

14 December 2022
Baby G

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Wednesday, 14 December 2022
(10.30 am)

(Delay in proceedings)

(10.46 am)

(No audio feed from court)

(10.47 am)

MR JUSTICE GOSS: Thank you.

(In the presence of the jury)

MR JUSTICE GOSS: Good morning, members of the jury. I'm sorry about being kept waiting and I apologise to the witness for being kept waiting as well. We are in a position to proceed.

One of you sent a note to me about rising early tomorrow at 3.30 for good reason and so I'm telling you all now that, as far as tomorrow is concerned, we will finish by 3.30. But it may be in order to get through the work that we'll have a shorter lunch, all right, as we've done before when we've finished earlier to, if we need to, get the evidence heard. I hope it's of some reassurance to the person who's suffering with the tooth problem. Thank you very much.

Mr Myers.

[NURSE B] (continued)

Cross-examination by MR MYERS

MR MYERS: My Lord, thank you.

[Nurse B], you've explained that you took over the care of [Baby G] at about 11.30 on 21 September.

NURSE B: Yes.

MYERS: Could I ask you to keep your voice up if you could, please? I know it's a big room.

Can I ask, was the reason for that that Ms Letby had been caring for a number of babies so the staffing was changed to try to lighten that workload at that point?

NURSE B: I believe it was due to workload, but I was following shift leader instructions from Caroline Bennion.

MYERS: All right. Thank you. As to the events as we go through the afternoon, [Baby G] had had to be fitted with a cannula, hadn't she, to receive the treatment she needed? She had a cannula when she came to you, didn't she?

NURSE B: She did.

MYERS: Thank you. And during the afternoon it was noted that the cannula wasn't working; is that right?

NURSE B: Well, the cannula was put in during the morning under Lucy's care. It may have been removed prior to me taking over, but she was certainly trying to be fitted with a working cannula when I took over.

MYERS: Thank you. As we get into the afternoon, the doctors then had to re-site the cannula; is that correct?

NURSE B: Correct.

MYERS: And the first doctor who attempted to do that was Dr Chang, is that right, from what you can recall?

NURSE B: I don't recall Dr Chang doing it under my watch, but from records, it shows she was the first one, yes.

MYERS: But she was unable to re-site it, wasn't she?

NURSE B: Correct.

MYERS: And so Dr Harkness and Dr Gibbs both attended to deal with the cannulation of [Baby G], didn't they?

NURSE B: They did.

MYERS: That cannulation took place in nursery 4, didn't it?

NURSE B: Yes.

MYERS: And by your recollection, there were maybe a total of three babies in that room?

NURSE B: Maybe more. It was a busy room.

MYERS: A busy room. And there were parents in the room as well at points, weren't there?

NURSE B: Yes.

MYERS: As it happens, although you had been given [Baby G] to look after, you also had a baby in nursery 1, didn't you?

NURSE B: I don't remember being in nursery 1, but I definitely had a workload elsewhere.

MYERS: And so is that why you were coming and going from the room as the cannulation went on?

NURSE B: Correct.

MYERS: The screens are put up -- as you have described to us, they go around the process, don't they?

NURSE B: Portable screen, yes.

MYERS: Portable screens. And when the cannulation took place, [Baby G] was put or placed on what's called a procedure trolley, wasn't she?

NURSE B: She was.

MYERS: And a difference between that and a cot is the procedure trolley doesn't have sides, does it?

NURSE B: It does have sides, but not to the extent of -- it's not a sleeping facility.

MYERS: All right, thank you. It's just one that's used temporarily when, as it says, there is a procedure to be performed; is that right?

NURSE B: That's right, yes. You wouldn't leave a baby unattended on it because it does not have secure sides. The sides are able to be brought down, so the doctors or nurses performing the procedure can access a limb, for instance, for a cannula.

MYERS: Thank you. It seemed to take a little time for the cannulation to be performed successfully, didn't it?

NURSE B: Correct.

MYERS: And there were multiple attempts by Dr Harkness and Dr Gibbs working together, weren't there?

NURSE B: I believe it was Dr Gibbs attending to the cannula and Dr Harkness assisting, but they were certainly working together, yes.

MYERS: All right. And from what you know, did it take multiple attempts to site the cannula?

NURSE B: It did.

MYERS: At the conclusion of a process like that, what should happen when the doctors are finished is that the screens are removed? That's what should happen?

NURSE B: Correct.

MYERS: The baby should be replaced back in the cot?

NURSE B: Correct.

MYERS: And then one or other of the doctors come and tell the designated nurse, or someone, that the process has been completed?

NURSE B: Correct.

MYERS: As it happened, the first that you knew that there was any issue with [Baby G] was when Lucy Letby called for help?

NURSE B: Correct.

MYERS: And when she called, is that when you then went into the nursery?

NURSE B: I went -- I answered the call for help, I went to the doorway, yes.

MYERS: Thank you. And you could see that [Baby G] was not the correct colour?

NURSE B: That's correct.

MYERS: Was she a dusky colour or can you not remember?

NURSE B: I cannot remember the exact colour. I remember her looking poorly.

MYERS: [Baby G] was struggling to breathe?

NURSE B: She wasn't breathing.

MYERS: She wasn't breathing. You could see that Ms Letby, Nurse Letby, was obviously concerned by what was taking place, wasn't she?

NURSE B: She was concerned, yes.

MYERS: And she was responding appropriately as far as you could see?

NURSE B: As far as I could see, yes.

MYERS: The monitor was not on, was it?

NURSE B: The monitor was not on.

MYERS: And you're not sure in fact whether it was attached; is that right?

NURSE B: I'm unsure whether the probe was attached. The monitor was not on.

MYERS: Right. Do you recall whether [Baby G] had been put back in the cot by this point or do you not know?

NURSE B: She was in the cot.

MYERS: She was in the cot. And we talked about the screens yesterday. Do you recall whether they'd actually been pushed back a bit or, from your recollection, were they in the same position?

NURSE B: Possibly, I just remember it still being there.

MYERS: All right. I just want to deal with events later that afternoon. You explained to us yesterday, I've got the note of how the evidence was, that you contacted the police about a month ago, is that right, [Nurse B]?

NURSE B: That's correct.

MYERS: Thank you. And you did that after you'd read the opening speeches online?

NURSE B: Correct.

MYERS: And it had seemed or you'd seen that it was suggested that Lucy Letby had turned the monitor off?

NURSE B: Correct.

MYERS: And from what happened, and we're going to come to that, you knew that wasn't the case?

NURSE B: As far as I am aware, I believed that was not the case.

MYERS: Right. When you say as far as you're aware, that's because this is what happened, isn't it? Later that day, Dr Gibbs and Dr Harkness came to you, didn't they?

NURSE B: They came to me.

MYERS: And they spoke to you in the corridor outside nursery 4?

NURSE B: Yes.

MYERS: Your belief was they must be coming to you because you had mentioned to Eirian Powell that the monitor had been switched off. That's what you thought had happened; is that right?

NURSE B: I can't remember the order, whether I spoke to Eirian Powell first, or Dr Harkness and Dr Gibbs came to me.

MYERS: In any event, you can't remember which one it was who spoke or whether both of them spoke, you can't remember that precisely?

NURSE B: Correct.

MYERS: But you do recall they were both present when this conversation took place?

NURSE B: Correct.

MYERS: Both of them were very apologetic, weren't they?

NURSE B: They were.

MYERS: And they were apologetic because, as they explained, they hadn't told you they had finished with [Baby G]?

NURSE B: Correct.

MYERS: And apologetic because they hadn't switched the monitor back on?

NURSE B: Correct.

MYERS: And apologetic because they had left [Baby G] behind the screen?

NURSE B: Correct.

MYERS: And as you have explained to us, the nurse, or a person, should have been told when they left, shouldn't they?

NURSE B: Someone, ideally the nurse allocated to them.

MYERS: And certainly she should not have been left behind a screen, should she?

NURSE B: Correct.

MYERS: And the monitor should have been turned back on?

NURSE B: It should.

MYERS: In fact the reason that you discovered where [Baby G] was and what was happening was because Nurse Letby had called out for help?

NURSE B: She had.

MYERS: After that, after the incident where you had gone to Nurse Letby because she'd called for you --

NURSE B: Yes.

MYERS: -- I'm just going back in time a little bit -- afterwards did she talk to you about finding [Baby G] there; do you recall that?

NURSE B: I don't recall that conversation.

MYERS: All right. I'm just going to ask you a few things about what I'm going to suggest happened, but you say if you recall it or if it didn't happen.

NURSE B: Okay.

MYERS: Was she cross that the doctors had left her behind the screen with the monitor off; do you remember that?

NURSE B: I don't remember that.

MYERS: You don't.

NURSE B: I remember her being concerned for [Baby G]'s welfare.

MYERS: Thank you. Do you recall whether she had said, "Maybe this is something to make a complaint about", a formal complaint?

NURSE B: I don't remember, but I did go to my manager to report it myself without anyone else suggesting.

MYERS: Again, agree or disagree as you see fit, [Nurse B], but did she raise the prospect of putting a report on what's called the Datix system because of [Baby G] being left like that?

NURSE B: I don't recall.

MYERS: Could she have said that and you just don't recall?

NURSE B: It's highly likely.

MYERS: All right.

MR JUSTICE GOSS: Well, I think that's an interesting proposition. Do you recall any such conversation?

NURSE B: No.

MR JUSTICE GOSS: Well, why do you say it's highly likely then?

NURSE B: Because that's the reporting system of an incident.

I remember reporting to my manager directly. So whether the incident has been reported from my manager on to a Datix, I don't know. I didn't complete the Datix myself.

MR JUSTICE GOSS: You didn't do one yourself?

NURSE B: No, I didn't.

MR JUSTICE GOSS: And you don't know whether anyone else did?

NURSE B: Correct.

MR MYERS: I'm grateful, my Lord. There's a subsidiary question that goes with that that may knit that together.

What I was going to ask was this, [Nurse B]: was there a conversation where Ms Letby explained what had happened and raised an issue with it and you said to her you would deal with it your way? Do you recall saying something like that, that you'd speak to someone about it?

NURSE B: No, I don't.

MYERS: And I will ask, was there any aspect of you being anxious at all about raising a complaint then about what the consultants had done or not?

NURSE B: I reported it to my manager as soon as [Baby G] was stabilised in nursery 1. I didn't delay, I reported it on exactly the same day.

MYERS: And do you recall who it was in terms of your manager who you reported it to? Do you know who that was?

NURSE B: Eirian Powell.

MR MYERS: Right. Well, thank you very much for dealing with that, [Nurse B].

Re-examination by MR ASTBURY

MR ASTBURY: Just one matter dealing with that last question. Is it open to any individual nurse to complete a Datix form if they have a concern about an incident that's taken place?

NURSE B: Anyone working within the trust, no matter what role, has access to report a Datix incident form.

ASTBURY: So any nurse who feels strongly about an incident can enter it on to the form and submit it in the usual way?

NURSE B: Nurse, doctor, porter, cleaner, anyone. Anyone within the trust, if there's an issue, can report an incident.

MR ASTBURY: Thank you.

I have no more questions. Does my Lord?

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

MR ASTBURY: That's it for this witness today.

MR JUSTICE GOSS: It is, yes.

Thank you very much. Please just remain seated where you are.

Is the witness coming back again? I haven't checked.

MR ASTBURY: Yes.

MR JUSTICE GOSS: So as before, please don't talk to anyone about anything to do with this case. Thank you very much. Stay where you are.

Sorry, members of the jury, you'll have to leave the court for a few minutes.

(In the absence of the jury)

Could anyone else who is not a lawyer in the case please leave the courtroom just for a few minutes?

(Pause)

(In the presence of the jury)

MR JUSTICE GOSS: The next witness, I'm told, is on their way, but as you know, that can take 5 minutes, so Mr Astbury is going to read a statement now to fill in the time.

Witness statement of VALERIE THOMAS (read)

MR ASTBURY: Thank you.

My Lord, it's a statement from Valerie Thomas, returning to the chronology. She signs her statement on 19 March 2020 and she says as follows:

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

"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.

"Referring to 21 September 2015, I have reviewed my medical notes and rotas from 16 September 2015. I was working a night shift, that's 19.30 hours to 08.00 hours, beginning on 20 September 2015, going through into 21 September.

"My first entry on the medical notes that relate to [Baby G] is timed at 07.24 on 21 September. The notes do not say which nursery room [Baby G] was in. [Baby G]'s observations were satisfactory. Her temperature was 36.4 to 36.7. 36.4 is a little low, but she was well wrapped up, being nursed in a cot. [Baby G] was still on three-hourly feeds. She was completing her own bottles, but she had one nasogastric tube at 3 o'clock to rest.

"[Baby G] settled after the 21.15 feed that her father gave her. She passed urine and had her bowels open. She had her medication as prescribed by the neonatal staff. At 6 am, 06.00 hours, I took routine bloods that morning from [Baby G]. [Baby G] was due for immunisation that day. At 08.00 hours that day I went off duty."

Witness statement of DR RACHEL CHANG (read)

MR ASTBURY: My Lord, it's slightly out of turn, but I turn next, please, to Rachel Chang who, we heard a moment ago from [Nurse B], was involved in treatment on the day of the 21st and whose notes we'll look at in due course with a different doctor. If I could read her statement now also.

This is a statement dated 30 April 2018. Dr Chang says as follows:

"In September 2015 I was an ST3 in paediatrics posted for 6 months as a registrar in the Countess of Chester Hospital.

"This was my first post as a senior doctor. My role at that time was to oversee and cover all children under the age of 16 and those who were under 18 with mental health problems who come into the Countess of Chester. I would be split between the neonatal unit (NNU), accident and emergency, deliveries, or the children's ward depending on the rota.

"In reference to 21 September 2015, from memory I cannot remember anything about this particular date, the NNU unit or

anything in reference to [Baby G]. From the notes I have written, I would have started my duties at 08.30, possibly ending either 17.00 or 18.00. However, if I was on call it could have ended at 21.00.

"[Baby G], on 16 September 2015, was returned from Arrowe Park Hospital physically stable. On 21 September 2015, it appears senior house officer Dr Peter Fielding was doing a ward round when [Baby G] had had a large vomit and went tachycardic. Dr Fielding has been asked to review [Baby G]. At this stage Lucy Letby is the designated nurse for [Baby G].

"In Dr Fielding's notes, made at 10.30 am, he states that [Baby G] had an episode at 10.20 am. The nurses called for help. Dr Fielding goes to [Baby G], who was by that time recovered. He examines [Baby G], documenting that she had a low temperature and that her tummy was distended. There is a mention from the nurses that this is 'normal for [Baby G]'. Dr Fielding has then discussed [Baby G]'s condition with me, possibly by telephone. I have suggested to aspirate the nasogastric tube and 'leave on free drainage', the idea being to empty [Baby G]'s stomach of any air that may be causing the distension, and I suggested delaying the next feed, monitoring [Baby G]'s stomach and testing [Baby G]'s blood via a heel prick.

"At 11.50 am, I have documented that I have reviewed [Baby G], saying that she is pale, tachycardic, with a heart rate up to 190 beats per minute, had one feed delayed, and had no further vomiting. I documented that according to nursing staff and parents that 'she is not herself'. On examining her she was self-ventilating in air, had good oxygen levels, and her heart rate had settled to 160 to 170. I mentioned she is quieter than normal. With regards to her distended tummy, I have said that she is soft and distended, so I have recommended for partial screening for sepsis. Dr Gibbs is mentioned as having reviewed [Baby G]'s condition and recommended a broad spectrum antibiotic called cefotaxime.

"A temporary cannula was fitted at this point into [Baby G], possibly by me, but I can't remember, in order to get samples so we could check for bugs in her bloodstream. This was also used to administer antibiotics and 10% dextrose intravenously into [Baby G].

