

27 October 2022 (Day 17)

Baby C

CONTENTS

Housekeeping

MRS KATE TYNDALL (continued)

Examination-in-chief by MR JOHNSON (continued)

MRS CLAIRE HOCKNELL (recalled)

Examination-in-chief by MR JOHNSON

DR SALLY OGDEN (sworn)

Examination-in-chief by MR DRIVER

Cross-examination by MR MYERS

DR GAIL BEECH (sworn)

Examination-in-chief by MR DRIVER

Cross-examination by MR MYERS

Re-examination by MR DRIVER

MS YVONNE GRIFFITHS (sworn)

Examination-in-chief by MR DRIVER

Cross-examination by MR MYERS

Re-examination by MR DRIVER

Thursday, 27 October 2022

(10.30 am)

(In the absence of the jury)

Housekeeping

MR MYERS: May it please you, my Lord.

MR JUSTICE GOSS: Yes.

MR MYERS: We're due to start with the evidence shortly. I would just be grateful if I could raise one matter just to state our position on one part of the arrangements that arises.

MR JUSTICE GOSS: Yes.

MR MYERS: It has been brought to our attention that the two prosecution experts, certainly Dr Bohin, and as I understand it, Dr Evans, are keen to be in court, in this court, during proceedings from this point.

That comes principally as a request from Dr Bohin after giving evidence. Up until this point they've been in the alternative courtroom, which of course has provided acceptable facilities.

MR JUSTICE GOSS: Yes.

MR MYERS: I recognise it's certainly not a matter for the defence, in the absence of any very specific reason, to seek to say who should or shouldn't be in court, so we don't put it as high as that. We simply observe at this point, with our view of the case, that it isn't the optimal arrangement that we would -- from our view. It's something that we do not find attractive. We know it isn't our decision, but it's important I say this given what we have seen and what we anticipate.

We do not regard it as attractive and we question how appropriate it is in a case where they are in the position they are in and will return multiple times to give evidence. However, it's a matter for the court. It's not something we can object to any more firmly than that, but we raise our unhappiness and concerns with that arrangement.

MR JUSTICE GOSS: Thank you, yes. Conventionally, of course, experts sit behind counsel.

MR MYERS: Yes.

MR JUSTICE GOSS: But that can't be done at this stage. The original arrangements were, given this was a small court, that family members of those involved in this case would be accommodated in the courtroom and they are. Family members, children, one side, and the defendant the other. I'll hear what Mr Johnson says.

MR JOHNSON: Well --

MR JUSTICE GOSS: I can state my position: it's all or nothing, Mr Johnson.

MR JOHNSON: I made that absolutely clear. I spoke --

MR JUSTICE GOSS: All or none.

MR JOHNSON: -- to Mr Worthington -- after I had sent the message, I spoke to him face-to-face and made it clear that was the position: unless all could be accommodated I accepted that none could be accommodated. One can't have preferential treatment for one side or the other, so there's no dispute about that, my Lord.

MR JUSTICE GOSS: No -- sorry.

MR MYERS: I should just say, our concern wasn't all or one in the sense that we know Dr Hall is quite content with the arrangements in the other court, he's able to work there, listen to the evidence and probably is the more comfortable. So we don't anticipate we would seek to bring him into court and we don't raise any question because of any apparent imbalance in that; that's his choice. It's just in the circumstances of this case, we question the need for it and why it happens. But as I've made plain, my Lord, at this stage it's not anything that we will take further than that, but we do identify our concerns and it's an area we haven't finished with yet.

MR JUSTICE GOSS: Mr Johnson, why is it particularly desired? Because if I was in that situation I would rather have a desk where I could put my laptop on and take notes or write or whatever it is rather than sitting in a chair that --

MR JOHNSON: I think the perception is that it's better to see things in the flesh than via a screen. I think it's as simple as that.

MR JUSTICE GOSS: Well, they see everything that we see and hear everything that we hear. Let's not spend time on it now. For the moment I am not going to accommodate this request. One factor is that the jury sit there and they sit there.

MR JOHNSON: Yes.

MR JUSTICE GOSS: And they may not, consciously or sub-consciously, react to any piece of evidence, but it just adds a risk that doesn't need to be added.

MR JOHNSON: Understood.

MR MYERS: Thank you, my Lord.

MR JUSTICE GOSS: Also, there may be other -- that may fill up there --

MR JOHNSON: Oh, undoubtedly it will from time to time.

(In the presence of the jury)

MRS KATE TYNDALL (continued)

Examination-in-chief by MR JOHNSON (continued)

MR JUSTICE GOSS: Two short matters. Firstly, I gather you would like to have a mid-afternoon break. Sorry, I'd received a message, maybe it was earlier, that you didn't need a mid-

afternoon break. That's why we didn't have a mid-afternoon break. So we will have a mid-afternoon break. If anyone is not able to concentrate or feels unwell at any stage, please just raise a hand and we'll break off at that point. We'll have the mid-morning break as usual and we'll have a mid-afternoon break.

MR JOHNSON: Mrs Tyndall, we'd got to tile 287 -- sorry, 227, I beg your pardon.

We can see recorded there [Baby C]'s time of death at 5.58 on the morning of 14 June 2015.

TYNDALL: Yes.

JOHNSON: Thank you. If we move on in the sequence, we have clinical notes written by Dr Davis at the same time --

TYNDALL: Yes.

JOHNSON: -- or 2 minutes later, I should say. And nursing notes written by the designated nurse, Melanie Taylor, relating to [Baby C]'s death --

TYNDALL: Yes.

JOHNSON: -- at 8.14 that morning.

TYNDALL: Yes.

JOHNSON: Those notes. There are some other notes just after that in the sequence. And yet more notes written by Yvonne Griffiths much later in the day at 17.27 --

TYNDALL: Yes.

JOHNSON: -- obviously, relating to events that fall within the sequence that these tiles appear on the screen?

TYNDALL: Yes, that's correct.

JOHNSON: Thank you. We have some further notes of Melanie Taylor and then another addendum from Nurse Taylor?

TYNDALL: Yes.

JOHNSON: Followed by nursing notes written by Sophie Ellis at 8.46?

TYNDALL: Yes.

JOHNSON: An addendum to those notes written by Nurse Ellis at 9.11?

TYNDALL: Yes.

JOHNSON: Then we come back to messages that were being exchanged between Lucy Letby and Jennifer Jones-Key via WhatsApp.

TYNDALL: Yes.

JOHNSON: Could you take us through those messages, please.

TYNDALL: At 7.38 on the 14th, Lucy Letby messages Jennifer Jones-Key saying:

"Sorry if I was off. Just wasn't a great start to shift but sadly it got worse x"

JOHNSON: Thank you.

TYNDALL: Jennifer Jones-Key replies at 8.42:

"You weren't off, you just weren't happy and there's nothing I could say that was going to make it any better. To be fair, didn't have the energy neither. I'm wiped after them 2 days. I don't mean you but sometimes I don't think people realise how hard it is in 4 with all the babies and parents, et cetera. My mind gone lol. Hope you're feeling slightly better and get some sleep x"

JOHNSON: Thank you. That's 8.42. The next message from Lucy Letby?

TYNDALL: At 8.48 she replies with:

"I was struggling to accept what happened to [Baby A]. Now we've lost [Baby C] overnight and it's all a bit much x"

At 8.53 Jennifer Jones-Key replies:

"It will be but it does happen to these babies, unfortunately. Maybe [you'll] feel better when you know what happened to [Baby A]. Was [Baby C] in 1? I'm all confused. It's a very sad part of our job and I think cause we don't see it as much it's harder. We lost a baby in N4 and I beat myself up over it but it was overwhelming sepsis and nothing would have saved they (sic) baby."

Lucy Letby replies at 8.57:

"[Baby C] is the little 800g baby. Went off very suddenly. Sophie was looking after him. I know it happens but it's still so sad and cruel isn't it x"

Jennifer Jones-Key replies at 09.00:

"Yeah, was around when he delivered. Sophie helped [redacted] with him. It is and it's horrible and you have to be strong though as especially he's parents need you to be. That's wasn't a good combination on last night neither then. How was [Nurse B]? And probably Sophie first? Was Yvonne G okay? She had a lot to do with him [as read]."

JOHNSON: Thank you.

TYNDALL: Lucy Letby replies at 09.07:

"Sophie devastated. She couldn't stay in the room during resus but did very well. [Nurse B] was fine actually but think it'll hit her once home. Parents didn't stay long. Caroline B cried when came on today. Jo been told by phone and upset. Yvonne has taken over paperwork etc today for him x"

Jennifer Jones-Key replies at 09.11:

"Glad she did okay. Don't mean this rudely, it might do [Nurse B] some good. Yeah, bet Jo gutted as he had a good day but they always do. This is where we have to pull together and look after each other. You need to try and switch off and get some sleep x"

Lucy Letby replies at 9.13:

"We worked really well and Mel was great. Think we all supported each other brilliantly, just such a shock especially after Mon. [Nurse B] went out bright and breezy, only one who didn't cry, but think it was just an act. I'll try. Just leaving now x"

Jennifer Jones-Key replies at 09.14:

"Yeah, that's what you'll need. I think it was just a front from [Nurse B] and maybe she felt she had to as was in charge and not appropriate. Switch off for a bit."

Jennifer Jones-Key continues with another message at 09.15:

"I feel sorry for Yvonne to all the crap only ever happens when Eirian away and she won't appreciate how hard we've all worked this week [as read]."

Lucy Letby replies at 09.22:

"It's been horrible for all involved and would be when Eirian away. Anyway, it's happened and have to carry on x"

At 09.25 Lucy Letby messages Susan Letby --

JOHNSON: Is that her mother?

TYNDALL: Yes:

"We lost a little one overnight. Very unexpected and sad xxx"

Susan Letby replies at 09.27:

"Ahh sorry to hear that xxx"

Jennifer Jones-Key replies to Lucy Letby at 09.30:

"It has been for you guys but does affect us guys too and the parents in 3 and 4. Okay x"

Lucy Letby replies to Jennifer Jones-Key at 09.38:

"It affects everyone xxx"

Jennifer Jones-Key replies at 09.39:

"Defo. Hoping you're going to be okay. This isn't like you, sending you biggest hugs xx"

Lucy replies to Susan Letby at 09.40:

"He only weighed 800g. Sophie, the new girl, was looking after him. She's devastated."

And there's a bit that's not relevant to this:

"Hope you have a good day xxx"

Lucy Letby replies to Jennifer Jones-Key at 09.41:

"I think it's harder to deal with here than at Women's. I just keep seeing them both. No one should have to see and do the things we do. It's heartbreaking but it's not about me. We learn to deal with it. Thank you xxx"

Susan Letby replies to Lucy Letby at 09.42:

"Ah, so sad. Try and have a peeps. We are so proud of you. Love you xxx Just on our way x."

Lucy Letby replies at 09.43:

"Love you xxx"

Jennifer Jones-Key replies to Lucy Letby at 09.43:

"It is horrible and heartbreaking and I don't think them babies ever leave you. I remember mine. Course it's about you [too] but also about everybody. Northern term: chin up chuck and will get through it together."

Lucy Letby replies at 09.45:

"It's not about me or anyone else. It's those poor parents who have to walk away without their baby. It's so unbelievably sad. Thanks, we will x"

Lucy Letby messages [Nurse A] at 09.45:

"When are you next in work?"

[Nurse A] replies at 09.47:

"Tuesday. You?"

Lucy Letby replies at 09.48:

"Tonight and Wed. We lost little [Baby C] overnight. Everyone devastated."

[Nurse A] replies at 09.49:

"Damn. Infection? Crap week. How's [Baby B]?"

Lucy Letby replies at 09.51:

"We don't know. Doing well on Optiflow then [collapsed]. All happened very quickly. Sophie had him and is devastated. [Nurse B] not good so Mel and I did handprint, et cetera. Such a rubbish week. [Baby B] is doing well on Optiflow. They visited [Baby A] yesterday. Mum now been discharged."

[Nurse A] replies at 09.56:

"Damn. As quick as [Baby A]? Yeah, shit week [sad face emoji]."

Jennifer Jones-Key replies to Lucy Letby at 10.01:

"I know but it does still hurt. Hope [they're] going to be okay. Try and rest x"

Lucy Letby replies to [Nurse A] at 10.05:

"Yes, pretty much. Hey carried on with resus whilst waiting for dad and priest to arrive, by then had HR of about 30. Stopped but he carried on with HR and gasping for several hours. Horrible."

At 10.06, she continues with another message that reads:

"Parents sat with him in family room and we gave morphine. Once confirmed he had died they left. Didn't want photos. Persuaded them to have hand/footprints but they just wanted to go home."

[Nurse A] replies at 10.08:

"That's so sad. Don't know what to say. Try and sleep xx."

Lucy Letby replies at 10.09:

"There are no words. It's been awful. I'll try x"

[Nurse A] replies at 10.12:

"Yes. A really tough week esp for you."

JOHNSON: Do we then come to Dr Gibbs' clinical notes, recorded at 13.30 on Sunday 14 June?

TYNDALL: Yes.

JOHNSON: Thank you. I think as a matter of -- just to put them in context, they relate to events immediately following [Baby C]'s death?

TYNDALL: Dr Gibbs' notes?

JOHNSON: Yes.

TYNDALL: It's a message about phoning the coroner's office.

JOHNSON: Right, okay. Let's just go to that to have a look. At the top is events immediately following [Baby C]'s death, isn't it?

TYNDALL: Yes, written by a different doctor.

JOHNSON: That's a different doctor, I beg your pardon. So at the bottom of the page therefore. So yes, you're quite right, it's Dr Davis and then Dr Gibbs, as you have said, and it relates to phoning the coroner's officer at 13.30.

TYNDALL: Yes.

JOHNSON: Thank you. Just going back to the sequence then. What's the next item in the sequence, please?

TYNDALL: At 15.25, Lucy Letby performs a Facebook search on [Parents of Baby C].

JOHNSON: Is that how [Surname of Baby C] was spelt in the search?

TYNDALL: Yes.

JOHNSON: So although their names actually are spelt in the more conventional way, [Surname of Baby C], those are the search terms that were entered?

TYNDALL: Yes.

JOHNSON: Do we then have a update from Yvonne Griffiths in the nursing notes?

TYNDALL: Yes.

JOHNSON: Then back to the messages, starting with a sequence between Lucy Letby and Sophie Ellis.

TYNDALL: Yes. At 18.31 Lucy Letby messages Sophie Ellis:

"Have you slept? xx"

Sophie Ellis replies at 18.32:

"On and off. Have you? It's only really hit me when I woke up xxx"

Lucy Letby replies at 18.34:

"I slept for a couple of hours. Got up at half 4 and went for a walk. I don't really want to go in tonight. Text when you're leaving and we can walk together x"

Sophie Ellis replies at 18.36:

"I don't particularly but we'll get each other through it. I will do [emoji] xxx"

Lucy Letby replies at 18.37:

"We are a good team and we'll get through. You did so so well. See you in a bit xxx"

Sophie Ellis replies at 18.47:

"We all did!!! So lucky to work with such an amazing and supportive team xxx"

Lucy Letby replies at 18.48 with two emojis.

JOHNSON: Thank you. Then in the sequence, another update by Melanie Taylor on the nursing notes?

TYNDALL: Yes.

JOHNSON: Followed by two addenda from Sophie Ellis on the system as well?

TYNDALL: Yes.

JOHNSON: Just to put these events into context, do we see, on 22 June at 01.30, the first [Baby D] event?

TYNDALL: Yes.

JOHNSON: Followed by the second at 3 am, the same day?

TYNDALL: Yes.

JOHNSON: And then at 3.45?

TYNDALL: Yes.

JOHNSON: And then at 4.25 that Monday morning, [Baby D]'s time of death.

TYNDALL: Yes.

JOHNSON: Thank you. Then about a week after that, 8 days after that, do we have more text messaging between Lucy Letby and [Nurse A]?

TYNDALL: Yes.

JOHNSON: Could just deal with that, please?

TYNDALL: At 21.01 Lucy Letby messages [Nurse A] saying:

"[Baby B] in 4 now."

[Nurse A] replies at 21.30:

"Yay, bless her. How are [Parents of Babies A & B]?"

Lucy Letby replies at 21.31:

"Okay I think. Getting used to the idea that she's not monitored and nearly ready for home."

[Nurse A] replies at 21.45:

"Fab. She's never so much as hinted at misbehaving again."

Lucy Letby replies at 21.45:

"Thank goodness."

And [Nurse A] replies at 21.49:

"Yeah. There's something odd about that night and the other 3 that went so suddenly."

Lucy Letby replies at 21.49:

"What do you mean?"

Followed by another message at 21.51:

"Odd we lost 3 and in different circumstances?"

[Nurse A] replies at 21.57:

"I dunno. Were they that different?"

Then another message at 21.58 with:

"Ignore me, I'm speculating."

Lucy Letby replies at 21.59:

"Well [Baby C] was tiny, obviously compromised in utero, [Baby D] septic. It's [Baby A] I can't get my head round."

JOHNSON: In this context [Baby D] is assumed to be [Baby D]; is that right?

TYNDALL: Yes. [Nurse A] replies at 22.04:

"Was she definitely septic? Did the PM confirm?"

Lucy Letby replies at 22.05:

"I don't think the full PM is back yet. Debrief is next week but I'm away."

[Nurse A] replies at 22.07:

"When's [Baby A]'s? They were talking of doing a joint one for all 3 as all close together and similar in being full arrests in babies that were essentially stable. Dunno if they are doing though."

Lucy Letby replies at 22.08:

"Ah, not sure but [Baby C]'s is Thursday and [Baby D] next week."

At 22.08 follows another message from Lucy Letby:

"No mention of [Baby A]."

[Nurse A] replies at 22.12:

"I'd like to go to [Baby D] and [Baby A]'s."

Lucy Letby replies at 22.13:

"Speak to Eirian. I think [Baby D]'s is 6th."

[Nurse A] replies at 22.17:

"Ah okay, we'll see. Don't really want to contact work this week."

Lucy Letby replies at 22.17:

"No, don't blame you. I can't wait till Fri and some time off. Enjoy the rest of yours."

JOHNSON: We then come to some more notes made by Dr Gibbs.

TYNDALL: Yes.

JOHNSON: And does this relate to the debrief?

TYNDALL: Yes.

JOHNSON: Let's just go behind this because it's relevant to the text we've just been reading. Does it record the fact that Lucy Letby was present at the debrief?

TYNDALL: Yes.

JOHNSON: Thank you. We can go back to events, please.

There's then notes relating to an SUDIC strategy meeting, which we'll leave for Dr Gibbs. Do we then return to messaging and of course we've moved on quite a distance in time now from [Baby C]'s death --

TYNDALL: Yes.

JOHNSON: -- to 21 August 2015?

TYNDALL: Yes.

JOHNSON: Does it start with a message from Lucy Letby to Sophie Ellis?

TYNDALL: Yes. At 20.44 Lucy Letby sends a message to Sophie Ellis saying:

"Hey, wanted to let you know. Little [Baby C]'s parents had a meeting with Dr Gibbs today. He came to me [to] say they wanted him to pass on how grateful they were for all that was done for him. Mum had asked how you were as she could see you were upset and wanted you to know they have nothing but thanks for you and everyone involved xx"

JOHNSON: Thank you.

TYNDALL: Sophie Ellis replies at 20.49:

"Hey! Aw bless, thank you for letting me know. I was hoping she maybe wouldn't have noticed. Hopefully they can find some sort of closure now xxxx."

Lucy Letby replies at 20.52:

"[Redacted]. Nothing came back on PM other than RDS but Dr Gibbs said they seem okay and are coping. We've got 18 babies, unit closed. Almost did exchange transfusion. May still need one overnight! xx"

JOHNSON: Thank you?

TYNDALL: Sophie Ellis replies at 20.56:

"I hope so, aww okay, that's good to her. Oh no, is everywhere else closed? Isn't an exchange transfusion usually level 3? xxx"

Lucy Letby replies at 21.02:

"We've admitted 2 TC babies and 2 from ward already on ABX. Exchange baby on CPAP. Used to be done in regional units but now done in level 2+ so long as got the equipment, which we have.

But very (sic) people have actually done them. Fairly rare now as usually managed well in utero. It's a 3-person job. Still above exchange line on quad photo but coming down so hoping it won't need one. We've given blood and immunoglobulin xx"

Sophie Ellis replies at 21.10:

"Oh jeez sounds manic. Oh okay. Fingers crossed you won't have to do it then. I am guessing we're pretty busy for a level 2 unit ha ha xxx"

JOHNSON: I think that's the conclusion of the timeline. I just want to deal with a few of the tiles that we skipped over in passing, all right, yesterday afternoon because there are a few notes that are made by people who are not being called as witnesses --

TYNDALL: Okay.

JOHNSON: -- just so that they are dealt with in evidence. Can we start with a series of four notes made by Christopher Booth between tiles 11 to 14, please. We're going back to 11 first.

Just to put this in context, [Baby C] died in the early hours of 14 June. These are notes that were made on 10 June.

TYNDALL: Yes.

JOHNSON: So several days before events that led to his death. Can we start with going behind tile 11, please. Have you there reproduced everything that relates to this time in the nursing notes?

TYNDALL: Yes.

JOHNSON: Could you read that into the record for us, please?

TYNDALL: "Blood gas alkalotic therefore ventilation reduced at 17.00 and extubated at 18.00. CPAP commenced at 5 to 6 centimetres H2O in approx 35% oxygen. [Baby C] tolerating CPAP well. Respiratory rate 60 to 80BPM with moderate recession."

JOHNSON: Thank you. Then the next tile, please. This is a communication with [Baby C]'s dad; is that right?

TYNDALL: Yes.

JOHNSON: Has Christopher Booth, Nurse Booth, simply recorded:

"Spoke with dad re need for admission, proposed management of [Baby C] on the NNU."

TYNDALL: Yes.

JOHNSON: Thank you. And tile 13, please. Could you take us through this one?

TYNDALL: Yes. So:

"Delivered at 15.31 by elective section for IUGR/reverse EDF. Birth weight 800g.

"Born in good condition. Transferred to NNU and displaying signs of increased WOB."

JOHNSON: Is that work of breathing?

