

1 December 2022
Baby G

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Housekeeping

Thursday, 1 December 2022
(10.30 am)

(In the presence of the jury)

MR JUSTICE GOSS: Mr Johnson.

MR JOHNSON: Thank you, my Lord. Usually, we would start an individual case by reading the parents' statements.

We are going to vary that today and do the sequence first, if that's acceptable, just because of printing issues, something as simple as that.

So could I call Kate Tyndall, please?

MRS KATE TYNDALL (recalled)

Examination-in-chief by MR JOHNSON

MR JOHNSON: My Lord, you will recall that we reviewed at an earlier stage, I think in the context of [Baby C]'s case, Lucy Letby's working pattern and put it against the indictment, and we're going to do that now and bring it up to date to [Baby G].

So if I could invite the jury to look at the indictment and ask Mr Murphy to put the shift pattern on to the screen.

This is a composite document that covers Lucy Letby's working pattern between the beginning of June 2015 and the end of July 2016.

Is this -- I'm sorry, Mrs Tyndall, would you identify yourself for the purpose of the record?

TYNDALL: Yes, I'm Kate Tyndall, intelligence analyst.

JOHNSON: Is this your work, this document --

TYNDALL: Yes, it is.

JOHNSON: -- that we see on screen? Thank you.

If we could turn the page figuratively, please, Mr Murphy, and expand June 2015 first of all. So we see that count 1 is the allegation of murder in respect of [Baby A] on 8 June. We see that that was the first of two night shifts so far as Lucy Letby was concerned.

Count 2 is an allegation of attempted murder of [Baby B]. The jury will recall those events happened overnight from the 9th into the 10th, so that night shift, that's the second in the block of two.

Count 3, over the page, is an allegation of murder of [Baby C] on the night shift of the 13th into 14 June, which we see is in the next block of night shifts.

Count 4, the murder of [Baby D] on 22 June, which we see is in the middle of the next block of night shifts.

Count 5 is the allegation of the murder of [Baby E] on 4 August, which we see, if we move on, please, so we can see there are a couple of blocks of night shifts on the 27th and 28 June, the 1st and 2 July; is that right, Mrs Tyndall?

TYNDALL: Yes.

JOHNSON: Could we scroll down, please, Mr Murphy.

Sorry, can we go back? I've been asked to do the rest of July. There were no night shifts other than the two at the beginning of the month in July 2015.

So we move on to August 2015, please. The allegation is of murder on 4 August, which we see that day is the final -- the 3rd into the 4th and the 4th into the 5th are the two final night shifts of a block of four. That's [Baby E].

Count 6, the attempted murder of [Baby F], which is the case the jury has just considered, which we all now remember. A TPN bag

was hung just after midnight, the 4th into 5 August, and that night shift would have finished at about 8 am on the 5th.

We move on now to -- so if we look at the rest of August we see there are no night shifts for the remainder of that month.

We move on to September. Looking at the indictment, we see an allegation of attempted murder, the attempted murder of [Baby G]. The date of the offence is 7 September and, as we will see shortly with you, Mrs Tyndall, those events happened towards the end of that night shift, which is the final one in that block of four, starting on the 6th, going into 7 September; is that right?

TYNDALL: Yes.

JOHNSON: So that's the context.

If we can now, please, with Mr Murphy's assistance, move to the sequence of events, please.

MR JUSTICE GOSS: Again, completing the context to an extent, that's count 7 to which you have just referred?

MR JOHNSON: It is.

MR JUSTICE GOSS: But then of course there are counts 8 and 9, which both also are alleged offences of the attempted murder --

MR JOHNSON: Yes.

MR JUSTICE GOSS: -- of [Baby G] later in the month. So there are the three counts that we will be considering one after the other.

MR JOHNSON: We will. And so that the jury understand, the way we are going to present this case, subject to witness issues, which we always have to take into consideration, is we are intending to deal with count 7 as an individual piece of evidence, so to include the expert evidence on count 7, and then to move on to counts 8 and 9, which we will take together, for what are probably obvious reasons, because the two incidents happened on the same day, on 21 September.

MR JUSTICE GOSS: All right, thank you.

MR JOHNSON: So that's the plan as things presently stand, but of course always subject to alteration if we run into witness problems.

MR JUSTICE GOSS: Thank you.

MR JOHNSON: So Mrs Tyndall, going to the sequence of events, we remind ourselves of the fact that [Baby G] was born on 31 May 2015 at Arrowe Park, which is on the Wirral.

TYNDALL: Yes.

JOHNSON: [Baby G] was, as a matter of fact, the youngest and the smallest of all the babies in this case.

TYNDALL: Yes.

JOHNSON: Can we go behind that tile, please, Mr Murphy?

[Baby G]'s father's surname is [Surname of Baby G]?

TYNDALL: Yes.

JOHNSON: Her mother's surname is [redacted], if that's how you pronounce it.

We see that [Baby G] was very, very premature at 23 weeks plus 6 days. She weighed just over 1 pound at 535 grams. Her delivery was a spontaneous vaginal delivery and she was in poor condition at birth, requiring ventilation. There is reference there to the difficulties that [Mother of Baby G] had suffered in pregnancy.

TYNDALL: Yes.

JOHNSON: We see also the Apgar score. There was no record at all at 1 minute. It was at the lowest at 1 at 5 minutes but had significantly increased to 10 at 10 minutes.

TYNDALL: Yes.

JOHNSON: If we move on, please, Mr Murphy to the second tile. Do we then see, Mrs Tyndall, that [Baby G] was cared for at Arrowe Park Hospital for the succeeding 13 weeks and 4 days? In other words from her birth on 31 May until her admission to the Countess of Chester Hospital shortly before midnight on 13 August?

TYNDALL: Yes.

JOHNSON: Thank you. So by that stage her nominal gestation would have been about 37 weeks, adding the 23 plus 6 to the 13 plus 4, there or thereabouts?

TYNDALL: I'll go with your maths on that.

JOHNSON: Very dangerous, but hopefully basic enough for even me to get right.

So we see a note to which there were contributions by Caroline Bennion and Dr Alison Ventress, relating to [Baby G]'s admission shortly before midnight on Saturday, 13 August.

TYNDALL: Yes.

JOHNSON: Sorry, I say Saturday. It's a Thursday. I can't even read.

TYNDALL: Yes.

JOHNSON: On the screen it says Thursday.

If we move on to tile 4, please, do we see a nursing note -- tile 4, please, Mr Murphy.

Do we see Caroline Bennion updating the nursing notes on the computer at 05.08 the following morning, Friday, 14 August?

TYNDALL: Yes.

JOHNSON: My Lord, Caroline Bennion isn't giving evidence in relation to this case, so we'll deal with the note if we may at this stage.

Can we go to the note? This is your transplant, in effect, of what she has written in slightly more legible format. Could you take us through what you have produced there, please?

TYNDALL: It reads:

"[Baby G] transferred from Arrowe Park Hospital for continuing care, and mum was booked into Chester Hospital. [Baby G] was delivered via NVD at 23 plus 6/40, weight 535 grams. For past problems and management please see medical notes. Currently [Baby G] is on CPAP, PEEP of 4 in 29-40% oxygen with good compensating CBG. [Baby G] has been on CPAP since 17/7/15 and has occasional desaturations.

"[Baby G] is trialling off CPAP in ambient oxygen and manages 1 hour in two episodes daily. May be eligible to trial Optiflow. A PDA was detected but not audible on examination to today. [Baby G] will require a CUSS at 36 weeks and has mild dilation. Fluids are all enteral feed, 180ml/kg, 2 x 12, all OGT. EBM with Gaviscon and fortifier."

JOHNSON: Thank you. In that context, the CUSS is the head scan?

TYNDALL: I believe so, yes.

JOHNSON: The OGT, the orogastric tube, so rather than going through the nose and straight down the throat, through the mouth?

TYNDALL: Yes.

JOHNSON: And EBM, expressed breast milk?

TYNDALL: Yes.

JOHNSON: Can we move to tile 5, please? This is a continuation of the same notes of Caroline Bennion, made slightly later, an hour later. Would you read those for us, please?

TYNDALL: They're made at the same time, it's just this transposition issue (inaudible) amount of content:

"Mum intends to breast feed and is expressing well. Pump offered but mum has her own to try first. [Baby G] has no ROP and is due a review for ROP. Referral to be faxed in the morning. First immunisations have been given on 1/8/15. [Baby G]'s medication is sodium supplements, diuretics, lactulose, caffeine, lactulose [again], Gaviscon and Sytron and fortifier. Baseline bloods obtained and a CBG. [Baby G] has had metabolic bone disease but is not currently treated. Mum and dad have been shown around the unit and given contact numbers."

JOHNSON: Thank you. Do we then move on to tiles 6 and 7, which are your summaries, aren't they?

TYNDALL: Yes. Just explaining that [Baby G] continued to receive the care from that point onwards until the point where the sequence starts at 02.00 on 06/09.

JOHNSON: And the next tile, which is tile 7?

TYNDALL: Just saying this is where the detail starts.

JOHNSON: Just to put this into context again, we've now moved from 31 May, which is [Baby G]'s birthday, to 6 September.

The allegation made against Lucy Letby is that it happened on 7 September, so we're at the beginning of the day before the allegation given the circumstances -- the circumstances giving rise to the allegation?

TYNDALL: Yes.

JOHNSON: Thank you. Tile 8, please. I'm not going to go behind these, but do we have the standard observation chart, showing [Baby G]'s heart rate, respiratory rate and temperature --

TYNDALL: Yes.

JOHNSON: -- recorded at 2 o'clock in the morning by Valerie Thomas? This is a shift, we know from the fact that the tile is blue-edged, on which Lucy Letby was also working as a matter of fact?

TYNDALL: Yes.

JOHNSON: Thank you. Tile number 9 shows some detail which I'd just like to highlight if we can go behind it, please.

You have typed for us here what's contained on the tile itself. Notably, the first detail that you have transcribed is that this was the 99th day after [Baby G] had been born.

TYNDALL: Yes.

JOHNSON: She was being fed expressed breast milk with Gaviscon and a fortifier?

TYNDALL: Yes.

JOHNSON: The amount she was being fed is 45, presumably millilitres?

TYNDALL: Presumably.

JOHNSON: The route, 35 of those 45 via bottle and 10 down the NGT?

TYNDALL: Yes.

JOHNSON: PU, do you know what that means?

TYNDALL: I think it stands for passed urine. And then a tick.

JOHNSON: There is a tick, which we can just see after the -- I didn't even see that the first time. And then a comment, "Demand feed"?

TYNDALL: Yes.

JOHNSON: Anyone with babies probably knows what that means.

Thank you. Can we move on to tile 10, please? Are these more nursing notes, this time made by Valerie Thomas,

concerning -- if we go behind it, I won't ask you to read it out because Valerie Thomas will be giving evidence so she can deal with it herself.

We can see for ourselves that that deals with the feeds and other related issues.

TYNDALL: Yes.

JOHNSON: Go back to the carousel, please, Mr Murphy.

Do we then have a sequence of five separate tiles, being tiles 11 through to and including 15, which relate to various medications and oxygen that were being given to [Baby G]?

TYNDALL: Yes.

JOHNSON: We see that each of those five tiles bears the name of Lucy Letby alongside that of [Nurse E]?

TYNDALL: Yes.

JOHNSON: So to tile 16, please. At 5 o'clock that morning, have you put in for us the neonatal feeding chart?

TYNDALL: Yes.

JOHNSON: And also in the succeeding tile, the chart which records [Baby G]'s heart rate, respiratory rate and temperature?

TYNDALL: Yes.

JOHNSON: Thank you. Tile 18. Have you recorded the fact that the night shift ended, the day shift began, and [Baby G] was handed over?

TYNDALL: Yes.

JOHNSON: I'm not sure whether -- it may be recorded on the information behind, it may be a new name here that we haven't seen before. Yes. Vicky Blamire was the designated nurse for [Baby G]?

TYNDALL: Yes.

JOHNSON: We know -- I think Vicky Blamire is a band 4 nurse; is that right?

TYNDALL: I believe so, yes.

JOHNSON: So going back to the sequence then, please. In tiles 19 and 20, do we have the hourly observations recorded?

TYNDALL: Yes.

JOHNSON: Then in tiles 21 to 25, another sequence of five medications or similar prescription records --

TYNDALL: Yes.

JOHNSON: -- at 8 am? At tiles 26 and 27 do we have the hourly observations recorded?

TYNDALL: Yes.

JOHNSON: This time by Vicky Blamire?

TYNDALL: Yes.

JOHNSON: Then at tile 28 do we have another new name, so far as the evidence is concerned at least, Dr Stephen Brearey, who is one of the consultants at the Countess of Chester; is that right?

TYNDALL: Yes.

JOHNSON: If we go behind that, please, Mr Murphy, do we see your typed version of his written records? And if we just click again, please, to see the written records, Mr Murphy.

Not the most legible handwriting, but it appears from that that Dr Brearey conducted an examination of [Baby G]?

TYNDALL: Yes.

MR JOHNSON: My Lord, Dr Brearey will be giving evidence about this so I'm not going to go into the detail if that's acceptable.

Returning to the carousel, do we then have three records timed at 11 o'clock of fortifier, Gaviscon and oxygen being administered to [Baby G]?

TYNDALL: Yes.

JOHNSON: Followed 3 hours later, at 2 pm, tiles 32 and 33, by the observations and the feeding record?

TYNDALL: Yes.

JOHNSON: At tiles 34 to 37, again -- well, slightly differently, actually, they start at 14.00 hours and conclude at 14.30, but do they record similar information to that which had previously been recorded, the administration of fortifier, Gaviscon, oxygen and sodium chloride --

TYNDALL: Yes.

JOHNSON: -- to [Baby G]? Thank you.

We come next to tile 38. Is this Vicky Blamire's notes written at 15.37, so mid-afternoon, concerning the care given to [Baby G] from 8 o'clock that morning?

TYNDALL: Yes.

JOHNSON: If we just -- to put what we've seen into context, if we just go to the note, please. Do we see that there, Nurse Blamire essentially records similar information to that which we've seen in so many different nursing notes concerning the safety equipment?

TYNDALL: Yes.

JOHNSON: She then summarises the fact that [Baby G] had been fed?

TYNDALL: Yes.

JOHNSON: And there are references to some of the medications for which we have seen the prescription records?

TYNDALL: Yes.

JOHNSON: Thank you. So going back, please, to the carousel.

Do we then come to the observation feeding charts at 5 pm?

TYNDALL: Yes.

JOHNSON: Then at tiles 41 to 45, do we have five records of various substances being administered to [Baby G], being fortifier, Gaviscon -- well, actually, the fortifier is 5 pm, the others are after 6, so 18.17 through to 18.33, but for various medications including Gaviscon, oxygen, furosemide, spironolactone.

TYNDALL: I don't know how to pronounce that.

JOHNSON: I'm sure others can do better than I can. Anyway, we'll hear all about it, I'm sure.

Finally, before the shift change, do we then have Vicky Blamire's updated nursing note?

TYNDALL: Yes.

JOHNSON: If we go to that. We see that there had been a recent successful bottle feed and [Baby G]'s bowels were open?

TYNDALL: Yes.

JOHNSON: That's the day up to and including the end of the day shift on 6 September. The event with which the jury are concerned on this count happened at about 2 am on this shift, didn't it?

TYNDALL: Yes.

JOHNSON: So we're going to deal with events on this shift. Can we click behind tile 47, please, Mr Murphy? First of all, do we see there that the paediatrician of the week was Dr Brearey?

TYNDALL: Yes.

JOHNSON: As we have seen, he actually examined [Baby G]. There is the coincidence of the fact that he was also on call for the shift that we're about to examine.

TYNDALL: Yes.

JOHNSON: The registrar was Dr Alison Ventress --

TYNDALL: Yes.

JOHNSON: -- whose notes we have seen in other cases, but who we have not yet met. The night SHO was Charlotte Newton.

TYNDALL: Yes.

JOHNSON: The shift leader was either Ailsa Simpson or Christopher Booth.

TYNDALL: Yes.

JOHNSON: The designated nurse for [Baby G] on this shift was [Nurse E].

TYNDALL: Yes.

JOHNSON: And Lucy Letby was also working?

TYNDALL: Yes.

JOHNSON: Finally, the nursery nurse was Lisa Walker?

TYNDALL: Yes.

JOHNSON: I think a bit further down we have the map showing that that evening there were seven children working -- as patients in the unit.

TYNDALL: Yes.

JOHNSON: So seven children, four nurses, and we see the relative designations. At least two children in nursery 1?

TYNDALL: Yes.

JOHNSON: One was a child whose initials were RIH, for whom the designated nurse was Lucy Letby?

TYNDALL: Yes.

JOHNSON: The other child, AC. Her designated nurse was Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: In nursery 2 was [Baby G], whose designated nurse was [Nurse E]?

TYNDALL: Yes.

JOHNSON: There were two children in nursery 3, MC and IO --

TYNDALL: Yes.

JOHNSON: -- whose designated nurse was Lisa Walker?

TYNDALL: Yes.

JOHNSON: But there were also, as denoted in that box in the bottom right-hand corner of the screen, two other children for whom the designated nurses were Christopher Booth and [Nurse E] respectively?

TYNDALL: Yes.

JOHNSON: So just to put that into a slightly different format, [Nurse E] had a child in nursery 2, who was [Baby G]?

TYNDALL: Yes.

JOHNSON: She had another child, and we don't know where that other child was?

TYNDALL: No.

JOHNSON: Christopher Booth, who may or may not have been the shift leader, had a child, DB, whose location we don't know?

TYNDALL: Yes.

JOHNSON: And the other potential shift leader, Ailsa Simpson, had a child in nursery 1?

TYNDALL: Yes.

JOHNSON: Going back to the carousel, please, at about the time of physical handover, do we see that, in respect of [Baby G], the administration of sodium chloride, fortifier, Gaviscon and oxygen was recorded in tiles 48 to 51?

TYNDALL: Yes.

JOHNSON: And that Lucy Letby was the co-signer for those substances alongside the designated nurse, [Nurse E]?

TYNDALL: Yes.

JOHNSON: Do we then have administration records on the computer for those substances, which are tiles 52 to 55?

TYNDALL: Correct.

JOHNSON: And they are timed either 2 or 3 minutes after the prescription records are signed and co-signed by the respective nurses?

TYNDALL: Yes.

JOHNSON: At 8 pm, so tiles 56 and 57, please, do we have the observation charts for [Baby G] --

TYNDALL: Yes.

JOHNSON: -- and the neonatal feeding chart?

TYNDALL: Yes.

JOHNSON: If we can go back to the observation chart, please, Mr Murphy, if you wouldn't mind. Just click on so that we can get an idea of the -- and the document itself.

So we're dealing with 6 September at 8 o'clock, which is the very far left of the chart. We can see that [Baby G]'s heart rate has been recorded, for the rest of that day, twice at about 160 or thereabouts; is that right?

TYNDALL: I think -- I just can't see the whole chart. I think that that's... If we go down the bottom, we can see the... So actually, it's the 8 o'clock in the middle of the chart where it's saying 7 --

JOHNSON: Is it, right.

TYNDALL: I'm pointing, you can't see me pointing. Where it says 07/09, it's that 20.00 record there.

JOHNSON: Right. So where Mr Murphy has put the cursor; is that right?

TYNDALL: Yes.

JOHNSON: We can deal with this with the witnesses in due course, but it gives us an idea of the general position that the jury can contextualise from the knowledge that they've heard and the evidence they've heard in other cases anyway. Thank you.

If we come out of that, please. So that's tiles 56 and 57.

At tile 58 -- we'll take these, I think we've probably been dealing with these a bit too quickly for some people, so can we deal with this slowly, please?

This is a text from Lucy Letby, sent at 20.22, so in other words about half an hour after her shift had started, anything between an hour and half an hour and 50 minutes after her shift had started. It is sent to Kate Bissell; is that right?

TYNDALL: Yes.

JOHNSON: Thank you. Could you read that for us?

TYNDALL: "Hi Kate, it's Lucy. Just checking I's milk and 4 bottles haven't got a date/time expressed. Do you know when mum expressed them? x"

JOHNSON: In this context I is the child, or may well be the child, IH who was Lucy Letby's designated charge that evening.

TYNDALL: Yes.

JOHNSON: Thank you. On to the next one, please, because this is Kate Bissell's response to Lucy Letby, 4 minutes later.

Could you help us with that, please?

TYNDALL: Yes, she replies:

"Hi Lucy. Sorry, she put them in the fridge herself. I didn't check she'd written anything on them. Must have been about 16.30 hours today when she came back down for skin to skin x"

JOHNSON: Thank you. Did Lucy Letby spend to that about 7 minutes later?

TYNDALL: Yes. She responded with:

"Ok, thanks. I'll give mum and ring and just double-check x"

JOHNSON: Then a virtually immediate response from Kate Bissell?

TYNDALL: "Yeah, ok, have a good night x"

JOHNSON: So that's 20.30. Just so that we're entirely clear about this in previous cases we have seen observations being taken on the hour, every hour?

TYNDALL: Yes.

JOHNSON: That was not the case for [Baby G] at this stage, was it?

TYNDALL: No.

JOHNSON: So the previous observations, as we saw from the chart, were at 8 pm. This next set of observations as we see and the neonatal feeding chart were 23.00 hours, 11 pm?

TYNDALL: Yes.

JOHNSON: So this is three-hourly observations and feeding; is that right?

TYNDALL: Yes, that's correct.

JOHNSON: We've seen the chart, at least a glimpse of the chart already. But that data was recorded -- those data were recorded at 23.00 hours. We also see at tiles 64 and 65 the record of the prescription for fortifier and Gaviscon being signed by [Nurse E], the designated nurse, and co-signed on this occasion by Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: Ailsa Simpson being with Lucy Letby in nursery 1 with her child at that stage?

TYNDALL: Yes.

JOHNSON: Thank you. So that's 11 pm.

Is the next material past midnight into the early hours of 7 September?

TYNDALL: Yes.

JOHNSON: Do we see the prescriptions for sodium chloride and Gaviscon at tiles 66 and 67 respectively, signed and co-signed by [Nurse E] and Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: Therefore, do we have a set of three tiles, being 68 to 70, all timed at 01.46, being the computer update for fortifier, Gaviscon and sodium chloride?

TYNDALL: Correct.

JOHNSON: Followed a minute later by the prescription being signed and countersigned by [Nurse E] and Ailsa Simpson for fortifier?

TYNDALL: Yes.

JOHNSON: And then the update on the computer at the same time with the same signatory and co-signatory for the Gaviscon and fortifier?

TYNDALL: Yes.

JOHNSON: Thank you. We come next to the three-hourly observations at 2 am; is that right?

TYNDALL: Yes.

JOHNSON: These were recorded by [Nurse E], the designated nurse?

TYNDALL: Yes.

JOHNSON: If we go to tile 75, please, and go behind that. We see that the day of [Baby G]'s life had changed. This was day 100 since she had been born?

TYNDALL: Yes.

JOHNSON: We see that [Nurse E] recorded a feed of expressed breast milk, plus Gaviscon, plus fortifier?

TYNDALL: Yes.

JOHNSON: The amount being 45ml via the nasogastric tube?

TYNDALL: Yes.

JOHNSON: The fact that she had taken an aspirate, so we have the pH value confirming the acidity of the aspirate?

TYNDALL: Yes.

JOHNSON: And that [Baby G] was asleep. If we just look at the chart itself, please. There we see presumably [Nurse E]'s writing recording that information that you have transposed on to the typed preceding sheet?

TYNDALL: Yes.

JOHNSON: Thank you. We see also the corrected gestation in the left-hand column, four rows down: 38 weeks, day 100?

TYNDALL: Yes.

