there". We'll do it that way.

MR JOHNSON: Yes.

MR JUSTICE GOSS: Then we'll look into this more carefully.

MR JOHNSON: Yes.

MR JUSTICE GOSS: Right, thank you very much.

I think you said you thought you'd be about another hour.

MR JOHNSON: I think so.

MR JUSTICE GOSS: Mr Myers, would you like a short break before -- I think it's better to have a short break before.

MR MYERS: That's helpful, thank you, my Lord.

MR JUSTICE GOSS: We'll have a 10-minute break at that point.

Jury in, please.

(In the presence of the jury)

I'm sorry you're a little late coming into court. We've actually been discussing matters that we have to deal with today, in particular in relation to the tutorial you're going to receive, and I'm going to receive, in the use of the iPads, things like that, so we've just been dealing with the mechanics of what's going to happen later today. We are ready to proceed.

Mr Johnson.

Opening by MR JOHNSON (continued)

MR JOHNSON: Thank you, my Lord. There's also the issue of discharging the supplemental jurors that we'll need to deal with.

MR JUSTICE GOSS: Exactly, but I thought we would deal with that after Mr Myers.

MR JOHNSON: Thank you.

Good morning, ladies and gentlemen. Home straight now as far as I'm concerned, at least -- or listening to me is concerned.

Can I just deal with a mistake that I made yesterday. I was giving you my layman's description of the epiglottis and, predictably, I got it wrong. The epiglottis is actually a flap of tissue that sits beneath the tongue at the back of the throat and its main function is to close over the windpipe when you swallow so food or liquids don't go into your lungs. So sorry about that.

We are going to move back to the indictment, please, and the case of [Baby P]. It's count 21. At the end of yesterday I told you that his brother, [Baby O], had been murdered by Lucy Letby on 23 June. You will see on page 8 of the indictment [Baby P]'s

name appearing. We allege that Lucy Letby murdered [Baby P] on the following day, on the 24th.

So I'm going to start, so far as [Baby P] is concerned, with what happened from his perspective on the day we say Lucy Letby murdered his brother, so 23 June. Do you remember, by that stage, this was day 3 for him, having been born on 21 June?

[Baby P] was breathing for himself on the 23rd in air, so no supplemental oxygen required, from 6.30 on the morning of the 23rd. And as I've already told you, I'll just remind you, he was in room number 2 with his brother, [Baby O].

Lucy Letby fed [Baby P] some donor expressed breast milk on the day shift at 8 am, 10 am, noon, 2 pm and 6 pm. The final feed, the one at 6 pm, which you know is an hour and a half or so, up to 2 hours before the end of the shift, Lucy Letby recorded at 6. If it was accurately recorded, the time of it was accurately recorded, it was at about 13 minutes after [Baby O] had died.

There was no record of anything unusual happening with [Baby P], either before or after he was fed. I'm just going to show you the feeding chart now if, I may. It's page 23981.

I'm sure you're already reasonably familiar with how these things work, but I'll just remind you, if I may. In the top left-hand corner, [Baby P]'s name appears. His date of birth underneath. In the top right-hand corner, day 3, in other words -- you remember the day of birth is counted as day 1.

You can see when the NGT, the nasogastric tube, was due to be changed, there's the length of the tube from mouth to stomach, 19 centimetres, and you can see where it was and the tube inserted was on the 23rd -- I think it says "right" -- and then "20", so maybe that's 20 centimetres.

Underneath there we have the feeding chart itself. Okay? If you go down -- if we go down the chart to where it says "Feeds", which is -- thank you. Perfect. What we can see is that -- and if you look right down to the bottom of the page you can see initials at the bottom of the page and the signature line at the very bottom.

There are two sets of initials in some of these cases. RM and LL. Lucy Letby, obviously, is LL. RM is the student nurse I told you about yesterday, Rebecca Morgan.

So you can see immediately that [Baby P] was being fed every 2 hours. He was being fed at the beginning of the shift at 8 o'clock, 13 millilitres, you can see. Then when you get on to 2 pm you can see the amount of feed was increased to 15

millilitres, and above where it says "15" you can see "NG", which is route, so nasogastric tube rather than a bottle, and above that you can see "EBM", which means expressed breast milk. And you can see -- underneath the 15, you can see what in effect is a running total for the day. Okay?

So up to and including the feed at 12 o'clock, [Baby P] that day had had 76 millilitres, plus the 15 given at 14.00 hours, which gives you the running total of 91 and so on.

So just going back to the bottom line again, the signature line, as I said, Rebecca Morgan and Lucy Letby. But you can see that the 6 o'clock feed, so the last feed of the day shift, is Lucy Letby alone, so no Rebecca Morgan countersignature.

If we now go, just to make this page look more complicated, to just below the feed box that's now in orange, there's another line saying "Aspirates". What I'm going to concentrate on, ladies and gentlemen, is the aspirates during the day shift, so 8 o'clock onwards.

Do you remember what an aspirate is? I'm sure. I keep repeating this because in the context of this case it's important. It's the amount drawn up with a syringe through the nasogastric tube from the stomach. So it's checking whether there's anything in the stomach before the baby was fed.

What you can see in handwriting is, at 8 o'clock, trace. 10 o'clock, trace. Midday, I think it's a small vomit. 2 pm, trace. 4 pm, trace. And nothing at all written in there on the occasion that Lucy Letby was doing this alone.

And yet when we get to the first feed of the night shift, so almost at the moment that Lucy Letby handed over [Baby P] to the night shift nurse, when the night shift nurse drew the aspirate, the night shift nurse retrieved 14 millilitres of milk, which is 1 millilitre short of what, if the chart is the truth as to what Lucy Letby withdrew, it's all but 1 millilitre of what [Baby P] had been fed 2 hours earlier.

Because [Baby O] had died in such unusual circumstances, [Baby P] was reviewed by the consultant, Dr Gibbs, at 6 pm, and Dr Gibbs recorded that [Baby P]'s abdomen was full and mildly distended. There was no tenderness, he had active bowel sounds, which is a good sign, as is the lack of tenderness of his abdomen. He was screened for infection. An X-ray taken at 8 o'clock, so the time that that 14-millilitre aspirate was removed from [Baby P]'s stomach, showed a striking gaseous distension, a swelling caused by gas throughout his stomach and his whole bowel.

Undoubtedly that was at a time when Lucy Letby was still on the ward because the electronic note that she made, which is timed automatically by the computer, is timed at 8.24. Putting it bluntly, ladies and gentlemen, the allegation here is that she deliberately caused a problem for [Baby P] as she was going off duty so that overnight he'd have problems, which would divert attention away from Lucy Letby. So that's the allegation. I'm sure you've seen that coming, but that's the allegation.

Anyway, on the night shift, the milk feeds were stopped for [Baby P] because another large part-digested aspirate was drawn up the nasogastric tube at feeding time. And during the night shift [Baby P]'s abdomen was full but soft. So full, a warning sign; soft, a good sign. However, by 6.39 the following morning, the night shift nurse, who was Sophie Ellis, recorded in the notes that:

"Abdo has been soft and non-distended..."

So the abdomen had gone back to normal and was soft, that 25 millilitres of air had been aspirated by one of the nurses and that the nasogastric tube had been put on free drainage, which you'll remember means any excess air can vent, so it doesn't cause a problem.

So, ladies and gentlemen, it looks from the records that the problem that Lucy Letby handed over [Baby P] with to Sophie Ellis had been resolved by the end of the night shift and it seems that the problem, or one of the problems, was too much air in [Baby P].

The next medical note, in other words the next doctor's note, was made on the 24th, so the day [Baby P] was to die, at 9.35 in the morning. But before that, when the day shift came on at 7.30/8.00, Lucy Letby had been designated as [Baby P]'s nurse again. [Baby P] was still in room 2, this time he was with his brother, [Baby R], so the third triplet, and also [Baby R]'s designated nurse was Lucy Letby. But as events unfolded with [Baby P], Christopher Booth became [Baby R]'s designated nurse.

On this day shift the other nurses were [Nurse D], Yvonne Farmer and the student Rebecca Morgan, Janet Cox and Angela McShane were the nursery nurses, so there had been a couple of changes in personnel again from the day before.

Text messages that Lucy Letby sent to [Dr A], just after 8.30 that morning, so about an hour after she'd arrived at work, suggest that she had sent or was sending the student Rebecca Morgan with a baby who was leaving the unit to go for an MRI scan, a magnetic resonance imaging scan.

Another registrar, Dr Ukoh, recorded that at 9.35, so this is the first medical note of the shift, [Baby P] was self-ventilating in air, that he had desaturated plus, and had had a bradycardia, which means his heart rate was decreased, that he had a moderately distended bloated abdomen and a slightly mottled skin. So this is an hour and a half or so after Lucy Letby took over again.

In the nursing notes, and I'll show you these, which were made by Lucy Letby, she recorded this -- and it's the bit that's highlighted, ladies and gentlemen, you can see that these are made much later in the day. These are made after the end of the day shift between 21.28 and 22.00 hours, so that evening.

You can see above the highlighted part it says:

"Written in retrospect [this is a reference to the notes themselves] for care given from 8 in the morning."

Then the standard checks are set out. You'll see this sort of entry in pretty much every example of the nursing notes.

Moving on to the highlighted part:

"NG tube on free drainage. Trace amount in tube. Abdomen full. Loops visible."

That's a reference to the loops of bowel, so literally the loops visible through the skin. That's the suggestion:

"Soft to touch. Registrar Ukoh arrived to carry out ward round. [Baby P] had an apnoea..."

So breathing problems:

"... brady [bradycardia, reduced heart rate], desaturation [reduced oxygen saturations] with mottled appearance, requiring facial oxygen and Neopuff for approximately 1 minute. Abdomen becoming distended. Decision made to carry out bloods and gas, approximately 09.30."

So what we see here, ladies and gentlemen, the reason I started with the day before, is the day before [Baby P] had been fine, no problem.

At the moment he was handed over to another nurse, all of a sudden [Baby P] had a problem. Overnight, the other nurse resolved the problem and yet within an hour and a half or 2 hours of the reappearance of Lucy Letby, the problem reappeared.

Fifteen minutes later, [Baby P] suffered an acute desaturation, a crash call went out, and [Dr B] and Doctor Ukoh, [Dr A] and Cooke attended. On their arrival, [Baby P]'s heart rate was about 80 beats a minute, his saturations were down to 60%, and he had to be intubated, so the ET tube had to be put down his throat and that improved him. Efforts were then made to transfer [Baby P] to the more specialist hospital at Arrowe Park.

While those efforts to relocate [Baby P] were going on, [Baby P] desaturated again at 11.30. This time he was given adrenaline and he was paralysed with a drug which would have helped the ventilation.

Due to the treatment, his spontaneous circulation was restored, but he continued to deteriorate through the day. And at 12.30, a punctured lung, a pneumothorax, was identified from an X-ray that had been taken about 33 minutes earlier and the treatment for that started 10 minutes after it had been identified in the X-ray.

At 3 pm the transport team from Arrowe Park arrived and just before they arrived, [Baby P]'s blood gases had been taken and were satisfactory. [Dr B], who was supervising [Baby P]'s treatment and was optimistic for his prospects. All of a sudden Lucy Letby said to him, Lucy Letby said to [Dr B], something like, "He's not leaving here alive, is he?", an echo of what she had said when [Baby C] collapsed. Do you remember?

That remark surprised [Dr B], but Lucy Letby's prediction came true. After all, she knew what she had done to [Baby P] and therefore she knew what was likely to happen. And it was certainly what she intended because it was the same thing that she had done to so many other children.

[Baby P]'s final collapse came at about 3.15 that afternoon and all efforts to resuscitate him failed and [Baby P] was pronounced dead at 4 pm.

His body was examined by a pathologist, and Dr Kokai concluded that [Baby P] had died from what's called sudden unexpected postnatal collapse. Dr Kokai was unable to identify the underlying cause, and so he certified the cause of death as prematurity.

The medical independent experts have reviewed [Baby P]'s case. Dr Evans initially suggested that the cause of death was complications from the punctured lung, but he was suspicious of the large volume of air in [Baby P]'s stomach and intestines that I've told you about that had been noted from the X-ray. And in his subsequent reports, Dr Evans concluded that excess air in the stomach could have splinted [Baby P]'s diaphragm, which

would have compromised his breathing. Do you remember I explained that to you a couple of times before?

Dr Bohin also concluded that the swelling in the abdomen had splinted [Baby P]'s diaphragm and that that had meant that [Baby P] was unable fully to expand his lungs and had led to his collapse. She concluded that subsequent resuscitation and intubation involving high pressures from the ventilator, together with vigorous resuscitation, can cause a punctured lung. So it's the treatment for the problem that was caused by Lucy Letby that had caused the punctured lung, putting it in simple terms.

Dr Bohin described the abnormal gas pattern seen in [Baby P]'s stomach, which ran all the way down his bowel to his rectum, and she concluded that it was caused by somebody injecting him with air through the nasogastric tube. She described that as "the only plausible explanation". That excess air had splinted the diaphragm, compromised [Baby P]'s breathing and had caused his collapse.

The pathologist, Dr Marnerides, thought that on balance the most likely explanation for [Baby P]'s collapse was his having received excessive air injected into his stomach, so he agreed. He concluded that the pneumothorax, the punctured lung, was the consequence of the treatment and he could find no evidence when reviewing the post-mortem examination, no evidence of any clinical disease or trauma, although he did notice an injury to [Baby P]'s liver, but in [Baby P]'s case, as opposed to [Baby O]'s case, where he thought it was trauma, such was the nature of the injuries to [Baby P]'s liver that he thought it was probably the result of CPR rather than a deliberate assault.

Ladies and gentlemen, as with all these cases, it is the coincidence of problems happening when Lucy Letby was about and the coincidence of the same problems happening with different babies at different times which we suggest is so telling and indicates that it was her malign hand at work.

In her interviews insofar as the events of 23 June were concerned, in other words the time that's covered by that feeding chart I showed you at the beginning, Lucy Letby explained that the student nurse fed [Baby P] at two-hourly intervals up to 4 o'clock and that she alone had fed [Baby P] at 6 o'clock, and that corresponds to the initials, doesn't it, at the bottom of the chart?

With regard to 24 June, the day [Baby P] died, she agreed that she had agreed to be [Baby P]'s designated nurse because the parents had asked for some continuity. She said that early in the shift, at about 8 o'clock, she could see loops in his tummy

and had brought those to the attention of the doctor. Having seen loops at 8 o'clock in the morning, of course, is what she recorded retrospectively when she made the notes at 9 pm, after the end of the shift.

If it was true, and this is another case where we invite you to view her notes with a degree of cynicism, if what she noted was true it would suggest, wouldn't it, that when she took over the care of [Baby P] from the night shift, [Baby P] had a developing problem? But we know that wasn't the case because Sophie Ellis' notes, made at 6.40, say that the issue had been resolved.

As a matter of fact at 8 o'clock when she said she saw the loops of bowel, she was busy sending messages on her phone. The first time [Baby P] was seen by a doctor on that shift was at 9.35 when he was seen by Dr Ukoh. So, ladies and gentlemen, we say this is a clear example of Lucy Letby making factually false entries in the medical records, in effect to cover herself, to make it look like this is all a problem that occurred on somebody else's watch, somebody else's shift.

