

31 October 2022 (Day 19)
Baby C

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Monday, 31 October 2022
(11.30 am)

(In the absence of the jury)

MR JUSTICE GOSS: My apologies to everyone for the fact that I'm late. On behalf of Northern Rail, I extend their apology as well for cancelling my train.

(In the presence of the jury)

MR JUSTICE GOSS: I have a note from one of you. I'll deal with that. The answer is, yes, it'll be accommodated, just to reassure you.

I'm sorry we're late starting today. The clock hasn't been put back either, it says 12.30, it's actually 11.30. Shortly before I was due to get a train it was cancelled, so there we are. But that has prompted me to say that we will address the issue of the rail strikes that are coming up. Unfortunately, trains do seem to be getting cancelled rather than a lot at the moment.

MR DRIVER: My Lord, the witness [Nurse B] is in the witness box. Could she be sworn, please?

NURSE B (sworn)

Examination-in-chief by MR DRIVER

MR JUSTICE GOSS: Please sit down. All right? You'll be being asked questions, as you know, from there. Try and keep your voice up, please. The microphone won't cause your voice to be amplified to the jury. Your natural voice has to carry around

the room. If you want a break at any time, just ask for a break, all right?

MR DRIVER: Could you tell the members of the jury your full name, please?

NURSE B: [Nurse B].

DRIVER: [Nurse B], could you inform the jury as to your occupational status back in June 2015?

NURSE B: Yes. So I was a band 6 neonatal nurse at the Countess of Chester Hospital at that date, and that basically means I was a shift leader.

DRIVER: In a very short while I'm going to be asking you questions that directly relate to the baby and patient, [Baby C], but before doing so, I'd like to invite you to expand a little more about your role within the unit at that time.

You told the jury moments ago that you were a band 6 nurse and a shift leader. Does it follow that every band 6 nurse is a shift leader or not?

NURSE B: On our neonatal unit, yes.

DRIVER: As of June 2015 for how long approximately had you been a band 6 and a shift leader?

NURSE B: A few years. I can't remember, I'm sorry.

DRIVER: That's more than sufficient. Thank you.

As a shift leader on any particular shift, would you be designated the responsibility of caring for a specific baby or babies?

NURSE B: When I was the shift leader?

DRIVER: Yes.

NURSE B: So ideally, no. The shift leader is ideally supernumerary, so that means that you oversee the care given to all of the babies. At times when it is extremely busy you may be allocated a baby, but ideally, no. You would cover breaks, so you would be -- you would be -- allocate breaks to cover them, but you wouldn't be allocated them for the duration of the shift unless necessary.

DRIVER: Thank you. So you'd be performing some sort of overseeing role?

NURSE B: Yes.

DRIVER: For the whole unit?

NURSE B: Yes.

DRIVER: And for all the nurses and all the babies?

NURSE B: Yes.

DRIVER: Prior to the commencement of a shift, what, if any, contribution would a shift leader make to the allocation of particular babies to particular nurses?

NURSE B: So you would allocate the babies according to their requirements, whether that -- that depends on the level of care that they need. So it depends on the care of the baby, so whether they're transitional care, special care, high dependency or intensive care. And then it depends on the qualifications of the staff member. So an ITU baby -- do you want me to say -- would be one nurse to one baby. Then the lower the care, the more babies allocated to one nurse.

DRIVER: Thank you. That answer you gave me had a number of parts to it, so if I can just retrace through that answer. Does it follow that shift leader has the responsibility for the allocation?

NURSE B: Yes.

DRIVER: You exercise some professional judgment --

NURSE B: Yes.

DRIVER: -- and you deem which nurses will look after which babies?

NURSE B: Yes.

DRIVER: But in order to reach such decisions, you apply certain guidance --

NURSE B: Yes.

DRIVER: -- and certain criteria? And that criteria takes into account, you told us, firstly the individual nurse's qualification and experience?

NURSE B: Yes.

DRIVER: And on the other side of the equation, the particular babies' --

NURSE B: Yes.

DRIVER: -- needs. As to that criteria, do you receive that guidance externally? Is there a national standard?

NURSE B: We will be following BAPM standards.

DRIVER: BAPM being?

NURSE B: BAPM -- oh gosh, you're testing me.

DRIVER: Is it the British Association --

NURSE B: British Association of Perinatal Medicine.

DRIVER: Thank you. I should have been in there earlier to help you. Apologies.

So they provide a standard --

NURSE B: Yes.

DRIVER: -- a set of guidelines?

NURSE B: A set of guidelines for the baby, but obviously, as a shift leader, you know the staff individually.

DRIVER: Yes.

NURSE B: Yes.

DRIVER: That anticipated my next question: are those guidelines applied rigidly, without deviation at all?

NURSE B: They will depend on staffing levels.

DRIVER: Yes. And anything else?

NURSE B: And the staffing that you have at that time on shift.

DRIVER: Thank you. As for the baby, how is the baby's status defined? For example, an intensive care baby, how is that defined?

NURSE B: So that is very much defined by BAPM.

DRIVER: Yes.

NURSE B: So an example would be a baby on a ventilator, receiving ventilatory support, would be classed as intensive care, which will be ideally one-to-one nursing.

DRIVER: And a high dependency baby, what qualifies a baby to attract that status?

NURSE B: Again, many different things, but an example would be a baby on CPAP, respiratory support, but with peripheral venous access, not central access.

DRIVER: And to go down the scale one more stage, a special care baby?

NURSE B: Would be a baby that isn't receiving any additional breathing support, but that doesn't include supplementary oxygen which would be either in the incubator in the ambient space or from nasal prongs but no additional ventilation needs.

DRIVER: Thank you. Moving away from the babies and nurses and just looking at the unit itself for a moment, we have already been informed that, as of June 2015, the Countess of Chester neonatal unit was what's deemed a level 2 unit.

NURSE B: Yes.

DRIVER: And it follows, does it, that again there'd be certain criteria which would ideally be applied that govern whether a baby should be ideally delivered at the unit and, if so, kept at the unit?

NURSE B: Yes.

DRIVER: And you would be familiar with that criteria?

NURSE B: Yes.

DRIVER: Let's move from the general to the specific now if you would. I'm going to ask you about the shifts that you led that involved the care of [Baby C], who the jury know was born at 15.31 hours on 10 June 2015.

Rest assured, [Nurse B], if you're asked questions about the detail of his care, that screen in front of you will assist as to detail and nursing records.

You made a witness statement in relation to these proceedings on 13 February 2018. Prior to doing so, were you afforded the opportunity of reminding yourself of the contents of the nursing notes --

NURSE B: Yes.

DRIVER: -- in relation to baby [Baby C]?

NURSE B: Yes.

DRIVER: Independent of those notes, do you have a memory, do you recall some or all of the events?

NURSE B: Some, yes.

DRIVER: Thank you. Did you ever have direct responsibility for the hands-on designated care of [Baby C]?

NURSE B: No, I didn't.

DRIVER: But were you a shift leader during the time when your colleagues did?

NURSE B: Yes.

DRIVER: And did you direct or designate his care in the way that you've already described generally to the jury?

NURSE B: So during the shift I was overseeing the care but I do not whether I allocated the nurse to him because back in 2015, around that time, we changed the system of who allocated. So today, we allocate the shift before. So say for instance this shift in question we're talking about is a night shift, the day shift would now allocate for the night staff coming in.

DRIVER: Yes.

NURSE B: However, around that time, we changed, so I'm not sure I allocated [Baby C]'s nurse on this night because it was around that time we changed and it was the shift leader coming on that shift that night, who would have been me, that allocated. So the allocation may have already been done when I came in.

DRIVER: I understand. And when you refer to that night, I think you're talking about the shift, the night shift, that began on the evening of 13 June and went overnight into 14 June. Just to remind the jury, [Baby C]'s death, tragically, was timed at 05.58 hours on 14 June. So very much the shift that you were alluding to, I think.

You were working as shift leader on that night shift; is that correct?

NURSE B: Yes.

DRIVER: Do you recall who was designated as [Baby C]'s nurse?

NURSE B: Yes.

DRIVER: And it was?

NURSE B: Sophie.

DRIVER: Sophie Ellis?

NURSE B: Yes.

DRIVER: But does it flow from what you told us a minute or two ago, you can't be certain whether you selected that designation --

NURSE B: Yes.

DRIVER: -- or whether you inherited it --

NURSE B: Yes.

DRIVER: -- in effect? But whichever it was, would you have applied your mind to the appropriateness of that designation?

NURSE B: Yes. Sophie was my former student, she was a very competent nurse.

DRIVER: Thank you. So when you say she was your former student, could you elaborate on that a little?

NURSE B: Sorry, yes. So when Sophie was in her training, she came through the neonatal unit as a student nurse on a placement and I was her mentor during the placement. So I was the one overseeing her during her training, during that placement.

DRIVER: Which training and placement had concluded prior to --

NURSE B: Yes.

DRIVER: -- June 2015 and the jury have heard evidence from Sophie Ellis and they will recall that at this point she was a band 5 nurse. Does that accord with your recollection?

NURSE B: Yes.

DRIVER: Was she fresh out of training at that point in time, do you recall?

NURSE B: I don't recall exactly where she was, but she had -- Chester wasn't her first job after qualification, she had some level 3 unit experience.

DRIVER: The jury have heard that such units are designated into three tiers: local units being a level 1, places like Chester level 2, and tertiary, level 3. And at this point in time for your area that would have been Alder Hey or -- sorry, that would have been Liverpool Women's Hospital or Arrowe Park?

NURSE B: In our network, yes. I don't think she was in the network.

DRIVER: Do you happen to know where she was elsewhere?

NURSE B: I think it was Manchester or Leeds.

DRIVER: In any event that was at a level 3 unit?

NURSE B: Yes.

DRIVER: And what if any significance did you attach to that at that time?

NURSE B: That she was familiar with caring for babies such as [Baby C].

DRIVER: Right. Let's focus on [Baby C] for a moment then.

"Babies such as [Baby C]", what do you mean by that in this context?

NURSE B: Requiring the level of support, the size he was.

DRIVER: So [Baby C] was, as of 13 June, an intensive care baby?

NURSE B: Yes.

DRIVER: And you've alluded to his size. We know he was born at about a weight of about 800 grams.

NURSE B: Yes.

DRIVER: Which others have already told us that for his gestational age was deemed light.

NURSE B: Yes.

DRIVER: Is that a fact that you would have taken into account --

NURSE B: I would, yes.

DRIVER: -- at the time? Other than that, what if anything did you inform yourself about the general condition of baby [Baby C] when you took over as leader of that shift?

NURSE B: So like at the start of any shift, I receive a full handover and I'll do a general walk around, not necessarily read into too much detail about each baby at that stage, just a general walk around. And from looking at the monitor that [Baby C] was attached to, and looking a quick glance at the charts, everything seemed stable. I had no concerns at the start of the shift.

DRIVER: When you say stable, do you mean clinically stable?

NURSE B: Clinically, his observations were stable.

DRIVER: Thank you. He was in nursery room 1?

NURSE B: Yes.

DRIVER: We understand. From your oversight of the unit on this shift, do you recall whether he was alone there or whether there was other baby or babies within that room?

NURSE B: There was one more baby in that room.

DRIVER: Was Sophie Ellis designated for both babies or just for [Baby C]?

NURSE B: Just for [Baby C].

DRIVER: And do you recall who else was nursing in that room?

NURSE B: Yes, Melanie Taylor.

DRIVER: In terms of your assessment of Melanie Taylor's level of experience and qualification, could you describe that to the jury, please?

NURSE B: Yes. Melanie is also a band 6 nurse, an experienced band 6 nurse, so the allocation being, whether it was my allocation or the shift before, the band 6 that will have also been a considering factor for -- if I wasn't available to be in the same nursery all the time with Sophie, then Mel would be there for support for Sophie.

DRIVER: And that's something that you took into account at the time, is it?

NURSE B: Yes.

DRIVER: You told us about the change in practice as to who was given responsibility of designating the nurses. You can't say whether or not you designated [Baby C] to Sophie Ellis or vice versa?

NURSE B: I can't.

DRIVER: If not you, would you be able to say who it would have been?

NURSE B: The shift leader on the day shift.

DRIVER: And at this distance in time you can't remember?

NURSE B: No.

DRIVER: So Melanie Taylor was in the same room as Sophie Ellis and [Baby C], with another baby, and you were there to oversee the whole unit?

NURSE B: Yes.

DRIVER: Thank you. We also know that nurse Lucy Letby was on duty during that night shift.

NURSE B: Yes.

DRIVER: Do you recall which baby she was allocated to and, if so, please don't say the baby's name, but do you recall?

NURSE B: I recall one baby. I think there were more, but I do definitely recall one.

DRIVER: In which nursery was the baby that you recall?

NURSE B: Nursery 3.

DRIVER: Could you tell us that baby's initials, if you remember them?

NURSE B: JE.

DRIVER: JE. Thank you. What is it about JE that causes you to recall that baby?

NURSE B: So at the start of the shift, when I was doing my general walk around and becoming familiar with the babies, this particular baby, baby JE, I was familiar with and I was concerned about -- he had some signs of respiratory distress.

DRIVER: Thank you. When you say you were familiar with JE, could you expand upon how you were familiar with him?

NURSE B: So I had been on shift when that baby was in the unit prior and I think I'd been his designated nurse, if not a shift leader, I was -- he had definitely been there a time period, I don't remember how long. But I remember noting straightaway his breathing status at the start of that shift was not as I remembered it.

DRIVER: Right. Had it improved or deteriorated?

NURSE B: Deteriorated.

DRIVER: What informed you of that, what data or what symptoms informed you?

NURSE B: He was grunting, which is loud audible noise on expiration.

DRIVER: And had you previously noted that within baby JE?

NURSE B: Not when I had cared for him or seen him prior.

DRIVER: Was that an alert to you as the shift leader?

NURSE B: Yes.

DRIVER: What did that prompt you to want to do for that baby?

NURSE B: So I asked Lucy to increase his observations, charted observations, from two-hourly to one-hourly so we could make a proper assessment and see a trend in the data.

DRIVER: Yes.

NURSE B: And asked Lucy to call the registrar on call to come and review him immediately.

DRIVER: Thank you. And he, baby JE, was housed in nursery number 3, and from the hierarchical description you gave us earlier, it may be thought that a baby in nursery 1 necessarily would require more intensive observations than a baby in nursery 3. Is that overly simplistic or is that right?

NURSE B: That could be true, but depending on the busyness of the ward, even a baby that is very close to discharge out in one of the nurseries, if they were to acquire an infection could deteriorate at any time.

DRIVER: Thank you. In any event there was something -- well, there was the grunting from baby JE that caused you to instruct Nurse Letby to increase the frequency of the recorded observations and to notify the on-call -- the duty registrar; is that right?

NURSE B: Yes.

DRIVER: Were those instructions observed?

NURSE B: I can't remember about the observations, whether they were increased from two to one-hourly, but yes, the registrar did come and review.

DRIVER: Was that done at the first time of asking on your part or not?

NURSE B: I don't remember.

DRIVER: Now let's move through the shift and let's go to the time of [Baby C]'s collapse, which is recorded on the note -- I shan't take you there -- at about 23.15 hours, so about quarter past 11 on the night of the 13th.

Where were you when you first became aware of a crisis in relation to [Baby C]?

NURSE B: I do not remember where I was, but I was not in nursery 1.

DRIVER: Do you recall what alerted you to the crisis?

NURSE B: A shout for help.

DRIVER: Do you recall who shouted?

NURSE B: No.

DRIVER: Do you recall what was shouted?

NURSE B: I think "help". I don't remember.

DRIVER: Thank you. How did you respond?

NURSE B: I immediately went in.

DRIVER: On entering nursery 1, what did you see?

NURSE B: From memory and reading my statement this morning, I saw Mel and Sophie with [Baby C].

DRIVER: Mel Taylor, Sophie Ellis?

NURSE B: Yes.

DRIVER: Where were they?

NURSE B: They were beside his incubator.

DRIVER: And what were they doing?

NURSE B: They were -- they had a Neopuff device. They were trying to ventilate him because he wasn't breathing.

DRIVER: Do you recall who was doing what?

NURSE B: No.

DRIVER: Thank you. And did you go straight to the incubator?

NURSE B: I don't remember.

DRIVER: Do you recall whether at that point or soon thereafter you noted his data, as it were, his --

NURSE B: Yes.

DRIVER: And what did you note?

NURSE B: I noticed he wasn't breathing and his heart rate was very low.

DRIVER: Yes. Oxygen saturation levels?

NURSE B: Very low.

DRIVER: Did the Neopuffing -- was it successful, did it cause [Baby C] to breathe?

NURSE B: He didn't begin to breathe, but the Neopuff gave [Baby C] chest movement, so it was -- the Neopuff was breathing for him, but he did not begin to breathe himself.

DRIVER: Thank you. Did you notice at this stage anything about his appearance?

NURSE B: He was -- he didn't look well, he looked very unwell.

DRIVER: Thank you.

NURSE B: He was mottled.

DRIVER: And was a crash call for the medics put out?

NURSE B: Yes.

DRIVER: Do you remember who put out the crash call?

NURSE B: No.

DRIVER: Do you remember who was present when the crash call was put out?

NURSE B: I remember Lucy being in the nursery at that stage, but I don't remember -- the doctors certainly weren't on the unit.

DRIVER: Okay. For precision, you say being "on the nursery", which nursery?

NURSE B: Sorry, in the neonatal unit. They weren't in the neonatal unit at the time, the doctors. That's why the official crash call had to go out.

DRIVER: Thank you. So that's the medics?

NURSE B: Yes.

DRIVER: Had a doctor been at hand, he or she could have been shouted --

NURSE B: Yes.

DRIVER: -- as opposed to a crash call? What about Lucy Letby do you recall -- do you know where she was at the time the crash call was put out?

NURSE B: At that specific moment, I couldn't remember that moment, no.

DRIVER: Do you recall a time when Lucy Letby was in the room?

NURSE B: There's not one specific moment I remember her entering the room or already being in the room.

DRIVER: Thank you. The crash call went out. Did the doctors respond?

NURSE B: Yes.

DRIVER: Can you recall which doctor first responded or first entered nursery 1 or not?

NURSE B: No.

DRIVER: We understand that there came a time when Nurse Sophie Ellis became emotionally upset?

NURSE B: Yes.

DRIVER: Do you recall that?

NURSE B: Yes.

DRIVER: Do you recall at what point in the sequence of events that happened?

NURSE B: Within the first few minutes.

DRIVER: And as shift leader, what action did you take at that point?

NURSE B: I advised her to step outside.

DRIVER: At the point that you advised Sophie Ellis to step outside, did you deem that there was adequate support for [Baby C]?

NURSE B: Yes.

DRIVER: Can you recall who was there at that point?

NURSE B: So I don't know at which point the doctors entered and Sophie became upset, no.

DRIVER: Thank you. We have heard a detailed account of the resuscitation process and the jury, on an earlier day, have looked at a list of the medication that was given. For several of those entries you were the co-signer retrospectively --

NURSE B: Yes.