"I would have been assisted by a nurse but I don't remember who. This line that I may have fitted has obviously failed at some point. Dr Gibbs was called to assist in the fitting of the next cannula, possibly by me but I can't remember. It also documented that Dr Gibbs has recommended a suppository in case she is constipated.

"After being informed by somebody I can't remember, rather than being a witness to this episode, I have then made an entry at 15.30 saying that [Baby G] had a desaturation, requiring bagging (Neopuffing) due to poor respiratory effort.

"Dr Fielding had noted that [Baby G] desaturated and her oxygen level went down to 30% and [Baby G] appeared to be apnoeic. The notes then say that by 15.30, Dr Gibbs inserted a cannula into [Baby G]'s left foot. This is usually after the initial one failing. I can't remember if I was present or not when Dr Gibbs fitted the cannula.

"I made no further entries within the notes that day, which would suggest that I had nothing further to do with [Baby G] as in the nursing notes it appears she is stable and recovering. I cannot remember if any screens were around [Baby G] when the cannula process was taking place."

MR JUSTICE GOSS: Thank you.

MR ASTBURY: We'll stop there, please, and hopefully call Dr Fielding if he's here.

MR JUSTICE GOSS: Yes. Ideally, it might have been better for Dr Fielding, who's referred to in that witness's evidence, to be called first. There's obviously an overlap between the two.

DR PETER FIELDING (sworn)

Examination-in-chief by MR ASTBURY

MR ASTBURY: Good morning. Can we start with your full name, please?

FIELDING: Peter Fielding.

ASTBURY: And your profession, please?

FIELDING: I'm a doctor.

ASTBURY: Were you employed, back in September 2015, at the Countess of Chester Hospital?

FIELDING: Yes, I was.

ASTBURY: We've just heard some agreed evidence to indicate that you were a senior house officer at the time.

FIELDING: Yes, that's correct.

ASTBURY: And that you were occupied in the neonatal unit.

FIELDING: And the paediatric ward as well, across both.

ASTBURY: You've come here today to assist with events on 21 September 2015 --

FIELDING: Yes.

ASTBURY: -- some time ago.

FIELDING: Yes.

ASTBURY: And in particular, a baby named [Baby G] and your treatment of [Baby G].

FIELDING: Yes.

ASTBURY: Are you able to recall anything of [Baby G] from September 2015?

FIELDING: From memory, it's quite difficult. When I gave my statement it was mostly sort of from my -- the medical notes that I'd made at the time.

ASTBURY: Okay.

FIELDING: Some vague memories of [Baby G] but nothing specific.

ASTBURY: We can assist with you that. You'll see a screen to your right, which will hopefully in a moment show the notes. Before we go to that, were you on a day shift on 21 September?

FIELDING: Presumably. Obviously I was writing the notes at -- I think it was 10.20, so I'd either been on a short day shift, which is 9 am to 5 pm or 9 to 9 if I was on the long day. It'd be one of those two shifts.

ASTBURY: Have you effectively relied on the notes for the purposes of your statement in this case?

FIELDING: Yes.

ASTBURY: All right. Do you happen to remember, when you went to see [Baby G] at the time you just mentioned, what other members of staff were present in the nursery?

FIELDING: Not from memory.

ASTBURY: All right. Let's go then, if we may, please, to tile 51, Mr Murphy. You'll see a presentation and behind it, you'll see some notes. If we scroll down the page, I think we'll see

there on the 21st at 10.30, as you indicated, your name. Do you recognise the handwriting?

FIELDING: Yes, that's mine.

ASTBURY: That's your handwriting. What I'm going to suggest -- if you just have a read of it first before I ask you any questions about it, I'll ask Mr Murphy in a moment to scroll down so you can read the whole thing before we start.

(Pause)

It's quite a long note, so just bear with us.

(Pause)

Is that your signature --

FIELDING: Yes.

ASTBURY: -- under what I think what we've come to know as the plan?

FIELDING: Yes.

ASTBURY: If we go back to the start of that note, please. It seems to be, to me, set out in sections; is that right?

FIELDING: Yes.

ASTBURY: So if we go through each section. You begin by indicating [Baby G]'s, first of all, gestation at birth and then, as it were, bringing it up to date.

FIELDING: Mm-hm.

ASTBURY: And then you have a list of problems set out.

FIELDING: Yes.

ASTBURY: Take us through those, please.

FIELDING: Sure. So I tend to start most daily notes like this just to give context to each baby and how they look on that particular day.

So this is just a list of any kind of issue or detail that [Baby G] had had in her life to date that we need to bear in mind when we make assessments of her.

ASTBURY: This is a retrospective --

FIELDING: Yes. This is a summary (overspeaking) --

ASTBURY: -- (overspeaking) for the coming examination?

FIELDING: Exactly.

ASTBURY: Let's run through them, please, because a number of them are abbreviations, so if you can take us through them, please.

FIELDING: Point 1 there is just "prem" for prematurity, just a generic comment that we need to bear in mind [Baby G]'s prematurity and certainly the degree of prematurity.

The second is CLD, which is chronic lung disease.

Most babies born at such an extreme of gestation will have some long-term lung issues usually. That tends to get better over time as babies grow and they grow new healthy lung tissue, but it's always worth bearing in mind the fragility of the lungs when premature babies are born and some of the problems that can go hand-in-hand with that.

Point 3 is PDA for patent ductus arteriosus. That's just a tube that is present for babies when they're inside the womb. Because they don't breathe through their lungs they get all of their oxygen through mum's placenta, and that tube normally --

MR JUSTICE GOSS: I think we've heard evidence of that.

I don't think we need to -- don't worry. You don't know what we've heard. We have heard a lot of witnesses and that's been explained. We've even seen diagrams.

MR ASTBURY: My fault, doctor, not yours.

MR JUSTICE GOSS: You'll remember this. In the placenta the blood comes through, it doesn't go through the lungs, the oxygen come directly from the placenta, and there is that valve, that flap that was referred to --

MR ASTBURY: Thank you. I think, in fact, the flap is the PFO. This is the PDA, which I think is a blood vessel.

FIELDING: Yes. It's a duct, yes, a direct duct.

ASTBURY: And that was still present in [Baby G] and that's why you have noted it?

FIELDING: Yes.

ASTBURY: All right. Again, "ROP zone 1". Could you very briefly explain what that means to us, please?

FIELDING: Yes. ROP is retinopathy of prematurity and that's to do with the blood vessel development at the back of the eye. That process can be not fully complete if you're born prematurely and can lead to some problems with vision as a consequence.

ASTBURY: I'll guide you through the remainder, if that helps.

There had been an MRI head scan, that's at point V, and ischaemic changes had been noted and her mum and dad had been updated about that.

FIELDING: Yes.

ASTBURY: Is that hypoglycaemia?

FIELDING: Hyopkalaemia, so low potassium, and hyponatraemia, which is low sodium.

ASTBURY: There's a note there of supplementation in order to tackle those two issues; is that right?

FIELDING: Yes.

ASTBURY: Her return from Arrowe Park, we know, on 16 September 2015. If we scroll down, please. Treated with -- is that meropenem?

FIELDING: Meropenem, which is the antibiotic.

ASTBURY: For 7 days for presumed sepsis. Sorry, I can't read the next two lines.

FIELDING: So it's:

"No positive cultures."

So if we think a baby has sepsis or an infection we tend to take samples from all of the common sites that an infection can sit. And that point is that despite taking all of those tests they didn't grow a particular bug that might be responsible for infection in [Baby G]'s case.

ASTBURY: So would they have been taken at the stage that sepsis was suspected?

FIELDING: Yes.

ASTBURY: And then retrospectively the results arrive and it's ruled out because there are no cultures?

FIELDING: Yes, we didn't find a particular bug that might cause infection in that situation.

ASTBURY: And the bottom line in fact:

"CRP peaked at 218."

We've heard that from another source. So if we scroll down.

Is that "self-ventilating in air"?

FIELDING: Yes.

ASTBURY: Then you have noted the rate at which she was receiving nutrition, which is 165ml/kg/day by way of expressed breast milk --

FIELDING: Yes.

ASTBURY: -- via a combination of bottle and NGT, nasogastric tube?

FIELDING: Yes.

ASTBURY: Thank you. Is that "fully fed"?

FIELDING: Yes.

ASTBURY: Sorry, I can't read that first word.

FIELDING: It's the medicine. The first one is DaliVit, folic acid and Sytron, which are just generic multi-vitamins and iron supplements that all premature babies would be on.

ASTBURY: Thank you. Sodium chloride?

FIELDING: That's the hyponatraemia we mentioned earlier, that's the supplement for low sodium.

ASTBURY: Phosphate -- I'm afraid I am struggling with the next one.

FIELDING: Phosphate Sandoz. Again, that's a medication to support low phosphate levels which can be common in premature babies.

ASTBURY: And the potassium chloride?

FIELDING: A potassium supplement for low potassium levels.

ASTBURY: And you note there that she is due the vaccinations for a 3-month old?

FIELDING: Yes.

ASTBURY: Thank you. You then set out a series of results for her bloods timed at 02.17 that morning.

FIELDING: Yes.

ASTBURY: I won't take you through those, someone else may ask you questions, but we can see those recorded. Then presumably you've moved on to the history, what you had been told; is that right?

FIELDING: Yes, that's right.

ASTBURY: You were told that [Baby G] had had an episode at -- is that around 10.20?

FIELDING: Yes, roughly 10.20.

ASTBURY: Where she:

"Had 2x projectile vomits witnessed by nursing staff, after which she was apnoeic for around 6 to 10 seconds, went blue, sats down to 30%", is that?

FIELDING: 30, yes.

ASTBURY: "Last feed 9 am. Nurse called for help. On going back to [Baby G]" -- is that an arrow?

FIELDING: Yes, it is an arrow.

ASTBURY: And then "colour N"?

FIELDING: Normal.

ASTBURY: "Breathing and crying."

Those are good signs.

On examination, so having been told what you had, you then examined [Baby G]?

FIELDING: Yes.

ASTBURY: "Currently settled."

Is that the anterior fontanelle was soft?

FIELDING: Yes.

ASTBURY: Is that something in situ?

FIELDING: NG, nasogastric tube.

ASTBURY: You found her to be well hydrated; is that right?

FIELDING: Yes.

ASTBURY: But pale. The capillary refill time, I think, is CRT and that was 2 seconds?

FIELDING: Yes.

ASTBURY: Which is what would be hoped for; is that right?

FIELDING: Yes.

ASTBURY: And then a zero with a circle through it. What does that mean, please?

FIELDING: No, just an abbreviation for "no".

ASTBURY: So no respiratory distress?

FIELDING: Yes.

ASTBURY: And then this is a diagram we've seen before. This, I think, represents the lungs?

FIELDING: Yes.

ASTBURY: And the way you've drawn it suggests that it is clear?

FIELDING: Yes, no issues.

ASTBURY: And your note, "good bilateral", is that?

FIELDING: Yes.

ASTBURY: And remind me what AE is, please?

FIELDING: Air entry.

ASTBURY: Thank you. Then the note underneath, "1 plus 2 plus 0", is normal heart sounds?

FIELDING: Yes.

ASTBURY: You have made some observations on the right of the page. Temperature 36.2 at -- is that 17.00 yesterday?

FIELDING: Yes.

ASTBURY: And then you have noted there had been a few episodes of relatively low temperatures and is that --

FIELDING: "No high temperatures and pyrexias."

ASTBURY: Then I think this is a tummy?

FIELDING: Yes.

ASTBURY: You have noted distended and -- is that "stiff"?

FIELDING: "Staff", sorry.

ASTBURY: "Distended. Staff think perhaps more so than usual. Mum more..."

FIELDING: "Mum unsure."

ASTBURY: Thank you. Next line, I'll just ask you.

FIELDING: That's "no organomegaly". In the context of a distended tummy the organs underneath, the liver and the spleen all feel a normal size, so they wouldn't be responsible for the distension.

ASTBURY: So that rules them out as a cause?

FIELDING: Yes.

ASTBURY: "Soft" -- what's the next word?

FIELDING: That's "non-tender".

ASTBURY: Okay. So the reason for noting it soft and non-tender at that stage?

FIELDING: I'm just trying to explore causes of a distended tummy.

There are certainly types that will give you a very tense, tender, discoloured tummy, so it's looking for potential causes of that distension of the tummy.

ASTBURY: So you'd expect to find it soft and non-tender --

FIELDING: Yes, that's a normal finding yes.

ASTBURY: You put:

"Bowel sounds active. Bowels open."

Is that "loose stool"?

FIELDING: Yes.

ASTBURY: A green colour?

FIELDING: Yes.

ASTBURY: Before we move on:

"Distended. Staff think perhaps more so than usual."

Do you know who the staff were?

FIELDING: Not from memory. My assumption would be it would be the nurse who asked for help and the nurse who was looking after [Baby G] at that point in time.

ASTBURY: Thank you. We can scroll down.

Then is that "discussed with"?

FIELDING: Registrar, SPR Chang.

ASTBURY: And do the next points represent what you discussed with her, what she advised you?

FIELDING: Yes. On discussion, what we thought the best plan would be going forward.

ASTBURY: So:

"Aspirate NG tube and leave on free drainage. Delay next feed."

Please correct me if I read any of these wrong again:

"Observe stomach over next hour and heel prick bloods."

And I think is it -- is FBC full blood count?

FIELDING: U&E, which is kidney function.

ASTBURY: And CRP, which can be an indicator of infection?

FIELDING: Yes.

ASTBURY: You then recorded the results from, is that --

FIELDING: That's --

ASTBURY: Would that be the same blood gas from the heel prick?

FIELDING: Yes, it's done at the same time, but it's a test in its own right.

ASTBURY: We can see that was carried out contemporaneously at 10.40. And you have made a number of entries there.

Again, I'm not going to take you through those, but you may be asked about them.

If we scroll down again, please. P for plan?

FIELDING: Mm-hm.

ASTBURY: The plan is "As per SPR"?

FIELDING: Specialist registrar.

ASTBURY: Specialist Registrar Chang:

"Hold off immunisations at present..."

Because we have heard they were due that particular day -- and is that "review" or "revisit"?

FIELDING: "Review in 1 hour."

ASTBURY: (Overspeaking) blood results. We can see your signature there.

There's nothing in the notes, but do you recall seeing [Baby G] again in the course of that day?

FIELDING: No, not from memory, no.

MR ASTBURY: Okay. Thank you. I have no more questions, doctor. If you wait there, please.

Cross-examination by MR MYERS

MR MYERS: Not many, Dr Fielding, if you could just help with these, please.

Were you the first doctor to arrive after help had been called for?

FIELDING: I think so.

MYERS: When you got there, you received a report, we've just looked at in your notes, didn't you, from the nurse or the nurses looking after the baby?

FIELDING: Yes.

MYERS: Do you remember how many nurses were there when you did arrive or do you not recall? Don't guess.

FIELDING: I don't recall.

MYERS: All right. Just so we can be quite clear, you didn't witness the episode at all, did you?

FIELDING: No, I didn't.

MYERS: By the time you arrived, [Baby G] appeared to have already settled?

FIELDING: Yes, she seemed to be recovering.

MYERS: No breathing difficulties?

FIELDING: No.

MYERS: And her colour appeared normal?

FIELDING: Colour normal, but slightly more pale than --

MYERS: Colour normal, slightly more pale. We've just seen in the notes, it may not be necessary to go back to it, you made a reference to the "loose stool, green colour".

FIELDING: Mm-hm.

MYERS: Can a loose stool like that indicate something abnormal or is it a natural finding?

FIELDING: So it's more about what's normal for each individual baby, I guess, and if that's a departure from the norm.

