

10 February 2023  
Baby I  
+ starting on Baby J

## CONTENTS

### Housekeeping

DR SANDIE BOHIN (continued)  
Examination-in-chief by MR JOHNSON (continued)  
Cross-examination by MR MYERS  
Re-examination by MR JOHNSON

Summary of interview with LUCY LETBY re [Baby I] (read)

[MOTHER OF BABY J] (sworn)  
Examination-in-chief by MR JOHNSON  
Cross-examination by MR MYERS

MRS KATE TYNDALL (recalled)  
Examination-in-chief by MR JOHNSON

Friday, 10 February 2023  
(10.30 am)

(In the presence of the jury)

### Housekeeping

MR JUSTICE GOSS: Good morning, members of the jury. Before we recommence with the evidence, just future sitting dates in the light of the notes that I received yesterday afternoon. We will not be sitting on this case next Friday, 17 February.

We will also not be sitting before 1 pm on 21 February, which is the following week, the Wednesday, I think, of the following week -- Tuesday, Tuesday, thank you, of the following week. If we can sit at 1 o'clock, I would quite like to sit at 1 o'clock and then have a half hour break in the afternoon so we can have a slightly longer day. It's not a full day, but we can have a fuller day than we would if we sat at 2 o'clock.

Then we will not be sitting again on 17 March, but that's a long way off now, but I'll remind you of that when we get nearer to the time. Thank you very much.

Mr Johnson.

MR JOHNSON: Just on that subject, my Lord, I think your Lordship's arrangements meant we couldn't sit on the 13th of March either.

MR JUSTICE GOSS: Oh yes. Unfortunately, we can't sit on Monday, 13 March either. Sorry about that. I have to be somewhere else that day. So sorry about these interruptions, but they happen.

MR JOHNSON: Dr Bohin, please.

MR JUSTICE GOSS: Thank you, Mr Johnson, for reminding me of that.

DR SANDIE BOHIN (continued)

Examination-in-chief by MR JOHNSON (continued)

MR JOHNSON: Dr Bohin, welcome back from yesterday. We had just started to deal with your opinion relating to events on the four separate occasions and you had dealt at least in part with your opinion concerning [Baby I]'s first collapse on 30 September. But because that was foreshortened by the break, I'd just like to retread that ground if we may, if you'll forgive me for that.

Going back to your paragraph 5.12.

You told us yesterday or had given us a summary of the circumstances which you had taken into account in reaching your opinion and I'd like you now, if you would, please, to give us your opinion for the events related to [Baby I]'s collapse at 16.30 and 19.30 on 30 September, please.

BOHIN: Yes. In my opinion, the collapse of [Baby I] at that time was caused by administration of air into the nasogastric tube, via the nasogastric tube into the bowel.

JOHNSON: Whilst you have explained the mechanism to us before as to why that would compromise a child like [Baby I], in short form perhaps, could you just remind us of the mechanism?

BOHIN: Yes, of course. An excess amount of air within the bowel will cause the abdomen to distend, so become much fatter, and in turn, as well as becoming fatter, it pushes up on the diaphragm, the muscle between the chest and the abdomen, and that in turn squashes the lungs and affects respiration. We know that the lungs were not entirely normal in any case, so actually by squashing them that further compromises them and it in turn -- that will then eventually cause a collapse.

JOHNSON: So far as other possibilities were concerned, we've heard that there was a real-time caution about the possibility of NEC. Given all the circumstances, have you discounted that as being the cause of [Baby I]'s collapse on the 30th?

BOHIN: Yes. Necrotising enterocolitis has to be considered in any baby with a distended abdomen, but a distended abdomen is not the only feature of necrotising enterocolitis and [Baby I] had no other features of necrotising enterocolitis, either clinically or on X-ray, in my opinion.

JOHNSON: So moving to 13 October next, please. Just to contextualise that event, it happened at about 03.20 that morning. It's the event when [Baby I] was in nursery 2 and the other nurse or the nurse who gave direct evidence about the circumstances was Ashleigh Hudson. Can you tell us what was, in your view, the cause of [Baby I]'s collapse on that occasion?

BOHIN: Again, in my opinion the appearances of the X-ray associated with the collapse and the discolouration of the abdomen can be accounted for by exogenous administration, so outside administration, of air via the nasogastric tube into the bowel and also an air embolus, ie air being deliberately administered into an intravenous line.

