

6 December 2022
Baby G

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Tuesday, 6 December 2022
(10.30 am)

(In the absence of the jury)

MR ASTBURY: My Lord should have a bundle of the witness statements (overspeaking) set out.

I was helpfully reminded there's another witness statement at the back of the last bundle my Lord had that we hadn't reached, Valerie Thomas, so I'll do that one first. It's page 29.

MR JUSTICE GOSS: I don't have that bundle in front of me, but never mind, I'll listen and I'll then put it with these. Thank you.

(In the presence of the jury)

MR JUSTICE GOSS: Mr Astbury.

Witness statement of VALERIE THOMAS (read)

MR ASTBURY: Thank you, my Lord. There are four witness statements to read with my Lord's leave, please.

MR JUSTICE GOSS: Yes.

MR ASTBURY: The first being from a witness by the name of Valerie Thomas. Her statement is signed on 19 March 2020. She says as follows:

"In 2015 I was a full-time nursery nurse on the NNU at the Countess of Chester Hospital, predominantly working in special care rooms 3 and 4 within the NNU.

"The babies within 3 and 4 are described as stable babies, not on ventilation, starting to begin to feed, which we describe as feeding and growing. At a certain point babies within 3, mainly 4, get to the point that they are fit enough that they are allowed to go home.

"I have no recollection of [Baby G] or her parents. I will have to refer to the medical notes.

"In referring to the 7 September 2015 episode I have reviewed my medical notes and rotas from 1 September. I was working a night shift, 19.30 to 08.00 hours of 3 September going into 4 September. I don't remember looking after [Baby G] prior to 3 September.

"My first entry on the medical notes that relate to [Baby G] is timed at 06.16 on 4 September. The notes do not say which nursery room [Baby G] was in. [Baby G] was stable, being nursed in nasal-pronged oxygen as she had occasional desaturations, mainly after feeds. However, they were all self-correcting, which means there was no input for stimulation or to alter her oxygen levels, she automatically came back to normal herself.

"[Baby G] was offered an alternate bottle and nasogastric tube to which we were adding Gaviscon and fortifier to. We were starting to offer bottles to [Baby G] at that stage. However, [Baby G] did not complete any bottles for me that night.

"She passed urine and her bowels had opened, and medication was given as prescribed by two members of trained staff. As a nursery nurse I am not trained staff and all I could give medication-wise was vitamins and paracetamol, which would be checked by trained staff.

"The next entry by me on [Baby G]'s notes was timed at 05.59 on 5 September 2015. I was working the same night shift as 3 September. [Baby G] was classed as stable again and was in nasal-pronged oxygen. She was still having the occasional desaturations after feeding, all self-correcting. She was still being offered a bottle and nasogastric tube. At 5 am [Baby G] did manage to complete a full bottle. [Baby G] was still having Gaviscon and fortifier. She passed urine and had her bowels open. Her medication was given as prescribed. [Baby G]'s father was on the unit at 20.15 that night. [Baby G] I would describe as quite well."

My Lord, that concludes that statement.

Witness statement of LISA WALKER (read)

MR ASTBURY: Next, please, the statement of Lisa Walker.

This statement is dated 13 September 2018. The jury will recall, I'm sure, Lisa Walker, one of the neonatal nursery nurses from whom we've already heard, as in fact was Valerie Thomas, who I have just read. I should have probably said in advance, I'm sorry.

MR JUSTICE GOSS: I think the name will have rung a bell.

MR ASTBURY: Yes. Lisa Walker in this statement says as follows:

"I have been specifically asked into the care of [Baby G] [as read]..."

She gives [Baby G]'s date of birth at 31 May 2015:

"... on 7 September 2015. I have had the opportunity to view nurses' notes relating to [Baby G] to which I may refer.

"With regard to 7 September 2015, referring to my notes, between the 6th and the 7th, I was a night shift, 19.30 to 08.00 hours with [Nurse E], Lucy Letby, Christopher Booth and Ailsa Simpson.