JOHNSON: Thank you. If we go back, please. Do we then see the black tile, which denotes an event?

TYNDALL: Yes.

JOHNSON: Then at tile 77 do we have a note written by Lucy Letby at the end of the shift?

TYNDALL: Yes.

JOHNSON: This note refers to the fact that she took over the care of [Baby G] following the event?

TYNDALL: Yes.

JOHNSON: Can you read that for us, please?

TYNDALL: I have put in, "Care of [Baby G] transferred to Lucy Letby", but in the nursing notes is written:

"Written in retrospect for care given from 02.00 to present."

JOHNSON: Thank you. Could we look at the document itself, please? It's that sort of bottom right-hand corner of the page, please, I think.

If we just look at this as a piece and then we'll see how it fits into the chronology. Could you take us through that note, please?

TYNDALL: All of it?

JOHNSON: I think so.

TYNDALL: Okay:

"Written in retrospect for care given from 02.00 to present. [Baby G] had large projectile milky vomit at 02.15. Continued to vomit ++. 45ml milk obtained from NG tube with air ++. Abdomen noted to be distended and discoloured. Colour improved few minutes after aspirating tube. Remained distended but soft. Reg Ventress asked to review. To go nil by mouth with IV fluids. Doctor called to theatre."

JOHNSON: We'll stop it there because we then move on to events at 03.15?

TYNDALL: Yes.

JOHNSON: So we have a record there made by Lucy Letby of the fact that there was a projectile vomit at 02.15, there was -- [Baby G] then continued to vomit ++, and she or somebody had obtained 45ml of milk from the NG tube with air ++?

TYNDALL: Yes.

JOHNSON: We saw, didn't we, that at 02.00 hours there had been an acidic aspirate which wasn't quantified?

TYNDALL: Yes.

JOHNSON: And that [Baby G] had been fed 45ml of milk?

TYNDALL: Yes.

JOHNSON: Therefore we have the 45ml that's recorded as going in being retrieved by an aspirate --

TYNDALL: Yes.

JOHNSON: -- but the projectile vomit and the vomit ++ being additional milk on the face of it? All right.

If we can go back, please. [Baby G] was a child being fed every 3 hours?

TYNDALL: Yes.

JOHNSON: All right. So that was the note at tile 77. If we go to tile 78. This is [Nurse E]'s note. She, of course, was the designated nurse for [Baby G] at the start of the shift. If we go to your transposition of what's written by her. Could you take us through that, please?

TYNDALL: "Nurse L Letby taken over care following vomit/apnoeic episode after 02.00 feed."

JOHNSON: Thank you. Moving on to tile 79, please. Is that Lucy Letby's note of the projectile vomit and the 45ml and air ++ and vomit ++ that we've just seen?

TYNDALL: Yes.

JOHNSON: Thank you. So that's timed by you, taking Lucy Letby's timing of 02.15?

TYNDALL: Yes.

JOHNSON: Thank you.

Tile 80. Do we have the notes of the registrar's, Dr Ventress, examination of [Baby G], the examination taking place at 02.35, but the notes being retrospectively recorded at 04.40?

TYNDALL: Correct.

JOHNSON: We'll go to this in detail if we may, please. Could you take us through what Dr Ventress recorded?

TYNDALL: "Called to RV [Baby G] urgently at 02.35. Had very large projectile vomit (reaching chair next to cot plus canopy). Abdo appeared discoloured, purple and distended. [Baby G] distressed and uncomfortable. Red in face and purple all over. O2 increased to 1 litre via nasal cannula. Desat to 80s but heart rate okay. Full feed (45ml aspirated). Large watery stool passed, after which abdo slightly better and [Baby G] relaxed and appeared back to usual self. Planned to cannulate IV fluids plus bloods but unfortunately delayed due to delivery of another preterm baby."

JOHNSON: Thank you. Going back to the carousel, please, and tile 81, do we have Lucy Letby's notes, which we should go to, please, if we may, or just to your reproduction of them.

TYNDALL: This reads:

"Bowels opened. Large green watery stool at 03.00."

JOHNSON: So that in effect replicates, at least to a degree, that which is recorded by Dr Ventress?

TYNDALL: Yes.

JOHNSON: Then if we use the bottom right-hand arrow, please, Mr Murphy, to go straight to the next note made by Lucy Letby at 03.15, or events at 03.15, which is where I stopped you earlier.

So this is the note made by Lucy Letby. Taking it up, please, for us, Mrs Tyndall in about the fifth line of the text that we can see?

TYNDALL: "Approx 03.15 [Baby G] had profound desaturation to 20%, marked colour loss with apnoea. Bradycardia to 50s. Neopuffed in 100% oxygen. Observations improved but [Baby G] remained apnoeic. Doctors arrived. Intermittently breathing/apnoea.

"Decision made to intubate. Moved to nursery 1. Intubated without drugs as unable to site IV access. Size 3 ET tube, SIMV 18/5, rate 40 in 40% oxygen. High leak and resistance on ventilator, frequent desats and crackly air entry."

JOHNSON: Thank you. Going back to the carousel, please, Mr Murphy. Do we have a record at tile 83 of [Baby G] being moved from where she had been into nursery 1?

TYNDALL: Yes.

JOHNSON: Is there then a continuation of Dr Ventress' notes? We recall that in the last section that you read to us, you told us that Dr Ventress had said that she had:

"... planned to cannulate [Baby G] to give intravenous fluids and bloods, but unfortunately delayed due to delivery of another preterm baby."

Is this Dr Ventress' notes made in relation to being recalled from the delivery room to [Baby G]?

TYNDALL: Yes.

JOHNSON: I think a rogue S has crept into "retrospect" there.

I don't know how that's happened. Anyway. If we just go to Dr Ventress' notes, please. Take us through that, please.

TYNDALL: "Called out of theatre to say [Baby G] gone apnoeic and dusky. Dr Brearey called in. On arrival, sats 50% in FiO2 100%. Receiving IPPV from nurse. Heart rate okay. Took approximately 5 minutes for sats to pick up. Moved to room 1. Pink and well perfused with mask CPAP. Active, so tried for IV access x2 unsuccessfully. [Baby G] then had another profound apnoea plus decreased heart rate to 70. Sats 40%. Perfusion decreased. CRT 3 secs. IPPV given and gradual improvement again. When sats increased, perfusion also improved. Decision to intubate due to 2 profound desats and concerns re abdo so not keen for CPAP. No IV access so no drugs used. Intubated size 3.0 ETT, 8 centimetres at lips. Bloodstained fluid noted coming up from trachea/between cords. Capnograph positive plus good B/L air entry. Dr Brearey in attendance then. Vent settings 18/5. Rate 40. FiO2 weaned down to 30%. Good gas 30 mins post-intubation. Decreased to 16/5. Large leak noted on ETT but good air entry and sats so left. IV vit K given due to blood from trachea."

JOHNSON: So this is another child with blood coming up the throat --

TYNDALL: Yes.

JOHNSON: -- according to this record?

Tile 85, please. Do we then have Dr Brearey's notes relating to his attendance on [Baby G] at 03.30?

TYNDALL: Yes.

JOHNSON: If we go to those, please. If you could help us with those, please.

TYNDALL: "Called in at 03.30. History as Dr Ventress' entry. Large vomit and loose watery stool earlier followed by desat and bradycardia. Intubated by Dr Ventress, size 3.0 ETT, on my arrival and connected to ventilator. A small amount of blood visible on intubation. Blood samples taken and sent. IV cefotaxime commenced. CXR showed satisfactory ETT position and lung fields consistent with CLD but nil focal. AXR: gases abdomen no perforation. Good AE. Good gas post-intubation."

JOHNSON: Thank you. The next tile, which is 86, is a note written by [Nurse E] about [Baby G]'s parents being called; is that right?

TYNDALL: Yes.

JOHNSON: That's at 03.45. At 3.50 do we have Lucy Letby's note of the fact that [Baby G] was intubated?

TYNDALL: I think this is -- there's a checklist. Have we seen one of these before?

JOHNSON: I'm not sure we have, so if we could go to that, please.

This is clearly a pro forma neonatal elective intubation checklist and we can see that various steps, presumably prescribed steps, are ticked off by those who conduct the intubation; is that right?

TYNDALL: I believe so, yes.

JOHNSON: At the bottom we have the nursing staff name, L Letby, with Lucy Letby's signature, date and time?

TYNDALL: Yes.

JOHNSON: Top right-hand corner, of course, we have [Baby G]'s details recorded?

TYNDALL: Yes.

JOHNSON: Thank you. Can we move on, please, to tile 88. If you could tell us what's that about, please.

TYNDALL: This is a sample that was taken of -- a venous blood sample for culture.

JOHNSON: At tile 89, is that the collection of the sample, timed at exactly the same time?

TYNDALL: Yes, this is a blood sample for the blood levels -- the... what they're looking for in the blood.

JOHNSON: Yes. And without you having to take us through it, if we click on, we have seen this sort of thing before, but do we there see various matters that the blood sample -- on which the blood sample returns results?

TYNDALL: Yes.

JOHNSON: Thank you. Tile 90. Is that the observations at 4 am?

TYNDALL: Yes.

JOHNSON: Can we click on one on that right-hand arrow, please, Mr Murphy?

So we're back to a system now that we've seen in many of the previous cases, aren't we?

TYNDALL: Yes.

JOHNSON: We've got three sets of observations being recorded on the hour and, as we will see as we progress, being recorded every hour?

TYNDALL: Yes.

JOHNSON: So in other words, [Baby G] has gone from three-hourly observations and feeds to hourly monitoring --

TYNDALL: Yes.

JOHNSON: -- in the light of her collapse? I don't think we need to deal with the detail of those. So if we could scroll on to -- that's it, thank you.

At tile 93 there is a prescription for intravenous dextrose; is that right?

TYNDALL: Correct.

JOHNSON: That's at 04.15 in the morning, signed by Lucy Letby and co-signed by Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: A prescription at 04.15 also for morphine sulphate?

TYNDALL: Yes.

JOHNSON: Then also signed and co-signed by Lucy Letby and Ailsa Simpson.

Then blood gas results for [Baby G] at tile 95 at 04.26 that morning?

TYNDALL: Yes.

JOHNSON: If we move on -- sorry, Mr Murphy, my fault.

If we click on the blood gas record, I'm not going to keep going back to this. If we click on that.

So as we've seen in many other cases, this is a record which covers observations using the machine from, in this case, 14 August down at the bottom to 7 September, which is this particular measurement; is that right?

TYNDALL: Yes.

JOHNSON: And we see Lucy Letby's initials at the bottom right-hand corner of the form?

TYNDALL: Yes.

JOHNSON: Thank you. If we go back, please.

Next do we see an X-ray which is reported by a Dr Rehman?

TYNDALL: Yes.

JOHNSON: If we go to that, please. This concerns the ET tube; is that right?

TYNDALL: Yes.

JOHNSON: Dr Rehman reports:

"The tip of the ET tube is slightly low. The nasogastric tube is in a satisfactory position."

He refers to this as being:

"A slightly expiratory study with satisfactory cardiothymic contour, but patchy bilateral consolidation throughout the lungs, raising the possibility of CLD. No convincing confluent consolidation, pneumothorax or hyperinflation."

So far as [Baby G]'s abdomen is concerned, it's:

"Generally slightly distended bowel loops, but gas noted in the rectum. No transition point, mural or free gas detected on balance."

TYNDALL: Yes.

JOHNSON: Is that right?

TYNDALL: Yes, that's correct.

JOHNSON: Thank you. Going to tiles 97 through to 99, is that the hourly observations on the hour at 5 am?

TYNDALL: Yes.

JOHNSON: Tiles 100 to 102. Do they record various medications given to [Baby G] at 5.11 and 5.12, being morphine, phytomenadione and oxygen?

TYNDALL: Yes.

JOHNSON: And then at 05.15, those medications recorded and updated on the IT system?

TYNDALL: Yes.

JOHNSON: Then at 05.30, tile 106, do we see on the neonatal prescription chart the morphine is referred to?

TYNDALL: Yes.

JOHNSON: And A change of rate of infusion and the time that that was finished, which was the following day at 01.45?

TYNDALL: Yes.

JOHNSON: That was signed by Lucy Letby and Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: Do we come next to Dr Ventress' clinical notes at 05.30 that morning?

TYNDALL: Yes.

JOHNSON: If we can deal with those, please.

TYNDALL: "Approximately 05.30 had another profound desat, heart rate decreased to 60 plus sats to 40%. Taken off vent and IPPV Neopuff via ETT. Capnograph still positive and chest movement okay. Recovered slowly but desat when back on vent. [Query] ventilator problem. So flow sensor changed and then whole ventilator changed. Large leak remained but sats plus heart rate okay."

JOHNSON: We'll deal with what that means with the doctor. But is there another note with the same time from Dr Brearey, presumably relating to events at the same time?

TYNDALL: Yes.

JOHNSON: If you deal with that, please.

TYNDALL: "05.30, further desat and brady on vent. Dr Ventress changed ETT to 3.5 with less leak and better F/V loops. Post-intubation gas satisfactory compensated metabolic acidosis leading to IV 10ml/kg fluid bolus and IV dopamine infusion to start as one further bradycardia since then and poor perfusion. Sedation, morphine plus midazolam at 60 micrograms per kilo per

hour. For further gas at 09.00. Will need discussion with Arrowe Park Hospital/Liverpool Women's Hospital as now needing inotropic support plus vent. Parents fully updated."

JOHNSON: Are there then prescriptions for various substances at 05.47 and 05.48?

TYNDALL: Yes.

JOHNSON: And a record of those substances being administered to [Baby G] signed by Christopher Booth and Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: At 6 am, so tile 113 -- and at the same time tile 114 -- do we have the observations --

TYNDALL: Yes.

JOHNSON: -- that we've seen before, made by Lucy Letby in each case?

TYNDALL: Yes.

JOHNSON: Tiles 115 and 116, do we have a record of atropine and a drug called, I think, suxamethonium chloride, being administered --

TYNDALL: Yes.

JOHNSON: -- to [Baby G]? Thank you. Those are recorded by Ailsa Simpson and Lucy Letby?

TYNDALL: Yes.

JOHNSON: Then tile 117, at 06.05, and at five-minute intervals following that, do we have a series of clinical notes made by Dr Ventress?

TYNDALL: Yes.

JOHNSON: Starting with the entry at 6.05, take us through that please.

TYNDALL: "Profound desat to 40% plus heart rate decreased to 80. Decision to re-intubate. IPPV given via ETT initially. Heart rate 120 but sats remained 50 despite increased PIP to 26 plus 100% O2."

JOHNSON: And 5 minutes later, a further note made by Dr Ventress.

TYNDALL: "ETT removed at 06.10. Thick secretions ++ in mouth. Blood clot at end of ETT. IPPV via face mask given. Despite jaw thrust and Guedel, poor chest movements and sats decreased to 17%. Heart rate decreased to 70. Dr Brearey called in urgently. NG aspirated as abdo appeared very large; approximately 100ml aspirated. Sats gradually increased after this."

JOHNSON: Then at 06.15, which is the next tile, a further note made by Dr Ventress.

TYNDALL: "Re-intubated at 06.15. Size 3.5 ETT with intubation drugs. Tight fit through cords. Bloodstained fluid in oropharynx. Suctioned below cords but nil obtained. Secured at 8 centimetres at lips. Capnograph positive. Good B/L air entry. Clinically leak much better. Vent 20/6 rate 40, 60% oxygen, but weaning. Plan: discuss with Dr Brearey. Pancuronium bolus then start midaz infusion. Gas in 30 minutes. Continue morphine 30. NBM plus IVI cefotaxime. Parents updated."

JOHNSON: And is the next tile, 120, the nursing note made by Lucy Letby relating to those same events?

TYNDALL: Yes.

JOHNSON: Deal with that please.

TYNDALL: "Re-intubated at 06.15 with intubation drugs. Position confirmed on X-ray. Ventilator settings currently 26/6. Rate 50 in 50% oxygen. Inspiratory time 0.4. Clear air entry and bilateral chest movement. Blood gases as charted. Times 3 peripheral lines obtained. 10% glucose commenced 150ml/kg. Morphine running at 30 micrograms per kilogram. Midazolam 5 micrograms per kilogram per minute. [Baby G] agitated and fighting ventilator. Pancuronium given as prescribed. Now synchronising well. Observations as charted. Temperature low. Incubator temp increased. BP maintained. Drifting from 07.00. Mean 25. Dopamine commenced by day staff. Colour pale, capillary refill 3 seconds."

JOHNSON: Thank you. Then at 6.15, which is the next tile, 121, do we have a record made by Lucy Letby of the re-intubation at that time?

TYNDALL: Yes.

JOHNSON: Followed at tile 122 by [Baby G]'s observations, namely heart rate, respiratory rate and temperature?

TYNDALL: Yes.

JOHNSON: 123. Is there a record of the prescription of sodium chloride?

TYNDALL: Yes.

JOHNSON: Followed by updates on the computer a minute later, all of which are signed by Lucy Letby and, from time to time, co-signed by Ailsa Simpson, relating to the administration of atropine, suxamethonium chloride and sodium chloride?

TYNDALL: Yes, Lucy is the co-signer on those.

JOHNSON: Yes. And then at 127, do we have a further X-ray reported by Dr Rehman?

TYNDALL: Yes.

JOHNSON: If we go to that, please. This refers, by comparison, back to the report that he provided at tile 96 at 4.49, so almost exactly 2 hours. Can you deal with what it says?

TYNDALL: "If comparison made with 2 hours earlier. ETT in situ. Tip perhaps slightly low. NGT in situ. Position stable and satisfactory. Stable cardiothymic contour and lungs with slightly improved appearances. Probably reflecting improved inspirations. No pneumothorax, no new features."

JOHNSON: Thank you. At 6.45 is there a record of a pancuronium prescription signed by Ailsa Simpson, co signed by Lucy Letby?

TYNDALL: Yes.

JOHNSON: That pancuronium is recorded in the intensive care chart at tile 129?

TYNDALL: Yes.

JOHNSON: And the administration of pancuronium recorded at 6.57 at tile 130?

TYNDALL: Yes.

JOHNSON: We then have, at 131, the observation chart for events at 7 am, which is just before the handover?

TYNDALL: Correct.

JOHNSON: Together with the corresponding intensive care chart of the same time at tile 132?

TYNDALL: Yes.

JOHNSON: And the fluid balance chart also 7 o'clock at the same time?

TYNDALL: Yes.

JOHNSON: All signed by Lucy Letby?

TYNDALL: Yes.

JOHNSON: Do we then come to the neonatal infusion prescription chart relating to the administration of midazolam?

TYNDALL: Yes.

JOHNSON: Which includes instructions on how to prepare the infusion, signed by Lucy Letby and Christopher Booth?

TYNDALL: Yes.

JOHNSON: There is a blood gas record at 07.36, signed by [Nurse A] --

TYNDALL: Yes.

JOHNSON: -- which is tile 135? Then at 136, we have Dr Ventress' review of the X-rays?

TYNDALL: Yes.

JOHNSON: At 137 do we have [Nurse E], who we will remember was the original designated nurse for this shift before [Baby G]'s care was handed over to Lucy Letby --

TYNDALL: Yes.

JOHNSON: Do we have her notes? And if we can deal with those, please.

TYNDALL: "Notes written in retrospect for care taken over at 19.45. Emergency equipment, feed calculation and alarm parameters checked at start of shift. [Baby G] was being nursed in a kanbed with Phillips monitoring in situ. Oxygen 0.07 to 0.08 litres via nasal cannula to maintain saturations. Feeds 180ml/kg, 3x8, EBM with fortifier and Gaviscon via alternate bottle/NGT. Abdomen full but soft with no discolouration. Aspirates minimal. Partial digested milk. PU and BO ++. Short period of straining/uncomfortable at start of night when having cuddles with dad. Dr Ventress aware. Usual for [Baby G]. Then had large bowel movement. Dr Ventress not wanting blood gas overnight; to wait for weekly bloods. Nurse L Letby taken over

care following vomit/apnoeic episode after 02.00 feed. Her notes to follow."

JOHNSON: So we will remember, having seen [Nurse E]'s note of giving [Baby G] a feed at 2 am that morning, the fact that the pH value of the aspirate was 4, which mean it's acidic, but here is the additional information that that aspirate was minimal, to use her word.

TYNDALL: Yes.

JOHNSON: Before she was fed and before she vomited and then had the feed removed, there was, according to this, minimal material in her stomach?

TYNDALL: Correct.

JOHNSON: At 07.50, tile 138, do we have the record of midazolam signed by Lucy Letby?

TYNDALL: Yes.

JOHNSON: And then at tile 139, at 07.59, [Nurse E]'s record of her contact with [Baby G]'s dad?

TYNDALL: Yes.

JOHNSON: If we go to that, please. This is from the beginning of the night shift at the beginning and then moving on to later in the night shift.

TYNDALL: Yes:

"Dad present for early part of night shift. Had cuddles with [Baby G]. Parents called by me approx 03.45 when Dr Ventress decided to intubate and arrived soon after."

JOHNSON: Do we come on the next tile, 140, to the handover from that night shift to the following day shift?

TYNDALL: Yes.

MR JOHNSON: My Lord, it might be that that's a good moment to have the mid-morning break.

MR JUSTICE GOSS: Yes, certainly. We'll have our customary 10-minute break, ladies and gentlemen.

(11.47 am)

(A short break).

(11.57 am)

MR JUSTICE GOSS: Mr Johnson.

MR JOHNSON: Thank you, my Lord.

We'd got to tile 140, which was the handover, so can we move on, please -- well, I think we need to establish that [Nurse A] was the designated nurse on the succeeding day shift; is that right?

TYNDALL: Correct.

JOHNSON: Thank you. We then see that there are the standard three sets of records on the hour, recording observations and the like; is that correct?

TYNDALL: Yes.

JOHNSON: At tiles 144 and 145 we have prescriptions for sodium chloride and for dopamine?

TYNDALL: Yes.

JOHNSON: At tile 146 we have a retrospective note written by Lucy Letby. So this is a note that's timestamped by the system, is that right, by the computer?

TYNDALL: Yes.

JOHNSON: If we just click on that, please. So what you have recorded here is that insofar as this record relates to matters that occurred at various stages at, in effect, various times or denoted timed stages by Lucy Letby, you have put them in at those appropriate stages?

TYNDALL: Yes.

JOHNSON: And what does the balance of the material relate to then from "abdomen appears less distended"?

TYNDALL: "Abdomen appears less distended and soft. Bowels opened. Large green watery stool at 03.00. Urine output 0.3ml/kg/hour. NG tube to free drainage. [Baby G] re-screened. CRP less than 1. Cefotaxime given as prescribed. Oral secretions ++. Clear mucus. Nil obtained via ET. Blood noted beyond vocal cords during intubation. IV vitamin K given as prescribed. Other oral medications omitted. [Baby G] having frequent profound desaturations on ventilator, requiring Neopuff with high pressures and 100% oxygen. Takes several minutes to recover."

JOHNSON: So this clearly is a note that was made at 8.57. Does any of that material appear earlier in the sequence or is this just the balance of the material that was untimed from the earlier entries?

TYNDALL: No, I think that the "abdomen appears less distended, bowels open" has definitely been put in.

JOHNSON: That's all right, I'm just trying to be clear. So from the green watery stool at 3 am, is the balance of that material then material that hasn't been put in at specific times earlier in the sequence?

TYNDALL: Yes.

JOHNSON: Okay.

So moving on, please, to tile 147. Is this a clinical note made by Dr Harkness at 9 am?

TYNDALL: Yes.

JOHNSON: If we go to just behind the tile rather than to the notes, does that record the fact that on examination, [Baby G] was paralysed and sedated?

