

19 October 2022
Babies A & B

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Wednesday, 19 October 2022
(10.30 am)

(In the absence of the jury)

Housekeeping

MR JUSTICE GOSS: Mr Johnson, Mr Myers, in relation to that initials issue that we had, I've given you each a copy of the response. The last paragraph is really the relevant part for you.

MR JOHNSON: Yes, thank you.

MR JUSTICE GOSS: But I've noticed that you had actually adopted that. There is obviously -- I'm quite satisfied. I looked at it very carefully and there is no power.

MR JOHNSON: No. With regard to the jury's note yesterday about co-signing, that will be answered in the evidence.

MR JUSTICE GOSS: What I'll do is, I won't read the note out, I will simply say one of you raised a query about co-signing, it will be addressed in the evidence.

Are you content with that, Mr Myers?

MR MYERS: I am, my Lord, thank you.

MR JUSTICE GOSS: Good. We will have a 10-minute break so just choose an appropriate moment when you get to it.

MR JOHNSON: Yes. The menu, so far as this morning is concerned, is the balance of the sequence of events for [Baby B]. Then the neonatal review, which is also Mrs Hocknell on this occasion. Then some reading, which takes us to the end of the morning session. This afternoon we have some live evidence.

MR JUSTICE GOSS: Good, thank you very much indeed. I think the routine we seem to be getting into is to have a mid-morning break because that's the longer session and then the afternoon, just have a 2-hour session essentially unbroken. Unless anyone finds that is difficult, but the jury seem to be coping with it all right.

MR JOHNSON: Yes.

MR JUSTICE GOSS: And obviously if the defendant --

MR MYERS: Just confirming, the only exception to that may be at certain points if we need to ask your Lordship to allow us to rise a little early to take any instructions we haven't been able to. We have been able to work within the time frame at the moment, but it may happen at some point that we may need a little extra time.

MR JUSTICE GOSS: You'll be accommodated, Mr Myers.

Thank you.

Jury in, please.

(In the presence of the jury)

MR JUSTICE GOSS: Good morning, members of the jury. We will be going back to the iPads straightaway, won't we, I think?

MR JOHNSON: We will, my Lord.

MR JUSTICE GOSS: I haven't logged on yet. We'll all have to do that. But while that is happening and you're getting things ready, when we rose yesterday afternoon I received a note from one of your number about the co-signing of prescriptions; whoever is the author of that note will know what it's about. Can I just reassure that member of the jury, and all of you,

that the question of co-signing prescriptions will be dealt with in the evidence. But I'm not going to deal with it now, it's going to be dealt with during the course of the evidence.

MRS CLAIRE HOCKNELL (continued)

Examination-in-chief by MR JOHNSON (continued)

MR JOHNSON: The iPad will always default to the first case, so to [Baby A]. So it's necessary to go to the menu in the top left and select [Baby B]'s case, please.

Then we had reached the handover at the end of the night shift into the day shift of 10 June 2015. That's tile or still 287. I think we'd actually got to 290, but if we start at 287, just to contextualise where we'd reached.

MR JUSTICE GOSS: Got there? Three-quarters of the way along the scroll bar.

MR JOHNSON: Mrs Hocknell, I think yesterday you had told us about the material in the nursing notes relating to the handover. So as we see there on the screen, tile 287 represents the nursing notes made by [Nurse A] --

HOCKNELL: That's correct.

JOHNSON: -- who had been the designated nurse for [Baby B] on the night shift.

HOCKNELL: That's correct, yes.

JOHNSON: We went behind that, as indeed I believe we went behind 288, which is material written by Laura Eagles, who's the day shift designated nurse on 10 June.

HOCKNELL: Yes, that's correct.

JOHNSON: It simply relates to her taking over care of [Baby B] at 8 am?

HOCKNELL: That's correct, yes.

JOHNSON: And it's a note she wrote towards the end of the shift at 17.52?

HOCKNELL: That's correct, yes.

JOHNSON: Thank you. Can we go to 289 then, please, and just deal with this? If we can go behind that, please. It's a note

relating to what happened at 8.09. Can you deal with that, please?

HOCKNELL: This is a note made by [Nurse A]:

"Parents had gone to ward to sleep. Asked to be called if anything changed. Contacted after doctors called to attend and arrived shortly afterwards. Kept updated throughout. Very upset and have remained on unit throughout the night since with maternal grandparents for support. Mum has slept in recliner for a few hours and dad has slept for periods in parents' accommodation. Updated re D-dimer this morning by Dr Lambie and though glad to have the start of an answer are understandably upset too. Mum became very upset blaming herself because of her own clotting disorder."

JOHNSON: Thank you. The next still is 290, which we're becoming familiar, I think, with the system now. It is the hourly observations, this time at 10 minutes past the hour, but we have the usual collection of the observation chart, the intensive care chart and the equipment settings.

HOCKNELL: That's correct, yes.

JOHNSON: So that triptych, if you like, of pictures. Then a further nursing update made by [Nurse A] from the night shift.

HOCKNELL: That's correct, yes.

JOHNSON: We put this in because it's timestamped by the system as having been made at that time.

HOCKNELL: Yes.

JOHNSON: What does it read, please?

HOCKNELL: "Nil by mouth since midnight due to resus and ventilation."

JOHNSON: So that's a reference to, just to put that in context, to the fact that liquid feeds through the mouth, through the oral route, had been stopped because of what had happened?

HOCKNELL: That's correct, yes.

JOHNSON: Then at 8.31, some blood gas records. At 8.48, the collection of some blood, a blood sample. Is that right?

HOCKNELL: That's correct, yes.

JOHNSON: We'll leave that for the doctors. Then the blood test results at 8.59. Then at 9 am, Dr Saladi, the on-duty consultant, did a ward round and there is a note of his examination of [Baby B].

HOCKNELL: That's correct, yes.

JOHNSON: Can we deal with that, please? Is this your typed transposition of what is written in the notes?

HOCKNELL: Yes, it is.

JOHNSON: Thank you. Can we deal with it, please?

HOCKNELL: "Events overnight noted. 31 plus 2. Day 4."

Which is then corrected to 31 plus 5:

"M morphine [medication morphine], teicoplanin, cefotaxime, caffeine, nystatin. Fluids TPN 90ml/kg. On examination: pink, well perfused. Capillary refill time 2 seconds and fontanelle soft. HS 1 plus 2 plus 0. No murmur. Abdo: soft not tender."

Then there's a drawing in the notes:

"D-dimer 6210. Discussion with parents. ?why she had acute episode overnight. Explained that D-dimer is raised ? in babies more commonly related to DIC. Two-hourly (sic) to injection rather than clotting abnormally."

JOHNSON: Is that "secondary to"?

HOCKNELL: Secondary to, sorry.

"Secondary to injection rather than clotting abnormally. We will discuss with Alder Hey plus NNU in Liverpool. Supportive treatment for the baby. Plan: repeat CRUS [cranial ultrasound scan], continue with antibiotics, discussion with specialists at Alder Hey and NNU at Liverpool regards events overnight."

JOHNSON: Yes. Then there's a record of his observations.

HOCKNELL: That's correct, yes.

JOHNSON: Thank you. Sometimes these notes are written by one of the junior doctors who is with the specialist, with the consultant; is that right?

HOCKNELL: That's correct, yes.

JOHNSON: And sometimes they're in the consultant's own handwriting?

HOCKNELL: That's correct, yes.

JOHNSON: Can we go back to events, please? Still at 10 past the hour, we have the three separate sets of readings.

HOCKNELL: That's correct, yes.

JOHNSON: Then we go to the three same separate sets of readings, but defaulting back to on the hour at --

HOCKNELL: That's correct, yes.

JOHNSON: Thank you. Further clinical notes of Dr Sally Ogden, one of the -- I think she is a registrar, is she, ST3?

HOCKNELL: ST3, yes.

JOHNSON: That's the bottom grade of registrar in effect. Can we go to those, please? I'm not going to ask you to read these out because we will deal with them with the witness. All right?

HOCKNELL: Okay.

JOHNSON: Now we've established what the system is. But you have there typed out what she has written in her legible handwriting?

HOCKNELL: That's correct, yes.

JOHNSON: Thank you, all right. And of course the handwriting is behind.

Can we go back to events then, please. Then what's classified as medication, sodium chloride, saline solution?

HOCKNELL: Yes.

JOHNSON: And caffeine at 10.33, which is signed and countersigned by Laura Eagles and Christopher Booth.

HOCKNELL: That's correct.

JOHNSON: Carry on, please. The observation charts again at 11 o'clock, which we've seen before.

HOCKNELL: That's correct.

JOHNSON: The observation chart is repeated at midday?

HOCKNELL: That's correct, yes.

JOHNSON: And then of course Lucy Letby had gone off duty -- her shift had ended formally at 8 o'clock. At 12.04 we have a series of messages between her and Jennifer Jones-Key. I think these have been already read through by you in the context --

HOCKNELL: I think this might be different.

JOHNSON: I was wondering whether it was just my memory. Okay. Let's deal with this because this is different, I think. I'm relying on your memory. Thanks.

HOCKNELL: At 12.04 a WhatsApp message is sent by Lucy Letby to Jennifer Jones-Key:

"Been for breakfast with [Nurse E]. Feel quite awake now. Going to unpack a bit and [wash] uniform. Hope your day okay. Will you let me know if any change with [Baby B], please."

Then there are a series of WhatsApp messages of a social nature between Lucy Letby and Minna Lappalainen between 12.29 and 12.40 hours.

JOHNSON: Thank you.

The observations of [Baby B] continued. A blood gas record just before 1 o'clock and then the habitual observations on the hour. Further saline, sodium chloride, at 1.30, nystatin and cefotaxime.

HOCKNELL: That's correct, yes.

JOHNSON: At 2 o'clock, as before, some readings. Then a clinical note at 2 pm -- or two sets of clinical notes. The first from Dr Sally Ogden, the registrar. If we just look at that, please. That's just setting out what is going on, so further discussion with haematology, so they're investigating the blood issue, potential blood issue, I should say.

Then back to events, please. Dr Brearey, not to be confused with [Nurse A], who is one of the nurses, [Nurse A]. Dr Stephen Brearey is one of the consultants. Just click on that, please. That relates to a review that he undertook of [Baby B]'s heart, doesn't it?

HOCKNELL: That's correct, yes.

JOHNSON: Again, I'm not going to ask you to read that out, other than to remark on the fact that everything appeared to be normal.

Back, please. Again, no doubt delayed because Dr Brearey was examining [Baby B] at 2 o'clock, the observations at 14.10. Then resumed at 15.00 hours.

HOCKNELL: That's correct, yes.

JOHNSON: At 16.00 hours, the same?

HOCKNELL: That's correct, yes.

JOHNSON: Then some nursing notes relating to events at 4 pm. Can we just deal with those, please?

HOCKNELL: "Nursed on SIMV 20/6. Weaned to 18/6 at 16.00. Rate initially increased from 25 beats per minute to 40 as CO2 rising. Has since weaned to 30 on capillary blood gas results. ET suction not needed. Op suction yielding clear secretions. Air entry equal and clear."

JOHNSON: Thank you. The observation chart is again at 5 pm?

HOCKNELL: That's correct.

JOHNSON: Dr Ogden's notes at 5 pm also, please.

This relates to the report from the pathologist, who had conducted a post-mortem examination of [Baby A]?

HOCKNELL: That's correct, yes.

JOHNSON: Can we focus on the final paragraph where recorded is "no obvious cause of death found".

HOCKNELL: That's correct, yes.

JOHNSON: Thank you. Can we return, please?

Blood gas record at 17.07?

HOCKNELL: That's correct.

JOHNSON: Further medication administered and countersigned by Laura Eagles and Belinda Simcock?

HOCKNELL: That's correct.

JOHNSON: And the nursing notes -- the time that the nursing notes have been made to cover the day was 17.52?

HOCKNELL: That's correct, yes.

JOHNSON: Can we just turn to those, please? And again, this is further detail of material that we've seen in other people's notes in effect.

HOCKNELL: Yes, and also outlined at 8 o'clock and 4 pm.

JOHNSON: Yes. Thank you. Can we go back to events, please?

This is a message to Lucy Letby at 18.31 from Jennifer Jones-Key.

HOCKNELL: That's correct. She writes:

"Day manic and got a 30 weekend vented. No change with [Baby B] when I had left."

JOHNSON: It may be that autocorrect had corrected "weeker" to "weekend".

HOCKNELL: Yes.

JOHNSON: That may be an explanation for why it says "weekend".

HOCKNELL: Then at 19.11, Lucy Letby replies:

"Oh dear."

Jennifer Jones-Key replies:

"It's okay, six on all week now and Yvonne F doing an on-call."

Lucy Letby replies:

"Good, hope you're okay. W."

Jennifer Jones-Key replies:

"Yeah, just tired. Did feeds, ROP and 5 resus with parents and 6 lots of baby massage. Working Friday now."

And follows that up with:

"Hope you are okay."

Lucy Letby replies:

"Wow, well done. Had a few hours with Minna this aft and walk into town. Just had shower and going to chill."

Jennifer Jones-Key replies:

"Sounds good to me."

Lucy Letby then sends a message to [Nurse A] at 22.09:

"How is [Baby B]?"

[Nurse A] replies:

"Looks really good. Wanted her vented overnight but blocked her tube and happy on CPAP. Not that that means anything after last night!"

Then she follows up with:

"We also have a 30/40 [or 30-weeker] 800-gram and new 31/40 twins. T1 girl. T2 boy. Boy vented and in [Baby A]'s space. Other two newbies on CPAP."

Further message sent:

"[Baby A]'s prelim report. No gross abnormalities. So [no] bleeds, clots or line issues. [Baby B], all ultrasound normal. D-dimer result not significant. So no idea what's happened."

Lucy Letby replies:

"Hmm, a lot of Qs still to be answered then. I so hope it isn't due to the line for [Baby A] and that [Baby B] is okay."

Lucy Letby follows that up:

"They've had a busy day then!"

[Nurse A] replies:

"The twins arrived for us on handover."

And further says:

"It said no line issues. They'd have been visible if there were."

Lucy Letby replies:

"Oh I misread what you put, thought you meant no abnormalities, so looking at lines, clots, et cetera."

She further writes:

"At least that's a positive but think we all need answers."

JOHNSON: That's 22.45 on 10 June.

HOCKNELL: That's correct, yes.

JOHNSON: Slightly under an hour later, 50-odd minutes later, she searched for [Mother of Babies A & B], [Baby B] and [Baby A]'s mum, on Facebook.

HOCKNELL: That's correct, yes.

JOHNSON: That's 10 June. We then skip 2 days to Friday, 12 June. Could you take that up, please?

HOCKNELL: So on 12 June there are nine text messages between Lucy Letby and Ashleigh Hudson about [Baby A] and [Baby B], which -- the full contents of which is in [Baby A]'s sequence of events.

JOHNSON: Yes. We then have marked for contextual purposes an event concerning [Baby C] just before midnight when we can see, from the blue rim to the tile, the blue edging to the tile, Lucy Letby was on duty.

HOCKNELL: That's correct, yes.

JOHNSON: [Baby C]'s death at just before 6 am, towards the end of that night shift, 13 to 14 June?

HOCKNELL: That's correct.

JOHNSON: Then 8 days later, events concerning [Baby D] in the early hours of 22 June at 1.30, 3 o'clock, 3.45 and then [Baby D]'s death at 4.25.

HOCKNELL: That's correct, yes.

JOHNSON: Again, on the shift where Lucy Letby was present?

HOCKNELL: Yes, that's correct.

JOHNSON: So that's 22 June, the Monday, the death of [Baby D].

On Thursday, 25th, at 21.50 what do we see?

HOCKNELL: We have another Facebook search for [Mother of Babies A & B].

JOHNSON: Thank you. Then on the Saturday, the 27th, there's some more WhatsApp messages, aren't there?

HOCKNELL: Yes, at 13.33 hours, Minna Lappalainen sends a text message to Lucy Letby:

"Okay. We'll try to have a chat at work?"

Lucy Letby replies:

"Honestly Minna, I shouldn't have asked. Just concentrate on the move. I'll be fine."

Lucy Letby follows this up with:

"I don't want to talk about it like this. I'm fine today. The last week or so has just been a bit tough, but I'm off from Friday so all will be okay."

JOHNSON: Later that afternoon, indeed within a few --

HOCKNELL: Minutes, yes.

JOHNSON: -- within 4 minutes of that WhatsApp, there's then a text from Lucy Letby to [Nurse E]; is that right?

HOCKNELL: That's correct, yes:

"Ha ha, nodding off in cinema isn't a good look! I had a mini meltdown last night about what's happened at work and thinking about Walton, et cetera. I just need some time off with mum and dad."

Then this is an entry that I've made as a descriptive:

"[Baby B]'s medical records indicate that [Baby B] continued to receive care in the neonatal unit until she was discharged on 09/07/2015."

JOHNSON: Thank you. That's Thursday, 9 July. Sunday the 12th, we have some more WhatsApp messaging.

HOCKNELL: There were some further WhatsApp messages between Lucy Letby and Jennifer Jones-Key about [Baby B] and her discharge home.

JOHNSON: Then the next tile, please.

HOCKNELL: Then on Tuesday, 14 July, there is a conversation between Lucy Letby and [Nurse A] about [Baby B] and her discharge home.

JOHNSON: Thank you. So that's a Tuesday, so 1 day short of 3 weeks later, we then have the [Baby E] event.

HOCKNELL: That's correct.

JOHNSON: Just to remind the jury, the one at 9 pm is the blood round the mouth episode. [Baby E], of course, died, as shown by these stills, at 01.40 that morning.

HOCKNELL: That's correct.

JOHNSON: And we have on the following day, Wednesday, 5 August, the insulin incident involving his twin, [Baby F].

HOCKNELL: That's correct, yes.

JOHNSON: Following that, the next entry is almost a month later, 4 weeks precisely later, Wednesday, 2 September. Did Lucy Letby search for [Mother of Babies A & B] again?

HOCKNELL: That is correct, yes.

JOHNSON: Then 17 days later on Saturday, 19 September, was there some further WhatsApp conversation between Lucy Letby and [Nurse A] about [Baby B]?

HOCKNELL: That's correct, yes.

JOHNSON: Does that conclude the sequence of events for [Baby B]?

HOCKNELL: It does, yes.

JOHNSON: Thank you very much.

I wonder whether we can turn to the neonatal review now, please. All these documents, these neonatal reviews, follow the same format, don't they?

HOCKNELL: That's correct, yes.

JOHNSON: The jury heard from your colleague yesterday because she had done the review for [Baby A], but you did the one for [Baby B]?

HOCKNELL: That's correct, yes.