Lucy Letby explained that she'd been present to assist the doctors throughout the day as [Baby P] had continued to deteriorate. After he died, she spent time with his parents and at one point took a photograph of both [Baby O] and [Baby P] together in a cot. She denied deliberately causing [Baby P] any harm.

So ladies and gentlemen, to the final count in the indictment, please, count 22, the attempted murder of [Baby Q]. [Baby Q] was born on 22 June, so a day after the [Babies O, P & R] triplets, and Lucy Letby attempted to murder him, we say, on 25 June, which was the day after she had murdered [Baby P].

[Baby Q]'s parents were [Parents of Baby Q]. [Baby Q] was 31 weeks plus 3 days gestation at birth. He was born in the early hours of the day and he was a reasonably good weight of 2.076 kilos.

He got some breathing support through CPAP for the first 20 hours of life and he was admitted to the neonatal unit because he needed some breathing support. Initially, he was stable, he had a catheter, a tube, in place through his umbilicus for nutrition, but as it happened he was well enough to start feeding through the nasogastric tube.

Initially, he was put into room 1 with [Baby R] at a time when [Baby P] and [Baby O] were in room number 2. When the nursing staff checked [Baby Q]'s NGT on 23 and 24 June, they noticed small amounts of bile, but the amounts weren't sufficiently

great to cause concern or to stop him being fed milk and he was still in room 1 at that stage.

On the night shift of the 24th into 25 June, so the shift immediately after [Baby P] had died, [Baby Q]'s designated nurse was Samantha O'Brien, and she monitored [Baby P] through the night and he was being fed the tiny amount of milk of 0.5, one half of 1 millilitre of milk, every 2 hours, at 3 am, 5 am and 7 am on the 25th.

Nurse O'Brien was content with [Baby Q]'s condition, although his blood gas readings deteriorated slightly, so she referred [Baby Q]'s case to the registrar, [Dr D], and when [Dr D] reviewed [Baby Q] she wasn't at all concerned about him.

So 25 June was a Saturday and that morning, that day shift, Lucy Letby was working and she was [Baby Q]'s designated nurse from 7.30 in the morning. Other nurses working the shift were Minna Lappalainen, who was the shift leader, Mary Griffith, [Nurse B], and Nicola Dennison was the nursery nurse. By the time this shift started, [Baby Q] had been moved from room 1 down to room 2.

At 8 o'clock, Lucy Letby made notes on [Baby Q]'s fluid/feeding chart and because he was only taking a tiny amount of milk, he was also being fed Babiven, the total parenteral nutrition. Do you remember that yellow-coloured liquid in a bag that you saw in the video of a couple of days ago, what I was suggesting had had insulin put into it in the case of [Baby F]?

At just after 9 o'clock that morning, that Saturday morning, Lucy Letby and Mary Griffith were together in nursery 2. According to Mary Griffith, Lucy Letby was attending to [Baby Q] and Nurse Griffith herself was attending to the other child in the room.

Nine o'clock was, for these children, or for [Baby Q] at least, his feeding time and the time for his observations to be taken. According to the record, the handwritten record, [Baby Q]'s heart and breathing rates both increased over a short period of time after 9 o'clock, which is the feeding time.

But what is actually in the feeding chart is, we suggest, most unusual. I'm going to show you another feeding chart. This is 24331, please.

I'll just run through the same routine, ladies and gentlemen, not because I don't think you understand, it's just to try and reinforce how these things work so that you can hit the ground running when you start to hear the evidence.

Top left-hand corner, name of the child, [Baby Q]. "Day 4" you can see highlighted there. The date on the left-hand side below the name, which is highlighted, 25 June. You can see that the feeding times are inserted along the top row there, every hour, and you can see that the fluid is Babiven via a UVC, which is a line going in through the umbilicus.

You can see there that at 3 o'clock, [Baby Q] was fed half of 1 millilitre of milk. He was fed the same at 5 o'clock and at 7 o'clock, and underneath you see the running total, rising in increments of half a millilitre. You can see the aspirates recorded and highlighted.

But you'll remember what I said about [Baby Q] starting to deteriorate just after the 9 o'clock feed. And if you look right in the bottom line of the chart, you see the signatures or the initials of the nurses. What you can see is that Lucy Letby, LL, her initials appear first at 8 o'clock, and they're partially obscured by a hole that's been punched in the paper and then photocopied, which is why you have the black circle.

Let's just look at the column for 9 o'clock. You already know enough about how these charts work. If you read down from the top from 9 o'clock, so we're going vertically now, you can see the amount of the Babiven fluid that was being administered, the rate at which it was being administered, but then in the feeding chart -- so that's a note apparently made at 9 o'clock -- [Baby Q] was due to be fed at 9 o'clock. But what do we have? Absolutely nothing. No note in the milk row at all and it was not initialled either, almost as if something caused her to leave at 9 o'clock before she'd finished making the records.

Nurse Griffith, who was the other nurse in the room, who had her back to what was going on with [Baby Q] behind her, was asked by Lucy Letby to monitor [Baby Q] while she went to nursery 1 to do cares for another baby. Cares is a term of art which has -- it involves nurses doing a set regime of things for another baby. And she had another baby for whom she was the designated nurse in room number 1.

There's an entry on the other baby's chart at 8.30, so half an hour before this, signed by Lucy Letby and another entry on the other baby's chart in room number 1 at 9 o'clock, which isn't signed, like this one that isn't signed for [Baby Q].

But Lucy Letby did sign on yet another baby's chart, so we've got -- [Baby Q] is baby 1, the baby in room number 1 is the second, and there was a third baby in room 1, the second one in room 1, but the third baby overall, including [Baby Q], which -- and Lucy Letby did sign his chart at 9.04.

Anyway, just back to 9 o'clock, so having given you the context of the documents, going back to 9 o'clock when what we see highlighted there is supposed to be going on. Mary Griffith agreed to keep an eye on [Baby Q] figuratively rather than literally, I suppose, because she had her back to him, and continued to do what she was doing with the other child in the room.

A few minutes later, [Baby Q]'s monitors started to alarm or his monitor started to alarm. We say that what Lucy Letby did to [Baby Q] at 9 o'clock was to inject him down the NGT with air and a clear fluid, whether it was water, whether it was saline, we can't say, but it was a clear fluid. She was trying to kill him.

Nurse Griffith heard the alarm, she called for help, and she was joined by Nurse Lappalainen, and [Baby Q] had been sick. The nurses used a suction catheter whilst [Baby Q] was given help with his breathing and then Lucy Letby appeared with the doctors, who were responding to the call for help. The doctor's notes indicate that they were called to the unit at 9.17 as [Baby Q] had "just vomited", and his oxygen saturations had dropped to the low 60s, so very low. The medical staff gave [Baby Q] help with his breathing, using the Neopuff device, they cleared his airways with a suction device, and the records show that not only had [Baby Q]'s oxygen rates dropped but his heart rate had dropped as well and he's described as "mottled" in appearance.

When the nasogastric tube was aspirated, the doctors retrieved a substantial amount of air, air that had just been put in there by somebody, we say, because if the feeding regime had been correctly followed at 9 am when Lucy Letby has made a partial note saying she was there, the person who fed or was to feed [Baby Q], ie Lucy Letby, would have aspirated the tube to see if there was anything in his stomach before he should have been fed that minuscule amount, half of 1 millilitre of milk.

There's another chart that was filled in at the time, or another form that was filled in at the time, and I'm going to show you that. It's 24314, please.

Do you remember me telling you that when the alarm went off and Nurse Griffith called for help, Lucy Letby didn't appear, Nurse Lappalainen appeared? This is a chart that's been filled in by Nurse Lappalainen. You can see on the right-hand side in the signature column, her signature. What we see on the left-hand side is the time and date: 25 June, 9.10. This is a form which is designed to record if a child stops breathing, has a low heart rate or has a fit.

We can see the heart rate -- this is a low heart rate for such a small child -- of 98. You can see the desaturation down to 68%, "Query fit?", then, "Duration: 3 minutes intermittently".

Then what we have noted by Nurse Lappalainen is:

"Baby found to be very mucousy, clear mucus from nasopharynx/oropharynx removed. Clear fluid+++."

Lots of clear fluid coming out of the airway of this small baby:

"O2 [oxygen] via Neopuff."

So oxygen given using the Neopuff device -- sorry, given post-suctioning:

"[Dr A], emergency call to attend."

Then:

"NGT [nasogastric tube] used to aspirate stomach by nurse L Letby."

Given that Lucy Letby was [Baby Q]'s designated nurse on this shift, and that she performed the aspiration of air, you might think it is a little surprising that it wasn't her that actually made the note. And yet she did make notes in the records of other babies at about the same time. And we question whether this is an attempt by her to create a documentary alibi, so if ever anyone went back to the records to see who was dealing with [Baby Q] at the time, who would they think it was? She's alibied herself in the third child's notes by making a note at 09.04. So we suggest a cynical and fairly sophisticated way of making the notes appear as if she had nothing to do with what was going on.

The computerised notes that Lucy Letby made for that morning's events recorded this, and I'll quote -- I won't show you this one, I'll just tell you what it said. It says this:

"At 9.10, [Baby Q] attended to by Nurse Lappalainen. He had vomited clear fluid nasally and from mouth, desaturation and bradycardia [so low heart rate] mottled++. Neopuff and suction applied. Registrar [Dr A] attended. Air++..."

So one fewer plus in her notes than -- it may mean nothing:

"... aspirated from NG tube."

Following [Baby Q]'s collapse, blood was taken to test for infection and a test of that blood suggested that he was unwell. Whatever the problem was, it had resolved by 11.12. [Baby Q] was

started on a course of antibiotics as a precaution and [Dr A]'s recorded view at the time was that [Baby Q]'s collapse was a result of presumed sepsis with jaundice.

A chest X-ray taken at the time showed nothing untoward and more detailed blood tests were recorded at 1.50 in the afternoon that showed slightly abnormal results, which were treated, and [Baby Q] made a reasonable recovery through the day.

By the end of the shift, at 7.20, he was described as looking tired and doctors took the decision to intubate him because his respiratory rate had dropped to 19, which is low, and his heart rate was high, between 160 and 200 beats per minute. But despite that, his blood gas readings were good.

We say, ladies and gentlemen, that when she went home that night, Lucy Letby was worried. She must have got the impression that people were becoming suspicious of what she had been doing and she texted [Dr A] at 10.09 -- sorry, at 10.46, so quarter to 11 that evening, and asked this question:

"Do I need to be worried about what Dr Gibbs was asking?"

And [Dr A] sought to put her mind at rest and told her that Dr Gibbs was only asking to make sure that the normal procedures had been carried out. And she replied to [Dr A] that after [Baby Q] had collapsed she, Lucy Letby, had walked into the equipment room and [Dr A] had been asking Mary Griffith, who had been present in the room when [Baby Q] had collapsed.

MR JUSTICE GOSS: Sorry, do you mean [Dr A]?

MR JOHNSON: I beg your pardon, Dr Gibbs. So she is speaking to [Dr A]. What she asked [Dr A] or what she told [Dr A] was that after [Baby Q] had collapsed, when she'd walked into the equipment room, Dr Gibbs had been asking Mary Griffith, who had been present in the room when [Baby Q] collapsed, how quickly someone had gone to him because she, Lucy Letby, hadn't been there.

She continued her text to [Dr A], telling him that she had needed to go to another designated child in room number 1, which of course was the excuse that she had given to Mary Griffith at the time.

Well, the next day, so far as [Baby Q] was concerned, at 6.50 that morning, [Baby Q]'s blood gases were unsatisfactory, but it was noted by [Dr D], who was on duty, that [Baby Q] had had the tube removed 4 hours earlier and he was in air, breathing for himself and had good oxygen saturation, so a good sign.

Medical staff on that shift noted a mildly dilated loop of bowel on his left side and raised the possibility that perhaps he had NEC. Do you remember that bowel disorder? So [Baby Q] was transferred to Alder Hey Hospital in Liverpool, the children's hospital in Liverpool, and you know what I'm going to say. He quickly stabilised, no surgery proved necessary, and the breathing support was removed.

He returned to the Countess of Chester on 28 June and he, we say, was yet another child who suffered life-threatening problems. Investigations at the time could find no issue and when he was moved out of the orbit of Lucy Letby, he made a rapid recovery.

Other than 3 days the following week, that was the last time that Lucy Letby worked in the neonatal unit at the Countess of Chester Hospital.

So far as the expert review of [Baby Q]'s case is concerned, in the opinion of Dr Dewi Evans, [Baby Q]'s collapse on the morning of the 25th was due to inappropriate care. He believed that [Baby Q] had been injected with air through his NGT. He thought that the significant amount of air that had been aspirated from his stomach couldn't have arisen in any other way because [Baby Q] hadn't been receiving any breathing assistance and was being fed only minuscule amounts of milk.

The "clear fluid+++" noted by Minna Lappalainen that was vomited by [Baby Q] had to have been given to him by somebody because it wasn't going in as feed. It had to get in there to come out, didn't it, and it hadn't been part of the half of 1 millilitre of milk. And Dr Evans thought that therefore it had to be either normal water or saline, the sort of water that is used in medical treatment, salty water.

The stomach findings, thought Dr Evans, were not explicable by his bowel condition. He didn't have a bowel condition, but were consistent with [Baby Q] having received a lot of air through the NGT and some clear fluid some time before 9.10 that morning.

Dr Bohin noted that [Baby Q] was well up until events on 25 June and she also concluded that something happened at about 9 o'clock. She made the same points as Dr Evans about what he was being fed, what was going in and what came out. She also remarked on the large volume of air that was suctioned from or aspirated from [Baby Q] and concluded that a lot of air in the stomach would have splinted the diaphragm, which would have squashed the lungs, which would have compromised [Baby Q]'s breathing.

In dealing with the fact that [Baby Q] wasn't particularly well for the rest of the day, she concluded that although a baby may recover quickly after such an event, the baby may remain unstable for some time thereafter.

An expert neuroradiologist, so a doctor with a particular expertise in interpreting scans of the brain, Dr Stavros Stivaros, reviewed brain imaging of [Baby Q] that had been taken in November 2019, so more than 3 years later, and he found evidence of abnormalities in [Baby Q]'s brain which, whilst they were not diagnostic of him having suffered a brain injury as a result of being given excessive air and liquid, were explicable by such an event having occurred. So abnormalities of the brain, you can't say what the definite cause of that is, being given excess air and liquid, but what he could say was that finding is consistent with that having happened.

Lucy Letby was questioned about these events. Her home was searched. In the search of her home the police found the handover sheet, the sheet that the nurses get of the patients and the designated nurses from the shift on which we say she sabotaged [Baby Q] on the 25th. And like the others, it's a document which shouldn't have left the hospital. To be fair, she had a lot of these documents at home.

When she was interviewed by police, Lucy Letby agreed that [Baby Q] had been well enough for her to have left him at just after 9 o'clock on the morning of the 25th. When she was asked about the excess air aspirated from his stomach, she suggested that sometimes babies gulp air when they vomit. Well, it was the air and the liquid that caused him to vomit, it wasn't the result of the vomit, we say. She denied putting excess air down his nasogastric tube.