TYNDALL: Yes.

JOHNSON: "Well perfused, abdomen soft, no masses, bowel sounds + distended femorals ++. Plan: drop PEEP to 5. Arterial line. Increase dopamine to 10mg/kg/hour. Discuss with tertiary centre. Clotting with next bloods."

Then at 9 am, so tiles 148 to 150, do we have the standard three sets of records?

TYNDALL: Yes.

JOHNSON: Followed at 9.15, tile 151, by a further Lucy Letby note?

TYNDALL: Yes.

JOHNSON: If we could deal with that, please.

TYNDALL: "Parents attended the unit and have been fully updated on [Baby G]'s condition and management by myself, Reg Ventress and Consultant Brearey. Anxious but understand need for ventilation/drugs. Have sat with [Baby G] and offered containment. They have now gone home and will return shortly. Bedroom offered."

JOHNSON: Thank you. In the succeeding tile, 152, is that a prescription chart recording the administration of dopamine?

TYNDALL: Yes.

JOHNSON: Followed by a further Dr Harkness clinical note at 10 am?

TYNDALL: Yes.

JOHNSON: Recording the fact that he was unable to site the arterial line?

TYNDALL: Yes.

JOHNSON: He records [Baby G]'s blood pressure, her capillary refill time, the fact her colour was improved and her capillaries were warm. And the plan:

"Ventilator weaned to 24/5, rate to 40. Repeat gas in 30 minutes."

TYNDALL: Yes.

JOHNSON: Do we then have in the succeeding three tiles the -- sorry, succeeding two tiles the neonatal fluid balance chart and the equipment settings?

TYNDALL: Yes.

JOHNSON: At 10.07, are there some blood gas results for [Baby G]?

TYNDALL: Yes.

JOHNSON: Followed by the observation chart, which of course would usually be on the hour, but it may well be was delayed by the necessity to carry out the blood gases?

TYNDALL: Yes.

JOHNSON: Further blood gases at tile 158 at 10.41?

TYNDALL: Yes.

JOHNSON: And then a text message, sent by Lucy Letby to Sophie Ellis?

TYNDALL: Yes.

JOHNSON: Could you deal with that, please.

TYNDALL: Lucy Letby messages:

"Hey. Could you tell Sian that I had [that's a baby's name] a clean incubator overnight, please, as the other one was alarming fan inoperable. I forgot to put a clean house sticker on the new one. Hope your day isn't too busy xx"

JOHNSON: All right. Lest there's any misunderstanding about that, it may be that we can amend that at the end just to make it clear that I in this context is a reference to the baby --

TYNDALL: Yes.

JOHNSON: -- for whom she was the designated nurse at the beginning of that shift. So we'll add in that detail at the conclusion of the evidence for this particular incident.

MR JUSTICE GOSS: All it needs, if it needs anything at all, because it's contained in the passage in parentheses at the end "redacted for third party name", if you want to put after I "name redacted" or "redacted name", that's the easy way of doing it.

MR JOHNSON: It is, thank you.

At tiles 160 and 161 and 162 we have the standard three sets of observations recorded at 11 am?

TYNDALL: Yes.

JOHNSON: At tile 163, a prescription for sodium chloride?

TYNDALL: Yes.

JOHNSON: 164, an incoming text message from Sophie Ellis, possibly in response to the outgoing message sent at 159?

TYNDALL: Yes:

"I will do [smiley face]. It's not too bad. Hope you're ok. Try get some sleep xxx"

JOHNSON: At tile 165 is there a pharmacist's note timed at 11.45?

TYNDALL: Yes.

JOHNSON: If we click on that, please, could you tell us what it says?

TYNDALL: "Note currently prescribed cefotaxime 25mg/kg [and then '??' because I can't read the writing]. Please review if to increase to 50mg/kg [again not sure what that says] per trust policy for late onset neonate sepsis. Please add dopamine and midazolam to system as marker drugs. I have done."

JOHNSON: And I think you have not been able to establish who wrote that note, but it's there in the records. At midday, do we have the fluid balance chart at 166, the intensive care chart at 167?

TYNDALL: Yes.

JOHNSON: Blood gases were taken 8 minutes later at 168?

TYNDALL: Yes.

JOHNSON: And then the observation chart, as it had the previous hour, comes a few minutes later at 169?

TYNDALL: Yes.

JOHNSON: At 170 is there a record at 12.50 hours for cefotaxime?

TYNDALL: Yes.

JOHNSON: And then starting at 1 o'clock and concluding at 13.15, tiles 171 to 173 being the standard three sets of records?

TYNDALL: Yes.

JOHNSON: Thank you. Was there then a further message sent to Lucy Letby at tile 174 by one of the other nurses, Jennifer Jones-Key?

TYNDALL: Yes. That reads:

"How you doing? x"

JOHNSON: Going back to [Baby G] at 13.35, tile 175, were [Baby G]'s blood gases recorded again?

TYNDALL: Yes.

JOHNSON: Then at 14.00 hours, is there a neonatal fluid balance chart and the intensive care chart?

TYNDALL: Yes.

JOHNSON: Thank you. Moving on, do we at 178 have Lucy Letby's response to the question posed by Jennifer Jones-Key?

TYNDALL: Yes:

"Had rubbish nights x"

JOHNSON: Then at 179, is there a prescription for the infusion of sodium chloride?

TYNDALL: Yes.

JOHNSON: Did Jennifer Jones-Key respond to the "had rubbish nights" text from Lucy Letby at 14.12?

TYNDALL: Yes, with the words:

"Yeah, gathered x"

JOHNSON: And Lucy Letby replied to that?

TYNDALL: "Thought someone would have told you x"

JOHNSON: Followed by?

TYNDALL: "Nothing else to say really just hope they are both okay x"

JOHNSON: Then Jennifer Jones-Key?

TYNDALL: "Don't know ins and outs as tried to avoid it, needed a break. Found Thursday horrendous. Not really slept since then. Hope [you're] ok xx"

JOHNSON: At about that time were [Baby G]'s heart rate, respiratory and temperature recorded on the standard chart?

TYNDALL: Yes.

JOHNSON: Then a minute after that, the timing of those observations, did Lucy Letby respond to Jennifer Jones-Key's WhatsApp?

TYNDALL: Yes. With the words:

"That's understandable. Won't tell you anything. I'm ok thanks. Just tired now. Didn't leave till 10 x"

JOHNSON: At tile 168 do we have the record of the collection of a pathology sample?

TYNDALL: Yes.

JOHNSON: Is that followed at 187 by a further WhatsApp message from Jennifer Jones-Key?

TYNDALL: Yes, that reads:

"Got it but didn't ask for more details as just couldn't take it. Know that sounds horrible. Back in tomoz. Oh that's not good. Hope [you're] having a chilled day x"

JOHNSON: And Lucy Letby responded to that?

TYNDALL: "Don't be daft. Who told you about last night then, [Nurse D] and Caroline?"

JOHNSON: Thank you. At 189 do we have the record of the collection of the pathology sample that we saw a few lines ago?

TYNDALL: I think it's a different pathology sample.

JOHNSON: Thank you. Do we have a continuation of the conversation via WhatsApp between Jennifer Jones-Key and Lucy Letby?

TYNDALL: Yes.

JOHNSON: So the question that had been posed by Lucy Letby, "Who's told you about last night then, [Nurse D] and Caroline?", and the response from Jennifer Jones-Key?

TYNDALL: "Neither!!"

JOHNSON: And Lucy Letby?

TYNDALL: "Who then? Lol x"

JOHNSON: Jennifer Jones-Key?

TYNDALL: "I thought that would puzzle you. Try again."

JOHNSON: And Lucy Letby?

TYNDALL: "Yvonne G?"

JOHNSON: Then [Nurse A] sent a text to Lucy Letby saying?

TYNDALL: "Morphine infusion to 30 at 05.30 needs signing. Still not very well. Hope you've slept."

JOHNSON: Thank you. Jennifer Jones-Key responded to the question "Yvonne G?" with the word?

TYNDALL: "No."

JOHNSON: And then Lucy Letby replied to [Nurse A] who'd requested that she sign a morphine infusion and "Still not very well, hope you slept" with the response?

TYNDALL: "Ok. Ailsa checked it with me? Is she in tonight? I'll call in later to do it. Is she going to be transferred?"

JOHNSON: And then?

TYNDALL: That's Lucy Letby responding to [Nurse A].

JOHNSON: And to Jennifer Jones-Key in the "guess who told you" conversation?

TYNDALL: "Ali?"

MR JUSTICE GOSS: Sorry, can we just go back then to the previous tile, 196? According to the tile, that was from Lucy Letby to Jennifer Jones-Key. Shouldn't it be in response to the morphine infusion, [Nurse A]'s one at 194?

TYNDALL: Yes, on this it is [Nurse A]. I don't know why it's Jennifer Jones-Key on there.

MR JOHNSON: So the screen is incorrect?

TYNDALL: Yes.

JOHNSON: We'll correct that.

Just so we can make this clear, 196. 196 on the screen says Lucy Letby to Jennifer Jones-Key, but what it should say is Lucy Letby to [Nurse A]. So this is a response to the request to sign the morphine infusion at 5.30; is that right?

TYNDALL: Yes, that's correct.

JOHNSON: Okay.

MR JUSTICE GOSS: Sorry.

MR JOHNSON: No, no, it's probably worked out, my Lord, that we're working from the paper version. There's a correction that's not gone into the digital version.

MR JUSTICE GOSS: I'm following it on the iPad.

MR JOHNSON: Thank you. I do look at this stuff in advance, but don't always --

MR JUSTICE GOSS: There's an awful lot of detail.

MR JOHNSON: All right. Ali was the guess of the person that had been given the information, sent by Lucy Letby to Jennifer Jones-Key. Jennifer Jones-Key responded at 198.

TYNDALL: "Ali. [She's] not having a good time."

JOHNSON: And then Lucy Letby responded to that?

TYNDALL: "No, I know. It's been awful for her but she's coped with it all brilliantly and got back up when needed etc."

JOHNSON: Thank you. The messaging stopped for a while. In between times, at 14.40, the neonatal infusion prescription chart shows that the -- it relates to the dopamine that was being administered to [Baby G]; is that right?

TYNDALL: Yes.

JOHNSON: Then the texting resumed with Jennifer Jones-Key sending a message to Lucy Letby at 14.42.

TYNDALL: Yes:

"Can't fault her. Thursday was made that much" --

JOHNSON: I think you have missed one.

TYNDALL: Sorry, I have:

"Oh, I don't know how she's done it. She was fab on Thursday speaking to them parents. I'm here if you need to message as back in work mode now but ignored it over weekend. Don't think Phil knew what to do with me lol."

JOHNSON: Thank you. Then Lucy Letby in response to that message from Jennifer Jones-Key replied?

TYNDALL: "Can't fault her. Thursday was made that much worse by the language barrier and she did brilliantly. Don't blame you. Well, sounds like [Baby I] ok just need to get [Baby G] sorted."

JOHNSON: Then we see at 203 some clinical notes made by Dr Chang --

TYNDALL: Yes.

JOHNSON: -- a registrar. If we look at the note itself, please, could you talk us through what's recorded?

TYNDALL: "Long line inserted to right hand. Aseptic insertion to 14 centimetres. Dopamine started prior to X-ray as no peripheral access. Agreed by consultant. Chest X-ray: adequate long line position. Long line secured. Baby tolerated procedure well. BP39 (post dopamine initiation). Plan: repeat gas at 15.00."

JOHNSON: Thank you. Do we then have a new correspondence, so far as the messaging is concerned, with Lucy Letby sending a message to Minna Lappalainen?

TYNDALL: Yes:

"Hi! Keep meaning to ask: wrote to TV Licensing to change details over. Have they confirmed?"

JOHNSON: Minna did respond to that, but just before she responded an X-ray was taken of [Baby G], which showed the right-sided long line in situ. It reported that the tip of the line was projected over the subclavian vein and was otherwise stable, allowing for technical factors. So that's another report from Dr Rehman, the radiologist.

TYNDALL: Yes.

JOHNSON: So the response -- sorry, no. Too many conversations going on now.

TYNDALL: Yes.

JOHNSON: Jennifer Jones-Key responding to Lucy Letby, and just to remind us, the message from Lucy Letby that provoked this response:

"Can't fault her. Thursday was made that much worse by the language barrier and she did brilliantly. Don't blame you. Well, sounds like [Baby I] ok just need to get [Baby G] sorted."

The response was?

TYNDALL: "Yeah, it was, but she was so calm speaking to them parents. That's good. Let's hope ok. Going to be a long stretch to wedding, I think."

JOHNSON: Thank you. Then Lucy Letby responded?

TYNDALL: "Hopefully it'll go quick."

JOHNSON: Back to the [Nurse A] conversation or a [Nurse A] conversation now. [Nurse A] sent a message at 14.46?

TYNDALL: Yes:

"No idea re Ailsa. Too busy to look. Just managed to go to loo for 1st time. Not well enough to even consider moving at mo. Had BP issues as cannula kept going. Was improving quickly every time. Dop running tho so now have LL [I presume that's long line]. If that the case probably stay as vent weaning."

JOHNSON: As a reminder that was a response to -- "Is she going to be transferred?" was the question.

TYNDALL: Yes.

JOHNSON: Which is presumably a reference to [Baby G]. But let's move on. Lucy Letby responded, please?

TYNDALL: "No problem. She was query for doing an extra tonight but I'll come in at some point to sign for it. Ok. Hopefully will improve."

JOHNSON: And it may be that that's a response to the question "Morphine infusion to 30 at 5.30 needs signing".

Lucy Letby then asked a question of [Nurse A]?

TYNDALL: "Still having those desats?"

JOHNSON: And followed that up a minute later with?

TYNDALL: "Sorry I know you are busy, just tell me later."

JOHNSON: Jennifer Jones-Key then took up the conversation that she'd been having with Lucy Letby, which was about speaking to some parents, and "It's going to be a long stretch to the wedding". Lucy Letby had said:

"Hopefully it'll go quick."

And Jennifer Jones-Key responded?

TYNDALL: "Not if it carries on like this at work. I've got 7 weeks to get through."

And then the rest of the message is of a -- social interaction.

JOHNSON: Have you then summarised the fact that over the succeeding 13 minutes there were social messages passing between Lucy Letby, Jennifer Jones-Key and Minna Lappalainen?

TYNDALL: Yes.

JOHNSON: Thank you. So at 3 pm, do we see at tiles 214, 215 and 216 the standard sets of data being recorded?

TYNDALL: Yes.

JOHNSON: Followed at 15.02 by the blood gases for [Baby G]?

TYNDALL: Yes.

JOHNSON: The text messages then resume between [Nurse A] and Lucy Letby. So lest anyone has the same problem as me in working out which conversation is which, we have Lucy Letby sending to [Nurse A] a series of three:

"No problem. She was query for doing an extra night tonight but I will come in at some point to sign for it. Hopefully will improve."

Then:

"Still having those desats?"

Then:

"Sorry, I know you're busy. Just tell me later."

Here we have the response.

TYNDALL: "No. Only when dopamine not running. Got a long line now so fingers crossed that helps things."

JOHNSON: She then followed that at about the same time with?

TYNDALL: "Just going to try and get a break."

JOHNSON: Thank you. Were blood results then phoned through?

TYNDALL: Yes.

JOHNSON: And those are recorded in the notes. Then at 15.20, there is a prescription for sodium chloride, 20ml of 0.9% of 1% sodium chloride infusion?

TYNDALL: Yes.

JOHNSON: Followed by clinical note at tile 222, written by Dr Jayaram?

TYNDALL: Yes.

JOHNSON: And if we can go to those, please.

TYNDALL: "Spoke with Dr Lee consultant neonatologist at Arrowe. Agrees with current management plan. At 15.10 decreased BP to 27 systolic. Gas increased metabolic acidosis plus lactate 6.6. OE [on examination], V 24/6, rate 40, FiO2 70%, sats 93, refill 3 secs. Mean BP 27, cool hands and feet. Abdo distended but soft. Meds: dopamine 10mic/hour/minute, 3x10mol/kg saline bolus. P [I presume is plan]: another bolus 10ml/kg. Increase dopamine to 15mic/kg/min. Consider 2nd central access and adrenaline infusion. Decrease PEEP to 5 (to reduce inadvertent PEEP). Post bolus: mean BP 35."

JOHNSON: Thank you. At tile 223 do we then have a neonatal infusion prescription chart --

TYNDALL: Yes.

JOHNSON: -- referring to the prescription of dopamine followed by a text from [Nurse A] at 15.32 to Lucy Letby?

TYNDALL: Yes:

"Ravi just banished me for inability to form a sentence. Putting a 2nd LL in and Ailsa in tonight. Things improving a bit now we have central access."

JOHNSON: Thank you. Ravi in this context may be Ravi Jayaram, consultant?

TYNDALL: Yes.

JOHNSON: At 15.33 did Lucy Letby reply?

TYNDALL: "You definitely need a break!! Ok that's good."

JOHNSON: And Lucy Letby 9 minutes later?

TYNDALL: "In the end K walked out to desk and said doing obs has and going for break even if no one covers me [as read]."

JOHNSON: A minute later?

TYNDALL: Lucy Letby replies with:

"Why hasn't someone taken over?? Sophie and Caroline only got 1 baby each? Oh, have you had admissions?"

JOHNSON: And [Nurse A] then replied?

TYNDALL: "No admission. [Nurse D] split between 1 and 2 as D mum a pain in arse in N1. I suggested soon took D so [Nurse D] could stay in N1 and was ignored [as read]."

JOHNSON: D in this context, is that a reference to one of the children?

TYNDALL: Yes.

JOHNSON: That's the redaction for the name of a third party?

TYNDALL: Yes.

JOHNSON: Okay. So at the same time did [Nurse A] send a further message to Lucy Letby?

TYNDALL: "Caroline for the msg when all the C(?) said [Nurse A] needs to eat [as read]."

JOHNSON: And did Lucy Letby respond?

TYNDALL: "So is D in 2?"

JOHNSON: Again, D is one of the children?

TYNDALL: Yes.

JOHNSON: And followed that up with another message shortly afterwards?

TYNDALL: "It's not on. Shift leader with a baby that she doesn't actually need to have. Should be covering breaks and being your checker etc in 1."

JOHNSON: [Nurse A] appears to have agreed with that because she replied?

TYNDALL: "Exactly!! Yes, that mum is a pain in arse. Very needy because all busy with [Baby G] and listening in and asking for things when obvious busy. FFS. Wanted me to check with a doctor his hiccups were normal when [Baby G] was ringing off all her alarms and I was clearly dealing with her."

JOHNSON: Yes. Did Lucy Letby respond to that?

TYNDALL: "OMG that's all you need isn't it! Yet dad stayed overnight and hardly spoke."

JOHNSON: And 3 minutes later?

TYNDALL: "I have done BP every 20 mins and 2x dop infusions 4x bolus. She's had 2 more cannula and LL catheterised. Caroline kept saying go for lunch and I'll pop in and out. I was like, no needs someone all the time."

JOHNSON: Then a further -- an addition to that, perhaps, in a further message?

TYNDALL: "Leg and arm both went dopamine white. Okay now though. Temp now 38.1. Now ok but periph cold."

JOHNSON: Did Lucy Letby respond to that within a minute or so?

TYNDALL: Yes:

"FFS, pop in and out when you've got a ventilated baby on inotropes?"

JOHNSON: Further one.

TYNDALL: "Didn't get art line then?"

JOHNSON: And then another one?

TYNDALL: "Not well at all, is she? Poor parents."

JOHNSON: And [Nurse A] then responds to that?

TYNDALL: "They're all faffing. I need an urgent bolus and C did oral ranit 1st as was late."

JOHNSON: Then did she say, "Sorry, I'm ranting"?

TYNDALL: Yes.

JOHNSON: Do we then have a series of 4 tiles between 241 and 244 dealing successively with blood gases just before 4 o'clock and then the standard three sets of data recorded at 4 o'clock?

TYNDALL: Yes.

JOHNSON: They were all done by Caroline Oakley, I believe; is that right?

TYNDALL: Yes.

JOHNSON: I think, as a matter of fact, Caroline is referred to in one of the text messages at 229. [Nurse A] said:

"Caroline for the msg when all the C(?) said [Nurse A] needs to eat [as read]."

TYNDALL: Yes.

JOHNSON: It may be that that's the Caroline, but anyway.

So also at 4 o'clock, at tile 245, was there an infusion prescription chart for what appears to have been the continuing administration of dopamine to [Baby G]?

TYNDALL: Yes.

JOHNSON: And then do we come to a long series of messages between Lucy Letby, who of course isn't in work, and [Nurse A], who was in work?

TYNDALL: Yes.

JOHNSON: These run from 16.04 through to 16.26, so a period of about 22 minutes?

TYNDALL: Yes.

JOHNSON: All right.

TYNDALL: I think they go to 16.37.

JOHNSON: They do. With that correction in mind can we start at 246, please?

TYNDALL: Lucy Letby messages [Nurse A]:

"No [you're] not. It's ridiculous. Like Caroline and [Nurse D] but both a bit oblivious to things when not their own baby. Like [Nurse D] didn't once come over the whole time I was there to offer to check anything with you help out etc [as read]."

JOHNSON: She followed that up, I think, 2 minutes later with?

TYNDALL: "First [Nurse D] did was moan about state of nursery and starting messing tidying paperwork etc [as read]."

JOHNSON: [Nurse A]'s first response -- there were two sequentially, but the first was what?

TYNDALL: "Nope. To be fair O [which is a baby's name] keeping her busy. The allocation outside need rejigging. Oh well."

JOHNSON: Then perhaps in answer to the second of the texts from Lucy Letby?

TYNDALL: "Yeah. Well, it looks even worse at mo lol."

JOHNSON: And Lucy Letby responded?

TYNDALL: "Ha."

JOHNSON: And?

TYNDALL: "Well, you can sort it out when in charge tomorrow lol."

JOHNSON: And [Nurse A] repeated the laugh out loud?

TYNDALL: Yes.

JOHNSON: And then said?

TYNDALL: "I'm treating myself to some sweets from shop before I go back. All for me lol [as read]."

JOHNSON: And Lucy Letby responded to that saying?

TYNDALL: "Absolutely!!! Don't share."

JOHNSON: Then [Nurse A] a minute later?

TYNDALL: "Ailsa should never have given C a baby or [Nurse D] 2."

JOHNSON: And Lucy Letby?

TYNDALL: "She asked me who to give who but didn't listen to what I said. She didn't want Sophie to have an Optiflow. Chris said to give [Nurse D] both as he had 2. Just silly."

JOHNSON: Then [Nurse A]?

TYNDALL: "Why can't we open resource room door? It's likes an oven in here."

JOHNSON: And Lucy Letby responded?

TYNDALL: "I think they've done the flooring out there."

JOHNSON: And [Nurse A]?

TYNDALL: "Why can't Soph have Optiflow?"

JOHNSON: That presumably is a reference to Sophie Ellis?

TYNDALL: I presume so.

JOHNSON: Yes. And the answer from Lucy Letby?

TYNDALL: "Because she's new?"

JOHNSON: And then from [Nurse A]?

TYNDALL: "Ah, so hopefully temporary."

JOHNSON: And?

TYNDALL: "Not that new!!!!"

JOHNSON: Lucy Letby responded?

TYNDALL: "Well and when the choice is her or shift leader when unit busy I think she's more than capable! [as read]"

JOHNSON: Did Lucy Letby add a further message?

TYNDALL: Yes:

"Was thinking earlier NN have been having babies in 2 more and I know [Baby G] and [Baby I] were both stable but really they are high-risk babies and don't necessarily think NN should have them unless necessary."

JOHNSON: Thank you. Did [Nurse A] then respond?

