

2 February 2023
Baby I

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Thursday, 2 February 2023
(10.30 am)

(In the presence of the jury)

MR JUSTICE GOSS: Mr Astbury.

Witness statement of SHELLEY TOMLINS (read)

MR ASTBURY: My Lord, some statements to read to conclude the evidence relating to the 13th into 14 October and event 3, as it's been described to the jury.

I begin, please, with a statement to be read from Shelley Tomlins, which is page 77 in my Lord's bundle.

Shelley Tomlins provided a statement on 13 June 2019 in which she says:

"I have been asked by DC Birch from Cheshire Police about my recollections of and involvement with a baby called [Baby I], who died on 23 October 2015 at the Countess of Chester Hospital.

"I have been asked in particular about 29 September 2015 and 14 October 2015. Prior to providing the statement, I have had the opportunity to review [Baby I]'s clinical notes and I make this statement based on those notes and my own personal recollection.

"I do remember [Baby I]. I can't remember exactly how premature she was, but I remember she initially came in from another hospital because I think I was the first one who initially looked after her when she arrived at Chester.

"I remember her family and looking after her multiple times. I can't remember the intricate details, but remember she had ongoing respiratory distress you might associate with being premature, and definitely had feeding and gut problems. I also remember she had problems with a distended abdomen.

"I remember someone saying they thought she had strictures, I think because she possibly had NEC in the past. It was like there was scar tissue in her bowel, which meant there was narrowing. She stopped tolerating feeds and it was like there were blockages in her bowels, which meant she would get really distended. It was probably one of the medical team talking about it, but I can't remember who it was. It may have come from surgeons looking at X-rays of her bowel.

"With regards to 29 September 2015, I was on a long day and I was the designated nurse for [Baby I]. The notes state that at 08.00 hours I took over care for the long day, she was self-ventilating in air, her Masimo monitoring had been discontinued the day before, and an apnoea alarm was in place. My notes say she was slightly constipated and straining to open her bowels. She was mottled in appearance. Mottling is when a person's skin looks a little bit like corned beef. It is purplish-white, like when someone is really cold. It's a bit blotchy. In my experience I can say that some babies can look like that all the time and sometimes it can be a sign that they are a little bit unwell, for example if their perfusion is not that good.

"She wasn't on very much monitoring at that time and was just feeding and in a hot cot rather than an incubator. That would indicate to me that she was clothed and I would have to remove her clothing to change her nappy throughout the day and generally have a look at her whole body. My notes don't detail exactly where her mottling was on her body but it was probably her whole body, although I can't say for certain.

"With regards to 14 October 2015, I was on a long day. My first notes were written at 9.22, but I came on duty at 07.30. We hand over from 07.30 to 8.00 in the morning but I think I went straight in to get a bedside handover at 0.7.30 from Lucy Letby

because [Baby I] wasn't well and there was going to be a lot to talk about.

"Lucy was probably already at the bedside when I walked into nursery 1, but I can't be 100% sure. I remember standing with Lucy at the bedside and we had started the handover. I don't remember how long we got into the handover or how much I was told, but we were talking about her and she had a cardiac arrest right when we were looking at her.

"In terms of who was in the room, there was Yvonne Farmer, who I remember because I think I drew up the medications, including adrenaline, with her during the resus. There was Jo Williams and she did chest compressions. There was Matt Neame, who was the registrar and who was leading the resus. Her mum and dad were there, potentially Laura Eagles may have been, but I can't be sure.

"After a little while, Ravi Jayaram, a consultant, arrived. My notes state that I arrived on the unit minutes before the arrest. [Baby I] had just been re-tubed when she desaturated and bradycardia occurred. Full resuscitation was required to bring her back and I wrote 'See medical notes for full details', which meant the doctor's notes.

"She was then stable on a ventilator with a size 3 ETT, which was 7.5 centimetres at the lips, pulled back by half a centimetre by Dr Jayaram, one of the consultants. Her ventilator pressures were 28/5 and the rate was 40 with an increased respiratory time of 0.5 seconds."

She says:

"It actually says '0.5 centimetres' but that's an error by me.

"She had a fluid allowance of 150ml per kilogram per day. She had 10% dextrose infusing through a peripheral cannula and morphine and dobutamine infusing through a long line in her right leg. The site was satisfactory.

"She had a previous extravasation burn on her right arm from her resuscitation on 13 October. A cannula is supposed to be in the vein but giving fluids and drugs through it will burn the tissue if it isn't going via the right route.

"I recorded that she passed urine and had a small bowel movement and that her abdomen was very large, pale and veiny, with an umbilical hernia evident.

"I noted an area of discolouration. If it was mottling I would have written it down if that's what it was. I would describe

discolouration as slightly greyish in colour and would have been darker than the rest of her body.

"I noted that pancuronium was administered at 08.30 because [Baby I] was difficult to ventilate and desaturating and also notes that her antibiotics from the night shift were only half given due to her collapse and that doctors were aware.

"My next notes were written retrospectively at 17.08 hours. I recorded that her ventilation was weaned steadily throughout the day due to over-ventilated gases. At that time she was on 16/4, with a rate of 35, and a respiratory time of 0.4 seconds. She had good air entry bilaterally (both lungs) and suction had yielded only a small amount of clear secretions -- that's suction of mucus from inside the breathing tube.

"Her oxygen requirements dropped to 24%, but had recently raised to 35% following handling for intravenous access. That happens when you move the baby around as you can stress them out.

"Attempts at long lines and cannulas had been unsuccessful and therefore the plan was to wean dobutamine as tolerated and discontinue it as soon as possible. Her blood pressure mean was in the 50s and she was to have bloods taken later that day. We would have to move midazolam to another intravenous port due to infusion incompatibilities. We were also waiting for urine and electrolyte results as we were checking her for low potassium and potentially run a potassium infusion through a central long line.

"She did settle well throughout the day after the start she'd had. My next notes are 20.27 that evening. Her blood pressure mean remained satisfactory, therefore dobutamine was discontinued at 18.00 hours. Midazolam was running centrally, leaving peripheral access free for blood transfusion and antibiotics. The potassium infusion was never commenced due to difficulties with access and also because her levels rose slightly. Her latest potassium from gases was 3.2 and her capillary blood gas was good at 19.15 hours. We did not commence her on ciprofloxacin due to it being unavailable.

"I noted that her mum and dad were present during the day with her siblings and I also noted that after advice from Alder Hey surgeons, we may need to remove free air from her bowel using a tube or something if her tummy was to blow up again. I think it was because of the morning when I came on and her bowel had blown up so massive that it was compressing her lungs and I think that's what caused her to collapse. It was massive and I don't know at what point it went like that, but it was what caused the arrest so I imagine it would have been there at 07.30 hours.

"I remember thinking during the resus that morning that we'd lost her as it was a long time, almost 15 minutes. I think the parents thought that too. They were there for all the resus. Someone must have called them, but I can't remember if they were already there at handover when I got there.

"That day sticks in my mind because it was the last ever shift I did at the hospital as I left a few days after it."

Witness statement of MS JOANNE WILLIAMS (read)

MR ASTBURY: My Lord, the next statement is that of Joanne Williams at page 81.

This statement is dated 25 June 2018:

"DC Birch from Cheshire Police asked me about the night of 13 October into the morning of 14 October and my recollections of and involvement with [Baby I].

"I had looked after [Baby I] when she first came to Chester so I knew her and her family. She left Chester on a couple of occasions and I looked after her on her first return to the unit, I think, but since then I hadn't been her nurse.

"With regards to the 13 October night shift, rotas show me working with Caroline Oakley, Laura Eagles and Lucy Letby. There may also have been a band 4 nurse on but I'm not sure. I wasn't [Baby I]'s designated nurse that night.

"I have had the chance to review the notes and, from memory, have a very brief recollection of helping with chest compressions on [Baby I] that night. I have checked our records and I did not book any drugs out with regards to [Baby I] on the 13th into 14 October. Even having read the notes, I can't remember what time the collapse happened. In addition to being involved in chest compressions, I can remember where she was in the nursery and her mum being there, but other than that I can't recall anything else.

"With regards to where she was in the nursery, she was in nursery 1 and in the middle of the room."

Witness statement of MS LAURA EAGLES (read)

MR ASTBURY: My Lord, back to page 64, please, for the next statement, that of Laura Eagles. It's one of those statements, my Lord, of which we read part of an earlier event, so it's the statement dated 24 October 2019.

I go to 64:

"I was also asked by DC Birch about the dates of the 13th into 14 October 2015 in relation to [Baby I]. Again, I've had the opportunity to go through the notes and I could see that she had two collapses, one at 07.00 and one at 07.45 on the 14th.

"I don't really remember anything too specific from that night, such as who was where and who did that. I wasn't looking after [Baby I]. Lucy Letby was her designated nurse and I know that from reading the notes. Caroline Oakley was in charge of the unit that night and I was looking after an ITU baby, an HDU baby and another sick baby.

"I'm sure I would have come to help but it was very busy. Jo Williams and Janet Cox were also on and from our Badger system I could see there were three ITU babies, two HDU babies and seven special care babies that night.

"I have been informed that I co-signed for two lots of sodium chloride, which is a bolus, for [Baby I] at 06.28 hours and 06.35 hours on 14 October, but I was unable to see that when I looked at the notes as it is recorded on the electronic medication administration record."

They are the forms that we'll see, very different from the nursing notes, on the sequence of events chart:

"We don't have access to those once babies are discharged. Also I have been told I co-signed for teicoplanin, an antibiotic, at 06.27 hours that day. Again, I couldn't see that as it was on EMAR. I can look at the scanned paper prescriptions but not at my electronic signatures.

"From the notes I can see [Baby I] was re-intubated at 07.00 hours, but she really didn't pick back up significantly and by 07.45 hours CPR was commenced. I don't think she particularly recovered from the 07.00 collapse, so the 07.45 hours was a continuation of that first collapse.

"I don't really have recollections of that but I obviously signed for drugs and so was clearly involved at some level. I remember [Baby I] well. I just don't remember all of the events. She was ill several times and was on the unit a long time. It is hard to say which one was which and each event is hard to separate from another within my memory."

My Lord, that concludes Laura Eagles' statement.

Witness statement of DR DAVID HARKNESS (read)

MR ASTBURY: We can return, please, to Dr Harkness, who -- and in particular page 73 of my Lord's bundle. Again, picking up his statement, part of which we've already read and which is dated 17 October 2018, Dr Harkness says this:

"She [meaning [Baby I]] had quite an eventful night overnight on the 13th into the 14th. Looking at the notes, her oxygen requirements had gone up a bit. She needed chest X-rays again with possibly some collapse of her lung. She had had a new endotracheal tube for ventilation to see whether that would help and that seemed to improve things at that point in time. Then she deteriorated again and the worry seems to be from the notes that there was a pneumothorax there and Dr Jayaram had been called. She carried on deteriorating and she needed CPR in the early hours of that morning.

"The next entry written by me was on 14 October 2015 at 11.00 hours. This was another ward round routine review. She was 36 weeks plus 5, so day 63 of life. Problems-wise, I wrote that she'd had two cardiac arrests, was on a ventilator and we were suspecting NEC.

"They were quite long arrests as well, 20 minutes or so of resus, which is a long time. At this point she was on relatively high pressures on the ventilator, her oxygen level had come down quite quickly, so one of the medications I gave her that morning was a dose of a paralysis agent, which helped her stop moving and fighting against the ventilator. This can make it easier for them to breathe. Her blood gases were acceptable but not fantastic and were still on the poor side.

"Her lactate, which can be a sign of poor perfusion and them being unwell, particularly with things like NEC was 7.6, which is quite high. You'd normally like it to be about 1 or 2.

"Examining her, I found some crackle on the left side of the lungs. There had been a suggestion of a bit of a collapse of the lung and those noises pointed to a collapse or infection or fluid on the lung, which may explain why we were struggling with ventilation. We had her on some fluids via the lines with no TPN or feeds. She had opened her bowels and had good urine output of 3.8ml per kilogram per hour. You want to see more than 1 millilitre per kilogram per hour. This is a good sign of your blood pressure and your perfusion to your kidneys and organs, so that was good. It suggested her blood pressure was good. She was also on some meds for blood pressure.

"We were still waiting on any blood cultures to see if there was any proof of an infection. Her CRP was 3. CRP can go up with immunisations as well and doesn't always go up in babies with infections. Where CRP is useful is when it is high and if you

are treating something, you want to see it coming down. So if you are looking at a trend of it coming down, it suggests that whatever was there is getting better.

"Where it is not helpful is when it never goes up. It doesn't mean they haven't got an infection. Her white blood cell count was around 25.6, which is high. You'd normally expect it to be around the 10 mark. That's a sign of infection, inflammation and stress.

"I had also looked at the X-rays at this point, which showed something new, but did show previous changes in chronic lung disease.

"After my entries, there is advice from the Alder Hey surgical team on her the notes. This was a phone call back from one of the surgical consultants discussing [Baby I] with [Dr B], who thought that because she previously may have had an episode of NEC that had been medically treated, she now had a stricture, a narrowing of the gut. The surgical consultants didn't think at this time there was any perforation of the gut and they suggested carrying on for a week on the antibiotics as we were doing, keeping her nil by mouth, and feeding her TPN.

"They said that if the abdomen carried on getting bigger and bigger, to put a tube into the rectum to vent some air off. They also wanted daily X-rays to look for any further signs that this was NEC and it was getting worse. Not just X-ray signs but also from further blood tests, looking at CRP and whether it went up or if platelets came down, which can both be signs of things worsening. Then they would consider doing surgery at that point.

"It was about monitoring her closely and then once she was better they would consider doing some contrast studies where you put radioactive dye into the bowel to look for a narrowing to see if there was anything that was causing problems. If they found something they would have to remove it, but this was all planned for 1 to 2 weeks down the line.

"My next entry was at 16.00 hours the same day, the 14th. Her ventilation was much improved and the pressures on the ventilator had come down nicely. She needed some blood as she was anaemic, but her blood pressure was better so the plan was to stop the dobutamine for that.

"One of the issues we'd had was it had been very difficult for us to get any access to give her anything. The discussion was around giving her blood through the cannula that we were no longer giving her dobutamine through. This was all anticipated to be in the next 12 hours or so.

"Again I also summarised the previous conversations [Dr B] had had about the daily X-rays and the surgeons' plan not to restart any feeds and the idea of putting a tube up her bottom to let out any air if we needed to. I don't believe we ever needed to do that. That was just what they had said if her abdomen was so big it affected her breathing by putting pressure on her lungs. It is more common in adults and is often called a flatus tube but we never needed to do that.

"The commonest things that sets things off in premature babies is infection. They are still vulnerable being on a neonatal unit as there are more people and more exposure to bugs, but they're equally not safe at home. Their immune system isn't quite there and so the chance of getting an infection is there. They shouldn't be born yet so the amount of stress on their body means they are more prone to getting something.

"With [Baby I], her CRP had been high and come down. The problem we get is that it is very rare you'll find bacteria in the blood that give you answers. X-rays are only so good at showing us what's going on. They are not good enough or sensitive enough that we can look at them and say exactly what it is that's going on, we look for suggestions of things going on. Her X-rays had never given us the categorical answer that this was NEC. It all suggested there might be this stricture there from a previous episode and it was causing her problems again. We don't know with NEC how often it actually happens and the only way you can confirm it is once you have done the surgery and removed the bowel.

"In a lot of suspected cases you give them antibiotics, you rest their gut and they get better, which was probably what was happening with [Baby I]. Certainly the way she deteriorated with her abdomen becoming distended fits with the abdomen being the cause of the problem. The abdomen got larger and firm and bowel sounds were there but none consistently. She wasn't opening her bowels regularly and it all pointed towards it being related to her bowel.

"In the last week of her life, I don't appear on the clinical notes and I don't know if I was away or working on the children's ward covering. I do remember [Baby I]'s death and I remember her parents coming back to the unit a few times over the next year or so."

That concludes Dr Harkness' statement.

MR JUSTICE GOSS: Thank you.

Witness statement of DR SRINVASARO BABARAO (read)

MR ASTBURY: My Lord, there is one more statement to be read in this section from the case from Dr Babarao.

This is a statement, my Lord, from Dr Srinvasaro Babarao. It's dated 29 March 2019 and it deals with [Baby I]'s transfer on 15 October to the tertiary centre. Dr Babarao says:

"I am a consultant neonatologist at the Wirral University Teaching Hospital. This is also known as Arrowe Park Hospital. [Baby I], date of birth 7 August 2015, was referred to us at Arrowe Park Hospital from the Countess of Chester on 15 October 2015.

"I was the consultant for the clinical shift on that day covering the neonatal unit. I don't recall the exact conversations I've had prior to transport. However, referring to the medical notes, there were conversations between consultants at Chester, Liverpool Women's Hospital and Arrowe Park Hospital and it was decided that [Baby I] should be sent to Arrowe Park as it was closer to home and we are a tertiary/level 3 unit which cares for such babies.

"[Baby I] was transported by Cheshire and Mersey Neonatal Transport Service. She arrived with us at 15.30 hours approximately on 15 October 2015. There was a routine clerking of the baby as normal practice, as she came on to the unit. She was day 68 of life on that day. Her corrected gestation was 36 plus 6, so 36 weeks and 6 days, having been born at 27 weeks' gestation, with a birth weight of 0.97 kilograms and current weight of 1.83 kilograms.

"The background information was she had respiratory distress syndrome as a preterm, chronic lung disease, again due to prematurity, and there was suspected necrotising enterocolitis (NEC) infection/inflammation of the gut, which is not uncommon in preterm babies.

"[Baby I] had already been discussed with the surgical team at Alder Hey Children's Hospital and the intention was that she would be conservatively managed. There were discussions between the Countess of Chester consultants and the surgical team at Alder Hey Hospital as a plan from the surgical perspective that she may require some contrast studies to look if there were any strictures or obstruction in the gut.

"From the medical notes, I can see that [Baby I] had two cardiac arrests in the 36 hours prior to her arrival at Arrowe Park. There had been a discussion with Liverpool Women's Hospital the previous day to her admission and discussions whether she should be transferred there. However, it was agreed and decided at that

time she did not need to be transferred to Liverpool Women's Hospital and remained at Chester.

"The following day, in the early hours of the morning, she had another acute episode of cardiac arrest and, further to this, she was on the ventilator with a breathing tube and the discussions were again to transfer [Baby I].

"She was accepted by myself to Arrowe Park Hospital for continuing care at a level 3 unit. [Baby I] arrived on 15 October 2015, ventilated with a breathing tube in. It was the appropriate size and correct length. She was on a moderate amount of ventilation and oxygen requirements of 36%, which is not a lot.

"She was kept nil by mouth as per the plan from the Chester neonatal unit. She was on intravenous fluids. This was changed to total parenteral nutrition and lipid, which is what we do for any preterm baby who is nil by mouth via a central line, which is also known as a long line.

"She was also on sedation of midazolam and morphine, which is routine. She had already commenced on antibiotics for necrotising enterocolitis and a possible infection. These were co-amoxiclav, metronidazole and gentamicin.

"On assessment the baby was pink, warm and well perfused and her vital signs were within normal limits. Her abdomen" --

MR JUSTICE GOSS: Sorry, could you pause there for a moment?

JUROR: Can I just have a moment, please?

MR JUSTICE GOSS: Certainly, yes. A moment out?

JUROR: For a moment if that's okay.

MR JUSTICE GOSS: Yes, certainly. Well, I think... I don't know if it's possible for -- when you say a moment -- JUROR: Just a moment so I can just cool down a little bit.

MR JUSTICE GOSS: Yes. You've got some water there, have you and everything? Do you have any tissues?

JUROR: I haven't.