JOHNSON: Have you adopted the same parameters and references for [Baby B]'s case as your colleague did for [Baby A]'s?

HOCKNELL: Yes, we set terms of reference for that.

JOHNSON: Thank you. So set out there on the front page is the time period, namely 22.00 hours on the 9th to 02.25 on the 10th?

HOCKNELL: That's correct, yes.

JOHNSON: All records from the shift where Lucy Letby appears?

HOCKNELL: That's correct.

JOHNSON: And if records relating to a specific baby do not appear in the time frame that you are considering, the closest record outside the terms of reference have been included to give context?

HOCKNELL: That's correct, yes.

JOHNSON: Thank you.

As before, any records relating directly to [Baby B] have a yellow background to the entry?

HOCKNELL: That's correct, yes.

JOHNSON: And records relating to Lucy Letby are produced in that blue-coloured text?

HOCKNELL: Yes.

JOHNSON: Thank you.

So can we go to page 2 of 7 then, please? Here do we see that on this particular shift, Lucy Letby was dealing with a number of -- I think at least two children as revealed on page 1, HM and EB, is that right?

HOCKNELL: Yes.

JOHNSON: And we see at lines 28 and 29, the observations put into context for [Baby B] at 10 pm?

HOCKNELL: That's correct, yes.

JOHNSON: Thank you. Page 3, please. There, almost halfway down the page, we see a black line denoting [Baby B]'s collapse at line 47?

HOCKNELL: That's correct, yes.

JOHNSON: We see further up at 36 and 37, we see the observations taken by [Nurse A] for [Baby B] at 11 pm?

HOCKNELL: That's correct, yes.

JOHNSON: And the fact that at about that time, Lucy Letby was giving medication to the child HM?

HOCKNELL: That's correct, yes.

JOHNSON: We have, at line 48 in the sequence, a nursing note made by [Nurse A] relating to [Baby B]?

HOCKNELL: That's correct, yes.

JOHNSON: And to remind the jury, is that the dislodgement of the nasal prongs?

HOCKNELL: That's correct, yes.

JOHNSON: At midnight, we have the hourly entry made by [Nurse A]?

HOCKNELL: That's correct.

JOHNSON: And then at 00.05, we see that Lucy Letby, with [Nurse A], was involved in setting up or continuing the TPN --

HOCKNELL: For [Baby B], yes.

JOHNSON: Which is the liquid feed for [Baby B]. And 5 minutes later, we can see that Lucy Letby made a note in the records of another child. I'm afraid my eyesight is so bad, I can't read the initials.

HOCKNELL: JE.

JOHNSON: JE, okay.

MR JUSTICE GOSS: It's not just you, I can't read it either. But the blue actually is not a good colour for definition purposes. I'm not being critical, but it just isn't clear on the screen.

MR JOHNSON: No. These are going to be printed and they're going to be printed in A3, my Lord, and put in a bespoke folder.

MR JUSTICE GOSS: Good. I was going to suggest that.

MR JOHNSON: Yes. We've left a note. We've removed -- the sharp-eyed will have noted that we've removed the lawyers' references from the right-hand column and left those for notes and they'll be able to be cross-referenced. As we go through with the medics, we'll be able to cross-reference these to the sequence of events. So where there's a tile, cross-references to entries here, we'll be able to do that exercise as we go through with the witnesses or the experts. So that's the plan.

Can we move on to page 4, please? We have the second and the much more serious event for [Baby B] at line 70; is that right?

HOCKNELL: That's correct, yes.

JOHNSON: We see that the most proximate entry prior to that event in [Baby B]'s records -- is that shown at line 66?

HOCKNELL: That's correct, yes.

JOHNSON: Which is a blood gas record taken from [Baby B] by Lucy Letby?

HOCKNELL: That's correct, yes.

JOHNSON: And we see that afterwards, we have the nursing note of [Nurse A] at 71.

HOCKNELL: That's correct.

JOHNSON: But that of course was made later in the shift?

HOCKNELL: That's correct.

JOHNSON: We have Dr Lambie's notes at 00.33.

HOCKNELL: That's correct, yes.

JOHNSON: Therefore, the most proximate nursing note for [Baby B] after the collapse is also made by Lucy Letby at line 74?

HOCKNELL: That's correct, yes.

JOHNSON: Thank you. We see also the involvement of the consultant, [Dr B], at 00.36?

HOCKNELL: That's correct, yes.

JOHNSON: Can we remove the highlight, please? Thank you.

Thereafter, we see at lines 81 to 83 further references to Dr Lambie and [Dr B] interspersed with a timed nursing note at 00.50 from [Nurse A]?

HOCKNELL: That's correct, yes.

JOHNSON: Again, I think that 00.50 note is retrospective, so made later in the shift?

HOCKNELL: Yes.

JOHNSON: And so the hands-on, so to speak, nursing note here, again, isn't made by the designated nurse but made by Lucy Letby --

HOCKNELL: That's correct.

JOHNSON: -- at 00.51, being the blood gas?

HOCKNELL: Yes.

JOHNSON: Thank you. We see further observations taken, the hourly observations at 1 o'clock, again taken by Lucy Letby?

HOCKNELL: That's correct.

JOHNSON: And when medication was required to be given to [Baby B], once again it wasn't the designated nurse, [Nurse A], involved, it was Lucy Letby with Mary Griffith?

HOCKNELL: That's correct, yes.

JOHNSON: That's at 01.10. Thank you.

Over the page again, please. We see references to the child HM and Lucy Letby taking HM's observations and administering medication with Mary Griffith at 2 o'clock?

HOCKNELL: That's correct, yes.

JOHNSON: And also, at 02.07, Lucy Letby involved this time with the designated nurse, [Nurse A], giving medication to [Baby B]?

HOCKNELL: That's correct, yes.

JOHNSON: Further down the page we can see Lucy Letby involved with other children -- sorry, yes, there is the single -- there's further medication given, sorry, I missed that, to [Baby B] at 02.25 by the designated nurse, [Nurse A], and Lucy Letby?

HOCKNELL: That's correct, yes.

JOHNSON: And then further down the page, Lucy Letby involved with other children, two other children, I think.

HOCKNELL: That's correct, yes.

JOHNSON: Thank you. Again, please.

The next page, which is page 6 of 7, shows Lucy Letby's involvement with other children?

HOCKNELL: Yes, from 05.04 hours.

JOHNSON: And finally, page 7 of 7. That continues with the child NM?

HOCKNELL: Yes, up to 06.36 hours.

MR JOHNSON: Would you remain there, please, in case there are any questions for you.

Cross-examination by MR MYERS

MR MYERS: I'm just going to ask you something about the Facebook searches we have heard about, we'll receive more evidence on this later, but just so we can have the general picture. We've seen there are several occasions where you've identified and we have included Facebook searches for [Mother of Babies A & B].

HOCKNELL: Yes.

MYERS: And she, [Mother of Babies A & B], as we know, is the mother of [Babies A & B]?

HOCKNELL: That's correct, yes.

MYERS: You've been able to identify them from a download of Ms Letby's social media, haven't you?

HOCKNELL: That's correct, yes.

MYERS: Would you agree that from that download it's apparent there are a volume of Facebook searches for parents generally?

HOCKNELL: That is correct.

MYERS: So the entries that we have for [Mother of Babies A & B] are from or amongst those searches; is that correct?

HOCKNELL: Yes, that's correct.

MYERS: And indeed, we will see that there are also searches for parents of some other children who are subjects of the charges in this case, aren't there?

HOCKNELL: That is correct.

MYERS: But there's also a substantial volume of searches for children who were not the subject of these charges, I apologise,

for parents of children who are not the subject of these charges?

HOCKNELL: I understand that there are a lot of searches for different people in the data, yes.

MYERS: Yes, different people. Amongst them are parents of children who are not subjects of these charges?

HOCKNELL: That's correct, yes.

MR JOHNSON: Thank you.

MR JUSTICE GOSS: Thank you, Mr Myers.

Thank you very much. That completes this session as far as you're concerned.

(The witness withdrew)

MR JOHNSON: My Lord, we're going to move on to some reading of agreed witness statements now, please.

MR JUSTICE GOSS: Yes. I was given the bundle last week, wasn't I? Sorry, just take a moment. I'm sorry about this.

You'll remember what I said to you about statements being read as agreed evidence last week. Listen carefully to the content of these statements. It is not disputed what the witnesses are saying, the significance of it is for you to decide in the context of all the other evidence in the case obviously. You'll tire of hearing me say that and I won't keep repeating it.

(Pause)

Witness statement of DR LORRAINE DINARDO (read)

MR DRIVER: My Lord, so I will begin today's reading with the statement of Dr Lorraine Dinardo, which is at page 46 of the pagination in the top right-hand corner of the bundle provided to your Lordship --

MR JUSTICE GOSS: Thank you very much.

MR DRIVER: -- and my learned friends electronically.

This is a statement, members of the jury, dated 5 December 2019. It begins with this:

"I am a consultant obstetrician and gynaecologist and currently the clinical lead for gynaecology at the Countess of Chester

Hospital. I am a member of the Royal College of Obstetricians and Gynaecologists.

"I commenced my role as a consultant obstetrician and gynaecologist at the Countess of Chester Hospital in April 2011. My main role at the Countess of Chester Hospital is both in obstetrics and gynaecology. I have patients booked under me antenatally and I review them in the antenatal clinic, labour ward and post-natally. I have been asked to provide a statement about my care of [Mother of Babies A & B].

"I make this statement with reference to my medical notes. I have no recollection of the delivery of [Mother of Babies A & B]'s twins, but I do have some recollection of her maternal history and some of the intensive input of care that [Mother of Babies A & B] received.

"[Mother of Babies A & B] was booked under our care at the Countess of Chester Hospital."

Her hospital number reference is given:

"This was her first pregnancy and she had a twin pregnancy. She was a high-risk antenatal patient and had very extensive antenatal care provided by my colleagues. She was not booked under my care but under one of my fellow consultant colleagues here within the department. My colleagues had liaised extensively with colleagues in London as she did have increased risk factors in her pregnancy.

"[Mother of Babies A & B] was diagnosed with antiphospholipid syndrome, a clotting abnormality. [Mother of Babies A & B] was on long-term warfarin and under the care of University College London Hospital. On [Mother of Babies A & B]'s first antenatal visit there had been extensive discussion that she was at increased risk, because of her medical conditions, for pre-eclampsia, gestational diabetes, due to a raised BMI of 45, and she was at risk of venous thromboembolism, a blood clot in her leg or lung.

"With regard to the foetuses, there was risk of intrauterine growth restriction, foetal loss, and preterm labour with early delivery.

"[Mother of Babies A & B] was aware that she was a high-risk pregnancy and she was on low-dose molecular weight heparin and aspirin throughout. I was aware that she had been admitted to the ward for observation from 29 weeks and 3 days on 25 May 2015."

That of course is a reference to her gestational state/stage:

"This was because she had shown an increased amount of protein in her urine and her blood pressure had become slightly increased and labile, requiring her to go on an oral anti-hypertensive medication and receive intramuscular steroids to assist with foetal lung maturation in the event of early delivery.

"My first physical contact with [Mother of Babies A & B] was when I was consultant on call for the day. She had been an inpatient for a number of weeks and I first met her as a patient on 7 June 2015 when she was 31 weeks and 2 days. On that day I was working with a senior experienced registrar.

"As [Mother of Babies A & B] had dichorionic diamniotic twins and a high-risk pregnancy, there had already been quite an extensive plan put in place by the consultants that were directly looking after her. We were concerned that she was developing a condition called pre-eclampsia, where her blood pressure would go up and therefore there was a potential of going on to develop eclampsia, where she could potentially fit.

"The planning in her notes detailed that if there was a deterioration in her blood results, if she became symptomatic for pre-eclampsia or if her blood pressure rose above 160/100 on two occasions then we were to consider delivery. I believe [Mother of Babies A & B] was aware of this plan.

"I had reviewed her earlier that day on the ward at 12.10 hours, having noted and written her blood results in the previous day. [Mother of Babies A & B]'s liver function was raised but had been stable and her blood pressure was stable so my plan had been to continue her care as per my consultant colleagues: performing daily bloods and monitoring her blood pressure.

"The registrar contacted me later on in the afternoon, around about 17.17 hours, telling me that there had been a deterioration in her blood results, a number of them had increased and some had decreased, and there had also been a rise in her blood pressure. The decision was taken at that stage that she should be transferred from the ward directly down to our central labour suite, which is a safer environment for one-to-one care. That was so that we could try to help to stabilise her blood pressure.

"I came directly to the labour ward. The babies' heart rate was recorded with a CTG machine, and their monitoring was satisfactory throughout. Our efforts were concentrated on stabilising [Mother of Babies A & B].

"We then liaised with a number of staff members. The staff involved in caring for [Mother of Babies A & B] at this time were myself, the senior registrar Dr Finney, and midwifery staff. At the time we would have been gaining venous access in order to take further bloods from mother and we placed her directly on a drug called magnesium sulphate, which helps to prevent mothers having a fit and going on to develop eclampsia.

"If there was an escalation in her pre-eclamptic features she potentially could go on and fit. We also asked the anaesthetist to come and review her. We put [Mother of Babies A & B] on the pre-eclampsia protocol, for which there is a high dependency chart with frequent measures of her blood pressure. She was catheterised to measure her urine output and she was fluid restricted. This was all in an effort to prevent her condition worsening and developing eclampsia.

"I discussed the situation with the anaesthetist and haematologist because [Mother of Babies A & B] was on low molecular weight heparin, which is to help to thin her blood due to the APS. We prepared [Mother of Babies A & B] for theatre by having her blood cross-matched and specific blood infusions that we use in theatre to help the uterus to contract, all to minimise blood loss for her were we to go ahead and deliver her.

"Her blood pressure was not adequately stable and we were further required to give her anti-hypertensive medication intravenously to help to bring her blood pressure down as it remained high. We made the decision at 18.15 hours to deliver her because of this instability and worsening pre-eclampsia.

"We obtained verbal and handwritten consent from [Mother of Babies A & B]. We worked to optimise her into a more stable condition, informing the people who had to be there, the anaesthetist, the haematologist, and the neonatal team. The babies had already received steroid injections to help with the lung maturation because of prematurity.

"Once we had liaised with everyone, stabilised [Mother of Babies A & B], and had all the team present, we transferred her into the theatre at 19.45 hours. In the theatre, there would have been two anaesthetists, two midwives, one each to take the baby, the paediatric team. There would have been two neonatal Resuscitaires in the room and each of them would be staffed by independent neonatal staff. Myself, my assistant and a theatre scrub nurse were also present. We also had the additional assistance of the senior house officer.

"There would also have been an operating department practitioner to assist the anaesthetic staff. The anaesthetist had contacted his consultant as well.

"Her blood pressure was very markedly raised in theatre, so we had to further stabilise her and give her further intravenous anti-hypertensive medication to bring her blood pressure down. The anaesthetic team put in specific lines, arterial lines, to help assist them in their management of her blood pressure. The general anaesthetic was commenced around about 20.17 hours.

"Although the decision (inaudible) for delivery was made at 18.15 hours, the general anaesthetic was not commenced until 20.17 hours because our priority was to stabilise [Mother of Babies A & B] as there was a risk that she might have a significant fall in her blood pressure once the babies and the placenta were delivered.

"I then commenced the procedure. I was the lead surgeon and my assistant was Dr Finney. One of the senior house officers, Dr Batt(?), additionally assisted in theatre.

"Knife to skin, the start of the operation, was at 20.25 hours and I delivered twin 1 at 20.30 hours. Twin 1 was the female twin and she was passed directly to the paediatric resus and neonatal team.

"I delivered twin number 2 at 20.31 hours and passed him directly to the neonatal team at the paediatric resus station. That was the end of my contact with the babies.

"Twin 1 was a cephalic, head down presentation, an easy delivery, and passed directly to the paediatricians. Twin 2 had been lying transverse, but I delivered him through breach techniques, which is routine for delivery of a transverse lie, and passed him directly to the paediatricians.

"It is documented that this was a routine caesarean section. There were no complications and minimal blood loss of 700 millilitres. My concentration at the time of the cesarean section was on delivering the babies and passing them safely across to the midwife. The midwife then transfers them across to the paediatric resus and neonatal team. I would have clamped and cut the cord of the first baby, allowing transfer to the neonatal team, whilst I dealt with the next baby, cut the cord and transferred it also directly across.

"The babies were only in my hands for a matter of seconds and I did not make any assessment as to the condition of them, the babies. It was an uncomplicated, routine, straightforward delivery. [Mother of Babies A & B] would then have been transferred back on to one of our labour ward high dependency rooms.

"I was on call until 8.30 hours on 8 June 2015, during which time I saw [Mother of Babies A & B] and the babies' father for a debriefing.

"Post-operatively, the babies would have been on the neonatal unit and mum and dad would have been on the central labour suite, but with access to go through directly. [Mother of Babies A & B] was subsequently discharged home a number of days later and had a post-natal review some 6 weeks later by her consultant who had administered the antenatal care.

"I am aware that [Baby A] had, sadly, died on 8 June 2015. I am not sure how I heard about this, whether it was from a formal meeting or otherwise. I was unaware that [Baby B] had suffered a collapse at the hospital."

MR JUSTICE GOSS: There were some medical terms in that statement, some of which the jury will have been familiar with. I am sure that most women and a lot of men would know about eclampsia and pre-eclampsia and the risks of eclampsia, but there were others that I hadn't heard of before. I don't think it's important. People needn't worry about those. Anything that requires any definition, it'll be in the glossary. All right?

Witness statement of RACHEL WRIGHT (read)

MR DRIVER: Thank you.

The next statement was made by a midwife called Rachel Wright. She made her statement on 11 March 2019 and informed us that she is a band 6 midwife at the Countess of Chester Hospital.

She, in her work, would only look after women if they came into hospital and usually working on ward 32, which is the post-natal ward where mothers and babies would go after delivery. This ward also accommodates mums who also require medical attention when they are pregnant. Examples of this could be not feeling the baby move frequently, having a bleed or even being involved in a car accident. Initially, mums would attend the labour ward and if their medical condition needed monitoring they would then be moved to ward 32 to be cared for until they were fit to leave:

"I have been asked to provide details of my involvement with [Babies A & B] and their mother, [Mother of Babies A & B]. From memory, I do not recall my involvement. I have used the maternity notes that I made during my shift on the 7th into 8 June 2015 to assist me.

"On 7 June 2015, I was known as Rachel Hope. I was working on the labour ward on a night shift. Back in June 2015, the night

shift would start at 8 pm and would finish at 8.30 am, the following day.