That's all I have to say about [Baby Q]'s case at this stage, ladies and gentlemen. I'm just going to say a few words in conclusion, pretty quickly.

Following events in that year, between June 2015 and June 2016, the consultants at the Countess of Chester suspected that the deaths and the life-threatening events of these 17 children were not medically explicable but were the result of the actions of Lucy Letby.

No doubt they were acutely aware that making that sort of an allegation against a nurse was as serious as it gets. They, at the time, didn't have the benefit of the evidence that you are going to hear and the decision that was taken by the hospital at the time was to remove her from a hands-on role and she was moved to clerical duties where she wouldn't come into contact with children.

The police were contacted and they conducted a lengthy and complex inquiry. That involved the instruction of the doctors that I have referred to already to review many cases which had passed through the neonatal unit in Chester, and following that review, the decision was taken to arrest Lucy Letby and, as I have already told you, I think, the first arrest took place in July 2018.

The first arrest was 3 July 2018. It took place at her home at 41 Westbourne Road in Chester and the house was searched. As I have already told you, a large quantity of paperwork from the hospital was recovered.

In addition to the paperwork relating to some of the children I have told you about and other children, they also found some other interesting items. There were some Post-it notes. You know what I mean, those little yellow tabular notes, with closely written words on them, some of which included the names of her colleagues. On some of the notes were phrases like: Why?" How has this happened? What process has led to this current situation? What allegations have been made and by whom? Do they have written evidence to support their comments?"

In her writings, she expressed frustration at the fact that she wasn't being allowed back on to the neonatal unit and she wrote:

"I haven't done anything wrong and they have no evidence, so why have I had to hide away?"

And her notes also expressed concern for the long-term effects of what she feared was being alleged against her. There are also many protestations of innocence. But I want to show you one note in particular and it's J321.

MR JUSTICE GOSS: I think it's 312 just for the record.

MR JOHNSON: I'm sorry.

There's all sorts of material on this document. But just where that cross is now, just to the right of that, it says:

"I don't deserve to live. I killed them on purpose because I'm not good enough to care for them. I am a horrible, evil person."

At the bottom:

"I am evil. I did this."

Well, ladies and gentlemen, that, in a nutshell, is your task in this case. You have to decide on the evidence whether she did do

these things or any of them. It's important to remember that the prosecution brings this case and therefore we, the prosecution, must prove it. And in order to prove it, we must make you sure.

Thank you, my Lord.

MR JUSTICE GOSS: Yes, thank you, Mr Johnson.

What will happen shortly is that Mr Myers will address you, not at the length that you've been addressed by Mr Johnson, but just essentially to explain to you, as I understand it, the defence in this case. That will take -- I think Mr Myers you indicated about an hour and a half, something like that?

MR MYERS: Up to 2 hours, my Lord. It may be that I can deal with half of it before lunch and finish the other half afterwards.

MR JUSTICE GOSS: I thought that's exactly what we'll do. We'll have a comfort break now for 10 minutes or so and then at the end of that, when Mr Myers has completed his address this afternoon, we will then take stock of the situation at that point, all right, in relation to you remaining a jury of 14? Thank you very much.

So just 10 or so minutes now, as long as is needed.

(In the absence of the jury)

Thank you.

MR MYERS: I wonder whether we could have a slightly longer break. I've been asked to go down and see Ms Letby.

MR JUSTICE GOSS: I picked that up because I can see and hear things that are going on. Certainly, you should be afforded that facility. I'm just thinking of the jury, the mechanics of you getting down there, speaking, coming back up again is going to take quite a long time, I think.

MR MYERS: Probably about 30 minutes, my Lord, to deal with it.

MR JUSTICE GOSS: Don't worry.

Could you please, usher, very kindly -- is there a better room the jury can go to? Just say I've been informed the break will be longer, it's going to be a longer break than 10 minutes, it'll be at least half an hour, and I'll keep them informed in about half an hour if we're not ready. All right. Thank you. And you'll keep the court informed, I know.

MR MYERS: Of course, my Lord.

MR JUSTICE GOSS: Thank you very much.

Ms Letby, your lawyers are going to come down and see you and speak to you, all right, if that's what you want. Just check that is what she wants.

MR MYERS: That's what we'll do. Can we keep the arrangement as it is, my Lord, and we'll deal with it?

MR JUSTICE GOSS: Yes, thank you very much. You can always communicate with me.

(11.42 am)

(A short break)

(12.10 pm)

MR MYERS: My Lord, we're grateful for the opportunity to speak with Ms Letby. In fact, it was something which did not take long and it was an organisational matter. We dealt with it upstairs, in fact. She spoke to us from the dock and we understand it has been resolved. But we are grateful for that. Thank you.

MR JUSTICE GOSS: That's all right, thank you. Well, when the jury comes back in, Mr Myers, you just choose an appropriate moment around 1 o'clock. If it's slightly after 1 o'clock, don't worry about that. Just whatever's the most convenient time to break off.

MR MYERS: Thank you.

(In the presence of the jury)

MR JUSTICE GOSS: Yes, Mr Myers.

Opening by MR MYERS

MR MYERS: May it please you, my Lord.

It's difficult, ladies and gentlemen, to think of allegations that could be more upsetting than these allegations and it's difficult to think of allegations that strike harder at our desire to protect than these allegations and it's difficult to think of allegations that make it harder to stand back and look fairly at the actual evidence than these allegations.

The sympathy of everyone will rightly be with the families whose children are involved in this case and for those children. We all share the same feelings and the same experiences. We all

have families, parents, children of our own or children that we know. It's natural to sympathise, we'll all do it, we're all made of the same stuff. So we recognise the sadness and the distress, and even the anger, that comes with allegations like these and I start, ladies and gentlemen, on behalf of the defence by acknowledging how upsetting the allegations will be and by acknowledging the very great loss and sadness to the families involved. And nothing that we do, the defence, or I do or say in this trial is intended to diminish that in any way.

It's obvious to us, as it will be obvious to anyone listening to this case, and it will be obvious to every one of you, ladies and gentlemen, that where we have such terrible allegations, it would be terribly easy to let emotion take the place of reason and to want to convict without even hearing a word of evidence. It would be easy and staggeringly unfair.

Each of you has come forward to sit as a juror in this trial and you will know, ladies and gentlemen, that we haven't come to a trial for up to 6 months because we are here to rubber-stamp an allegation and you're not going to give up months of your time to do that. And that has to be said at the outset in a case like this where there has been a lengthy investigation and a huge prosecution mounted and the allegations are so upsetting.

We identify this right at the start: there is a real danger that people will simply accept the prosecution theory of guilt. That's all that we have so far, ladies and gentlemen: a theory of guilt based firmly on coincidence, if anything can be based firmly on coincidence, and we are grateful to his Lordship for the direction given to you at the start of the trial to consider and judge the evidence calmly, rationally, fairly and dispassionately. My goodness, it needs that.

When we do that, or when you do, and if you find that things have gone wrong in these cases or any of them that we're looking at, it is important to be careful that blame is not heaped on that woman (indicating) when there may be others who have made mistakes or a system that has failed or where, actually, in truth, we cannot be sure what happened but what we're left with is coincidence.

What the defence say, ladies and gentlemen, is that in the events we'll be looking at in this trial, sometimes what happened was the result of a genuine deterioration in the health of one or other of these children. And sometimes, in fact, nobody can really say why a particular baby deteriorated or died as she or he did, although the pressure to find a fault-based explanation is powerful.

But also, we say that sometimes things have gone wrong or the necessary standards of care have not been met, irrespective of anything to do with Ms Letby, and when that has happened or may have happened, she should not get the blame if she is not responsible.

And it is amazing, isn't it, how with allegations like these, everyone turns and focuses on Lucy Letby? Some people, we say, at the outset, with the rather trusting presumption that because the allegation is brought that she is guilty, she must be guilty, and the worse it sounds, the more guilty she must be.

We and you will be focusing on Ms Letby too, but we will also keep our attention on the surrounding picture, insofar as we can see it, and it's relevant, and you may wish to do that too.

You know, ladies and gentlemen, I defend Ms Letby together with Mr Maher and Ms Clancy, and we are grateful to the court for this opportunity to introduce the defence case to you. At this early stage of the trial I'm going to identify key issues, so far as the defence are concerned, and to outline the response to the prosecution case. But as you know, it is only an outline.

The purpose of that is to assist you in following the evidence when we come to it so that you can weigh it up and you have an idea of the things that the defence are focusing upon and you can put everything into context.

Over the past 3 days, or 4 days in fact, you've heard the prosecution opening speech setting out their case in detail, and of course it's lengthy because they have a lot of detail they want to show to you. We're not complaining about that, but what I'm about to say to you is not a defence speech in that way, where I explain to you in detail why we say Lucy Letby is not guilty. That comes much later in the trial, so please don't think that at this point I am saying all that there is to be said. I am barely touching on it. There's massive detail in this case. Without the detail, the allegations do not count.

This is not a defence equivalent of what you've been listening to from the prosecution, but the rules allow for the defence to introduce the issues in the case from the defence point of view at this point, so that's what I'm going to do and it will take no more than a couple of hours. It will go up to lunchtime, then a break, and then I can carry on afterwards and finish in the first part of this afternoon, give or take a bit. You'll find the timings, although we do our best, can sometimes be a bit imprecise, but that's roughly how long.

So I emphasise again, ladies and gentlemen, on behalf of the defence, I will be talking to you about why Lucy Letby is not

guilty a good deal longer when we get to the end of the case. This is just a brief introduction.

There will be a lot to look at in this trial, but having set this out in outline now, you will have a better idea of what to expect and what to look out for and the general nature of the defence response. What I'm going to do this morning and into this afternoon is just break down what I'm going to say into three general areas.

The first one, Lucy Letby and the general nature of her defence and some issues relating to her. Then we'll have a look at what the defence say about coincidence, and then we'll have a look at the medical evidence, only a brief one, it's enormous, but just a quick look so you can understand where the defence are coming from with this.

We suggest, ladies and gentlemen, that the medical evidence is a key area in this case and so when I come to that, which might be this afternoon, or it will be, I'll try to assist you by setting out the overall areas to focus on and then go to key issues on each count.

And it is really just an outline so you have an understanding of the type of issues and the way this will go when we get to the evidence. Don't worry about, for example, trying to absorb the detail of everything from this. It's entirely up to you what you note or what you do with what I say, but it's really just to help you so you can see, all right, the prosecution have said that, this is the sort of thing the defence or their experts are going to say when they're dealing with the issues on that count.

So I'll be going through them almost like bullet points, but since one of the purposes of this is to simplify it by identifying issues to help you and the court with what we are looking for, that's what I'll do when I come to that.

We'll also touch on issues in relation to Ms Letby's presence or absence at the time of events in the indictment and finally introduce you to what we say is a potentially relevant question with respect to failings in care at the Countess of Chester Hospital Neonatal Unit that have nothing to do with Lucy Letby.

So let me start with the general nature of the defence case and Ms Letby. What is the defence case? Well, the defence say that Lucy Letby was a dedicated nurse. She trained hard to become a neonatal nurse and what she wanted was to care for the babies she looked after and we say she did her best to do so for years and in no way did she want to harm them.

The defence say Lucy Letby is not guilty of intentionally causing any harm to any baby or intentionally killing any baby and, so far as she knows, she hasn't caused harm.

Her case is that she was a dedicated nurse who loved her job, who cared deeply about the babies she looked for, and cared also about their families. She lived a fulfilling life with friends, a life outside of her work, but a life where her work was what she was dedicated to. You might well have taken a good look at Lucy Letby in the time we've already had in this trial, but you know, ladies and gentlemen, you won't get the answer to this case or the answers simply by looking at that woman in the dock now.

This is how she is now and where she is, you will keep in mind, 6 years after starting to face allegations like this, and you can imagine that must be utterly gruelling for anyone.

You may want to keep the effect of that in mind as we go through the evidence in this case and when you come to assess things she has said or says and how she is now. And this is an important part of her case, so I identify it now: the requirement to keep context in mind and to distinguish how she was at the time events took place compared with how she is now.

You will want to keep in mind what this must be like: a young woman had trained hard to be a nurse, who had worked for qualifications for years, and who cared for very many vulnerable babies for years.

We say a woman who loved what she did, who then discovered she was being blamed for the deaths of babies she cared for. It's important to keep this in mind at the beginning, with these allegations: we are dealing with a real person who is where she is now, the defence say, because of a litany of allegations that are extraordinary, far from straightforward and, crucially, not one of which has yet been proved. Anybody who approaches this as if it's some sort of done deal has got this very badly wrong.

So we ask you to keep that in mind and the effect of the allegations which, you may agree, will be very powerful and keep that in mind when looking at various parts of the case relating to various things she has said or done after she began to face the allegations.

And by way of example, let me take you back to that note we looked at just before the break, J312, please.

If we can just enlarge it. I'll come to what we say about the content in a moment. Just enlarge it first, thank you.

The prosecution finished their opening speech with this, so let me by way of introduction deal with what we say about it, although you will look at this with your own views and experiences of life and other notes like it because you'll not -- not the same context but other notes from Ms Letby during the case.

It was introduced as evidence supportive of guilt, the prosecution would say. We suggest that anyone who reads this fully, with an ounce of human understanding, will appreciate that this is the anguished outpouring of a young woman in fear and despair when she realises the enormity of what is being said about her and this is her way of expressing it, in the moment, to herself.

Before I come to some of what's there, it's important, ladies and gentlemen, that you know that before her first arrest in July 2018, there was a period during 2016 and onwards when Lucy Letby was dealing with issues in relation to her employment. So this is after she'd come off clinical duties but before the police were ever involved, dealing with issues in relation to her employment and going through a grievance procedure with the NHS trust, and that that was when she discovered what was being said about her. This will emerge so it's important to put these things into context so you can fit them together, ladies and gentlemen.

So she knew what was being said before arrest and we say the impact of that and those allegations was devastating and destructive, and with that in mind we then ask you briefly just to look at the note we have here. You will see at the top it doesn't say guilty, it says "Not good enough".

To the right-hand side:

"An awful person. I pay every day for that right now. I'll never have children or marry, I'll never know what it's like to have a family. Despair."

Opposite that on the left-hand side:

"I haven't done anything wrong."

Go through and pick out one bit, pick out another bit, pick out what you like. You know, ladies and gentlemen, that when someone's upset very badly, they can scribble thoughts and feelings that reflect how they feel, even though what they write may not accurately reflect what is going on around them or has gone on. You will have to assess this type of thing when presented with this type of material in this case.

We say people can pour their feelings on to paper as a way of coping and it's the outpouring that matters. And we say this note reflects the anguished state of mind that Ms Letby found herself in, how she felt when she learnt she was being accused of killing children she believed she'd done her best to care for.

I will have a lot more to say about this on behalf of the defence and Ms Letby when we get to the end of this trial, but for now, we say that what you see there is anguish, not guilt. We can take that down, I'm going to move on, please. Thank you, Mr Murphy.