"The staffing levels were fine for that night shift and everything was as normal. [Nurse E] was the designated nurse for [Baby G] that night. After the initial handover that evening I was allocated the care of two stable babies that were in special care nurseries 3 and 4 within the NNU.

"I do have access to all four nurseries and there is no restriction of movement. However, my babies would mainly be in nurseries 3 and 4. If the ward is quiet, nursery 4 could be closed and I could be in nursery 2 and 3 looking after my designated babies. I cannot remember how many babies were on the ward that night. If there is an emergency we, as nursing assistants, will step up and make sure all the other babies in any of the nurseries are looked after while the emergency is in progress.

"From the nursing notes [Nurse E] went for a break. Shortly after [Baby G] had a large vomit. [Baby G] had a full abdomen and was straining. After [Baby G] had vomited she had an apnoeic episode dropping her saturation levels. Somebody must have called the doctor. Dr Ventress arrived within minutes. [Baby G] was taken into nursery 1 and had to be vented that night. [Baby G] went on to nil by mouth. She then went on to 10% dextrose as she wasn't feeding.

"From memory, [Baby G] was in nursery 2, in the far left corner as you enter the room. Leading up to [Nurse E] taking her break later that morning, I cannot remember what time she actually

went, but I did not notice anyone going to nursery 2 prior to [Nurse E] taking that break. However, I can't say for sure.

"I do know that I did not go into nursery 2 prior to [Nurse E] taking her break. According to the notes, it was whilst [Nurse E] was on her break that [Baby G] had vomited. I cannot remember exactly what nursery I was in at this time but I would have been looking after another baby within nursery 3 or 4. I don't remember any alarm being sounded at the time of [Baby G]'s collapse. I can state that if I was in either nursery 3 or 4, I cannot see nurseries 1 and 2 from either one of them as my vision is blocked by walls. However, I would be able to hear any alarm activation in any of the four nurseries.

"I do remember being in a position to see at least Lucy, and possibly Ailsa, cleaning up the vomit around [Baby G]'s cot in nursery 2. Therefore I must have been, at some time, outside nursery 2 in the corridor. I cannot say for sure if I actually assisted with the cleaning up of the vomit but I don't think I did as I didn't see the vomit for myself. I do remember Lucy discussing with, I think, Ailsa that the vomit was everywhere around the cot within nursery 2.

"Obviously, someone had called for the doctor to attend. I cannot remember if it was me from instruction or whether it was somebody else. Dr Ventress did attend within minutes to care for [Baby G]. Dr Brearey, later on into the shift, did attend the unit. I cannot say where Christopher was during this event.

"I cannot remember how long it was before [Baby G] was moved to nursery 1 or who by. I cannot remember if I did go into nursery 1 from that point onwards. I believe, according to the notes, Lucy became the designated nurse once [Baby G] had entered nursery 1. I am not aware of any debrief that has taken place regarding the care of [Baby G]. I didn't see [Baby G]'s vomit, full abdomen or straining."

That concludes, my Lord, Lisa Walker's statement.

MR JUSTICE GOSS: Yes, thank you very much.

Witness statement of [NURSE A] (read)

MR ASTBURY: If we move on next, please, to [Nurse A], who again the jury will recall, I'm sure.

MR JUSTICE GOSS: Yes.

MR ASTBURY: Her statement in this matter is dated 27 April 2018:

"I am making this further statement to Chester Constabulary regarding the investigation concerning increased neonatal mortality at the Countess of Chester Hospital NHS Foundation Trust between June 2015 and July 2016.

"I have been informed this particular interview..."

Pausing there, my Lord, the jury will recall that some witnesses are interviewed in advance and then the statement prepared from that particular interview:

"... is in reference to [Baby G], date of birth 31/5/2015. I have had the opportunity to view medical notes relevant to the dates that have been specified to me.

"With regard to 7 September 2015, from memory I remember this day in particular as [Baby G] was 100 days old. The NNU will celebrate this particular birthday as it is seen as a milestone. A member of staff will bake a cake and there will be balloons around the bedside of the baby concerned. I was working a day shift and I was the designated nurse for [Baby G] that day, who was in nursery 1 on a ventilator. I remember [Baby G] being very poorly that day, which surprised me and the staff as prior to 7 September [Baby G] was stable and in one of the outside nurseries.