It's slightly tricky in a baby that's recently had a course of antibiotics as well because a side effect of that can be a slightly looser stool.

MYERS: Putting antibiotics aside, is it possible to say generally whether a loose stool is an abnormal finding?

FIELDING: Not as a one-off isolated event.

MYERS: You look at the whole picture?

FIELDING: Yes.

MYERS: In any event, it seemed to you, when you got there, that fortunately this had been a brief episode and there had been a relatively swift recovery, hadn't there?

FIELDING: Yes.

MYERS: And as far as you could see -- and no breathing support had been required as it happens?

FIELDING: No. I think looking at the notes soon afterwards, I think that did progress but at that point in time...

MYERS: At that point no support required, so self-correcting in fact?

FIELDING: Yes.

MR MYERS: Thank you.

MR ASTBURY: I have nothing arising. Does my Lord have any questions?

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

Thank you for coming, Dr Fielding.

MR ASTBURY: It's Dr Gibbs next -- we think not, but these things can occasionally change, I don't know whether Dr Fielding is expecting to coming back.

MR JUSTICE GOSS: Are you --

FIELDING: As far as I am aware, no --

MR JUSTICE GOSS: According the sheet I've got, no. But just in case you are unexpectedly required some time later, would you please not talk to anyone about this case and, in particular, your evidence or anything to do with any of the events?

FIELDING: Yes.

MR JUSTICE GOSS: Thank you very much indeed.

(The witness withdrew)

MR ASTBURY: My Lord, it's Dr Gibbs next. I'm not entirely confident that he's outside yet.

MR JUSTICE GOSS: I doubt he is unless he was warned 5 minutes ago.

MR ASTBURY: I know it's a little early -- he's not going to be done in 30 or 40 minutes, I don't think, there's a bit to take him through.

MR JUSTICE GOSS: We've only done about 35 minutes today.

Would you like a break now? If we don't have a break now then we'll go right through to 1 o'clock. If any of you think you're going to need a break between now and 1.00 -- we'll take it now, yes, let's play safe.

(In the absence of the jury)

MR ASTBURY: I apologise for that.

MR JUSTICE GOSS: No, it's all right. We'll have a 10-minute break then or thereabouts. I'll say quarter to, which is just under 10 minutes.

MR ASTBURY: Apologies, I'm not sure reading anything would have made sense.

MR JUSTICE GOSS: No, we have a break at some time and we're just taking it a bit early.

(11.36 am)

(A short break)

(11.45 am)

(In the presence of the jury)

DR JOHN GIBBS (recalled)

Examination-in-chief by MR ASTBURY

MR ASTBURY: Dr Gibbs, we have heard from you before. Could I ask you please to reintroduce yourself for the purpose of the record?

GIBBS: I'm John Gibbs. I was a consultant paediatrician at the Countess of Chester Hospital until 2019, when I retired.

ASTBURY: Thank you. You've been asked to come along to assist with events on 21 September 2015 in which you were involved, concerning a baby by the name of [Baby G].

GIBBS: Right.

ASTBURY: In your witness statement you have helpfully set out a summary of [Baby G]'s life up until 21 September. I'm going to go through that very briefly with you, really to, I hope, assist you and just to remind ourselves of the pertinent dates.

So [Baby G], we know, was born prematurely at Arrowe Park and you have noted that that was at 23 weeks and 6 days and you also noted her very low birth weight; is that right?

GIBBS: That is correct, yes.

ASTBURY: And she was mechanically ventilated for the first 36 days of her life?

GIBBS: Yes.

ASTBURY: And thereafter that ventilation decreased and became less invasive; is that right?

GIBBS: That's correct, yes.

ASTBURY: She was 76 days old when she was transferred to the NNU at Chester, that being 4 August 2015?

GIBBS: Um... Not sure it was 4 August, but she was --

ASTBURY: 14th?

GIBBS: 14th, yes. She was 11 weeks old, yes.

ASTBURY: At the time of that transfer she was suffering with, amongst other things you've noted, chronic lung disease of prematurity?

GIBBS: Yes.

ASTBURY: And she was also suffering from gastro-oesophageal reflux?

GIBBS: Yes.

ASTBURY: Is that an unusual feature in infants of her age and gestation?

GIBBS: Gastro-oesophageal reflux, or just reflux and possetting, is common in many babies, but particularly so in premature babies. So it was a common problem.

ASTBURY: You noted that scans at Arrowe Park revealed mild dilation of the ventricles within her brain?

GIBBS: Yes, that's ultrasound scans in the early weeks of life.

ASTBURY: And that you observed that mild ventricular dilation is not always associated with subsequent adverse developmental progress?

GIBBS: No, it's difficult to prognosticate, to know the outcome from just ultrasound scans.

ASTBURY: You summarised that she was stable during the first 3 weeks following her transfer from Arrowe Park.

GIBBS: Yes.

ASTBURY: And you note events on 7 September 2015, where she suddenly deteriorated, as you put it, with a profuse vomit.

GIBBS: Yes, but I wasn't directly involved at that time.

ASTBURY: You had, as you indicate here, no direct involvement with [Baby G] on 7 September and she thereafter spent 9 days at Arrowe Park.

GIBBS: Yes, that's right.

ASTBURY: And you note that her blood C-reactive protein rose to 218 whilst at Arrowe Park.

GIBBS: Yes.

ASTBURY: We have heard that that was some time on 9 September, so 2 days after her transfer.

GIBBS: Right.

ASTBURY: She returned to Chester on 16 September. You summarise that over the next few days, the doctors who examined her recorded that she was stable and continuing to manage without any supplemental oxygen.

GIBBS: That's correct, yes.

ASTBURY: On 20 September, you note that [Dr C], your consultant colleague, had a conversation with [Baby G]'s parents about the results of an MRI scan.

GIBBS: That's correct, yes, a brain scan.

ASTBURY: Thank you. And ischaemic changes were noted to the brain?

GIBBS: That's correct, yes.

ASTBURY: Brought about by the lack of blood and oxygen reaching parts of the brain in that particular case?

GIBBS: That's correct.

ASTBURY: You first became directly involved with [Baby G] on 21 September; is that right?

GIBBS: That's right, yes.

ASTBURY: I think you were consultant of the week.

GIBBS: I'd started -- at the beginning of the week it was a Monday and I had started as consultant of the week, yes.

ASTBURY: And that gave you, did it, responsibility for the care of the patients on the NNU during the daytime?

GIBBS: That's correct.

ASTBURY: Do you have any direct recollection of the events of 21 September?

GIBBS: Only a vague recollection. Most of my recollection is from reviewing the medical notes.

ASTBURY: Did you or were you present during any collapse that [Baby G] suffered on that day?

GIBBS: As far as I can recall, I was present after her collapse in the morning. You have heard from Dr Fielding, who was immediately summoned when she first had the vomiting in the morning, and then a registrar, Dr Chang, attended to [Baby G], and I went to the unit, as is normal practice.

After doing the ward round on the paediatric ward, the normal practice each day is to go to the neonatal unit, which is when I became involved with [Baby G] at that time.

ASTBURY: In your witness statement you have noted that from his(?) notes that a fall to 30% by way of desaturation is a significant event.

GIBBS: Yes, that's a severe desaturation, drop in oxygen level.

ASTBURY: You have recited, and I'm not going to do it with you because we, as you rightly point out, have just looked at it. You recite the content of Dr Fielding's notes?

GIBBS: That's correct.

ASTBURY: So you had those in mind presumably when you saw [Baby G] later in the day?

GIBBS: Yes, and particularly Dr Chang, the registrar, who had seen [Baby G] as well.

ASTBURY: Dr Chang's notes are available. Perhaps if we can go to those, please. Tile 57.

If we can look at the notes. That's the end of Dr Fielding's, but we have an entry at 11.50 from Dr Chang which I think you -- would you have seen this when you attended [Baby G] that day?

GIBBS: Likely to have but certainly that would have been discussed with me.

ASTBURY: I think if we just scroll -- I will just give you an opportunity to look at it, please, to refresh your memory from that particular day and ask you if anything stands out to you in that particular entry.

GIBBS: Well, Dr Chang is being asked to see because [Baby G]'s heart rate had increased and she was looking pale, but before that she had had some projectile profuse vomiting that Dr Fielding has recorded, and yet the encouraging fact is when it says "resp" in the left margin, that's respiratory, she's remaining in air, that's spontaneous ventilation in air, SVIA, and her saturations, oxygen levels, were good at 94% to 96%, so that was reassuring, that given she's a vulnerable premature baby with chronic lung disease, despite the problems she'd had that morning, her breathing was satisfactory.

And the CRT at the bottom is just capillary refill time, an estimate of circulation and it says less than 2 seconds. That's reassuring as well at the time.

ASTBURY: There's an entry there about heart rate. Tell us about that, please.

GIBBS: That's faster than usual. It should be up to 170 to 180 but that's a little high.

ASTBURY: But it would appear that it settled after that initial --

GIBBS: Yes. And other indicators I have mentioned were encouraging.

ASTBURY: Can you just scroll through the rest of that entry, please. Again these are the notes which you would have been familiar with on the day and that you refreshed your memory from. Is there anything there that stands out to you as a treating consultant?

GIBBS: The fact that [Baby G] had had a large vomit -- in fact, I think Dr Fielding recorded it as two large projectile vomits, and it's just unusual for a premature baby, who had been feeding entirely satisfactorily since returning from Arrowe Park Hospital, to actually have projectile vomiting.

ASTBURY: Right.

GIBBS: Her abdomen is distended, but many premature babies, particularly like [Baby G], who have had a difficult time with ventilation for 5 weeks followed by needing continued support for some weeks for their breathing with CPAP and Optiflow administration of oxygen, it's not uncommon to have a slightly distended tummy because of the increased work of breathing over many weeks and the lax soft abdominal muscles that premature babies have. So [Baby G] had frequently quite a distended tummy.

ASTBURY: If we scroll down the note, I think there may be a diagram of her tummy, which is described as soft.

GIBBS: Yes. It's distended but soft and good bowel sounds present.

ASTBURY: The plan at 11.50, if we could just have a look at that, please, scroll down a little bit, Mr Murphy. Thank you.

Certainly after the reference to a partial screen, it would seem you've been certainly involved to an extent following that examination. Could you tell us about that, please?

GIBBS: There would have been at least a discussion between Dr Chang and myself and one possibility for a baby who vomits and who is looking quieter, more pale than usual, is they might have an infection and we tend to cover for infections first because it's serious if we delay treatment for infections. So the plan

for [Baby G] at that time was to do a partial screen and that means to check for infection, but "partial" means to omit a lumbar puncture because that's quite an invasive, traumatic procedure. It involves curling a baby up into a C shape to expose their back and stick a needle in and with someone like [Baby G], who had had a lot of problems with her breathing, that could compromise her breathing. So we weren't going to do a lumbar puncture but we did do blood tests and the blood culture and started an antibiotic.

ASTBURY: Is that the reference to --

GIBBS: Yes.

ASTBURY: -- cefotaxime?

GIBBS: Yes. It says "reviewed", which means I would have seen Paige (sic), so:

"Dr Gibbs reviewed. For cefotaxime only currently."

Now, if she'd suffered from necrotising enterocolitis, which has been discussed with other babies before, if she was suffering from that we'd normally give several antibiotics. But I felt at that time -- I must have felt at that time that she was unlikely to have necrotising enterocolitis, and so we were only covering for other infections at that stage.

ASTBURY: Then you move on to agree a plan with Dr Chang. Tell us about that, please.

GIBBS: Yes. [Baby G] at that time didn't have intravenous access, didn't have a cannula, she'd needed that at various times in the past, but because she'd been feeding well and stable, she didn't have intravenous access but because she'd had this vomit or several projectile vomits and then had been quieter than usual and then had a temporary increased heart rate, we were covering for infections, so the plan was not to feed her into her tummy at that, stage to give her intravenous fluids and intravenous antibiotics, but to do an abdominal X-ray, looking for other complications, particularly necrotising enterocolitis signs on the X-ray.

ASTBURY: Okay.

GIBBS: But also she -- [Baby G] had also suffered from constipation and was on lactulose, a laxative, for her constipation.

And I wondered -- I think at this stage I must have seen the abdominal X-ray. I can't now recall the actual abdominal X-ray,

but I suggested she has a suppository as well. Because her tummy was distended and because the X-ray -- it's recorded somewhere -- yes, so stools in the rectum, it's written there by Dr Chang, I wondered whether she was a little bunged up at the bottom end and that was adding to her abdominal distension, so a suppository might help her.

ASTBURY: Right. We can go, I think, to tile 60, if that's possible, and look at the X-ray if that assists.

Let's check the time and the date on the X-ray before I ask you if it's... Can we scroll down a little bit, Mr Murphy? So that's at 12.21 on the 21st, so about half an hour after Dr Chang began making her note.

GIBBS: Correct, yes.

ASTBURY: So does that -- can you confirm that's the X-ray that you'd have looked at?

GIBBS: It's likely to have been, yes, because it showed a bowel filled with air, with gas, and that's what this X-ray shows. Down the bottom end, so it's where the pelvis is at the bottom, it's more opaque, sort of just diffusely grey rather than that black gas appearance, which is what I assumed could have been faeces in her rectum, knowing that she suffered from constipation.

ASTBURY: That prompted the suggestion of a suppository to help, if that's right?

GIBBS: Correct.

ASTBURY: You mentioned some bloods that were taken from -- blood tests taken from [Baby G].

GIBBS: Yes.

ASTBURY: If we can go next, please, to tile 59, and look at the document. We can see [Baby G]'s name in the top left, collection at 12.17. Tell us what the result of that blood test tells us, please, or tells you.

GIBBS: This blood test collected on the 21st, it's several days later and the date when it was authorised, the report is the 27th, but after several days the bottom line says:

"Culture: no bacterial growth after 5 days of incubation."

So at the time when we're suspecting infection we usually can't tell from blood tests immediately that there is a bacterial

infection present. We take the blood, it has to be incubated in a laboratory for several days. We usually get a report back within 48 hours from the laboratory, but the final report is after 5 days and this report shows that no bacterial infection was grown from [Baby G]'s blood at that time.

ASTBURY: So what does that tell you about the possibility of infection?

GIBBS: It lowers the possibility of infection, it doesn't rule it out because premature babies can suffer from infection without always showing a positive blood culture.

ASTBURY: Thank you. If we go back to our sequence of events chart and look at tile 67. If we can look at the results, please.

We can see again [Baby G]'s name towards the top left-hand side of the form and confirming that the collection date for that was 21 September. If we scroll down, please, there are a number of results shown. What are you able to tell us, please, about those results, Dr Gibbs?

GIBBS: The first few results there, the sodium, potassium, urea, are showing the electrolytes in the blood. The sodium is at the low end of normal, but we knew from various treatments [Baby G] had had, she'd been on diuretic treatment to help her chronic lung disease, that does tend to drop the sodium, but those are satisfactory results.

The most relevant abnormal result, which has the H next to it, is the CRP level, which is 18. It should be less than 10. That would suggest she could have an infection. But it has to be taken in the context of the fact that we knew, just under 2 weeks earlier, her CRP level had been 218 and I couldn't be sure at this stage whether this is a new rise in the CRP level or just the previous high CRP level actually still falling.

We hadn't had a CRP checked on [Baby G] since she'd come back to the Countess of Chester 5 days earlier.

ASTBURY: Right. So was this when you had spoken earlier about putting [Baby G] on that first line of antibiotics?

GIBBS: Yes.

ASTBURY: Were these the kind of results that you were balancing in that decision?

GIBBS: Yes.

ASTBURY: We can scroll down the rest of that document, please.