Can I ask, before deciding what you make of the notes and other notes taken from Ms Letby, that you wait until we get to the end of the evidence? That's so important. By that stage of the case, you will probably know a lot more about her and what she'd been through and the case in general and what you make of it than you can possibly know at the moment, what anyone listening to this can possibly know at the moment. That is a more balanced and appropriate way of putting this note and the evidence in this case in context generally.

There will be other notes and papers to look at during this trial. There was a substantial amount of paperwork taken from Ms Letby's home once the police became involved in the investigation and arrested her and took her away to be interviewed. When it comes to all these notes and papers, you may well want to ask whether Ms Letby had them in her possession for a sinister motive, which is the thrust of what the prosecution say on many aspects of them, or whether she had them simply because she is one of those people both who scribbles things down a lot on paper, we say you will see that, and who hangs on to pieces of paper that come into her possession afterwards. And it's nothing more extraordinary than that.

I'm aware this is only an introduction to the case and you'll understand that I'm not by any measure going into everything we would like to say or plan to say at the conclusion when you have the benefit of the evidence. I'm going to move to the next topic I identified, which is coincidence.

The prosecution has spoken at length about coincidence and so we turn to that next and we identify how the defence respond to that so that you can keep this in mind and measure this against what you see in the course of the trial.

We say, ladies and gentlemen, that this prosecution case is driven by the assumption that someone was doing deliberate harm, that assumption of deliberate harm combined with the coincidence on certain occasions of Ms Letby's presence. Two things. I'll

repeat that and then we can come back to it at various points. But we say there is an assumption that someone is doing deliberate harm. Start with that or have that in mind and then have a look and find the coincidence apparently of Ms Letby and the two things are then put together. That's important in identifying this and I will explain further what we mean.

Can I start with this. What it isn't driven by, ladies and gentlemen, is evidence of Ms Letby actually doing what is alleged against her. So I ask you to absorb that. When we turn to the evidence time and time again there is in fact, when you look back at what you've heard already, it would appear, no evidence of the actual acts being alleged.

For all the assumptions and coincidences, you will find, from what we have heard, no evidence of her actually doing harm to any child. I'll expand upon what I mean by that. These allegations are allegations of attacks. You've heard the prosecution use words like poisoning, attacking, even sabotage, repeatedly. Powerful words that are likely to have had a powerful emotional impact on you and anyone who hears them.

But you will want to weigh that against whether or not in the course of this case reference can be made to any piece of evidence that actually shows Ms Letby engaged in any of the attacks alleged. So we identify this now so you can keep this firmly in mind when we proceed through the case.

Using syringes to inject air. No, we say. Tampering with bags of fluid. No. Or in some other way poisoning them. No. Physically assaulting children, smothering them.

We are dealing with 24 events and the defence will say the prosecution do not describe in opening anything that is in that territory. And we identify that now, we say it is significant. And by way of an illustration of the type of process we say you will need to apply to this, do you remember what the prosecution said in reference to [Mother of Babies E & F], the mother of [Baby E] and [Baby F], who they say was there as Lucy Letby was attacking [Baby E]? Do you remember that, that Lucy Letby was in the course of attacking [Baby E] when his mother came in and she was just fobbed off?

We'll come to that in due course and when we do, you may want to ask, by way of an example, whether that evidence actually shows Lucy Letby attacking a baby in front of his mother or not. When you hear the allegations, we ask you to measure them against the evidence you will hear.

So considering assumption and coincidence, can I enlarge upon what we mean when we describe an assumption of guilt? We say

that in this case, there is a danger that the theory that intentional harm was done, combined with the assumption that if Lucy Letby is there, she must be doing that harm, has made the allegations self-fulfilling. In other words, and you measure the evidence against this, the fact that Lucy Letby has been present at the time there has been a deterioration in the health of a child has itself become an explanation for that deterioration even though we say, we ask you to look for this, there is no evidence to show that she has caused that to happen.

Which brings us back to coincidence and I would like us to look, if we could, at the chart the prosecution rely on in this area, CEH16A. You will remember this, ladies and gentlemen, you'll probably see it during the course of this case.

Because of that, and because we have the opportunity now to outline the defence response and the issues that arise, I would like to tell what you we say about this because this is, it would seem, central to what the prosecution say.

We say that when we look at this it is important to keep in mind, first of all, that this table exists because the prosecution created it and it has been put together by the prosecution for the purpose of this prosecution.

It contains material selected with a view to showing that Lucy Letby was present at time of what had been declared to be the key events or suspicious events. Of course, ladies and gentlemen, the prosecution are entitled to do this, it is their case they bring and this is a way they have chosen to represent what they say is the evidence.

In response to that, the defence will say that to a large extent this is a self-serving document and the defence will say what we have here is presented like this because the prosecution have chosen to present it this way.

What it shows are what the prosecution say are events when intentional harm was done to the babies named and what they say is the coincidence with the presence on the unit. Now, in identifying where the issues lie and the defence response to this fairly central piece of evidence, we identify the following: what this table doesn't show, and the sort of things you may want to look for in evidence when we actually come to it.

It doesn't show the actual health or condition of the child concerned. It doesn't show any problems that child had from birth and what risks followed on from those. It doesn't show the course of treatment and problems encountered during that period. Some of the periods are quite lengthy and you will find very

much more went on than the incidents or the aspects of them that you have focused on so far.

We recognise, in fairness, the prosecution have to deliver an opening speech in a reasonable period of time. If they went through everything, it would be like doing the trial twice. But we say it is important when we're identifying the things to look at, you will need to look at the course of treatment and the problems over that period.

It doesn't show whether there had been other desaturations or collapses on other occasions when Lucy Letby wasn't present. It shows the ones where, by the plotting, something happens which the prosecution say is significant and she is there. It doesn't show if there may be other significant events, the defence say, and this will be for the evidence, when she wasn't there.

We do say there have been other events in the course of many of these babies' histories. You don't know about them yet, but we'll come to it in the evidence, which is one of the reasons why it will take time and it will have to be detailed. Now you know one of the ways in which we say that will be relevant and you know what to look for.

It doesn't include shortcomings in care that may be the fault of others and which may have had an impact on that particular baby. It doesn't show the impact of how busy the unit was at the time the events happened, it doesn't show how busy the unit was, and it certainly doesn't show what Lucy Letby was actually doing at the time of a particular event. These are all the sort of things you may think it's going to be important to look out for in the evidence, wherever that takes you, because they are, you may think, important things. It may make you more or less confident of what the prosecution say, but they are important parts of the case.

It doesn't show whether or not Ms Letby was anywhere near to a child at the time of an event and it doesn't show how, as the defence will say, there are some occasions when a problem can be traced, the start of a problem can be traced to a point before Ms Letby was ever actually either on duty or near to that child. There is a massive amount it doesn't contain.

When we come to look at the defence case, what the defence cannot do on every occasion is to explain why certain children deteriorated or died and actually nobody here would say that Ms Letby has to be able to do so. This is something that's been quite a difficult question even for the experts in this case. As someone who's done their best to look after children in their care, the defence would say they may very well not have an explanation for what had happened.

I have spent a little time outlining some aspects of the defendant's case and what we say about this table. We can take that down for now, please, Mr Murphy. What about other areas the defence say are key areas to focus on? In particular I'm referring to the medical evidence and evidence relating to Lucy Letby's presence at the time of various events. Can I say, by the way, ladies and gentlemen, there are obviously far more areas and aspects to this case than just those two or the ones we've been looking at. But we are going to suggest that when we strip away all the surrounding detail -- messages, Facebook searches, pieces of paper, even amateur psychology -- what the case will come down to is the medical evidence. That's what we say. That's the key material in this case, the medical evidence and what it can safely prove and what it can't, and the question of what we can safely conclude from the evidence of Ms Letby's presence or not.

We don't say the other areas of evidence are unimportant, they may be, you will make of them what you wish. They may be important for both sides in this case, but what we do say is that the foundation of the case is the expert medical evidence and the question of coincidence.

So medical evidence and the general approach to that. We say that in the case of these children, ladies and gentlemen, the cause of deterioration or death is not always clear from the medical evidence and there may be on occasions be a number of possibilities. You will need to keep this in mind, it might have struck you already: generally, we are dealing with babies who are clinically fragile and their condition can change very swiftly and when that happens they are capable of deteriorating very rapidly.

You've heard about babies who are premature or may be called preterm. Some are very preterm, extremely preterm, low birth weight. Both conditions like that can be accompanied by serious developmental or health problems: struggling to breathe, not able to breathe unaided, desaturating, dropping in oxygen, time and again, whether or not Ms Letby is there. You have heard about babies like that, you've heard about babies who one, [Baby H], required chest drains. A baby who had undergone surgery, leaving her with two stomas, which means, as you now know, if you didn't before, the passage of material that would pass through the bowel outside the body. Babies fed by tube. Receiving nutrition intravenously. Infections.

It is crucial to keep in mind the starting point in these cases. We also say there is a question as to whether this hospital should have been looking after all of these children and whether it did so to the required standards. That is something you might

want to look at. There is so much more to the evidence in this case than simply coincidence, something happened, guilt.

When we're dealing with children like this, ladies and gentlemen, there will be deteriorations. There will. And the cause may not always be clear. Just because the cause may not be clear, that is no basis for guilt and, as we may see in this case, in medicine the explanation for why things happen is not always clear and there is not always one possible explanation. But where that uncertainty is combined with a suspicion or an assumption that what has happened may be the result of an assault, then that assumption may become the explanation even though nobody can say for sure what has happened.

We suggest, ladies and gentlemen, that there are times in this case, and again we identify this now and we will ask you to keep this in mind when we get to the evidence, when an event that clearly fits an ongoing and clinically difficult condition of a particular baby has been converted into an event of deep suspicion because of the assumption that harm is being done.

In a way, by way of illustration, you saw that at work repeatedly at certain points in the prosecution opening with all those lead-ups -- you remember the lines about "And you know what happened next"? What did happen next? What happened next, in fact, when that was said, was Lucy Letby standing there doing none of the specific acts alleged against her, however unexpectedly someone came into the room. Not one.

For a nurse in a neonatal unit standing there when a child is unwell is unremarkable, unless you are going to approach this with an assumption of guilt combined with a mere fact that her presence alone is now treated as sinister, whether or not the evidence shows her doing anything.

So we need to look at the medical evidence very closely and the expert medical evidence in particular. When we come to that, ladies and gentlemen, the experts, you will need to look at their opinions and how strong the basis for them is. That's what the evidence is for and we'll spend a lot of time looking at it. And for those people who are not doctors or nurses, which must be most of us in this courtroom, but maybe not all of us, it may look daunting to start with, but as we go along you will become increasingly comfortable with looking at it.

The defence ask you to consider five issues when we come to the medical evidence -- I'm going to home in now and identify issues with the medical evidence in particular -- five issues that we say are important in each case. Again, there may be some overlap. I'm going to list them, say a little about each one, and in particular some detail about the medical explanations for

the events when we get to it. A lot to take in, compressed into a period of time, but if, when we finish, you have at least a better idea of what the type of issues are, what the responses will be and the type of things to look for, that will help, and then, as we go along during the case, we'll keep returning to the sort of issues we're looking at with different children, often with the same expert witnesses, and you will become increasingly familiar with what both prosecution and defence are saying.

The five areas we identify as important and important issues are, first of all, the birth condition of the baby we are looking at. That must surely be relevant.

Secondly, whether there were any problems in the health or care of the child we're looking at, leading up to the event we are considering. Time and again the prosecution identify these events by saying, "What happened was quite unexpected, it came out of nowhere". Well, in fact, we say, first of all, things with babies like this can be unexpected and they can come out of nowhere. But we also say, when you get down to the detail of the evidence, it's not always that clear and it isn't always unexpected if you look closely, if you actually look at the information that's available. That's the second point.

Third, whether the prosecution expert medical evidence proves there was deliberate harm done. Pretty central, that one. And when I come to that, which will be after lunchtime, ladies and gentlemen, as I've said, I'll indicate the defence response to what the prosecution experts say where we can do that. But I will be doing so in bullet form, I won't be going through, spending the time the prosecution did. Again, I know you know, but that's because this is meant to be an outline, it's not a speech with all the detail in. That comes at the end. That's something to look forward to or to face with trepidation, we'll see, but that comes at the end of this. That's when you'll be in a position to weigh it up.

The fourth matter is this: whether Lucy Letby was present at the relevant time and what the evidence can establish about what she was doing if she was there.

And finally, we suggest you're going to want to consider whether there were failings in care by other people involved with the baby we're looking at or by the unit as a whole. I'll return to that towards the end of what I'm going to say this afternoon. It was just touched on once or twice by the prosecution in their opening. It's going to be more than touched on by us.

I will just deal with the first one of those if I may, my Lord.

MR JUSTICE GOSS: Certainly.

MR MYERS: That is the birth condition of the babies themselves. I have touched on this previously, so I can deal with it relatively briefly, but it is important. It's really important because it establishes a starting point in terms of what might be expected in the course of that child's care.

Remember, ladies and gentlemen, in this case we are dealing with some of the most medically fragile babies, some of them, that can survive post birth as a result of intensive medical care. Not all of them come into that category but a number of them do. Some aren't on such a cliff edge but all of them bar one are premature to varying degrees and some had potentially significant problems in addition to the mere fact of prematurity and low birth weight.

The defence ask you to look for evidence relating to that and we say it is important because in many cases these babies are already at risk of deterioration and when it happens it can be unexpected and it can be rapid. Over and again you hear allegations based upon how unexpected an event was and how quick it was. We submit that, and we'll suggest to you, that very often that can happen with children like this. We are not starting from a baseline of what could be considered good health in any ordinary sense of that word and you will, of course, listen with interest to those medical experts who tell you how well these children were doing.

My Lord, I wonder if I could pause.

MR JUSTICE GOSS: Certainly, if that's convenient for you, Mr Myers. It's very close to 1 o'clock.

We'll have a break now, members of the jury. Can you be ready, please, to come back into court at 2.10? So just an hour and 10 minutes from now until you'll be back in your seats. Please remember, I know this is becoming very repetitive and quite tiresome, but I am obliged to keep reminding you of the fact that you are under the solemn obligation not even to speak to each other about this case, let alone anyone else, or to conduct any research in relation to the case. Thank you very much.

(In the absence of the jury)

I didn't mention, Mr Johnson, this morning, about the glossary. You'll remember there was going to have to be one amendment to that, but it's not important. We'll deal with that at a convenient point. It's something to remain on the list.

MR JOHNSON: We've identified further amendments.

MR JUSTICE GOSS: Rather than trying to do this piecemeal, you go through it all and make sure -- that's you, both sides -- and make sure that what the jury get as their final version is all correct and agreed. Thank you very much.

(12.59 pm)

(The short adjournment)

(2.10 pm)

MR JUSTICE GOSS: I have caused to be sent on to both sides a concern that's been raised in relation to what's available on the web. I have to say, I have not read it all, but I'm led to believe that it is an American website, by that I mean a United States of America website, and I think it is linked to Fox News and people like that.

What I would ask is that people who -- obviously Mr Myers is going to be busy now and you'll be busy listening, but there will be other people who could actually look at this.

MR JOHNSON: Yes.

MR JUSTICE GOSS: I rather fear that there may be little that can be done because it's foreign domain --

MR JOHNSON: Yes.

