

2 December 2022
Baby G

CONTENTS

DR ALISON VENTRESS (continued)
Cross-examination by Mr Myers (continued)
Re-examination by MR ASTBURY

Witness statement of DR LARA BUNNI (read)

Witness statement of MS VALERIE DALE (read)

MRS VICTORIA BLAMIRE (affirmed)
Examination-in-chief by MR DRIVER

[NURSE E] (affirmed)
Examination-in-chief by MR DRIVER
Cross-examination by MR MYERS
Questions from THE JUDGE

MISS AILSA SIMPSON (affirmed)
Examination-in-chief by MR ASTBURY
Cross-examination by MR MYERS
Re-examination by MR ASTBURY

Friday, 2 December 2022
(10.30 am)

(In the presence of the jury)

DR ALISON VENTRESS (continued)

Cross-examination by Mr Myers (continued)

MR JUSTICE GOSS: Yes, Mr Myers.

MR MYERS: Good morning, Dr Ventress.

VENTRESS: Good morning.

MYERS: Before we continue with where I left off yesterday, I'd be grateful if we could just clarify the order in which particular events happened from the notes --

VENTRESS: Okay.

MYERS: -- just before we go through them and then I'll pick up from where I'd got to. I'm going to ask Mr Murphy to put up on the screens tile 80 from the [Baby G] section 1 section.

Ladies and gentlemen, if you're following it on the iPads, you know how to get there, so tile 80.

It's a feature of the notes. They are over three pages, but tile 80 has the first two pages on and then tile 107 has pages 2 and 3 on, so there's a bit of an overlap that way.

Can you see them, Dr Ventress?

VENTRESS: I can, yes.

MYERS: Can you see them, ladies and gentlemen? Thank you.

This is just to get back in our heads the order in which things happened. There's some dense detail here.

Starting on tile 80, you are called at 02.35?

VENTRESS: Yes.

MYERS: That's right, isn't it?

VENTRESS: Yes.

MYERS: You make the notes at 04.40 or you start making the notes, but you were called at 2.35 and you went from the children's ward to the neonatal unit?

VENTRESS: I assume I was on the children's ward. I don't know definitely. I wasn't on the neonatal unit according to the notes.

MYERS: I'm not going to go through the detail of everything right now, we've been through a lot of the details, and there are some items I am going to go to, but I just want to get the order in which things happened clear.

At 2.35, you go to the neonatal unit. Once you'd been there, you had to leave because you were called away back to the maternity unit?

VENTRESS: Yes.

MYERS: So let's go over the page then to the second page of slide 80, just to follow the sequence of where we get to.

Having left, you were then called back to the neonatal unit. And when we looked at the timings it looks like it's some time just before 3.30, maybe about 3.20.

VENTRESS: Yes.

MYERS: So you're next back at 3.20. And at that point there has been a report of another desaturation?

VENTRESS: I think that's the first desaturation.

MYERS: That's the first desaturation. Thank you. That's important. Thank you. That's the first desaturation.

[Baby G] is moved to room 1. Dr Brearey has been called.

VENTRESS: Yes.

MYERS: And then [Baby G], having been moved to room 1, there is a further desaturation.

VENTRESS: Yes.

MYERS: Right. So this is the second desaturation. And you take the decision that it's going to be necessary to intubate [Baby G]?

VENTRESS: Yes.

MYERS: Right. You do intubate [Baby G] and that's the point when you describe, as we can see in the notes halfway down, bloodstained fluid up from the trachea?

VENTRESS: Yes.

MYERS: Stephen Brearey, the consultant, he then attends; that's the next thing?

VENTRESS: Yes.

MYERS: To start with, things seem to be working well enough on the ventilator, we've got down here:

"Good gas 30 minutes post-intubation."

Do you see that?

VENTRESS: Yes.

MYERS: Then the next timing we have, three or four lines up from the bottom of the second page, is 5.30 when there's another, as it's described there, profound desaturation; that's right, isn't it?

VENTRESS: Yes.

MYERS: I know you're nodding, Dr Ventress. It might seem a bit laborious, but you need to say yes or no.

[Baby G] is then taken off the ventilator that she had been on, just at the bottom of that page. Do you see that?

VENTRESS: Yes. That wasn't when the ventilator was changed.

MYERS: She's taken off that ventilator?

VENTRESS: Yes.

MYERS: Let's go through this as it is in the notes so we get the structure of it.

To get to the next page of the notes, we have to go to slide 107, so let's go there, if you would, Mr Murphy.

If we go behind that to the notes. We need to go to the second page to pick up where we were. We can see:

"Recovered slowly but desat when back on ventilator."

Does that suggest she was taken off the ventilator for a short period?

VENTRESS: Yes, she was disconnected so we could use the Neopuff device.

MYERS: So we've had a further desat at 5.30, then disconnected from the ventilator so the Neopuff could be used.

Recovered slowly, back on the ventilator, but then desaturated?

VENTRESS: Yes.

MYERS: This is the point at which you check the flow sensor or the flow sensor is checked?

VENTRESS: Yes.

MYERS: And then was the whole -- it says "whole ventilator changed".

VENTRESS: Yes.

MYERS: So you switched to a different ventilator?

VENTRESS: Yes.

MYERS: Right. Next, 6.05, another desaturation, down to 40%; is that correct?

VENTRESS: Yes.

MYERS: It says "IPPV given". That's intermittent positive --

VENTRESS: Pressure ventilation.

MYERS: So she's off the ventilator again at that point, [Baby G]?

VENTRESS: Yes. Whenever it says IPPV, that would refer to the Neopuff device.

MYERS: So 6.05, profound desaturation. Off the ventilator. On to the Neopuff. And then we see the ETT removed at 6.10; that's the next thing?

VENTRESS: Yes.

MYERS: When that was removed, thick secretions were found in the mouth, plus plus?

VENTRESS: Mm-hm.

MYERS: And a blood clot on the end of the ETT?

VENTRESS: Yes.

MYERS: That's the endotracheal tube. I'll come back to that.

The Neopuff continues to be used; is that correct?

VENTRESS: Yes. Then this time with a mask instead of via the ETT.

MYERS: Thank you. Three lines below that we can see:

"Dr Brearey called in urgently."

So he must have gone away but was called back; is that correct?

VENTRESS: Yes.

MYERS: At this point, the NGT, the nasogastric tube, is aspirated and there was the 100ml aspirated from that?

VENTRESS: Yes.

MYERS: Which, to the best of your recollection, is most probably going to be air because if it was anything other than that you'd have said so?

VENTRESS: Yes.

MYERS: And then we come to 6.15. [Baby G] is re-intubated, this time with a slightly larger 3.5 endotracheal tube?

VENTRESS: Yes.

MYERS: Which you described as a "tight fit through the cords"?

VENTRESS: Yes.

MYERS: You see bloodstained fluid in the oropharynx?

VENTRESS: Yes.

MYERS: Suction takes place, but from this point on, so far as the ventilation is concerned, things seem to settle; is that correct?

VENTRESS: Yes, as far as I've documented there, yes.

MYERS: As far as it goes, all right. I just wanted to go back through that so we had the stages that we go through with what we have in the notes.

Just to go back to the detail now to go through some of what we have looked at, you were called back for the second time a little bit before 3.30 because of a desaturation that had taken place, weren't you?

VENTRESS: Yes.

MYERS: I'm going to ask Mr Murphy to put back up tile 80, just in case we want to follow this as I go through the questions now. We're on page 2 of that tile.

So you've been called back for that. And then the second desaturation happened when you were there, didn't it, so far as you can recall?

VENTRESS: Yes.

MYERS: It was as a result of that that you decided it was necessary to intubate, didn't you?

VENTRESS: Yes, that's right.

MYERS: We got to this point yesterday, so I can pick it up from here. You'd seen, as you described in the notes, bloodstained fluid, but not fresh blood or any active bleed?

VENTRESS: Um... I can't say if it was fresh blood because fresh blood would just mean bright red. So it's likely to be fresh but a small amount. So if -- I said bloodstained fluid so it wasn't pure blood.

MYERS: You've described it as bloodstained fluid, so fluid with bits of blood in it that would sound like?

VENTRESS: Yes.

MYERS: It doesn't suggest here you identify any active bleed or fresh blood being produced from any source in the tissue, do you?

VENTRESS: No.

MYERS: And you didn't see that, did you?

VENTRESS: No.

MYERS: Thank you. Just moving down to the bottom of that page, let's move forwards now to approximately 5.30. Towards the bottom of that page. By this point, [Baby G] has been on the ventilator for about 30 minutes and things have been reasonably stable; is that correct?

VENTRESS: I think she was intubated soon after 3.30, wasn't she, so more like 2 hours.

MYERS: All right, 2 hours stable. Just looking up from approximately 5.30, six lines up, we've got:

"Good gas 30 minutes post-intubation."

Can you see that?

VENTRESS: Yes.

MYERS: We've got:

"Good gas 30 minutes post-intubation. Large leak noted on ETT but good air entry."

VENTRESS: Yes.

MYERS: "Vitamin K given."

That's to improve the clotting process, isn't it --

VENTRESS: Yes.

MYERS: -- in case there's a bleed? And:

"Approximately 5.30, had a further profound desaturation."

Then that's the period when we go into trying to work out what it is that's happening with the ventilators or with the flow; is that correct?

VENTRESS: Yes.

MYERS: That's what happens. When there was a problem with the ventilator, do you recall, did it alarm or was it just something that you noticed?

VENTRESS: Um... I don't recall that there was a problem, that there was -- there would have been alarms that her oxygen levels and heart rate had dropped from the monitor, but I don't know if the ventilator was alarming as well.

MR JUSTICE GOSS: Sorry? Can I just be clear about that.

We're talking about alarms. Can we just clarify? If the patient desaturates, an alarm goes off?

VENTRESS: Yes.

MR JUSTICE GOSS: That's on the monitor measuring the saturation levels?

VENTRESS: Yes, the heart rate, the saturation, the breathing rate are all on the monitor. If any of those go outside the set parameters then an alarm will go off.

MR JUSTICE GOSS: Is there an alarm on the ventilator itself?

VENTRESS: Yes. That would go off, for example, if say -- the flow sensor detects breath going in and out. If it stopped detecting that, the ventilator would alarm to check if something had become disconnected or -- it measures various pressures and volumes and if they're vastly outside the set limits then it can alarm for that too.

MR JUSTICE GOSS: Right. What alarms can you recall went off at this --

VENTRESS: I can't recall about the ventilator.

MR JUSTICE GOSS: Because I think it was -- I didn't know whether you were suggesting it went off or whether there were just alarms going off.

MR MYERS: In fact I was asking whether the alarm on the ventilator went off, whether Dr Ventress has any recollection of that.

VENTRESS: I don't know.

MR JUSTICE GOSS: You just don't know about that?

MR MYERS: All right.

VENTRESS: I haven't documented it and I can't recall.

MR JUSTICE GOSS: Thank you.

MR MYERS: Thank you.

Let's carry on then through to the end of this. If we go to slide 107 -- I apologise, ladies and gentlemen, for the coming and going, but it's having three pages over two tiles.

We get to the third page, which is on the second page of tile 107; I'm training myself to say tile instead of slide all the time. I was a slide enthusiast to begin with, but we've moved to tile I think now, my Lord. I'll try and stick with that.

Tile 107, page 2. What seemed to be happening, Dr Ventress, is that when [Baby G] was taken off the ventilator and there was manual ventilation, she seemed to be all right.

VENTRESS: Mm-hm.

MYERS: But when she is put back on the ventilator there was a problem and she seemed to desaturate; that's where we get to, isn't it?

VENTRESS: Yes. That's why we looked at the ventilator and the flow sensor and changed those things.

MYERS: That's right. In fact, you took the precaution of changing the ventilator itself, didn't you --

VENTRESS: Yes.

MYERS: -- to be quite clear, but even then there was a desaturation taking place?

VENTRESS: Yes.

MYERS: And were you there trying to work out what it was that was happening during all of this?

VENTRESS: Yes.

MYERS: No criticism of that. That's what you would be doing as you want to see what is taking place.

VENTRESS: No, that's the standard practice, yes.

MYERS: During all of this, a little bit below halfway down this page, is the point, some time after Dr Brearey had been called to return, that the air was aspirated from the NGT?

VENTRESS: Yes.

MYERS: Now, we know that [Baby G] had been receiving oxygen or receiving air manually with the Neopuff over a period of hours, hadn't she --

VENTRESS: Yes.

MYERS: -- on and off?

VENTRESS: Yes.

MYERS: And there'd also been a period with CPAP right at the beginning, hadn't there --

VENTRESS: Yes, right at the beginning.

MYERS: -- although you didn't repeat that?

What had been happening was in between each session on the ventilator, she was being given breathing assistance with the IPPV?

VENTRESS: Yes.

MYERS: And in your experience, certainly, when a baby is receiving air through a breathing tube like that, air can be directed into the stomach, can't it?

VENTRESS: So when the IPPV is being given via the ET tube then the air does not go into the stomach, but when it's given via a face mask, then the air would go into the stomach, yes.

MYERS: All right. And there were times when a face mask was used, weren't there?

VENTRESS: Yes. After the ET tube was removed and before the ET tube was inserted for the first time.

MYERS: Yes --

VENTRESS: But there were several instances in the middle where it was used via the ET tube as well.

MYERS: As well.

VENTRESS: Yes.

MYERS: But in any event --

MR JUSTICE GOSS: But that wouldn't go into the stomach?

VENTRESS: No.

MR MYERS: It wouldn't then but it would when it's used via the face mask?

MR JUSTICE GOSS: Exactly, yes (overspeaking) --

VENTRESS: Yes.

MR MYERS: In any event, when you noticed [Baby G]'s abdomen was large that struck you as something that could happen by air going into the stomach rather than the lungs?

VENTRESS: Yes.

MYERS: And that's what you thought with your clinical experience at that time?

VENTRESS: Yes. That was just after she'd had a period of IPPV via the face mask.

MYERS: That's right. We see that. And the point is it was after that period that you noticed about her stomach being -- her abdomen being distended, didn't you?

VENTRESS: Yes.

MYERS: Is that right?

VENTRESS: Yes.

MYERS: That's it? Just so we can follow the link between those. Thank you.

So IPPV with a face mask. You notice after that the abdomen appeared large and, it seems, a large quantity of air was taken from it, aspirated from the abdomen?

VENTRESS: Yes.

MYERS: Thank you. Re-intubated after that at 06.15?

VENTRESS: Yes.

MYERS: This was with a larger, as we've just discussed, tube, wasn't it?

VENTRESS: Yes.

MYERS: And that seemed to work better, didn't it?

VENTRESS: There was less of a leak, but clinically -- yes, clinically not too much difference, I think.

MYERS: One of the things that had happened just before you did that was a clot had been removed, a blood clot from the end of the ETT?

VENTRESS: Yes.

MYERS: In fact, it's quite possible is it, you tell us, if there's a clot on the end of the ETT that might have been interfering with airflow into [Baby G], mightn't it?

VENTRESS: Yes.

MYERS: You have, nothing critical about this, quite properly gone through all the stages to work out what is happening, haven't you --

VENTRESS: Yes.

MYERS: -- including changing the ventilator --

VENTRESS: Yes.

MYERS: -- but it was when you came to withdraw the tube and check that that you saw there was a blood clot on the end of it?

VENTRESS: Yes.

MYERS: So it's reasonable to take the view that will have been blocking the flow of air?

VENTRESS: Not completely but partially --

MYERS: Interfering with the flow of air?

VENTRESS: Interfering, yes.

MYERS: And the fact is that once a fresh tube was put in without a blood clot on it, [Baby G] then seemed to settle and the ventilating seemed to proceed as you'd have wanted it; is that correct?

VENTRESS: Up to the end of my note. I can't comment on what happened after that.

MYERS: Absolutely. But I'm just making it quite clear, a tube without a blood clot on the end of it seemed to solve the problem; that's right, isn't it?

VENTRESS: Yes.

MYERS: After that re-intubation at 6.15, or maybe during it because these things may happen together a little bit, you've described, we can see a few lines up from the X-ray sticker:

"Bloodstained fluid in oropharynx."

VENTRESS: Yes.

MYERS: And you put:

"Suction below cords but nil obtained."

VENTRESS: Yes.

MYERS: Does that mean that in the -- what I might call the upper part of the throat you'd spotted some blood or bloodstained fluid?

VENTRESS: The oropharynx is probably below where you'd see by just looking with your eyes into the mouth. I'd have seen it when I put the laryngoscope in, so it's sort of there (indicating) just below the throat.

MYERS: Right.

VENTRESS: It's where you would see the entrance to the vocal cords and the food pipe, the oesophagus.

MYERS: We know there's bloodstained fluid there, but when you suction below the cords nothing comes out?

VENTRESS: No.

MYERS: Does that suggest it's some sort of bloodstained fluid to do with the area of the cords, round about there, since there's nothing further down?

VENTRESS: Not necessarily. That's often an area where secretions and fluid will pool on a baby that's laying down, so I wouldn't be able to comment where that fluid had come from.

MYERS: But certainly no production of blood coming up from anywhere at that point that your suctioning reveals?

VENTRESS: No.

MYERS: And is it right, is it common or does it sometimes happen, let me put it that way, that when a baby is being intubated in that part of the throat you may get bloodstained secretions?

VENTRESS: If it's been a traumatic intubation, which does sometimes happen, especially with multiple attempts, then you can sometimes cause some trauma to the area.

I haven't commented that I saw any obvious trauma or swelling there, which if it was a significant finding I would have commented (overspeaking) but I can't comment. I can't say 100%.

MYERS: Sorry, Dr Ventress, I interrupted you.