TYNDALL: Yes:

"Intubated by paediatric registrar and Curosurf administered. Initial blood sugar 1.0mmol/l, 3ml/kg, 10% dextrose given as prescribed. Repeat blood sugar 4.2. UVC sited by Dr Brunswick. Found to be too high and pulled back by 2.5 centimetres. Awaiting repeat X-ray to confirm position. Blood gas alkalotic, therefore ventilation reduced at 17.00 and extubated at 18.00. CPAP commenced at 5 to 6 centimetres H2O in approximately 35% oxygen. [Baby C] tolerating CPAP well. Respiratory rate 60 to 80bpm with moderate recession. Initial axilla temperature on admission 35.9 degrees C. Now approximately 36.6 degrees C."

JOHNSON: Thank you. Then finally for Nurse Booth's notes, the very next tile, tile 14. So still on 10 June. Does that record the fact that [Baby C]'s father had seen [Baby C] in theatre and on the unit?

TYNDALL: Yes.

JOHNSON: And had been updated on his current management?

TYNDALL: Yes.

JOHNSON: Thank you very much.

There are two tiles for Dr Chowdhury which are tiles 6 and 10. These also date to very early on in [Baby C]'s life. The first are some -- his observations on being admitted to the neonatal unit, his temperature, heart rate, respiratory rate, sats, something to do with oxygen, and something recorded as BM. Do you know what BM is in this context?

TYNDALL: I think it's the blood sugar.

JOHNSON: That would fit with what Nurse Booth --

TYNDALL: Yes.

JOHNSON: -- that measurement, wouldn't it?

TYNDALL: Yes.

JOHNSON: Thank you. Then tile 10, please. Is this:

"Discussion with Dr Brunton"?

TYNDALL: Yes.

JOHNSON: "As needed intubation. Send blood culture."

And then the type of things they're looking for. It refers in shorthand to starting [Baby C] on antibiotics.

TYNDALL: Yes.

JOHNSON: Thank you. Dr MacCarrick next at tile 31. If we could click on that, please. This relates to some tests and observations as interpreted by Dr MacCarrick, which no doubt will be referred to by witnesses as we go through the live evidence.

TYNDALL: Yes, it's just Dr MacCarrick is the name of the doctor on the order form --

JOHNSON: Yes.

TYNDALL: -- rather than knowing whether she's...

JOHNSON: I see. So is the system this: that when samples are sent for analysis to the pathology lab, they have to go under the name of a doctor? Is that it or...?

TYNDALL: I don't know specifically, but I know that from looking through the notes sometimes a doctor's name is on there, sometimes a nurse's name, but a name is filled out in that "order doctor" field.

JOHNSON: Yes, and we see that recorded by you in the summary right at the bottom of that page don't we, "Order: Dr Theresa MacCarrick"?

TYNDALL: Yes.

JOHNSON: Her name appears?

TYNDALL: Yes.

JOHNSON: No doubt they'll be referred to if thought relevant to any opinion. So that's Dr MacCarrick.

Finally, Ailsa Simpson who's one of the nurses, tiles 117, 118, 119.

These relate to observations that are taken of [Baby C] at 18.00 hours, so towards the end of the day shift before the night shift on which [Baby C] died.

TYNDALL: Yes.

JOHNSON: And they, as we have seen many times now, are incorporated into that general table and will be no doubt referred to in that context by other witnesses?

TYNDALL: Yes.

JOHNSON: Thank you very much.

I think that concludes the sequence of events. I don't know whether there are any questions -- no, I believe not. Thank you very much.

Is Mrs Hocknell dealing with the neonatal review on this one?

TYNDALL: Yes.

MR JOHNSON: Thank you.

MR JUSTICE GOSS: Thank you very much.

(The witness withdrew)

MR JOHNSON: Could I call Claire Hocknell, please?

My Lord, we've got the printed versions of the neonatal reviews now for the jury. It's a bit of a weightlifting exercise for somebody, this, I'm afraid, so probably best done in phases.

MRS CLAIRE HOCKNELL (recalled)

Examination-in-chief by MR JOHNSON

MR JOHNSON: If I could explain, my Lord. We can't get dividers that fit into these files and so within the little plastic pocket there, there is a little wallet of stick-on dividers or markers. Because they're sticky, they're actually stuck

behind -- into the pocket, so good luck in getting them out.
Well done.

If you want to divide between the cases, you can just put one of these and write the name on or a number just to give you a way of easy reference.

Mrs Hocknell, I think we've dealt already with [Baby A] and with [Baby B]. If we go to the back of the file, we have a nine-page neonatal unit review for [Baby C]; is that right?

HOCKNELL: That's correct, yes.

JOHNSON: Thank you.

I think, for the elimination of any enquiries, this was originally compiled by one of your colleagues, Nicola Patten?

HOCKNELL: Yes, that's correct.

JOHNSON: But you have reviewed this work, you are familiar with the material that underlies it, and you are in a position if necessary to deal with any questions that arise from it?

HOCKNELL: That's correct, yes.

JOHNSON: Thank you. It's a few days ago now, but does it follow the same format as the previous reviews that related to the [Babies A & B] twins?

HOCKNELL: That's correct, yes.

JOHNSON: And so we can see on page 1 the time period covered is on the 13th at 9 pm, so an hour after the shift started?

HOCKNELL: That's correct.

JOHNSON: To 8 am, which is 2 hours and a couple of minutes after [Baby C]'s death was formally recorded?

HOCKNELL: That's correct, yes.

JOHNSON: And it includes all records where Lucy Letby's name appears during the shift where the event occurred?

HOCKNELL: That's correct, yes.

JOHNSON: And if within the time parameters, in other words 9 pm to 8 am, within that period there are no records relating to a specific baby in the unit at the time, then the closest record outside the parameters has been included for reference?

HOCKNELL: That's correct, yes.

JOHNSON: And the colour coding and the highlighting follows the same system, the same conventions?

HOCKNELL: That's correct.

JOHNSON: As have been observed in the previous neonatal reviews?

HOCKNELL: Indeed, yes.

JOHNSON: Thank you very much.

So could we go to page 2 of 9, please? Do we see there highlighted with the yellow background all the issues or records relating to [Baby C]?

HOCKNELL: That's correct, yes.

JOHNSON: And we see the familiar pattern of three separate charts on the hour every hour?

HOCKNELL: That's correct, yes.

JOHNSON: And we see that Sophie Ellis was the nurse responsible for making those records?

HOCKNELL: That's correct, yes.

JOHNSON: And we also see at lines 17, 20, 28 to 30, 37 to 41 and 45 to 46 the records that Lucy Letby made or in which she was named in the time period between the beginning of the shift and 22.21?

HOCKNELL: That's correct, yes.

JOHNSON: Thank you. Turning over to the second page, please.

MR JUSTICE GOSS: Ie page 3 of 9.

MR JOHNSON: Sorry, yes, it is. Page 3 of 9. Thank you, my Lord.

Again, the trilogy or the trio of entries for [Baby C]'s observations on the hour at 23.00 hours?

HOCKNELL: That's correct, yes.

JOHNSON: And we see the event for [Baby C] at 23.15?

HOCKNELL: That's correct, yes.

JOHNSON: Then we see, following that, there is a whole series of notes relating directly to [Baby C] from the time of his collapse through to 23.47 at the bottom of the page and then over on to page 4 of 9 to line 87?

HOCKNELL: That's correct, yes.

JOHNSON: At lines 101 and 103 we have two entries relating to Babiven, which is being given to [Baby B] and to a child, GC?

HOCKNELL: That's correct, yes.

JOHNSON: And in each of those cases, the name Lucy Letby appears together with that of Sophie Ellis, who of course was the designated nurse for [Baby C] on this shift?

HOCKNELL: That's correct, yes.

JOHNSON: We see at lines 104 to 105, 117 and 125 further entries relating to [Baby C]?

HOCKNELL: That's correct.

JOHNSON: The Lucy Letby entry at 126 relating to the child JE?

HOCKNELL: That's correct.

JOHNSON: Then over on to page 5 of 9, we can see several entries in the records of [Baby B], the child PE, the child JE, and the child GC, made by or co-signed by Lucy Letby?

HOCKNELL: That's correct, yes.

JOHNSON: Together with a single prescription for medication for [Baby C] at 2.10, line 138?

HOCKNELL: Yes.

JOHNSON: On page 6 of 9, at 4 o'clock, do we see half a dozen entries in blue relating to actions carried out by or co-signed by Lucy Letby?

HOCKNELL: From 4.40 onwards, yes, and there's one at 4 o'clock, yes.

JOHNSON: Thank you very much.

Page 7 of 9. At 4.22 at the top of the page, at lines 210 and 211, do we see e-prescriptions for the child GC --

HOCKNELL: That's correct, yes.

JOHNSON: -- where Lucy Letby, her name, appears alongside that of Melanie Taylor?

HOCKNELL: That's correct, yes.

JOHNSON: At 5 o'clock, line 223, Lucy Letby co-signing with [Nurse B] --

HOCKNELL: That's correct.

JOHNSON: -- for child MRE? Then four entries made within about a minute between lines 234 and 237 relating to medication or prescriptions concerning the child GC?

HOCKNELL: That's correct, yes.

JOHNSON: We see the time of [Baby C]'s death recorded at line 239?

HOCKNELL: That's correct, yes.

JOHNSON: And a further entry made on a chart by Lucy Letby at line 243?

HOCKNELL: That's correct, yes.

JOHNSON: Thank you. On the penultimate page, page 8 of 9, at 7 am, do we see more entries made by Lucy Letby in relation to other children, one of whom was [Baby B]?

HOCKNELL: That's correct, yes.

JOHNSON: 7.30, lines 277 and 278, further entries made by Lucy Letby on the child PE's records?

HOCKNELL: That's correct, yes.

JOHNSON: And 7.44 and 7.45, the child PE and [Baby B], Lucy Letby recorded as a user of the digital equipment in relation to a prescription?

HOCKNELL: That's correct, yes.

JOHNSON: Thank you. There is an entry for [Baby C] after his death, of course, at line 290, but that concerns the time a note was made by Melanie Taylor.

HOCKNELL: That's correct, yes.

JOHNSON: Then finally on page 9 of 9, entries made by Lucy Letby in the records of three other children?

HOCKNELL: That's correct, yes.

JOHNSON: And that would have been at the end of that night shift or thereabouts?

HOCKNELL: Yes, thereabouts, yes.

MR JOHNSON: Thank you very much. I don't know whether there are -- there are no questions for you. Thank you very much for your help.

MR JUSTICE GOSS: Thank you.

(The witness withdrew)

MR DRIVER: My Lord, the next witness to be called is a Dr Sally Ogden. I was told a minute ago she was on her way down from the waiting area.

DR SALLY OGDEN (sworn)

Examination-in-chief by MR DRIVER

MR DRIVER: Could you please state your full name to the jury?

OGDEN: Dr Sally Rebecca Ogden.

DRIVER: Dr Ogden, we understand that, as of June 2015, you were employed within the Countess of Chester Hospital?

OGDEN: Yes.

DRIVER: And could you remind us, please, as to your role within the hospital at that point in time?

OGDEN: I was a paediatric registrar, so I was an ST3 level doctor in my first registrar job.

DRIVER: Thank you. I appreciate that you're looking at me when answering my questions, but could you direct your answers to the jury?

So when did you qualify as a doctor?

OGDEN: I qualified in 2010.

DRIVER: So by the summer of 2015, you were in your third year of specialist training; is that right?

OGDEN: That's correct, yes.

DRIVER: And that would have been in a role that traditionally would have been referred to as a registrar; is that right?

OGDEN: It is, yes.

DRIVER: Thank you. And we are, with your assistance, going to look during your evidence at notes made by you during the shifts that you worked that week. So we're not going to be testing your memory as to detail, but for the benefit of everyone in the courtroom we'll be going to the notes and asking you to talk us through them essentially.

OGDEN: Yes.

DRIVER: Thank you very much. We know, we've been informed, that [Baby C] was born at 15.31 hours on 10 June 2015. It was an elective, it was a prearranged caesarean section delivery; is that right?

OGDEN: Yes.

DRIVER: And because, of course, you, the staff at the hospital, knew of the stage of the gestation, which was early, as a matter of protocol, as a matter of course, it was deemed appropriate that a clinician such as yourself would be present during the delivery; is that right?

OGDEN: Yes, that's correct, yes.

DRIVER: And there was an assumption that a baby born at that stage of the gestational period would automatically on delivery be transferred to the neonatal unit?

OGDEN: Yes.

DRIVER: Is that right?

OGDEN: It is, yes.

DRIVER: And effectively, your first role was to oversee all of that?

OGDEN: Yes.

DRIVER: Thank you very much.

I wonder whether, Mr Murphy, we could go to slide number 5, please. Just to assist you, Dr Ogden, you'll see on screen a

number of slides which, if you run your eye along the line, the bottom line within the rectangles, you can see the day of the week, the date, the time. And you will see, and I'm sure you recognise, your own name, the name of your colleague, Dr Chowdhury, and these are the headlines, as they were.

If we click on to that, Mr Murphy, you'll see behind that particular slide, which is timed at 15.31 hours, 10 June, the time and date of [Baby C]'s birth. You'll see a description a third party has summarised from your notes, and if you click on the bottom you will see where we get this information from, Dr Ogden, which are the actual notes from the Countess of Chester Hospital. So these screens follow that pattern throughout.

So could you confirm that you were present at [Baby C]'s birth?

OGDEN: Yes, I was.

DRIVER: And that you facilitated his reception into the neonatal unit?

OGDEN: Yes, I did.

DRIVER: All of which was planned and anticipated?

OGDEN: Yes.

DRIVER: Thank you.

If we could, please, I think we are still -- yes. Scroll down, please. We'll see that the pregnancy and particular features of the pregnancy are described in shorthand there.

OGDEN: Yes.

DRIVER: Is that actually your writing, is this your entry?

OGDEN: I don't think that's my writing, no.

DRIVER: You don't think so? But it contains information that would have been known to you and under the heading "Problems in pregnancy", it has been noted:

"IUGR."

Can you just educate us all, remind us all?

OGDEN: Intrauterine growth restriction.

DRIVER: In short, [Baby C] was small?

OGDEN: Yes, smaller than expected for that gestation.

DRIVER: Thank you. And "reverse EDF"?

OGDEN: "Reverse end diastolic flow." So the pattern of blood flow from the placenta to [Baby C] during the pregnancy, at times it was going back on itself.

DRIVER: In layman's terms this is problematic, this was one of the reasons, would it have been why the caesarean delivery was planned at this very early stage?

OGDEN: Yes, that can be a reason to do a planned preterm delivery.

DRIVER: Thank you. I wonder whether Mr Murphy, we could go back to the main page, please. Back to the carousel, as it were, Mr Murphy. Thank you. Sorry, click back on tile 5, Mr Murphy. My mistake.

We can see here a description of the background, his parents, the stage of gestation, the nature of the delivery, his weight at 800 grams. What, if any, particular significance would you have attached to that birth weight in the context of delivery within the Countess of Chester Hospital?

OGDEN: So that birth weight is probably small for 30 weeks, but my understanding at the time was that was a weight limit that was acceptable to be delivered at the Countess of Chester.

DRIVER: The jury have heard a little about the tier systems of hospitals and how, as it were, the Countess of Chester Hospital occupied the middle tier at this time, June 2015, and babies who had very particular needs or fell into very particular categories would preferably, all things being equal, be either delivered at or moved to a tertiary centre. In this context, I'm sure you know Arrowe Park Hospital or the Liverpool Women's Hospital.

OGDEN: Yes.

DRIVER: And it's in that regard that you describe this birth weight as acceptable, which was your word, I believe?

OGDEN: Yes. It wouldn't have been my decision at that time whether or not he would or wouldn't be born at the Countess of Chester or whether he should or shouldn't have been moved. But my understanding from the time was that that was acceptable to the people who were making the decisions.

DRIVER: Thank you. Under "Observations", towards the bottom of this screen, we see that the Apgar test scores -- the jury have heard already a little about this -- are 7 at 1 minute, 9 at 5 minutes and 9 at 10 minutes. In general terms how would you describe those scores?

OGDEN: Those scores I'd describe as being pretty good for a baby who's preterm. The scores are out of a maximum of 10. So a range between 7 and 9 would be good at those levels -- those minutes of age.

DRIVER: Thank you. I wonder whether, Mr Murphy, we could have exhibit J1910 up, please, which is another aspect of the records for [Baby C]. I think they may be underneath this tile, Mr Murphy. Thank you.

Is it possible to expand that at all? Thank you.

So these are entries made at 17.00 on 10 June 2015. They are your notes?

OGDEN: Yes.

DRIVER: And some of which we've already seen have been transposed onto the other screen that we looked at, that is to say his gestational age at the time and date of birth, his weight, those issues that you'd previously identified, his size, his IUGR, the reverse EDF.

The next entry says:

"No RF..."

Is that shorthand for risk factors?

OGDEN: It is, yes.

DRIVER: "... for sepsis."

OGDEN: Yes.

DRIVER: What was the basis of your knowledge that caused you to make that note?

OGDEN: So we have -- there are some standard risk factors that are acknowledged for raising the concern a newborn might have an infection. He didn't have any of those risk factors to make an infection a more immediate concern at the time of his birth.

DRIVER: Thank you. The next is a reiteration of the fact that this was an elective caesarean section because of the compromised growth; is that right?

OGDEN: Yes.

DRIVER: Is there any link between those two entries, the absence of risk factors for sepsis and the fact that this was an elective caesarean section delivery or are they...?

OGDEN: A spontaneous preterm delivery is a risk factor for an infection in itself so because this was planned and his mother's membranes and waters were intact, that reduced the risk of infection.

DRIVER: Thank you. Your next entry records in words that which we've seen in numbers, the Apgar score tests, that he was born in good condition, and you record:

"Delayed cord clamping..."

Is that for 2 minutes?

OGDEN: It was, yes.

DRIVER: Two minutes post-birth?

OGDEN: Yes.

DRIVER: Was there anything particular to [Baby C] about that or was that just the practice at the unit or what?

OGDEN: That's normal practice in preterm births. I can't remember specifically if we did it for every case at the Countess of Chester at that time, but it's a normal standard practice for preterm births.

DRIVER: Thank you. He came out crying. Is that good respiratory effort?

OGDEN: It is, yes.

DRIVER: Do you recall these events or are you going exclusively from your records?

OGDEN: I'm going exclusively from the notes.

DRIVER: Understood.

Next entry, does that record that there was no resuscitation needed --

OGDEN: Yes.

DRIVER: -- immediately upon delivery? He, the baby, was pink and well perfused. What is that indicative of?

OGDEN: Just that his circulation was good.

DRIVER: Thank you. Could you break down the next line for us, please?

OGDEN: I've written that his heart rate was more than 100, which is what we would expect if a baby is not requiring any resuscitation, and that his oxygen saturations at this point in time were 95% in room air.

DRIVER: What evaluation would you have made of that data?

OGDEN: So both of those things suggest that he'd been born in very good condition and didn't need any additional support at this time.

DRIVER: Thank you. You next record that he was wrapped in a plastic bag. This is just part of the protocol of transferring the baby from the mother, effectively, is that right?

OGDEN: It is, yes, it's standard for preterm births.

DRIVER: Is that a measure, in short, to keep the baby warm?

OGDEN: It is, yes.

DRIVER: Thank you very much.

Could we continue? We have, thank you.

As you've already informed us, it was part of your job to oversee or to facilitate the transfer to the neonatal unit. Is this your record of this part of the process?

OGDEN: It is, yes.

DRIVER: So he was brought there. Then you record that he -- you tell us what that records.

OGDEN: I've documented that he had grunting, tracheal tug and subcostal recessions, which are all different clinical signs that he was starting to struggle with his breathing and he was requiring more effort to breathe than he had previously.

DRIVER: Thank you for that general explanation. But could we just briefly and in layman's terms deal with each of those three features. The grunting?

OGDEN: The grunting is a noise that he'd be making when he's breathing out.

DRIVER: Yes. The tracheal tug, does it say?

OGDEN: Yes. That's a sign on his neck that you could see it sucking in, each time he took a breath, round his neck.

DRIVER: And finally the subcostal recessions?

OGDEN: You could see -- as he took a breath in, you could see an indent on his ribs.

DRIVER: I'm sure we can all picture that. Are they just clinical signs that he was working hard to breathe?

OGDEN: Yes.

DRIVER: Next entry, "Decision to intubate." Whose decision was that?

OGDEN: That would have been my decision.

DRIVER: Thank you. Is that decision because of the entries we've just read, the respiratory related entries, or for some other reason?

OGDEN: It will have been because of the comments above about the grunting, tracheal tug and the subcostal recessions, and the knowledge that if a preterm baby is struggling to breathe they need a medication called surfactant and that can only be given through a breathing tube.

DRIVER: Before we move on, those features that you observed and recorded, the grunting, the tracheal tug, the subcostal recessions, were they exceptional presentations for a baby of this gestational age or would they be something that you might expect?

OGDEN: They would be something that we often see in preterm babies. It wouldn't be exceptional. The respiratory signs can change relatively quickly after birth, so in itself it wouldn't be unusual that he needed something more at that point than he did at the time of birth.

DRIVER: Thank you. So you deemed that he ought to receive surfactant and the jury have already heard a little about this

protein. Correct me if I'm wrong, but does it avoid or work against stiffness of the lungs?

OGDEN: Yes. It helps make the lungs open and close more easily.

DRIVER: Thank you. It can only be given through a certain route, therefore intubation was required, and the size of the intubation tube would have been proportionate to the size of the baby, no doubt?

OGDEN: Yes.

DRIVER: Thank you. And you record where it was placed. Can you help us in regards to that?

OGDEN: I've documented that it was placed at 7 centimetres at the lips. We normally document the depth of the insertion of the tube at the level of the lips because that's the number you can see on the outside of the baby.

DRIVER: Because the tube has markers?

OGDEN: It does, yes. It has centimetre markers on it.

DRIVER: Thank you. The next entry records that the capnograph changed colour.

OGDEN: Yes. That's a device that you attach to the end of the tube to make sure that it's in the trachea as opposed to being malpositioned or placed in the wrong place. So it's meant to change colour if the tube is in the right place.