MR JUSTICE GOSS: -- and websites with foreign domains are outside the jurisdiction.

MR JOHNSON: Yes.

MR JUSTICE GOSS: Then one is faced with the dilemma of saying, do you draw people's attention to the fact that they shouldn't do any research because there will be information there, but it's -- well, it's blatant. It's absolutely blatant and it's outrageous in that sense. This is something that should not be reported because it's not being said in the presence of the jury --

MR JOHNSON: Yes.

MR JUSTICE GOSS: -- and we have responsible media organisations here, but this is the worldwide web. So we'll put that on hold for the moment but come back to it.

There is one other matter, Mr Costello, I gather, wants to... It's about a link. Is it just as and when, not permanently? All right, thank you very much.

MR MYERS: It bypassed me altogether, my Lord.

MR JUSTICE GOSS: Thank you very much. It shouldn't be a problem providing technologically it can be done. Thank you very much.

MR MYERS: I'm grateful, my Lord.

MR JUSTICE GOSS: All right, we'll continue then.

Mr Myers, when you have completed your opening remarks, we will then take that as the time to consider the jury and deal with any jury issues.

MR MYERS: Very well, my Lord.

MR JUSTICE GOSS: Thank you very much.

Jury in.

(In the presence of the jury)

MR JUSTICE GOSS: Yes, Mr Myers.

MR MYERS: Ladies and gentlemen, I'd said there were five issues or areas just to keep in mind when we get to the real substance of the case so far as medical evidence is concerned. I said they were the birth condition of the baby, problems in the health or care of the child we are looking at leading up to the event, medical evidence about the event, and then questions relating to the presence of Lucy Letby at the relevant time and then, finally, any relevant failings in care by people around her or the unit.

We got to the second of those, which is the question of matters leading up to the event we're looking at. When we refer to that, ladies and gentlemen, we are looking at the medical situation which leads up to that event and, again, it's a little bit like the first one where I was asking you to keep in mind the condition of a particular child from birth. When we look at the history of them, you may hear witnesses say -- all sorts of witnesses will come and say how well a child was doing and how unexpected the event was and the reasoning being that if a deterioration is unexpected then it must be down to Lucy Letby interfering with that baby with the intention of killing it. Because that's the allegation that's what has to be proved.

Well, again, being sensible, in most cases we are hardly starting from a baseline of robust good health and we suggest you will need to look very carefully at what has happened on the way to each of the events that we look at, remembering how quickly problems can develop and also, and this may be important, that sometimes the ability to identify problems before they escalate depends on doctors and nurses watching closely, spotting it, recording it, communicating it.

These sort of points that I'm making probably sound a bit general and unrelated from anything, but when we get to the evidence and we return to looking at what happened, hopefully you'll remember that we've identified this kind of thing as something that could be important. And the business of watching closely, recording and identifying may be difficult if a unit is understaffed and overstretched. You may just want to listen out for any evidence that relates to that.

So I'm going to come to the third area, which is the area of the expert medical evidence, particularly prosecution expert medical evidence, and whether it can prove that deliberate harm was done. This is a critical area in the case and I'm sure it's one we will look at very closely.

What the experts do is to work generally by looking at the birth condition of the baby whom they are concerned with, looking at the course of the care and any health problems leading up to the event, looking at all that clinical history, and then in the sad event of a death, the pathology. We'll get the technical descriptions of what these mean, but I'm sure you'll have a good idea of what we mean by pathology, the findings, sadly, after death, when that has happened, and then they tell us what can be established about the cause. It is after they have done that you will hear them say, well, it was this mechanism or that mechanism and it was done deliberately.

Well, the defence say this is an area too where we have to be careful about the assumption of guilt or the influence of a theory of guilt. In the context of medical evidence, the dangers are opinion being influenced by an overarching assumption that what has happened is because of deliberate harm rather than naturally or a mistake. In other words, happening almost the wrong way round. If someone goes into it with that expectation, is that what they're going to end up seeing?

We say that if an expert -- and the fact they're an expert doesn't mean this cannot happen. If an expert sets out with an expectation or a suspicion of harm having been done, or even, in a way, positively going out to look for that, that may make it more likely that he or she will reach explanations that are harm-based whilst rejecting alternatives that may provide an

innocent explanation, we are not even thinking about it. And where there is no clear explanation for what has happened, and that can sometimes happen in medicine, the defence say, in a case like this, there's a danger in an expert being drawn into filling the absence of an explanation with an explanation that is influenced by the prosecution theory that harm has or might have been done. So the expert might be drawn into landing on a harm-based explanation where that may not be the only explanation. You'll see how that's dealt with and whether that is the case when we come to the evidence.

I appreciate it's slightly in a vacuum as I'm describing it now, but it's a bit like if somebody looks for something with something in mind, no matter how they try to get rid of that thought, they may well see that and not see other things. It's an example of what people call confirmation bias sometimes: once you have an idea in your head, you tend to just see the things that fit with that and you either reject or don't even look for other things. That can happen without people realising it's happening or the strength with which it's happening. That's when you are so important in assessing that evidence: if you're aware of this, you're not inside their head, you can assess it overall.

Well, this case has involved, ladies and gentlemen, the consideration of reports by experts on behalf of the prosecution and the defence and we'll hear from prosecution experts during the prosecution case and if the defence call any expert evidence, that comes as part of the defence case, although you will appreciate there is no burden on the defence to call any expert evidence at all. But the fact is there has been a number of experts who have looked at the situations in this case and, as you'll hear in the evidence, they have been provided with one another's reports before this trial and they've even met as a group and considered their opinions jointly, so they all know what one another is saying. That's quite normal in a situation like this, it helps narrow down where the areas of disagreement are, but there is plenty of disagreement, we say.

So let me set out, ladies and gentlemen, the issues on the medical evidence across the counts on the indictment, and I have to say, as far as simplifications go, this is a big one, but just a couple of words of caution first.

When I do this, you'll understand, the burden isn't on the defendant to provide an explanation. I'm not saying that as an excuse for anything because we're seeking to do so, you'll see that, but as a matter of law it's not. But in case where we are dealing with complex evidence like this, it is important to keep that in mind because the answers won't always be clear. Doctors don't always have the answers and nor do medical experts.

So please keep in mind sometimes there may not be an immediate and apparent explanation, and I just say that as a way of caution. The fact, for example, that Ms Letby cannot explain a particular event or that it can't be explained on her behalf does not mean she must be responsible for it. We'll look at all the evidence for that.

The second word of caution is this: what I am about to do is done to help you and the court with this complicated part of the evidence. What I'm not doing is to provide a checklist of points for the defence case to be measured against as if this is some sort of game. You'll appreciate that: we are not playing a game here.

The burden remains always on the prosecution to prove the case. What I'm setting out is a bare summary of the issues. We don't have to do that, but we want to help and we want you naturally to understand important parts of the case and this will be looked at far more closely when we come to the evidence, and you will see there is a good deal of challenge where the evidence is concerned.

What I'm not going to do each time I come to one of the counts on the indictment, ladies and gentlemen, is remind you that Ms Letby is adamant that she has done nothing intentionally to harm any of these babies. That applies to every count, but it doesn't require me to say it every time we turn to it. It will help you -- you may have it already -- if you can see the indictment just as we turn to this now and have a look at these issues.

So count 1. An allegation of murder in the case of [Baby A]. I'll remind you each time -- again, an absolute bare summary -- what the prosecution say. They say this is the result of an air embolus being introduced into a blood vessel, so air of some form.

A general point, since this is the first time we come to the question of air embolus, air emboli or air emboluses. A general point: the defence accept in this instance, and other cases involving the allegation of air embolus, we accept it is a theoretical possibility. That's the first thing: it's accepted it's something that can happen or could happen. So we're not saying this is an impossibility. But of course, the defence accepting that it is a theoretical possibility doesn't really establish very much since in medicine many things can be a theoretical possibility. Many things could be the case. We don't start convicting people of murder and attempted murder because it could be the case. That's important.

The issue is whether in each case the evidence proves what's being said, whether it's sufficient to safely diagnose that it was an air embolus. It's one thing to say, yeah, it could be. But could it? Was it? All kinds of things could be.

So the question when we come to this is: does the evidence take us there? What's the basis for it? And then we'll come to questions relating to the practicalities: well, maybe it is, how? Or if it could be, how? I'm not going to go into that every time on these because I am going to assist you by focusing on the medical evidence. Questions of what happened factually on each occasion we'll probably hear or look at in more detail with the witnesses describing what happened. This is just to do with the medical evidence.

So on this count, the defence do not accept that air embolus is the cause of what happened. What we do say is that the care given to [Baby A] at the unit was, to use an expression you have heard before, sub-optimal. This is the polite and legal way of saying below the right standard. It wasn't optimal, it wasn't what it should be -- and plainly not a reference to Lucy Letby when we say that.

We say that [Baby A] may have collapsed either as a result of a lack of fluids, we'll come to the evidence behind this when we get to the contents of the trial, either as a result of a lack of fluids or a result of the various lines that had been put into him and poorly sited, including the potential for them to interfere with his heart rate.

Now, you will hear, and you may not recall, but you may, that in his case, as in some of the others, air is identified in one or more abdominal vessels after death. There are radiographs taken where you can sometimes see air.

You will hear in this case that the fact of air on a radiograph after death is not of itself something that automatically goes to prove, for example, an air embolus. Air is produced in the body after death very rapidly and is capable for accounting for air seen on that kind of imaging. It's what's called a post-mortem (inaudible: distorted) and it happens quickly. So that will be something to consider. These are real issues. It's not enough to say there's air in the abdominal vessels -- that can happen post-mortem. That's [Baby A].

I'm going to turn next to count 2, [Baby B]. We'll follow these as we go through. The allegation here is that [Baby B]'s airway was blocked in some way or there was an air embolus given to her. The defence say no. She had been in a precarious condition from birth. Like [Baby A], she had been born at 31 weeks and in her case she was blue and floppy when she was born. We do not

accept that the signs she exhibited give any support for diagnosing an air embolus nor is there anything to support an airway being blocked.

We say that's a good example of the assumption of guilt: there's been a collapse, there's been some sort of problem, and we say -- and you'll assess this -- those involved in looking at it, the prosecution experts, have been influenced by the theory that harm was done and that's influenced the outcome rather than simply looking at it neutrally and concluding that harm was done.

We say it's also relevant in [Baby B]'s case that she had other episodes when she struggled to breathe after the time on the indictment here, episodes that don't appear in that table, but there were other episodes when she struggled to breathe, so it's part of an issue that she appeared to display.

Count 3, ladies and gentlemen, [Baby C]. I'm going to pause just to say this -- and really it's going back to something I said at the outset: I appreciate I am trying to go slowly, but at the same to travel through these. We realise this is people's lives and these are babies and to do with families. Please don't think -- I wouldn't want anyone to think, when I'm going through it like this, we don't appreciate that. That's always the case. So there's nothing meant to be insensitive or heavy-handed in dealing with it in the way I am now, it is just to help you, and I am sure everyone understands this is where the key areas are going to be on the medical evidence.

Count 3, [Baby C]. The prosecution experts say that in this case death was a consequence of air introduced exogenously, so brought into the stomach, by the nasogastric tube. They're saying that's been done on purpose. We'll see, again, exactly how that is explained when the prosecution experts come to give evidence.

But pausing before I deal with [Baby C]'s case in particular, a general point about those allegations that involve air being said to have been forced down the nasogastric tube. Again, I hope this is reasonable and helps, so we know what we're dealing with. We accept in this case, as in other ones where that's the mechanism alleged, that someone's injected air or forced it or forced something down the tube to cause abdominal distension. We agree that is a theoretical possibility. I'm not saying it couldn't have happened. It's a theoretical possibility. But that, as you will understand, is a very long way from saying, yes, the evidence proves that's what's taken place. Again, all sorts of things might account for abdominal distension.

It wouldn't be very helpful if we were even disputing something which, as a matter of theory, could account for it. Of course it could. When we come to look at the allegations you will need to look, for example, at the practicalities of that, how this is meant to have been done. This is another matter altogether.

And the question of whether there are alternatives that account for abdominal distension, because abdominal distension, swelling in the stomach and intestinal area and into the bowel, is not uncommon in babies or babies on neonatal units. And you will see reference to it at other times that don't appear on this indictment. The prosecution would say, yes, but they're not as dramatic as this. Well, we'll see and we'll go through all of that.

So coming to [Baby C]. He was 30 weeks gestation and 800 grams, so that is very premature and very low birth weight. Connecting that with an issue I've identified earlier about birth condition, as a starting point, sadly, a baby like that will be vulnerable to a variety of complications, what's called respiratory distress syndrome, which is when it's difficult to breathe because, of course, their lungs have not developed. The mere fact of the baby being born doesn't mean that they are going to be at the same (inaudible: coughing) as a baby that is term. That growth is meant to go on. More vulnerable to infection.

And we say, for a starting point, he should have been at a unit delivering more specialist care. He was at the Countess of Chester and we say they did not provide appropriate care and that condition, NEC, that you heard about, the bowel condition, necrotising enterocolitis, or infection, are both potential causes of collapse and death.

We also say it's relevant that the pathology, so after death, identified acute pneumonia with acute lung injury. That was one of the findings. Again, to help, the response from the prosecution, we anticipate, would be, yes, it's one thing to die with pneumonia, that doesn't mean somebody died of it. So to be of help, we point out there's two sides of looking at that, but it may be a relevant finding.

There is also, we say, a question as to whether in the formation of his gut in the abdominal cavity there was a structural blockage that could have caused distension. There are a number of issues there. But when we go back to the cases in detail we'll come back to these and you'll see them then with the evidence.

Count 4, [Baby D], one of the allegations of air embolus, air into a blood vessel. The defence say, no, we do not accept that

air embolism can be properly diagnosed here. We say the hospital failed to provide appropriate care -- and actually this is accepted by the prosecution to some extent, as they said in opening, and as they would have to do, because it's beyond dispute she was not put on antibiotics when she should have been; there was a delay of hours.

In a little baby, that's a big delay. When people talk about -- what you'll hear is the golden hour or the time in which various things should be done to look after a neonate, there's a reason why they should be done quickly. In her case there was a delay of hours.

She was never able to breathe unaided and we say there is strong evidence that infection may have played a part in her death and a good deal stronger than any suggestion of air embolus. And in her case there is clear evidence also of pneumonia after her death. How relevant that is is something we'll consider with the experts, but that's a finding.

And where there is air in her system, seen in it on imaging after death, we say that is potentially due to post-mortem changes or even resuscitation.

Count 5, [Baby E]. The allegation here, in fact, is of air embolus and acute gastrointestinal haemorrhage, a lot of bleeding from the stomach area or the intestine area. You will remember, ladies and gentlemen, [Baby E] is the little boy who the prosecution say was attacked by Lucy Letby in front of his own mother.

Well, we'll come to the evidence on which that is said to be based in due course. We say there is no evidence of an air embolus, no proper evidence, and actually no evidence of direct trauma identified that could account for the blood loss. For all that's said about that, there's no evidence of it, although he did die of acute haemorrhage.