MR JUSTICE GOSS: Usher, I think that would help in the first instance, wouldn't it? I don't really want everyone to have to go out if it isn't necessary. Is it possible for you to slip out for a minute to compose yourself?

Does anyone have any objection to this juror -- we'll remain here -- just leaving the court for a moment to compose herself? Thank you very much.

Take as long as you like, we'll wait here.

(Pause)

MR JUSTICE GOSS: I apologise again for the fluctuating temperatures we get here. As I've said several times before, I don't have any real control of it. I try and ask for it to be a median temperature, which is sort of generally acceptable to everyone, but it's impossible to achieve, I'm afraid.

(Pause)

MR JUSTICE GOSS: All right? Just raise your hand if you need another break. If I hear you coughing, I'll look at you, obviously. Thank you.

MR ASTBURY: I'll go back a little bit, my Lord.

MR JUSTICE GOSS: Yes, please, because it was difficult.

MR ASTBURY: I was not sensitive to it and I'll have another crack at those antibiotics as well when we get there.

So:

"[Baby I] arrived on 15 October 2015, ventilated with a breathing tube in, which was the appropriate size and correct length. She was on a moderate amount of ventilation and oxygen requirements of 36%, which is not a lot.

"She was kept nil by mouth as per the plan from Chester neonatal unit. She was on intravenous fluids and this was changed to total parenteral nutrition and lipid, which is what we do for any preterm baby who is nil by mouth via a central line, which is also known as a long line.

"She was also on sedation of midazolam and morphine, which is routine, and she'd [already] commenced on antibiotics for necrotising enterocolitis and a possible infection. These were co-amoxiclav, metronidazole and gentamicin.

"On assessment, the baby was pink, warm and well perfused and her vital signs were within normal limits. Her abdomen was soft, but bowel sounds were not heard, which is not unusual when treating issues with the gut. The plan at the time was to stabilise the baby and to keep her nil by mouth, monitor gases, continue parenteral nutrition, continue antibiotics, and follow

the plan by the surgical team at Alder Hey, which was to conservatively manage this episode and this would be 7 days nil by mouth, 7 days of antibiotics and then considered doing a contrast study, which would be done either at Alder Hey Children's Hospital or at Liverpool Women's Hospital.

"Routinely, an X-ray would be done if a baby comes to us ventilated. An X-ray was done that evening. It showed the breathing tube to be in a reasonably good position and also showed the long line, the central line, to also be in good position. There are no comments in the notes as to the appearance of the gut, but there are comments that the lungs looked like preterm lungs.

"On 15 October 2015 I finished my duty at 17.00 hours and I was not on call that evening. I had handed over to colleagues. I can see from the senior registrar and the consultant notes from that evening that [Baby I] was stable on the unit until around 00.13 hours on 16 October 2015 when there was a sudden episode of bradycardia and desaturation. This means her heart rate and oxygen levels dropped suddenly following suction through the breathing tube, which is a usual practice that nurses carry out.

"At this time she was Neopuffed, which means she was disconnected from the ventilator and efforts were made to bag her manually through the breathing tube. From the medical notes, there was no improvement of the heart rate with the bagging and there was no chest movement after bagging. The chest should move with bagging unless there is an obstruction or the tube has displaced.

"At this time there was no air entry and the tube position was confirmed using a capnograph. This is where a tiny device is placed on top of the breathing tube to establish if there is any carbon dioxide coming out. If there is, it will trigger a colour change on the device. It did not change colour so it meant the breathing tube was obstructed or had moved from its position, so the safest thing to do is to remove the breathing tube.

"[Baby I]'s tube was removed at this time and was found to be blocked with dark-coloured blood, probably from the previous collapse in Chester. As the tube was removed, she responded very quickly and the heart rate and saturations came up. This confirmed it was the tube that was the problem as it was blocked. Once the tube was removed, it was assessed if she could be re-intubated and the tube put back, but the notes state she was spontaneously breathing and she received positive end-expiratory pressure, PEEP, to support her breathing. She was saturating well and given the fact that she was 36 weeks, nearly 37 weeks, and a good weight, and looking at the respiratory

pattern, they decided not to re-intubate her but to try a lower level of respiratory support, which was high flow.

"At this time they also visually checked the oral cavity and the vocal cords where the breathing tube went in to check for any evidence of trauma. They were checking for any ongoing bleeding. The notes mention there was no fresh bleeding or any significant injury noted so they were satisfied to commence with high flow on 5 litres, which is an optimal amount of flow, and she was in about 35% oxygen.

"The parents were updated by the consultants and senior registrar at this time. The following morning, the registrar and junior doctor reviewed [Baby I] at 04.30 am, which was routine. She was stable in high flow, 5 litres, in about 30-35% oxygen. She had very good blood gases, minimal recessions, no issues with her breathing, no respiratory difficulty. The mean blood pressures were fine, urine output was good and she'd been kept nil by mouth.

"[Baby I]'s abdomen was soft and it was not distended and her bowel movements could be heard at this time and it was reassuring that the tummy was fine and not worsening. She hadn't opened her bowels. However, this was not unusual as she'd been kept nil by mouth. A featureless bowel was noted from the X-ray and there was no noted gas from lack of gut movement.

"From the infection perspective, the inflammatory markers were non-impressive. The CRP used in an infection marker was less than 5, which is normal, and the blood cultures from Chester were also negative. The triple antibiotics were continued and [Baby I] was also commenced on a phosphate infusion as the routine blood tests carried out at Arrowe Park did show low phosphate. All other blood tests were reasonable.

"The plan was to leave [Baby I] on high flow and reduce the oxygen as tolerated and keep her for 7 days nil by mouth and continue with triple antibiotics for the 7 days as per the original surgical team plan arranged by Chester.

"The following morning, on 16 October 2015, I was back on duty and a review was completed and notes were made to reduce the phosphate infusion to half the dose as her levels were coming up and to discuss when the contrast studies would happen with relevant surgeons. There was ongoing monitoring of the gases and blood pressure and she was moved to the high dependency unit based on that she was 37 weeks, stable on high flow, and her gases were good. Her oxygen requirements were coming down.

"I had also made a plan that if [Baby I] continued on high flow with no issues, I suggested she should be discussed with Chester for repatriation(?) the following day.

"We had observed the baby. We extubated the baby and she had been stable on low respiratory support and there was no ongoing need for a tertiary level input, so the baby could return to Chester to be closer to home with parents for ongoing care.

"Later that day, 16 October 2015, at around 16.45 hours, the call was made to Alder Hey Children's Hospital to confirm the surgical plan. However, the registrar couldn't get hold of the consultant. However, remember that evening I have documented I had spoken to [Dr B], who is a consultant at Chester neonatal unit. I have updated her with all the existing issues and mentioned how stable [Baby I] had been since being transferred to us.

"I clarified with her about the surgical plan as she had discussed with the Alder Hey surgical team and she stated [Baby I] would need a contrast study. This procedure involves a dye being inserted via the tummy to see how the dye goes into the gut and X-rays would then be taken and this would allow them to confirm if there is any narrowing in the bowel at any point or any obstruction. [Dr B] advised she would be sorting out the contrast studies either at Alder Hey or Liverpool Women's Hospital. She was happy to have the baby back the following day on the basis of the information given. The transport team were informed of the required transport for the following day. There were no issues overnight and gases remained good. Oxygen requirement was down and she remained stable.

"As this was not the first episode and she had been conservatively managed previously, this is why we suspected there may be issues with the stricture, which is not unusual after necrotising enterocolitis. However, no stricture was found and her treatment received is routine treatment for necrotising enterocolitis.

"The following morning, on 17 October 2015, at 9 am, my colleague, Dr Lee, was working and again she spoke to a consultant at the Countess of Chester Hospital. This was Chester consultant [Dr C] and it was confirmed again the circumstances around the transfer of [Baby I] back to Chester and [Dr C] has also agreed to the return to Chester for [Baby I]. She left here at around 11.00 hours on 17 October back to Chester."

That concludes that statement, my Lord.

MR JUSTICE GOSS: Thank you.

MR ASTBURY: And for now the evidence in relation to event 3.

MR JUSTICE GOSS: Thank you.

MR JOHNSON: Before I call Mrs Hocknell to deal with the sequence, I wonder whether we can distribute the documents to go behind divider 12, documents for event 3 and the forthcoming final event 4.

MR JUSTICE GOSS: Thank you.

MR JOHNSON: They come as a pair, they're separate. One should have a -- ah, right.

MR JUSTICE GOSS: Sorry, one should?

MR JOHNSON: It's all right.

MR JUSTICE GOSS: These are just three at the moment?

MR JOHNSON: Just three.

(Handed)

MR JUSTICE GOSS: Do you have a sticky divider on this one?

You do? All right.

MR JOHNSON: Did I leave you out, my Lord? I'm sorry.

MR JUSTICE GOSS: It's all right. I'll put one on from here. I'll take it from here.

MR JOHNSON: I have a little package of them here if you want.

(Pause)

MR JUSTICE GOSS: To state the obvious, 3 are the documents you have seen on screen this far or they've been pointed out on screen and these are some of the paper copies of some of those documents. But 4 are ones that we're going to be referred to by Mr Johnson when he goes through the sequence of events, I anticipate, and by witnesses in due course.

MR JOHNSON: When we've done that, there's also an addition for event 1 and this will be the third sheet in, so if you go back to the beginning of divider 12, you'll see that the first two documents you have are pages 14714 and 14715. If put this sheet in next at 14740, it will come before the feeding chart, which at the moment is the third document, 14778, something we overlooked.

(Pause)

MR JUSTICE GOSS: Sorry, I was doing other things.

Could you tell me, this should be the third document in section 1 within section 12?

MR JOHNSON: Divider 12, yes.

MR JUSTICE GOSS: Right. So as you said, between 14715 and 14778?

MR JOHNSON: Correct.

MR JUSTICE GOSS: Good, thank you.

Are you all done, all happy you've got everything in the right place? Good.

MR JOHNSON: Thank you. Claire Hocknell, please.

MRS CLAIRE HOCKNELL (recalled)

Examination-in-chief by MR JOHNSON

MR JOHNSON: Welcome back, Mrs Hocknell. Just for the sake of the record, could you identify yourself, please?

HOCKNELL: Claire Hocknell.

JOHNSON: Thank you. We're now going to move on to the fourth and final sequence of events presentation dealing with the case of [Baby I]; is that right?

HOCKNELL: That's correct.

JOHNSON: Unhappily, just to remind the jury, this sequence results with [Baby I]'s death; that's right, isn't it?

HOCKNELL: Yes.

JOHNSON: At slide number 1, do you record the fact that between and including the 15th to 17 October, [Baby I] was transferred out of the Countess of Chester Hospital to Arrowe Park, being returned back to Chester on the 17th?

HOCKNELL: Yes.

JOHNSON: Does what follows, just looking at slide number 2, provide a detailed account of [Baby I]'s records from midnight on the 21st into 22 October?

HOCKNELL: Yes, that's correct.

JOHNSON: Just so that the jury can contextualise that, [Baby I] died about 24 hours later?

HOCKNELL: Yes.

JOHNSON: The next two slides, which are also timed at midnight, are they [Baby I]'s observation chart and the neonatal fluid balance chart?

HOCKNELL: Yes.

JOHNSON: The jury have just received those documents in paper format.

Tile 5, is that the neonatal fluid balance chart half an hour later at 01.30?

HOCKNELL: Yes.

JOHNSON: Each of these documents at the moment is being completed by hand by Ashleigh Hudson; that's right, isn't it?

HOCKNELL: Yes.

JOHNSON: At tile 6 do we have a further observation chart?

HOCKNELL: Yes, at 2 o'clock.

JOHNSON: And the general pattern at this stage was that the observation chart, which is the yellow and white coloured document, is being completed every 2 hours, wasn't it?

HOCKNELL: Yes.

JOHNSON: The neonatal fluid balance chart, however, was being completed rather more frequently. Tile 7 is figures timed at 02.15?

HOCKNELL: Yes.

JOHNSON: And tile 8, figures timed 45 minutes later at 3 am?

HOCKNELL: Yes.

JOHNSON: At tile 9, do we have Ashleigh Hudson's notes made at 03.04 hours?

HOCKNELL: Yes.

JOHNSON: And as we have seen many times before in this context, do they cover or do they include a summary of the care given by Ashleigh Hudson from the beginning of the shift at 8 pm, 20.00 hours, the previous day?

HOCKNELL: Yes, that's correct.

JOHNSON: Just so that we can bring ourselves up to date with [Baby I]'s condition at this stage, and although Ashleigh Hudson will be giving evidence in due course, I'd just like to look at her note on this occasion, please. Could you take us through that slowly, please?

HOCKNELL: "Written for care taken over at 20.00 hours 21/10/15. Emergency equipment, alarm limits and fluids checked. Continues to be nursed in an incubator. Philips monitor in situ. Self-ventilating in air. Saturations 96% and above. No increased work of breathing. Other observations satisfactory as charted.

"[Baby I] is pink and well perfused. Longline remains in situ, patent. VIP score zero. Pressures 270 to 300 at times. Resolved on repositioning. TPN and lipid running as prescribed. Rates increased at midnight due to weight gain. New TPN and lipid in situ. Free drainage via nasogastric tube. Minimal aspirates recorded. Clear fluid. Abdomen soft and non-distended. Unsettled at start of shift and rooting. Settled with dummy. Settled and sleeping at present. Alert when awake. Passed urine."

JOHNSON: So at 4 o'clock, tiles 10 and 11, do we have two of the standard three --

HOCKNELL: Yes.

JOHNSON: -- being the observations and the fluid chart?

HOCKNELL: Yes.

JOHNSON: At tile 12, at 05.20, is the fluid chart completed with further data by Ashleigh Hudson?

HOCKNELL: Yes.

JOHNSON: At 6 o'clock, 06.00 hours, tile 13, [Baby I]'s vital signs were charted by Ashleigh Hudson?

HOCKNELL: Yes.

JOHNSON: Tiles 14 and 15, at 06.00 and 07.00 hours respectively, was the fluid chart data completed by Ashleigh Hudson?

HOCKNELL: Yes.

JOHNSON: Then at tile 16, is there a marker in there, timed at 07.30 to 08.00 hours, denoting the handover of the nursing responsibilities from Ashleigh Hudson to Caroline Oakley?

HOCKNELL: Yes.

JOHNSON: Is that followed at tile 17 by Caroline Oakley's notes concerning -- notes which were actually made at 10.25, so 2.5 hours or so after she'd come on shift, but relating to this time at the beginning of the shift?

HOCKNELL: Yes.

JOHNSON: Again to put us in the picture so far as [Baby I]'s overall condition was concerned, can we just deal with what Caroline Oakley wrote, please?

HOCKNELL: "Written for care given from 08.00. Handover taken. Equipment, alarm limits and IV fluids checked and satisfactory. [Baby I] self-ventilating in air. Long line in situ right leg. Positional with high pressures. VIP score zero. S/B Dr Neame. Continue as plan. [Dr A] chasing Alder Hey Children's Hospital for barium enema. Observations satisfactory."

JOHNSON: Just putting the barium enema in context, we all understand that you're not medically qualified, but we've heard about contrast studies and a barium enema is connected to a contrast study, isn't it?

HOCKNELL: That's my understanding.

JOHNSON: Yes. Tile 18 is also timed at 08.00 hours and behind it we would see [Baby I]'s vital signs recorded?

HOCKNELL: That's correct.

JOHNSON: Tile 19, 08.00 hours, the fluid balance chart?

HOCKNELL: Yes.

JOHNSON: As is tile 20, an hour later, at 09.00 hours?

HOCKNELL: Yes.

JOHNSON: And 21, yet a further hour later, 10.00 hours, tile 21?

HOCKNELL: Yes.

JOHNSON: Tile 22 is the time at which, 10.25, the note that has been put in at 08.00 hours was actually updated on the computer by Caroline Oakley?

HOCKNELL: That's correct.

JOHNSON: Two minutes later, Nurse Oakley added a further update in the nursing notes, tile 23, recording the fact of:

"Parents visiting and updated by Dr Neame. Parents have [Baby I] out for cuddles."

HOCKNELL: Yes.

JOHNSON: Tile 24, at 11.00 hours, is the on-hour record, which seems to be being kept every 2 to 3 hours, of [Baby I]'s vital signs?

HOCKNELL: That's correct.

JOHNSON: Then tile 25 concerns a prescription for sucrose --

HOCKNELL: That's correct.

JOHNSON: -- so sugar, at 11.00 hours. And the fluid balance chart filled in at 11.00 hours, tile 26?

HOCKNELL: That's correct.

JOHNSON: By Caroline Oakley?

HOCKNELL: Yes.

JOHNSON: Followed by Dr Neame's clinical notes concerning an examination of [Baby I] at 11.30?

HOCKNELL: Yes.

JOHNSON: We'll go to this again as it picks up a theme that's been raised. Can you take us through his note, please?

HOCKNELL: "Current gestation is 37 plus 6 at day 71. Problems: preterm, recurrent abdo distension [query] cause. Previous cardiac arrests. Ventilation: self-ventilating in air. Fluids, 150ml per kilogram per day of TPN. Nil by mouth. Passing urine. No significant aspirates. Medication nil regular. [I think it's 'investigation']. No current concerns. Lines: long line right leg, tip L1/2 [or half]. Plan: chase contrast enema. Remain nil by mouth for now."

JOHNSON: Thank you. Following that, is there in effect a fairly unremarkable afternoon between midday and 5 pm, so perhaps we can summarise tiles 28 to 35 by saying that on the hour, every hour, between and including 12.00 hours to 17.00 hours, [Baby I]'s fluid balance chart was completed?

HOCKNELL: Yes.

JOHNSON: And her vital signs, her observations, were taken at 14.00 hours and 17.00 hours, being tiles 30 and 35?

HOCKNELL: That's correct, yes.

JOHNSON: So moving on to tile 36, do we come to a further nursing note made by Caroline Oakley?

HOCKNELL: Yes.

JOHNSON: Does that record -- we probably don't need to go to it at the moment -- the fact that there'd been no progress in relation to transferring [Baby I] to Alder Hey Children's Hospital in Liverpool for a barium enema?

HOCKNELL: Yes.

JOHNSON: Actually, we will go to it because there is a relevant note in there. Does it also say:

"Unsettled at times, obviously very hungry"?

HOCKNELL: Yes.

JOHNSON: "Usually settles with dummy"?

HOCKNELL: Yes.

JOHNSON: We can see for ourselves the balance of that note.

Tile 37 next, please. Is that a further prescription for sucrose?

HOCKNELL: Yes.

JOHNSON: Followed at tiles 38 and 39 by two fluid balance charts timed at 18.00 and 19.00 hours respectively?

HOCKNELL: Yes.

JOHNSON: Then at 40, at 19.07.30, by an incoming message, to Lucy Letby from [Nurse E]?

HOCKNELL: Yes:

"Let me know if Dec off-duty is out."

JOHNSON: Which may or may not be a request to know if the rota for December is --

HOCKNELL: Yes.

JOHNSON: -- available.

Then between tiles 41 and 45, is there door swipe data concerning the entrance of Melanie Taylor and Lucy Letby, Ashleigh Hudson and Christopher Booth?

HOCKNELL: Yes.

JOHNSON: Those are all timed between 19.14 and 19.27?

HOCKNELL: Yes.

JOHNSON: Thank you. So far as those ladies and gentleman are concerned, we're about to see that they were the staff for the night shift, but before we do that, can we go to tile 46 and have the list. Before we go to who they were responsible for, we have the list. Do we see that the paediatrician of the week was [Dr C]?

HOCKNELL: Yes.

JOHNSON: On call was Dr Gibbs?

HOCKNELL: Yes.

JOHNSON: The night registrar was Dr Chang?

HOCKNELL: That's correct.