DRIVER: Thank you. And that change of colour informs you, the observing doctor, that?

OGDEN: That the tube is in the trachea. It detects carbon dioxide coming out of the lungs. So it's in the right place.

DRIVER: It's in the right place and he's breathing as you'd like him to be; yes?

OGDEN: Yes.

DRIVER: Thank you. The tube was secured. How?

OGDEN: I can't remember directly if -- the exact mechanisms they had at the time. There are a few different ways, but it will have been secured so it stayed at 7 centimetres at the lips and didn't move.

DRIVER: And the desired surfactant was given?

OGDEN: Yes.

DRIVER: As intended?

OGDEN: Yes.

DRIVER: Thank you. Next paragraph of notes:

"Ventilator set up."

OGDEN: Yes.

DRIVER: Describe that to us and explain the digits that follow that entry, please.

OGDEN: I've documented "20/5", so those are the pressures that we started the ventilator on, so the 20 is the highest amount of pressure that he would receive when the ventilator was breathing in for him, and the 5 is the lowest background level of pressure so that it didn't go completely to zero. "R40" means a rate of 40 so it gave 40 breaths a minute.

DRIVER: Thank you. And that combination of settings, as it were, were they exceptional or are they standard for the context?

OGDEN: No, they're standard for the context.

DRIVER: Thank you. [Baby C] was not for morphine. Can you explain that to the jury, please?

OGDEN: So when we put a baby on a ventilator, you are trying to estimate how long you think they will need ventilation for. If they're likely to need ventilation for a longer period of time or are uncomfortable on the ventilator then you may give them morphine to help with that. But if you're planning to take the breathing tube out relatively quickly, which is what I was doing, I had planned not to start morphine because that can be a respiratory depressant, so it may have made it harder to take the breathing tube out if we were planning on doing that quickly.

DRIVER: And what was it that caused you to plan to extubate quickly in relation to [Baby C]?

OGDEN: It's difficult because it's from memory and I've not documented -- but he had been relatively stable at birth, so that may have been what led to that. I can't remember anything more clearly.

DRIVER: If you can't remember, don't hesitate to say so.

MR JUSTICE GOSS: The point is that at the time, you were planning that he should only be intubated for a relatively short time on a ventilator?

OGDEN: Yes.

MR JUSTICE GOSS: So that was your medical assessment at that time?

OGDEN: Yes, at that time that was my assessment that he would be on a ventilator for a short period of time.

MR DRIVER: I'm grateful. The final entry on this page, "IV access".

OGDEN: So I've just documented that he's got a peripheral cannula inserted into his right hand to give the drugs that he needed.

DRIVER: Thank you. I wonder whether, Mr Murphy, we could come out of this page, please, and go to tile 7 of 315.

It bears your name again.

Click behind, please, Mr Murphy. Then click the page itself, the original.

We can see that this is clearly a pro forma document, Dr Ogden, the likes of which I'm sure you're well familiar with.

OGDEN: Yes.

DRIVER: If we scroll down we can see that your colleague, Dr Chowdhury, records actions taken by you?

OGDEN: Yes.

DRIVER: Was he a junior colleague?

OGDEN: He was, yes.

DRIVER: So Dr Chowdhury recording you communicating with [Baby C]'s mum and dad --

OGDEN: Yes.

DRIVER: -- where we were at at this stage?

OGDEN: Yes.

DRIVER: Thank you. We can come out of that, please, Mr Murphy, and go to the next tile, tile 8.

Now we are at 17.00 hours or thereabouts still. If we go down on to the underlying document and look at exhibit J1911. Keep scrolling down. Back up to the previous page, make sure -- yes, that's where we'd got to. The next page.

Having taken those measures and made those assessments of [Baby C] at that time, you were then looking forward, were you, to the immediate future and how he should be cared for within the unit?

OGDEN: Yes. This was my plan for the next steps that needed to be taken.

DRIVER: So this is your plans. So firstly, "gas"?

OGDEN: So that would be to take a blood gas so we can see how he's responding to the ventilator and see if there are any changes that needed to be made. And then a full blood count and a CRP, so some baseline blood tests.

DRIVER: FBC is full blood count?

OGDEN: Yes, and CRP is a test for infection.

DRIVER: Thank you.

OGDEN: Then I have put "Not for antibiotics currently". This was based on him not having any risk factors, as we mentioned before.

DRIVER: Right. So the tests for infection, were they a matter of protocol, effectively?

OGDEN: Yes.

DRIVER: Measures that -- tests would always be taken of a baby of this gestational age in this context?

OGDEN: Yes, from my memory at the time it would have been a routine test to take.

DRIVER: Rather than something triggered by a presentation?

OGDEN: Yes.

DRIVER: Thank you. Next?

OGDEN: I've written:

"90ml per kg per day of 10% dextrose."

This was the rate of fluids that we would start him on and that's a normal standard starting rate of fluids for a baby of that weight and gestation.

DRIVER: So that's what he was going to receive and does the next line tell us how he was going to receive it?

OGDEN: So the plan would be that he would need TPN because it is likely to take him a while to start full feeds or establishing up to full feeds. So it would be standard practice for babies of this prematurity and gestation to have TPN, which is total parenteral nutrition, and that needs to be given through a central line rather than the cannula that I'd put in. So the 10% dextrose can be given through a cannula but the TPN that he would need would need to be through a central line, which is what a UVC is.

DRIVER: So the cannula would have been fitted on a hand or foot?

OGDEN: Yes.

DRIVER: And the dextrose can be fed in through it effectively, but the TPN requires a different mode of entry?

OGDEN: Yes.

DRIVER: And therefore part of your plan was a recommendation or direction that [Baby C] should be fitted with a UVC through his umbilicus to enable the TPN to be fed through that?

OGDEN: Yes.

DRIVER: Thank you. Next?

OGDEN: Then I've documented:

"Discussed with Liverpool Women's Hospital due to his weight."

Because he was small for his gestation. It wouldn't be my decision whether he would stay in Chester or would be transferred out, so to have that discussion.

DRIVER: Does this go back to what you told us earlier, that there are thresholds, there are parameters, and he being as light as 800 grams, you felt the need for somebody to -- ask the question whether he should stay there or move elsewhere?

OGDEN: Yes.

DRIVER: Thank you.

OGDEN: Then I've documented "Not for morphine currently", as I discussed above, and "Parents", that they were fully updated.

MR DRIVER: Thank you.

My Lord, I'm going to continue through the next couple of shifts with this doctor.

MR JUSTICE GOSS: That's a good moment.

MR DRIVER: Thank you.

MR JUSTICE GOSS: You may or may not have been told that we do conventionally just have a short break in the middle because it's detailed stuff. So it'll be about a 10-minute break, please, and then you'll come back and continue your evidence.

OGDEN: Okay.

MR JUSTICE GOSS: Thank you very much.

Right. You know the drill, members of the jury. Thank you very much. It'll be about midday when we resume.

(11.47 am)

(A short break)

(12.00 pm)

MR DRIVER: Dr Ogden, we'd just been through your plan for [Baby C] and if we could go back to the screen, please, Mr Murphy. They were entries that you had made on his clinical notes during the course of the day.

If we scroll down, please. Sorry, scroll up. We'd got to the bottom of your note here. Keep going down the page, please, Mr Murphy.

So there's your plan and having made the plan, you conveyed it to the parents?

OGDEN: Yes.

DRIVER: And part of that plan was for discussions to be held between the Countess of Chester Hospital and the Liverpool Women's Hospital?

OGDEN: Yes.

DRIVER: You were on a day shift?

OGDEN: Yes.

DRIVER: So your shift would have come to an end at about when?

OGDEN: Probably about 5 o'clock.

DRIVER: Or thereabouts. And so responsibility for executing the plan would have transferred to the night shift, as it were; is that right?

OGDEN: It would have been one of my colleagues, so one of the registrars would have been on, on until about 8.30 at night, so they would have done the evening work.

DRIVER: A later shift?

OGDEN: Yes.

DRIVER: So if we just scroll down, in due course we'll hear agreed evidence from this doctor, Dr Brunton, but I just wanted to fasten on this element. We can see that at 18.00 hours, so 6 pm, after your shift had finished, Dr Brunton records that he D/W, discussed with, a Dr Yoxall re transfer.

OGDEN: Yes.

DRIVER: And does the name Dr Yoxall ring a bell with you or not?

OGDEN: He was a consultant at Liverpool Women's Hospital at that time.

DRIVER: So that's putting into effect that part of your plan to communicate with the tertiary centre at Liverpool Women's. We won't take you through any more of Dr Brunton's note; we'll come back to that in due course.

As I understand it, you were on duty the following day, on 11 June 2015?

OGDEN: Yes.

DRIVER: And if we go forward to tile 15, please, we're told that, and this is a general explanation, that, as one would expect, his medical records indicate that [Baby C] continued to receive treatment during the remainder of his time within the unit.

If we could please go to exhibit, Mr Murphy, J913.

You'll no doubt recognise your writing there of notes?

OGDEN: Yes, that's my writing.

DRIVER: Made at 11.00 hours on 11 June?

OGDEN: Yes.

DRIVER: You'll recall your duties generally, I'm sure, at this point, as an ST3 registrar. Would that have included participating in a morning ward round?

OGDEN: It would, yes.

DRIVER: And part of that ward round would be to consider and to note all things of relevance for each of the babies within the unit under your care?

OGDEN: Yes.

DRIVER: Which of course included [Baby C]?

OGDEN: It did.

DRIVER: And so if we look at your very detailed notes here, we can see that each of them follow a pattern. The first one, letter V, is that V for ventilation?

OGDEN: Yes, it is, yes.

DRIVER: Does that list all relevant observations and detail in relation to [Baby C]'s respiratory support?

OGDEN: It does, yes.

DRIVER: In terms of developments from the day before and the content of your notes the day before, what does this tell us in relation to [Baby C]'s treatment and care in relation to respiration and/or ventilation?

OGDEN: I've documented that he was now on CPAP, which is a different type of breathing support, so the breathing tube and the ventilator had been discontinued and he was now breathing on CPAP support, which means he was breathing for himself but with some support. The pressure at which -- the level of support he was getting was 5, which is a standard pressure for CPAP, and he was now in 41% oxygen and he'd had the one dose of surfactant I'd given the night before.

Then I've documented his blood gas, the last one he'd had done, and I've documented a pH of 7.33, which is a normal pH for a baby of that gestation. His CO₂, which is 5.3, which is also normal. A base excess of minus 5. A bicarbonate level of 20 and a lactate of 4.3. And I've written that he was active, tachypnoeic, which means he was breathing faster than a normal breathing rate, but minimal increased work of breathing. So he wasn't working as hard as he could have done.

DRIVER: Thank you. So the movement from the ventilator to CPAP, what's the direction of travel there in relation to this baby and the respiratory support given to him?

OGDEN: That was progress from being ventilated.

DRIVER: Thank you. 41% oxygen, what does that inform the clinician of?

OGDEN: So it's a sort of moderate level of oxygen for a preterm baby, but by itself wouldn't indicate that anything would or wouldn't need changing. It would need to be taken in the context of all the other factors, such as the blood gas, and how he examined.

DRIVER: Thank you. When it helps you evaluate whether anything would or would not need changing, what options were you contemplating at that point?

OGDEN: So the option, if I thought he needed more support, would be to put him back on a ventilator and to intubate him again.

DRIVER: Plainly, we can see that you deemed that wasn't necessary. What were the factors that, so far as the notes can assist you with, that drove you to that conclusion?

OGDEN: From the notes the main factor for that would be that his blood gas was normal from a respiratory perspective.

DRIVER: Thank you. Surfactant, is that just a record of the fact that he had been provided with surfactant as part of your desire and designs from the previous day?

OGDEN: Yes, you can give multiple doses of surfactant as well, so it was a record of how many doses he'd needed.

DRIVER: What about the lactate record here? It says 4.3, does it say?

OGDEN: It does, yes.

DRIVER: What, if any, significance would you have attached to that?

OGDEN: So that's a high level for the lactate. A high lactate in itself is a sign rather than a diagnosis and it needs to be reviewed in context of the whole baby and any other clinical signs. It also needs to be noted in context with what the trend of that lactate has been, which I haven't documented there, and whether that was increasing or decreasing.

DRIVER: So you say it's a sign rather than a diagnosis of?

OGDEN: So it's not a diagnosis of anything in itself. It's a sign that he -- multiple different conditions could cause your lactate to rise and it's a sign to look for those conditions.

DRIVER: Thank you. Moving down a paragraph, we have the letter F -- for fluids, is it?

OGDEN: It is, yes.

DRIVER: What have you recorded under that sub-heading?

OGDEN: I've documented that he's still on 90ml per kg per day and he's now getting TPN and he's having it via a UVC. I've documented that his blood sugars are stable, he's passing urine at 6.8ml per kg per hour, that he's not opened his bowels yet, and that the humidity had been reduced in the incubator yesterday but had now been increased again.

DRIVER: What, if anything, do those readings inform you of when taken together and in addition to the respiratory data that you've recorded?

OGDEN: So all of those findings help you work out how much fluid you think the baby should be on at that time. It's -- all of those things are very stable signs that you would expect for a preterm baby. If his urine output -- depending on how high his urine output was, that might alter how much fluid you gave him, so documenting that is important.

DRIVER: Thank you. The next paragraph. S for?

OGDEN: Sepsis. So any infection concerns. Then I've just written that he was screened yesterday, so a septic screen, so since I left someone had started him on antibiotics, so he was on benzylpenicillin and gentamicin. The CRP that had been sent off -- I think that number is a 1 next to what I've written, which is a normal low level of CPR, and that a blood culture had been sent.

DRIVER: In this context does "screened" just mean tested?

OGDEN: Yes.

DRIVER: Thank you. So the day before you understand that the test had been taken?

OGDEN: Yes.

DRIVER: The fact that he was now on those antibiotics, does that demonstrate the results from the tests had been received and taken into account or not necessarily?

OGDEN: Not necessarily. It would have been standard practice if we wanted to test for an infection to start antibiotics at the same time and wait for the results to come back rather than waiting for the results and then starting antibiotics.

DRIVER: So is that a precautionary measure?

OGDEN: Yes.

DRIVER: So the CRP, what does that -- if it is a -- 1 and it's your handwriting, you think it is -- what does that inform you of?

OGDEN: That's a low level of CRP or a normal level of CRP. Anything less than 10 we would say is normal.

DRIVER: What does CRP levels inform the doctor of?

OGDEN: So the CRP is a protein that goes up in infection. So it wasn't raised so didn't suggest that there were any signs from that blood test of an infection at that point in time.

DRIVER: So taking those all in combination and together with everything else recorded on that page, under the heading "Sepsis", was there anything to suggest the onset of sepsis in [Baby C] at this stage?

OGDEN: I don't know the exact reason the antibiotics were started, because that wasn't on my shift, so I don't know if the reason for starting the antibiotics indicated some level of infection, but the results that we have back and the fact he's having antibiotics could be sort of a standard practice for a baby of that gestation. But I didn't make the decision to start the antibiotics so I can't comment on the level of concern at that point in time.

DRIVER: Thank you.

If we could scroll down, please.

Next paragraph, M -- does that stand for metabolics?

OGDEN: Metabolic concerns, yes.

DRIVER: And the notes record that?

OGDEN: So I've written "bili", which is for bilirubin, of 91. All bilirubin measurements, which is a sign of jaundice, are documented on a separate chart to indicate if treatment is needed or not and I have documented that it was just over the treatment line.

DRIVER: So a measure of 91 is just over the treatment line?

OGDEN: For a baby of that gestation at that point in time.

DRIVER: Thank you. And crossing the treatment line, as it were, in this context, does that necessarily thereafter trigger treatment?

OGDEN: It means that phototherapy treatment would be started, yes.

DRIVER: Thank you. "CV" is cardiovascular?

OGDEN: Yes.

DRIVER: And "no concerns" speaks for itself. The next line?

OGDEN: Mean blood pressure of 36, which would be a normal mean blood pressure for a baby of his gestation.

DRIVER: L?

OGDEN: For lines, so what access, what lines he had in. He still had a peripheral cannula and a UVC.

DRIVER: Meds?

OGDEN: The medications in total that he was on, so caffeine and the dose of 5mg per kilo, benzylpenicillin, gentamicin and nystatin.

DRIVER: Taking them inn turn. Caffeine, is that something particular to [Baby C] or is that medication that would be given to all such premature babies?

OGDEN: All premature babies of his gestation would be started on caffeine.

DRIVER: Thank you. The other entries, are they a reiteration of the antibiotics that you've already described to us?

OGDEN: Yes, and nystatin, which is a prophylactic treatment for fungal infections for preterm babies, so as prophylaxis rather than treatment.

DRIVER: Can you help us with what that means?

OGDEN: To prevent him getting a fungal infection rather than treating him for one.

DRIVER: N for neurology?

OGDEN: Yes, any neurological concerns. I have written that he handled well.

DRIVER: Why would you record that the fact that he handles well? What's the significance of that to you, the clinician?

OGDEN: If a baby is very irritable or upset or distressed or if a baby's very quiet and not responding to any interaction, both of those would be worrying signs for a variety of different reasons.

DRIVER: Thank you. So not susceptible to being recorded as data, but important information to you, the clinician?

OGDEN: Yes.

DRIVER: So next we have, do we, a list of observations?

OGDEN: So examination findings.

DRIVER: Is that OE or IE?

OGDEN: O/E, so "on examination".

MR JUSTICE GOSS: Observations on examination.

OGDEN: Yes, thank you.

MR DRIVER: Thank you very much. We know he handles well.

Next?

OGDEN: I've written that he was active and that he was pink, well perfused, and his capillary refill time is 2 seconds, which is a normal capillary refill time. I have then written his heart

sounds of 1 plus 2 plus 0, which is a way of documenting normal heart sounds and no added sounds.

DRIVER: Right.

OGDEN: I have written that his chest sounded clear but he still have some slightly increased work of breathing slash tachypnoea, which is an increased respiratory rate, but good air entry. That his femoral pulses are palpable, his hips were normal, his palate was normal, he had normal male genitalia, although the testes were not descended. I had not checked his eyes but for his spine I have written NAD, no abnormality detected.

DRIVER: Thank you. I won't go through them one by one, but the femoral pulse palpable, what's that indicative of?

OGDEN: So that's feeling for the pulses in his groin and checking that you can feel them. If you can't feel the pulses in the groin that is a sign that there might be something wrong with his circulation.

DRIVER: In [Baby C]'s case it was palpable, so you could feel it?

OGDEN: Yes.

DRIVER: That's that a sign of or an indicator of?

OGDEN: That's normal, that's what you'd expect.

DRIVER: Thank you. So putting them all together, those observations on examination, together with all the data that we've already been through, what was the general picture here in relation to [Baby C]?

OGDEN: That he was responding as any preterm baby of that gestation would and as to be expected at 30 weeks' gestation.

DRIVER: Hence you put in place, if I may say so, would this be a generic plan?

OGDEN: Yes.

DRIVER: So nothing in particular designed to address any specific need or requirement that [Baby C] had been exhibiting as part of your examination of him?

OGDEN: Yes. These are all just fairly standard sort of next steps in the plan for caring for a preterm baby.

DRIVER: So the first next step is to take the blood gases in the afternoon?

OGDEN: Yes. So we normally do them at different time frequencies, so specifying the next time I wanted one taken of 1 pm. Then I've documented an arterial line, which again can be very common in preterm babies. It helps measure the blood pressure and also take blood tests more directly from the line rather than having to use needles on the baby to take blood tests.

DRIVER: Yes?

OGDEN: And then I've put check U&Es and CRP. So urea and electrolytes, which is how his kidneys are functioning, and the salt levels in his blood. And the CRP, which is the infection level, to see if that had changed. We normally do these most days for preterm babies and I have written that if the sodium is ever high, that we would need to increase the fluids because that would indicate he needed more fluids than he was currently on.

DRIVER: So that's not a reaction that you are making yet but you're putting a marker down just in case?

OGDEN: Yes, it's sort of pre-empting what might be seen on the tests.

DRIVER: So phototherapy because of the bilirubin?

OGDEN: Yes, phototherapy because the bilirubin was above the treatment line.

A cranial ultrasound scan, so that's what the CRUSS stands for, which we would do on day 1 or day 2 for all preterm babies.

To start trophic feeds, so a very small amount of feed, if available. Often this is not enough to quantify and give regularly, so trophic feeds is just to start a little bit.

DRIVER: Is that primarily to trigger the digestive system as opposed to provide nutrition to the baby?

OGDEN: Yes. And then I've written to continue the CPAP because his blood gas is stable on that and to update the parents.

DRIVER: Thank you.

Can you go to 1916, please? Not your entries, entries from a colleague, Dr Beech. But does this record that as you had planned, the cranial ultrasound was undertaken?

OGDEN: Yes.

DRIVER: Thank you. Another entry from a Dr Rylance, a fact that I think you were informed of later, that records -- thank you -- that at 7 in the morning on 12 June 2015, and I'll just read it:

"Reviewed. UVC found in bed."

Was that a fact that was shared with you at a later time, do you remember?

OGDEN: I don't recall specifically being told or not being told.

DRIVER: Very well. Then we'll move on, please.

We'll go to tile number 77. Pausing there so we can orientate ourselves in terms of time. It's now 9.30 in the morning on Saturday, 13 June. Your next shift?

OGDEN: Yes.

DRIVER: We can see in the form that mirrors the notes from the previous shift that we've just been through, a summary is given here, but if we go beneath it, please, to see Dr Ogden's own notes. Again, are these your ward round notes, as it were?

OGDEN: Yes.

DRIVER: Thank you. So [Baby C] born at a gestational age of 30 weeks and a day. Now he's in day 4 of life?

OGDEN: Yes.

DRIVER: The problems are the special features that you recorded at the point of his birth. They still exist, they're his background --

OGDEN: Yes.

DRIVER: -- issues. And then do we see in the same format, your list of observations upon examination?

OGDEN: Yes.

DRIVER: So again, V for ventilation. I won't ask you to go through each and every one of these. But in general terms, what do those recorded readings and data tell you? What did they tell you at the time?

OGDEN: He's in less oxygen than he was a few days ago and his blood gas is still a normal blood gas. The lactate has come down. He's on a different amount of fluids now but what's changed -- he was having these very dark, bilious aspirates. That describes the colour of any fluid that was coming out of his feeding tube.