"When we come on duty at 8 pm we would go into the office and all stand around a board with all the ladies' names and details relating to their labour. We would get allocated a patient each, then have a safety briefing. After the briefing, we would head off to our patients and take over from the midwife who had been looking after them. Once we meet our patient we receive a more in-depth handover from the midwife who had been on the day shift.

"On the evening of this night shift, 7 June 2015, I can see from the notes that there was no handover, like I have just described, as I went straight down to theatre about 20.10 hours. I would have left the initial handover and headed to get changed into some scrubs, which consist of top and trousers, which are cleaned especially at the hospital, and a hair net.

"It looks as if my first entry on the notes is at 20.30 hours. I arrived after the first baby was born, which was [Baby B]. The second twin, [Baby A], was born at 20.31 hours.

"I would have gone into the theatre and over to the table where [Mother of Babies A & B] was having her caesarean section and the scrub nurse would have handed me a large sterile piece of paper to put over my arms to take the baby, and then Hannah Blake would have had one too as it was a twin delivery. Hannah Blake is the midwife who was looking after [Mother of Babies A & B] during the day shift.

"We would have been at the side of the table waiting for the babies to be born. Hannah would have given me a verbal handover about what had taken place prior to my arrival. I cannot recall who else was in the room. There would have been a double resuscitation team also there, one for each baby at different tables in corners of the theatre. This is the norm when twins are being born, especially as these babies were very preterm. The resuscitation teams are there as a precautionary measure.

"There would have been quite a lot of people in theatre due to the twins being early and mum had high blood pressure and was on medication for that. Once the twins were delivered, Hannah and I had taken a baby each to the resuscitation team. I do not know which baby I had. The notes also do not say.

"At 20.33 hours, according to the notes, I had taken some blood from the placenta. This would have been taken from the veins and arteries in two syringes. This would have happened at the opposite side of the theatre. The surgeons would have put the placenta in a pot on the table and I would have taken some

bloods with a syringe. The reason I would have done it is because there had been an emergency caesarean, so we have to take blood from the cord to ensure oxygen levels in the blood were okay for the babies at the time they were delivered.

"I would have given the bloods to either my shift leader or another midwife, asking them to put the blood through the analysis machine, so I didn't have to leave theatre. They would have then brought me the results on a piece of paper. The results, according to the notes, show that there was good oxygen levels as the babies were born.

"I actually remember looking over to the two resuscitation tables and I remember Hannah Blake giving CPR to [Baby B]. I remember being shocked as we were not expecting [Baby B] to have this kind of intervention. [Baby A] was fine.

"The babies then went through to the neonatal baby unit with the teams. [Baby A] would have been wrapped up well, the baby having oxygen on his face as he was so premature, but it was the little girl, [Baby B], that I remember having any treatment.

"The next entry I have written was at 21.50 hours when we had come out of theatre, so in between these times I had most probably been looking through the notes, making sure I had not missed much from the handover and getting the paperwork ready.

"After theatre, [Mother of Babies A & B] was returned back to her room. During the rest of my shift until the handover the next morning, I cared for [Mother of Babies A & B] on the labour ward. I cannot remember anything significant about the shift. The notes show that I have reported to [Mother of Babies A & B] and her partner that the babies were doing well in the neonatal unit and I have recorded normal entries regarding [Mother of Babies A & B]'s observations throughout the shift.

"My notes show that I went through to the baby unit at 23.30 hours for an update on the babies. At 23.55 hours, dad had gone through to the unit to check on the babies too. I have updated the parents again at 04.30 and 06.30 hours. I may have just telephoned the unit and verbally asked about the babies at these times.

"At 8 am on 8 June 2015, I handed the care of [Mother of Babies A & B] over the next day to a midwife called Carolyn O'Donnell. I don't recall any other involvement in the care of [Mother of Babies A & B] or the babies and there is nothing in the notes to say that I have."

MR JUSTICE GOSS: Sorry, Mr Driver, I wasn't paying close attention. Did you tell the jury the date that statement was made?

MR DRIVER: I did.

MR JUSTICE GOSS: That's why both the midwife and the consultants are saying they don't have a recollection because they were talking about events 4 years before.

MR DRIVER: They are. I remind the jury, that statement was made on 11 March 2019.

MR JUSTICE GOSS: Yes. So this will have been one of many such procedures that they've gone through. So they didn't have much of an independent, if any, recollection of the event and they're relying on the notes they made at the time.

MR DRIVER: My Lord, the next statement in terms of chronology of events at the hospital is Dr Beech.

Your Lordship has been provided with a copy of this statement, although not within the bundle.

MR JUSTICE GOSS: I have it, thank you. I/575.

Witness statement of DR GAIL KARA BEECH (read)

MR DRIVER: That's the one, thank you very much.

This is dated 30 April 2019, so again just short of 4 years later.

"I am Dr Gail Kara Beech. I qualified as a doctor in 2010 and commenced my training in paediatrics in August 2012. I have been asked to provide a statement detailing my involvement in the care of [Babies A & B]. I have had access to a copy of their clinical records to assist me along with my personal recollection of the events.

"I have also used the report that I originally prepared for the coroner on approximately 29 February 2016, which relates solely to [Baby A]. Some minor amendments were made to this report and I was asked about my involvement with his sister, [Baby B]."

Dr Beech states that she worked at the Countess of Chester Hospital from 3 September 2014 to 1 September 2015:

"I worked on the children's ward and neonatal unit as a paediatric registrar, grade ST3, for the whole time. In June

2015 I had been qualified as a doctor for 5 years and working in paediatrics for 2 years and 10 months."

Dr Beech says:

"I first met [Babies A & B] on 7 June 2015 when I was on the on-call shift, 8.30 am to 21.00 hours (9 pm). I attended their delivery, which was by emergency caesarean section with my senior house officers colleagues, Dr Emily Thomas and Dr Kate Lyddon, along with Staff Nurse Caroline Bennion from the neonatal nursing team. Our attendance was required because it was a twin delivery under general anaesthetic and they, the babies, were premature at 31 weeks and 2 days' gestation.

"I have been present at many deliveries of babies prior to this, including a large number via emergency caesarean section, many of which were under general anaesthesia, many preterm deliveries and some deliveries of twins and triplets, so this was not something I was unfamiliar with.

"As [Baby A] was twin (sic), I asked Dr Thomas and Dr Lyddon to stabilise his sister, who was twin 1."

It should read "as [Baby A] was twin 2".

MR JUSTICE GOSS: "As [Baby A] was a twin, I asked..."

MR DRIVER: It does read that, sorry. My mistake:

"As [Baby A] was a twin, I asked Dr Thomas and Dr Lyddon to stabilise his sister, who was twin 1, after her delivery and I said I, as the registrar, would manage [Baby A] as he was twin 2. And it is well-known that often the second twin needs more assistance than the first. I asked Staff Nurse Bennion to assist me in case more than one pair of hands was needed. I had checked the resuscitation equipment in theatre prior to [Baby A] being born and was satisfied that all I may require was available and working correctly.

"The caesarean section would have been carried out by members of the obstetric team. After delivery, the babies would then have been passed to a midwife who brings them each to a Resuscitaire. In general, at a delivery, there is often two obstetric doctors, a scrub nurse, at least one anaesthetist, at least one midwife, and at least one healthcare assistant, along with the neonatal team.

"[Baby A] was born at 20.31 hours in the theatre on the labour ward. He was brought from his mother to the Resuscitaire, where I was waiting for him, which would have been next to the wall in theatre in order to provide it with power, oxygen and suction.

"A Resuscitaire is a table with a soft mattress, with towels on, with an overhead heater, a clock, which is very important as you start the timer as soon as the baby is born, oxygen, and other equipment which may be required to stabilise a newborn, such as gloves, stethoscopes and endotracheal tubes. They are in all labour rooms as well as theatre.

"[Baby A] was brought to me, wrapped in a NeoWrap, which is a plastic sheet into which babies born at less than 32 weeks' gestation are put, in order to keep them warm and moist.

"I assessed him in the way in which all newborns are assessed at birth. He had good tone, meaning he was not floppy. He was blue/pink in colour, which is normal for a baby who has just been born. I listened for a heartbeat, but was unable to hear one. [Baby A] showed some signs of breathing, but these were minimal and not enough for him not to require any assistance.

"As per the neonatal life support guidelines, I gave [Baby A] five inflation breaths using a Neopuff face mask over his mouth and nose in order to inflate his lungs. With each of these breaths, there was no adequate chest wall movement seen, as would be expected if these breaths were effective at pushing air into his lungs. However, after these breaths, I reassessed for a heartbeat and could now hear it at approximately 40 beats per minute, which is low.

"Chest compressions were not commenced at this time as I felt that I had not yet inflated [Baby A]'s lungs adequately and that, if I could, his heart rate would hopefully improve, as I had been taught on the neonatal life support course and seen in practice multiple times previously. Therefore, as per the neonatal life support guidelines, I gave [Baby A] a further five inflation breaths but his chest wall movement was still poor. I therefore increased the pressure of the breaths I was giving him.

"With these breaths at a higher PIP, much better chest wall movement was seen and [Baby A] became pinker, showing that his blood was being oxygenated. Staff Nurse Bennion increased the oxygen given from air gradually to 80% during me giving these breaths.

"[Baby A]'s heart rate when next reassessed after this had come up to above 100 beats per minute, which is within the normal range. After these breaths, he gave a short cry and was breathing regularly by himself following this, by which time he was 4 minutes old."

MR JUSTICE GOSS: I'm sorry to interrupt you, Mr Driver, but there's been a strike through the sentence before the one that begins:

"With these breaths at a higher PIP, much better chest wall movements..."

In fact this was the third lot. The previous sentence says she gave five more breaths at the higher pressure and it was with these that the breathing increased.

MR DRIVER: That will be recorded on the data, on the iPad.

Your Lordship is quite right to make it plain to the jury that there are three sets of assisted breathing.

MR JUSTICE GOSS: Yes, two at the lower pressure, then she increased the pressure and that --

MR DRIVER: Did the job.

MR JUSTICE GOSS: Exactly, got him breathing properly.

MR DRIVER: Thank you:

"When he was stimulated by rubbing, he cried and was vigorous in his movements, both of which are good signs. However, when he was not stimulated, [Baby A] had some pauses in his breathing, which would not be unexpected for a preterm baby.

"As a result of this, I gave him ventilation breaths using the Neopuff face mask, which means that I was ensuring he got adequate oxygen into his lungs when he was not taking a breath for himself. I gave these for a short time before reassessing him again by taking off the face mask. He now had fewer pauses in his breathing, which showed that he was improving.

"I therefore held the mask over his mouth and nose so that he was given oxygen and a very small amount of pressure by it, but he was taking all of his breaths by himself. A saturations monitor had been applied by Staff Nurse Bennion and [Baby A] had very good oxygen levels of 95 to 100%. So therefore the amount of oxygen that I was giving him via the face mask was gradually decreased back to room air and [Baby A] was able to maintain good oxygen levels in this.

"[Baby A] was fully breathing by himself regularly in air with a small amount of pressure from the face mask by 10 'minutes of age. It is not unexpected that a preterm infant would need to be given some pressure in this way at this age.

"I assessed [Baby A]'s Apgar scores at being 4 at 1 minute of life, 9 at 5 minutes of life, and 9 at 10 minutes of life. This score is used in order to give people who are not present at the delivery an idea of the condition of the baby at 1, 5 and 10 minutes of age. The highest possible score is 10. [Baby A]'s Apgar scores are not unusual for a baby born at his gestation and the fact that they were 9 at 5 and 10 minutes show that he responded to initial measures quickly and was in a good condition by these times.

"As [Baby A] was a preterm baby, I decided that we should transfer him to the neonatal unit. This was done on the Resuscitaire with me still giving him some pressure via the face mask. [Baby A] had at some point passed urine during the above resuscitation measures. His father and grandmother were waiting outside theatre, so I showed [Baby A] to them on the way to the neonatal unit. Transferring [Baby A] to the neonatal unit was the last direct contact that I had with him.

"[Baby A] was weighed on arrival in the neonatal unit by members of the nursing team, then transferred to an incubator and put on to CPAP..."

Which we know is continuous airway positive pressure:

"... which is a form of breathing assistance regularly given to preterm infants, which gives them a small amount of pressure into their lungs continuously in order to prevent the small airways from collapsing. The nursing team set this up and put [Baby A] on to it.

"Whilst I documented [Baby A]'s resuscitation, Dr Lyddon inserted a cannula into him in order to be able to give him intravenous medications and took some blood samples from him to look for markers of infection. This is a standard procedure for a baby of this gestation requiring this level of respiratory support.

"My plan for [Baby A] was typical of that for a preterm baby of his gestation born at the Countess of Chester Hospital and one that I have made for several babies previously.

"As it was the end of my shift, 21.00 hours, I did not carry out the plan personally but I know that my colleague Dr Lyddon prescribed some of the drugs for [Baby A].

"I ensured that Dr Brunton, who was on for the remainder of the night shift, knew what had happened to [Baby A], as detailed, and where his condition was at currently and also what still needed to be done for him.

"After I had finished my documentation of the resuscitation of [Baby A], which I started to do at 21.00 hours, I then left and went home. This was the last physical contact that I had with [Baby A].

"My involvement with [Baby B]. As I have mentioned, myself and Dr Thomas and Dr Lyddon knew we were going into a complicated delivery as it was an emergency caesarean section, twins and premature as well. We sometimes anticipate that the second twin may have more issues than the first and so generally the more senior person will normally take the second twin when they are born. Therefore, for the birth of these twins, Dr Thomas and Dr Lyddon took [Baby B], twin 1, after she was delivered. Her brother, [Baby A], was brought over to me and Staff Nurse Bennion and I completed everything that I have already detailed.

"As I was dealing with [Baby A], I remember seeing Doctors Thomas and Lyddon doing chest compressions on [Baby B], which alarmed me. By this stage I knew they would have already completed the airway procedures like I had done with [Baby A]. I knew this was a bad sign in that I needed to go over and help as [Baby B] was very unstable, but [Baby A] was also unstable too. It was difficult to know, as the most senior doctor present, which baby I should assist with as I felt [Baby B] was probably more unstable but that [Baby A] was not stable enough for me to leave only with Staff Nurse Bennion. It was just at this moment that Dr Brunton walked in and asked what was going on and where he was needed. I immediately told him to help with [Baby B]. I then remained with [Baby A], focusing on him.

"I noted an entry in [Baby B]'s notes from Dr Thomas that Dr Saladi arrived when [Baby B] was 14 minutes of age. I cannot remember seeing Dr Saladi as I must have been busy caring for [Baby A].

"I did not have any direct dealing with [Baby B] on this shift. I believe she eventually went into the neonatal unit. After the delivery of [Babies A & B], I came back into work on Tuesday, 9 June 2015. I don't think I was on duty on 8 June 2015.

"I next met [Baby B] on 9 June 2015 on the ward round. I have listed her problems as: prematurity, as she was born at less than 37 weeks' gestation; RDS, which stands for respiratory distress syndrome, because [Baby B] was receiving some help with her breathing. There was a suspected sepsis because she was on antibiotics to cover for a possible infection. And establishing feeds as she was not yet having her full requirement of feeds into her stomach.

"I also noted that mum had multiple health issues and that [Baby B] had jaundice. I have also noted that twin 2, [Baby A], had died.

"I have then listed [Baby B]'s medications. With regard to ventilation, [Baby B] was on CPAP, which is a mask that goes over the nose and provides oxygen and pressure to keep the lungs open. I also examined [Baby B] from top to toe. I would have listened to her lungs with a stethoscope, listened to her heart and her abdomen as well as feeling this.

"On 8 June, urea and creatine are a little raised. There are markers to show -- these are markers to show how your kidneys are working and can be raised if you are dehydrated. There is nothing too concerning, though. The CRP has gone up to 3 but this is still a normal result.

"On 9 June, urea and creatine have increased further. This is something which needed to be monitored closely."

I think if we look at the screen, the iPad, briefly, on the [Baby B] file, please.

(Pause)

Slide 57. That's an entry by Dr Gail Beech, the doctor whose statement I'm reading. If we click behind that tile, please. We see the analyst's summary of the notes and her observations. If we go to the underlying note.

My Lord, there are -- although there isn't much of this statement to read, there will be reference to another half a dozen tiles or so.

MR JUSTICE GOSS: We'll have a break then.

You're going to be looking at the notes made by the doctor. We're not going to hear from the doctor, obviously, because her statement is being read, so you may have to go through it and just point out... All right. We'll have a 10-minute break then, a comfort break essentially.

Can you be ready, please, to resume at quarter past, which is just over 10 minutes?

(12.02 pm)

(A short break)

(12.15 pm)

MR DRIVER: My Lord, members of the jury, I was in the process of reading the contents of a statement from Dr Beech, who had taken us up to the care and observations of [Baby B] on 9 June.

Mr Murphy has displayed on the screen now Dr Beech's notes, which lie behind slide 57 on the folder devoted to [Baby B] and I was reading to you Dr Beech's observations. If you look at this document:

"The Countess of Chester: weekly neonatal review."

The date, [Baby B]'s gestation age, day 3, consultant's name, and you may recall just before the break I read out to you what Dr Beech had put in the set. The problem list: prematurity, respiratory distress syndrome, suspected sepsis, establishing feeds, multiple maternal problems, and so on.

Dr Beech's statement says:

"Under abnormal microbiology, I have documented 'BC 33 hours no growth'. This refers to a blood culture, which is a blood sample taken when she was born, which was then sent to the laboratory. And over a period of 36 to 48 hours the lab sees if it grows any bugs, which would also mean that they are present in [Baby B]'s body. My documentation means that at 33 hours, the blood sample has not grown any bugs."

So as well as some problems that [Baby B] was having, she'd recorded the feedback from the lab.

"The management plan for [Baby B] was to start allowing time off CPAP, to perform a cranial ultrasound scan, complete her baby check, to increase her fluids to 90ml/kg/day, with the aim of giving her more hydration. I have queried in my plan as to whether [Baby B] can come off her antibiotics and to request a blood test to see if her blood is clotting normally, both of which I have said I will discuss with the consultant. I have then documented that I spoke to Dr Saladi, who was happy for [Baby B] to come off her antibiotics, as both hers and [Baby A]'s blood cultures were negative.

"At 10.55 on 9 June I documented a review that was completed by Dr Saladi, where I acted as his scribe."

If we could now go to slide number 63, please. We see the clinical notes has this doctor's name and the consultant, Dr Saladi. We have the analyst's summary of what we're about to see in the handwritten original that you've already seen previously.

Dr Beech's statement says:

"Dr Saladi noted that the last blood gas was good and the glucoses [as in blood sugars] on the gases were fine."