JOHNSON: The SHO, Dr Ladde?

HOCKNELL: Yes.

JOHNSON: I don't believe you've been able to identify who the shift leader was for this shift.

HOCKNELL: No.

JOHNSON: The four registered nurses working were Ashleigh Hudson, Lucy Letby, Melanie Taylor and Christopher Booth?

HOCKNELL: That's correct.

JOHNSON: I think we know from evidence we've already received that of those nurses, Christopher Booth was the most senior?

HOCKNELL: I think so, yes.

JOHNSON: Finally, do we see that Valerie Thomas was the nursery nurse?

HOCKNELL: Yes.

JOHNSON: So the next slide gives us the population distribution and relative responsibilities amongst the staff. Can we start in room 1, nursery 1? [Baby I] was in nursery 1; is that right?

HOCKNELL: Yes.

JOHNSON: Together with another child whose initials are AB?

HOCKNELL: Yes.

JOHNSON: Ashleigh Hudson was responsible for both children?

HOCKNELL: That's correct.

JOHNSON: Moving round to nursery 2, do we see in there a child HS, for whom Lucy Letby was the designated nurse?

HOCKNELL: Yes.

JOHNSON: Then in nursery 3, two children, MC, for whom Lucy Letby was the designated nurse --

HOCKNELL: That's correct.

JOHNSON: -- and [Baby G], for whom Christopher Booth was the designated nurse?

HOCKNELL: Yes.

JOHNSON: There were two children in transitional care, OC and CL, to whom Valerie Thomas was designated?

HOCKNELL: Yes.

JOHNSON: Then finally, a child JB, for whom Melanie Taylor was responsible but whose location you've been unable to confirm?

HOCKNELL: That's correct.

JOHNSON: So having established that Ashleigh Hudson was [Baby I]'s designated nurse for this night shift, we move on to tile 48 next.

Can you tell us or read to us the note that Ashleigh Hudson made at the beginning of the shift? If we go behind that, please, Mr Murphy.

HOCKNELL: "Written for care taken over at 19.45 hours on 22/10/15. Emergency equipment, alarm limits and fluids checked. Nursed in an incubator. Philips monitor in situ. Self-ventilating in air. Observations satisfactory as charted. [Baby I] was unsettled and rooting at start of shift. Settled with dummy and containment holding."

JOHNSON: Thank you. At 8 pm, 20.00 hours I should say, at tile 49, were [Baby I]'s vital signs recorded by Ashleigh Hudson?

HOCKNELL: Yes.

JOHNSON: Together with the neonatal fluid balance chart?

HOCKNELL: Yes.

JOHNSON: Does tile 51, which is the next tile in the sequence -- is that timed at 20.09 hours, and does it record the fact that there were social messages being texted between [Nurse E], who plainly was not in work, and Lucy Letby who was?

HOCKNELL: Yes.

JOHNSON: Do we then have a sequence of five records from the door swipe data between tiles 52 and 56?

HOCKNELL: Yes.

JOHNSON: Do they record the movements of Dr Rachel Chang, Dr Buv Ladde and Nurse Melanie Taylor?

HOCKNELL: Yes.

JOHNSON: So the registrar, the house officer and Melanie Taylor, who was looking after JB, whose location we don't know?

HOCKNELL: Yes.

JOHNSON: Thank you. Tile 57 next is a message which is in the context of social messaging which had gone before, sent by Lucy Letby to [Nurse E]?

HOCKNELL: Yes.

JOHNSON: Could you read it for us, please?

HOCKNELL: "Oh, that's fantastic. Unit nice. Transport on way to take my baby back to Stoke. Only 8 babies. Off-duty not out."

JOHNSON: Thank you. On that population chart that we saw before, we'd seen that there were eight babies and we had seen that Lucy Letby had two, HS in nursery 2 and MC in nursery 3?

HOCKNELL: Yes.

JOHNSON: Moving on to the next tile, please, 58. Was there a further message sent 30 seconds later by Lucy Letby to [Nurse E]?

HOCKNELL: Yes:

"I think I need to see Grey's Anatomy!"

JOHNSON: Then at 59, within a few seconds, did [Nurse E] respond to the first of those two messages sent by Lucy Letby?

HOCKNELL: Yes:

"Aw, the Stoke baby from Mon came then. How come the transferring overnight? It's amazing!"

JOHNSON: The end of that may be a reference to Grey's Anatomy, who knows.

HOCKNELL: Yes.

JOHNSON: The next message came from Lucy Letby; is that right?

HOCKNELL: Yes.

JOHNSON: These are all in fairly quick-fire sequence, so if you deal with the Lucy Letby messages and I'll deal with the responses.

HOCKNELL: Okay.

JOHNSON: Can we start with tile 60?

HOCKNELL: "Yeah. Transport been unable to take since Tuesday despite Stoke having beds but free tonight, so doing it as nothing else pending."

JOHNSON: Does [Nurse E] respond at tile 61:

"Has C gone back to Liverpool Women's Hospital"?

HOCKNELL: That's correct. And then Lucy Letby replies:

"Yeah, today. Just went to tell baby's parents that transport coming. Mum came to bedroom door after lots of what sounded like scrabbling in a tiny lacy nightdress hardly covering anything, with dad in the bed."

JOHNSON: Did [Nurse E] respond:

"OMG! How can they even contemplate that behaviour after just having a baby! Who else you got"?

HOCKNELL: That's correct.

JOHNSON: Is there then a neonatal fluid balance chart at 9 pm?

HOCKNELL: Yes.

JOHNSON: Then at the same time pretty much, did Lucy Letby send a further message to [Nurse E]?

HOCKNELL: Yes:

"I know!! Especially when rooming in! MC."

JOHNSON: Is MC one of the children in the unit?

HOCKNELL: Yes.

JOHNSON: And in fact was one of the two to whom Lucy Letby was designated?

HOCKNELL: That's right.

JOHNSON: Did [Nurse E] then respond:

"Thought she was went out Mon? Did [Baby I] have contrast done?"

HOCKNELL: Yes.

JOHNSON: There's then some swipe data for Dr Chang?

HOCKNELL: Yes.

JOHNSON: Then a response from Lucy Letby?

HOCKNELL: "No, haven't got any beds at Arrowe. [Baby I] still waiting but has had abdo scan that was fine."

JOHNSON: [Nurse E] responded, "What a pain".

Then 70 and 71, at 21.23 and 21.26, both Dr Ladde and Dr Chang went into the neonatal entrance doors?

HOCKNELL: That's correct.

JOHNSON: Followed by a message, this time incoming from Jennifer Jones-Key; is that right?

HOCKNELL: Yes.

JOHNSON: Did that read:

"How's work"?

HOCKNELL: Yes.

JOHNSON: More door data for Melanie Taylor at 73 and 74.

Followed at 75 by the fluid balance chart record made at 22.15 by Ashleigh Hudson?

HOCKNELL: Yes.

JOHNSON: Followed at 76 by more of Dr Chang's swipe data, as indeed it is at 77 as well?

HOCKNELL: Yes.

JOHNSON: Is the next tile, 78, a further message from Lucy Letby, this time to Jennifer Jones-Key, who had asked her shortly before, "How's work"?

HOCKNELL: Yes. She replies:

"Fine. HS going back. Transport on way."

JOHNSON: HS, just to put that in context, was one of Lucy Letby's two children and he or she was in nursery 2?

HOCKNELL: Yes.

JOHNSON: So that would have left her with a single child in nursery 3.

Did Lucy Letby then send a further message to Jennifer Jones-Key?

HOCKNELL: Yes:

"Has Janet text about reading?"

JOHNSON: Did Jennifer Jones-Key respond:

"Thought he would do"?

HOCKNELL: Yes.

JOHNSON: Then, "Yeah". So presumably that's an answer to, "Fine. HS going back transport on way", and "Yeah" to, "Has Janet text about reading"?

HOCKNELL: Yes, so Lucy Letby replies:

"How random that it's the same."

JOHNSON: And then Jennifer Jones-Key responds "Very". Do we then see that Dr Gibbs was certainly in the hospital --

HOCKNELL: Yes.

JOHNSON: -- though he was nominally on call?

HOCKNELL: Yes.

JOHNSON: Swipe data going into the maternity exit, first of all, and then into the maternity ward, tiles 84 and 85, 22.36 hours?

HOCKNELL: Yes.

JOHNSON: Is that followed by further swipe data recording the movements of Valerie Thomas?

HOCKNELL: Yes.

JOHNSON: 86, the SHO Dr Ladde. Tile 87, more Dr Gibbs movements at tile 88.

HOCKNELL: Yes.

JOHNSON: And tile 89 --

HOCKNELL: Yes.

JOHNSON: -- coming back in?

At tile 90 was the tip of the central line sent examination by the pathologists?

HOCKNELL: Yes.

JOHNSON: And then do we have, at tile 91, a nursing note that puts that action into context, recorded by Ashleigh Hudson?

HOCKNELL: Yes.

JOHNSON: So we're now about 3 minutes to 11 pm, 22.57. Can you tell us what Ashleigh Hudson wrote, please?

HOCKNELL: "Long line removed due to constant occlusions. Neonatal Nurse Lucy Letby unable to flush, so Paediatric Registrar Rachel Chang informed. Dressing stripped and line pulled back. Still not flushing so removed. Tip sent for MC&S."

JOHNSON: Was that then followed by a further note made by Ashleigh Hudson?

HOCKNELL: Yes.

JOHNSON: And can you just -- are these ones that are over two tiles because of the word limit in --

HOCKNELL: I think it's two separate activities --

JOHNSON: Okay.

HOCKNELL: -- so I've split it.

JOHNSON: 92 reads what, please?

HOCKNELL: "Site normal. VIP score zero. No oedema or duskiness. Cannula sited in right foot. TPN given peripherally and lipids stopped until long line could be sited. High pressures via this initially, then reduced on repositioning. [Baby I] tolerated this very well. Sucrose offered but happy with dummy. [Baby I] pink and well perfused at this time. Awake and alert."

JOHNSON: Thank you. Tile 93, which is the very next tile, does that record the movements of Valerie Thomas?

HOCKNELL: Yes.

MR JOHNSON: My Lord, we're about to come to the event and if we are going to have a break, that's probably --

MR JUSTICE GOSS: Certainly, that's a good time.

We'll have our ten-minute break now, members of the jury.

(In the absence of the jury)

MR JUSTICE GOSS: Was there an iPad issue, Ms Clancy?

MS CLANCY: My Lord, yes. My understanding is Ms Letby's iPad was showing a completely different allocation.

It's been communicated to Mr Murphy --

MR JUSTICE GOSS: I thought that's what the difficulty was, that what was on her iPad didn't match what was on the screen.

MS CLANCY: It did, but I think it's going to be rectified by Mr Murphy.

MR JUSTICE GOSS: Okay. I'll leave that with you, Mr Murphy, then. Thank you very much.

(11.51 am)

(A short break)

(12.01 pm)

MR JOHNSON: Just before the jury comes back, my Lord, we're trying to juggle witnesses and use as much court time as we can and equally not have people hanging around trying if there is no realistic chance of reaching them.

There's still a fair way to go with this sequence.

We then have Dr Chang and Nurse Hudson to call to give live evidence this afternoon. We have here Dr Gibbs as well. We're in two minds as to whether or not we are likely to reach Dr Gibbs. If there is a bit of spare time, there's all sorts of filing from the earlier cases that I have held back for just such an occasion. It may be best just to wait until lunchtime and see exactly where we are.

MR JUSTICE GOSS: So what you're saying is that we may not get to Dr Gibbs today?

MR JOHNSON: Correct.

MR JUSTICE GOSS: So putting him over to tomorrow?

MR JOHNSON: Yes. If we can avoid having him sitting here all day not to be reached, I would rather avoid that.

MR JUSTICE GOSS: So would I. Let's wait until 1 o'clock and make a decision then. I know it's inconveniencing him potentially for another hour.

MR JOHNSON: I don't think he's too worried about that but he doesn't want to be here all day.

MR JUSTICE GOSS: 1 o'clock. Excellent. Thank you.

MR JOHNSON: Thank you.

MR JUSTICE GOSS: Can I just say, I wasn't following the sequence of events on my iPad, so I don't know whether this was a common problem that the jury had as well.

Were counsel following it on the iPad?

MR MYERS: In fact, mine needed to be restarted so event 4 would be on it, and I anticipate that may be my fault, but I'll be able to follow it now I should think. I'm grateful to Mr Murphy for his help.

MR JUSTICE GOSS: It's sorted now? Ms Letby has one that she can...?

(Pause)

(In the presence of the jury)

MR JUSTICE GOSS: Yes, Mr Johnson.

MR JOHNSON: I think we'd got to tile 94, which is the fluid balance chart at 23.00 hours. Do we also note here that there was no record made in the observations chart at this stage?

HOCKNELL: That's correct.

JOHNSON: 23.00 hours. The last note had been at 20.00 hours, so if we just look at that. Do we see there, Mrs Hocknell, that plainly the plan was to take observations every 3 hours, so 11, 14, 17, 20, and 23?

HOCKNELL: Yes.

JOHNSON: But as a matter of fact, there was no record made at 23.00 hours.

HOCKNELL: That's correct.

JOHNSON: All the way down. We see that there, can't we?

HOCKNELL: Yes.

JOHNSON: At tile 96 and 97 -- 96 is 23.17, a movement of Valerie Thomas recorded by the swipe data.

HOCKNELL: Yes.

JOHNSON: 97, Dr Chang coming into the neonatal unit, is that right --

HOCKNELL: That's correct, yes.

JOHNSON: -- at 23.56?

HOCKNELL: Yes.

JOHNSON: This is now the time of the beginning of the fatal decline of [Baby I]; is that right?

HOCKNELL: Yes.

JOHNSON: So tile 98 is the marker for that fact. Tile 99 is Ashleigh Hudson's note made at 23.57?

HOCKNELL: Yes.

JOHNSON: Sorry, made concerning events at 23.57.

HOCKNELL: Yes.

JOHNSON: Albeit the note itself was made at 03.39 on 23 October.

HOCKNELL: That's correct.

JOHNSON: Does it record that -- just click on it:

"[Baby I] was very unsettled [query] due to hunger as rooting. Dummy offered and containment holding to no effect. [Baby I] then placed prone as this usually settles her."

HOCKNELL: Yes.

JOHNSON: Then that continues to the next tile, please. If we go straight to the text:

"After repositioning, [Baby I] became quiet, apnoeic and dusky in appearance. With the help of Neonatal Nurse Lucy Letby, I repositioned [Baby I] on to her back and at first applied the Neopuff with 30% oxygen, saturations of oxygen 98%. Heart rate steady, 130 to 140 prior to this. Neopuff applied due to colour and apnoea. Colour didn't improve and saturations and heart rate began to drop rapidly until oxygen saturations 47% and heart rate 50. Neopuff increased to 50, then 100% with no effect."

HOCKNELL: Yes.

JOHNSON: Then the next of Nurse Hudson's notes, tile 101, timed at midnight:

"At the same time Paediatrics Registrar Rachel Chang and Dr Ladde were crash bleeped to the unit. This was midnight. Cardiac compressions started after confirming Philips monitor trace via auscultation."

HOCKNELL: Yes.

JOHNSON: At tile 102 do we have -- and we'll be hearing from Dr Chang -- her notes timed at midnight concerning the crash call?

HOCKNELL: Yes.

JOHNSON: At tile 103, Dr Chang's notes concerning chest compressions being given to [Baby I] and the calling of Dr Gibbs?

HOCKNELL: Yes.

JOHNSON: Is the fact of Dr Gibbs being called also recorded at tile 104 by Ashleigh Hudson?

HOCKNELL: Yes.

JOHNSON: Then at 105 by Dr Gibbs himself in his note, albeit he put the time at 00.05 or thereabouts?

HOCKNELL: Yes.

JOHNSON: As a matter of fact, the door data, tile 106, establishes that Dr Gibbs was going through one of the doors in the hospital at 00.05.

HOCKNELL: Yes.

JOHNSON: Tile 107, the same time, through a "side exit to ops internal door", as it's recorded --

HOCKNELL: Yes.

JOHNSON: -- in the hospital. And then at 00.06, maternity neonatal entrance doors in. So that's Dr Gibbs?

HOCKNELL: Yes.

JOHNSON: Tile 107. Did Ashleigh Hudson make a note of [Baby I] having been intubated?

HOCKNELL: Yes.

JOHNSON: That she'd been put on to a ventilator?

HOCKNELL: That's correct.

JOHNSON: And become more alert and was crying?

HOCKNELL: Yes.

JOHNSON: And that her abdomen was soft and not distended prior to resuscitation?

HOCKNELL: That's correct.

JOHNSON: Tile 110. Do we have Dr Gibbs' notes, which he can deal with?

HOCKNELL: Yes.

JOHNSON: At tile 111, Dr Chang's notes concerning the intubation and chest compressions?

HOCKNELL: Yes.

JOHNSON: Do her notes, that is Dr Chang's notes, continue on to tile 112?

HOCKNELL: Yes.

JOHNSON: And there she records [Baby I]'s heart rate and similar data, the like of which we've seen in [Baby I]'s and other cases?

HOCKNELL: Yes.

JOHNSON: Tile 113. Is there a record made in the fluid balance chart at 00.15?

HOCKNELL: Yes.

JOHNSON: At tile 114, does the door swipe data record the entrance of Dr Ladde into ward 30?

HOCKNELL: Yes.

JOHNSON: Tile 115. Is there a continuation of Dr Gibbs' notes concerning [Baby I]'s presentation when put on to the ventilator?

HOCKNELL: Yes.

JOHNSON: Then at tile 116, is there an X-ray report?

HOCKNELL: Yes.

JOHNSON: At tile 117, was there a prescription for sodium chloride?

HOCKNELL: Yes.

JOHNSON: Then at tile 118, did Dr Chang make a note of what she could see on the X-ray that had been taken at 00.23?

HOCKNELL: That's correct.

JOHNSON: As did Dr Gibbs in the succeeding tile, 119?

HOCKNELL: That's right.

JOHNSON: Then at tile 120, timed at 00.30, Dr Chang noted the plan?

HOCKNELL: Yes. That was the time at which she'd written her notes that were previously in the other slides.

JOHNSON: Yes, thank you. Is there some door swipe data for Dr Chang a minute later at tile 121 --

HOCKNELL: Yes.

JOHNSON: -- 00.31? Followed by the fact that [Baby I] was then extubated, in other words the ET tube was taken out?

HOCKNELL: That's correct.

JOHNSON: If we just look at that, please. Not at the original but at your version of it:

"[Baby I] coped well post extubation, was relatively settled and was sucking her dummy."

HOCKNELL: Yes.

JOHNSON: At 00.45, tile 123, can we look at your transposition of Dr Gibbs' handwritten note? Did he write:

"In view of vigorous movements plus resisting ventilation, decided to extubate rather than morphine plus paralysis to facilitate ventilator. Impression: from history, vigorous movements once resuscitated plus no changes on chest X-ray, likely generalised lung collapse [arrow] very slight. Small

volume lungs due to distress and crying. Plan: no septic screen at present. Offer sucrose if distressed. If further similar collapses will need full ventilation (with paralysis)."

HOCKNELL: Yes.

JOHNSON: At tile 124, is there there Ashleigh Hudson's note of the taking out of the ET tube?

HOCKNELL: Yes.

JOHNSON: At 125, Ashleigh Hudson's note concerning having contacted [Baby I]'s parents and having explained to her what had happened?

HOCKNELL: Yes.

JOHNSON: Are the next three tiles, 126 through to 128, swipe data for Nurse Taylor and Dr Chang?

HOCKNELL: Yes.

JOHNSON: Then at 130 --

HOCKNELL: There's a marker at 129.