GIBBS: Unfortunately, the blood sample that was sent for the full blood count, looking at the white cell count and the haemoglobin level, had clotted, and so there was no results available. But I think later in the day we did get a full blood count.

ASTBURY: Right, okay. I'm going to move on, please, in the day to about 3.30 that afternoon and tile 75. This is another note by Dr Chang in which you are involved. So I'm going to ask Mr Murphy if we can scroll down again, please, and you have an opportunity to look at what's been noted.

(Pause)

GIBBS: Dr Chang here is recording that -- she's recording at 3.30 in the afternoon that [Baby G] had had a desaturation, not quite as low as in the morning, down to 50%, still a very significant drop, and in fact required some bagging. That just means temporary ventilation support because she was showing a poor respiratory effort at that stage.

Now, I can't recall whether I was there with [Baby G] at the time that happened. What Dr Chang is noting then is that I had inserted a cannula into [Baby G]'s left foot and I can't remember whether, having inserted that cannula, I was still there when [Baby G] had this desaturation or whether I'd left the unit by that stage, but I'd been there recently and inserted a cannula.

ASTBURY: What can you remember of the occasion that afternoon when you fitted the cannula to [Baby G]?

GIBBS: I can't remember much, 7 years ago, what happened during the cannula insertion. [Baby G], like any other premature baby, who was by then 4 months old and had had lot of intensive care treatment in the early weeks or the first few months of her life, would have by that stage been very difficult to insert a cannula into because most of her veins would have been used for cannulation. So it was difficult to find a vein to insert a cannula and I believe that I was the last of several people who tried to insert a cannula that day into [Baby G].

ASTBURY: Okay. Do you remember whether anyone was with you when you were attempting to fit that cannula?

GIBBS: I can't remember who specifically was with me. It would normally be the nurse or nurses looking after [Baby G].

ASTBURY: Do you remember what room you were in when you fitted that particular cannula?

GIBBS: No, sorry. I know that subsequently, the hospital notes say -- medical notes say that [Baby G] was then moved into the intensive care room, nursery 1, so she was in one of the outside nursery rooms, but I don't remember which one.

ASTBURY: You can eliminate number 1 based on the notes, but you don't know --

GIBBS: No, I can't remember which one she was in.

ASTBURY: You told us it's difficult, with a baby like [Baby G], to cannulate given her history. Can you remember whether you tried more than one location to cannulate her?

GIBBS: No, I can't remember, but given that several people tried, various locations would have been tried.

ASTBURY: Do you recall where or what type of bed, if that's the right word, [Baby G] was in or on at the time you were cannulating her?

GIBBS: No, I can't remember. It's likely to have been a cot, but I can't remember what bed she was in. Sometimes babies are moved on to an open cot, which just means the sides can be lowered to gain access to their limbs more easily to insert a cannula. But I can't remember on this particular day what sort of cot [Baby G] was in when I was trying to put the cannula in.

ASTBURY: We've heard about a trolley, which is a flat surface, which can be used sometimes.

GIBBS: That's the open cot I meant.

ASTBURY: But no recollection which it was?

GIBBS: I can't remember, no, back 7 years.

ASTBURY: Okay. Do you remember, once you had successfully fitted the cannula, what you then did?

GIBBS: No.

ASTBURY: Do you remember whether there were screens around [Baby G] at the time you were fitting the cannula?

GIBBS: No, I can't remember whether there were screens.

I mean, if other babies had been in the room, and particularly other parents sitting with their babies, then screens are often put up, just to shield the baby undergoing a procedure from other parents. But I can't remember on this day whether there were any screens up.

ASTBURY: Do you remember whether [Baby G] was connected to an alarm or monitor of any sort?

GIBBS: Well, she should have been because, given her problems, given she'd come back from having needed to be ventilated again from Arrowe Park Hospital just 5 days earlier, she should have been on monitoring, yes.

ASTBURY: Having ruled out room 1 as the location, does that assist you with the type of monitor that [Baby G] would have been connected to?

GIBBS: I can't recall on this day exactly what monitor she was attached to but she was likely to have had had an oxygen saturation monitor attached to her.

ASTBURY: And how are they attached to the baby?

GIBBS: The probe that detects -- the little light from the probe that detects the oxygen level through the skin is either wrapped round a foot, a hand or sometimes the earlobe. And it can be moved around.

ASTBURY: We've heard it referred to as a Masimo monitor.

GIBBS: Yes.

ASTBURY: Is that the type that -- are you describing the same --

GIBBS: Yes.

ASTBURY: -- type of device?

And when you are attempting different locations with a cannula, does, from time to time, the sensor need to be moved?

GIBBS: Yes, it does because if you're trying to cannulate, say the foot or the hand, and the monitor is wrapped around that foot or hand, you have to take it off.

ASTBURY: Are you able to recall whether you had to do that on this occasion?

GIBBS: I can't remember.

ASTBURY: Did you, as a matter of course, have a protocol or a routine when that situation arose?

GIBBS: We didn't have a fixed protocol, written protocol, to follow. But if a monitor is taken off because you need access to a part of a baby for a procedure, then it should be applied to some other part of the body, so you would move it from one hand to the other or one leg to the other. I could either do it myself or the nurse looking after the baby would do it.

ASTBURY: Okay. Would the monitor ever be removed altogether?

GIBBS: There shouldn't be no monitoring at all.

ASTBURY: Okay. Are there occasions you can think of when it has been -- for example, the sensor's been left on the mattress or taken away from the baby for some reason?

GIBBS: Well, if that does happen it should be very temporary, unless there's some other form of monitoring. Now, the babies in the outside rooms in the neonatal unit can have an apnoea monitor as well and I don't remember whether [Baby G] had an apnoea monitor. But if she had some other form of monitoring then the oxygen saturation monitor may be left off for a while as long as there's some other monitor attached to [Baby G].

ASTBURY: If it's just a Masimo monitor?

GIBBS: It shouldn't be left off, no.

ASTBURY: Shouldn't be left disconnected. Should it ever be switched off?

GIBBS: No, if that's the only monitoring device for a baby.

And they were undergoing that monitoring at the time.

ASTBURY: Are there any circumstances when you have had to turn one off whilst cannulating a baby?

GIBBS: I can't remember having to do that and I can't remember exactly what I did for [Baby G], but I know for babies I have had to move the monitor, where it was attached to the baby, from one limb to another or asked the nurse looking after the baby to do that, but I can't remember in [Baby G]'s case exactly what we did with the monitor.

ASTBURY: Okay. You told us you can't remember what happened after you'd cannulated [Baby G].

GIBBS: That's correct.

ASTBURY: What would your routine be once you'd successfully fitted the cannula?

GIBBS: Well, the cannula was needed for fluids and for antibiotics, so the nurses would have set those up.

I would have checked that [Baby G] was stable at the time, otherwise I wouldn't have left, which is why I'm not sure that I was there when she had this desaturation and needed to be bagged.

ASTBURY: So what would checking [Baby G] was stable have involved before you left her after cannulation?

GIBBS: Firstly, just looking at a baby to make sure she was breathing regularly and her colour looked normal and if the monitor was attached, which it should be, that the monitor was giving a satisfactory reading.

ASTBURY: If you weren't fitting the cannula with the nurse, would you need to alert anybody once you'd finished?

GIBBS: Well, I wouldn't have just left [Baby G] by herself without telling anyone. Yes, I would have had to tell someone.

ASTBURY: Who would you ordinarily tell once it was fitted?

GIBBS: Whichever nurse was looking after [Baby G] if they were still on the unit. They might have been off on a break, so one of other nurses. But it's usually when you're undertaking a procedure like trying to insert a cannula that the nurse would still be around.

ASTBURY: So if not the nurse, the designated nurse, then whoever -- whichever nurse was available?

GIBBS: Yes, one of the other nurses looking after babies, and ideally in that same room.

ASTBURY: Right.

GIBBS: But I have to admit I can't remember exactly who I told and what I did at the time [Baby G] had her cannula.

ASTBURY: Okay. You can't remember leaving [Baby G]. Do you recall having any conversation with anyone on the unit after you'd left [Baby G] about the cannulation?

GIBBS: No, I can't remember having such a conversation.

ASTBURY: We've heard that Eirian Powell was, I think, in charge of the unit on that particular day. Did you have any conversation with her that you can recall about cannulation or monitors or anything of that sort?

GIBBS: I can't remember that conversation, no.

ASTBURY: Do you recall any conversation with -- we have heard that [Baby G]'s designated nurse was [Nurse B].

You know [Nurse B], I assume?

GIBBS: I do know her, yes.

ASTBURY: Do you remember any conversation with [Nurse B] after you had cannulated -- any relevant conversation after you'd cannulated [Baby G]?

GIBBS: I can't remember that now. If it had been a significant discussion then usually the staff nurse would have recorded that in the nursing notes if there'd been a worry about the procedure, some concern about it.

ASTBURY: Okay. Which nurse would have entered that in the nursing notes?

GIBBS: Well, if there was a nurse, which I thought there would have been, attending to [Baby G] at the time I was trying to cannulate her, or if there wasn't one there at the time, whichever nurse I had spoken to after I'd finished the cannulation. But I can't remember who that was.

ASTBURY: In your experience, the type of thing that would be noted in the nursing notes?

GIBBS: If there was some concern that something wrong had happened or there had been some worry. But if I'd been particularly concerned I should have recorded it in the medical notes and I didn't.

ASTBURY: Right. I'm going to go back to tile 75, please. We're on 75. Go back to 71, please.

This is the line insertion and removal record chart.

I'm sure you'll recognise it. Is that your signature or is that your handwriting on the form?

GIBBS: No. Someone else has written that. They've put my name there, but someone else has written it.

ASTBURY: That indicates it's a peripheral IV, fitted to the left foot by yourself, and that's the 7th attempt by multiple staff, which echoes, I think, what you were telling us earlier.

GIBBS: Yes. It wasn't all seven attempts by me, but...

ASTBURY: No. Do you recall any other contact with [Baby G] during the course of that particular day?

GIBBS: No, I can't remember. I wouldn't have been on call that evening, so another colleague would have taken over that evening, which means at 4.30/5ish, we have a handover and discuss all the neonatal patients.

ASTBURY: According to your witness statement, you next saw [Baby G] on 27 September; is that right?

GIBBS: That's correct -- well, I next wrote in her notes.

ASTBURY: Sorry, thank you for correcting me. In fact, at that time [Baby G] was continuing to manage in air?

GIBBS: Yes.

ASTBURY: [Baby G] remained on the neonatal unit for another 5 weeks before discharge; is that right?

GIBBS: That's correct, yes.

MR ASTBURY: I'm just checking my notes, Dr Gibbs.

(Pause)

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

Cross-examination by MR MYERS

MR MYERS: Dr Gibbs, when [Baby G] came to the Countess of Chester Hospital, gastro-oesophageal reflux had been recognised as potentially part of her condition, hadn't it?

GIBBS: Yes.

MYERS: And in fact, reflux like that can be common in a preterm infant, can't it?

GIBBS: Yes.

MYERS: And that may lead to vomiting by the infant, mightn't it?

GIBBS: Yes, but not usually projectile vomiting.

MYERS: No, not usually. It could be forceful vomiting, couldn't it?

GIBBS: Possibly.

MYERS: You've explained you didn't have any involvement in the incident on 7 September.

GIBBS: That's correct.

MYERS: But in terms of moving on from 21 September that you've been telling us about, going on in the period at the Countess of Chester Hospital, [Baby G] did continue to have a pattern of vomiting, didn't she?

GIBBS: She did in those last 5 weeks, but she didn't for a week or so after that episode on the 21st.

MYERS: No, but taking the whole period as a whole, the vomiting continued, didn't it?

GIBBS: Yes, she did have intermittent vomiting and had to have treatment for her reflux.

MYERS: And some of the vomiting was described as either large or projectile, wasn't it, in that period that followed?

GIBBS: Some of the vomits were described as large. I can't remember when I have looked through the notes that any other -- the only time it was described as projectile was on the 21st, in the morning, and on 7 September.

MYERS: I won't go through all the notes with you but we'll look at the notes in due course and see if that's so. In terms of the incidents on 21 September you've been asked to summarise some of the findings with them. Infection is a possible cause, it may not be the cause, but do you agree it's a possible cause of those incidents?

GIBBS: Yes.

MYERS: Again, these are matters to be determined in the context of all the evidence, we know that, but gastro-oesophageal reflux, that could be a possible cause, couldn't it?

GIBBS: Yes. But as I said before, not usually of projectile vomiting.

MYERS: No. It can be, but not usually?

GIBBS: Correct.

MYERS: Cannulation and monitors I would like to ask you next about, Dr Gibbs. You touched on this, but cannulation can be a difficult process for a premature or a preterm neonate, can't it?

GIBBS: Yes. Particularly when they've had many cannulations before.

MYERS: Yes. I was going to ask. Particularly like [Baby G], who had been unwell for some time?

GIBBS: Yes.

MYERS: And one of the problems, by the time we get to someone like [Baby G] on 21 September, is that the veins are very small and few might remain accessible after previous cannulations.

GIBBS: That's correct.

MYERS: So does it sometimes happen that you have to actually compress the limb a little bit above the point of insertion to get the vein to fill with blood so that you can cannulate?

GIBBS: Yes.

MYERS: This is a process normally that would be done by at least two people, isn't it, the cannulation process?

GIBBS: Often by two, but can be done by one.

MYERS: All right. Do you recall when you were dealing with [Baby G] the person that was assisting you was Dr Harkness?

I'd like you to cast your mind back to that and see if you can recall that.

GIBBS: On the 21st?

MYERS: Yes.

GIBBS: I can't remember.

MYERS: Is that to say you absolutely have no memory or you don't believe it was him, can I just be clear about that?

GIBBS: I don't have a memory of who was helping me.

MYERS: I'm going to suggest it was. We'll hear a little more in due course about that.

How many attempts would it normally take, if it's possible to answer this, to cannulate a baby like [Baby G]?

GIBBS: I can't give a specific number. We know on this occasion it was seven attempts.

MYERS: Yes.

GIBBS: You would hope it'd only be one or two attempts but it can take many attempts in a baby like [Baby G].

MYERS: That can be a difficult experience for the baby being cannulated, can't it?

GIBBS: Yes.

MYERS: And handling can be stressful for the baby, can't it?

GIBBS: Yes.

MYERS: And does the baby sometimes struggle against it whilst it's taking place?

GIBBS: Some babies would, but I can't remember [Baby G] struggling particularly, and she is described repeatedly in the notes as being quiet and less responsive than usual on the 21st.

MYERS: Yes. Again, do you recall, just so we understand the picture, whether a baby in this situation might display that they experience pain and discomfort?

GIBBS: A baby can, yes.

MYERS: Do you accept that it's not surprising that [Nurse B] recorded, following the cannulation, that [Baby G] had had a further apnoeic episode with a desaturation and bradycardia?

GIBBS: That could be related to having handled her and distressed her with the cannulation, yes.

MYERS: Yes. So we can be quite clear, the cannulation process could be a cause of the desaturation and bradycardia and apnoea that followed?

GIBBS: A prolonged cannulation attempt, as in [Baby G] with multiple attempts, could be -- could distress her and cause her breathing difficulties, yes. But it only could do.

MYERS: Yes, well, do you agree, you described it as not surprising that it was recorded by [Nurse B] that there was a further apnoeic episode with the desaturation?

GIBBS: Yes.

MYERS: You did say that, didn't you, not surprising?

GIBBS: In my statement, yes.

MYERS: Yes.

GIBBS: But I didn't say -- it doesn't mean that was the cause.

MYERS: No. But we're looking at your opinion and you find it not surprising.

GIBBS: Yes.

MYERS: Is it sometimes necessary to remove the monitor lead temporarily because of the way you have to manipulate the babies' limbs in an attempt to cannulate?