JOHNSON: Did you take into account particularly the appearances on the X-ray that I think we looked at yesterday at 4.25 on 13 October?

BOHIN: Yes, I did. There's no evidence of necrotising enterocolitis, there's no evidence of an obstruction and I couldn't find any pathological reason for the abdomen to have those appearances on X-ray.

JOHNSON: Did you look specifically -- and I'm looking particularly at your paragraphs 5.11 and 5.12, did you look at the records to see whether there was -- whether you could establish the issue -- the presence or otherwise of an NGT being in place at the time?

BOHIN: I think that's a really important point because historically, looking at all of these cases, the nursing staff were not particularly good at recording when they inserted or removed or change nasogastric tubes, despite their paperwork having boxes for nurses to fill that in.

It was often incomplete. So it's difficult looking at the notes to establish whether there was or was not a nasogastric tube in place.

[Baby I] was bottle feeding and had been for several days so there was no clinical need for her to have a nasogastric tube in place. However, it is normal practice to leave a nasogastric tube in place for some days after a baby gets to full bottle feeds, just because it's an unpleasant procedure to undertake, and so you don't -- if a baby goes on to full bottle feeds, they

may be okay for a couple of days and then require tube feeds again.

So the nursing staff tend to leave them in for several days. I don't know what the policy is in Chester and there is no evidence that a tube was removed, but there was no evidence that a tube was replaced either.

JOHNSON: As a matter of practicalities, how long does it take to put in place an NGT?

BOHIN: A matter of seconds.

JOHNSON: And to remove it?

BOHIN: Seconds.

JOHNSON: What would the reasons why on this occasion you believe that air in the vein was a possibility?

BOHIN: The staff give a description of a bruiselike discolouration over the right side of the sternum and the medical staff made a comment that they thought this was down to the result of earlier chest compressions, so CPR. In my experience, CPR does not cause that sort of bruising.

Over the years, sadly, I've attended many, many resuscitations of newborn babies, both on a neonatal unit and in a regional cardiac unit, where CPR is much more common, but I have not seen children or babies end up with significant bruising over their chest to account for it, so I couldn't account for this discolouration from a pathological process and therefore I deduce from that that this was down to an air embolus associated with the ensuing collapse.

JOHNSON: Moving on to events on 14 October, please, so this is number 3. We have two events fairly close in time, 00.55 and 07.00 or thereabouts, or 07.30, that sort of time. So it was the succeeding night shift, in other words.

What conclusions did you -- what was your opinion as to the reasons for [Baby I]'s collapse at that time?

BOHIN: Again, in my opinion, based on the appearances of the X-ray, the discolouration of the abdomen and the collapse can be accounted for by the exogenous administration of air into the bowel and air embolus, ie air being inserted into a vein. My reasons for that were that as well as the bruising on the right side of the chest that was noted previously, the abdomen had become distended, hard and the staff noted spreading areas of

discolouration over the abdomen and then resuscitation was required within the hour.

The X-ray after that showed that there was widespread gaseous distension that we'd seen previously and I could find no clinical pathological reason for that appearance.

JOHNSON: Moving on, finally, to the fourth occasion which we have examined in detail [Baby I]'s progress. We begin a couple of minutes before midnight of the 22nd into 23 October and then with [Baby I]'s final collapse and death, which was described to us yesterday by Dr Gibbs. What conclusions have you reached so far as the cause of [Baby I]'s death?

BOHIN: In my view, the cause of [Baby I]'s death was air embolus, that is air being injected into an intravenous line.

JOHNSON: Are there any specific features of the evidence which in your opinion account for that as the cause?

BOHIN: As well as the sudden and unexpected catastrophic collapse, the thing that was compelling to me was the issue of being unsettled and agitated and crying in a way that nurses felt was unusual. Babies cry for all sorts of reasons and parents and experienced nurses get a sense of why babies are crying, whether it's through hunger or brief discomfort, for example if a blood test is taken. But in those instances, babies can usually be consoled, so either by a cuddle -- not in this case, but either by a cuddle or some containment holding or some sucrose or a dummy. This was very different and the staff have said very clearly that this was different and this was inconsolable crying, which is extremely unusual in a baby and I think [Baby I] was in pain at this time and must have been in severe pain to be this upset and agitated.

This, and the distension of the abdomen and the sudden collapse, led me to think that this was an air embolus.

JOHNSON: Looking at it from the other end of the telescope, so to speak, in your view was there anything to support the suggestion that this collapse and death was the result of a normal "innocent" process?