You have seen this and looked at the contents previously. If we could then move, please, to slide number 69, which is Dr Beech's clinical notes at 11.05 on the morning of 9 June. You can see that the doctor has recorded communication with -- you'll become familiar with this -- AHCH, Alder Hey Children's Hospital, which is the surgical unit for the regional neonatal services. That's set out in your agreed facts. And the feedback from Alder Hey was that [Baby B]'s mother's condition, the syndrome about which there had been some concern earlier, is due to acquired antibodies and should not cross the placenta, ie wouldn't pass to the babies, and therefore not an issue from the view of the experts at Alder Hey.

If we could then go to slide 85, please. Later, now in the afternoon, 14.50 hours on 9 June, a note of further feedback from the haematology, the blood, special registrar, I think that is, at Alder Hey Children's Hospital, who reported that she, at Alder Hey, had spoken to a couple of her consultants and they have recommended that the Countess send a coagulation screen and D-dimer and they've asked for samples on twin 2, [Baby A], and for an urgent post-mortem of [Baby A], particularly to look for thrombosis, as this may have implications for [Baby B].

I'm sure you get the gist of that, members of the jury. The events regarding [Baby A], the tragic events regarding [Baby A], caused the doctors to take special analysis of [Baby B] and monitor her conditions as a precaution.

That is effectively the evidence of Dr Gail Beech in relation to her presence at the delivery and her subsequent care of [Baby B].

Witness statement of DR EMILY THOMAS (read)

MR DRIVER: Next, my Lord, the statement of Dr Emily Thomas, which is at page 58 of the bundle provided. It's dated 21 November 2017 stating:

"I qualified as a doctor in 2011. I have specialist training in paediatrics with the intention of becoming a consultant paediatrician."

Dr Thomas set out the location of her training and stated:

"Whilst at Chester I was in my first year of training and when working on the neonatal unit I was not as involved with patient care as the more senior trainees were. It has been a while since

working at Chester and I cannot remember the names of all the nurses. Stephen Brearey was the lead neonatal consultant.

"At the start of every shift the doctors have a handover process, which is usually led by the registrar. On Sunday, 7 June 2015 I was working and assisted with the delivery of twins, [Baby A] and [Baby B]. I remember before they were born I went with a registrar to talk to the mother. I was learning how to counsel parents who were having premature babies about what they should be expecting.

"During the delivery, I worked with my registrar, Dr Gail Beech. It was an emergency section and it was a preterm twin delivery. There was a requirement for two doctors to be present. There were neonatal nurses present but I cannot remember who was there.

"I took the care of twin 1, which was [Baby B], along with the support of Dr Kate Lyddon. Dr Gail Beech took the care of twin 2, [Baby A], at her Resuscitaire with the support of one of the nursing staff.

"[Baby B] was born blue and floppy with a low heart rate. I followed the neonatal life support algorithm and commenced resuscitation, which progressed to CPR due to a persistently low heart rate after I felt I had seen adequate ventilation. I attempted to intubate her at this point but was unsuccessful. The night registrar, Andrew Brunton, took over and continued with the resuscitation.

"Her heart rate picked up, although she continued to need respiratory support, and she was transferred to the neonatal unit, intubated and placed in an incubator and on a ventilator. This was my only involvement with [Babies A & B] as their care was handed over to the night team. I was on leave the following week when [Baby A] sadly died.

"In September 2015 I moved to Alder Hey Hospital in Liverpool."

Witness statement of DR ANDREW BRUNTON (read)

MR DRIVER: Next, my Lord, is a statement from Dr Andrew Brunton, page 62 of your bundle, dated, members of the jury, on 10 April 2018.

He states that he is a fully registered medical practitioner with the General Medical Council and a member of the Royal College of Paediatrics and Child Health:

"I moved to the Mersey Deanery in August 2011 as part of my paediatric training and started at the Liverpool Women's

Hospital. The training includes being moved to different hospitals within the area on a 6-month basis. In February 2013 I had my first rotation at the Countess of Chester Hospital as a specialist trainee before moving to Alder Hey Hospital. In February 2015 I returned to the Countess of Chester Hospital for the second time and remained there until July 2015.

"At this time I was a specialist trainee year 4 in paediatrics and my mentor or educational supervisor was [Dr C]. It was a mixture of day and night shifts during this time.

"In reference to the neonatal unit, nursery 1 is the intensive care room where a sick/premature baby is admitted from the labour ward. It will be allocated a bay within the nursery. The baby would then be assessed, examined and appropriate treatment would then be started.

"As the intensity of the baby's care reduces, then it could be moved to one of the side nurseries before being discharged."

Pausing there, my Lord, the jury were shown, a day or two ago, a walk-through of an empty neonatal unit at the Countess of Chester Hospital. We've now recovered and are in a position to play a video recording from within nursery 1, recorded well, well after these events, but at a time when it was still populated.

We're ready to play it. I think it's probably as good a time as any, and we'll hear from a witness this afternoon who will talk about the configuration of that room, so the sooner the jury see it and absorb it, perhaps the better.

MR JUSTICE GOSS: Yes.

MR DRIVER: There is no commentary attached to this short footage.

MR JUSTICE GOSS: So this is just of nursery 1, is it?

MR DRIVER: It is.

MR JUSTICE GOSS: Right.

(Video played to the court)

MR DRIVER: Turning to Dr Brunton's statement, page 67 of the paper bundle that your Lordship has. Dr Brunton sets out his involvement with the care of [Baby A] as follows:

"I first met [Baby A] when I arrived for my night shift at approximately 20.35 hours on 7 June 2015."

You'll remember from the statement of the earlier medic, how the doctor came into the delivery ward very soon after the twins had arrived:

"I performed a routine medical review of [Baby A] at approximately 23.50 hours."

That's what it reads. I think that might be inaccurate, but if we could look, please, at slide 24 of the [Baby A]...

So we can see at 24, there is the clinical notes of Dr Brunton. The slide says it's 23.50. For confirmation of that, we go to the original. So that's Dr Beech's notes continued. Then further down the page indeed we have notes here, which we'll see are Dr Brunton's and they are indeed timed at 23.50. So with that on the screen I'll return to his statement.

Having arrived at 23.35, he tells us:

"I performed a routine medical review of [Baby A] at approximately 23.50 hours. At this time he was clinically stable. He required a small amount of breathing support via CPAP [continuous positive airway pressure] but was only requiring a very small amount of oxygen to maintain saturations to within normal limits. His heart rate and respiratory rate were within normal limits when settled and he appeared well.

"[Baby A] was examined fully by myself and this was completely normal. [Baby A] had intravenous access established by Dr Lyddon following admission to the neonatal unit and had been commenced on antibiotics and intravenous fluids by Dr Lyddon. He was also nil by mouth at that time. I reviewed his three blood gases taken on admission to the neonatal unit, which showed no abnormalities. However, there was no blood glucose or blood lactate available on the samples and I asked for these to be repeated immediately. These results were repeated at 00.13 hours on 8 June 2015 and were also normal. I also ordered a chest X-ray at this time. [Baby A]'s chest X-ray was performed at 00.30 hours on 8 June."

And if we could, please, go to slide number 31. Thank you. It will show at 00.29, a minute out, an X-ray was taken by the consultant radiologist, Dr Anne Boothroyd, and the analyst's summary of the findings say:

"Chest X-ray revealed heart size was normal, there is mild ground glass shadowing bilaterally, consistent with hyaline membrane disease. The tip of the nasogastric tube is seen projected over the distal third of the oesophagus."

And the advice was that that should be advanced by at least 3 centimetres.

If we could then, please, go to slide 32, which is Dr Brunton's review of that X-ray. The radiologist takes the X-ray, the paediatrician reviews it. If we go to Dr Brunton's note, please. We see there the familiar diagrams of the chest:

"Good air entry, clear chest."

Below is the abdomen with the notes that we will soon become familiar with. It's soft. There was no "organomeg", which I think we'll learn in due course means oversized organs or enlarged organs, "organomeg". And there is the plan as set out by the doctor.

So to go back to his words, he reviewed the X-ray and it showed a slight haziness of both lung fields in keeping with mild respiratory distress syndrome, RDS, of prematurity, but nothing else of note:

"His nasogastric tube was also sitting slightly above the oesophagogastric junction, therefore I asked this to be advanced by 3 centimetres by the nursing staff. Thereafter there were no new concerns noted over the course of my night shift.

"At approximately 06.45 hours on 8 June 2015, I was informed by the neonatal nursing team that the lactate on [Baby A]'s repeat capillary gas was 2.6, which was slightly outside normal limits. I advised that we would continue to monitor this during the day. This was the last contact I had regarding [Baby A] and he was handed over to the day team on 8 June at 08.30 hours for ongoing management.

"I have been made aware that [Baby A] collapsed at around 20.26 hours on Monday, 8 June 2015. I was not on duty at this time."

Witness statement of DR THERESA MacCARRICK (read)

MR DRIVER: Next, a statement from a Dr Theresa MacCarrick at 70 of your Lordship's bundle. Dr MacCarrick made a statement dated 17 September 2019. She informs us that she has undertaken her paediatric training to date in the Mersey Deanery, the region that we are focusing upon, and confirms that she was asked to provide a statement detailing her involvement in the treatment of [Baby A]:

"I have had access to a copy of the clinical records and a report that I completed for the coroner to assist me.

"I was employed at the Countess of Chester Hospital between 4 March and 2 September 2015. During this time my role as senior house officer was a training role and I worked under the supervision of more senior colleagues, a registrar, consultants, and in conjunction with other health professionals, including pharmacists, nursing staff and dieticians. As an SHO I worked across the paediatric, neonatal and post-natal wards.

"Typically on the paediatric ward I would attend ward rounds and write up the notes for the leading clinician, who would be a registrar or consultant. I looked after children admitted to the paediatric ward or assessed patients referred for review by doctors in A&E or GPs.

"As the SHO I would usually be the first paediatric doctor to review the new referrals. I would then discuss the case with a senior colleague who will review the patient shortly afterwards. If any treatment or investigations were required whilst waiting for review by a senior, I would instigate these following discussion with the senior. I would also complete ward jobs, including prescriptions and investigations such as blood tests. I would carry out procedures such as inserting cannulas, sometimes with a senior assisting or training me, depending on the complexity of the procedure.

"When allocated to the post-natal ward I would complete the first medical examination of the newborn babies, which is a national screening requirement. I would also review newborn babies who were being treated for suspected sepsis and jaundice. I would always have access to senior support, usually a registrar, and departmental guidelines for help and advice when completing these duties.

"When allocated to the neonatal unit, I would write up the ward round for the leading clinician, registrar or consultant. If there was a very stable baby on the unit I would sometimes be asked to complete their daily review by myself. In these circumstances I would update my registrar or consultant with my findings and plan to ensure there was nothing I had missed. I undertook procedures, initially cannulas and lumbar punctures."

Turning to Dr MacCarrick's involvement with [Baby A], she states:

"I first met [Baby A] on 8 June 2015. I was on a day shift, 8.30 in the morning until 4.30 in the afternoon. [Baby A] had been assessed on the neonatal ward round at 09.45 on 8 June 2015 during the ward round completed by Dr Ogden. On this particular day I do not recall which area I was allocated to. To the best of my knowledge I had not been allocated to the neonatal unit, but rather was invited to go there in the afternoon because

there was an opportunity to gain experience in umbilical line insertion, which was a requirement of my training at that stage.

"To the best of my recollection, it was Sally Ogden, the paediatric registrar, who invited me over to the neonatal unit with the intention of teaching me how to carry out this procedure after she'd completed the neonatal unit ward round.

"The reason [Baby A] required the UVC was due to [Baby A] being born prematurely. His gut was not ready to absorb milk in the volumes that he required for nutrition. It would have been safer for [Baby A] to receive total parenteral nutrition (TPN). This is nutrition that is administered through a vein. If TPN is administered through a cannula it can cause problems due to the vein being so small, so the safest way to give TPN is through a central vein. The safest way to gain access to a central vein is to pass a catheter into the umbilical cord via an umbilical venous catheter (UVC). The UVC also provides a reliable way of administering other medication required intravenously, for example antibiotics.

"In a freshly cut umbilical cord three vessels, two arteries and a vein, can be identified. The umbilical vein leads to a much larger vein, the inferior vena cava, which brings blood back to the heart to be pumped through the lungs where it is supplied with oxygen. Blood is then pumped back round the body, delivering this oxygen to the tissues.

"The UVC was inserted under sterile conditions, which is the usual practice, to reduce the risk of infection. Dr Ogden and I completed the procedure together. I inserted the UVC with Dr Ogden and cannot recall any problems or concerns arising during the procedure. [Baby A] would have been covered by a sterile sheet with monitoring equipment attached to him, measuring his heart, oxygen levels, et cetera, and these would have been displayed on a screen next to his incubator. Dr Ogden and I would have been aware of these readings throughout.

"[Baby A]'s nurse would have kept records of these numbers periodically. These observations did not indicate any cause for concern with [Baby A]'s condition throughout the procedure.

"Inserting a UVC can take a significant amount of time. In addition to the procedure itself there are many steps involved in preparing for the procedure, including collecting all the equipment, scrubbing in, et cetera. Dr Ogden was teaching me and this would have added extra time at each stage. Steps involved in the procedure itself include cutting the umbilical cord, examining the blood vessels and identifying the umbilical vein, passing the catheter into the umbilical vein and then, once the catheter has advanced to the required distance, then checking

that blood can be aspirated [ie drawn back in a syringe] from the catheter. This indicates that it, the catheter, is in a large vein, and then flushing the catheter with saline.

"Once sited, the UVC needs to be secured in place. In essence, this involves taking a needle and thread and stitching through the jelly part of the cord, then wrapping the thread around the catheter in a ballet shoe style with multiple knots. This part of the procedure can take a long time, especially for a trainee who is learning the skill.

"Once the UVC has been inserted a portable chest and abdominal X-ray was requested to assess the position of [Baby A]'s UVC. This is the standard method of checking the UVC position."

"The intended position for a UVC was the inferior vena cava. However, as UVC insertion is a blind procedure, the catheter can deviate to one side. A UVC catheter deviating into the hepatic circulation is a common complication in this procedure. It is my usual practice to wait with the baby until the X-ray is completed and the line position can be assessed."

If we could please go to [Baby A] on the screen and go to slide 128.

128. We can see the name of Dr Anne Boothroyd again, the consultant radiologist. If we click behind, please. Confirmation that an X-ray was taken. We have the analyst's summary of what was seen:

"The heart size was normal. Improved aeration of both lungs. Tiny traces of fluid in the horizontal fissure was resolved, suggesting this was at least partly due to transient tachypnoea of the newborn. The tip of the nasogastric tube is projected over the body of the stomach. The tip of the UVC lies 12 millimetres proximal to the junction. However, it is a medial curvature, suggesting it may lie in the left branch of the portal vein. The bowel gas pattern is within normal limits for the baby's age."

That sets all that out. If we go to the main page, please, a slide 134. We'll see on the chronology, 134 is the review that I'm about to tell you about:

"Dr Ogden and I [it says Dr MacCarrick] reviewed the X-ray. The UVC appeared to be sited in the hepatic circulation."

We see on our screen a reference to liver. That's the same thing:

"So it is there in the hepatic circulation rather than the intended position in the IVC. Dr Ogden and I sought advice from the responsible paediatric consultant, Dr Jayaram."

So we see in abbreviated form:

"Discussed with Dr Ogden and Dr Jayaram."

Dr Jayaram had just finished his clinic and was in the vicinity:

"Dr Jayaram agreed that the UVC had deviated from its intended course and appeared to be sited in the hepatic circulation. When this happens, it is standard practice to take the UVC out and straightaway replace it with a new catheter, which is what Dr Jayaram advised us to do.

"I returned to the neonatal unit to remove the original UVC and replace it immediately as advised by Dr Jayaram. This was again completed under sterile conditions. On this second occasion I worked independently without direct supervision. This had been agreed between me, Dr Ogden and Dr Jayaram. Dr Ogden was the only registrar on shift that day and was required to go to the paediatric ward to review some patients. I felt confident to complete the procedure independently on this second occasion. Even though I had only just completed the procedure myself for the first time, I had observed colleagues inserting UVCs many times previously and was aware of the steps and important precautions.

"The paediatric ward where Dr Ogden needed to go is located next to the neonatal unit and she was easily contactable if I encountered any difficulties."

If we could go, please, to slide 143. Thank you.

Just click on to Dr MacCarrick's notes. So recording in brief that which I've just read out in more detail.

Going back to Dr MacCarrick's statement, if I may:

"Once I had inserted a new UVC, a repeat chest and abdominal X-ray were requested to assess its position. On inspection of the repeat X-ray, the UVC again appeared to me to be situated in the hepatic circulation rather than the IVC."

Dr MacCarrick requested Dr Ogden and Dr Harkness to review the X-ray with her. If we then go to slide 144, please and we go to the underlying notes, please.

You'll be familiar with this sort of page, members of the jury. You can see an X-ray review comes on -- you'll hear some doctors

refer to it as a sticker that should be placed on to the notes. It's a distinctive red typeface. We see Dr Ogden's signature at the bottom. The time of the X-ray, the date of the X-ray and the comments on the position, et cetera, of the feature being examined and then the comment as to what should happen. Then we have some contribution from Dr Harkness below.

Going back to Dr MacCarrick's statement, she requested Dr Ogden and Dr Harkness review the X-ray with her. They agreed with Dr MacCarrick's impression that the UVC appeared to be in the hepatic vein and that [Baby A] would need a long line, as previously discussed with the consultant, Dr Jayaram:

"At this time [Baby A] remained in the neonatal unit being monitored by the nurses and the inserted UVC would not have been used. It is standard procedure not to use a UVC until it has been confirmed to be in the correct position on an X-ray."

So more than one attempt, not successful, and therefore not used for the purpose for which it was inserted in the first place:

"I did not return to the neonatal unit to remove the UVC after this discussion as both Dr Ogden and Dr Harkness assured me that, as I had already stayed beyond the end of my shift, I could go home and they would complete all remaining jobs. I left the hospital some time after 5 pm, leaving [Baby A] in the care of Dr Harkness and Dr Ogden. I had no concerns regarding [Baby A]'s clinical condition at any point during the insertion or replacement of the UVC. This was the last contact I had with [Baby A]. I heard that [Baby A] had passed away when I came back into work the following day.

"I remember worrying that anything to do with the UVC insertion attempts could have been connected to [Baby A]'s death. The first promise of the Hippocratic Oath is to do no harm and wondering whether my procedure could have done anything to damage [Baby A] or cause his death was upsetting. I always feel sad when a patient I have treated passes away and I always reflect on whether anything could have been done differently to save them. Despite being reassured by several colleagues that my UVC was very unlikely to have anything to do with [Baby A]'s death, I was not 100% reassured until I reviewed the examination findings of [Baby A]'s post-mortem examination."