JOHNSON: I beg your pardon. There's a marker then at tile 129 concerning a further collapse of [Baby I]; is that right?

HOCKNELL: Yes.

JOHNSON: That is described in what follows, which is tile 130, the nursing note; is this right?

HOCKNELL: Yes.

JOHNSON: Can you deal with that, please?

HOCKNELL: "01.06 hours. [Baby I] became unsettled again. Dummy and sucrose offered with no effect. Slowly became dusky and saturation of oxygen dropped to the 60s. Heart rate 70s. I ran to labour ward theatre to inform Paeds Registrar Chang. Neonatal Nurse Letby and Senior Neonatal Practitioner Chris Booth maintained airway and applied Neopuff at this time."

JOHNSON: Thank you. At 131 is there swipe data for Ashleigh Hudson going from the neonatal unit to the labour ward?

HOCKNELL: Yes.

JOHNSON: At 132, are there further clinical notes made by Dr Chang --

HOCKNELL: That's correct.

JOHNSON: -- which recount the fact that she was called back to the neonatal unit?

HOCKNELL: Yes.

JOHNSON: At 133 do we have Dr Chang's notes of what confronted her when she came back?

HOCKNELL: Yes.

JOHNSON: At 134, do we have Ashleigh Hudson's note of the fact that compressions were started again for [Baby I]?

HOCKNELL: Yes.

JOHNSON: At 135, Dr Chang's notes of [Baby I] being re-intubated?

HOCKNELL: Yes.

JOHNSON: Followed at 136 by Nurse Ashleigh Hudson's note of the same event?

HOCKNELL: That's correct.

JOHNSON: At 137, a note made by Ashleigh Hudson to the effect that whilst that was going on, [Baby I]'s mum had rung to ask for an update?

HOCKNELL: That's correct.

JOHNSON: And that she had been asked to come in immediately?

HOCKNELL: Yes.

JOHNSON: And that they did whilst [Baby I] was being -- whilst attempts were being made to resuscitate [Baby I]?

HOCKNELL: Yes.

JOHNSON: Tile 138, timed at 01.16, was the first adrenaline bolus given?

HOCKNELL: Yes.

JOHNSON: Followed at 139 by Dr Chang's notes?

HOCKNELL: Yes.

JOHNSON: And at 140, timed at 01.18, by the second bolus of adrenaline?

HOCKNELL: Yes.

JOHNSON: 141, a note by Dr Chang that she had called Dr Gibbs for help?

HOCKNELL: I presume Dr Gibbs, yes.

JOHNSON: At 142, the notes contain a record of the fact that Dr Ladde was acting as the scribe?

HOCKNELL: Yes.

JOHNSON: 143, Ashleigh Hudson's note that Dr Gibbs had been called to the unit again?

HOCKNELL: That's correct.

JOHNSON: At the same time, 01.18, Dr Gibbs' note that he was called back at that time?

HOCKNELL: Yes.

JOHNSON: 01.20. Dr Chang recorded the giving of sodium bicarbonate?

HOCKNELL: Yes.

JOHNSON: 146 at 01.22 and at 147 at the same time, door swipe data recording the movements of Dr Gibbs?

HOCKNELL: Yes.

JOHNSON: Just passing over 148 for a second, 149 recording the arrival of Dr Gibbs at 01.23?

HOCKNELL: That's correct.

JOHNSON: At 01.22 is recorded a 10ml per kilo saline bolus given to [Baby I] at 00.22?

HOCKNELL: Yes.

JOHNSON: And the prescription for that bolus is recorded at 150?

HOCKNELL: Yes.

JOHNSON: Signed for and countersigned by Christopher Booth and Lucy Letby respectively?

HOCKNELL: Yes.

JOHNSON: 151, a sodium bicarbonate flush recorded, given at 01.23 by -- or recorded by Dr Ladde?

HOCKNELL: Yes.

JOHNSON: Tile 152, timed at 01.25, a record of the fact that Dr Chang recorded the arrival of Dr Gibbs --

HOCKNELL: Yes.

JOHNSON: -- and her clinical notes.

At 153, Dr Gibbs' own note recording his arrival at about 01.25 and the fact that -- if we just go to this one, please. The fact that:

"[Baby I] was intubated and given Neopuff ventilation and chest compressions. She had poor perfusion, was mottled, purple/white. [Query] good air entry/chest movement. Neopuff changed to bag (with overriding and blow-off volume) which seems to have resulted in good chest movement and air entry, but crackles on inspiration."

He can explain that to us, but that's what he's recorded; is that right?

HOCKNELL: Yes.

JOHNSON: At tile 154, do we have a prescription for adrenaline?

HOCKNELL: Yes.

JOHNSON: At 155, Dr Ladde's notes of the third dose of adrenaline being given to [Baby I]?

HOCKNELL: Yes.

JOHNSON: 156, sodium chloride medication recorded --

HOCKNELL: Yes.

JOHNSON: -- by Christopher Booth and Lucy Letby?

HOCKNELL: That's correct.

JOHNSON: 157, administration of a 3ml flush?

HOCKNELL: Yes.

JOHNSON: 158, at 01.28, a further prescription for adrenaline?

HOCKNELL: That's correct.

JOHNSON: 159, a further bolus of adrenaline administered to [Baby I]?

HOCKNELL: Yes.

JOHNSON: This will be the fourth. Followed by a flush recorded by Dr Ladde at tile 160?

HOCKNELL: That's correct.

JOHNSON: Then at 161, at 01.35 hours, a dose of atropine?

HOCKNELL: That's correct.

JOHNSON: The prescription for which is recorded on the next tile, 162?

HOCKNELL: Yes.

JOHNSON: Together with a prescription at 163 for sodium chloride?

HOCKNELL: Yes.

JOHNSON: And followed at 164 by Dr Ladde's notes of a flush?

HOCKNELL: Yes.

JOHNSON: 165, at 01.36, and this is some door swipe data concerning Valerie Thomas?

HOCKNELL: That's correct.

JOHNSON: Followed at 166 by a prescription for glucose?

HOCKNELL: Yes.

JOHNSON: We see there, and indeed on the atropine prescription at 162, that this time Ashleigh Hudson, the designated nurse, her details are on with Christopher Booth rather than Lucy Letby's details being on with Christopher Booth, as previously with at least four of the prescriptions?

HOCKNELL: Yes.

JOHNSON: At 166 -- I think I dealt with the glucose, didn't I?

HOCKNELL: Yes.

JOHNSON: At 167, therefore, is there a chart noted up with that information, the administration of dextrose?

HOCKNELL: Yes.

JOHNSON: 168, Dr Ladde wrote that into the medical notes?

HOCKNELL: Yes.

JOHNSON: We then have a further prescription for adrenaline at tile 169?

HOCKNELL: Yes.

JOHNSON: At 170, Dr Ladde making a note of that having been administered?

HOCKNELL: That's correct.

JOHNSON: So that's the fifth dose of adrenaline?

HOCKNELL: Yes.

JOHNSON: Followed by a flush?

HOCKNELL: Yes.

JOHNSON: Followed by a prescription at 172 for calcium gluconate?

HOCKNELL: Yes.

JOHNSON: The administration of that recorded by Dr Ladde at tile 173, timed at 01.40?

HOCKNELL: That's correct.

JOHNSON: At the same time at 174, also recorded by Dr Ladde, a further flush?

HOCKNELL: Yes.

JOHNSON: At 175, a yet further prescription for adrenaline?

HOCKNELL: That's correct.

JOHNSON: Followed by Dr Ladde's notes that that was administered at tile 176?

HOCKNELL: Yes.

JOHNSON: So this is now the sixth adrenaline; is that right?

HOCKNELL: Yes.

JOHNSON: Followed by a flush at 177?

HOCKNELL: That's correct.

JOHNSON: Then, 2 minutes later, if we just read this, please, this is Dr Gibbs' note:

"Compressions stopped at 01.45 (resuscitation had started at 01.16) [29 minutes]. Sats 95 to 100 with hand ventilation. Remained mottled and poorly perfused."

HOCKNELL: Yes.

JOHNSON: At 179, further sodium chloride medication noted?

HOCKNELL: That's correct.

JOHNSON: 180. Did Dr Ladde record that fact --

HOCKNELL: Yes.

JOHNSON: -- in the medical notes, as did Dr Gibbs at 181?

HOCKNELL: That's correct.

JOHNSON: Then at 182, if we could just go to that note, please.

"5 minutes later (01.50) heart rate to 70. Sats 70 to 80 and no pulse palpable. Cardiac compressions restarted at 01.50."

That was also noted in the next tile by the scribe, Dr Ladde; is that right?

HOCKNELL: Yes, that's correct.

JOHNSON: At tile 184, is there a further adrenaline prescription?

HOCKNELL: Yes.

JOHNSON: And administration at 185?

HOCKNELL: Yes.

JOHNSON: This had been the seventh?

HOCKNELL: Yes.

JOHNSON: Followed by a flush at 186?

HOCKNELL: That's correct.

JOHNSON: Followed, 4 minutes later, by the eighth prescription for and administration of adrenaline?

HOCKNELL: That's correct.

JOHNSON: Followed by a flush at 189?

HOCKNELL: Yes.

JOHNSON: Then at 190, do we have Dr Gibbs' note?

HOCKNELL: That's correct.

JOHNSON: Deal with that, please. We see there recorded:

"Explained [Baby I] was not responding to prolonged resuscitation and although her heart was beating there was no effective circulation. At 02.10, heart rate 40 per minute on monitor. No pulse (but heartbeat audible without cardiac compression). No [respiratory] effort. Pupils fixed and dilated. Resuscitation stopped. Extubated. Handed to parents."

HOCKNELL: Yes.

JOHNSON: 191, at the same time, did Ashleigh Hudson make a note to the same effect?

HOCKNELL: Yes.

JOHNSON: At 192, did Ashleigh Hudson make a note of what happened when [Baby I] was handed to her parents?

HOCKNELL: Yes.

JOHNSON: Did that include the fact that she and Lucy Letby had spoken to the parents concerning what would happen next?

HOCKNELL: Yes.

JOHNSON: And that a decision was made to bathe [Baby I]?

HOCKNELL: Yes.

JOHNSON: 193. Do we have or have you reproduced for us Dr Gibbs' notes of the chronology of the resuscitations?

HOCKNELL: Yes.

JOHNSON: We've dealt with that as we've gone through, so we'll return to that with him.

But at 194, do we have further swipe data for Dr Ladde?

HOCKNELL: Yes.

JOHNSON: And at 195, further data for Dr Chang?

HOCKNELL: Yes.

JOHNSON: At 196/197, did Dr Gibbs certify [Baby I]'s death at 02.30?

HOCKNELL: That's correct.

JOHNSON: Does that also appear in the nursing notes courtesy of Nurse Hudson at tile 198?

HOCKNELL: Yes.

JOHNSON: Then in the 45 minutes or so following, between and including tiles 199 to 204, is there a series of door swipe data records --

HOCKNELL: Yes.

JOHNSON: -- relating to Valerie Thomas, Melanie Taylor, Rachel Chang and Lucy Letby?

HOCKNELL: Yes.

JOHNSON: 205. Is that the time, which is timed at 03.39, Ashleigh Hudson made her retrospective notes concerning the events that we have dealt with as we've gone through the chronology?

HOCKNELL: Yes.

JOHNSON: And similarly, at 206, at 03.50 hours, did Dr Chang make her detailed notes?

HOCKNELL: Yes.

JOHNSON: At 207 is there a note made by Ashleigh Hudson at 06.25?

HOCKNELL: Yes.

JOHNSON: I'd just like to deal with this, please.

HOCKNELL: "Nasogastric tube on free drainage. Produced 2ml minimal aspirations of clear mucus and air ++ during both resuscitations. Green stool and urine present post resus."

JOHNSON: Did [Nurse E] send a message to Lucy Letby at 6.51 saying:

"Hey. You okay? Good shift?"

HOCKNELL: Yes.

JOHNSON: And at 209 through to 219, were updates made on the computer concerning many of the medications that we have seen records of but were used during the two resuscitations of [Baby I]?

HOCKNELL: Yes.

JOHNSON: At 220, was the care of [Baby I]'s body handed over to Caroline Oakley --

HOCKNELL: Yes.

JOHNSON: -- on the day shift? Then at 221 to 223, were various notes made which have been dealt with during the course of our journey through the chronology?

HOCKNELL: Yes, at 222 it's the start of Caroline Oakley's shift.

JOHNSON: Yes. Thank you. Moving on then, please, to 224, where we have the update made on the computer for calcium gluconate, which was one of the drugs that we encountered during one of the resuscitation --

HOCKNELL: Yes.

JOHNSON: -- efforts.

Then do we have a Datix report concerning the death of [Baby I] at tile 225?

HOCKNELL: Yes.

JOHNSON: At 226, is there a note of the fact that [Dr A] informed Alder Hey Hospital that the procedure that had been planned for [Baby I] was now not required?

HOCKNELL: That's correct.

JOHNSON: Then at 227, timed at 09.40, did Dr Gibbs report [Baby I]'s death to the coroner?

HOCKNELL: Yes.

JOHNSON: There's then a series of messages involving Lucy Letby.

At the beginning at least, the other correspondent was [Nurse A]; is that right?

HOCKNELL: Yes.

JOHNSON: They begin at tile 228, the time of which was 11.58, from [Nurse A] sent this message:

"You okay? You heard about last night. Did you have [Baby I]?"

HOCKNELL: Lucy Letby replied:

"Yeah, I'm okay thanks. Ashleigh had her."

[Nurse A] replied:

"Bet you were all drawn in though. So sad after so much."

Lucy Letby replied:

"Yeah, only 5 on so everyone involved."

With a further message:

"Dr Gibbs was great. We tried everything. Just don't think she was strong enough this time."

[Nurse A] replies:

"It's like each time been harder to get her back. Did mum and dad get there in time? Big hugs to you all."

Lucy Letby replied:

"Yes, they were with her thankfully."

And a further message:

"And L and M spent time with her too."

[Nurse A] replied:

"Glad they were there. Poor family. I keep thinking about her brother."

Lucy Letby replied:

"Sad, isn't it?"

And:

"A little frustrating that still waiting for tests etc."

[Nurse A] replies:

"Ah, message got mixed up. Glad L and M had time too."

Then there were further messages of a social nature.

Then at 17.25 hours, an incoming Facebook message from Alison Ventress:

"Rachel just been telling me about last night."

At 17.25, afterwards, Lucy Letby sent a message to [Nurse A]:

"Who told you about [Baby I]?"

At 17.26, Lucy Letby replies to Alison Ventress:

"You aren't in tonight, are you?"

And then again:

"Thanks, Ali."

Alison Ventress replies:

"I'm meant to be but called in sick."

We switch to a conversation between [Nurse A], and [Nurse A] replies:

"Ali. Rachel told her."

We switch back to a reply from Alison Ventress at 17.27:

"So don't you who you have instead. George is SHO anyway."

JOHNSON: Was the SHO around this time or one of the SHOs around this time Dr George Varghese --

HOCKNELL: Yes.

JOHNSON: -- who we'll be hearing from next week? Sorry to interrupt.

HOCKNELL: It's okay. At 17.27, continued, [Nurse A] replies:

"Ali had messaged Rachel cos she's not well."

Lucy Letby replies to [Nurse A]:

"Yeah, Rachel said overnight Ali not well."

And again:

"Haven't really worked with her before but she's nice."

She then further replies to Alison Ventress:

"Aw, hope you are ok."

[Nurse A] replies again at 17.28:

"Rach was thinking of offering to do tonight but after last night decided not. Dunno who's covering. Saw Ali today, she looks dreadful."

Lucy Letby replies to [Nurse A]:

"Yeah, Rachel said she didn't think she could face it. Least we'll have an SHO that can do things tonight."

And:

"Oh, does she?"

JOHNSON: Right. That may be a reference to "Saw Ali today, she looks dreadful"?

HOCKNELL: Yes. [Nurse A] then replies:

"Yup re SHO. And Alison is consultant."

Lucy Letby replies to [Nurse A]:

"Cool."

[Nurse A] replies:

"Hope they find a registrar for you otherwise I guess Alison will have to stay all night."

Lucy Letby replies:

"Last night was mad. Went to theatre for 33-weeker, then had to call Rach back for [Baby I], and Mel had to go to theatre on own as SHO on paedS."

JOHNSON: Rach in that context is Dr Chang; is that right?

HOCKNELL: I think so, yes.

Then at 17.35 there was another message about work but not relevant to the baby.

Then Lucy Letby replies:

"Gosh, no, and paedS was busy last night. She's just told me anaemic and keeps feeling faint, etc. She couldn't work like that."

There was then some further messages between 17.37 and 17.38 about work and not relevant to [Baby I].

At 17.39 Lucy Letby replies to [Nurse E] -- it's not a reply, sorry, sends a message to [Nurse E]:

"Hey, how has your day been?"

And then there's a further incoming message from [Nurse A], again about work but not relevant to [Baby I].

At 17.39, Lucy Letby sends another message to -- a message to Ashleigh Hudson:

"Hey, how you doing?"

And then there's further messages between 17.40 and 17.47 between Lucy Letby and [Nurse A], again about work but not relevant to [Baby I].

At 17.58 Lucy Letby sends a message to [Nurse A]:

"There has never been an appropriate opportunity to speak to [Nurse B] but I was chatting with Eirian today, not about that, but about various things and feel more positive now."

Then there were three more messages between 18.06 and 18.07.

JOHNSON: Thank you. Is that then followed by Caroline Oakley's nursing update on the computer?

HOCKNELL: Yes.

JOHNSON: Does that concern -- well, let's deal with it. Does that read:

"[Baby I] with parents and family in bedroom 2. [Baby I] placed on cooling mattress. Bereavement administrative checklist commenced as policy. Parents updated by Dr Gibbs and informed of corner's decision for post-mortem. Parents unhappy but accept it is a legal requirement. They have expressed they are very unhappy with Alder Hey Children's Hospital for failing to accept [Baby I] for her barium enema and want her back from AHCH post-mortem ASAP. Bereavement coordinator has spoken to parents and will facilitate their request. Medical photography have taken photos at parents' request. [Baby I] taken to mortuary at approximately 14.00. I then escorted parents to mortuary at 15.00 hours for their appointment to see her. Parents have just left unit after spending time in bedroom 2. All mementos given to parents. They have an appointment to see [Baby I] tomorrow. I have asked them to ring any time if they have any questions/worries."

HOCKNELL: Yes.

JOHNSON: So whilst that was being updated, did the text communications continue?

HOCKNELL: Yes. At 18.09, Ashleigh Hudson replies to Lucy Letby:

"I'm all right. I had a chat with Soph earlier so I'm feeling much better thank you. How are you feeling?"

JOHNSON: I'm sorry, that was a response to a text that had been sent by Lucy Letby, isn't it --

HOCKNELL: Yes.

JOHNSON: -- saying, "Hey, how you doing"?

HOCKNELL: Yes. And then [Nurse A] also at 18.09 replies to Lucy Letby:

"Yes, that's what I was thinking too re [Nurse B]."

JOHNSON: Did Lucy Letby then send a text to [Nurse A] in response?

HOCKNELL: Yes:

"We were talking about allocation and she was saying about people not always pulling their weight and different expectations of staff, etc. Said that people like me who work full-time, do extras, etc, and are happy to go into 1 get the rubbish but not always the thanks, etc. Things always seem to get back to her one way or another and she said herself and a lot of team, including doctors, speak very highly of me and need to be confident in my role without feeling the need to prove myself, which I have felt recently."

JOHNSON: Did [Nurse A] respond:

"Good old Eirian. Nail on head as always."

HOCKNELL: Yes. At 18.12 Lucy Letby replies to Ashleigh Hudson:

"Oh good. Without sounding patronising, you did really well Ashleigh and should be proud. I'm okay, thanks."