GIBBS: Yes, but usually it should be applied to another limb when that is done.

MYERS: Yes. You would usually try to attach it as soon as possible to another limb, wouldn't you?

GIBBS: Yes.

MYERS: If a baby is attached to a monitor and the monitor is on, as this process takes place, is there any likelihood of the alarm alarming as the baby gets distressed or reacts to the cannulation process?

GIBBS: Possibly. The Masimo oxygen saturation monitor is especially designed to reduce movement artefacts, so if a baby is wiggling, they are still able to pick up a reasonable oxygen signal. So the answer is possibly, but not usually causing the oxygen saturation monitor to alarm by distressing a baby with cannulation.

MYERS: Is the monitor sometimes switched off during cannulation?

GIBBS: It shouldn't be, no.

MYERS: It shouldn't be, but is it sometimes in fact in practice switched off during cannulation?

GIBBS: If it's the only monitor a baby has, it shouldn't be switched off during cannulation, no. I can't remember the details of what we did with the monitor on 21 September, 7 years ago.

MYERS: Did you read your statement before coming into court today?

GIBBS: Yes.

MYERS: Well, let me just remind you of something and we can show it to you if it assists. Can we put up page 1942?

It's page 16 of 19. It's only a sentence, Dr Gibbs.

It's for Dr Gibbs to see and his Lordship and the lawyers.

Can you see paragraph 96, Dr Gibbs?

GIBBS: Yes.

MYERS: What you said at the beginning of that, where you're talking about this aspect of what we're dealing with, is:

"I cannot recall whether [Baby G]'s monitoring equipment was switched off during the attempts to insert an intravenous cannula on 21 September."

Do you see that?

GIBBS: Yes.

MYERS: And do you agree the fact you say "I cannot recall"

means that it is possible, of course, it could have been switched off?

GIBBS: Yes, because I can't remember I don't know that it wasn't switched off. But that would not be usual.

MYERS: But do you therefore agree switching it off is something that might happen sometimes?

GIBBS: It shouldn't normally happen but I can't say it didn't happen because I can't remember what happened to her monitor on that day.

MYERS: We can take the statement down.

After a process like this, and when it is concluded, I'm going to ask you about a number of things that should happen. If the

baby has been put on a treatment trolley, the baby should be put back in the cot, do you agree?

GIBBS: Yes.

MYERS: If there is a screen that has been erected around the baby, the screen should also be removed, shouldn't it?

GIBBS: At some stage after the procedure, yes.

MYERS: If the monitor had been removed and was off, it should of course be reattached before you leave the baby?

GIBBS: Yes, definitely.

MYERS: And if the monitor had been turned off it should be turned back on before you leave the baby, if you turned it off?

GIBBS: Yes.

MYERS: When you have completed, the designated nurse, or at least another nurse, should be told that you have finished?

GIBBS: Yes.

MYERS: You should never just leave and just leave the baby there, should you?

GIBBS: That's correct, yes.

MYERS: Now, on this occasion, I'm going to suggest to you that you left without [Baby G] being placed back in the cot from the trolley. Do you agree, do you disagree, or do you simply not remember?

GIBBS: I don't remember.

MYERS: Do you agree it's possible you could have left without putting her back in the cot?

GIBBS: It's possible because the trolley has sides that can be erected -- they can be flattened so you can get to the baby easily. You should never leave a baby with the sides down. But the trolley, which I call the open cot, you can nurse a baby in for a while, yes.

MYERS: I'm going to suggest that you left without removing the screens that had been erected around the trolley; do you agree that's possible?

GIBBS: Well, I can't remember the screens on that day, but if they were shielding other parents who were in that same room then they may not have been removed immediately.

MYERS: I'm going to suggest, Dr Gibbs, that you and Dr Harkness left, having turned the monitor off, but without turning it back on.

GIBBS: I don't recall that at all.

MYERS: Is that possible?

GIBBS: It should not have happened.

MYERS: No. I'm going to suggest that you and Dr Harkness left without telling [Nurse B] or any other nurse that you had finished. Could that have happened?

GIBBS: That shouldn't have happened, but I don't remember, as I said, who I spoke to after completing the cannulation.

MYERS: It would be a serious error, I'm going to suggest, certainly to leave a baby behind a screen without a monitor on and not to have said that the baby was being left like that, wouldn't it?

GIBBS: If we didn't speak to any nurse about that.

MYERS: Yes. Now, I suggest absolutely clearly, Dr Gibbs, those are things that you and Dr Harkness did do.

GIBBS: Well, I can't remember, but we shouldn't have done.

MYERS: And later that afternoon, both you and Dr Harkness spoke to [Nurse B] to apologise for that. Now, that happened, didn't it?

GIBBS: I'm sorry, but I don't remember that.

MYERS: If you had left a baby unattended without the monitor on and it was a matter you had to apologise for, you would surely remember that, wouldn't you, Dr Gibbs?

GIBBS: I would expect to, yes.

MYERS: It is not something you would do regularly, is it?

GIBBS: No.

MYERS: And it would stand out if it happened, wouldn't it?

GIBBS: It should have done, yes.

MYERS: And you did apologise to her -- I want you to think back to this -- in the company of Dr Harkness, outside nursery 4, later that day?

GIBBS: I can't remember from 7 years ago the conversation we had with any of the nurses on the unit.

MYERS: If you had left a baby like this, would it have concerned you?

GIBBS: Yes.

MYERS: How could you forget now, even looking back, if you had done that?

GIBBS: Well, it depends why I'd left the baby, whether I'd been called to another emergency or something urgent.

MYERS: Yes. If it was very busy?

GIBBS: Yes.

MYERS: And if you were being stretched across different parts of the hospital?

GIBBS: Well, between the neonatal unit and the adjacent paediatric ward.

MYERS: If you'd had to leave in a rush, for instance?

GIBBS: That's one reason why we might not have had time to speak to one of the nurses when we should have done, but I can't remember.

MYERS: Because I've asked you before about the pressures the unit was under, haven't I, and you have had things to say about that?

GIBBS: I'm not sure about the pressure the unit was under, but we've spoken about the cover that the consultants had to cover the paediatric ward and the neonatal unit, yes.

MYERS: As more staff have to cover more babies at a higher level of care, the possibility of something being missed or something going wrong increases, doesn't it?

GIBBS: Sorry, could you repeat the beginning?

MYERS: I apologise. If there are more babies at a higher level of care requirement but no increase in staff to reflect that -- my fault, my question wasn't clear -- but no increase in staff to reflect that, that increases the risk of something going wrong or something being missed, doesn't it?

GIBBS: Yes.

MYERS: And if it's the case that you had to rush away because you were required elsewhere and that meant [Baby G] was left behind a screen without the nurse being told, that's an example of that happening, isn't it?

GIBBS: If that had happened, yes.

MYERS: Coming back to when I was asking you -- I suggest to you, Dr Gibbs, there was an apology by and you Dr Harkness. I'm going to tell you the terms of the apology and ask you if you remember them.

First of all, both of you apologised for the fact that you hadn't told [Nurse B] that you had finished looking after [Baby G].

GIBBS: If we'd left without telling her then it's appropriate to apologise, yes.

MYERS: That is what happened, isn't it?

GIBBS: I can't remember.

MYERS: And you apologised for the fact that she had been left behind the screen unattended, didn't you?

GIBBS: Well, if this is what [Nurse B] says, then that must have happened, yes. I wouldn't deny that. I just don't remember that.

MYERS: All right. I'll give you the rest of it. You apologised for not switching the monitor back on?

GIBBS: I can't remember that, but if that's what [Nurse B] said, presumably that's what happened.

MR MYERS: Right. Thank you, Dr Gibbs. There's no further questions.

MR ASTBURY: Nothing arising. Does my Lord have any questions?

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

MR ASTBURY: We think Dr Gibbs is expected back again.

Thank you to Mr Myers for his assistance.

MR JUSTICE GOSS: Thank you. That completes your evidence today on this issue. Thank you very much, Dr Gibbs.

You will be coming back again later during the course of the trial, so please don't talk to anyone about anything to do with any part of this case. All right? Thank you very much indeed.

(The witness withdrew)

MR JOHNSON: The next witness is screened.

MR JUSTICE GOSS: Right. A bit of an in-and-out day for you, sorry. So it'll just be the 2 minutes or thereabouts it takes.

(In the absence of the jury)

(Pause)

(In the presence of the jury)

MRS CAROLINE BENNION (recalled)

Examination-in-chief by Mr Johnson.

MR JOHNSON: I think you've been here before.

BENNION: Yes, I have.

JOHNSON: I was wondering whether it was just me. On 21 October?

BENNION: Yes.

JOHNSON: It seems a long time ago. Just to remind us all, could you tell us your name for the sake of the record, please?

BENNION: Caroline Bennion.

JOHNSON: Thank you. As it seems at least one of us forgot, what was your role at the Countess of Chester Hospital back in 2015?

BENNION: A senior neonatal practitioner.

JOHNSON: Thank you. Just to give us all a bit of a reminder, is that a sort of enhanced band 6 or is that a band 7?

BENNION: It's a band 6 senior staff nurse. Sometimes there's a shift leader also as one of the senior nurses on duty.

JOHNSON: Thank you very much. Now, you've been asked here today to tell us what you can remember about [Baby G] and, in particular, the events of 21 September 2015.

BENNION: Yes.

JOHNSON: On that day, can you now remember anything about what happened about [Baby G], generally speaking, first of all?

BENNION: I can recall from my statement that I was the shift leader and I was in charge that day and I can recall two members of staff, again from my statement, that I was on duty with, which was Lucy Letby and [Nurse B].

JOHNSON: Let's deal with things slowly. So far as allocating specific nurses to specific babies is concerned, whose responsibility would that have been back in 2015?

BENNION: From my recollection, it was either the night shift before, whoever was in charge the night shift before, or it was the shift leader of that shift.

JOHNSON: And by "that shift", do you mean the shift on which the nurses were being allocated?

BENNION: Yes.

JOHNSON: So in this context, the responsibility to designate a specific nurse to a specific child either fell to the shift leader the night before or to you on this specific shift?

BENNION: Yes.

JOHNSON: All right. Do you remember the fact that you were working the day shift on that specific day?

BENNION: I do.

JOHNSON: And do you remember that [Baby G] was unwell?

BENNION: I remember it just from reading my statement, not from my own recollection.

JOHNSON: All right. When you made your witness statement, were events, insofar as you set them out in the witness statement, still relatively clear in your memory?

BENNION: Not crystal clear because of the time lapse between giving the statement and the episode that you're talking about.

JOHNSON: All right, well, let's see how far we can take it. Do you remember that one of the issues that arose on this particular day shift was the fact that [Baby G] needed to be cannulated?

BENNION: Yes, I do recall that.

JOHNSON: And do you remember that, at some stage during the shift, the senior consultant, Dr Gibbs, was asked to carry out that cannulation because other doctors had failed?

BENNION: Yes, I do.

JOHNSON: Can I show you tile 55, please, on our sequence of events. I think you probably remember how this system works: things come up on that screen to your right.

If we can go to the notes themselves, please, which is, I think, J7399. At the top left, can you read that all right?

BENNION: I'm sorry, I can't, no.

JOHNSON: It's all right, don't worry. We can expand it.

This is a note that's written at between 12.47 and 12.51; is that right?

BENNION: Yes, that's correct.

JOHNSON: I'm not sure whether we've actually had this evidence from anybody. If we have, I apologise. Just dealing with those times, we see the two times recorded to the right of where it says "Create". Do you see that in the --

BENNION: Yes, I can.

JOHNSON: Is that the system, that as soon as the note in effect is opened, that's the start time, 12.47; is that right?

BENNION: Yes.

JOHNSON: And as soon as it's closed or completed, that's where we get the 12.51 time from?

BENNION: Yes.

MR JUSTICE GOSS: Sorry, forgive me interrupting. Just so that I'm getting this right. Is that done by a computer itself or is it the person inputting the note who puts the time down?

BENNION: I believe at the time this was a system where we were documenting on a computer.

MR JOHNSON: Yes.

MR JUSTICE GOSS: So the computer program would --

BENNION: Would acknowledge that time. It's not an input by the member of staff, it's generated by the computer.

MR JOHNSON: It's a timestamp created by the machine?

BENNION: Yes.

JOHNSON: All right. So we see here that between those times, therefore, Lucy Letby has written a note saying:

"Written for care given from 08.00 hours."

Then she sets out what we've seen in many other of these sorts of notes, that the emergency equipment was checked and various circumstances relating to the child in issue; is that right?

BENNION: Yes.

JOHNSON: We then see, about four lines down in the note, that:

"At 10.15 x2 large projectile milky vomits, brief self-resolving apnoea, and desaturation to 35% with colour loss. NG tube aspirated. 30ml undigested milk discarded. Abdomen distended, soft. Doctors asked to review."

So 35, we have heard, is a very low desaturation, serious desaturation; is that right?

BENNION: Yes, it's a significant desaturation.

JOHNSON: Do you have any recollection of having been told about that event?

BENNION: I don't have any recollection. However, normal practice would be, as the shift leader, that whoever is -- we would be informed and we would be aware of any deterioration or any event that we felt needed escalating and we've asked the doctors to review, so as the shift leader it was either myself that would have asked them to review -- they potentially may have been present on the unit at that time because at 10.15 we would have still been doing the ward round. So potentially, the doctors, the medical team, would have been present on the unit.

JOHNSON: Okay. But if they weren't, this clearly was escalated or, according to the note it was escalated, "Doctors asked to review", and if that is the case that would be done through you as the shift leader?

BENNION: Not always, but normally if the person is dealing with the baby and you are the free person to ask the doctors to review -- and as a shift leader you need to be aware of all the cases -- all the needs of the patients, the babies on the unit at that time.

JOHNSON: Okay. Do you now have any independent recollection of this event?

BENNION: Not of that event, no.

JOHNSON: We heard that at some stage after this, the care of [Baby G] was handed from Lucy Letby, who at the beginning of the shift was the designated nurse, on to [Nurse B].

Is that a decision in which you would have been involved?

BENNION: Yes, that would have been my decision.

JOHNSON: And what criteria would you have applied to the circumstances as they presented themselves to you?

BENNION: Numerous criteria. If a child has deteriorated and needs an increase in support then they would need to move from a lower level nursery into a higher level nursery, which is still on the same unit, just to move the room. And I can recall that [Nurse B] was actually looking after another baby in nursery 1 and we needed to move [Baby G] into that level of nursery and then it would make more sense for [Nurse B] to resume care of [Baby G] in that higher level of nursery care.

JOHNSON: Yes, all right. But before that decision was made, and whilst [Baby G] was still in -- we know from other evidence that she was in nursery 4, okay?

BENNION: Okay.

JOHNSON: Before that decision was made, do you recall Dr Chang having made efforts to cannulate [Baby G]?

BENNION: I do. It's mainly, again, from my written statement, but I do remember some failed attempts of cannulation.

That was why Dr Gibbs, as a more senior medic, was asked to come to cannulate.

JOHNSON: Were you present when Dr Chang was making those attempts?

BENNION: I can't recall.

JOHNSON: Well, there's no issue with me reminding you of what you said in your statement, okay? So what you said to the police -- I can show you the statement if necessary. In fact, it's probably better if I do. If Mr Murphy would help, please. It's page 1891.

I don't know whether you can see at the top of this page -- this is a witness statement that you made as long ago as 12 March 2018. All right? So four and a half years ago. Four and three-quarter years ago.

What you told the police then was that, together with Lucy Letby, you were present with Dr Chang whilst the fitting of the cannula took place, that you were trying to settle [Baby G] down as Dr Chang attempted to put in the cannula. Can you see that?

BENNION: I can.

