

27 January 2023

Baby I

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Friday, 27 January 2023
(10.30 am)

(In the presence of the jury)

MR JUSTICE GOSS: Mr Astbury.

MR ASTBURY: My Lord, Dr Lucy Beebe, please.

DR LUCY BEEBE (affirmed)

Examination-in-chief by MR ASTBURY

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

BEEBE: Lucy Sian Beebe.

ASTBURY: Thank you. And your occupation?

BEEBE: I'm a GP.

ASTBURY: Thank you. Dr Beebe, very politely you're directing your answers towards me. If you could try and project them, please, to the back of the room to ensure that everyone who needs to hear you can hear you, thank you.

BEEBE: Certainly.

ASTBURY: Were you engaged as a doctor in the Countess of Chester Hospital in September and October of 2015?

BEEBE: Yes, I was.

ASTBURY: And back in September and October 2015, what was your position then?

BEEBE: At that point I was a GP trainee doctor.

ASTBURY: Was your experience limited to a trainee (sic) within GP practice?

BEEBE: No. So prior to moving to GP training, I was a paediatric trainee for a number of years.

ASTBURY: So although your training was with the purpose of qualifying as a GP, you did have some experience within a neonatal setting?

BEEBE: Yes, it was the fifth neonatal unit I had worked in.

ASTBURY: Thank you. I'm going to ask you, please, about your contact with a baby by the name of [Baby I] over the period that I've mentioned. I think, correct me if I'm wrong, you first appear -- were you given the opportunity to look at the clinical notes before you provided a statement in this case?

BEEBE: Yes, I was.

ASTBURY: And was the first occasion when you appeared in those notes on 29 September 2015?

BEEBE: I believe so, yes.

ASTBURY: Thank you. If you look to your right we have a screen.

It's not a memory test, so we're going to show you the notes.

BEEBE: Thank you.

ASTBURY: I'm going to ask Mr Murphy, my Lord, to go to tile 46, please.

I'm reminded that we skipped a little between 1 and 2. This is sequence 1, please. We're just finishing off, you may remember yesterday, the events around 30 September.

If we can go to the first page, thank you.

This, I suspect, is a form you'll recognise, doctor?

BEEBE: It is, yes.

ASTBURY: Can you explain to us, please -- we've heard about grand rounds, which was the name of the tile in front, but what

was the system in Chester that gave rise to this form being completed, please?

BEEBE: From my memory of working on the unit, we would complete a grand round sheet the day before the grand round would happen. So a junior doctor like me would go through the notes, compile all the kind of problem lists, the medication, go through all the investigations that were relevant to that baby and do an examination. That would be in preparation for then the consultant to go round the following day and kind of have their overall view.

So every baby had a very detailed view each week.

ASTBURY: Thank you. Do you recognise the handwriting on this particular form?

BEEBE: I do.

ASTBURY: I'm going to just ask you to have a look at it first before I ask you any questions so you can refresh your memory, please. If we scroll gently down, please.

I think we have a second page, Mr Murphy.

I will take you through it in a moment, just an opportunity to familiarise yourself with it again.

(Pause)

Thank you, doctor. In the box we were just looking at, it had "Grand round Wednesday" --

BEEBE: Mm-hm.

ASTBURY: -- but I think, am I right, given the date on the top -- and I should say it appears in our timeline as the Wednesday, but this in fact is a form you'd have filled in on the Tuesday, the day before?

BEEBE: That's correct.

ASTBURY: And would have reflected a careful examination of [Baby I] on that date?

BEEBE: Yes, on the 29th, yes.

ASTBURY: In readiness for the consultant the following day?

BEEBE: Yes.

ASTBURY: Can we go through it, please? We have the date at the top. We have [Baby I]'s gestation at birth.

BEEBE: Mm-hm.

ASTBURY: Age, 53 days?

BEEBE: Yes.

ASTBURY: The named consultant and -- POW?

BEEBE: Paediatrician of the week.

ASTBURY: Thank you. Then you've listed the problems that [Baby I] had experienced up until 29 September?

BEEBE: Mm-hm.

ASTBURY: She was preterm. Can you read that next line for us?

BEEBE: It means previously treated conservatively for necrotising enterocolitis.

ASTBURY: That's a condition that we've heard a little bit about and that that tends to be treated on suspicion and proactively with antibiotics rather than waiting for symptoms to develop?

BEEBE: Yes.

ASTBURY: Underneath, "grade 1" is that?

BEEBE: Yes.

ASTBURY: Tell us about that, please.

BEEBE: Grade 1 intraventricular haemorrhage.

ASTBURY: That's a note that you have made. Any significance in the grade 1 note?

BEEBE: So from my memory, it is the first grade, so the smallest or least significant amount of bleeding in the ventricles, which is common in extremely premature babies.

ASTBURY: If we scroll up to medication, what's Sytron, please?

BEEBE: Sytron is a liquid iron medication that is given to premature babies.

ASTBURY: Is that "breast milk fortifier"?

BEEBE: Yes. That's added to mum's breast milk to increase the calorie content of the milk to help them to gain weight.

ASTBURY: Ventilation. We have heard that means self-ventilating in air?

BEEBE: Mm-hm.

ASTBURY: So no assistance with breathing for [Baby I] at that stage?

BEEBE: No.

ASTBURY: You've made some notes under cardiovascular -- is that heart rate?

BEEBE: Yes, heart rate.

ASTBURY: What's the next entry, please? Is it 1 plus 2 plus 0?

BEEBE: Yes, you could hear both the first and second heart sounds and there were no added sounds, ie no murmurs.

ASTBURY: Thank you. I'm sorry, what have you written underneath with the ticks?

BEEBE: So that is that both femoral pulses, the pulses in the baby's groin, are both there and palpable, so we can feel them.

ASTBURY: Have you then made a note about -- it's under the heading "Fluids and growth". We can see weight. What does OFC stand for, please?

BEEBE: It basically means the head circumference.

ASTBURY: By way of -- in both instances you've placed that within a centile, which I think, am I right, is a comparison to what would be expected of a baby in a similar position by way of average; is that right?

BEEBE: Yes, so you plot it on a chart and it basically monitors the kind of expected growth rate compared to a baby of that gestation.

ASTBURY: Thank you. We've then got the fluid rate at 165ml/kg/day.

BEEBE: Mm-hm.

ASTBURY: TPN and lipid presumably not relevant because she's receiving enteral feeds; is that right?

BEEBE: That's right.

ASTBURY: Which is expressed milk and the fortifier?

BEEBE: Mm-hm.

ASTBURY: "Three times 8"?

BEEBE: She was on three-hourly feeds.

ASTBURY: Right. That means eight times a day?

BEEBE: Mm-hm.

ASTBURY: And is that NGT and bottle?

BEEBE: Yes.

ASTBURY: So a combination of both feeding methods?

BEEBE: Yes.

ASTBURY: You've noted the weight gain for the last week.

BEEBE: Mm-hm.

ASTBURY: You've then entered, next to neurology, "Handles well".

Is that a figure next to that entry, 1.625, or is that from the entry above?

BEEBE: I'm not sure, sorry. I don't know what that relates to.

ASTBURY: And AF, is that anterior fontanelle?

BEEBE: Yes, so the soft spot at the top of the head was normal.

ASTBURY: Thank you. You've noted when the head scan took place, or head scans, the 23rd and 25 August.

BEEBE: Mm-hm.

ASTBURY: Then you've put a bit more detail about those -- are they the ventricular bleeds --

BEEBE: Mm-hm.

ASTBURY: -- underneath our reference number at 14360? Does that indicate they've been seen by [Dr B]?

BEEBE: Yes, they've been reviewed by the consultant.

ASTBURY: Thank you. Scroll down again, please. This is a note of your examination of [Baby I]. You describe her as "Settled, a little pale". Is that CRT?

BEEBE: Yes.

ASTBURY: That's capillary refill time and is less than 2 seconds, which we've heard is what is expected and hoped for; is that right?

BEEBE: Yes, that's correct.

ASTBURY: "No respiratory distress, chest clear"?

BEEBE: Yes.

ASTBURY: Then we've got the similar entry, 1 plus 2 plus 0, which you've told us about.

BEEBE: Mm-hm.

ASTBURY: "Abdomen full but soft."

Is that:

"Umbilical hernia present/reducible"?

BEEBE: Yes.

ASTBURY: Just explain that, please, to us.

BEEBE: So babies, particularly premature babies, the area around the tummy button, there can be a little hole there where the bowel can protrude. That often doesn't cause any problems and gets better by itself, particularly in the first year of life. So the fact that you can reduce it, ie push whatever is coming out of the bowel back inside, indicates that there's no problem and it's as expected.

ASTBURY: Thank you. Generally, on examination, how did you assess [Baby I] on that particular occasion? What was your feeling of her condition?

BEEBE: She seemed to be a stable baby who was feeding and growing.

ASTBURY: Did you have any concerns as a result of your examination that perhaps aren't reflected there?

BEEBE: Not that I can remember, no.

ASTBURY: There's a reference -- did you check her tone when you examined her? Would you have checked her tone?

BEEBE: That would be part of an overall assessment of a baby, of a neonate. I haven't documented that, but certainly if she had abnormal tone, that is something that I would have documented.

ASTBURY: Right. How was she handling, do you recall?

BEEBE: I think I wrote "handles well" on the other side.

ASTBURY: Sorry. I think you're right. If you scroll up again.

BEEBE: Yes. So that's an assessment of a baby's overall tone, the fact that they handle well, they respond normally to your examination.

ASTBURY: And what would you conclude from that?

BEEBE: That it was normal.

ASTBURY: Okay. Just scrolling down again, you've told us she wasn't on any ventilation, so there were no issues with her breathing; is that right?

BEEBE: Yes.

ASTBURY: The next heading is "Abnormal blood results", can you tell us a little about those, please?

BEEBE: So those bloods were taken on 28 September, I think kind of routinely as part of normal weekly checks. The ALP, which is an enzyme that can reflect bone and liver health, is a little bit raised, which is very normal in a premature baby. Albumin, which is the protein level within the blood, is a little bit on the low side.

Again, not unusual in a preterm baby. The adjusted calcium, which again is calcium within the blood, is very slightly high from what I can remember in terms of normal reference ranges, but nothing that would cause major concern.

Platelets, slightly high. Again, nothing that would be of concern.

And Hb, which is the kind of red blood cell count, is low, ie she was anaemic, which again is very common in preterm babies.

The reticulocytes are the baby precursor red blood cells, which -- so basically, it shows that her bone marrow was trying to respond to that anaemia to correct it.

ASTBURY: Thank you. Are you able to help with this? Did her anaemia -- was that reflected by her appearance?

BEEBE: Yes, so she did -- I have documented that she looked a little pale, which would be in keeping with a baby who was slightly anaemic. But her other cardiovascular parameters were normal, so she wasn't -- didn't have a very high heart rate or problems with her capillary refill time.

ASTBURY: Thank you. Moving on to the microbiology entry below, I'm going to ask you, please, to read that one.

BEEBE: Really?

ASTBURY: If you can! Don't worry, I'll have a go if you can't!

BEEBE: So from what I've documented, she's colonised with this particular bacteria, which I would pronounce as *stenotrophomonas*.

ASTBURY: Does it have an abbreviation in the trade?

BEEBE: It's an unusual bacteria, not one that I've ever encountered previously or since, so sorry, I'm not sure.

ASTBURY: I'd much rather you told us. Anything you are able to tell us about that in addition to the note that you've made?

BEEBE: No, sorry.

ASTBURY: Okay. The next entry, ROP, I think is concerned with retinopathy, is that right, eyesight?

BEEBE: Yes.

ASTBURY: And you've made some entries there about something -- is this on 23 September?

BEEBE: Yes. So she's had her retinopathy of prematurity screened by an ophthalmologist on 23 September and the plan was to repeat that again in 2 weeks' time.

ASTBURY: Thank you. And if we scroll down again to the management plan, please. You have touched on this in your evidence already, but obviously going forward, what was the priority for [Baby I] as a result of your examination of her?

BEEBE: So to continue feeding and growing. You could see from the previous kind of slide, she was still having some of her milk via the NG tube, so she needed to continue to learn to bottle feed and grow.

ASTBURY: Would that have been the primary concern at that stage with [Baby I], given everything you'd found on your examination?

BEEBE: Yes.

ASTBURY: We can see, just to supplement that, if we go down to the next box, and we'll hear from Dr Newby, but just while we're here, the grand round was completed the next day.

BEEBE: Mm-hm.

ASTBURY: And the plan appears to be, is that "Immunisations, Monday"?

BEEBE: Yes.

ASTBURY: Does a baby have to be in any particular condition to be able to have their immunisations?

BEEBE: So you would not give immunisations to a baby who was unwell with an infection or you had serious concerns about, so it indicates that we were very happy with her at that point.

ASTBURY: Thank you. Mirroring your note the day before:

"Establishing feeds. Wean hot cot as appropriate."

Just very briefly explain that to us, please.

BEEBE: So when babies, extremely premature babies, are first born, they're often put into an incubator to control the environment and keep them as warm as possible because they're not able to maintain their body temperature. As they get older and become bigger they then go into a cot that is open but is heated from underneath, and gradually, as that baby becomes older and gains more weight, they can start to maintain their own body temperature, so you gradually reduce the heat in that hot cot. That's a bit of a balancing exercise, but that was the plan for her.

ASTBURY: Finally, again, "Feed and grow"?

BEEBE: Mm-hm.

ASTBURY: Thank you. If we can go next, please, to tile 51, which is your next note in the medical notes. This is the day after

you'd completed the form, a little after, would it be, the grand round, because it appears after that in the notes?

BEEBE: Yes. So the grand round hasn't been timed as to when it was, but we would normally start at kind of 9 o'clock in the morning, so it was after.

ASTBURY: Right, thank you. Could you, with me, please, go through that note? Is that:

"Asked to review as [is that a downward arrow] temperature"?

BEEBE: Yes.

ASTBURY: So just tell us, please, why you were asked to review [Baby I].

BEEBE: Her temperature was 36.2, and the lower end of what we would want would be 36.5, so the nurse had asked me to review and assess as to why that was the case.

ASTBURY: Right, okay. I think you've -- that in fact is your next note, that [Baby I] was in a hot cot, and that was her temperature. You've also noted that she was taking full bottles at this stage and gaining weight --

BEEBE: Mm-hm.

ASTBURY: -- relevant to what you'd written the day before, no doubt.

Then "O/E", is that on examination?

BEEBE: Yes.

ASTBURY: And if we can scroll down a little bit, please. Do you happen to recall who the nurse was who called you at 11.40 for that examination?

BEEBE: I do not.

ASTBURY: Okay. "A little pale", is that?

BEEBE: Mm-hm.

ASTBURY: We've covered that. "Continues to handle well"; is that right?

BEEBE: Yes.

ASTBURY: We've got the CRT again recorded. Is that, "Warm and well perfused"?

BEEBE: Yes.

ASTBURY: You've listened to her heart again because we can see those entries.

BEEBE: That's right.

ASTBURY: And, "Chest clear, no distress". Just explain that to us, please.

BEEBE: So I listened to her chest with a stethoscope and I couldn't hear any added sounds consistent with infection or fluid, and no distress means that -- so when babies are struggling with their breathing, often their tummy sucks in, their ribs will suck in, and up here (indicating) will suck in as an indicator that they are struggling to breathe or having to work hard to breathe and there wasn't any evidence that she was working hard to breathe.

ASTBURY: Thank you. This is a little diagram that we've become familiar with, an abdomen; is that right?

BEEBE: That's correct.

ASTBURY: Is that, "Full but soft"?

BEEBE: Mm-hm.

ASTBURY: And you've recorded again, "Reducible umbilical hernia"?

BEEBE: Mm-hm.

ASTBURY: Over to the right, "Appears similar to yesterday's examination"?

BEEBE: Yes.

ASTBURY: So the note was done yesterday, we know you examined her then and you didn't detect any change, is that right, in condition from one day to the next?

BEEBE: Yes, there had been no change.

ASTBURY: Thank you. "During examination, bowels opened"; is that right?

BEEBE: That's correct.

ASTBURY: And you described that which emerged as a "normal yellow seedy stool".

BEEBE: That's correct.

ASTBURY: Does that mean anything?

BEEBE: Yes, it does. So it indicates that the baby's gut health is normal at that point. So often babies who are starting to develop symptoms of the necrotising enterocolitis, or anything like that, will sometimes have blood or mucus in their stool. So it indicates that she is feeding normally and then what's coming through at the other end is normal as well.