JOHNSON: Did she respond to [Nurse A]?

HOCKNELL: "Yup, I feel better because it all came about very naturally and was just a general conversation. If manager has confidence in me and my role then I feel I can step back a bit and just be me a bit more without trying to prove myself."

JOHNSON: Then another message.

HOCKNELL: "You've been a brilliant support as always."

JOHNSON: Did [Nurse A] then send a message:

"Yup. Look at Jo the other week. Just keep doing what you do and those that are slow to catch on will. You don't need their approval, and thank you"?

HOCKNELL: Lucy Letby replied:

"I learnt from one of the best."

JOHNSON: And then [Nurse A]:

"Again, thank you."

HOCKNELL: At 18.19 [Nurse E] replies to Lucy Letby:

"Hey not stopped but been ok. U sleep well?"

And Lucy Letby replied:

"Yeah, not too bad thanks."

[Nurse E] then replies:

"Aw, good. [Baby I]'s mum n dad haven't long left."

Lucy Letby replied:

"Aw, glad they've had that time together."

[Nurse E] replied:

"Yeah. They weren't happy she has to have post-mortem."

Lucy Letby replied:

"Hmm, I can understand that but I think it's of benefit to know."

18.31, [Nurse E] replies:

"Yeah. Eirian has sent an email out about siblings under no circumstances being allowed to stay in parents' accommodation. I didn't know there had been."

Lucy Letby replied:

"I was just looking at that. I think it's come from when [Baby I] was ill last week. Parents brought siblings in and stayed for couple of hours because couldn't get anyone to look after them, but I know staff had raised concerns about how late in the evening they were both visiting anyway."

[Nurse E] replied:

"Okay. I think it's a bit different if baby is very poorly surely. Plus the youngest isn't in school, so what does it matter if term time? Lol."

Lucy Letby replied:

"Yeah, I think it's a bit of common sense and so long as supervised."

At 18.54 Ashleigh Hudson replies:

"Oh thank you, it means a lot. I think we did very well as a team. Good, you should hopefully have a better night tonight."

Lucy Letby replies to Ashleigh Hudson:

"Yep, I think we all worked well and did everything possible. Hope you felt supported. Enjoy your time at home."

Ashleigh Hudson replied:

"I did feel really supported. I will make the most of it."

JOHNSON: That was Friday the 23rd. Tile 292, Monday, 26 October at 14.30 hours, was a post-mortem examination carried out of [Baby I]?

HOCKNELL: Yes.

JOHNSON: Moving on 10 days to tile 293, on 5 November did Lucy Letby conduct three searches in fairly quick succession?

HOCKNELL: Yes.

JOHNSON: Can you tell us about those, please?

HOCKNELL: At 23.40, [Mother of Babies E & F] was searched for. At 23.41, [Mother of Baby G] was searched for. And at 23.44, [Mother of Baby I] was searched for.

JOHNSON: If we look in jury bundle 2 at the front of the file, we can see Lucy Letby's work rota. It's page 4 of the rota. Do we see that that was a day off so far as Lucy Letby's work was concerned?

HOCKNELL: Yes.

JOHNSON: So that's a Thursday. The following Tuesday, if we go to tile 297 first of all, please, at midday was that [Baby I]'s funeral?

HOCKNELL: Yes.

JOHNSON: If we go back a tile to 296, if we just click on that, please, there do we see a condolence card --

HOCKNELL: Yes.

JOHNSON: -- with handwriting on it, addressed to "[Mother of Baby I], [Father of Baby I] and family"?

HOCKNELL: Yes.

JOHNSON: Does it read:

"There are no words to make this time any easier. It was a real privilege to care for [Baby I] and to get to know you as a

family, a family who always put [Baby I] first and did everything possible for her. She will always be a part of your lives and we will never forget her. Thinking of you today and always. Sorry I cannot be there to say goodbye."

And then on the other side of the card, the printed message and written underneath:

"Lots of love, Lucy."

HOCKNELL: Yes.

JOHNSON: Again, just looking at the work rota, where we were before, do we see that on the 9th and the 10th and 11 November 2015, Lucy Letby was working a block of three nights?

HOCKNELL: That's correct.

JOHNSON: That therefore the picture of that card was taken at the back end of the shift of the night of the 9th into 10 November, so taken pretty much at handover time?

HOCKNELL: Yes. These images were captured on Lucy Letby's mobile phone.

JOHNSON: Yes. Then the final entry in this sequence is dated 29 May; is that right?

HOCKNELL: Yes.

JOHNSON: 29 May 2016.

HOCKNELL: Yes.

JOHNSON: It's timed at 23.00 hours; is that right?

HOCKNELL: Yes, that's correct.

JOHNSON: It concerns a Facebook search for [Mother of Baby I]?

HOCKNELL: Yes.

JOHNSON: If we go to page 7 of the work history, the rota, do we see that that was Lucy Letby's day off?

HOCKNELL: Yes.

MR JOHNSON: Thank you. I don't know whether there are any questions for you. There are no questions.

MR JUSTICE GOSS: Thank you very much.

Thank you very much. That's obviously a convenient point to break off. Can you be ready, please, members of the jury, to continue at 2 o'clock?

(In the absence of the jury)

MR JOHNSON: The issue of Dr Gibbs.

MR JUSTICE GOSS: Exactly, that's what I was -- we've got Ashleigh Hudson, Dr Chang --

MR JOHNSON: We don't think --

MR JUSTICE GOSS: Have you discussed this with Mr Myers at all?

MR JOHNSON: We have.

MR JUSTICE GOSS: You think it's unhelpful to keep him here on the off chance of starting his evidence this afternoon?

MR JOHNSON: Yes. It's fairly hard going, this material, anyway.

MR JUSTICE GOSS: Yesterday was a long day as well and if we finish a little bit earlier, we finish a little bit earlier. But I'd rather he's not inconvenienced unnecessarily, therefore I will say that Dr Gibbs can go and come back tomorrow.

As far as tomorrow is concerned, we have obviously Dr Arthurs lined up and then Dr Evans and Dr Bohin. We may or may not complete their evidence, I don't know.

MR JOHNSON: I don't think we think we will.

MR JUSTICE GOSS: I would be surprised if we got Dr Gibbs as well. I think it was pretty optimistic anyway, but there we are, it doesn't matter, we get to where we get to.

MR JOHNSON: Thank you.

MR JUSTICE GOSS: Thank you very much. Thank you, Mr Myers, for your contribution in discussions in relation to assisting.

MR MYERS: Thank you, my Lord.

MR JUSTICE GOSS: 2 o'clock then, please. Thank you.

(12.58 pm)

(The short adjournment)

(2.00 pm)

(In the presence of the jury)

MR JUSTICE GOSS: Mr Johnson.

MRS KATE TYNDALL (recalled)

Examination-in-chief by MR JOHNSON

MR JOHNSON: Welcome back. Just for the record, would you give us your identity, please?

TYNDALL: I'm Kate Tyndall.

JOHNSON: We're moving to the final neonatal review schedule in the case of [Baby I]. I wonder whether all the ladies and gentlemen have got it out. Good. It's right at the back of the files that we have. It follows the same conventions as all the others; is that right?

TYNDALL: Yes.

JOHNSON: Thank you. Page 2 of 8 gives us the population distribution in the unit together with their respective designated nurses; is that right?

TYNDALL: Yes.

JOHNSON: If anybody wants to make a note, it equates to tile 47 in the sequence of events. The baby HS, who's in nursery 2, by the end of the shift had been transported to Stoke, but otherwise we've been through this information in the context of the sequence of events so I won't linger there.

Can we move to page 3 of 8, please? As before, all entries in blue concern Lucy Letby; is that correct?

TYNDALL: Yes.

JOHNSON: And all entries on that yellow-shaded background concern, in this case, [Baby I]?

TYNDALL: Yes.

JOHNSON: So we see that page 1 -- sorry, page 3 of 8, which is the first page of the numbered schedule, so to speak, covers lines 1 through to 53. It covers the time from 20.00 hours to 23.18?

TYNDALL: Yes.

JOHNSON: There are only four entries concerning [Baby I]; is that right?

TYNDALL: Yes.

JOHNSON: Three of those four are the fact that, about an hour apart, notes were made on [Baby I]'s neonatal fluid balance chart?

TYNDALL: Yes.

JOHNSON: The only other entry is that at 37, which is a collection of a sample for pathology?

TYNDALL: Yes.

JOHNSON: Thank you. We see that quiet picture replicated at the top part of page 4. The event, as it's marked at line 62, is a demarcation between a calm picture and a much more difficult picture; is that right?

TYNDALL: Yes.

JOHNSON: Thus we see that, from just before midnight, [Baby I] started to decline?

TYNDALL: Yes.

JOHNSON: We also see that Lucy Letby's name appears against [Baby I]'s name at line 76?

TYNDALL: Yes.

JOHNSON: Just after midnight, Lucy Letby has made notes in the charts of MC and HS, which are lines 69 and 70?

TYNDALL: Yes.

JOHNSON: And after the second collapse, which is at line 86, we have Ashleigh Hudson's note, first of all, at line 87, which is a retrospective note. So far as the contemporaneous records concerning [Baby I] are concerned, so far as the nurses are concerned, at least, they are signed by Christopher Booth and Lucy Letby in the top half of the page; is that right?

TYNDALL: On page 5.

JOHNSON: On page 5, I beg your pardon.

TYNDALL: Yes.

JOHNSON: In the bottom half of the page we see the reappearance of Ashleigh Hudson's name at line 108 and in some succeeding lines?

TYNDALL: Yes.

JOHNSON: Albeit Lucy Letby's name reappears at line 114 at 01.40 hours?

TYNDALL: Correct.

JOHNSON: And line 119 at 01.43?

TYNDALL: Yes.

JOHNSON: Over the page again, please. In the top half of the page, in other words above line 139, which was the time [Baby I]'s death was certified, we see Lucy Letby's name appearing in [Baby I]'s records on three occasions?

TYNDALL: Yes.

JOHNSON: So far as the other entries are concerned, the contemporaneous entries, they are all doctors' records.

Ashleigh Hudson's nursing note, being a retrospective entry, that appears in there at 02.10?

TYNDALL: Yes.

JOHNSON: Thereafter, on the page at 145 and 146, Lucy Letby made entries in the chart of MC --

TYNDALL: Yes.

JOHNSON: -- a child in room 3?

At 155, there's an Ashleigh Hudson note that she makes retrospectively covering the time before then at line 155?

TYNDALL: Yes.

JOHNSON: Then over the page, again we see by this stage [Baby I] had died. We have Dr Chang's notes, the time those notes were made, and the time that Ashleigh Hudson's notes were made at lines 159 and 172 respectively?

TYNDALL: Yes.

JOHNSON: And between 176, pretty much all the way down to 192, with one or two exceptions, Lucy Letby making entries in the notes of HS, MC and [Baby G]?

TYNDALL: Yes.

JOHNSON: At the bottom of the page some retrospective signatures on the administration of prescribed medicines at 193 to the bottom of the page and then over to the end of line 201 on page 8 of 8?

TYNDALL: Yes.

JOHNSON: Then finally, we have the population record set out on the final page; is that right?

TYNDALL: Yes.

JOHNSON: So far as those children are concerned, just looking at the differences, we've already pointed out the movement of HS out of the unit --

TYNDALL: Yes.

JOHNSON: -- between the beginning and the end. Otherwise, in nursery 2, from where HS had been taken, in room 2 appeared AB and DC; is that right?

TYNDALL: Yes, AB appears to be moved from nursery 1 to nursery 2.

JOHNSON: Yes, thank you. So AB was the other child in nursery 1 with [Baby I] at the beginning of the shift?

TYNDALL: Yes.

JOHNSON: And by the end of the shift was in nursery 2; is that right?

TYNDALL: Yes.

JOHNSON: There's also the -- that child's designated nurse had been changed from Ashleigh Hudson to Christopher Booth?

TYNDALL: Yes.

JOHNSON: Otherwise, are there any other differences?

TYNDALL: There was a baby, DC, that was admitted to the unit at 01.40.

JOHNSON: Yes, thank you. And is also in nursery 2?

TYNDALL: Yes.

MR JOHNSON: I don't know whether --

MR MYERS: No thank you, my Lord.

MR JUSTICE GOSS: Thank you.

MR JOHNSON: Does your Lordship have any questions?

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

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

Mr Johnson is just adding to the witness box bundle the charts, et cetera, that were distributed a little earlier today.

MR JUSTICE GOSS: Thank you.

MS ASHLEIGH HUDSON (recalled)

Examination-in-chief by MR DRIVER

MR DRIVER: Could you state your full name for the record, please.

HUDSON: Yes, it's Ashleigh Victoria Hudson.

DRIVER: Ms Hudson, you understand, I'm sure, that you're still bound by the oath or affirmation that you took when you were with us last Friday, I think it was --

HUDSON: Yes, of course.

DRIVER: -- on which occasion you gave evidence about the care that you gave to the patient, the baby, [Baby I] on the 10th, the 11th, the 12th and the 13th, going into 14 October 2015?

HUDSON: Yes.

DRIVER: You will recall, I am sure, that [Baby I] was transferred from the Countess of Chester to Arrowe Park Hospital on 15 October 2015?

HUDSON: Yes.

DRIVER: And as I understand it, could you confirm, the next time that you acted as [Baby I]'s designated nurse was during the night shift of 21 October?

HUDSON: Yes, that's correct.

DRIVER: That was the first of two consecutive nights when you cared for her because you were her designated nurse again on the night shift of the 22nd into 23 October?

HUDSON: Yes.

DRIVER: Is that right?

HUDSON: Yes.

DRIVER: May I ask Mr Murphy to put tile 9 up on the screen, please. If we go behind it, we will see an image of the nursing notes that you compiled.

HUDSON: Yes.

DRIVER: If we could please, Mr Murphy, go to the left of the page as we look at it. The paragraph in the centre left. Thank you very much indeed.

That is your summary of the cares that you provided to the baby from the takeover, which took place at about 20.00 hours?

HUDSON: Yes.

DRIVER: That summary would have been derived, is this right, from amongst other things contemporaneous notes that you made throughout the shift as you took observations, provided fluids and the like?

HUDSON: Yes.

DRIVER: I'm going to ask our usher to hand to you a bundle. If you can look behind divider 12, you'll see some documents, some of which you were shown last week. I'm going to invite your attention to the documents that have a number 4 in the top right corner. You may wish to take them out of the folder so we can turn them over as we go through.

So members of the jury, this was the mini-bundle that was handed out to you by Mr Johnson prior to lunch.

The first page of which is an observation chart.

Do you have that?

HUDSON: Yes.

DRIVER: Thank you. We can see, looking at the date line across the top, it goes from the 20th to 21 October, and if we just glance at the initials at the bottom, Ms Hudson, do you recognise your AH initials towards the right of that page --

HUDSON: Yes.

DRIVER: -- which, unsurprisingly, correspond to the time of 20.00 hours on 21 October.

HUDSON: Yes.

DRIVER: So that would have been the time when you, as designated nurse, began to undertake observations of [Baby I]; is that right?

HUDSON: Yes.

DRIVER: Were they two-hourly observations at this point in time?

HUDSON: Yes, they were.

DRIVER: Just looking at the observations that you took, from 20.00 hours through to 08.00 hours, in terms of her heart rate, how was she?

HUDSON: From the observations, it seems as though her heart rate was stable, certainly within normal limits for a baby of her age.

DRIVER: Her respiration?

HUDSON: It looks like it is slightly elevated at the 22.00 observations. It's just on the line, the cusp there, about 65. But it's a one-off reading and the rest appear to be within normal limits for her age.

DRIVER: Thank you. Her temperature?

HUDSON: Temperature remains stable throughout.

DRIVER: If we look down the page, we can see you've recorded -- is that the cot temperature?

HUDSON: Yes, the incubator temperature.

DRIVER: Incubator temperature. Pausing there, [Baby I] was housed at this point in time in nursery 1; is that right?

HUDSON: That's correct.

DRIVER: Which we know, from evidence we've heard about other babies, was sometimes referred to as the intensive care room?

HUDSON: Yes.

DRIVER: Was she an intensive care baby at this point in time?

HUDSON: Not at this point in time, no.

DRIVER: Why was it that she was housed in nursery number 1?

HUDSON: From what I recall, it was based on her previous history, the fact that she'd suffered collapses, been transferred out and come back to us. I think it was more of a precautionary measure than a reflection of how she was at the time.

DRIVER: And you've just informed us that she was in an incubator as opposed to a cot?

HUDSON: Yes.

DRIVER: Why was it that she was in an incubator?

HUDSON: I think it was for ease of -- if anything changed with [Baby I] in that time period, if she was escalated to intensive care, we wouldn't have to move her from a cot to an incubator in order to undress her and to visualise her properly, she'd already be in the appropriate equipment.

DRIVER: Again, was that a precautionary measure --

HUDSON: Yes, it was.

DRIVER: -- based on her troubled history?

HUDSON: Yes.

DRIVER: Thank you. Looking further down the page, your observation data. What else have you recorded there?

HUDSON: I've recorded that she's self-ventilating in air, so with no added oxygen, and that her oxygen saturation levels I've recorded are anywhere between 96 and 100%, which is optimal.

DRIVER: Thank you. We can see, can you confirm this is right, that looking at the initials at the bottom of the page, it seems to be your initial four times, somebody else, you, and then that somebody else again?

HUDSON: That's correct.

DRIVER: Would that reflect breaks or transfer in care?

HUDSON: I would assume that the 4 am ones would be my break and then the 8 am would be the transfer of care to the day team.

DRIVER: Pausing there and going back to your summary, you have already told us that she was continuing to be nursed in an incubator and you explained why. You've spoken about the fact that she was self-ventilating in air and you've given us an account of her sats and the like. Returning to the remainder of your note here, "No increased working on breath", does that reflect the respiratory notes that you made?

HUDSON: Yes.

DRIVER: The respiratory picture, as it were:

"Other observations satisfactory as charted. Pink and well perfused."

HUDSON: Yes.

DRIVER: "Long line remained in situ and patent."

I think we'll hear in due course that there did develop something of a problem with the long line --

HUDSON: Yes.

DRIVER: -- but at this point all was well.

The VIP score, the VIP score, remind us how that's arrived at?

HUDSON: So yes, that's assessing the line every hour to ensure there isn't any change in how the site looks. So a long line is slightly different to a peripheral cannula.

You'd be looking at the insertion site, is it bleeding, is it leaking, is it warm to the touch, is the perfusion of the limb that it's in normal, is that pink. And also you'd have noted at the start of the shift where the tip was sited on the X-ray, so you might be looking -- if it was an upper line, you'd be looking at where the tip was situated and looking at the chest as well.

DRIVER: So that's a gauge, is it, of the functionality of the line and its interaction with the baby?

HUDSON: Yes.

DRIVER: A zero score is the optimum score?

HUDSON: Perfect, yes.

DRIVER: So the pressure was between 270 and 300 at times. Does it follow from the remainder of your sentence here that that was sub-optimal, so you addressed it by repositioning the line?

HUDSON: Yes, that's correct.

DRIVER: "TPN and lipid running as prescribed."

Through the long line?

HUDSON: Yes.

DRIVER: "Rates increased at midnight due to weight gain."

Can you expand on that for us?

HUDSON: Fluids are worked out in millilitres per kilogram.

Quite often the standard is 150ml per kilogram of weight for the baby. As the baby grows, we increase that to reflect the weight gain.

DRIVER: Thank you. So it was upped, increased, as your note tells us:

"New TPN and lipid in situ."

So the nutrition, as it were, was attached to the long line?

HUDSON: Yes.