JOHNSON: When you made that statement, did you have a recollection of what had happened?

BENNION: I must have to document it -- to have it documented there, yes.

JOHNSON: And was that an accurate recollection so far as you could remember?

BENNION: Yes.

JOHNSON: All right. Just dealing with that, would it be standard practice for a nurse to be present at the attempted cannulation of any child on the unit at the time?

BENNION: Yes, to provide some containment, possibly some sucrose, which is a little bit of pain relief for the baby, and to help assist with the fixing of the cannula once it's inserted.

JOHNSON: Is there a strict line of demarcation between what the doctors do and what the nurses do? Is that a nursing job or would it be unfair to characterise it in that way?

BENNION: Some of the senior staff nurses, myself included, can insert cannulas, however we know our limitations, and if a registrar has failed to insert a cannula then, as a nurse, you

wouldn't attempt to do that, it needs escalating to somebody more senior.

JOHNSON: Sure. But so far as the containment element of the process is concerned, was that standard practice in cases of cannulation?

BENNION: Yes, it was.

JOHNSON: And perhaps was it more so in cases of difficult cannulation?

BENNION: Yes, because you want to ensure that -- the least amount of discomfort and pain to the baby and to make sure that they are settled and as still as possible.

JOHNSON: Is that something that, putting it bluntly, the nurses are better at than the doctors?

BENNION: Yes.

JOHNSON: So does it follow that whenever there is a difficult cannulation, you would expect one of the nurses to be present to carry out that role?

BENNION: Potentially the nurse that's looking after the child or the shift leader, who's supernumerary, would be doing that. However, there are times when, if a nurse wasn't available, another doctor may assist, because they can do the comforting and settling role. However, it normally is a nurse.

JOHNSON: Do you recall -- you've got the benefit of your statement now there on the screen. Do you recall that a temporary cannula was inserted by Dr Chang but it was necessary to escalate things to Dr Gibbs because something rather more permanent was required?

BENNION: I do recall that.

JOHNSON: Thank you. It may be that we can use the statement to help you. If we can just scroll down a little, please, Mr Murphy.

It has just appeared up from the bottom of the screen. Do you see that when you were being referred to the records, you remarked on the fact that at 11.30 care of [Baby G] was handed or responsibility for care of [Baby G] was handed from Lucy Letby to [Nurse B]?

BENNION: Yes, I do.

JOHNSON: And that, as you've told us, was your decision?

BENNION: Yes.

JOHNSON: Moving on, do you recall an event later in the shift where [Baby G] -- there was an event, putting it in a neutral way, concerning [Baby G]?

BENNION: Again, from my statement I can recall that whilst [Baby G] was in nursery 1, so an escalated nursery that can deliver more support, I can recall that she did require what's called Neopuffing in 100% oxygen. So that was a more significant event than the one previous.

JOHNSON: Right. So you recall that as happening in nursery 1?

BENNION: I do.

JOHNSON: Which, as we've heard, is the intensive care nursery?

BENNION: Yes.

JOHNSON: What do you remember of what happened to [Baby G] at that time?

BENNION: I can't recall. I remember the event, her requiring Neopuffing in 100%, which is quite a significant event.

However, I don't recall the management or the intervention following that.

JOHNSON: Do you remember, did you see any of that happening or is this just information that you were being given by other people?

BENNION: I can't recall whether I was present. Potentially, as the shift leader, I would have been called. It's a small unit and I would have verbally been called to assist and potentially I would have been the one, if the doctors weren't present, to call the doctors to attend, but I can't recall from my memory.

JOHNSON: Okay. Can you remember who it was that called for assistance?

BENNION: No, I can't.

JOHNSON: Do you remember what, if anything, you did to assist?

BENNION: Not from my recollection, no.

JOHNSON: Right. Do you recall at any stage, after the issues that occurred with [Baby G], whether there was any discussion concerning what had happened so far as this event was concerned?

BENNION: Well, because [Baby G] had been cannulated and had become unwell and vomited, so we are treating her for suspected infection and putting her nil by mouth, so not giving her any fluids, and putting her back on to some respiratory support, the discussion would have been that she's deteriorated and potentially had suspected sepsis.

JOHNSON: I'm more interested in whether there was any discussion about the circumstances in which [Baby G] was found to have deteriorated --

BENNION: No.

JOHNSON: -- in other words, the physical environment she was in at the time her deterioration was discovered.

BENNION: No, there was no discussion over that.

JOHNSON: No one raised an issue with you about whether [Baby G] had been left in certain circumstances or anything like that?

BENNION: I was aware of the first event, and that was appropriately escalated to the medical staff, and then literally an hour -- not even an hour later she'd obviously had another event, so I was aware of that, but there was no discussion about what the reasons were or why that had occurred.

JOHNSON: Okay. So you say literally an hour after. We know that the first event was around about 10 o'clock --

BENNION: Yes.

JOHNSON: -- in general terms. The second event, from doing your best to remember now, what time would you put on that now?

BENNION: That looks as if it was later on in the afternoon, but I know that the care had been handed over at 11.30 to [Nurse B], so our management had been escalated up, so appropriately I had -- we had moved her care to a more intensive room, so within 45 minutes of the first event we had felt that we needed to move her to a higher level of care. So we had acted appropriately at that point, but I can't recall the exact time of the second more significant event where she required the Neopuffing in 100%.

JOHNSON: Just so we understand, in terms of moving [Baby G] physically from room 4, nursery 4, to nursery 1, from where do

you derive the timing information in estimating that happened shortly after the 10 o'clock incident?

BENNION: We would have had -- from my recollection, we would have made sure that the cannula was secured first before we moved [Baby G]. Nursery 4 was more of a going home nursery, so it was predominantly quite well babies that were nursed in nursery 4. That's the last nursery, so you have to come past nursery 3, nursery 2 -- it's a small unit -- to get back to nursery 1.

So once that -- I don't know exact time, but once that cannula was secure and we were happy that [Baby G] would have tolerated the movement and we were safe to do so, we would have moved her. But looking at that documentation that Lucy's handed over care at 11.30, it's between that window.

JOHNSON: All right. So is that your source of information from which you derive the movement of [Baby G] as being some time between the event at about 10 o'clock and the handing over of care at 11.30?

BENNION: Yes.

MR JOHNSON: Right, okay.

My Lord, I have no further questions. Thank you.

MR JUSTICE GOSS: Thank you.

Mr Myers, you're going to be more than just a few minutes?

MR MYERS: Yes, I am.

MR JUSTICE GOSS: I'm afraid we're going to break off now because people make arrangements to break off at this time. We'll resume again at 2.05, in an hour's time.

All right? Thank you very much. Stay where you are and please don't talk to anyone about anything to do with this case. Thank you very much.

(In the absence of the jury)

MR JUSTICE GOSS: If you stay there, I'm going to leave the courtroom, everyone else will leave the courtroom and then you'll be escorted out.

(1.05 pm)

(The short adjournment)

(2.05 pm)

(In the presence of the jury)

Cross-examination by MR MYERS

MR MYERS: Mrs Bennion, would it be fair to say that outside the actual records themselves, it's very difficult to have a clear recollection of precisely what happened on this day?

BENNION: Yes, it is.

MYERS: All right. What I'm going to do, to start with, if I can, is just to confirm what you say your recollection is, but then just to look at some of the records to check some of the timings. None of that is done to be critical of the position you're in because you're trying to remember back and construct things as best as you can over a very long period of time. But just so that we can be clear, can I do that with you, please?

BENNION: Yes.

MYERS: Thank you. What you've described to us this morning, and I'm only going to summarise it so we can follow, was that the first incident with [Baby G] happened at about 10.15. We know that. Do you agree?

BENNION: Yes.

MYERS: When you came to -- when you were asked when the second incident was, your recollection at that time was that it was literally an hour, maybe not even an hour, after the first one. That's what your recollection was, wasn't it?

BENNION: Yes.

MYERS: All right. Your recollection was that [Baby G] had been moved to nursery 1 from nursery 4 after that first incident; is that correct?

BENNION: Yes.

MYERS: Your recollection also was that she would not have been moved until after she had been cannulated?

BENNION: Yes.

MYERS: That's what you say. I think we're going to go through the notes in a moment. I think you said this morning it was important to make sure it was secured before she was moved.

BENNION: Yes.

MYERS: And your recollection was that, certainly at some point, Lucy Letby had been present with Dr Chang when that took place?

BENNION: Yes.

MYERS: We know care was handed over to [Nurse B] at 11.30.

BENNION: Yes.

MYERS: And your recollection was that the move to nursery 1 happened at some point between the cannulation but before care had been handed to [Nurse B]; is that correct?

BENNION: Yes.

MYERS: That's how you recall the events?

BENNION: Yes.

MYERS: Again, not being at all critical, but I'd like us just to go through the documents now just to see what the timings are because you said that you had relied upon Nurse Letby's notes.

BENNION: Yes.

MYERS: But we've got other documents to look at, so let me look at those with you. I'm going to ask Mr Murphy, first of all, if we could put up the nursing notes, which are at tile 55, please. You'll see these appear close to you, Mrs Bennion.

Can we enlarge, please, the top left-hand corner?

There we are.

Let's read through this. This is the note which was made at 12.47 by Lucy Letby. You can see that, Mrs Bennion?

BENNION: I can, yes.

MYERS: What the notes say is:

"Written for care given from 0800. Emergency equipment checked, fluids calculated. [Baby G] nursed in a cot. [Baby G] appears pale. Temperature 36.4. Hat in situ and well wrapped. NG tube feed (EBM) [expressed breast milk] given AWT 09.00 [or 'about 09/00'] as [Baby G] asleep and due immunisations. At 10.15 x2 large projectile milky vomits, brief self-resolving apnoea and desaturation to 35% with colour loss. NG tube aspirated. 30ml

undigested milk discarded. Abdomen distended, soft. Doctors asked to review. Temperature remains low. Tachycardic [that's higher than 180 beats per minute] since vomit. Mum states that [Baby G] does not appear as well as she did yesterday. U&E, FBC and CRP taken and sent."

Those are for samples:

"Blood gas as documented. Blood sugar 9.6mmol. To go nil by mouth. Commence IV fluids and antibiotics. Care handed over to S/N [Nurse B] approx 11.30."

You see all of that, Mrs Bennion?

BENNION: Yes.

MYERS: Just there, that's the note that we have from Nurse Letby and that covers the period up to 11.30 and the note is made at 12.47; is that correct?

BENNION: Yes.

MYERS: And actually, when we look at that, first of all, by 11.30 on that note there's no suggestion cannulation has taken place, is there?

BENNION: There's no suggestion that cannulation has taken place.

However, you've got U&Es, FBC and CRP sent. That possibly might have been via the cannula to obtain the blood. If a blood culture would have been taken that would have definitely been via a cannula because that can't be taken via a heel prick. Those bloods could have been taken by a heel prick. However, they could have also been taken via a cannula being inserted.

MYERS: I am going to suggest the actual cannulation involving Dr Chang and then Dr Gibbs happens later. Could that be right? We are going to come to the notes but could that be right?

BENNION: It could be right.

MYERS: Taking us up to 11. 30, this is an hour and 15 minutes after the first episode and there's no suggestion of a second episode yet, is there?

BENNION: No.

MYERS: If we go down to [Nurse B]'s notes, please. Down at the bottom of the page we've got the note for 17.20.

Can you see, this is by [Nurse B], and it says:

"Cares taken over at approximately 11.30..."?

Do you see that?

BENNION: Yes, I do.

MYERS: So this follows on from that time:

"... due to staff workload. [Baby G] pale/asleep in cot. Masimo monitor in situ. Self-ventilating in air. Initially tachycardic at 175 following vomiting episode documented by Nurse Letby in previous notes."

This note we see is at 17.20. It then says this:

"Cannula inserted first attempt by Registrar Chang but would not advance past [and over the page and up, please] junction but able to give IV ABs via it. Bloods obtained for culture. CRP 18, HB 95. Lumbar puncture required due to symptoms but not yet performed. Numerous failed attempts then at cannulation. Finally inserted by Dr Gibbs. Without fluid for 6 hours as nil by mouth. Blood sugars were stable throughout. All oral medications omitted as per Registrar Chang.

"Further significant apnoea/brady/desat following cannulation requiring Neopuff and 100% oxygen. Help summoned and transferred to nursery 1 and placed in incubator for close observation. IV fluids commenced: 10% dextrose. Passed urine and bowels open. Yellow mucousy stool. Optiflow commenced per Registrar Chang. Flow 5 litres in air."

Do you see that, Mrs Bennion?

BENNION: Yes, I do.

MYERS: So from there we can see, first of all, that the cannulation procedure appears to take place when [Nurse B] is the designated nurse, doesn't it?

BENNION: Yes.

MYERS: I'm going to look for some timing on cannulation, but I'm going to suggest it happens, certainly it would appear, possibly a period of hours after the first episode, doesn't it?

BENNION: Yes, it does.

MYERS: It also appears that the move to nursery 1 happened after the second episode, doesn't it?

BENNION: Yes, it does.

MYERS: All right. Just to help us with the other sets of notes that present the picture here, and whilst you're able to help, I'm going to ask to put up tile 51, page 4, and this is from the clinical notes now.

It starts with some notes by Dr Fielding, but if we go to the final page we have an entry from Dr Chang at 11.50.

So by this point there's been the first episode, hasn't there, at 10.15?

BENNION: Yes.

MYERS: [Baby G] was transferred to [Nurse B] at 11.30, wasn't she?

BENNION: Yes.

MYERS: But we know now, having gone through those notes, she's still in nursery 4 at this point?

BENNION: It appears so.

MYERS: Yes. If we look at this point at Dr Chang's notes, it's a review, but there's though reference to the cannulation having taken place, any note to that, at 11.50, is there?

BENNION: No.

MYERS: This is the cannulation involving multiple attempts and Dr Gibbs stepping in. That hasn't taken place on this, has it?

BENNION: Not documented on there.

MYERS: No. If we then move to tile 75, which is the notes from later, and we go behind that. Thank you, Mr Murphy.

We can see again, Mrs Bennion, a note by Dr Chang, now timed 15.30, so we are well into the afternoon; yes?

BENNION: Yes.

MYERS: And in this note there's reference, as it happens, the first reference after "ATSD" is to a "desaturation down to 50 and requiring bagging"; do you see that?

BENNION: I do.

MYERS: Which we understand to be the second incident. It also includes in this note here now the reference to Dr Gibbs inserting the cannula; do you see that?

BENNION: I do.

MYERS: Although we know, as a matter of evidence, the insertion of the cannula comes before desaturation, that's just how Dr Chang has written it in the notes. Do you see that and understand?

BENNION: Yes.

MYERS: Thank you, Mrs Bennion. So I'm grateful for you letting me go through that with you, but what we can see from the timings, see if you can agree with this, is event 1 takes place at or about 10.15?

BENNION: Yes.

MYERS: That's a fixed point. The care goes to [Nurse B] at 11.30, doesn't it?

BENNION: Yes.

MYERS: At that point [Baby G] is still in nursery 4?

BENNION: Yes.

MYERS: At some point, it seems, later in the afternoon, certainly before 3.30 when Dr Chang's note was made, the cannulation takes place, doesn't it?

BENNION: It does.

MYERS: And there is a desaturation, isn't there?

BENNION: Yes.

MYERS: And then we know from [Nurse B]'s notes then there is the move to nursery 1?

BENNION: Yes.

MYERS: Now, as it happens, therefore, during the time of cannulation, the nurse who was designated for [Baby G] was [Nurse B] in fact, wasn't it?

BENNION: Yes.

MYERS: Do you have any -- outside the notes do you have any independent recollection of who was doing what at the various points or not?

BENNION: No.

MYERS: No, all right. Thank you for helping with that.