DRIVER: I'll come to that recording in the next paragraph.

OGDEN: Yes.

DRIVER: Just in terms of the respiratory readings, as compared to yesterday's, as it were, what does that tell you in terms of [Baby C]'s condition?

OGDEN: So that suggests that his breathing is stable and possibly improved from a day or two before.

DRIVER: Thank you. Let's go to fluids. The first line just records what he's receiving?

OGDEN: Yes.

DRIVER: Then you were telling us about the entry or the finding that is recorded on the next line. Tell us about that, please.

OGDEN: I've documented that he had very dark bilious aspirates/black aspirates, and that these are aspirates that would have come up the feeding tube that he will have had in place. That will have been taken from the nursing records, what they aspirated from that tube.

DRIVER: Thank you. You probably answered this question, but spell it out. When you say they would have come up the tube, would that have been spontaneously or would they have been aspirated manually by the treating or caring nurse?

OGDEN: Potentially either. I haven't specified in my notes, but sometimes they can come up spontaneously, sometimes they need aspirating.

DRIVER: Thank you. You've made more than one reference here to the colour of the aspirates. Why and what does that inform you potentially of?

OGDEN: So bilious or dark green coloured or black aspirates aren't normal colour for aspirates. They would suggest that there was potentially a concern with his abdomen and the way he was tolerating any feeds, if he'd been on them, or how his bowel was responding to being preterm.

DRIVER: The findings you have recorded in those terms, would they have been a concern?

OGDEN: Yes, that would have been a concern.

DRIVER: Thank you. Concern because they might indicate what?

OGDEN: They may have indicated a condition called necrotising enterocolitis or potentially infection.

DRIVER: Thank you. Moving through the other entries on the fluids paragraph, urine, then a measure of his output. Anything exceptional about that?

OGDEN: No.

DRIVER: "Bowels not yet opened." This is day 4 of life; anything significant about that?

OGDEN: In itself not necessarily, but it would be taken in context with his aspirates, how his abdomen examined, how much feed he'd been having. By itself it's just a statement that they'd not been opened yet.

DRIVER: Thank you. "Not started feed yet" speaks for itself.

Next line?

OGDEN: Those were -- his sodium result was 142 and his potassium was 3.4, both of which are within normal limits.

DRIVER: Thank you. You've noted to the side here -- is that a reference to an X-ray --

OGDEN: Abdominal X-ray, yes.

DRIVER: -- taken on 12 June? So that's the time of the X-ray -- date of the X-ray?

OGDEN: Yes.

DRIVER: Does it follow that you examined that X-ray, that picture?

OGDEN: It would suggest that I had seen the X-ray. All I've documented is what it showed, but I can't remember whether that was looking at the X-ray or reading someone's interpretation of the X-ray.

DRIVER: So to assist the jury in that regard, an X-ray is taken either as part of protocol or in response to a specific request by a clinician such as you?

OGDEN: Yes.

DRIVER: Examined on the ward by the clinician?

OGDEN: Yes, at the time the X-ray was taken.

DRIVER: At the time it was taken, and another doctor told, and then subsequently considered by a radiologist?

OGDEN: Yes.

DRIVER: Thank you. S for sepsis, suspected sepsis?

OGDEN: Yes.

DRIVER: Is that based on any of the other findings on this page or is that for the same reasons as you've recorded the day before?

OGDEN: I'm unsure because I don't know exactly what happened between my two entries as to whether there were any other additional concerns, so it may be the same infection screen or it may have been a different one. I don't know from my notes if that was a new concern or not.

DRIVER: Thank you. You reiterate the antibiotics that he'd been prescribed and was receiving.

OGDEN: Yes. So he was on benzylpenicillin and gentamicin still.

DRIVER: Then we have the CRP, which on your last corresponding set of notes was at 1, if you were reading your handwriting correctly.

OGDEN: Yes.

DRIVER: But now this appears to read "1, 23". What does that tell us?

OGDEN: So that shows us the repeat level of the CRP had gone up to 23, which is elevated and is higher than a normal range of CRP, so would suggest that there was some element of an infection that he had.

DRIVER: I'll come back to that in a moment, but does it follow that at least your note-taking convention is to record each entry, "1, 23", and then --

OGDEN: It appears so, yes.

DRIVER: So plainly, it's elevated as compared to the previous day?

OGDEN: Yes.

DRIVER: But in more general terms, how high is a reading of 23?

OGDEN: So we would treat a -- we would be worried. Any CRP higher than 10 would be suggestive of an infection, but the range that a CRP can increase to is very variable and can be up to 100 or higher. In itself, the number doesn't always signify the severity of an infection, it's just a marker that there's an infection there, that it's in that spectrum of above normal but not as high as it could potentially be.

DRIVER: But nonetheless, one of the factors that would go into consideration?

OGDEN: Yes.

DRIVER: The next entry?

OGDEN: So I've written that his blood culture was negative, which shows that it hadn't grown any specific bacterial infections.

DRIVER: Let's take a step back. Blood would have been taken from [Baby C]?

OGDEN: Yes, at the time the antibiotics were started.

DRIVER: So we're now going back 24 to 36 hours.

OGDEN: Yes. From whenever that day/time was, yes.

DRIVER: But at this time when you're making these notes, does it follow that you have received information from the testing of that blood?

OGDEN: Yes, we normally get interim reports from blood culture results anywhere from sort of 24 to 48 hours after the blood culture is taken. But at any time, if it were to grow an infection -- and a final result usually comes about 5 days later. But at this point in time the blood culture wasn't growing in infection.

DRIVER: Just to spell that out, colleagues elsewhere are monitoring the blood taken from [Baby C] to see whether there's any evidence of bugs, bacteria, I suppose; is that right?

OGDEN: Yes, it was being analysed by the microbiology lab.

DRIVER: And at this point, the latest information was that it was negative, there were no such bacterial --

OGDEN: Yes.

DRIVER: -- developments within that blood. Is that, like the elevated CRP on the line above, is that another of the factors to be taken into consideration when assessing whether or not there was sepsis, NEC or what?

OGDEN: Yes, it would be taken into account with everything else. You can have babies or patients that are unwell with an infection that have a negative blood culture and you can have patients that have positive blood cultures for a variety of different reasons.

DRIVER: On the next entry there's reference to "LP". You'll correct me if I'm wrong, I think might be lumbar puncture?

OGDEN: Yes.

DRIVER: You record that [Baby C] had not yet had a lumbar puncture?

OGDEN: Yes.

DRIVER: And the reason for that?

OGDEN: Is that his platelets were low. So you would want a relatively stable platelet count before doing any tests where there was a potential for any bleeding and a lumbar puncture has a potential to cause bleeding at the site.

DRIVER: How did you know that his platelets were low? Is that contained within some of the other data in this document or from somewhere else?

OGDEN: I haven't documented it in those notes there, but I would have seen his full blood count result on some other set of investigation results, which would have documented that.

DRIVER: Right. The low platelet count, as shown by the downwards arrow, as well as militating against undertaking a lumbar puncture, what, if anything else, of significance would you attach to that reading?

OGDEN: That could have been low from an infection, from necrotising enterocolitis or the background of having uterine growth restriction.

DRIVER: Thank you.

Next, the cardiovascular entry.

OGDEN: I've written that his mean blood pressure is 36 to 40, which would be normal readings for his gestation, and that there was no cardiovascular concerns.

DRIVER: The next entry?

OGDEN: I've documented the neurology that he handles well and that the cranial ultrasounds, I've written NAD, so no abnormality detected when it was undertaken on day 2.

DRIVER: Thank you, the next?

OGDEN: Again for the metabolic concerns that he's now off the phototherapy yesterday and that the bilirubin level today is 111. That would need to be taken in context with the bilirubin chart.

DRIVER: Thank you. These are also your entries, it's a continuation of the data that you were just alluding to there?

OGDEN: Yes. So this is where I've documented next the blood test results that we had back.

DRIVER: Does that tell you anything additional to that that you have already conveyed to the jury in the last few minutes?

OGDEN: It just quantifies that platelet count that I mentioned was low, was 39.

DRIVER: Thank you. What does a reading of 39 tell you? Is it in the spectrum of a platelet count for a baby like [Baby C]?

OGDEN: It's just a low platelet count. Normal would probably be above 150. The level of how low it is doesn't necessarily indicate anything.

DRIVER: The long line?

OGDEN: So --

DRIVER: The lines generally, forgive me.

OGDEN: So L for lines. He now has a long line, which would be a peripherally inserted central line that was in through his left saphenous vein and he had a cannula in his right hand.

DRIVER: And the saphenous vein?

OGDEN: It's a vein in the foot.

DRIVER: Does it run up the leg?

OGDEN: It does, yes.

DRIVER: Thank you. So you are recording that one was in place but you didn't put it in place?

OGDEN: No, I'm just documenting its presence.

DRIVER: Then we have your other observations on inspection, which, correct me if I'm wrong, mirror those made previously?

OGDEN: Yes. So I've documented that he's still pink, well perfused, his capillary refill time is 2 seconds, his heart sounds -- those notations mean they were still normal sounds, that his chest was clear, that he had no increased work of breathing, the femoral pulses were palpable, his testes were still not descended, there were no hernias felt, and that his abdomen was soft, ie that it wasn't distended, and that I could hear bowel sounds.

DRIVER: What if any significance would you attach to the fact that his abdomen was soft and not distended?

OGDEN: That would be a more reassuring sign. If we thought we were treating him for necrotising enterocolitis you often see signs in the abdomen that I have not seen.

DRIVER: So this information taken from different sources all gets put together and considered by you in the round?

OGDEN: Yes.

DRIVER: Thank you. If we move on to your plan:

"To continue the application of CPAP. For gas readings to be taken at 3 in the afternoon. [Question mark] start feeds."

OGDEN: Yes. That was in view of the bilious aspirates. So whether to start them or not.

DRIVER: And did the presence or the discovery of bilious aspirates militate against starting feeds?

OGDEN: Yes, you'd be more cautious at starting feeds if the baby had bilious aspirates.

DRIVER: You wanted to repeat -- the next line?

OGDEN: The full blood count in view of the low platelets and then to hold off the lumbar puncture for now because the platelets were low.

DRIVER: And a second ultrasound?

OGDEN: Yes, that would have been routine, so a repeat ultrasound is usually done several days later.

DRIVER: As you indicated to us earlier, at this stage in your career you'd have been an ST3?

OGDEN: Yes.

DRIVER: Or a registrar in the old label. And does it follow therefore that when undertaking an examination of someone like [Baby C], your readings and plans would be reviewed by the consultant?

OGDEN: Yes. So I would see the patient first and then discuss with the consultant, who would make any changes or review the baby if they felt they needed to.

DRIVER: Would this baby at this time -- did you engage in that interaction with the consultant, with Dr Gibbs, in this case?

OGDEN: Yes.

DRIVER: So although these notes here at the bottom of the page are in your handwriting, are they --

OGDEN: They are my handwriting, yes.

DRIVER: -- they reflect views shared with you by your senior colleague, Dr Gibbs?

OGDEN: Yes. That's the plan that Dr Gibbs had told me to enact in view of the findings I'd told him.

DRIVER: Could you help us as to his --

OGDEN: He'd suggested giving a medication called ranitidine, so IV ranitidine. He'd suggested we were holding off the feeds for now and to review that later.

DRIVER: Let's go back to the IV -- ranitidine, did you say it is?

OGDEN: I did.

DRIVER: What's that a medicine targeted for?

OGDEN: That's a medication that targets any stomach acids that can be used if we think there's -- if you think there's any irritation in the stomach.

DRIVER: Thank you:

"Hold off the feeds."

Echoing your cautious plan. Then does it say -- is that "review this afternoon"?

OGDEN: Yes, I've said review this afternoon. If the aspirates aren't getting any worse then we could start trophic feeds but if the aspirates worsen then for a repeat abdominal X-ray and change the antibiotics.

DRIVER: Thank you. If we keep scrolling down, I think that's the end of this note. Yes.

I think that was the last examination and last set of notes that you made in relation to this patient.

OGDEN: Yes.

MR DRIVER: Is that right? Thank you.

Could you remain there and answer any further questions that may come your way.

Cross-examination by MR MYERS

MR MYERS: Dr Ogden, I just have some questions. I'll start now. My Lord it may go over lunchtime, I think it almost definitely will. We'll see how we get on.

MR JUSTICE GOSS: Stop at an appropriate point.

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

Dr Ogden, you have told us a little bit about the decision as to which hospital [Baby C] should be in.

OGDEN: Yes.

MYERS: I just want us to help the jury to quickly summarise the position with the hospital. So let me see if this is right: with neonatal care there are three levels of care, aren't there?

OGDEN: Yes.

MYERS: Or there were. Yes. And level 3, which is called tertiary care, offers the highest level of intensive care; is that correct?

OGDEN: It is, yes.

MYERS: And the level 3 units in the Cheshire and Merseyside area included Liverpool Women's Hospital?

OGDEN: Yes.

MYERS: And did it include Arrowe Park as well?

OGDEN: It did, yes.

MYERS: And then level 2, which is the next level down, that's not an assessment of what's good or bad, but it's just what's required, level 2 offers intensive care but at a reduced level and usually for a reduced period?

OGDEN: Yes.

MYERS: The neonatal unit at the Countess of Chester at the time we're talking about was a level 2, wasn't it?

OGDEN: Yes.

MYERS: We know that changed when we get somewhere into the middle of 2016.

Then special care units, which are the lowest level of care, in terms of intensive care, I don't mean the quality, they're called level 1, special care centres, aren't they?

OGDEN: Yes.

MYERS: All right. So for level 2, which is the Countess of Chester at this time, they could accept, if you're looking at a single baby, babies from -- is it 27 weeks and up? Was that the level?

OGDEN: I believe so.

MYERS: That's in terms of gestation. In terms of weight, the minimum weight was in fact 800 grams, wasn't it?

OGDEN: I believe so, yes.

MYERS: So looking at [Baby C]'s position, 800 grams puts him on a level which is called extremely low birth weight, doesn't it?

OGDEN: Yes.

MYERS: And his gestation puts him at very preterm, his actual weeks of birth, doesn't it?

OGDEN: Yes.

MYERS: So on those facts alone he was really right on the borderline, wasn't he, of what could be accepted at the Countess of Chester?

OGDEN: Yes.

MYERS: We know also from what you've said and from the records we have that he had intrauterine growth restriction; is that correct?

OGDEN: Yes.

MYERS: And that's a problem, as it suggests, with the growth and development in the uterus, isn't it?

OGDEN: Yes.

MYERS: And also I think you said reverse EDF, which translating that, is a problem with the arterial flow whilst in the uterus, isn't it?

OGDEN: Yes.

MYERS: The umbilical arterial flow. Now, if you get a baby who's got IUGR and reversed end diastolic flow during pregnancy, that can be a strong indicator of problems that might follow, can't it?

OGDEN: Yes.

MYERS: One of those problems, and one that you've mentioned before, is NEC, isn't it?

OGDEN: Yes.

MYERS: That's one, but there might be other problems associated with the conditions when the baby is born, mightn't there?

OGDEN: Yes.

MYERS: And do you agree, though it's never at all a nice thought to have, that when you get a combination of factors like that in a little baby like [Baby C], there is an associated increased risk of infant mortality, isn't there?

OGDEN: Yes, all those factors could increase mortality.

MYERS: You've described, at the time of his birth at least, he was considered to be in good condition; is that right?

OGDEN: Yes.

MYERS: But would you agree also, he could be described as a high-risk baby at that point?

OGDEN: Yes.

MYERS: So just so we can understand how a baby could be high risk and in good condition, high risk, of course, because of the factors that I've just been suggesting to you, the problems there could be; is that correct?

OGDEN: Yes.

MYERS: But by good condition do you mean, well, taking everything into account, he was doing as well as you could expect at the time that he was born or do you mean something different? It's for you to explain.

OGDEN: No, I mean that at that time he was born, and taking all those factors into consideration, he was in a good condition considering all of those factors.

MYERS: All right. That, of course, can change, it could get worse over time, couldn't it?

OGDEN: Yes.

MYERS: And so it's crucial that a little baby like [Baby C] is watched very, very closely; is that correct?

OGDEN: Yes.

MYERS: You've explained to us that he was born with the Apgar scores he had. I'm just going to ask if we could put up, please, tile 5, which is J1903. If we go behind that, thank you, Mr Murphy.

If we just scroll down, please, to where we've got the Apgar scores: 7, 9 and 9. Just so that we can follow what Apgar scores relate to, Dr Ogden, there are five factors that the person making the scores will look at, aren't there? Five factors and each factor can get a score of 0, 1 or 2?

OGDEN: Yes.

MYERS: So it's a quick way of checking how the baby seems to present almost immediately on delivery, isn't it?

OGDEN: Yes.

MYERS: So the person assessing it will give those scores and then will get to a figure, well, up to 10 as a maximum?

OGDEN: Yes.

MYERS: Just so that we can all understand, that's something which is done by the person -- their view at that point of the baby, isn't it?

OGDEN: Yes.

MYERS: It's not a case that's there been some sort of test done to the baby or some measuring or a machine that's done something, is it?

OGDEN: No, it's a subjective measure.

MYERS: A subjective indication, thank you.

To get a really good idea of how the baby is and how the baby's doing it's one thing that you can take into account with the other material that's available; would you agree with that?

OGDEN: Yes.

MYERS: I'm going to ask please if we could have a look next at the clinical notes at slide 8, which is 1911. If we could go behind that, please.

If we could just go down, please. It may in fact just be over the page, which I apologise for. Here we are. Thank you.

You explained to us:

"D/W LWH due to..."

Is that weight, WT?

OGDEN: Yes.

MYERS: We're getting there with these abbreviations but it's slow. That's:

"Discussed with Liverpool Women's Hospital due to weight"?

OGDEN: Yes.

MYERS: And that's because there is communication between the level 2 centre and the tertiary centres, isn't there?

OGDEN: Yes.

MYERS: And so far as possible, efforts are made to place the right baby in the right centre for the care that they need?

OGDEN: Yes.

MYERS: So at this early point your view was certainly Liverpool Women's Hospital needed to have some communication as to whether anything should happen with [Baby C], a transfer to another unit; is that what that means?

OGDEN: Yes, that they should be informed of the birth and to discuss it between the consultants from both sides.

MYERS: [Baby C] was on the borderline between being a level 2 or level 3, wasn't he?

OGDEN: Yes.

MYERS: He's right on the limit of what Chester could accept. If you don't feel able to answer this, please say so, Dr Ogden. I'm not trying to get you to commit to something you're uncomfortable with. But if we have somebody who, just by virtue of their age and weight, is on the borderline, it may very well be the case that if they have other problems associated with it, that might take them over that and mean they should go to a tertiary centre. Do you agree with that?

OGDEN: Potentially. It would depend on the circumstances, yes.

MYERS: Who actually decides when, for instance, the Countess of Chester, at this time, can't take any more babies or a baby should go across to Liverpool Women's? Can you help us with who took that decision?

OGDEN: It would be a joint decision between the advice from Liverpool Women's Hospital, from their consultant, and the consultant at the Countess of Chester who's caring for [Baby C].

MYERS: So it would be the particular consultant with care of [Baby C] or would it go further up the chain to the senior consultants who were running the unit?

OGDEN: It would be the consultant who was on call or covering the unit at that point in time.

MYERS: And it would be a decision between that consultant -- you mentioned Dr Yoxall, who's a doctor at Liverpool Women's Hospital?

OGDEN: Yes.

MYERS: So the two consultants would discuss it with one another; is that how it would work?

OGDEN: Yes.

MYERS: Would the decision as to which unit the child, the baby, went to be based purely on medical need or was there an element of bed availability with this?

OGDEN: I... I don't feel like I can answer that because I wasn't part of that conversation, so I don't know.

MYERS: In general, let's move away from [Baby C]'s case. From your knowledge of the way this worked, to what extent was that decision affected by any question of bed availability? So you might have a baby who could go there, maybe should, but because they're very close to when it would be to go or not go, they stay at the level 2, just because it's difficult to accommodate them at a level 3.

OGDEN: If there was a decision that the baby needed level 3 care in that conversation then there are other level 3 units that would be able to accommodate a patient if that specific hospital couldn't.

MYERS: Thank you. Again, this is something which I'd ask you to answer only as far as you're comfortable answering it. If you don't want to, you must say so. But the decision, for instance, in [Baby C]'s case to keep him or that he should stay at the Countess of Chester, that would be based, for instance, on the view that there would be sufficient staff to look after him properly, wouldn't it?

OGDEN: Yes.

MYERS: And would it also be based on a view that there would be, at that point, no additional complications which meant he needed more intensive care?

OGDEN: It's difficult to answer without having been part of those conversations, I'm afraid. Those are the conversations that -- they're the types of conversations that would have been had.

MYERS: Well, then I respect that, I'm not going to say more about that than you comfortably can.

In the period we're talking about, and you're dealing with round about June 2015 and onwards here, would you agree that was a particularly busy time at the Countess of Chester?

OGDEN: Yes.

MYERS: I think you told the police in the statement we've got -- so it helps me, I know you will have read it so let me help you, it's page 928 -- that you think that at the time [Baby C] was born it was a particularly busy time for the neonatal unit.

OGDEN: Yes.

MYERS: And that's how you recall it, is it?

OGDEN: Yes.

MYERS: And you also say that he was on the unit at the same time as [Baby A] and [Baby B], who we have heard about. [Baby A] and [Baby B]. And all three of these were small preterm babies which, for a small unit like Chester, would make it busy?

OGDEN: Yes.

MYERS: So in terms of making the unit busy, is it the case it's not just a question of the sheer numbers of babies, but it's also a question of how much care each individual baby is going to need?

OGDEN: Yes.

MYERS: Because whilst they may occupy particular cots, some babies are going to need even more close scrutiny than others, aren't they?

OGDEN: Yes.

MYERS: When you say that:

"All three of these were small, preterm babies, which for a small unit like Chester would make it busy."

I'm going to ask you: is that because it's not just a question of the demands put on the unit by the one particular baby who stays, but if the demands increase because of looking after some particular babies, that has a knock-on effect across everybody on the unit?