DRIVER: "Free drainage via NGT, minimal aspirates recorded. Clear fluid."

Could you expand upon that sentence, please?

HUDSON: Yes. Free drainage just refers to -- there's a couple of ways that we do it. Sometimes we leave a feeding syringe without the plunger in attached to the end of the tube and hang it up so that any kind of aspirates or air can come out of the stomach without disturbing the baby. Other times there will be a bag attached so if any fluids were to come out of the stomach they'd go into the bag. But it appears in this situation minimal aspirates are recorded, not much was coming out.

DRIVER: Thank you. You examined the baby's abdomen, it would seem?

HUDSON: Yes.

DRIVER: And we know from your evidence last week that [Baby I] was a baby who had presented at times with a distended abdomen --

HUDSON: Yes.

DRIVER: -- and that was something that you knew about?

HUDSON: Yes.

DRIVER: And you were alert to, it would seem?

HUDSON: Yes.

DRIVER: On this occasion you recorded it was both soft and non-distended.

HUDSON: Yes.

DRIVER: She was, it would seem, unsettled at the start of the shift and rooting.

HUDSON: Yes.

DRIVER: We know at this point in time she was nil by mouth; is that right?

HUDSON: That's correct.

DRIVER: And you settled her with a dummy?

HUDSON: Yes.

DRIVER: And she was sleeping at the time you made that note at 03.11 and when awake she was alert?

HUDSON: Yes.

DRIVER: So putting all those component parts together, on your assessment, upon your being reunited with [Baby I] after a break, how was she?

HUDSON: From what I recall, she looked very well, she looked, I would say, better than I'd seen her for a while previously. Like I've noted, I've said she's pink and well perfused -- I didn't say pale pink, I've said pink.

Her colour was much better. Her abdomen was soft, it was non-distended, which, as we've already talked about, often it was distended and quite full, sometimes quite veiny looking. So in all she was a very stable baby considering what had happened in the weeks prior.

DRIVER: You explain that notwithstanding the location, both within an incubator and within nursery 1, that she wasn't classed as an intensive care baby. What classification of neonate patient was she?

HUDSON: I imagine she would still be classed as HDU. I think when she first came back to us, I think she was on a high flow device, alongside the central line, which would definitely make her a high dependency. I don't recall 100%, but it might well be that because there's kind of IV nutrition and a central line in situ she would still be classed as high dependency because you are having to check that line every hour. It's an increased workload.

DRIVER: Thank you. But for the cautious approach being taken because of her rocky history, would she -- as a high dependency baby, where would she otherwise have been located?

HUDSON: Nursery 2.

DRIVER: Did anything of note happen during your night shift of the 21st into the 22nd?

HUDSON: Not that I recall.

DRIVER: You were next on duty the following day?

HUDSON: Yes.

DRIVER: Were you aware that there were communications between the Countess of Chester and Alder Hey in relation to the possibility of a barium enema procedure being undertaken with [Baby I]?

HUDSON: Yes, I was.

DRIVER: Was that being dealt with on an urgent basis or was it being dealt with on a conditional basis dependent upon her progress?

HUDSON: From what I recall, from our perspective, on the neonatal unit it was urgent because of her history and what had happened and us not having a particular answer for why she'd been so sick. But we are very much, when dealing with a

hospital, at the mercy of their beds and what other patients they've got coming through the door.

So from our point of view it was urgent but it wasn't an emergency case.

DRIVER: Thank you. Could we move forward then to 22 October.

Could we go, please, Mr Murphy, to tile 48, which merely records the fact that there was a handover at the usual time and that you began to make -- take over the care, details of which you noted retrospectively.

HUDSON: Yes.

DRIVER: Could we click on that tile for a moment, please?

Page 14954. Look at the bottom left of that page, please:

"Written for care taken over at 19.45 hours."

Do we read that literally, that you literally took over care at 19.45?

HUDSON: Yes.

DRIVER: Can you infer anything from the fact that it was 19.45 as opposed to 20.00 hours, as we sometimes see with a night shift starting?

HUDSON: I think because I'd taken care of her the day prior, the night prior, I don't think there was a great deal to hand over in that time. She remained quite stable, well in herself, so handover would have been fairly concise.

That's probably why.

DRIVER: So just to explain that a little further, when you say not a great deal to hand over, do you mean not a great deal of information?

HUDSON: Yes.

DRIVER: So as is the protocol, we know, you began by checking all equipment and satisfying yourself that it was all satisfactory; is that right?

HUDSON: Yes.

DRIVER: Then you considered her charts or did you start to make entry in the charts?

HUDSON: I can see that I detailed some observations at 8 pm.

DRIVER: Thank you. So if we look back -- return rather to the paper document, the -- where do we find your 8 pm observations? Is that overleaf at page J15035?

HUDSON: Yes, that's the one.

DRIVER: So we can see your initials appear once and once only on that chart?

HUDSON: Yes.

DRIVER: And they correspond to 20.00 hours, 8 pm, at which point her heart rate was?

HUDSON: Heart rate was around 135.

DRIVER: Is that satisfactory?

HUDSON: Yes, very much so.

DRIVER: Respirations?

HUDSON: Respirations around 50, again satisfactory.

DRIVER: Temperature?

HUDSON: Temperature is about 36.8/36.9, which again is optimal.

DRIVER: Sats?

HUDSON: Saturations 96% in air, which again is optimal.

DRIVER: Next, O₂, your predecessor, Caroline Oakley, has put some digits but you have just put the word "air" above your initials?

HUDSON: Yes.

DRIVER: Does it follow that she, [Baby I], was not receiving any respiratory or ventilatory support of any kind at this point in time?

HUDSON: Yes.

DRIVER: We can see that somebody, are you able to say whether it was you or not, has entered 23.00 hours for the time?

HUDSON: Yes, that was me.

DRIVER: But not entered any observations taken beneath that --

HUDSON: No.

DRIVER: -- time column? Are you able to help us as to why not?

HUDSON: Yes. It was -- the long line had stopped working, had to be flushed and then later removed, and then [Baby I] had had to be re-cannulated by the doctor. So I think that had happened in that time period, between kind of like quarter past 10 and 11. So if you have got a patient who's just had a procedure done you wouldn't necessarily record observations at that time because they might be unsettled or they might not be accurate so you'd leave them for a little bit to rest, basically.

DRIVER: Is that because the procedure may have unsettled them and disturbed the observations?

HUDSON: Yes, potentially.

DRIVER: So let's look at your note:

"Observations satisfactory as charted."

Then:

"[Baby I] was unsettled and rooting at the start of shift."

But you managed to settle her with a dummy and the containment holding technique?

HUDSON: Yes.

DRIVER: Then we get to the event that you've just explained to us. Her long line was removed due to constant occlusions, which is lack of flow?

HUDSON: Yes.

DRIVER: You were assisted by your colleague Lucy Letby; is that right?

HUDSON: Yes.

DRIVER: Who was unable to flush through the long line?

HUDSON: Yes.

DRIVER: And therefore did you seek assistance from the registrar, Dr Chang?

HUDSON: Yes, that's correct.

DRIVER: What happened as per your record there?

HUDSON: I think Dr Chang had come and pulled the dressing back, tried to reposition the line, so in these circumstances you can't insert the line any further because it's been outside the body, but you can pull it back. So from my notes I can see she'd attempted that, tried to flush it, it didn't work, so we did remove a line in the end.

DRIVER: Thank you. And was at least, for an intended temporary measure, a cannula sited in [Baby I]'s right foot?

HUDSON: Yes.

DRIVER: Before we consider that, I've skipped over -- upon removal of the long line, was the site of the long line examined?

HUDSON: Yes.

DRIVER: And did you detect anything that may have suggested that [Baby I] had been troubled by that long line?

HUDSON: No.

DRIVER: So no oedema, no swelling, yes --

HUDSON: Exactly, yes.

DRIVER: -- and no duskiness? What would duskiness be indicative of?

HUDSON: You're looking at discolouration of a limb, less common in long lines than umbilical lines. It's just essentially important to make sure that you are happy that the perfusion of the limb hasn't been affected by the line itself and that's why I've documented that it's completely normal.

DRIVER: Thank you. So was the provision of nutrition transferred from the long line, which now had been removed, to the cannula?

HUDSON: The clear liquid, the TPN, was. The lipid, which supplies the fats, was stopped because that's not able to be given peripherally.

DRIVER: Right. As you said:

"Lipids stopped until long line could be sited."

New sentence.

"High pressures via this initially, then reduced on repositioning."

What's the "this" in that sentence?

HUDSON: High pressures via the cannula.

DRIVER: Thank you. Was that just to get things moving?

HUDSON: Yes.

DRIVER: And did they move satisfactorily?

HUDSON: Yes, they did.

DRIVER: The remainder of this note tells us how [Baby I] reacted, if at all, to this procedure.

HUDSON: Yes.

DRIVER: She tolerated it very well?

HUDSON: Yes.

DRIVER: "Sucrose offered but..."

And then if we go to the top of the other side of the single page, so top right:

"Sucrose offered but [Baby I] happy with dummy. [Baby I] pink and well perfused at this time, awake and alert."

Can you just talk us through "sucrose offered but [Baby I] happy with dummy"?

HUDSON: Sucrose is what we use often if it's a painful procedure, uncomfortable procedure for babies. It's essentially sugary water. I think the thought process is it acts on receptors to offer pain relief. You'd offer it, she already had a dummy in her mouth. If she's happy with the dummy, you'd kind of offer, but if they don't -- you'd expect them to suck on the applicator as if they were having a dummy or if they were having a bottle. I think in this case she was happy just to stay with a dummy so I didn't push it any further.

DRIVER: Taking a step back from the notes for a moment, I'm going to ask you to tell us a little about [Baby I] as a patient in this sort of context. Compared to other babies, was [Baby I]

a baby, a patient, who was difficult to settle, easy to settle or don't you have an opinion?

HUDSON: From what I remember of my experience of [Baby I], generally she was quite easy to settle. I think dummy, sucrose, containment holding or being held by family, she generally settled quite quickly. From what I remember in terms of a staff perspective she was quite happy once you put her back into the incubator or cot and just kind of leave her be, she would settle quite nicely.

DRIVER: Thank you. So we've got here you explaining why it is that you undertook observations at 20.00 hours, had endorsed the chart in anticipation of making more observations at 23.00 hours, but because of this, that you have just described to us, you elected not to --

HUDSON: Yes.

DRIVER: -- at 23.00 hours, at 11 pm?

Now we're going to shortly go to your notes of the events just before midnight. Before we look at the note, if we could turn the screen off for a moment, please. I'm going to ask you what you actually remember about this as opposed to what you have recorded retrospectively.

HUDSON: Okay.

DRIVER: Do you recall the events approaching midnight on this night shift?

HUDSON: Yes, I do.

DRIVER: What's the first feature of this event that you recollect?

HUDSON: I remember -- I think it was just prior to midnight, I think [Baby I] was unsettled, crying, so I had attended to her in the incubator to try and settle her. I think I tried the usual measures of containment holding, the dummy, sucrose. It didn't seem to work. She was very unsettled, it was quite a relentless cry. So the last thing I tried was to reposition her on to her tummy, which sometimes would settle her. On this occasion it didn't.

DRIVER: Pause there if you would, please, Ms Hudson. She was unsettled and so you tried to address it first by offering her sucrose?

HUDSON: Mm-hm.

DRIVER: It might be obvious to you, but if you can explain to us your thought process there.

HUDSON: I think in [Baby I]'s case, because she wasn't receiving any milk feeds, what we would do sometimes to settle her was give sucrose. Although she's not having a procedure, she is uncomfortable, and generally speaking you would usually feed a baby in this instance, but we couldn't. Sucrose is absorbed buccally, in the gum, so there usually isn't any danger of giving it to a baby who's not having any other oral feeds, so it's a comfort measure.

DRIVER: Right. It didn't work?

HUDSON: No.

DRIVER: So next effort on your part?

HUDSON: I don't remember the sequence, but I'd offered the dummy, containment holding, and generally it used to work. After those didn't work, I repositioned her.

She'd been lying on her back, face up. And I repositioned her on her tummy with her head to the side, to see if that settled her.

DRIVER: When you say generally it used to work, do you mean generally with all babies or generally with [Baby I] or both?

HUDSON: Generally with [Baby I], generally with most babies, but every baby is an individual. It did tend to work with [Baby I].

DRIVER: But not on this occasion?

HUDSON: No.

DRIVER: She continued to express in a way that you deemed that she was very unsettled?

HUDSON: Yes.

DRIVER: We will look at your notes for that phrase, which we'll go to in due course. Was she crying?

HUDSON: Yes.

DRIVER: Were you familiar with [Baby I]'s cry?

HUDSON: Yes.

DRIVER: Was this bout of crying typical of [Baby I] or atypical?

HUDSON: In my experience, atypical.

DRIVER: Could you expand upon that, please?

HUDSON: Um... It was... It was a type of cry that I hadn't myself experienced her make before. It was very loud -- it was, like I said, relentless, almost constant. There was no stopping and starting. There was no fluctuation.

It was just constantly very loud and something that I'd not heard from her before.

DRIVER: You can't, you told us in fairness, be sure of the sequence, but you tried the sucrose, the dummy, you tried containment holding and you tried repositioning?

HUDSON: Yes.

DRIVER: Was repositioning the last --

HUDSON: Yes, it was.

DRIVER: -- attempt?

HUDSON: Yes.

DRIVER: And what happened upon repositioning [Baby I]?

HUDSON: She then, within seconds of putting her on her tummy, became very quiet and I noticed that she was having pauses in her breathing. I can't remember exactly what I'd -- the sequence, but I had turned her back over and shouted for help around the same time and that's when Lucy came in to give me assistance.

DRIVER: So on repositioning, she stopped crying, but not in a way that satisfied you that you'd achieved your objective?

HUDSON: No.

DRIVER: Was there a problem at this stage?

HUDSON: Yes.

DRIVER: Was she being monitored at this stage?

HUDSON: Yes.

DRIVER: And what did those monitors tell you?

HUDSON: I can't remember without kind of looking at what I've written.

DRIVER: In general terms?

HUDSON: In general terms, I think her observations started to dip, so her oxygen levels started to decrease and her heart rate had started to drift as well. That's when, just prior to seeing that on the monitor, I'd called for help after she'd gone quiet, and then we got her in position for giving ventilation breaths.

DRIVER: "We" being?

HUDSON: Myself and Lucy.

DRIVER: And having positioned her for ventilation and breaths, did you say --

HUDSON: Yes.

DRIVER: -- was she provided with assistance --

HUDSON: Yes.

DRIVER: -- in that regard? What did the two of you do and who did what?

HUDSON: I don't recall who did what now, but we start with airway always. So we'd have positioned her airway in a neutral position, given oxygen to begin with, and then would have progressed to ventilation breaths had she not made any effort herself. And then I think after an initial period of -- I don't know how long -- less than a minute of her not really responding and recognising that it was an acute episode, we called for further help and crash bleeped the paediatric doctors who were on that evening.

DRIVER: We will have their notes and we'll hear from Dr Chang in due course. But let's go back to your nursing note of this phase of the evening:

"[Baby I] very unsettled."

You queried whether it was due to hunger. You recorded the efforts you made to no effect.

HUDSON: Yes.

DRIVER: She was placed prone because, in your experience, from previous nursing of [Baby I], that would usually settle her:

"She became very quiet, apnoeic, dusky in appearance."

Do you remember that?

HUDSON: Yes.

DRIVER: Is that indicative of poor perfusion?

HUDSON: Yes.

DRIVER: With the help of Lucy Letby, you repositioned [Baby I] on to her back, Neopuffed, and there are your data.

Applied due to colour and stop... cessation of breathing, but to no avail because the colour didn't improve --

HUDSON: Yes.

DRIVER: -- and her sats and heart rate began -- perhaps continued -- to drop rapidly. You increased the amount of assistance being given with no effect, so no doubt in consequence there was a crash bleep sounded and the paediatricians attended?

HUDSON: Yes.

DRIVER: Cardiac compressions began at around midnight. Was that by the doctors or you or both?

HUDSON: I can't recall.

DRIVER: You can't recall. Dr Gibbs was called and he attended, and we'll hear from Dr Gibbs in due course.

HUDSON: Yes.

DRIVER: And at this point your records suggest that [Baby I] was intubated, placed on a ventilator, whilst awaiting chest X-ray?

HUDSON: Yes.

DRIVER: "Prior to ventilation, [Baby I] had become more alert and crying."

So was that post-intubation?

HUDSON: That was, I think, post-intubation but prior to being connected to the ventilator, was still receiving manual assistance.

DRIVER: Then your note reflects, back prior to the resuscitation, when you noted, new sentence:

"Her abdomen was soft and non-distended prior to resus, no change from handover."

HUDSON: Yes.

DRIVER: So was that meant to inform we the readers of her condition from 8 pm until this event, this acute event, approaching midnight?

HUDSON: Yes, it was.

DRIVER: And you refer us to the clinical notes, which the jury will hear about in due course.

There was an X-ray. Was that the chest X-ray that you referred to in your earlier note?

HUDSON: Yes.

DRIVER: NAD, no abnormalities detected?

HUDSON: Yes.

DRIVER: And the medics decided to extubate [Baby I], she having been intubated a little time earlier, as per your note.

She was, you recorded, quite distressed and working against the ventilator.

HUDSON: Yes.

DRIVER: So what was that indicative of?

HUDSON: That she'd recovered quite quickly and ideally what you like with a baby on a ventilator is that they're synchronised with the breaths being given by the machinery. If a baby's working against it, you're not going to get very good oxygenation if you leave them that way and potentially you're going to cause lung damage, which is -- at that point we were making a decision, do we keep her on the ventilator potentially, having to sedate and paralyse her, or do we go by clinical look and take her off, which we did.

DRIVER: Thank you. Looking at the remainder of that sentence, on extubation, how was she?

HUDSON: She was back to how she'd been prior to the event itself. Like I said, she's awake, alert, breathing

independently, and cueing for a feed, so seemingly displayed normal behaviour despite what had just happened.

DRIVER: The next entry, Mr Murphy. We won't go there now.

So there was this acute event and we'll read that you, as her designated nurse, reported this event to her parents.

HUDSON: Yes.

DRIVER: Do you recall that?

HUDSON: I do, yes.

DRIVER: Her parents, we know, were very often on site. Were they there or not at this point in time?

HUDSON: Not at this evening.

DRIVER: We know it's about midnight when the event started.

Can you recall approximately how long this all took when you were -- your priority was to assist in the care for [Baby I]?

HUDSON: I don't remember how long, it was all very quick. Maybe within 30 minutes, I think, between -- it was a very quick resuscitation, it wasn't prolonged, there was no drugs given, and I don't think she was connected to the ventilator for very long. I'm not sure, you'd have to look at the timestamps of X-rays and things.

DRIVER: It's unfair of me to ask that when the clinical notes will tell us no doubt in due course.

When you communicated with the parents, did you communicate with them in the midst of this or --

HUDSON: Afterwards.

DRIVER: -- after it had resolved?

HUDSON: Yes.

DRIVER: And forgive me if this is -- if we go to tile 116, please, first. We can see there, there was an X-ray at tile 116. If we look at tile 117, 00.25, an infusion being prescribed. If we keep going through the tiles without necessarily going behind them, we can see Dr Chang and Dr Gibbs write up their notes and we'll look at them in due course.

Keep going across, please. We can see that Dr Chang was, it would seem, on the move at 00.31.

HUDSON: Yes.

DRIVER: If we could just look at Dr Gibbs' note for the extubation. Perhaps in fairness to you, I'll leave that to Dr Gibbs. Let's go back to the carousel. Forgive me, everybody.

We'll leave that now. It's not fair for me to invite you to comment on other people's notes. But you made a note of the fact that you'd communicated with [Baby I]'s parents?