DRIVER: -- with Melanie Taylor, and I don't intend to take you through all of that.

We've also heard that the resuscitation process was very prolonged, partly because, at the request of the parents, everybody awaited the arrival of a cleric to baptise --

NURSE B: Yes.

DRIVER: -- the baby. Does that accord with your memory?

NURSE B: Yes.

DRIVER: Tragically, there came a time when it was realised, is this right, that the resuscitation process was futile and [Baby C] and his parents were left in private and I think you oversaw the provision of some palliative care to make the baby more comfortable?

NURSE B: Yes.

DRIVER: Thank you.

Moving to the period after [Baby C] had died, the jury have heard something of the process of the creation of a memory box. Whose responsibility is it to ensure that that memory box or the offer of a memory box is made and one is created? Who takes responsibility for that role?

NURSE B: So it would be the designated nurse at the time if they felt able.

DRIVER: Thank you. You say if they're able. Of course at the beginning of the shift, Sophie Ellis was the designated nurse. She'd become upset and you'd effectively asked her to stand down.

NURSE B: Yes.

DRIVER: And who took over as designated nurse thereafter?

NURSE B: Melanie Taylor.

DRIVER: Was it Melanie Taylor who was given the job of offering the memory box service to [Parents of Baby C]?

NURSE B: Yes.

DRIVER: And did she do so?

NURSE B: Partly.

DRIVER: What was the other part?

NURSE B: So after -- when [Baby C] went to the family room with his parents and grandparents, everyone that had been in nursery 1 I reassigned to different babies.

DRIVER: Yes.

NURSE B: So I took over the baby that Mel had been caring for.

DRIVER: Yes.

NURSE B: I asked Lucy to focus back in nursery 3 on baby JE because I was still heavily concerned about him. However, Lucy went into the family room a few times and I asked her to come out and to leave that family with Mel.

DRIVER: When you say Lucy went into the family room a few times, could you expand upon that?

NURSE B: I don't know what happened because I wasn't in the room at the same time.

DRIVER: Yes. Was it any part of the responsibilities that you had provided to her, you had designated her to -- for her to go -- for her, Lucy, to go into that family room after this point in time?

NURSE B: Not that I can remember.

DRIVER: You just told the jury that you asked her or instructed her to return her attention to baby JE. Did you do that once more than once?

NURSE B: More than once.

DRIVER: Can you recall how many times?

NURSE B: No.

MR DRIVER: Thank you. Could you remain there and answer any questions my learned friend may have for you?

Cross-examination by MR MYERS

MR MYERS: I'm just going to ask you some questions on behalf of Ms Letby, [Nurse B]. I just have some general questions first and then we'll come to the particular events, if that's all right.

I think you made reference to the fact that you'd made a statement to the police. You have made a number of statements during the investigation, haven't you?

NURSE B: Yes.

MYERS: And the one which deals with this particular aspect of it was made on 13 February 2018?

NURSE B: Yes.

MYERS: And that followed a process of having had a witness interview with the police, didn't it?

NURSE B: Yes.

MYERS: One of the things that you told the police about back in 2018 was just how busy the unit had been between 2015 and 2016. Do you remember telling them about that?

NURSE B: Yes.

MYERS: And certainly it seemed to you, didn't it, that the admission rate seemed to increase into the unit over that period 2015 and 2016?

NURSE B: Yes.

MYERS: It also seemed to you that you had far more intensive care babies than you'd seen before?

NURSE B: Yes.

MYERS: In fact, the impression that you formed from what you could tell was that you had a higher rate of admissions than Arrowe Park, which is the tertiary unit; is that correct?

NURSE B: One of the tertiary units.

MYERS: One of the tertiary units. And that's the impression you formed; is that correct?

NURSE B: Yes.

MYERS: Although that was going on in terms of admissions and what we understand is called the acuity of the babies, how much intensive care they need, there were no changes in staffing levels to reflect that, were there?

NURSE B: I think staffing remained a constant at that time.

MYERS: Yes, it remained a constant. And it was a fact of life there that sometimes the ward manager was fighting for more staff to try to stay BAPM compliant?

NURSE B: The manager will have continually reviewed data on a monthly basis and she will have looked at the amount of admissions versus the BAPM compliance, and if she felt at any point then she would have highlighted that to her seniors.

MYERS: Didn't you describe it to the police in terms that the ward manager was fighting for more staff, though?

NURSE B: She will have asked for more staff certainly.

MYERS: All right. The word "fighting" comes from you, doesn't it, [Nurse B]?

NURSE B: I can't remember.

MYERS: Perhaps can we just, just to assist you, I don't want you to think there's anything being suggested you didn't say. Can we look at page 969 of your statement? It'll come up in front of you the witness, please, Mr Murphy and his Lordship and the barristers.

There we are. If you just look down towards the bottom of that page, it's a statement that you will have read, I imagine, recently, [Nurse B]. Can you just see that large paragraph, a few lines up from the bottom?

NURSE B: (Pause). Yes, that's what I've written.

MYERS: What you said to the police was this:

"I recall that the ward manager was fighting for more staff."

That's what it begins, doesn't it?

NURSE B: Yes.

MYERS: "She still is."

This is what you said in 2018, isn't it?

NURSE B: Yes.

MYERS: Although by that point the unit had been designated a level 1 instead of a level 2, hadn't it?

NURSE B: Yes.

MYERS: "We sometimes weren't meeting BAPM guidelines for staff ratios."

Yes?

NURSE B: Yes. Mm-hm.

MYERS: Although you said:

"That was an issue across the whole of our network and nationally."

NURSE B: That's correct. I've quite clearly pointed out that wasn't just a Chester issue.

MYERS: No, but of course at the same time, at the beginning of that paragraph, you have pointed out that between 2015 and 2016 there'd been an increase in the number of admissions and, it seemed, an increase in the number of intensive care babies; yes?

NURSE B: Yes.

MYERS: Yes. And you added this:

"As a staff we worked really hard over that period, missing breaks and doing whatever we could to make it function."

Yes?

NURSE B: Yes.

MYERS: All right, thank you. We can take that down. Thank you, Mr Murphy.

You agree that was not an ideal experience for staff, was it?

NURSE B: No.

MYERS: And not ideal really for babies, is it?

NURSE B: Can you rephrase that differently?

MYERS: If the staff are struggling like that, there is a danger it will have a knock-on effect on to the babies they're looking after, isn't there?

NURSE B: Just because the amount of babies increased doesn't mean we weren't BAPM compliant on every single shift. So for this shift in particular, or any shift that you are making reference to, you will have to look at the care level of the baby versus the BAPM standard, you have to look at that individually.

MYERS: Do you agree, [Nurse B], that in general, if staff are struggling to cope, then that may increase or may impact upon the level of care they can deliver?

NURSE B: I didn't say that staff were struggling to cope.

MYERS: If staff are struggling to cope, would that or could that impact upon the care of the babies they're looking after?

NURSE B: The care would have been given because the nurses were missing their breaks.

MYERS: In your view, this period coincides with the increase in mortality that we're looking at, doesn't it, on the unit?

NURSE B: Yes.

MYERS: Your impression was that was connected to a period when it was extremely busy; is that correct?

NURSE B: Yes.

MYERS: The criteria by the British Association of Perinatal Medicine that you've referred to about intensive care, those are guidelines by a professional body, aren't they?

NURSE B: Yes.

MYERS: Do you agree those guidelines are there for a reason?

NURSE B: Yes.

MYERS: They indicate what is optimal or best practice, don't they?

NURSE B: Yes.

MYERS: Do you agree that it wasn't always the case that you could follow those guidelines on the unit?

NURSE B: That would... Are you referring to staffing levels or are you referring to, say, the ITU status of the baby an ITU baby being at Chester?

MYERS: In general, it wasn't always possible to follow the right numbers of staff for the babies who were being looked after, was it?

NURSE B: Yes.

MYERS: When... Yes? Are you agreeing with me when I say that?

NURSE B: Yes.

MYERS: All right. Could I ask you just to raise your voice a little bit, if you could, [Nurse B]? It's difficult because of all the screens, everyone understands. No one's going to think you're being rude if your voice is loud.

When it comes to defining a baby on intensive care, that's actually described in -- I'm going to call them, the BAPM guidelines -- isn't it?

NURSE B: Yes.

MYERS: And it includes things like this -- I'm not going to read them all out, but a baby who is on mechanical respiratory support is an intensive care baby?

NURSE B: Yes.

MYERS: So that means being ventilated with an endotracheal tube; is that correct?

NURSE B: Yes.

MYERS: A baby who is on CPAP and also receiving perinatal (sic) nutrition through a line would be on intensive care; is that correct?

NURSE B: TPN?

MYERS: TPN.

NURSE B: TPN, yes.

MYERS: Yes. I'm not going to go through all of the list but it's carefully set out, isn't it, in the guidelines?

NURSE B: Yes.

MYERS: I'll add this because we've heard something of these: a baby who has an umbilical venous line is also an intensive care baby; that's correct, isn't it?

NURSE B: Yes.

MYERS: Just before I turn to [Baby C]'s situation, [Nurse B], can I just ask you something about the notes that the nurses make on the unit.

NURSE B: Yes.

MYERS: As a general rule, I'm not going to any particular set, this is just to help us, is the nurse who's looking after a baby meant to put in as much as she or he can remember that is relevant to the period they've looked after the baby?

NURSE B: Yes.

MYERS: And would a nurse who comes on duty and want to see what is going on with the baby or the babies they've been designated ideally read through notes from earlier just to see what had been going on with the baby?

NURSE B: At an appropriate time, yes.

MYERS: At an appropriate time, yes. I suppose it follows that if a nurse was to make an entry that was put under the wrong set of baby's notes, then a nurse who comes in later won't get to read that entry until that's been corrected?

NURSE B: It would have been spotted by the nurse caring for the baby where the wrong -- where it was wrong. Does that make sense? And they would have been alerted. But without the notes, everything that has happened -- the notes are your written and you've already had that significant verbal handover at the cot side.

MYERS: There's that as well.

NURSE B: So the handover is there as your first -- the notes are there for potential future or further reference.

MYERS: But a nurse coming on and looking after a baby or other babies, he or she may well go to the written notes just to see the history of the child recently?

NURSE B: Yes.

MYERS: Turning to [Baby C], do you recognise or do you agree, [Nurse B], that he was a baby in a potentially fragile condition?

NURSE B: Yes.

MYERS: Do you agree that, given his size and his prematurity and his conditions, there was a risk that he could die?

NURSE B: Yes.

MYERS: You've been asked questions about the allocation of staff that night. You've been asked those questions and I'm going to ask you questions about that as well. Your recollection is this may have been at a period when staff were allocated by the shift leader before you came on duty?

NURSE B: Yes.

MYERS: So it may well not have been your decision?

NURSE B: Yes.

MYERS: By your recollection, this was a busy shift, wasn't it?

NURSE B: Yes.

MYERS: Perhaps something that those people who don't work with babies in units like this may not appreciate, but I'm going to ask you about, is that babies don't necessarily stop in their care requirements at night, do they?

NURSE B: No, it's 24 hours.

MYERS: It is 24 hours, so shifts can be busy day or night, can't they?

NURSE B: Yes.

MYERS: You knew Sophie Ellis because you'd been involved to some extent in her training?

NURSE B: Yes.

MYERS: Is that correct? And you were comfortable with her being in the position of being allocated to [Baby C]?

NURSE B: Yes, I could have changed the allocation had I wanted.

MYERS: You said earlier that she was familiar with babies such as [Baby C]. Can I just ask, she'd been qualified for about 5 months by this point?

NURSE B: Mm-hm.

MYERS: When you say she was familiar with babies such as [Baby C], do you mean babies as small as him who'd had an intrauterine growth restriction, or do you mean basically premature babies who needed a lot of looking after?

NURSE B: Requiring intensive care --

MYERS: Yes. But do you know whether -- I spoke over you, sorry.

NURSE B: It's okay.

MYERS: Do you know whether she'd ever looked after anybody just like [Baby C] before or not?

NURSE B: I don't.

MYERS: Is one of the factors that gave you confidence with her being in that position that Melanie Taylor was also in nursery 1?

NURSE B: Yes.

MYERS: And as we know and as you have explained, Melanie Taylor was a band 6 nurse?

NURSE B: Yes.

MYERS: She was also looking after a baby that she'd been designated in there, wasn't she?

NURSE B: Yes.

MYERS: And the baby that she was looking after was one that was ventilated, wasn't it?

NURSE B: Correct.

MYERS: So both [Baby C] and both that baby were intensive care babies?

NURSE B: Yes. They had one baby each.

MYERS: One baby each, yes. And is another factor that gave you confidence with Sophie being in that position that you were available to be there in an overseeing position if necessary?

NURSE B: Yes.

MYERS: You've explained also that Lucy Letby was put in charge of a baby whose initials are JE?

NURSE B: Yes.

MYERS: I think it's understood that Ms Letby had said she wanted to work in nursery 1 at one point, hadn't she, that evening?

NURSE B: I'm not sure if she said that to me.

MYERS: All right. But she got on with looking after JE once she was allocated to JE; is that correct?

NURSE B: Prior to the collapse that was correct.

MYERS: Let's just deal with that. In your opinion, even though he wasn't in nursery 1, JE did require close monitoring and observation?

NURSE B: Yes.

MYERS: And so for that reason, it was your view that it was right that a nurse of Ms Letby's level of experience was looking after him?

NURSE B: Yes.

MYERS: And there were various observations and checks that she had to do with him over the hours that followed, weren't there?

NURSE B: Yes.

MYERS: And tasks like, you have given us this example, getting the registrar to come and check he was all right?

NURSE B: Yes.

MYERS: So as far as you understood she was occupied with that?

NURSE B: Yes.

MYERS: One of the comments you made to the police was that some nurses prefer working in nursery 1, some nurses prefer working in other nurseries. That is fact of professional life, isn't it?

NURSE B: Yes.

MYERS: I'm going to ask you next about what happened when the collapse of [Baby C] took place. Without looking at the nursing notes, which give us a time for the collapse, I take it it would be very difficult to remember exactly when the collapse happened if you didn't have the notes?

NURSE B: Correct.

MYERS: Doing the best you could at the time you spoke to the police in 2018, was it your recollection that you were dealing with [JE] and Lucy when, some time between 10 and 11, you were called to assist with [Baby C]?

NURSE B: So I don't mean directly with them, I wasn't beside them, but my time was consumed by that fact, yes.

MYERS: Just so there's no mystery, what you'd said was:

"I was dealing with JE and Lucy when, sometime between 10 and 11, I was called to assist with [Baby C]."

NURSE B: Yes.

MYERS: So you're saying you can't say precisely where you were or what you were doing, but that was the sort of thing you'd been doing?

NURSE B: Yes.

MYERS: All right. You certainly weren't in nursery 1 at that point when you were called to assist, were you?

NURSE B: No.

MYERS: But as you've told us this morning, when you entered nursery 1, you saw Sophie and Melanie Neopuffing [Baby C]?

NURSE B: That's my memory.

MYERS: And that's what you told the police in 2018?

NURSE B: It is.

MYERS: Yes. You went on -- I don't want you to be at any disadvantage. Could we let [Nurse B] see page 971 of the statement, please? Again, this is for [Nurse B]'s benefit, his Lordship and the lawyers. Ladies and gentlemen, it's not being rude, it's just to assist with recollection.

Perhaps it's less of a mystery if you have the statement in front of you that you made and signed in 2018, [Nurse B]. So what you told the police was you remember that you had seen [Baby C] early in the shift and confirmed that Sophie and Melanie were okay. And as I was asking:

"[You were] dealing with JE and Lucy when, some time between 10 and 11, [you were] called to assist with [Baby C]."

That's to the best of your recollection?

NURSE B: Yes.

MYERS: What you told the police was:

"When [you] entered nursery 1, Sophie and Melanie were Neopuffing [Baby C] in an attempt to assist his breathing."

NURSE B: Yes.

MYERS: If we just look on, I'm summarising, you describe the situation with the bradycardia and the low oxygen levels and what was happening with the Neopuff. And, as you told us, you couldn't recall who had made a crash call, but a crash call was put out.

NURSE B: Yes.

MYERS: You said:

"Sometimes premature babies do forget to breathe for themselves and a brief spell of Neopuff is enough to wake them up. It can also be a sign of infection or a bleed on the brain, but normally they respond."

Is that correct?

NURSE B: In general, yes.

MYERS: In general. I just want to read on to see where it is that you mention Lucy for the first time:

"I remember the doctor intubating [Baby C] at some point and when it became clear that [Baby C] was not responding, we put out the crash call for the consultant, Dr Gibbs. As always he arrived very quickly."

That was your recollection; yes?

NURSE B: The initial crash call, because it was the night shift, remember, so the initial crash call brings you the SHO and the registrar. So they will arrive within a few minutes because they're on site. They weren't on the neonatal unit, as I said earlier. Then an additional crash call is put out for the consultant, who is potentially off site because it's a night shift.

MYERS: That's right. And that was Dr Gibbs on this occasion?

NURSE B: Yes.

MYERS: And he came later, didn't he, a little later?

NURSE B: Yes.

MYERS: [Baby C]'s mother was upstairs on the post-natal ward and she was called down around the same time?

NURSE B: Yes.

MYERS: You say:

"I also think Lucy was in the room by now as well."

Meaning there were four nurses present?

NURSE B: Yes.

MYERS: So it seems at some point after you got there, you had been joined by Lucy?

NURSE B: Obviously, I did this 3 years after the incident.

MYERS: All right. But what we --

NURSE B: That's what I've written in my statement.

MYERS: "I also think Lucy was in the room by now."

NURSE B: Mm-hm.

MYERS: That was the best you could say then. Thank you. We can take that down now, Mr Murphy.

A resuscitation situation, I think, is -- can be tense and anxiety creating. Everyone's professional, but it can be tense, can't it?

NURSE B: Yes.

MYERS: And everyone involved is as professional as they can be, but they can feel the stress sometimes; is that correct?

NURSE B: Yes.

MYERS: And it became apparent to you, didn't it, that Sophie found this upsetting?

NURSE B: Yes.

MYERS: There's no criticism made of that.

NURSE B: No.

MYERS: Right. But I just want you to confirm that it was you who then took Sophie aside and gave her the advice perhaps that she should step out and let other people carry on, discreetly?

NURSE B: Yes.

MYERS: And even though you were dealing with this situation, [Nurse B], you remained clear-headed enough to see that and deal with that?

NURSE B: Yes.

MYERS: Then you described that afterwards, Lucy Letby -- first of all, Lucy Letby had been involved in the resuscitation process, hadn't she?

NURSE B: Yes.

MYERS: And afterwards there was a period when she seemed to want to assist with the family, but that was something you had designated Mel Taylor to do?

NURSE B: Correct.

MYERS: And then eventually, you discussed it and she got on with what it was you wanted her to do, which was to look after baby JE?

NURSE B: Yes.

MYERS: And Melanie Taylor looked after [Baby C] and his parents?