OGDEN: I think it's difficult to answer fully because it would be a combination of the staffing levels, the acuity of the wider unit, how many babies of each different level there were at that point in time.

MYERS: And by acuity, that's a term meaning the degree of intensive care, isn't it, or a degree of care?

OGDEN: Yes.

MYERS: The higher the acuity, the higher the intensive care that is required?

OGDEN: Yes.

MYERS: So busyness is a function really of the number of babies, the acuity of the babies, and the number of available staff?

OGDEN: Yes.

MR MYERS: Thank you, Dr Ogden.

My Lord, with the court's leave, that's a suitable place to stop.

MR JUSTICE GOSS: Certainly.

You've got some more questions to answer. Could you be back, please, to continue with your evidence, in other words to be in court, for 2.10?

OGDEN: Okay.

MR JUSTICE GOSS: Thank you very much. Please don't talk to anyone about your evidence or anything to do with this case.

OGDEN: Okay.

MR JUSTICE GOSS: Right. Thank you very much, members of the jury. Be ready to come into court at 2.10, then, please. Remember -- I know you're tired of hearing this, but please

remember and adhere to your obligations as jurors. No conversation by any means with anyone other than when you're all together and no research into anything to do with this case or anyone. Thank you.

(In the absence of the jury)

MR JUSTICE GOSS: I don't know whether I misheard some question that was put, Mr Driver, but the implication was that -- we know that [Baby C] was born on Wednesday the 10th. He was seen the next day by this witness, the 11th, but not seen the following day by this witness. You did, I think, probably inadvertently, refer to the previous day, because she came back on the 13th.

MR DRIVER: She did.

MR MYERS: If it assists --

MR JUSTICE GOSS: I didn't want to interrupt at that point, but --

MR MYERS: I certainly took it that Mr Driver made it plain that it was the 11th she was there, she had come back on the 13th, and even made reference to the 12th. But I certainly didn't take that as meaning she was there --

MR JUSTICE GOSS: It was just a word, "on the previous day", but just so there's no confusion --

MR MYERS: As it happens, I was going to go through (overspeaking) --

MR JUSTICE GOSS: I thought you were. I didn't want to raise it because I thought it would be made perfectly clear. It was probably just me but I was making some notes and I was just checking.

MR DRIVER: It sounds like I should be the one making apologies.

MR JUSTICE GOSS: It probably was -- we're all prone to those, so don't worry about it.

The other thing is that of course when reading out one of the WhatsApp messages, there was reference to mum's occupation. I didn't say anything at the time. They may have picked up from the tone of the statement that this was someone who had medical knowledge, who was writing it in any event, but I'm not proposing to say anything about it and I don't think it's relevant.

MR DRIVER: As far as we could, we've done the best we can to avoid any reference to it to try and preserve [Mother of Baby C]'s privacy.

MR JUSTICE GOSS: Exactly. I'm acutely aware of that. That's why -- but there we are. The message obviously is in. All right. Thank you very much.

(1.03 pm)

(The short adjournment)

(2.07 pm)

MR JUSTICE GOSS: Yes, please.

(In the presence of the jury)

MR MYERS: Dr Ogden, I just want to pick up now and go to your particular involvement with [Baby C], Dr Ogden, and just start with what you had said about infection. I think you told the jury this morning that [Baby C] didn't have "risk factors to make infection a more immediate concern". Those were the words you used. And then you linked that to the way in which he'd been -- the nature of his delivery. You contrasted that with a spontaneous delivery where you said a risk factor is -- that's more of a risk factor in itself. I know you're nodding, you have to say yes or no so it records it.

OGDEN: Yes, sorry.

MYERS: I want you to help me deal with why that is because that might be a new concept to some of us here as to what the difference is when we're dealing with infection. So see if you can help us with this please: is it the case that in hospital when we're dealing with neonatal situations, infection can be what's called vertical or horizontal? I'm going to elaborate on that in a moment with your assistance.

OGDEN: Okay.

MYERS: Are you familiar with that way of describing it?

OGDEN: Yes.

MYERS: It's a delicate language that's used, isn't it? Vertical -- if we think of birth by the vaginal delivery, a baby born that way, whether people in day-to-day life realise it or not, is actually at high risk or higher risk of acquiring infection?

OGDEN: Yes.

MYERS: Is that correct?

OGDEN: Yes.

MYERS: So that's why we use the rather unprosaic expression vertical infection?

OGDEN: Yes.

MYERS: If someone is delivered, for instance, by caesarean section, that risk of infection doesn't exist?

OGDEN: Yes.

MYERS: Is that the distinction you were making when you talked about spontaneous delivery is a higher risk factor?

OGDEN: Yes. There's a fairly standardised set of criteria that are sort of standardised risk factors across all neonatal care, and those sort of natural, sort of vertical transmission would fit into that more than a caesarean section would.

MYERS: So a baby that's been born vaginally, not by caesarean section, is at a higher risk of infection?

OGDEN: Yes.

MYERS: However, once the baby is then in the world outside, over time there's an increasing risk of what's called horizontal infection, isn't there, which is healthcare-related infection?

OGDEN: Yes.

MYERS: That can rise, can't it, once we are into the area of lines or -- obviously people are being careful but lines or catheters being used or inserted into the baby?

OGDEN: Yes.

MYERS: That increases the chance of infection, doesn't it?

OGDEN: It does, yes.

MYERS: All right. I just want everyone to understand when you're talking about infection not being an immediate concern, that refers really to the way in which [Baby C] had arrived, if I put it that way; is that correct?

OGDEN: Yes, that's correct.

MYERS: I'm dealing with it delicately, but that's the situation.

Now, once [Baby C] was there, it's important, isn't it, always to regard infection as a potential risk?

OGDEN: Yes.

MYERS: And if we could please put up slide 8, which is 1910.

(Pause)

We can see that for [Baby C], if we look towards the centre of the page, once he'd been born there were some breathing issues quote early on; is that correct?

OGDEN: That's correct.

MYERS: We are just going to highlight where he has started to have grunting -- and what was the next expression, please?

OGDEN: Tracheal tug.

MYERS: Tracheal tug and subcostal recessions.

OGDEN: Yes.

MYERS: Does that all indicate some sort of resistance or difficulty with breathing?

OGDEN: Yes.

MYERS: And although it's a very early stage, does that mean you have to bear in mind the risk of things like respiratory distress syndrome in the neonate?

OGDEN: Yes.

MYERS: And indeed you have to keep in mind the risk of infection or whether this is a sign of infection?

OGDEN: Yes.

MYERS: And as we go through the procedures that follow -- if we can go back to the page and just scroll down it please, Mr Murphy -- we can just see at the bottom of the page that it's necessary for intravenous access to be put in. And almost as soon as we start doing procedures like that, or as soon as you do, then again the risk of infection can increase?

OGDEN: Yes.

MYERS: If we could go over the page, please, to 1911. If we look up at the entry for 10 June at 18.00, so this is now into the notes that you'd set up, the notes that you made. These are notes by Dr Brunton, this is the point at which the UVC was inserted as well?

OGDEN: Yes.

MYERS: But the staff caring for [Baby C], we would hope, you would hope and expect, would be alert to any signs of infection?

OGDEN: Yes.

MYERS: We know that on the 10th, on this particular day, there are two radiographs or X-rays taken of [Baby C]'s lungs. Are you familiar with them or have you seen them?

OGDEN: I don't recall them. I may have seen them at the time, but I don't recall them now.

MYERS: All right. If we could perhaps just go -- are we on 1912? If we could perhaps go down, please, to 1912.

Just enlarge the section at the bottom, please.

I'm just going to this -- you didn't -- this isn't you dealing with this issue, this is Dr Rylance, isn't it? This is at 22.37 the X-ray is taken on 10 June?

OGDEN: Yes.

MYERS: So we've moved on later into the evening and we can see, looking at the bottom left, it's Dr Rylance who reviews this at 23.09; is that correct?

OGDEN: Yes.

MYERS: And she's noted:

"Hazy left lung field. Clear right lung field."

I won't go to the images because you didn't see them but that's certainly in the notes by that point, isn't it?

OGDEN: Yes.

MYERS: If there is a haze on the lung, or anything like that, there may be a number of explanations but infection could be one of them, couldn't it?

OGDEN: It could be one of them, yes.

MYERS: Let's move forwards, if we could, please, now to the following morning, which is taking us to 11 June, and could we go to 1913, please.

These are all things you looked at this morning, Dr Ogden, and we have as well. You explained to us that early on, very soon after [Baby C] was born, he'd been put on a ventilator but then he was put on to CPAP.

OGDEN: Yes.

MYERS: And I think the expression that was used to you, and you agreed, was at that point the direction of travel was good.

OGDEN: Yes.

MYERS: And obviously if a baby goes from ventilator to CPAP that's, on the scale of things, an improvement?

OGDEN: It is, yes.

MYERS: Just keeping in mind the idea of direction of travel, I'd like to have a look at what we have here with your assistance.

Just go down to where we have 10.45. If we start here, please, where your review is, Dr Ogden. First of all, having come off the ventilator, [Baby C] remained on CPAP over the period that we're dealing with?

OGDEN: Yes.

MYERS: Are you aware of that?

OGDEN: Yes.

MYERS: Right. So that bit remains the same. If we look at the list where it says "Problems". Preterm, that's there, isn't it, because the very fact of being a preterm baby carries with it certain risks, doesn't it?

OGDEN: Yes.

MYERS: I've already asked you about IUGR and reverse EDF and you have explained to everyone about that. Where you have put "suspected sepsis", to be clear, does that mean there are things there that mean you did suspect it or does it mean you have to be alert for it and therefore you're keeping that in mind?

OGDEN: It means he's been treated for suspected sepsis because antibiotics have been started prior to my review.

MYERS: RDS is respiratory distress syndrome?

OGDEN: Yes.

MYERS: And that reflects difficulties with breathing and respiration?

OGDEN: Yes.

MYERS: A need to establish feeds, is that what the "establish feeds" is for?

OGDEN: It does, yes.

MYERS: And high lactate. We've seen on blood gas that lactate is one of the readings that we get, isn't it?

OGDEN: It is.

MYERS: And it should be in the region up to about 2, shouldn't it?

OGDEN: It should, yes.

MYERS: Again just so we can all follow this, if there are difficulties with breathing does that mean lactic acid can gather in the body?

OGDEN: It's not necessarily related to the breathing.

MYERS: Oh right.

OGDEN: The raised lactate may be related to lactic acid, but that doesn't necessarily refer to breathing concerns; it may be other causes.

MYERS: Does it indicate the body is labouring in some way?

OGDEN: It suggests that there is some other condition that needs reviewing and managing.

MYERS: But it's just helpful to know that because we've seen the expression high lactate before. It might be useful to know what that indicates. So it's an indicator of a potential issue beneath the surface then, something to look for, another condition?

OGDEN: Yes, but it doesn't specify what --

MYERS: Right, it's non-specific?

OGDEN: Yes.

MYERS: Go over the page, please, Mr Murphy, to page 1914.

If we look at the top part under where you put the entry for 11/6/15, 11.00, we can see there lactate 4.3. That's what you were referring to, is it?

OGDEN: Yes.

MYERS: So 2 is what the upper limit would normally be, but 4.3. Where it says tachypnoea, is that referring to increased rate of breathing?

OGDEN: It is, yes.

MYERS: I am going to go down a little bit further where it says "Not opened bowels yet". Can we identify that it's three lines up from this entry? There's all sorts of signs, as we have seen, and systems (sic) that the staff looking after [Baby C] will look to to gauge how well he is and how he's doing, aren't there?

OGDEN: Yes.

MYERS: And watching what's happening with the bowels is one of them, isn't it?

OGDEN: Yes.

MYERS: If things are working as you would hope, as they should, at what point might you expect the first time for the bowels to open to occur after birth?

OGDEN: For a preterm baby, it can be very variable. So it could be anywhere up to several days, depending on how much feed they were getting and when feeds were started, so it's very non-specific in terms of a set time.

MYERS: So it's something you can watch, it just depends on the whole picture?

OGDEN: Yes.

MYERS: In terms of direction of travel, there are things here to watch, would that be fair to say?

OGDEN: Yes.

MYERS: Nothing here which is a matter of any urgency over and above the general care for a baby like [Baby C]?

OGDEN: Yes.

MYERS: Right. We know, as you explained this morning, you weren't on duty on 12 June, the following day, you weren't there?

OGDEN: I don't know if I was in the hospital or not. I haven't documented anything.

MYERS: You were not involved in the treatment of [Baby C]. So we can pick things up now from 13 June and I'd be grateful if we could go to page 1921, which I think is at slide 77, ladies and gentlemen, or tile 77.

We'll go through some of the detail here, but I'm going to suggest that by the time we get to 13 June there are apparent problems beginning to emerge in what we see with [Baby C]. Would you agree with that suggestion?

OGDEN: I think it's hard to say for certain without the specifics.

MYERS: All right. Let's have a look. Just so you know, that's what I'm suggesting: there are increased issues when we think of direction of travel. Before we look at what you put in the notes here, were you aware by this point or are you aware that there had been an X-ray of the abdomen on the 12th, which showed quite a significant distension of [Baby C]'s stomach?

OGDEN: So I'm only aware of what I documented, so at the point I documented this I noted that X-ray.

MYERS: Right.

OGDEN: But I can't really comment how much more than that I was aware of.

MYERS: I'm going to stick with what you have put here then; the X-ray can come from somewhere else. If we come down and look at what we have here I'm going to go down to the section where it has "very dark bilious asps". That's aspirates. We see that. Would you agree, dark bilious aspirates are a cause for some concern?

OGDEN: Yes.

MYERS: And in terms of direction of travel it's not such a great direction if we're starting in a very good place it's not such a good place is it?

OGDEN: No, it's a concern that those are occurring at that time.

MYERS: I think you were asked whether or not they were as a result of being aspirated or if they'd come out automatically, I think was the way it was put, and I think you said you didn't know at that point.

OGDEN: I haven't documented it (overspeaking) --

MYERS: No, you haven't documented -- of course, you might find or the nursing staff might find dark bilious aspirates by aspirating from the stomach, in other words taking it out and seeing it? That's one way isn't it?

OGDEN: Yes.

MYERS: Another way in which you might discover what's in the stomach contents is if it comes out through a vomit?

OGDEN: Yes.

MYERS: And do you agree that if you were to get dark bilious aspirates and vomit, that is potentially quite a serious issue, isn't it?

OGDEN: It's difficult to quantify if it's any more or less serious than them coming just directly from the tube because the tube itself would alleviate vomiting. I think the medical process that's causing them is the same whether they're vomits or through an NG tube.

MYERS: All right. So would you say there's no distinction between aspirates being done manually by staff and vomiting when it comes to dark bile?

OGDEN: Not specifically, no.

MYERS: In any event would you agree therefore that if you do encounter dark bilious aspirates it's one of those things that you might consider a red flag in terms of things to do or to check?

OGDEN: It's certainly a worrying sign that would need more investigation.

MYERS: Just to help us with why it is worrying, first of all, in a baby who may be at risk of NEC, it might be a sign of that, mightn't it?

OGDEN: It could be, yes.

MYERS: It could be a sign of some obstruction in the gut, couldn't it?

OGDEN: Yes.

MYERS: Whatever that is. Or some other type of -- I suppose, until you've investigated it you don't know what the problem might be.

OGDEN: No.

MYERS: Those are the sort of things. Thank you.

So we've got the abdominal distension from the day before but that's not something which you looked at or identified?

OGDEN: Not that I can comment on.

MYERS: All right. The dark bile, however it comes to be there. If we just pull out from the enlarged view and look further down, we can see "CRP 1, 23". Just follow the cursor. Does that indicate it's risen from 1 to 23?

OGDEN: Yes.

MYERS: As you have said, when that goes over 10, that becomes a matter a bit more worrying --

OGDEN: Yes.

MYERS: -- because it's an indication of -- it's an inflammatory marker?

OGDEN: It is.

MYERS: It might be infection or it may be some other sort of inflammation in the system?

OGDEN: Yes.

MYERS: Also if we carry on over the page, please, Mr Murphy, we can see now, just at the top where it's got platelet count -- did you tell us earlier, Dr Ogden, that the platelet count to be expected would be in the region of 150?

OGDEN: Yes.

MYERS: And that's per quantity of blood that we're looking at, isn't it?

OGDEN: Yes.

MYERS: So a platelet count of 39 is certainly well below what the comfortable reading would be, isn't it?

OGDEN: Yes.

MYERS: So that would be another matter of concern, wouldn't it?

OGDEN: It would.

MYERS: Is it the case there could be a number of explanations for why platelets drop or a number of reasons why they do?

OGDEN: Yes.

MYERS: Would you agree that by this point, there are some concerns as to the direction of travel with [Baby C]?

OGDEN: In terms of those specific markers, yes.

MYERS: Actually, by this point we are 3 days into [Baby C]'s life, he hadn't yet been reviewed by a consultant, had he?

OGDEN: I can't remember. If it's not documented then I'll presume not.

MYERS: We can see that it's documented on the 13th later on. There doesn't appear to be one before then. Would that suggest he hasn't been reviewed by a consultant before that point?

OGDEN: Potentially.

MYERS: Right. We also know, as we get to this point, that his weight had actually dropped. If we have a look at the nursing notes, please. It's behind tile 69, it's 1947.

We'll probably go into this in more detail with another witness, so I'm not going to go through all of this with you, Dr Ogden, but JW is a nursing practitioner by the name of Joanne Williams. It's a note for 13 June that was made at 4.19. If we look down at the bottom we can see it says:

"Weighed today in incubator without CPAP and current weight 717 grams."

Can you see that?

OGDEN: I can, yes.

MYERS: As it happens, had that been [Baby C]'s weight at birth he wouldn't have been at the Countess of Chester, would he?

OGDEN: I don't think so.

MYERS: No, irrespective of any other issues, that alone would have meant he'd have gone to a tertiary if there was space. So do you agree, certainly by the time we get to your dealings with him and the period we've looked through here, he was a baby where there were some potentially significant concerns?

OGDEN: Yes.

MYERS: And he was a baby who needed to be watched carefully?

OGDEN: Yes.

MR MYERS: Thank you, Dr Ogden.

MR DRIVER: I have no re-examination. Does the court have any questions?

MR JUSTICE GOSS: I don't, thank you very much.

Thank you very much for coming and giving your evidence. Can I just check whether you are coming back?

OGDEN: I'm not sure.

MR JUSTICE GOSS: I'm just looking at the list I've got. I don't think you're scheduled to be coming back. So that means you probably won't be, but I can't categorically assure you that you won't. It would seem likely. So thank you very much for coming and giving your evidence, Dr Ogden. Please now don't talk to anyone about this case or the evidence in the case, particularly any evidence you've given or any questions you've been asked about --

OGDEN: Okay.

MR JUSTICE GOSS: -- until it's all over --

OGDEN: Okay.

MR JUSTICE GOSS: -- which will not be for some time.

OGDEN: Okay, thank you.

MR JUSTICE GOSS: Thank you very much indeed.

(The witness withdrew)

MR DRIVER: My Lord, the order of witnesses previously provided to the court indicated that there would now be some reading before we call a nurse by the name of Yvonne Griffiths. We'll not get through all that we'd hoped we'd get through today, so we're going to revise that order if we may --

MR JUSTICE GOSS: Of course.

MR DRIVER: -- and next call Dr Beech, Dr Gail Beech.

MR JUSTICE GOSS: So what you're saying is, ideally -- this is slightly out of turn, that's not ideal, I was going to say something else, but this is slightly out of turn -- ideally you'd have wished to adduce some other evidence.

I'm sure you'll understand it because you're familiarising yourself -- we're going to be visiting these records and various events and matters identified in the records.

So Dr Gail Beech then.

MR DRIVER: Thank you.

(Pause)

MR JUSTICE GOSS: Perhaps while we are waiting, because this may take a few minutes, I did, as you'll all recall, canvass the possibility of sitting early tomorrow if necessary because we're going to finish earlier, by 2.40. I said that I would ask you to consider whether that was possible from your point of view. Would anyone have any difficulty in starting at 10 on the basis that we're going to finish -- please say so if you would.

No? All right.

Would it cause any difficulties as far as anyone else is concerned or any witness?

MR DRIVER: No, not that we're aware of, thank you. If we were to be beset by an unexpected or unanticipated problem with the timely arrival of a witness, there are relevant statements we would otherwise have read out this afternoon that we can interpose.

MR JUSTICE GOSS: Okay. We will start at 10.00. We'll have probably a slightly more substantive break, a 15-minute break,

in the middle of the morning because it's a longer morning, and then we'll break off, have a lunch break, but only a short session in the afternoon. It's because arrangements are made for the trial to proceed at a certain pace, one can't keep to it all the time, it's only an estimate. But if we get behind then it might cause difficulties further down the line and I'm anxious not to waste time and therefore money. I want to keep going.

We'll also have to consider rail strikes, I think, coming up. But I'll discuss that with counsel, first of all, and I'll come back to you, those of you who are dependent upon train services.

(Pause)

DR GAIL BEECH (sworn)

Examination-in-chief by MR DRIVER

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

BEECH: Yes, Gail Kara Beech.

DRIVER: Dr Beech, we understand, is this right, that in June 2015 you worked at the Countess of Chester Hospital?

BEECH: Yes.

DRIVER: And can you tell us in what capacity?

BEECH: I was an ST3 doctor, so a doctor in my third year of paediatric training.

DRIVER: In olden terms, would you have been described as a registrar?

BEECH: Yes, a first year registrar.

DRIVER: Thank you. And you have made at least one witness statement in relation to these proceedings; is that right?

BEECH: Yes.

DRIVER: And I'm looking at a statement dated 26 May 2020. I understand, could you confirm, that prior to making that statement, you had access to the medical, the clinical records in relation to an infant patient by the name of [Baby C]?

BEECH: I did.

DRIVER: And you were able to refresh your memory of your involvement with that patient from the clinical records?

BEECH: Yes.

DRIVER: Thank you. Can I reassure you that you're going to have access to those records on screen in front of you.

BEECH: Okay.

DRIVER: So you're not going to be tested about your precise memory of data and --

BEECH: Okay.

DRIVER: -- and the like.