ASTBURY: Right. The next line:

"Mum reports [is that] low temperature has been happening over past few days"?

BEEBE: Mm-hm.

ASTBURY: Do we assume from that that mum was present during the examination?

BEEBE: I assume from that that mum was present.

ASTBURY: You don't actually recall it, but it's based on your notes?

BEEBE: Based on my notes, she would have been there.

ASTBURY: All right. Just on the subject of mum, do you recall [Baby I]'s mum?

BEEBE: I do.

ASTBURY: Was she somebody you saw frequently or infrequently on the ward?

BEEBE: Um... So I saw her frequently on the ward. She was there visiting [Baby I] a lot.

ASTBURY: Anything else you remember about mum or her attendance on the unit?

BEEBE: I remember that she was friendly with staff, that you would be able to have a chat with her. I remember talking about her other children.

ASTBURY: So you have a recollection of [Baby I]'s mum?

BEEBE: Yes.

ASTBURY: "P" is plan, I think, going back to the note?

BEEBE: Yes.

ASTBURY: Is that, "Increase temperature of hot cot"?

BEEBE: Yes.

ASTBURY: "Monitor closely if further concerns for sepsis screen."

Just explain that to us, please.

BEEBE: So sometimes babies show subtle signs of infection, kind of early on, so as we do with all babies in the neonatal unit, we need to watch them and be careful. So if, despite the increase in her hot cot, she had continued to have temperature instability or she developed other signs of concern, then we would have a very low threshold for taking blood tests and blood cultures and look for -- that look for infection, and then at the same time start antibiotics while we wait for those test results to come back.

ASTBURY: Okay. So there's no confusion later when the note is considered, should there be a comma after "monitor closely" or is that one line?

BEEBE: There should be a comma.

ASTBURY: Okay, thank you. And the sepsis screen would be triggered if there was a further change in that or the temperature didn't improve?

BEEBE: Yes.

ASTBURY: But you've concluded there:

"Appears clinically well at present"?

BEEBE: Yes.

ASTBURY: Thank you. Any significant distinction, do you recall, in her condition from the Tuesday into the Wednesday morning when you looked at her?

BEEBE: Looking at my documentation and my examination findings on both occasions, it would appear that she presented in the same way.

ASTBURY: Thank you. That's your last note on 30 September. If we could go next, please, to sequence of events 2, everyone, and anyone who's following on the iPad, the next sequence of events chart, please. If we go to tile 143.

This is a form we've seen before. Is that your handwriting again?

BEEBE: It is.

ASTBURY: And was it the same process, this was completed on Tuesday, 13 October, with an examination by you; is that right?

BEEBE: I believe so, yes.

ASTBURY: Shall we just scroll down then and just remind yourself of the note, please, doctor, before I ask you anymore questions.

(Pause)

It's certainly prepared in readiness for the Wednesday. It wouldn't appear that the grand round has taken place, certainly using this form anyway, with [Baby I].

BEEBE: Mm-hm.

ASTBURY: So if we can go back to the start, please. You have filled in the same details as you did the week before.

We can see there that it's now day 62, 36 weeks plus 4 days.

BEEBE: Mm-hm.

ASTBURY: You've put [Dr B] down in both boxes this time. Then the problem list is very different from the week before.

BEEBE: Yes.

MR JUSTICE GOSS: Sorry, you keep saying -- it's 2 weeks before.

MR ASTBURY: Yes, of course, because it's 62 after 53, so it's 9. That must be normal, mustn't it? It's 13 days.

MR JUSTICE GOSS: No, Tuesday to Tuesday, 2 weeks, the 29th to the 13th.

MR ASTBURY: Sorry, I was concentrating too hard on the detail, I apologise.

So, "Cardiac arrest overnight". Then is that, "[Question mark] cause"?

BEEBE: So "query cause". We didn't understand the reason for it yet.

ASTBURY: Okay. Is that then, "Required compressions"?

BEEBE: Mm.

ASTBURY: Perhaps if you take me through this note, doctor, so I don't misquote again.

BEEBE: "Required compressions [ie chest compressions, so CPR] and adrenaline."

That is a drug that is used to try to restart the heart or increase the heart rate. I have documented that she needed 20 minutes of CPR.

ASTBURY: Is that a significant note to make or a significant feature of what you've written down?

BEEBE: That's a long time to be in cardiac arrest for.

ASTBURY: The next one, we can see:

"Presumed sepsis. Re-screened post-arrest."

BEEBE: So any baby that's deteriorated rapidly with no explanation, we would think -- we would be concerned about infection and, as I discussed before, a sepsis screen -- as much of a sepsis screen as we safely can perform would be done as soon as we can once that baby was stable after arresting.

ASTBURY: Thank you. You've then summarised the medication, which includes morphine and some antibiotics, with which we're becoming familiar.

BEEBE: Mm-hm.

ASTBURY: If we go down, please. Last time we recall [Baby I] was breathing without any assistance. She's now receiving mechanical ventilation.

BEEBE: Yes.

ASTBURY: You've recorded the pressure, the rate and the amount of oxygen in the gas she was receiving?

BEEBE: Mm-hm.

ASTBURY: You also -- are they blood gas results that you've entered?

BEEBE: Yes, that's a blood gas taken at 8 am.

ASTBURY: Thank you. Can you tell us if anything stands out within those, please?

BEEBE: So she's got a slight acidosis, so her blood is slightly acidic.

ASTBURY: Is that the pH entry?

BEEBE: PH, yes. There's a combination of it being both a lung cause and a body acid cause because her lactate is slightly raised as well and her glucose, her blood sugar, is high.

ASTBURY: Just going back to the acidosis that you mentioned, what does that tell you in layperson's terms? What does it tell you if the pH is raised and the CO2?

BEEBE: The pH is low and the CO2 is a little bit up, so it just indicates that the baby is poorly.

ASTBURY: Okay. We've then got under the cardiovascular entry some figures, one of which is circled. Is there anything you can tell us about that?

BEEBE: That's the mean blood pressure.

ASTBURY: What does that tell you?

BEEBE: It's an indication of their cardiovascular status.

I can't recall enough neonatal medicine now to know whether that is normal for a baby at that gestation.

ASTBURY: Okay, that's understandable. "Fluids and growth."

We can see on the left:

"Feeds have been stopped overnight."

BEEBE: Mm-hm.

ASTBURY: And as a consequence, [Baby I] was now receiving fluids at that rate with 10% dextrose?

BEEBE: Yes.

ASTBURY: Scan down. I think your neurology entry reflects that which you made 2 weeks ago, the same information?

BEEBE: Yes.

ASTBURY: If we go down again, please. You've examined [Baby I].

Is that "abdomen distended"?

BEEBE: Yes.

ASTBURY: And you put "++".

BEEBE: Yes.

ASTBURY: Just explain, if you can, what you found then on that examination in that regard.

BEEBE: It's a reflection of the fact that their abdomen was really quite distended. It's quite different to the last entry that I made. Her abdomen was bigger than then.

ASTBURY: Okay. I think you described it as soft on the last occasion?

BEEBE: Mm-hm.

ASTBURY: You have put there "firmer than", is that --

BEEBE: Firmer than yesterday.

ASTBURY: Who would have given you that information; can you recall?

BEEBE: I don't remember. I may have examined her the day before and -- I don't know, I can't remember.

ASTBURY: Okay. "Desat and brady on palpation."

BEEBE: Mm-hm.

ASTBURY: Is that a reaction to being handled?

BEEBE: It certainly could be a reaction to being handled due to pain in her abdomen or just the fact that she's unstable and doesn't want to be touched.

ASTBURY: Okay. "Bowel sounds present"?

BEEBE: Mm-hm.

ASTBURY: We've heard something about that. Is that, "Good air entry bilaterally"?

BEEBE: Yes.

ASTBURY: Is that, "Bit squeaky"?

BEEBE: Yes.

ASTBURY: Just explain that to us, please.

BEEBE: I think from my recollection there may have been some air leaking from around where the endotracheal tube was placed and that was what was making the noise.

ASTBURY: So by leaking, I think we've heard that the tube goes down the neck to fit as snugly as possible.

BEEBE: Yes.

ASTBURY: But there can be a bit of leakage from outwith, with air coming back up the tube, as it were, the trachea?

BEEBE: That's correct.

ASTBURY: Is that, "Bruises, right hand, chest"? And then you've queried whether that was from the compressions.

BEEBE: Yes.

ASTBURY: Presumably during her resuscitation, as we'll hear, in the early hours of that morning?

BEEBE: Mm-hm.

ASTBURY: "Abnormal blood results." Again, anything there, please, that we need to have our attention drawn to?

BEEBE: So I haven't documented when those bloods are from, which is -- so it's difficult to pass comment. Whether they were taken pre-arrest, post-arrest, I'm not sure.

Her blood count is lower than when she had bloods done 2 weeks before. Her white cell count is slightly up, platelets are actually lower, from my memory, than the last grand round sheet that I filled in, and her ALP is slightly up, and I explained that before, that's very normal.

ASTBURY: You've noted there that [Baby I] was a transfer from Liverpool Women's Hospital.

BEEBE: Yes.

ASTBURY: You made an entry again about the retinopathy, I don't think we need to go through that again. If we go scroll down, please. You have again entered a management plan.

Is that, "Discussed with surgeons"?

BEEBE: Yes.

ASTBURY: Take us through that note, please.

BEEBE: So the plan was to discuss with surgeons, I would presume at a tertiary centre because at the Countess of Chester the surgeons wouldn't have been involved in a neonate's care. I think it was to get an opinion as to whether there was anything surgical happening.

ASTBURY: Is that, "Needs urine"?

BEEBE: We needed to make sure that we monitored her urine output so we could monitor her fluid balance carefully, ie the fluids that she was receiving through the drip and then what she was excreting so we could manage her fluid balance.

ASTBURY: Right. And then, "Repeat gas and bloods"?

BEEBE: Yes.

ASTBURY: That concludes your notes in the matter, doctor. Can I ask you this: I asked if you remembered [Baby I]'s mum earlier, but do you recall [Baby I]?

BEEBE: Yes.

ASTBURY: Why do you recall [Baby I] in particular?

BEEBE: I recall [Baby I] because it was unusual that she was seemingly well and then became unwell -- in my memory, I don't know how many times it actually happened, but it felt that she was shipped out to a tertiary unit, made a rapid recovery, and was brought back very quickly, and that seemed to happen a number of times. I don't know whether my memory is correct about the number of times it happened, but it certainly stuck out in my memory because it had never happened before to a baby that I had been involved in their care in any of the other neonatal units that I had worked in.

ASTBURY: Okay. Did you -- you discovered that [Baby I], sadly, passed away on 23 October 2015?

BEEBE: Mm-hm.

ASTBURY: Do you recall your reaction to that?

BEEBE: Shock and frustration at the time because, on reflection, I... I thought there was something else going on with [Baby I] that we weren't getting to the bottom of and I was frustrated about how quickly she would bounce back in. Internally, I just felt, why didn't the tertiary centre just keep her? And I was sad because I knew the -- I remember the family and the whole situation was just very sad and frustrating.

ASTBURY: Okay. Now, by the time you came to provide your statement in this case, you were aware of the police investigation; is that right?

BEEBE: Yes.

ASTBURY: Do you recall telling the police anything about your recollection of Lucy Letby from around that time?

BEEBE: I remember discussing my recollections about Lucy Letby.

I don't remember -- it was during the time that I worked at the neonatal unit, I don't know where it was in relation to [Baby I].

ASTBURY: Okay. What did you describe to the police, can you recall?

BEEBE: So I remember Lucy in the kind of the step down from ITU/HDU rooms crying with another nurse, and I don't remember which other nurse, and it was very much on the gist of, "It's always me when it happens, my babies..."

ASTBURY: I don't want to interrupt you, sorry.

BEEBE: No, it's always... "It always happens, it's happening to me a lot", kind of thing.

ASTBURY: And who was saying that?

BEEBE: Lucy.

ASTBURY: You can't remember precisely when that was?

BEEBE: No.

ASTBURY: Are you aware whether something had just happened when that conversation was taking place?

BEEBE: I presume so, but I don't remember.

ASTBURY: Okay. Over what period were you engaged in the NNU at Chester? When did you start, when did you finish?

BEEBE: I can't remember.

ASTBURY: Just to give us an idea of when it may have been.

BEEBE: I remember I finished around December because I got married then and I was -- when I was married, I was in the neonatal unit. I was working there then, but I can't remember when I first started. I think it was the summertime of that year, but I can't remember.

ASTBURY: Okay. You know you finished in December of 2016?

BEEBE: December/January, from my memory, and I moved on to obstetrics and gynaecology.

ASTBURY: So it would have been before then?

BEEBE: Yes.

ASTBURY: Do you recall, if you can help me here, how long would the rotation have been to assist the jury?

BEEBE: This is where it get tricky. It would have been a 6-month rotation -- either a 4 or 6-month rotation, but I was less than full-time, so it's around --

ASTBURY: That's why you're struggling to --

BEEBE: Between 6 to 8 months, I think, my rotation was.

MR ASTBURY: All right. Thank you, doctor, I have no more questions, but if you could wait there, please?

MR JUSTICE GOSS: Can I just clarify something? You were in the unit for about 6 to 8 months, as you recall, because that was the rotation pattern that would go on and then you'd move to another area of specialisation?

BEEBE: Yes, when I was at the neonatal unit I was also working at the paediatric ward at the same time.

MR JUSTICE GOSS: The events that you've described we know were September/October 2015.

BEEBE: Mm-hm.

MR JUSTICE GOSS: Would you therefore have -- your recollection -- when did you get married? You'll remember that date, I expect.

BEEBE: 21 December.

MR JUSTICE GOSS: Of?

BEEBE: 2015.

MR ASTBURY: So that makes January 2016 when the doctor (overspeaking).

MR JUSTICE GOSS: Yes, exactly. It was just unclear. Just so we have clarified it. Right. So it was the 6 to 8 months leading up to about December 2015.

Cross-examination by MR MYERS

MR MYERS: Just picking up on that last thing you were staying about Ms Letby, if I could just start with that.

You described seeing her very upset on one particular occasion; is that right?

BEEBE: Yes.

MYERS: I think you told the police that, looking back, given what was happening, it seemed a pretty normal reaction to you given how upsetting it all was?

BEEBE: Yes.

MYERS: And it was difficult with [Baby I], wasn't it, because she seemed to get better, then she got worse, and then she seemed to get better and then she got worse. Is that one of the things that sticks in your memory with [Baby I]?

BEEBE: Yes.

MYERS: And you've described how she got -- I think you used the expression "shipped out" but that's probably for those in the business, but transferred to the tertiary centre, didn't she?

BEEBE: Yes.

MYERS: Then she would return and things seemed to deteriorate again; is that how you recall it?

BEEBE: That's my memory of the situation, yes.

MYERS: This isn't meant to be a memory test and there's nothing wrong with saying you can't remember things, Dr Beebe, but we have looked at events that happened on 23 August and also some events on 5 September. Those aren't matters you've dealt with now. Do you recall any particular events being drawn to your attention with regard to those dates or not?

BEEBE: No.

MYERS: It obviously pre-dates what you're dealing with now. We know that [Baby I] was taken to Liverpool Women's Hospital after the 5th and 6 September. There was an incident then. And she came back then a few days later, back to the Countess of Chester. You may well not, but let me just ask you, do you have any specific recollection of that or not?

BEEBE: Not specifically, no.

MYERS: But you do remember her going and coming back and problems continuing?

BEEBE: The problem of her going and coming back continuing, yes.

MYERS: All right, thank you.

I just want to ask you a couple of questions about the notes that you've been through for 29 September, so it's the first of the pre-grand round preparation notes, which, with Mr Murphy's assistance, was under the [Baby I] event 1 section, tile 46.

Just to have a look at a couple of the details, [Baby I], with a gestation of 27 over 40, would be classified, would you agree, as extremely preterm?

BEEBE: Yes.

MYERS: Which comes with problems of its own, doesn't it? An extremely preterm baby has some difficulties that she or he will face just by virtue of being so preterm?

BEEBE: Yes.

MYERS: Now, on the actual notes that we've got here, looking at them, we've got on the problem list, "Preterm". It also says:

"Previously treated conservatively for NEC."

That's something that happened in the past; is that right?

BEEBE: Yes.