MR JUSTICE GOSS: It's actually "several senior colleagues".

MR DRIVER: "Several senior colleagues", forgive me. She expresses sympathy for the family.

MR JUSTICE GOSS: Some people have lost power who are observing these proceedings from another building, so that's a convenient point --

MR DRIVER: Thank you.

MR JUSTICE GOSS: -- to break off. Hopefully it can be restored before we recommence at 2.10, please, members of the jury. Thank you very much.

(In the absence of the jury)

MR DRIVER: My Lord, can I indicate what the afternoon --

MR JUSTICE GOSS: Please, that would be helpful.

MR DRIVER: There will be one more statement to be read, a statement of Dr Ogden. Then Nurse Melanie Taylor will be called to give evidence. It's difficult to assess how long that will take, but when her cross-examination or evidence is completed in full, the next live witness, Dr Harkness, has not been warned until tomorrow. I'm sure the court will understand the professional commitments of the various witnesses.

MR JUSTICE GOSS: No, don't worry if we finish a little bit early. It's not a problem.

MR MYERS: I anticipate it will take the afternoon.

MR JUSTICE GOSS: In any event?

MR MYERS: I have to say, it'll be my first endeavour using the IT in the course of working through it with a witness, so that will no doubt delay everything in any event.

MR JUSTICE GOSS: Don't worry. Whatever the situation --

MR MYERS: Thank you.

MR JUSTICE GOSS: -- I'm not concerned. Thank you very much.

(1.03 pm)

(The short adjournment)

(2.10 pm)

MR DRIVER: Can I just remind the court that a statement will be read and then Nurse Melanie Taylor will be called. She is a witness for whom special measures, in the form of screens, has already been granted.

MR JUSTICE GOSS: Yes. What will happen is when you have read the statement and the witness is due to be called, the jury will just have to leave the courtroom, the public gallery cleared, and the defendant just to leave the court. Apparently it'll take a very short time.

MR DRIVER: Yes, thank you.

MR JUSTICE GOSS: Yes. Jury in, please.

(In the presence of the jury)

Witness statement of DR SALLY OGDEN (read)

MR DRIVER: Members of the jury, may I continue to read some evidence, this time a statement from a Dr Sally Ogden.

Dr Ogden made a statement on 6 February 2018, detailing her involvement in the care of [Baby A]. Dr Ogden confirmed that she had been given access to a copy of the clinical records to assist her in her recollections and that the account is written from a review of those medical records and from her personal recollection.

Dr Ogden stated:

"I first met [Baby A] on 8 June 2015 when I was working a standard day shift between 8.30 am and 16.30, ie 4.30 pm, as a paediatric registrar on the children's ward of the neonatal unit. Dr David Harkness returned from his other commitments out in the community to take over as a paediatric registrar from 16.30 hours to complete the rest of the long day until 20.30 hours.

"[Baby A] is also referred to as [Baby A]. The reasons for this are all babies born in hospital are registered under their mother's surname. This is to make sure both sets of case notes marry up and to avoid any confusion.

"At the beginning of each day a ward round is conducted. On 8 June 2015, I was the paediatric registrar on duty. I was in company with senior house officer Theresa MacCarrick. Part of the ward round is to assess each individual baby on the neonatal unit. As the paediatric registrar I would have assessed the babies in the intensive care unit. I reviewed [Baby A] on the unit at 09.45 hours on 8 June 2015."

If I could ask Mr Murphy to put up slide 84, please, we can see Dr Ogden's name.

If we go behind that slide, we have the analyst's description of what it was that Dr Ogden noted in her clinical notes. If we could go to Dr Ogden's underlying notes, please.

You can see her name on the top line. 09.45 on 8 June, ST3, specialist trainee 3, S Ogden. It records that [Baby A] was twin number 2. This is day 2 of his life. He hadn't(?) been born after 31 weeks and 2 days.

We'll leave that on the screen and I'll go back to Dr Ogden's statement about the assessment made at 09.45 on 8 June:

"The assessment is conducted to establish the clinical management of each baby, to identify any immediate medical requirements and to assess the baby's level of respiratory support (do they require intubating, assistance with CPAP)? Is intravenous access required? Are they having antibiotics? Are fluids levels correct? These are just some of the considerations made during my assessment on each baby during the ward round.

"From memory, I do not recall anything particular out of the ordinary with either [Baby A] or [Baby B]. I would have reviewed their clinical and medical needs during the morning ward round. From memory, I recall [Baby B] was slightly more unstable than [Baby A], but without reviewing her medical notes I am unable to go into detail.

"I recall they both required long lines putting in to provide nutrients in a more secure way. At the time they both had intravenous access and there was no immediate concern. If there were any immediate medical concerns I would have expected them to have been highlighted during the handover and discussed during the ward round or, if they required immediate attention, an emergency crash call would have been put out.

"From the ward round on the neonatal unit that morning, I would have created a list of jobs that required completing. Any urgent jobs would have been done at the time."

The statement goes on and this reflects the note on screen:

"[Babies A & B] were preterm twins who had been born the previous day at 31 weeks and 2 days' gestation. They were both 12 hours old.

"After reviewing [Baby A], my plan was to keep him on continuous positive airway pressure ventilation but start to feed him. He needed a central line for ongoing parenteral nutrition and needed a cranial ultrasound performing. He needed repeated blood tests taken later on 8 June 2015 to check his renal function, C-

reactive protein and bilirubin level. [Baby A] had a peripheral venous cannula for intravenous access."

Moving on in time now:

"During the afternoon of 8 June 2015 myself and Dr Theresa MacCarrick, who at the time was an ST1 paediatric trainee, inserted an umbilical venous catheter with aseptic technique to 8 centimetres of length. I was teaching Dr MacCarrick how to perform this procedure and we jointly performed this procedure under my supervision. I reviewed the position of the umbilical venous catheter on the abdominal X-ray."

We'll go to it very quickly because we've already looked at it. Go to slide 142, please. We've already heard Dr MacCarrick, through her statement, speak of this. This was the X-ray taken by Dr Anne Boothroyd that Monday afternoon, 8 June 2015. Then if we go forward to slide 144, we see the joint X-ray review taken by Dr Ogden in the company of Dr MacCarrick. So there we have Dr Ogden's note, timed at 17.00, written in retrospect, recording how the UVC was earlier inserted, using the aseptic technique, the sterile technique, to 8 centimetres, and how it was X-rayed and the result of the X-ray and the consequential action.

So going back, if I may, to Dr Ogden's statement:

"I reviewed the position of the umbilical venous catheter on the abdominal X-ray with Dr Jayaram, the paediatric consultant on call. The X-ray showed it positioned in the hepatic vein. I remember going into clinic and interrupting Dr Jayaram to show him [Baby A]'s X-ray. After liaising with Dr Jayaram we both agreed that the line was not in a satisfactory position. His advice was to remove the umbilical venous catheter and replace it with a new catheter to try and position it in the inferior vena cava.

"I was the only paediatric registrar in the department on the afternoon of 8 June 2015 and at this particular point in time I had been asked to review a patient on the children's paediatric ward."

So Dr Ogden was the only registrar in the department and she'd been asked to do something else:

"I approached Dr Theresa MacCarrick and asked her if she was happy to take out the umbilical venous catheter and insert a new one under aseptic technique by herself using the technique I had shown her earlier. She informed me she was able to do this while I reviewed the child on the children's ward."

If we go to slide 144, please. 145. Thank you. So we have a note from Dr Ogden, timed at 17.00 hours, but written in retrospect. To give context to this and from Dr Ogden's statement:

"At 16.00 hours on 8 June 2015 I handed over to the evening registrar, Dr Harkness, who had returned from his other commitments. During handover, I once again reviewed the X-ray of the new umbilical venous catheter that had been inserted by Dr MacCarrick. This showed that the catheter was still sited within the hepatic vein. I asked Dr Harkness to remove this umbilical venous catheter and to insert a peripheral long line instead into [Baby A]. It was around the same time I was informed by one of the neonatal nursing staff that [Baby A]'s peripheral cannula had tissued. This was the line that [Baby A] was receiving his nutrition through and therefore it had become slightly more urgent during the handover. I informed Dr Harkness of this.

"After handing over the evening jobs to Dr Harkness, I went back to the neonatal unit at 17.00 hours to retrospectively document the events of the afternoon. This was due to workload as I had not yet documented it in the notes."

So hence the retrospective note on screen timed at 17.00 hours.

If we could go to the underlying note, please. We can see the X-ray sticker and Dr Ogden explains:

"I made an error when documenting on the X-ray sticker for the second X-ray as I stated I had removed the second umbilical venous catheter. I had not removed this catheter. Instead I had asked Dr Harkness to do this when I handed over as my shift had ended and I had gone off duty. This was the last contact I had with [Baby A]."

Tomorrow you'll hear from Dr Harkness, members of the jury:

"The following morning, on 9 June 2015, I came on duty for a normal day shift starting at 8.30 am. I received a handover from the night registrar, Dr Rachel Lambie. She informed the team that [Baby A] had died during the evening. I remember this came as a big surprise. It was completely out of the blue and very upsetting. [Baby A] showed no signs throughout the day of any problems. He was handling well and I had no concerns at all for either him or his twin sister."

I'll just check something with Mr Maher.

(Pause)

That concludes the relevant part of Dr Ogden's statement to be read to the jury.

My Lord, now we'll depart from written statements and call a witness, Nurse Melanie Taylor next.

MR JUSTICE GOSS: Yes. This witness is going to be screened from certain people in the courtroom.

MR DRIVER: Yes.

MR JUSTICE GOSS: I'll just say something to the jury about that and explain why I'm asking them to leave and the fact that witnesses are screened.

It's very common now for witnesses in trials in the Crown Court to give their evidence screened from other people in the courtroom.

So there will be a number of witnesses in this case who will give their evidence screened from others, but they will not be screened from you or me or the barristers asking the questions, obviously. So they can be seen. The important thing is that you can see them. As I say, it's very common.

The purpose of screens being erected is to try and make what is a difficult experience less difficult and to enable the witnesses to, as it is described, give their best evidence or achieve their best evidence. In other words, give their best evidence in the trial as a result of this measure. Other witnesses give their evidence over video links and things like that. It is, as I say, commonplace.

The important thing is, and this is a legal direction, which I shall give you now and I shall put in writing in due course, but by then that will be at the end of the case when you have seen umpteen witnesses giving their evidence over a screen and you will have done exactly what I'm about to say you should do. That is to ignore the fact that there are screens and you attach no significance whatsoever to the fact that a witness is screened from anyone in the courtroom. You treat the witness as though the screens were not there and you judge the witness as you would judge any other witness, screened or not. Do you understand?

I'm sure you would, it's just part of being fair in your assessment. The important thing is your assessment of them as a witness.

So I will, to begin with, when a witness comes along and there is a screen there, I will say, "Remember what I said to you about screens, don't attach any significance to it". What you certainly do not do is hold it against this defendant or her

case that a witness is screened from others in the court. All right? Thank you very much.

In order to do this, and for the witness to be brought into court, I'm afraid you have to leave court. It's only for a few minutes. It should only take a few minutes. Then when you come back in, the screens will be there and the witness will be there and we'll just continue and you will ignore the fact the screens are there. Thank you.

(In the absence of the jury)

Thank you. It'll literally just be a couple of minutes, please, into the back room.

(Pause)

Can I just reassure you, before anyone else comes into court, the only people who can see you are the people you can see. So far as screens are concerned, you're not going to be put on a screen into any other room. So as I say, the only people who will see you are the people you can see, but of course anyone in this courtroom will be able to hear you.

THE WITNESS: Okay.

MR JUSTICE GOSS: What's going to happen now is the others are going to come in, the members of the public and the media who are here and the defendant as well, please, and then the jury will come in and take their seats.

(Pause)

(In the presence of the jury)

I'm sorry, that was a little bit longer than I would told it would take. We'll just wait until everyone's in their seats.

Thank you.

MISS MELANIE TAYLOR (affirmed)

Examination-in-chief by MR DRIVER

MR DRIVER: Could you state your full name, please?

TAYLOR: It's Melanie Anne Taylor.

DRIVER: Would you like me to address you as Miss, Ms or Mrs Taylor?

TAYLOR: Miss.

DRIVER: Miss Taylor, we understand that in 2015 you were a nurse employed within the neonatal unit of the Countess of Chester Hospital; is that right?

TAYLOR: Yes.

DRIVER: You will recall, I am sure, being asked questions by a police officer in a recorded situation about the cares that you provided to [Babies A & B].

TAYLOR: Yes.

DRIVER: And that initial question and answer session, or interview, took place on 21 May 2018.

TAYLOR: That sounds right.

DRIVER: Take that from me. And you later signed a written statement, a witness statement, and that is dated 24 October 2018.

TAYLOR: Again, I can't -- but yes.

DRIVER: And of course you were looking back on the events of 8, 9 and 10 June 2015, so almost 3 years after the event. Could you confirm that before answering questions to a police officer and before making the statement, you were given the opportunity to refresh your memory from the nursing notes, the care notes, relating to those two babies from back in June 2015?

TAYLOR: Yes, I did.

DRIVER: And additionally, to assist you remember when you were on duty, you were also shown the shift rotas from the hospital to help you orientate yourself?

TAYLOR: Yes.

DRIVER: If we are going to go to the detail of those notes, you'll see them on screen, so don't worry about any sort of memory test.

TAYLOR: Yes.

DRIVER: Can you confirm that you came on duty in this relevant time at about 7.30 in the morning on 7 June?

TAYLOR: Yes.

DRIVER: Thank you. That's my mistake and I apologise. It was 8 June.

TAYLOR: Yes. I worked on the 7th as well though.

DRIVER: And the babies were born, the twins were born on the evening of 7 June, during the night shift, as it would be from your perspective, but you weren't on duty then.

TAYLOR: I wasn't, sorry.

DRIVER: You came on duty the following morning and you took over from a colleague whose name is Ashleigh Hudson; do you remember that?

(Pause)

MR MYERS: I'm asking if the witness could raise her voice a little bit. I apologise for interrupting.

MR JUSTICE GOSS: This is quite a big room and there are a lot of sound barriers.

TAYLOR: I'll speak louder.

MR JUSTICE GOSS: So although the jury sit opposite you, other people have to hear and it's difficult for people right at the back to hear.

MR DRIVER: I wonder whether we could put on the screen, please, number 59.

On the screen is a visual display and we're growing familiar with it, but you will never have seen this ever before, is that right?

TAYLOR: No.

DRIVER: And you can see that we have recorded there in the middle of the screen the shift handover took place at about 7.30 in the morning on Monday, 8 June. If we go one behind that, please, Mr Murphy, there you will see a list of names, people who will be familiar to you I am sure. So we've got the paediatrician of the week, the consultant, a list of doctors and list of nurses, all of whom were working, we understand, on this shift.

TAYLOR: Yes.

DRIVER: If we go one behind -- there isn't one behind on this one, so if we could then, please, go to slide number 61.

The records suggest that care was handed over to you, that is to say care of [Baby A], that morning at about 8 o'clock. We will see when you first made notes in relation to this particular baby. If we can click below, please, Mr Murphy.

That's not a terribly clear image to my eyes at least. But before we look at the detail, could you just explain to the jury the handover process?

TAYLOR: Yes. So there was a process of change around that time -- I've written this in my statement. I'm not sure whether this happened before or after this event. So we would have what we would call a huddle at the beginning of the shift, where all the staff, all the nursing staff who came on for that shift would have a huddle that was given by the shift leader from the previous shift, just to update -- a brief update on all the babies on the unit.

So we'd have that and then we would go to our allocated babies, to the cot side or the incubator side, to the incubator and have one-to-one handover from the -- direct for the babies just that we're caring for from the nurse who was caring for them from the previous shift.

DRIVER: Thank you. If we go back to slide number 59. We'll just review that process that Ms Taylor's just described to us. Go down to the nursing staff.

So the huddle that you described would have involved all of the nurses coming on for that shift. Would it also involve all of the nurses from the previous shift?

TAYLOR: No.

DRIVER: Or not?

TAYLOR: Just the shift leader from the previous shift.

DRIVER: So shift leader from the previous shift, shift leader for your shift and your colleagues coming on shift at the same time as you?

TAYLOR: Yes.

DRIVER: And that would be intended, would it, as you've just said, to provide a general overview as to the patients --

TAYLOR: Yes.

DRIVER: -- on the ward --

TAYLOR: Yes.

DRIVER: -- in the unit, I should say, more accurately, at that time.

You have told us in terms that each of you registered nurses would be informed of which baby or babies had been designated under your care?

TAYLOR: Yes.

DRIVER: And also, you would have been told which nurse from the previous shift was designated to look after those same babies?

TAYLOR: Well, we would get direct handover from them.

DRIVER: Right. So that's a second phase: there's the overview in the huddle, as you call it, and then there's one-to-one interaction between you and your predecessor?

TAYLOR: Yes.

DRIVER: What was the purpose of that? I know it's obvious, but you spell it out to us. What sort of information would be exchanged at that point?

TAYLOR: So in the huddle -- it's just so that everybody has an awareness of what is going on on the unit. It's not -- wasn't intended to be an in-depth handover, it was more if there was any sort of concerns, anything, so we kind of had an idea generally what was happening. And then when we had our handover, our one-to-one handover for the patient that we were taking care of, that was obviously an in-depth handover for that baby. So it would be previous history, maybe delivery information, it would include what care, what medication they're on, what has happened throughout the day and whatever the plan of care is that is ongoing.

DRIVER: Thank you. You've talked about it in the singular, each baby, the baby you'd be the designated nurse for. Would you only ever be designated nurse for a single baby or might you be designated nurse for more than one baby on a shift?

TAYLOR: No, you could be -- it could potentially be one baby or it could be more than one baby. Do you want me to go into the sort of... how... whether it's one to one?

DRIVER: Yes, please.

TAYLOR: So we follow something called BAPM standards, which sets out the sort of ratio of patient to nurse care. So it says that ITU babies, so intensive care babies should be one to one --

DRIVER: Yes.

TAYLOR: -- HDU babies, high dependency babies, should be two to one, and special care babies can be four to one.

But it can depend on the shift. So we could have -- it depends on how many babies we had at that time as well. We could have a quieter shift where actually we wouldn't be at that maximum ratio, you could maybe have one HDU baby or something like that.

DRIVER: That's the protocol --

TAYLOR: Yes.

DRIVER: -- that's the standard that you aim to, but in practice you might depart from that?

TAYLOR: Yes, and the same, you know, sometimes babies come through and you can't not accept them. So it may -- it very rarely happened, but it might be that you had more than that.