I'm going to ask you about something a little different now and ask Mr Murphy if he could put up something called the neonatal nursing review. It's a plan, Mrs Bennion, of the nurseries and the babies and the nurses who were in charge of them on this day or designated, sorry.

If we can put it on the screen, Mr Murphy, it's page 2 of 9. I'm going to ask to enlarge that a little bit so we can see it.

We haven't looked at this in your evidence yet, have we, Mrs Bennion?

BENNION: No.

MYERS: So let's let you familiarise yourself with it. Going in anti-clockwise order but starting at nursery 1, this is at the start of the shift. There's Shelley Tomlins looking after two babies in nursery 1 and [Nurse B] looking after one. Do you see that?

BENNION: I do.

MYERS: Nursery 1 is the intensive care nursery, isn't it?

BENNION: Yes.

MYERS: Nursery 2, which is designated high dependency, there's Caroline Oakley looking after two babies, NC and AC, isn't there?

BENNION: Yes.

MYERS: You were designated to look after RH, weren't you?

BENNION: As it appears on there, yes.

MYERS: As it appears there. And Janet Cox, a baby designated IH; yes?

BENNION: Yes.

MYERS: Were you the shift leader on this shift?

BENNION: I was.

MYERS: In nursery 3 there are two babies, IO and a baby called [Baby I], and Janet Cox was the nurse for both of them, wasn't she?

BENNION: Yes.

MYERS: Was she a band 4 nurse, Janet Cox?

BENNION: Yes.

MYERS: And nursery 4, where [Baby G] was with two other babies, Lucy Letby was the designated nurse there, wasn't she?

BENNION: Yes.

MYERS: And also you can see a box at the bottom right saying "Baby whose location is unconfirmed". Do you recall that there was another baby who you were or may have been looking after at this time, AO?

BENNION: No, I don't.

MYERS: Earlier in the case we considered, and we may have considered with you in fact, about what the staffing levels are for looking after babies in the nurseries.

BENNION: Yes.

MYERS: Just to refresh us, though we may not have forgotten, it's meant to be one-to-one for intensive care babies, isn't it?

BENNION: Yes.

MYERS: And those nurses have to be intensive care trained, don't they?

BENNION: Yes.

MYERS: For high dependency, one nurse can look after up to two babies; is that correct?

BENNION: That's correct.

MYERS: And in special care one nurse can look after up to four?

BENNION: Yes.

MYERS: Ideally, the shift leader should be what's been described as supernumerary, in other words able to move anywhere, but not designated to any particular child; is that correct?

BENNION: Yes. Ideally. Or if they are -- if they do have a patient workload it's a lighter patient workload.

MYERS: If we look at the number of babies, there appear to be 13 or possibly 14, depending what the position with OR was. Thirteen with six staff, including you. That's staff stretched, let me put it this way, very, very tightly over a lot of obligations, isn't it?

BENNION: Well, if you've got special care babies, it's one to four. So actually six staff... Um... That's actually quite -- that's within BAPM guidelines, which were set in 2011. So actually one nurse, or nursery nurse, is looking after four -- is capable of looking after four patients, so -- and although actually some of those babies, it doesn't actually give us the ratio of whether they are special care, high dependency in 2, 3 or 4 on there either. Presuming that nursery 3 and 4 are special care babies, that's an appropriate workload.

MYERS: Yes. If we get to nursery 1, if they are intensive care babies in there, then ideally it should be one-to-one, shouldn't it?

BENNION: Ideally it should be one to one.

MYERS: And ideally if [Baby G] was redesignated to [Nurse B], that would take [Nurse B] outside the BAPM guidelines, at that point, wouldn't it?

BENNION: It would slightly. However, you've got another registered member of staff in there, so you've got two members of staff to support each other within there, so it wouldn't be as if [Nurse B] would be on her own in there, she's got another band 5 nurse, and [Nurse B] is a very senior band 6 nurse.

MYERS: I'm just looking at it alongside the guidelines and on the guidelines if there are intensive care babies it should be one to one, shouldn't it?

BENNION: Ideally it should be.

MYERS: And in fact, as we've seen in the notes, the reason that [Baby G] was transferred to [Nurse B] was sheer staff workload where Lucy Letby was concerned, wasn't it?

BENNION: And also reallocation of nurseries. So if [Baby G] needed to move from nursery 4 to nursery 1, that made sense for

[Nurse B] who had the smallest workload to resume care of [Baby G].

MYERS: As it happens, we know [Baby G] wasn't moved to nursery '1 until after the second event.

BENNION: Yes.

MYERS: So at the time that [Baby G] was reallocated to [Nurse B] she wasn't in the process of being moved, was she?

BENNION: It was a few hours later, yes.

MYERS: And after the cannulation and the desaturation?

BENNION: Yes.

MYERS: In any event, the workload was at least a factor in why [Baby G] was redesignated to [Nurse B]; is that correct?

BENNION: It was, yes.

MYERS: So far as you're aware from what we see, what happened in event 1 was relatively brief and there appears to have been a swift recovery afterwards, wasn't it?

BENNION: The first event was.

MYERS: Yes. Do you recall saying to the police you wouldn't describe the event at 10.15 as a collapse, more as a significant event due to [Baby G] self-resolving?

BENNION: Yes, correct.

MYERS: So not a collapse, a significant event due to self-resolving?

BENNION: Yes.

MYERS: And just this in conclusion where [Baby G] is concerned, Mrs Bennion: she was, in your view, a risk-vulnerable baby, wasn't she?

BENNION: Yes.

MYERS: Who did have the potential to deteriorate as she did?

BENNION: All our babies have got the potential, that's why they're closely monitored, to deteriorate, yes.

MYERS: That's right, isn't it? A neonatal unit is for close monitoring for babies who have the potential to deteriorate, don't they?

BENNION: Yes.

MYERS: And it's something you commented on, that [Baby G] had the potential to deteriorate in the way that she did; do you agree?

BENNION: Yes, because she was an extremely premature baby, who although was doing well, did have the potential at any stage to deteriorate.

MR MYERS: All right. Thank you, Mrs Bennion.

MR JOHNSON: Does your Lordship have any questions?

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

That completes your evidence. Thank you very much for coming and giving it. According to the document that I have, it is not expected that you will be required again. Have you been told you're required again or not?

BENNION: Not required again, no.

MR JUSTICE GOSS: You're not required again. But just in case, would you please not talk to anyone about anything to do with this case until it's finished?

BENNION: Of course.

MR JUSTICE GOSS: Thank you very much indeed.

(In the absence of the jury)

MR JUSTICE GOSS: Two minutes, please.

(Pause)

MR JUSTICE GOSS: Thank you very much for coming. There's no one else in court now.

(The witness withdrew)

MR ASTBURY: My Lord, we've moved apace today. We have one live witness left, three short statements to read, Dr Harkness cannot be here today.

MR JUSTICE GOSS: That's all right.

MR ASTBURY: He is the last remaining witness before the experts. I'm afraid to say...

MR JUSTICE GOSS: It'll be an early finish?

MR ASTBURY: Yes.

MR JUSTICE GOSS: Can I just come back, before the jury come in, about tomorrow? As you know, we're going to finish at 3.30. Do we need to have a shorter lunch or not?

MR ASTBURY: I don't think we do. I'm happy to be corrected if anyone disagrees. We have two experts after Dr Harkness and the interview summary. Bearing in mind where we're going to be on Friday, we may run into Friday, but I think we will have made -- certainly we will have reached the point that we'd hoped to reach by Friday.

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

MR MYERS: That seems to be the case, my Lord, I agree.

MR JUSTICE GOSS: Ms Letby, we were just talking about timetabling while we're waiting for people to come back in again to see about tomorrow because there's a juror who's got to have an emergency dental appointment tomorrow afternoon and that's why we're going to finish at 3.30 tomorrow afternoon. But it looks as though we'll have a normal lunch break tomorrow then. That's one thing. If it could be slightly longer than normal, simply because of another commitment that I have, which I was prepared to forego, but if I can make it I would like to make it, so have an hour and a quarter for lunch.

MR ASTBURY: Yes. The experts, as my Lord knows, are here each day, so of all the days to make those sort of changes, it's probably the most convenient.

MR JUSTICE GOSS: Thank you very much. Jury back then, please.

(In the presence of the jury)

MR ASTBURY: My Lord, Eirian Powell, please.

MRS EIRIAN POWELL (affirmed)

Examination-in-chief by MR ASTBURY

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

POWELL: It's Eirian Lloyd Powell.

ASTBURY: Is it Miss or Mrs Powell?

POWELL: Mrs.

ASTBURY: Were you employed at the Countess of Chester Hospital in September of 2015?

POWELL: I was.

ASTBURY: In what capacity, please?

POWELL: As the neonatal manager.

ASTBURY: Thank you. You have come here today to deal with events on 21 September 2015 and you know that?

POWELL: Yes.

ASTBURY: And also to answer any questions about [Baby G] that anyone may have, a baby called [Baby G].

POWELL: Yes.

ASTBURY: If we begin at the beginning. Do you remember [Baby G] from your own recollections?

POWELL: No, I don't, actually.

ASTBURY: Okay. In respect of 21 September, have you had the opportunity to check the notes that would have been made at the time?

POWELL: Yes, I have. I was currently off sick until the 21st, where -- on the 21st, I'd returned on a phased return after fracturing my leg.

ASTBURY: So it's a day you remember?

POWELL: Yes.

ASTBURY: A phased return, what does that mean?

POWELL: It means you start off with a few hours initially and you build up on it, which is agreed with your superior manager.

ASTBURY: So do you remember what shift you were pencilled in for on 21 September?

POWELL: Yes. Looking at the -- it looks like I was doing a 5.5-hour, according to the diary.

ASTBURY: Okay. What time, do you remember, did you come on duty?

POWELL: I don't remember what time I actually came on duty, but I was supposed to leave at 1, so working back, I must have come on about 7.30.

ASTBURY: Right. So if it was a 5.5-hour shift and assuming you finished at 1, you have worked out you probably started at 7.30?

POWELL: Yes.

ASTBURY: And did you leave at 1?

POWELL: I can't remember if I did.

ASTBURY: What would your duties have entailed then in the neonatal unit on that particular day?

POWELL: Well, I was asked to -- I'd got in my diary that I had [Baby G]'s immunisations to do that morning, so I went round to -- I always check to make sure that they're sufficiently stable to have the immunisations because they can compromise the babies' well-being. There was some instability with the temperatures, so I was told that she wasn't well enough at that time to have the immunisations and therefore they were withheld.

ASTBURY: Do you remember roughly what stage of your shift or what time of the day that conversation took place?

POWELL: No, I don't.

ASTBURY: Do you remember who it took place with?

POWELL: I don't know. I'd be guessing.

ASTBURY: We don't want you to guess. If you don't remember, please say so.

Okay, so your shift, as you recall it to be, the whole of that shift would have been spent within the NNU?

POWELL: Not necessarily. I mean, there would be a return to work with my immediate manager at some point. Again I don't remember what time that would have been. And it would be trying to catch up, really, with what I'd been off...

ASTBURY: Did you have any meetings outside of the unit on that particular --

POWELL: It said I had a specialty meeting at 12.00. I don't remember.

ASTBURY: How long would that be?

POWELL: That would be from 12 o'clock to 1.30, 2 o'clock.

ASTBURY: Okay. That would take you beyond the end of your shift, as you recall it?

POWELL: Yes.

ASTBURY: Okay. Do you happen to remember if you returned to the NNU after the meeting?

POWELL: I can't remember. I can't even remember if I went to the meeting.

ASTBURY: Okay.

POWELL: Yes, I can't.

ASTBURY: That certainly makes that clear. You told us that you recall going on to the unit and having a conversation about [Baby G]'s immunisations due that day.

POWELL: Yes.

ASTBURY: Did you have any other conversations that you remember about [Baby G] or her treatment?

POWELL: No.

ASTBURY: No?

POWELL: No.

ASTBURY: Any conversations with anybody about events that could be described as untoward on the unit that day?

POWELL: No. How do you mean, untoward?

ASTBURY: It's a term that is used in your witness statement, so I've been very careful to use that. Whatever interpretation you put on that, anything that seemed incorrect, anything wrong on the unit?

POWELL: No, there wasn't anything, no.

ASTBURY: What was the process -- if an incident that you did consider to be untoward had taken place, what was your responsibility as a manager on the unit?

POWELL: Well, it would be reported to me directly or Yvonne, my deputy, and I would be dealing with that directly. It depends on what actually it entails because if it was a performance issue, it would be Datix-ed, as in a clinical incident would be reported. But if it was something personal or something that could be resolved with talking to that person directly or requiring additional supervision, then that could be done from that point in time.

ASTBURY: Okay. So in a management role --

POWELL: Yes.

ASTBURY: -- rather than a more formal role, would that be fair to say?

POWELL: Yes.

ASTBURY: When you describe an incident as a clinical incident requiring a Datix form, is it required in the event of a clinical incident?

POWELL: What?

ASTBURY: A Datix report.

POWELL: In the clinical --

ASTBURY: Is it mandatory --

POWELL: Well, yes. Anything that's not followed procedure, a clinical incident would actually be done and anyone can do that.

ASTBURY: Okay (overspeaking) --

POWELL: It doesn't have to go through me. But I usually get a copy of that incident reporting.

ASTBURY: Okay. You may have just helped with one form of incident where you said failing to follow procedure.

POWELL: Yes.

ASTBURY: I'm just wondering what you meant, for those laypersons amongst us, by a clinical incident. What definition would you give to those matters that required reporting on Datix?

POWELL: Well, it's as wide as it's long. It can be absolutely anything from not giving a medication within a given time, with omitting or failure to give, withholding, or even -- well, for instance, if you have to cannulate an infant more than three times.

ASTBURY: Right.

POWELL: That's usually considered as an incident. Not always done, because sometimes it's not possible to do, you know... From the natural... They're very difficult to cannulate and when they're poorly it's even harder because they do actually -- I'm going to use this terminology now -- shut down --

ASTBURY: Right.

POWELL: -- where the vessels are not easy to access, so it's even harder. So you know, it can be difficult to cannulate.

ASTBURY: Okay. Picking up something you said, another thing you said a moment ago, it doesn't have to be you that makes the Datix report?

POWELL: No.

ASTBURY: Can it be any member of staff?

POWELL: Anybody can do it.

ASTBURY: And can it relate to an omission or a failure by any other member of staff regardless of their status?

POWELL: Yes. And we were very good at doing that, yes, as a collective.

MR ASTBURY: Thank you, I have no more questions, Mrs Powell. If you could wait there for a moment, please.

Cross-examination by MR MYERS

MR MYERS: Mrs Powell, can I pick up on what we were talking about there, just a couple of things. You say that if there was an issue, sometimes it's a Datix report that would be lodged; is that correct?

POWELL: Yes, which is the clinical incident.

MYERS: A clinical incident. And you gave the example of cannulation in fact, didn't you?

POWELL: Yes.

MYERS: That if there's been three -- more than three times arguably that could be something that would be a Datix report?

POWELL: Yes.

MYERS: And if there were seven attempts --

POWELL: Yes.

MYERS: -- that could be as well, couldn't it?

POWELL: Yes.

MYERS: And it doesn't have to be any person in particular, does it, who makes the report?

POWELL: No, anyone can do it.

MYERS: So if a doctor, for example, had taken seven attempts to cannulate, he or she could choose to make a Datix report about it --

POWELL: Yes.

MYERS: -- or they might not?

POWELL: Yes, but they could explain also in the clinical notes as to what the problem was.

MYERS: They could.

POWELL: Yes.

MYERS: There might be a number of ways of resolving issues that arise, would that be fair to say?

POWELL: Yes.