HUDSON: Yes.

DRIVER: And that note is behind our tile 125. If we could look, please, at the paragraph, top left of that page, Mr Murphy.

You recorded retrospectively that [Baby I]'s parents were contacted by you --

HUDSON: Yes.

DRIVER: -- regarding [Baby I]'s first resuscitation?

HUDSON: Yes.

DRIVER: You noted here that you managed to get through to the parents, your words, "after many attempts".

HUDSON: Yes.

DRIVER: Do you recall that?

HUDSON: Yes.

DRIVER: How long did it take you to successfully communicate with the parents? What do you mean by managed to get after many attempts?

HUDSON: I think it just took calling quite a lot before the phone was picked up. It was in the middle of the night, so it's to be expected, but I couldn't recall how long that took. I don't think it was a substantial amount of time, but I think it was in between managing the situation and trying to call. It's a bit blurry, I'll admit.

DRIVER: Attempts that were ultimately successful to communicate with them by phone?

HUDSON: Yes.

DRIVER: Mobile phone or landline?

HUDSON: I don't recall.

DRIVER: Where would you have got their number from?

HUDSON: So it's documented in the notes on admission.

DRIVER: Right. And they're retained on [Baby I]'s computerised notes?

HUDSON: Yes. I think back then we'd often have a front sheet printed as well, which would also have parents' phone numbers, which we confirm with them verbally on admission as well.

DRIVER: The front sheet on the computerised notes or --

HUDSON: In paper notes.

DRIVER: Paper notes. Thank you for that.

Could we then, please, go to tile 129, which marks the fact that there was an event, which you time at 01.06 on the next tile. Before we consider that, are you able to tell us how [Baby I] was between events?

HUDSON: Between events, she was behaving exactly as she had prior to the initial event that evening, seemingly back to normal, so what was normal for [Baby I] at that time, and within that period between the two events, there hadn't been anything to cause concern.

DRIVER: Were you with [Baby I] at all times between the two events?

HUDSON: No.

DRIVER: Where were you immediately prior to realising that there was a second event?

HUDSON: I don't remember where in particular. I was either at the nursing desk or at the computer, which was directly opposite the nursing desk in nursery 1. I'd stayed close, but I tried to come out of the room just to give -- to maintain quietness in the room. But I was nearby to hear the monitor, which I think is why I went into the room for this event.

DRIVER: So you were near nursery 1?

HUDSON: Yes.

DRIVER: Sorry to make it explicit, were you inside nursery 1?

HUDSON: No.

DRIVER: How did you realise there was a second acute event?

HUDSON: I think I was first alerted to [Baby I] being unsettled -- I don't recall whether it was the monitor alarming or hearing her cry. Either one of those was why I re-entered the nursery. At which point Lucy was already with her, trying to comfort her, trying to settle her, and at that point in time her observations were normal, she wasn't desaturating, she wasn't bradycardic, and like I say she was crying, so she wasn't apnoeic.

DRIVER: Pausing there, and considering the two possibilities that you just alluded to, you were alerted, you say, either by an alarm sounding on the monitor, yes --

HUDSON: Yes.

DRIVER: -- or by the baby herself crying?

HUDSON: Yes.

DRIVER: Let's deal with them in turn. If it was the former, what sort of alarm was attached to -- was part of the monitoring of [Baby I] at this point in time?

HUDSON: At that point in time, from my Meditech notes, she was on a Philips monitor on continuous monitoring. If I recall, she had a sats probe in situ and potentially also some ECG leads as well.

DRIVER: So taking those various pieces of equipment as one, what changes in the baby could potentially trigger an alarm?

HUDSON: So there are parameters that are set in these monitors, they might be slightly different per baby. If an observation -- so saturations, respiratory rate, heart rate -- falls outside of those set parameters the monitor will alarm. Depending on the severity and how far outside those parameters it is, it will alarm with an orange alarm and an orange colour will flash or a red colour will flash. Both of them are equally as loud, but one is slightly faster than the other.

DRIVER: So a fall in any of those vital signs, if I might use that phrase --

HUDSON: Or a rise.

DRIVER: -- or a rise, quite so -- could potentially have triggered one or more of the alarms?

HUDSON: Yes.

DRIVER: But you can't be sure, is this fair, whether it was the alarm or [Baby I] --

HUDSON: Yes.

DRIVER: -- that caught your attention? You re-entered nursery 1 and Nurse Letby was there at [Baby I]'s -- well, where was she?

HUDSON: At the incubator, with her hands in the incubator with a dummy, trying to settle [Baby I].

DRIVER: Do you recall upon your re-entry into nursery 1 at this point in time whether or not [Baby I] was crying?

HUDSON: Yes.

DRIVER: What sort of cry?

HUDSON: It was the same cry I'd heard her display the first time, the first event of that evening. Once again, I can only explain it as loud as relentless and unlike any cry I'd heard her make previous to this night shift.

DRIVER: What did you think?

HUDSON: My initial concern was, despite the fact that at that point in time her heart rate wasn't bradycardic, she was obviously breathing, her saturations were satisfactory, my concern was that because this sound, this cry, was the same that she was going to have another episode. My only reason being for that is that I had not heard it before and when she'd done it previously she'd then had a collapse. That was my concern.

DRIVER: Did you articulate that concern?

HUDSON: Yes.

DRIVER: To whom?

HUDSON: Lucy.

DRIVER: How soon after re-entering nursery 1 did you make mention of that concern?

HUDSON: Within, I would say, about 60 seconds of being there, after kind of hearing the sound for slightly longer and kind of looking at her and seeing that she wasn't interested in the dummy that was being offered. That's when I said, something along the lines of, "She's going to do it again, it's the same cry", something like that.

DRIVER: So whatever actual words you used was an expression, was it, of concern that the events of an hour or so earlier were about to repeat?

HUDSON: Yes.

DRIVER: And you said that to Lucy Letby?

HUDSON: Yes.

DRIVER: Did she respond?

HUDSON: Yes.

DRIVER: What did she say?

HUDSON: I think Lucy was trying to reassure me and just said, "She just needs to settle, she just needs to settle".

I think from previous experience, she would have, but it's just because I had heard that sound previously.

DRIVER: When you heard it previously an hour earlier, were you alone or were you with anybody else?

HUDSON: I was alone to begin with until I shouted for help, at which point that's when Lucy had entered the room after she'd already stopped breathing.

DRIVER: What happened next?

HUDSON: Um... The events happened similar to the event prior: she had this relentless cry, we couldn't settle her, and then she became quiet, began to have slow pauses in breathing, and her heart rate started to drift down, become bradycardic, and her saturations started to drift.

DRIVER: How did you respond to this deterioration?

HUDSON: We initiated oxygen delivery again. We hadn't started compressions at this point because I think they were 70 to 80, her heart rate, and we'd given some stimulation and I think started airway management, so ventilation breaths, and from what I recall beyond that, shouted for further help from one of our

colleagues and then at that point I knew that the medical team were in the room next door waiting for a delivery, so rather than put out a crash bleep, I ran through the double doors to alert them to the situation once Chris had entered the room.

DRIVER: Is that Nurse Christopher Booth?

HUDSON: Yes.

DRIVER: Is he the colleague you referred to a moment or two ago?

HUDSON: Yes.

DRIVER: Could we please go to tile 131?

Swipe data. That's a sensor on a door. It tends to evidence a movement on your part. Would this be at 01.12, as you've just described to us, you rushing to get a medic?

HUDSON: Yes.

DRIVER: Because you knew that Dr Chang, was it, was in theatre --

HUDSON: Yes.

DRIVER: -- dealing with somebody (inaudible: coughing)?

HUDSON: Yes.

DRIVER: Did you fetch Dr Chang?

HUDSON: Yes.

DRIVER: And did you bring her to [Baby I]'s aid?

HUDSON: Yes.

DRIVER: As per the last event, Dr Chang took over immediate management of the problem?

HUDSON: Yes.

DRIVER: But shortly thereafter, was Dr Gibbs called --

HUDSON: Yes.

DRIVER: -- to give yet more assistance?

HUDSON: Yes.

DRIVER: If we go to tile 144, please. We see that that was within minutes. We're now at 01.18.

At tiles 146 and 147, we'll see that Dr Gibbs was there again shortly thereafter at 01.22 hours, according to the swipe data.

Did Dr Gibbs lead a very prolonged resuscitation attempt?

HUDSON: Yes, he did.

DRIVER: And did you participate in that as best you could?

HUDSON: Yes, I did.

DRIVER: And Dr Gibbs will tell us all the detail of that, so I needn't go through it with you, Ms Hudson. We all know tragically that it was all to no avail and that [Baby I] passed away.

HUDSON: Yes.

DRIVER: Did you communicate with her parents during this?

HUDSON: I don't think I did directly. From what I recall, it was one of our nursery nurses had taken a phone call -- I think [Baby I]'s mum had rang back to the unit whilst this was ongoing and we were all very much in the thick of it, so from what I recall, the nursery nurse, Valerie Thomas, had relayed our information to say they had to come in immediately. I don't know then if anybody took over the phone call. I don't recall that far.

DRIVER: Very well. There's one more part of your note that I invite you to assist us with, please, and that's behind tile 207.

If you'd click behind it, Mr Murphy, I'd be very grateful.

To the bottom of the right of that page, please. In the previous paragraph, you'd described the dramatic events that we've just touched upon, but then in retrospect, you wrote at 06.25 the following:

"Asterisk. NGT on free drainage, produced 2ml."

What was this a reference to, can you recall?

HUDSON: Yes.

DRIVER: When was it a reference to?

HUDSON: So that was in reference to, I think, the second event.

It's good practice in a resus, if you can, to have a nasogastric tube in situ, so if you're giving ventilation breaths via a Neopuff and not an ET tube, some air will inevitably get in through the oesophagus into the stomach, so you aspirate the NG as much as you can. In this case free drainage was already in situ -- I think have actually put both resuscitations -- and also knowing previously that we'd had abdominal issues and I wanted to make clear what I'd observed in relation to that.

DRIVER: You recorded in terms that measures had been put in place to ensure that, despite the urgent respiratory support she was being given, air could get out --

HUDSON: Yes.

DRIVER: -- and not go into her system?

HUDSON: Not to accumulate in her abdomen and splint her diaphragm, which would have made resus very difficult.

DRIVER: Thank you. The NGT on free drainage, 2ml of what were produced?

HUDSON: I've put clear mucus.

DRIVER: Thank you. And "air ++" during both -- if we call it the midnight and the 01.16 events?

HUDSON: Yes.

DRIVER: Thank you.

One more thing: as you told us last Friday, you have endorsed some plans and the like to help us understand your evidence, so I just want to look at one of those.

We see your name in the top right corner?

HUDSON: Yes.

DRIVER: Do you remember endorsing this plan when speaking to a police officer?

HUDSON: Yes.

DRIVER: If we could look at -- thank you. We can see what appears to be the date, 23/10.

HUDSON: Yes.

DRIVER: So when endorsing this, were you trying to help us understand the events of 23 October?

HUDSON: Yes. I was asked on this occasion to detail, on both occasions that I've been called for, where [Baby I] was situated at that time.

DRIVER: All right. Can you talk us through this then? We can see the word "desk". Thank you.

HUDSON: Yes.

DRIVER: Are you controlling the mouse there?

HUDSON: Yes.

DRIVER: You just talk us through it then and direct us with --

HUDSON: So this here (indicating) and this here (indicating) are from a previous statement relating to previous events.

Then this is where [Baby I] was nursed on that final event (indicating).

DRIVER: Thank you. The desk just outside, did you add that to aid our understanding generally or about one date or another?

HUDSON: I think that was in relation to both. On the previous occasion I'd been asked where staff were sat when I'd asked them to listen out for her, which was at the desk, and then also when I was outside of the nursery where I would have been sat.

DRIVER: If you were at the nurses' desk, which is one possibility --

HUDSON: Yes.

DRIVER: -- that you gave us? Thank you. I'm grateful.

Could you remain there and answer any questions?

MR JUSTICE GOSS: Mr Myers, are you going to be more than a few minutes?

MR MYERS: Yes, I will be, my Lord.

MR JUSTICE GOSS: I thought you might be. We'll have our break then at this stage.

We have a mid-afternoon break and this is the middle of the afternoon, work afternoon, for us. So we'll just have a ten-minute break. Could you be ready to come back in to continue in 10 minutes, please?

HUDSON: Of course.

MR JUSTICE GOSS: Thank you very much.

(3.13 pm)

(A short break)

(3.23 pm)

Cross-examination by MR MYERS

MR MYERS: Ms Hudson, what you have described to us will have been an upsetting experience for you and for other people involved with it. I just want to make it plain, everyone understands that. Also for those close to [Baby I] and her family too.

So the questions I'm going to ask, which may sometimes seem a little technical, are not asked with any lack of sympathy for what took place. Okay?

HUDSON: Yes.

MYERS: When you last came to give evidence, you were telling us about events on the night of 13 October; do you recall that?

HUDSON: Yes.

MYERS: When you came to look after [Baby I] on the nights that we're dealing with today, you knew at that point that in between then there'd been further collapses and arrests, didn't you?

HUDSON: Yes.

MYERS: And you knew that some time around the 15th to 17 October, [Baby I] had been transferred to Arrowe Park and then brought back to the Countess of Chester; is that right?

HUDSON: That's correct.

MYERS: And certainly your understanding was that she'd been very ill at the time she had gone to the Arrowe Park Hospital, hadn't she?

HUDSON: Yes.

MYERS: You have described how [Baby I] presented so far as you could see on the night that we're dealing with --

HUDSON: Yes.

MYERS: -- or the nights that we're dealing with now?

HUDSON: Yes.

MYERS: But would you agree a baby like [Baby I] is a baby that does have to be watched closely, however stable she appears?

HUDSON: Yes.

MYERS: There is always the potential for a deterioration, isn't there?

HUDSON: Yes.

MYERS: An expression that used in your statement, if it comes to mind, is that she's never completely out of the woods, I think is the way that you put it?

HUDSON: Yes.

MYERS: One of the issues is you can't be complacent because they can be unpredictable in what happens?

HUDSON: Yes, that was my view at the time.

MYERS: All right. You were asked about the classification of [Baby I] in terms of the care she was receiving.

HUDSON: Yes.

MYERS: When I'm putting it that way, that's what I mean about not wanting to sound insensitive, but we understand there are categories of care?

HUDSON: Yes.

MYERS: And [Baby I] was high dependency care on this night; is that right?

HUDSON: That's correct.

MYERS: You explained last time that you were within about the first 8 or 9 months of qualification at this time?

HUDSON: Yes.

MYERS: You're a good deal more experienced now, of course.

HUDSON: Yes.

MYERS: You, of course, look after the baby that you are allocated to look after, don't you?

HUDSON: Yes.

MYERS: So I'm not suggesting you've made any choice as to who you look after or what you're doing, you will do your best to look after whatever baby is yours, won't you?

HUDSON: Yes.

MYERS: Just so we can follow, at the time we're dealing with, you wouldn't have been intensive care trained then, would you?

HUDSON: No.

MYERS: And is there a special training for being able to do neonatal resuscitation that nurses can take?

HUDSON: For newborn resuscitations, so that done at delivery, yes.

MYERS: That's a different thing then from this?

HUDSON: Yes.

MYERS: Right. Is there particular training for a nurse so that she or he is qualified to handle long lines and that type of procedure?

HUDSON: There isn't specific training. But generally speaking, at the point that I was then, I was able to care for babies with them, but I wasn't able to use the lines myself.

MYERS: You could care for them --

HUDSON: Yes.

MYERS: -- but you couldn't use them?

HUDSON: Couldn't access them, couldn't flush them, couldn't give drugs by them.

MYERS: Is that one of the reasons why when the line had to be dealt with later on the evening of the 22nd, Nurse Letby and then Dr Chang had to be involved with that?

HUDSON: Yes.

MYERS: Again, just looking at the period we're dealing with, these couple of nights, the 21st and 22 October, was [Baby I] nil by mouth at that time?

HUDSON: Yes.

MYERS: So she was receiving nutrition by the long line; is that correct?

HUDSON: Yes.

MYERS: Did it seem to you that she did -- over that period there were points when she seemed to be unsettled because she seemed to be getting hungry?

HUDSON: Yes.

MYERS: And I'm going to come to the crying you have told us about when we get there. We'll look at what you're describing there, but in general when they get hungry, can they be quite shouty and demanding?

HUDSON: Yes.

MYERS: Just looking at her being unsettled, I'd like you to look, if you would, please, at tile 9 first. We saw this when you were asked questions by the prosecution.

If we go into that, thank you, Mr Murphy.

This is a note on 22 October at 03.04, isn't it?

HUDSON: Yes.

MYERS: So this is from the shift you would have begun around about 8 o'clock on 21 October?

HUDSON: Yes.

MYERS: If we just go down to the last couple of lines on there.

Can you see it says:

"Abdomen soft and non-distended"?

And below that:

"Unsettled at start of shift and rooting. Settled with dummy."

HUDSON: Yes.

MYERS: And is that an example of the type of behaviour that [Baby I] was exhibiting because it seemed to you she was hungry?

HUDSON: Yes.

MYERS: Can we move forwards, please, to tile 36. This is just for continuity's sake. I'm going to pop into this one -- it's not one of yours notes, it's a note of one of your colleagues, Caroline Oakley, just to follow this point through if we may. If we can just enlarge the entries on the lower left middle, please.

We're looking at 22 October 2015, 17.43. So this is the time just before you came on to your shift, isn't it?

HUDSON: Yes.

MYERS: We can see the note from Caroline Oakley, a couple of things:

"No progress re transfer to Alder Hey Children's Hospital for barium enema."

Were you aware that people were waiting for there to be an investigation with [Baby I] of an enema?

HUDSON: Yes.

MYERS: "Remains nil by mouth."

Then:

"Unsettled at times. Obviously very hungry but usually settles with dummy."

HUDSON: Yes.

MYERS: And then just if we could look at tile 48 next, please, Mr Murphy. Look on the bottom left of that tile to start with. Just enlarge that if we could, please.

It's a note that you made at 03.39 on 23 October, isn't it?

HUDSON: Yes.

MYERS: So actually, in this note you update what happened since you took over the cares from 19.45, don't you?

HUDSON: Yes.

MYERS: But of course very sadly, at the time you were dealing with this, this is after [Baby I] had died, isn't it, that you made this entry?

HUDSON: Yes.

MYERS: You note about three lines into this towards the end:

"[Baby I] was unsettled and rooting at start of shift. Settled with dummy and containment holding."

HUDSON: Yes.

MYERS: Now in the course of the night -- in the course of the night there was the issue of the long line that had to be dealt with, wasn't there?

HUDSON: Yes.

MYERS: When you gave your evidence, you were asked about what happened with [Baby I] round about this time and you said the procedure happened about 10.15 to 11 pm, then you leave them to rest as the procedure has the potential to unsettle them or disturb them.

HUDSON: Yes.

MYERS: Is that because handling can have that effect on a baby?

HUDSON: Generally speaking, a baby of this age, not usually.

But because she'd been so unwell preceding this and wasn't being fed, it was very -- she was very sensitive.

MYERS: Yes. Was the upshot of this that as a result of this procedure, obviously she had to be handled so that the line could be removed and a cannula inserted; is that right?

HUDSON: Yes.

MYERS: And she ceased to be provided with the fluids that she'd been receiving at this point; is that right also?

HUDSON: Yes.

MYERS: So she wasn't getting any nutrition from the long line at this point?

HUDSON: No.

MYERS: Just so we can be quite clear then with what takes place then, could we look at the fluid chart, which is at tile 75, Mr Murphy, please.

This is in the paper charts that you've got, ladies and gentlemen, but it will come on the screen anyway.