DRIVER: Thank you. In terms of location, where would the huddle take place?

TAYLOR: So again, it's changed over the years. At that time I want to say it was -- we had a separate room, a little room which we would all gather in and we'd do it in there, and then the one-to-one would be by the cot side.

DRIVER: We've seen on screen and you're well familiar with it, for each baby there's a computerised record of their cares and the like. Obviously that would be kept within the computer. But at the cot side was there any data to be seen with reference to each baby, literally on paper at the cot side?

TAYLOR: Yes. So they would have a clipboard or -- yeah, which would have observation charts, fluid charts, and other charts depending on what charts the baby required. There may be some that if babies are having apnoeas and desats needing intervention, we would have a chart for that. There would be a few charts, yes.

DRIVER: We've seen on the records already the hourly observational charts --

TAYLOR: Yes.

DRIVER: -- that nurses undertake. Are they the sort of records that you're referring to?

TAYLOR: Yes.

DRIVER: Thank you. So they would include, as you've said, observations, blood gas charts?

TAYLOR: Yes.

DRIVER: A record of any apnoea or bradycardia, the heart rate of the babies, the respiratory events --

TAYLOR: Yes.

DRIVER: -- if any, of the babies. And blood oxygen records, would they be on the clipboard chart?

TAYLOR: There would be an observation chart which would be heart rate, all the sort of observations, so it would be the hourly -- heart rate, respiratory rate, oxygen saturations, temperature, blood pressure if that's being taken, they would be on one chart.

DRIVER: Thank you. When a nurse such as you practising in this environment undertook those hourly observations, would the records always be made up immediately or might they be done later retrospectively?

TAYLOR: So with the observation charts, they would be written as we were doing them. Yes, so handwritten notes, the sort of overview on the computer at the end of the day -- or that may be throughout the day or it may be retrospectively, but the observations and sort of the charts with the sort of the fluid requirements, what we read in the drip reads(?), that would be at the time. We would be writing them as we're doing them.

DRIVER: Because by the very nature, they contain data, they contain precise numbers --

TAYLOR: Yes.

DRIVER: -- and measurements?

TAYLOR: Yes.

DRIVER: It'd be impossible to retain that sort of information, so they're noted as taken?

TAYLOR: Yes.

DRIVER: But you were suggesting that there's other types of notes, perhaps just a general --

TAYLOR: General nursing notes.

DRIVER: -- report of the events of the day or developments of the day, they might be done at the time or might be done retrospectively --

TAYLOR: Yes.

DRIVER: -- am I right to assume, depending on the demands on your time --

TAYLOR: Yes.

DRIVER: -- during the shift. Thank you.

So going to Monday, 8 June 2015, is it right that you were allocated as designated nurse for both [Baby A] and [Baby B]?

TAYLOR: Yes.

DRIVER: Both the twins were in nursery room 1 --

TAYLOR: Yes.

DRIVER: -- is that right, the ICU room? And I'm going to ask Mr Murphy if he could play the video recording that we watched just before lunchtime. It's a recording within nursery 1 at a time when all the machinery and the like was in there but, of course, taken well after the events that we're -- just so you can assist us as to your recollection as to who was where if you're able to.

TAYLOR: Yes.

(Video played to the court)

DRIVER: Do you recognise that as nursery 1 or the ICU --

TAYLOR: Yes.

DRIVER: -- at the Countess of Chester Hospital?

TAYLOR: Yes.

DRIVER: A room you're well familiar with?

TAYLOR: Yes.

DRIVER: When did you begin work at the Countess of Chester Hospital?

TAYLOR: 2010.

DRIVER: Thank you. Did you begin as a band 5 nurse?

TAYLOR: Yes.

DRIVER: Am I right that at the time that we are considering, you'd become a band 6 nurse?

TAYLOR: Yes.

DRIVER: But relatively recently?

TAYLOR: Yes.

DRIVER: Do you actually remember where [Babies A & B] were within that nursery on the morning?

TAYLOR: Yes, this is also looking back at my notes, my statement that I've given, because obviously that was a couple of years ago. So my memory was clearer then than it is now.

DRIVER: Yes.

TAYLOR: So as the video, you were going in, the first on the right-hand side door, the first door, [Baby B] was on the far right side.

DRIVER: Would it help if we played the video again and --

MR JUSTICE GOSS: I think, so we can just lay out the geography so that we've all seen -- because you know it, we are only seeing it from here. There are clearly two doors from the corridor into it.

TAYLOR: Yes.

MR JUSTICE GOSS: The camera goes in first through the door on the right and pans around and we can see on the right there is one behaviour, then there are two more in front.

TAYLOR: Yes.

MR JUSTICE GOSS: And where there's a partial separation into the next door room, so it comes out of that door, you can obviously go through it, go through one part of the big room to the other, but if you go in the other door then there are more incubators there, a total of four.

TAYLOR: Yes.

MR JUSTICE GOSS: So would it be helpful if we numbered them? Did they have numbers?

TAYLOR: If they did we didn't tend to refer to them.

MR JUSTICE GOSS: All right. I think what you've described, tell me obviously if I'm wrong, is it was in the right-hand one as you go in that first door.

TAYLOR: Yes.

MR JUSTICE GOSS: Right. So we can look at that one.

TAYLOR: Yes, if it was right-hand incubator, incubator 1.

MR JUSTICE GOSS: Yes.

TAYLOR: Next one along, 2, 3, and then the left-hand side, 4. [Baby B], I think, was in incubator 1. [Baby A] was in incubator 2.

MR JUSTICE GOSS: So you recall them being next door to each other?

TAYLOR: Yes. [Baby B] -- I'm like 95%, about [Baby B] being in incubator 1, but [Baby A] was in incubator 2.

MR DRIVER: Thank you. We can play it again.

(Video played to the court)

MR DRIVER: There's a breakdown in the link to the satellite court.

MR JUSTICE GOSS: I thought it had been deliberately paused at that point.

MR DRIVER: It has, both! Thank you. Pause there. Of the incubators on the screen now you tried to help us by numbering them. Are they the incubators you were numbering?

TAYLOR: Yes.

DRIVER: And the one to the right of our screen as we look at it, what number do you give that?

TAYLOR: Number 1, where I'm pretty sure [Baby B] was. Number 2 where [Baby A] was.

DRIVER: Right. Thank you. Can you remember whether or not the other incubators were occupied during this shift or can't you remember?

TAYLOR: I can't remember. I know we were very busy and the likelihood is they were, but I couldn't say for certain.

DRIVER: Thank you. I wonder whether you can remove that from the screen, please, Mr Murphy, and go back to the timeline in relation to [Baby A]. I'm going to ask you, Miss Taylor, about your recollection of his condition at the time that his cares were handed over to you.

In general terms, on the basis of the information you received from Ashleigh Hudson and your initial assessment of [Baby A], how was he?

TAYLOR: So he was a premature baby, so he was on respiratory support, which was what we would expect. But in terms of his gestation and how well he was coping with his respiratory support, he was stable.

DRIVER: Thank you. Can you remember the nature of the respiratory support that he was receiving when you first took over?

TAYLOR: Yes, he was on nasal CPAP.

DRIVER: Nasal CPAP. As to his general condition, how was he on your assessment?

TAYLOR: He was stable. The only thing that I mentioned in my statement or in my notes is that his respiratory rate was elevated at times, which is not unusual for a baby who's requiring CPAP. But otherwise, his other observations -- so his heart rate, his temperature, his oxygen saturations -- were satisfactory and stable.

DRIVER: Thank you. If we could move along, please, Mr Murphy, and go to Miss Taylor's notes at number 61.

Below -- I think we may have looked at this already. If we can click on the underlying document.

Are you able to -- no.

Clearly, you recognise this format.

TAYLOR: Yes.

DRIVER: It's part of your everyday work --

TAYLOR: Yes.

DRIVER: -- over the last decade or so. We can see the date and the time, 13.08. Would that be the time of the creation of the note, the administrative exercise of typing up the information?

TAYLOR: Yes. I think it's the time of -- I think that is possibly -- I'm not -- I think that might be the time it started and the 13.23 is possibly when I finished, when I saved them.

DRIVER: So patient notes, nurse's note, it says, create, and we have the date, 13.08, and then we have the date again and then 13.23. So that's -- the administrative exercise of typing up those notes took about 15 minutes at around that time. Thank you.

The next sentence tells us what it's all about:

"Written for care handed over from 08.00."

So it's your retrospective note of the events in the first 5 hours or so of you looking after [Baby A] and, as it happens, his sister.

We can see your technical notes of the cares given to [Baby A]:

"Nursed on N CPAP."

That's the nasal CPAP that you have told us about?

TAYLOR: Yes.

DRIVER: Pressures?

TAYLOR: The pressure is the flow of oxygen that we deliver via the CPAP. So that's what we actually set it at to the actual flow -- sorry, no, excuse me, sorry, the pressures are what we're aiming for, so that we give a flow of air or oxygen and air and the pressures are this volume, sort of -- I can't explain it very technically, I'm afraid. But the volume in the lungs that we're aiming for is -- and it's 4 to 5 centimetres H₂O technically, but I've just written 4 to 5. And that's pretty standard, what we would be aiming for for a stable baby on CPAP.

DRIVER: So it's a record of his respiration with assistance?

TAYLOR: Yes.

DRIVER: "Minimal recession" -- we're not going to go through every note --

TAYLOR: No, it's fine.

DRIVER: "Minimal recession." What does that mean, recession, in this context?

TAYLOR: Recession is a sign that a baby is working hard to breathe. So recession -- there's different types, subcostal recession, intercostal recession. So if a baby is having to work hard to breathe they are using muscles, so you can see that when they're breathing, you can almost see a pulling-in around the stomach and around --

DRIVER: Is it what a layman might regard as sort of panting action?

TAYLOR: Yeah, and it's a physical, actual sort of drawing-in almost, using the muscles.

DRIVER: Right. Thank you. "In air", what does that mean in this context?

TAYLOR: It means that he was being delivered, via the CPAP, just air, what you and me are breathing, rather than a concentration of oxygen. He wasn't needing any added oxygen.

DRIVER: Thank you. So just air, but with added pressure --

TAYLOR: Yes.

DRIVER: -- to help it go in and out?

TAYLOR: Yes.

DRIVER: Thank you. "Temperature raised", is that the baby?

MR JUSTICE GOSS: Have you deliberately passed over resps?

MR DRIVER: No, I haven't, thank you.

"Resps: 60 to 65", is that the rate?

TAYLOR: It's 60 to 75. That's the rate of respirations, so how many breaths per minute.

DRIVER: In terms of what would be expected or hoped for a premature baby of this gestation where does that fall?

TAYLOR: Yes. On CPAP we would say that was okay. 75 is on the higher end, slightly higher end, but you know, is acceptable on a baby who's stable on CPAP.

DRIVER: Thank you. "Temp" -- temperature, I assume -- "raised"?

TAYLOR: Yes. So I have taken a temperature at some point throughout the shift on that morning or early afternoon and it was slightly raised. The incubator is heated, so I will -- I have written I've reduced the incubator temperature accordingly and it's responded.

DRIVER: So raised in this context, is that as compared to a previous reading or as compared to the line where (overspeaking)?

TAYLOR: If it's above -- our ideal is 36.6 degrees Celsius to 37 degrees. That's what we aim to keep the baby's temperature. So anything above 37 really, so 37.1, even though it's not technically a temperature, it's more than we would -- of a therapeutic range that we would like. So the baby there hasn't got a high temperature, it's just slightly more than the sort of therapeutic range that we like them in.

DRIVER: So accordingly, you reduce the incubator temperature --

TAYLOR: Yes.

DRIVER: -- as noted? "Resps slightly raised at times"?

TAYLOR: Mm-hm.

DRIVER: Is that again periodically his respiration would be elevated?

TAYLOR: Yes.

DRIVER: "Other observations within satisfactory limits."

TAYLOR: Mm-hm.

DRIVER: What are the -- in general terms what are the other observations that were satisfactory?

TAYLOR: Oxygen saturations and possibly, if I've done it -- I would have to have a look at the observational charts, but if I've done a blood pressure -- but to be honest I have put most of them on there, it's probably mostly referring to the oxygen saturations.

DRIVER: Thank you. Going down, we have a list of the fluids provided to the baby --

TAYLOR: Yes.

DRIVER: -- via a cannula.

TAYLOR: Yes.

DRIVER: "Slight oedema in the arm around the cannula."

In layman's terms what were you noting there?

TAYLOR: So we will check a cannula site hourly because --

DRIVER: You're pointing to the back of your hand. Not everybody can see you at the moment.

TAYLOR: They're not always in the back of the hand, they can be in the arms, feet, legs, but we would check it hourly for any sort of swelling -- so by oedema there's a bit of fluid around, a slight swelling, and that can be a sign that a cannula is leaking or the cannula -- the veins are irritated and needs a new one. If it's a slight oedema, if everything else is okay, we would just watch for maybe the early signs of something. Sometimes it can be just be positional, if a baby has held its hand in a certain position.

DRIVER: In consequence did Dr Ogden, Registrar Ogden, check the site and confirm that she was happy?

TAYLOR: Yes. So I will have asked her to look at it because of the oedema, just to double-check that she's happy that the cannula is still okay and she's agreed that it's fine.

DRIVER: Next, you've noted digestive matters, that he had passed urine; is that right?

TAYLOR: Yes.

DRIVER: "BNO"?

TAYLOR: Bowels not opened, so not --

DRIVER: Yes:

"Mucousy aspirates obtained from the nasogastric tube."

TAYLOR: Yes.

DRIVER: Remind the jury what were you recording there, please?

TAYLOR: The nasogastric tube is a feeding tube into the stomach. We would -- at this point he wasn't being fed but we would still sort of aspirate -- so we would pop a syringe on to the end of the nasogastric tube and aspirate if there is anything in the tummy. Sometimes it can be air, sometimes it can be milk if they've been fed. In this case just some mucousy aspirate, which we would expect is normal for a baby who's not being fed.

DRIVER: Thank you. And we've already heard from the statements read from the doctors, a UVC was inserted by Dr Ogden. You were a -- an X-ray was taken, at this stage you are recording you were awaiting confirmation that everyone was happy, having reviewed the position of it as per the X-ray.

TAYLOR: Yes.

DRIVER: Thank you very much. I wonder if we could go to the chronology, please, away from these specific notes.

If we could go, please, to 63. Miss Taylor, I'm not going through all of these, but this is an example. It's on the hour, it's 8 o'clock, so this is the hourly observations. Could you confirm? That's somebody else's summary of the contents of your chart, but if we look at the chart itself, there we have the time, date and time bar across the top. Did you manually add the data on this graph, as it were?

TAYLOR: So not all of them on this graph are my entries.

DRIVER: No, because they begin on the 7th, they go into the 8th before you --

TAYLOR: Yes.

DRIVER: If we look to the bottom of this document, there's initials at the bottom.

TAYLOR: Mm-hm.

DRIVER: And can you tell us -- if we move the cursor along and we get to the first of yours, we see lots of AHs, no doubt Ashleigh Hudson.

TAYLOR: That's me there (indicating).

DRIVER: That's you there where the cursor's pointing now?

TAYLOR: That will be from 8 o'clock.

DRIVER: So this is one of your many hourly observations of this baby, just plotting heart rate, respiration, temperature and the like?

Back to the main page, please, numbers 65 and 66. 65 is the fluid chart. So the source document, please. Can we see the whole thing, please, Mr Murphy?

So you'll recognise the likes of this, I'm sure. In general terms, can you tell the jury what it is you were recording on this document in relation to [Baby A]?

TAYLOR: Okay. So this is an intensive care chart. So we would use this on a baby who -- usually either intensive care or high dependency and this is the fluids that [Baby A] was receiving within a 24-hour period from 1 o'clock until -- on the 8th.

DRIVER: Thank you. Back to the main page, please.

We go to slide 68, please. We are now at 9 in the morning. We see your noting of the fluids he was provided with sits alongside your observation chart, so in summary there's a constant record --

TAYLOR: Yes.

DRIVER: -- of everything of note in relation to that baby?

TAYLOR: Yes.

DRIVER: And taking a step back from the detail, in general what was your assessment of the baby during this shift?

TAYLOR: I had no concerns with him. He was stable, he was on CPAP, but he was stable. Observations were as to be expected of a baby of his gestation.

He -- there was -- one thing is that he didn't have fluids for a couple of hours due to issues with lines throughout the day.

DRIVER: Let's just dwell on that for a moment or two then. The issue with lines, can you explain to the jury what you mean by that?

TAYLOR: So the cannula, which is a peripheral venous line, is the line that we used and he initially had at the beginning of shift, which we can use for fluids, medications. So that tissueed at some point during the shift, so that means that the cannula wasn't able -- we weren't able to use that cannula anymore.

MR JUSTICE GOSS: What does tissueed mean?

TAYLOR: It's a term we use, basically saying the vein has gone for some reason and we can't use it because fluid will be leaking out or into the tissue.

MR JUSTICE GOSS: I see.

MR DRIVER: So that vein is no longer suitable for fluids to be pushed through the cannula into that vein?

TAYLOR: Yes.

DRIVER: So you seek a different route --

TAYLOR: Yes.

DRIVER: -- in short?

TAYLOR: Yes. At that point I don't know whether the UVC had already been attempted to be put in. A UVC is an umbilical venous catheter, so that is a line that goes into a vein in the umbilical cord. But it has to be X-rayed, and it's under sterile conditions, and we have to ensure that it's in the right position before we can use that line.

DRIVER: And for this baby on this day, the jury have heard this morning that process where the doctors made two attempts, X-rayed them, and weren't perfectly content with the position, so hence, does it follow from your recollection that the baby, [Baby A], was not provided fluids through the UVC?

TAYLOR: No, he wasn't, no.

DRIVER: So another option was desired?

TAYLOR: Yes.

DRIVER: Can you explain what that was to the jury?

TAYLOR: So they attempted to -- well, they sited another type of line, which is called a long line, which is a more central venous line. So again it has to be done under sterile conditions.

DRIVER: By a doctor?

TAYLOR: By a doctor. And has to be X-rayed and the position confirmed before it can be used. In some circumstances basic fluids can be put up as long as -- but it has to be okayed by a doctor before that can be done. So we wouldn't use it, if it wasn't confirmed, with any medication or anything like that.

DRIVER: When you say basic fluids could be put up, what do you mean when you use the phrase "put up"?

TAYLOR: In regards to the fluids?

DRIVER: Yes.

TAYLOR: Sorry, it's my nursing speak: just connecting some intravenous fluids. So in his case it will have been Babiven, which was total parenteral nutrition, and 10% glucose, and the reason we -- I think we probably say "put up" is because it's often a bag which we hang up and it's via a line into the -- long line, UVC, whatever line the baby has.