So can you confirm that you worked day shifts on the 11th and 12 June 2015?

BEECH: Yes, I did.

DRIVER: And amongst other babies and families, you had in that period some involvement with [Baby C] and previously you'd had some involvement with his parents, antenatally?

BEECH: Yes, that's correct.

DRIVER: Thank you. I wonder whether, Mr Murphy, we could please put up J1916. Dr Beech, we're going to look at some of your entries on the babies' notes. If we could, the top entry, timed at 15.10, on 11 June 2015.

Your signature, your name and your training, status ST3.

BEECH: Yes.

DRIVER: And could you explain to us what this entry means, please?

BEECH: So at that time I've documented that I did a cranial ultrasound, that's what the CRUSS stands for. So that is a head scan, an ultrasound scan, of [Baby C]'s brain essentially. So I've done that and said that I've done it and that the images need a consultant review. I've then said that the images were reviewed by Dr Saladi, one of the consultants, and he said NAD, which means no abnormalities detected, so it was a normal scan.

DRIVER: To break that into its component parts, at or around that time you personally undertook the scan?

BEECH: Yes, I believe so, from the way that I have documented that.

DRIVER: And whether or not you considered the content of the scan, you provided it to your senior colleague, Dr Saladi, a consultant?

BEECH: Yes.

DRIVER: And Dr Saladi considered the contents of the scan?

BEECH: Yes.

DRIVER: And, no doubt from what Dr Saladi said to you, you recorded that it was no abnormalities detected?

BEECH: Yes.

DRIVER: From this note, are you able to tell us whether or not Dr Saladi would have had any interaction with the baby himself at this point or just with the scan of the baby?

BEECH: I think I would have documented if Dr Saladi had at this time been involved with the baby or his family, given the results. So given that I've written it like that, I would make the assumption that Dr Saladi's just looked at the images.

DRIVER: Understood. If we could remove this magnified part, please, and look further down this page. We can see that, below your entry that we've focused upon, a colleague, I think it's Dr Rylance, undertook a review at 07.00 hours on 12 June. Do you remember Dr Rylance?

BEECH: I do, yes.

DRIVER: A colleague of yours at the time?

BEECH: Yes.

DRIVER: But then beneath Dr Rylance's entry, and again if we could zoom in on this, we can see an entry in your name at 10.15 but now on to 12 June --

BEECH: Yes.

DRIVER: -- 2015, which, as your record informs us, was day 3 of life for this baby, [Baby C].

BEECH: Yes.

DRIVER: Thank you. CGA, is it, after day 3 on that first slide?

BEECH: Yes. So that stands for corrected gestational age. [Baby C] was born at 30 weeks and 1 day.

DRIVER: That's your first entry?

BEECH: Yes. So on day 3 of life, although he's 3 days old, his gestation is 30 weeks and 3 days.

DRIVER: Thank you. You will have -- we've already looked at some of [Baby C]'s notes as prepared by your colleague, Dr Ogden. So to a degree we're familiar with the layout here. And we can see that you have recorded there, alongside the heading "Problems", a list, and we've looked at the equivalent of that list with Dr Ogden already.

BEECH: Okay.

DRIVER: And they are the features that [Baby C] brought with him into life and, as it were, into the neonatal unit that you clinicians were aware of. Is this in effect you repeating what you knew about him --

BEECH: Yes.

DRIVER: -- in advance of your direct dealings with him?

BEECH: Yes.

DRIVER: If we could then move on, please, to see your subsequent note or a continuation of the note, I think.

So we are now on our page J1917, the next page, and this is just a continuation of a single noting on your part, isn't it?

BEECH: Yes.

DRIVER: And we can see we're still at 10.15 or thereabouts. And have you made these notes from an examination of data that had been previously recorded in relation to this particular baby?

BEECH: Yes. So I would have made these notes from looking at, for example, nursing charts and looking at the bed space surrounding [Baby C] because -- we'll probably go on to it, but I didn't actually examine [Baby C] himself at this time, so I would have been looking at monitors and the CPAP machine to see what setting he was on and things like that.

DRIVER: Right. So this is a record of the data as opposed to your actual physical examination of --

BEECH: Yes.

DRIVER: -- the baby? Thank you. Would it be right for us to assume that you would be considering this data against the backdrop of previous similar data that had been recorded and noted in his files?

BEECH: Yes.

DRIVER: Thank you. So under the heading "Ventilation", we can see that you have noted that he's receiving the benefit of CPAP?

BEECH: Yes.

DRIVER: And you've recorded the pressures?

BEECH: Yes.

DRIVER: And what's the next entry, what does that evidence?

BEECH: So the pressures are 4 to 5, so that's how much sort of pressure the oxygen was being given to [Baby C].

DRIVER: Yes. And the following beyond that comma?

BEECH: Thirty to 40% FiO2. That means how much oxygen the CPAP machine was giving to him, so 30 to 40%, with normal room air being 21%.

DRIVER: Yes. How was he or how was his data?

BEECH: I've said that he was saturating between 91% and 98% on those settings. So saturations can obviously be 100% but rarely do we see 100%. We are probably all saturating lower than that now. And that he hadn't had any documented desaturations, so that would be looking at the nursing charts. They would document if his oxygen levels were going too low for him essentially. So it looks like he was pretty stable on those CPAP settings.

DRIVER: Thank you. And your next entry that reads "gases satisfactory".

BEECH: Yes.

DRIVER: Is that a reflection of that data that you've just taken us through or is that something additional to it?

BEECH: So it's something additional to it. It means that he would have been having blood gases taken, periodically, at certain times. They show how -- one of the things is how a baby's ventilating, how effective their ventilation, their

breathing is. I have said they were satisfactory, I have not said there was anything wrong with those.

DRIVER: So his blood gases were satisfactory. Would you have described his saturation levels and recent history as being satisfactory or not?

BEECH: From what I've written there, yes.

DRIVER: Moving to the next heading, "Fluids". That is a record of what he was being provided with?

BEECH: Yes.

DRIVER: Nil by mouth?

BEECH: Yes.

DRIVER: And we've seen similar entries: TPN, we've been educated as to what that is; lipids, which is essentially fats; is that right?

BEECH: Yes.

DRIVER: "10% dextrose. Minimal gastric aspirates."

Is that taken from the nursing records?

BEECH: Yes.

DRIVER: Similarly is there a record of how much urine he'd been passing per hour?

BEECH: I can't remember. So it would have been from the nursing records and either from what they've recorded, I've worked out how many mls, millilitres, per kilogram of his body weight per hour he's passing or the nurses have worked that out. I can't remember.

DRIVER: Thank you. But at the time, as well as recording that information, from wherever it was drawn, did you make an assessment as to where that level of the passing of urine fell within the expected or desired range?

BEECH: I think it was slightly high but not concerningly so. So something to kind of bear in mind.

DRIVER: Thank you. The fact that his bowels had not opened at this stage in his young life, was that an issue of concern or not?

BEECH: No, not at this time because I don't think he'd received any feeds into his stomach at this point. And also being premature as well, it wasn't a concern, but again something to be mindful of and to know and keep an eye on.

DRIVER: Next you've recorded his medications. As I indicated earlier, Dr Ogden has taken us through some -- the previous and indeed some subsequent notes which reflect this. So unless there's anything in particular that you want to draw to our attention, we'll move through that rather quickly.

BEECH: That's fine.

DRIVER: Thank you very much. Can we see the next entry.

Thank you.

So under the heading "Sepsis", you have recorded that [Baby C] was screened -- and we understand that just means checked -- at birth.

BEECH: Yes.

DRIVER: And checked or screened would be for infections?

BEECH: Yes.

DRIVER: Does it flow from the fact that you haven't added to that note that there were no known or identified infections established through that screening at birth?

BEECH: Yes.

DRIVER: The next is the CRP. Are we right to read this entry, that it had moved from around 1 to up to 23?

BEECH: Yes, that's correct.

DRIVER: And alongside that entry, you have endorsed "A/W LP". Could you help us with that?

BEECH: Yes. So the A/W means "awaiting" and LP stands for lumbar puncture. That's a test which we do which, to all intents and purposes, rules in or rules out meningitis.

DRIVER: So as part of your clinical analysis of this data, as you recorded it, what if anything, what significance, if any, would you have attached to the upward movement of the CRP measure from about 1 to 23 or thereabouts?

BEECH: So we often are reassured if the CRP doesn't go up or goes down, because if it goes down, that shows an improvement. The fact that it's gone up shows us that we need to be mindful of that. We do see CRPs kind of up in the 80s, 90s, even into the 100s. So 23, although it's a rise and we need to be aware of that, it's not a huge rise. But because it has risen to 23, that's why he needs the lumbar puncture and I think in my plan I say he needs to carry on with his antibiotics for 7 days and again that's because of the rise in CRP.

DRIVER: "WBC", is that white blood cells?

BEECH: It is, yes.

DRIVER: And the measure, 2.3, where's that derived from, the data?

BEECH: It would be from results that came from the lab.

DRIVER: Right. And what, if any, significance would you have attached to that count?

BEECH: So that's low. I can't remember what the lower reference range that the lab gives us is, but that is low. Again, nothing concerning, but something that we need to be mindful of and [Baby C] would have been having blood tests probably every day so it was something we could keep an eye on.

DRIVER: Should we read the next two or three entries together or shall we read them independent of each other?

BEECH: The next two, neutrophils and lymphocytes, they are a type of white blood cell and again they're on the low side, just to be mindful of those.

And then "PLT" stands for platelets. That's something we all have in our blood to help our blood to form blood clots. And 90 is low. Again, we need to be mindful of it, nothing that we need to action at that time, but something that we need to keep an eye on and look at the trend, whether it's going up or down.

DRIVER: Thank you. The next entry?

BEECH: So he was on his third day of antibiotics, ABX stands for antibiotics.

DRIVER: Thank you. Dr Ogden told us earlier that blood cultures had been taken and were being monitored elsewhere --

BEECH: Yes.

DRIVER: -- and the information being fed back to you in the unit, as it were?

BEECH: Yes.

DRIVER: And so far so good in that regard; yes?

BEECH: Yes.

DRIVER: The next entry or set of entries. Can you help us with that?

BEECH: Yes, so metabolic, that's looking at a particular system, so I've said that [Baby C] was on phototherapy, so that's the blue light treatment that you give for babies who are jaundiced. His SBR, which stands for serum bilirubin result, was 81, and that was taken at 6.49 that morning. And I have said that it is about 50 below the treatment treat line, that's what that stands for. So when a baby's jaundiced we use standardised graphs and we plot the results of their bilirubin, that shows us how jaundiced they are. The graphs have two lines on them that show us whether a baby needs phototherapy, the light treatment, or if it's -- if they're more jaundiced there's a higher up line that shows they need a different kind of treatment. "50 below the treatment line" means that it is below the phototherapy line and I think it is around about 50 below the treatment line that we would think about stopping the phototherapy.

DRIVER: Right. So he's been on phototherapy and it seemed to be working, is that a layman's --

BEECH: I think so, yes.

DRIVER: Thank you. Lactate?

BEECH: Yes.

DRIVER: These two sets of digits, what do they, taken together, inform the clinician?

BEECH: So I've said that his lactate levels were between 1.8 and 2.8 on his last few blood gases, because the blood gas, as well as telling us about the oxygen and carbon dioxide, gives us a lactate level. In a neonate a lactate is probably normal if it's less than 2.5. So 2.8 is on the high side, but I think I said in my statement that it had previously been higher, so the fact that it's coming down towards normal is a positive sign.

DRIVER: And a positive sign of what?

BEECH: So your lactate can go up for a number of different reasons, including infection, dehydration. It kind of tells us how well your organs are being perfused and how well your tissues are being perfused with blood and with oxygen. So there's a number of reasons why it can go up.

DRIVER: In short that measurement has it still on the high side but you would have been pleased to read that it was lower than the last corresponding measurement?

BEECH: Yes.

DRIVER: Thank you. "Glucose 4.9 on last gas"?

BEECH: Yes, that's within the normal range for a neonate.

DRIVER: The next entry, just reiterates that which you've already taken us to, the scan --

BEECH: Yes.

DRIVER: -- that you undertook and shared with, I think, Dr Saladi, wasn't it?

BEECH: Yes.

DRIVER: The next entry, does that just inform us that, as you indicated you would, that you didn't undertake a physical examination of the baby --

BEECH: Yes.

DRIVER: -- because at this time he was with his mum --

BEECH: Yes.

DRIVER: -- and therefore that took --

BEECH: Yes, that took the priority.

DRIVER: That trumped your need to physically examine him --

BEECH: Yes.

DRIVER: -- at that point?

Then you record at the bottom how you updated [Baby C]'s mother as to the picture?

BEECH: Yes.

DRIVER: Thank you very much.

So looking at all that data together, going back to you there with [Baby C] at this time, what does that -- what did that all together lead you to conclude?

BEECH: There's nothing there that kind of stands out as worrying or concerning. It looks like a fairly standard ward round entry for a premature baby. There's a few things there that we need to be mindful of, like the lactate being on the high side, the white blood cells being a little bit on the low side, and the CRP having jumped a bit, but nothing -- and also the fact that [Baby C] was out of his incubator having skin to skin with his mum, that shows that he was a nice stable baby, because if he wasn't, we wouldn't have been able to do that, he'd have been in his incubator.

DRIVER: Okay. I didn't deal with that. So the fact that he was having -- him and his mum were sharing that time together in itself was a positive indicator?

BEECH: Yes.

DRIVER: Thank you. And I think you then added a plan for his continuing treatment; is that right?

BEECH: Yes.

DRIVER: And if we could just briefly look at that, which I assume is going to be on the next page. 1918, Mr Murphy. There is your plan. "Examine later", because you didn't examine him because he was with his mother?

BEECH: Yes.

DRIVER: "Start cautious trophic feeds"?

BEECH: Yes.

DRIVER: They are tiny amounts anyway --

BEECH: Yes.

DRIVER: -- even by the standards of trophic feeds?

BEECH: Even smaller.

DRIVER: Thank you. Next, "Needs lumbar puncture today"?

BEECH: Yes.

DRIVER: "Continue..."?

BEECH: Antibiotics.

DRIVER: As you indicated earlier, for another 3 days -- a week, isn't it. 7/7 --

BEECH: Yes.

DRIVER: -- yes, is medical shorthand for a week.

"Repeat SBR and gas at 15.00 hours [that day]"?

BEECH: Yes.

DRIVER: SBR again?

BEECH: Serum bilirubin, the measure of jaundice.

DRIVER: Thank you. And you have noted that he, [Baby C], in your view, needed a long line?

BEECH: Yes.

DRIVER: Reasons for that?

BEECH: Dr Rylance's entry says that his line into his umbilical cord had come out during her shift so he needed a different kind of line putting in to be able to give him mainly the TPN.

DRIVER: I'm not going to ask you to look at other people's notes and pass comment on them but did you see the UVC had come out? Did you have any dealings with that?

BEECH: No, I have not written anything about it and because it was before my shift I presume it had already been cleared away.

DRIVER: Its absence caused you to include in the plan for the future the introduction of a long line?

BEECH: Yes.

DRIVER: Thank you. I think that was the extent of your involvement with [Baby C] on that day, although you were back on on 12 June 2015 and if we go to -- there we are -- exhibit J1918. Same page, of course. Forgive me.

Further down the same page, you are noting that here, a long line was inserted?

BEECH: Yes.

DRIVER: By you?

BEECH: Yes.

DRIVER: And you inform the reader, it's said, "under sterile conditions"?

BEECH: Yes.

DRIVER: And I think we've already heard something of this in relation to another patient, but that is doing everything possible within the unit to ensure sterility --

BEECH: Yes.

DRIVER: -- during the introduction of a long line?

Now, is it right that you had more than one attempt --

BEECH: Yes.

DRIVER: -- for the introduction? So the first attempt was through the right saphenous line?

BEECH: Yes, saphenous vein.

DRIVER: Forgive me. And that, we were told this morning, is a vein that runs from the foot up the leg; is that right?

BEECH: Yes.

DRIVER: And your note says "vein bruised".

BEECH: Yes.

DRIVER: You read the entry and then explain it to us, if you would.

BEECH: "Vein bruised and long line would not thread beyond bruise, therefore removed."

So I think what I mean by that is that when I tried to put the long line in, the vein then bruised because I wouldn't have tried to put the long line in a vein which was already visibly bruised. Then I couldn't pass the long line any further than the bruise so it wouldn't have been in enough, so I had to take it out.

DRIVER: Thank you. So it follows that the bruising was a consequence of the introduction of the long line?

BEECH: Yes.

DRIVER: And a consequence that prevented or impeded the successful introduction of the long line?

BEECH: Yes.

DRIVER: So you reversed?

BEECH: Yes, I took it out.

DRIVER: You took it out?

BEECH: Yes.

DRIVER: And tried again?

BEECH: Yes.

DRIVER: Your second attempt was "more proximal". What does that mean in layman's terms?

BEECH: That means further up towards the middle of the body, so higher up than where the bruise was but in the same vein.

DRIVER: So effectively you were steering around the bruise; is that right?

BEECH: Yes, avoiding it by going higher up, yes. And I have said that the same thing happened, the vein bruised and I couldn't get it past that bruise, so I took it out again.

DRIVER: Thank you. So they were two attempts on the right?

BEECH: Yes.

DRIVER: So the third attempt was on the left?

BEECH: Yes.

DRIVER: Same vein, different limb, obviously?

BEECH: Yes.

DRIVER: And this was successful?

BEECH: Yes.

DRIVER: So:

"Long line threaded to 11 centimetres as measured"?

BEECH: Yes.

DRIVER: Explain that to everybody, please.

BEECH: When we're going to put a long line into a baby, we'll use a tape measure and literally measure how long we think the line needs to go in and the lines themselves have got markers on them, so we know exactly how many centimetres has gone into the baby because we can see the marker that's just outside where it's gone into the skin. So I must have measured that [Baby C] needed the long line putting in to 11 centimetres and that's what I've done, I've put it into 11 centimetres.

DRIVER: Thank you. As is the protocol, did you cause an X-ray to be taken of the baby so you could satisfy yourself or inform yourself, more accurately, as to the position of the long line within the baby?

BEECH: Yes.

DRIVER: Does that say "secured and X-rayed"?

BEECH: Yes.

DRIVER: And then a dash or an arrow, "Happy" --

BEECH: "With position".

DRIVER: So as well as causing an X-ray to be taken, you considered the X-ray?

BEECH: Yes.

DRIVER: I think Mr Murphy, if we could go to J1996.

We can see there an X-ray that says it's timed at 12.36 on 12 June 2015. The notes we were just looking at were timed at 12.45. Obviously the notes have to be made after the event.

BEECH: Yes.

DRIVER: And so you're happy that this is the X-ray that you noted, you considered post the introduction of the long line?

BEECH: Yes.

DRIVER: Thank you. So that's the X-ray that you considered and deemed the long line position to be satisfactory?

BEECH: Yes.

DRIVER: I'm not sure they were your words, but if we could go back to J1918, I won't misquote you.

You were happy with the position?

BEECH: Yes.

DRIVER: Sorry. So having arrived at that, you then removed the -- is that the guide wire?

BEECH: Yes.

DRIVER: We heard a little about that. Is that something within the long line that helps the clinician steer it through?

BEECH: It's more to enable you to see it on an X-ray because the plastic tube of the long line wouldn't show up on an X-ray. Whereas the guide wire is a very thin piece of metal so you can see it. That's why you leave it in until you've X-rayed and then you can see it.

DRIVER: So you X-rayed, you considered the X-ray, you were happy with it, then you removed the guide wire and you attached a device referred to as an octopus?

BEECH: Yes.

DRIVER: And just could you tell us what that is?

BEECH: It's a little device that goes on the end of a line, which enables the nursing staff mainly, whoever's giving medications through that line, to attach a syringe or an infusion and give it -- put it into the line, give the medications.

DRIVER: And does its name imply that it has more than one port, it would allow multiple entries into a single attachment?

BEECH: Yes. I can't specifically remember, but because I've written octopus, I would think so, yes.

DRIVER: You have, it would seem, attached a sticker there?

BEECH: Yes.

DRIVER: Is that just to keep an audit trail that would enable the reader to go to the X-ray in question?

BEECH: No. So that sticker there is from the long line that was put in. So it tells us the batch number and the expiry date of the line because all -- even medical devices have got expiry dates. So that's more if there is an issue with the line, kind of in the future, we can look back at that, because all the packaging will have been discarded, and know what batch number it was, so we could get in touch with the manufacturer if we needed to and say, there's a problem with this line from batch whatever.

DRIVER: Thank you. That was my error. My apologies.

BEECH: It's okay.

DRIVER: And you last noted for this point this time that, having undergone this procedure, in your opinion you left [Baby C] in a comfortable state?

BEECH: Yes.

DRIVER: Thank you.

I think your final contribution to the notes is on the next page on J1919 where there is an X-ray review. I think these are stickers too, are they?

BEECH: Yes.

DRIVER: They are. Pro forma stickers which record, and we look at the bottom of it, how you had undertaken a review of an X-ray at 12.55 on 12 June 2015?

BEECH: Yes.

DRIVER: That being an X-ray timed at 12.36?

BEECH: Yes.

DRIVER: Which, I think, is the same X-ray we just looked at?

BEECH: Yes.

DRIVER: And you, having reviewed that X-ray, you note, firstly, that there's no ET tube in which we knew, no UVC in for reasons that you've alluded to --

BEECH: Yes.

DRIVER: -- already. A long line was in place and its tip was just beyond --

BEECH: "The left hip joint."

DRIVER: Right. You've already told us that you were happy with that?

BEECH: Yes.

DRIVER: The NGT or OGT position was in the stomach.

BEECH: Yes.

DRIVER: It seemed straight. Was that satisfactory or not?

BEECH: Sorry, I was looking more -- when I at the X-ray I was looking for at the long line.

DRIVER: Do you want to go back to the X-ray?

BEECH: Yes, if that's okay.

DRIVER: That's at J1919.

BEECH: In the stomach is a satisfactory position.

DRIVER: We're going to look at that. While we go to it, we might as well also look at the "large stomach bubble gaseous" entry as well to save going back and forth, back and forth.

I think Mr Murphy might be able to make this a bit bigger. Is that of more assistance to you, Dr Beech?