"I remember giving [Baby G] various medicines throughout the day and I was aware that [Baby G] was going to be transferred back to Arrowe Park Hospital. I have looked after [Baby G] before in the past. I couldn't say how many times but essentially she was what we call 'feeding and growing' on these occasions. I cannot remember if I was working the day before on 6 September.

"Referring from the notes and memory, [Baby G] was born at Arrowe Park Hospital and then transferred to the Countess of Chester Hospital NNU. I was working a 07.30 to 20.00 hours shift. I can't remember who I was working with. I was the designated nurse for [Baby G] on that day and only [Baby G] was in nursery 1.

"When I first came on duty, and during the verbal handover process from Nurse Lucy Letby, Lucy told me that [Baby G] had vomited whilst under the care of [Nurse E] and then became unwell. Lucy told me that she had taken over as designated nurse from [Nurse E] for [Baby G] as [Nurse E] did not have her intensive care course qualification, which was required to care for [Baby G] during the remaining (sic) of that shift.

"From the notes there were blood pressure issues all day with [Baby G]. From the notes, [Baby G] had vomited a large projectile vomit and Dr Ventress was asked to review [Baby G].

[Baby G] was reviewed by Dr Ventress and put on nil by mouth. Dr Ventress was then called away to theatre to another baby. In the meantime [Baby G] had become apnoeic and it was later on that [Baby G] was intubated and put on a ventilator.

"I would have checked all of [Baby G]'s requirements, checking what fluids and medication she was on. If I remember rightly, her CRP was raised; this would indicate infection."

My Lord, pausing there, this witness appears on the sequence of events chart on a number of occasions, so I'm going to summarise those entries she's made for the assistance of the jury.

Mr Murphy, if we could go, please, to tile 134, first. And if we can go behind it -- sorry, 135, I do apologise. If we can go behind it, please.

Ladies and gentlemen, if we look, please, initially at this document and knowing that [Nurse A] came on at 07.00 hours on the 7th and recognising perhaps, as far as we can, previous documents she's endorsed, we can see her signatures down the right-hand side of the form throughout the shift. Apart from one occasion, which I think is at 15.58, where it's a different signature, but in effect this is the blood gas record that she has completed through the shift.

We can see the last entry there in the middle of the page at 8.07. So that's the first document that's relevant and in the sequence of events. We can go next, with a bit more confidence, to 141, please. If we look at the chart.

To the right-hand side we can see a row of initials which appear to indicate [initials of Nurse A], if we scroll up, consistent with the time when she was on duty.

Reading from that particular column, from 08.00 onwards, we can see the entries that she has made in respect of heart rate, which we've heard from other witnesses before is clearly in excess of what would be expected in the circumstances.

If we can scroll down, please, we can also see her entries in respect of respirations and temperature.

Other entries that we're all becoming familiar with lower down the page. But that's where to find that document if anybody needs to see it.

My Lord, I'm only going to refer to it once, like a number of documents, because the same document appears on the hour over and over again, so I'm not going to refer to it again for the

purposes of this exercise. So they are her entries on the observations chart.

I'm reminded there are also hard copies of this particular document in the files, as there are most of these core documents. We'll go through them now if we may just to remind the jury where to look if they need to on the system.

Tile 142 next, please. This is headed "Environmental safety check form". It's in a different format than we've become used to with other babies. If we look to the bottom, we see across the bottom signatures or initials "[Nurse A]". Thank you.

If we scroll up, Mr Murphy, we can see, by comparison to the times, a number of entries from 08.00 hours across until 19.00 hours with the various measurements and readings that [Nurse A] entered on that particular form. So any queries with regards to that can be accessed via tile 142.

Next tile, please, 143. If we can look at that.

Dated 7 September. This is a midnight to midnight form, of course, so we can scroll down a little bit, please.

Pausing there, Mr Murphy, we can see at 4 am the commencement of the glucose with [Baby G] having gone nil by mouth after the vomiting.