You don't see any significant trauma around there?

VENTRESS: No.

MYERS: There have been repeated efforts to intubate, haven't there (overspeaking) --

VENTRESS: There'd been one successful and this was the second one, yes.

MYERS: All right then. So it's possible this could be something connected with the intubation process or it could be something different; do you agree?

VENTRESS: This time, yes. The first time was not connected to the --

MYERS: This time you say it could be?

VENTRESS: Possibly. I think the most likely would be it was the same fluid that was seen the first time, but I can't say 100%.

MYERS: We've taken it up to the end of the notes pretty much.

As you say you can't speak for what goes on after that.

VENTRESS: Yes.

MYERS: But in terms of what view was formed as to what had happened with [Baby G] at this time, there were blood tests taken, I'm going to go to them in a moment, which were certainly consistent with her having an infection, weren't they?

VENTRESS: Yes.

MYERS: And the view taken was this was connected to an infection, wasn't it?

VENTRESS: Yes.

MYERS: If we could put up, please, slide 89, first of all -- sorry, after all that effort by me. Tile 89, please, Mr Murphy. Tile 89.

These are pathology samples that are obtained.

If we just look where it says "collected" --

VENTRESS: Yes.

MYERS: -- which is at the centre of the rectangular table in the dark print: collected on 7 September 2015 at 03.59.

So this would be during the events that you've described to us.

VENTRESS: Yes.

MYERS: And I'm going to ask us all, if we might have your assistance, if we could, Mr Murphy, with this, looking under "comments" on the left-hand side, we're going to go down to the reading of CRP, which is six entries down under "comments". We can all see that. We can see at that point the CRP reading is -- it says "less than 1", doesn't it?

VENTRESS: Yes.

MYERS: We've heard a bit about this. Anything under 10 is something that is unremarkable?

VENTRESS: Yes.

MYERS: Would you agree?

VENTRESS: Yes.

MYERS: Once you get above 10, depending how far we go, it may be indicative of an inflammation and that may be indicative of infection?

VENTRESS: Yes.

MYERS: It takes between maybe 24 to 48 hours for a CRP to peak, doesn't it?

VENTRESS: Yes.

MYERS: So at this point it's at 1. If we move forwards, please, to slide 186, we have another pathology sample.

Again if we can all see in the rectangle under "collected", this is now collected later that day. It's 7 August 2015 and the time is 14.18.

VENTRESS: Mm.

MYERS: If we look down the left-hand side under "comments", the cursor down to CRP, if we look across now we will -- we were 1 in the early hours of the morning and it's risen to 28 at this point?

VENTRESS: Yes.

MYERS: You may spot this immediately, Dr Ventress, but these are new documents to us so it takes a little longer to go through it -- or it takes me a little longer.

A CRP of 28. So that has risen into a potentially significantly range when we consider infection, hasn't it?

VENTRESS: Yes.

MYERS: Thank you. Then if we go next, please, to tile 350 and we go behind that into the reading -- into the actual pathology results. Again we can see now, in the centre of the rectangle, this is a result from a sample collected at 22.53, so a little before 11 pm on 7 September, that same day, and by this point now, if we look at the bottom of that table, the CRP has risen to 106?

VENTRESS: Yes.

MYERS: That's quite a significant rise from where we started?

VENTRESS: Definitely, yes.

MYERS: And in fact what we find -- and I'll put this up on the screen, if we can put up J7303 and J7304, we don't have it at the tiles yet -- it just shows what the reading was later on the 9th at Arrowe Park.

(Pause)

MR JUSTICE GOSS: I can't possibly read that.

MR MYERS: I'll simply identify the letter. It's just one entry on the following page, my Lord.

Can we just move up to the head of the letter so we have who it's from? We can see the formality of this, please. We can see there, this was a letter from Arrowe Park. We know that [Baby G] was admitted to Arrowe Park, as this says, on 8 September in the early hours of the morning.

VENTRESS: Yes.

MYERS: Thank you, Dr Ventress. This is a letter from the conclusion of her time at Arrowe Park, but if we go over the page to the section marked "infections", and scroll down to the second page, which is on 7304, if we read down, on the third line below that, it says -- I'll read the whole of it:

"Diagnosis: infection risk. Late after first 48 hours of birth. Sepsis suspected. On admission [Baby G] was on triple antibiotic therapy which was changed to monotherapy with meropenem."

Is that --

VENTRESS: It's an antibiotic.

MYERS: "Blood CSF."

What does that mean?

VENTRESS: Blood and CSF. So CSF is cerebrospinal fluid.

MYERS: Right.

VENTRESS: So she'd had a lumbar puncture.

MYERS: Right.

VENTRESS: There should be a comma there.

MYERS: "Blood[,] CSF, respiratory, urine cultures were all negative."

Just pausing there, the cultures may be negative if the patient is on antibiotics; is that correct?

VENTRESS: Yes.

MYERS: "However, her CRP rose to 218 on 09/09/15 and she completed a [week long] course of meropenem."

VENTRESS: Yes.

MYERS: That's what I wanted just to establish, that the CRP seems to peak at 218 on 9 September.

VENTRESS: Yes.

MYERS: Obviously the events we're dealing with are on the early hours of 7 September.

VENTRESS: Yes.

MYERS: And certainly at the time, and I say that because we're looking at things afresh now, we may end up in the same place, we may not, but at the time the view was that [Baby G] had an infection and that was the cause of the collapse; that's correct, isn't it?

VENTRESS: Yes.

MYERS: And in your experience, Dr Ventress, an episode like this, including projectile vomiting, can happen with infection, can't it?

VENTRESS: Vomiting definitely can, yes.

MYERS: Vomiting definitely. Do you have your statement there still?

VENTRESS: Yes.

MYERS: I just wonder if you could look at page 10 of 12.

VENTRESS: Yes.

MYERS: Just look at the bottom line if you would, please.

Page 10 of 12. It's page 1851 of our statements, my Lord. Do you agree, in fact, projectile vomiting may be one of the symptoms with infection?

VENTRESS: Yes, I can't comment on the projectile nature of the vomiting because I didn't see it, but vomiting in general, yes, can.

MYERS: But in general, yes. What you said was that, when talking about [Baby G]'s position, you say:

"This has happened before with other babies, including symptoms of projectile vomiting."

That's what you say, isn't it?

VENTRESS: I didn't see that over the page. Yes.

MYERS: So this seemed to be consistent with infection?

VENTRESS: Yes.

MR MYERS: Thank you, Dr Ventress.

Re-examination by MR ASTBURY

MR ASTBURY: Just some matters arising, doctor, from the questions you've been asked.

You were helpfully reminded, we touched upon it, that you'd written a statement and that you refreshed your memory from it and you were helpfully reminded with regard to two aspects of that statement. I'd like to take you back to them please.

First of all, if we can go to page 8. Near the top of page 8. You were asked about the start of your shift and being in the children's ward. Do you recall?

VENTRESS: I have said there I would more than likely have been on the children's ward and I agree with that. I would more than likely have been there, but I can't guarantee 100%.

ASTBURY: Okay. It was really this that I wanted to explore with you. Going back to the start of your shift, you said in your witness statement:

"There were no prior concerns with [Baby G]. She'd been examined on the ward round on the morning of 6 September and she was stable at the start of my shift..."

And we have heard that was about 8 o'clock that evening; is that right?

VENTRESS: 8.30.

ASTBURY: "... and my handover regarding [Baby G] had no concerns."

Is that your recollection?

VENTRESS: It's my recollection at the time I did this.

ASTBURY: Thank you.

In a similar vein you were asked about when you left [Baby G] because of the bleep that you received to go, I think, to the labour --

VENTRESS: To the labour ward, yes.

ASTBURY: Could I ask you, please, to look at the top of page 9 of your witness statement. Three lines down you record this:

"I had been called to the labour ward theatre as another preterm baby was about to be born in there, so at that point I left [Baby G] as [Baby G] was looking a lot better and the other baby took priority."

VENTRESS: Yes.

ASTBURY: So again, is that, having refreshed your memory from the statement, what you were thinking at the time?

VENTRESS: So I'd made a plan that [Baby G] was going to have a cannula, start her on some fluids and start some antibiotics, but before I could do that I was called away.

ASTBURY: Okay. But you took that (overspeaking) --

VENTRESS: But my plan was still to come back and do that after I had dealt with the other baby.

ASTBURY: Next, please, you told us how when you first came to intubate [Baby G] and you looked down her throat with the laryngoscope and the light, that's when you saw some bloodstained fluid?

VENTRESS: Yes.

ASTBURY: Now, is this right, are you able to see beyond the vocal cords?

VENTRESS: No.

ASTBURY: And I think you told us it was coming from below the vocal cords?

VENTRESS: Yes.

ASTBURY: So you simply weren't in a position to see --

VENTRESS: No. The vocal cords in a baby like that would be, you know, maybe 2 millimetres, to get -- very small, so you wouldn't be able to see past them.

ASTBURY: So you couldn't ascertain where that blood was coming from at that stage?

VENTRESS: No, I couldn't see the source of the blood, no.

MR MYERS: If I may, my Lord, it is bloodstained fluid, rather than blood, I think the doctor said.

MR JUSTICE GOSS: Yes.

MR ASTBURY: Sorry:

"Unusual to have blood coming up from below the vocal cords was my note."

So I apologise if that's misleading in any way.

Certainly looking at your notes, what you saw, is this right, was sufficient for you to prescribe some vitamin K for what you'd seen?

VENTRESS: Yes.

ASTBURY: Finally, this, please. You were taken to your note -- and I think it's behind tile 107, please. Scroll down a little, please, to the entries at 06.05 and 06.10.

Thank you.

So we can see about a third of the way up:

"NG aspirated as abdo appeared very large and around 100ml aspirated."

VENTRESS: Yes.

ASTBURY: That, as we read up, follows from events at 06.10, is that right --

VENTRESS: Yes.

ASTBURY: -- when you removed the ET tube and noticed these secretions and the blood clot at the end of the tube?

VENTRESS: Yes.

ASTBURY: If we continue to read up, the event before that was 6.05 when there was a profound desaturation.

VENTRESS: Yes.

ASTBURY: So I understand, is 6.05 and 6.10 the window between the original ET tube being removed and a new one being placed?

VENTRESS: No, the new one was placed at 6.15.

ASTBURY: So at the time you noted the abdomen appearing very large, the Neopuff had been in use between about 6.05 and 6.15; is that right?

VENTRESS: So the Neopuff had been in use via the ET tube from 6.05 to 6.10. And then the ET tube was removed and we used the Neopuff with a face mask after that.

MR JUSTICE GOSS: It was 5 minutes of face mask, between 6.10 and 6.15?

VENTRESS: Yes.

MR ASTBURY: If we go to your -- just to put this into, I hope, some context, if we can go back to tile 80, please. It may even be behind this tile. It's the earlier part of the note, I'm sorry. Keep scrolling down. Sorry, we'll have to go back to tile 80. It's the very first page.

Apologies, if you just bear with us, doctor.

(Pause)

This is the reason you were called. And even at the time you were called, we can see that the note reads:

"Very large projectile vomit. Abdo appeared discoloured, purple and distended."

VENTRESS: Yes.

ASTBURY: Okay.

VENTRESS: I noted at the end of that paragraph that she appeared relaxed and back to her usual self, so I think the abdomen

improved by the end of that section and then was worse again later.

ASTBURY: You anticipate the question. It appears in your note twice: firstly, when you're first called, you made your note to the effect that it resolved when you were called or had resolved by the time you were called away to the theatre.

VENTRESS: Yes.

ASTBURY: And you don't note it again until round about 6.15, when 100ml of, you assume, air were aspirated after about 5 minutes via the Neopuff. The question, I suppose, is this: for the sake of 5 minutes of Neopuff did 100ml strike you as unusual to be aspirated from the stomach at that stage?

VENTRESS: I'm just trying to think how much we would normally get.

Yes, it's probably a bit larger than usual for 5 minutes.

MR ASTBURY: Those are my questions. Does my Lord have any questions?

MR JUSTICE GOSS: No, I don't. Thank you very much, Dr Ventress, for coming and giving evidence and coming back again this morning to complete it. As events have shown, it was a good job we didn't try and press on yesterday afternoon. You are coming back to give evidence.

VENTRESS: Yes.

MR JUSTICE GOSS: Relatively shortly, I think.

VENTRESS: Yes, the next two.

MR JUSTICE GOSS: Thank you. You remember what I said to you before about not talking to anyone about the case.

(The witness withdrew)

MR JUSTICE GOSS: I appreciate that some of you are finding it a bit hot in here. Others, from the fact you're wearing coats, are obviously not finding it hot. It is what it is, I'm afraid. There's nothing... For 2 days now there's been a request to change the ventilation but nothing's happened as far as I can tell.

MR ASTBURY: We'll soldier on, my Lord --

MR JUSTICE GOSS: Oh yes.

MR ASTBURY: -- despite our coats.

My Lord, we took Dr Ventress a little out of time order. Could we return, please, to the chronology as best we can? I'm going to read two more statements to the jury. They are in the bundle that my Lord received yesterday.

MR JUSTICE GOSS: Yes, thank you.

Witness statement of DR LARA BUNNI (read)

MR ASTBURY: The first is from Lara Bunni.

In a statement dated 20 November of 2018, Lara Bunni stated thus:

"I am currently a registrar clinical fellow in paediatric intensive care in Manchester Children's Hospital. Back in 2015 I was a senior house officer dedicated to the neonatal unit at Arrowse Park Hospital.

"I have been asked to comment on a [Baby G] who was born on 31 May 2015 at Arrowse Park Hospital.

"Referring to medical notes, [Baby G] was born at 23.57 hours on 31 May 2015, the circumstances of which are as follows.

"I was working a night shift, which would have been 20.30 until 09.30 hours. I would have been covering the post-natal ward as well as the neonatal unit. My registrar at that time was Dr Vicky Nesbitt. I remember I was actually on the post-natal ward reviewing a child when I heard an emergency alarm going off. I ran straight to the woman's room, which took no more than 10 seconds. That was where the alarm was coming from.

"I saw [Baby G]'s mother [Mother of Baby G] sat on the toilet. [Mother of Baby G] was saying that she went to the toilet thinking she needed to go to the toilet, she felt that she'd actually had her baby in the toilet. Realising that she may have had the baby, [Mother of Baby G] said that she had pulled the emergency cord, a nurse and a healthcare assistant had arrived, but I cannot recall their names.

"I asked [Mother of Baby G] to get up and move to the side of the toilet. [Baby G] was actually still attached to her mother via the umbilical cord. [Baby G] was in the water of the basin of the toilet. I scooped [Baby G] out of the toilet. At this stage the crash bleep had gone out and people started to arrive at the toilet within about 15 seconds.

"I asked the staff to get me a cord clamp, a cord cutter and towels. We got the cord clamp on and cut the cord. Within 3 minutes of being born, I took her straight to the Resuscitaire. [Baby G] was not breathing. [Baby G] was the colour of blue and physically floppy. At the Resuscitaire there was myself, Dr Nesbitt and a neonatal nurse I cannot remember the name of. A hat would have been put on [Baby G] and [Baby G] would have been put in a plastic bag in order to retain [Baby G]'s heat; [Baby G] would have lost body heat whilst in the toilet water.

"We then took action to stabilise [Baby G] and to get her breathing. We gave her five inflation breaths initially, which weren't effective, so we adjusted her head and gave her another five inflation breaths, which would have continued ventilation breaths as the adjustment was effective. [Baby G] was then intubated and given ventilation breaths [as read].

"Her heart rate was as low as 60. A 2.5-millimetre tube was inserted into [Baby G]'s throat, guided by the vocal cords. However, there was no increase in heart rate. This tube was removed. A second 2.5-millimetre tube was inserted and it was decided to leave this in as [Baby G]'s heart rate increased to 120. She seemed to be recovering.

"Curosurf was then administered via the endotracheal tube to assist with the inflation and deflation of her lungs. At that point [Baby G] stabilised. She was transported via incubator to the neonatal unit intensive care nursery and placed into the NNU incubator.

"I was with [Baby G] in the NNU. At that point [Baby G]'s heart rate was greater than 120. Her saturations were 90 in 80% oxygen. She was pink and well perfused.

"Whilst at the NNU there was a plan to insert umbilical catheters and cannulas in order to get fluids and antibiotics into [Baby G], plus any other resuscitation medications if needed. This was all completed prior to the end of the shift with myself taking part.

"Within the initial 24 to 36-hour period [Baby G] was in poor condition. She was in respiratory distress, she was intubated, she needed extra support requiring three doses of Curosurf. She had a raised CRP, which is an infection marker sign, and she was still at risk of not surviving.

"Other than treating [Baby G] on her first day I did treat [Baby G] on a number of occasions. However I can't remember the dates prior to her transfer on 13 August 2015.

"Once things had settled down [Baby G] began feeding and growing, as we call it. However, due to her prematurity and other factors, ie being born into a toilet, she would have had blips where she would have taken a few steps back, however generally she improved.

"Of note in [Baby G]'s medical notes was a particular dip on 4 June 2015, a desaturation resulting in a drop of blood pressure, [Baby G] was given a saline (fluid) bolus.

"From the notes made on 8 August 2015, [Baby G]'s summary of problems encountered are as follows:

"'[Baby G] has chronic lung disease, distended tummy, extreme prematurity, damaged kidneys, [Baby G] required numerous blood transfusions.'

"At the beginning of August, [Baby G] showed some instability, with temperatures, bradycardia and desaturations. [Baby G] had a routine infection marker which showed she had an infection marker of 84 CRP, which is a raised number. [Baby G] was treated as she had an infection and so was given seven days of antibiotics. [Baby G] was treated for sepsis, [Baby G] was treated for NEC. [Baby G] had high blood sugar during her stay. [Baby G] had a pulmonary haemorrhage on 29 June. This would have been a massive setback.