NURSE B: Well, she did look after them, yes, but there were some times when Lucy also went into them and myself as the shift leader also went into them.

MYERS: So a number of you went into them at some point?

NURSE B: Yes.

MYERS: But your decision was that Lucy should ultimately go and look after JE, which she did do?

NURSE B: Yes, after a number of askings.

MR MYERS: Yes, after a number of askings. Thank you.

Re-examination by MR DRIVER

MR DRIVER: [Nurse B], you were asked about the increased demands on the unit in that general period of time and about how staffing levels were static, remained the same. Was the level of care provided to [Baby C] on 13 and 14 June 2015 influenced in any way by the increased demand on the unit and the static levels of staffing?

NURSE B: So on that night shift, he will have needed one-to-one care. He received one-to-one care.

DRIVER: Thank you. Was the quality of care provided to [Baby C] on that night shift in any way diminished by the general increase in demands on the unit and the static staffing levels?

NURSE B: No.

DRIVER: That one-to-one care was provided by Sophie Ellis, a relatively recently qualified band 5 nurse. It was suggested to you that she'd been qualified for just 5 months, I think it may have been 10 months, but we can determine whether it was 5 or 10 months. Was she, in your opinion as shift leader, competent to look after that particular baby with his particular needs at that time in that context?

NURSE B: I would have allocated Sophie had I not already done so, I'm not sure if it was myself or not, to [Baby C] because Mel was also in there with a one-to-one baby, so she couldn't really leave the nursery. So there was always someone very senior by her side and I was available also if she needed me.

DRIVER: Thank you. You'll remember being taken to your witness statement or part of your witness statement where you described the collapse and the events immediately prior to the collapse. You were taken to a part of your statement where you had said that some time between 10 and 11 pm you were called to assist with [Baby C]. We know as a matter of record [Baby C]'s collapse was actually at 11.15, but you don't have the notes in front of you.

When taken to that sentence, you said that at that time your time was consumed, was your phrase, with the baby JE and Lucy Letby. What did you mean by that?

NURSE B: I was worried about baby JE. In my opinion, he was the most poorly baby on the ward that night.

DRIVER: So that's your concern, but in answer to my learned friend you said your time was consumed. What did you mean by that?

NURSE B: Because I was regularly checking on that baby, JE, to ensure he was getting what he needed.

DRIVER: And was he?

NURSE B: I believe that he should have had a septic screen, so no is the answer, but that is a medical decision. The medical decision was at that time that baby JE was okay. I did not believe that to be true.

DRIVER: Thank you.

You were taken to other parts of the same part of your witness statement, which gave your account of the collapse, your response to the collapse, and the people in the room, et cetera.

That witness statement, dated 13 February 2018, followed on from an interview, a question and answer session, that you'd had with the police on an earlier date. Do you recall that?

NURSE B: Yes.

DRIVER: I wonder whether, Mr Murphy, the witness could be shown page 38 of 56 of the transcript. Using the pagination at the bottom of the page, I'd like 38 of 56, please.

MR JUSTICE GOSS: Can you give me the reference number for this?

MR DRIVER: I will in due course. I don't have it at my fingertips, apologies.

(Pause)

Just looking at the question and answer at the bottom of this page and going over to the next -- I'm not inviting anyone to read it out loud, [Nurse B] -- and if Mr Murphy could continue to scroll for the witness.

(Pause)

How sure are you as to who was in the room when you first entered to respond to the crisis?

NURSE B: As I said, it was 3 years after the event, so from my memory at that point in time Sophie and Mel were there.

DRIVER: Yes. How sure are you?

NURSE B: Well, I've written there "not 100%" -- well, I haven't written that, that's not in my statement, that's during my interview.

DRIVER: Thank you. I'm grateful to Mr Johnson. That is our page reference K2703, my Lord.

MR JUSTICE GOSS: Well, I think for the sake of completeness we could...

"Question: Just to confirm, who exactly was in the room when you went in to answer the crash?

"Answer: I believe it was Sophie and Mel.

"Question: Okay.

"Answer: But I 100% couldn't tell you."

So those are her exact words.

MR DRIVER: They are. I have no further questions. Does your Lordship have any questions for the witness?

MR JUSTICE GOSS: No, I don't. Thank you very much.

MR DRIVER: This is the last use of the screens for the day.

MR JUSTICE GOSS: All right.

You will be coming back later in the trial, but that completes your evidence at this stage. Please do not talk to anyone -- and I mean anyone -- about your evidence or anything to do with this case, the questions you've been asked, what you've said in evidence. Don't talk about it until the trial is over, which is after you will have given evidence again. All right? Thank you very much.

NURSE B: Thank you.

MR JUSTICE GOSS: If you just remain where you are.

Mr Driver, are you calling the next witness?

MR DRIVER: My learned friend Mr Astbury shall.

MR JUSTICE GOSS: I know we've done just over an hour this morning. What we'll do if that's all right with you, members of the jury, and it's my responsibility, not my fault, but I'm responsible for the delay this morning, we'll start the next witness. We'll have literally a few minutes break to allow the witness to leave the courtroom and the next witness to be ready to come in. We'll do a bit with the next witness and we'll break off between 1.00 and 1.10, something like that, as long as none of you have any commitments at 1 o'clock. I doubt any of you have.

If you'd like to go into the back room for a few minutes.

(In the absence of the jury)

If the members of the public could leave the courtroom, please, just for a few minutes.

(Pause)

I'm going to stay here. There's no one else in court apart from the barristers, who you have already seen. Someone will come and help you out the way you came in. Thank you.

(Pause)

MR JUSTICE GOSS: I am not surprised we have got this question and I will just show it to counsel.

I didn't want to dwell on it at the time, but I will do and I will just remind the media.

(Pause)

(In the presence of the jury)

MR JUSTICE GOSS: I'm not surprised I've received the question that I did receive from one of you in relation to the identity of the other baby referred to. That baby has been referred to as JE, but he was accidentally named and I'm going to indicate to the press who are present that there is a reporting restriction in relation to the actual name and I have asked for discretion in relation to even using the initials. So it's "the other baby", thank you very much, because he is still alive. Thank you very much.

Coming back to the note from one of you about a difficulty of being able to sit late one evening, what I'm going to ask is that today and overnight each of you considers the difficulties that are going to be caused by the rail strikes that are scheduled. I think what we'll do is get a definitive list, insofar as there is one, as to which companies are striking. I think it's most of them, frankly, the providers, and the difficulties that causes with you getting to court on those days, which is a strike day, and we'll review the situation tomorrow and take it from there. All right? We'll deal with that.

It's not this week. The first strike is on Saturday, I believe.

MR JOHNSON: No, there is one this week.

MR JUSTICE GOSS: There is on Friday, is there?

MR JOHNSON: I think it's 3 November, which I think is Thursday.

(Pause)

MR JUSTICE GOSS: Anyway, we'll get a definitive list as to how things stand and then we'll take it from there. But don't worry about it. We'll get it sorted in advance -- not the strikes, that is!

MR ASTBURY: My Lord, I call Dr Katherine Davis, please.

DR KATHERINE DAVIS (sworn)

Examination-in-chief by MR ASTBURY

MR ASTBURY: Could we begin, please, with your full name?

DAVIS: My name is Katherine Jane Davis.

ASTBURY: And Dr Davis, when did you qualify as a doctor?

DAVIS: So I qualified in 2009.

ASTBURY: Thank you. I'm going to ask you, please, specifically about a period of time in June 2015. Do you recall your status as of June 2015?

DAVIS: So I was a paediatric registrar working in the Countess of Chester.

ASTBURY: Thank you. We've heard training expressed as numbers and ST. Do you happen to recall what you'd have been attributed at that stage?

DAVIS: I think I was an ST4.

ASTBURY: Okay. So that reflects about 4 years of specialist training --

DAVIS: Yes.

ASTBURY: -- as a registrar? All right.

You told us you were employed at the Countess of Chester Hospital. Your specialism, please?

DAVIS: Paediatric trainee.

ASTBURY: Thank you. I'm going to ask you, please, in a moment about a specific baby named [Baby C].

Just before we do that, I think you were on a night shift on 13 June into 14 June 2015. You were also, is this right, on the night shift the preceding night, 12 June into 13 June?

DAVIS: Yes.

ASTBURY: During the course of those night shifts what would your responsibilities have been in respect of providing care for babies?

DAVIS: So as the paediatric registrar on call I'd have been the most senior paediatric trainee on site, responsible for all babies on the neonatal unit, any kind of paediatric admissions, and any deliveries of babies.

ASTBURY: Is there any, as it were, routine on which babies you would see and which babies you wouldn't?

DAVIS: So in terms of babies on the neonatal unit we would routinely review any babies who were receiving intensive care or any babies that there were any concerns about from nursing staff.

ASTBURY: Right. We've heard that [Baby C] was born on 10 June 2015 and we've also heard about both IUGR and reverse end-diastolic flow, which were two of the issues he presented with. Were you aware generally, when you came on duty for the night of the 12th, of [Baby C] and his pre-existing conditions?

DAVIS: Yes, so there would have been a handover when all the babies would have been discussed including [Baby C].

ASTBURY: Right. Okay. He was born at 30 plus 1 weeks' gestation and weighed 800 grams, we've heard.

Can I ask you, first, then about your treatment of [Baby C] on 12 June. Do you recall treating [Baby C] or seeing [Baby C] on 12 June, on that night shift?

DAVIS: So I have seen my statement this morning but I don't have a memory of the events of the 12th.

ASTBURY: In that case --

DAVIS: That was my first night shift, wasn't it, the 12th?

ASTBURY: You kept a note, we're going to put your notes up on the screen if that assists. Slide number 30, please, Mr Murphy. If we can go behind that. This is not something you'll see before, but in a moment we are going to click into what is behind, which I hope you will recognise in a moment.

DAVIS: Yes.

ASTBURY: If we can have the top half of the page, please. Can you help us with the handwriting? Is that yours?

DAVIS: Yes, that's my handwriting.

ASTBURY: Good, okay. We can see on 12 June 2015, at 9.20 in the evening, you have made a note of -- is that an examination of [Baby C]?

DAVIS: Yes.

ASTBURY: So let's take you through it if I may. "30 plus 1", what does that stand for?

DAVIS: That's how many weeks pregnant mum was when he was born, so born at 30 plus 1 weeks' gestation.

ASTBURY: And 30 plus 3?

DAVIS: So that's what he corrected to, so he was on day 3 of life, so that's what he would have been at the time.

ASTBURY: Thank you. And the 03 figure?

DAVIS: It's a D, sorry, day 3.

ASTBURY: You have then put a heading of "problems". You have written "IUGR", which we have heard something about, and as I suggested a moment or two ago, reverse end-diastolic flow. "ROS"?

DAVIS: RDS, respiratory distress syndrome.

ASTBURY: And on CPAP. We're familiar with CPAP being a form of assistance with breathing.

"Suspected sepsis"?

DAVIS: So at some point he would have, in one way or another, made somebody think that he might have an infection so he would have been screened for infection and on antibiotics, which we refer to as suspected sepsis.

ASTBURY: Are these your observations or, as it were, an update on the situation as you understood it to be?

DAVIS: So the problem list will be a list of things that are ongoing.

ASTBURY: Right, okay. "Est feeds"?

DAVIS: Establishing feeds. So he wasn't yet fully orally fed, he was --

ASTBURY: We have heard he was receiving nutrition by way of TPN, as I think is the abbreviation. It's got "jaundice" underneath that particular entry. Just explain that to us, please.

DAVIS: So jaundice is very common in premature babies. So at some point he's been jaundiced and may or may not have received phototherapy for that.

ASTBURY: We have a V on the next section. Just explain, please, to us the entries next to that?

DAVIS: So this is just a methodical way of assessing him. So from a ventilation point of view he was on CPAP with a PEEP, so that's the pressure, of 5 with the range of oxygen he was requiring. Then I commented that he'd had no desaturations or bradycardias, where his oxygen levels or his heart rate had dropped, and the blood gas was the latest test that would have been done at that point.

ASTBURY: Pause there. So "blood gas 1759". What does that stand for?

DAVIS: The time it was done.

ASTBURY: You have then entered the values presumably of that blood gas test?

DAVIS: So not all of them but the ones relevant to his ventilation, yes.

ASTBURY: What can you tell us about those, please, or any conclusion that you have reached from those?

DAVIS: They're acceptable, they're not worrying.

ASTBURY: F?

DAVIS: Fluids.

ASTBURY: And then this is a reference, I think, to what I mentioned a moment ago, TPN nutrition?

DAVIS: Yes.

ASTBURY: And we've got 120ml per kg per day. Is that a standard, as it were, dose?

DAVIS: So it will change depending on his age and other things, like his urine output and his blood results.

ASTBURY: We've heard about lipids. We can also see there that he's receiving some additional dextrose by way of fluids; is that right?

DAVIS: Yes.

ASTBURY: "NBM due to bilious aspirates."

DAVIS: So NBM is nil by mouth, so there would have been nothing kind of going either down a nasogastric tube or an orogastric tube.

ASTBURY: Reference to bilious aspirates, is that something you were aware of at the time, something that had been brought to your attention?

DAVIS: When we are reviewing babies, that is one thing that we would look at, what aspirates nurses were getting up their tubes. And it's just something to be aware of. Again, very, very common in premature babies.

ASTBURY: Okay. Sufficient at that stage to cause any concern from your note?

DAVIS: We know this baby had -- [Baby C] had reverse end-diastolic flow combined with bilious aspirates, which is probably why we're on day 3 and he has not had anything orally. And that is an indication that we would need to be cautious in feeding him.

ASTBURY: Right, okay:

"BNO since birth."

I think that is bowels not opened.

DAVIS: Yes.

ASTBURY: And the next entry?

DAVIS: Is urine output --

ASTBURY: Right.

DAVIS: -- 3.2ml per kilogram per hour over the last 15 hours.

ASTBURY: Can you assist us with the relevance or otherwise of that?

DAVIS: So it's slightly high but a lot of premature babies will have a big urine output, much higher than that. So that would

hopefully be on the way down from where it had been the previous few days. Obviously I haven't got that that information.

ASTBURY: Right, okay. Next I think is an S?

DAVIS: Sepsis.

ASTBURY: CRP?

DAVIS: CRP 23. So CRP is a non-specific marker of infection and inflammation. It doesn't tell us what or where just something to be aware of. 23 is a little bit high.

ASTBURY: Right, okay. BC?

DAVIS: Blood culture.

ASTBURY: Just tell us a little bit. It says:

"No growth at 36 hours."

DAVIS: So whenever we are worried about an infection in a baby we take blood cultures and start them on antibiotics. It's something we do while we are proving if they or don't have an infection. So we will have had a blood culture taken which will have gone to then lab to be cultured, which would be reviewed at various points and 36 hours is a good cut-off for -- at that point, usually, if they're positive they would have been positive.

MR JUSTICE GOSS: Sorry, sorry, could you go more slowly, please?

DAVIS: Sorry.

MR ASTBURY: My fault, not yours:

"BC no growth."

What would growth tell you?

DAVIS: So initially, when you get growth on a blood culture it suggests that an infection has grown in his bloodstream in the blood sample we have taken. Initially you'd just get information that it had grown something. Then, over the days to come, they would tell you what it was and then what it was sensitive to. But at this point nothing's grown.

ASTBURY: And you mentioned 36 hours is a good point --

DAVIS: In a lot of babies, if we got a low suspicion of infection and their bloods are otherwise normal and they're

well, 36 hours would be the point at which we would be happy to stop antibiotics.

ASTBURY: Could you explain the next line, please?

DAVIS: So because [Baby C]'s CRP was 23, a decision had been taken to do a lumbar puncture, so "AW" is awaiting. And again, that's the test to look for meningitis, to take a sample of fluid, which hadn't been done at that point. But somebody had decided, who'd seen him, that he was going to have 7 days of antibiotics either way.

ASTBURY: If we can scroll further down the page, please. M stands for?

DAVIS: Medication.

ASTBURY: Could you tell us about the three lines that follow?

DAVIS: So [Baby C] was on some caffeine, which is standard for babies of this gestation. Benpen and gentamicin, so benzylpenicillin and gentamicin are the two standard antibiotics that he would have been given initially if somebody initially had thought about, could this be infection --

ASTBURY: Pausing there, when you tell us about the line above this, someone decided to give him antibiotics for 7 days, they're the two antibiotics --

DAVIS: Yes.

ASTBURY: -- he'd have been receiving? Okay. And before we move on, the purpose of caffeine?

DAVIS: So some premature babies, they're not designed to be out in the world, they're designed to still be inside mum and sometimes they forget to breathe, and caffeine is a stimulant that helps reduce those apnoeas.

ASTBURY: Right, okay. And nystatin?

DAVIS: Nystatin is a preventive medication for oral thrush, that again is common in premature babies.

ASTBURY: Thank you. I'm not sure -- what's in the --

DAVIS: The next circle says "met" for metabolic. And this is the comment that he was jaundiced and it looks like his phototherapy, so his blue light treatment for the jaundice, had been stopped at 7 pm.

ASTBURY: So pausing there, jaundice very briefly is?

DAVIS: So jaundice is very common in newborn babies. It's a result of their blood cells not living as long as adult blood cells do and liver immaturity is more common in premature babies, so when they break down their red blood cells they make something called bilirubin, which makes them yellow. If that's left untreated it can cause damage to their brains but we treat at a very low level to prevent that.

ASTBURY: And the answer may well be in the line, but how is it treated?

DAVIS: The phototherapy is a blue light.

MR JUSTICE GOSS: I've asked you to slow down. You naturally speak very quickly and you're using some quite complicated words. It is not me trying to take a note, it's someone who is a professional stenographer who is struggling to keep pace.

MR ASTBURY: It's been a problem before. I apologise.

Jaundice, you have told us, is a condition whereby the red blood cells don't break down properly and cause a yellow colouration to the skin?

DAVIS: The red blood cells in newborn babies break down quicker than they do in adults and then what happens to that breakdown product is that it is converted by the liver and then it's excreted, but several steps along that process aren't as efficient in premature babies, which is where their jaundice comes from.

ASTBURY: And the appearance is?

DAVIS: Babies often look yellow.

ASTBURY: And again the treatments used for jaundice?

DAVIS: Is ultraviolet light. They have a light put above their incubator or cot on exposed skin, which helps convert the bilirubin into a form that they can excrete.

ASTBURY: Right, thank you. I think you told us that the time, 19.00, suggest that that treatment had come to an end (overspeaking) --

DAVIS: That had stopped but it's something that we would check again. It looks like the plan was to check it again at 2 in the morning.

ASTBURY: Thank you. Is that:

"OE: handles well"?

DAVIS: "On examination, handles well."

ASTBURY: "HS"?

DAVIS: His heart sounds are normal. He didn't have any murmurs to be heard. He was well perfused, so that means kind of he was warm, he was nice and pink. Capillary refill time is another measure of perfusion and that was less than 2 seconds, which is normal.

ASTBURY: Okay, let's pause there. So capillary refill time, I think we've heard, is the test where a clinician presses their finger on the baby's skin?