BOHIN: Obviously I've considered a number of innocent processes, but I can think of nothing that would cause the mottling of the trunk. Dr Gibbs described that [Baby I] had a pink face, but her trunk and limbs were mottled, associated with her becoming very, very unsettled. That, to me, is a baby in pain and it may well have been that she was hypoxic at that point, ie there was low oxygen in her blood because that causes you to become agitated.

It doesn't cause you to have inconsolable crying, but hypoxia can cause you to be agitated.

The inconsolable crying is a baby in pain and that may be due to the fact that the heart has become starved of oxygen in the process of an air embolus. When air goes into the heart it can cause a lock in the heart, which effectively causes the collapse, which is what I think happened here, but that can be a painful process.

MR JOHNSON: Would you remain there, please, Dr Bohin?

There will be some further questions for you.

Cross-examination by MR MYERS

MR MYERS: In the case of every child in this trial, Dr Bohin, you received and read Dr Evans' opinions before providing an opinion of your own, didn't you?

BOHIN: Yes, I was asked to peer-review Dr Evans' notes.

MYERS: We've heard about peer review. If we want your independent views of what may have happened, the way to do that would have been to give you the material without Dr Evans' reports and see what you concluded independently of Dr Evans, wouldn't it?

BOHIN: My reports are independent views.

MYERS: We don't know and we will never know what conclusions you would have drawn had you not been provided with Dr Evans' reports first.

BOHIN: That's correct, but I have been appointed as an expert witness in this court and my duty is to give an independent view and that's what I've done.

MYERS: Do you agree that as a basic principle of scientific method, if you want to get an independent assessment of a situation you have an experiment or a review conducted independently of the first one to compare?

BOHIN: I'm sorry, you've lost me. Could you repeat the question?

MYERS: Do you agree that as a simple part of scientific method, if you want to review or check one set of findings, you conduct an independent experiment elsewhere?

BOHIN: Yes.

MYERS: That means doing it without working off the findings of the first one, doesn't it?

BOHIN: If I'm not mistaken, I think you're suggesting that I've merely rubber-stamped Dr Evans' reports, which I think is less than discourteous. What I've done is review these cases. I was asked by Cheshire Police to establish whether, having reviewed the cases, I agreed with Dr Evans, whether I disagreed with Dr Evans or whether I found a different cause. That is what I have done and already in the cases that we have heard there have been times when I have disagreed with Dr Evans' findings and also when I have introduced my own findings into my report. So this was not a rubber-stamping exercise.

MYERS: First of all, Dr Bohin, I have been nothing other than courteous to you throughout --

MR JUSTICE GOSS: This isn't going to be very helpful, Mr Myers. Let's just detach ourselves for a moment and concentrate on you putting questions and the witness answering those questions.

MR MYERS: That is what I've been trying to do throughout, my Lord. Comments are being made about my questions both by this witness and the last one.

MR JUSTICE GOSS: If I may say so, the implication behind the questions was quite clear and that is what the witness picked up.

MR MYERS: Very well, my Lord.

MR JUSTICE GOSS: But let's just press on with the questions you want to ask.

MR MYERS: The next thing, Dr Bohin, is I'm not suggesting you are rubber-stamping what Dr Evans says, but you are supporting what he has said so far as you feel able to do so.

BOHIN: Yes.

MYERS: Let me be clear that you don't misunderstand my question. What I mean is you are backing up what he has said so far as you feel able to do so.

BOHIN: No, I'm not backing up what he said: I'm reviewing the case and coming to my own opinions. And if that is in alignment with Dr Evans' view, then it's in alignment with Dr Evans' view, but on occasion it is not in alignment with Dr Evans' view.

MYERS: And I suggest you would never have come up with air embolus in the way you are doing had you not first been exposed to Dr Evans' theories at the very least on air embolus.

BOHIN: I disagree.

MYERS: Do you have a coherent theory of exactly how an air embolus presents?

BOHIN: Yes.

MYERS: What is it?

BOHIN: An air embolus can present in a variety of ways in neonates. It occurs very rarely. I happen to have seen it twice in my career. Once in a baby who was receiving ECMO therapy, which is a specific sort of therapy, on a cardiac unit, where babies are put on a kind of bypass machine as a temporary measure until their lungs or lungs and heart recover from their underlying illness.