We say there is no clear explanation in his case for what happened. But that being so, it is not right to reach or rely upon the assumption of guilt. You may recall this is a case where there was no post-mortem. The prosecution told you about that and they said that was a big mistake, like somehow there was a problem for them. Well, yes, too right that's a mistake. You may wonder who's paying the price for that now because, in the absence of a post-mortem, the defence will say the prosecution are able and the experts are able to float suggestions as to deliberate harm, the reality of which we do not know.

Counts 6 and 15, ladies and gentlemen. I'm going to deal with those together. You may realise why. That's because they're the two counts that involve allegations of insulin being introduced. Count 6, [Baby F]. Count 15, [Baby L].

The defence cannot say what has happened and, to be fair, it might be observed if someone has done nothing wrong, how could they? It's difficult to say what has happened if you don't know. We say because of that, rather than just not looking at it closely, there is all the more reason to look very closely at the evidence relating to both of these allegations. And we invite that.

From what happened with the bags, the TPN bags that are said to have been hung up with insulin in them, to the point that the samples were taken and the testing, these are hotly disputed, as are the other allegations. And as with other allegations our concern is the absence of being able to explain things is not converted into evidence of guilty.

But such a lot has been made of this and so much said about poisoning that I am going to pause and identify an issue on the facts just to illustrate that these are not simple allegations that can just be rolled out and automatically lead to a conviction. Far from it.

I don't know how much you remember of the description of what happened with the various bags that were put up involving [Baby F]. You'd do well if you can remember it because even though it was gone through in detail, quite properly, it's a little while ago.

Just to remind you, a bag was put up when Lucy Letby was on duty, a little after midnight on 5 August. And there were problems, low blood sugar, some hours later. That bag was changed some time around midday of the next day when she wasn't there, and the problems continued, even though the bag was changed. And then the sample that was taken and is relied on in this count for the insulin reading came from the second bag, the bag that was put up when she wasn't there, whatever lies behind that.

The prosecution say, well, that must have been a random stock bag. So that isn't even anything that was designated for [Baby F]. And yet that found its way to him when she wasn't there and when that simply cannot be blamed on her.

The prosecution are fixed to the theory that this is all to do with Lucy Letby, so in trying to explain how this can have happened, the different bags and different times and when she isn't there, they have the authority on this, Professor

Hindmarsh, who you may recall has given not one but three possible explanations for what happened, none of which directly implicate Lucy Letby, and that might leave you thinking, and this is the point, we'll come to it in the evidence, this is a good deal less clear than it sounded when you were first told about insulin poisoning.

We observe it's hardly surprising the prosecution ended up saying, as they did when dealing with this, "It's all a bit of a headache". You may not remember that being said, we would say not surprising, no, but not very reassuring.

They also said on this topic it's not straightforward and we certainly agree. That doesn't mean we just use the assumption of guilt to make it straightforward.

Two bags, at least, three possibilities, and Lucy Letby not there when the bag was put up from which the sample that was analysed was taken.

So after all of that, the prosecution, we say, hardly surprising, say, let's see how the evidence goes, and with that we agree wholeheartedly. If there's anything we should walk (sic) away from this it's: let's see how the evidence goes.

We come to [Baby L]. There are issues there relating to the documentation and the entries and the timing of what happened with the bags and who was involved. So we challenge these allegations too, however much reliance is put on them, and we repeat that there is nothing in fact, after all of that, to establish any act certainly by Lucy Letby that shows her doing what is alleged against her.

[Baby G], ladies and gentlemen, counts 7, 8 and 9. The prosecution experts say there are a number of things that happened here. They say there was excessive milk forced down the NGT, the nasogastric tube, on two occasions, counts 7 and 8, and then on count 9 there's the incident when it's said that Lucy Letby was behind a screen with [Baby G] when the doctors had been -- after the doctors had finished fitting a cannula to her and [Baby G] was desaturating.

Well, [Baby G]. Her starting point was an extremely premature baby, born on what the doctors would describe, it's not meant to be insensitive, but born on the margins of viability. These are all official terms and medical terms as you'll hear. Again you'll know, and you'll be learning, if you didn't know already, that that means there will be problems that you can predict and that will automatically be associated with this.

So experts coming along and say, oh, so-and-so's doing really well -- well, we'll look at that. In any real world sense we say, no, that's not a baseline to start from. She was a high-risk baby with a history of abdominal distension and vomiting, irrespective of anything associated with Lucy Letby, and on occasions that don't feature in any reference that's been made so far in this indictment or that table. We say they all form part of an ongoing and relevant picture.

In addition, the defence say she exhibited signs of infection and so we do not accept that Lucy Letby had anything to do with causing the vomits on counts 7 and 8.

Again, when we get to the evidence you'll be able to see and weigh up what all parties say about what could have happened. These are the things to look out for: a history of vomiting, reflux, things like that, which fit with what we find on the 7th and the 8th. Nor do the defence accept that Ms Letby did anything to cause the desaturation on count 9, and that's a count where we will hear evidence of who was where and who did what and what could possibly have lay behind the moment that Lucy Letby called [Nurse B] to come and help her because [Baby G] was desaturating. She called for help.

Counts 10 and 11, ladies and gentlemen, [Baby H]. You will become increasingly familiar with the situations for each of these little children as we go through the case and then you'll begin to think, yes, this is the case that involves the following things, and of course the person that's behind them. It's all about people.

[Baby H] is the baby who was treated with three chest drains. I will just remind you that in opening the prosecution said that her case is complicated to a degree by the sub-optimal treatment she received at the beginning of her life. An unacceptable delay in intubating her. An unacceptable delay in giving her surfactant, which is the protein that's put into the lungs to assist with breathing. She wasn't paralysed when put on the ventilator initially. Butterfly needles were left in her chest for prolonged periods of time, which may have punctured her lung.

We say, and the prosecution accept this, so far as those things are concerned, first of all, another example of sub-optimal care. And the prosecution experts appear to have no real explanation for what happened. Certainly no specific way is proposed in which she was deliberately harmed. It seems, we observe, that a good deal of harm which was done to her by what happened in the hospital has nothing to do with Lucy Letby, but despite all of that, she's there. And we say that [Baby H]'s collapses were probably the result of infection or the trauma of

what happened in the unit and it isn't anything that Lucy Letby did and in fact there is nothing to establish that it was.

Count 12, ladies and gentlemen, [Baby I]. You'll remember when we come to [Baby I]'s case, although the allegation of murder relates to 23 October 2015, on this count we're looking at a series of events, a number of events that happened that the prosecution say were attempts to kill her leading up to that date, three previous events.

Various mechanisms are proposed here by the prosecution experts. There is excessive air into the NGT, air embolus into the blood vessel on different occasions and sometimes together. Dr Dewi Evans, who is an expert for the prosecution, agrees this is a complicated case and we observe most of what we are dealing with in this trial, we would suggest, is fairly complicated. But we say if you follow [Baby I]'s course of health and treatment across her sadly short life you will see that her collapses and ultimately her death are part of a series of ongoing clinical problems that may well have been inevitable given her extreme prematurity. She was 27 weeks old at gestation.

We also say when we are looking at the question of abdominal distension there are times when CPAP may have caused or contributed to that distension. We do not accept that air was forced down the NGT and we do not accept that air embolus is something that happened at all.

I want to pause there for a moment to explain what I mean when I say CPAP may have caused abdominal distension. You have heard this referred to already by the prosecution, it's in the glossary but I will just read it:

"CPAP is continuous positive airway pressure, a method of non-invasive respiratory support, by which air with supplemental and/or oxygen (as necessary) is administered through a face mask or plastic tubes into the nose at a constant pressure to reduce the work of breathing and improve oxygenation in babies."

So by non-invasive, that means it's not the tubes -- endotracheal tubes going all the way, like on a ventilator. It's not as, if I put it this way, extreme or invasive as that as. It comes in on a mask or tubes into the nose and of course that means there is a pressure of air entering the baby. And it's a recognised complication of CPAP that it can, in circumstances, cause an expansion or a distension of the abdomen; it's called CPAP belly.

There are measures that can be taken to avoid that or to reduce it, to ensure air is taken out of the baby as the baby is on CPAP and things like that, but whilst it isn't for the defence

to provide explanations for everything, we do observe that there are times when CPAP may have caused or contributed to abdominal distension in this case.

Count 13, ladies and gentlemen, [Baby J]. We say there's not a great deal of explanation here from the prosecution experts as to what caused the deterioration in [Baby J]'s case. Dr Evans has suggested airway obstruction. Well, we'll see, but just to refresh your memories, [Baby J] was the little girl who had the ileostomy performed and was provided surgically with stomas, and those are to enable faeces to pass outside her body. It may be her collapse was due to infection, but what we do say is that the Countess of Chester Hospital was well out of its depth in looking after or attempting to look after [Baby J] and knowing how to treat her.

We say that you will see here, or may see, an assumption of deliberate harm combined with Lucy Letby's presence on the unit being used to direct blame at her when what we actually have is a baby receiving inadequate care and a baby for whom there is no mechanism that can be identified that links her collapse to anything that Lucy Letby did.

[Redacted]. Again, I hope -- (inaudible) all going in, it's a lot to deal with.

We'll take it through like this, hopefully, ladies and gentlemen, bit by bit you'll be able to listen to relevant matters when we get to these counts in the evidence. I'm sure the prosecution will do the same to assist.

[Redacted]. I am just keeping an eye on the time and the temperature.

If I may, I will continue for the time being, with your Lordship's leave, but, ladies and gentlemen, it may be before I get to the end if what I have to say, that depending on the time, a short break would be of assistance, but could I stop at that point, my Lord, and just check with the court?

MR JUSTICE GOSS: Certainly, yes.

MR MYERS: Count 16 is next, ladies and gentlemen. We have had a brief look at count 15 as we have had brief looks at the other counts. Count 16, [Baby M]. The allegation is air embolus being introduced or airway obstruction.

The defence recognise there is no obvious cause of collapse in this case. But we certainly don't accept that the evidence establishes an air embolus or any other form of interference. It's just how that is. There is no obvious thing. We're not

pointing to this or pointing to that. No obvious cause. There may be some sign he was developing an infection. Be that as it may, we say we are back in the territory, really, of blame being put on Ms Letby because there is no obvious alternative. That is what I mean (sic) earlier when I was talking about the assumption guilt and the coincidence -- we get to a point in this case where just the mere fact she is there when something has happened is almost being used as an explanation for it happening.

Counts 17 to 19, ladies and gentlemen, are relating to [Baby N]. On 3 June the allegation is there was some kind of inflicted trauma, so something done to him physically that caused him to scream or air was being injected. On 15 June, it's alleged that bleeding was caused by an NGT being pushed into his throat. You'll remember the things the prosecution have said about [Baby N] and the diagnosis that he was or may be a haemophiliac and therefore they say maybe that's what lies behind this.

Well, as for 3 June, which is count 17, the defence observe there are many reasons why a baby will shout or scream. Their being hurt is one of them but in fact on a neonatal unit not the most obvious, unless you are going to assume that someone's done it. We say it is far more likely to be hunger, and that might sound banal, it might sound a bit obvious or simple. Well, sometimes things can be. You certainly won't find evidence of anything else and no basis for injected air.

That's 3 June. 15 June, counts 18 and 19. In particular I'm going to concentrate on count 18, in the morning, the allegation that Lucy Letby did something that caused him to bleed in his throat.

Just to remind you, it was at about 8 o'clock that morning when [Dr A] had to intubate [Baby N] and what the prosecution say is that when he came to do that, he saw blood already in [Baby N]'s throat. So the allegation is, well, something had been done to [Baby N] to make him bleed. And that's the prosecution case on that, and because [Baby N] was with Lucy Letby, or she could have been with him, she had done something to do it.

The defence disagree. We are going to have to look carefully at the medical notes here. We disagree that Lucy Letby harmed him then, or at any time that day, and in fact the only fair and reasonable interpretation of the notes and what happened is that blood was not identified until intubation had happened or was part-way through. There were three attempts to intubate him by [Dr A] and the defence say squarely that there was blood by the end of that, but there is no basis for saying there was blood before it.

We say also in [Baby N]'s case there was sub-optimal care and he is another child who should have been at a tertiary unit and not at the Countess of Chester.

I am coming to the last three here, ladies and gentlemen. That's not to diminish their importance. I'm grateful for the focus, it's a lot to take in in detail like this.

Count 20, [Baby O], also known as [Baby O]. The allegations here are various. What is proposed is intravenous air embolus, so air into the bloodstream, trauma being done to the liver, so some sort of attack or impact into the area of the liver, and excessive air into the nasogastric tube.

The defence do not accept any of those three mechanisms proposed by the prosecution experts and we say they are not the only possible explanations. The question of discolouration, which is used to support air embolus -- and you'll remember -- you'll hear, I imagine, a lot about this in evidence from the experts, so here's something to identify, the way that the changes in colour on a baby's skin are said to indicate an air embolus having been injected. That's what that comes down to, whether or not that can be used to identify an air embolus, whether it's good enough to be used for anything diagnostically, there's this question of the strange mottling or the colour of children who have an air embolus. We do not accept anything approaching that is established on this count. We also say there were signs of infection in [Baby O] and that could have played a part in his collapse.

We also say this: that a rapid rate in the increase -- or rather the rate of increase in his feeding at this time, together with the respiratory support he was receiving -- you heard me talk about CPAP, CPAP belly -- those combined will have increased the pressure in his abdomen and the extent of the distension, and the distension is caused or can be caused by that, rather than air forced down the NGT. Again, you will understand at this point we're just focusing on the bare medical evidence. You will have the advantage of taking the medical evidence and also listening to evidence from doctors or nurses who were there where that's available and what they describe what happened so then you can think, well, what are the practicalities of this, what might or might not have happened or, rather, when we're dealing with serious criminal allegations, what are we sure has happened.

So far as the injury to [Baby O]'s liver is concerned, the defence say that is in fact something that could have been caused during resuscitation. The prosecution do not accept that. I have not been saying every time the prosecution do not accept that, but I'm sure you follow, ladies and gentlemen, the

prosecution say one thing and often the defence do not accept that. The defence say something, often the prosecution do not accept that. But it would be very tedious if I kept on saying they don't accept it every time.

Again in [Baby O]'s case we say that where air was identified on radiographs post-mortem that is a natural occurrence that happens after death.

Count 21, [Baby P]. It is another allegation of excessive air into the stomach, which, as we have heard, splints the diaphragm, so holds it hard, and then the baby can't breathe and then collapse follows. That's the allegation. The defence agree that collapse can occur, or could have occurred here, by splinting of the diaphragm but we don't agree with the way that it is alleged to have happened.

We say that the air that was identified in [Baby P]'s stomach and intestine is consistent with the build-up of air from something called Optiflow, which no doubt I'll be corrected eventually, but for the purposes of this is a bit like CPAP, it's air going into the baby for respiratory support, and that was blowing into the nasopharynx area for hours. That's this area here (indicating) that goes down into the throat area, towards the chest area.

Again, in his case, that was happening at the same time as a rapid advancement in the rate of his feeding. That can account for the dilation. And in his case, ladies and gentlemen -- and this is something, an issue to identify, keep in mind -- there was a significant degree of distension in [Baby P]'s case, almost, it seems, the entire bowel from the stomach to the rectum. And there's an issue, isn't there, as to how long would that take for somebody to inflict that? That's one of the examples of what we mean by what are the practicalities? It's one thing to say, well, we're not sure what it is, but she was there and harm has been going on, so she did it. Well, how?