We can then see in the bolus column, various boluses through the course of the 24-hour period. Again if we look to the right -- scroll down a little bit further, please -- we can see those initials [Nurse A] on each and every occasion on the hour, relevant endorsements in respect of fluids.

Moving on next, please -- I should say her entries are all between 08.00 and 19.00 on that particular form.

Tile 144 next, please. This is the intravenous and subcutaneous infusion prescription chart on 7 September.

The second entry is made at 08.20 hours and appears to have [Nurse A] in the initials. Certainly it may be that the entry at 15.20 is the same. I'm not going to speculate about others, but that reflects those infusions that were given during the course of the shift that [Nurse A] is recounting.

We can go next, please, to tile 145. Similar information represented in a slightly different format.

Again, it illustrates the provision of various infusions through the date during the shift of [Nurse A]. So that tile, if any queries arise in that regard.

Could we go next, please, to tile 170. No need to go behind this one, I don't think. It simply indicates the administration of what we've learned is an antibiotic at 12.50 in the afternoon, together with Nurse Williamson as she is now known.

I am not going to repeat all of those charts again through the course of the shift, but if we could go next, please, to tile 284, and look at that form, please, Mr Murphy.

You can see the continuation of the observation chart follows on from the one we looked at earlier, with [Nurse A] making the first four entries according to the signatures. If we can just scroll up again, that will accord, I suspect, with the times in the top box: 17.00, 18.00, 19.00 and 20.00.

MR JUSTICE GOSS: No, no, first three entries. If you look at the initials at the bottom -- I'm looking at the paper copy we have --

MR ASTBURY: Yes.

MR JUSTICE GOSS: -- I think the fourth one is BS, Belinda Simcock.

MR ASTBURY: Nurse Williamson, yes. Difficult to keep up.

MR JUSTICE GOSS: I've been following which ones with got in paper. Some of these that have been referred to, you've got the paper copies, others you haven't. This one, you do have the paper copy in section 7 of file 2.

MR ASTBURY: Thank you.

So that's both of the observation charts covered.

If we can look next, please, at 287. It's a new fluid balance chart.

That commences with what appears to be an infusion of dobutamine, commenced at 17.00. We have an entry of nil by mouth on the left-hand column. It looks to me like certainly two of the signatures on the right, not three, are those of [Nurse A] and it would be consistent with the times in the left-hand box, which is 17.00, 18.00 and 19.00 hours respectively.

Finally, please, in respect of charts, tile 289.

A form we saw particularly in the case of [Baby F], a prescription for Babiven Maintenance, TPN as we've been calling it. That was first hung at 17.10 on 7 September.

Returning now, please, if I may, to the witness statement, my Lord:

"From my notes [says [Nurse A]] I remember [Baby G]'s physical condition as peripheral, ie cool on the edges, hands and feet, and [Baby G] was pale too. [Baby G] had several infusions to support her blood pressure. She had cannulas put in with a long line inserted. In my nursing notes with regards to medication that day, [Baby G] had four saline boluses, we increased the quantity of antibiotic cefotaxime to 50 milligrams per kilogram. [Baby G] was also on inotropes, dopamine and dobutamine. My notes are timed at 20.50 that evening, therefore obviously I have remained on duty for whatever reason I cannot remember."

Then if we go to those notes now, please, 319 is the first tile. [Nurse A] has entered "08.00 until present":

"During handover required x2 episodes of Neopuff. All fluids and lines checked with L Letby. Correct and lines patent. Ventilation increased to 26/6 as responded to higher pressures on Neopuff. CBG showed over-ventilation so pressure and rate reduced as charted.

"NiBP dropped around 08.00 and dopamine commenced peripherally as no long line at time. Blood pressure improved slightly and inotrope titrated as prescribed. BP [we'll assume that is blood pressure seeing as that's the entry in the statement] deteriorated and cannula site became white. Moved to another cannula. BP again improved. Doctors trying to obtain long line for better access. Second cannula tissued and for a short time no dopamine running until long line available. Long line obtained and dopamine and Maintenance transferred to it. Midaz and morph continued to run peripherally. Further cannula obtained for bolus and [antibiotics]. Chest clear and CBG/ABG [arterial the latter I assume] continue to be metabolic acidosis x4. Sodium chloride 0.9% bolus given as prescribed. Cef increased to 50mg/kg and given as prescribed. Initially pyrexial. Now normothermic but periph cold. Perfusion has remained poor all day."