MYERS: Where it says, "Grade 1 IVH", you explained that was a grade 1 what's called intraventricular haemorrhage?

BEEBE: Mm-hm.

MYERS: So for those whose anatomy may not be up to the speed of yours, is that in the brain?

BEEBE: Yes.

MYERS: And if you scroll down a little bit further towards the foot of the page, Mr Murphy, if you just look where the number is, we can actually see there is says R -- it's hard to read behind that, "left grade 2". Can you see that?

BEEBE: Yes.

MYERS: Is that a further reference to intraventricular haemorrhages?

BEEBE: It is, and it indicates that my entry at the top of the notes is incomplete because I've only put grade 1.

MYERS: There's no criticism for that, there's just further detail put here.

BEEBE: Mm-hm.

MYERS: So is a grade 2 intraventricular haemorrhage a little more marked than a grade 1?

BEEBE: It is, yes.

MYERS: And you said that can be encountered in preterm babies; is that right?

BEEBE: Yes.

MYERS: And can both sorts of haemorrhage be encountered in preterm babies?

BEEBE: Yes.

MYERS: Is it quite common or not?

BEEBE: It is quite common particularly with extreme preterm babies.

MYERS: Right. If we just carry on, please, on to the next page. On examination, she was settled -- you put "a little pale". That

describes her kind of colour, is that how that -- that refers to?

BEEBE: Yes.

MYERS: "Abdo full but soft."

So does that mean when you palpate it, you can feel it's a little bit resistant to your pressing? What's that based on? Let me ask that.

BEEBE: So neonates -- often the musculature of their abdomen is not fully formed, so the tummy looks protuberant, but when you feel, it's soft to the touch. It's a very normal examination finding in a preterm baby.

MYERS: You explained the blood results that we have there, which are a little abnormal but again something you might expect to find in a preterm baby?

BEEBE: Yes. You wouldn't describe them as normal but you wouldn't be kind of significantly concerned in relation to her background.

MYERS: None of this triggered any immediate clinical intervention, did it?

BEEBE: No.

MYERS: And then under "abnormal microbiology", does that identify there's a bacterium of some variety that's been identified in her or from her blood?

BEEBE: Yes. I don't know whether it was from her blood, but it was certainly... I've written "colonised", which would indicate that it was present on her skin, but I don't know whether that's true.

MYERS: Thank you for clarifying that. In any event, as you've explained, there are a number of problems you may get with a preterm baby and these are examples of that; is that right?

BEEBE: Yes.

MYERS: At this point there's no requirement for any immediate particular clinical intervention, is there?

BEEBE: No, she just needs nursing care to feed and grow.

MYERS: I think you also explained, Dr Beebe, that close observation is required because there's a potential for problems to develop; is that correct?

BEEBE: Yes.

MYERS: I think you said you have to watch them, but watch and be careful, watch and be careful? That's right?

BEEBE: Yes.

MYERS: I'm not criticising you for that, it's just so -- there's nothing happening right now but all of these things mean problems can develop; that's the point, isn't it?

BEEBE: Yes.

MYERS: Can I just ask you something about the weight gain entry. Can we scroll down, Mr Murphy? It may be on the page beforehand, I'm sorry, I didn't realise. Could we scroll up? Thank you.

We can see at this point we've got -- [Baby I]'s weight is 1.7 kilograms and it says "Centile line: 9th".

BEEBE: Mm-hm.

MYERS: Are you able to tell us, from what you have here or from your recollection, whether she was putting on weight as expected at this point?

BEEBE: It looks as though she gained, from what I've written, 75 grams in the past week, which gives her a weight gain, if my maths was correct, at 14.7 grams per kilogram per day, and the target is 15, so that would indicate that she is gaining wait at the expected rate.

MYERS: And the 9th centile -- if we imagine the lines, is the 9th centile where you would expect a baby to be in this way at this time?

BEEBE: A centile line is a baby's individual growth line, so it would be normal for her to be plotted on any of those lines as long as she was following that line.

MYERS: Right. So if a baby drops, for instance, from the 9th to the 3rd centile, that would be a significant drop if you encountered that, in weight?

BEEBE: Depending on other factors, but that would be something that you would need to look into.

MR MYERS: All right. Thank you very much, Dr Beebe.

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

Questions from THE JUDGE

MR JUSTICE GOSS: Only this, and forgive me asking this question, but your married name -- I assume it is your married name -- do you pronounce it "bee-bee" or "beeb"?

BEEBE: "Bee-bee."

MR JUSTICE GOSS: Thank you very much.

MR MYERS: I apologise --

MR JUSTICE GOSS: Out of courtesy to you, I thought I would ask you so it is pronounced correctly in future for the case.

Thank you very much for coming and giving your evidence and you are not required again.

MR ASTBURY: No.

MR JUSTICE GOSS: All right, thank you very much. You are free to go. Don't talk to anyone who's involved in this case about it until it's over. Thank you very much.

(The witness withdrew)

MR DRIVER: May I call Nurse Ashleigh Hudson, please.

(Pause)

My Lord, it seems that the staffing levels at Witness Support are challenged today and that's causing a delay, has caused a delay and will cause another five-minute delay. Once in the witness box, this witness will be here for quite some time.

MR JUSTICE GOSS: Well, shall we have our mid-morning break?

It's earlier than normal, but we might as well. If we're going to have a five-minute delay, we might as well have a ten-minute break and then we'll go through until around 1 o'clock after that.

(In the absence of the jury)

MR DRIVER: Apologies, my Lord. There may have been a breakdown in communication, but Mr Astbury assures me that he'd put a request for the witness to be ready outside this courtroom by 11

am. The usher's note suggests that the problem might be within Witness Care.

MR JUSTICE GOSS: It's all right. As I say, we're just having an earlier break than normal, but it's not going to cause any difficulty.

(11.33 am)

(A short break)

(11.43 am)

(In the presence of the jury)

MR DRIVER: May I invite the court usher to allow Ms Ashleigh Hudson to take the affirmation, please.

MS ASHLEIGH HUDSON (affirmed)

Examination-in-chief by MR DRIVER

MR DRIVER: Because everything has to be recorded, could you state your name for the record?

HUDSON: It's Ashleigh Hudson.

DRIVER: Thank you, Ms Hudson. We've heard reference to you in evidence already and we know that in September and October 2015 you were employed within the neonatal unit at the Countess of Chester Hospital; is that right?

HUDSON: Correct.

DRIVER: Could you direct your answers to the ladies and gentlemen of the jury, so project your evidence in that direction, if I may ask you to do so. In what capacity were you employed within the unit?

HUDSON: At the time I was a band 5 staff nurse.

DRIVER: Just remind us as to the degree of experience that you would have had at that point in time as a band 5 staff nurse.

HUDSON: At that point in time I'd have been qualified just over a year. I'd worked on the unit since February that year and I think I'd started my induction course in specialty, which is extra education and learning.

DRIVER: Thank you for that. So would it be fair to say, certainly compared to your level of experience now in the early part of 2023, you were at the beginning of your career --

HUDSON: Yes, I was.

DRIVER: -- (inaudible: coughing) nurse. Academically qualified, but beginning to gain direct hands-on experience?

HUDSON: Yes.

DRIVER: Thank you. As you, I know, appreciate, you've been invited here to give evidence in relation to your involvement in the cares of a baby called [Baby I].

HUDSON: Yes.

DRIVER: Can you confirm whether or not you actually remember the patient [Baby I]?

HUDSON: Yes, I do remember [Baby I].

DRIVER: We've heard, and does this accord with your memory, that [Baby I] was a baby who was within the unit for quite a long time?

HUDSON: Yes.

DRIVER: And also a baby who had spells at different hospitals, at tertiary centres, and then returned to Chester at intervals?

HUDSON: Yes, she did.

DRIVER: Just to remind us all, if I may, my Lord, [Baby I], born on 7 August, transferred into Chester on 18 August, transferred back to the Liverpool Women's Hospital on 6 September, before returning to the Countess 7 days later on 13 September. It's the period after that that I'm going to ask you to give evidence about.

We have copies of the nursing records and some charts and the like and they'll appear on the screen to your right. Do you recall, Nurse Hudson, that on a number of different days and nights you were the designated nurse given responsibility for the care of [Baby I]?

HUDSON: Yes, I was.

DRIVER: Does it follow from that that she was a baby with whom you were very familiar?

HUDSON: Yes, I was.

DRIVER: We'll begin, if we may, with our electronic presentation of what we describe as event 1, please, Mr Murphy.

If we could just go to tile 90 for a moment to remind ourselves that [Baby I] suffered a significant event at 19.30 hours on Wednesday, 30 September 2015.

Nurse Hudson, we're going to look at some documents now, which tend to suggest that you were on duty and you were looking after [Baby I] the following day. So that's where I'm going to take you to now, if I may, and if Mr Murphy could go to tile 196, please, we'll see your name there.

HUDSON: Yes.

DRIVER: You can see, to the left of the screen, that the records suggest that handover of responsibility came in your direction on the morning of Thursday, 1 October.

HUDSON: Yes.

DRIVER: And we understand, can you confirm, that as part of your responsibilities in looking after babies you would input summaries into the nursing notes to keep a record --

HUDSON: Yes.

DRIVER: -- of how things had gone on a day-to-day basis? So that's what we'll look at first.

If we could click behind that tile, please. We can see your initials, can we?

HUDSON: Yes.

DRIVER: We know that the time and date stamp alongside those initials are computerised, computer-generated.

HUDSON: Yes.

DRIVER: And we know that very often, nurses enter retrospective notes, reviewing what had gone on in the hours --

HUDSON: Yes, that's correct.

DRIVER: -- before, a summary, as it were.

Could we just look at your summary as entered at 13.36 but a summary for the cares taken over earlier that morning, as we saw

a moment or two ago, 7.30, the long day shift. We know from previous witnesses that the protocol is to check all the equipment and the like and you make a note of having done all of that.

HUDSON: Yes.

DRIVER: Then if we look at your summary of baby [Baby I]'s condition, the third line down, do you record in summary form that her observations were satisfactory?

HUDSON: Yes.

DRIVER: And you would have charted the particular observations at regular time intervals?

HUDSON: Yes.

DRIVER: But this is a sweeping retrospective summary?

HUDSON: Yes.

DRIVER: Temperature stability was good?

HUDSON: Yes.

DRIVER: You noted that [Baby I] appears pale but pink and well perfused?

HUDSON: Yes.

DRIVER: We'll look at further references that you make at different times as to [Baby I]'s pallor. Knowing her as you did, are you able to remember whether or not she was a baby who tended to present a little more pale than other babies or not?

HUDSON: From what I recall, yes, she was. It's quite common for preterms, even later on, to be a bit pale. They might be kind of borderline anaemic, but I've also documented that she's pink and she's well perfused, which means that despite being pale, circulatory-wise she appeared to be well.

DRIVER: Thank you. You make reference to the method and the form of some sustenance being provided to her there.

HUDSON: Yes.

DRIVER: It was all working fine. A VIP, a VIP score, can you just remind us what that is?

HUDSON: A VIP score is an assessment of the site of where a line has been sited, so you're assessing the colour, you're assessing to see if there's any oedema, you're making sure that the line remains where it should be, and that it's functioning properly, and that it hasn't caused any damage to the surrounding tissue.

DRIVER: Thank you. That was all okay?

HUDSON: Yes.

DRIVER: A zero scores one hopes for, I imagine?

HUDSON: Yes.

DRIVER: The next, "Pressures low with optimal positioning".

Pressures of?

HUDSON: On my IV chart it should say the specific pressures.

Ideally, you're aiming -- I think for a cannula, we used to aim for a certain number below 150. "With optimal positioning", that's just in reference to babies move around quite a lot and sometimes if they're in a different position the pressures might spike higher for a short period but that has obviously been corrected by repositioning.

DRIVER: So that's a reference back to the cannulas?

HUDSON: Yes.

DRIVER: Thank you. Was she give some antibiotics intravenously?

HUDSON: Yes.

DRIVER: And her systems were working well in the sense that she was passing urine but her bowels had not opened there at this point. So that's a note that we can see you made 13.36 in the afternoon reflecting upon what you'd observed that morning.

HUDSON: Yes.

DRIVER: Then, later, immediately below, you have made another note at 19.48 at the end of your shift or thereabouts.

Does it follow that this note reflects observations and the like made in the afternoon and into the evening?

HUDSON: Yes.

DRIVER: Thank you. So the second phase of your shift --

HUDSON: Yes.

DRIVER: -- as it were? And comparing the two, what, if any, were the developments with [Baby I] from morning/lunchtime, on the one hand, to afternoon/evening on the other?

HUDSON: By my notes I can see that she's actually remained stable. Her abdomen appeared to be less distended and much softer, which is why I put "Query [the question mark] start cautiously feeding". So we would -- like I said, the SHO -- I had asked them to come and review to see whether we could do that, they'd then go and speak to a senior doctor to make that plan. I have taken a CRP which is a blood test to repeat, which checks for infection, and we were just awaiting the result at the time.

DRIVER: So we know that there was an event prior to your shift.

You inherited whatever problems might have still been persisting, but is it fair to infer from this that she seemed to be improving --

HUDSON: Yes.

DRIVER: -- and her stability seemed to be increasing?

HUDSON: Yes.

DRIVER: And was she nil by mouth and you questioned whether she can return to feeding in the traditional sense?

HUDSON: Yes.

DRIVER: Thank you. Just one last feature of this day.

Mr Murphy, if we could go to tile 197, please. The format of the chart is well familiar to you, I'm sure.

Date, 1 October. If you just allow Nurse Hudson to look at the bottom of the sheet to satisfy herself where her initials begin and end.

HUDSON: Yes, I can see.

DRIVER: We can see a bank of your AHs there, can't we --

HUDSON: Yes.

DRIVER: -- towards the left? If we go back to the top to see what time they correspond to, and predictably they are through the morning into the early evening of that date.

Does it follow from what we can see there that the regime post the event on 30 September was for two-hourly observations?

HUDSON: Yes.

DRIVER: And looking at that bank of observations for heart rate on your shift, any views as to the heart rate?

HUDSON: It appears to be fairly stable. There's a little bit more fluctuation from around 6 pm, but the heart rate still seems to be within acceptable limits for a baby of that age.

DRIVER: Thank you. Respiration?

HUDSON: Again, respiration is slightly varied, which is normal, again within satisfactory range for a baby of that age.

DRIVER: Temperature?

HUDSON: Same as the others, quite stable. There is -- towards the end of the shift, I think I've increased the incubator temperature because her temperature had dipped slightly, which isn't unusual, but it seems to have responded well after that increase.

DRIVER: Having said that, we can see that the temperature -- thank you, Mr Murphy, where we are. We can see that the temperature there -- is that [Baby I]'s temperature or the equipment temperature?

HUDSON: So if you look, it says "Cot/inc temperature". That's the equipment temperature and there is a little arrow that points upwards, which indicates I have increased it from 31.7 to 32 degrees.

DRIVER: Thank you. It's entirely my fault, I should have told you, there should be -- I think there is -- a mouse there that has a cursor. If and when you ever want to take our attention to a specific detail, please feel free to do so. You don't have to, it's entirely a matter for you.

You've identified that arrow and that's where you've adjusted upwards?

HUDSON: Yes.

DRIVER: Anything else in this bottom part of this obs chart that is noteworthy or exceptional in any way?

HUDSON: Nothing that stands out. Her oxygen saturation levels appear to be very stable, documented as 98 to 100%, which is optimal, really, and that's in room air without any additional oxygen.

DRIVER: That's all I wanted to ask you about for that day, 1 October.

As you've indicated, you were [Baby I]'s designated nurse on several days during this time period.

HUDSON: Yes.

DRIVER: It's a matter of record, not controversial in any way.

We know that you were her designated nurse on 1 October, on 7 October, doing a long day shift --

HUDSON: Yes.

DRIVER: -- and then on the night shifts that begin on 10 October, 11 October and 12 October.

HUDSON: Yes.

DRIVER: It's that time period that we're now going to consider.

Mr Murphy, if you could take us to the next sequence of events for [Baby I], please.

You will see there from the second tile, Nurse Hudson, the date this presentation begins is effectively 5 October onwards, but I'm going to take you, please, to tile 31 and the fact that nursing shift handover and baby allocation commenced, as we know, always around 7.30/8 o'clock in the evening, and that your nursing notes, although made later, were referable to this period in time.

In fact, forgive me, can we go back, please, to tile 6? Thank you. Click behind that, please. In the top right, I think we can see your initials, AH?