DAVIS: Yes.

ASTBURY: And then times how long before the colour returns?

DAVIS: Yes.

ASTBURY: We've then got a small diagram. Tell us what that is. I think we've been told before. Is that the lungs?

DAVIS: They're a pair of lungs. I have written "good AE", which is good air entry.

ASTBURY: And we can see the word "active" to the right-hand side?

DAVIS: Yes.

ASTBURY: Active in what way?

DAVIS: This suggests that in terms of "handles well" -- and "active" suggests that this was a baby who was -- (overspeaking) so he would be active and moving round.

ASTBURY: The next diagram, please?

DAVIS: Is an abdomen. I've commented that his abdomen was soft, he had bowel sounds, and there was no discolouration on his abdomen.

ASTBURY: We've heard that earlier that day, round about lunchtime, there was an X-ray which showed a lot of air in [Baby C]'s tummy. Is that examination relevant to that in any way?

DAVIS: So with a -- lots of air, presumably a distended tummy, the two thought processes being "infection-related something", but he is also on CPAP, so lots of babies on CPAP do have distended gassy tummies. I haven't commented on distension so I can't tell you whether his tummy was distended or not, but there's nothing worrying about his tummy in what I've documented.

ASTBURY: At that particular time --

DAVIS: Yes, at that point.

ASTBURY: -- 21.20 on 12 June?

DAVIS: Yes.

ASTBURY: All right. Then we touched on the plan. Just take us through the plan, please.

DAVIS: So "a gas" refers to a blood gas, which is a blood test we do to look at parameters around ventilation. "Bili" is bilirubin, which would be to look at his jaundice level to see which way that had gone after we'd stopped treatment. And then glucose -- I presume at some point there had been either some concern about his sugars or we'd changed something with his fluids that meant that we wanted to look at what his blood sugar was. And "chase" implies that somebody prior to this has done a full blood count, the results of which are not back, so an acknowledgement that we need to look at that.

ASTBURY: All right. You signed off on the right?

DAVIS: Yes.

ASTBURY: That was -- did you say that was a routine review of [Baby C]?

DAVIS: This looks like a routine review of a baby who would have technically been an intensive care baby, so just a routine nightly review. This doesn't imply that there were concerns about him.

ASTBURY: Okay. Did you carry out a routine review the following night, on 13 June?

DAVIS: From my recollection, he had a cardiac arrest prior to me seeing him.

ASTBURY: So you were planning to do so?

DAVIS: Yes.

ASTBURY: But there was then an incident before you had the opportunity to do so?

DAVIS: Yes.

ASTBURY: I'm going to ask you about that. Do you recall roughly what time that incident took place?

DAVIS: I think it was pre-midnight.

MR ASTBURY: Okay. Shall we go, in fact, to the tile so you can look at your notes again. I'll just check the number. It's 187, please.

That might be a good point, in fact, my Lord, to take a break. I'd forgotten the time.

MR JUSTICE GOSS: That's all right.

We'll break off. Could you be ready, please, to continue at 2.05? Just about an hour, give or take a minute. Remember your obligations and responsibilities. No conversations and no research. Thank you very much. 2.05.

Dr Davis, can you be back ready to start again at 2.05, please? Thank you very much. And don't talk to anyone about the case.

(In the absence of the jury)

MR MYERS: I should say, my Lord, I realise it was I who read out the name when going through the statement.

MR JUSTICE GOSS: Don't worry. It was inadvertent.

MR MYERS: I apologise for that. I'd programmed myself to use initials elsewhere but not when I was reading from the statement.

MR JUSTICE GOSS: Don't worry. The representative in court certainly was alive to it, I'm sure he will have -- he wouldn't...

MR MYERS: I'm grateful, my Lord, thank you. I apologise.

MR JUSTICE GOSS: Right, thank you.

(1.06 pm)

(The short adjournment)

(2.05 pm)

(In the presence of the jury)

MR ASTBURY: Dr Davis, you were about to go on and tell us something of [Baby C]'s collapse on the night shift of the 13th into 14 June. Before we go on to that, could you just tell us, please, how you were alerted to what was taking place?

DAVIS: I believe I had a crash bleep.

ASTBURY: Tell us then, please, what you did when you got that crash bleep?

DAVIS: So the crash bleep would have said to go urgently to the neonatal unit, which is what I would have done. I think from memory I was relatively close when it happened.

ASTBURY: Tell us, please, at this stage from your memory, what you remember when you arrived.

DAVIS: So I remember arriving on the neonatal unit with a lot of activity around [Baby C]. There was a Guedel airway in situ --

ASTBURY: Let's pause there. So where was [Baby C] when you went into --

DAVIS: [Baby C] was in room 1 on the neonatal unit.

ASTBURY: Okay. And when you describe activity, that was around his incubator, presumably?

DAVIS: So there were several nurses there at the time.

ASTBURY: Right. Can you remember who?

DAVIS: Not for certain. I remember there being a senior nurse, who I think was [Nurse B], who was clearly in charge and directing what was going on, but beyond that, I don't remember who was there.

ASTBURY: Okay. I'd like to take you then, please, to your note rather than rely on your memory. If we can go, please, into that tile we had up. 187.

If we can look at the note behind it, please.

A little bit out of time order. If we can scroll down, please. I'm sure you recognise that's your handwriting from earlier?

DAVIS: Yes.

ASTBURY: It's a note from you, 14 June, timed at 1.30, and as the heading says, written in retrospect. We can see:

"23.26, crash bleeped to attend NICU."

DAVIS: Neonatal intensive care unit.

ASTBURY: "Myself and SHO Jian Min Hor arrived on unit in less than 1 minute."

That was your recollection a moment or two ago, you were very quick?

DAVIS: Yes.

ASTBURY: Then you've noted:

"On arrival, Guedel airway in situ."

We've heard a couple of times about a Guedel airway, a device that is used to assist in opening the airway, we understand?

DAVIS: Yes.

ASTBURY: Do you remember who was using that?

DAVIS: I don't know who put it in, it was already in when I got there.

ASTBURY: "Being bagged by Neopuff [or via Neopuff] by nursing staff."

I've already asked you if you can remember and the only person you remember is [Nurse B]?

DAVIS: Yes.

ASTBURY: And:

"Chest compressions in progress."

I take it you can't remember who was administering them? Okay. Your note says:

"Occasional intermittent gasps noted."

Tell us, please, how [Baby C] appeared when you arrived at the NICU?

DAVIS: So I think from --

ASTBURY: Can you remember what he looked like when you arrived?

DAVIS: No, other than I think somewhere in my statement I put that he looked pale.

ASTBURY: Obviously, intermittent gasps, you're talking about [Baby C] there when you assessed him. Just moving to the second line, please:

"Chest compressions stopped."

At what stage did that take place?

DAVIS: As a registrar on arrival, my first job would have been to assess him from the beginning to see what was happening. He obviously had a monitor on, which was showing a heart rate. But while chest compressions are ongoing it's difficult to know if that's his heart rate or if that's a response to the chest compressions. So the implication of chest compressions stopped is that I would have asked them to be stopped briefly for me to assess [Baby C], so for me to listen to see if he had a heart rate and to see if he was breathing himself.

ASTBURY: Okay. Does your note assist whether -- when those chest compressions were stopped (inaudible)?

DAVIS: "No HR/RR" is no heart rate or respiratory rate on auscultation.

ASTBURY: Auscultation is the use of a stethoscope?

DAVIS: Yes.

ASTBURY: How did that combination strike you at that point?

DAVIS: So it was very unusual for that to be the case. So I've been to a number of collapses of neonates over my career and usually, even with the very smallest, sickest babies, there is some heart rate, but it's a slow heart rate, or there is some respiratory effort, but there was nothing in [Baby C]'s case at all.

ASTBURY: So neither of those features -- just simply absent on both counts?

DAVIS: So he wasn't breathing, he was gasping intermittently, but there was certainly no -- I remember clearly that there was no heart rate at all.

ASTBURY: Okay. So what did you decide to do?

DAVIS: It's clear from this situation that [Baby C] needed significant resuscitation. So at this point, we've restarted the chest compressions by whoever was doing them and I've asked for someone to go and call Dr Gibbs, who was the consultant on call, who would have been at home and not on site. And I have taken over managing [Baby C]'s airway, so I've taken the Neopuff off whoever was doing that.

ASTBURY: Let's pause there: is that your responsibility as the doctor to take over the airway?

DAVIS: It's not set in stone, it's usually what you go to as the most experienced person. I would have been the only person who could intubate, so there's always the question is that what needs doing.

ASTBURY: All right. So you took over the airway. Did you attempt to intubate?

DAVIS: Yes, I think I did.

ASTBURY: Was that successful?

DAVIS: No, it wasn't. So I think -- I can just about see on the bottom line there -- when I've gone to look, I've seen where the tube needed to go, but his vocal cords were very swollen so I have not been able to -- so I will have abandoned that attempt and then what I've done is I've got a smaller tube, because if you're having difficulty often if you go to a smaller tube and you're using something called an introducer, that makes the tube a bit stiffer.

ASTBURY: Let's just pause there for a minute. So you went to intubate?

DAVIS: Yes.

ASTBURY: And tell us what you saw, please.

DAVIS: I got a good view of where I should be able to -- where the tube needed to go. But the hole that was there wasn't visible because his vocal cords were swollen.

ASTBURY: You have used another term there on your note, "Swollen and"?

DAVIS: Oedematous.

ASTBURY: What does that mean, please?

DAVIS: Kind of fluid swollen.

ASTBURY: Did you notice that when you first went to intubate [Baby C] or was that something that developed?

DAVIS: No, so that was my first attempt, so before I'd even attempted to put anything in.

ASTBURY: So you attempted -- we have heard that the numbers 3 and 2.5 refer to the size of the tube that you are attempting to -- with which you are attempting to intubate. So it was a size 3 that you were unable to introduce and you went on to tell us what you were doing with the 2.5.

DAVIS: So I've made the decision to try again with a smaller tube and something called an introducer. So an introducer is a bit of wire that's plastic covered, that you put inside the tube that makes it a little bit stiffer. So if you've got either a very small hole or you're trying to go through something that's quite difficult, it just gives you a little more -- the tube is less likely to just bend and...

ASTBURY: Were you successful with the introducer?

DAVIS: No. I have had two further attempts at doing that and again have not been able to intubate. So at that point I have taken the decision not to --

ASTBURY: Okay --

DAVIS: -- attempt further.

ASTBURY: Your note says:

"Unable to pass ET tube as cords..."

Is that plus plus?

DAVIS: Yes.

ASTBURY: What does the plus plus --

DAVIS: I presume the word "swollen" should be there.

ASTBURY: Okay. Then the next line, please?

DAVIS: "Clear oral secretions and no blood seen."

ASTBURY: Right. So we know that the Guedel airway is in place and as your next note suggests, Neopuffing continued using that particular device?

DAVIS: Yes. So it would have had to have been removed in order for me to attempt intubation but then by re-putting it in and using the Neopuff, we were getting good chest movement so it was achieving what we needed to. So that's why we didn't have -- I didn't have further attempts at intubation at that point because we were managing the airway in a different way.

ASTBURY: "Chest compressions continued."

Any success with the resuscitation that you were attempting?

DAVIS: No.

ASTBURY: We've heard that there is a list of medication that's given, adrenaline and bicarb being two of those, bicarbonate of soda being two of those measures.

DAVIS: Yes.

ASTBURY: Next line, please:

"Heart rate checked?"

DAVIS: "Heart rate checked approximately every 30 seconds..."

Which would be standard for newborn resuscitation:

"... to reassess."

And throughout we didn't hear any heart rate at all.

ASTBURY: So no response to any of the resuscitation attempts --

DAVIS: No.

ASTBURY: -- that you undertook?

DAVIS: None at all.

ASTBURY: Okay. The next note, I suspect, speaks for itself. Dr Gibbs arrived as the second dose of bicarbonate of soda was given and you have put:

"See previous notes for full resus details."

That's what we have just been through?

DAVIS: I presume that is Dr Gibbs' notes that you showed me briefly above mine.

ASTBURY: Right, okay, we will leave those for Dr Gibbs if we may. There's a list underneath of drugs given. I am not proposing to go through each and every one of them but is it your recollection that that's an accurate record of each and every attempt to administer drugs to resuscitate [Baby C]?

DAVIS: The likelihood is in a situation like this the SHO who was present, who I believe was a GP trainee rather than a paediatric trainee, so had limited neonatal experience, would have made notes as we went along as to what was given and then I've written the times down subsequently from that contemporaneous note.

ASTBURY: And I think we may -- if we go down to the next line, please, that may explain:

"Above prescribed on printed drug chart retrospectively."

DAVIS: Yes.

ASTBURY: Okay. Thank you.

Your next note is at 2 am. Did [Baby C] respond to resuscitation once Dr Gibbs had arrived?

DAVIS: No. So from memory, we had a fairly prolonged attempt at actively resuscitating [Baby C] with multiple drugs. His parents were called. Mum was still an inpatient at the time and I believe dad was called in from home.

ASTBURY: Right.

DAVIS: It became obvious that we really were not winning, but we hadn't got a heart rate, so a discussion would have been had with the parents as to where we were and a decision taken to stop resuscitation.

ASTBURY: That failure to respond to resuscitation, how did that strike you at the time?

DAVIS: It's really unusual. So even the smallest, sickest babies will usually respond in some way, even if only for a brief period of time, that we would get a heart rate or we'd get them back for a short period and they may go on to have subsequent arrests if they're really unwell. But this was clearly very unusual at the time that we had absolutely no response in a baby who had been relatively stable.

ASTBURY: Right, okay. So not responding to resuscitation. We've heard there comes a point where a decision is discussed amongst the medical staff; is that right?

DAVIS: Yes.

ASTBURY: And do you remember that discussion taking place in this case?

DAVIS: I don't remember what was actually said, but I remember that a decision was taken that active resuscitation was seemingly futile, that we needed to stop.

ASTBURY: And were the parents engaged in that conversation?

DAVIS: The parents would have been told that that's what we were thinking.

ASTBURY: Okay. Now, did those attempts at resuscitation, once a decision had been reached, stop immediately?

DAVIS: No, they didn't. We asked the parents, as would be standard practice, if they had any spiritual or religious needs or wants for [Baby C], and christening/baptism was discussed with them. That was something that they said they would like. In order for babies to be christened or baptised, that takes place while the baby is technically and legally still alive. So for that reason, although we stopped giving further drugs and I believe we turned the monitors off, we continued the chest compressions and the bagging while we were waiting for that process to happen.

ASTBURY: Okay. I think, perhaps for reasons we needn't go into, it took a while for the baptism to be completed.

DAVIS: It didn't feel like it at the time, but I've aware from looking at the times that, yes (overspeaking).

ASTBURY: Yes, all right. And once baptism had been completed, what happened then?

DAVIS: Towards the end of -- during the baptism, we had something called a capnograph on the end of the tube -- because [Baby C] was intubated by this point.

ASTBURY: Pausing there, capnograph?

DAVIS: A capnograph is a plastic device that sits on the end of the tube and it measures -- it changes colour if carbon dioxide is coming up the tube.

ASTBURY: Because the principle being that being oxygen breathed in with carbon dioxide but more carbon dioxide breathed out?

DAVIS: (Overspeaking) and it's a way you can tell in babies who are breathing, it's an indication that that tube is in the right place.

ASTBURY: Okay.

DAVIS: But babies in cardiac arrest, such as [Baby C], we wouldn't expect that colour change to be happening. But as the -- it was me and a nurse who was -- I was -- I think I was bagging and a nurse was doing chest compressions. As we were going on, [Baby C] started gasping again, and then the colour change started to change colour. That was the first time in this process we'd had colour change.

ASTBURY: When you say "first time in the process"?

DAVIS: From the early resuscitation attempts --

ASTBURY: So from when you arrived?

DAVIS: It wouldn't have gone on until the tube went in.

ASTBURY: Okay. So from the point of intubation?

DAVIS: Yes.

ASTBURY: Okay.

DAVIS: Which is expected when a baby's in cardiac arrest --

ASTBURY: Lest I missed it, at what stage did intubation take place?

DAVIS: I think Dr Gibbs intubated when he was there.

ASTBURY: I think I missed that, I apologise.

MR JUSTICE GOSS: I don't think it had been mentioned, actually.

MR ASTBURY: That's why I've gone back to it. Thank you. So it was Dr Gibbs that succeeded with the intubating --

DAVIS: It wasn't me that intubated.

ASTBURY: Thank you. From that point, that was the first time you'd had any reaction on the capnograph?

DAVIS: Yes.

ASTBURY: Okay. So tell us what happened then.

DAVIS: I remember trying to -- obviously, we were -- it was -- the monitors were off so there's nothing alarming, we're not actively monitoring [Baby C] at this point, so I've asked someone to go and get Dr Gibbs, who would have been on the unit but might not have been next to us, and explained that this is what had happened. We completed -- the baptism was completed and the blessing was completed and at that point our standard practice would be, when we finished our attempts at resuscitation, the necessary baptism had taken place, we would take the breathing tube out and we'd hand [Baby C] to his parents in the expectation that he would die.

But unusually, unexpectedly, given what had happened, [Baby C] didn't die immediately. By this point he had some of his own breathing effort and he had a heart rate.

ASTBURY: Okay. What decision then was made in light of those signs that appeared?

DAVIS: So then there was a discussion around what is the appropriate way forward, and as you've already pointed out, it had actually been quite a long time from when we were first called to when we stopped, so [Baby C] unfortunately had had a very long period of time with what would have been sub-optimal oxygenation of his brain because we cannot -- no matter how good our resuscitation attempts are, we can't recreate what you would do yourself.

ASTBURY: So, let's just pause: sub-optimal oxygenation of the brain?

DAVIS: No matter what we would have done, we can't recreate a normal blood supply to the brain when we're resuscitating and the feeling was that [Baby C] would have suffered a pretty catastrophic brain injury as well as other problems likely to continue in terms of perfusion of things like his kidneys and it was decided it was probably in [Baby C]'s best interests not to jump back into intensive care.

ASTBURY: Okay. Again a decision taken by everybody?

DAVIS: That decision is likely to have been led by the consultant present at the time.

ASTBURY: Okay. If we go back to your notes, please -- what happened once that decision was made, I should ask, not, as it were, to start again with resuscitation?

DAVIS: So [Baby C]'s parents were offered time with [Baby C] and I believe they went into our sitting room on the neonatal unit.

I think some other family members came in and they were given time with him.

ASTBURY: Right.

DAVIS: At that point I think Dr Gibbs left. He offered to stay but we agreed that where we were at currently, that he would leave site, but any decision that needed to be taken, I would ring him and he would come back in if needed. And it looks like I --

ASTBURY: That leads us I think to your next note. In fact, if we go down to the 2 am note, please, Mr Murphy.

I think this sets out what you just recalled for us yourself. Thank you:

"Mum came from quiet room. [Baby C] still gasping and has a pulse. Explained to mum this is likely a brainstem response following resuscitation. Mum aware [Baby C] has suffered prolonged ischaemic insult."