"At that time she had a Broviac line fitted at Alder Hey Hospital. This line was removed on 30 July.

"[Baby G] had a PDA, which is a patent ductus arteriosus, a complication with the heart that was picked up through an echo. [Baby G] had jaundice. [Baby G] had neonatal hypoglycaemia, metabolic bone disease. [Baby G] had low sodium.

"At the point of transfer of [Baby G] to the Countess of Chester Hospital on 13 August 2015, [Baby G] had to be well enough prior to any transfer. [Baby G]'s condition was as follows. [Baby G] was off the ventilator, then on to CPAP, and at the time of transfer [Baby G] was on high flow oxygen which was a real improvement. From a heart point of view she was stable. Neurology: cranial ultrasound did show a mild bilateral ventricular dilatation, which shows potential bleeding on the brain. Ophthalmology showed no problems. [Baby G]'s haemoglobin level was good.

"In respect of her tummy there were no concerns at the point of discharge. [Baby G] had been on full feeds (expressed breast milk) since 22 June. Her discharge feeds were 185ml per kilogram per day via an orogastric tube.

"From a renal point of view, [Baby G]'s kidneys, there were no concerns. [Baby G] required sodium supplements to keep her sodium level up. [Baby G]'s CRP on the day of discharge was shown as normal. Her infection markers were shown as normal.

"[Baby G]'s discharge weight was 1,260 grams. I would describe [Baby G]'s condition at the point of transfer to the Countess of Chester Hospital on 13 August 2015 as stable.

"[Baby G] had her problems at the Countess of Chester, returning to Arrowe Park on 8 September 2015. I did not treat [Baby G] upon her return but I will refer from the medical notes [as read].

"[Baby G]'s discharge summary from Arrowe Park Hospital made on 16 September is as follows. [Baby G] had been ventilated for 6 days. However, on discharge she was self-ventilating with no respiratory concerns. Cardiovascularly, there were no concerns. Neurologically, cranial ultrasound showed that the right side is bigger than the left side and that there are still ventricular patches. Due to [Baby G] having the occasional jittery movements and the results of the cranial ultrasounds, [Baby G] had an MRI scan on her head. However, the report had not been received at the time of her discharge.

"Ophthalmology. [Baby G] has grade 1 retinopathy prematurity and will require further surveillance. [Baby G] had a blood transfusion on 9 September with extra doses of vitamin K.

"From a tummy point of view [Baby G] was fine. [Baby G]'s kidneys were fine. [Baby G], due to being sick, had to be reintroduced to feeds. She was tolerating 14ml two-hourly of expressed breast milk and they were increasing that amount slowly.

"[Baby G] was peeing and pooing well, so there were no concerns there. [Baby G]'s CRP on 16 September was 11, which is fine. On discharge [Baby G] was 2,095 grams and on very little medication. [Baby G]'s parents were interested in everything we did and tried to get as involved as much as they could with [Baby G]'s care."

That, my Lord, concludes that statement.

MR JUSTICE GOSS: Thank you.

Witness statement of MS VALERIE DALE (read)

MR ASTBURY: The next statement, please, from Valerie Dale.

Signed on 20 December 2018. She is a senior neonatal nurse and says as follows:

"I have reviewed the relevant medical notes concerning [Baby G], who was born at Arrowe Park Hospital on 31 May 2015.

"I am a state-enrolled and a registered general nurse. I also have two neonatal qualifications. My responsibilities in my current role include being shift leader, looking after the staff and babies on the neonatal unit, although I may be given individual babies to look after if I am not the shift leader.

"I have no recollection of [Baby G] or her parents and I will have to refer to the medical notes. My first entry on the medical notes for [Baby G] is on 4 June 2015 timed at 15.33. My shift for this day was 07.30 to 20.00 hours. I was [Baby G]'s designated nurse and she was very unstable. [Baby G] had problems with her blood pressure. We countered this with dopamine and dobutamine and changed her sodium bicarbonate infusion as her gases were poor.

"Her blood pressure and saturations both dropped at 09.00 and I asked for consultant, Dr Rath, to attend and review. At 9.20 I gave [Baby G] a saline bolus of 6ml. Immediately her blood pressure and saturations improved with the bolus. [Baby G] was given extra glucose and potassium, dopamine and dobutamine, at that time on 15 micrograms.

"Throughout the morning [Baby G]'s gases improved. She had a further infusion of sodium bicarbonate. [Baby G] was being oscillated at the time and it was decided to take her off that and put her on conventional ventilation.

"At 2.30 pm that day, it was decided that with her O2 saturation dipping [Baby G] was put back on to the oscillator.

"The second entry is retrospective and is time at 19.20, again on 4 June 2015. Along with a general notes, they state that [Baby G]'s blood pressure level was to be kept above 30, which is quite high. However, considering her respiratory problems that would explain the high number. This level would keep [Baby G] stable. This particular entry would suggest, even though [Baby G] is really unwell, she had improved from the initial entry. There was a plan to reduce [Baby G]'s dobutamine to 12.5 micrograms and to reassess her over the next 4 hours where, at that time, she was kept on 15 micrograms.

"[Baby G] had a chest X-ray that confirmed the ET tube was in the correct place. In an attempt to reintroduce insulin to [Baby G], an attempt to place another cannula into [Baby G] was made, however it was unsuccessful.

"At 19.00 the entry states that [Baby G] was still on the oscillator, however her colour was improving. Again [Baby G]'s parents were updated.

"I made an entry on 12 July 2015 at 07.44. From the notes they would suggest I had taken over the care of [Baby G] who was now in the special care high dependency room and she was a lot better and quite stable."

That concludes that particular statement.

MR JUSTICE GOSS: Thank you.

MR DRIVER: My Lord, may I call Victoria Blamire, please.

MRS VICTORIA BLAMIRE (affirmed)

Examination-in-chief by MR DRIVER

MR DRIVER: May I ask you to begin by stating your full name as loudly and as clearly as you can.

BLAMIRE: It's Vicky Lisa Blamire.

DRIVER: Mrs Blamire, could you inform the jury of your occupation as of September 2015?

BLAMIRE: I'm a neonatal assistant.

DRIVER: And you were in 2015?

BLAMIRE: 2015, I was a neonatal assistant, yes.

DRIVER: Thank you. And you were based, we understand, in the neonatal unit at the Countess of Chester Hospital?

BLAMIRE: Yes.

DRIVER: We are going to ask you questions in relation to your care for a baby patient there by the name of [Baby G] --

BLAMIRE: Yes.

DRIVER: -- who we understand was born in Arrowe Park Hospital on 31 May 2015, and moved to the Countess of Chester Hospital on 13 August 2015. We understand, and could you confirm, that you were the designated nursery nurse for [Baby G] on the day shift of 6 September 2015?

BLAMIRE: Yes, that's correct.

DRIVER: And to assist your recollection of any detail that you may be asked about, there's a screen to your right there. I wonder whether Mr Murphy could put up tile 18, please.

You'll see on this screen a visual representation that makes reference to a colleague of yours by the name of Valerie Thomas. Do you remember Valerie Thomas?

BLAMIRE: Yes, I do, yes.

DRIVER: In the centre it simply states that there was a nursing handover on the morning of Sunday, 6 September 2015, and thereafter there's reference to your name and some observations that you may have made. If we go back to the carousel, please, Mr Murphy.

Do you recall the handover of responsibility of care for [Baby G] that morning?

BLAMIRE: I don't recall what Valerie said to me, no, sorry.

DRIVER: But do you recall the fact that there was a handover?

BLAMIRE: Oh, of course, yes. Yes, yes.

DRIVER: And as part of such handovers, would Valerie have imparted to you some general information about [Baby G]'s condition and the regimes that she was subjected to?

BLAMIRE: Yes, that's correct, yes.

DRIVER: Thank you. If we could, please, go to tile 10 for a moment, please, Mr Murphy. And click behind it and go to the nursing notes, please.

Pausing there, just to familiarise you, Mrs Blamire, you can see here there is a description of the contents of a set of nursing notes. Not your notes, Valerie Thomas' notes. Then please, Mr Murphy, click on the original document itself.

That description, that summary, has been derived from the actual nursing notes, which you'll see now.

There you will see, in a format that I hope you recognise -- do you recognise the format from the screens at the Countess of Chester?

BLAMIRE: Yes, I do.

DRIVER: We can just see there in a few sentences how your colleague, Valerie Thomas, described [Baby G]'s condition, the assistance she was being provided with, the feeding regime, and some events that took place during the shift prior to Valerie Thomas handing over to you.

BLAMIRE: Yes.

DRIVER: So you were [Baby G]'s designated nurse. At the point that she came under your care, in general terms where was [Baby G] being kept and what sort of attention was she receiving?

BLAMIRE: I don't recall what nursery she was in. The documentation that I have documented on [Baby G] stated she was a special care baby, feeding three-hourly, bottle and tube, on nasal prong oxygen, and she was stable.

DRIVER: Thank you. Could you define in ordinary term what a special care baby is? What does the label special care suggest?

BLAMIRE: A baby that's just requiring nursing attention, helping with feeds, observations may be necessary, some medication.

DRIVER: Thank you. As your colleague Valerie Thomas had for the prior night shift, did you during or towards the end of the day shift contribute your own nursing notes, your own summary --

BLAMIRE: Yes, I did.

DRIVER: -- of the position?

BLAMIRE: Yes.

DRIVER: Let's take you to those at tile 46, please, Mr Murphy.

Let's look at the original document, which should be J6644, please.

Sorry, these aren't this witness's notes. Forgive me. Let's go to tile 38. My error, apologies.

The original document. J6643. Your initials?

Do you recognise your initials?

BLAMIRE: Yes, I do, yes.

DRIVER: Thank you. So this entry is timed at 15.37, so it's a day shift, so you're several hours into your shift by this stage. Did you at that point record what had taken place, what

you had -- the care you'd provided between coming on to shift in the morning and this point in time?

BLAMIRE: Yes, I did, yes.

DRIVER: Thank you. You, as with all your colleagues, first of all, checked that the safety equipment was present and correct?

BLAMIRE: Yes.

DRIVER: The next entry relates to the feeding regime, so:

"Continues to feed 3x8."

What does that mean in this context?

BLAMIRE: It means [Baby G] was having feeds every 3 hours.

DRIVER: Thank you.

BLAMIRE: Eight within an 24-hour period, yes.

DRIVER: And divided into three-hour spaces?

BLAMIRE: Yes.

DRIVER: Over three-hour spaces:

"Offering NGT feeds and [I assume that should read] bottle feeds."

BLAMIRE: Yes.

DRIVER: What does offering mean in this context?

BLAMIRE: So if a baby is awake and alert then we would offer a bottle. If the baby was asleep and needed resting and had a nasogastric tube, then we would use the tube.

DRIVER: Thank you. So if awake and willing, bottle feed?

BLAMIRE: Yes.

DRIVER: If asleep, you wouldn't wake a sleeping baby --

BLAMIRE: No, no.

DRIVER: -- to feed her? Rather you, the nursery nurse, would provide the feed via the naso --

BLAMIRE: If the baby needs to be rested, yes.

DRIVER: Thank you:

"Gaviscon and fortifier added."

Gaviscon, is that to help with reflux?

BLAMIRE: Yes.

DRIVER: And fortifier?

BLAMIRE: It's a nutritional calorie benefit.

DRIVER: And was that added to the expressed breast milk?

BLAMIRE: Yes, it was.

DRIVER: Thank you very much. Let's look in more detail at the feeding chart that I'm sure you would have completed.

That, I hope, is behind tile 27.

Thank you. If we scroll down, please. Pausing there. Let's keep going down. Thank you very much.

So we can see the date of 6 September 2015.

Do you see your own initials in there?

BLAMIRE: Yes, I do, yes.

DRIVER: Are they below what appears to be a hole punch --

BLAMIRE: Yes.

DRIVER: -- the black circle on the right?

BLAMIRE: Yes.

DRIVER: Prior to your entries are entries made by Valerie Thomas --

BLAMIRE: Yes.

DRIVER: -- for the night shift prior to your shift. And we can see there:

"EBM plus Gaviscon and fortifier."

So that's expressed breast milk with the additives that we have heard reference to:

"Consistent amount..."

Is that 45ml?

BLAMIRE: Yes, it is.

DRIVER: And that was an amount that was established as part of this routine regime?

BLAMIRE: Yes.

DRIVER: So eight times a day, every 3 hours, at a set amount?

BLAMIRE: Yes.

DRIVER: Thank you. The route, we can see for your four entries, goes NGT, B, NGT, B. Does that suggest that it was alternated between bottle --

BLAMIRE: And tube.

DRIVER: And tube?

BLAMIRE: Yes.

DRIVER: We can see, looking at your entries, your first entry here at 08.00, the "through the tube", and the comment "cares".

BLAMIRE: Yes, so basically I would done a nappy change.

DRIVER: Right. "Bathed" after that and then the next NGT was whilst the baby was asleep?

BLAMIRE: Yes.

DRIVER: And so does that demonstrate the system that you've mentioned earlier: if the baby is asleep and needs to rest --

BLAMIRE: Yes.

DRIVER: -- you don't wake her --

BLAMIRE: Yes.

DRIVER: -- to feed her with a bottle? Thank you.

In addition to recording the feeds that you provided to the baby, would you have made entries on the daily observation chart?

BLAMIRE: For observations?

DRIVER: Yes.

BLAMIRE: Yes.

DRIVER: Forgive me, I'm moving now from feeds to observations.

Tile 26, please, Mr Murphy.

Go to the bottom so you can first identify your own initials.

BLAMIRE: Yes, I do, yes.

DRIVER: Do they begin on that -- I think the fifth entry where the cursor is now?

BLAMIRE: Yes.

DRIVER: Prior to that, VT, Valerie Thomas, has made a series of entries?

BLAMIRE: Yes.

DRIVER: So let's just look at the state of the observations. So heart rate monitored by you from 8 am --

BLAMIRE: Yes.

DRIVER: -- having previously been monitored by Valerie Thomas?

And considering those heart rate measurements together with -- and if we scroll down -- the respirations and together with -- scroll down again -- the temperature measurements, how was [Baby G] when under your care during that day shift?

BLAMIRE: [Baby G] was a stable baby. No concerns.

DRIVER: Thank you very much. Do you know whether you were the designated nurse for any other babies during that shift?

BLAMIRE: Having looked back on the medical notes, I did have other babies to look after on that day as well.

DRIVER: Can you remember whether that was another single baby or more than one other baby?

BLAMIRE: It was more than one baby, I'm sure.

DRIVER: Thank you. Given the level of care and attention that [Baby G] needed and was given, was that workload excessive,

looking after at least three babies at a time, or was that just par for the course?

BLAMIRE: No. A nursery nurse, a band 4, can have up to four patients, four special care patients.

DRIVER: Did you frequently do so?

BLAMIRE: At busier times, yes.

MR DRIVER: Thank you. Could you remain there and answer any questions if there are any?

MR MYERS: No. Thank you, Mrs Blamire. My Lord, we do not have any questions for Mrs Blamire.

MR JUSTICE GOSS: Right. Thank you very much for coming and giving your evidence. That completes it.

MR DRIVER: I don't anticipate that this witness will be invited to return, my Lord.

MR JUSTICE GOSS: It's not expected that you're going to have to give evidence again during the course of this trial, but just in case, because sometimes things arise, that do require someone to come back and give evidence, would you please not speak to anyone about anything to do with this case --

BLAMIRE: Yes.

MR JUSTICE GOSS: -- or your evidence in relation to it?

Not that it's hugely significant -- it is significant, but it's nothing exceptional, what you have told us about [Baby G]'s condition that shift.

BLAMIRE: Yes.

MR JUSTICE GOSS: But just don't talk about that to anyone.

Thank you very much for coming.

(The witness withdrew)

MR JOHNSON: We have now got the charts in paper form, which we can distribute while the jury have their break.

MR JUSTICE GOSS: All right. There we are. You're going to get the -- the charts will be distributed and in your places for when you come back after the break.

Thank you very much.

(11.49 am)

(A short break)

(12.00 pm)

(In the absence of the jury)

MR JOHNSON: My Lord, we invited the witness in because it's warmer in here than it is on the corridor. If I can just explain this to the jury before the witness is sworn, please.

MR JUSTICE GOSS: Certainly, yes. Jury in, please.

(In the presence of the jury)

MR JUSTICE GOSS: Mr Johnson.

MR JOHNSON: Ladies and gentlemen, you've got a new bundle.

Hopefully it won't get too large. What we're going to invite you to do is to put a number 2 on this one. So we'll refer to the original one, which has the indictment in at the front, as bundle number 1, and we'll refer to this one as bundle number 2.

What you will see, if you look inside, is, as soon as you open it, you have Lucy Letby's work rota, which is colour coded, which we've gone through partially up to this stage.

Thereafter, you have 24 numbered dividers. There are 22 counts on the indictment. What we will do is put documents relevant to each count behind the respectively numbered divider, all right? So what you have at the moment is blank 1 to 6. We'll backfill that at some convenient moment with the relevant documents.

What you have behind number 7 are documents with which you are now, of course, very familiar, the observation charts. We've preserved the J number pagination, which is what appears on the electronic presentation, because that's the way all the lawyers have cross-referenced the documents.

After the three observation charts, you have the intensive care chart, which records the input and output of fluids. That's a single page. Then you have the blood gas records because those have been referred to and, no doubt, will continue to be referred to.