HUDSON: Yes.

DRIVER: And if we can just zoom in on those entries in the top right quarter of the page, please. Thank you.

This is again your summary, now for cares taken over in the evening, for the night shift of 11 October.

HUDSON: Yes.

DRIVER: All the equipment was checked as per the protocols. In summary, you record that [Baby I] at this point in time was stable?

HUDSON: Yes.

DRIVER: In a word, tolerating feeds, soft abdomen, which is what one hopes for --

HUDSON: Yes.

DRIVER: -- in a premature baby? "Slightly distended", it says, "as normal". Can we read into that, as normal for [Baby I]?

HUDSON: Yes.

DRIVER: Thank you. She was passing urine and her bowels were opening. That's your entry a little after midnight, halfway or so through your shift. Then later, getting towards the end of your shift, nothing to report --

HUDSON: Yes.

DRIVER: -- in effect? So as we were, no change, no concerns, stable?

HUDSON: Yes.

DRIVER: If we go to tile 8, please, and click behind it. We are still in this shift. Do you record on the feeding chart -- are they your initials there?

HUDSON: My signature.

DRIVER: Your signature, forgive me. Quite right. Are they your signatures there?

HUDSON: Yes, the top two at 1.30 and 5.30.

DRIVER: And in short, does that evidence that [Baby I] was taking a bottle?

HUDSON: Yes.

DRIVER: And as you summarise, urine and faeces were passing through --

HUDSON: Yes.

DRIVER: -- as one would hope?

Tile 13 tells us that you handed over care on the next shift to your colleague, Vicky Blamire. I won't take you through hers notes but then we'll go to where I went to too early and tiles 31 and 32, please, which is the next shift.

Nurse Blamire does the long day and you come back to do a second consecutive set of nights?

HUDSON: Yes.

DRIVER: Could we click on, please, Mr Murphy, behind tile 32.

Thank you.

As part of receiving a baby and familiarising yourself with what, if anything, had happened with that baby in your absence, would you have read the notes of Vicky Blamire in this instance?

HUDSON: Yes.

DRIVER: If we can look at Ms Blamire's notes. They may be at the bottom there, then up to the top corner, top right, I think. Did anything exceptional happen with or to [Baby I] on the day shift that fell between your two consecutive night shifts?

HUDSON: Nothing in particular, no.

DRIVER: Nurse Blamire noted that in the early evening she was straining a lot after her feed; is that an exceptional presentation?

HUDSON: Yes.

DRIVER: It is? That is noteworthy?

HUDSON: Not exceptional, sorry. It is very, very normal for extremely preterm babies to strain to open their bowels.

DRIVER: Thank you. Nurse Blamire noted that:

"[Baby I] looked pale this evening. Tummy looks full but soft to touch. Routine bloods reviewed. Hb only 7 [as read]."

What does that inform the reader?

HUDSON: It means that her haemoglobin level was 70 (sic), so was already knowingly anaemic. I think Vicky is kind of tying the two, looking a bit pale and being anaemic, together. It is something that we'd expect of a baby of this age, but if behaviourally they are stable, medically they are stable, we wouldn't treat it at that time.

DRIVER: Thank you. We know that [Baby I] was in a cot in nursery 2 at this point. Does that accord with your memory?

HUDSON: Yes.

DRIVER: That she was a special care baby?

HUDSON: Yes.

DRIVER: And could you describe, in just a few words, the nature of that designation of special care baby?

HUDSON: Yes. So it's the last stage that a baby -- as kind of care intensity, it's the last stage of that before they go home. So lots maybe might start in ITU, intensive care, high dependency, and then special care. And special care is usually the longest period of care for these babies, but it's the last stage before going home.

So they are generally stable and not needing a high intensity of care.

MR JUSTICE GOSS: You're speaking quite softly now.

Could you please try and keep your voice up? It's difficult sometimes to hear.

HUDSON: Yes, apologies.

MR JUSTICE GOSS: Thank you.

MR DRIVER: So the primary aim, was it, was to feed her up, to enable her to grow, so she'd be ready to go home?

HUDSON: Yes.

DRIVER: In a folder, I think it's the one nearest me, that black folder, behind divider 12, there are some paper documents that everybody else has. Thank you. There are two sets, one should have a number 1 in the right corner, the other behind it should have the number 2 in the right corner.

HUDSON: Yes.

DRIVER: If you could move to the number 2 bundle and perhaps extract it from the file because it's held together with treasury tags, I hope. Thank you.

Can you see your initials down to the bottom of the front page?

HUDSON: Yes.

DRIVER: The first page. Thank you. This is an observation chart. There is some information missing here, so if we can just help ourselves fill in the blanks, as it were. We can see on the date line at the top we have 9 October.

HUDSON: Yes.

DRIVER: I won't repeat this for every day, but we can see the obs were taken at 01, 05, 09, 12, 16, 21 there.

HUDSON: Yes.

DRIVER: On 10 October at intervals between 0100 and 2100 hours.

11 October, as recorded there at 01, 05, 07, 09, 13, 17, 21.

HUDSON: Yes.

DRIVER: After which there isn't a date, but the next time is 09, so does it follow that the last observation taken on 11 October, last recorded observation, was at 21.00 hours?

HUDSON: Yes.

DRIVER: And the next one must be the next day or is that wrong?

HUDSON: I would assume so.

DRIVER: Because if we look at the next set of entries, it says 09, 13, 17, 21.

HUDSON: Yes.

DRIVER: Are you with me?

HUDSON: Yes.

DRIVER: They look like a set of observations taken through the course of the day, doesn't it?

HUDSON: Yes.

DRIVER: Does it follow then that in all probability the last recorded observation on 11 October is that recorded at 21?

HUDSON: Yes, it appears so.

DRIVER: And the first observation for the next day, that is 12 October, was that recorded at 09?

HUDSON: Yes.

DRIVER: 09, 13, 17, 21. Then the last entry on this page is recorded at a time of 01.

HUDSON: Yes.

DRIVER: And would it follow that that -- we've then moved from the 12th into the 13th October?

HUDSON: Yes.

DRIVER: And if we just look at the bottom to see where your initials feature. So just to the right of centre, there appears to be, am I right, four AHs --

HUDSON: Yes.

DRIVER: -- at the bottom of the page? If we look up, they correspond to entries on 11 October.

HUDSON: Yes.

DRIVER: Then to the far right of the page there appears to be, is this right, can you confirm, I know it's a little obscured by a stamp that's been put on to this page, there appear to be two AHs towards the right?

HUDSON: Yes.

DRIVER: And if we run our eye up the page, that would correspond to entries recorded at 21, ie --

HUDSON: Yes.

DRIVER: -- 9 pm --

HUDSON: Yes.

DRIVER: -- on 12 October? And 01 must be the 13th?

HUDSON: Yes.

DRIVER: For the sake of completeness, if we turn the page, we don't see any of your initials at the bottom there, so I won't ask you about them.

So in terms of the observation regime in relation to [Baby I] during your shifts, firstly on 11 October, how often were you intending to record observations in relation to [Baby I]?

HUDSON: Every 4 hours.

DRIVER: But if we look at the last AH in that bank of four at the bottom, and we go up the column, we can see some handwriting, which, if we rotate the page, seems to read "temp check only"?

HUDSON: Yes.

DRIVER: It must be very obvious to you, but can you explain to us why we have that and why we have a lack of data on the top upper part of the page?

HUDSON: I don't recall why, but I think a decision had been made, potentially because she was very stable and gearing up for home, to stop doing continuous monitoring observations, which is why there's a little line following the heart rate and respiratory rate that's been documented at 21.25 on the 10th. After that the only purpose was to just her check temperature because she remained on a hot cot at that time.

DRIVER: Thank you. Does that fit with a protocol that you're familiar with that there is a -- that is applied to special care babies reaching a certain stage --

HUDSON: Yes.

DRIVER: -- of their progress?

HUDSON: Usually, yes, if they're stable.

DRIVER: Thank you. Just one more detail on this page you can help us with before we move on. If we look to the left of the page, it says "heart rate", "respiration", "temperature", if we keep going down, the cot temperature, you took us to earlier. The bottom two handwritten entries, the first one seems to read "probe"; is that right?

HUDSON: Yes.

DRIVER: Are you able to help us with the entry below?

HUDSON: "Position."

DRIVER: Position. Let's deal with that first, position.

Is that literally the baby's position?

HUDSON: Yes.

DRIVER: You tell us, why is an entry -- position, what does that denote?

HUDSON: That we've changed the position, the baby's not remained in the same position throughout the shift, so generally speaking it ties in with when they've had cares, so a nappy change or if they've had a bottle feed, and they'll have come out of the cot and then gone back into it.

DRIVER: Is that so the same part of the skin isn't up against the hot cot?

HUDSON: Essentially yes, although at this age it's not quite as strict as when they're younger because we do try and nurse them on their back, with their feet to the bottom of the cot, to prepare them for safe sleeping at home.

It's something that tends to carry on throughout their stay, but it is much more important earlier on when their skin is very fragile and they'll be nursed on their side, on their back and on their front.

DRIVER: But can I take from what you've just said at this stage of progress, development, you try to put them in the traditional position --

HUDSON: Yes.

DRIVER: -- head at the top, feet --

HUDSON: Yes.

DRIVER: -- pointing down, preparing them for life in that way?

What about "probe"?

HUDSON: Probe is changing the limb the probe is in situ on. It might be on one foot and then when you do nappies and cares you'll change it to another foot so it's not in contact with the same patch of skin for too long.

DRIVER: Thank you. We can see there are gaps in that line, that row, some of which correspond with your initials.

If we look to the right of centre, do you see that?

HUDSON: Yes.

DRIVER: Then, immediately after your responsibility was handed to -- it looks like a KB --

HUDSON: Yes.

DRIVER: KB has made entries but they're not ticks, they're just dashes --

HUDSON: Yes.

DRIVER: -- it would seem. Then there's a tick that might have been squiggled out.

HUDSON: Yes, because the -- at that point the probe's been removed because it's the probe that monitors the continuous heart rate, saturations and respiratory rate at times. So because we are only doing temp checks the probe is no longer in situ.

DRIVER: Is this another feature of downscaling the amount of observations that were being applied --

HUDSON: Yes.

DRIVER: -- to [Baby I]? We understand what a probe would be and you've explained it. That's physically attached to the baby?

HUDSON: Yes.

DRIVER: Once that's removed, is there any other -- was there any other, for [Baby I] at this stage, electronic/technical monitoring of the baby or was that it, she's just detached?

HUDSON: Yes, back then we used apnoea monitors, so this was a monitor that was taped to the abdomen and what it did was it recorded breaths and if there was a period of time longer than 20 seconds where the baby didn't breathe, the apnoea monitor would sound and alert staff to say there was a problem.

DRIVER: Right. So the degree of monitoring had been reduced but hadn't yet reached a stage where there was none at all?

HUDSON: Yes.

DRIVER: There was this apnoea monitor?

HUDSON: Yes.

DRIVER: And that was purely motion sensitive --

HUDSON: Yes.

DRIVER: -- was it?

HUDSON: Yes.

DRIVER: Thank you. Whilst we've got the paper out, if we could turn through the two observation charts, the third page there is an intensive care chart; is that right?

HUDSON: Yes.

DRIVER: Again, a different format, but we can see from the right side of the page it applies to 13 October, so the same time period?

HUDSON: Yes.

DRIVER: We can see an absence of any AH initials there.

HUDSON: Yes.

DRIVER: Equally, we see an absence of any entries for the time/hours 01, 02, 03. Can you explain that to us?

Is that in keeping with the reducing regime?

HUDSON: Well, this isn't because this is an intensive care chart on the 13th, I imagine this was commenced after the collapse --

DRIVER: Right. Thank you.

HUDSON: -- which is why we've moved from one chart to another.

So the initial period from 1 to 3 would have been on a different chart.

DRIVER: If I can remind us all, it's not controversial, that the collapse is first timed at 03.20 hours, and that would be consistent with the answer you have just given us, pre-collapse, not subject to this sort of regime, post-collapse, 04.20 onwards --

HUDSON: Yes.

DRIVER: -- she was.

Over the page, please. Again, consistent with that, no checks for the periods 01, 02, 03, 04, but they seem to begin and are comprehensively entered after that point in time --

HUDSON: Yes.

DRIVER: -- but not under your watch as it were?

HUDSON: No.

DRIVER: Because, can you remember, post the collapse, responsibility, and we'll come to the collapse in a moment, but responsibility for [Baby I] was transferred away from you to your colleague, Nurse Letby?

HUDSON: Yes, that's correct.

DRIVER: Let's just finish going through the paperwork. Then we'll put it away.

Next, the blood gas record. Again, this document appears to start at just after 4 am on 13 October.

There's therefore no entries from you. Would you have been taking blood gas -- blood for gas analysis from [Baby I] pre-collapse?

HUDSON: Yes, if it was required and I was her named nurse.

DRIVER: We'll look to see whether there is a corresponding sheet, I don't think there are any entries, but we'll double-check that.

Then next, feeding chart. We've already seen this, a version of this page, I think, so on 12 October, the previous night shift, as it were, bottles from you at 01.30 and 05.30?

HUDSON: Yes.

DRIVER: Then over the page, 13 October, we can see an entry at 01.30?

HUDSON: Yes.

DRIVER: Feeding type?

HUDSON: Bottle.

DRIVER: That's a bottle again. Amount?

HUDSON: 55ml.

DRIVER: Thanks. The route was a bottle and expressed breast milk, that was what I was struggling to remember. But no signature, but notwithstanding the absence of a signature, can you say whether that's your writing or not?

HUDSON: That is my writing.

DRIVER: That's you. You gave [Baby I] at 01.30 on 13 October -- it just so happens you didn't sign it off. Finally, over the page, we have a neonatal unit fluid balance chart.

Are they your initials at the bottom of the first four entries?

HUDSON: No.

DRIVER: That's not you. Then I won't trouble you any further with that.

So if we could put the paperwork away for a moment, please, Nurse Hudson. Then if we go back to our screen and scroll down. We can see nursing notes made by you at a time of -- a computer timestamp of 05.04; yes?

HUDSON: Yes.

DRIVER: Which follows the familiar process of written in retrospect for cares taken over at 19.45, checking the equipment. She was self-ventilating in air at handover, she was breathing for herself, she was on a hot cot.

And you record that she was demanding and tolerating four-hourly feeds?

HUDSON: Yes.

DRIVER: A hearty sign?

HUDSON: Yes.

DRIVER: She was feeding well, alert when awake, pale pink in colour but well perfused?

HUDSON: Yes.

DRIVER: So again, is that a variation on what we'd seen earlier?

HUDSON: Yes.

DRIVER: Pale-ish?

HUDSON: Yes.

DRIVER: That's the way she was?

HUDSON: Yes.

DRIVER: But well perfused, which is a counterindication?

HUDSON: Yes.

DRIVER: We can see there's an entry at 03.22. If we could turn the screen off for a moment because, first, I'd like to ask you what you recall about the events immediately before the collapse that you noted there.

Do you have a living memory of the events in the early hours of that morning?

HUDSON: Yes, I do.

DRIVER: At that stage was [Baby I] still in nursery 2?

HUDSON: Yes.

DRIVER: You were her -- I think we're both being told off for talking too quietly.

MR JUSTICE GOSS: Yes. It is important that you do keep your voice up. One of the difficulties is instinctively you speak towards the person who's asking you questions, but if you could imagine you're actually speaking to the jury, the back row of the jury, they've got to hear what you're saying.

HUDSON: Okay.

MR JUSTICE GOSS: Thank you very much. So you have a memory of the events --

HUDSON: I do, yes.

MR JUSTICE GOSS: -- leading up to this event on the morning of 13 October?

MR DRIVER: And we have established that you were [Baby I]'s designated nurse at this point in time?

HUDSON: Yes.

DRIVER: And she was in nursery 2?

HUDSON: Yes, she was.

DRIVER: Do you recall whether or not there were other babies in nursery 2 at this time?

HUDSON: I think, from what I'd written in my statement, there was one other baby in the room that night.

DRIVER: Do you recall whether or not you were the designated nurse for that baby?

HUDSON: I don't recall.

DRIVER: Do you recall whether or not there was another nurse giving care to that other baby in that room in the first part of your night shift?

HUDSON: I don't recall.

DRIVER: Do you recall [Baby I] pre-collapse?

HUDSON: Yes, I do.