That's what you were talking about before with oxygenation of the brain?

DAVIS: Yes.

MR JUSTICE GOSS: Starvation of oxygen to the brain --

DAVIS: Yes, lack of oxygen.

MR JUSTICE GOSS: -- causes brain damage?

DAVIS: Yes.

MR ASTBURY: "DW"?

DAVIS: Discussed with.

ASTBURY: Dr Gibbs?

DAVIS: Yes.

ASTBURY: "Happy for..."

DAVIS: "... oral or IV morphine to be given in a pain-relieving dose."

ASTBURY: Okay:

"Further discussion with parents in quiet room. Happy for IV morphine to be given."

DAVIS: Yes.

ASTBURY: So an intravenous method?

DAVIS: Because we weren't able to get a suitable strength of the oral morphine. [Baby C] was a very little baby, so the implication would be that the dose we needed to administer wouldn't have been immediately available orally.

ASTBURY: Okay.

DAVIS: And I believe he had intravenous access in situ so we weren't having to do an invasive procedure in order to give him intravenous medication.

ASTBURY: All right. Your note concludes:

"Aware that [Baby C] unlikely to survive. Maternal grandparents also present."

So other family members had arrived at that time?

DAVIS: Yes.

ASTBURY: Going on to your note later in the morning:

"Further discussion with Dr Gibbs."

DAVIS: So that would have been another phone call.

ASTBURY: "[Baby C] still gasping with heart rate. Hand and footprints taken."

We've heard a little bit about the memory boxes that are prepared for babies in these circumstances:

"Agrees..."

Is this Dr Gibbs?

DAVIS: Yes.

ASTBURY: "... that reinstating intensive care is not appropriate. In present situation IV dextrose to maintain..."?

DAVIS: Blood sugar.

ASTBURY: "Oxygen to maintain sats"?

DAVIS: Saturations.

ASTBURY: "... and would involve monitoring and again inappropriate."

So are you ruling those things out in that note?

DAVIS: This would have been -- would imply a discussion around -- is this -- are we still all in agreement that [Baby C] is unlikely to survive given what's happened? And this could well have come from questions from nursing staff about should we -- what do we need to do to make sure he is comfortable, do we need to give him some sugar, do we need to think about giving him some oxygen, because obviously prior to this event, he was in a little bit of oxygen. But the discussion would have -- looks like it would have centred around the fact that any of those interventions would have needed monitoring and would have needed intervention and actually wouldn't have affected our outcome. So these things in and of themselves wouldn't have increased his chance of survival, they wouldn't have impacted his comfort level, but what they would have done was put more barriers and more intervention in for that precious time that he had with his family.

ASTBURY: Right. But Dr Gibbs did advise a second dose of morphine for --

DAVIS: Distress.

ASTBURY: Okay. Right.

So that's your note at 5 o'clock. Do you recall what happened next?

DAVIS: I think my next entry or the next time I was involved was after [Baby C] had died.

ASTBURY: What can you tell us about that, please?

DAVIS: I think what happened was that a family member's come out to say that they thought [Baby C] had passed away and I would have gone in and did the necessary medical examination with regards to that to confirm that.

ASTBURY: Right. That's the end of that note.

Did you have any more dealings that shift with either the family or [Baby C]?

DAVIS: I think the family left pretty soon after I verified that [Baby C] had passed away and I had nothing to do with the family after that. The nursing staff will have done the necessary with [Baby C]'s body, but again I wasn't involved, I wouldn't have been involved in that.

ASTBURY: Did you attend a debrief regarding [Baby C]'s death?

DAVIS: Yes.

ASTBURY: Took place, I think, some weeks later?

DAVIS: Yes, I'm not sure of the time, yes.

ASTBURY: We'll come to that perhaps later this afternoon. But you attended that with others --

DAVIS: Yes.

ASTBURY: -- and discussed the circumstances of that particular shift?

DAVIS: Yes.

MR ASTBURY: I have no more questions. If you could wait there, please.

Cross-examination by MR MYERS

MR MYERS: Dr Davis, you recognise, don't you, that [Baby C] was a baby on the very limits of what the Countess of Chester Hospital could deal with?

DAVIS: He was very little, yes.

MYERS: Yes. What I was asking was he was right on the limit of what Chester could deal with, wasn't he?

DAVIS: I think our limit was 800 grams and I think he was 800 grams.

MYERS: It's just the expression you used to the police:

"He was right on the limit of what Chester could treat."

That's why I'm asking you that.

DAVIS: Yes.

MYERS: Thank you. That's just as he was -- not that there's any "just" about it -- but just as he was at the time of birth, isn't it?

DAVIS: Yes.

MYERS: That was before there was any other potential issue arising from him, isn't it?

DAVIS: Yes.

MYERS: I want to just look at how he presented at the time of the time shift when you made your note on 12 June 2015. That we saw was at page 19250, which is slide S30. I wonder if we could see that, Mr Murphy. I want to go behind that.

This is 21.20 on the night of 12 June. So about a little over 2 days after [Baby C] had been born. Is that correct?

DAVIS: I believe so, yes.

MYERS: At this point amongst the various items you've identified for us, there is, as it happens, a raised CRP -- you can see where that is?

DAVIS: Yes.

MYERS: Just next to the S in a circle?

DAVIS: Yes.

MYERS: That, of course, indicates inflammation?

DAVIS: Yes.

MYERS: It can be a marker of to infection, can't it?

DAVIS: Yes.

MYERS: And so, of course, a baby in [Baby C]'s starting position is at a risk of infection; is that correct?

DAVIS: Absolutely.

MYERS: And there's certainly a potential marker for infection there, isn't there?

DAVIS: Yes.

MYERS: And also, a baby from [Baby C]'s starting position is at risk of abdominal problems?

DAVIS: Yes.

MYERS: We can see above the CRP reading it's got:

"[Nil by mouth] due to bilious aspirates."

DAVIS: Yes.

MYERS: I'd like to ask you about that. Will you have made enquiry and looked at the records as to the nature of those bilious aspirates?

DAVIS: Yes. So every baby, as well as the nursing notes on the computer, the medical notes that are handwritten will have numerous nursing observation charts that that would have been documented on.

MYERS: All right. Well, let's have a look then at 2009, which is at slide 25. Whilst that's being found, it'll come up in a moment...

(Pause)

We'll go into the detail of this. It's rather tiny at the moment, Dr Davis, but don't worry, it will enlarge courtesy of Mr Murphy.

Before we go to that, can I ask you this: dark bile aspirates should be a cause for concern with a baby, shouldn't it?

DAVIS: We always take them seriously and think about what's caused them, yes.

MYERS: Combined with vomiting of dark bile, that's something that should be regarded as a potentially serious concern, shouldn't it?

DAVIS: Any green aspirates coming out of the digestive system of a baby, yes.

MYERS: Is it even more of a concern if it's dark or black?

DAVIS: I would worry about any type of green --

MYERS: Vomit with bile coming out of a baby can be a red flag for an underlying problem, can't it?

DAVIS: Yes.

MYERS: If we just take a look at the bottom half of this chart -- and this is for 12 June, it's the chart on the right-hand side that we're looking at. This is for 12 June so this is leading up to the period that you've come on duty and then into the night shift. It's a little bit difficult to read, all of this. We've seen a note from earlier in the afternoon by the nurse looking after [Baby C], Yvonne Griffiths, as to bile and vomit. The first entry we can see clearly on here is at 21.00?

DAVIS: Yes.

MYERS: We've got:

"0.5ml dark bile."

DAVIS: Yes.

MYERS: As we go into the evening, 24.00:

"Vomit, dark bile."

DAVIS: Yes.

MYERS: Now, you recognise as you said that's a -- that is a cause for concern, isn't it?

DAVIS: It is, but it's not uncommon in a baby such as [Baby C].

MYERS: It depends very much, the level of concern, what it is that lies behind dark bile or vomit being produced, doesn't it?

DAVIS: Yes.

MYERS: This having been identified, and given that it could be a problem, what was your plan as to what should be done about it?

DAVIS: So this is obviously something that had been going on prior to me seeing him because it was in my original problem list, so the thing that you always need to think about in a baby such as [Baby C], with all his other risk factors, is necrotising enterocolitis. That said, the bile in and itself is not diagnostic of that and we look at the bigger picture of him. I believe -- this is the first night shift I saw him, isn't it? His abdomen was soft, he had bowel sounds and he handled very well. So the dark bile was something we were aware of, which is why he hasn't been fed up to that point, but there were no suggestions that we needed to do anything differently given that he was very well in himself.

MYERS: If the production of dark bile had been going on for longer than this, that's more of a reason of concern not less of a reason of concern, isn't it?

DAVIS: Not necessarily because if he had necrotising enterocolitis that we weren't treating because he wasn't on antibiotics -- he wasn't on metronidazole, which would be the antibiotic we would use to treat necrotising enterocolitis -- he had got no worse, he remained very well. If he had untreated necrotising enterocolitis I would expect him to look very different than he did.

MYERS: There are other problems, abdominal problems, aren't there, that can lead to the creation of or the production of vomit and black bile or dark bile apart from NEC, aren't there?

DAVIS: Yes.

MYERS: There could, for instance, be blockages in the gut that could cause that?

DAVIS: Yes.

MYERS: So even if you or others were thinking NEC, that isn't the only explanation for what was happening to [Baby C], potentially, was it?

DAVIS: No.

MYERS: So what was done to check out what it was that could lie behind this?

DAVIS: So we examined him and his tummy was soft so there was no suggestion -- I'd expect him tummy to be kind of really sore, him to react -- and I think I used the phrase handled well and what we tend to see with babies who are unwell with an abdominal or any significant cause is when we examine them, they will drop their oxygen levels, they will drop their heart rate, and that's with the desats and bradys that I have talked about and none of that was happening with [Baby C].

MYERS: How long do you leave them producing or vomiting black bile for before you take it beyond waiting?

DAVIS: So he hadn't opened his bowels, so the other option with him remaining so well is that he's just a baby with quite sluggish bowel. There was no set time that you would say we have to do anything and actually we were doing lots of things for him in terms of repeated examinations, the blood tests that were being done.

MYERS: So sluggish bowel. That could also be consistent with a blockage in the bowel, couldn't it?

DAVIS: Yes.

MYERS: And when you say doing so well, he wasn't in a great starting position given his prematurity, the intrauterine growth restriction and the reverse end-diastolic flow, was he?

DAVIS: No, so he had a lot of challenges but, despite all that, was a well baby, a relatively well bay given hos challenges.

MYERS: He is a baby with the potential to deteriorate very quickly if he became unwell, isn't he?

DAVIS: Yes.

MYERS: Can we just go and have a look, please, at the chart that follows this and it's at 2010, so the following page. It appears at S67 for those of you following it on the screens.

I appreciate this goes on beyond just the shift that you were dealing with but we're looking at the right-hand side, Dr Davis. I'd be grateful if Mr Murphy could enlarge the right-hand side, at least the first half of it.

If we look here where we see the entries we can see, certainly at 09.00, black bile. Can you see that?

DAVIS: Yes.

MYERS: 13.00, which may be after you've finished your shift, I'm sure it would be, dark bile again.

DAVIS: Yes (overspeaking).

MYERS: It's increasingly concerning, isn't it, if a little baby likes [Baby C] keeps on producing black bile like this, isn't it?

DAVIS: I would almost say he's not getting sick, so if he had, for example, a blockage or necrotising enterocolitis that we were effectively not doing something for, I would expect him to be getting sicker. So yes, it's not something we should ignore and it's something that we need to be aware of, which is why we check for it. But I don't think that there was anything extra we should have done in this situation.

MYERS: First of all, it's not normal, is it, to be producing black bile, dark bile?

DAVIS: Not normal, but common in premature babies.

MYERS: And it's a cause for concern?

DAVIS: Yes, and that's why we keep documenting it and looking at it and keep examining him.

MYERS: And there is not, for instance, at this point any test done to check anything internal, is there, right now so far as you know?

DAVIS: He may or may not have had an abdominal X-ray, but beyond that, there was no other test that we would do in this situation.

MYERS: You could ask, and this is no disrespect to your level of experience at that point, I hope you understand, but you could ask a more experienced doctor to come and take a look, couldn't you?

DAVIS: He would have been discussed with a consultant twice a day, yes.

MYERS: But you could ask a consultant to come and check him, couldn't you?

DAVIS: Yes.

MYERS: He wasn't actually seen by a consultant until some time on 13 June; are you aware of that?

DAVIS: No.

MYERS: So 3 days after he'd been born, yes. This is a baby who you recognise was right on the limits of what Chester could treat; yes?

DAVIS: Yes.

MYERS: Who had by this time, the time we get to the 12th and the 13th, displaying some markers for potential infection?

DAVIS: Yes.

MYERS: Displaying certainly a marker for a potential abdominal, issue because of black bile?

DAVIS: Yes.

MYERS: The appropriate step would have been for a consultant to see him some time before the third day of his life, wouldn't it?

DAVIS: He would have been discussed. I can't tell you if he was seen or not. But he will have -- a consultant will have been aware of all these issues. I don't know who saw him prior to me.

MYERS: Can we just go, please, to slide 77, page 1921. This is going on to 13 June, 9.30 in the morning. Not when you were on duty; this is Dr Ogden. If we could go to the next stage to see how things progress or don't. Slide 77 but page 1922.

We saw that entry began at 9.20. Can you see at the bottom of the page, certainly there, it makes reference to "review by Dr Gibbs"?

DAVIS: Yes.

MYERS: That's on 13 June. By this time we can see, if we look at the top of the page, that the platelet count has dropped to 39. That is low, isn't it?

DAVIS: Yes.

MYERS: There could be a number of reasons for 39 being the reading. One of them, not the only one, could be a marker of infection, couldn't it?

DAVIS: Yes.

MYERS: That's something that, if you're going measure it in this way, is worse than the day before when you saw him, isn't it?

DAVIS: I don't know what his platelet count was the day before.

MYERS: Ninety, in the region of that, possibly.

DAVIS: Ninety or 19?

MYERS: Ninety. We can check, actually. I'm doing this from memory, but it's not as low as that.

You came on duty on the 13th, didn't you, for the evening -- for the afternoon into the evening shift?

DAVIS: That's my second night shift, yes.

MYERS: (Overspeaking) into the 14th?

DAVIS: Yes.

MYERS: Right. We saw that you'd reviewed [Baby C] at 9.20 on 12 June.

DAVIS: Yes.

MYERS: We've just been looking at that. If we just go over the page, please, so S190 or 1923. We can see there is a scan, a head scan --

DAVIS: Yes.

MYERS: -- at 15.55 with Dr Gibbs. But apart from that entry in the morning, there's no other notes making reference to any review of [Baby C], is there? Are there?

DAVIS: Other than the one on the previous page is the same day, yes.

MYERS: Other than that one. And would you have been intending to review [Baby C] at some point that evening?

DAVIS: Yes. And if anything, my review on the first night was significantly earlier than would be standard.

MYERS: Right. We know, I'm not going to go back there, we have seen it and we can go back again, he did continue to produce dark bile aspirates on the 13th.

The collapse happened before you had the opportunity to review him, didn't it?

DAVIS: Yes.

MYERS: And you were on the -- this isn't critical of you when I say this, but you were on the children's ward at the time that took place, weren't you?

DAVIS: Yes.

MYERS: I'm going to ask you some questions about what happened from that point onwards. Again, I'm anxious to make it plain when I ask questions about this I appreciate I am standing here in the relative calm of a courtroom and when you're dealing with things as they unfold in real life it can be more intense sometimes and more difficult than when we stand here reflecting on it now. I recognise that.

It's crucial, if there's a collapse, to maintain breathing -- there are a number of things that are crucial but breathing is key, isn't it?

DAVIS: Yes.

MYERS: The jury have heard you and others talk about efforts to intubate or to keep breathing rates at a particular level, saturations at a particular level, and that's because respiration has got to take place if anything else is going to work and if it's going to be successful?

DAVIS: Yes.

MYERS: The collapse, we understand from Nurse Ellis' note, is at about 23.15. About that time. The steps that the nurses can take to support breathing are limited after a certain point, aren't they?

DAVIS: Depending on the experience of the nurses present, yes.

MYERS: So for example, to intubate so that a baby can be put on a ventilator, is certainly something in this situation that a doctor would have to do?

DAVIS: A doctor or an advanced practitioner, yes.

MYERS: None of the nurses looking after [Baby C] on this particular night were advanced practitioner nurses?

DAVIS: None of them were able to intubate, no.

MYERS: In a tertiary unit, like Arrowe Park or Liverpool Women's Hospital, would you expect to have advanced practitioner nurses or a higher number of advanced practitioner nurses?

DAVIS: On a night shift or at any point?

MYERS: On a night shift then.

DAVIS: So relatively the tertiary units you mentioned are bigger units so, yes, they have more staff.

MYERS: Again, this isn't said critically of staff at the Countess of Chester in this way, but are the nursing staff at a place like Arrowe Park then, some of them, more able or able to intubate in a way that they couldn't do with [Baby C] on this night at the Countess of Chester?

DAVIS: As far as I'm aware nursing staff do not intubate.

MYERS: So they never intubate?

DAVIS: The advanced nurse practitioners do, but nursing staff don't.

MYERS: Then I wasn't clear about that.

Are there advanced nurse practitioners at Arrowe Park who could intubate that weren't present at the Countess of Chester?

DAVIS: I can't comment about Arrowe because I have never worked at Arrowe but certainly in Liverpool Women's Hospital, when I worked there in the 6 months prior to this job, yes, there were, but didn't do night shifts.

MYERS: Okay. In terms of consultant cover can you help us with this? Was it Liverpool Women's Hospital you worked at?

DAVIS: Yes.

MYERS: Was there a greater level of on-site consultant cover in the neonatal units there?

DAVIS: Certainly not. Overnight they were on call from home.

MYERS: On call from home. What about in the day?

DAVIS: In the day there was two consultants on but that was one for intensive care and one for high dependency, which was relative to the number of babies they had.

MYERS: Yes, because, of course, they have babies with a higher acuity there, don't they?

DAVIS: Yes.

MYERS: At Liverpool Women's Hospital, during the day, there would be two consultants on the neonatal unit?

DAVIS: The two consultants responsible for, not necessarily on the unit.

MYERS: Responsible for, yes.

Which is a higher level than you'd have had during the day at the Countess of Chester, isn't it?

DAVIS: In terms of there was one consultant covering the ward and the neonatal unit.

MYERS: That's right. Covering the children's ward and the neonatal unit?

DAVIS: Yes.

MYERS: Two for the neonatal unit at the Liverpool Women's Hospital?

DAVIS: Yes, but it's four or five times the size.

MYERS: Yes. Are you aware if there's ever an issue in placing the right baby in the right hospital for the level of care that he or she needs?

DAVIS: What do you mean by issue?

MYERS: Well, does a baby that needs to get to a tertiary unit always get to a tertiary unit on the basis of care alone or are there other considerations?