TYNDALL: "And they had had them. It's wrong."

JOHNSON: And added to that with?

TYNDALL: "Why could Cheryl have C?"

Which is a baby's name.

JOHNSON: And the response from Lucy Letby?

TYNDALL: "Would be too much with a discharge..."

JOHNSON: [Nurse A]'s response to that?

TYNDALL: "WTF!!!! Since when?"

JOHNSON: And?

TYNDALL: "Okay then. Sian. It's 4 to 1 SC, 2 to 1 HDU and shift leader meant to be back up [as read]."

JOHNSON: And then [Nurse A] said?

TYNDALL: "M [which is a baby's name] hardly complicated discharge, esp with that family."

JOHNSON: Was there then a clinical note for [Baby G] recorded in the notes by Dr Chang?

TYNDALL: Yes.

JOHNSON: Which you have I think transposed to:

"Abdomen is mildly distended not tense. AXR [a reference to an X-ray]: Gaseous distension. On call doctors aware of handover. Will attempt art [arterial] line and long line."

TYNDALL: Yes.

JOHNSON: Did the text conversation between Lucy Letby and [Nurse A] continue?

TYNDALL: Yes.

JOHNSON: With Lucy Letby sending a message saying what, please?

TYNDALL: "I know, I know, but not necessarily Ailsa's fault. Caroline should have reallocated once aware of situation."

JOHNSON: And [Nurse A] responded?

TYNDALL: "Yup."

JOHNSON: And Lucy Letby?

TYNDALL: "How are parents?"

JOHNSON: [Nurse A]?

TYNDALL: "Devastated but determined she'll get through it as always. Thought that if she got to 100 then they could feel confident she'd be fine."

JOHNSON: That appears to be a reference to the fact that when she collapsed [Baby G] was 100 days old?

TYNDALL: Yes.

JOHNSON: Lucy Letby responded?

TYNDALL: Awful, isn't it? We'd all been sat at desk at start of night making banner."

JOHNSON: [Nurse A] says?

TYNDALL: "Yup. Mary brought her cake in."

JOHNSON: Then?

TYNDALL: "Right, best go back. See you shortly."

JOHNSON: Was that followed with two kisses from Lucy Letby to [Nurse A]?

TYNDALL: Yes.

JOHNSON: Then at tile 280 in the clinical notes did Dr Chang record:

"Plan from consultant at 16.30. As unable to thread second long line, then to start dobutamine 10mcg [whatever that means] per kilo. Reduce total 100ml/kg/day. I have updated parents. Remains unwell and requiring second long line. Made them aware she has been discussed with APH [Arrowe Park Hospital]."

TYNDALL: Yes.

JOHNSON: Despite signing off, [Nurse A] then sent a further message; is that right?

TYNDALL: Yes.

JOHNSON: To what effect?

TYNDALL: "I come back and C left. She's worse and dobut starting now plus fluid restriction. NPU."

JOHNSON: It may be that the dobut is a reference to the previous note of Dr Change refers to dobutamine.

Was there then an unhappy face emoji sent by Lucy Letby?

TYNDALL: Yes.

JOHNSON: Followed by, "Needs to go out"?

TYNDALL: Yes.

JOHNSON: At 5 pm were the standard sets of data recorded on the three standard charts?

TYNDALL: Yes.

JOHNSON: Together with the fact that the dobutamine medication was commenced at that time?

TYNDALL: Yes.

JOHNSON: They were all signed by [Nurse A]?

TYNDALL: Yes.

JOHNSON: Do we then have the neonatal infusion prescription chart timed at 17.10, which is signed and co-signed by [Nurse A] and Caroline Oakley?

TYNDALL: Yes.

JOHNSON: Together with a prescription for TPN?

TYNDALL: Yes.

JOHNSON: Tile 290. Pathology. A urine sample was taken; is that right?

TYNDALL: Yes.

JOHNSON: And the results of that are behind the tile, but I don't think we need to go into them now. Did [Nurse A] then recommence messaging Lucy Letby?

TYNDALL: Yes.

JOHNSON: And that began how, please?

TYNDALL: [Nurse A] messages:

"Too sick to move."

JOHNSON: Did Lucy Letby respond, "Oh no"?

TYNDALL: Yes.

JOHNSON: And [Nurse A]?

TYNDALL: "Yup. I know. Looks dreadful. Getting puffy."

JOHNSON: And Lucy Letby:

"Any idea what's caused in?"

It may be that should be "it". There we are.

At 6 pm, do we have the standard documents that we tend to see in many of these cases recording data of observations?

TYNDALL: Yes.

JOHNSON: Together with blood gas results at the same time at tile 299?

TYNDALL: Yes.

JOHNSON: And then [Nurse A] sending another message to Lucy Letby at 18.06, saying what, please?

TYNDALL: "Nope. Just seemed to be a circ collapse. Chest sounds clear."

JOHNSON: At tile 301, indeed was the neonatal infusion prescription chart annotated with the fact that the dobutamine administration was continuing?

TYNDALL: Yes.

JOHNSON: And then at 19.00, tiles 302 to 304, we have the standard three sets of data?

TYNDALL: Yes.

JOHNSON: Did Lucy Letby then send a further message at tile 306 to [Nurse A] --

TYNDALL: Yes.

JOHNSON: -- timed at 19.23?

TYNDALL: Yes:

"Hmm, what can cause that? Is it that she is an extreme prem who had long-term inotrope and vent dependency and now she's older and doing more for herself? It just takes a little bug or something to tip her over as no reserves and chronic lung, etc. I'm going to come in some time tonight so won't see you."

JOHNSON: [Nurse A] respond to that enquiry?

TYNDALL: Yes, with:

"We're going with sepsis. Def not asp."

JOHNSON: And then in the following tile, a minute later?

TYNDALL: "And yes to no reserves. She looks grim."

JOHNSON: Then within a minute or so did Lucy Letby respond:

"Who's having her tonight?"

TYNDALL: Yes.

JOHNSON: With the answer from [Nurse A]?

TYNDALL: "Belinda."

JOHNSON: Lucy Letby said:

"Try and get home ASAP as back tomorrow."

Was there then a further shift handover at tile 312 between 19.30 and 20.00 hours at which [Baby G]'s designated nurse was nominated as Belinda Simcock?

TYNDALL: Yes.

JOHNSON: Belinda Williamson as she's now known. Thank you.

At 8 o'clock, between tiles 313 and 317, do we have the standard sets of observations recorded together with the intravenous dobutamine and blood gas result?

TYNDALL: Yes.

JOHNSON: Then did [Nurse A], who'd presumably just come off shift by this stage, send a further message to Lucy Letby at 20.12 at tile 318?

TYNDALL: She says:

"Yup. Just writing notes."

So she is still in the unit.

JOHNSON: Yes. That was in response presumably to, "Try and get home ASAP as back tomorrow"?

TYNDALL: Yes.

JOHNSON: So tile 319 contains [Nurse A]'s nursing notes for the shift. So as she said in the message, "Just writing notes", so she was --

TYNDALL: Yes.

JOHNSON: -- a minute later. Can we deal with those, please?

TYNDALL: "08.00 to present. During handover required x2 episodes of Neopuff. All fluids and lines checked with L Letby. Correct

and lines patent. Ventilation increased to 26/6 as responded to higher pressures on Neopuff. CBG showed over-ventilation so pressure and rate reduced as charted.

"NIBP dropped around 08.00 and dopamine commenced peripherally as no LL at time. Blood pressure improved slightly and inotrope titrated as prescribed. BP deteriorated and cannula site became white. Moved to another cannula. BP again improved.

"Doctors trying to obtain LL for better access. Second cannula tissued and for a short time no dopamine running till LL available. LL obtained and dopamine and Maintenance transferred to it. Midaz and morphine continue to run peripherally. Further cannula obtained for bolus and [antibiotics]. Chest clear and CBG/ABG continued to be metabolic acidosis. X4 NaCl 0.9 bolus given as prescribed. [Cefotaxime] increased to 50mg/kg and given as prescribed. Initially pyrexial, now normothermic, but periph cold. Perfusion has remained poor all day."

JOHNSON: Did that continue -- it's reproduced on a different tile for the reasons you explained about the capacity of Excel to accommodate a limited amount of text in a line?

TYNDALL: Yes.

JOHNSON: Does that continue on the next tile, please?

TYNDALL: Yes.

JOHNSON: Can you deal with that?

TYNDALL: "Discussion with pharmacy. Dopamine, dobutamine and adrenaline can [all] be run via same LL if required if no other alternative available. No ETT or oral suction required all day. Minimal urine output all day. Blood plus 1. Protein plus 1. Catheter in situ. BNO."

JOHNSON: At 20.40, tile 231, is there a dose of hydrocortisone recorded?

TYNDALL: Yes.

JOHNSON: Then at tile 322 at 20.51 did the nursing notes made by [Nurse A] continue?

TYNDALL: Yes.

JOHNSON: These related to contact with [Baby G]'s parents; is that right?

TYNDALL: That's correct.

JOHNSON: Can we look at what was recorded there, please?

TYNDALL: "Parents on unit throughout day and updated. Aware that BP is too low and IV access difficult. Understandable. Very upset and struggling to see her this poorly again. Have looked at 100-day cake and are trying to remain positive at this stage. Are staying tonight and have currently gone home to get supplies. [Dr C] will update in full detail when they return."

JOHNSON: Thank you. Then so far as [Nurse A] is concerned, her final update to the notes. At 20.54 did she record:

"CBG continued to deteriorate. Despite increasing inotropes, colour and perfusion deteriorate. Doctors present at the time of handover"?

TYNDALL: Yes.

JOHNSON: Thank you. Moving on, we now come to records made by Belinda Williamson, aka Simcock, at tile 324. Do we have the -- and in the succeeding few tiles, the standard sets of observations recorded --

TYNDALL: Yes.

JOHNSON: -- at 9 o'clock?

At tile 328, do we have the neonatal infusion prescription chart recording the addition to the infusion of adrenaline, dobutamine and dopamine?

TYNDALL: Yes.

JOHNSON: And the prescriptions for some of those substances together with morphine, midazolam, oxygen and cefotaxime appear timed between 21.41 and 21.42, between tiles 333 and 334?

TYNDALL: Yes.

JOHNSON: At tile 335 do we have a further clinical note, this time made by the consultant [Dr C]?

TYNDALL: Yes.

JOHNSON: And recording the fact that she, [Dr C], had discussed [Baby G] with Dr Shreer, the consultant at Arrowe Park?

TYNDALL: Yes.

JOHNSON: What else was recorded, please?

TYNDALL: "Recommends art line if possible. Bicarb correction to allow inotropes to work properly. Increase adrenaline as needed. Can add norad and wean dobutamine. They are happy to accept [Baby G] at Arrowe Park Hospital. He will discuss with transport team and add in meropenem for Gram-negative cover."

JOHNSON: Thank you. Do we then see a prescription prescribed by [Dr A]. That's a new name for us, one that we will see repeatedly from this point forward, another one of the registrars, for a sodium chloride infusion?

TYNDALL: I've got -- oh yes, sorry.

JOHNSON: At line 337, do we then have [Dr C]' clinical notes, timed at 21.55, recording the previous clinical history and the ventilator settings?

TYNDALL: Yes.

JOHNSON: At 338, 339 and 340 do we have the standard three sets of data recorded on the hour at 22.00 hours?

TYNDALL: Yes.

JOHNSON: Together with at 341 the intravenous dobutamine and adrenaline?

TYNDALL: Yes.

JOHNSON: Then at 22.08, Christopher Booth, who's one of the band 6 nurses, recording a call to the transport team, presumably the Arrowe Park --

TYNDALL: This is taken from the notes that the transport team make and they've noted that Chris Booth has called them.

JOHNSON: And this relates to the transfer of [Baby G] from the Countess of Chester back to Arrowe Park, where she had been born?

TYNDALL: Yes.

JOHNSON: The referral formally done by the consultant [Dr C] at tile 343?

TYNDALL: Yes.

JOHNSON: And then three different substances prescribed to [Baby G], two seem to be the same, with the same prescription number, but different times.

TYNDALL: Yes.

JOHNSON: Being the sodium chloride, which may be before -- we have heard, on several occasions now, from some of the treating professionals that there was a bolus of sodium chloride followed by the medication, then flushed through with some -- it may be that's the explanation.

TYNDALL: Yes.

JOHNSON: But we have two drugs and two sets of sodium chloride anyway.

Blood gases at 348, timed at 22.38. The time that the transfer ambulance was booked at 22.43. Line 349.

The fact of a collection of a pathology sample ordered in the name of [Dr A] at line 350, timed at 22.53.

TYNDALL: Yes.

JOHNSON: Then a message from Lucy Letby with some responses from -- and messages from [Nurse A]. Take us through that series of messages, which starts at 22.56 --

TYNDALL: Yes.

JOHNSON: -- and ends at 23.04. So a period of about 8 minutes.

TYNDALL: Yes. Lucy Letby messages [Nurse A]:

"She looks awful, doesn't she? Hope you get some sleep."

[Nurse A] replies:

"Yeah. Going to APH. On triple antib's now, adrenaline, hydrocortisone and a bit more stable."

Lucy Letby responds with:

"Yes, just left work. Last gas 7.0, lactate 9."

[Nurse A] responds:

"So no better. Damn."

And follows this up with:

"I have a bad feeling. At least they know APH."

JOHNSON: The fact of the transport team being mobile is recorded at 23.00 hours?

TYNDALL: Yes.

JOHNSON: And at the same time Lucy Letby responded to [Nurse A] with a further message or further two messages saying what, please?

TYNDALL: "BE minus 13. Not looking good. But yes least going to where she is known."

JOHNSON: And?

TYNDALL: "Just hope they get her there."

JOHNSON: Thank you. As we've seen so often before in many cases, on the hour every hour, a standard set of data recorded, this time at 23.00 hours?

TYNDALL: Yes.

JOHNSON: The continuation of the intravenous dobutamine and adrenaline recorded at tile 362, followed by a prescription for hypromellose, if that's how you pronounce it, at the same time.

TYNDALL: Yes.

JOHNSON: And the text message conversation continued between [Nurse A] and Lucy Letby; is that right?

TYNDALL: Yes. [Nurse A] responds with:

"HMMMMMMM, not sure they will."

JOHNSON: And then, "On today of all days", from Lucy Letby?

TYNDALL: Yes.

JOHNSON: And [Nurse A], please?

TYNDALL: Responds with:

"Considering usually pos base."

JOHNSON: And?

TYNDALL: "Yup. Poor parents."

JOHNSON: Lucy Letby:

"Yeah, she's declining bit by bit."

[Nurse A] next?

TYNDALL: "Yup. Right, need to try and switch off. I'll update you tomorrow."

JOHNSON: And then:

"You've done well today. Hope you get some sleep."

Said Lucy Letby?

TYNDALL: Yes.

JOHNSON: And that was followed by some kisses from [Nurse A]?

TYNDALL: Yes.

JOHNSON: And in between times there was a further infusion of sodium bicarbonate recorded in [Baby G]'s notes --

TYNDALL: Yes.

JOHNSON: -- at tile 371?

TYNDALL: Yes.

JOHNSON: And then the nursing notes were updated by Belinda Simcock at 23.35; is that right?

TYNDALL: Yes.

JOHNSON: Could you take us through that update please?

TYNDALL: "Taken over care of [Baby G] at 20.00 hours. Infant intubated and ventilated. Size 3.5 ETT 8 centimetres at lips. Air entry: R equals L, symmetrical chest movement. Remains on SIMV 21/5 rate 60, IT 0.40. FiO2 30 to 40. Rate initially 40. Increased as charted following cap gases. NGT in situ on free drainage. TFV equals 100ml/kg/day. Long line in situ in right arm. TPN at 4ml/hour. Dopamine: 20 micrograms per kilogram per minute equals 1ml per hour. Dobutamine: 15 micrograms per kilogram per minute equals 0.75ml/hour. Adrenaline: 100 nanograms per kilogram per minute equals 0.1ml per hour. PIVC in left foot. Morphine at 30 micrograms per kilogram per hour equals 1.5ml per hour. Midazolam at 60 micrograms per kilogram per hour equals 1ml per hour. PIVC in left hand patent and clamped. Mean BP 23 at commencement of shift. Hydrocortisone bolus given at 20.40 hours followed by a normal saline bolus. IV ABs given as charted. Bicarb infusion given as charted. Urine

output 1ml for the last 6 hours. Infant to be transferred to Arrowe. Awaiting transport team."

JOHNSON: Thank you. Then we have some blood gas records and further nursing notes written by Belinda Simcock recording the arrival of the transport team --

TYNDALL: Yes.

JOHNSON: -- that she recorded as having occurred at 23.50, handover given by [Dr C], second dose of hydrocortisone given followed by a second sodium bicarbonate infusion as per, no doubt, the instructions of the transport consultant?

TYNDALL: Yes.

JOHNSON: We then have at midnight the observation charts, the intensive care chart, the neonatal fluid balance charts, times two, recording the standard fields of data.

Do we have, from the transfer team at midnight, tile 380, a record of the fact that they arrived at the Countess of Chester at midnight?

TYNDALL: Yes.

JOHNSON: Dr Kamalanathan, his or her plan of a further dose of hydrocortisone being given at 1.10 with some sodium bicarbonate and other measures that they put in place to help [Baby G]?

TYNDALL: Yes.

JOHNSON: Thereafter, do we see that the hydrocortisone, this is now tile 382, appears to have been authorised, prescribed, by [Dr A]?

TYNDALL: Yes.

JOHNSON: At tile 383, clinical notes made by [Dr C] of the arrival of the transport team from Arrowe Park?

TYNDALL: Yes.

JOHNSON: And the fact that [Baby G] remained very sick, despite multiple inotropes and the transfer to Arrowe Park had been arranged?

TYNDALL: Yes.

JOHNSON: At 00.55 a prescription for noradrenaline and that -- and at 385, the fact that that infusion had been started at 00.59 that morning?

TYNDALL: Yes.

JOHNSON: Thank you. At 386, we have the observation chart recording the heart rate, respiratory rate and temperature of [Baby G]?

TYNDALL: Yes.

JOHNSON: Followed by some clinical notes made by the transport team at 1 o'clock, line 387?

TYNDALL: Yes.

JOHNSON: And the neonatal fluid balance chart at 388?

TYNDALL: Yes.

JOHNSON: Together with the intensive care chart at the same time, 01.00 hours?

TYNDALL: Yes.

JOHNSON: And then at 01.01, further clinical notes made by the transport team?

TYNDALL: Yes.

JOHNSON: That recorded that [Baby G]'s abdomen was full and veiny, the nasogastric tube was on free drainage, her temperature, she was cold peripherally, and that the dose of noradrenaline had been increased to 40 nanograms per kilo per minute?

TYNDALL: Yes.

JOHNSON: Thank you. We then have various other records from tile 391 down to 393, with nursing notes relating to the adrenaline prescription.

TYNDALL: Yes.

JOHNSON: And the noradrenaline?

TYNDALL: Yes.

JOHNSON: Followed by clinical notes at 394 and 395, made by the transport team?

TYNDALL: Yes.

MR JOHNSON: My Lord, there are a few more pages to go, so it may be that that's an appropriate point.

MR JUSTICE GOSS: Yes, we will break off.

Could you please be ready to resume at 2.05? Just over the hour. Thank you very much indeed.

(In the absence of the jury)

MR JUSTICE GOSS: The document that was put up on the screen at the very start of the proceedings today, is it on here or not?

MR JOHNSON: Not yet, but it will be.

MR JUSTICE GOSS: I think that may be a document that it'd be helpful to have in paper form in colour.

MR JOHNSON: Yes. It's the words "in colour" that fill me with terror.

MR JUSTICE GOSS: They're not scarce items, colour photocopiers.

MR JOHNSON: They are in this building, but yes, I know.

I'll do my best.

MR JUSTICE GOSS: All right. Thank you very much.

MR JOHNSON: What we're intending to do in due course is to alter it slightly to put the times of the incidents on to it.

MR JUSTICE GOSS: Right.

MR MYERS: There may be some discussion about that.

MR JUSTICE GOSS: Exactly. I don't think that is as important as just having those basic dates. I don't think that detail needs to be put on unless it's really necessary.

MR JOHNSON: If it's controversial...

MR MYERS: The problem is once it begins one way, so to speak, then there becomes an imperative to start putting in timings and events the other way. Perhaps, in as neutral form as possible, that's the easiest way.

MR JUSTICE GOSS: Exactly. I'm with Mr Myers on this.

Otherwise it starts and then you end up getting a very complicated document. Thank you very much.

(1.03 pm)

(The short adjournment)

(2.05 pm)

(In the presence of the jury)

MR JUSTICE GOSS: Mr Johnson.

MR JOHNSON: Thank you, my Lord.

Mrs Tyndall, I think we'd got to 395, which relates to clinical notes made by the transfer team that was taking [Baby G] from Chester to Arrowe Park.

TYNDALL: Yes.

JOHNSON: This is some of their notes recording various treatments that they were giving [Baby G], either at the time of or before the time that they moved her from Chester to Arrowe Park.

TYNDALL: Yes.

JOHNSON: We see at 396 some blood gases recorded at 01.30, recorded by Belinda Simcock?

TYNDALL: Yes.

JOHNSON: Then moving on to 397, do we see a repetition of the blood gases -- sorry, some nursing notes, I beg your pardon, relating to pressures of ventilation?

TYNDALL: Yes, and the blood gas being taken.

JOHNSON: Yes. Then at 01.35 some more notes made by the transport team, which included their blood gas measurement --

TYNDALL: Yes.

JOHNSON: -- taken from [Baby G]?

At 01.40, in Belinda Simcock's notes, if we click on that, please, Mr Murphy, do we see that the ET tube was suctioned with nil -- sorry:

"Suctioned nil from ETT. Moderated [maybe that should read 'moderate'] amount thick white secretions obtained orally."

So nothing from the tube, but from the mouth some thick white secretions?

TYNDALL: Yes. "Moderated" would have been how it was written in the nursing notes.

MR JUSTICE GOSS: Sorry, you're dropping your voice.

TYNDALL: Sorry. The "moderated" is -- it would be a copy and paste from the nursing notes. It's not a mistype.

MR JOHNSON: So you're not taking responsibility for the spelling mistakes?

TYNDALL: Not in this case.

JOHNSON: At 01.45, we have prescriptions for sodium bicarbonate and morphine sulphate?

TYNDALL: Yes.

JOHNSON: That's 402 and 403. More notes from the transfer team at 01.45?

TYNDALL: Yes.

JOHNSON: Followed by the nursing notes, which also record an increase in the dose of adrenaline --

TYNDALL: Yes.

JOHNSON: -- which was noted by the transport team?

TYNDALL: Yes.

JOHNSON: At 2 am, we have 406, 407 and 408, which are the three sets of notes on the hour?

TYNDALL: Yes.

JOHNSON: Then also at 2 am, more notes from the transport team concerning the administration of adrenaline and noradrenaline --

TYNDALL: Yes.

JOHNSON: -- together with other drugs?

TYNDALL: Yes.

JOHNSON: We then have Belinda Simcock's notes at 410 through to 414 concerning her contribution and the fact that -- the fact of the administration of various drugs together with the fact that at 02.25, [Baby G] was moved to the transport incubator?

TYNDALL: Yes, that's correct.

JOHNSON: Thereafter, at 02.30 and 02.35, we have the transport team's notes, so that's tiles 415 to 418 --

TYNDALL: Yes.

JOHNSON: -- which culminate in the handover in the name, from the Chester perspective at least, of [Dr A] --

TYNDALL: Yes.

JOHNSON: -- at tile 418? Then some further notes made by Belinda Simcock at 419 concerning maybe capillary gas, possibly, "cap gas attended" is what it says.