Then right at the back there's another feeding chart, which covers the time under consideration in respect of count 7. So I

hope that, given that you're now so familiar with these documents, I hope that's helpful. It has the advantage, of course, that you can write your own notes on these pages if there's anything that occurs to you as we go along.

I'll now hand back over to Mr Driver.

[NURSE E] (affirmed)

Examination-in-chief by MR DRIVER

MR DRIVER: Could you please state your full name?

NURSE E: [Nurse E].

DRIVER: Is it Ms or Mrs [Nurse E]?

NURSE E: It's Ms.

DRIVER: Although I'll be asking you the questions, could you direct and project your answers to the jury across the room, please.

[Nurse E], we understand, and could you confirm, that you were the allocated or designated nurse for a patient by the name of [Baby G] for the night shift of the 6th and 7 September 2015?

NURSE E: That's correct.

DRIVER: And could you just inform the jury as to your occupational status at that point in time?

NURSE E: Band 5 neonatal nurse.

DRIVER: Thank you. We're going to direct your attention to some of the notes, the charts, that you would have completed during the course of that shift. They'll appear on that screen to your right. So the detail will all be there to assist you in your recollection of the events.

I understand that you made a statement to the police about this shift, a written witness statement, that's dated 7 December 2017; is that right?

NURSE E: Yes.

DRIVER: Before making that statement you were given, and I understand you took, the opportunity to remind yourself of some of the detail of the shift from the notes that I have just referred to.

NURSE E: Yes.

DRIVER: But before reminding yourself of the detail of the notes, did you have a memory of this shift?

NURSE E: Yes, at that time, yes.

DRIVER: And what was it about the shift that enabled you to remember it 2 years on?

NURSE E: I think it was because when I came back from my break, the baby had moved rooms and was a lot poorer than when I'd gone on the break.

DRIVER: How much poorer?

NURSE E: Um... The information I was given when I came back from my break was that the baby was having breath-holding episodes, which she wasn't having before, so was needing more input from the nurses, so was quite a lot poorer.

DRIVER: Thank you.

I'm going to put some images on the screen. If we go to tile 56, please, Mr Murphy. This is our representation of the chronology of the number of days within the unit, including Sunday, 6 September. You'll never have seen this sort of image before, but if we click behind -- Mr Murphy does it for us -- you will see a more familiar document, I'm sure.

NURSE E: Yes.

DRIVER: We heard from a previous witness that, as of this point in time, [Baby G] was deemed a special care baby; does that accord with your recollection?

NURSE E: Yes.

DRIVER: That designation, that labelling of special care, what does that mean to you as a neonatal nurse?

NURSE E: Well, the label comes from BAPM standards, so there's ITU, HDU and special care and it's to do with what level of care the baby is receiving and how many babies a nurse can look after at once. So with the special care babies a nurse can look at four at one time.

DRIVER: That BAPM standard, you have just told us about three levels of designation and have you just given them to us in descending order?

NURSE E: Yes, so ITU would be one nurse to one baby. HDU, two babies to one nurse. And special care, four babies to one nurse.

DRIVER: Does IT stand for?

NURSE E: Intensive care.

DRIVER: And HD?

NURSE E: High dependency.

DRIVER: And so does it follow that special care babies would be those requiring the least intensive care and attention of those babies within the NNU unit where you were working?

NURSE E: Yes.

DRIVER: And on this occasion, was [Baby G] the only baby you were looking after or were you looking after more than one baby during the shift or don't you remember?

NURSE E: I don't remember. I've looked at my statement this morning and I think in that I've written that I was looking after more than one baby, but I don't remember as a memory.

DRIVER: Do you remember where [Baby G] was kept, where her cot was placed in the unit?

NURSE E: I've read in my statement where I've said her cot was placed. I remember she was in nursery 2, but I don't remember where in the nursery she was now.

DRIVER: That was my question really. So she was in nursery 2?

NURSE E: Nursery 2.

DRIVER: And do you recall whether or not there were any other babies in nursery 2 at that time?

NURSE E: I don't remember.

DRIVER: Thank you. So let's scroll to the bottom of this chart and see notes, entries more accurately, that you made on this occasion. Do you see your initials there?

NURSE E: Yes.

DRIVER: Thank you. Where do your initials begin?

NURSE E: Do you want me to point or...?

DRIVER: Yes.

NURSE E: There (indicating). That's my initial there that the arrow is pointing to.

DRIVER: Where the cursor is pointing?

NURSE E: Yes.

DRIVER: Thank you. So observations made at 20.00 hours?

NURSE E: Yes.

DRIVER: And 23.00 hours, 11 pm?

NURSE E: Yes.

DRIVER: Let's go back down to the bottom, please. The third entry under your initials?

NURSE E: Yes.

DRIVER: Let's go back up to see the time that that corresponds to. That's at 02.00 hours?

NURSE E: Yes.

DRIVER: Let's consider the entries you've made against the various headings, firstly heart rate. Let's do it in time. So 8 pm, let's look at them all together. At 8 pm, the heart rate marker there is in what appears to be the centre-ish of the white band; do you agree?

NURSE E: Yes.

DRIVER: Let's look at the respiratory rate for the same point in time, and the temperature for the same point in time.

Thank you.

So when monitoring the baby, would you have considered those measures in isolation or together?

NURSE E: Both, really. I think if there was an area of observation that was outside parameters, you're obviously looking at the whole picture but you'd be looking at them individually as well. So it would depend what the observations were as to how you would look at the chart, really, because they all matter as a picture together and also individually.

DRIVER: Thank you. Let's take them individually firstly then for 8 pm. The heart rate measurement, how did you regard that? How do you regard that?

NURSE E: That's normal.

DRIVER: Respirations?

NURSE E: At the higher end of normal.

DRIVER: And the temperature?

NURSE E: Normal.

DRIVER: So those three measurements taken at 8 pm individually and collectively, what did that inform you of as to [Baby G]'s state at 8 pm during this shift?

NURSE E: So yeah, that would -- you'd see that as being stable.

The respiratory rate is at the higher end of normal, so obviously you would be making sure that that hadn't gone up any further at the next period of observations. But I wouldn't need to escalate that to anybody at that point. We'd take those into account with the oxygen saturations as well, with the baby being on oxygen.

DRIVER: Thank you. So together, all within normal parameters, but the respiration level would have led you to keep an even closer watchful eye on that?

NURSE E: Yes. If a baby is on oxygen, we're obviously keeping a closer eye than a baby that's in room air anyway, but yeah, you'd be making sure they didn't have any worsening in breathing.

DRIVER: And do you recall whether or not [Baby G] was on oxygen at this point in time?

NURSE E: Only from looking at the statement earlier on today.

DRIVER: The statements that were made on 7 December 2017, having reminded yourself of the note?

NURSE E: Yes.

DRIVER: And what was the position in terms of assistance with breathing?

NURSE E: So looking back at my statement, [Baby G] was on nasal prong oxygen, so a little nasal cannula that went up both her

nostrils, so she'd be breathing for herself but was on -- from looking at the statement, I think it was 0.07 to 0.08 litres. So she wasn't at stage of coming off oxygen, she was still needing an amount of oxygen at all times.

DRIVER: Having recorded that data, and effectively noted that her respiration levels ought to be watched even more closely, you made the following observations at 23.00 hours. So the heart rate, we can see, has that gone down a little?

NURSE E: Heart rate's gone up a little bit.

DRIVER: Yes, of course, sorry, I was looking at the wrong column. And respiration level?

NURSE E: Similar. It's down ever so slightly by the looks of it but very similar.

DRIVER: And the temperature?

NURSE E: Her temperature is fine as well. 36.9 is normal.

DRIVER: Considering each of those individually, would any of them have caused you any concern at the time?

NURSE E: No. Her respiratory rate is still at the higher end of normal. However, it hasn't worsened. It looks like it's got ever so slightly better, so you'd be looking at that with the whole picture of the baby as well and making sure they are not having any difficulty breathing as well as the respiratory rate. There doesn't appear to be anything there that would be concerning me anymore.

DRIVER: Thank you. Let's move to the last entries that you made on this chart at 2 in the morning. Heart rate?

NURSE E: It looks like her heart rate's come down to -- similar to where it was at 8 pm now, around the 140.

DRIVER: Respiration?

NURSE E: That looks like it's improved to the low 50s.

DRIVER: And temperature?

NURSE E: I obviously haven't taken her temperature there. We don't necessarily take the temperature every time we do observations, especially if the baby is asleep. The other temperatures have been fine and nothing's changed in where they are or whether they've gone from -- if nothing's changed to whether they're in a cot or moved from a cot or anything like

that, we wouldn't necessarily always take it every 3 hours, the temperature.

DRIVER: We will look at some other data shortly which might assist to remind you whether or not she was asleep at (inaudible: coughing). Now just looking at combination of the heart rate and respiration measurements, as of 2 am what was your impression of [Baby G]'s condition at that time?

NURSE E: Well, the respiratory rate looks improved, it looks -- the two together look stable. As I say, you'd look at that alongside whatever she'd been doing on her monitor with her oxygen saturations as well. But from those two, there's nothing there that would concern me from just those.

DRIVER: Thank you. Let's move now to feeds, please, and ask Mr Murphy to put up tile 57.

If we scroll down to see if [Nurse E] recognises her own signature. Pausing there for a moment is that the first time we see your signature under the word "night"?

It's under the headings to the right of the page we are now looking at.

NURSE E: Yes.

DRIVER: If we scroll down for the page number. This means nothing to you, for us it's J7012.

So you've signed there. Have you done that just to register in or to put your name to the three ticks that lie alongside it?

NURSE E: Yes. The charts then we sign to say that we had checked the emergency equipment, any prescription charts, and that we'd cleaned any equipment and the area down where the baby was.

DRIVER: So that is effectively you signing off the checklist of the equipment that is being considered and is fine?

NURSE E: Yes.

DRIVER: We can see signatures that we've already been told belong to colleagues by the name of Thomas and Blamire, if I might use their initials, because I think they have the same first name, don't they?

NURSE E: No, they have a different first name.

DRIVER: Do they?

NURSE E: Yes.

DRIVER: Forgive me. Are they both not Victoria, is that not right?

NURSE E: No, one's Val.

DRIVER: Valerie and Victoria. Two Vs, different names.

MR JUSTICE GOSS: Valerie and Vicky.

MR DRIVER: My error.

Let's see where you first sign the feeds on this chart. Is your first entry at 20.00 hours?

NURSE E: Yes.

DRIVER: Does that record the type of feed?

NURSE E: Yes, it says NGT, which is nasogastric tube feed.

DRIVER: Thank you. We'll come to the route in a moment --

NURSE E: Sorry, the feed type there, yes. It's expressed breast milk, which would be mum's expressed breast milk, otherwise we'd put a D in front of that if it was donor breast milk. So it would be mum's expressed breast milk then it has "plus Gav plus fort", which would be plus Gaviscon and plus fortifier.

DRIVER: Thank you. And the amount?

NURSE E: 45ml.

DRIVER: Do you recall, having refreshed your memory from the notes, of the feeding regime that [Baby G] was subject to at this time?

NURSE E: Only from looking at my -- yeah, only from looking at my statement that she was on nasogastric tube and bottle feeds.

DRIVER: And the frequency?

NURSE E: Every 3 hours.

DRIVER: And what would determine whether or not the feed was given via a bottle or via the tube?

NURSE E: Well, we'd look at the baby's -- whether the baby was awake, whether they were kind of queueing for a feed.

We would be looking at how the baby's observations were and whether we felt that they would be able to take a bottle feed without becoming more tired. So if the baby was having difficulties with their breathing etc, then we wouldn't give them a bottle and we might electively give them a tube feed to rest them.

So yes, it just depends how the baby was displaying at that time really. They might be on -- somebody might hand over the baby was having one bottle feed to one tube feed but you wouldn't necessarily carry on with that if you weren't happy with how the baby was being in themselves.

DRIVER: If we look at the route column, the entries that precede yours on the 6th, there were two nasogastric tube feeds and then bottle, tube, bottle, and then yours at 8 pm via the tube.

NURSE E: Yes.

DRIVER: Look alongside it. We can see under the comment section that the baby was asleep.

NURSE E: Yes.

DRIVER: So at 8 pm, [Baby G]'s asleep, and you elected to feed her via a nasogastric tube?

NURSE E: Yes.

DRIVER: For no doubt a combination of factors, the likes of which you've just described to us?

NURSE E: Yes.

DRIVER: Could you describe the process of the feeding of 45ml of EBM and additives via the tube? Take us through it from start to finish.

NURSE E: So we'd take the milk out of the fridge, measure the milk out, warm the milk in the milk warmer -- we have special milk warmers where we can put in how many millilitres, whether it's taken out of the fridge or the freezer, and that works out how long it'd take to warm the milk up, and that's already programmed in the machine. We would start warming the milk up while we do the baby's observations and get the baby ready for the feed.

Once the machine makes its noise, like alarms to say that the milk's warm, we take the milk out. We'd add the Gaviscon and the fortifier to the milk, shake it up to make sure it's all mixed together.

We had have our equipment there. So we'd have -- the baby would obviously have a nasogastric tube in, we'd get a syringe, some pH indicator strips. And then -- do you want me to say what I's do next?

DRIVER: Yes, please.

NURSE E: So we'd attach the syringe to the end of the nasogastric tube, we withdraw a bit of the stomach contents, what we call an aspirate, and then we put that on to one of the pH indicator strips to see what pH we get from the milk, because that would determine whether the tube is in the right area of the body or not. We're looking for an acid reaction, which is 5.5 or below. And that would tell us then that the milk had come from the stomach.

And then once we'd done that, if we'd taken a little bit too much milk aspirate contents, we put that back in the baby's tummy. If we had just taken a little bit that might have been everything that we used to put on the indicator strip, so the syringe might be empty at this point.

And then basically we would take the syringe off, take the plunger out, attach it again to the tube and then pour the milk that we're going to feed the baby into the tube, use the end of the plunger just to -- basically causes a vacuum effect to make the milk then go down, because if you just poured the milk in it wouldn't go down the syringe, so we just put the plunger in the edge and kind of -- I don't really know how you'd explain it, but you basically just tilt it to one side and then the milk would feed by gravity and it would go down. Then we would top up the syringe as the milk goes down until it's all gone. And then we'd unattach the syringe and put the end back on the nasogastric tube.

DRIVER: You mentioned that whilst the milk was warming, you would take the observations?

NURSE E: Yes.

DRIVER: And we've just looked at an observation chart and we've seen that you did note observations at 20.00 hours.

NURSE E: Yes.

DRIVER: So would that have coincided with the process that you've just explained to us at this juncture, at 8 pm?

NURSE E: Yes. We write the feed time and the observations down at the same time. They obviously don't happen at exactly the

same time. They're written within that time frame. So it might be a few minutes before, it might be a few minutes after. We don't kind of tend to write 20.01 or 19.58 or whatever. It would be for that 8 o'clock feed.

DRIVER: Would the observation chart entries, for example, be made before or after the feeding itself?

NURSE E: Before.

DRIVER: Before.

NURSE E: Because if you did them afterwards, usually babies' breathing rates might have gone up a bit because their stomach contents -- you know, their stomach's got full of milk and that has an effect on the lungs. So you would always tend to do your observations before, unless the baby was upset, potentially you may do them afterwards -- if the baby's very hungry for a feed, for example, because then they might be crying for the feed.

So you want to do it when the baby is settled and stable to get the correct figures.

DRIVER: What's your practice? Because the observations, the respiration rate, temperature, the heart rate, it's quite precise data. Would you record it immediately after taking it or record it on to the chart immediately after taking it or would you make a note of it and put it on to the chart?

NURSE E: No, I tend to put it on to the -- the observations, I would do them all and then put them on the chart before I did the feed unless for some reason the chart wasn't there. So for example if a doctor's got the chart, sometimes they say -- if they take them to look at them, you can't write them there and then and you might have to write them later on. But as a general rule you would write them -- I would write them when I have done them.

DRIVER: So you retain three sets of data --

NURSE E: Yes.

DRIVER: -- and then jot them down?

NURSE E: Yes.

DRIVER: Moving to the feeding process. So having obtained the milk, measured the milk, and warming the milk, is this right, you told us that you would aspirate the contents of the baby's digestive system?

NURSE E: Yes, not the full contents. You would just take a small amount of milk. Because [Baby G]'s fully fed you wouldn't take all her stomach contents, like you might do with a baby that was only on a few millilitres of milk.

Sometimes you would take all the contents then if it was a baby that was only on a few millilitres, because you want to be checking how much they're digesting of the milk. But with a baby who's on full feeds and has -- looks like they've been a full feeds for a while, you would take a small amount, to maybe approximately half a millilitre, maybe just under, and then you would test that amount. So you're not pulling back everything the baby's had out their tummy.

DRIVER: So you would take approximately half a millilitre and then undertake the test at that point?

NURSE E: Yes. So you might not always get half a millilitre.

Babies can sometimes have digested virtually everything.

You might just literally get a few drops. But if you get an acid reaction you still know that's in the right place.

DRIVER: Let's focus upon this test for a moment. You've taken half a millilitre or so, a few drops maybe, and you then drop that on to an indicator strip, did you say?

NURSE E: Yes.

DRIVER: This is everyday work for you, but could you remind us all, please, what's the point of this test on to the indicator strip?

NURSE E: So the pH indicator strips are to show you whether the liquid that you've got is acidic or alkaline. So a pH indicator strip, if you're testing milk from a baby's stomach, you want that number to be 5.5 or below.

DRIVER: Yes.

NURSE E: And that would then indicate that the nasogastric tube is in the baby's stomach.

DRIVER: You'd like it to be 5.5 or below you say, but what's the potential range?