DAVIS: They're always discussed with the tertiary unit and a decision about where to place them will often be guided by them. Some babies -- for example, usually there's a cut-off with ventilated babies, that we would discuss them at a set period of time, be that 24 or 48 hours with the network saying, ideally these babies should be in a tertiary unit --

MYERS: Slow down a little bit, Dr Davis.

DAVIS: Sorry.

MYERS: So there would be a discussion?

DAVIS: There'd be a discussion and it's a risk-benefit discussion because moving a baby is inherently dangerous.

MYERS: Pause there a moment, please. Before that you said something about the baby being in the right unit. What were you going to say about that?

DAVIS: So if a baby is intubated in a district general hospital, such as Chester, there would be a discussion at a certain point with the tertiary unit. Part of that discussion would be should we keep them or should they go elsewhere. Whilst there is -- my understanding is at the time there's some evidence around 48 hours kind of being the cut-off for district general hospitals. If that baby's expected to come off a ventilator in the short term keeping them is a lot less risky than putting them in an ambulance. So it's a discussion, there's no black and white in these discussions.

MYERS: And did something as simple, that may be fundamental, as bed availability ever play a part in deciding which baby went to which unit?

DAVIS: No, because we could always transfer out of region if needed.

MYERS: Although, as you say, the fact of transport can be an added risk to a baby, can't it?

DAVIS: Any transport is a risk, yes.

MYERS: Right. Getting back to what I was asking you, and that was my fault for taking you away from that, there are some questions I wanted to ask you. The nurses who were looking after [Baby C] after his collapse had got to the point of inserting a Guedel airway; is that correct?

DAVIS: Yes.

MYERS: And is that a preliminary to intubation taking place?

DAVIS: No, it's an alternative method of maintaining an airway.

MYERS: When you arrived -- you got to the unit just looking at your note -- you can scroll back if you want, but you got back there at about 23.26. Perhaps we could just go back, Mr Murphy, a page. Sorry, go forwards a page to Dr Davis' note.

We can see here, it might be approximate, but 23.26 is when you received the bleep?

DAVIS: I imagine that's the time of bleep.

MYERS: You were on the children's ward at that point?

DAVIS: Yes.

MYERS: But you got across to the neonatal unit within a minute?

DAVIS: Yes.

MYERS: When you arrived there, the Guedel airway was in place we can see and the nursing staff were -- is that using the Neopuff on [Baby C]?

DAVIS: Yes.

MYERS: And chest compressions were in progress. Can it be said at that point whether he was receiving the oxygen that he needed or was he not in all probability?

DAVIS: So I presume I -- although I haven't documented it, it would be our standard practice in this situation to be using 100% oxygen, so they were doing all they could. I haven't commented on his chest movements at this point.

MYERS: Why did you take the decision that it was necessary to intubate?

DAVIS: That's a good question and something that maybe reflects on the decision-making at the time. I don't think intubating or not intubating was a right or wrong answer. The advantages of intubation -- if you can intubate a baby and secure the tube, it frees somebody up, it frees -- you need to be less skilled to bag via a secured tube than a non-secured tube but it doesn't -- as long as you're getting chest movement, ET tube versus a Guedel airway doesn't make any difference to what you're achieving.

MYERS: Thank you for explaining that. Is there any issue of him not receiving the oxygen that he would have needed via the Neopuff but he would have received it if he was on the ventilator and intubated?

DAVIS: So in this situation he wouldn't have gone on to a ventilator; he would have been Neopuffed via the tube.

MYERS: Right. When you came to intubate you say that you became aware that the cords were swollen and blocking the route.

DAVIS: Yes.

MYERS: By the time you saw those cords, he'd already had a Guedel airway inserted by the nursing staff, hadn't he?

DAVIS: Yes.

MYERS: Was that removed for when you came to do the intubation, Dr Davis?

DAVIS: Yes, it has to be.

MYERS: So as to how they came to be swollen, that's difficult for you to say from what you're describing?

DAVIS: A Guedel airway should sit much higher than the cords.

MYERS: Right, okay. Or as to when they became swollen is something you can't tell us?

DAVIS: I can't say that, no.

MYERS: You weren't able to intubate; is that correct?

DAVIS: Yes.

MYERS: Would he have been receiving the oxygen that he needed over the period that you were attempting to intubate him?

DAVIS: So you stop bagging for a brief period of time, but part of the reason we abandon an attempt -- so it looked -- I... I will have had an attempt and then stopped to re-bag. We don't want to leave him for prolonged periods of time without bagging. So in that moment, yes, but we usually put a limit of about 30 seconds in which you'll try and then, if you're not successful, you abandon it and carry on with what you were doing, which is why after these three attempts I didn't try any further.

MYERS: Right. Dr Gibbs, I think from the note, arrived at about 11.35 pm.

DAVIS: Yes.

MYERS: Can I just ask about that. Was the decision to call Dr Gibbs taken as soon as the collapse happened or at a later stage?

DAVIS: From my notes it looks like I've arrived and I have asked someone to call. So certainly in that situation, with a child in cardiac arrest, I would have asked for the consultant to be called straightaway.

MYERS: And then he arrives at about 11.35, which is about 20 minutes after the collapse?

DAVIS: Yes, which is obviously very -- is very quick for a consultant from home.

MYERS: Yes, although any period of time without receiving oxygen properly is potentially damaging, isn't it, for a baby -- or anyone?

DAVIS: Yes, but he was receiving resuscitation prior to the consultant's arrival.

MYERS: Could I just ask you to confirm something about [Baby C]'s breathing during all of this. Again, I appreciate we're talking about a little person when I'm saying this, I'm not trying to sound too academic about it, but I need to ask you these questions.

You've described, when you were telling the police about this that -- this is at some point during the intubation process, after you have seen his cords:

"[You] could see however that [Baby C]'s chest was moving and his saturations levels were good with the ventilatory support we

were providing. Therefore our resuscitation efforts were working correctly."

So we can understand, does that mean he was effectively at that point getting the oxygen that he needed?

DAVIS: So he -- we were moving his chest, which means we were moving air in and out of his lungs. And I believe that (inaudible) saturation monitor, he would have had a monitor on, which would have had a reading, which would have measured the oxygenation in the blood that we were pumping around via chest compressions. But that -- but a measure of oxygenation in presumably a hand or a foot isn't the same as what we were perfusing elsewhere. We don't measure his brain perfusion, we don't measure his blood pressure and things like that, we just measured his peripheral oxygen saturations, which were showing up as reasonable.

MYERS: And so is that with why you say there were questions raised as to whether or not he would have received sufficient oxygen to be well enough to preserve life beyond when you did?

DAVIS: In terms of why we didn't restart intensive care?

MYERS: Yes, yes.

DAVIS: [Baby C] had had a huge period of time without a heart rate and although we were moving his chest and we were putting oxygen in and out of his lungs, we know from experience and from -- we know what happens to other children that we've seen, the effect of even brief periods of time of cardiac arrest and [Baby C]'s period of time in cardiac arrest was really long.

MYERS: Can I just ask this (inaudible) I need to ask you, Dr Davis: did the delay in being able to intubate him in your opinion create any issue that made it more difficult for [Baby C] to be resuscitated?

DAVIS: No. And as a more experienced doctor now, I would be even less likely to have even tried because we were moving his chest, which is the important thing.

MR MYERS: Yes. All right. Thank you very much.

Re-examination by MR ASTBURY

MR ASTBURY: Just a couple of questions from me. You told my learned friend that it was not normal to see dark bile but common in premature babies or not uncommon.

DAVIS: Yes.

ASTBURY: When you see bile like that and taking into account the constellation of other features in this case and all the other information to hand, would you expect a collapse as sudden and as like this in such circumstances?

DAVIS: Absolutely not. I've seen a lot of babies with significant abdominal issues and even as far as babies who have necrotising enterocolitis that have perforated their bowel, so made a hole in their bowel, so the air's come out and into their abdomen, they don't behave and they don't die in the way that [Baby C] died.

ASTBURY: Okay. In the context of swelling to the vocal cords that you saw, you were asked about the Guedel airway and you said it sits above the cords. Could you just explain that to us, please?

DAVIS: So a Guedel airway -- so the vocal cords are where you'd put the tubes through. I don't know whether you've seen pictures of them but they are a bit -- there are kind of two bits that sit and open and close as you breathe. And when you intubate, you would go through the hole that's there.

A Guedel airway is not an invasive secure airway that goes through the cords, it just -- they're much shorter. Obviously, I don't know, I can't recall what size was put in or how it would be put in, but I wouldn't expect a Guedel airway to have caused that swelling.

ASTBURY: Where would it sit? Where would the Guedel airway sit?

DAVIS: It sits above the cords to hold the airway open.

MR ASTBURY: Right, okay. I have no more questions. Does my Lord have any questions?

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

That's it?

MR ASTBURY: Yes, we don't expect this witness, at the moment, to be required.

MR JUSTICE GOSS: It's not anticipated that you will be required to give evidence again during the course of this trial, but certainly you have now completed your evidence in relation to this baby. Although you have finished your evidence and you're unlikely to be giving evidence again, would you please not talk to anyone about your evidence or anything to do with this case until the trial is all over?

DAVIS: Yes.

MR JUSTICE GOSS: Thank you very much. You'll understand why that is.

DAVIS: Yes.

MR JUSTICE GOSS: Particularly if it's someone who's going to be a witness in the case and talking about it is not appropriate. It's said to every witness who's given evidence.

DAVIS: Yes.

MR JUSTICE GOSS: Or until the trial is over. Thank you very much indeed.

That's a good moment to have a break. We'll have our mid-afternoon break now and then...

MR ASTBURY: We have another witness lined up then.

MR JUSTICE GOSS: Is it Dr Gibbs?

MR ASTBURY: Yes.

MR JUSTICE GOSS: Dr Gibbs will follow, who you've probably worked out is likely to be the next witness. Thank you very much. A 10-minute break.

(3.05 pm)

(A short break)

(3.15 pm)

DR JOHN GIBBS (sworn)

Examination-in-chief by MR ASTBURY

MR ASTBURY: Could we begin with your full name, please?

GIBBS: John Michael Gibbs.

ASTBURY: Thank you. Your profession, please?

GIBBS: I'm a retired consultant paediatrician. I used to work at the Countess of Chester Hospital.

ASTBURY: Thank you. I'm going to ask you in a moment specifically about events in June 2015 when I understand you

were employed there in that capacity, but could I first ask, please, when you first qualified at a doctor?

GIBBS: 1983.

ASTBURY: Thank you. You hold a number of qualifications.

GIBBS: That's correct.

ASTBURY: Can you summarise them for us, please?

GIBBS: Oh. My basic medical degree was bachelor of medicine, bachelor of surgery and I also have BSc in biochemistry. Member of the Royal College of Physicians, fellow of the Royal College of Paediatrics and Child Health, a medical doctorate and diploma in child health.

ASTBURY: Thank you. When did you become a consultant paediatrician?

GIBBS: In 1994.

ASTBURY: Thank you. When did you start work at the Countess of Chester?

GIBBS: In 1994.

ASTBURY: Did you have an educational role at the hospital?

GIBBS: Yes.

ASTBURY: What was that, please?

GIBBS: All of us consultants were educational supervisors for several junior doctors in our department.

ASTBURY: And did you at the time have a particular interest in any specialty?

GIBBS: I was a general paediatrician with an interest in neonatology, as we all were for the nature of the job in Chester, in that district general hospital, but my particular interests were child development, disability and epilepsy.

ASTBURY: Thank you. I have already indicated I'm going to ask you questions about events in June 2015. I'm particularly interested, please, in a baby called [Baby C]. We've heard quite a bit about [Baby C]'s birth and condition at birth and the first 2 days of his life. I'm going to concentrate, please, on the contact you had with [Baby C] directly.

On 13 June in particular, am I right, that you were actually on duty within the unit that particular day?

GIBBS: Yes. Obviously these events took place 7 years ago. I prepared a statement two and a half years after [Baby C]'s birth and death and I hadn't seen his notes since then and I'm now retired, so I can't remember all the details of what went on, but I'm quite happy to be shown any records that are relevant and I can confirm them.

From my statement, I'd seen [Baby C] several times during the first few days of his life. I had seen him on the morning of 13 June. The registrar, Dr Ogden, had done a ward round, but I'd come round to see some of the babies on the unit that morning and there's an entry in the medical notes from Dr Ogden saying I had reviewed [Baby C] that morning and a suggestion of what future treatment plans we might offer him.

ASTBURY: In fairness to you I think we should go to the notes if that's what you're relying on, please. There's a screen to the right. If we can start at slide 77, please.

If we can click into that. Dr Gibbs, you will see, first of all, a summary on the first page of the notes that lie behind this document. But if we can click into the notes themselves, we can see there initially a note by Dr Ogden timed at 9.30 that particular morning, 13 June.

If we scroll down. And down again, please. We can see at the bottom -- I don't think it's your handwriting, but there's an indication, "Reviewed by Dr Gibbs". Can you see that?

GIBBS: Yes, I think it's Dr Ogden again from the signature at the bottom of that that put that entry in, saying that I'd reviewed [Baby C].

ASTBURY: Okay. Does that help jog your memory in that limited regard?

GIBBS: Um... There was no particular concern about [Baby C] that morning. He did have some gastric aspirates and we knew that being a baby who was premature, but also small even for being premature, because of reduced blood flow to him from the placenta inside the womb before he was born, that he was at risk of complications, one of them being this condition known as necrotising enterocolitis.

ASTBURY: Thank you.

GIBBS: Now, the gastric aspirates he was showing were not of any concern at that time, they weren't copious --

ASTBURY: I'm going to ask you to pause there. Only because what you're saying is being noted down elsewhere. It's all very helpful but we need to make sure that particular person keeps up.

You were telling us about the risk of NEC and what had actually been seen by way of -- was it aspirates in that particular regard?

GIBBS: Yes, aspirates but looking back --

ASTBURY: Would it help you to see the full note of Dr Ogden?

GIBBS: No, no, I'm fine, I'm just looking up at the notes we've got on the screen here. When Dr Ogden's written OE, on examination, about the eighth line down, it says:

"Abdo soft not distended."

Which is very reassuring because when babies are developing necrotising enterocolitis, their abdomens become distended, so it was good to note that his abdomen was soft.

Dr Ogden doesn't record everything that I felt when I reviewed him, but the fact she doesn't record anything else means I would have agreed with the findings that she has put down. So his tummy is nice and soft, but he was having some gastric aspirates, and that can sometimes be common in any baby that has not been fed as the stomach naturally produces some acid and stomach secretions --

ASTBURY: Pause there, then, please, sorry. We know that, at this stage, [Baby C] hasn't had any feed by mouth.

GIBBS: Yes.

ASTBURY: So that's a consideration when it comes to these sort of aspirates from the stomach?

GIBBS: Yes. I'm not... Well, yes in that if a baby is being fed, that helps the stomach to empty and to get the gastric juices and all the other intestinal juices flowing. And until that baby starts feeding and having milk into its stomach, sometimes the gastric acid can accumulate in the stomach.

ASTBURY: Right. And would that be, as far as you're concerned, consistent with what was being found by way of aspirates up to that stage?

GIBBS: Yes, yes, but those aspirates can irritate the stomach, as can the nasogastric tube, the plastic tube lying in the stomach. And that's why I had recommended starting some ranitidine, which is what Dr Ogden is writing at the bottom of that page, "IV ranitidine". That's an antacid, to counter the acid in the stomach.

ASTBURY: That's the reason for the medication?

GIBBS: Yes.

ASTBURY: The next line:

"Hold off feeds..."

GIBBS: Yes. The aspirates that [Baby C] was producing at that time, which I think were around about up to 2ml each time the nurses checked, were not of concern but if the aspirates got steadily larger then that could indicate his bowel wasn't functioning normally. And if he started vomiting that would be a concern because that can be a sign of early necrotising enterocolitis.

And necrotising enterocolitis is felt to be precipitated by starting feeds, if a baby's prone to necrotising enterocolitis, which is why at this stage the plan was just to monitor the amount of aspirates and to hold off giving any feeds at the moment.

ASTBURY: Okay. And I think the note made on your behalf reads -- is that "Review this PM"?

GIBBS: Yes.

ASTBURY: "If aspirates not getting worse start trophic feeds"?

GIBBS: Yes, that means start a small amount of feed, a trophic feed. It's not going to be full nutrition, which [Baby C] was receiving at that stage, that's just a small amount of feeds, and that would allow the stomach to empty better.

ASTBURY: Thank you. Your note continues:

"If worsens, repeat AXR."

GIBBS: That's abdominal X-ray. If the aspirates got larger or he started vomiting, it doesn't mean he is developing necrotising enterocolitis, but that would be a concern. One way of helping to diagnose early NEC is by taking an abdominal X-ray, but also if there is a suspicion a child may be developing NEC, they shouldn't be fed into the stomach because that can worsen the

NEC and that's why it says if the aspirates are worsening to do an X-ray. And to change antibiotics is because [Baby C] was already on antibiotics from birth or from early soon after birth. If you suspect a baby may be suffering from NEC, then there's a different range of antibiotics that are given particularly to cover bowel bacteria.

ASTBURY: Okay.

GIBBS: That was the plan if it got worse.

ASTBURY: Okay. Thank you.

I think you had some more contact with [Baby C] later that day, if we can go, please, to slide 108, Mr Murphy.

At the top of the notes there we can see -- I think this time it is your handwriting.

GIBBS: It is, yes.

ASTBURY: And we can see an entry timed at 15.55 that afternoon. Can you explain to us, please, what you recall of that?

GIBBS: That is "US head", which is abbreviation of ultrasound of the head, but really it's of [Baby C]'s brain and it says normal because I had performed an ultrasound of his head.

Premature babies are at risk of having bleeds in the central parts of their brain and so we do intermittently ultrasound scan babies born at about 34 weeks to check whether there are any bleeds in their head. That scan was normal in [Baby C].

I don't say much else apart from just signing it there but if I'd been worried about [Baby C] in any other way at the time I did his head scan I would normally note that in the notes. So the fact I noted nothing else means there was nothing else that was concerning me about [Baby C] at that time.

ASTBURY: Nothing else about the scan or [Baby C] generally?

GIBBS: [Baby C] generally because I have to examine him to scan him, and if I'd been concerned about him at that stage I ought to have reported something else in the notes.

ASTBURY: Pausing there, you'd have actually been present for the scan taking place?

GIBBS: Yes, I did the scan.

ASTBURY: Okay. And that would have, in any event, resulted in an examination of [Baby C] at or around 15.55 that afternoon?

GIBBS: Not necessarily a full examination of the nature of the examination recorded earlier in the day by Dr Ogden, but I have to look at the baby and scan his head, but little babies aren't all dressed up at that stage, so if I'd been concerned about him in any way or the nurses had been concerned about him, or his observations had been significantly abnormal, I would have written something else other than just ultrasound of his head.

ASTBURY: Thank you. We're going to come to what else you wrote about [Baby C] in a minute but that I think, according to the notes, was your last contact with [Baby C] during the day shift.

GIBBS: That's correct.

ASTBURY: I think that particular night you were paediatric cover on-call consultant?