And during that, unfortunately it's a known risk that you can get air embolus in that circuit and you can actually see that because you can see blood in the circuit because it is outside of the body, so babies are put on a heart lung bypass machine. I saw a patient who developed -- you could see bubbles in that and the child immediately had a cardiac arrest.

So that child was on ECMO, clearly was seriously ill, not the same as the cases that we've seen here, but for the other symptoms I can only go on what was reported in the literature and that presents either as a full, unexpected collapse and the person dies or it can present with a collapse where, after resuscitation, the person recovers.

Most of the studies, as we've already discussed in the trial, have been done in older children and adults.

There may be a drop in blood pressure, there may be a drop in heart rate, there may be skin changes. The clinical presentation is wide and varied. So that is my theory on how air embolus presents.

The pathophysiology behind it is that if you inject air into an vein, normally that air will go to the right side of the heart and would be, if it was a small amount, just be absorbed and would not cause any problem at all. If it was a large amount, it may well cause a problem and may cause a collapse.

This is not what we're talking about here because those -- in those instances there would be no skin changes or other

manifestations. The mechanism I am proposing is that air is injected into a vein, it goes into the right side of the heart and then goes across a small hole between the top two chambers of the heart called the foramen ovale. That is present in newborn babies and closes but it also remains patent in a large percentage of the population.

If that happens, then blood can go across that little hole and if you inject air, air can also go across that little hole. With pumping of the heart, it means air is then pumped round the left side -- through the left side of the heart and around the circulation and can lodge in the skin and other organs.

Additionally, the volume of air may be such that it's so large that -- well, large, but we're talking -- in a baby it's a small volume of air but large enough to fill the chamber of the heart, in which case the heart stops.

Additionally, if air goes across the PFO, the small hole between the right and left upper chambers, and is pumped around the body, it will also get pumped into the coronary arteries, which are arteries that actually supply the heart with oxygen. So in adults you know that when people have a heart attack, their coronary arteries get blocked. The coronary arteries receive their oxygen. Once the left side of the heart pumps the blood goes round the body but also supplies the heart muscle itself with oxygen and in this case, I think as well as air being distributed round the body, it is likely, certainly theoretically likely, that air went down the coronary arteries.

MYERS: What you say about discolouration and air embolus changes from case to case, doesn't it?

BOHIN: I don't think so.

MYERS: What you say about the likelihood of collapse and not being able to resuscitate changes from case to case, doesn't it?

BOHIN: No.

MYERS: What you say about distress appears in some cases, doesn't appear in other cases, doesn't it?

BOHIN: With any clinical condition, there are a number of clinical features that one might see, but you don't need to have all of those features to make the diagnosis. So you don't have to have distress in every single case, you don't have to have skin lesions in every single case. As we've discussed before, skin lesions don't appear in the literature in every single case.

MYERS: What you are doing, I suggest, Dr Bohin, is you're adapting the allegation of air embolus to cover any situation in this case where you don't find any other cause to identify and blame the collapse upon.

BOHIN: No, that's not the case. What I have done is look for pathological -- plausible pathological causes for the collapse. I didn't find one.

MYERS: Yes, and what you're doing when you don't find one, when you say you don't find one, is just reaching for air embolus as a general catch-all and simply trying to attach whatever the clinical findings are to it.

BOHIN: No, that's not the case.

MYERS: Let me just pause and look at what you say about discolouration and event 4. We'll come to event 4 in due course, but whilst I'm asking this question.

There's nothing in event 4, the 22nd into 23 October, that marks out any discolouration indicative of air embolus, is there?

BOHIN: Which part of my report are you referring to?

MYERS: Well, I'm asking you.

BOHIN: Give me a moment, I'll find it.

(Pause)

Dr Gibbs was struck by purple-white discolouration of the skin.

MYERS: Dr Gibbs gave evidence yesterday, didn't he?

BOHIN: Yes.

MYERS: You heard that?

BOHIN: I did.

MYERS: He described mottling.

BOHIN: Yes.

MYERS: Which is not remarkable, is it?

BOHIN: Not necessarily, no.

MYERS: He described the colouring on both occasions as due to poor perfusion, didn't he?

BOHIN: He said it may be a sign of poor perfusion, but he also said that the face was white and the trunk and limbs were mottled and he was struck by that difference.

MYERS: He said that, dealing with the first part of this, there was a problem with the circulation. That's what he believed. It's in his evidence yesterday.

BOHIN: Well, there was because she'd collapsed.