NURSE E: Well, in terms of -- if it is in the stomach you tend to find you see more of a pH from 2 to about 5.5. It depends how digested the milk is the baby has had in their stomach, whether

they have had any additional medications that would make -- would alter the acidity in the tummy.

DRIVER: And if it's not where it should be, if it's not in the stomach?

NURSE E: What would the pH be?

DRIVER: Yes?

NURSE E: It's going to be higher because it's going to more likely be just milk, just frank milk, rather than mixing with stomach acid.

MR JUSTICE GOSS: The more acidic it is, the lower the figure?

NURSE E: Yes.

MR DRIVER: Having undertaken that test, do you then record the results or do you go to a different stage in the process?

NURSE E: Sorry?

DRIVER: Having undertaken the test, a few droplets on to the indicator strip, how does that arrive at a reading, first of all? What informs you of the pH level?

NURSE E: The pH indicator strip is like a strip of paper and it has three squares on the end of the strip, which is where you put the milk. Then you would hold that next to the box that the pH strip has come out of and that has all the pHs written around it in 0.5 increments and you'd hold that next to one of the lines until it marries up with the colours you're looking for. So they can vary in colours from reds, purples, blues -- it depends on the brand as well of the strips.

DRIVER: And from that colour-coding spectrum, you arrive at the pH number?

NURSE E: Yes.

DRIVER: And having determined that pH number, what would be the very next thing that you'd do?

NURSE E: So if you're happy that it's an acidic reaction, you would then move on to feed the baby. If you weren't happy then you'd be looking at trying again, maybe moving the baby on to its side, because sometimes the nasogastric tube can stick to the stomach wall, so it might be that it's not actually sitting in the milk, that it just has a little bit of maybe milk that was already residual within the tube. Sometimes you don't get a

pH at all and that could be that the baby has digested all the milk or that it is sitting maybe slightly high in the stomach, but in the stomach. So you might move the baby around or if it was a bottle-fed baby and you weren't getting a pH, you could give the baby a little bit by bottle and then test to check that it wasn't just that they had digested all the milk in the stomach.

DRIVER: How long does it take to feed a baby 45ml of milk through this process?

NURSE E: From warming the milk as well or from just feeding?

DRIVER: From the beginning of the feed, the act of feeding?

NURSE E: It would vary really on whether the baby was settled and asleep, what extra additives you have got in the milk, because sometimes babies strain when you are feeding them and the milk will go back up the syringe.

DRIVER: Here we have seen that it was a sleeping baby according to your comment.

NURSE E: Yes. They can strain in their sleep sometimes as well.

I know I've put in my statement a time, but I don't think you can really put a time on it really because it would vary so much.

DRIVER: What sort of ranges? Does it take hours to do it?

NURSE E: No, it doesn't take hours.

DRIVER: How long?

NURSE E: I think if the milk wasn't very thick you could be looking at kind of 5 to 10 minutes. If you've maybe put the Gaviscon and fortifier, if you put them in and then you don't feed the baby, quite soon after they thicken up a little bit, so it can take longer if the milk's had time to thicken, so it could take a little bit longer than that.

DRIVER: A little bit being?

NURSE E: Another 5 to 10 minutes potentially.

DRIVER: So we're talking anywhere between 5 and 20 minutes?

NURSE E: Possibly, yes. It's hard to say. We don't really time ourselves (inaudible: coughing) make a note of it either so it's difficult.

DRIVER: You do make a note of the pH level though?

NURSE E: Yes.

DRIVER: Is it your practice to do that before or after the feed?

NURSE E: I probably tend to write the whole thing down together, to be honest. Sometimes if I've done a nappy change I might write the nappy change down first, but then I would tend to write all the feed information down at the same time.

DRIVER: And is that done before or after the completion of the feed?

NURSE E: After usually, because your hands are full with everything else.

DRIVER: Understood.

Let's move to the next entry at 23.00 hours, the same food type, the same amount, different route, bottle. B for bottle; yes?

NURSE E: Yes.

DRIVER: No entry under the "vomit/asp" column.

NURSE E: No.

DRIVER: Why would that be?

NURSE E: We wouldn't check the pH of an aspirate if the baby was all bottle fed anyway. And from that, I'm assuming there wasn't any vomit either.

DRIVER: So is it your practice to take an aspirate whenever you're using the nasogastric tube or does that depend on other factors?

NURSE E: No, you would take an aspirate. However, if the baby, for example, had had virtually all the feed by bottle, you're not going to really get an acid reaction if you then aspirate the tube following that. So say for example if it was a 45ml feed, and you gave the baby 40 of it by bottle, but we still wanted them to have the extra, say, 5ml, if you then aspirated the baby's tube after they'd just taken 40ml by bottle you're going to get frank milk rather than stomach contents with an acid reaction because of how much milk's already within the baby's tummy.

DRIVER: I think another witness said frank milk mean undigested?

NURSE E: Yes, just basically plain milk, like as though you had just dipped straight in the bottle of milk.

DRIVER: Thank you. Moving along our entries for 23.00 hours we can see that the baby has passed urine; is that correct?

NURSE E: Yes.

DRIVER: The next, is this a -- what does BO stand for?

NURSE E: Bowels open.

DRIVER: So bowels open plus plus?

NURSE E: Yes. Plus plus is like a large bowel movement.

DRIVER: You've gone on to describe the stool.

NURSE E: Yes, "Soft, seedy and yellow".

DRIVER: Is that an uncommon finding or is it indicative anything? If so what?

NURSE E: No, that's common for a baby that's on expressed breast milk. They tend to have kind of seedy stools, yellow stools, soft. I may have put what type of stool because I put how much -- that there was quite a lot potentially, which is why I've described what it was like.

DRIVER: Is that noted and described because that's your practice or is it noted and described because there's anything exceptional or concerning about that?

NURSE E: No. I would assume that I've written the type of stool because I put plus plus, so if a baby's had a large bowel movement you would -- you might put what type of bowel movement that was.

DRIVER: Next column. What does "N/B x2" mean?

NURSE E: The charts, as we had them then, that was where the name band column was. So that says the baby's got two name bands on.

DRIVER: Next entry under "comment".

NURSE E: "Fed well."

DRIVER: Bottle feed?

NURSE E: A bottle feed that she'd obviously taken it well, she'd done well with the bottle.

DRIVER: And your initials?

NURSE E: Yes.

DRIVER: Moving down, please. We need to go to a different page, sorry. That's my error. Go to tile 75, please, Mr Murphy. J7013.

So now we've gone from 11 pm on the 6th to 2 am on the 7th; is that right?

NURSE E: Yes.

DRIVER: Thank you. Is that your signature to the right?

NURSE E: Yes.

DRIVER: At 2 am, [Baby G] was receiving a feed of the same type --

NURSE E: Yes.

DRIVER: -- of the same amount, 45ml?

NURSE E: Yes.

DRIVER: And having gone tube, bottle, we are now back to tube?

NURSE E: Yes.

DRIVER: It's 2 in the morning. [Baby G] is asleep according to your comment note.

NURSE E: Yes.

DRIVER: Would they have been factors that you took into account when deciding whether to give her a bottle or whether to feed via the tube?

NURSE E: Yes.

DRIVER: Would you have followed the same process that you described in detail for us when considering the 8 pm feed?

NURSE E: Yes. It's standard, really, how we would do a nasogastric tube feed.

DRIVER: Thank you. We can see that here under the column "vomit/asp", you have made an entry. Could you read that to us, please?

NURSE E: Yes, pH 4.

DRIVER: Where would you have derived that information from?

NURSE E: From testing the aspirate from the nasogastric tube with the pH strip.

DRIVER: Do you recall aspirating [Baby G] at or around 2 am this morning?

NURSE E: I don't remember doing that. But as I say, it's standard and I have written a pH there, so...

DRIVER: So?

NURSE E: I would have tested -- we always test the tube before we feed the baby.

DRIVER: Thank you. When testing the tube, when taking an aspirate, is there any way of measuring whether there's any significant amount of undigested feed?

NURSE E: No. As I was saying before, with babies that are on smaller volumes or babies that are maybe on part intravenous fluids and milk, we may take out all of the tummy contents to see how much they've digested, not at every feed but at some feeds. But when babies are on this volume of milk and on (inaudible) milk, we wouldn't aspirate the tube fully, we'd just take a small amount to test because it interferes with the baby's digestion.

The more you're pulling out more and more milk that interferes with how digested the milk becomes and obviously makes the baby very uncomfortable if you take, say, 10 or 15ml out if a baby hadn't fully digested that.

DRIVER: We know that 3 hours had passed between the bottle feed that we looked at at 11 pm and this 2 am entry. But there are no further entries on this page. Does it follow that this was the last feed that you gave [Baby G]?

NURSE E: Yes.

DRIVER: And can you recall what you did, having fed [Baby G] and completed the neonatal unit feeding chart for these events at 2 am on 7 September?

NURSE E: Following completion of the feed, I went on to my night-time break. We take an hour in one block, so I fed the baby and then went on my break.

DRIVER: So the night shift, we know, runs approximately 7.30 to 8 pm to -- 7.30 to 8 am?

NURSE E: Yes.

DRIVER: Does it follow from what you've just told us that you would have been allocated, my word not yours, a slot for your 1 hour break?

NURSE E: Yes. So the shift leader would decide when everybody's going on their break. That would be decided early on in the shift and they tell you when to go. So if you had something due around that time they might say, do that and then go on your break and let me know when you're going for your break.

DRIVER: What, if any, factors are used to determine who would have their break when?

NURSE E: So sometimes it's preference of when people like to go.

Some people are quite specific about when they like to go. Or it could be that things aren't due with your baby when you're due to go. The business of the unit as well, so sometimes breaks have to change because we get an admission or something like that. It's a lot of factors, really, for the shift leader and yourself to decide when your break is and obviously it's making sure there's enough people on the unit still and not everybody's gone on their break at the same time. So everybody has to stagger their breaks through the night.

DRIVER: You mentioned one of the factors was whether anything was going on with your baby.

NURSE E: Yes.

DRIVER: Are the breaks, the timing of the breaks determined at the beginning of the shift or on an ad hoc basis as the shift goes a long?

NURSE E: Well, it would be before the breaks start. So it would be before kind of midnight, earlier on in the night, they are usually determined. They do change though depending on what is happening on the unit, so it might be that you were allocated a break at say, you know, 3, 4 o'clock, but then that might end up changing to later or earlier dependent on the flexibility of what's happening on the unit.

DRIVER: Having fed [Baby G] at or around 2 am on 7 June (sic), do you remember leaving [Baby G] and going on your break?

NURSE E: I don't remember actually leaving her. I remember that I was -- I went on my break, but I don't remember kind of what was happening around that time. I know that I went on my break after I did the feed.

DRIVER: And how was she when you went on your break?

NURSE E: I can't actually remember. However, if I was concerned I wouldn't have gone on my break, but I don't actually remember that point in time.

DRIVER: Could you expand upon that, please? You have just stated that if you were concerned, you wouldn't have gone on your break.

NURSE E: So if she looked unwell or if her monitor was alarming or if she hadn't tolerated her feed, if she'd woken up and was upset, if any of those things had happened, I wouldn't have gone on my break.

DRIVER: And were any of those things happening?

NURSE E: I would assume not because I went on my break.

DRIVER: And prior to going on the break, would you have completed the entries on the charts for 2 am that I have taken your attention to today?

NURSE E: Yes.

DRIVER: Where did you take a break or where do nurses take their break within the unit?

NURSE E: Then we had a break room that was near the double doors, so just before you left the neonatal unit there was a break room to the side of the double doors off the unit there, so we would have gone there for our breaks.

DRIVER: Do you know how soon after the completion of the observations, the feed and the notes, how soon after that you would have taken your break?

NURSE E: After looking at my statement it says that I went straightaway afterwards.

DRIVER: We don't know the precise time because the duration of a feed --

NURSE E: The duration changes and if -- when the milk's warmed we wouldn't sit and look at the clock and wait for 2 o'clock to hit. If it had warmed at 1.56, we'd feed the baby there and then. So yeah, in terms of precise timing, I wouldn't know.

DRIVER: She was on a three-hour feeding regime?

NURSE E: Yes.

DRIVER: So it would be around 3 hours after her last feed; is that right?

NURSE E: Yes.

DRIVER: You went to the break room that you have just described?

NURSE E: Yes, I would assume. We didn't really take breaks particularly anywhere else at that time, so I assume I went to the break room for my break.

DRIVER: And what's your next recollection post-break?

NURSE E: So I came back from my break and the lights were on in nursery 1, which was straight ahead of where you come out of the break room, and I went -- from looking at my statement I went past that room to nursery 2, but [Baby G] wasn't in there. So looking at my statement I went back to where the other staff were in nursery 1 to discover that [Baby G] was in there.

DRIVER: Just to remind ourselves of numbers, you headed to nursery 2 to return to [Baby G]?

NURSE E: Yes.

DRIVER: Passing nursery -- the illuminated nursery 1 which was populated by staff?

NURSE E: Yes.

DRIVER: Arriving at your nursery, effectively, where you've been working with [Baby G], she was gone and then you put 2 and 2 together, did you?

NURSE E: I don't know whether I put 2 and 2 together. I think I probably just went to see the staff and see what was happening. I don't really know off the top of my head.

DRIVER: And what was happening?

NURSE E: Um... She was in nursery 1 -- I can't actually remember what they were doing at the time. But there was staff with [Baby

G] and they told me she'd been unwell while I'd been on my break.

DRIVER: Was that development expected or unexpected?

NURSE E: It was unexpected.

DRIVER: Why?

NURSE E: Because she'd been in a cot in nursery 2, fed and settled when I left her, and there'd not been anything on her observations so far that shift that had caused me any more concern than usual for a baby that's on low flow oxygen.

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

Cross-examination by MR MYERS

MR MYERS: [Nurse E], just a few questions if you'd help us, please. Dealing with the final bit first about taking the break and the time of the break, is it fair to say it's difficult to be precise about exactly what time you would have taken the break?

NURSE E: Yes.

MYERS: Just working with the rough figures we have, you take the break after the 2 o'clock feed has been completed; is that right?

NURSE E: Yes.

MYERS: You've explained to us in detail how the feed is prepared and how it's given, an NGT feed.

NURSE E: Yes.

MYERS: And that may take anything from 5 to 15 minutes, maybe 20 minutes if it's thickened up a bit?

NURSE E: Yes. It could take longer than that. It depends -- yeah, it depends on varying factors. As I say, if a baby is a little bit uncomfortable -- they could be asleep and still moving and straining a little bit --

MYERS: Right, thank you.

NURSE E: -- then it comes back up the syringe a little bit and then it has to go down again.

MYERS: So the paperwork with the feed, do you complete that once you have done the feed or before or during it or do you not know?

NURSE E: You complete it after because you don't actually know how the feed's going to go to be able to complete it.

MYERS: The feeds are at set times, aren't they?

NURSE E: Yes.

MYERS: So you have the set times, it may be, is it, that the feed might be completed a little bit before or a little bit after the set time?

NURSE E: It wouldn't necessarily complete before if it was a volume of, say, 45 ml but you may have started it before that time, because you tend to put the milk in to warm in the warmer, giving yourself time to do your observations and things, and if that alarms a little bit sooner, with a nasogastric tube or a bottle feed, you wouldn't then kind of stand there and wait for another 3 or 4 minutes to feed the baby, as long as you were within kind of that time frame.

MYERS: So if it's a feed at 2 o'clock, could it be the whole process is finished and you can leave maybe at 2, maybe at 2.055 or 2.10?

NURSE E: Yes. Possibly not at 2, maybe more like 2.05/2.10.

MYERS: All right. So then you go to take your break?

NURSE E: Yes.

MYERS: And then when you return, you see that [Baby G] at that point is receiving care and in a different room?

NURSE E: Yes.

MYERS: Just dealing with that, we know that after the time that [Baby G] became unwell, one of the nurses who looked after her was Lucy Letby.

NURSE E: Yes.

MYERS: And you're aware of that, aren't you?

NURSE E: Yes.

MYERS: And we know from the various records that Ms Letby then continued to look after [Baby G] over the period that followed.

NURSE E: Yes.

MYERS: And you're aware of that too, aren't you?

NURSE E: Yes.

MYERS: You actually were -- you then took on the duties of looking after one, or maybe more, of the other babies on the unit, didn't you?

NURSE E: After looking at my statement, yes.

MYERS: That's right. Just so that we have the detail, at the time that we're talking about in 2015, were you intensive care trained at that time?

NURSE E: No.

MYERS: But Ms Letby was, wasn't she?

NURSE E: Yes.

MYERS: And so it's in the natural course of these things that if [Baby G] has gone to nursery 1 and is being cared for, it would be, if possible, an intensive care nurse who was looking after her?

NURSE E: Yes. That would be the shift leader's decision to make.

MYERS: It would be, wouldn't it? So Ms Letby being intensive care trained, it makes sense she would continue to look after [Baby G] and you would be redesignated to somebody else?

NURSE E: Yes. That's kind of a common thing that does happen.

We do have to change the babies we're looking after sometimes during the shift.

MYERS: Thank you. You've been through the process of feeding via the NGT in some detail, which is assisting us all to understand how it's done and you've explained that with smaller babies it may be necessary to actually empty the whole of the stomach contents just to check how they're doing; is that correct?

NURSE E: Yes. You wouldn't do it at every feed because that would mess with the digestion, but you may do it once or twice in a shift potentially.

MYERS: All right. And obviously if a baby appears to be stable up to a certain point, then you would -- you and others would

work on the assumption that, unless there are clinical changes elsewhere, that's what would continue?

NURSE E: Yes.