DRIVER: How was [Baby I] under your care pre-collapse?

HUDSON: My perspective was that she was in good clinical condition, she was behaving appropriately for her age, behaviourally she seemed very stable, her temperature had been very stable, and the fact that she was waking and cueing for feeds herself was really encouraging at the time. There had been discussions, I think, around that time about discharge planning, although she wasn't quite ready, that it would be happening within the next couple of weeks, so our perception was that she was very stable at the time.

DRIVER: I'm going to jump forward a little for a moment before returning. We know that there came a time in the early hours of this morning when there was an emergency.

HUDSON: Yes.

DRIVER: Where were you when you first realised that there was a crisis?

HUDSON: I was in the nursery at the time.

DRIVER: I'm now going to ask you about the period for about half an hour or so prior to that.

HUDSON: Yes.

DRIVER: During that period did you remain in nursery 2 constantly or did you at some point leave nursery 2?

HUDSON: No, I left nursery 2 to assist with a procedure in nursery 1 and then asked one of my colleagues, I don't recall who, to observe [Baby I] and listen out for her while I was away for that time period.

DRIVER: How long before you first became aware that there was a crisis was it when you left nursery 2? How long were you away for?

HUDSON: I think I was away for about 15 minutes. It was a relatively simple procedure on a different patient and then I became aware that there was an issue after I'd come back into [Baby I]'s nursery, nursery 2.

DRIVER: Thank you. Before we focus on that, can you recall the colleague that you assisted with a relatively simple procedure?

HUDSON: Yes, it was Laura Eagles.

DRIVER: Was that assistance done at her request, at the direction of supervisors, or did you volunteer to assist?

HUDSON: From what I recall, she'd requested help and I volunteered out of the few nursing staff that were around at that time.

DRIVER: In which room did that procedure take place?

HUDSON: Nursery 1.

DRIVER: You've given us your assessment of [Baby I]'s general condition and well-being at this point in time.

HUDSON: Yes.

DRIVER: Does that assessment apply to the point in time at which you left nursery 2 to go and help your colleague in nursery 1?

HUDSON: Yes.

DRIVER: Would you have left [Baby I] if she'd been unsettled?

HUDSON: No.

DRIVER: Do you recall asking a colleague to keep an eye on [Baby I]?

HUDSON: Yes.

DRIVER: Do you recall which colleague?

HUDSON: No. I recall that there were two of my colleagues around the area and by the desk at the time, but I don't recall whether I directed it to one of them in particular or just asked in general.

DRIVER: Does it follow from that that the colleague who you asked to keep an eye on [Baby I] was at the desk?

HUDSON: Yes.

DRIVER: Who were the two colleagues at the desk, can you remember?

HUDSON: Lucy Letby and Caroline Oakley.

DRIVER: Did you go to assist Laura Eagles?

HUDSON: Yes.

DRIVER: You've told us it was a relatively simple procedure.

Was it a lengthy procedure?

HUDSON: Not particularly, no.

DRIVER: About how long did it take to perform or assist in the performance of that procedure?

HUDSON: I think it was roughly around 15 minutes.

DRIVER: Having completed that, what did you do next?

HUDSON: I left nursery 1 and went to the milk room, which is past the nurseries -- you have to walk past nurseries 2 to 4. The milk room is a separate room within the unit where we kept expressed breast milk at the time, along with bottles, teats, sterilisation equipment, things like that.

DRIVER: Did you go to fetch milk?

HUDSON: Yes. From what I recall, she wasn't due a feed at that time. There was one more feed due that evening and generally speaking you prepare milk for the next shift and that might include defrosting a new batch for the next person to use.

DRIVER: When you say she wasn't due a feed, which baby?

HUDSON: [Baby I].

DRIVER: So does it follow that you went to the milk room to fetch expressed breast milk with the intention of having it at hand to feed [Baby I]?

HUDSON: Yes.

DRIVER: So the procedure in nursery 1 wouldn't have taken more than 15 minutes?

HUDSON: No.

DRIVER: The journey from nursery 1 to the milk room?

HUDSON: Maybe 20 seconds, if that.

DRIVER: The process of collecting the milk from the fridge?

HUDSON: Again, seconds.

DRIVER: The refrigerated milk was cold, one imagines?

HUDSON: Yes.

DRIVER: What's the next step?

HUDSON: If you're warming up the milk, you would decant it into another feeding bottle and warm it up. That takes -- the amount of time it takes to warm depends on the amount. Defrosting takes a bit longer but that happens in the nursery.

DRIVER: Right. My next question. So the decanting, does that take place in the milk room or the nursery?

HUDSON: It can take place in either.

DRIVER: On this occasion, can you remember?

HUDSON: I did it in the nursery.

DRIVER: Does it follow that you simply took refrigerated milk from the milk room and took it to the nursery?

HUDSON: Yes.

DRIVER: Which nursery?

HUDSON: Nursery 2.

DRIVER: To do so, did you have to walk past the place that you told us earlier your colleagues were sitting when you asked one of them to keep an eye on [Baby I]?

HUDSON: Yes.

DRIVER: Was anybody there?

HUDSON: I think so, but I can't recall who.

DRIVER: Did you enter nursery 2?

HUDSON: Yes.

DRIVER: Was anybody there?

HUDSON: No.

DRIVER: The babies were there?

HUDSON: Yes, the babies were there.

DRIVER: No colleagues?

HUDSON: No.

DRIVER: What did you do next?

HUDSON: From what I recall, I was preparing the milk, either for warming or defrosting, on the worktop, which was to the left of [Baby I].

DRIVER: When preparing the milk on that worktop, would you have been facing [Baby I], side on to [Baby I], or back to [Baby I]?

HUDSON: Back to [Baby I].

DRIVER: What happened next?

HUDSON: Um... I was preparing the milk. I can't remember at what point in time, Lucy was standing in the doorway, and we were talking. I don't remember the content of the conversation. But she then pointed out from where she was that she thought that [Baby I] looked pale.

DRIVER: Pause there, please. Lucy being Lucy Letby; is that correct?

HUDSON: Yes.

DRIVER: From the position she was at when she made mention of this to you, how far away from [Baby I]'s cot was Lucy Letby about?

HUDSON: I think about 5 or 6 feet.

DRIVER: Would you care to point to something in this room that's about the same distance from you?

HUDSON: Um...

DRIVER: About.

HUDSON: I'd imagine potentially where your colleague is sat here (indicating) --

DRIVER: Thank you.

HUDSON: -- if the cot was where this desk is.

MR JUSTICE GOSS: Just to be clear, you're pointing to the clerk sitting in front of me?

HUDSON: Yes.

MR JUSTICE GOSS: And the cot is the desk in front of you there?

HUDSON: Yes.

MR JUSTICE GOSS: All right. You can see that distance.

MR DRIVER: How far from the doorway into nursery 2 was Ms Letby when she made this comment or remark?

HUDSON: She was in the doorway.

DRIVER: What was her words, can you remember?

HUDSON: It was something along the lines of, "[Baby I] looks pale", or, "Don't you think [Baby I] looks pale?"

DRIVER: Pause there. Before Ms Letby said those words or words similar to them, had you examined [Baby I] since your return from nursery 1 and the milk room?

HUDSON: No.

DRIVER: What was the lighting like in nursery 2 at this point in time?

HUDSON: The main light for the room was switched off, but the light that was on the corridor where the nursing desk was situated was on, so you were able to do things in the room and have enough light to kind of see where your patients were situated and where your equipment was.

DRIVER: So lights dimmed or off in nursery 2?

HUDSON: Off.

DRIVER: Lights on in the corridor?

HUDSON: Yes.

DRIVER: And the window dividing nursery 2 to the corridor --

HUDSON: Yes.

DRIVER: -- a clear window?

HUDSON: Yes. I think from what I recall, there was, on the lower half of the window, maybe just some copies of guidelines or policies, but it didn't obscure much of the light at the time.

DRIVER: We've seen in some images, just so there's no confusion, glass within the neonatal unit that has some murals, some pictures painted on. It's not one of those windows?

HUDSON: No.

DRIVER: [Baby I] was in a cot, we know.

HUDSON: Yes.

DRIVER: A hot cot with a hot mattress?

HUDSON: Yes.

DRIVER: What, if any, other features had been applied to that cot at that time?

HUDSON: There was a canopy over the cot, quite commonly used in preterm babies when we transition them from an incubator. It looks almost like a tent over the top.

It's supported by a piece of -- a bar which comes with the cot itself. It's part of the kind of manufactured final product. What it does is it just obscures the light from the baby's face so if we do switch on the lights for any reason hopefully it doesn't disturb them, doesn't disturb their sleep, and therefore their neurological development.

DRIVER: Thank you. Pause there. Does that canopy cover all of the cot or part of the cot?

HUDSON: It covers about half of the cot.

DRIVER: Does it cover the upper part or the lower part?

HUDSON: The upper part.

DRIVER: You told us earlier when we were considering the position data on the chart how babies of this stage of development are placed in the traditional position --

HUDSON: Usually, yes.

DRIVER: -- in a cot, head to the top feet pointing towards the bottom. Was [Baby I] in that position at this point in time?

HUDSON: Yes.

DRIVER: The canopy that covers the upper part of the cot, how does the length of that canopy compare to the length of [Baby I]?

HUDSON: I think... From where she was situated, it covered about halfway down the length of [Baby I]. If I recall at the time we were still using nests, which is a rolled-up towel or blanket, which is within the cot and the baby is situated within that to ensure they feel contained and comfortable. So she wouldn't have been right with her feet at the bottom of the cot, but she would have been more central with her bottom half enclosed by this barrier.

DRIVER: Right. Could you help us understand this nest a little more? Is that cushioning or --

HUDSON: It's usually a rolled-up couple of towels, sometimes we'd have nests that were premade. What it does is it creates a short boundary around the sides, usually in the bottom half of the baby, which helps to keep them contained and, like I said, it makes them feel safe, secure, and it supports muscular skeletal development essentially.

DRIVER: In any event, you told us that the length of the canopy would reach to about half of the length of [Baby I] --

HUDSON: Yes.

DRIVER: -- as she was lying in that cot at this time --

HUDSON: Yes.

DRIVER: -- on this morning? I know it may be an obvious answer I'd invite you to give, would that be her top half or her bottom half?

HUDSON: Covering her top half.

DRIVER: When you left [Baby I], was there any blanketing at all or were you relying upon the hot cot to keep her warm?

HUDSON: No, there were blankets in place.

DRIVER: Again forgive me for inviting what might be an obvious answer, were those blankets over or under the baby or both?

HUDSON: They were over [Baby I].

DRIVER: Having received this information or this query from Lucy Letby, what did you do next?

HUDSON: I looked towards [Baby I]. I couldn't see her. I could see that she was in the cot, but I couldn't see the top half of her because it was obscured by the lighting and the canopy, so I turned back round and the switched the main light on in that nursery to get a proper look at her.

MR JUSTICE GOSS: Voice up.

HUDSON: Yes.

MR JUSTICE GOSS: So you switched the main light on?

HUDSON: Yes.

MR JUSTICE GOSS: Otherwise you couldn't see her?

HUDSON: Yes.

MR JUSTICE GOSS: Right.

MR DRIVER: At that point when you first looked at [Baby I], who was closer to [Baby I], you or Lucy Letby?

HUDSON: Me.

DRIVER: Was there anything about the circumstances of the layout or the lighting within that room that would have afforded Lucy Letby a better view of the baby than the one you had?

HUDSON: No.

DRIVER: What happened next?

HUDSON: After switching the light on, I immediately went to [Baby I], pushed back the canopy and peeled back the blankets to have a proper look at her to assess her, and that's when I recognised that she was in quite poor condition.

DRIVER: Pause there. We'll come back to that in a moment.

Are you able to carry on?

HUDSON: Yes.

DRIVER: Did you at a much, much later date return to that nursery with a police officer and a scenes of crime officer?

HUDSON: Yes.

DRIVER: And did you witness the taking of some photographs?

HUDSON: Yes, I did.

DRIVER: As part of that process, did you, as best you could recall, ensure that a cot was placed in the position of [Baby I]'s cot?

HUDSON: Yes.

DRIVER: Did you, as best you could, ensure that the structure of that cot and the fittings as closely resembled [Baby I]'s cot as you could recall?

HUDSON: Yes.

DRIVER: And were you present when a number of photographs were taken?

HUDSON: Yes, I was.

DRIVER: Were those photographs taken with varying lighting --

HUDSON: Yes, they were.

DRIVER: -- various degrees of illumination?

HUDSON: Yes.

DRIVER: And were you later shown a number of photographs?

HUDSON: Yes.

DRIVER: And did you select the photograph which best accorded with your memory of the amount of light in that room --

HUDSON: Yes, I did.

DRIVER: -- at that time?

Mr Murphy, could you please put the photograph RAC2220 up?

Is that the reconstruction photograph of the position of the cot that you advised the police to place?

HUDSON: Yes.

DRIVER: Of course it's not going to be perfect, but does that resemble, as best you can recall, the lighting?

HUDSON: Yes.

DRIVER: The light to the right of the photograph, as we look, would that be the artificial light coming through the window from the corridor within which the nurses' desk is placed?

HUDSON: Yes.

DRIVER: Was [Baby I]'s face in the shadow cast by that covering?

HUDSON: Yes, it was.

DRIVER: I think you also assisted the police to orientate the position of the cot and the people by marking a plan at some point. Do you remember doing that?

HUDSON: Yes, I do.

DRIVER: I wonder whether Mr Murphy could show us the plan. If we could, with Mr Murphy's assistance, magnify the area.

Thank you.

Can we deal with it in stages. We have nursery 1 -- and this may have been annotations you made about a later event. We can see the word "desk" -- is that "desk"?

HUDSON: Yes.

DRIVER: Is that the nursing desk or is that a different desk?

HUDSON: That's the nursing desk.

DRIVER: If we could pull out then, please, Mr Murphy. If you can find nursery 2.

Could you use your cursor? Does it work?

HUDSON: Yes, it does.

DRIVER: Thank you. Could you show us then the journey from nursery 1 to the milk room and to the nursery? Is that all on the screen at the moment or do we need to --

HUDSON: Yes, I can see it all.

DRIVER: Thank you.

HUDSON: So this is mine and Laura's position within nursery 1 with the procedure and different patient (indicating).

MR JUSTICE GOSS: That's the 15-minute procedure position?

HUDSON: The 15-minute procedure position, yes. There are in fact two doors to nursery 1, one being here (indicating) and one being here (indicating). So I would have exited via one of those doors, walked around, past nursery 2, past nursery 3. This room that's marked as an isolation room is actually the milk room --

MR DRIVER: Thank you.

HUDSON: -- which is where the expressed breast milk was kept.

Then I would have walked back around and into nursery 2.

DRIVER: Thank you. Could you show us approximately where the workbench was in nursery 2 that you were using to prepare the milk?

HUDSON: Yes, it was against the window, which was situated here (indicating).

DRIVER: I know we've seen a photograph, but so it corresponds to the plan, where was [Baby I]'s cot?

HUDSON: Here (indicating).

DRIVER: And where was Lucy Letby when she made the comment, remark or question?

HUDSON: Here (indicating).

MR DRIVER: Thank you.

My Lord, I'm now next going to go to the events and I wonder whether, in all of the circumstances, it might be better to have a slightly earlier break.

MR JUSTICE GOSS: Certainly. Then we can do that all of...

(Pause)

MR DRIVER: Mr Johnson invited me to clarify one more thing on this plan. The cursor where it is at the moment, did the door open in the way the plan suggests?

HUDSON: No, it opened towards the left. This way (indicating).

So it would have been kept open in this position here (indicating).

MR DRIVER: That's very helpful, thanks for that correction.

MR JUSTICE GOSS: So we have to treat the structures as shown here with a great deal of caution?

MR DRIVER: Yes.

MR JUSTICE GOSS: You have corrected where they are actually incorrect. It doesn't show, for example -- there's a door opening the wrong way and so on. I'm not being critical, but we must bear that in mind.

HUDSON: Yes.

MR JUSTICE GOSS: All right.

Right, members of the jury, we'll break off now because obviously we don't want to do a few more minutes and break off in the middle of an important part.

Could you be ready, please, to continue at 2 o'clock?

Thank you. Just over the hour. Thank you very much.

(In the absence of the jury)

MR JUSTICE GOSS: Ms Hudson, can you be ready to come into court at 2 o'clock? There's someone from Witness Support who'll look after you. Don't, please, talk to anyone about your evidence or anything to do with this case.