Then more notes from the transport -- an observation chart annotated by the transport team at 420 --

TYNDALL: Yes.

JOHNSON: -- recording various observations made of or from [Baby G].

Thereafter, ultimately, if we get to 425 you have recorded at 3 am [Baby G]'s exit from the Countess of Chester Hospital.

TYNDALL: Yes.

JOHNSON: And that particular tile is -- in the four tiles before there are other notes made by the transport team?

TYNDALL: Correct.

JOHNSON: Belinda Simcock's notes tie in with your note at 425.

They appear, that is Belinda Simcock's notes, at 426 recording the transfer together with some peripheral detail.

TYNDALL: Yes.

JOHNSON: [Dr C]', that is the consultant [Dr C], clinical notes also record [Baby G]'s departure from the Countess of Chester at 03.00 hours?

TYNDALL: Correct.

JOHNSON: Thereafter, there are a series of notes made by the transfer team at 3 o'clock and just after 3 o'clock, which coincides at 429 with a record made in the neonatal fluid balance chart of various drugs being administered to [Baby G], that record having been made by Belinda Simcock?

TYNDALL: Yes.

JOHNSON: Thank you. Then moving through the notes made by the transport team, which takes us to tile 438, please, we come to the time at which Belinda Simcock was updating her notes in the records at Chester.

TYNDALL: Yes.

JOHNSON: And you have put in, at the appropriate times, what those notes are, rather than reproducing them at this stage of the process?

TYNDALL: Yes.

JOHNSON: 439 is a note made at 05.20 by Belinda Simcock, recording the fact, if we click on it, please, that [Baby G]'s parents have been fully updated by [Dr C] and the transport consultant through the night and that [Baby G]'s parents had followed the ambulance back to Arrowe Park with [Baby G].

TYNDALL: Correct.

JOHNSON: The balance of this document, therefore, if we could return to the carousel, please, contains two further text messages, the first sent by Ailsa Simpson at 08.51, so a short time after that night shift had ended. Could you help us with what she sent, please?

TYNDALL: "Hi Lucy. Just to let you know that [Baby G] has been successfully transferred out at 3 am this morning to APH. She is stable and latest CBG has improved! Fingers crossed for her!!
xx"

JOHNSON: And 2 minutes later Lucy Letby responded?

TYNDALL: "That's good news. Thanks for letting me know. See you Thursday."

JOHNSON: There's one final tile on this sequence. Is that your summary to the effect that between 3 am on 8 September and 16 September 2015, [Baby G] was cared for at Arrowe Park Hospital?

TYNDALL: Yes.

JOHNSON: Just so that the jury can put this in context, on the 16th she was returned to the Countess of Chester?

TYNDALL: Yes.

JOHNSON: And there then followed further events, which are specified or particularised in some later counts on the indictment?

TYNDALL: Correct.

JOHNSON: Thank you very much. I don't know whether there are -- no, there are no questions for you concerning the sequence.

Can we move on to the neonatal review then, please.

We are going to have to distribute the papers, please.

(Pause)

Does this follow the same conventions as the previous NNU reviews followed?

TYNDALL: Yes.

JOHNSON: If there's any doubt about those, they are set out on the front sheet, aren't they?

TYNDALL: Correct.

JOHNSON: This document covers simply the night shift on which the event in respect of which the charge relates?

TYNDALL: Yes.

JOHNSON: Do we see reproduced on the second page, therefore, the same material that appears in the sequence of events?

TYNDALL: Yes.

JOHNSON: On the third page we have the beginning of events on the night shift. The child IH, whose identity appears in the first line, is of course Lucy Letby's designated patient.

TYNDALL: Yes.

JOHNSON: He or she was in nursery 1. Just to remind us, [Baby G], of course, was in nursery 2?

TYNDALL: Yes.

JOHNSON: So we see between lines 1 and 8 a series of entries relating to IH and to another child, MD. MD was a child in nursery 3; is that right?

TYNDALL: Yes.

JOHNSON: And Lucy Letby was involved with MD as well as her own charge, IH?

TYNDALL: Yes, giving medication.

JOHNSON: Yes or co-signing. Thank you.

We then see between lines 9 and 11, three sets of observations -- two sets of observations and a prescription at 23.00 hours?

TYNDALL: Yes.

JOHNSON: None of those involved Lucy Letby?

TYNDALL: No.

JOHNSON: A midnight, lines 17 and 18, the child IH was fed and observations were taken by Lucy Letby?

TYNDALL: Yes.

JOHNSON: At 27 through to 31, more medication given to [Baby G] in nursery 2?

TYNDALL: Yes.

JOHNSON: 33 and 34, again the child IH fed and observations recorded?

TYNDALL: Yes.

JOHNSON: We then have at the same time, at 2 o'clock, observations and the feed of [Baby G]?

TYNDALL: Yes.

JOHNSON: That's the 45ml feed --

TYNDALL: Yes.

JOHNSON: -- recorded by [Nurse E]? There is also a note of that time in the nursing notes made by Lucy Letby concerning the transfer of care of [Baby G] to Lucy Letby?

TYNDALL: Yes.

JOHNSON: Lucy Letby's notes concerning [Baby G]'s collapse appear at 02.15 in the chronology at line 40.

TYNDALL: Yes.

JOHNSON: And we see the attendance of Dr Ventress noted at line 44 at 02.35?

TYNDALL: Yes.

JOHNSON: Thereafter, there are four entries relating to [Baby G], two made by Lucy Letby at lines 46 and 50?

TYNDALL: Yes.

JOHNSON: And the other two made by the attending physicians, Doctors Ventress and Brearey at lines 51 and 52?

TYNDALL: Yes.

JOHNSON: At 03.30, in line 53, do we see that the child IH was now being cared for by [Nurse E] --

TYNDALL: Yes.

JOHNSON: -- who had previously been the nurse for [Baby G]?

TYNDALL: Yes.

JOHNSON: [Nurse E] made a note concerning the calling of the [Parents of Baby G] which she had timed at 3.45?

TYNDALL: Yes.

JOHNSON: But otherwise, so far as the observations were concerned of [Baby G] at around that time and at around 04.00 hours in the morning, those were made by Lucy Letby?

TYNDALL: Yes.

JOHNSON: Again, as we see at 59 and 60, IH was being cared for by [Nurse E]?

TYNDALL: Yes.

JOHNSON: And the entries relating to almost all the entries relating to [Baby G] down to and including line 89 were made by Lucy Letby?

TYNDALL: Yes.

JOHNSON: The one exception being the radiology entry at 75?

TYNDALL: Yes.

JOHNSON: Thereafter, so after 89, we have several entries concerning [Baby G]. The first two, 90 and 91, made by Doctors Ventress and Brearey at 05.30?

TYNDALL: Yes.

JOHNSON: And then at 97 to 99 some medication given to [Baby G], signed for by Christopher Booth and Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: Over again on to the next page, lots of entries concerning [Baby G]. The majority of them, maybe the balance of them, made by Lucy Letby?

TYNDALL: Yes.

JOHNSON: So the examples of those are lines 102, 109, 112, 117, 120 to 122, 128, 131 to 133, 138 and 142 --

TYNDALL: Yes.

JOHNSON: -- with some other notes made by other people, including Dr Ventress, [Nurse A], [Nurse E]... I think that's all the people who make notes other than Lucy Letby?

TYNDALL: Yes.

JOHNSON: Oh, Ailsa Simpson as well.

On the final page, we can see that Lucy Letby was involved once again with the child IH, or apparently involved with the child IH, between lines 149 and 152, but of course those are nursing notes made which, as we have already seen, concern events before the collapse of [Baby G]?

TYNDALL: Yes, they're the times she updating IH's nursing notes.

JOHNSON: Yes. Thank you very much.

The very final entry concerns a co-signed for -- or a user or a co-signer for a prescription for the child AC?

TYNDALL: Yes.

JOHNSON: And AC, if we turn over to the final page, page 7 of 7, we can see was a child who, by that stage of proceedings, was in the same room as [Baby G], being room number 1?

TYNDALL: Yes.

JOHNSON: Okay, thank you very much. I don't know whether there are any -- no. Thank you.

One question that someone will ask, and I don't know whether you know the answer to it: if we look at IH -- I've just answered it for myself, actually. IH moves from nursery 1 at the beginning of the shift, is that right --

TYNDALL: Yes.

JOHNSON: -- between 8 and 2, and reappears in nursery 2 between 3.30 and 8, and therefore you have recorded the fact that between 2 and 3.30 we don't know where IH was.

TYNDALL: No, sorry, it's just that Lucy Letby is IH's nurse between 20.00 and 02.00, but in the notes it suggests that she moved at 3.30 when [Baby G] was moved into nursery 1.

JOHNSON: I see. So the locations of [Baby G] and IH were reversed?

TYNDALL: Yes.

JOHNSON: And it's not that we don't know where IH was at any stage, but you think that IH moved at 3.30; is that right?

TYNDALL: Yes.

MR JOHNSON: Okay. It may be entirely irrelevant, but that's the answer to the question that just occurred to me. Thank you.

I don't know whether there are any questions.

MR MYERS: No questions, my Lord, thank you.

MR JOHNSON: Thank you. Once again, thank you very much.

(The witness withdrew)

MR ASTBURY: My Lord, I want to begin by reading the evidence of [Baby G]'s parents.

MR JUSTICE GOSS: Yes. This is relevant parts from statements they made. Mr Astbury will tell you when the statements were made. Remember, this is agreed evidence, no one wants to ask any additional questions about this evidence, but it's agreed so you can accept it. The use to which you put it is entirely for you.

Thank you.

First witness statement of [Mother of Baby G] (read)

MR ASTBURY: Thank you, my Lord.

The first statement is from [Mother of Baby G]. It's dated 26 April 2019 and she says as follows:

"I am married to [Father of Baby G] and we have a daughter called [Baby G]. [Baby G] was born on 31 May 2015. When I was 9 weeks pregnant I bled and I thought we had lost her. Obviously I didn't and things went okay with the pregnancy until 22 weeks when I started bleeding again. So I was back at the Countess and found out that my placenta was very low. I spent 1 week in the hospital, then went home for a day, and then straight back. I was 23 weeks then.

"My waters were leaking so they sent me to Arrowe Park where they just monitored me as I was only 23 weeks and they don't do much when you're 23 weeks. It was on a Sunday and I was complaining about stomachache and they were saying it was because of the iron tablets I was having.

"The family stayed for a while and after everyone left I was still complaining about stomach cramps. I was trying to sleep and I told the midwife I couldn't help it any more and I needed something to help me go to the toilet. I went to the bathroom and [Baby G] came out.

"The emergency bell didn't work, I was pulling it and nothing happened. No one came. But something told me to stay there and so I was screaming and hitting the walls. Then whoever was next door came and I told them [Baby G] was only 23/24 weeks. They went for help and everyone just rushed in. I didn't even know whether she was a girl or a boy at first and when they said it was a girl I just said, 'Save [Baby G]'.

"They were trying to calm me down and trying to calm her down. But as they were putting wires on her she kept taking them off. She was only 1 pound and 2 ounces and she was just a little tiny thing, fighting them. So it showed that she was a fighter.

"During her time at Arrowe Park they had something like five discussions with us about [Baby G] not making it, but she showed the doctors that she was a fighter. She actually made good progress and there were no issues. They took brain scans all the time, particularly at 23 to 24 weeks, because premature babies have a lot of brain bleeds, but it all went well.

"At the start of her time at Arrowe Park she was in the first cot in intensive care, but then she ended up in the fourth cot and that was like graduation because you can go to the high dependency unit after that. I think she was 7 weeks old when I was finally able to hold her for the first time.

"I remember the day [Baby G] moved to the HDU because [Baby G] was smiling and was really alert with the nurse. I would read to her, stuff like that, sing to her, and you could notice the difference in her when you did. It was just a case of her growing and getting bigger and stronger at Arrowe Park.

"By 12 weeks old she had done so well that they said she could now go to Chester. She was nearly full term when we got to the Countess, about 35 weeks, and she weighed about 4 pounds. She was there for 2 weeks then turned 100 days old. The nurses did a banner and a cake and I remember it was Lucy who was looking after her that day.

"We had visited during the day but when [Father of Baby G] and I were at home that night, the hospital phones us and told us [Baby G] had vomited but was okay. But when we got to the hospital she was in intensive care with all these machines and everything. It was such a shock to us and she looked like she was going to die.

"[Baby G] then had to go back to Arrowe Park again. We stayed in Arrowe Park for 9 days before she was as well enough to go back to Chester.

"When we got back to Chester she had to initially go into the high dependency unit for a day because they needed to see if she had any infectious or bugs. But after that we went directly to the second room. Then we almost got to the nursery, but [Baby G] got sick again and had to go back to intensive care.

"[Baby G] was much better when she got back to the Countess but it was then we noticed a difference with her. Her expression had changed after she had been sick and she looked different. They took a lot of brain scans but said she would just have little catches and would just be a little clumsy but nothing more.

"[Baby G] stayed on breast milk for 6 months. I did everything in my power to help her.

"I remember an occasion at the Countess when Lucy told me she needed to take [Baby G]'s bloods as they thought she had an infection again. She said I should go and wait in the parents' room. That wasn't unusual for when they took bloods: the nurses would say, go out for a bit, then come back. I went for a coffee but something just pinched me and I decided to go back early. I just couldn't wait any longer so I went back to nursery 2.

"[Baby G] was freaking out and screaming and just looked so puzzled. Lucy was with another member of staff and both were trying to calm [Baby G] down but I can't remember who it was with her. They let me hold her in the end because that's the thing that calms her down, cuddles. [Baby G] went to intensive care that day.

"In total she ended up in intensive care three times after she got back to Chester. Every time she moved up to the nursery room, it seemed she would end up sick again.

"My normal routine was that I would spend the whole day with [Baby G] and then [Father of Baby G] would go in the evening and stay until about 12. At the weekend we always went together and stayed until 1 am or something like that. I would always ring at 6 o'clock in the morning to find out how [Baby G] had been through the night and then I would phone at 7 or 8 in the morning to find out which nurse was going to take care of [Baby G] that day. It wasn't that I had major concerns, I just wanted to know who was having her.

"We just tried to take our time in the Countess day by day and [Baby G] finally came home on 4 November when she was 156 days old. She has now been left with quadriplegic cerebral palsy and has microcephaly. She is visually impaired and is fed by a GJ tube into her stomach and so is nil by mouth."

Second witness statement of [Mother of Baby G] (read)

MR ASTBURY: My Lord, there's a second statement from [Mother of Baby G] dated 4 March 2020.

She says as follows:

"I have been asked about [Baby G]'s dad [Father of Baby G] and I feeding her while she was in hospital. I remember we didn't start bottle feeding her until we went to the Countess from Arrowe Park, but when she first got to Chester on 13 August she was still being fed through her nasogastric tube.

"I can't recall who it was at Arrowe Park who showed us how to feed [Baby G] but they would let us hold the syringe of milk after they had filled it with the correct amount of milk. The nursing staff would measure out the breast milk I had expressed and they would always be the ones who would put the milk into the syringe. They never let us do that.

"We were never allowed to aspirate either. That was always done by the nurses in both hospitals prior to us being allowed to hold the syringe.

"The way we were shown would be to hold the open syringe without a plunger in it and let the milk fall through just using gravity. We were shown how to hold our thumb over the end of the syringe and count to five, then remove your thumb from the end, count again for five, put your thumb back over and continue.

"I was told that if you held the syringe too high then the milk would rush through too fast and potentially make the baby sick, so you had to make sure you didn't do that and that you held it around chest height. We would always be stood up when we fed her.

"It was only a few minutes of being shown how to do the feeding and each nurse would check with you that you knew what you were doing before they would let you hold the syringe. It was all to do with making sure the milk didn't go into the baby too quickly.

"Although I can't recall who showed us at Arrowe Park, I'm pretty much it wasn't while we were in intensive care and it was only when we got to the HDU that we did it.

"When we moved to the Countess the procedure was just the same: the nurses would measure out the milk I'd expressed and they would fill the syringe and would often allow us to feed her. It wasn't all the time that we were allowed to hold the syringe though: it depended on which nurses were feeding her and how busy they were. Lucy would never let us hold the syringe to feed [Baby G] though. She always held it and fed her herself.

"When [Baby G] moved on to the bottle, I was always the one to give her the bottle if I was there, which I always was during the day. She would be on three daytime feeds a day and then I'd always ask them to wait until about 8.45 am for the first feed as I would be in and would have expressed fresh milk by then. The nurses would still be the ones who measured the amount out though.

"After she was poorly and got moved to Arrowe Park, we arrived back at the Countess on 17 September and she was then fed

through the tube again and not through a bottle, although we have a photo that shows no feeding tube, so she must have been back on the bottle by then and that's dated 25 October.

"It was again the nurses who did the measuring and filling of the syringe or bottle. We were only allowed to give it to her but not measure it out."

Witness statement of [Father of Baby G] (read)

MR ASTBURY: Turning next, please, to a statement from [Father of Baby G]. This is dated 15 November 2019:

"[Baby G] was born prematurely on 31 May 2015 at 23 weeks into [Mother of Baby G]'s pregnancy. At the time [Mother of Baby G] gave birth to [Baby G] she used her maiden name of [redacted]. [Baby G] was a IVF baby.

"[Mother of Baby G]'s pregnancy was rocky. At about 11 weeks [Mother of Baby G] started bleeding and we thought she was going to miscarry. We phoned up the maternity unit at the Countess of Chester Hospital and they told us to come in. They arranged for [Mother of Baby G] to have a scan the following day and the baby was fine and the pregnancy continued.

"At 22 weeks, [Mother of Baby G] started bleeding again and we went back to the Countess of Chester Hospital. They monitored the baby's heartbeat and kept [Mother of Baby G] in for a few days until she stopped bleeding. Once she had stopped bleeding she went home.

"About 2 days later, at 23 weeks into her pregnancy, [Mother of Baby G] started bleeding again. We went to the maternity unit at the Countess of Chester Hospital. [Mother of Baby G] was taken into the delivery suite and she was eventually taken upstairs on to the labour ward. [Mother of Baby G] stayed in for the next few days and they monitored the baby's heartbeat.

"A few days later, on the Friday, whilst [Mother of Baby G] was still in hospital, she phoned me at work to say her waters had started leaking and she was being moved to Arrowe Park Hospital as they thought the baby was coming. Arrowe Park Hospital had a more specialised neonatal unit for babies born prior to 28 weeks.

"[Mother of Baby G] was going to be transferred to Arrowe Park by ambulance, so I left work and drove myself to Arrowe Park Hospital. I met [Mother of Baby G] in the delivery suite at Arrowe Park where she stayed for most of the day. Later on she moved to a private room on the labour ward.

"[Mother of Baby G] stayed in Arrowe park over the weekend and the hospital monitored the baby's heartbeat. I visited [Mother of Baby G] on the Sunday with my mum and sister-in-law, who was staying with us, and we left [Mother of Baby G] at the hospital between 8 and 9 pm and went home.

"Around midnight I received a phone call from Arrowe Park Hospital to say that [Mother of Baby G] had gone into labour and the baby had come. The three of us -- me, my mum and sister-in-law -- all jumped in the car and drove to Arrowe Park Hospital.

"Eventually one of the doctors came to see us. They told us [Baby G] was stable and that we could go and see her in the intensive care unit. Only [Mother of Baby G] and I were allowed into the room to see [Baby G] and [Mother of Baby G] had to be wheeled in in a wheelchair. [Baby G] was in an incubator.

"[Baby G] was born on Sunday, 31 May 2015. Her due date was 21 September 2015. We were told by the doctors that [Baby G] only had a 5% chance of survival. [Baby G] weighed 536 grams -- that's 1 pound and 2 ounces -- when she was born. She was no bigger than your hand but she looked like a tiny person.

"[Baby G] was kept in Arrowe Park for 11 weeks. During those 11 weeks we were called in four or five times as they thought she was going to die. Her lungs were underdeveloped and she had ups and downs. We were told that once [Baby G] was strong and stable enough she would be moved back to the Countess of Chester Hospital.

"After the first couple of weeks, [Baby G] was much more stable. The older she got, the more we thought she was going to make it. I did not pick [Baby G] up until she was 2 pounds in weight as she was so small. We were told that very early neonatal babies are prone to bleeds in the brain, therefore [Baby G] had regular ultrasounds while at Arrowe Park to check for bleeding. [Baby G] did not have any bleeds to her brain while she was at Arrowe Park and all her scans showed that her brain was forming normally.

"After 11 weeks, [Baby G] was stable enough to be transferred to the Countess of Chester. It was the nearest hospital to our home address and she was taken by ambulance. When we arrived at the Countess of Chester Hospital we went to the neonatal unit and a nurse came to the door and accompanied us into the unit. [Baby G] was in the high dependency unit room.

"Our general routine whilst [Baby G] was at the Countess of Chester was that [Mother of Baby G] would phone the unit in the morning, about 6 to 6.30 am, to see how [Baby G] had been in the

night and then she would phone again about 7.30 after they did the handover to see who was looking after [Baby G] that day.

"[Mother of Baby G] would go to see [Baby G] every day, arriving at the Countess of Chester between 9 and 10 am. [Mother of Baby G] would stay with [Baby G] all day. I would then pick [Mother of Baby G] up on my way home from work, about 5.30, and we would go home and have our tea together. I then returned to the hospital about 7 and sat with [Baby G] until 10 or 11 pm.

"[Baby G] spent the first few weeks at the Countess of Chester Hospital in the HDU (room 2). She had a hot cot and was on low-flow oxygen. When [Baby G] was in the HDU at Chester I think she always had her own nurse. As time went on, [Baby G] moved out of the HDU and into nursery 4. In nursery 4 the nurses had to look after two or three babies each, however the nurses' station was right outside the door of the nurseries, so I felt confident to go home and leave [Baby G] in the care of the nurses all night.

"I never saw anything that caused me any concerns about anything at the Countess of Chester Hospital or about any of the nurses or doctors. I never saw anyone behave unprofessionally or cause me any concern.

"[Baby G] stayed in the neonatal unit at Chester for about 2 to 3 weeks with no real issues during that time up until the time she was 100 days old.

"On the day when [Baby G] was 99 days old I spent the evening with her as usual in the unit. [Baby G] was in the HDU. She was not on that much oxygen, just low flow, but she was still in a hot cot. She had been fed and was settled so I left at about 10 pm. She was fine when I left.

"I went home and went to bed. I then got a phone call in the early hours of the morning which woke us up. The call was made to my mobile phone. I think it was about 1 am or 2 am. The call was from the nurse who had been looking after [Baby G] that night; I think her name was [Nurse E] or similar. She said not to worry but that [Baby G] had vomited and aspirated and that she had to go back on the ventilator. She said there was no need to rush over to the hospital but [Mother of Baby G] and I decided to go straight to the Countess of Chester to see [Baby G] anyway.

"When we arrived, [Baby G] had been moved to the ITU. I noticed that the nurses had put up a banner in the HDU for [Baby G] to celebrate that she was 100 days old that day.

"When we went into the ITU, they were putting [Baby G] on the ventilator. We waited most of the day and most of the evening

for [Baby G] to stabilise. I think Dr Stephen Brearey was there at some point but I'm not sure if it was overnight or in the day.

"At one point we were sent to the meeting room while the consultants did their ward rounds. After the ward rounds they decided [Baby G] was just about stable enough to transport her. We were told that [Baby G] had only vomited the once, but it was projectile vomit. She had never done this before. She has done it since several times. I was concerned because I thought that [Baby G] had drowned in her own vomit while the nurses were stood around chatting.

"We waited most of the day and night for transport to arrive. The female consultant with the glasses was with [Baby G] when the transport team came for her. She was transferred to Arrowe Park Hospital in an ambulance. [Mother of Baby G] and I followed her there.