MYERS: So if there have been no particular issues with [Baby G] up to the 2 o'clock feed, you'd have no reason, for instance -- or anyone else -- to start taking out all the contents of her stomach to check how she was doing, would you?

NURSE E: No, you wouldn't do that with a baby like that.

MYERS: And so, none of this is saying you have done something -- we are not being critical of what's taken place up to 2 o'clock. But you would work on the assumption that the milk in her tummy from earlier was digested?

NURSE E: Yes.

MYERS: But there's nothing done to actually check whether it has been or not?

NURSE E: No.

MYERS: So if for some reason something has changed, something happens which means that the milk has not digested, the fresh milk would go in on top of undigested milk?

NURSE E: Yes.

MYERS: Can I just ask this: in terms of the NGT feed, that final NGT feed, the record is 45ml that you gave her?

NURSE E: Yes.

MYERS: And does that record establish that must be what you gave her? Are you sure about that? Could it be more, could it be less, or would it be 45ml?

NURSE E: No, it'd be measured out to 45.

MR MYERS: Measured out, all right. Could you wait for one moment, please, [Nurse E]?

Thank you, my Lord. Thank you, [Nurse E].

MR DRIVER: My Lord, I have no re-examination. Does your Lordship have any questions for the witness?

Questions from THE JUDGE

MR JUSTICE GOSS: Just this about not knowing whether any of the previous feed of 45ml has been digested or not: does the pH figure that you took at 2 o'clock give you any information or not about that?

NURSE E: Not really because if the milk is in the stomach, you would have some kind of acid reaction anyway regardless of how much milk was there.

MR JUSTICE GOSS: Yes. So there's simply no way of knowing?

NURSE E: No. The baby may vomit if there's more milk there than they can cope with. But if there's no vomit, you wouldn't know.

MR JUSTICE GOSS: Right. Thank you very much.

Just one other thing. You said your break was for an hour?

NURSE E: Yes.

MR JUSTICE GOSS: Does that mean that if, for example, you left the room at, say, 1.10, would that mean you'd come back at 2.10 for does it mean you come back at 2.

NURSE E: No, no, you take a full hour.

MR JUSTICE GOSS: You would take the full hour?

NURSE E: So unless somebody came to get you in advance of or they told you pre that you were taking a shorter break for whatever reason, sometimes you might have six shorter breaks if we couldn't fit them all in if the unit was busy, but if we were taking our standard hour break you would go at whatever time past the hour and come back at the same time past the next hour.

MR JUSTICE GOSS: From your statement you made and looking at the notes, this would have been just the standard 1 hour break?

NURSE E: Yes.

MR JUSTICE GOSS: Whenever it was, from 2 to 3 or from 2.10 to 3.10?

NURSE E: Yes. Unfortunately, I don't have a memory of what happened that particular shift.

MR JUSTICE GOSS: You'd be remarkable if you did.

NURSE E: Yes, but that's standard, what we would do.

MR JUSTICE GOSS: Thank you very much.

MR DRIVER: There is a possibility that the witness might return, but that's under review.

MR JUSTICE GOSS: All right. That completes your evidence for today; thank you very much for giving it and coming today. There is apparently a possibility you may have to give evidence again, a possibility. Please don't speak to anyone about this case, anything to do with this case, until it's all over.

NURSE E: Okay.

MR JUSTICE GOSS: Thank you very much indeed.

(The witness withdrew)

MR JUSTICE GOSS: You will have realised that these documents that were being put up on the screen, you've got the paper copies of these so you can follow them as well. That's the charts, the feeding charts.

Right.

MR DRIVER: Sorry, my Lord, I made the assumption, it being 12.58. Apologies.

MR JUSTICE GOSS: That's all right. We will have our break and we'll recommence at 2.05, please, members of the jury.

(1.00 pm)

(The short adjournment)

(2.03 pm)

MR JUSTICE GOSS: Are you ready?

MR ASTBURY: We're just making sure that the witness's file is up to date. It will be any moment, so we are ready, yes.

(In the presence of the jury)

MR ASTBURY: I call Ailsa Simpson, please.

MISS AILSA SIMPSON (affirmed)

Examination-in-chief by MR ASTBURY

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

SIMPSON: Ailsa Heather Simpson.

ASTBURY: Thank you. Your profession, please?

SIMPSON: Neonatal -- sorry, I'm getting flustered. Neonatal nurse.

ASTBURY: Thank you. Nurse Simpson, we are -- obviously I'm asking the questions, but if you can make an effort to your keep voice up, please, so everybody in the room who needs to hear you can hear you, please, and with there also obviously being a screen we need you to keep it up even louder if you can -- without shouting, obviously.

If you can just keep your voice up, we'd be very grateful.

We understand that you were employed at the Countess of Chester Hospital in September of 2015; is that right?

SIMPSON: Correct.

ASTBURY: And in what capacity were you employed then?

SIMPSON: Neonatal nurse.

ASTBURY: And we've heard the various levels of neonatal nurse in the neonatal world. What band would you have been at that time?

SIMPSON: Band 6.

ASTBURY: Thank you. I'm going to ask you, please, about your treatment of a patient by the name of [Baby G] and, in particular, a shift which began on 6 September of 2015 into the morning of 7 September 2015.

I think you've had an opportunity to look at the medical notes in [Baby G]'s case; is that right?

SIMPSON: That's right.

ASTBURY: Before we come to 6 September specifically, I think you are able to confirm that you had had contact with [Baby G] on previous shifts; is that right?

SIMPSON: That's correct, yes.

ASTBURY: And your impression, please, given the contact you'd had with [Baby G] over that period of her position or her progress by the start of that shift on 6 September?

What sort of condition was [Baby G] in by then?

SIMPSON: By 6 September, she was in good condition. She was what you'd class as a special care baby.

ASTBURY: Okay. So we've heard there's special care, increased to high dependency, increased to intensive care?

SIMPSON: Correct.

ASTBURY: In respect of feeding and weight, can you assist us with your impression of [Baby G] at the start of that shift, please?

SIMPSON: She was a reasonable weight, just under 2 kilograms.

ASTBURY: And as far as weight was concerned, was she progressing as the nursing staff would hope?

SIMPSON: Yes.

ASTBURY: Good, okay. I promised to ask you specifically about 6 September. I'm going to ask you to look at a screen, which is slightly to your right, which I hope will reflect the notes that you've had the opportunity to look at in advance of giving evidence.

If we can start with tile 47. Thank you. If we can go behind tile 47.

If we look at those boxes for now, please, we can see the consultant who was both paediatrician of the week and on call that particular night, the registrar and SHO who would have been there in the hospital to support, and also the nurses on duty that night.

Next to shift leader is your name together with Christopher Booth's. Are you able to say whether you were the shift leader or Nurse Booth?

SIMPSON: From my statement, it was myself, I was shift leader.

ASTBURY: Right. Of course, speaking of [Baby G], her designated nurse was [Nurse E]; is that your recollection?

SIMPSON: That's correct.

ASTBURY: And also on duty that night was Lucy Letby?

SIMPSON: That's correct.

ASTBURY: We can see a little bit further down, in addition to those nurses, was a nursery nurse by the name of Lisa Walker.

SIMPSON: Yes.

ASTBURY: Scroll down a little further, please, Mr Murphy.

You may recognise the green-shaded plan in the middle of this particular page. Hopefully that, as you recall it, represents the NNU?

SIMPSON: It does, yes.

ASTBURY: The larger room to the right and the centre being nursery 1?

SIMPSON: Yes.

ASTBURY: Just to orientate you, and on the left we have in ascending order nurseries 2, 3 and 4.

SIMPSON: Yes.

ASTBURY: We can also see that you, in nursery 1, were allocated a baby given the initials AC.

SIMPSON: Yes.

ASTBURY: There was another baby in nursery 1 for whom Lucy Letby was designated nurse?

SIMPSON: Yes.

ASTBURY: And then if we look below, two more babies whose location from the paper is unconfirmed. You only have initials, I appreciate, but I don't know whether you can assist us with that, whether you have any recollection of where any other babies were.

SIMPSON: I can't, I'm sorry.

ASTBURY: Okay. We have in nursery 2, [Baby G].

SIMPSON: Yes.

ASTBURY: With, as you've already informed us, [Nurse E] as her designated nurse. And to the left, in nursery 3, two babies to whom Lisa Walker was designated.

SIMPSON: Yes.

ASTBURY: Are you able, from looking at that and from recollection, to tell us whether this was a particularly busy shift or not on 6 September?

SIMPSON: From the amount of babies I would say it wasn't as busy as it has been, so no, relatively -- we don't like to use the word quiet --

ASTBURY: Okay, sorry.

SIMPSON: -- because we jinx ourselves so I would say it was a relatively calm shift.

ASTBURY: Calm, that's the word we'll employ.

I appreciate you have relied on the notes in part for your recollection, so we'll come to what you can actually remember in a moment, but by way of assistance I wonder if we could go next, please, to tile 64 on our presentation.

We may not need to go behind it, but the tile suggests that you and [Nurse E] provided medication for [Baby G] at around 11 pm; is that correct? We can go behind it if you don't recall.

Can we have a look at the document behind?

Is that a form that you're familiar with with your experience at the NNU?

SIMPSON: Yes.

ASTBURY: And if we scroll down can you see the time and the date on that? Was that the original prescription where we have in the middle of the page "Started 14 August"?

SIMPSON: Yes.

ASTBURY: If we can scroll down and see if there's an entry which supports the tile. I think in the lower of the boxes we can see there, 23.00 hours, as I suggested, 6 September. We've heard that there's a system where nurses countersign with one another for any medication.

SIMPSON: Yes, that's correct.

ASTBURY: We've also heard that where it says "user" and where it says "co-signer" isn't always reflective of how things actually took place; is that your recollection?

SIMPSON: That's true, yes.

ASTBURY: User tends to be whoever's inputting into the computer?

SIMPSON: Yes.

ASTBURY: Co-signer is whoever then adds their name for their involvement?

SIMPSON: Yes.

ASTBURY: All right. Can you confirm that the entry on the left, "Non-scheduled, 06/09, 23.00", suggests that dose was given at 11 o'clock that night?

SIMPSON: That's correct, yes.

ASTBURY: Thank you. If we come out, please.

Go to the next tile. We don't need to go behind it I don't think but that suggests, again, you were involved with [Nurse E] with administering Gaviscon at the same time?

SIMPSON: Yes.

ASTBURY: Thank you. Can we go next, please, to tile 66, the next tile? We can see there, similar team work, if I put it that way. A little later now, it's 01.42 in the shift, and you and [Nurse E] are administering sodium chloride.

SIMPSON: That's correct.

ASTBURY: Which in itself I'm not sure would have been a medication, but we have Gaviscon on the next tile at 146.

We then have the update on the computer.

I understand that there's two stages: the medication is administered, then it has to be entered as having been so on the computer system?

SIMPSON: That's correct.

ASTBURY: So we have the update at 1.46 in the morning. On the next two tiles, in fact it goes a little further, it may be that that was updated for the earlier doses as well.

It's not always straightaway?

SIMPSON: Not always straightaway.

ASTBURY: Okay. But we can see that's being done at 1.46 and on the next tile, 1.47 in the morning. And indeed the next tile. And the next. Thank you.

So any recollection of those events or are they just helpful to see on the record but no specific memory?

SIMPSON: Helpful to see on the record.

ASTBURY: All right. Now, do you have -- we have taken you up to about 1.47 that morning. Do you have any specific recollection of events around 2 o'clock involving [Baby G]?

SIMPSON: Yes. I remember her being fed at that time.

ASTBURY: Is that, can I ask, from recollection or from having reviewed the notes or a combination of both?

SIMPSON: A combination of both.

ASTBURY: All right. Can we concentrate on what you remember yourself first and then we'll go to the notes and see what assistance they give.

So you remember [Baby G] being fed at 2 o'clock?

SIMPSON: Yes.

MR JUSTICE GOSS: Around 2 o'clock.

MR ASTBURY: Around 2 o'clock, thank you.

We've heard at that stage she was receiving expressed breast milk.

SIMPSON: That's correct.

ASTBURY: Specific quantities?

SIMPSON: Mm-hm.

ASTBURY: Each and every 3 hours?

SIMPSON: Yes.

ASTBURY: All right. Would that have been a routine feed at that stage?

SIMPSON: Yes.

ASTBURY: All right. Do you remember who gave the feed?

SIMPSON: My colleague, [Nurse E].

ASTBURY: Do you happen to remember where [Baby G] was at this stage?

SIMPSON: She was located in nursery 2 in the far corner, near a window.

ASTBURY: Right. Do you remember how [Baby G] was fed on that particular occasion?

SIMPSON: She was fed by a nasogastric feeding tube.

ASTBURY: We've heard that on occasions she was being fed by a bottle. Was there a reason why she wasn't, do you recall, fed with a bottle at that time?

SIMPSON: She'd had -- prior to what I've read from my statement, she'd had a bottle previously on her last feed and it's routine for a baby, if she is feeling tired and doesn't want to feed for the next, she would be rested and we'd give her a tube feed.

ASTBURY: Okay. Did you have any interaction with either [Baby G] or do you remember who did feed her?

SIMPSON: [Nurse E].

ASTBURY: Did you have any contact with either [Baby G] or [Nurse E] during the course of that feed that you recall?

SIMPSON: Not during that feed.

ASTBURY: All right. Do you remember what happened after [Nurse E] had fed [Baby G]?

SIMPSON: She went for a break after she'd finished her feed.

ASTBURY: Was that a prearranged break or was that reactive to the situation that [Baby G] was in?

SIMPSON: It would have been a prearranged break.

ASTBURY: Right. In your experience and as designated nurse for that particular shift, would you have expected [Nurse E] to have gone on her break if there had been any issues arising out of the feed around 2 o'clock?

SIMPSON: Yes, she would still have gone unless it was a significant thing that had happened. I would expect her to have still gone for her break.

ASTBURY: And do you remember anything significant before she went on her break?

SIMPSON: No.

ASTBURY: Do you remember anything significant after [Nurse E] had gone on her break?

SIMPSON: Um... Obviously, with regards to my statement, about 15 minutes after she'd been fed, that's when we heard the projectile vomit.

ASTBURY: So you mentioned "We heard the projectile vomit"; who was "we"?

SIMPSON: That was me and my colleague, Lucy Letby.

ASTBURY: Right. Do you recall where you were when you heard the projectile vomit?

SIMPSON: We were sitting at the nurses' station, just located not far from the nursery.

ASTBURY: I'm going to ask Mr Murphy if he doesn't mind going back to tile 47, please, just to have a look, if you can tell us, so far as you recall, where the desk was in relation to nursery 2.

Is it possible to enlarge it a bit, Mr Murphy?

We'll do it in a different way. So slightly different plan. But if you can -- we can see again 1, 2, 3 and 4 by way of nurseries. Could you explain to us where you think you were at the time? You may well be sure where you were when you heard the vomiting.

SIMPSON: Sitting at the desk of the nurses' station.

ASTBURY: Is that sort of almost right in the middle, above the S and the E, and there are two chairs behind the desk?

SIMPSON: That's correct, yes.

ASTBURY: Are you able to recall what time this was?

SIMPSON: That we were sitting?

ASTBURY: That you heard the vomiting.

SIMPSON: About 2.15.

ASTBURY: We have the benefit of, and I'm going to ask you to look at another document that everybody has, a review of the shift which may enable you to be a little bit more sure about the time.

My Lord, I'm referring to the NNU review of [Baby G], which is the most recently provided to everybody on the jury. If they could turn to that document, please.

(Pause)

I can see, Nurse Simpson, that you've got it open at the plan which we began with in your evidence.

SIMPSON: Yes.

ASTBURY: Could I ask you, please, to turn over to the next page, which should look something more like an Excel spreadsheet. It should have in the bottom right-hand corner "page 3 of 7".

SIMPSON: It does, yes.

ASTBURY: Okay. We've all seen one of these before, but so that you know, it's an analysis of what nurses were doing in the unit at or around any particular given time. I'd like you to please begin -- if you can go down to line 26 on the left-hand side.

SIMPSON: Yes.

ASTBURY: We can see there that from the various medical notes that were available to the investigation team that on 7 September 2015 at 01.15, a baby by the name of AC, who I think we saw earlier was your allocated baby.

SIMPSON: That's correct.

ASTBURY: According to the feeding chart you fed her at 1.15. I'm going to take you, if I may, to the feeding chart itself because I've got one or two questions about that.

That is at J29015.

MR JUSTICE GOSS: Say again, please. J?

MR ASTBURY: 29015, my Lord.

MR JUSTICE GOSS: Thank you.

MR ASTBURY: So we can see the date in the top left, into 7 September now. Obviously, this is not [Baby G]'s chart, this is

another baby's chart, if anyone is wondering why the figures are as they are. But we can see at midnight, a feed; is that right?

SIMPSON: That's correct, yes.

ASTBURY: And then if we look down at 1.15, emphasis on the word "demanded"; is that right?

SIMPSON: Yes.

ASTBURY: A hungry baby?

SIMPSON: Yes.

ASTBURY: Being fed expressed breast milk?

SIMPSON: Yes, that's correct.

ASTBURY: The amount -- is this 40ml?

SIMPSON: Yes, that's correct.

ASTBURY: By bottle?

SIMPSON: Yes.

ASTBURY: And you confirm that's your initials on the right-hand side?

SIMPSON: That's correct, yes.

ASTBURY: Thank you. I'm not going to come back to it, but we can see, and we'll see it in the chart in a moment, you repeated the process at 02.20 as well.

SIMPSON: Yes.

ASTBURY: So 01.15. Are you able to tell us how long it would have taken to feed a hungry baby 40 ml from a bottle?