MR JUSTICE GOSS: Sorry, I think you read it -- sorry, you read... Just go back to that.

MR ASTBURY: Of course.

MR JUSTICE GOSS: The last paragraph:

"Chest clear and [capillary blood gases] and [arterial blood gases] continue to be metabolic acidosis."

Then a full stop:

"Times four sodium chloride 0.9% bolus given as prescribed."

MR ASTBURY: Ah, I have got my "times four" in the wrong place.

MR JUSTICE GOSS: Exactly. It was four boluses of sodium chloride.

MR ASTBURY: Thank you.

MR JUSTICE GOSS: Sorry about that, but it's just the way you read it.

MR ASTBURY: My mistake. If we can go to the next note, please. Tile 320. Timed at 20.12:

"Discussed with pharmacy. Dopamine, dobutamine and adrenaline can [I think that should be 'all'] run via same long line if required if no other alternative available. No ETT or oral suction required all day. Minimal urine output all day. Blood plus 1, protein plus 1. Catheter in situ..."

And I think we all know now that's bowels not opened.

322, please. This is the parental communication update, made at 20.51:

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

Finally, please, tile 323. This is the final note made on the shift at 20.54:

"Capillary blood gas continued to deteriorate despite increasing inotropes. Colour and perfusion deteriorating. Doctors present at the time of handover."

My Lord, again, just concluding the statement now:

"From the notes, I handed over to Belinda Simcock. The parents of [Baby G] were on the NNU most of the day until returning home to get provisions just before handover at the end of my shift."

Referring from the doctors' notes, there are entries of [Baby G] being transferred to Arrowe Park Hospital.

"My opinion of [Baby G]'s condition was sepsis or possibly something that we call NEC, which is an infection of the bowel. I would describe the parents as a lovely, caring couple who were committed to [Baby G]. They were very competent when doing things for [Baby G]."

My Lord, that concludes [Nurse A]'s statement.

Witness statement of DR PEK WAN LEE (read)

MR ASTBURY: We move on in the timeline at this stage to Dr Lee. In his statement, his first statement on 28 August 2019, he heads his statement with [Baby G]'s name and the admission period of the 8th to 16 September 2015. It says as follows:

"I am Dr Pek Wan Lee, neonatal consultant at Wirral University Teaching Hospital since March 2011. I have been a consultant since March 2001. I was the named consultant for [Baby G] for this admission. I looked after her from the 8th to 10 September 2015 as I was the service week consultant, and the following service week consultant looked after her until her discharge back to the Countess of Chester NNU.

"[Baby G] was born at the Wirral University Teaching Hospital on 31 May 2015 at 23 plus 6 weeks. Birth weight was 535 grams. She was an in utero transfer from the Countess of Chester Hospital and therefore was discharged with a diagnosis of chronic lung disease of prematurity to the Countess of Chester NNU on 13 August 2015 when her need for tertiary level neonatal care was over.

"Following a respiratory deterioration due to presumed sepsis at the Countess of Chester Hospital NNU on 7 September 2015, she was transferred to our NNU on 8 September 2015 at 04.30 hours when she was 100 days old. Her weight on admission was 1,985 grams and temperature 36.8 degrees Celsius.

"She required ventilatory support with 100% oxygen on her first day, which was then gradually weaned. Her sedation on admission was with morphine and midazolam. She was extubated on 13 September 2015 to nasal cannula oxygen before self-ventilating in air from 15 September 2015.

"She had severe hypertension, requiring support with fluid boluses and inotropic medications of dopamine, dobutamine, adrenaline, noradrenaline and hydrocortisone. These medications were gradually reduced and finally discontinued on 12 September

2015. She also had metabolic acidosis, which required bicarbonate correction.

"She had jittery movements at times which were never treated with anti-convulsants and later resolved. She underwent an MRI brain scan on 15 September 2015, which was reported as a difficult scan to interpret due to movement with resulting limitations.