On the other hand, it's entirely possible for a baby in this situation, who's on CPAP or Optiflow over a period of time, for air to build up in that way if it isn't being aspirated or drained in some other way.

We agree that once he collapsed it is not clear why he didn't respond to resuscitation, but that doesn't go to show that this is inflicted harm. Just so you can follow what's said.

There may be an issue in his case, let's put it this way for the time being, as to whether the amount of adrenaline given to him during the collapse might actually have contributed to that deterioration and made it worse.

Count 22, [Baby Q]. It's the last count on this indictment. Air injected via the nasogastric tube and possibly a fluid of some sort being given to him as well. This might be a little fresher in your recollection because we listened to this described by the prosecution this morning.

Again, the defence do not accept this and we say that in the days prior to his collapse, [Baby Q] had actually developed bile-stained aspirate, so what was being drawn out of his stomach area is stained by bile. That shouldn't be there. We say that indicates a problem with his bowel and is capable of supporting a diagnosis of NEC -- remember the gut complaint, quite a serious one, that can occur in small children and babies -- and that a poorly functioning bowel is probably what led to him being unwell and vomiting on 25 June.

And yes, gas was aspirated from his stomach, but again he had been receiving what's called positive pressure ventilation. You can't possibly say the gas wasn't from that, it was from an assault of some sort.

So ladies and gentlemen, you will see -- that is a simple -- to say it's a simple summary is no overstatement, it really is a simple summary of what we are dealing with. You will see there are real issues to be considered but the purpose for going through it that way, and I'm grateful for you for (inaudible: distorted) to that is that so you understand the type of issues we're looking at and the sort of things to look for.

There are two areas I'd like to deal with before I conclude.

My Lord, if we were to break, this would be the point, but I don't want to delay things unnecessarily. It will probably take me about 20-25 minutes just to finish this.

MR JUSTICE GOSS: Well, I think in the circumstances, we will have a short break. We're going to have a break, the question is whether we have one now or in 20 or 25 minutes when this is finished because we're going to have to have a break to deal with you continuing as a jury of 14 in any event. Are you happy to wait until then? Wait until then?

MR MYERS: Very well.

(Pause)

The fourth area. Looking now at Ms Letby and the question of her presence at the relevant time and what the evidence can establish about what she was doing. These are far more general comments than the earlier part of what I have said to you, so

I'm not going through, on this count did this and on that count did that, but these are the sort of things we can keep in mind generally and then look at the evidence.

When we come to the question of where Ms Letby was and what she was doing, nothing is meant to sound sinister in saying that. It's just a simple question: where was she, what was she doing? I need hardly say, it's important not to guess or, even worse, proceed on an assumption of guilt. It's important to keep this in mind because a lot of the time you're going to find the evidence cannot pinpoint exactly where she was any more than it can pinpoint exactly where another person was.

Even where we have timings on certain documents, they will not always be precise timings of what we're dealing with. Some will be more precise than others.

She can certainly hardly be expected to remember. How on earth, outside notes that are made at the time, is anyone going to remember. But of course that makes it all too easy for someone to say she could have been attacking a child. That is in fact what we get over and over again, we say.

When you come to look at the relevant detail in these events, in particular when we look at particular problems as they develop, we say there are many occasions when Lucy Letby was simply not there at the time she would have had to be present if she'd been doing the type of deliberate harm alleged. And it would be very unfair to say she is responsible because she's there and enters the scene when the course has already been set.

Sometimes there are relevant events that take place when she's nowhere near to what's happening and we say some events like that don't make it on to that table.

Now, to assist, so you have both sides of this issue in mind, we acknowledge the prosecution may say, or will say, yeah, but the events on that table are the relevant events, they're the ones that matter for these children. They may say other things are not as dramatic or serious or unexplained, it's these ones that stand out.

The defence are saying, no, there are other ones we need to look at to put these in context, and deciding that is part of what will be involved in that trial, but then you have both sides of that issue, ladies and gentlemen, and it's something to consider as we go along. I've endeavoured to put both sides of it there so you can see what the competing arguments are.

Even when Ms Letby is present, even when there is no dispute that she is looking after one of these children at the time of

one of these events, really that does not get anywhere close to proving what the prosecution allege.

And disregarding how unfair it would be just to treat mere presence as evidence of guilt -- and we are going to submit to you that's where this gets to very much -- you'll need to keep this in mind. This is something to look at when you come to the evidence, something to be considered in the questioning of how events or shifts were arranged on the unit. She was a young nurse with no immediate family commitment and, the defence say, someone who built her life around her work in the neonatal unit. She obtained the qualifications, both to do that and to be able to deliver intensive care because, sadly, a number of children there labour under serious health problems.

So, we say, she was often called in to cover shifts where there were babies with those sort of difficulties and sometimes at short notice and she was ready to do so. So it follows that someone in that position and that role is more likely to be looking after the more clinically difficult babies and be more likely to be there when deteriorations happen and that doesn't mean she made it happen.

Finally, on the subject of Ms Letby and her presence and what did happen or what didn't happen, it's important, isn't it, to bear in mind that she will, perhaps often, not be able to remember all the details relating to specific children and particular events? I'm saying that now because of course you have heard things that were said in interviews, you have heard summaries of that, and we'll come to the interviews in due course. But just keep that in mind, that in that regard she's like any other witness in this case whose recollection often cannot go beyond the notes made at the time. You'll weigh this up when you hear what's said.

Although you may find some examples of prosecution witnesses whose memories have improved over time, we'll see. Look out for that. Goodness knows how many babies she will have cared for over the years. Keep in mind she cannot be expected to remember details better than any other witness. And sometimes it may be impossible for her to say what she was doing when there are no records to help. I should think it must be uncontroversial to say that would make her guilty of nothing. Look out for the way that any difficulties she has in recollection is in any way used against her.

And the fifth and the final area that I'm going to deal with in this outline of the facts, ladies and gentlemen, or rather outline of the issues, is the issue relating to other staff and the unit as a whole.

That must be important, mustn't it? It must be because it would be unbalanced and unfair to focus on Lucy Letby's role with a particular child if there are associated and potentially relevant problems created by others or in the way the unit was run. That may explain or may go some way towards explaining what happened. This is one of the things we've identified that doesn't appear on the prosecution's chart. Why would it? It's not a part of that exercise.

Now, nobody -- nobody -- is going to expect perfection day in, day out. What is expected in terms of care from medical practitioners is generally not to make things worse. And can I make it plain, we do not suggest that the doctors and the nurses on this unit were anything other than dedicated to doing the best they could and the work they do is admirable and crucial. But if this is going to be fair, if we're going to weigh this up fairly, you may think it is important to consider whether any problems in practice or in the way the unit was staffed and run could have contributed to what we have on this indictment unless we're simply not interested in finding out what's happened, we're just going to say, oh well, we don't really care about that, it's just the coincidence when she was there. You may agree, that would be desperately unfair.

What I'm saying is not fanciful. We say there were problems with the way this unit performed that had nothing to do with Lucy Letby and we will look closely at this in evidence. I'm not going to go through a list of things now.

But you may have sensed, as we've reminded you, an element of it and one or two concessions in the protection opening. The failure to give antibiotics to [Baby D] is a legitimate target of criticism, although Lucy Letby is held responsible for her death on count 4.

The fact that the care of [Baby H] was sub-optimal repeatedly, although Lucy Letby is held responsible for the collapses on counts 10 and 11.

The defence say there are very many more examples of sub-optimal performance in this unit that are also legitimate targets of criticism. We will come to that in the evidence and then you can weigh up what I'm suggesting and identifying for you now.

Included in this area is the way in which a significant number of children in this case recovered well, or better, when they were moved from the Countess of Chester Hospital. Repeatedly, the prosecution have said how much better certain babies did when they were moved to a tertiary unit, like Arrowe Park Hospital or Liverpool Women's Hospital, and the prosecution

consistently put that down to the fact that they had been moved away from Lucy Letby. You've heard that repeatedly.

Of course, an equal and alternative and equally viable interpretation is that their improvement coincided with removal from the Countess of Chester Hospital, which could not deliver, we say, on all occasions the care that was necessary or the expertise for some of the children it looked after.

We say that the improvement in some of these children when they went to a tertiary unit is evidence of how the unit at the Countess of Chester did not always deliver the care at the level it should have been provided. To turn that round and put it all back on to Lucy Letby, is unfair and inaccurate.

You may recall, during the period on the indictment, that the neonatal unit at the Countess of Chester was what's called a level 2 unit. I'm going to deal with this because this is an important aspect of this part of the case.

You'll hear there are three levels of unit in neonatal care. Level 1 is the -- I think this is a simplification again -- the least intensive care. Level 3 offers the highest level of intensive care. That's called the tertiary unit, that's the highest level, the most specialist. So units like Arrowe Park and Liverpool Women's Hospital are level 3 or tertiary, they specialise in the highest level.

As a level 2 unit, so that's, you might think, in the middle, it can provide some degree of intensive care, the Countess of Chester could offer care to babies from 27 weeks gestation if they were what's called single births and 28 weeks for multiple births. So if a baby's gestation is lower than that, he or she should go to a tertiary, they shouldn't be at a secondary like Countess of Chester.

We say there are occasions when the level of care at this unit could not reach the level of care required for the babies it was caring for, whether that is because of a lack of technical medical skill on behalf of doctors or because it was accepting babies with too high a care requirement for its capacity, or simply because it was too busy because and could not deliver what was required with the staff it had available. I'm identifying this now, ladies and gentlemen, so you are able to listen out for evidence relating to this if it emerges during the course of the trial.

It's an issue we say that will feature in the evidence so I'm identifying it for that reason. You will learn, when we get to the evidence, that in July 2016, shortly after Ms Letby had been moved to non-clinical duties, the Countess of Chester neonatal

unit was redesignated to a level 1. So in effect, the seriousness of the cases it could deal with was reduced. I'm sure there are more formal bureaucratic expressions for that. I'm not going to use the expression "downgraded" because every level of care is important, but, you can follow, they could no longer provide care for babies at the level they did, they could provide level of care for babies of 32 weeks and up. That's what you get with level 1.

You can imagine, in a situation like that, there is bound to be concern -- just imagine the reality of that in a hospital unit -- and an inquiry into what has happened. Its redesignation, it's not fair to call it a downgrading, but you can imagine how some people might feel that's what has happened, senior people, people involved with the managing of it, and that may form part of the relevant background in this case, which is almost certainly going to be featuring in the evidence and we say you need to be aware of that.

And in a similar vein, in terms of the relationship between Lucy Letby and the unit where she worked, something else the prosecution touched on rather coyly was Dr Jayaram and his suspicions. We cannot leave that hanging in this introduction and we want to assist by identifying this. This came up, you'll remember, when we were dealing with [redacted].

You may wonder what on earth that is about because if the prosecution are really saying that Ravi Jayaram, one of the lead consultants on the unit, has suspicions about Lucy Letby, when did that start? Under what basis, you may want to ask? An inquiry like this, looking at everything? You may think that if one or more consultants had suspicions like that, if Lucy Letby was allowed to continue, that's concerning, to put it lightly, if that's what they think. You may wonder whether there's any real basis for suspicion at all and (inaudible: coughing) what Dr Jayaram is talking about when he says that.

You may also think, and this is something to consider when we come to the evidence, that if we're talking about suspicions like that, one or more senior consultants, for example, deciding Lucy Letby is to blame before any formal outside agency is brought in, that that really is fertile, self-serving territory for an assumption of guilt to take hold, and once it does, it affects, we say, the way people look at what is happening, whether they realise it or not. However genuine they are in that belief, it becomes self-serving and self-fulfilling, and often other potentially relevant factors are disregarded.

I'll leave this for the evidence but these are things that have been raised by the prosecution and we cannot move on without dealing with that. For her part Miss Letby would say that, yes,

she became in due course a target of blame and wrongly so. So against that background, concluding the redesignation of the unit from a level 2 to a level 1, you may want to ask whether the doctors -- this isn't meant to be some unreasonable assault on everybody, we're not saying it's happening all the time, but whether there are relevant instances in this case where doctors have not given the right care, whether the unit was too busy, whether other members of staff did exactly what was required at key times, and whether they identified all the problems that were emerging at an early enough stage to prevent more serious deterioration. That matters, you will understand, ladies and gentlemen, for three reasons.

First, we say it would be very unfair to judge Lucy Letby by standards that are different or higher than those we are going to apply in this case to other staff at that unit. It would be most unfair to regard something, something she's done or something she's failed to do, something she wrote, something she failed to write, as evidence of murder in her case if it's treated as just one of those things that happen when you come to see how others go about what they do. And that applies not only to nursing practice but to other areas of evidence, such as the way in which she messages her friends and colleagues, or the timing of that or the interest she shows in families of children she's cared for.

So please don't judge her when we come to the evidence against standards or expectations that are different from those that apply to other nurses on the unit.

Secondly, and more fundamentally, if others have failed to provide appropriate care or if the unit is too busy or not properly staffed, you may agree that creates a situation in which things can go wrong, developing problems may be missed, treatment hurried, mistakes made and records not kept as they should be. They may not always go wrong immediately, but it may happen.

So we must be careful when we turn to the evidence not to hold Lucy Letby responsible if it suggests we are looking at circumstances or outcomes that may not be of her making, whether she's there or not at the time it happens.

And third, keeping in mind what Ms Letby says about the question of blame in her defence, we identify this: that if this unit has failed in such a way that that failing in care has caused or contributed to this uncharacteristic spike in deaths during June 2015 to June 2016, you can imagine pressures to find an explanation. We say the inclination to favour an explanation that distances the unit or those who are directly responsible for running it from blame is quite natural.

Given the scale of what we're dealing with here, the defence say that this may be fertile territory for unconscious bias or for an assumption of guilt to become increasingly attractive. So we say, in conclusion, that is something to keep in mind, isn't it, if we're going to be fair here, as I know you will be, when dealing with what the defence say must be a massive failure in care in a busy hospital neonatal unit and what the defence say is far too great a readiness to lay blame on one person.

Ladies and gentlemen, that really is a brief introduction to the defence case. This whole case is a complex case. It's not straightforward and in that dock is a young woman who says this is not her fault. So we need to look at the evidence and that's something that we'll be turning to shortly.

Housekeeping

MR JUSTICE GOSS: Thank you, Mr Myers.

That, ladies and gentlemen, brings us to the point at which you cannot continue as a jury of 14. That is the introductions. You have had some of the evidence pointed out to you, but as has been emphasised from the very outset when I first addressed you, the jury will in due course try this case on the evidence that they hear during the whole of the trial. You've just had addresses that have introduced you to the nature of the evidence, the reasons for the allegations that are made and what the defence invite you to look out for as you're hearing the evidence and what is in issue and what is not in issue, which is obviously very helpful because then you're not hearing the evidence in a vacuum.

But so far as you as a jury of 14 are concerned, as I say, we're now at the point where that can no longer continue. I am aware that in the case of one of you, it is not possible for that juror to continue, and that juror will be discharged. So I'm now going to address the remaining 13 of you.