HUDSON: Yes.

MR JUSTICE GOSS: In the meantime. Thank you very much. If you'd like to go with the gentleman there.

(The witness withdrew)

(12.57 pm)

(The short adjournment)

(2.00 pm)

(In the presence of the jury)

MR JUSTICE GOSS: Yes.

MR DRIVER: May I recall Ms Ashleigh Hudson, please.

MR JUSTICE GOSS: Thank you.

MR DRIVER: Ms Hudson, could we continue with your recollections of the events in nursery 2, please?

HUDSON: Yes.

DRIVER: Could we begin at the point when your colleague Lucy Letby directed your attention to [Baby I]?

HUDSON: Yes.

DRIVER: What did you do next?

HUDSON: After she'd highlighted that she felt [Baby I] looked pale, the first thing -- I looked over my shoulder towards [Baby I]. I couldn't see her clearly so I switched the light on for nursery 2 and then went to her cot immediately, kind of peeled back the canopy and the blankets to properly assess her, and that's when I noticed that she was in quite critical condition.

DRIVER: Pause there, please. What was it about the baby that informed you that she was in quite critical condition?

HUDSON: She was incredibly pale in colour, she was no longer kind of pale pink and well perfused, she was very pale, almost white. She hadn't responded to me disturbing her by pulling the blankets back, she was very still, she was hypotonic, therefore not moving her limbs off the bed, and she was making gasping breathing movements, so not a regular respiratory pattern.

DRIVER: Pause there a moment, please. You have previously made mention that [Baby I] tended to be a little more pale --

HUDSON: Yes.

DRIVER: -- than some babies. How did her pallor at this moment compare to her usual appearance?

HUDSON: There was no pink tone to her skin. So, as previously, we documented that she was pale pink and at this moment in time she was no longer pink, she was just pale, very pale, like I said almost white in colour, which is not a pallor you would see on a well baby.

DRIVER: You mentioned she was hypotonic. I think you defined that by explaining to us that you came to that conclusion by her lack of movement when you pulled back the blanket.

HUDSON: Yes. Another more commonly used word for that would be floppy, so a floppy tone, but yes, non-responsive.

DRIVER: Did you touch her?

HUDSON: Yes.

DRIVER: Did you form any view as to her temperature upon touch or not?

HUDSON: Not that I recall.

DRIVER: Could you please expand upon her respiration?

HUDSON: Yes. So at first glance it appeared that she wasn't breathing at all, there was no chest or abdominal movement, but after slightly further assessment, it appeared that she was gasping a handful of times within a minute -- I presumably didn't kind of stop to look at her for that long, but rather than having a regular respiratory pattern, which you expect to be maybe between 40 and 60 for a baby of that age, it was a one-off, very deep agonal breath, which you would not see characteristically in a well baby.

DRIVER: Could you repeat the adjective you used, a very deep what breath, sorry?

HUDSON: Agonal.

DRIVER: What does that mean?

HUDSON: It's a phrase that's used to describe gasping. Sorry, it's quite difficult to explain it, but essentially it was almost a very, very deep breath, but one by itself, not followed by any others.

DRIVER: In providing that explanation, you told us that you would expect a baby of this gestation/size, I think you said, to breathe 40 to 60 --

HUDSON: In or around that bracket. Generally speaking we accept respirations from 30 to 65, that's usually within normal limits.

DRIVER: 30 to 65 in what time?

HUDSON: Breaths within a minute.

DRIVER: Thank you. No one would expect you to measure with precision [Baby I]'s breaths at this crisis, but approximately how frequently was she gasping?

HUDSON: Maybe four to five times in a minute. That is an approximation. I didn't stop to examine her for longer than maybe 20 seconds before we started to intervene.

But her apnoea alarm hadn't sounded, so that's partly what my approximation was based on, that if she was breathing and the gap was longer than 20 seconds, the alarm should have sounded and it hadn't, which just suggested to me that potentially it was four to five times a minute.

DRIVER: You have told us earlier that although monitoring levels had been decreased --

HUDSON: Yes.

DRIVER: -- she still had a monitor attached to her abdomen --

HUDSON: Yes.

DRIVER: -- which was to sound or alarm should she have become apnoeic?

HUDSON: Yes.

DRIVER: And does it follow from what you've just said to us that that was still in place?

HUDSON: Yes.

DRIVER: But not alarming?

HUDSON: No.

DRIVER: What was your first thought when you saw [Baby I] at close quarters in that cot?

HUDSON: My first, I think, thought -- my worry was that she had deteriorated so rapidly that I was too late, the change in her from shortly prior being quite remarkable, so it's very surprising.

DRIVER: What did you do?

HUDSON: So I think the first step is to give some stimulation to speak to the child, but I'd obviously -- Lucy was still within the doorway and she was aware that something was also not right, so she had come to the cot side to assist.

The next thing, the first stage is to call for more help, shout for somebody to put out a crash call, which is a type of message that's sent via the switchboard at the hospital, which immediately alerts doctors to the fact that there's an emergency and where the emergency is. Then while that was happening, we had begun to try and resuscitate [Baby I]. So we'd used the Neopuff device, which was on the wall behind her, I think initially I managed the airway by giving some inflation and ventilation breaths to try and stimulate spontaneous respiration from [Baby I].

And if I recall correctly, I think Lucy then took over the airway and I moved on to chest compressions to facilitate full resus.

DRIVER: Pause there a moment, if you would, please.

(Pause)

Was the call for help heeded?

HUDSON: Yes.

DRIVER: Who came as best you can recall?

HUDSON: There was an SHO present, one of the junior doctors, I can't recall their name.

DRIVER: Male or female?

HUDSON: Female. Then Dr Matthew Neame was the registrar on that evening, he also presented shortly after.

DRIVER: What about nursing colleagues in addition to yourself and Lucy Letby?

HUDSON: Yes. The other nursing staff came into the room. From what I remember, that was Laura Eagles and Caroline Oakley.

DRIVER: Thank you. You told us at the beginning of your evidence that you were still in the first year of practice.

HUDSON: Yes, just past it.

DRIVER: Just past it, forgive me. We know of -- and your colleagues, were they, Laura Eagles, Caroline Oakley, significantly senior colleagues to you?

HUDSON: Yes.

DRIVER: And Ms Letby also significantly senior to you?

HUDSON: Yes.

DRIVER: Did you take a step back and allow them to assist the doctors?

HUDSON: Yes. Once -- I think I initially assisted Dr Neame with the airway -- he took over the manual application of the mask and holding the airway in place and I think I gave some ventilation breaths and then, as more senior staff got involved, I then took a step back to get equipment, run gases and also contact [Baby I]'s parents.

DRIVER: Were you able to effectively communicate with [Baby I]'s mum and dad?

HUDSON: Yes, I think it took a few attempts to get through, but yes, I was able to convey the message about what was happening at the time.

DRIVER: And did they shortly thereafter attend with [Baby I]'s siblings --

HUDSON: Yes.

DRIVER: -- soon after the resus, which was a success --

HUDSON: Yes.

DRIVER: -- care for [Baby I] was transferred from you to Lucy Letby?

HUDSON: Yes, it was.

DRIVER: But prior to that, do you have a recollection of a review undertaken of [Baby I]'s blood results from earlier --

HUDSON: Yes, I think it was -- during the ongoing resuscitation efforts we were asked to bring them up for the doctor.

DRIVER: Right. So during the resus, Dr Neame, was it --

HUDSON: Yes.

DRIVER: -- asked for blood results --

HUDSON: Yes.

DRIVER: -- as part of the investigation? Can you remember whether there were any significant results to share with him?

HUDSON: Yes, I think, on review, because we didn't have any other indication for why this had happened, we treated her haemoglobin being low and her being anaemic as a risk factor and a decision was made to give her an emergency blood transfusion.

DRIVER: And that was part of the emergency response, was it?

HUDSON: Yes.

DRIVER: And were there some practical complications?

HUDSON: Yes. We had some issues accessing the emergency blood fridge to begin with. I think myself, Lucy and Caroline had all tried to access it with our swipes and, for whatever reason, the machine was malfunctioning, so we had to use the emergency access in order to access it, essentially.

DRIVER: Thank you. At that stage in your career, were you cognizant of -- were you aware of the symptoms of low haemoglobin in a premature baby --

HUDSON: Yes.

DRIVER: -- like [Baby I]?

HUDSON: Yes.

DRIVER: And what are the indicators, what are the symptoms, the warnings?

HUDSON: So if an infant was on continuous monitoring still you'd be looking for dips in oxygen levels, you'd be looking for changes in the breathing pattern and work of breathing. You'd be looking at temperature stability.

Behaviourally, you'd be asking yourself has the behaviour of a child changed, have they become lethargic, are they waking for their feeds as they were before, when they are awake are they active, are they alert, or again are they kind of rousable but

not very active. And when they feed, do they become out of breath or are they normal and settle off normally?

DRIVER: And during that shift, prior to this crisis, had [Baby I] displayed any of those symptoms whilst under your care?

HUDSON: No.

DRIVER: And in the preceding night shifts under your care on the shifts that began on the 10th, 11th and 12 October, are you conscious -- do you recall any such indicators?

HUDSON: No, I think there was maybe -- I think there was a period where her temperature was slightly lower, but was still within normal range, and it's quite normal to be a bit variable in a baby of that age who's relying on a hot cot and coming out for feeds, but there wasn't anything to indicate that she was symptomatic of anaemia.

DRIVER: Post these dramatic events, of course it was incumbent upon you to create a record of what had happened.

HUDSON: Yes.

DRIVER: I wonder whether we could return to your nursing notes, where we left off, please, behind tile 32. We got as far as the time 03.22. These are nursing notes written retrospectively and we've got the computer-generated timestamp of 05.04. So does it follow that you wrote these an hour and a half or so after the crisis?

HUDSON: Yes, they were written in retrospect.

DRIVER: Thank you. Your note reads:

"At 03.22 when in the nursery..."

How were you able to time that with such precision?

HUDSON: To be honest, I don't recall. It's quite instinctive.

When significant events happen, you can look and if you're looking -- either potentially if you've switched the monitor on, like we had attached to her, there is a time on the monitor, but there is also a clock on the wall of the nursery. It might well have been that I instinctively looked at the time, but I can't recall.

DRIVER: Thank you. Let's look at your account:

"When in the nursery, Neonatal Nurse Lucy Letby noticed that [Baby I] looked quite pale."

So when in the nursery, is that a reference to you, to Ms Letby or to both of you?

HUDSON: Both of us.

DRIVER: "When turning the light on for closer examination, we found [Baby I] to be very pale in colour and not moving."

Would you expand upon that for us?:

"Apnoea alarm in situ had not sounded. Breathing was shallow and respiratory rate", is that?

HUDSON: Yes.

DRIVER: "... appeared low. Philips monitoring commenced."

Explain that to us?

HUDSON: The Philips monitor is the continuous monitor that had previously been in situ on [Baby I]. That monitor has probes attached to it which will pick up her oxygen levels and her heart rate. You can apply further monitoring which will then pick up an ECG trace.

DRIVER: Was that Philips monitoring commenced in consequence of her concerning presentation?

HUDSON: Yes, it was to -- in order to facilitate knowing what her heart rate was throughout the resuscitation and then it would be then confirmed by auscultating and listening to the chest, but it also gave us an accurate reading of her oxygen levels at the time.

DRIVER: "Laura Eagles came, as did Senior House Officer Ekaterina Clegg..."

Is that the female junior doctor that you were referring to a few minutes ago?

HUDSON: Yes. I must admit, I can't recall Ekaterina, but if that's what it says in my notes then yes.

DRIVER: "... came to assist. Neopuffing. Oxygen commenced whilst the Philips monitor was seeking to establish a trace."

HUDSON: Yes.

DRIVER: Then we have your note of the monitors:

"Sats..."

Would this data have been collected from the monitor after the event or contemporaneously?

HUDSON: Probably contemporaneously. I couldn't say for certain.

DRIVER: Chest compressions commenced within a couple of minutes of the beginning of the discovery of this problem:

"No heart rate heard."

Who was using the stethoscope, one of the doctors, one of nurses or --

HUDSON: I don't recall.

DRIVER: Dr Neame contacted, was bleeped. He arrived, and as you told us earlier, he took over management of the airway from Ms Letby?

HUDSON: Yes.

DRIVER: Time passed. At 03.29, still no heart rate?

HUDSON: Yes.

DRIVER: Is that literally right, no heart rate for those 7 minutes?

HUDSON: Yes. So I think the monitors picked up heart rate in the 50s, but listening in, if you have a very shallow heartbeat it's not always very easy to hear it. I'm not sure -- like I say, I can't recall who was listening.

It's not always easy, especially if people are doing resuscitation, to hear the heartbeat itself which is why the monitor was in situ to assist with that.

DRIVER: There's some detail of the resuscitation and we'll hear from Dr Neame, so we can rely on his notes to that rather than troubling you with them.

Could we go briefly please to tile 38 first -- I've taken us to the wrong tile, apologies.

Tile 47. This is a continuation of your notes?

HUDSON: Yes.

DRIVER: So you record the time of the notification that you gave to the parents after trying three or four times, as you indicated earlier. You advised [Baby I]'s mum to come as soon as possible?

HUDSON: Yes.

DRIVER: You noted the resus medications given?

HUDSON: Yes.

DRIVER: You use that phrase. Then you expand upon the blood transfusion issue and the problems that were -- that you faced and overcame:

"Dr Neame requested emergency blood after reviewing the weekly blood results. Lucy Letby attempted to get blood from Bloodhound..."

Is that a system?

HUDSON: That was the system name, yes.

DRIVER: "Pass code didn't work."

Multiple attempts by yourself, Ms Letby, Caroline Oakley. Did you override the security, as it were, by pressing the emergency button to get the blood which may have been needed urgently?

HUDSON: Yes, that's correct.

DRIVER: Then by the time you came back [Baby I] had been transferred to the higher intensity regime of nursery 1?

HUDSON: Yes.

DRIVER: Could you scroll down, please, Mr Murphy.

That's later in the morning. Is that where your responsibilities -- your note of the communications you had with [Baby I]'s father --

HUDSON: Yes.

DRIVER: -- possibly in the presence of her brother? Her family stayed on the unit in the immediate aftermath?

HUDSON: This note is in retrospect also, so at the start I'm talking about family being present at the start of the shift.

DRIVER: Understood.

HUDSON: And as you go down, I'm then talking about after the resuscitation attempt.

DRIVER: Thank you. Scroll down again, please, further down the page.

A note made on the same nursing note page at 07.59 but made about events during your shift as designated nurse for [Baby I]. The note is signed by LL, Lucy Letby, one assumes. That gives an earlier time.

So you had 03.22 for the crisis event, as it were, and this note, Lucy Letby's account:

"[Baby I] noted to be pale in cot by myself at 03.20. [You were] present. Apnoea alarm in situ had not sounded. On examination, [Baby I] centrally white with minimal shallow breaths followed by gasping observed. Ventilation breaths."

Do you agree with the timing of that when it was brought to your attention?

HUDSON: I mean, I can't describe the couple of minutes' discrepancy. I think we're definitely talking about the same event. Whether it was 20 or 22 minutes past, I couldn't recall exactly now. I know that the other timings will have been written down at the time, as is usual practice in a resus, but I can't say for certain with that one.

DRIVER: "Apnoea alarm in situ had not sounded."

You've already recorded that and (inaudible). You told us that [Baby I] was under blankets.

HUDSON: Yes.

DRIVER: It next reads:

"On examination [Baby I] centrally white."

Did you remove the blankets from [Baby I]?

HUDSON: Yes.

DRIVER: Was she clothed or unclothed?

HUDSON: She was unclothed. She was -- if I recall correctly, we undressed her during the start of resuscitation in order to see her chest, see her colour and see her abdomen.

DRIVER: Do you have a recollection of her colour of her abdomen?

HUDSON: Like I said previously, pale and generally white in colour.

DRIVER: Do you agree with that description? Sorry, does that description accord with your memory that, on examination, [Baby I] was centrally white?

HUDSON: Essentially, I would say that she was generally white, so white everywhere rather than just centrally.

DRIVER: If we could just go back up to the page to your note of the events we looked at, perhaps the 03.22. Perhaps we don't need to jump about. We remember your retrospective note of your cares for [Baby I] earlier on and the 03.22 event. That note was timed at 05.04.