"It was the early hours of the morning when we arrived at Arrowe Park so they let us stay in the parents' room for the rest of the night. It took a couple of further days until they were able to properly stabilise [Baby G].

"When we had previously left Arrowe Park when [Baby G] was 11 weeks old she was on air up her nose, known as Optiflow or something like that. It forced the oxygen up her nose. At the Countess of Chester, before she vomited, she was on low flow. This did not force the air up her nose but still gave her oxygen. After a couple of days at Arrowe Park she did not need to be on any oxygen at all any more and they took her off the ventilator and weaned her off the oxygen completely. We thought it was brilliant, even better than before.

"However, I noticed that something had changed about [Baby G]. When [Baby G] was in the incubator at the Countess of Chester, before she vomited, I would speak to her in the incubator and she would smile at the sound of my voice and react. Once she had had the vomit, I could see that she was different as she didn't respond to my voice the same anymore.

"Once [Baby G] was stable, we were told she would be transferred back to the Countess of Chester, but we had to wait for there to be a free cot at the Countess of Chester. [Baby G] was at Arrowe Park for another couple of weeks. The day before she was transferred back to Chester [Baby G] had an MRI. [Baby G] was then transferred back to the Countess of Chester by the transport team and, on arrival, [Baby G] went into the HDU.

"At the time I asked a consultant if there was a virus or anything in the hospital as another baby who had been in the

same room as [Baby G] at the Countess of Chester Hospital was also poorly. Her name was [Baby I]. [Baby I] had been transferred to Liverpool Women's Hospital. [Baby I] came back to the Countess of Chester either a day or two before or after [Baby G]. I can't remember which. The consultant assured me they had not caught a virus and nothing was wrong with the ward.

"As time went on, [Baby G] improved and she was moved from HDU to nursery 4. However, there were a few times [Baby G] had to move back from nursery 4 to the HDU and on one occasion [Baby G] went back to the ITU. On this occasion I came to pick [Mother of Baby G] up from the unit and when I arrived [Baby G] was in the ITU. They were trying to cannulate her to give her antibiotics and she was proper stressing. They had been trying for a while. [Mother of Baby G] said, let me hold her, and when [Mother of Baby G] held [Baby G] she immediately calmed down. They were then able to cannulate her and give her the antibiotics. I am not sure if she was only in ITU on this occasion because HDU was too busy.

"On each occasion [Baby G] was in the HDU she would improve and be moved into nursery 4 before taking a turn for the worse and having to return to HDU again. We knew that once you were in nursery 4 and out of HDU or ITU you're only a few days away from going home. It seemed that every time [Baby G] was well enough to move to nursery 4 and was nearly going home something happened and she dropped back into the HDU.

"[Baby G] was in HDU most of the time she was at the Countess of Chester. Thankfully [Baby G] never had to go back on a ventilator again and, as far as I'm aware, [Baby G] never needed CPR while she was at the Countess of Chester.

"[Baby G] stayed at Chester until she was 156 days old. She was then discharged home. This was in November 2015. When she came home she was still only 5 pounds. Once [Baby G] came home she remained stable for the first year and a half to two years. However, [Baby G] missed some of her milestones and the doctors were keeping an eye on her head measurements as her head had not grown as expected.

"[Baby G] had an MRI at the Countess of Chester Hospital at about 2.5 years old. It was only after that that we realised the true extent of her brain damage.

"I have seen [Baby G] projectile vomit on other occasions since this incident where she has covered the cot. I think on those occasions they were linking her projectile vomit to reflux. There have been several occasions since [Baby G] was discharged from the neonatal unit where she has had to go to Alder Hey Hospital for medical procedures and/or treatment. Last year,

2018, she had to be ventilated six times in 10 months. She also had to be ventilated the year before as well.

"In addition, she has also had to have numerous courses of antibiotics. However, she has had a good year this year so far and she hasn't been ventilated since July of 2018. This is probably because [Baby G] is now PEG fed. She is nil by mouth. She has actually improved her health as she is no longer prone to chest infections as she is not aspirating as much.

"[Baby G] is still under the care of Dr Brearey. We've kept under his care at the Countess of Chester as this is the hospital that is closest to us. [Baby G] has now been diagnosed as having quadriplegic cerebral palsy. She has level 5 cerebral palsy. She suffers with dystonia, which was causing her spasticity, which means she goes really stiff and can stop breathing or holds her breath. At first when this happened we thought [Baby G] was having a tantrum, but we now understand this is involuntary.

"[Baby G] also has microcephaly. Microcephaly is where her head is small for her age and her brain is not fully developed. [Baby G] is also visually impaired. I don't know what [Baby G]'s life expectancy is. [Baby G] needs 24-hour care. [Baby G] currently goes to school a couple of hours day. She has nurses that come to our home for a couple of hours to week to support us. The majority of her care comes down to [Mother of Baby G] and me."

That concludes the statement of [Father of Baby G].

Could I call, please, Dr Alison Ventress.

DR ALISON VENTRESS (recalled)

Examination-in-chief by MR ASTBURY

MR ASTBURY: Could I ask you to state your name for the record?

VENTRESS: Dr Alison Lois Ventress.

ASTBURY: Thank you, Dr Ventress. You have given evidence before -- in fact, a few day ago --

VENTRESS: On Monday, yes.

ASTBURY: I'm going to go on, please, to ask you about another shift you completed at the Countess of Chester Hospital's neonatal unit in 2015 and in particular your treatment of a baby by the name of [Baby G].

We've heard that [Baby G] was born at Arrowe Park Hospital and transferred to the Countess of Chester on 13 August 2015.

VENTRESS: Mm-hm.

ASTBURY: Before we move on to the shift that we're interested in, you have seen before we have a presentational device before the jury. I'm going to ask Mr Murphy to go to tile 3, please.

Just to remind us, it's there on the tile, your name and you were at your stage of training as a registrar ST5, is that correct, at the time?

VENTRESS: Um... I think I was ST4 then seeing it was in September. So I think the day --

ASTBURY: Not far off 5?

VENTRESS: Not far off, yes.

ASTBURY: On the cusp?

VENTRESS: Yes.

ASTBURY: All right.

MR JUSTICE GOSS: So 1 month off?

VENTRESS: Yes.

MR ASTBURY: Thank you.

I was going to ask you about the shift, but your name in fact appears on the document which appears to be the admission form for [Baby G]. So I'm just going to ask you to look at that very briefly and see if you have any recollection of it, really for the sake of completeness.

If we can look at what's behind, please.

I think the first page is a nursing note.

VENTRESS: Mm-hm.

ASTBURY: If we can go down to that, please. Certainly we're becoming a little more familiar with these. If we can zoom in about halfway down on the left-hand page, please.

This is a nursing note which you wouldn't ordinarily make any entries on, but we can see under the heading of "admission

interview", your name appears as having at least spoken to the parents. Do you have any recollection of that event?

VENTRESS: No, not directly. I've seen in the medical notes I did do the admission documentation, so it was standard practice for us to speak to the parents when they arrived and just --

ASTBURY: All right.

VENTRESS: But I can't remember exactly doing it.

ASTBURY: No. I'm just dotting Is because I think, apart from where we're going to go now, that's the only time your name appears in this particular part of the case.

So if we can come out of that, please, and I'm going to ask you about the shift that I introduced earlier.

Were you on a night shift from the 6th into 7 September 2015?

VENTRESS: Yes.

ASTBURY: Have you relied in part on the medical notes to remind yourself of what happened on that particular shift?

VENTRESS: Yes, almost entirely (overspeaking) --

ASTBURY: Do you have any independent recollection of the shift?

VENTRESS: Very little.

ASTBURY: Okay. All right. Do you remember what time you'd have started the shift?

VENTRESS: We started -- we had handover at 8.30 pm.

ASTBURY: We've heard that's, as the name suggests, the day shift going off, passing on as much information as they can to those taking over, is that right --

VENTRESS: Yes.

ASTBURY: -- and briefing on each baby who requires it?

VENTRESS: Yes.

ASTBURY: Do you remember anything about [Baby G] that was communicated to you during the course of that handover?

VENTRESS: No, not directly.

ASTBURY: Were there any prior concerns about [Baby G] at that stage?

VENTRESS: No, not that was handed over.

ASTBURY: Were you aware that she had been examined on the ward at the start of that particular day shift?

VENTRESS: That's standard practice. So I wasn't aware that she had been, but I would expect that she had been, if that makes sense.

ASTBURY: All right. You don't remember any concerns being raised with you at that stage --

VENTRESS: No.

ASTBURY: -- about [Baby G]'s condition?

VENTRESS: No. That's correct.

ASTBURY: Did there come a point in the shift when you did have cause to see [Baby G]?

VENTRESS: Yes, based on the medical notes.

ASTBURY: Would it be easier if we went to the medical notes to refresh your memory?

VENTRESS: Yes.

ASTBURY: Thank you. Your medical notes, so everybody knows, are spread across three pages of clinical notes.

My Lord, they're broken up in the presentation, so I'm going to go through the notes in their entirety.

But for anyone who wants to make a note of where they appear on the tiles, they are 80, 84, 107, 117 to 119 and 136.

Unfortunately nowhere do they appear in full because they've been broken down into time, but I'm just going to take the doctor through the notes.

So this note is headed with your name, doctor.

Do you recognise the handwriting?

VENTRESS: Yes, I do.

ASTBURY: It's your handwriting?

VENTRESS: It is.

ASTBURY: So it's your note, good. Although it's timed at 4.40, this is a note that's written in retrospect?

VENTRESS: Yes, it says I was called to review her at 2.35.

ASTBURY: All right. I asked you earlier whether you had any direct recollection of being called to see [Baby G]. Is there anything you can remember about the initial request to see her?

VENTRESS: No.

ASTBURY: Nothing?

VENTRESS: No.

ASTBURY: Okay. Let's just go through your notes then, please:

"Had very large projectile vomit (reaching chair next to cot and canopy). Abdo appeared discoloured, purple and distended."

Is that something you recall or is that something you saw or something you were told?

VENTRESS: I would not have been there for the vomit. So I didn't see [Baby G] actually vomit. I can't remember if there was still evidence of the vomit on the chair or not from my notes.

ASTBURY: Okay, all right. That suggests you were told about the vomit?

VENTRESS: Yes.

ASTBURY: Were you told about the abdomen or is that your examination at that stage?

VENTRESS: Um... I can't be 100% sure from those notes.

ASTBURY: Okay.

MR JUSTICE GOSS: Let's read on and see what you --

VENTRESS: Yes.

MR JUSTICE GOSS: We can see it all in context.

MR ASTBURY: "[Baby G] distressed and uncomfortable. Red in face and purple all over."

Perhaps if you could take us through the note, doctor, and whatever may assist your memory, if you can fill in those details.

VENTRESS: As you can read... (Pause). It's hard for me to remember which parts of it I was told from the nurses or which parts I would actually have seen for myself.

ASTBURY: All right. Are you able to remember whether you saw [Baby G] distressed and uncomfortable?

VENTRESS: No.

ASTBURY: "Red in the face and purple all over"; can you recall that?

VENTRESS: I would... From how I usually set my notes, that feels like it was a bit of a rushed note in retrospect.

I think I would have seen that from what I've written, but I can't be 100% sure.

ASTBURY: Okay. If you can carry on and just explain to us from "O2" what that note indicates to you?

VENTRESS: The oxygen had been increased -- I'm not sure how much she was on before. I know she was in oxygen anyway, but it had been increased up to 1 litre via the nasal cannula, which is the prongs up the nose.

ASTBURY: Okay.

VENTRESS: So the nurses would usually have done that if she's desatting and that's fine.

ASTBURY: Okay.

VENTRESS: Desat, so her oxygen levels dropped down into the 80s, but her heart rate stayed okay, so normal.

ASTBURY: Okay.

VENTRESS: "Full feed 45ml aspirated."

So again, I'm not sure if I would have asked the nurse to do that, which I would have done if I'd seen her abdomen was large and distended and she'd had a vomit, but the nurse may have done that before I arrived as well, I'm not sure which of those.

ASTBURY: So still not sure whether this is your examination or what you have been told by the nurse --

VENTRESS: Yes.

ASTBURY: -- when you arrived? Do you remember who the nurses were when you arrived?

VENTRESS: Only from reading the notes. I don't have any actual recollection of it, no.

ASTBURY: So from the notes, who do you understand it was?

VENTRESS: [Nurse E], I think, from reading the notes.

ASTBURY: Okay. Perhaps if we scroll down and you just have a read of the rest of the note before we go any further, certainly for this part of the page.

That might be the end of the page, actually. If you look at the next page.

(Pause).

Just take a moment to read it and refresh your memory if you would, please, doctor.

VENTRESS: So the --

ASTBURY: Sorry, could you -- (overspeaking) --

MR JUSTICE GOSS: I think you actually missed out the bottom line on the previous page.

MR ASTBURY: It might help the doctor to read all of the notes before going any further.

MR JUSTICE GOSS: Exactly. You can't scroll through like we can on our own devices.

MR ASTBURY: Just read it for now. Then I'll go back to where we left off and I'll ask you some questions. If you can read that part of the page, please.

(Pause)

Then carry on, please, Mr Murphy, for the next part of the note.

(Pause)

Have you read that part?

VENTRESS: Yes.

ASTBURY: Thank you. I think that's the second page. We can go on to the third page.

(Pause)

The next part, please, Mr Murphy.

(Pause)

Then there's the final part, doctor.

(Pause)

That takes us through to about 7.45 in the morning.

Perhaps if we could go to that first portion, you having refreshed your memory from your notes. We'd got as far as, I think, two-thirds of the way down:

"Full feed (45ml aspirated)."

VENTRESS: Yes.

ASTBURY: And you couldn't remember whether the nurse had done that or you'd asked the nurse to do that. Has reading the entirety of the note helped?

VENTRESS: Not on that.

ASTBURY: Okay. Let's read the next line. It refers to a stool.

Just read that out for us, please.

VENTRESS: It says:

"Large watery stool passed, after which abdo slightly better and [Baby G] relaxed and appeared back to her usual self."

ASTBURY: Are you able to help us with that was something you were told or something you had found and seen for yourself?

VENTRESS: Again, it would be an assumption rather than 100% sure.

ASTBURY: We don't want you to assume, thank you.

The next line begins:

"Planned to cannulate."

VENTRESS: Yes.

ASTBURY: Does that reassure you this perhaps is more your input than anybody else's?

VENTRESS: Yes. I would have seen [Baby G] for myself before I'd made that plan. I would hope that I had examined her, that's what I would do, but I haven't documented that examination. So I can't --

ASTBURY: Tell us what the plan was, please. We'll skip over to the next page as soon as you have finished that first line.

VENTRESS: So:

"Plan: to cannulate [so insert an IV cannula], start IV fluids."

And take some bloods.

ASTBURY: Okay. Just explain that to us, please. IV fluids, what is the purpose of IV fluids?

VENTRESS: So because of the large vomits and the concern over what had happened, we'd planned to give her a rest from her milk feeds and to give her IV fluids to keep her hydrated and to keep her sugars up while we worked out if there was anything else going on or not.

ASTBURY: We've heard something of the types of IV fluids, what would you have had in mind at that stage?

VENTRESS: So it'd just be clear fluids. It would usually, for a baby that age, be 10% dextrose with some saline.

ASTBURY: Bloods? What does that mean, blood tests?

VENTRESS: Blood tests, yes.

ASTBURY: All right. And then we've got a "but", so we'll go on to the next page, please. It would appear that there was some sort of intervening event at that stage.

VENTRESS: Yes.

ASTBURY: So do you recall being called away from your examination of [Baby G]?

VENTRESS: I don't recall the actual being called away. I do have a slight recollection of being in theatre and being called back again, but again it's slight.

ASTBURY: When you were called away, do you recall the condition in which you left [Baby G] at that stage?

VENTRESS: So I'd previously documented that she looked better and back to her normal self. So that would be -- I would have been happier -- I was obviously happy enough to leave her at that stage and I didn't call the consultant right then, so I wasn't that worried at that stage.

ASTBURY: Okay. So you have noted that she looked better?

VENTRESS: Mm-hm.

ASTBURY: You were called away urgently. And the fact that you haven't asked for the consultant at that stage, can we conclude that you were happy to leave [Baby G] at that stage with the nurses?

VENTRESS: Yes. I think... I didn't think I would be away that long and then I was coming back to her to carry out my plan.

ASTBURY: Okay.

VENTRESS: If I thought I'd have been away for a long time, I would have called the consultant to come and help, more for an extra pair of hands rather than needing the consultant.

ASTBURY: Okay. Do you remember how long you were engaged with the other task?

VENTRESS: Not exactly. From the notes, it was less than half an hour before I was called back.

ASTBURY: And do you remember being called back?

VENTRESS: It was 7 years ago, so as much as I can remember something from 7 years ago, yes.

ASTBURY: You're obviously having some difficulty recalling. Do you remember making a witness statement in this case?

VENTRESS: Yes.

ASTBURY: And have you had the opportunity to refresh your memory from it today?

VENTRESS: Yes.

ASTBURY: Okay. Would it be of any assistance to do so again now?

VENTRESS: I can do.

ASTBURY: Right.

My Lord, a copy is just being obtained. I don't want this witness to continue to labour with a memory test if that helps and no one has any objection.

MR JUSTICE GOSS: Well, the note goes on:

"Called out of theatre to say [Baby G] gone apnoeic and dusky."

VENTRESS: Yes.

MR JUSTICE GOSS: So sequentially, it looks as though you made your plan as to what you were going to do, you couldn't put it into effect because you had to go to the delivery of another preterm baby, but whilst you're there, you are called out of theatre to go back?

VENTRESS: Exactly, yes.

MR ASTBURY: I'm happy to go on with the note for now --

MR JUSTICE GOSS: Are you happy?

VENTRESS: I can't add anything more to that.

MR JUSTICE GOSS: We'll see in due course if your statement adds any further detail.

MR ASTBURY: Thank you, my Lord.

So clearly from the note you were called out of theatre. You told us about half an hour, you think?

VENTRESS: Less than half an hour.

ASTBURY: So bearing in mind that you first went to [Baby G] at about 2.30, what time of the morning do you think you are now?

Are you able to say?

VENTRESS: I'm sure I've seen it elsewhere in the notes. But I can't remember offhand. I'm sure I've seen it elsewhere in the note. I think on Dr Brearey's note it says what time he was called in and that would put (overspeaking) --

ASTBURY: Would it help to look at Dr Brearey's note?

VENTRESS: If it's for the timing, yes.

ASTBURY: Mr Murphy, could we scroll through to the page after these notes conclude?

Bear with us a second, we'll see if we can help.

(Pause)

It may be behind tile 85 if there's any difficulty, Mr Murphy, or thereabouts.

(Pause)

Again, as we did before, if you'd just like to have a look at that. Thank you.

(Pause)

There may be a little bit more further down as well.

VENTRESS: It says here "Called in at 3.30", so it was around that time.

ASTBURY: Look at the rest of the note and see if it jogs your memory in respect of any other treatment while you were present.

(Pause)

So we can go back to your note, please, and the stage at which you told us you were called back from the delivery suite to see [Baby G] for a second time, this was, during that morning.

VENTRESS: Yes. So somebody had come to theatre to say she was apnoeic and dusky, so I've written on arrival, her sats, her oxygen levels, were 50% in 100% oxygen, which is the most oxygen you can give.

ASTBURY: Pausing there, apnoeic?

VENTRESS: Stopped breathing.

ASTBURY: Dusky?

VENTRESS: Sort of purple/navy colour skin. Low oxygen levels.

ASTBURY: Very poor colour?

VENTRESS: Yes.

ASTBURY: Okay. And 50% sats, what do they tell you?

VENTRESS: So it should be over 92, really. So very low oxygen levels.

ASTBURY: All right. So also on your arrival, you point out that [Baby G] is receiving IPPV. Could you tell us what that is, please?

VENTRESS: That stands for intermittent positive pressure ventilation from the nurse. So that's using a mask on her, on her face over her nose and mouth. You have probably seen it on TV with a bag that you squeeze, but in the neonatal unit we've got a Neopuff machine, so you just press, put your finger on and off the top and it does the same thing.

ASTBURY: So help with breathing?

VENTRESS: Yes.

ASTBURY: But you note that HR -- is that heart rate?

VENTRESS: Yes.

ASTBURY: -- is okay. You note continues:

"Took 5 minutes for sats to pick up."

VENTRESS: Took around 5 minutes, yes.

ASTBURY: Is that what happened, do you recall?

VENTRESS: Yes. That's what I've written.

ASTBURY: All right. And then "Moved to room 1"?

VENTRESS: Yes.

ASTBURY: Was that your decision?

VENTRESS: Yes.

ASTBURY: Why moved to room 1?

VENTRESS: So room 1 at Chester was the more intensive care room and I felt at that stage [Baby G] definitely needed a close eye keeping on her and likely more support with her breathing.

ASTBURY: Okay. You go on to describe -- just tell us the description you place underneath the decision to move to room 1, please?

VENTRESS: I have written:

"Pink and well perfused with mask CPAP."

So the mask that you use to give the breaths, the IPPV that they were doing before, once she starts breathing again you can continue the mask, to put the mask on her face, but without putting your finger on and off the top and that just gives her a bit of constant pressure to make the breathing easier, but she is doing the breathing herself at that stage.

ASTBURY: The manual assistance from the nurse has stopped with the button that --

VENTRESS: Yes.

ASTBURY: -- you described to us, but there's now a mask delivering CPAP; is that right?

VENTRESS: It's the same mask, so you just stop doing that (indicating) with your finger and hold it there.

ASTBURY: Okay, all right. And we've heard that the idea of CPAP is to leave some pressure in the lungs --

VENTRESS: Yes.

ASTBURY: -- even when the baby breathes out to stop the lungs collapsing?

VENTRESS: Yes.

ASTBURY: All right. You describe [Baby G] as active?

VENTRESS: Mm-hm.

ASTBURY: So on the face of it, are these positive signs, having collapsed in the way that you've -- you were told whilst you were in theatre?

VENTRESS: Yes. Often when a baby has an apnoea, they might need some help to recover from it, but then they'll be -- once they've recovered from that apnoea then they'll go back to being active again.

ASTBURY: And that was what you found with [Baby G]?

VENTRESS: Yes.

ASTBURY: "Tried for IV access x2 unsuccessfully."

Tell us about that, please.

VENTRESS: So I tried to insert a cannula or a drip, but wouldn't -- unsuccessfully on two occasions.

ASTBURY: What was the purpose of that?

VENTRESS: To give the fluids and antibiotics that I'd planned to before I'd gone to theatre.

ASTBURY: So they hadn't yet started?

VENTRESS: No.

ASTBURY: And in fact you were unable at that stage to --

VENTRESS: Yes.

ASTBURY: -- put a cannula into [Baby G] to start administering --

VENTRESS: Yes.

ASTBURY: Okay.

VENTRESS: So that's again -- [Baby G] was born at 23 weeks, so being 3 months old at this stage, it's not uncommon that they have very difficult veins by that stage.

ASTBURY: Okay, all right. The next line, please?

VENTRESS: Yes:

"[Baby G] then had a further profound apnoea and her heart rate went down to 70 and sats went down to 40."

ASTBURY: Pausing there, was that in your presence?

VENTRESS: Yes, 99%, yes.

ASTBURY: All right. Now, correct me if I'm wrong, but why describe an apnoea as profound?

VENTRESS: So it's quite common for babies to have short pauses in their breathing, but a profound apnoea would mean that their sats dropped very low and their heart rate dropped significantly as well.

ASTBURY: As you put on the next line, the heart rate, although it was okay, when you first arrived, it had dropped to 70; is that right?