Are any of you now aware of any difficulties of which you have not been aware up to this point whereby you cannot continue to serve as jurors in this case? No? No difficulty? Right. So be it.

I formally then discharge the juror. It will become apparent to you who it is in a moment when you leave this courtroom. I discharge that juror and I direct my remarks to juror number 13. You, madam, at the end of the row. You will take the seat that is now vacated by the juror who I have discharged. All right? And you will continue to serve as a juror in this case.

You, sir, juror number 14, thank you very much, but your services are no longer required in this case. I hope you've understood the reason that it has been necessary to do this and why in this case, as is not uncommon, reserve jurors are called upon at this stage of any trial. So thank you very much for -- I'm addressing my remarks to you, sir, and to the juror who I'm now discharging. Thank you very much for your care and attention, your participation in this trial process up to this point. Obviously neither of you, the juror who I'm discharging and you, sir, will be required again, and indeed I don't anticipate you will be required to continue with jury service this time because it is actually coming near to the end of what is the conventional period of jury service. So when you have completed your business with the jury officer at the end of day you will leave this building.

I just want to address you two, first of all in the presence of the remaining jurors, just in case you do see each other. You may be travelling in the same form of transport for a time and have the opportunity to talk. You've all been under the strict instruction not to talk to anyone, including a fellow juror, about this case. As far as the two of you are concerned, you remain subject to that embargo. Please do not talk to anyone about this case until it is all over. All right? So don't discuss the matter with family members, just say, "I've been involved in a case but I'm not actually needed to try the case as it transpires now", and then in due course you can, if necessary, explain what the situation is, but that's a long time away. All right?

So thank you very much indeed. It's all to do with maintaining the integrity of the jury system. Thank you very much.

So what we will do now, you'll have your break, but then you're going to come back into court again and be a jury of 12, and I will give you some further jury instructions at that particular point. All right? So it should only take 10 minutes, I think, I'm looking at the usher now. About 10 minutes, yes. Thank you very much. We'll be ready for you when you're ready.

Thank you.

(In the absence of the jury)

MR JUSTICE GOSS: Mr Johnson, I'm just wondering about the appropriateness of the iPad instructions this afternoon or whether that should be deferred until tomorrow morning. I don't know, are you confident it can be done in 20 minutes?

MR JOHNSON: It's not my confidence that matters, my Lord, it's Mr Murphy's, I think. One way of doing it would be to do the

lawyers now and the jury in the morning if your Lordship's worried about their...

MR JUSTICE GOSS: I'm just thinking at the end of the day, they've had a lot of information today.

MR JOHNSON: Absolutely.

MR JUSTICE GOSS: Some may be tech savvy, some may not be so tech savvy. We also have some other issues to discuss that we can deal with, so I think what we will do is when the jury comes back into court as a jury of 12, I will just address a few remarks to them and then send them away to come back for 10.30 tomorrow morning.

MR JOHNSON: Yes, thank you.

MR MYERS: I agree, my Lord.

MR JUSTICE GOSS: Thank you very much, Mr Myers. Good. That's what we'll do then.

We'll touch on other matters that need to be addressed insofar as we can, or perhaps at least indicate what can and can't be done and perhaps come back to it tomorrow as well. All right, thank you very much indeed.

So this is only going to be about 10 minutes, this break. Thank you.

(3.37 pm)

(A short break)

(3.50 pm)

(In the presence of the jury)

MR JUSTICE GOSS: Right, members of the jury, you are now the jury for the rest of this trial. You, madam, your materials have been moved to the desk that you are now at, so you should have everything, but it's worth just checking that you do have everything in due course, any notes that you may have made. Good, thank you very much.

Time has moved on a bit and we're now at the stage where the next thing that will happen, as far as you're concerned, is you will receive a demonstration on the use of the iPad. That's not going to happen this afternoon, it's going to happen first thing tomorrow morning because I have to deal with some other things and I don't want to send you away -- keep you waiting and call

you back in at 4.10 or something like that. So I'm going to -- it's been quite a long day for you -- send you away now and, fresh tomorrow morning, you'll have an introduction to the iPad which it is thought will take a maximum of half an hour. Some of you may be very good on iPads already, others of you may not, but it doesn't matter. As Mr Johnson said, you will become very familiar with how to use them and what you can and can't do on them.

But they are iPads -- I'll tell you now and if I'm wrong in this I'll be corrected tomorrow -- they are simply devices which will have the material in this case on it and nothing else, so you will not be able to access any other source via this iPad.

Each of you will have a personal passcode to it, so you cannot use anyone else's iPad and no one can use your iPad, and you will leave them here, just as you leave any notes here, at the end of the day and they will be here waiting for you the next day and they will be charged overnight. So that's what will happen to them, so they'll all be charged when you're using them and you will be able to make notes.

That will all be explained to you, how you can use them -- interactive devices, is that the correct expression? So what you can and can't do with them. Right.

Just finally I'm going to come back to those -- remember I gave you my typed directions as well as the note about your responsibilities as a juror? You are now the jury of 12. The situation has now been reached, therefore, that when you are all together as a group of 12, for example if you're sitting outside waiting to come into court, but you're in a private place where other people can't hear what you're saying, apart from the other 11 of you, you may talk about the case to each other. But please do it so that everyone can hear what's being said, so if someone's expressing a view, making a comment or raising something, then the others can hear, unless it's a matter relating to the integrity to you as jurors. In other words, if one of you says, "I'm really worried because something has been said by one of the jurors that shouldn't have been said", you wouldn't discuss that. I told you what you would do when that happens: you instantly bring it to my attention and you don't sit and chat about it as a group of jurors. All right? So that's the situation.

But the other main rules still remain: you must not talk to anyone else, apart from a fellow juror in the presence of all jurors, about this case, particularly friends and family members. Don't communicate in any way -- don't message, send text messages, do anything like that -- to anyone about anything to do with this case.

Do not conduct any research about this case or anything to do with this case. If you read media reports -- and there have been a lot of media reports, as I anticipated there would be -- remember it's very selective. You'll have realised that if you've read any of the media reports. The reporters pick certain things out. What they think is important is irrelevant, it's what you think is important. All right?

So thank you very much. 10.30 tomorrow morning then as far as you're concerned.

(In the absence of the jury)

Further housekeeping

MR JUSTICE GOSS: I don't know whether anyone wants to say anything about any other matters before we deal with these -- have we got time to deal with this now?

MR JOHNSON: I believe so if you'd like to deal with them, my Lord.

MR JUSTICE GOSS: Are you happy?

MR MYERS: Yes, if it's convenient for the court, my Lord.

MR JUSTICE GOSS: Right, thank you.

The matter that was brought to the court's attention that I brought to your attention. Is there anything anyone wants to say at this stage?

MR JOHNSON: I don't think so immediately. The information I've received, which corresponds to some Google research I did whilst Mr Myers was talking, is that the website is in India, as it happens. That may just be -- as your Lordship's told the jury, information on the internet is not always reliable.

MR JUSTICE GOSS: I think that's being generous.

MR JOHNSON: Well, quite.

MR JUSTICE GOSS: A lot of information on the internet is very unreliable and indeed this is unreliable information as well.

MR JOHNSON: Yes.

MR JUSTICE GOSS: There we are. I don't think there's anything we can do. If anyone has any ideas... I'm not proposing to say to

the jury, "You should be particularly careful because there's some misreporting", because it will just incite their curiosity.

MR JOHNSON: Yes.

MR MYERS: We'd agree, my Lord. The important thing is the jury have been directed not to look for material and it may be from time to time, I anticipate, if there's going to be a break or something like that, your Lordship probably would remind them not to look at material, but certainly we don't suggest that this should trigger a specific direction because that's almost bound to draw attention to it.

MR JUSTICE GOSS: I do keep reminding them. I will only be doing it once a day. It will probably come to the stage when I do it once a week almost, but I keep doing it because we're told to keep doing it.

MR MYERS: Yes. Until events prove otherwise, we have to work on the basis that, quite properly, they'll follow the directions they receive and therefore there's no reason why anybody should be encountering that website and it's not something that would ordinarily -- you would expect it would come to their attention anyway unless someone was looking for it, which they shouldn't be.

MR JUSTICE GOSS: We all have to proceed on the basis that, in the absence of any evidence to the contrary, the jury are following their instructions. That is a mantra often repeated by the Court of Appeal.

MR MYERS: Yes, I've heard that.

MR JUSTICE GOSS: Yes, thank you.

Right. Now, Mr Johnson, am I going to be privy to this or is it just going to be for you?

MR JOHNSON: I think the position is that your Lordship's offered a bespoke service, if you want it.

MR JUSTICE GOSS: I'll probably be slower than anybody else. Would it be more convenient -- I don't want to trivialise this in any way whatsoever. Would it be better if I had mine at 10 o'clock tomorrow morning?

MR JOHNSON: Maybe, and then your Lordship can in effect supervise the jury's version of it.

MR JUSTICE GOSS: That's what I was wondering.

MR JOHNSON: Yes, from the position of greater knowledge than theirs.

MR JUSTICE GOSS: Right. In those circumstances, what about the defendant? She'll just get the same as the jury?

MR JOHNSON: Yes.

MR JUSTICE GOSS: Do you understand that, Ms Letby? When it comes to the demonstration about using the iPad, you will hear what the jury are instructed to do and will you follow it as well? And if you then find you have any difficulty in relation to it, you can communicate in due course with your solicitor and the matter can be taken further, so that you're able to follow it just as much as anyone else.

MR MYERS: Thank you, my Lord.

MR JUSTICE GOSS: There was one other matter in relation to the request from one of the media organisations, I think -- is it the BBC? Yes.

MR MYERS: Yes, it's a note that's been displayed in the course of the speeches. It hasn't yet been displayed in evidence, but starting with the end point of the inquiry. Inevitably or naturally, we would shy away from greater publication of it. That's a reaction to that. In answer to the request as to whether they would be entitled to have it once, we would say in particular, it's been in evidence, that's entirely a matter for your Lordship.

MR JUSTICE GOSS: Yes.

MR MYERS: There are cases where it's in the nature of evidence, for example video evidence, that other witnesses who are yet to give evidence might be affected by that. One might argue there are good reasons for it not to go beyond the court until those witnesses have given evidence. Save for the instinctive caution of defence counsel when faced with the prospect of a greater dissemination of a piece of evidence like that, save for that, I can't, at this point, point to any particular issue that could arise from it.

MR JUSTICE GOSS: No.

MR MYERS: I can't, so notwithstanding our caution at the prospect of it ultimately being published, there's nothing we can say that says it cannot be.

MR JUSTICE GOSS: Yes.

MR MYERS: Nothing we can foresee that prevents it.

MR JUSTICE GOSS: It's been quite extensively referred to, not in its entirety but a lot of it has been referred to, and they can report a lot of the phrases that appear in it.

MR MYERS: Yes.

MR JUSTICE GOSS: But it's a -- well, I won't comment on it as a document, but it's not actually easy to quite piece it all together. I think one can if you have time to study it.

Mr Johnson, do you have any observations?

MR JOHNSON: No. Clearly, it's a case of intense public interest and the piece of evidence is an important piece of evidence.

MR JUSTICE GOSS: It's an important piece of objective evidence. It is what it is.

MR JOHNSON: Yes.

MR JUSTICE GOSS: And I can't see how any witness is going to be prejudiced --

MR JOHNSON: No.

MR JUSTICE GOSS: -- or therefore the administration of justice is going to be prejudiced by its publication.

MR JOHNSON: No.

MR JUSTICE GOSS: Right. In those circumstances you may publish it. Thank you.

MR JOHNSON: Can I raise the issue of the initials, the letter that your Lordship received this morning?

MR JUSTICE GOSS: Certainly, yes.

MR JOHNSON: To adopt a different system now to the one we've --

MR JUSTICE GOSS: I understand what you're saying. It would be difficult to change it. But why is that exactly? I'm not quite sure I understand why someone who was JE and it becomes number 3...

MR JOHNSON: A host of -- well, it introduces for all of us a conceptual level of complexity to an already very complex case that on the face of it -- if there is justification for it, then of course we'll have to get on with it. One of the problems is

that we have -- there are two documents, in a loose term, or compilation of documents. One is the sequence of events. I don't know if your Lordship's actually seen it.

MR JUSTICE GOSS: You gave me two examples, yes.

MR JOHNSON: So we have that, which concentrates on the medical records of a specific child, so each of the children named on the indictment. What we also have is what's been termed the neonatal review or the neonatal unit review. That concentrates on events in the unit that surround the events that the prosecution say in respect of an individual child are significant. So taking as a --

MR JUSTICE GOSS: Are you saying that documents would have to be changed?

MR JOHNSON: Yes.

MR JUSTICE GOSS: And a lot?

MR JOHNSON: And a lot. If it's done in a rush, it's likely to cause havoc, and it could actually hold up the trial. The basic point, my Lord, is that the issue that is being raised in the letter actually is an issue -- it's making the point that people who already know about something are having what they already know confirmed.

MR JUSTICE GOSS: I know.

MR JOHNSON: It's not alerting the wider public. So if parents have already told people about the position of their child, in other words if they've decided not to insist on confidence, they now want to row back from that by in some way making this trial more complicated, and we would submit that that's just not justified, however well-intentioned the solicitor's letter may be.

MR JUSTICE GOSS: I think what I'm going to do at the moment is I shall invite the court office to respond to -- and there are contact details here?

MR JOHNSON: Yes.

MR JUSTICE GOSS: Speak to the solicitor in question to explain the situation and to invite him, if he wishes to, to come to court and explain in more detail the justification for this because of the points that you raised that it's going to require a considerable -- there's no right to anonymity as such.

MR JOHNSON: No, exactly, that's the point, and I can imagine that -- well, anyway.

MR JUSTICE GOSS: No, no, it's all right. The point is there. It's all right, I understand. Then just say come along and we can probably solve it that way.

MR JOHNSON: Yes.

MR JUSTICE GOSS: In a sense that does not appear to uncaring in relation to the issue.

MR JOHNSON: We're all intensely sympathetic, but there comes a stage at which taking individuals who are not directly affected by the litigation's sensibilities into account makes the litigation itself that much more unmanageable.

MR JUSTICE GOSS: And the specific request is to amend the reporting restrictions.

MR JOHNSON: We can't do that.

MR JUSTICE GOSS: No.

MR JOHNSON: All your Lordship could do in effect would be to make a case management --

MR JUSTICE GOSS: I could make a polite request that they could just report "another baby" rather than giving the initials. But that's, as I would see it, as high as I can go. All right.

Enquiries are going to be made. Apparently there was someone here from the solicitor's firm this morning in the overflow court. We'll deal with it, but at the moment I'm not going to do or say anything because we're not going to get to that for a time yet, are we?

All right. Thank you all very much, anything else? No? Thank you very much.

So as far as the court is concerned, it's sitting at 10.30 tomorrow. Officers, dock officers, just to confirm, the court is sitting at 10.30, so the fact that I'm doing something else at 10 o'clock doesn't matter. 10.30 is the sitting of the court. Thank you very much.

(4.09 pm)

(The court adjourned until 10.30 am on Friday, 14 October 2022)