SIMPSON: Roughly no longer than half an hour.

ASTBURY: Okay. And how accurately can we rely on the time at 01.15? Is that an approximation or is that going to be about right?

SIMPSON: That's about right.

ASTBURY: So that takes us possibly to 01.45 in the morning.

SIMPSON: Yes.

ASTBURY: If we come out of that document now, thank you, and go back to our carousel and tile 66 again.

This is our 1.42 medication we touched on before.

We didn't go behind this tile, but if we could now, please. If we can scroll down. Thank you.

We can see in the box, helpfully pointed out by the cursor, that we've got medication and you appear as co-signer.

SIMPSON: Mm-hm.

ASTBURY: So involved to some extent. Administered at 01.42?

SIMPSON: Yes.

ASTBURY: And if we read across, that's being inputted into the computer at 01.46. So assuming around half an hour if that's right, not holding you to it, but about half an hour, that would be consistent with you then being free to assist with the medication for [Baby G] at about 01.42.

SIMPSON: Mm-hm.

ASTBURY: Right. We probably don't need to go into it, but we can follow, please, down the left-hand side. That was entry 27. Entries 28, 29, 30 and 31 mirror the tiles on the presentation. They all span that period between 1.42 and 1.47.

MR JUSTICE GOSS: Yes. Not what's on the screen --

MR ASTBURY: I'm talking about the tiles. My mistake. If we go backwards --

MR JUSTICE GOSS: Mr Murphy was just scrolling down because he was -- so we're back on the...

MR ASTBURY: Thank you.

So that takes us to about -- we can keep going to the right to the last of those tiles, please, Mr Murphy.

We can confirm the time if necessary, but the last one seems to be 1.47. Thank you.

So about 5 minutes spent giving medication and updating the computer. Where's the computer by the way?

SIMPSON: They're located just outside the nursery.

ASTBURY: Oh right. So not back at the nurses' station?

SIMPSON: There is one there, but the one that we would use for medication is either outside the nursery or it was just slightly to the side of the nursery.

ASTBURY: Okay, all right. Just putting together this period of time, we can see again, and we've seen it already, and you have told us that the feed for [Baby G] was at or around 2 o'clock. And we've heard, and does this sound right, the process is: take observations, then feed the baby, in that order?

SIMPSON: Yes.

ASTBURY: All right. We can see that the next entry for you, Nurse Simpson, is at line 39, which is, we saw it earlier on, the feed of AC. In fact, it's line -- I do beg your pardon. It's line 41. If we go across from line 41, at 2.20 you're feeding again the hungry baby we saw before. Assuming the time to be correct at 2.20, tell us, please, what happens before you come to feed the baby. Is there a process before the bottle actually reaches the baby?

SIMPSON: Yes. So I would take a set of observations, so heart rate, saturation, temperature, depending on the level of care, and if she doesn't need any nasal prong oxygen then it would just be a temperature.

ASTBURY: Right. What about the milk? Where's the milk stored?

SIMPSON: In the milk fridge in the milk room.

ASTBURY: Could we just go back to the plan, Mr Murphy, and have a look -- and you can show us, please, where the milk would be stored.

It might be pretty obvious, but if you can point out to us, please, where the milk is stored on the plan?

SIMPSON: It's letter S.

ASTBURY: Immediately above the nurses' station, a specific milk kitchen; is that right?

SIMPSON: Yes.

ASTBURY: All right. Does the milk have to be warmed before it's given to the baby?

SIMPSON: Yes, it does.

ASTBURY: Is it stored in refrigerator?

SIMPSON: In the refrigerator, yes.

ASTBURY: So there's a process -- we've heard there's a specific bottle warmer which can be programmed to get it to the right temperature?

SIMPSON: Yes.

ASTBURY: How long is the process from fetching the milk, warming it, going to the baby and feeding them?

SIMPSON: It depends how much milk you've got; the warmer will programme it.

ASTBURY: I think we were 40 on the chart, weren't we?

SIMPSON: Yes. It will -- you programme it and it will roughly say 7 minutes to warm. I don't know for definite the length of time, but approximately it will give you the time to warm the milk.

ASTBURY: Okay. Where is the milk warmer?

SIMPSON: Located in the nurseries.

ASTBURY: Can you tell us where?

SIMPSON: It will have been in each nursery.

ASTBURY: So there's an individual warmer in each of the nurseries?

SIMPSON: Yes.

ASTBURY: Okay. I'm trying to recall where baby AC was. Let me just double-check. So that would be nursery 1?

SIMPSON: Nursery 1.

ASTBURY: So if that's right you'd have gone to the milk kitchen at about 2.10 or thereabouts?

SIMPSON: Not at 2.10.

ASTBURY: No?

SIMPSON: No.

ASTBURY: When do you think you'd have gone to the milk kitchen for a 2.20 feed?

SIMPSON: Earlier.

ASTBURY: Earlier?

SIMPSON: No, it will have been roughly about... I'd say earlier.

ASTBURY: Okay. All right. We've heard that the feed that [Nurse E] gave [Baby G] was 2 o'clock.

SIMPSON: Mm-hm.

ASTBURY: And you're feeding baby AC at 2.20. Working backwards to going and getting the milk and warming the milk in nursery 1, how far back from 2.20 does that take us?

SIMPSON: About half an hour.

ASTBURY: Okay. So you'd have warmed the milk before 2 o'clock?

SIMPSON: Yes.

ASTBURY: And then not got round to the feed until 2.20.

Is that --

SIMPSON: Yes.

ASTBURY: All right. Sorry, I'm just trying to piece together the timeline, you see. You finished the medication and the updating at 1.47?

SIMPSON: Mm-hm.

ASTBURY: You think that you've gone to possibly collect the milk from the fridge at about -- half an hour would be 1.50?

SIMPSON: Yes.

ASTBURY: You'll have then taken it to nursery 1 to warm it up?

SIMPSON: Mm-hm.

ASTBURY: You think overall that would have taken about 10 minutes?

SIMPSON: Roughly around 10 minutes, yes.

ASTBURY: So we're now 2 o'clock.

SIMPSON: Mm-hm.

ASTBURY: Please correct me if I'm wrong. I'm just trying to align with the documents and if your memory assists, that would be perfect. So the feed is at 2 o'clock?

SIMPSON: Mm-hm.

ASTBURY: You now have warm milk waiting in nursery 1 for baby AC?

SIMPSON: Yes.

ASTBURY: How long after you heard the vomiting do you think -- sorry, how long after the feed by [Nurse E] and her going on her break do you think you heard the vomiting?

SIMPSON: Fifteen minutes after.

ASTBURY: Right. How long do you think you'd been sitting then, bearing in mind all the things we've been through, at the nurses' station when you heard it?

SIMPSON: About 10 minutes, if not 5.

ASTBURY: Five or 10 minutes. Just so I understand, once the milk is warm, presumably there's no problem leaving it for 5 or 10 minutes, but that would be the amount of time you would spend away; is that about right?

SIMPSON: Roughly.

ASTBURY: Okay. So what did you do, please, when you heard the vomiting?

SIMPSON: So I got up straightaway and went into the nursery. Me and my colleague, Lucy Letby, and the monitor that [Baby G] was on alarmed to tell us obviously there was a drop in oxygen levels and heart rate.

ASTBURY: Okay. Again just trying to break it down a little bit.

You heard the vomiting. At what stage did you hear the alarm?

SIMPSON: It's like literally a -- about 30 seconds after.

ASTBURY: So vomiting first. You react to the vomiting, hearing the vomiting. Was it quite loud?

SIMPSON: Loud enough to hear, yes, from the nurses' station, yes.

ASTBURY: We've heard about possets.

SIMPSON: Yes.

ASTBURY: But this is something --

SIMPSON: It was a significant projectile vomit.

ASTBURY: Right, okay. You heard the vomiting, you go to [Baby G]?

SIMPSON: Mm-hm.

ASTBURY: You hear the alarm. Do you think you hear the alarm by the time you've reached [Baby G] or before you get to her?

SIMPSON: Just as we're approaching her.

ASTBURY: Okay. Tell us what you found, please.

SIMPSON: A large milky digested vomit.

ASTBURY: Okay. When you say digested, what do you mean?

SIMPSON: So she's tolerated -- well, not tolerated the milk, but it's digested milk that she's had -- like been fed and then it's just (indicating).

ASTBURY: You're indicating it's come back up.

SIMPSON: It's come back up, yes.

ASTBURY: All right. What did you do when you got to [Baby G]?

SIMPSON: Sat her up.

ASTBURY: Right. The purpose of that being?

SIMPSON: To help her just to -- well, it's a natural reaction if someone's sick, quite naturally you put the baby up.

ASTBURY: And how much vomit was there?

SIMPSON: A large amount. It had gone from over her cot and on to the chair next to her, next to her cot.

ASTBURY: You told us before she was in a cot in the corner of nursery 2. All right. Was it in the cot?

SIMPSON: On the sheets, some on the bed sheet.

ASTBURY: Was it out of the cot?

SIMPSON: Yes.

ASTBURY: Where was it out of the cot?

SIMPSON: Down the side of the cot and on to the chair that was situated next to her.

ASTBURY: Were you shown a photograph of the nursery and asked to give the police an idea of where it was?

SIMPSON: I was.

ASTBURY: Thank you. I wonder if we could have a look at that photograph, please, Mr Murphy.

First of all, is that nursery 2?

SIMPSON: That is, correct, yes.

ASTBURY: We can see it's a corner. Is that where you remember the cot being positioned that night?

SIMPSON: Yes.

ASTBURY: Is that the same type of cot that [Baby G] had been sleeping in?

SIMPSON: Yes.

ASTBURY: Which way would [Baby G] have been lying?

SIMPSON: Head under the -- well, I guess pointing towards the canopy and her feet at the bottom of the cot.

ASTBURY: The purpose of the canopy?

SIMPSON: Just to get -- well, protect her from the light because she was early -- early born.

ASTBURY: So is that fitted in the daytime as well or just at night-time?

SIMPSON: It's all day.

ASTBURY: Okay. We've got three circles on the photograph. Who drew them on?

SIMPSON: Um... Dr Stonier. Not Dr Stonier, no, a police officer.

ASTBURY: A police officer, DC Stonier, I think.

SIMPSON: Yes.

ASTBURY: Why did she draw them there? An obvious question.

SIMPSON: Because that's where I've said the vomit was.

ASTBURY: So we've got an area inside the cot. Is that slightly to the right of where -- sorry, the left as we look, but as [Baby G] would have been lying, slightly to her right?

SIMPSON: Yes.

ASTBURY: You mentioned it was down the side of the cot.

SIMPSON: Yes.

ASTBURY: So we can see the side of the cot. And below the side of the cot we've got another circle. Was there more vomit on the floor?

SIMPSON: Yes.

ASTBURY: Then there is a circle over on the chair. What does that circle denote, please?

SIMPSON: That it also reached the chair as well.

ASTBURY: The vomit reached the chair?

SIMPSON: The vomit reached the chair as well. That chair isn't the actual chair that was in the nursery at the time.

ASTBURY: Okay. But were you -- is that chair fairly where the other chair would have been?

SIMPSON: It is.

ASTBURY: And it reached on to the seat of the chair?

SIMPSON: Yes.

ASTBURY: Okay. So you sat [Baby G] up?

SIMPSON: Mm-hm.

ASTBURY: Do you recall what happened next? You said one of the alarms was activating.

SIMPSON: Yes. Yes, so we would have gone -- from reading my statement, we would have gone over to [Baby G] and assisted, sat her up, and then realised that she was dropped in heart rate and dropped in saturation levels.

ASTBURY: Right.

SIMPSON: So we would have reached for some respiratory support to help her.

ASTBURY: Okay. All right. And do you remember what that respiratory support would have been?

SIMPSON: It's called a Neopuff. That gives the baby breaths if they're not breathing.

ASTBURY: And we've seen earlier today a demonstration of how the nurse pushes the button to deliver the air or the oxygen or whatever is to be delivered.

SIMPSON: That's correct.

ASTBURY: Can you remember who actually did that?

SIMPSON: I can't remember exactly whether it was me or my colleague, Lucy.

ASTBURY: We've heard that -- well, you told us that an alarm went off. Do we assume from that that [Baby G] was attached to a monitor?

SIMPSON: Yes.

ASTBURY: What information did the monitor give you, can you recall?

SIMPSON: Heart rate and saturation levels.

ASTBURY: We've heard that sometimes nurses can deal with situations, senior nurses can deal with certain situations. How was this one dealt with, please?

SIMPSON: So at that time that that happened, we were giving her breaths and then we would have called for help straightaway.

ASTBURY: Who would you have called for help?

SIMPSON: I did... Well, I can't remember, but it was either myself or my colleague Lucy that would have shouted outside. So I think from reading the statement, it was Lisa Walker that came in to assist.

ASTBURY: Did anybody else come to assist?

SIMPSON: Not that I can remember.

ASTBURY: Did anybody call for a doctor?

SIMPSON: I... I assume from reading the statement, it would have been Lisa that would have been called -- called for them.

ASTBURY: Do you remember who that doctor was?

SIMPSON: Alison Ventress.

ASTBURY: We've heard from Dr Ventress. Can you recall anything about [Baby G]'s appearance when you were responding to the alarm and her vomiting?

SIMPSON: I can't, no.

ASTBURY: All right. Do you recall whether her parents attended that morning?

SIMPSON: I... I can confirm that they were there at the start of the shift.

ASTBURY: Just going back to the NNU, and I apologise for this, but if we look at line 39, bearing in mind the times that you've given us, we can go to the document in a moment but you may be able to remember. At 2.13 you're recorded as assisting Nurse Booth with medication for a baby initialled DB. Do you have any recollection of that?

SIMPSON: No.

ASTBURY: Just fitting that into our timeline, you think you were at the nursing station about 2 o'clock for 5 to 10 minutes, I think was your recollection.

SIMPSON: Mm-hm.

ASTBURY: How long do you think you were engaged with [Baby G] when you responded to her being so sick?

SIMPSON: I can't remember.

ASTBURY: We know you were feeding again by 2.20.

SIMPSON: Mm-hm.

ASTBURY: Did this incident happen before 2.20?

SIMPSON: It was at 2.15.

ASTBURY: Right. So let's go, please, if we may, to J29020. If we go down, please, to the relevant entry.

Again this obviously isn't [Baby G]'s record and it's not your baby's record, this is DB's record. If we can scroll down, please, to the entry in the early hours of -- thank you -- 7 September. That's the 8th, we need the 7th, sorry, a little bit earlier. There we go, thank you.

We can see there that yourself and Nurse Booth are administering medication at 02.13.

SIMPSON: Mm-hm.

ASTBURY: If the vomit was at 02.15, which seems to be the time that -- are you confident about 02.15?

SIMPSON: Yes.

ASTBURY: So does that suggest that you were engaged at 02.13 with at least co-signing on the computer with Nurse Booth for the administration of medication?

SIMPSON: Yes.

ASTBURY: And the computer would have been where, just remind us.

SIMPSON: Just located outside the nursery.

ASTBURY: Which nursery, please?

SIMPSON: I'm not sure which computer that was documented on.

ASTBURY: Okay. It may be that we can make some enquiries into that.

So would that have been before the vomit, if your timing is right?

SIMPSON: Yes.

ASTBURY: Just before?

SIMPSON: Just before.

ASTBURY: All right. Thank you. So from your recollection, so I understand, and please correct me if I'm wrong, you're at the desk by about 2 o'clock, you're with Nurse Letby for, you think, 5 or 10 minutes. At 02.13, you're engaged with medication with Nurse Booth, and at 02.15 [Baby G] vomits in the way that you've described?

SIMPSON: Mm-hm.

ASTBURY: You told us that mum and dad arrived a little later.

Can we, just for the sake of completeness, go back to the EPE, please. Do you recall any further contact with [Baby G] during the shift?

SIMPSON: No.

ASTBURY: It may be that you assisted -- if we look at tile 93, please, and we look at the document behind it. Our note suggests it's 04.15 on the 7th. I think that is the entry right at the top. Do you recognise your signature?

SIMPSON: I can, yes.

ASTBURY: Thank you. If we can go back to tile 94, please, and look at that document.

Is this the same event reflected on two different forms?

SIMPSON: It is.

ASTBURY: It is timed the same, 4.15?

SIMPSON: It is, yes.

ASTBURY: And can you confirm that's your signature?

SIMPSON: I can confirm that.

ASTBURY: Thank you very much. Is that yours to the right as well?

SIMPSON: I can confirm that as well, yes.

ASTBURY: Thank you. So involved again at 05.30 with [Baby G]?

SIMPSON: Yes.

ASTBURY: Thank you. If we go back to the EPE. It may be that we don't need to go behind the remainder of the tiles, but we'll run through them.

That's 04.15. If we can carry on again, please, to tile 100. So at 05.11, assisting with the administration of morphine sulphate. I'm not going to try and say that one, but further medication at the same time.

SIMPSON: Yes.

ASTBURY: Oxygen at 05.12, 05.15. We have heard that obviously on the unit, because you need two signatories for medications, it's not unusual for other nurses to assist.

SIMPSON: No.

ASTBURY: And if we continue to go across we can see those medications being entered on to the computer in the way we've already seen on other tiles. Carry on, please.

Another entry on the neonatal infusion chart.

That's at 106.

109, please. Just scrolling along, more medication, this time assisting Nurse Booth with medication for [Baby G]. Do you have any recollection of that or not?

SIMPSON: No.

ASTBURY: Okay. 115, please. A little bit after 6 o'clock in the morning. Further medication.

Just pausing there, those medications are synonymous with, I think, intubation; is that right?