MYERS: He expected that that would improve with saline; do you remember him saying that?

BOHIN: Yes.

MYERS: And he said it did over the next few minutes when she was given saline.

BOHIN: Yes.

MYERS: He's described something that's quite unremarkable in colouring with poor circulation, dealt with by saline, hasn't he?

BOHIN: On that particular occasion, but when he was called back there was purple-white discolouration of the skin again.

MYERS: Let's deal with that one first of all because you have relied on that to tell this jury that's supporting evidence of air embolus, haven't you?

BOHIN: Yes.

MYERS: In fact, if that's an air embolus, it's not going to be dealt with by a saline infusion, is it?

BOHIN: A saline infusion will improve the circulation. So with air embolus, depending on the volume of air that's been administered, you will either collapse and die and there will be no amount of resuscitation that can save you, or you may survive with active resuscitation, and in this case, on the first event, [Baby I] survived with active resuscitation, including a bolus of saline.

MYERS: And Dr Gibbs regarded nothing out of the ordinary for the circumstances of poor circulation with that colouring, did he?

BOHIN: I don't remember him saying that it was nothing out of the ordinary.

MYERS: He's not described anything out of the ordinary, has he?

BOHIN: Well, he described the mottling, which is not normal.

MYERS: Mottling is very normal for [Baby I], Dr Bohin.

BOHIN: If it was very normal, people wouldn't have commented on it. Where things were normal for [Baby I], like a distended abdomen, people quite often said in their notes, "Normal for [Baby I]", but then went on to say, when her abdomen became bigger, this was out of the ordinary.

So I think if [Baby I] was mottled all the time, people would not have mentioned it. This must have been out of the ordinary for them to have mentioned it.

MYERS: Are you saying there's no other references to [Baby I] being mottled in the notes?

BOHIN: No, I'm not saying that. I'm saying she may well have been mottled but for people to have written this down at the time of her collapse, it must have been out of the ordinary.

MYERS: Mottled is written down in many places of the notes of [Baby I], isn't it?

BOHIN: Yes.

MYERS: Not because it's out of the ordinary, it's just how she presented.

BOHIN: Yes. It may have been but she didn't present always mottled with a collapse.

MYERS: And the second part of that incident, again Dr Gibbs described that as being what appeared to him to be poor perfusion, didn't he?

BOHIN: Well, she'd collapsed, so yes, he wasn't thinking of air embolus.

MYERS: And there's absolutely nothing specific about that discolouration that makes that characteristic of an air embolus, Dr Bohin, is there?

BOHIN: No, discolouration is not pathognomonic of air embolus but is consistent with air embolus.

MYERS: And this case, so far as has been dealt with up to now, if I understand it correctly, is the issue of discolouration with air embolus is that it's quite a specific discolouration --

BOHIN: No.

MYERS: -- isn't it?

BOHIN: No, it isn't.

MYERS: Right. So you no longer maintain that what's described in, for example, the article by Lee and Tanswell is a characteristic description?

BOHIN: Yes, I do, but if you ask anyone to look at a description of a rash, you will get very different answers about the same type of rash. So I'm reliant on people writing what they see in a cardiac arrest situation where they've got lots of other things to write. So we're unlikely to get a huge amount of detail about the rash because they've got so much else to be considering.

So I think that in air embolus, the type of rash -- you may get linear lines, you may get the circular lesions. There are a number of things you may get with air embolus and I think the staff have described that.

MYERS: So there could be any number of discolourations now which are air embolus, is that where we are?

BOHIN: No.

MYERS: [Baby I] was poorly on many occasions from her birth, wasn't she?

BOHIN: Yes.

MYERS: She's extremely preterm at 27 weeks, wasn't she?

BOHIN: Yes.

MYERS: And extremely low birth weight?

BOHIN: Yes.

MYERS: And throughout the notes you've seen, there are problems that are consistent and recur, aren't there?

BOHIN: Yes.

MYERS: And that includes desaturation, doesn't it?

BOHIN: Yes.

MYERS: It includes abdominal distension on a variety of occasions, doesn't it?

BOHIN: Yes, it does.

MYERS: And actually, mottling is described in her notes on a number of occasions, isn't it?

BOHIN: Yes.

MYERS: She failed to put on weight over the period we're dealing with, the whole period of her short life, sadly, didn't she?

BOHIN: She did put on weight.

MYERS: She failed to put it on in the way that should have happened?