VENTRESS: Yes.

ASTBURY: And the sats are even lower than they were
(overspeaking) --

VENTRESS: Yes.

ASTBURY: You made a note about perfusion.

VENTRESS: Mm-hm.

ASTBURY: Tell us about that, please.

VENTRESS: So her perfusion had worsened, that's what I mean by the downward arrow. CRT is capillary refill time, that was 3 seconds. It should be less than 2 -- 2 or less than 2.

ASTBURY: Okay. Next line, please.

VENTRESS: So IPPV, as I said before, breathing for [Baby G] via a mask was started again, and a gradual improvement was seen again. So her sats started to come up and the perfusion also improved with that.

ASTBURY: So rather than leaving it on CPAP, the nurse goes back to assisting -- actively assisting [Baby G]?

VENTRESS: Yes.

ASTBURY: You then, according to the note, made a decision to intubate?

VENTRESS: Yes.

ASTBURY: Just explain that to us, please.

VENTRESS: She'd had at least two significant apnoeas in a relatively short period of time, needing intervention with the nurse breathing for her, so we can't carry on in that situation.

ASTBURY: No.

VENTRESS: So I decided to intubate, so insert a breathing tube into her windpipe, so we could put her on a ventilator.

ASTBURY: And the ventilator then breathes for the baby?

VENTRESS: Yes.

ASTBURY: Okay. The next line, is that "and concerns", "plus concerns"? Is that the next line?

VENTRESS: "And concerns re [about] abdo [yes] so not keen for CPAP."

ASTBURY: Is that another consideration for ventilation?

VENTRESS: Slightly, yes. So sometimes if a baby has apnoeas, you can try them on CPAP with -- I know I said we can do it with a mask, but that's not quite as good as the proper CPAP although it's the same principle. So that is a temporary thing and then you put them on proper CPAP if you want to keep them on it.

ASTBURY: Right.

VENTRESS: So that would -- sometimes that can help babies who are having apnoeas, keep stimulating them to breathe, but the downside is it forces air into their tummies as well. So if you're concerned about their tummy being large already, you don't want to make it worse.

ASTBURY: Was that a feature that was concerning you at that time, the tummy?

VENTRESS: It looks like it from the notes. I think it was a secondary -- I think the decision to intubate was mainly because of the apnoeas but that was a secondary concern underneath.

ASTBURY: Okay, all right. And then it probably speaks for itself, but is that:

"No intravenous so no drugs used"?

VENTRESS: Yes.

ASTBURY: Scroll down, please. Your note continues, just explain that first line to us, please.

VENTRESS: "Intubated with a size 3..."

ETT is endotracheal tube. So that's just giving the details of the size of the tube that was used and "8 centimetres at the lips" is where I fixed it.

ASTBURY: That's the length from the tip of the tube --

VENTRESS: That's the length from the lips to the tip of tube, yes.

ASTBURY: Then you have made a note about bloodstained fluid.

Tell us about that, please.

VENTRESS: It says:

"Bloodstained fluid noted coming up from the trachea or between the cords."

So that's the vocal cords.

ASTBURY: Is that something that you saw whilst you were intubating?

VENTRESS: Yes.

ASTBURY: Then we've heard that the capnograph is a device that changes colour to show carbon dioxide.

VENTRESS: Carbon dioxide, yes.

ASTBURY: Do we take it that the word "positive" suggests the capnograph was showing that (overspeaking) --

VENTRESS: Yes, it changed colour, so it shows that the endotracheal tube was in the windpipe, yes.

ASTBURY: And is that "good"?

VENTRESS: "Good bilateral air entry."

So we listen to the lungs with a stethoscope and there was good air entry on both lungs.

ASTBURY: So the ventilation is working and it's working equally on both sides?

VENTRESS: Yes. I don't think she was connected to the ventilator quite at that point. We'd have still been -- that same device that -- we connect that to the breathing tube once it's in --

ASTBURY: Right.

VENTRESS: -- rather than a mask.

ASTBURY: All right. So we're still at the stage with the nurse helping?

VENTRESS: Yes.

ASTBURY: Okay. Do you remember --

VENTRESS: It could have been me.

ASTBURY: Okay, all right. Do you remember any of the nurses that were assisting in this process?

VENTRESS: Only from the notes.

ASTBURY: You don't have any memory yourself?

VENTRESS: No.

ASTBURY: So you then noted that Dr Brearey's attended?

VENTRESS: Mm-hm.

ASTBURY: From his note now that seems to be about 3.30?

VENTRESS: Yes.

ASTBURY: And you've then made a number of notes. Could you just take us briefly through the following notes, please?

VENTRESS: "Vent settings" is the ventilator settings that we started [Baby G] on. So 18/5 is the pressures that we set and with a rate of 40 breaths a minute.

ASTBURY: Right.

VENTRESS: Then I've put -- FiO2 is the amount of oxygen we are giving to [Baby G]:

"Weaned down to 30%."

So she was in (overspeaking) reducing it so that's a good sign.

ASTBURY: All right, okay:

"Good gas 30 minutes post intubation"?

VENTRESS: Yes.

ASTBURY: What does that mean?

VENTRESS: That's a blood gas that we'd have taken as a heel prick sample from [Baby G] to look at her carbon dioxide levels and acid levels in the blood. So it was good, that means -- so we weaned the ventilation settings, so we reduced the amount of help the ventilator was giving her at that stage.

ASTBURY: Are they the figures at the end of the line (overspeaking)?

VENTRESS: So 16 (overspeaking) decreased to 16/5 and an arrow down.

ASTBURY: (Overspeaking). So from 18/15 to 16 stroke -- sorry --

VENTRESS: 18/5 to 16/5, yes.

ASTBURY: Then comment about a large leak. Could you explain that to us, please?

VENTRESS: So the tube is quite a narrow tube --

ASTBURY: Right.

VENTRESS: -- and they only come in certain sizes and obviously babies come in different sizes, so you go for what you think is the appropriate size, but sometimes the vocal cords, the windpipe, is a bit bigger than the tube so you get a leak round the edge.

ASTBURY: When you talk about a leak, is it a leak from -- which way is the leak going and what's it of and (overspeaking) --

VENTRESS: So the tube is in the windpipe, so we're pushing air down the tube and then coming back -- I guess it comes back up from the ventilator.

ASTBURY: Does it come up the same tube?

VENTRESS: Yes.

ASTBURY: So where does the leak occur?

VENTRESS: So it's near -- so the tube is usually about 3 -- 2 or 3 centimetres into the windpipe by the time it has gone down the mouth and the vocal cords. So it would just be -- it could be when you're pushing air into the lungs or out, it could leak out -- rather than pushing it into the lungs it can leak out into the mouth and... yes.

ASTBURY: Okay, all right. But that's round the edge of the tube as it passes through the vocal cords?

VENTRESS: Yes.

ASTBURY: Okay. But was it something that didn't concern you at the time?

VENTRESS: Um, no. So it's quite common to have a leak on a tube.

If it's a large leak, that sometimes means we need to use higher pressures than we would if it was a smaller leak to compensate for it. But we had good gases, her oxygen requirement had come down, she had good air entry, as I said, so it wasn't causing her an issue at the time, so we left it.

ASTBURY: Okay. Is that "IV vit K"?

VENTRESS: Yes.

ASTBURY: Tell us about that please.

VENTRESS: So:

"IV vitamin K given due to blood from the trachea."

Is what I have written. So because of the bloodstained fluid that I'd seen coming up from the lungs, any unusual bleeding in a baby we tend to treat with vitamin K because all babies are born deficient of vitamin K and that's an important factor in blood clotting.

ASTBURY: Okay, all right. So you have said the air entry is good, sats are good. Do so we read into that that, following Dr Brearey's attendance at 3.30, was there an improvement in [Baby G]'s condition?

VENTRESS: Yes, I'd say so. She responded well to the treatment that we'd given her anyway.

ASTBURY: Okay, all right. But then at approximately 5.30 you've made another note. Could you tell us about that, please?

VENTRESS: So I said:

"She had a further profound desat, heart rate down to 60, sats down to 40. Taken off the ventilator and..."

I shouldn't use so many abbreviations.

ASTBURY: It's okay, just expand it to us (overspeaking) --

VENTRESS: IPPV, as I said before, is breathing for [Baby G]. And the Neopuff is that piece of kit that they have in the neonatal unit instead of squeezing the bag. It does the same thing.

ASTBURY: So at 5.30 do we assume from that then that [Baby G] was still ventilated?

VENTRESS: Yes.

ASTBURY: So she would still be receiving ventilation in that way that you (overspeaking) invasive ventilation?

VENTRESS: Yes.

ASTBURY: And you had good air entry on both sides because you checked?

VENTRESS: Mm-hm.

ASTBURY: And the capnograph was positive?

VENTRESS: Yes.

ASTBURY: But notwithstanding that, we can see that there's another, as you describe it, profound desaturation despite the ventilator?

VENTRESS: Yes.

ASTBURY: If we can scroll down, please, the next line repeats the situation with the capnograph. It's still positive --

VENTRESS: Yes.

ASTBURY: -- and there's still -- it says "okay". Is that...

VENTRESS: If the heart rate and the oxygen levels drop on a ventilator, there's a few things that we always look for. You know, things change minute to minute so we can't assume that if the tube was in a good place at 3.30 or 4 o'clock that it's still in a good place at 5.30.

ASTBURY: Right.

VENTRESS: So we'd look for a displaced tube, obstruction, anything that's obstructing the tube, a pneumothorax, so a collapsed lung, or is it something to do with the equipment that was causing an issue. Those are our four standard things we would look for.

So "capnograph still positive" would indicate that the tube is still in the windpipe, it's not dislodged, and the chest movement still being okay would indicate again they've got air moving from the ventilator into the lungs, so there's nothing blocking it completely.

ASTBURY: If we go to the next page please:

"This time recovered slowly."

Is that right?

VENTRESS: Yes. She'd recovered slowly on each occasion so far looking back on the notes.

ASTBURY: Okay, all right. Just read on with your note, please, and tell us about this recovery.

VENTRESS: So recovered slowly with -- doing the breathing for her, with the Neopuff, still via the breathing tube. But when we put her back on the ventilator, she desaturated again, so we'd have taken her off and done the IPPV breathing for her again.

ASTBURY: Right.

VENTRESS: So at that stage I wondered if it was a problem with the equipment that was causing it because we could get her oxygen levels good without the ventilator, but it was when we put her back on the ventilator this time they went down again. So I was looking at if there was an issue with the equipment.

ASTBURY: So fine when she's having assistance through the button device that you told us about --

VENTRESS: Yes.

ASTBURY: -- but once back on the ventilator, would deteriorate?

VENTRESS: Yes.

ASTBURY: So you query ventilator problem, we see the question mark on the left-hand side.

VENTRESS: Yes.

ASTBURY: What's the flow sensor, please?

VENTRESS: So it's a device that is on the end of the breathing tube, connected between the breathing tube and the ventilator, and it talks to the ventilator to -- it detects how much is flowing through it, the flow sensor, and then it lets the ventilator adjust itself in response.

ASTBURY: Pretty well what it says on the tin --

VENTRESS: Yes.

ASTBURY: -- it senses the flow between --

VENTRESS: Yes.

ASTBURY: -- the end, ie the baby, and the ventilator itself?

VENTRESS: Yes.

ASTBURY: Okay. But then "whole ventilator changed"?

VENTRESS: Yes. We changed the flow sensor and that didn't make a difference, so then we changed the whole ventilator to see if that would fix the problem.

ASTBURY: Okay, all right. A comment about the large leak remaining, could you just explain that to us, please?

VENTRESS: As I said before about the leak, I've commented on the previous page there was a large leak. This was still the case.

ASTBURY: Still there --

VENTRESS: Yes.

ASTBURY: -- but because of sats and the heart rate --

VENTRESS: Yes, I didn't think that was causing the problems.

ASTBURY: Okay, all right. So after this event is [Baby G] still ventilated with the new ventilator and the new flow sensor?

VENTRESS: Yes.

ASTBURY: But at 6.05 we can see another event?

VENTRESS: Yes.

ASTBURY: So this is, again, about half an hour later, does that sound about right?

VENTRESS: Yes.

ASTBURY: Tell us, please, from the notes what happened at 6.05.

VENTRESS: So another profound desat with a drop in the oxygen level and heart rate and then I have written "Decision to re-intubate". So from the rest of the notes that feels like I've covered every other base and it's not really helped, so this is -- we'll do that.

ASTBURY: Okay.

VENTRESS: So it says:

"IPPV [so again the breathing] given via the breathing tube initially."

So the heart rate came up to 120, but the sats remained low at 50, despite increasing the pressure we were giving and giving 100% oxygen. So I think it was after that, the decision to re-intubate...

ASTBURY: Just generally, we've heard about 2.30, moving [Baby G] to room 1.

VENTRESS: Mm-hm.

ASTBURY: Events at 3.30, 5.30, 6.05. Were you with [Baby G] at her cot side throughout this period?

VENTRESS: Probably for most of it given what's happened --

ASTBURY: All right.

VENTRESS: -- or at least in the -- at some stage I'd have started to write some notes, I wouldn't be at the cot side but I'd be at the desk in the room. I think the initial note was started at 4.40, wasn't it?

ASTBURY: Yes.

VENTRESS: So at that time I would have sat down and started writing notes.

ASTBURY: Okay. So we've got, I think, to the ETT removed at 6.10?

VENTRESS: Mm-hm.

ASTBURY: Take us through what you found then, please.

VENTRESS: It says:

"Thick secretions ++ in mouth and blood clot at the end of the ETT."

ASTBURY: What, if anything, might those two features tell you?

VENTRESS: So thick secretions was -- you know, phlegm or equivalent was what we call secretions.

ASTBURY: Does the plus plus tell you anything?

VENTRESS: Just tells me more than I'd expect.

ASTBURY: Okay.

VENTRESS: Then a blood clot on the end of the tube. We saw some blood coming up from the lungs when they're intubated so there was some blood in the lungs somewhere that's caused that blood clot on the end.

ASTBURY: Okay. Are you able to conclude it was in the lung or just at a point below the end of the ET tube?

VENTRESS: Um... Windpipe or lungs, yes.

ASTBURY: I'm not --

VENTRESS: No.

ASTBURY: -- just --

VENTRESS: Yes.

ASTBURY: And we can see again:

"IPPV via face mask given."

VENTRESS: Mm-hm.

ASTBURY: Then:

"Despite jaw thrust and Guedel..."

VENTRESS: Yes.

ASTBURY: Tell us about that, please. I'm not sure we've come across jaw thrust before.

VENTRESS: It's all right. So again, we were trying to breathe for [Baby G] using the mask now because we had taken the breathing tube out, so a jaw thrust is when you try and bring the chin forwards to keep the tongue out -- off the back of the airway. Obviously [Baby G] would be laying on her back at this point so it's easy for the tongue to drop back into the airway. So we lift up the jaw to keep it off the airway. And a Guedel is a little plastic tube that you can put in the mouth to do that for you, to basically lift the tongue off the back of throat.

ASTBURY: Okay, all right. And that's all, is it, to make sure there's no obstruction to the airway?

VENTRESS: Yes.

ASTBURY: All right. On this occasion you've made a slightly different note about chest movement. Tell us about chest movement by this stage.

VENTRESS: Yes, we weren't getting good chest movement despite these actions that were taken. So we'd have -- it would have been me doing the breathing at this stage from reading that.

ASTBURY: Okay. Would you do the jaw thrust and use the Guedel?

VENTRESS: Yes.

ASTBURY: But poor chest movement -- and do we see the sats have fallen?

VENTRESS: Yes.

ASTBURY: Is that a very low figure?

VENTRESS: It is, yes.

ASTBURY: And the heart rate's dropped as well to 70?

VENTRESS: Yes.

ASTBURY: If we can scroll down, please. Had Dr Brearey gone by this stage?

VENTRESS: Yes. I'm not sure at which stage he went, but he wasn't there then.

ASTBURY: But we can see he was called in again, as you describe it, urgently.

VENTRESS: Yes.

ASTBURY: And tell us please about the next entry, about the NG.

VENTRESS: So:

"NG [nasogastric] tube was aspirated as the abdomen appeared very large and around 100ml aspirated."

ASTBURY: So this is post 6.10 when things have taken a significant turn for the worse? You're trying to work out -- well, you have taken out the ET tube and you have used the airway assister and the jaw thrust technique.

Tell us about the aspirate, please, what you can remember of it.

VENTRESS: So it's quite common when you're giving the breathing support via the mask for their tummies to get bigger because when you're trying to force air into their lungs, you also force air down into the stomach as well.

So it's quite common in that situation that the stomach would get bigger and you would aspirate air out of the stomach --

ASTBURY: Was it air?

VENTRESS: I can't say 100% from that. I would think, yes, but I haven't documented it, so I can't say exactly.

ASTBURY: All right. Do you recall if -- well --

VENTRESS: I think I would have documented it if it wasn't air because that would be more unusual.

ASTBURY: And can you tell us anything about the quantity, the 100ml, is that usual, unusual?

VENTRESS: It is a lot but, as I said, we have been doing that, forcing air in, quite a lot.

ASTBURY: All right. Did that have an effect?

VENTRESS: It says the sats gradually increased after this.

ASTBURY: Okay. We can see you then re-intubated [Baby G] at 6.15, this time with a slightly larger tube?

VENTRESS: Yes.

ASTBURY: And she received intubation drugs to assist?

VENTRESS: Yes. It's kind of like a mild anaesthetic, the intubation drugs. It knocks them out a bit.

ASTBURY: And perhaps because of the slightly larger size we can see the next entry:

"Tight fit (inaudible)."

VENTRESS: Yes.

ASTBURY: Did that eliminate the leak that you had noted early on the shift?

VENTRESS: Yes, it should have helped, yes.

ASTBURY: All right:

"Bloodstained fluid in oropharynx."

Is this in addition to what you told us about before?

VENTRESS: Yes. So that would have been when I looked in the mouth to intubate.

ASTBURY: So you have seen it the first time you intubated?

VENTRESS: Yes.

ASTBURY: When you have extubated there's been a blood clot on the end of the tube, on the tip of the tube?

VENTRESS: Yes.

ASTBURY: And then when you've intubated the second time you have seen more bloodstained fluid --

VENTRESS: The first time I documented it was coming from the windpipe, from the trachea. This time I've said it's in the oropharynx, so that refers to the throat basically. So it's not necessarily --

ASTBURY: That's my next question: what's the oropharynx?

VENTRESS: Yes.

ASTBURY: All right. That's more the throat than --

VENTRESS: It's just below the throat, yes. So it's not just the windpipe, yes.

ASTBURY: All right:

"Suctioned below the cords but nil obtained."

Explain that, please.

VENTRESS: So when I went to intubate her, I'd have passed a thin suction catheter through the vocal cords into the windpipe to suction down the windpipe.

ASTBURY: Is this because of what you'd seen?

VENTRESS: Because of what I'd seen before with the history of the blood clot, so I wanted to make sure there wasn't another blood clot or anything I could pull out that was sitting there before I put another tube in.

ASTBURY: Okay. But "Nil obtained" does that say?

VENTRESS: Yes.

ASTBURY: Okay. You then secured the tube at 8 centimetres again?

VENTRESS: Yes.

ASTBURY: A positive result on the capnograph?

VENTRESS: Yes.

ASTBURY: And again is that good bilateral air entry?

VENTRESS: Yes, it is.

ASTBURY: And (inaudible: coughing) I may have jumped the gun:

"Clinically leak much better"?

VENTRESS: Yes.

ASTBURY: Okay. So what was your impression -- from the notes what's your impression of [Baby G]'s reaction to that intubation at 6.15?

VENTRESS: So we put her back on the ventilator at slightly higher pressures and I have put she was in 60% oxygen but weaning, so she responded well again to being intubated.

ASTBURY: Then are they the settings again along the bottom of your manuscript note?

VENTRESS: Yes, 20/6 and a rate of 40.

ASTBURY: A little bit higher than you had earlier in the shift, but same rate of breathing; is that right?

VENTRESS: Yes.

ASTBURY: We can carry on down the page, please. Tell me please which comes first. There's a -- we've heard this a sticker that goes on the notes --

VENTRESS: Yes.

ASTBURY: -- after an X-ray so that people can fill in what needs filling in and then it looks like there's some manuscript to the right. Can you say which came first?

Because it suggests the sticker because you've squeezed your writing over to one side. Okay, so if we look at the sticker first.

VENTRESS: Yes.

ASTBURY: We've got --

VENTRESS: I'd have looked at the X-rays as they happened but not filled in the sticker, so I would have filled in the sticker when writing the notes and that looks like I was trying to fit it all on one page.

ASTBURY: That's helpful. X-rays taken at 4.48 and 6.36; is that right?

VENTRESS: Yes.

ASTBURY: We have heard that you get the opportunity to look at it at the cot side.

VENTRESS: Yes.

ASTBURY: Then do you get a better look once it has been -- are they still developed?

VENTRESS: They are put on the computer.

ASTBURY: Put on the computer, okay. So you get to see it in more detail; is that right?

VENTRESS: Yes.

ASTBURY: Okay. All right. And you've recorded:

"ET tube position is good, no long line or umbilical catheters"?

VENTRESS: No.

ASTBURY: The NGT or the OGT, do you remember which it was, was in the stomach?

VENTRESS: No.

ASTBURY: It matters not if you don't.

VENTRESS: No, I don't.

ASTBURY: And you've made a note about the lungs. Tell us about that, please.

VENTRESS: So I've written:

"Chronic lung disease, patchy +++ bilaterally."

So we know [Baby G] was born at 23 weeks and was on a ventilator for a significant period of time at the beginning of her life. And chronic lung disease of prematurity is -- all babies born at 23 weeks would have changes of that on their X-ray.

ASTBURY: All right.

VENTRESS: We know she was still requiring oxygen before any of this happened.

ASTBURY: Right.

VENTRESS: So I would expect to see chronic lung disease changes on her X-rays.

ASTBURY: So that reflects what you saw on the X-ray?

VENTRESS: Yes.

ASTBURY: The answer to this have been implicit from your answer, but anything that stood out as unusual or concerning in that respect?

VENTRESS: Not from my notes with her lungs, no.

ASTBURY: Okay. Move on to the abdomen. I think that's what "abdo" stands for.

VENTRESS: It is, yes. I just put "generalised gaseous distension".

ASTBURY: In a nutshell, what does that mean, please? What did you see that caused you to write that or what would you have seen to have caused you to have written that?

VENTRESS: So throughout her bowels lots of air in the bowels. So if there's a blockage or an obstruction it's often just up to a point and then you can't see any after that, but that just looks like you could see lots and lots of air but the whole way through.

ASTBURY: You have signed that, timed and dated that at 7.45 on the 7th. So coming towards the ends of your shift?

VENTRESS: Mm-hm.

ASTBURY: And we have to the right a plan. Does that indicate you discussed this with Dr Brearey?

VENTRESS: Yes.

ASTBURY: Tell us what the plan was.

VENTRESS: It says "pancuronium bolus", which is a muscle relaxant medicine, so it basically paralyses her.

ASTBURY: And the purpose of that?

VENTRESS: To try and get better control of her breathing.

ASTBURY: Right.

VENTRESS: So sometimes an active baby on a ventilator, especially a slightly older baby like [Baby G], would try and breathe against a ventilator.

ASTBURY: Okay.

VENTRESS: So... That kind of takes it out of the equation.

ASTBURY: Okay. "Gas in 30 minutes"?

VENTRESS: Yes.

ASTBURY: Explain that.

VENTRESS: Just do a blood gas test so --

ASTBURY: Another blood gas test in 30 minutes' time?