"The appearances were suggestive of a significant hypoxic or ischaemic insult, abnormality in both cerebellar hemispheres, possibly established infarcts. A second opinion from Alder Hey Children's Hospital was advised as well as a repeat scan in a couple of months. Her retinopathy screen showed grade 1 retinopathy of prematurity.

"[Baby G] required a blood transfusion on 9 September 2015 for anaemia. She was also given additional vitamin K doses for 48 hours as her coagulation was mildly deranged and there was bloodstaining of her endotracheal aspirates.

"Due to significant oedema her fluids were restricted initially to 100ml per kilogram of 10% glucose with sodium and potassium supplementation. Fluids were gradually liberalised as her clinical condition improved. She was catheterised for monitoring of her urine input as initially it was very poor. It then gradually improved and there were no long-lasting concerns with her renal function.

"She was nil orally on being transferred and gradual feeding was introduced as her condition stabilised. There were transient abdominal concerns on the 12th to 13 September 2015 and her abdominal X-ray was discussed with the Alder Hey consultant paediatric surgeon who thought it was likely to be ileus related to sepsis. She was able to tolerate steadily increasing feeds after that. She received oral sodium and phosphate supplementation.

"Her triple antibiotic therapy, which was commenced in Chester, was changed to monotherapy with meropenem. Blood, cerebrospinal fluid, respiratory and urine cultures were all negative. Her respiratory viral screen was also negative. However, her C-reactive protein, CPR, which is an infection marker, was 150 milligrams per litre on admission, rose to 218 milligrams per litre on 9 September, before gradually coming down to 11 milligrams per litre by the 16th. She completed a seven-day course of meropenem.

"Her parents were updated on a regular basis. She was discharged to the Countess of Chester on 16 September 2015 at 15.00 hours with a weight of 2,095 grams, head circumference 30.5

centimetres. She was self-ventilating in air and continued to establish her enteral feeds.

"In summary, [Baby G]'s readmission on the 8th to 16 September was for presumed sepsis leading to multi-organ dysfunction requiring intensive support. She was very unwell on arrival and gradually improved to not needing any support on discharge except to fully establish enteral feeding.

"The presumption of sepsis was based on her clinical picture and markedly elevated CRP (normal is less than 5) as her cultures were all negative."

He then states that the statement is accurate within the best of his knowledge and belief.

My Lord, there's a second statement from Dr Lee.

MR JUSTICE GOSS: Yes. Wirral University Teaching Hospital is Arrowe Park?

MR ASTBURY: It is.

MR JUSTICE GOSS: Just in case you were wondering. As we know, [Baby G] came from Arrowe Park and then went back and went back again to the Countess of Chester. And there were quite a lot of medical terms in there in relation to hypoxia and that sort of thing. Hypoxia is essentially starvation of oxygen to whatever tissue it is, so if it's to the brain then it's an hypoxic brain injury.

MR ASTBURY: I think hypoxia is covered in the glossary.

MR JUSTICE GOSS: It is, I have just checked, and it does say:

"Hypoxia: a condition in which the body is deprived of adequate oxygen supply at the tissue level. Hypoxic due to insufficient oxygenation. Hypoxic ischaemic encephalopathy [he doesn't actually refer to the encephalopathy in that statement], a brain injury condition caused by oxygen deprivation to the brain."

There is reference to the cerebral hemispheres of the brain.

MR ASTBURY: Thank you, my Lord. We will be hearing from an expert with regard to those particular aspects.

MR JUSTICE GOSS: Exactly. It's just there was a lot of medical information in that statement.

Second witness statement of DR PEK WAN LEE (read)

MR ASTBURY: There's a second statement with that in mind from Dr Lee, who on 4 June 2020 provided a further statement which reads as follows:

"I would like to add that [Baby G] did not collapse on the 12th and 13 September 2015. She was fully weaned off her inotropic support on 12 September and extubated to nasal cannula oxygen on the 13th. Both these events are in keeping with an increasingly stable patient.