DRIVER: So although the cannula, the area where the cannula was tissueed --

TAYLOR: Mm-hm.

DRIVER: -- this was plan B. And although the attempt to put a UVC in place was problematic because they landed in the wrong position twice --

TAYLOR: Yes.

DRIVER: Plan C, the long line -- and you had to wait, I understand it, for that to be fitted. Whilst that process, those hiccups are being encountered, is it the case that [Baby A] was without any sort of fluid support or was that put up, to use your phrase, differently?

TAYLOR: Yes. So he will have had no fluids for -- I don't know exactly how long it was, I think it was a couple of hours. I can't...

DRIVER: Does the fluid chart, the intensive care chart, would that inform you as to the answer to that question?

TAYLOR: Yes, it will, actually.

DRIVER: And that's on the screen, I think.

TAYLOR: It's at 4 o'clock. Somewhere around 4 o'clock, or it will be after 4 o'clock, I haven't put exactly the time, but between 4 o'clock and 5 o'clock the cannula has tissueed, because I've done a reading at 4 o'clock, so the cannula was okay at that point. It's somewhere in between that time -- or actually, no, it may have tissueed at that point. That may be when I noticed it. So between 4 and 5 the cannula's tissueed.

DRIVER: Yes?

TAYLOR: Then if you go down...

DRIVER: When we say 4 o'clock, on our chart it's in the 24-hour clock, so 16.00 hours.

TAYLOR: Yes.

DRIVER: What's the next entry of note?

TAYLOR: There's no more entries of fluids. So --

DRIVER: Take us to 18, 6 o'clock, 18.00 hours. What does that entry inform?

TAYLOR: So there's two: there's one at 4 o'clock and there's one at 6 o'clock. So intravenous fluids, he hasn't had any between those times, but he's had some form of milk via his nasogastric tube. So he's had 1ml at 4 and 1ml at 6 pm.

DRIVER: Yes?

TAYLOR: And if you scroll slightly upwards, it will say what milk it is. It's EBM, which is expressed breast milk, so that will be milk that [Baby A]'s mum expressed.

DRIVER: Right. So that's in the input. Then whilst we're at the top of this page, we can see the output column, which speaks for itself.

TAYLOR: Yes.

DRIVER: And you took measurements there at 18.00, 6 o'clock. There's 25ml or thereabouts of urine being passed by the baby?

TAYLOR: Yes.

DRIVER: Then if we go to the entry, please, at -- no, we shan't do that. If we go to the main page, please, I think your shift effectively was coming to an end at about 19.30, about 7.30 at night.

TAYLOR: Yes.

DRIVER: So if we move forward, please, to 19.05. If we pause, please, at -- we've gone too far forward. Please go to number 86, please.

86. Your notes of 10 in the morning. The next. Still on the main page, please, Mr Murphy and we'll go through this quite quickly.

We will see all the notes that you make during that day. So at 87 the fluids, the intensive care chart again at 10 in the morning.

If we go to 89, please. Your records for medication at 10.15 in the morning.

91, caffeine and sodium chloride.

107, please. We have your hourly observation. This is taken at 10.30.

Could you go on to that, please? Click on, please, this here at 114.

So your hourly observations now at 11 in the morning. Anything of concern at that point? Go on to the chart itself, please.

TAYLOR: I wouldn't have been concerned about anything there. The temperature, like I was explaining in my notes, was a little bit raised, but it came down. Accordingly, the respiratory rate was slightly on the higher side, but had been relatively similar throughout the shift and actually had improved from the sort of late evening the day before. So I wouldn't have had concerns looking at -- and the saturations had been fairly stable and remained in air. So...

DRIVER: Thank you. Can we go to slide 120, please?

We'll see there, now we're at -- go on the main page, please, Mr Murphy.

We can see a series of notes and observations taken by you at around noon. If we go through -- slide across one by one. Slide 120, 121. Thank you. We see the intensive care chart followed by the equipment settings, fluids, observations. Keep going, please, Mr Murphy. All taken at 12. Then repeated at 1. Yes?

Your notes then, please.

Click on to 125, Mr Murphy. Go to the notes themselves, please. Zoom in on them. Thank you.

We've looked at these before in terms of your summary made in the afternoon, looking back towards the morning. We'll see that your addendum is made at 7.05, at 17.05 (sic), if we could go back to the main page, please, and would it follow, Miss Taylor, that each hour we'll see, if we laboured through the notes on an hourly basis, we'd see you repeat these measurements and take these readings at organised intervals?

TAYLOR: Yes.

DRIVER: Then if we go to 19.05, please, Mr Murphy. Could we click on there? The notes themselves, please.

We can see the addendum at 19.05 reporting that the UVC is still in the wrong position; is that right?

TAYLOR: Yes.

DRIVER: They've been reinserted by a senior house officer, Dr MacCarrick?

TAYLOR: Yes.

DRIVER: Again in the wrong position. Records the fact that the cannula is tissued:

"Doctors busy on ward 30."

TAYLOR: Yes.

DRIVER: What's that recording?

TAYLOR: Ward 30 is the children's ward, so the doctors cover the neonatal unit and the children's ward.

DRIVER: At this stage were you awaiting the return of doctors -- well, Dr Harkness, principally, at this point?

TAYLOR: Yes. I mean, obviously I've not written how I've spoken to them or I will have somehow communicated that this child needed -- you know, needed fluids --

DRIVER: Yes.

TAYLOR: -- but they were busy on ward 30.

DRIVER: Thank you. At what time was your shift scheduled to finish this evening?

TAYLOR: My shift would have finished at 8 o'clock and we start handover at 7.30 in the evening.

DRIVER: So that takes us back where we started. So the handover from you, coming to the end of your shift, you wouldn't be involved in the huddle?

TAYLOR: No.

DRIVER: You'd be caring for the baby --

TAYLOR: Mm-hm.

DRIVER: -- or babies until your successor, the night shift designated nurse, came to you to learn what had been happening with the designated babies?

TAYLOR: Yes.

DRIVER: And on this occasion, the end of your shift on 8 June, can you recall who it was that you were handing over the care of [Babies A & B] to?

TAYLOR: I don't remember physically handing over to a person, but I know, looking back at my notes, it will have been Lucy Letby.

DRIVER: All right. You have no recollection, direct recollection, of that handover; is that what you're saying?

TAYLOR: Yes, that's what I'm saying.

DRIVER: Do you recall making up these notes?

TAYLOR: Actually writing the notes?

DRIVER: Yes.

TAYLOR: I don't -- I remember sitting at the computer to write some notes, so the computer that you saw in the video. I remember sitting there when [Baby A] started to deteriorate and I will have just left those notes (inaudible) -- I wouldn't have finished them. So I would have started to write some -- they are the ones that I remember writing but they will not have been saved because that's when he started to deteriorate and I offered to help.

DRIVER: Let's take this in stages. I wonder whether we could go back to the video so you can inform the jury as to which computer you would have been using and we can all familiarise ourselves with its location.

(Video played to the court)

Could you pause it there, please? We can see two screens there. Are either of those the computer you're referring to?

TAYLOR: Yes.

DRIVER: Mr Murphy, could you put the cursor on one.

Is it that screen or the other?

TAYLOR: That one, yes.

DRIVER: We can see that is up against a wall. You indicated earlier -- could you confirm that the incubator immediately to the left of a person who would be sitting at that computer is the one that you are sure [Baby A] was in or not?

TAYLOR: The one behind that. You can't quite see it from this angle.

MR JUSTICE GOSS: I think let the recording continue.

MR DRIVER: Thank you.

If we go back a minute or so.

(Video playing continued)

Pausing there, go back a few seconds, please, Mr Murphy.

Are they the incubators that you referred us to earlier where [Babies A & B] --

TAYLOR: Yes.

DRIVER: -- were being cared for? The one to our right you're 95% sure that was [Baby B]'s incubator. The one to the left of centre of the screen you're sure was [Baby A]'s.

So then we continue, please, to take us to the computer in question.

(Video playing continued)

Pause there. So the terminal there in the bottom right corner of the screen.

Going back to 8 June, you've no recollection of the interaction with Lucy Letby, the exchange of information from you to her about [Baby A]?

TAYLOR: No.

DRIVER: But do you recall the nature of the report that you would have made at this point in time?

TAYLOR: I mean, I don't remember what I handed over because I don't remember the handover. But from reading my notes, I will

have handed over all the different areas, respiratory, fluids, what had happened throughout the shift, but that he had been stable respiratory-wise and that there were no concerns. It was the fluids that was the main concern, just getting some fluids connected.

DRIVER: Are you able to say whether he was put on fluids before or after your shift, your responsibility for his care ended?

TAYLOR: I can't remember. It may be that I've -- I'm not sure whether I've referred to that in my notes or in my statement. I can't remember at the moment.

DRIVER: Let's, please, go to -- we'll come back to this in a moment. Go to slide 174, please. Click on there, please. And the original document, please.

Are you familiar with this sort of document?

TAYLOR: Yes.

DRIVER: What does this record?

TAYLOR: So this is a paper chart, a prescription chart, which we would -- a doctor would prescribe fluids on for a patient. On this one, 10% dextrose has been prescribed.

DRIVER: At a volume of -- is that 500 millilitres?

TAYLOR: That's the size of the bag that we would have connected. But the rate that we will have run it at is 60ml per kilogram per day.

DRIVER: Yes.

TAYLOR: Kilogram is the kilogram -- the baby's weight, which on there it's been written, it's been calculated at 4.15ml an hour.

DRIVER: Thank you. Move along from left to right. We see under the heading "route" -- what does that tell us?

TAYLOR: I can't read that, sorry.

DRIVER: I'll try and enlarge it.

TAYLOR: Oh, I think it says "long line", possibly.

DRIVER: Yes. Then next column on that document is "prescribed by"?

TAYLOR: Mm-hm. Yes, so that will be the doctor that prescribed it and wrote up to that point, wrote that prescription. I don't know whose signature that is.

DRIVER: All right, not for you. Someone else will help us with that. Next column, "given by".

TAYLOR: So all fluids, medication, will be drawn up or will be checked by two nurses. So it's been signed that I have checked it with Lucy Letby.

DRIVER: Right. Let's just focus in on that box under the heading "given by". Two different names?

TAYLOR: Two different signatures, yes.

DRIVER: Two different signatures with a diagonal line separating them. Is the top signature yours?

TAYLOR: Yes.

DRIVER: And do you recognise the bottom signature as being Lucy Letby's signature?

TAYLOR: Yes.

DRIVER: The order of the signatures, ie yours on top of Lucy Letby's, does that denote anything?

TAYLOR: No relevance, no.

DRIVER: No relevance.

TAYLOR: I mean -- no, I don't think it does, sorry.

DRIVER: Does it indicate that you signed the document before Lucy Letby signed the document?

TAYLOR: Possibly, yeah, but there's no real protocol for where we sign on this.

DRIVER: So does that or does it not inform the reader as to the role of you and Ms Letby in terms of this procedure?

TAYLOR: Sorry, could you rephrase that?

DRIVER: The fact that your signature comes before hers, can we read anything into that or not?

TAYLOR: No, I wouldn't say so, no.

DRIVER: Thank you. Next, "Time and date started". That speaks for itself.

TAYLOR: Yes. That's when we will have connected the 10% dextrose fluids to [Baby A]'s line.

DRIVER: And so from that point, at 20.05, the fluids were attached and flowing into the long line?

TAYLOR: Yes.

DRIVER: We might come back to this, but if we go back a slide, please, to slide 169. Just a couple of slides up to 169, please, Mr Murphy. Go to the chart itself, please.

We've seen that before, 19.05. On this nursing record that we've looked at, not the zoomed-in part but the general, does that record when the handover took place or when responsibility transferred?

TAYLOR: Um... It's not documented on there, no.

DRIVER: No. All right.

Come out of that then, please, and go to slide 171, please. My mistake. Let's go to 170 first.

TAYLOR: Sorry, I think -- sorry, I may have written that I've handed over the care to Lucy at 8, actually, in my notes, I apologise.

DRIVER: Would that be --

TAYLOR: I am not sure if I did.

DRIVER: Thank you. Let's go to 169, back to 169 then, please. The analyst who's summarised your note does record that there was an entry that care was handed over to Lucy Letby at 20.00 hours.

TAYLOR: Yes.

DRIVER: If we go to the document itself, is there a set place on the document where that would be recorded?

TAYLOR: I think... Um... I'm not sure if that's further on. I can't see it there. That will be -- I think I've written that in my actual nursing notes at some point. I don't know if there's some more further on.

DRIVER: Okay. Come back out of this then, please. Go to the main page. So let's look at the contents of the next tile, please. The next slide, 170. Go to the underlying document.

So we can see an entry there written in retrospect on the morning of 9 June. If your analysis of the earlier similar document is right, the administrative exercise, the noting, would have taken place between 7.56 and 8.15 in the morning?

TAYLOR: Yes. This is Lucy Letby's notes.

DRIVER: Yes:

"Written in retrospect. Care taken over at 20.00 hours. Emergency equipment checked."

Is that part of the protocol of receiving responsibility for a baby? When there's the transfer from one nurse to the next, what takes place?

TAYLOR: After we've had handover, one of the first things we will do is check the emergency equipment, which includes the Neopuff and suction, which is by the incubator.

DRIVER: Yes?

TAYLOR: We'll check all the fluids, so we will check what fluids are up and whether they're running at the right rate, make sure that all the prescriptions are correct and everything is running as it should be.

DRIVER: So the equipment is checked, fluid levels and the like checked.

If we could go, please, to J1079.

Is this your note as to when there was a transfer of responsibility to Lucy Letby?

TAYLOR: Um... Yes.

DRIVER: Is that the note that you had a recollection --

TAYLOR: Yes.

DRIVER: -- that you may after all have recorded that event?

So we know from the dextrose chart that we looked at a few minutes ago that you've signed to the effect that the flow of the fluids began at 20.05.

TAYLOR: Yes.

DRIVER: The time of the handover, are you able to assist us with regards to that?

TAYLOR: So it will have been -- the verbal handover will have been between 7.30 and 8.

DRIVER: Yes.

TAYLOR: We officially finish at 8, so that's generally when the next nurse will take over and that's what I've written in my notes, that she took over the care after my verbal handover at 8.

DRIVER: Yes. At which you told us you sat at the computer within room 1 --

TAYLOR: Yes.

DRIVER: -- that you've identified?

TAYLOR: Yes.

DRIVER: You began the process of making notes?

TAYLOR: Yes.

DRIVER: You didn't complete that process. Did you tell the jury, therefore, the note itself would not have been retained, would not have been kept?

TAYLOR: Yes. I mean, I can't remember what I wrote in it, but I remember sitting at that computer to write notes. I don't know how far I'd got, whether I had started or was mid-note, but that was the point when [Baby A] started to deteriorate and I got up.

DRIVER: Are you therefore able to assist as to how long you'd been at that computer station for?

TAYLOR: I don't know, sorry.

DRIVER: How did you know that there was a problem with [Baby A]? What alerted you to it?

TAYLOR: So that computer that I was sat at, was sitting at, there is -- so it's a bit difficult to visualise it from the video.

DRIVER: Yes.

TAYLOR: When you're sitting in front of that computer, you can see the incubator that [Baby A] was in. So I -- I have a sort of a direct line, visual line, although he's not right next to me I could see that he started to deteriorate. So his heart rate dropped and his saturations dropped and Lucy Letby was standing by the incubator.

Initially I stayed because there he was fairly stable and Lucy was there, so I sat there and then when I realised actually he wasn't recovering from the deterioration, I then got up to help Lucy.

DRIVER: What informed you of the deterioration? Was it the sound of an alarm, was it the content of the screen of the monitors or both or what?

TAYLOR: It probably will have been both. So there is a monitor above the incubator, which has the heart rate, saturation levels and respiratory rate. When they fall out of a normal range, the monitor will alarm.

DRIVER: Thank you. To go back, the handover would have taken place at the cot side?

TAYLOR: Yes.

DRIVER: At the incubator side, more accurately. Thereafter, would you have left the nursery or gone straight to the computer that you've shown us? What happened, can you remember?

TAYLOR: I can't remember.

DRIVER: You can't remember. At the time you were at the computer and you became aware of a problem coming from [Baby A]'s incubator, where was Lucy Letby?

TAYLOR: She was standing next to the incubator.

DRIVER: Are you able to say how long you'd been away from the incubator for?

TAYLOR: I don't know, sorry.

DRIVER: Are you able to say a point in time when you sat down at the computer? Was that before or after the dextrose infusion had begun down the long line?

TAYLOR: I can't say for certain, but I think it was after.

DRIVER: And how did you react? What did you do?

TAYLOR: So initially, I was just keeping an eye on his desaturations and his heart rate and I was -- I thought he was going to recover quite quickly, some premature babies do have desats and drops in the heart rate, it's not uncommon, although he had, from what I remember, hadn't really done that during the day, so it was an unusual event.

But when he didn't recover I don't know whether I got up to help or whether I was called to help. But I got up and went over and at some point Lucy Letby was giving some breaths via a Neopuff.

DRIVER: Do you recall whether there was any other members of staff in the room at that time?

TAYLOR: I don't remember.

DRIVER: Do you recall the resuscitation or attempted resuscitation process?

TAYLOR: Um... It's a bit of a blur. I remember a very vague recollection but not a detailed recollection. I know that it was lengthy and carried on and I kept thinking he was going to recover, but he didn't. I was not directly involved in the resuscitation. I was -- from what I remember, I think I was drawing up emergency drugs, such as adrenaline, for somebody to administer during that.

DRIVER: So from the best of your recollection, you played a supporting but not direct role --

TAYLOR: Yes.

DRIVER: -- in the unsuccessful attempt to resuscitate [Baby A]?

TAYLOR: Yes.

DRIVER: Do you remember which doctors were present or do you not have a clear recollection?

TAYLOR: I don't remember. I know I've written in my statement that Dr Ravi Jayaram was present --

DRIVER: Yes.

TAYLOR: -- but I don't remember. I remember Caroline Bennion, who is a nurse, was there, and Lucy Letby was there.

DRIVER: Thank you.

As I'm sure you do remember, and quite tragically, the attempts were unsuccessful?

TAYLOR: Yes.

DRIVER: But you were there throughout the attempts --

TAYLOR: Yes.

DRIVER: -- and in the immediate aftermath; is that right?

TAYLOR: Yes.

DRIVER: But soon thereafter, your shift came to an end, and I don't think this is controversial, having left the hospital the following morning you were called back to complete the formalities of signing-off some of the notes?

TAYLOR: Yes.

DRIVER: And that's because in the trauma of the moment that administrative responsibility had been overlooked; is that right?