VENTRESS: Yes.

ASTBURY: Is that "continue morphine"?

VENTRESS: Yes, "Continue morphine at 30". 30 is the dose.

ASTBURY: Is that nil by mouth?

VENTRESS: Nil by mouth and IV -- intravenous infusion, so IV fluids.

ASTBURY: And cefotaxime --

VENTRESS: Cefotaxime is an antibiotic.

ASTBURY: Thank you. And I suspect the last note speaks for itself.

VENTRESS: Yes.

ASTBURY: Okay. That, I assume, would have concluded your shift that particular morning.?

VENTRESS: Yes.

ASTBURY: And we've heard that [Baby G], soon after, went back to Arrowe Park for a period of time?

VENTRESS: I think the next evening, yes.

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

MR JUSTICE GOSS: We haven't had a break. I don't know whether anyone wants a break or whether we just press on.

MR MYERS: It's very warm, but that's just me possibly --

MR JUSTICE GOSS: Would you like a break? Yes. I think someone would like a break. We'll have a short break.

MR MYERS: Thank you. I should say, my Lord, I'm likely to run into tomorrow with Dr Ventress if we stop at the normal time. That would happen whether or not we have a break. I wouldn't be done, I think, in 30 or 40 minutes. If I see that I can be, I'll let your Lordship know.

MR JUSTICE GOSS: Can I leave it to you? If it means overrunning by 10 minutes we'll do it, but if it's going to take us to about an hour's time from now then I think that is -- I don't know, presumably you've got clinical duties tomorrow?

VENTRESS: I'd prefer not to come back tomorrow if I could.

MR JUSTICE GOSS: We'll see what we can do. I'll check with the jury if there's any handicap to them sitting until later. There's none from my point of view.

MR MYERS: Nor from mine. But there are some preliminary matters beyond what we have dealt with already that I do need to deal with or at least raise with Dr Ventress and then I can -- just so your Lordship knows, there is more than just what we've dealt with -- and then I'll turn to the main material here. But if I can see that we can complete it without trespassing far beyond 4.30 of course I'll endeavour to do so.

MR JUSTICE GOSS: I'll leave it to your judgement. I don't know how long the jury want, but we may be able to keep this down to

5 minutes, this break, the shorter the better. Do you want a comfort break or are you all right?

VENTRESS: I'm okay.

(3.53 pm)

(A short break)

(3.58 pm)

MR JUSTICE GOSS: Mr Myers, I'm told one of the jurors does not want to sit beyond 4.30 this afternoon.

VENTRESS: I can come back tomorrow. It's just I'd rather not.

MR JUSTICE GOSS: That puts you under undue pressure, I imagine.

MR MYERS: It does. There's quite a lot of detail in this.

MR JUSTICE GOSS: I'm sorry, you'll have to apologise to your managers and patients. So choose your moment.

MR MYERS: I will, my Lord, just before 4.30.

(In the presence of the jury)

MR JUSTICE GOSS: When you left court I enquired of Mr Myers how long his cross-examination was likely to be and I gather one or more of you cannot or would not want to sit beyond 4.30. The consequence is that Dr Ventress will have to come back tomorrow, which obviously is unfortunate, but there we are. We'll break off at 4.30 or by 4.30.

Cross-examination by MR MYERS

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

Dr Ventress, you dealt with [Baby G] when she was first admitted to the Countess of Chester Hospital, didn't you?

VENTRESS: Yes.

MYERS: And we know that's on 14 August 2015. Did you meet with her parents as well?

VENTRESS: According to the notes, yes. I can't remember, but yes.

MYERS: We know that when she was admitted to Countess of Chester Hospital from Arrowe Park there was a discharge letter that accompanied her. Would you have seen that?

VENTRESS: Yes.

MYERS: Could I ask you to look at the first couple of pages so we can see a brief summary of the position that [Baby G] was in. I'm going to ask Mr Murphy to go to an item called D14. For those using the exhibits, it's at pages 6483 and 6484. There are more pages than that but I am going to summarise it.

If we look at the letter -- I wonder if you could scroll to the top of the page, please, Mr Murphy, first.

We're not expecting you to remember the details of this, of course, but it's something you would have seen.

So this would have come with [Baby G] and her family when she's admitted to the Countess of Chester. We can see it's dated 13 August and we can see it says "neonatal discharge summary" and it has got "Arrowe Park" up at the top. Is this a standard format?

VENTRESS: Yes, it is.

MYERS: It's got [Baby G]'s name, details, born 31 May 2015, and we see the gestation there. It sets out beneath that, under the heading:

"Dear neonatal team, thank you for accepting this baby into your care."

A summary of what her condition has been and what it is. I'm not going to go through everything we have on this, but we can see there are certain problems under "principal problems/diagnosis during stay", which summarise problems and concerns from the beginning of the time at Arrowe Park; is that right?

VENTRESS: Yes.

MYERS: Thank you:

"Chronic lung disease [which you have referred to], 28 days of age. Extreme prematurity. Sepsis suspected. NEC suspected. Hypoglycaemia."

I'm not going to go through all of those, there are a number of difficulties, but we have "active problems at discharge", that means those things which were concerns at the point that she came to the Countess of Chester?

VENTRESS: Yes.

MYERS: Right. So we can see at that point the principal concerns were "chronic lung disease" and "establishing feeds"?

VENTRESS: Yes.

MYERS: Thank you. There's more detail in that page and the following page than just that, but I'm going to leave it at that for this point because that leads up to where we can come across to what you have to say, Dr Ventress.

Chronic lung disease would be a persistent issue, potentially, for a baby in [Baby G]'s condition, wouldn't it, at the time she was at the Countess of Chester?

VENTRESS: Yes.

MYERS: And it was one of the conditions or a condition that she suffered from; is that right?

VENTRESS: Chronic lung disease just means persistent oxygen requirements or the need for respiratory support.

MYERS: It really describes the condition?

VENTRESS: Yes.

MYERS: It could be called chronic lung condition, in effect?

VENTRESS: Yes.

MYERS: You made the statement to the police and you have referred to it, or you were referred to it a little earlier, dated 30 January 2018. And at certain points, to assist you and to assist us, I'm going to ask you just to refresh your memory from it as we go along.

VENTRESS: That's fine.

MYERS: There may be a copy in court. I wonder if it could be handed to you, Dr Ventress. It starts at page 1842.

(Handed)

If I may be allowed, I'll direct you straight to certain passages in it, and you can see them and it will help. We're 7 years away from events now but you made the statement back in January 2018, so it was a little fresher in your mind then.

VENTRESS: It's still almost 5 years ago.

MYERS: It is, isn't it? Well, in fact, this statement was made about 2.5 years after events, wasn't it --

VENTRESS: Yes.

MYERS: -- 2018?

So a baby like [Baby G], she was relatively stable at the time that you were looking after that we're talking about, wasn't she?

VENTRESS: Yes.

MYERS: Relative to her overall condition?

VENTRESS: Yes.

MYERS: And the fact is, stable as she was, a very small baby like that requires medical help, doesn't she?

VENTRESS: Yes.

MYERS: One of the concerns at all times with a baby like [Baby G] is that of infection; would you agree?

VENTRESS: Yes.

MYERS: Because extremely premature babies are at a risk of -- always at a risk of infection and don't have the reserves to cope with it well, do they?

VENTRESS: No.

MYERS: Do you agree? We'll come back to this at the end of my questions, Dr Ventress, but by the time that [Baby G] went back to Arrowe Park after this, the understanding then was this was, in all probability, linked to infection?

VENTRESS: Yes.

MYERS: And it wasn't considered out of the ordinary in that context, was it?

VENTRESS: No, not really.

MYERS: Perhaps just to help you with that, I don't want you to feel you have to agree or disagree if you don't want to.

If you look at page 11, please, Dr Ventress, page 11 of 12. Just look down about eight lines. It says:

"[Baby G]'s condition was improving..."

Can you see that?

VENTRESS: Yes.

MYERS: "... prior to her collapse. She was still a very small baby that required medical help. There was no suggestion at this time that [Baby G] was going to be released from the unit."

VENTRESS: Yes.

MYERS: And then this -- I'd asked you whether the view was it was infection, you have agreed and we'll come back to that. I was asking you whether this was considered something that wasn't really out of the ordinary in these circumstances and you agreed at the time the view was there was nothing out of the ordinary or notable about what had taken place?

VENTRESS: No, it was symptomatic of a severe infection.

MYERS: Thank you. Just one other matter I'd like your assistance with before we turn to the events you've been telling us about. A medical matter, so I'm going to ask you. I'm going to ask Mr Murphy to put up the blood gas chart for [Baby G]. It's at slide 95.

Can we just scroll down the page, please?

I'm going to ask you, for a moment, to pause at the entries that we have for the 4th and 5 September, which are the penultimate lines. Do you see those, Dr Ventress?

VENTRESS: Yes.

MYERS: The second and third lines up.

VENTRESS: Yes.

MYERS: All right. We can also see an entry for 7 September, which is the time we're dealing with, but I'm just looking at the two before then. I don't know, Mr Murphy, whether you're able to include on this the title line, which has the units or the items that we're looking at, so we can see what they refer to. If you could pull that down I'd be grateful.

VENTRESS: I know what they're referring to if it helps.

MYERS: I'm certainly not there where you are, Dr Ventress, so I need the help. We're looking at the second and third from the bottom. If one looks at the pH value -- we've got a little understanding of what to expect from blood gases here. On the face of it, with that pH, there's nothing remarkable, it's in the normal range, isn't it?

VENTRESS: Yes.

MYERS: But do you agree, as we move from left to right, the carbon dioxide level is raised?

VENTRESS: Yes.

MYERS: And the bicarbonate level is also raised, isn't it, for both of those?

VENTRESS: Yes. That's typical of a baby with chronic lung disease.

MYERS: I was going to come to that when we look at this. Where it says "base excess", which we know is the last one along, that's a little high, isn't it?

VENTRESS: Yes.

MYERS: So what that tells us is that there is a kind of acidosis taking place in the baby, some respiratory issue that the body is struggling to deal with?

VENTRESS: That's completely typical for an ex-premature baby with chronic lung disease. They would often have a raised CO2 level, which their body then compensates with keeping a higher bicarbonate level and a higher base excess to compensate. So therefore the pH, as you said is normal. So they're not acidotic at the time because their body has compensated for it.

MYERS: So the kidneys adjust to make allowance for the pH, don't they?

VENTRESS: Yes.

MYERS: And again, although the pH in itself doesn't indicate anything, when you look across all of that it's consistent with the chronic lung disease, isn't it?

VENTRESS: Yes.

MYERS: That takes us up to the 5th at that point. I'm going to move to the events on the evening.

We noticed on the notes -- we'll look at those shortly -- we saw how it was that you'd gone to the unit at the start of the event and then you'd gone away because you had to deal with another baby and then you went back.

VENTRESS: Yes.

MYERS: Can I confirm with you that the way staffing worked at this time was that you would have been the registrar covering the children's unit and A&E and neonatal, wouldn't you?

VENTRESS: Yes. So the children's ward and neonatal, yes. A&E doctors -- the A&E doctors would deal with, unless there's a particularly sick child.

MYERS: Sorry, I wasn't particularly clear (overspeaking) --

VENTRESS: It was unusual that we'd have to go to A&E, so it's mainly children's ward and the neonatal unit.

MYERS: Children's ward, neonatal. Did you also cover the post-natal ward too?

VENTRESS: Yes. But again, it was mainly the SHO that would go to the post-natal ward.

MYERS: So depending on the number of patients, you may have quite a lot of ground to cover in the course of one evening?

VENTRESS: Yes.

MYERS: Which is no fault of yours, but that's how you had to work?

VENTRESS: Yes.

MYERS: We're going to have a look at the notes and I'm going to go through those with you, if I could. I'm going to start with slide 80, page 6542. Go into that, please.

Could you scroll down just to where Dr Ventress' notes commence? Thank you, Mr Murphy.

Just to assist with your recollection here, Dr Ventress, I'm going to ask you if you'd look in your statement at page 8 of 12. I'd like to go through the detail that you give there that lies behind what's in these notes. Can you help me with that?

Just look at the top of the page. The best you could remember in January 2018 was that at the time you were called for the first

time to the neonatal unit, you'd probably have been on the children's ward. That's the third line down.

VENTRESS: Yes.

MYERS: You received or you were asked by one of the nurses to come to review urgently [Baby G] urgently at 2.35 am; is that correct?

VENTRESS: Yes.

MYERS: Just carrying on, you go on to say that you would have gone straightaway to assist and review [Baby G]; is that right?

VENTRESS: Yes.

MYERS: All right. I'm just going to read from about halfway down to help us see what part of this was reported to you and what part you looked at afresh. You say:

"I believe [you are talking about the nurses] one of them was [Nurse E]."

Can you see [Surname of Nurse E] in large letters?

VENTRESS: Yes.

MYERS: All right:

"I do know from my notes that Lucy Letby was on duty and so she took over [Baby G]'s care later on but I'm not sure if she was present when I arrived. According to my notes, and not something that I actually saw myself, [Baby G] had just had a feed around 2 am then had a large vomit just before the call. Again from my notes, the nurse aspirated the milk from [Baby G]'s stomach. [Baby G] did have an NG tube through her nose down to her stomach for her feeds. From the notes it says 'large projectile vomit' and her abdomen appeared to be a funny colour, purple and distended, it looked like she was uncomfortable, red in the face and needing more oxygen. I would have been told this when I entered the room."

So does that help with whether that's something you were told or something that you saw yourself? Do you agree?

VENTRESS: Yes, it sounds like it from that, yes.

MYERS: "I cannot remember who would have told me. However, looking at my notes, it looks like it was a nurse called [Nurse E], but I may be wrong. I don't actually remember seeing any vomit but that doesn't mean there wasn't any."

Then you say:

"Again, referring to my notes, [Baby G] had a large distended abdomen. [Baby G] always had a big abdomen and that in itself is quite common in preterm babies but this was actually bigger than I would seen previously."

So this now is beginning to note things that you could see; is that right?

VENTRESS: Yes.

MYERS: Again, according to the notes:

"[Baby G] was already on oxygen. She had been gradually being weaned off her breathing support during the weeks before this episode. [Baby G] had never been off oxygen but during this episode her oxygen levels dropped, so the nursing staff quite rightly increased the amount she was getting."

Then you refer to the fact that in the notes it refers to [Baby G] opening her bowels with a large watery stool?

VENTRESS: Yes.

MYERS: Is the position that having attended the unit, having been called to attend, receiving the information that the nurses gave you about [Baby G] and then forming the plan as to what should happen, you were then actually called away before you could carry anything through yourself?

VENTRESS: Yes.

MYERS: Right. So if we look at the bottom of page 6542, where it says "planned to cannulate IV fluids and bloods", and let's just go over the page, please, Mr Murphy, if we could, "but unfortunately delayed due to delivery of another preterm baby".

VENTRESS: Yes.

MYERS: Right. So does that mean that having been ready to do those things, you couldn't deal with it because you were called back to deal with the delivery of a baby in the maternity unit?

VENTRESS: Yes, so it'd have been next door in theatre, yes.

MYERS: All right. Can we scroll down a little bit further, please, Mr Murphy? Thank you very much.

You were called -- we see three lines down:

"Called out of theatre to say [Baby G] had gone apnoeic and dusky."

VENTRESS: Yes.

MYERS: So having gone back to the maternity unit, you are then called back to the neonatal unit; is that correct?

VENTRESS: Mm.

MYERS: Right. I have to ask you to say yes if you agree.

VENTRESS: Yes, sorry.

MYERS: And your understanding is the time of that would be a little bit before you called Dr Brearey to attend?

VENTRESS: It would be around the time that I called.

MYERS: Round about 3.30, something like that?

VENTRESS: Yes.

MYERS: I'm not going to go back through all the steps that you took, but there will be some items I wish to deal with.

Can I just move down to the section that deals with "blood from trachea". Rather, "bloodstained fluid".

If we just scroll down the page. You summarised what was being done to deal with the desaturation and to assist [Baby G] with breathing, and you had taken the decision to intubate; is that correct?

VENTRESS: Yes.

MYERS: And you took that decision because of the two profound desaturations that had already taken place?

VENTRESS: Yes.

MYERS: Right. Where it says "intubated size 3 ETT", can you see that?

VENTRESS: Yes.

MYERS: You can see that, ladies and gentlemen. It says:

"8 centimetres at lips. Bloodstained fluid noted coming up from trachea between cords."

Looking at this, but you correct me if I'm wrong, is that something that you noticed after the intubation had taken place?

VENTRESS: No, during the intubation.

MYERS: During the intubation. And is it the case that it's not uncommon for an amount of blood to sometimes appear as a result of the intubation process?

VENTRESS: Um... It's not uncommon to have some injury to the back of the throat and around the entrance to the windpipe, but it is unusual to have blood coming up from beneath the vocal cords because that's not an area that we would touch with the laryngoscope.

MYERS: Right. This is something that you only saw in the course of intubating; is that correct?

VENTRESS: Yes.

MYERS: Had you intubated, and let me be clear, at the time you saw it, or do you not know --

VENTRESS: No.

MYERS: -- or can you be precise as to when you saw it?

VENTRESS: So I would have -- the only time during the intubation procedure you can see the vocal cords is when you have the laryngoscope, which is a metal thing with a light on the end, that you put down into the back of the throat and use to sort of lift up, so you can see the entrance to the vocal cords. So that's the only time during the procedure that I would see the vocal cords before I put the tube in.

MYERS: Right. So you put the laryngoscope in?

VENTRESS: Yes.

MYERS: You can then see the cords?

VENTRESS: Yes.

MYERS: Would you intubate if there was blood present?

VENTRESS: Yes, if she needed it, yes.

MYERS: It says a bloodstained fluid. So is that blood mixed with something, some secretion?

VENTRESS: Yes. As I said, I can't physically remember it, but from the notes it wouldn't have been pure blood, otherwise I'd have written that.

MYERS: All right.

VENTRESS: Yes.

MYERS: Once you'd intubated [Baby G], did the ventilator work to begin with as far as you can remember?

VENTRESS: Um... Yes, from the notes.

MYERS: And was there no issue, so far as you were concerned at that stage, with blood interfering with what was taking place?

VENTRESS: No.

MYERS: And there's nothing that you've noted indicating any continuing bleeding or anything of that sort, is there?

VENTRESS: No.

MYERS: And that's something you most definitely would look out for if you thought there was a bleed; is that correct?

VENTRESS: Yes.

MR MYERS: My Lord, I have endeavoured to move as expeditiously as I can through the material I have to.

There still is a little further to go, maybe about 20 minutes or so, and I'm aware of the timing.

I apologise for any inconvenience to Dr Ventress or to anyone else, but I have to stop at this point given the time that we're at, I think.

MR JUSTICE GOSS: Well, I was led to believe that it really had to be 4.30.

MR MYERS: Yes, and for that reason this is as good a point as any to stop.

MR JUSTICE GOSS: Right.

Would it be more convenient for you to start at 10 o'clock tomorrow or does it not make any difference?

I'm only saying exceptionally we could do it if it's going to make --

VENTRESS: No, it won't make a difference.

MR JUSTICE GOSS: We'll stick to the usual 10.30 then. All right.

So that's it for today then, members of the jury.

10.30 tomorrow morning, please. Please remember, no research into anything or anyone related to this case and no discussion with anyone who is not a fellow juror when you're all together, so no discrete discussions between any of you. Thank you very much.

(In the absence of the jury)

Housekeeping

MR JUSTICE GOSS: As before, don't talk to anyone about anything to do with this case. 10.30 tomorrow morning.

Thank you very much.

MR MYERS: My Lord, there's an administrative matter relating to my arrangements that I wish to raise with your Lordship. I can do that now.

MR JUSTICE GOSS: Certainly, yes.

MR MYERS: It relates to 6 December, which is next Tuesday.

As the court knows, as my learned friends know, there's a --

MR JUSTICE GOSS: Well, I know it'd be very difficult for you to be here on 6 December. I'm aware of that.

MR MYERS: It would be and I'm grateful that your Lordship is aware of that. I know my learned friends have sought to try to arrange matters to avoid anything that could be regarded of pivotal significance to be taking place at that point.

Now, in the way that fate can do these things, it seems that, were matters to run their ordinary course, the witnesses who the prosecution would seek to call on 6 December on this part of the indictment are Doctors Evans and Bohin, who are, as your Lordship knows, the principal experts for the prosecution --

MR JUSTICE GOSS: Yes.

MR MYERS: -- and witnesses for whom I need to be present to deal with them in cross-examination.

MR JUSTICE GOSS: Well, look, Mr Myers, I appreciate the difficulty. Can I leave it to -- is this something that has to be resolved at this stage in the sense that we can be confident that, barring something unforeseen taking place where we don't sit normal days, we don't get through the work as we expect to get through it, that will be the day? It won't cause them as witnesses any difficulty, will it, not being called that day?

MR JOHNSON: No, not at all. Bubbling on in the background, there are other things. It would potentially advantage Dr Evans not to be called on Tuesday. So in that sense, it would suit his personal convenience.

MR JUSTICE GOSS: So there you are, Mr Myers.

MR MYERS: I'm grateful for that. I'm not sure whether that means we'll be proceeding with other material.

MR JUSTICE GOSS: That can be looked at, can it, and see whether there's anything or not? I don't suppose there's much else, is there?

MR MYERS: Can I seize the proverbial bull by the horns, my Lord, and put it this way? Those are the witnesses who would naturally fall into place there and I understand that's what the prosecution had wished to do and it may be that, certainly so far as they are concerned, that would leave it as a day when they couldn't call evidence and wouldn't be ready to proceed, in which case I'd be in a position of asking if we could not sit that day, which I regret having to do because I'm anxious for the matter to proceed as much as anyone else is. But it is the type of thing, as the court knows, that, if at all possible, it would be good to go to and be present at.

MR JUSTICE GOSS: Don't worry, Mr Myers. If it means we don't sit that day, we don't sit that day --

MR MYERS: I'm most grateful, my Lord.

MR JUSTICE GOSS: -- providing it doesn't cause any undue difficulty to anyone.

MR JOHNSON: No, it causes no problems from our point of view at all. Mr Myers has an important thing that he needs to do. We have lives as well.

MR JUSTICE GOSS: It's not exactly the same, but it's almost equivalent of being required to attend in the Court of Appeal, where you have to go and courts are told in trials they just do not sit on that day.

MR MYERS: I'm grateful to your Lordship for taking that view. Thank you.

MR JUSTICE GOSS: It happens. Not to worry. That solves that problem. If there are any matters that can be dealt with, not relating to the calling of evidence, that can be dealt with then, one or both of your juniors will be able to assist.

MR MYERS: We've been discussing that, my Lord, and we'll let the court know. Thank you.

MR JUSTICE GOSS: Thank you very much. Sorry to keep you there. I should have said you could go, doctor. We'll see you tomorrow morning. Thank you very much, Dr Ventress.

All right. Thank you, dock officer.

MR JOHNSON: In terms of the overall timetabling of the case, the way things are panning out at the moment, it looks like we're either going to come up a day or two short of the 16th or, if we started the next child, we'd do a day, possibly, or 2 days possibly, then have 3 weeks off and carry on with that case.

MR JUSTICE GOSS: Yes. Let's just wait and see where we get to.

MR JOHNSON: I know, but I just thought I'd mention that so your Lordship can have it in mind in just judging how things are panning out.

MR JUSTICE GOSS: Thank you very much. As I said, I don't have any difficulty about Tuesday.

MR MYERS: I'm obliged, my Lord. Thank you.

MR JUSTICE GOSS: Thank you very much. So 10.30 tomorrow.

(4.29 pm)

(The court adjourned until 10.30 am on Friday, 2 December 2022)