"[Baby G] had an abdominal X-ray on 12 September 2015 as there was a concern that her abdomen looked distended, not because of a collapse. The abdominal X-ray was reviewed by the Alder Hey surgeons and they were not concerned. They thought they might have had ileus due to sepsis. This clinical concern lessened as she was able to tolerate increasing feeds.

"[Baby G] was transferred back to the Countess of Chester Hospital on 16 September 2015 because she was no longer needing intensive care support in a tertiary neonatal unit. [Baby G] was self-ventilating in air and continuing to establish enteral feeding. We were not concerned about her presumed sepsis status by then as her CRP had fallen steadily to a nearly normal level of 11 milligrams per litre [repeating there that normal is less than 5] from a peak of 218 milligrams per litre and all her cultures had returned negative. As [Baby G] was clinically stable, the Countess of Chester Hospital would be able to continue her care in their neonatal unit. We were following the neonatal network policy of transferring babies back to their referring hospitals after their need for tertiary neonatal care was over.

"[Baby G], on transfer to the Countess of Chester Hospital on 16 September 2015, was clear of sepsis as she was clinically stable with decreasing CRP and negative cultures.

"We would use the clinical picture, culture results, the CRP level and the full blood count to help diagnose sepsis. All of these were reassuring at the time we transferred [Baby G] back to Chester."

That concludes that second statement, my Lord.

MR JUSTICE GOSS: Yes. Thank you very much.

MR ASTBURY: My Lord, we're going to show the jury some videos, which we hope are of assistance and relevant to some of the evidence that they've heard recently.

Dr Ventress spoke of ventilating [Baby G] and the ventilator equipment and also suction having to be used at that time. So if

we could begin with those two respective videos, please. Firstly, the ventilator video, which I think Mr Murphy has available, it's about 15 minutes in length, my Lord, and then the suction video, a little over 9 minutes in length.

(11.14 am)

(Video played to the court)

(11.29 am)

MR JUSTICE GOSS: That was clearly edited at points --

MR ASTBURY: Yes.

MR JUSTICE GOSS: -- and unless I wasn't paying full attention, there was reference to a 20-second apnoea before the alarm sounded, which I think had been edited out. There was, it was said to be, a long time. It didn't specify 20 seconds. But if you remember, he keep the saying, "It's a long time, it's a long time". So that's a 20-second --

MR ASTBURY: Yes. We will have the engineer here to give evidence about the equipment --

MR JUSTICE GOSS: Right.

MR ASTBURY: -- so we can cover it in evidence, hopefully to bring everybody up to speed with the equipment. We can re-emphasise that when the witness comes.

MR JUSTICE GOSS: You could actually see on the tube that goes into the tube, the centimetre marking. We heard a lot of to 8 centimetres, or whatever it was, and you could see the tube, so that was quite useful to see.

And bilateral airways, going into both lungs, listened via the stethoscope, all these things fitted in with what we saw. Shall we do one short one now and then we'll have a short break?

MR ASTBURY: The next one is 9 minutes.

MR JUSTICE GOSS: That'll do and then we'll have a break.

MR ASTBURY: It's suctioning.

MR JUSTICE GOSS: Suctioning, right.

(11.31 am)

(Video played to the court)

(11.40 am)

MR JUSTICE GOSS: There we are, Mr Astbury.

MR ASTBURY: My Lord, if that's an appropriate time.

MR JUSTICE GOSS: Yes, certainly. We'll have a 10-minute break. I think looking at the timetable, as I told the jury who were here yesterday, we're not going to have a full day today.

MR ASTBURY: I was just looking. Remaining on the list there's about 25 or 30 minutes of video --

MR JUSTICE GOSS: Yes. There's about 30 to 35 minutes.

MR ASTBURY: -- without going into recordings, which at the moment don't really relate to what we've reached in the evidence, so that's as far as we'd be able to go.

MR JUSTICE GOSS: Right. Thank you very much.