BEECH: Yes. So the tip of the orogastric or nasogastric tube, you can't tell what it is from this, is in the stomach bubble that we can see, but I've commented that it seemed straight, because quite often you'll get a curve so I think I just wrote that down because it seemed a little bit unusual. And then I've written that he's got a large stomach and that there's quite a lot of gas in his bowel. Again, just something to note, but it wouldn't be a huge concern because he was on CPAP and when you're kind of blowing in air or oxygen through a mask, naturally some of that is going to go into the gastric tract and the stomach and the bowel.

DRIVER: Right. You're not a radiologist --

BEECH: No.

DRIVER: -- but part of your duties as a clinician require you to review X-rays to monitor the baby's well-being?

BEECH: Yes.

DRIVER: And that feature of this X-ray, that is to say the gaseous bubble or the gaseous bowel and stomach bubble, I think -- let's go back to your notes again at the risk of me misquoting you. 1996 again, Mr Murphy.

So in turn, firstly:

"NGT position in the stomach, seems straight."

Yes?

BEECH: Yes.

DRIVER: That records what you have just reviewed again.

Secondly, comments:

"Large stomach bubble, gaseous bowel" --

BEECH: Yes.

DRIVER: -- does that say?

BEECH: Yes.

DRIVER: Go on, you were telling us about that.

BEECH: So I've made a comment on it because it's what I've seen on the X-ray and I think it's something that was worth commenting on because it was a little bit sort of unusual, but nothing that was worrying because [Baby C] was on CPAP, so blowing the -- the CPAP effectively blows air or oxygen in through a mask and some of that, although it goes to the lungs, some of it goes into the stomach and the gastrointestinal tract. It is common for babies on CPAP to get gas in the stomach.

DRIVER: Going back to that last assertion of yours, when you say it's common, is it fair for us to derive from that that you would have looked at other X-rays of the abdomen of babies on CPAP?

BEECH: Yes.

DRIVER: And these findings on that X-ray, do they -- are they unusual in any way for a baby of this age on CPAP?

BEECH: Not the fact that there is air in there, but I think maybe that it looked like there was more than I'd seen previously. I'm not sure.

DRIVER: Thank you. So taking a step back and inviting you to go back to where you were on the afternoon of 12 June 2015, and taking into account all the data and the readings, and the X-ray, what was your general impression of the health of [Baby C] at that stage?

BEECH: He was stable but, like I said, for kind of my review doing this, there were things we needed to be mindful of going forward with him, to keep in our minds.

DRIVER: And they were the things you have noted and you have drawn our attention to specifically this afternoon?

BEECH: Yes.

MR DRIVER: Thank you. Could you remain there and answer any further questions?

MR JUSTICE GOSS: Mr Myers, I don't know how long you're likely to be.

MR MYERS: Well, actually, not very long, my Lord.

MR JUSTICE GOSS: All right. If you can do it in 10 minutes or so.

MR MYERS: I think it will be not much more than 10 or 15 minutes.

MR JUSTICE GOSS: Is that all right and then have the break?

Cross-examination by MR MYERS

MR MYERS: Thank you, my Lord.

Dr Beech, just starting with where you finished, by the time we get to round about lunchtime on 12 June, your view was that [Baby C] was stable, but there were things you needed to be mindful of?

BEECH: Yes.

MYERS: Thank you. There's just two areas I'd like you to give us a little more detail on and look at with us. The first is the line insertion at around 12.45 on 12 June so I'm going to ask Mr Murphy to put up what we've just been looking at, which is page 1918 in the notes.

If we have a look at this, please, Dr Beech. We've seen reading through that, Dr Beech, that for the reasons you explain, there were three attempts to insert the long line?

BEECH: Yes.

MYERS: Can you just help us with this? Is there a kind of guide to how many attempts it should take or different stages to go through as to who makes those attempts?

BEECH: So whoever's the most competent person on the shift that day, so for example you'd probably start with the most junior person, the most -- it's a procedure that will be done by a doctor, not a nurse. And you probably start with the most junior person who is competent to do it so that they get experience. And then if it becomes more difficult then you'd sort of work your way up the seniority.

MYERS: We understand it can be difficult to insert a line into a vein on a neonate.

BEECH: Yes.

MYERS: Is there a kind of recommended number of goes it should take for someone at a particular level or do you get someone else involved at a certain point?

BEECH: Yes. For example, if the most junior person has a look and they're not able to see a vein, then they wouldn't have a go. Then you'd go to the next person. There's kind of an unwritten rule -- I don't know if there were specific guidelines at Chester at the time, but usually we'd say that a registrar would be able to have two or three goes before then escalating to a consultant.

MYERS: Right, thank you. Is that partly because with the little neonates that you're working with, their veins are quite delicate, aren't they?

BEECH: Yes.

MYERS: You have to be -- and you touched on this perhaps when you mentioned skin-to-skin handling. Handling them can put them into a stress situation, can't it?

BEECH: Yes.

MYERS: In fact it's possible, isn't it -- I'm not suggesting this happened with you and [Baby C] by the way -- but it's possible a baby that's handled in a way that becomes stressful can even desaturate as a result of handling?

BEECH: Yes.

MYERS: Just looking at a little more detail on this note before we move on, where it says:

"Guide wire removed and octopus attached."

You mentioned this briefly, the octopus is the connecting device on the end of the line away from where the baby is?

BEECH: Yes.

MYERS: The opposite end?

BEECH: Yes.

MYERS: Then that allows other syringes or other tubes to be attached; is that correct?

BEECH: Yes.

MYERS: And are there a number of ends to the octopus?

BEECH: Yes. I can't remember how many these ones that Chester had have because there are different ones used at different places.

MYERS: Right. And they hang loose, do they?

BEECH: So there's one attachment to the line that's in the baby and then you get either one or multiple kind of lines going off that.

MYERS: Yes. But it could be -- is there a limit to how many?

BEECH: I don't know if there is. I think in my experience I've seen three, up to three. I don't think I've seen any more, I'm not sure.

MYERS: Do they hang loose?

BEECH: If they're attached to something else then it wouldn't be loose, but if there's nothing attached to one of them then that would kind of be attached to the baby and then may hang down, yes.

MYERS: We can see just after that you have put the word "flushed"?

BEECH: Yes.

MYERS: Does that indicate that you had flushed the line?

BEECH: Yes.

MYERS: And does that mean you have put saline through it to make sure it's clean and air free?

BEECH: Yes and working.

MYERS: And working. So we know you have done that because you've written "flushed" next to it?

BEECH: Yes.

MYERS: Is that good practice to write "flushed" when you have flushed? What's the position with that?

BEECH: Yes, from what I've always done, I was always taught it's good practice to write that.

MYERS: Because then we know you've done it?

BEECH: Yes.

MYERS: Because you haven't -- it may not be flowing correctly?

BEECH: Yes.

MYERS: And you also know if it's been flushed, any residual air has been taken out of it?

BEECH: Yes.

MYERS: Right. The next thing I would like to ask you about, the other thing, Dr Beech, is just the X-ray we saw and what follows from that. So could we just have a look, please, at 1996, which is the X-ray itself.

So this is a X-ray, we know, at 12.36 on 12 June.

BEECH: Yes.

MYERS: So you arranged for this, did you, just to make sure that the line you had put in was in the right place?

BEECH: Yes, so I don't know whether I ordered it or whether I asked a colleague to order it, but I would have asked for it to be done once the long line was inserted.

MYERS: And you're used to looking at X-rays like this, day in, day out, aren't you?

BEECH: Yes, at that time.

MYERS: Yes, at that time. Just at least to give us an idea of what we're looking at, because not everybody is, most of us here are not, which bit is the stomach?

BEECH: It's this big bit here (indicating).

MYERS: I've got the cursor on it -- there we are.

BEECH: The black bit.

MYERS: That's the stomach.

BEECH: Yes.

MYERS: We'll have a look in a moment what it might look like without so much air in.

And underneath it, is that the upper part of the bowel, the almost heart-shaped area beneath it?

BEECH: You can't -- it's very difficult to tell, especially on this whether it's -- which part of the bowel it is, but it is bowel.

MYERS: It's bowel?

BEECH: Yes.

MYERS: And the dark patches are air in that bowel as well?

BEECH: Yes.

MYERS: All right. Thank you. So we've got the stomach there and the bowel.

Then if we just look at the note that came with that. Could we go to page 1997? Just the first part, really. We can see there, Dr Beech, it says:

"There is now marked gaseous distension of the stomach and proximal small bowel."

Is this something you would have read?

BEECH: Not at the time.

MYERS: Ah.

BEECH: So this -- they get reported by one of the consultant radiologists afterwards.

MYERS: All right.

BEECH: So my opinion of it was as I was looking at it.

MYERS: That's fine. We know, we've had a look at the image with you, the stomach is the bit we saw at the top, slightly egg-shaped and on its side on that image. In the bowel have you got the small bowel and the large bowel?

BEECH: Yes.

MYERS: And small is above large, is that how it, works?

BEECH: Yes, it runs from the stomach into the small bowel and then into the large bowel.

MYERS: So this certainly, when it's been looked at, is:

"Gaseous distension of the stomach and the proximal small bowel"?

BEECH: Yes, that's the first bit next to the stomach.

MYERS: Thank you. Let's go back, if we could, please, to page 1998 just to help us with a comparison. This is one of the X-rays taken on the 10 June, 6.20, so this is soon after [Baby C] had been born. We can see: 10 June, 18.19. Page 1988.

Can you tell us on this one where the stomach is?

BEECH: Yes. It's this bit here (indicating).

MYERS: All right. You're pointing almost halfway -- there we are.

BEECH: Yes.

MYERS: Thank you, Mr Murphy. So that's the stomach without a significant distension of air in it, isn't it?

BEECH: Yes.

MYERS: That's what it was like on 10 June at 18.19. So we can see what it's like there. Then can we go back to that first one?

MR JUSTICE GOSS: Sorry, could I just ask you before we leave this one? Is that area that's now encircled with the purple line, is that air in the stomach or is that just the stomach?

BEECH: You will only see the stomach if there's air in it because it's air that makes it black.

MR JUSTICE GOSS: That's what I thought probably was the case. I just wanted to be clear. So the stomach is in fact a bigger area than that or not? Maybe not, I don't know.

BEECH: It's hard to tell, really. The blackness that you are seeing is air. So it could be that the stomach is -- probably all of it is air. There might be a little bit of fluid in it perhaps that you wouldn't necessarily see but it wouldn't be -- I'm not a radiologist so I'm kind of explaining it in my best terms. But you probably wouldn't see -- there wouldn't be more stomach, if you like, than what you can see that's black.

MR JUSTICE GOSS: I'm sorry to interrupt.

MR MYERS: No, not at all.

MR JUSTICE GOSS: It's just while we had the image up rather than having to put it up again have.

MR MYERS: So that's the image of it not long after [Baby C]'s birth. And then can we go back then to the image that you saw, finally, which was at page 1996. The one which was marked as "marked gaseous distension". Now we've seen this we can have a look. There we are. We've seen the stomach on there. So that dark patch, the oval that we're looking at now, is the amount of air filling the stomach?

BEECH: Yes.

MYERS: All right. We can all see that.

You were asked about this, but can I confirm, when you looked at this did it cause you any particular concern?

BEECH: Well, I noted that it was very gaseous. I haven't said that I've discussed it with a consultant or anything, but I have noted that -- and it's something to be mindful of.

MYERS: Your experience at this time was working day in, day out on the ward in the neonatal unit, wasn't it?

BEECH: Yes.

MYERS: And working day in, day out, hands-on experience, your view was this probably was the result of CPAP air blowing into the tummy?

BEECH: Yes.

MYERS: Is that something you called CPAP belly when you were working there?

BEECH: Yes. You can do, yes.

MR MYERS: Thank you, Dr Beech.

Re-examination by MR DRIVER

MR DRIVER: Just one brief point of re-examination. If Mr Murphy could take us back to exhibit J1918 and the doctor's entry before the long line audit sticker towards the bottom of the page. Thank you.

You were asked about your last entry before that, that audit sticker, if I can call it that. So we're talking about the long line, you're happy with its position, the guide wire had been removed, an octopus attached. Then you add "flushed".

BEECH: Yes.

DRIVER: What is it that had been flushed that you deemed fit to note?

BEECH: I can't remember exactly but I would have put a syringe on either one or all of the kind of lines of the octopus and flushed saline in to make sure that the long line as a whole was working.

DRIVER: Thank you. Prior to that, prior to the introduction of the long line, would that have been flushed with saline?

BEECH: Yes, and so would all the lines of the octopus.

DRIVER: Thank you. Would there, could there, be any residual air or gas in any part of that apparatus?

BEECH: There shouldn't have been, no, because I would have checked it when I did it, so made sure that there was no air in the flush itself, watched the saline come out of the end, and visibly checked each line of the octopus.

DRIVER: And that is a standard protocol --

BEECH: Yes.

DRIVER: -- cautionary measure?

BEECH: Yes.

MR DRIVER: Thank you. I have no further re-examination.

Does your Lordship have any questions for Dr Beech?

MR JUSTICE GOSS: No, I don't.

Thank you very much, Dr Beech. I think that's it, I don't think you'll be required again.

BEECH: Thank you.

MR JUSTICE GOSS: So thank you for coming and giving your evidence. You are free to go. Would you please not talk to anyone, in particular anyone who is going to be or may be going to be a witness in this case, about this case until it's all over?

BEECH: Yes.

MR JUSTICE GOSS: Thank you very much indeed.

(The witness withdrew)

MR JUSTICE GOSS: We'll have our break now, members of the jury. Ten or so minutes, thank you.

(In the absence of the jury)

MR DRIVER: We'll next call Yvonne Griffiths, Nurse Yvonne Griffiths, and your Lordship granted screens for this witness yesterday afternoon.

MR JUSTICE GOSS: Yes. Thank you very much. We'll do that shortly before quarter to. Are we likely to finish her this afternoon?

MR DRIVER: We've got a fighting chance.

MR JUSTICE GOSS: We'll see. If we can finish her, if it means sitting until 4.30, we will do.

(3.31 pm)

(A short break)

(3.41 pm)

(In the presence of the jury)

MR JUSTICE GOSS: I heard that. Thank you.

When you're referring to documents, could you please give the page numbers? Now, sometimes there's been reference to the slide number and then you go to the slide and you can click on, but you don't always get all the documents, and then you have to go to the column on the right and get the J number. You're wanting the J number, is it?

JUROR: Yes. We want both because (inaudible) just give us the J number we can't (inaudible) --

MR JUSTICE GOSS: I share the difficulty. You tend to refer to J numbers, so can we please refer to wherever can it be found?

MR DRIVER: We can. Of the original exhibits that were considered today, some of them are embedded into the presentation behind slides, others are not --

MR JUSTICE GOSS: Exactly.

MR DRIVER: -- but are in the side file folder.

MR JUSTICE GOSS: Quite a lot more are not in the presentation. You need to go to the J file. I think that's what we're all finding.

MR MYERS: The way we're trying to deal with it, my Lord, is where there's a slide number and a J number, we try to give both, but inevitably, as documents are being added as we go along, quite naturally, some of them are just as J numbers because (inaudible: coughing) with them behind the slides.

(Pause)

MR JUSTICE GOSS: Sometimes they're in the additional -- sometimes they're in other. So you have to give time for people to get it and to make a note of it as well. Because if someone wants to identify a particular document they want a note of the document number and it's gone from the screen...

DRIVER: We'll do our best. I think invariably now we're certainly mentioning the J number because that's sometimes the one that's definitely there, but we'll aim to mention the slide where the slide exists as well.

MR JUSTICE GOSS: That would be helpful, thank you.

If any of you haven't got the number, just raise a hand and ask for it. I'll try and make sure it's clear in sufficient time. Sorry about this, but it's with reference to documents and you'll be looking at documents.

MS YVONNE GRIFFITHS (sworn)

Examination-in-chief by MR DRIVER

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

GRIFFITHS: Yvonne Griffiths.

DRIVER: Is it Mrs Griffiths?

GRIFFITHS: Ms.

DRIVER: I have before me a statement dated 8 May 2020 that you provided to the police in regards to an investigation into the neonatal unit or events therein of the Countess of Chester Hospital. And at that point in time, your occupation was a neonatal unit manager?

GRIFFITHS: Deputy manager.

DRIVER: Deputy manager. What was your role back in 2015?

GRIFFITHS: Sorry, yes, I was the deputy manager in 2015.

DRIVER: We've heard reference to various job titles amongst the nursing staff at Chester back in 2015. Back then, were you a band 5 or a band 6 nurse? Can you remember?

GRIFFITHS: A band 6.

DRIVER: You were a band 6 nurse.

I've been asked to speak up -- oh, the witness.

MR JUSTICE GOSS: Yes. I think your voice can be heard quite clearly.

Can you keep your voice up, please?

MR DRIVER: Ms Griffiths, a band 6 nurse. We've also heard reference to a job title, senior nursing practitioner. Are they the same thing or not necessarily?

GRIFFITHS: A senior nurse practitioner is a band 6 nurse that's done extensive neonatal training. So you would do a foundation and your intensive care. And then there's an additional programme, which is entitled the ENB23, which is an extensive neonatal, so you can do extended roles, like cannulation, intubation, and so that's an extension of the role.

DRIVER: Thank you. So all senior nursing practitioners would be band 6 nurses with those additional experiences and qualifications?

GRIFFITHS: Yes.

DRIVER: Therefore, not all band 6 nurses would be senior nursing practitioners?

GRIFFITHS: No, and that's distinguished with the uniforms -- it's a darker navy -- on duty.

DRIVER: Thank you. Back in 2015, were you a senior nursing practitioner?

GRIFFITHS: Yes.

DRIVER: Thank you. You know that you've been invited here this afternoon to give evidence about the care that you provided to a baby on the unit by the name of [Baby C], who was on the unit in June 2015.

GRIFFITHS: Correct.

DRIVER: What we will do during the course of your evidence, Ms Griffiths, we'll take you to nursing notes and the like that were created at the time, so you're not going to be tested as to the precise detail of observations and the like and -- that's what the jury were referring to a few minutes ago -- you're going to see it on screen.

Before we look at your nursing notes, can you confirm for me, and I know this is not controversial, that you made notes during the day shift of 12 June 2015, but when you completed those notes, you effectively misfiled them, so the notes pertaining to [Baby C] temporarily went into the file relating to another, completely unrelated baby --

GRIFFITHS: Yes.

DRIVER: -- whose name we don't need to share with the jury? And when you realised the error, you extracted them out of that file and later put them into the correct file?

GRIFFITHS: Yes.

DRIVER: So that was just a simple admin error that was soon corrected?

GRIFFITHS: Yes.

DRIVER: Let's go to those notes. So Mr Murphy, members of the jury, this is a note that will be in the side folder, not behind a tile, and it is exhibit reference J1950.

I want to focus, please, on the right side of the page. That set of entries there.

Let's just deal with the admin error, which is dealt with on the first line there, "YG" being your initials, and you have described that admin error by:

"On reflection, notes from the 12 June day shift were written in [ie they were filed in and we have blocked that baby's name out] for [Baby C]."

So [Baby C]'s notes were filed in another baby's file?

GRIFFITHS: Yes.

DRIVER: Then you extracted them. So the nursing notes were printed and rewritten. So from your original note you created this note?

GRIFFITHS: Yes.

DRIVER: Thank you. So this note is, could you confirm, a narrative of what you observed on the day during the time that you were caring for [Baby C]?

GRIFFITHS: Yes.

DRIVER: Thank you. It says you assumed care of the infant at 20.00 hours; is that right?

GRIFFITHS: 8 o'clock in the morning.

DRIVER: That's an error. So it reads 8 o'clock at night, it should read 08.00 hours, shouldn't it?

GRIFFITHS: Yes.

DRIVER: Thank you. You recorded that he, [Baby C], was receiving the assistance -- receiving assistance with ventilation throughout the day; yes?

GRIFFITHS: Yes.

DRIVER: And that was nasal CPAP?

GRIFFITHS: Correct.

DRIVER: Thank you. And you recorded the pressures that were being applied and the level of oxygen and variations within that band. We've already heard evidence about that so we won't dwell on that.

The next line, could you help us with that?

"Nares red but not broken. DuoDERM applied."

GRIFFITHS: Yes. That's the nares. We are always concerned about the nose, the bridge of the nose, with the prongs, just to make sure that there's no rubbing with the prongs.

DRIVER: And is that a typo or was that a term you use, nares?

GRIFFITHS: Nares, yes.

DRIVER: What does it mean?

GRIFFITHS: The nares is just the bottom of the nose.

DRIVER: The bottom of the nose. So there's some reddening --

GRIFFITHS: Yes.

DRIVER: -- of the baby's skin, although the skin was not broken, is that what that means?

GRIFFITHS: That's right. It's just a little bit red so sometimes we alternate between a mask and prongs.

DRIVER: So you applied DuoDERM, which is some emollient, is it?

GRIFFITHS: DuoDERM is a little dressing that's just placed there and it prevents any sores or broken skin.

DRIVER: Thank you. Your narrative note records next that there were "No apnoeas noted", so no episodes of him stopping breathing during --

GRIFFITHS: Yes, that's right.

DRIVER: -- during your observations of him.

Caffeine was given as prescribed?

GRIFFITHS: Yes.

DRIVER: You have recorded, and we've already heard from Dr Beech, how a long line was inserted by Dr Beech?

GRIFFITHS: Yes.

DRIVER: And does your note suggest that, following that successful insertion of a long line, the pre-existing peripheral cannula in [Baby C]'s hand was removed?

GRIFFITHS: Correct.

DRIVER: Because the long line was now going to perform the role that the cannula had previously been put in place for?

GRIFFITHS: Yes.

DRIVER: "[Baby C] was unsettled at times."

Could you expand upon that?

GRIFFITHS: Because [Baby C] was corrected at 30 weeks, he was quite lively, so he was -- I just remember vividly that he only loved to be held by parents in a kangaroo style. So I think that's what we mean by being unsettled, he just liked to be held.

DRIVER: And that's what "kangaroo care" means in this context?

GRIFFITHS: Yes.