HUDSON: Yes.

DRIVER: If we return to the note entered by Ms Letby that we just looked at -- if Mr Murphy can take us back to that -- that was recorded at 07.59.

HUDSON: Yes.

DRIVER: When updating nursing notes, this one or generally, can the nurse who is entering a new note, can that nurse whilst doing so see any existing notes?

HUDSON: Yes, you have access to all previous nursing notes if they've been saved and published.

MR JUSTICE GOSS: Well, how do you save a note?

HUDSON: At the time, for that system, you'd press -- I think F12 -- you press a button and then it would save it and publish it for you. If you were halfway through writing a note, got called say to an emergency and you hadn't saved it, the system would automatically kick you out for safety, information governance reasons, and then that wouldn't be saved. So it'd only save it if you actually pressed save.

MR JUSTICE GOSS: So you have consciously to save it, press whatever button it is, F12, whatever it is?

HUDSON: Yes.

MR JUSTICE GOSS: Is the time at which you do that recorded in any way?

HUDSON: Yes, I think it gives you the time that you have started the note and you time you saved it.

MR DRIVER: If we look at the note that's on the screen at the moment, Ms Hudson, we have activity date, 13/10/15.

A time there, 07.59.

HUDSON: Yes.

DRIVER: Then down two lines, we have "create", the same date, the same time.

HUDSON: Yes.

DRIVER: Initials. Then we have same date and a second time, 08.10.

HUDSON: Yes.

DRIVER: Is 07.59 the time when this note, the creation of this note began?

HUDSON: Yes.

DRIVER: And is 08.10 the time of the saving of this note?

HUDSON: Yes.

DRIVER: And your Lordship and the jury may recall, we heard some evidence a while ago when there was an administrative error and one of the nurses saved the note to a different file altogether, a different baby, and they had to be transferred back to correct the error. It was saved but saved in the wrong file.

So it's a manual administrative exercise --

HUDSON: Yes.

DRIVER: -- by the author?

HUDSON: Yes.

MR DRIVER: Thank you. Could you remain there, please, and answer any further questions?

Cross-examination by MR MYERS

MR MYERS: Ms Hudson, I'd like you to help first with the layout of the room that we're talking about.

HUDSON: Yes.

MYERS: There will be two files in front of you. Ladies and gentlemen, could you reach for the first jury bundle, the one we started with, and I don't know if they say 1 or 2 on them, but hopefully they do.

HUDSON: Number 2.

MYERS: If you take number 1, please, and just go behind divider 4 inside it, there's a plan of the neonatal unit. Maybe whilst we look at the paper, Mr Murphy, you could put up on the screens AVH1, which was the hand-drawn, plan that we looked at when Ms Hudson first gave her evidence.

(Pause)

In fact, this is -- I think there was a second plan, please. That's the one, thank you very much.

This is just to help us get the layout, Ms Hudson, in a bit more detail. Starting first of all with the paper plan. When we look at that, can you see, if you hold it so it's landscape -- you've got it that way round -- if we look up the left-hand side, we can see nursery 2. It's the first green room we come to on the left-hand side.

HUDSON: Yes.

MYERS: Can you all see that, ladies and gentlemen? This is actually on the plan. It appears to be drawn -- I'm not sure if the blue is meant to indicate beds but it appears to be drawn with two beds in it, doesn't it, there?

HUDSON: Yes.

MYERS: In fact there were four beds in that nursery at the time we are talking about, weren't there?

HUDSON: Yes.

MR JUSTICE GOSS: I think we've got a different one up on the screen.

MR MYERS: We have. I've got two different things up, my Lord.

MR JUSTICE GOSS: So we're not looking at the one on the screen --

MR MYERS: We are just looking at the paper one in landscape at the moment, thank you.

Thank you for clarifying that, my Lord.

Looking at the paper plan, just make sure we're all looking at that one -- there we go, thanks. Nursery 2, which is the nursery you were in looking after [Baby I] --

HUDSON: Yes.

MYERS: -- is on the left-hand side and it's the first green room we come to?

HUDSON: Yes.

MYERS: And I was just establishing with you, we'll come to what's on the screens in a minute, but it's got two blue rectangles in nursery 2 on the paper plan, hasn't it?

HUDSON: Yes.

MYERS: But in fact, on the night we're talking about, there were a further two cots in there, weren't there?

HUDSON: I don't recall.

MYERS: A total of four babies in that --

HUDSON: A total of four babies could be in that room.

MYERS: A total of four could be in it, you say. Yes, to be quite clear, there are four cot spaces in the room, aren't there?

HUDSON: Yes.

MYERS: Put it that way. In fact, from the records we've had, we've seen that you were looking after three babies in that room that night.

HUDSON: Okay.

MYERS: So three babies, four cots.

HUDSON: Okay.

MYERS: Still staying with the paper plan, if we look to the right of the doorway we can see it's written "nurses' station"; can you see that?

HUDSON: Yes.

MYERS: If we look directly above the doorway, there's a kind of pale rectangle, a very narrow rectangle that's drawn in.

Is that the window which you were telling us about?

HUDSON: Yes, it is.

MYERS: Thank you. So the nurses' station, we've got the plan, is directly opposite the doorway and the window?

HUDSON: Yes.

MYERS: We've got the plan in front of us. If we just look now at the electronic plan that you drew that's up on the screens. What you have done on that is, first of all, to correct the way that the door opens, haven't you --

HUDSON: Yes.

MYERS: -- so the door opens in on the left?

HUDSON: Yes.

MYERS: The counter is where you've described that you went to to prepare milk for [Baby I]; is that right?

HUDSON: Yes.

MYERS: And you have drawn approximately the cot with the position that [Baby I] would have been in?

HUDSON: Yes.

MYERS: But putting together what we know there would have been another three cots in that room, wouldn't there?

HUDSON: Yes, potentially.

MYERS: So a total of four?

HUDSON: Mm-hm.

MYERS: And with three babies in, we know that. Thank you very much for that. I'm going to take the image down, please, and we can put those plans away for the time being.

The nursing station is where you remember a couple of your colleagues being when you went off just for a short period and asked for someone to keep an eye on [Baby I]; is that correct?

HUDSON: Yes.

MYERS: To the best of your recollection, the people there would have been Caroline Oakley and Lucy Letby; is that the best of your recollection?

HUDSON: Yes.

MYERS: And Caroline Oakley was the shift leader that evening; do you recall that?

HUDSON: I don't recall if she was the shift leader.

MYERS: All right. We know she was as a matter of record; I'm just asking you. One of the things a shift leader can do is to act as what's called a supernumerary, isn't it, that they can fill in and do whatever else needs to be done --

HUDSON: Yes, correct.

MYERS: -- if asked? Thank you.

I am just going to ask you next about the lighting in the room as you described it.

HUDSON: Yes.

MYERS: You've shown us a photograph -- or rather a photograph was shown to you that was taken with the police.

HUDSON: Yes.

MYERS: Do you remember that?

HUDSON: Yes.

MYERS: Just so the jury understand, you went with the police to the hospital in August 2020, didn't you, to take these photographs?

HUDSON: Correct, yes.

MYERS: The event that we're dealing with at the moment was on the night of the 12th into 13 October 2015?

HUDSON: Yes.

MYERS: It's August 2020 (sic) you went back, so about 5 years later?

HUDSON: Yes.

MYERS: When you went back you engaged in an exercise of arranging the room and the lighting as best as you could remember it from the time it took place?

HUDSON: Correct.

MYERS: Can I just check, at that time did you know that Lucy Letby had been arrested for these offences?

HUDSON: Yes.

MYERS: Yes. So you were well aware this was a police investigation into events at the hospital?

HUDSON: Yes.

MYERS: The image which you settled upon or selected as capturing the lighting was the one we saw at 25368. I'm going to ask if we could put that up, please. Pausing there, of course this appears just to have one cot or one incubator in the room, doesn't it?

HUDSON: Yes.

MYERS: At the time we're talking about, there would have been another one with the head towards the wall against the wall that we can see?

HUDSON: Potentially.

MYERS: Yes.

HUDSON: The room wasn't always full, so even if there was three patients in the room, you wouldn't have an empty cot in there. You would move one in if it was required, so that side of the room, if there was three, you try and keep one baby on that side purely due to space and two babies on the opposite wall.

MYERS: But you don't recall how many cots there were there on (sic) the exact time?

HUDSON: Yes.

MYERS: It could hold up to four?

HUDSON: Yes.

MYERS: If there was another cot, the cot we're looking at here would move closer towards the window, wouldn't it, to make space?

HUDSON: Yes.

MYERS: Can I just put up -- there were six photographs, weren't there, actually, that you took a look at?

HUDSON: Yes.

MYERS: Could we look at 25363, which is the first of the series of six, if we could put that up. There's one of them that was taken. Is it possible to put the two next to each other, please, Mr Murphy? Thank you.

I don't know if it's possible to enlarge the one on the left, but we can see it from looking at that. There we go, thank you.

There were six photographs taken. The one on the left was the one with the brightest light and the one on the right is the one you selected with the darkest light?

HUDSON: Yes.

MYERS: So from recollection, you certainly picked the darkest of the ones that was taken, didn't you?

HUDSON: Yes.

MYERS: But first of all, even with the light dimmed, it's possible the light could be quite variable as to how it was in that nursery, isn't it?

HUDSON: Yes. It's worth noting at the time these photographs were taken, the lighting outside in the corridor had been changed. So when the pictures were taken, the lighting was a lot brighter and it was also dimmable, if I remember correctly, whereas the lighting at the time of the incident was just one strength and different.

MYERS: Okay. What you did was to do the best you could to get the lights right?

HUDSON: Yes.

MYERS: But would it be fair to say it's impossible to recall precisely how the lighting would have been 5 years beforehand?

HUDSON: I would say I definitely couldn't claim for it to be precise, but it is an image that has been imprinted on my brain for quite some time.

MYERS: Oh yes.

HUDSON: So my recollection of it is quite vivid. So I did it to the best of my ability.

MYERS: That's what I'm checking, you did it to the best of your ability, casting your mind back over what it was like at the time it took place.

So far as the light is concerned, you were preparing milk in there you've described to us; is that right?

HUDSON: Yes.

MYERS: And to do that you have to check, do you, that you have the right bottle and the right serial number?

HUDSON: Yes.

MYERS: And then you have to draw it up -- do you draw it up into a syringe or something like that?

HUDSON: Yes.

MYERS: So however gloomy it is or it isn't, you certainly need enough light on that counter to be able to see what you're doing?

HUDSON: Oh yes, yes.

MYERS: The point being you wouldn't try to prepare a feed in pitch darkness or something like that?

HUDSON: No.

MYERS: Is the light controlled by a dimmer switch rather than an on/off switch?

HUDSON: Inside the nursery at the time, yes. Outside, no.

MYERS: Is it, from your recollection, a possibility that the light may well have been low but low on the dimmer rather than off, if you see the difference?

HUDSON: No, it was off.

MYERS: You can recall that?

HUDSON: Yes.

MYERS: I'm going to suggest it's dimmed because you are doing the milk. But you say it was off?

HUDSON: Yes.

MYERS: Even with it off, you could work around on the counter that we're looking at; is that correct?

HUDSON: Yes, because it's directly underneath the window.

MYERS: And then you'd be looking at the milk and sorting that out; is that right?

HUDSON: Yes.

MYERS: And as you've said to us, that placed you with your back to [Baby I]?

HUDSON: Yes.

MYERS: And was there a seat or were you standing there as you deal with it?

HUDSON: I am standing.

MYERS: And Ms Letby was standing in the doorway talking to you?

HUDSON: Yes.

MYERS: And do you recall whether she's slightly in the room, out of room, whereabouts, or just in the doorway somewhere?

HUDSON: She was in the doorway leaning up against the frame.

MYERS: All right. We know from the doorway she'll have her, if she's talking to you, shoulder or her back towards the door that's opened; is that correct?

HUDSON: Yes.

MYERS: Your recollection is that's is it 5 or 6 feet, you thought, probably, from the cot?

HUDSON: Yes.

MYERS: Something like that. And she would be standing -- obviously her head would be at a higher level from the cot if she's over by the door; is that correct?

HUDSON: Yes.

MYERS: Now you have been asked in detail, not surprisingly, about your recollections as to what you saw.

HUDSON: Yes.

MYERS: We've spent some time going over it in the courtroom with the questions. The events that actually took place from that conversation to dealing with [Baby I] would have taken place fairly rapidly, wouldn't they?

HUDSON: Yes.

MYERS: Although you've been asked about the view Ms Letby would or wouldn't have, it goes without saying you weren't standing where she was standing, were you?

HUDSON: No.

MYERS: So you know what you think about the lighting, but you can't actually say for sure what someone standing where she was is going to see at that time looking down?

HUDSON: No.

MYERS: When it was drawn to your attention that [Baby I] looked pale or quite pale or a bit pale -- do you remember which words were used, by the way, as to how pale [Baby I] was?

HUDSON: No, not specifically.

MYERS: All right. But was the first thing you did to look over your shoulder?

HUDSON: Yes.

MYERS: And you couldn't see very clearly at that point?

HUDSON: No.

MYERS: Did you then turn the lights up?

HUDSON: Yes.

MYERS: And it was when you turned the lights up that you could tell, I suggest, that she was white?

HUDSON: Yes.

MYERS: Now, you've been asked questions about blankets and what was where and what have you. I'm not going to take issue there are blankets in the cot. But as soon as you turned the lights up and then looked into there, there was enough of [Baby I] to see from her face or other parts of her skin that she was white, wasn't there? You're nodding, you have to say yes if you agree.

HUDSON: Yes. It all happened very quickly but once I turned the light on and I was standing over her, I could see her face.

MYERS: All right. Until the time that Lucy Letby had pointed out that she seemed pale, you hadn't focused on how [Baby I] looked at all, had you?

HUDSON: No.

MYERS: Because, so far as you were aware, you had no reason to do that at that point?

HUDSON: Yes.

MYERS: You've described to us how [Baby I] appeared to be breathing once you did begin to examine her and one thing you noted was that the apnoea alarm hadn't gone off.

HUDSON: Yes.

MYERS: So everyone can follow this, apnoea alarms work by sensing motion, don't they?

HUDSON: Yes.

MYERS: And is it that if there's been no breath within 20 seconds, then they will alarm; is that right?

HUDSON: Yes.

MYERS: Okay. But it seemed to you that what had happened was that [Baby I] was breathing, nothing like as regularly as she should have been doing, but often enough for the alarm not to sound?

HUDSON: Yes.

MR MYERS: Thank you very much, Ms Hudson.

Re-examination by MR DRIVER

MR DRIVER: Just dealing with the cots in the room. You needn't trouble yourself with this, Ms Hudson, but we have documents -- members of the jury, I'm referring to the neonatal review file at page 2 of 7 under "[Baby I]: Event 2". And the information informs us that there were three babies in nursery 2 at this point in time: [Baby I], a baby called [Baby G], and a baby whose initials are JF.

You agreed with my learned friend Mr Myers that there is, within that room, sufficient space to house four cots.

HUDSON: Yes.

DRIVER: When there were less than four babies in nursery 2, how many cots would there be?

HUDSON: Generally speaking, there would just be enough cots for the babies that were in that room. There was always -- occasion where a cot would be set up without a patient in it in anticipation of an admission, but if we could, we would remove any equipment from the nursery which wasn't required at the time because it was a very small unit and once you got more of the recliner chairs in there, there wasn't a great deal of room for parents.

DRIVER: Thank you. You were reminded that the occasion when you returned to nursery 2 to assist the police in understanding where you recalled the cot was and attempting to reflect the lighting as it was at the time and photograph the scene -- you were reminded that that event took place on 15 August 2018 (sic). And you confirmed, when it was put to you, that at that stage you were aware that Lucy Letby had been arrested.

When you assisted the police in that regard, were you doing your very best to tell the truth?

HUDSON: Yes.

DRIVER: Were you in any way influenced by the fact that you knew there had been an arrest?

HUDSON: No.

DRIVER: It was put to you, and you agreed, that from the bench where you were preparing the milk, when you turned around and looked at [Baby I], you were looking at her at that moment from a different place and a different perspective to Lucy Letby.

HUDSON: Yes.

DRIVER: You were not in her shoes?

HUDSON: No.

DRIVER: You couldn't see exactly what she could see?

HUDSON: No.

DRIVER: Have you ever stood in that doorway --

HUDSON: Yes.