GIBBS: I was, yes.

ASTBURY: Is it right later that night you received an emergency call?

GIBBS: Yes, I did. Can I talk about the notes here or just...?

ASTBURY: I think we should go through the notes. I'm going to ask you to break it up a little bit for that reason that notes are being taken but given what you said at the outset and the fact that you have relied on your notes, I think that's probably, if I may say so, the best way to do it.

If you can take us through your note line by line and explain where necessary and I'll hopefully prompt what it is that you have noted.

GIBBS: Thank you.

As is often the case when dealing with an emergency, it's not possible to deal with the emergency appropriately and write in the notes at the same time, so the note entries are after the event. So this note entry is made at 00.30 on the 14th but referring back to events that had happened over an hour or so before that.

And I have received -- I was on call from home in the evening and I was on call for the whole night. I was called at around 11.28. It's sometimes a bit difficult when you're phoned at night to know exactly what the time is the moment the phone call starts, but around 11.28, and asked to attend urgently.

I can't remember who spoke to me. It's often the hospital switchboard rather than anyone on the neonatal unit or wherever I've been asked to attend. I was told there's an emergency, I can't remember the details, but often it was said there is an arrest, which just means a patient in dire straits, who's often stopped breathing or their heart rate has stopped or heart has stopped. And it was on the neonatal unit.

I arrived there at about 25 to 12, 11.35.

ASTBURY: Pause there for a moment, let everybody catch up. What is it that you found when you arrived, doctor?

GIBBS: Well, little [Baby C] was being ventilated with a Neopuff ventilation. Has Neopuff been explained? Do the jury know about Neopuff?

ASTBURY: Yes, thank you.

GIBBS: So Neopuff ventilation was in progress and cardiac compressions were in progress. So [Baby C]'s chest was being compressed to help his circulation, to empty blood out of his heart.

[Baby C] had a poor colour and I have noted he was pale and mottled.

ASTBURY: Yes.

GIBBS: I don't talk about the actual colour and I can't remember exactly. It will be a purply/blue-y mottled colour, which is not uncommon in someone in a cardiac arrest situation because there's very little -- no circulation.

ASTBURY: Okay. I think it says "no heart sounds"?

GIBBS: Yes. I couldn't -- because I'm writing this, this is what I would have observed. There's no heart sounds. We feel for pulses and in babies a good place to feel for the pulse is in the groin, that's the femoral pulse, when the chest compressions are stopped. Because the whole idea of pressing the chest is to squash the heart and squeeze some blood out of it and you can feel weak pulses when you're doing that.

But to assess a child during resuscitation you stop for about 10 seconds to check whether there's any heart sounds, to check whether there's any pulse, and to check whether the child makes any breathing efforts. But there was no respiratory effort when the ventilation was stopped.

So there were no signs of life, essentially, in [Baby C]. But resuscitation to provide him with some circulation and to ventilate for him was being done.

ASTBURY: Right. On the subject of ventilation I think the next line suggests -- is it intubated or intubation?

GIBBS: Yes. Intubated and that's a -- size 2.5 ETT, so that's just naming the size, a small diameter tube called the endotracheal tube, which is passed through the mouth down into the windpipe, the trachea, through which you can provide much more effective ventilation than just using a Neopuff mask.

ASTBURY: Right. In brackets?

GIBBS: That says "with introducer". Now, I don't specify here all the details. I don't usually use an introducer immediately; that's when it's difficult to intubate. I think there must have been attempts beforehand to intubate that were unsuccessful and the introducer just stiffens the tube and assists intubation, that's putting the tube down into the trachea.

ASTBURY: All right. You can't assist with what those difficulties may or may not have been?

GIBBS: No.

ASTBURY: You don't remember now?

GIBBS: No, and I wasn't there at the time because I've just arrived. Well, I'd arrived after those attempts, I think, because I can't remember it in detail, who was doing what at the time 7 years ago or 2 years later when I did my statement.

ASTBURY: Hence we'll continue with the notes if that's more helpful.

"Good chest movement"?

GIBBS: Yes, that's having intubated, getting the tube down into the trachea, there is good chest movement, and you could hear air. So that's the air entry. R and L is right and left so you could hear entry on both sides.

It's important to say R and L because sometimes the tube's not gone into the right place, it might have gone down one lung and not ventilating both lungs, but those observations show that ventilation was effective at that time.

ASTBURY: So shows that air is going in and out of lungs. Is the baby breathing or is that simply the ventilation?

GIBBS: That's someone ventilating [Baby C] through the endotracheal tube.

ASTBURY: Right. I'm sorry, I can't read the next line. I can see it ends "ETT".

GIBBS: "Continued vent [which is ventilation] via endotracheal tube."

So continued with the ventilation down the tube. Having established it was in the right place and effectively ventilating both lungs, continued the ventilation through that tube.

And cardiac compressions. It really means continued cardiac compressions as well.

I should just add, although I say you get more effective ventilate by putting the endotracheal tube down into the windpipe, you can get good ventilation from the Neopuff as well, but it's just more effective and more secure, and you get less air blown into the stomach if you've got the tube right down into the windpipe rather than blowing it into the mouth with a Neopuff.

ASTBURY: Thank you. Next line:

"Repeated adrenaline via long line."

GIBBS: Yes.

ASTBURY: I think if we scroll a bit further down --

GIBBS: And we gave [Baby C] quite a lot of adrenaline. That's six doses there he was given throughout --

ASTBURY: Relatively speaking is that a lot of adrenaline in any given resuscitation?

GIBBS: Yes. You give adrenaline usually every 4 minutes or so. It is hard to time it exactly every 3 or 4 minutes. It just indicates it was quite a prolonged resuscitation effort in progress to have given 6 doses of adrenaline.

ASTBURY: Yes. We can also see on your note, three boluses of saline?

GIBBS: Yes.

ASTBURY: Two boluses of -- I can't see that, sorry.

GIBBS: It's 4.2%. That's just the chemical symbol for sodium bicarbonate. So that's -- the saline, the boluses are 10ml each and [Baby C] is a little baby so each of those 10ml should help to restore circulation to ensure's got a good volume in his cardiovascular system.

And then when there's been prolonged poor circulation the body becomes quite acidotic and that can impair cardiac function, so to counter that, we'd given some bicarbonate.

ASTBURY: So bicarbonate balances, did you say, the acid that builds up in the bloodstream?

GIBBS: Yes. The acid builds up because of prolonged cardiac arrest, but the acid building up then impairs any effort to try and restart the heart. So the bicarbonate is to counter and get rid of the acid.

ASTBURY: And it thereby adjusts the pH --

GIBBS: Yes.

ASTBURY: -- of the blood?

GIBBS: Brings it back towards normal.

ASTBURY: One bolus of, is that...

GIBBS: 0.3ml of 10% -- that's calcium gluconate. Calcium is not often used in resuscitation anymore. It used to be common when I first trained. By [Baby C]'s time we weren't using it very often, but it's sometimes used as a last resort because giving an intravenous dose of calcium can sometimes help to restart a heart when other measures have failed.

ASTBURY: Last resort because?

GIBBS: Because all the efforts we had done before with the ventilation and the cardiac compressions and multiple doses of different drugs and boluses had not restarted [Baby C]'s heart and he'd not started to breathe again spontaneously. So the calcium was the last effort to try and restart his heart.

ASTBURY: And then I think you then list, presumably, what you found having tried all of those methods.

GIBBS: Yes.

ASTBURY: Could you --

GIBBS: It says there "throughout" meaning during the whole time of his resuscitation. But to check the breathing, to check for a pulse, whether [Baby C] has got his own pulse or spontaneous breathing, you have to pause resuscitation for 5 or 10 seconds, not too long, to check will [Baby C] take a breath, has he got any pulse. So it's only at intervals throughout the resuscitation we were checking for signs of life. But each time we checked for signs of life there was never any heart sounds heard -- that's after I arrived anyway -- there was no pulse felt, and no spontaneous respirations.

ASTBURY: So where you put "no pulse" I think it says "when chest compressions stopped".

GIBBS: Yes.

ASTBURY: That's what you're telling us: there's a pause, you check, and you go back to it?

GIBBS: You keep pressing the chest regularly, sort of round about 100-120 times per minute, which means twice a second, really. You keep pressing the chest regularly, but every few minutes you ask people to stop resuscitation briefly to check does [Baby C] have a pulse. Because when you're pressing the chest, you sometimes have a weak pulse because the idea of pressing the chest is to try and compress the heart and squirt some blood round the body, so you're producing an artificial pulse.

ASTBURY: Thank you. Next line is:

"Cold light. No transillumination"?

GIBBS: Yes. It runs on a bit -- I'll explain what it means.

It's:

"Cold light. No transillumination suggestive of pneumothorax."

And pneumothorax is appearing on the line below because it runs off the page.

And a cold light is just a bright light that we shine against the chest of babies, although it's bright it's not hot, which is why it's called a cold light. And that is a quick method of checking has a lung collapsed. So air has escaped from a lung which might have burst and air has escaped on the outside of the lung --

ASTBURY: Okay. So that's a pneumothorax?

GIBBS: Pneumothorax, yes.

ASTBURY: So just tell us a little bit more, for the layperson amongst us, the -- so there's a burst in the lung?

GIBBS: There can be a burst -- well, in the pneumothorax there's been a tear somewhere in the lung surface.

ASTBURY: And what happens as a result of that tear?

GIBBS: Normally, the lungs fill the chest on either side and they reach out to the chest wall. If one of the lungs tears on its surface, air escapes out of the lungs, which could be roughly thought of as two large balloons. Air escapes on the outside of the lung, collects inside the chest wall, but compresses the lung from outside and the lung collapses down completely because of the air on the outside of the lung.

ASTBURY: So the lung would ordinarily fill the entire cavity?

GIBBS: On each side, yes.

ASTBURY: The air escapes, starts to fill the cavity, thereby reducing the space (overspeaking) --

GIBBS: Yes, compressing the lung underneath. That needs a chest drain inserting to get the air out to allow the lung to re-expand.

Now, the only reason we're looking for that is because we were failing to save [Baby C]. We could not get him to breathe him again or his heart to restart and we were looking for unusual reasons why the resuscitation was failing, was unsuccessful. That's why we looked for a possible pneumothorax.

ASTBURY: Why were you resorting to finding unusual reasons? Were things not progressing as you might have imagined?

GIBBS: There's two answers to that. The first answer is, no, they weren't progressing as I'd expected because most babies who suddenly collapse, who have not been obviously very ill for some time beforehand, you would expect to respond to resuscitation. They may not all survive in the long term but it's unusual not to be able to restart the heart and to help the baby to regain some breaths if they have suddenly collapsed without a prolonged preceding illness.

ASTBURY: Thank you. That's the first part. The second reason?

GIBBS: When undertaking a prolonged resuscitation, giving breaths to [Baby C], because he wasn't breathing by himself with

the Neopuff initially and then down the tube into his windpipe, inadvertently -- and it's just an adverse effect of having to ventilate someone -- you might rupture a lung by injecting gas under or squeezing gas under pressure into the lung. That could be compromising your ability to revive the patient because their lungs have collapsed. That's why we check for that possibility.

ASTBURY: So you use the cold light to check for that?

GIBBS: Yes.

ASTBURY: And briefly how does the cold light work? What would it show you if it was --

GIBBS: Well, you turn the lights out in the room -- you don't need to turn them all out but you need a dull light. When you shine the cold light against the chest wall, if there's no pneumothorax you don't see much at all, just a little bit of a brightness around where the light has been shone. If there's a pneumothorax, the whole side of the chest lights up like a lantern because that's the light radiating through the air on the outside of the lung.

ASTBURY: So that space that's been created by the leak is illuminated?

GIBBS: Yes, and that is called transillumination because it is illuminating through the chest. But it says there was no transillumination, so [Baby C] hadn't had a pneumothorax -- or at least if there was a pneumothorax it was very small and wouldn't be compromising the resuscitation.

ASTBURY: Okay. Thank you. I think the next line probably refers back to what you were telling us earlier, is that US?

GIBBS: Yes:

"Ultrasound brain. No PVH seen."

PVH is an abbreviation -- sorry, it's a long term. Have the jury been told about periventricular haemorrhages?

ASTBURY: They haven't, but just in laymen's terms for now, can you just tell us what you were ruling out?

GIBBS: Bleeds in the centre of the brain -- and I mentioned a little earlier that premature babies are prone to develop bleeds in the centre of the brain and this is -- they are called periventricular haemorrhages, so that's PVH.

But again, because [Baby C] had not responded as expected to these resuscitation measures, we were looking for other causes other problems that were compromising the resuscitation such as -- and it would have been a massive bleed inside his head for him not to have responded to resuscitation, but the ultrasound did not show any bleed.

ASTBURY: So that one is ruled out as well. "No further"?

GIBBS: Drugs.

ASTBURY: Okay. So:

"No further drugs or fluids given after 30 minutes."

And you have put a time there of 11.55?

GIBBS: Yes.

ASTBURY: Just explain that to us, please.

GIBBS: Yes. Here I'm recording the fact that resuscitation has failed and therefore we were not going to give any further drugs. We'd already given a large number of drugs as listed and discussed already.

ASTBURY: Yes.

GIBBS: And they'd failed to revive [Baby C] and he was showing no signs of life at this stage. Now, I'm sorry if it's misleading a bit, because I've thought about the timing. I say after 30 minutes, I think the resuscitation had started around about 11.15. I wasn't there then. I was called just before 11.30, I'd got there about 5, 6, 7 minutes later and the resuscitation continued for about 20 minutes after I arrived. But I knew it had been going on for about 20 minutes before I arrived.

ASTBURY: Okay.

GIBBS: Now, Dr Davis, who's given evidence, I believe, she was there very soon after the beginning of the resuscitation. So you can take her evidence of how long it had been going on before I arrived. So when I say 30 minutes, I think probably altogether all the efforts that Dr Davis and the nurses had been making for [Baby C] were probably more 40 minutes.

ASTBURY: Would the time be accurate, the 11.55?

GIBBS: Yes. Because when you decide you're going to stop resuscitation, you note the clock time because if you're

stopping because resuscitation has failed, that would be the time when normally you'd record death --

ASTBURY: Okay.

GIBBS: -- but we didn't in [Baby C] for reasons that'll become apparent in a moment.

ASTBURY: Yes. Your next line, I think, of your notes will explain what happened after 11.55.

GIBBS: Yes. At that stage resuscitation had failed. It's usually recommended in various paediatric texts and manuals for resuscitation of babies and children that resuscitation can be stopped or should be stopped after around 20 minutes with no response. That's no heart restarting, no spontaneous breathing. It is very common in practice to continue longer than that just in the hope you might be able to save a baby.

So the fact this was 40 minutes altogether is not unusual. But that is much longer than is normally considered appropriate because if, after 20 minutes or so of proper resuscitation, you've not restarted the heart or got breathing going again, it is generally futile to continue because the heart will not restart and the breathing won't start again.

ASTBURY: This suggests, am I reading it right, "Continued chest compressions"?

GIBBS: Yes. We continued with a token resuscitation for [Baby C] because his parents wanted him christened and they did ask if he could be christened by both a Catholic priest and a Church of England minister. The Catholic priest had been called at some stage during the resuscitation and he'd arrived by 11.55. The Anglican minister had not yet arrived.

ASTBURY: Right, okay.

GIBBS: And I don't know all the rules and regulations in the Church of England and the Roman Catholic Church but my understanding was christening or baptism is undertaken of a live patient and you shouldn't undertake it or it can't be undertaken after death, which is why we didn't officially say that [Baby C] was dead at 11.55 but carried on a token resuscitation waiting for his christening to then stop and check for signs of life to confirm he was dead.

ASTBURY: Okay. If we follow your note, please.

GIBBS: It's just to read through that? So:

"Continued chest compression and ventilation via the endotracheal tube [ETT]. Awaiting arrival of both Catholic priest and C of E vicar."

And I put in brackets:

"Performed by Dr Katherine Davis and Staff Nurse Mel Taylor."

That means that the chest compressions and ventilation were carried on by Dr Davis and Staff Nurse Taylor:

"Parents aware that resuscitation has been unsuccessful but we are awaiting [Baby C] to be christened before declaring him dead."

ASTBURY: Okay. Did you remain until such time as the christening or baptism had been completed?

GIBBS: Um... Yes. I can't remember what time I left the unit that night, but I was there until after the christening.

ASTBURY: We've heard, as you have pointed out, from Dr Davis already, so we know that events continued into the early hours.

GIBBS: Yes.

ASTBURY: Can you tell us what you recall up until you left?

GIBBS: Well, surprisingly, while we were waiting for the two ministers of religion to turn up to do the christening, there were some signs of life that reappeared in [Baby C]. I hadn't been expecting that. I was not sure initially what to do because we had stopped full resuscitation, we were only continuing a token form of resuscitation, just to allow [Baby C] to be christened before he was declared dead.

So really, I'm not sure why his breathing and a very feeble -- well, occasional gasps of breathing and feeble heartbeats restarted at that stage. But they did and after discussion with [Baby C]'s parents, it was my view, and they agreed, that it was not appropriate to institute full resuscitation and try to revive him again, even though he was showing some fairly minimal signs of life. Because he hadn't shown signs of life for such a long time, the chance of him recovering, if we were able to salvage him at that stage, was remote. The chance of him recovering without profound brain damage was extremely remote, so no further vigorous resuscitation was initiated at that stage.

ASTBURY: Okay. If we just finish your note, please, I think that may cover --

GIBBS: Right.

ASTBURY: We got as far as Dr Katherine Davis and Nurse Taylor?

GIBBS: "Parents aware resuscitation has been unsuccessful. Between 11.55 and 00.30, intermittent gasps but no heart sounds or spontaneous pulse."

Then I've signed it and put my name in capitals.

I should add, though, that later on that night, heart sounds were heard, I don't know about a pulse. Dr Davis might have informed you of that. I was writing this -- at the beginning of this entry it says 00.30. I think the christening hadn't taken place at that stage, we were still waiting for the Anglican minister to turn up. But some time after that, the heart sounds were heard.

ASTBURY: All right. We heard from Dr Davis that you then left in the early hours of the morning.

GIBBS: Yes.

ASTBURY: What was the situation, can you recall, when you left the unit?

GIBBS: After the christening, which was probably 50 minutes after the full resuscitation had been stopped, so nearly an hour afterwards, the intention was to declare [Baby C] dead then having been christened. But because he was showing these residual signs of life, gasping, respirations, a feeble heartbeat, he wasn't dead. But we planned to offer just palliative care, just to keep him comfortable because he was dying basically. But it was 5 hours after the christening that finally no heartbeat was heard and no further gasping respirations.

ASTBURY: We heard that even once you had gone home you were contacted I think on two occasions?

GIBBS: Yes.

ASTBURY: And asked about --

GIBBS: I can't remember how many occasions.

ASTBURY: You were certainly contacted again and asked about medications; do you recall that?