Just looking across to the right-hand side, we can see your initials at the bottom. We can see, if we look above them, the timings from 20.00 to 24.00. This is the evening shift that we're dealing with, isn't it?

HUDSON: Yes.

MYERS: All right. If we look down below 22.15, can you see it says "22.00 15" four boxes in from the right?

HUDSON: Yes.

MYERS: You can all see that? If we look down we can see it says: "Disconnected due to long line removal."

HUDSON: Yes.

MYERS: Is it right that after that point, there were no more observations in terms of the monitoring that were conducted on [Baby I]?

HUDSON: Yes.

MYERS: So if we take a look at the observation chart next at T35, please, Mr Murphy. Pull back for a moment, please, so we can see the whole chart. There we go.

The last entry at the bottom, I know it's very small, those are your initials right down at the foot of it, aren't they?

HUDSON: Yes.

MYERS: Can you see the chart I was look just looking at?

HUDSON: Yes.

MYERS: It's page 15035 at the foot in the red numbering, so we can see that's your final entry, and it's at 20.00, isn't it?

HUDSON: Yes.

MYERS: And no entry at 23.00?

HUDSON: Yes.

MYERS: If the handling with the lines that you described to us can have an effect of disturbing the baby, would there not be -- I'm just asking -- all the more reason to monitor her carefully after that's done rather than stop the monitoring?

HUDSON: Monitoring wasn't stopped, it was still in situ, I just haven't recorded them at that time. She remained on the Philips monitor and you could see her heart rate, respiratory rate and saturations constantly.

MYERS: So she's not attached -- well, what is it that's happening, you're just not recording?

HUDSON: I have not recorded them at that time.

MYERS: Is that why we can see, above the final entry where your letters are, we can see it says "96% air"? Can you see if you look up from you initials, AH --

HUDSON: Yes, yes.

MYERS: -- we've got SaO2, haven't we?

HUDSON: Yes.

MYERS: Which is oxygen saturation?

HUDSON: Yes.

MYERS: And that's 96%?

HUDSON: Yes.

MYERS: And she's breathing air at that point?

HUDSON: Yes.

MYERS: Had you noted that there had been a slight drop in the oxygen saturation?

HUDSON: I think within my statement I've referred to it being about 93%, very briefly, at the start of the evening, when [Baby I] was having cuddles with her mum.

MYERS: Right, I see. So you were performing observations on her --

HUDSON: Yes.

MYERS: -- so you could see how she was doing?

HUDSON: Yes.

MYERS: And caring for her that way during the course of the evening?

HUDSON: Yes.

MYERS: Was it in the course of that that you realised she was getting upset?

HUDSON: Yes.

MYERS: You've described to us how she was, how she was crying; is that right?

HUDSON: Yes.

MYERS: I'm going to ask you, is the thing which really stood out that all the things you would normally do to settle [Baby I] just didn't seem to be working on this occasion?

HUDSON: Yes.

MYERS: Was it in particular the persistence of how she just kept crying that really struck you?

HUDSON: Yes, and the kind of -- it's really difficult to explain -- the volume of it and that it was relentless.

MYERS: Okay. Just kept on?

HUDSON: Yes.

MYERS: So you called for help at that point or when you couldn't settle her, you called for help?

HUDSON: No, I called for help once she was in distress, so I settled her by myself, I turned her on her tummy, and then once I noticed, because I hadn't left her side, that she had paused in breathing and was seemingly in distress clinically and that's when I called for help.

MYERS: Right, thank you. When you do that, you would hope that one of your colleagues who's free will come as quickly as they can?

HUDSON: Yes.

MYERS: And Ms Letby came to help you?

HUDSON: Yes.

MYERS: I'm going to go back to look at the nursing notes just to see what action was taken at that point and it's on tile 48, please. It's the top right-hand side of this.

Can we just enlarge that first large paragraph, please, so we can all see that?

You start with the description of how [Baby I] was when, as you've put, she was "very unsettled [question mark]"?

HUDSON: Yes.

MYERS: Is that correct?

HUDSON: Yes.

MYERS: You put:

"... due to hunger as rooting."

That's how it struck you at least at first; is that fair to say?

HUDSON: With the question mark/query.

MYERS: "[Question mark] due to hunger as rooting."

You weren't sure why?

HUDSON: Yes.

MYERS: "Dummy offered and containment holding but no effect."

Then you go through to describe how she became and how you called for help?

HUDSON: Yes.

MYERS: I just want to go to this:

"I repositioned [Baby I] on to her back..."

Can we all see where it says that about five lines down? Can you see that, Ms Hudson?

HUDSON: Yes.

MYERS: "... and at first applied the Neopuff with 30% oxygen."

HUDSON: Yes.

MYERS: And you put "SaO2" -- is that oxygenation at 98%?

HUDSON: Yes, prior to the event.

MYERS: Prior to the event?

HUDSON: Yes.

MYERS: Heart rate was steady prior to this?

HUDSON: Yes.

MYERS: Right:

"Neopuff applied due to colour and apnoea. Colour didn't improve and oxygen and heart rate began to drop rapidly."

And that's where we go down to the desaturation at 47%, heart rate 50?

HUDSON: Yes.

MYERS: And at that point the Neopuff was increased to 50 and then to 100%?

HUDSON: Yes.

MYERS: But with no effect?

HUDSON: Yes.

MYERS: Was the Neopuff used up to the point of ventilation from what you can remember to try and get oxygen into [Baby I]?

HUDSON: Um... I don't recall. If she had remained apnoeic at that time then, yes. If by turning her over she had some respiratory effort then, no. You'd give ventilation breaths in response to what you see clinically at the time.

MYERS: All right. But the Neopuff was used with increasing pressure and oxygen?

HUDSON: Yes.

MYERS: You noted and you told us, moving forwards, your description in fact, not in the note, but your description to us that once [Baby I] was ventilated -- in fact before she was ventilated she began to cry; is that correct?

HUDSON: She -- yes, attempted to cry. I should just state that with an ET tube in situ via the cords they can't actually produce noise, but they will try to stimulate that and that's what she was doing at that time.

MYERS: I'm just going to look at the last three or four lines of that entry. We can see we've got:

"[Baby I] intubated and placed on a ventilator whilst awaiting chest X-ray."

HUDSON: Yes.

MYERS: Then you put:

"Prior to ventilation, [Baby I] had become more alert and crying."

HUDSON: Yes.

MYERS: "Abdomen soft and non-distended prior to resuscitation."

HUDSON: Yes.

MYERS: "No change from handover."

HUDSON: Yes.

MYERS: "Please refer to clinical notes for resuscitation information."

I just want to ask you about that because there's perhaps a little more detail there and I would like you to tell us. Because of [Baby I]'s history, you were aware [Baby I] had a history of abdominal distension, didn't she?

HUDSON: Yes.

MYERS: And so because of that, what was one of the first things that you did as soon as, it seemed to you, she'd started to desaturate?

HUDSON: I looked at her abdomen.

MYERS: Right.

HUDSON: So generally speaking, if you start a resus, if it's safe to do so, there are enough pairs of hands, you would undress the baby anyway so you can see their skin tone, their colouring, and it's much easier to see chest movement. But on

this particular occasion I paid specific attention to her abdomen, knowing her history.

MYERS: Mm. And you did that once she started to desaturate; is that correct?

HUDSON: I'm not quite sure on timings, I'll admit.

MYERS: Round about that time?

HUDSON: Yes.

MYERS: And did her abdomen seem to be fine at that point?

HUDSON: Yes.

MYERS: And that's why you made the note "No change from handover"?

HUDSON: Yes.

MYERS: Then did Neopuffing and then, in due course, resuscitation follow that?

HUDSON: Yes.

MYERS: Thank you.

Your understanding was that the ventilation having taken place, in fact the doctors then extubated [Baby I], in other words stopped the ventilation, took the tube out?

HUDSON: Yes.

MYERS: Because she seemed to be struggling against the ventilator?

HUDSON: Yes. And it was also based on the review of the X-ray.

We made sure the X-ray had come back and that I believe it was Dr Gibbs who reviewed it before he made that decision.

MYERS: Right. Thank you. Once you'd reached that point, that's about half an hour after this incident had begun, roughly, would you agree, roughly?

HUDSON: Yes, roughly.

MYERS: And certainly at that point [Baby I] seemed to be much better and more like she had been before the incident even took place?

HUDSON: Yes.

MYERS: If we continue with the note that we have here. I'm just going to move down now to the paragraph below the one we can see that starts at 01.06.

01.06, is that the time that you give for when you can first say you became aware that [Baby I] was unsettled again?

HUDSON: Yes.

MYERS: And your recollection, the best you can make it, is that it is either an alarm or a call for help which brought you to nursery 1?

HUDSON: It wasn't a call for help, it was either her crying or the alarm.

MYERS: Right, sorry, my mistake. A cry from her?

HUDSON: Yes.

MYERS: An alarm or a cry from her. When you went in, as it happens, so far as you could tell, there was no bradycardia and no apparent desaturation?

HUDSON: No.

MYERS: When you went in, Ms Letby was settling or trying to settle [Baby I] with a dummy?

HUDSON: Yes.

MYERS: Did this seem to be very much a repeat, to some extent, of what had happened earlier on?

HUDSON: Yes. By the sound of the crying and her behaviour, it seemed to mimic what had happened an hour prior.

MYERS: Right. And because of that, your concern was that this was going to be a repeat and you said that?

HUDSON: Yes.

MYERS: And Ms Letby appeared to be trying to reassure you, saying she thought she'd be all right?

HUDSON: Yes.

MYERS: And then, as you described to us, very sadly, she wasn't?

HUDSON: Yes.

MYERS: The doctors will deal with what happened in the course of the resuscitation and we'll hear from them. But did you have some involvement in assisting [Baby I] or perhaps more particularly her family immediately afterwards?

HUDSON: Yes.

MYERS: Could we just go to tile 125, please? Just pop behind that and have a look at what the note says, please.

Can you enlarge the top left, please, Mr Murphy?

It's the lower of the two.

We've got a note made at 08.40 on 23 October, Ms Hudson.

HUDSON: Yes.

MYERS: Just to make sure we have in the record what you said.

You put in here that:

"When treatment was withdrawn, her parents were informed by Dr Gibbs on why this was necessary. After which I wrapped [Baby I] in a blanket and handed her to mum. Parents were left with [Baby I] and I stayed nearby should they have needed anything. Me and neonatal Nurse Letby then spoke with parents about what happens next."

HUDSON: Yes.

MYERS: "After discussion, parents decided to bathe [Baby I], make hand and footprints, have photographs, and gave consent for hair to be cut and kept in a memory box. Informed of need for cooling. Mattress taken through with Senior Neonatal Practitioner Caroline Oakley and care handed over."

HUDSON: Yes.

MYERS: And that's care handed over to Caroline Oakley; is that correct?

HUDSON: That's correct.

MYERS: We know now, us in court dealing with this case, that there is a procedure on bereavement that's followed as to steps taken to care for the baby and care for the family.

HUDSON: Yes.

MYERS: In fact, had you done that before or is this the first time you'd been in that position?

HUDSON: This was the first time.

MYERS: Right. And did Ms Letby assist you with that because you'd not done it before?

HUDSON: Yes.

MYERS: But then afterwards, Caroline Oakley took over and helped the family in her capacity as senior nurse on the unit?

HUDSON: Yes.

MR MYERS: All right. Thank you very much for dealing with that, Ms Hudson.

Re-examination by MR DRIVER

MR DRIVER: Can I just clarify the meaning behind some of the expressions you've used and were taken to to describe [Baby I]'s presentation during this night. You've recorded at times, and you were taken to the note, that she was unsettled.

HUDSON: Yes.

DRIVER: That she was upset?

HUDSON: Yes.

DRIVER: And she was crying?

HUDSON: Yes.

DRIVER: In answer to a question asked a moment or two ago, you said in relation to the event at 01.06, and this is my note of your answer:

"By the sound of the cry and her behaviour, it seemed to mimic what had gone before."

HUDSON: Yes.

DRIVER: The sound of the cry, what was the nature of the sound of that cry?

HUDSON: It was loud, it was almost like a repetitive noise.

Like I say, it was relentless. From my interpretation, it would indicate distress, the cause of that I can't be sure. It was just markedly very different to how she'd cried on previous occasions when she'd been hungry in my experience.

MR DRIVER: Thank you. Does your Lordship have any questions for the witness?

Questions from THE JUDGE

MR JUSTICE GOSS: Well, I think we can all understand the word "rooting" is used a lot, not just by you but by another nurse.

HUDSON: Yes.

MR JUSTICE GOSS: Can you explain -- those of us who have contact with babies, from what we can remember of it, you know how babies sometimes are demanding, they appear to want feeding.

HUDSON: Yes.

MR JUSTICE GOSS: Can you just describe what this rooting gesture in [Baby I]'s case was that you're talking about?

HUDSON: Yes. So rooting is a classical sign of when a baby is asking for food. It usually happens before they start to cry. It's an early stage of hunger communication, and usually it's characterised by the baby's head moving from side to side, sometimes a little rapidly, and they tend to stick their tongue out and smack their lips a lot. It's a very specific behaviour that occurs when they're hungry.

MR JUSTICE GOSS: Thank you.

MR DRIVER: My Lord, I'm confident this is the last time that Ms Hudson will be called to give evidence.

MR JUSTICE GOSS: All right.

Thank you very much for coming back again this week and giving further evidence in relation to this.

You will not be required again. But just out of an abundance of caution, please don't speak to anyone, in particular anyone who may be still to be a witness in this case --

HUDSON: Yes, of course.

MR JUSTICE GOSS: -- about anything to do with it.

HUDSON: Yes.

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

(The witness withdrew)

MR JOHNSON: My Lord, we have two alternatives. One is to bring all the filing up to date, which will probably take 10 minutes or so. The other is to start a witness who will certainly not finish today. For reasons that I can explain in the absence of the jury, we'd rather adopt the first rather than the second.

MR JUSTICE GOSS: There's no need for you to explain it.

I trust you, Mr Johnson. If you're saying that would be a better way of doing things, even if it means we might finish slightly earlier this afternoon, no doubt for the assistance of others we'll do some other things. We won't start on the next witness, who will be Dr Chang, I assume.

MR JOHNSON: It will.

MR JUSTICE GOSS: So we're not going to start on Dr Chang?

MR JOHNSON: Whether we start with her tomorrow, that's one of the issues.

MR JUSTICE GOSS: Exactly. Just so that there's no real mystery about it, fitting in the other witnesses is difficult, so we may not start with that doctor, but we'll start with some other evidence from a witness.

MR JOHNSON: We certainly will.

MR JUSTICE GOSS: All right. But we're not going to start that now. All right? So what we're going to do is some tidying up. If you could help us with that then, please.

MR JOHNSON: Yes, of course. I'll get the witness box version and we will do that while the jury are there as well.

If we can start, please, with [Baby A], I think, from memory. So we're back to divider 1.

MR JUSTICE GOSS: We're going right back to the beginning.

(Pause)

MR JUSTICE GOSS: File 2. These are charts. You'll remember that the first six sections have nothing in them. That's what we're going to fill, I assume.

MR JOHNSON: We are, thank you.

MR JUSTICE GOSS: You'll remember that when you were hearing this evidence last year, it was said that you would be provided with some paper copies of some of the key documents because it was actually, I think, my suggestion that it would be helpful for you to have some paper documents and not rely entirely on the electronic versions of them. So there came a time when we got on to the seventh section, when we were putting paper documents in, but we now have to fill in the ones from before.

So we are going right back behind divider 1, which in my file is a yellow one, it's all yellow in your case as well. These go in, just checking that there are -- there should be six sheets.

MR JOHNSON: Yes.

MR JUSTICE GOSS: Just making sure. I'm sure there won't be an error, but sometimes there are clerical errors that creep in. It's worth checking it now.

MR JOHNSON: It is.

MR JUSTICE GOSS: So six sheets. If you all have six, it should be all right.

MR JOHNSON: Number 2 next, which is [Baby B]. Same routine, please.

(Pause)

MR JUSTICE GOSS: Seven sheets.

MR JOHNSON: It'll be [Baby C] behind divider 3, please.

(Pause)

MR JUSTICE GOSS: Ten, I think, Mr Johnson.

MR JOHNSON: I'll take your Lordship's word for it.

Then [Baby D], please, is next.

(Pause).

MR JUSTICE GOSS: You've all got 10 sheets in that? Good, thank you.

MR JOHNSON: We seem to have mislaid the [Baby D] ones.

We'll come back to [Baby D].

[Baby E] next, please. Number 5.

MR JUSTICE GOSS: So leave 4 empty for the moment, please.

(Pause)

MR JOHNSON: With the exception of [Baby D], of course, the next one, which is [Baby F], behind divider 6, should complete the set.

MR JUSTICE GOSS: Yes, thank you.

(Pause)

MR JUSTICE GOSS: Eight sheets of paper.

(Pause)

MR JUSTICE GOSS: Are you anticipating the [Baby D] sheets are going to arrive?

MR JOHNSON: No. I had them all in a pile and it's a mistake that I've clearly made somewhere, so I can't really ask somebody else to sort it out.

MR JUSTICE GOSS: No, it's all right.

MR JOHNSON: We'll have them for tomorrow --

MR JUSTICE GOSS: Yes.

MR JOHNSON: -- to be distributed at some convenient point.

MR JUSTICE GOSS: Certainly.

MR JOHNSON: Thank you.

MR JUSTICE GOSS: Is that far as you want to go today?

MR JOHNSON: Yes, please.

MR JUSTICE GOSS: Not to read any statements?

MR JOHNSON: No.

MR JUSTICE GOSS: Well, it's not actually very much earlier than normal. Yesterday was a long day and today's been a concentrated day as well. So 10.30 tomorrow then, please. Remember your obligations, you know what they are, your responsibilities as jurors.

(In the absence of the jury)

MR JUSTICE GOSS: I take it, Mr Johnson, that this is the question of doctor or Professor Arthurs as to whether he is going to be interposed first thing tomorrow.

MR JOHNSON: Yes. Perhaps between us, we can have a discussion about that and inform your Lordship as to --

MR JUSTICE GOSS: Well, it doesn't worry me at all, but you just speak to Mr Myers and then...

MR JOHNSON: It doesn't seem that he's too worried.

MR JUSTICE GOSS: It's not for me to say in which order you call the witnesses. Professor Arthurs, then we'll go back to Dr Chang, Dr Gibbs. There's a reading of statements as well?

MR JOHNSON: What I didn't want to say in front of the jury is Dr Chang is here and she is nursing a small baby.

Her husband is here to give her assistance but there is (inaudible: no microphone) she can't do what's required so that's why I (inaudible: no microphone) for obvious reasons.

MR JUSTICE GOSS: No, no, that's absolutely fine. As I say, it's been a concentrated day in any event. Thank you very much.

Mr Myers, do you want to -- yes.

MR MYERS: One or other of us will be going down to see Ms Letby.

MR JUSTICE GOSS: One of the barristers will be going down straightaway. Thank you very much.

MR JOHNSON: Because of Dr Chang's particular circumstances, we've asked her to be here at 1.30 tomorrow. That's the decision.

MR JUSTICE GOSS: That's fine. Will that prevent -- well, I don't know, it depends how long --

MR JOHNSON: I think we'll comfortably deal with Professor Arthurs -- there are five cases, but actually there's not a great deal of --

MR JUSTICE GOSS: No. That's a good estimate.

MR JOHNSON: I think so.

MR JUSTICE GOSS: Good, all right. We'll do whatever has to be done.

MR JOHNSON: Thank you very much.

MR JUSTICE GOSS: Thank you very much.

(4.06 pm)

(The court adjourned until 10.30 am on Friday, 3 February 2023)