As far as these videos are concerned, if at any stage during the course of the trial you want to see anything again, you've only got to ask. I think really it's just providing you with general information now -- in fact, visualising a lot of what you have heard described, which is quite helpful. Well, it's for you to say whether you find it helpful or not, but it is doing that. All right, thank you very much.

Ten minutes.

(11.42 am)

(A short break)

(11.54 am)

MR ASTBURY: My Lord, the next two videos relate to a monitor which the jury haven't yet heard about.

We have heard about the Philips monitor, the fixed monitor, but this is a different type that we'll hear about next week.

MR JUSTICE GOSS: Right, thank you.

(11.55 am)

(Video played to the court)

(12.05 pm)

MR ASTBURY: Thank you, my Lord. There's a short related video, if I could ask Mr Blythe to line that one up next, please.

(12.06 pm)

(Video played to the court)

(12.09 pm)

MR ASTBURY: We heard this morning from Dr Lee about [Baby G]'s transfer to Arrowe Park and we'd like to show next, please, the video of the transport incubator that would have been used.

(12.09 pm)

(Video played to the court)

(12.16 pm)

MR ASTBURY: My Lord, finally for today, a number of witnesses have referred to a mobile X-ray machine, so could we play that video, please, to the jury?

(12.16 pm)

(Video played to the court)

(12.20 pm)

MR ASTBURY: That concludes the videos for this morning.

MR JUSTICE GOSS: Thank you very much.

That, I'm afraid, is as far as we can go today.

I did warn you it was going to be half a day. Can you be ready to start again at 10.30 tomorrow morning, when we'll be having witnesses to continue to give oral evidence? And of course remember your obligations as jurors. Thank you very much. 10.30 tomorrow morning.

(In the absence of the jury)

MR JUSTICE GOSS: Mr Johnson, thank you for the document that was sent through in relation to the application that is in process. You'll have seen this, Mr Maher?

MR MAHER: I have, my Lord, and I have spoken to Mr Myers about it.

MR JUSTICE GOSS: And no doubt there will be a response?

MR MAHER: By the end of this week.

MR JUSTICE GOSS: Exactly. As I said yesterday, from my point of view there's no immediate rush in relation to it, but you will have seen that one of the matters that is raised is the appropriateness of asking any further questions of witnesses in relation to staffing levels and the like.

MR MAHER: Yes, we've seen those stark remarks, my Lord.

MR JUSTICE GOSS: There are matters obviously to be discussed. Thank you very much.

MR JOHNSON: Yes. Just so that your Lordship can think about it and direct us if you think it appropriate, the way we're foreseeing the timetable at the moment is we're going to finish [Baby G]'s case before the vacation. The question will arise as to whether or not we proceed on to [Baby H], which we will do if your Lordship thinks that's appropriate. An alternative, which we're also considering, is if we run up a couple of days short to try and fill those days with other material that can properly be deployed at this stage, which in a perfect world we might choose to deploy later, but which can be deployed at this stage without doing harm to either party.

To an extent it depends on whether we lose more time, but we are thinking about this.

MR JUSTICE GOSS: I think just keep thinking about it.

I think it's very helpful to keep both options potentially open. We just don't know. One thing that is quite obvious is that, including myself, it is the season for various upper respiratory tract infections.

MR JOHNSON: Yes. It's a bit like the Charge of the Light Brigade: coughing to the left of me, coughing to the right.

MR JUSTICE GOSS: And behind, exactly. So we just don't know, but we'll see how things progress. Thank you very much.

Do you wish to see Ms Letby before she leaves?

MR MAHER: No. We're grateful for the invitation, my Lord, and she's asked that she be allowed to go immediately to facilitate some outside recreation if possible.

MR JUSTICE GOSS: Yes, certainly. Did you hear that and understand that, dock officers? As soon as is convenient, Ms

Letby can be taken from the building, so there's no need to detain her here as far as the lawyers are concerned. Thank you very much indeed.

By way of reassurance, I have tested and it is an old-fashioned coronavirus, not the modern COVID.

Thank you very much.

(12.25 pm)

(The court adjourned until 10.30 am on Wednesday, 7 December 2022)