GIBBS: Yes. Firstly, we didn't expect [Baby C] to show any signs of life after we stopped full resuscitation. Then even though he did, I expected those to stop fairly soon, but Dr Katherine Davis phoned me, I can't remember how many times -- if it was twice I don't dispute that -- to say that [Baby C] is still showing breathing efforts and heartbeats. We weren't feeding him, we had stopped the intravenous fluids, he wasn't getting any nutrition, and he would have been getting dehydrated during that stage. It's very difficult to know what a 30-weeker feels anyway. We wouldn't know whether [Baby C] was in distress but I know that he would be getting dehydrated and hungry if we weren't giving him fluids and therefore it was appropriate to give him some morphine to relieve any distress, which is part of palliative care management.

ASTBURY: You didn't have any more dealings with [Baby C] that particular shift that morning?

GIBBS: Not that I recall.

ASTBURY: Okay. I think your next, if I can use this term, involvement came later in the day. If we can go, please, to slide 271, Mr Murphy.

If we scroll down the note. I am sure I can take the liberty of simply reading this: at 1.30 that afternoon you called the coroner's office and you left a message on the answerphone to notify them of presumably [Baby C]'s death?

GIBBS: Yes, because it was an unexpected and unexplained death, so he was referred to the coroner because I couldn't provide a cause for death.

ASTBURY: We've heard that in the event of a death of a baby on the unit, there would often be a debrief --

GIBBS: Yes.

ASTBURY: -- that would take place some time afterwards?

GIBBS: Yes.

ASTBURY: Could we go next to 308?

We have here, Dr Gibbs, your note of that debrief. We can see 2 July 2015.

GIBBS: Which is just over 2 weeks after [Baby C]'s sad death. It took 2 weeks, as it often does. A debrief ought to be carried out soon after any major event, but it does depend on the various people involved at the time of the event all being on

duty again because they're working different shifts. It doesn't mean everyone who was involved gets to the debrief but usually those at the debrief are at least some of the people involved in the incident for which the debrief is being held.

ASTBURY: If I can take you through the names. Eirian Powell?

GIBBS: She's the ward manager, the most senior nurse on the neonatal unit.

ASTBURY: Thank you.

GIBBS: She wasn't on duty at the time [Baby C] died, but being the senior nurse she's there to support her nursing colleagues, so she tends to attend debriefing sessions .

ASTBURY: Okay. And I'd hope the remainder of the names are people we've already heard from: Mel Taylor, Katherine Davis, Sophie Ellis, yourself and, of course, Lucy Letby.

Can you take us through the note, please?

GIBBS: Right. I say that -- I've written that:

"Discussed the events leading up to [Baby C]'s 'arrest'.

I put "arrest" in single quotation marks simply because that's what we call a sudden collapse, a seeming loss of any breathing and circulation, no heart beating or very slow heartbeat. Then I put little dashes here as points:

"Did not seem unwell."

Meaning [Baby C] didn't appear unwell beforehand. We were not expecting to have a cardiorespiratory arrest:

"He had been active."

Then I put down:

"Kept pulling out NG tubes."

Bear in mind I'm just recording what we've discussed in this debrief. This isn't a note for the debrief, this is a summary of the debrief. So this would be everyone involved in the debrief's views, so I'd imagine pulling out the nasogastric tube was something I was told by the nurses. But it just meant he was an active little baby.

CRP is a C-reactive protein.

ASTBURY: We've heard about that, thank you.

GIBBS: And the white cell count had suggested infection but was on -- this is where -- sorry, I've reached the end of the line. I put the word "antibiotics" underneath it with a little half square around it. It should read:

"CRP and white cell count suggested infection but was on antibiotics."

He'd been on antibiotics for several days.

ASTBURY: Then the fourth entry, please, "not related"?

GIBBS: "Not related to 0.5ml feed."

I think I was trying to write something and crossed it out and then put "feed". So not related to 0.5ml feed. Little [Baby C], we'd been holding off his feeds because he was at risk of possibly developing necrotising enterocolitis, and feeding can precipitate necrotising enterocolitis if you start it too soon in a baby prone to that condition. But we had that evening -- I said we had, I had in the morning from the notes we've already looked at, Sally Ogden, the registrar, had written down that I had suggested that if his aspirates didn't get any larger, then we could start some trophic feeds. That's a small amount of feed. The 0.5ml was the feed that was started because his gastric aspirates hadn't worsened. But that feed was given shortly before his cardiorespiratory arrest.

ASTBURY: We have heard from Nurse Ellis who dealt with that.

GIBBS: I can't understand how 0.5ml of feed would ever cause a cardiorespiratory arrest, that's why we're saying it's not related to that. The reason to put that down is obviously the nurses felt very bad that they had just given him a feed -- and it wasn't instantly, it was a few minutes later, maybe up to 15 minutes later, he had his cardiac arrest.

ASTBURY: The nurses felt bad about it?

GIBBS: Because they'd given the feed. I had said that he could be fed, but if you're the person that gives the feed and you wonder, did that cause him a problem, you would feel bad about having given the feed.

ASTBURY: Of course, yes.

GIBBS: But the feed did not cause -- was not related to his cardiorespiratory arrest, in my opinion, in any way.

ASTBURY: Is that "discussed resuscitation"?

GIBBS: Yes:

"Discussed resuscitation. Technically performed well. Team worked well together."

And the reason we discussed this -- it sounds we're all congratulating ourselves and poor little [Baby C] is dead. When a tragedy happens and we lose a patient we always ask ourselves could we have done anything about it, could we have predicted this, and could we have managed the resuscitation any differently or better. And the feeling from this debrief, that is it was our views, is that we'd done everything we could and we'd resuscitated him well, sadly unsuccessfully.

ASTBURY: There's a dash after "together". Is it "causes"?

GIBBS: Yes, "Causes of PEA", that's another abbreviation. It stands for pulseless electrical activity. That's a form of cardiac arrest. It's when the heart is not beating, there's no pulse, so there is no circulation, so effectively you are dead if your heart is not beating, but you can still see some electrical impulses on a monitor. That just means electricity is circulating around the heart like it's supposed to from the pacemaker, but the heart is not being or pumping any blood. It's a form of cardiac arrest.

ASTBURY: Okay.

GIBBS: But I was saying:

"Causes of cardiac arrest considered and their management."

So the different causes. And we had during the resuscitation thought about different causes of cardiac arrest, including this particular pulseless electrical activity, PEA, and we'd not been able to find them or we had given treatment to counter any of those causes.

But I'm saying here:

"[Although] [that's an abbreviation for although] it's not possible to exclude pulmonary [so lung] a pulmonary embolus or toxins at the time of the resuscitation."

ASTBURY: What's a pulmonary embolus?

GIBBS: That's usually due to a blood clot which has developed somewhere in the body. It's rare in babies and children, it's more common in adults where you get a blood clot developing in

one of the legs and you hear of that happening in people who haven't moved their legs for a long time on a long haul flight get blood clots in the leg. That's called a deep venous thrombosis, a DVT. But a blood clot can sometimes break off from elsewhere in the body, pass through the circulation, get into the lungs and block the circulation in the lungs. And that would lead to a cardiac arrest.

ASTBURY: Was this debrief taking place before or after the post-mortem?

GIBBS: Before the post-mortem -- no, the post-mortem had been held, this is 2 weeks after, but none of us knew the results of the post-mortem.

ASTBURY: You go on to -- you say:

"Not possible to exclude toxins at the time of resuscitation."

What did you have in mind there?

GIBBS: One of the rare causes of cardiac arrest that does not respond to the usual measures is that some poisoning has occurred. This is more common in older children, toddlers particularly, who have come across a parent's or grandparent's medication, think it's sweets, ingested the medication, and because it's an adult size dose that a little child has taken, some medications can have a severe adverse effect on the heart and cause cardiac arrest. So it's a massive toxin overdose.

ASTBURY: We've heard about excluding various things. These are thoughts being had before the results of the post-mortem had been received?

GIBBS: Yes. These are causes where resuscitation has been unsuccessful, what might have caused it. Well, a pulmonary embolus -- if the lungs are completely blocked with the clot you can't get the circulation restarted during resuscitation. If a patient has been severely poisoned sometimes all your efforts to restart the heart and breathing will be unsuccessful.

ASTBURY: Okay. The next line makes it clear that the post-mortem results are not yet available. Can we carry on, "following"? "Following decision" is it? If we can scroll down a little.

GIBBS: "Following decision to stop active resuscitation after 25 minutes..."

And I have to apologise, this is why I say the timing -- I say 30 minutes previously, I say 25 minutes here. It depends on whether you are timing it from when Dr Davis and the nurses

started it or when I arrived at 25 to. So there's a difference. But the total resuscitation, full resuscitation, was 40 minutes. But it was about 20 or 25 minutes after I had arrived, which is why I say 25 minutes.

So:

"Following the decision to stop active resuscitation after 25 minutes [because there was no pulse or respiration at that stage], ventilation and gentle chest compressions continued for another 50 minutes simply to allow baptism before formally and legally declaring [Baby C] dead."

ASTBURY: Is that "unfortunately"?

GIBBS: Sorry. Unfortunately, there was a delay. And it's something I've already mentioned:

"A delay in the Church of England vicar arriving (the Catholic priest arrived before the end of active resuscitation) and the parents wanted baptism by a C of E vicar, then blessing by a Catholic priest. By the end of the baptism, which was 40 minutes after we stopped the active resuscitation, [Baby C] had a pulse and intermittent gasping respirations. But agreed with parents that further life support measures were futile. [Baby C] showed some signs of life for the next 5 hours whilst being cuddled by parents."

I wasn't there for all of that, but this is from the debrief, so various nurses and Dr Davis, who had been involved, would have reported that.

ASTBURY: And if we can scroll down again, please.

GIBBS: It was an unusual situation to prolong token resuscitation after stopping proper resuscitation, but I did it in the best interests, I felt, at that time, to allow a christening by the two ministers of religion. But I think everyone who had been involved felt uncomfortable that [Baby C]'s heart and breathing had restarted at a stage when it was futile to continue any further, and we thought in future we would try and avoid this situation. So, in future, once active resuscitation stops, if no minister of religion is available, baptism should be performed by a member of staff rather than prolonging a token resuscitation that risks revitalising the brain, the brainstem functions, in an otherwise profoundly hypoxic ischaemic impaired infant. That means an infant who's suffered severe lack of circulation to all their body organs.

ASTBURY: This is a view going forward based on what --

GIBBS: Yes.

ASTBURY: -- had happened?

GIBBS: Yes, to try and avoid the situation of waiting for 40 minutes for ministers of religion to arrive. The situation of two ministers of religion being involved and parents wishing to wait for the second one to arrive who is delayed is unusual, but the principle of stopping resuscitation when felt to be futile should be followed.

Having said that's what we should do, the reason I put the next bit in capitals is a final decision hadn't been made because that's myself discussing it with some of the people involved in the resuscitation, with the ward manager there as well, (inaudible: coughing) hadn't(?) been discussed with the rest of the consultants in the department, and we take team decisions when we're changing policy. So, however, I will discuss with consultant colleagues.

ASTBURY: Right. Then we can see again your signature --

GIBBS: Yes.

ASTBURY: -- in the bottom corner.

GIBBS: But discussions with the consultant colleagues -- they all readily agreed we should follow this policy of not waiting for a minister of religion to arrive if we decide a child is dead to actually -- for someone on the unit to christen the child themselves.

ASTBURY: Thank you. If we can come out, please, and go to the next tile, Mr Murphy.

This is described as a SUDIC strategy meeting. What's that, please?

GIBBS: SUDIC is an abbreviation for sudden unexpected death in infancy. So any child who dies unexpectedly, which applies to many children's deaths -- if a child is being treated for cancer and is getting worse and is unresponsive to further treatment and then dies, that's an expected death. But a SUDIC means the death wasn't expected and they all have to be investigated.

ASTBURY: So these are the minutes of that meeting. If we scroll down, please, it's there for anyone to read at a later stage. If we scroll down, we can see [Baby C]'s name.

I have no more questions for you, Dr Gibbs.

GIBBS: Am I allowed to add another point?

ASTBURY: Of course you can.

GIBBS: It's a point I want to make because I'm aware that repeatedly I've said that [Baby C]'s parents wanted both ministers of religion to be there to christen him and that's why we continued a token, not a proper, resuscitation, waiting for the second minister to turn up. And it sort of implies, one might think, and the parents might think I'm blaming them that we had to wait for the other minister of religion to come. It's not their fault. The fault is that [Baby C]'s heart and breathing restarted again and that should never have happened. If you've had an unsuccessful resuscitation after 40 minutes of full resuscitation, the national guidelines are that you shouldn't continue for more than 20 minutes because it's futile if you haven't restarted the heart.

I can't imagine, can't think of any natural disease process that would allow a heart to restart later on when you hadn't been able to get that heart to restart with full intensive care and multiple doses of adrenaline and so on. So that suggests, and I can't say any more than that, I don't know what it was, that whatever catastrophic event led to his death was reversing or had reversed after we stopped resuscitation. I don't understand that from a natural disease process.

So it was quite reasonable for [Baby C]'s parents to request that we waited -- well, we christened him. It was a shame that it just took a bit of time for the two ministers of religion to both turn up. It was my decision that we carry on this token resuscitation so we would delay certifying [Baby C] dead until the ministers arrived. The problem was, his heart should not have restarted, he shouldn't have started breathing again, and that's the difficulty. So I'm not trying to say it went a bit wrong and we prolonged [Baby C]'s death because the parents wanted the two ministers to christen him.

MR ASTBURY: Thank you. I'm told there was a technical hiccup, so we can now, my Lord, go back to the form that was on the screen.

MR JUSTICE GOSS: Yes.

MR ASTBURY: If we just go to box 2, please, Dr Gibbs. This was your contribution to the inquiry that was made:

"Dr Gibbs stated that [Baby C] was born at 30 weeks gestation. Labour was induced due to poor in utero growth and his birth weight was 800 grams, which was half the expected weight of a baby for that gestational period. [Baby C] looked normal at birth. He was very small. The cause of the poor growth is as yet

unknown. He was initially ventilated for his first few hours and then he managed on Optiflow with 25% oxygen over the next few days. He was generally managing well and there were no concerns."

Is that --

GIBBS: Yes, I think that's correct. I think to be absolutely accurate, he was ventilated for the first few hours, then he went on to CPAP, which I think the jury have been told about.

ASTBURY: Yes.

GIBBS: And then he went on to Optiflow. It looks here as though he only had Optiflow afterwards, but I think that detail's just missing.

ASTBURY: Yes, we've been through that sequence. Thank you.

"Due to having a high risk of developing necrotising enterocolitis (which is common in very premature babies) [Baby C] was not given his first milk feed until he was 4 days old. [Baby C] was given 0.5ml nasogastrically and it was shortly after this feed that he collapsed. The feeding tube had been inserted correctly and if milk had got into his lungs, such a small amount would have caused minimal problems. Oxygen saturates dropped and there was no pulse [of] heart rate traced."

GIBBS: "Pulse or heart rate", yes.

ASTBURY: "CPR was started immediately following his collapse. The registrar arrived within 1 minute and attempted to intubate but was unable to do so and CPR continued. During this time there was good chest movement. After 10 minutes, the consultant was successful in intubating and there was no sign of milk present in the windpipe and [Baby C]'s lungs were clear. Resuscitation continued for a further 25 minutes, during which time [Baby C] received eight doses of IV adrenaline, saline volume expansion boluses, bicarbonate, a bolus of glucose and a final bolus of calcium. [Baby C] did not respond to resuscitation. He took no breaths and there was no heartbeat or pulse. His mum was present throughout and his dad arrived during resuscitation. It was agreed that it was futile to continue with resuscitation as [Baby C] had suffered severe hypoxic ischaemic encephalopathy.

"The parents requested that [Baby C] be baptised by both a Catholic priest and Anglican priest in keeping with both parents' religions. The Catholic priest arrived a few minutes before it was agreed to stop resuscitation but the Anglican

priest could attend for up to an hour as she had to travel from the Wirral."

Presumably "could not attend":

"It was agreed to continue with gentle chest compressions and some oxygen but that no further drugs would be administered. During this further period on resuscitation (50 minutes) there was a pulse present and the baby took a few gasping breaths. [Baby C] showed residual signs of life with no recovery and parents agreed that it was futile to continue once baptism had taken place. Resuscitation was stopped and [Baby C] was given to his parents to cuddle. [Baby C] died 5 hours later in his parents' arms. The case was discussed with the coroner and it was agreed that a post-mortem would be undertaken to ascertain the cause of death."

That's your entry on -- your contribution to the meeting.

GIBBS: Which is summarising [Baby C]'s --

MR ASTBURY: Yes, thank you. They are all the questions, Dr Gibbs, I have for you. Thank you, if you could wait there.

MR JUSTICE GOSS: Well, you'll be some time?

MR MYERS: I will be, my Lord, yes.

MR JUSTICE GOSS: I think just for the sake of completeness, severe hypoxic ischaemic encephalopathy is?

GIBBS: Right. Well, encephalopathy --

MR JUSTICE GOSS: We don't need a medical lecture, but basically if you can break it down as simply as possible.

GIBBS: Profound brain damage due to lack of blood and oxygen reaching the brain, which would also affect all other organs in the body.

MR JUSTICE GOSS: There we are. Thank you. We'll break off there. Thank you very much, Dr Gibbs. I'm afraid it's not been possible to complete your evidence, but looking at the chart that I have, you're going to be attending quite a few more times, it is likely. Thank you very much. You obviously know that you're in the middle of your evidence and not to talk to anyone about anything to do with this case and the evidence you've given. Thank you very much. Could you be ready, please, to resume at 10.30 tomorrow morning? Thank you very much, doctor. Either stay for the moment or leave as you wish.

(Pause)

Thank you very much. Would you please make what enquiries you can, those of you who travel by train and are reliant on train for getting to this courtroom, what the situation is going to be on Monday, Tuesday and Wednesday? And is it Thursday? And Thursday. Because I think Monday and Wednesday are strike days, but there are expected to be knock-on effects on Tuesday and Thursday because of the strikes. And what other possible alternative arrangements you may be able to make or not as the case may be so that we'll know tomorrow, or certainly Wednesday, how we're going to deal with the plan for next week. All right? Thank you very much.

And as far as you're concerned, you may be assured that that will be accommodated.

(In the absence of the jury)

Sorry, I didn't wish to sound rude, Dr Gibbs, when I said I don't want a medical lecture. You in fact summarised it very clearly and very concisely, for which I'm grateful.

GIBBS: I took the hint, thank you.

MR JUSTICE GOSS: No, no, they're terms with which I'm familiar, but I just wanted to make sure it was in evidence for the jury. Thank you.

I don't know whether anyone else is going to be affected by these strikes or not, but if anyone is, we will discuss the arrangements. I'm thinking of witnesses as well who may be scheduled for that time and may have difficulty and so on and so forth. But I think we ought to try and make sure this is resolved on Wednesday if possible or Wednesday and Thursday and certainly not leave it until Friday. But from your point of view, the earlier the better.

Thank you very much.

(4.20 pm)

(The court adjourned until 10.30 am on Tuesday, 1 November 2022)