DRIVER: -- at night? Have you ever looked towards a cot in that position --

HUDSON: Yes.

DRIVER: -- at night? In those circumstances, would that vantage point afford you a look at the baby's face?

HUDSON: Not for me.

DRIVER: How close to [Baby I] were you when you first realised that she was very pale indeed?

HUDSON: I was standing towards the foot of the cot, directly over her.

MR DRIVER: Does your Lordship have any questions for the witness?

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

You're not required to give evidence again during the course of this trial.

HUDSON: Okay.

MR JUSTICE GOSS: That completes your evidence therefore.

Thank you very much indeed.

MR DRIVER: Forgive me. As I understand it, this is Nurse Hudson's only visit to court. Enquiries are being made whether she was...

HUDSON: May I just say, I was her designated nurse on the night of the final collapse as well.

MR MYERS: That's what I was raising. There's a possibility Ms Hudson might be required.

MR JUSTICE GOSS: I'll give my usual direction then: there is a possibility you will have to come back and give evidence again. That will be decided next week, I anticipate. So what I'm going to say to you is: please don't talk to anyone about anything to do with this case, in particular your evidence about any of the events --

HUDSON: Yes, of course.

MR JUSTICE GOSS: -- concerning this case until the trial is all over.

HUDSON: Yes.

MR JUSTICE GOSS: All right?

HUDSON: Yes.

MR JUSTICE GOSS: Thank you very much. You're free to go now.

(The witness withdrew)

MR DRIVER: My Lord, the next witness is Dr Matthew Neame.

He's on his way.

MR JUSTICE GOSS: We will do a bit more, then we'll have a break, if that's appropriate. I don't know quite what the -- here we are. I'll leave it to you, Mr Driver.

DR MATTHEW NEAME (recalled)

Examination-in-chief by MR DRIVER

MR DRIVER: Could you state your full name for the record?

NEAME: Dr Matthew Neame.

DRIVER: Dr Neame, you're still bound by the oath or affirmation that you took on your last visit to court.

As you appreciate, you've been invited this afternoon to provide evidence in relation to the baby [Baby I]. Do you remember [Baby I]?

NEAME: Yes, I do.

DRIVER: Is it right that you were on rotation, as it were, at the Liverpool Women's Hospital certainly within the week of her birth?

NEAME: Yes.

DRIVER: And it so happened that shortly thereafter, you rotated to Chester and, as we know, the baby [Baby I] was transferred from Liverpool to Chester.

Did you have much or any involvement with her in Liverpool?

NEAME: Yes. I met her in the week following her birth. The way the system worked there, we would work within one nursery for the whole week and [Baby I] was in that nursery, so I met her over several days that week.

DRIVER: I'm going to ask you about, firstly, 5 September 2015, that is, and I don't believe this is on the carousel, Mr Murphy, but I do think it will be in the additional material file at J13773.

The lower part of the page, thank you. Your writing, Dr Neame?

NEAME: Yes.

DRIVER: Thank you. Was this part of a ward round examination?

NEAME: Yes, that's right.

DRIVER: Could you, quite briefly, take us through what it was you noted on examination of [Baby I] on this morning?

NEAME: It's a summary of [Baby I]'s background. So she's 28 days old then. It lists some of her known concerns, so preterm delivery, her resolving lung disease, sub-optimal growth to that point, and low salt levels, but on assessment that day she was breathing by herself in air, she had a good breathing blood test with no concerns about her breathing overnight.

She was being fed with milk. Her salt level/sodium level was quite -- or moderately low the day before and she'd been started on some sodium/salt supplements since the day before. No concerns about infection and then there's a list of her medications, which are largely the routine medications that would be prescribed for a baby of that gestation.

DRIVER: Going back to one feature of your list of her problems, as it were, sub-optimal weight gain. Was her weight gain slower than would have been hoped for?

NEAME: I don't recall that, but that refers to just slightly less than we might expect.

DRIVER: You can't expand upon the degree?

NEAME: Not based on my recollection or the note.

DRIVER: Thank you. Let's continue then, please.

Is that the end of the note, Mr Murphy, or is there something further down the page?

NEAME: (Inaudible) documentation of her examination:

"Pink and settled. No increased work of breathing. Normal respiratory observations."

A normal respiratory and cardiovascular examination.

Also, a normal examination of her neurological system and abdomen, that's soft and non-tender. So my impression is she was a well baby and the plan was to continue with her current care and reweigh her that day and a repeat of her blood tests the next morning.

DRIVER: That's the morning of 5 September. Next page, please, Mr Murphy. It's a continuation of this note, effectively. Dr Neame is the next contributor at 21.00 hours. You have seen her in the morning, you saw her in the night?

NEAME: Yes. I was asked to see [Baby I] regarding some low oxygen levels. I recorded that she'd been generally well that day but had an increased frequency of low oxygen levels over the previous hour, not associated with any reduction in her heart rate, and requiring treatment with some intermittent extra oxygen. I've documented her temperature, which is slightly lower than normal, but that she's been tolerating her feeds and has opened her bowels twice that day.

Then in my document, in my examination, she was alert and active and pink, but having some frequent low oxygen levels with the lowest level down to 60% and a slight reduction in her heart rate to around 100, but no pauses in her breathing.

DRIVER: Is that no pauses or with pauses?

NEAME: No pauses, no apnoeas, so no pauses in her breathing.

DRIVER: So the little circle above (inaudible) --

NEAME: Yes.

DRIVER: Thank you. Is there a continuation of that note, Mr Murphy? Thank you. Dr Neame, if you would.

NEAME: So further documentation of the examination. There's no increased effort or work of breathing. Her chest sounds clear. She has a normal examination of her cardiovascular system at that point. Same with her neurological system. Same with her abdomen, it's non-distended and non-tender with normal-sounding bowel sounds.

Overall, because of the low oxygen level it's -- my impression was that she might have an infection or possibly this might be related to ongoing resolution of her -- the lung disease that can be associated with prematurity, so I suggested doing a full infection screen, so late onset sepsis antibiotics, so the choice of antibiotics we'd use for a baby who wasn't recently born, a blood test to check her breathing, and then handing over to the night team to arrange her ongoing care. And I've documented that I've inserted a cannula into her arm.

DRIVER: Thank you. Mr Murphy, could we then go to page J14370, please. This takes us forward to 5 October 2015. This is a nursing update, I would like to look at the bottom of the page, plainly not yours, but you refer back to it in a note that we're going to arrive at in a moment.

So does this record that at 12.15 on 5 October, [Baby I]'s mum provided consent to the commencing of the vaccination programme?

NEAME: Yes, it does.

DRIVER: Are premature babies like [Baby I] who are inpatients at the hospital typically vaccinated in-house?

NEAME: Yes.

DRIVER: Would you, the treating physicians, be informed of that in advance? Would you have a contribution to make as to whether it was timely and appropriate?

NEAME: Yes, usually it'd be discussed and agreed.

DRIVER: And post-vaccination, do you, the clinicians, take any different steps or are you just a little more observant for changes?

NEAME: Perhaps a bit more observant and perhaps aware that sometimes it can be difficult to discriminate between effects of vaccination and effects of infection; they can present in similar ways.

DRIVER: Understood. Next page, please.

MR JUSTICE GOSS: Sorry, these are vaccinations for what?

What are the standard vaccinations?

NEAME: There's a number of infections and they are the routine childhood vaccinations for things like rotavirus infection, which is a gastrointestinal infection that is common in childhood, haemophilus, an upper respiratory tract infection,

pneumococcus, different types of childhood infections. I think it would have been potentially the polio vaccine as well. They make up the routine childhood immunisations. It's the same protocol for preterm babies as it would be for a child --

MR JUSTICE GOSS: The same as for a full-term baby?

NEAME: Yes, usually.

MR DRIVER: So the last words on that page are "was given", which tends to indicate that the immunisations and vaccines would be -- the programme had been completed.

If we go over the page, they were given orally, we'll find out. It was deemed satisfactory and [Baby I]'s mum was told to look out for a reaction in short.

That takes us to your entry immediately below, 15.15 hours on 7 October. Could you take us through this, at the same pace, please?

NEAME: That's a review of some blood tests that had been arranged for [Baby I] that day. Her infection or inflammation marker, her CRP, is higher than normally at 71. Her haemoglobin is lower than normal at 75, and her infection fighting cells are slightly higher than normal: 20 is the white cell count and the neutrophils are 8.9. However, I've documented that there is no clinical change in [Baby I] at that point, that she was breathing normally and still tolerating her milk feeds, and that her abdominal examination was relatively normal. I documented there that it remains distended, no significant vomiting or aspiration -- vomiting episodes or large aspirates. Usually that refers to aspirates from the feeding tube.

DRIVER: Thank you. What, if anything, should be read into the relatively lower haemoglobin and relatively elevated white blood cell count?

NEAME: The most common reason for lower haemoglobin in preterm babies would be anaemia of prematurity, which is a combination of factors: frequent blood tests and direct effects from being born prematurely. The raised white cell counts can be related to infection or could be related to the immunisations as well.

DRIVER: At the bottom of the page, is that "OR", on --

NEAME: "On examination."

DRIVER: OE, on examination, yes.

NEAME: So [Baby I] was pale pink, she had no increased work of breathing, a normal oxygen level, a normal heart rate and a capillary refill time of less than 2 seconds.

I've documented that her peripheries were mottled, but that she had normal heart sounds, a soft anterior fontanelle, and normal movements as part of her neurological examination, and a distended but soft abdomen, which was non-tender, with normal bowel sounds.

DRIVER: Mr Murphy, could you take us down to the final two paragraphs of this page, please?

Impression?

NEAME: That the raised CRP test might be related either to her immunisations or to early infection, so I suggested a full infection screen, starting antibiotics.

The next line, "LP performed", documents her lumbar puncture. "G&S" is the next line, group and save, which is a blood test we do if we're preparing for a possible blood transfusion.

And the following line is:

"Discussed with Dr Brearey regarding the blood transfusion."

And the final line is:

"Urine for microscopy, culture and sensitivity."

That's an additional infection test that we sometimes do to rule out urinary infection.

DRIVER: So they were options in a plan rather than procedures undertaken at that stage?

NEAME: I have briefly documented that I undertook a lumbar puncture --

DRIVER: You did.

NEAME: -- in that line as well.

DRIVER: I'm grateful for that clarification.

Could we go, please, Mr Murphy, to J14373 and 4?

This is not your handwriting on this page; is that right?

NEAME: That's correct, yes.

DRIVER: That's a weekly review on the 6th. If we go to the next page, I think you do make a contribution to this document, to the bottom of page 14374.

We can see the name Soni. This document, we heard from another witness earlier, is this the pre-grand round review of the patient to supply the information to the consultant who's expected the next day?

NEAME: That's correct, yes.

DRIVER: Dr Soni, a colleague of yours. You have made this contribution, I believe. It's at the bottom of the page. That's your signature, isn't it?

NEAME: Yes, that's correct.

DRIVER: So what does this inform us of?

NEAME: So that -- I may be mistaken. I think this plan -- this is the plan that then led to the blood test that I described in my previous comments just now. So it's Dr Brearey's plan to:

"Repeat CRP and a full blood count, collect urine for microscopy, and to review on the ward round."

Where there's a brief examination documented with a normal heart rate, a finding of [Baby I] being alert and active, and having a distended but soft abdomen with normal bowel sounds.

DRIVER: Thank you. Moving now to 13 October --

MR JUSTICE GOSS: About how much longer is it anticipated Dr Neame will be giving evidence? I'm only asking because we could have a short break.

MR DRIVER: I'm about to -- as your Lordship knows, Dr Neame responded to the crash call.

MR JUSTICE GOSS: Exactly.

MR DRIVER: That's where thematically we're about to go.

MR JUSTICE GOSS: We will just have a short break. Will we be completing Dr Neame's evidence that it was proposed to adduce today?

MR DRIVER: We will certainly complete his evidence-in-chief.

MR MYERS: I'm sure if that's the case, we'll complete Dr Neame's cross-examination as well.

MR JUSTICE GOSS: That will be helpful. With a break?

MR MYERS: Yes. I don't expect it will be very lengthy.

MR JUSTICE GOSS: I don't want to cause any undue inconvenience. Conventionally, we just have a short break for people to stretch their legs and refresh themselves a bit and have a comfort break if they need it. Thank you.

(In the absence of the jury)

MR JUSTICE GOSS: So you understand, Dr Neame, you will be giving that evidence today that you were expecting to give, but you'll be coming back on Wednesday next week to give evidence again. Don't talk to anyone about this case, the evidence to do with it, and we'll resume at just after 20 past.

(3.12 pm)

(A short break)

(3.22 pm)

MR JUSTICE GOSS: A member of the jury is indicating that they are feeling tired, they are prepared to continue but they are feeling tired. We all feel tired at times, but it's difficult.

Now, I'm happy to say -- because as Dr Neame is going to have to come back on Wednesday in any event, it's not going to cause any extra inconvenience to him, I don't imagine.

MR MYERS: We're in the court's hands, whatever is most convenient for the court and the jury, my Lord.

MR DRIVER: It's important evidence, as is all the evidence in this case, and if a juror's expressed fatigue...

MR JUSTICE GOSS: I think we should say that's it for today.

MR MYERS: Particularly since Dr Neame is returning next week in any event.

MR JUSTICE GOSS: Yes. It might be different if it was really important for Dr Neame to complete his evidence today.

MR DRIVER: We'll take all of Dr Neame's evidence in a single session, single sitting --

MR JUSTICE GOSS: We'll do that. I'm sorry about this.

(In the presence of the jury)

MR JUSTICE GOSS: I know, members of the jury, how hard each one of you concentrates on the evidence that is adduced in this case and, as I said to you at the very outset, you may recall, it is actually very tiring sitting and listening literally to every word that is put before you during the course of a normal court day. That's why the court day is not as long as a normal ordinary working day for most people. One of you said you're feeling tired. All of the evidence is important and this is a very important area of evidence obviously.

Dr Neame is coming back on Wednesday, which is when you're coming back next week, because on Monday and Tuesday you're not required. It's not going to cause the doctor any inconvenience. We're only going to lose three-quarters of an hour or thereabouts of court sitting time. Normally, of course, it's a precious resource, court sitting time, and we try to use it as much as we can, but it's vital that each of you is fresh and able to concentrate.

I'm going to say that's it for today. It's my decision and I'm just doing what I consider is in the interests of -- essentially, in the interests of justice, which is what trials are about: achieving justice in any case. All right?

So now it is a four-day break for you. I will remind you in clear terms yet again: no communication by any means whatsoever with anyone about anything or anyone to do with this case, any aspect of it at all, and no research into anything to do with this case.

You have a huge amount of evidence, in any event, placed before you and there's a lot more to come, so you've got plenty of materials with which you'll work during the course of this case.

Thank you very much. I'll see you on Wednesday, 10.30.

(In the absence of the jury)

MR JUSTICE GOSS: Thank you again, Dr Neame. Please go with the representative from Witness Support. 10.30 on Wednesday, please. Thank you.

(The witness withdrew)

MR JUSTICE GOSS: I confirm, as I said earlier in the week, the court will not be sitting on Monday. This case is not listed to be heard on Monday. It will be listed on Tuesday, 10.30, jury

not to attend, for the hearing of the application for which I thank you, Mr Myers.

I expect that by Tuesday morning the matter will have been considered and that which is controversial will be identified, if anything.

MR JOHNSON: Yes. Hopefully at some stage we'll give your Lordship some sort of written guide as to what the response is. Quite when that's going to arrive, I can't guarantee.

MR JUSTICE GOSS: Well, there's no rush, I've got -- as long as it arrives before Tuesday morning so I can read it before we commence the hearing.

MR JOHNSON: Yes.

MR JUSTICE GOSS: I can read all the materials Mr Myers has provided to me and then I can consider any response.

But obviously, if there are matters that are agreed, so be it. Some of them may be, some may not, I don't know, I've only skim-read it thus far. But the defendant is also required to attend?

MR MYERS: On Tuesday, my Lord, yes.

MR JUSTICE GOSS: I think that has already been communicated. It has.

When this case is next listed, in other words Tuesday of this week, the defendant to be here as well.

MR MYERS: And may we have a little time to see Ms Letby after this hearing?

MR JUSTICE GOSS: Yes. Counsel will come down to see Ms Letby shortly, just before you leave the building.

Thank you.

(3.29 pm)

(The hearing adjourned until 10.30 am on Tuesday, 31 January 2023)