TAYLOR: Yes.

MR DRIVER: Thank you. Could you remain there and answer any questions that are asked of you?

Cross-examination by MR MYERS

MR MYERS: My Lord, Miss Taylor, I may not complete the questions I have to ask this afternoon. I'm in your Lordship's hands. I can proceed until a suitable point to stop.

MR JUSTICE GOSS: If it means going on -- if you think you can complete by 4.30 or very close to 4.30, I'm not putting any pressure on you. But if it's obvious to you that we'd have to sit on much later -- are you able to come back tomorrow morning?

TAYLOR: Yes.

MR JUSTICE GOSS: Then choose your moment.

MR MYERS: I think that is likely, we'll see how we go.

MR JUSTICE GOSS: I'll leave it to you, Mr Myers.

MR MYERS: Thank you.

I'm going to ask you some questions, Miss Taylor, on behalf of Lucy Letby. You have told us that you made statements or the

statement in this case and you spoke to the police back in 2018; is that correct?

TAYLOR: Yes.

MYERS: So you're doing your best -- you were doing your best then to think back already about 3 or three and a half years; is that about right?

TAYLOR: Yes.

MYERS: And you were able to be assisted with notes and the records from the time to help you with your memory; is that correct?

TAYLOR: Yes.

MYERS: Do you find that even with the notes, things like that, it can still be difficult to remember all the detail of exactly what happened?

TAYLOR: Um... I mean, it is, because time has passed. However, in my statement I have said -- if I wasn't sure, I've said I'm not sure.

MYERS: Yes. That's right. So some things you remember clearly?

TAYLOR: Yes.

MYERS: And some things are more difficult to remember?

TAYLOR: Yes.

MYERS: In the time since this happened, I'm talking the years since this happened, did you continue to work at the Countess of Chester Hospital?

TAYLOR: I did. I left for about two and a half years and I have since gone back to the neonatal unit.

MYERS: Did you continue to work alongside some of the people who were working at the time we're dealing with now, the period of 2015 to 2016?

TAYLOR: Yes.

MYERS: Did people, when you were working day to day there, talk about events that had happened that we're now looking at in this trial?

TAYLOR: Yes, because they were significant events that happened, so they were discussed.

MYERS: All right. What I'm going to do if I may is go through some background issues with you, a bit like you've just done with Mr Driver, and then we'll come to the actual night and go through events that happened then and you help us with your recollection as best you can. All right?

TAYLOR: Yes.

MYERS: Thank you.

The first thing I want to ask you about is a little bit to do with the staffing. I'm not going into all the detail. I think you touched on this.

There are set nursing requirements for the staff that you require on a neonatal unit, aren't there?

TAYLOR: Yes.

MYERS: You mentioned the BAPM.

TAYLOR: Yes.

MYERS: Is that the British Association of Perinatal Medicine?

TAYLOR: I think so. We just tend to refer to it as BAPM, but yes.

MYERS: They've actually identified guidelines for what the correct staffing quotas are, haven't they?

TAYLOR: Yes.

MYERS: So, you tell me if this is right or not, for babies in intensive care it should be one nurse to one baby; is that correct?

TAYLOR: Yes.

MYERS: And that nurse should be what's called -- is that qualified in specialty?

TAYLOR: Yes.

MYERS: So intensive care trained?

TAYLOR: Yes.

MYERS: And for babies who are in high dependency that should be one nurse to two babies?

TAYLOR: Yes.

MYERS: And for babies who are in special care, so not as high as intensive care, not as high as high dependency, the next level down, one nurse can look up (sic) to four babies?

TAYLOR: Yes.

MYERS: Now, at the Countess of Chester neonatal unit, how many intensive care cots were there in nursery 1?

TAYLOR: Um... I can't remember what it was. It has changed since. I think there was two. I can't... I'm not 100% on that.

MYERS: We've seen four incubators in the picture. Does that mean it would sometimes hold up to four babies?

TAYLOR: Yes, I think it depended on, obviously, what came through from the labour ward but also our QT(?) on the rest of the unit as well.

MYERS: Does that mean that sometimes there might have been more intensive care babies in there than there was meant to be on paper?

TAYLOR: Potentially, yes.

MYERS: Yes. There was a rota, wasn't there, designed for who would be on a given shift; is that correct?

TAYLOR: Yes.

MYERS: And sometimes did the nurses only find out who would be on a particular shift sometimes within 24 hours, just 24 hours?

TAYLOR: No, we would have our shift rota out fairly early on. I don't know, maybe a month or so before. However, sometimes it could change due to sickness or, if it was busy, they may ask people to come in, you know, at short notice.

MYERS: And sometimes there might be a requirement for more nurses because of an increase in the number of babies?

TAYLOR: Yes.

MYERS: Is it right that sometimes there might be quite a short notice requirement for more band 5 nurses or band 6 nurses

because you've got more intensive care or high dependency babies?

TAYLOR: Yes. So only band 5s or band 6s could be (inaudible) intensive...

MYERS: Was it right that sometimes it was a bit of a struggle to get the right number of nurses to exactly the right number of babies given their requirements?

TAYLOR: To be honest, I couldn't really comment on that because it's -- I've... I didn't really do the rota. I wasn't involved. Sometimes if we were shift leader we would -- if we knew it was going to be busy for the next shift we would try and recruit somebody to come in as an extra person.

MYERS: [Babies A & B] were both intensive care babies, weren't they?

TAYLOR: So I'd have to double-check everything. I think at the beginning of the shift [Baby A] was a high dependency baby, but once the UVC was inserted, I believe that would have made him an intensive care baby, but not an unstable -- it was a stable care.

MYERS: It should be one band 5 looking after one intensive care baby, shouldn't it?

TAYLOR: Yes, but you know, if it changes, sometimes we had to carry on with the baby and actually in terms of his care, not much changes with the UVC being inserted. He wasn't unstable as you may expect a ventilator baby to be.

MYERS: I just want to go through this step by step and just get the figures right first before we go to how stable [Baby A] was.

It's right, isn't it, it should be one band 5 to one intensive care?

TAYLOR: One band 5 or one band 6.

MYERS: One band 5 or one band 6?

TAYLOR: Yes.

MYERS: You were dealing with one intensive care and a high dependency at the start of your shift, weren't you?

TAYLOR: I'm not sure if [Baby B] was -- was [Baby B]... I don't know what acuity they were. I'm not sure what they were, sorry.

MYERS: You've described how the handover procedure operates. You said it began with a huddle. Is that at the nursing station?

TAYLOR: No, it was in a side room, in a room.

MYERS: Is that all of the nurses gathering together at the start of the shift?

TAYLOR: No, it's just the new nurses that are coming on to the shift and the shift leader.

MYERS: The time for the evening shift that new nurses should come on is 7.30 in the evening, isn't it?

TAYLOR: Yes.

MYERS: But to be ready for 7.30, it's the case, isn't it, that sometimes people arrive a bit earlier, 7.20, 7.15, whatever's convenient for them; is that correct?

TAYLOR: Yes.

MYERS: And then who is it that gives the briefing to the huddle of new nurses, who will brief them?

TAYLOR: The shift leader from the shift that is just ending.

MYERS: Right. Pausing there, the shift leader. Who is the shift leader?

TAYLOR: It will be a band 6 nurse who has been allocated. So it's only band 6s that will take charge on the unit. And it will be -- at this time it has changed. Sometimes it was decided on the day but it did change where it was pre-allocated who the shift leader was going to be for that shift.

MYERS: Would the shift leader also be allocated a baby or babies?

TAYLOR: Um... Possibly, yes. In an ideal world, they would be supernumerary, but I think at this point they weren't considered supernumerary, so they would have possibly had a baby, yes.

MYERS: So you say in an ideal world they would be supernumerary. You mean in an ideal world, they would be free to apply themselves to whatever happened as a shift leader, wouldn't they?

TAYLOR: Yes and that did come in, but I think that was after -- I think that might have been at a later time they

became supernumerary. But they would always have a lighter workload.

MYERS: How long would the general huddle take, the initial briefing?

TAYLOR: Probably anywhere from 10, 15 minutes.

MYERS: Were the nurses who came on -- as well as being given, in talking to the shift leader, an account of what was happening, were they given anything else, any record of who was on, the babies, or who was in which room and what the babies were?

TAYLOR: Sorry, could you just repeat that question?

MYERS: In addition to the oral handover, were they given anything else, any documentation to assist them with who was on the unit, which babies?

TAYLOR: We have a paper handover with the list of babies that are on and a simple just outline of what care they have.

MYERS: So is that given a name --

TAYLOR: Just a handover sheet.

MYERS: A handover sheet.

TAYLOR: Mm-hm.

MYERS: All right. Is each nurse who comes on given a handover sheet?

TAYLOR: Yes.

MYERS: When are they given that, Miss Taylor?

TAYLOR: At the beginning of the shift.

MYERS: Is it given to them by the shift leader or do they just pick it up?

TAYLOR: It's -- usually the shift leader will take them into the room where we will have the huddle and then it's handed out.

MYERS: Can the nurse then keep that with him or her during the course of the shift that they're working?

TAYLOR: Yes (inaudible) shift.

MYERS: And do they tend to do that?

TAYLOR: Yes.

MYERS: Just stick it in your scrubs?

TAYLOR: Yes, pop it in their pocket, yes.

MYERS: Once the general handover has happened, the new nurse will go to the cot side for a more detailed hand over; is that correct?

TAYLOR: Yes.

MYERS: And that takes place with the nurse who's already been designated for the child or children they're going to look after; is that correct?

TAYLOR: Yes.

MYERS: How long will that take by the cot side as a rule, if there is a rule?

TAYLOR: To be honest, it can really vary -- if you've -- on how much is going on with that baby. So a more -- a baby that's got a lot of things going on and needing more care can take a lot longer than a special care baby which there's not as much to hand over.

MR JUSTICE GOSS: I think that's probably obvious, but perhaps -- were you asking roughly in time how long it would take?

MR MYERS: Yes.

TAYLOR: Sorry. To be honest, there isn't really a time because I mean some people will talk a lot more than others, some will have more questions, some will -- there isn't really a time. I mean, generally we will be done by 8.

MR MYERS: And your recollection is when Lucy Letby came on to this shift -- maybe tomorrow we'll look at the timings in a little more detail, but your recollection is the handover with Ms Letby took up to or around about 8 o'clock?

TAYLOR: I don't remember what time we finished.

MYERS: We'll have a look at the records with that.

I just want to ask you a few more questions about the duties for the nurse who's designated to look after a baby. That's what I'm going to ask you next.

As a general rule, the nurse who is looking after a particular baby will be the person that does the cares and the observations; is that correct?

TAYLOR: Yes, although it may be that other members of staff, if that nurse is busy, will be asked to or will offer to help and may do observations (inaudible: coughing).

MYERS: That's what I wanted to ask you: although you have a designated baby, you will still work together with people, so that if a nurse has to leave a baby for some reason, take a break or deal with another baby, one of her colleagues or his colleagues can step in and do whatever's required?

TAYLOR: Yes.

MYERS: And there are some tasks where you need to have two nurses present to deal with them, aren't there?

TAYLOR: Yes.

MYERS: For instance, giving medication or checking medication requires two nurses, doesn't it?

TAYLOR: Yes. We always have two -- we'll always check two -- and the name bands and we will -- two nurses will go up to the baby to check that it is the correct baby that we are giving medication to.

MYERS: And if a nurse has filled in for another nurse, maybe she's taken a break or been called to another child, will the nurse who is standing in fill in whatever sheet or documentation it is that applies for that time?

TAYLOR: Yes.

MYERS: So I'm going to ask if we could look at J1121. It's on the timeline, ladies and gentlemen, at slide 56. We can use either J numbers or slides. Let's see if we get to the right one. 1121.

I wonder if we can just expand that a little bit, Mr Murphy. This is just by way of an example. If we scroll down a little bit. I'm looking down at the line for 4 o'clock or thereabouts, 0400, that section. The 0400 above that section, please, Mr Murphy.

Thank you.

If we just look at this, this is a chart that applies to [Baby A] later on when you were involved, Miss Taylor. But at this time, we can see AH -- is that AH? Is that one of your colleagues?

TAYLOR: Yes, I believe that's Ashleigh Hudson.

MYERS: Ashleigh Hudson. We can see Ashleigh Hudson having completed that at 03.00 or thereabouts. And Ashleigh Hudson has done the hourly check at 05.00 from what you can see. Is there someone different who's stepped in for whatever reason and dealt with it at 04.00?

TAYLOR: Yes, that looks like Caroline Bennion.

MYERS: Is that an example of how, for instance, one nurse might, for whatever reason, step in and deal with cares or observations on a baby for another nurse?

TAYLOR: Yes.

MYERS: And fill it in on the chart?

TAYLOR: Yes.

MYERS: There's nothing unusual about that whatsoever, is there?

TAYLOR: No.

MYERS: Thank you. We can take that down, please, Mr Murphy.

I'm going to ask if we can just have a look at a map that we've been given of nursery 1. You might have it there, Miss Taylor. Ladies and gentlemen, you have it and your Lordship does. It should be behind divider 4 in that bundle in front of you.

We can see nursery 1 marked in the centre; is that correct?

TAYLOR: Yes.

MYERS: Can you see the one on the green plan?

TAYLOR: Yes.

MYERS: There we are, thank you, Mr Murphy.

Perhaps, just to help, so we can refer to this, when we look in there it's got four incubators marked, hasn't it?

TAYLOR: Yes.

MYERS: And you referred to them as incubators 1, 2, 3 and 4?

TAYLOR: Yes.

MYERS: Are those actually set numbers for those incubators, if you see what I mean? Or is that just how you call them?

TAYLOR: No, that's just how I was -- yes.

MYERS: Was there any way of referring to which incubator was which so a nurse would know who they were talking about?

TAYLOR: Um... Not that I can remember.

MYERS: Right. In any event, when you described the position that you were in and the computer and looking across, the incubator [Baby A] was in is the one we can see on the right-hand side on its own, below 5.5 metres? Is that correct?

TAYLOR: No, that was, I think, [Baby B].

MYERS: That's [Baby B]. And [Baby A] is, sorry, to the right of where it says 8.6 metres?

TAYLOR: Yes.

MYERS: Thank you. Can you see actually, if you stay there for a moment, above the top wall of the nursery, can you see it says "window blocked by film"?

TAYLOR: Yes.

MYERS: We saw this on the video. I just wonder whether we could just put up -- we call it D1, which is some photographs that come from exhibits. I'm going to ask you about that.

Pausing there. We've got the map in front of us. We've got the photograph. Is that the view? If we look at the map, the plan, above where it says "neonatal unit" there's a door. At the N of neonatal, can you see the door?

TAYLOR: Yes.

MYERS: Can everybody see that, ladies and gentlemen, in front of you on the plans?

(Pause)

That's the view standing at the door of the N of neonatal looking straight into that room, isn't it?

TAYLOR: Yes.

MYERS: So in fact opposite there, although it says "windows blocked by film", there was a kind of cartoon picture that went halfway up the window with those figures on it; is that correct?

TAYLOR: Yes.

MYERS: On the other side of that window we can see from the plan there's a corridor that runs behind it?

TAYLOR: Yes.

MYERS: Can we just look at the next photograph, please, so we can see just how far along that goes. There we are. Just to help with that.

The computer that you were telling us about is just to the right of where we've got the numbers J133, isn't it?

TAYLOR: Yes.

MYERS: When you were working at that computer filling in notes would you be standing or sitting?

TAYLOR: Sitting.

MYERS: Sitting.

We can take that down, thank you, Mr Murphy.

In fact, since the time of these photographs, the Countess of Chester neonatal unit has relocated to a different part of the hospital, hasn't it?

TAYLOR: Yes.

MYERS: It's a much bigger unit now, isn't it?

TAYLOR: Yes.

MYERS: Much larger rooms and more modern equipment.

TAYLOR: Um... Some of the equipment is more modern, some of it is the same.

MR MYERS: Thank you.

My Lord, I'm going to turn to the shift and details relating to that. I wonder whether this might be a suitable point to stop.

MR JUSTICE GOSS: Yes, certainly.

MR MYERS: Thank you, Miss Taylor.

MR JUSTICE GOSS: 10.30 tomorrow then, please, ladies and gentlemen. Remember your obligations: no communication with anyone other than a fellow juror when you're all together and no research about anyone or anything to do with this case. Thank you very much.

(In the absence of the jury)

I'm going to say this in the presence of the defendant and the witness because it's just something that I wanted to clear up.

We've seen the walk-through, we haven't actually got an identified date for when that walk through took place, but it's been shown to the witness and the jury and now we've seen some still photographs. They aren't exactly the same, I don't think. Were the stills taken from the video?

MR MYERS: Maybe not from the one we've just seen, but, as I understand it, they're contemporaneous with the earlier material we've seen. They come from the exhibits. We can confirm the date, but they're provided by the prosecution.

MR JUSTICE GOSS: I know. Unless it's me getting things wrong, there are just slightly small differences.

MR MYERS: Right.

MR JUSTICE GOSS: And the plan itself is not a wholly accurate plan in relation to the depiction of where the incubators were in relation to the wall. These are all very small points.

MR MYERS: Yes.

MR JUSTICE GOSS: But it's just a bit difficult when we're dealing with events that we know took place a long time ago and things will have changed round. Witnesses will all have the difficulty of remembering exactly how it was at the particular time. I just don't want anyone to be misled. It's just that if the jury see something and they pick these things up, they may raise them. So if we could just have a little more clarity, if possible, as to when these items that we've seen were actually taken, it would help everyone.

MR MYERS: I'm sure we can do that, my Lord. They all come from the prosecution. There's a record of all of them so we can make sure everybody knows and then there's no confusion about what was where.

MR JUSTICE GOSS: I don't want any confusion to be caused, I want to avoid that from everyone's point of view.

MR MYERS: Yes. Indeed that applies to all of the ones we've seen so far and it is something we need to do so people can keep track of it.

MR JUSTICE GOSS: Yes, exactly. Thank you very much.

You just stay there, please.

I'm going to ask that the defendant goes down and the public gallery to be cleared, please.

Can you be ready, please, to continue at 10.30 tomorrow morning? Thank you very much. And don't talk to anyone about your evidence or this case until it is all over. All right? Anyone who is or may be going to be a witness -- but just don't talk to anyone about it, certainly so far as your evidence is concerned, don't talk to anyone overnight about your evidence. Thank you very much.

Right. The usher will now take you. There's no one here apart from the barristers that you've seen.

THE WITNESS: Thank you.

MR JUSTICE GOSS: Thank you.

(4.23 pm)

(The court adjourned until 10.30 am on Thursday, 20 October 2022)