SIMPSON: That's correct, yes.

ASTBURY: We've heard that in fact [Baby G] was intubated around that time. That would be the administration of those drugs; is that right?

SIMPSON: Yes.

ASTBURY: 123, please, next. Some more assistance at 06.31 and 06.32. Scrolling along, please. Then at 128, I think we have your final entries on that particular shift, assisting with the administration of pancuronium at 06.45.

And then across to the next tile, please, next but one. And then that medication being inputted to the computer a few minutes later. Thank you.

I have no more questions. Thank you. If you could wait there, please.

Cross-examination by MR MYERS

MR MYERS: Is it Ms Simpson, Miss Simpson?

SIMPSON: Miss.

MYERS: Some questions to help us. You've just been asked by the prosecution to help with, as it's been described, piecing together the timeline. That's what you were being asked. Right.

In general, when it comes to looking at the documents that you've looked at, you don't have any particular memory of specific entries and timings on those documents, do you?

SIMPSON: No.

MYERS: I'll come back to some of them in a moment, but in many cases, on a document, when we see something like "2 o'clock feed" or something like that, that's going to be an approximate time to when things took place, isn't it?

SIMPSON: That's true.

MYERS: Yes. Although you've been asked now, 7 years after the event, for how long it took to do this or how long it took to do that, it's almost impossible now, casting your mind back, to know how long something actually took; is that fair?

SIMPSON: That's fair.

MYERS: Yes. We'll look at some of that in a moment, but against that, can I ask you this: you have described how you heard a vomit and you heard an alarm and you went to nursery 2; is that right?

SIMPSON: That's right.

MYERS: And you went there with Ms Letby, who had been with you at the nursing station?

SIMPSON: That's right.

MYERS: Unlike trying to think back to timings on documents that you don't have independent recollection of, do you have images in your head of that taking place and you can remember that?

SIMPSON: Not really.

MYERS: Do you recall how one event led to another event when you went to [Baby G], the nursery that [Baby G] was in?

SIMPSON: Could you repeat that?

MYERS: Yes. If we think about when you entered the nursery with Lucy Letby, you remember that happening, don't you?

SIMPSON: Yes.

MYERS: Right, that's what I mean. And you can remember hearing the vomit and hearing the alarm, can't you? And you can remember heading over there with Lucy Letby, don't you?

SIMPSON: Yes.

MYERS: Right. So those are things you actually can remember, aren't they?

SIMPSON: Mm-hm.

MYERS: Trying to remember now how long it took to prepare the milk for a feed at a certain time in the morning 7 years ago is something that you can't really remember, can you?

SIMPSON: Not exactly.

MYERS: All right. Let's just start, if we could, please, by a quick look at that plan. I don't know if you've actually got the one of the map, Mr Murphy, rather than the one from the timeline. The actual exhibit map. We do have it in paper and the jury bundle, ladies and gentlemen, but we can see if Mr Murphy is able to put it on the screen.

Thank you, there we go.

If we take a look there, we can see the nursing station, right in the middle of the unit; is that right?

SIMPSON: That's correct.

MYERS: One thing you have a clear recollection of is being there at the time that you heard the vomit?

SIMPSON: That's right.

MYERS: That's something we have. That nursing station gives you a clear view, certainly up the corridor, towards nursery 4, doesn't it?

SIMPSON: Mm-hm, yes.

MYERS: And you can see into nursery 3, can't you?

SIMPSON: Yes.

MYERS: And you can see into nursery 2 from the nursing station, can't you?

SIMPSON: Yes.

MYERS: And nursery 2 is the nursery that [Baby G] was in?

SIMPSON: Yes.

MYERS: Thank you. You can also, in general, hear what is happening in the rooms, can't you?

SIMPSON: Yes.

MYERS: You were able to hear a vomit; is that right?

SIMPSON: Mm-hm.

MYERS: If a baby was -- I'm not suggesting this happened on the night, but there is a reason, unrelated to what you're saying, why I'm going to ask this question. Help us with this: if a baby was screaming in the neonatal unit, and it's calm in the way you're describing, and you're sitting in the nursing station, would you expect to hear that if it was loud screaming?

SIMPSON: Yes.

MYERS: And if it was horrendous screaming would you expect to hear that?

SIMPSON: Yes.

MYERS: With regard to the neonatal review, you have a copy, you have it open in front of you still, have you, Ms Simpson? And have you, ladies and gentlemen? I'm going to briefly going to where we were, page 3 of 7.

If you look there, we can see in line 26, it says that you are feeding or you fed a baby with the initials AC at 1.15. Can you see that?

SIMPSON: Yes.

MYERS: You were asked, for example, how long would it take and you said no longer than half an hour; do you remember that?

SIMPSON: Yes.

MYERS: And then you were questioned on the basis, let's say, that it did take half an hour and all the questions followed that.

SIMPSON: Mm-hm.

MYERS: Again, just to make this clear, can you actually say how long that did take when you look back at it now?

SIMPSON: I can't remember for definite, the time.

MYERS: All right. When we move down that chart and we see the prescriptions for [Baby G] that you assisted with at lines 27 to 31, you assisted [Nurse E] with that, did you?

SIMPSON: I did.

MYERS: The full period of that appears to be over about 5 minutes, doesn't it?

SIMPSON: Yes.

MYERS: In between duties like feeding, where you did that, or helping with the prescription, as you do that, when you'd finished where would you go back to on this particular evening?

SIMPSON: I'd either go and collect the milk from the milk fridge or I would be sat back down again at the nurses' station.

MYERS: Right. So although we're looking at events, and you've been asked a lot about those, of course, in between then, however long they take, you'd return to the nursing station if you weren't dealing with the milk?

SIMPSON: That's correct.

MYERS: Is there a computer at the nursing station?

SIMPSON: There is.

MYERS: Is it possible to deal with electronic prescriptions using the link on the computer in the nursing station?

SIMPSON: Yes.

MYERS: Does that ever happen?

SIMPSON: Could you rephrase that, please?

MYERS: Yes. I'll tell you -- let me put an example up. If we have J29020, I think that was the reference. J29020.

This is line 39 on the neonatal review as I recall.

Do you remember seeing this, Miss Simpson? It says "administration 2.13", and you and Christopher Booth dealing with that.

SIMPSON: Yes.

MYERS: Does this tell us what time that medication was actually checked?

SIMPSON: It does.

MYERS: What time was it checked?

SIMPSON: 2.13.

MYERS: And the person who's logged on to the system from this would be Christopher Booth; is that correct?

SIMPSON: Yes.

MYERS: Is it possible to make any entries on this computer whilst sitting at the desk at nursery 2?

SIMPSON: Yes.

MYERS: Does that ever happen?

SIMPSON: I can only sort of do it next to another nurse.

MYERS: So for example if you were there and a nurse wanted to check with you, they could bring it to the nursing station and confirm it in that way; is that correct?

SIMPSON: Yes.

MYERS: But looking back over this period of time, are you able to say exactly what did or didn't happen at any particular time with any of these prescriptions?

SIMPSON: I can't remember.

MYERS: All right. Because, is this right, your actual recollection of events is that you had, for the larger period of time before the vomit, been sitting at the nursing station?

SIMPSON: Could you say that again?

MYERS: Your recollection, is this correct, is that you had been sitting at the nursing station for maybe the best part of an hour or so before the vomit?

SIMPSON: I would have fed the baby that I had at 1.15 --

MYERS: Yes.

SIMPSON: -- and then I would have obviously checked the medication and been sat -- and then sat at the nursing station.

MYERS: In terms of your actual recollection, if we put to one side all the documents you've been shown, in your mind do you have an image of having sat there for a period of time, maybe let's say half an hour or so, before the alarm went off?

SIMPSON: No longer than 5 or 10 minutes.

MYERS: All right. Just so you know the reason why I ask that, of course you made some statements to the police, didn't you, to assist with this?

SIMPSON: I did.

MYERS: And one of the statements is dated 6 September 2018.

I'm just going to ask if you can be shown the second page of that statement, just to help with something I want to ask you.

Mr Murphy, that's at page 1832 of the statements.

This is just for Miss Simpson, his Lordship and the barristers, please.

Did you have a chance to read the statement before you came to give evidence?

SIMPSON: I did.

MYERS: If you look at this, it's the second page of your statement dated 6 September 2018 and if you look about five or six lines down, I'm going to read it with you and just ask you something about it.

SIMPSON: Okay.

MYERS: You've just described in the statement the nursing station, its location, and you say:

"The station is about 10 to 12 feet away from [Baby G]'s cot."

That's right, isn't it?

SIMPSON: That's right.

MYERS: So for everyone who's not familiar with it, you're really very close to where [Baby G] was in nursery 1, aren't you, and when you first had a recollection of this, at the time of making this statement, you said:

"Lucy and myself were sat at the nurses' station from about 1.15 am."

And you said:

"At that point, as far as I can recall, neither Lucy nor I moved from that station during that time."

We've been through the documents and we can see there are other things that took place.

SIMPSON: Yes.

MYERS: So I'm not going to suggest that your recollection there means you didn't leave from 1.15. It's because of that that I ask you, was a large part of the time before the vomit spent with you at or around the nurses' station in your recollection?

SIMPSON: Yes.

MYERS: Yes. Your recollection now is that you were certainly there in the 5 to 10 minutes before you heard the vomit; that's right, isn't it?

SIMPSON: That's right.

MYERS: So if we just follow that through, Miss Simpson, you can help with this. You hear the vomit?

SIMPSON: Mm-hm.

MYERS: You've been at the nursing station with Ms Letby?

SIMPSON: Yes.

MYERS: And she's been there with you over that period that you can remember; is that correct?

SIMPSON: Yes.

MYERS: The two of you then go straight over to the nursery that's actually directly opposite the nursing station; is that right?

SIMPSON: That's correct.

MYERS: And then you assist [Baby G] when you go in there?

SIMPSON: (No audible answer).

MYERS: I know you have nodded but that's agreeing.

When you got into the nursery, the first thing that you say you did -- was it to reposition how [Baby G] was lying in the cot?

SIMPSON: It was, yes.

MYERS: And then to start to use the Neopuff to make sure she had the oxygen she needed?

SIMPSON: Yes.

MYERS: Is that right?

SIMPSON: Yes.

MYERS: And then your recollection is that Lisa Walker was asked to go and get help or go and get the doctor?

SIMPSON: Yes.

MYERS: After all I've been saying about timings, I'm not going to ask you to be more precise than you comfortably can be, but do you recall how long that would have taken from going in, helping [Baby G], starting the Neopuff and getting Lisa Walker to go for help? Do you know how long that sort of thing might take?

SIMPSON: Roughly no longer than 5 minutes.

MR MYERS: All right. Thank you, Ms Simpson.

Re-examination by MR ASTBURY

MR ASTBURY: Thank you. Nurse Simpson, you've been asked about a statement that you provided on 6 September 2018 --

SIMPSON: Mm-hm.

ASTBURY: -- in which you said:

"Lucy and myself were sat at the nurses' station from about 1.15. As far as I can recall, neither Lucy or I moved from that station during that time."

Now, you'd made, do you recall, an earlier statement in the investigation, in fact on 9 February 2018? And is it right that in that statement you said the following:

"Prior to [Baby G]'s observation monitor alarm activating..."

You can be shown this if you wish but I'm sure I'll be corrected if I misquote:

"... I cannot remember where the other staff were."

I'll read that again.

MR JUSTICE GOSS: Sorry, Mr Astbury, I think the witness should have it.

MR ASTBURY: Very good. It's I1828, please.

It's the bottom of that particular page. It's the second line up, please, if you can follow it with me, Nurse Simpson:

"Prior to [Baby G]'s observation monitor alarm activating, I cannot remember where the other staff were."

So this is 7 months before the statement that's been read out to you from September:

"Once the observation monitor alarm activated at the nurses' station, I immediately jumped up and ran into [Baby G]'s nursery along with Lucy."

So you can't remember where everybody was; is that right?

SIMPSON: That's right.

ASTBURY: But Lucy ran in with you?

SIMPSON: Yes.

ASTBURY: All right. And just so that there's no confusion, do you remember that that statement was prepared from an interview the police conducted with you on the same day, an audio-recorded

interview? Do you recall that? It may be you don't. No? All right.

We have a transcript. If we can go, please, to page K4914. In fact, 4915.

You were talking about where the staff were and you were asked:

"Question: Okay. So you said you don't remember Chris, so he could have been somewhere?"

That's Nurse Booth, is it not?

SIMPSON: Correct.

ASTBURY: You say:

"Answer: I don't remember Chris, no.

"Question: But you said 'me and Lucy into [Baby G]'. So where was Lucy?"

You were asked by the police. You replied:

"Answer: Either she was probably sat outside with me at the nurses' station --

"Question: Okay.

"Answer: -- or possibly in.

"Question: Right."

If we can scroll down a little bit more.

When you were interviewed by the police, was it your recollection that you were sitting with Lucy at the nursing station when the alarm went off or were you not sure where she was?

SIMPSON: She was sitting by me at the nurses' station.

ASTBURY: So the officer (sic) says:

"Answer: -- or possibly in."

The officer says:

"Question: Right."

Then you say this:

"Answer: Whoever she was looking after that night."

What were you talking about there?

SIMPSON: I can't remember.

ASTBURY: Okay. So it says:

"Either she was possibly sat outside with me at the nurses' station or possibly in" --

MR JUSTICE GOSS: "Probably":

"She was probably sat outside with me at the nurses' station or possibly in whoever she was looking after that night."

MR MYERS: (Inaudible) being put to the witness, I just rise to say at this point this is turning into cross-examination of the prosecution's own witness now.

MR ASTBURY: Okay, well, I'm happy to move away from that, but can I simply ask this: did you have the benefit of the review and the notes that you have now about that period when you made the statement to the police?

SIMPSON: I did.

ASTBURY: You had that material with you?

SIMPSON: Oh, this material?

ASTBURY: Yes.

SIMPSON: No.

MR ASTBURY: Thank you. I won't take it any further.

Does my Lord have any questions?

MR JUSTICE GOSS: No. Nothing else you want to ask? All right.

I haven't looked at the list. Is this witness going to be required again?

MR ASTBURY: She's not on the list at the moment.

MR JUSTICE GOSS: You don't understand you're going to be required to give evidence again?

SIMPSON: No.

MR JUSTICE GOSS: Well, you probably won't be, but there is a possibility. It can't be excluded entirely that you may be required to come and answer some more questions.

So please don't talk to anyone about this case or anything to do with this case until it's all over.

SIMPSON: Okay.

MR JUSTICE GOSS: Thank you very much indeed. That of course does complete your evidence. Please remain where you are. We'll have our short break and the court can be reconstituted.

MR ASTBURY: My Lord, we have no more live witnesses for this afternoon, nor do we have anything ready to read as yet.

MR JUSTICE GOSS: Oh, right.

MR ASTBURY: There is some video which we could play. It's over half an hour in length.

MR JUSTICE GOSS: The witnesses I've got here to read, they are not ready to be read?

MR ASTBURY: They're not.

MR JUSTICE GOSS: The video, you say, lasts about half an hour?

MR ASTBURY: Yes.

MR JUSTICE GOSS: What is it?

MR ASTBURY: It's ventilation and suctioning, which we've touched upon this morning.

MR JUSTICE GOSS: Well, I'm going to leave it to you. By you I mean plural, the bar, as to whether it would be helpful to hear -- see that video and listen to it if it has sound with it as well, which I assume it does, this afternoon, or whether, by reason of the timetable for next week, it's not going to make any difference if we put it off to next week. You know why I'm raising these questions.

MR ASTBURY: I suspect the latter, but we'll consult at the bar, my Lord.

MR JUSTICE GOSS: Would you? We'll make this a very short break, 5 or 8 minutes or so, I should think. And then when you come back, we'll see whether we're going to watch this or not this afternoon. Thank you very much.

(In the absence of the jury)

MR JUSTICE GOSS: We'll let you know when the court is ready to sit again, but it should only be 5 minutes or so.

Thank you.

(3.18 pm)

(A short break)

(3.23 pm)

MR JUSTICE GOSS: (Inaudible: no audio feed from court)

experience has shown that you actually have to concentrate quite hard on these videos because you get a lot of information in a relatively short space of time.

MR ASTBURY: Yes.

MR JUSTICE GOSS: All right. I'm sure the jury won't mind finishing half an hour earlier. Jury in, please.

(In the presence of the jury)

MR JUSTICE GOSS: I am told that if we do finish now, then this video recording can be played next week and it won't actually prolong the length of the trial in any way. You may wonder how that can happen, but it's simply because we're going to have to have a bit of a gap next week anyway, for good reason, on one day. So it will be fitted in, this video, some time next week.

As you know, when you watch these videos, you actually have to concentrate quite hard on the detail you get and it's half an hour or so, so we'll finish for the day rather than watch that now.

I'm sorry you've been inconvenienced for 10 minutes, but in the great scheme of things it doesn't make a great deal of difference.

Another weekend, therefore. Another prolonged opportunity in which to conduct research or to speak to someone else who's not connected with this case.

Obviously you're not to speak to anyone about anything to do with this case unless you're all together so please remember that. I will keep reminding you of this right until we get to

the end of this case, you'll get used to it, but it is just so important.

Thank you very much indeed.

(In the absence of the jury)

MR JUSTICE GOSS: I was just observing, it was actually cooler at 2 o'clock and now it's warmer again in here.

It's obviously uncontrollable.

There's nothing else?

MR ASTBURY: No, thank you, my Lord.

MR JUSTICE GOSS: Thank you very much indeed.

(3.27 pm)

(The court adjourned until 10.30 am on Monday, 5 December 2022)