DRIVER: The long line or the position of the long line was X-rayed and, once Dr Beech was satisfied with it, the introduction of fluids into [Baby C] through the long line was commenced; is that what that note --

GRIFFITHS: Yes.

DRIVER: -- tells us?

Then at 18.30, so getting towards the end of your shift, back end of your shift at least:

"Bile noted on blanket."

Was that an observation that you made, do you recall?

GRIFFITHS: Yes.

DRIVER: And do you recall that observation independently of this note or not?

GRIFFITHS: No, no.

DRIVER: Can you expand upon it in the circumstances then or not?

GRIFFITHS: With any baby, because obviously we're worried about introducing feeds too early because of the antenatal (inaudible) diastolic flow, so we would always be really cautious with any milk feeds that we were giving. And then we always would aspirate with the NG tube just to make sure there wasn't anything in the tummy, particularly air.

But on this occasion there was -- sometimes you can aspirate bile but -- I think it must have been noted on the bedding that there was a little bit of bile.

DRIVER: So the fact that you've observed and recorded "noted on blanket", does that tend to suggest that the bile had come out spontaneously as opposed to through aspiration by a nurse?

GRIFFITHS: Yes.

DRIVER: Thank you. Then does it flow, because of that, the nurse, you I should say, aspirated the nasogastric tube?

GRIFFITHS: We would do that quite frequently anyway. With a baby being on nasal CPAP we would always aspirate the abdomen at least every few hours, 4 hours, but obviously with the bile that is an indicator that you would need to aspirate just to make sure.

DRIVER: Thank you. Upon aspirating the NG tube, did that produce or withdraw 2ml of black-stained fluid?

GRIFFITHS: That's what's written, yes, that's what I've recorded.

DRIVER: And full stop. Separate note:

"The infant [that is to say [Baby C]] was too unsettled for lumbar puncture."

Would that have been -- firstly, how unsettled he was, would that have been an observation you made or somebody else?

GRIFFITHS: Usually, if there's an indication -- if the CRP is rising, and I think in this instance it did, then we would always do a lumbar puncture, but obviously we were quite mindful because it is a needle into the spine, so if the baby's too active or too upset then we wouldn't perform that because we wouldn't want to take the risk of him moving.

DRIVER: That decision to defer or postpone the lumbar puncture, would that have been a decision made by you, made by one of the doctors or made together?

GRIFFITHS: It's always a joint decision.

DRIVER: Thank you. So it was deferred and the plan was to reassess that decision --

GRIFFITHS: Yes.

DRIVER: -- later? And we know Dr Ogden considered the baby and advised, at the time, feed should be withheld to be reconsidered at a later stage?

GRIFFITHS: Yes.

DRIVER: And that is your note. I think that is all of your notes in relation to that shift that ended at about 8 pm on 12 June. Can you remember who you handed over to?

GRIFFITHS: Yes, it was Melanie Taylor.

DRIVER: Thank you. Do you recall whether or not you had any further direct dealings with young [Baby C]?

GRIFFITHS: Yes. I actually came into work on Sunday for an early -- a shift and that's unfortunately when [Baby C] had died, on the previous night, so I did help Mel with caring for [Baby C].

DRIVER: That was at a time after his death?

GRIFFITHS: Yes.

DRIVER: Thank you. But in life, your cares provided to him in life, are they summarised in this paragraph that we've focused upon?

GRIFFITHS: Yes.

MR DRIVER: Thank you. Could you remain there and answer any further questions?

Cross-examination by MR MYERS

MR MYERS: Ms Griffiths, [Baby C] was really just about at the limit of what you could accept at the Countess of Chester at this time, wasn't he; is that correct?

GRIFFITHS: We accepted under 27 weeks and 800 grams.

MYERS: Yes. I'm just looking -- you explain to us you made a statement to the police on 18 May 2020. So I'm just looking at

that, the last page, just to help with this. You'd said that he was a very small baby and we know that. He was intrauterine growth restricted and 800 grams and your view was you didn't often have babies of that weight for that gestation, did you?

GRIFFITHS: No, that's right.

MYERS: Normally, and you help us by giving a comparison, you'd normally expect at least 2 kilograms even for that gestation?

GRIFFITHS: Yes.

MYERS: So [Baby C] was very small. Is it right, if he'd just been about 10 grams less, he probably wouldn't have been able to stay at the Countess of Chester?

GRIFFITHS: It just depends. We always communicate very closely with our tertiary units, which is our level 3 unit, and I think you have to weigh up the -- remaining in a comfortable, stable unit or transferring in an ambulance when the baby's born. So I think you always have to consider the separation of mum and baby too.

MYERS: Certainly back in May 2020, you said to the police:

"[You] remember when he was born, if he'd been 10 grams less he wouldn't have been able to stay with us on the neonatal unit at the Countess of Chester."

GRIFFITHS: Yes. There would be a consultation with the tertiary centre, yes.

MYERS: But as a general rule, in an ideal world, 800 grams is the lowest limit, isn't it, for the Countess of Chester?

GRIFFITHS: When they're born, yes.

MYERS: When they're born.

Now, a baby in that condition physically is in a very precarious position; do you agree?

GRIFFITHS: Yes.

MYERS: I think you explained to the police that things are very uncertain about the outcome?

GRIFFITHS: Yes, I think any admission on to the neonatal unit, it's very uncertain.

MYERS: You said:

"[Baby C] was very small and very vulnerable and it was a very precarious time"; is that right?

GRIFFITHS: Correct.

MYERS: Things are very uncertain about the outcome of a baby that small; is that correct?

GRIFFITHS: Yes.

MYERS: I want to ask you about the shift you were telling us about, which is on 12 June. It was 8 in the morning to 8 in the evening; is that correct?

GRIFFITHS: Yes.

MYERS: And did you take over from a nurse called Bernadette Butterworth?

GRIFFITHS: Correct.

MYERS: Were you the designated nurse for [Baby C] in nursery 1?

GRIFFITHS: Yes.

MYERS: Do you remember who was on duty with you? That might be a bit of a feat of memory.

GRIFFITHS: I remember my colleague Yvonne Farmer was in nursery 1 with me.

MYERS: But that's the only person you can remember unaided?

GRIFFITHS: Yes.

MYERS: Ms Letby wasn't on duty that day, was she?

GRIFFITHS: No.

MYERS: And in fact, that day falls within several days when she wasn't in the unit; is that correct?

GRIFFITHS: Correct.

MYERS: I'm just going to go to Bernadette Butterworth's notes so we can follow through where we were up to with [Baby C] at the time you came on. Again, no one's going to expect you to remember the detail of this, Ms Griffiths. It's a J number, the notes are at 1940, and I should say this is one where there isn't a slide if that helps.

Forgive me for reading through it with you, Ms Griffiths, but this just takes us from where we were to where you begin. It says:

"For care commenced at 20.00."

Of course this is Nurse Butterworth meaning 20.00 when she came on duty; is that correct?

GRIFFITHS: Yes.

MYERS: So that would be 20.00 on the 11th going through to 8 o'clock on the morning of the 12th, which is when you started?

GRIFFITHS: Correct.

MYERS: "All safety checks completed and satisfactory. Continues to be nursed on NCPAP [and it gives the pressures] as required between 31 to 37% oxygen to maintain sats. Has remained tachypnoeic overnight."

Does that mean rapid breathing?

GRIFFITHS: High resps, yes.

MYERS: High respiration.

"Recession remained evident."

What's that a reference to, recession?

GRIFFITHS: Recession is -- when a baby's breathing on its back you can see, just by the xiphisternum there, that there's a bit of an indent so they're tugging a little bit.

MYERS: So harder work that they're doing to breathe?

GRIFFITHS: Yes. But sometimes recession can be seen more in a smaller baby.

MYERS: Yes:

"RPT BCG at 23.00 was satisfactory."

Is that the blood gases?

GRIFFITHS: Yes.

MYERS: Lactate was 2.8 and it's got:

"Glucose has risen to 12.8. Dr Rylance informed and asked for..."

Is that -- what does "RPT glucose" mean?

GRIFFITHS: Repeat.

MYERS: "[Repeat] glucose with morning..."

I'd better ask you these terms. "Gent level"?

GRIFFITHS: It's an antibiotic, gentamicin.

MYERS: Oh, gentamicin, right. So:

"[Repeat] glucose in the morning with [antibiotic]"?

GRIFFITHS: Yes. We always take a gent level at 36 hours so we don't want to take unnecessary blood samples in a small baby.

MYERS: "Informed her of slightly raised creatine. Dr Rylance happy for morning gentamicin dose to be given without waiting for result. Whilst obtaining morning bloods UVC was found to be out."

We're familiar now with what a UVC is:

"Bed damp, so it was thought had not been out long. Was in situ with previous observation."

Just pausing there, in your experience, Ms Griffiths, can things like a UVC come out because the baby can move around quite a bit?

GRIFFITHS: Yes.

MYERS: So although he is little, he can wriggle?

GRIFFITHS: Yes.

MYERS: "It was thought it hadn't been out long. Was in situ with previous observation. [Repeat] blood gas good, as was lactate, but glucose had dropped to 1.7. Dr Rylance informed. Plan to transfer into peripheral cannula and repeat glucose at 8 am. Not for fluid bolus at this time. Cap refill satisfactory."

Is that capillary refill time?

GRIFFITHS: Yes.

MYERS: We have the details of a repeat glucose:

"UVC oozing slightly. Fluids remain..."

And it's got the rate of fluids:

"... 120ml per kg per day, Babiven Start-up, lipids and 10% dextrose had been running via the UVC. Lipids stopped since fluids transferred to peripheral cannula..."

"Abdo", is that abdomen?

GRIFFITHS: Yes.

MYERS: "Abdo appears distended."

So does do mean a bit stretched at that point?

GRIFFITHS: Yes.

MYERS: "Soft, firm. Not had bowels opened. Minimal clear asps..."

Aspirates?

GRIFFITHS: Yes.

MYERS: So certainly at this point -- and we will come to this in a moment, but you described bile in the aspirates --

GRIFFITHS: Yes.

MYERS: -- but at this point they're clear?

GRIFFITHS: Correct.

MYERS: "Passing urine" and it's got the rate there:

"Phototherapy remains in situ. SBRs are still not 50. Under treatment line."

Is that a measurement to do with the phototherapy?

GRIFFITHS: It's a serum bilirubin level. So that's a blood level.

MYERS: "Has been quite unsettled at times and has required an increase in oxygen when handling as desats."

I will come back to that in a moment:

"Mum has visited this morning with expressed breast milk which has been put in fridge."

Could you help us, when it says:

"Has required an increase in oxygen when handling as desats."

We have perhaps heard something of that already, is it right that the babies can actually desaturate through handling?

GRIFFITHS: They can, yes.

MYERS: That's what that's a reference to so far as you can see?

GRIFFITHS: Yes.

MYERS: All right, thank you.

So that's the position when you come on and take over the care of [Baby C]; is that right?

GRIFFITHS: Yes.

MYERS: Thank you. Were you aware during the course of this day that there was an X-ray taken in which it was apparent that [Baby C] had a significantly distended stomach with air in the stomach and the small bowel?

GRIFFITHS: This is on reflection of notes that I've read since.

MYERS: Yes.

GRIFFITHS: So with -- I believe, because we did a long line, we would always check the position with and that position we would have a picture of the abdomen, an X-ray. And I believe it was noted that there was an air bubble in the tummy.

MYERS: Is that something that you -- this isn't meant to sound rude in any way, but gave any further thought to or, if you did think about it, what did you think about it? Could you tell us what you thought?

GRIFFITHS: We would always be cautious with feeds but I presume we weren't feeding at that time anyway because I know we were cautiously feeding and if we were it would just be a trickle of milk, and we were aspirating the abdomen, and then we would pass on any concerns to the medical team.

MYERS: So even with aspiration it still managed to get to the size that it did? You said you were aspirating during this?

GRIFFITHS: I can't envision what the X-ray looked like and how big the bubble was, but we did everything we could with an NG tube in and aspirated air.

MYERS: We'll put it up so we can see. If we look at it's again in the additions section, ladies and gentlemen, my Lord, and it's 1996.

This is just to assist if it does, Ms Griffiths. Would you have seen this at the time?

GRIFFITHS: I would have viewed it after the long line had been inserted.

MYERS: All right. We know that's described on the notes that come with it as:

"Marked distension of the stomach and the small intestine."

Do you know how that would happen whilst [Baby C] was in your care or on the shift that you were working?

GRIFFITHS: As I say, because we have nasal CPAP, sometimes air can be in the tummy so that's why we do aspirate. It can be a sign of infection, but I know he was covered on antibiotics, so I can't comment any further.

MYERS: What I wanted to ask was, if that's right, even if aspiration was taking place through the NGT, it's still possible, so far as you can see, for the stomach to distend like this with air going in through CPAP?

GRIFFITHS: I suppose it all depends when I last aspirated the stomach as well with air.

MYERS: So, to make it quite clear what we're discussing, aspirating a stomach involves drawing out the contents of the stomach through the tube that's going into it, doesn't it?

GRIFFITHS: Correct.

MYERS: And that could involve drawing out fluid?

GRIFFITHS: Correct.

MYERS: Or it might involve drawing out air if there's air in there?

GRIFFITHS: Correct.

MYERS: Is it right then you're saying [Baby C], so far as you recall, would have been aspirated over this period?

GRIFFITHS: We tend to aspirate every 2-3 hours because obviously you are not going to aspirate every hour, because then you are disturbing the baby. So we do tend to let the baby rest in the incubator.

MYERS: But in your opinion the most likely explanation, notwithstanding aspiration, is this is air that has gone in through the CPAP that's giving him extra oxygen?

GRIFFITHS: Possibly.

MYERS: Possibly. There could be other reasons?

GRIFFITHS: Yes.

MYERS: Thank you.

I'm going to move forwards now to the notes you made. Page 1950. That's in the additional section, ladies and gentlemen, so you can scroll down there.

1950.

Just some questions about these, Ms Griffiths. If we could go to the right-hand side, please, and just enlarge the notes there.

I think we've explained that the notes had been entered at the right time but in a different place and then you brought them across to [Baby C]'s notes on 14 June; is that correct?

GRIFFITHS: Yes.

MYERS: Right. So that's how it is that we have an entry at 1738 on the 14th dealing with notes from the 12th?

GRIFFITHS: Correct.

MYERS: Thank you. I just want to ask about one area in particular:

"Bile on the blanket and the aspirated black fluid."

Where bile on the blanket is concerned, that is most probably bile that's been brought up through vomiting; is that correct?

GRIFFITHS: Or dribble.

MYERS: Or dribble?

GRIFFITHS: Yes.

MYERS: But it's come back up through [Baby C] through his own body acting that way?

GRIFFITHS: Yes.

MYERS: Thank you. The 2ml of black-stained fluid, that's an aspiration that you or you and the doctor have taken?

GRIFFITHS: I would have taken that.

MYERS: You would have taken that?

GRIFFITHS: Yes.

MYERS: Thank you. Just pausing there, if we look in the clinical charts, and they're at page 2009, and there is an S on this, it's slide 39, or if you are using the J numbers, 2009.

We need to enlarge on the right-hand side, please, Mr Murphy. If we could make that a bit larger, and we might zoom in yet. I'm just going to -- after we've looked at what this is, I'm going to ask you to explain to us, Ms Griffiths, as best you can, where you think the aspiration you're talking about is.

This is 12 June. With got the hours running down the left-hand side. We probably need to go to the bottom half of the form, please.

So we can see -- it's a little difficult because we've got a big red J2009 right over the area perhaps where you might want to look. When you describe taking out the -- is it 2.5ml of bile?

GRIFFITHS: Yes.

MYERS: Is it possible from what you can see there to tell us what entry that would be?

GRIFFITHS: Usually I would put it between the 18 and 19, but perhaps it's not there, but sometimes I would put it on the ITU chart or if I've written the notes at 7 o'clock then it would be fresh in my mind.

MYERS: All right. Can I check, where we look on the right-hand side, there is a column which looks like there is a Y (overspeaking) --

GRIFFITHS: -- yes.

MYERS: Is that your initial on the right-hand side?

GRIFFITHS: Yes.

MYERS: Is that you, YG?

GRIFFITHS: Yes.

MYERS: Right. Certainly looking at this chart, it's difficult to see where it would be on this chart.

GRIFFITHS: Yes.

MYERS: Although there are other aspirations on it, aren't there?

GRIFFITHS: Yes.

MYERS: But in any event, we're not disputing that you did do it, I was just seeing if we could see it on the chart. That was all. You can't identify it; is that right?

GRIFFITHS: That's right.

MYERS: All right, thank you.

Do you agree, Ms Griffiths, that dark bile coming up is a matter for some concern with a baby like [Baby C]?

GRIFFITHS: I think any bile we're cautious with. The main thing we would do is just stop feeds, which -- we weren't feeding anyway.

MYERS: But you certainly recognised it as a potential issue of some sort?

GRIFFITHS: Yes, and I think, you know, we would -- that's why with lines in the tummy we're always very careful, but he didn't have a line in his stomach, so if we would have still had the UVC and that dark bile, we might have taken a line out, thinking --

MYERS: All right.

GRIFFITHS: But that wasn't the case.

MYERS: And is it the more serious if the baby has vomited bile up?

GRIFFITHS: Um... It was just -- I mean, he didn't desat with the vomit, so I wouldn't say it was... you know, obviously it's not good, but it was more of a dribble on the actual bed that I

noted. So it wasn't him, [Baby C], desatting that made me go over and then see that he was vomiting.

MYERS: But would you agree it's necessary, inevitably, to keep a close watch over a baby like [Baby C] in any event?

GRIFFITHS: Yes, correct.

MYERS: And certainly if we're dealing with dark bile, whether it's aspirated by the doctors or the nurses or whether it's by vomit, that could be a matter of concern, so you need to keep a close look on him?

GRIFFITHS: Yes.

MYERS: So I'm not asking two questions at once, it is potentially -- potentially -- a serious issue, isn't it?

GRIFFITHS: I think given that we're nil by mouth and he had bile, yes, I would -- and I think I did get the doctor to review [Baby C] at that time.

MYERS: Yes, Dr Ogden, didn't you?

GRIFFITHS: Yes.

MR MYERS: All right. Thank you, Ms Griffiths.

Re-examination by MR DRIVER

MR DRIVER: Ms Griffiths, you were asked to look at an X-ray, and this was the X-ray that is J1996, which was an X-ray taken at 12.36 hours on 12 June. And you were asked questions and gave answers about CPAP and its possible effects and you spoke about aspirating from babies. Then we looked at, and could we please go to, a chart, the intensive care chart, which again is in the additional documents at J2009, and if we could highlight the right side of this document, please, as we did a short while ago.

Can we highlight all of the right side of the document, please, Mr Murphy? My mistake. Thank you.

The jury have been shown the like of this before. But just to remind ourselves, it's divided into two parts: input and output. There is a column under "output" -- let's read them. "Blood sugar". The next says "NG asp/vomit". Are you familiar with this?

GRIFFITHS: Yes.

DRIVER: What's recorded in that column, "NG asp/vomit"?

GRIFFITHS: I haven't recorded anything.

DRIVER: No, but what's that column for?

GRIFFITHS: That is more when we're doing feeds because, obviously, if we're introducing feeds we want to make sure that that feed has been absorbed. So if we were going to give 10ml of milk then we would always aspirate the tube before we actually give that NG feed to make sure that that feed had been absorbed. But because [Baby C] wasn't receiving feeds then I didn't fill that column in, but normally we would just record feeds there or if we had bile, so we wouldn't necessarily record 10ml of air.

DRIVER: Are you able to measure the aspirated air or gas in the same way?

GRIFFITHS: Yes, you can aspirate and it can be 10ml and then you disconnect, and then it escapes, and then attach again, or sometimes you can put an NG tube on free drainage so that it's constantly releasing air.

DRIVER: Is there any record that we could go to to see, firstly, whether [Baby C]'s tube was on free drainage or not?

GRIFFITHS: Unless it was written in the medical notes or in the nursing notes, I wouldn't be able to say.

DRIVER: Right. We may return to that. But just focusing still with this column "NG asp/vomit", I don't want to misquote you, but did you say a moment or two ago that you may not have necessarily recorded if gaseous aspirates were drawn?

GRIFFITHS: That's correct.

DRIVER: As a matter of record, if we scroll down to when your entries again at 08.00 hours on this chart, we can see -- I'm looking at the initials YG. Can we see that in this column, other than the entry that my learned friend Mr Myers took you to, which has been obscured by our page stamp J2009, other than that have you entered anything in that column?

GRIFFITHS: Not in the NG column.

DRIVER: Is that capable of informing the jury or not as to whether anything was aspirated from [Baby C] in that period, whether it be fluid or gas?

GRIFFITHS: No.

DRIVER: It doesn't help us either way?

GRIFFITHS: No.

MR DRIVER: Thank you. I have no further re-examination.

Does your Lordship have any questions for the witness?

MR JUSTICE GOSS: I don't, thank you very much. I believe this witness will be required again later in the trial.

MR DRIVER: Indeed.

MR JUSTICE GOSS: Right. That completes your evidence today. Thank you very much. But you are going to be coming back later to give evidence in the case again about another baby.

Would you please not talk to anyone about anything to do with this case and, in particular, the evidence that you have given, the questions you have been asked and the answers you have given?

GRIFFITHS: Yes.

MR JUSTICE GOSS: Thank you very much.

That's it for today, members of the jury. 10 o'clock tomorrow morning, then, please, if you can be here ready to start at 10.00.

This witness, in common with a number of witnesses before you, has been screened. You remember what I said about screens. You just pay no attention to them whatsoever. I'm sure you weren't, actually, and until I drew your attention to it, you probably hadn't registered that much in your psyche, but the important thing is that, as I said to you at the time, it's a common measure afforded to witnesses now. It doesn't have any reflection on the witness himself or herself when a witness is screened and you certainly don't hold it against the defendant or her case that the witness has been screened.

Thank you very much. 10 o'clock tomorrow morning. And remember your obligations of which I reminded you earlier today.

(In the absence of the jury)

MR JUSTICE GOSS: Please just stay there. I will rise. The courtroom will then empty and someone will escort you from the courtroom.

THE WITNESS: Thank you.

(4.25 pm)

(The court adjourned until 10.00 am on Friday, 28 October 2022)