MYERS: One of the ways might be sometimes for someone to talk to someone about what had happened; is that correct?

POWELL: Yes.

MYERS: And it may be that the view is taken that's a better way of resolving the issue that's arisen; do you agree?

POWELL: Sorry, could you...?

MYERS: Maybe sometimes talking to someone about what happened might be a way of dealing with the issue --

POWELL: Yes.

MYERS: -- if I put it that way?

POWELL: Yes.

MYERS: Do you actually remember the conversations that you had on 21 September? I'm not going to suggest you would, but do you?

POWELL: No.

MYERS: And it sounds like it was the first day back after a bit of a break.

POWELL: Yes, literally.

MYERS: And there were a number of things that you'd have had to deal with that day?

POWELL: Yes.

MYERS: And do you remember any particular conversations about [Baby G] that day?

POWELL: No, only that I was to give the immunisations but I was told they didn't think she was well enough.

MYERS: Do you remember any conversations about [Baby G] or any aspect of her treatment in the days that followed, any particular conversation?

POWELL: Again, because I was on a phased return I didn't -- I think I was in perhaps three times that week on a shortened shift.

MYERS: All right. And do you remember any particular issues raised as to her care over that period with you?

POWELL: No.

MYERS: You just don't remember?

POWELL: No, not at all.

MYERS: Do you have a lot of conversations with a lot of people?

POWELL: I do, yes.

MR MYERS: All right. Thank you very much, Mrs Powell.

Re-examination by MR ASTBURY

MR ASTBURY: Thank you. Just this, Mrs Powell: you mentioned an alternative to completing a Datix form is to make a note in the clinical notes.

POWELL: Yes.

ASTBURY: Is that the perceived --

POWELL: It can be because again -- there were different issues and, like I said, because there's so many variable responses, and depending on what the issue was, I'd get the clinical incident to investigate, so I'd have to have a point of reference as to why something would happen and then report back then to the clinical incident team as to why that happened --

ASTBURY: Okay.

POWELL: -- so I had to have a point of reference --

ASTBURY: So you'd expect one or the other?

POWELL: Yes.

MR ASTBURY: Thank you.

Does my Lord have any questions?

Questions from THE JUDGE

MR JUSTICE GOSS: Just so I understand, so if an untoward clinical event has occurred, what you understood to be an untoward clinical event occurred, you would anticipate learning of that event, either by it being reported in Datix --

POWELL: Yes.

MR JUSTICE GOSS: -- in other words, or reported to you orally?

POWELL: Yes.

MR JUSTICE GOSS: Whichever it was, you would then have to investigate it?

POWELL: Yes.

MR JUSTICE GOSS: And you would then, what, provide a report on it?

POWELL: Well, we had a clinical incident team brief with the governance office and they would actually be involved in the meeting. So they'd have a copy of every report that came through and then we'd have to go through it collectively with the consultant, myself, the clinical lead, all of those people then had to investigate it to a satisfactory conclusion.

MR JUSTICE GOSS: Right. Thank you very much.

That completes your evidence. I don't think you're...

MR MYERS: Mrs Powell may be required back.

MR JUSTICE GOSS: You may be required again?

POWELL: Today?

MR JUSTICE GOSS: No, not today, no. But at some time next year.

POWELL: Okay.

MR JUSTICE GOSS: Would you please not talk to anyone about anything to do with this case?

POWELL: Okay.

MR JUSTICE GOSS: I'm saying this to every witness who's giving evidence, so nothing to do with anything to do with this case until it's all over. All right?

POWELL: Yes.

MR JUSTICE GOSS: Thank you very much indeed, Mrs Powell.

(The witness withdrew)

MR ASTBURY: I'm going to read some statements next if I may.

MR JUSTICE GOSS: Certainly.

Witness statement of DR ALISON VENTRESS (read)

MR ASTBURY: We're at page 15 of my Lord's bundle, I1842.

It's a statement from Alison Ventress, who I'm sure everyone will remember, a registrar on the unit at the time we're concerned with. In this statement, dated 30 January 2018, Dr Ventress says as follows:

"With reference to the treatment of [Baby G] on 21 September 2015, according to my notes only, as I cannot remember anything

about this particular day, [Baby G] had issues, ie two apnoeas and a large projectile vomit, on the morning of 21 September.

"I was on nights. My first entry on the notes was at 23.00 hours. From my notes I reviewed [Baby G] in nursery 1 at the beginning of my shift. I would have spoken to the nurses if they could offer anything further. [Baby G] was stable and improving. She had no issues during my shift."

So that's the night shift following the day we've been hearing about, my Lord.

The next two statements come from expert witnesses, but their content is agreed. So we're a little bit ahead in the chronology, but now seems an opportunity to deal with them if my Lord is content.

MR JUSTICE GOSS: Is it...?

MR ASTBURY: Page 27, Professor Kenny. And also page 30, Dr Stivaros.

MR JUSTICE GOSS: All right. This is being read to you as agreed evidence, members of the jury, by a witness who is not giving evidence of facts within their direct knowledge, they are giving it as an expert, so you've heard expert evidence from people who have looked at the material and then given their opinion in relation to what conclusions can and cannot be drawn from that material from their expertise point of view. So this is such a witness. I will give you a more detailed direction about how you treat expert evidence but that in a nutshell is it. It's just part of the evidence in the case, as with any other witness, but this is agreed expert evidence.

Witness statement of PROFESSOR SIMON KENNY (read)

MR ASTBURY: Thank you, my Lord.

This is a statement from Professor Simon Kenny.

It is dated 22 March 2020 and he says as follows:

"I, Simon Edward Kenny, a consultant paediatric surgeon at Alder Hey Children's NHS Foundation Trust will say as follows.

"I was appointed as consultant paediatric surgeon at Alder Hey Children's Hospital in March 2003. I am an honorary professor at the University of Liverpool. Throughout my consultant career I've had a clinical and research interest in Hirschsprung's disease. I am patron of the charity CHAMPS that exists to support parents and children with Hirschsprung's disease. With

two colleagues I run a clinic dedicated to children with Hirschsprung's disease. I am compiling this report at the request of Cheshire Constabulary who have asked me to comment about Hirschsprung's disease in relation to [Baby G].

"In compiling this report, I have had access to her case notes from the Countess of Chester Hospital, Wirral University Hospital Trust [that's Arrowe Park, my Lord] and Alder Hey Children's Hospital.

"In brief, [Baby G] was born extremely prematurely at 23 weeks' gestational age. She spent the early part of her life at Arrowe Park Hospital. She was transferred to the Countess of Chester Hospital on 13 August, remaining there until 8 September 2015. She became significantly unwell on 7 September, requiring a return to Arrowe Park Hospital. She remained there until 16 September. She remained at the Countess of Chester Hospital from 16 September until 2 November 2015. [Baby G] has significant neurodevelopmental delay, which has impacted greatly on her life.

"I will restrict my comments on this case to the aspects pertaining to the putative diagnosis of Hirschsprung's disease. On 21 September 2015, [Baby G] had an abdominal X-ray performed that suggested her symptoms may be due to Hirschsprung's disease. Dr Wright described a cut-off in gas pattern which was suggestive of a possible obstructive cause. She raised the diagnostic possibility of Hirschsprung's disease, although she also mentioned that sepsis could account for this appearance.

"Prior to discussing this further, I will briefly describe Hirschsprung's disease. Hirschsprung's disease is a rare congenital (birth) defect in which the nerve cells that normally populate the gut are absent from a length of gut, typically the rectum. The nerve cells in the bowel are responsible for coordinating contractions of the bowel to allow propulsion of bowel content as part of the digestive process. In the absence of these nerves the bowel is unable to coordinate contraction and thus children usually present in the first few days of life with bowel obstruction, which requires surgery to correct.

"Diagnosis is made by taking a small biopsy from the rectum. The disease affects 1 in 5,000 children. Premature babies are at a slightly higher risk of being born with Hirschsprung's disease but the incidence is still very low.

"[Baby G] did not have a rectal biopsy. Her abdomen spontaneously improved. It's not uncommon for children with sepsis to develop abdominal distension, which spontaneously resolves when the sepsis is treated. This was the differential diagnosis raised by Dr Wright.

"I note that [Baby G] had no further X-rays of her abdomen following this as her abdomen became less distended. Hirschsprung's disease would not spontaneously improve like this and the abdomen would remain distended.

"The clinicians looking after [Baby G] will have noted her improvement and therefore made the correct decision not to perform a biopsy because [Baby G]'s symptoms had resolved.

"In summary, [Baby G] did not clinically have Hirschsprung's disease. Dr Wright, as a radiologist, would not be aware of the clinical context and will have suggested this based on the X-ray alone. The clinicians looking after [Baby G] did not (sic) have that clinical context. It is my opinion that Hirschsprung's disease did not account for [Baby G]'s symptoms in September 2015."

MR JUSTICE GOSS: You did insert the word "not" there.

MR ASTBURY: Yes, "did not".

MR JUSTICE GOSS: "The clinicians looking after [Baby G] did not have that clinical context", you read. Is that what it says on your copy?

MR ASTBURY: Let me check. I'm sorry if I slipped into error.

MR JUSTICE GOSS: It's the last sentence of the penultimate paragraph.

MR ASTBURY: "The clinicians looking after [Baby G] did have that clinical context."

Thank you for correcting that. Rather important.

So that does conclude the statement of Professor Kenny.

MR JUSTICE GOSS: Thank you.

Witness statement of DR STAVROS STIVAROS (read)

MR ASTBURY: The next statement, my Lord, is the statement of Stavros Michael Stivaros. In his report Dr Stivaros says this:

"I am Stavros Michael Stivaros. My specialist field is paediatric neuroradiology. I am the lead consultant paediatric neuroradiologist at Royal Manchester Children's Hospital, which is one of the largest paediatric teaching hospitals in Europe.

"I have researched into paediatric neuroimaging and I am professor of paediatric neuroradiology and translational imaging at the University of Manchester. I hold a clinical contract as an honorary consultant paediatric neuroradiologist at the Royal Manchester Children's Hospital. My clinical duties include the routine clinical reporting of paediatric brain and spine scans, of which I routinely report approximately 2,500 per year.

"As part of my duties I report the majority of the neuroradiological imaging pertaining to suspected non-accidental injury that presents to the royal Manchester Children's Hospital as well as supra-regional peer reviews of said imaging due to our role as a tertiary referral centre. I also routinely report brain imaging looking for abnormalities which may relate to birth asphyxia.

"[Baby G] was born extremely prematurely. Despite this, neuroradiologically, she appeared to be well until the ultrasound scan performed on 8 September 2015. Prior to that scan, no significant brain abnormality had been detected. I defer to my expert neonatal colleagues' opinions in regards to the clinical events that occurred on 7 September 2015.

"From a brain imaging perspective, the imaging from that point onwards was in keeping with [Baby G] having suffered a significant global hypoxic ischaemic injury to her brain.

"The scans cannot determine a cause for this injury. The event that occurred on 21 September 2015 may or may not have contributed to the brain injury that [Baby G] had already suffered from. This cannot be determined from the scans given the extensive nature of the injury already suffered and identified on the MRI scan dated 15 September 2015.

"As evidenced by the scan of 12 August 2016, [Baby G] has suffered a severe and profound brain injury from which she will not recover."

My Lord, I am invited, and will include, the chronology that follows in the statement, which is as follows. It deals with the chronology of [Baby G]'s scans:

"Between birth and 15 September 2015 [this is 2.7], [Baby G] had multiple cranial ultrasound scans. There was a further ultrasound scan dated 1 June 2015. There was an ultrasound scan dated 4 June 2015. The following day, 5 June, a repeat ultrasound scan was performed by Oliver Rackham. On 6 June 2015, Sarah Thompson performed a repeat scan on [Baby G]. Sixteen images are presented for review from 9 June 2015. These again show no significant change in appearances as reported by Naomi Eastwood as follows:

"'Cranial ultrasound, normal midline. Normal gyral pattern for gestation. No intraventricular haemorrhage. Normal ventricular size. Will repeat scan in 14 days.'

"On 12 June 2015 Pek Wan Lee performed a repeat scan. [Pek Wan Lee] was able to better assess the brain on 14 June 2015. [Baby G] remained stable and as such no further imaging was undertaken until 29 June 2015. The scan was performed as she had a pulmonary haemorrhage.

"[Baby G] did not have any further imaging until 31 July 2015. An ultrasound was undertaken on 3 August 2015. On 13 August 2015 [Baby G] was transferred to the Countess of Chester Hospital. [Baby G] was then re-transferred to Arrowe Park Hospital for full intensive care measures. This occurred at 00.30 hours on 8 September 2015. She had a further ultrasound scan performed later that day.

"An MRI scan of her brain was performed on 15 September 2015. The final brain scan that [Baby G] had was an MRI scan dated 12 August 2016."

So that's the chronology upon which Dr Stivaros based his opinion.

MR JUSTICE GOSS: Yes.

MR ASTBURY: That concludes the statements to be read.

MR JUSTICE GOSS: There is that part on the images presented for review from 9 June where Dr Stivaros refers to:

"Normal gyral pattern for gestation, no intraventricular haemorrhage, normal ventricular size."

I was just looking up in our glossary to see whether there was any help for that. I don't think we've had it yet but we can get it from another witness. The ventricles of the brain -- there has been reference to it, hasn't there?

MR ASTBURY: Dr Gibbs touched on it, but we'll ensure we deal with it thoroughly.

MR JUSTICE GOSS: I think the answer is because it was a negative, I think we... We can deal with it.

MR ASTBURY: Of course.

My Lord, the next witness to be called is Dr Harkness and, due to his clinical responsibilities, I'm afraid we can't do that now.

MR JUSTICE GOSS: And there's nothing else?

MR ASTBURY: That concludes the read evidence without messing up the chronology or the order. I'm afraid that probably is all we can do.

MR JUSTICE GOSS: So far as tomorrow is concerned then, we are going to finish early.

MR ASTBURY: Yes.

MR JUSTICE GOSS: I canvassed the possibility of a shorter break. Is that going to be helpful?

MR ASTBURY: We at the bar don't think, with respect, it's necessary. We think we are destined to finish, if not late on Thursday with this part of the case, then Friday morning. So we're not concerned unless, of course, my Lord feels we should sit a little more.

MR JUSTICE GOSS: Well, so that the jury understand what is happening, we're going to reach a stage, you anticipate, either late tomorrow or on Friday when we are going to have a natural breaking point.

MR ASTBURY: Yes. It will conclude the particular counts that we are considering in respect of [Baby G]. In fact, all counts in respect of her.

MR JUSTICE GOSS: So we'd be moving on to the next baby?

MR ASTBURY: Yes. We've been having a short break anyway in between each baby.

MR JUSTICE GOSS: Yes. All right.

That's so that you know what the situation is. It's looking like you're either going to have all or at least part of Friday free, which is our last day that we are due to be sitting, before we start the break for Christmas, because you'll remember back to when we first met in early October and you had that questionnaire, I identified when we would definitely not be sitting.

That is as from next Monday through until January, early January. So that's it.

So tomorrow we'll see how we progress during the course of the morning as to how we're going to do it, but we will definitely be finished, as I said, to enable one of you to go to the dentist. All right? Very important. Difficult to get, dental appointments, and it can be incredibly painful when you have a tooth that gives you problems. Right, thank you. So 10.30 tomorrow morning, please.

(In the absence of the jury)

MR JUSTICE GOSS: Mr Myers, is anyone going to want to go down to see --

MR MYERS: Yes, my Lord, we would like to, please.

MR JUSTICE GOSS: Mr Myers will come down to see Ms Letby in a minute.

MR MYERS: Thank you, my Lord.

(3.07 pm)

(The court adjourned until 10.30 am on Thursday, 15 December 2022)