BOHIN: Well, that's because she was very ill.

MYERS: We might look at that again in a little bit, but do you agree failing to put on weight might also indicate an underlying problem?

BOHIN: No, not necessarily. [Baby I] was very premature, she was very low birth weight. In the first part of her life, when she was at the Liverpool Women's Hospital, she was on parenteral nutrition and was very ill, was on a ventilator, feeds were introduced very slowly, and she didn't put on weight very well during that time. In fact, she crossed a lot of the centile lines during that time.

By the time she got to the Countess of Chester she had started oral feeds but had a number of clinical events which meant that her feeds were stopped and therefore had no calorie intake for that time. So with infection or abdominal distension, if feeds are stopped and you've got no calorie intake you are not going to put on weight appropriately during that time. That is part and parcel of being a premature neonate: nutrition is paid attention to but the other aspects of care are much more important initially than nutrition.

Additionally, when [Baby I] was fed, she was fed breast milk, which is absolutely the right thing for premature babies. We know they do best on breast milk, but breast milk does not contain as many calories as formula milk, therefore quite usually breast milk has to have something added to it to increase the calorie content.

But that can come with its own problems, so the staff at the Countess of Chester stopped and started feeds, stopped and started fortifier, which provides extra calories.

So the reasons for the less than expected weight gain are explicable.

MYERS: [Baby I], dealing with -- 23 August I would like to come to. That's an event that Dr Evans identified as suspicious, wasn't it?

BOHIN: Yes.

MYERS: It's also an event that you regarded as suspicious?

BOHIN: I did.

MYERS: It's an event that includes abdominal distension, doesn't it?

BOHIN: Yes. But she didn't become unwell with that.

MYERS: If we can put up, please, Mr Murphy, J13803. It's not on the system, ladies and gentlemen, because it's not one of the key dates that features in the sequence of events, but it is a date which features in the reports.

If we enlarge the lower entry, please. This is 23 August at 05.53. I'll come to a later one shortly:

"Care commenced at 19.45. All safety equipment and alarms and fluids checked. At start of shift, [Baby I] weaning off CPAP. Having cuddles with parents."

The notes describes her being placed back on to CPAP due to a cluster of desaturations:

"Weaned her off for 2 hours and 35 minutes. Observations stable and temperature maintained well. Small milky vomit overnight. Abdomen remains full and distended at times and appears veiny. She passed urine, had bowels opened."

It describes the feeds she is receiving and what's happening with her treatment. I would like to move on to the next entry for that date, which is at page 13807, please, Mr Murphy.

It's the bottom entry on that page, please. We're moving into the evening of 23 August, 18.27. I'm going to read from the bottom and across to the top. This is an entry by [Nurse C].

BOHIN: Sorry, which part are you looking at?

MYERS: I'm looking at the bottom part, the entry, but by all means identify anything you wish to, doctor. Pause there --

BOHIN: The entry that says "Mum changed nappy"?

MYERS: In fact, can you see at the bottom it says "addendum" for 23 August at 18 --

BOHIN: Yes, but it doesn't say anything else.

MYERS: We're going to move across:

"Settled day. Off CPAP for 2.75 hours then clustered desats so returned to CPAP."

It's got the readings there:

"Warm and well perfused know following 2 low normal temperatures earlier. Tolerating feeds with a couple of possets this afternoon. Bowels opened and passed urine. Bowels opened earlier had fresh blood in it and also mucous. Reviewed by [Dr B]. Bloods sent..."

That's for blood tests for the CRP test:

"... and stool sample sent for reducing substances. CRP 4. White cell count raised but reduced from previous result. Abdomen distended and veiny, but soft and unchanged from this morning. Plan is to observe for now with low threshold for intervention if required."

Just so we can be clear, is that what you had identified when you said that was suspicious?

BOHIN: I'd have to look back at my notes.

MYERS: It might be at page 5.8 -- paragraph 5.8.

BOHIN: 5.7:

"[Baby I] developed abdominal distension and had an X-ray" --

MYERS: "... that showed generalised distension" --

BOHIN: "... generalised gaseous distension."

MYERS: That you did not regard as keeping in with any pathological --

BOHIN: I didn't think it was in keeping with CPAP belly, I didn't think it was in keeping with infection.

MYERS: All right. Thank you. I'm going to move forwards then, please. I'm not going to every incident on the way through, just some dates before we come to the events on the sequence of events and I'm moving next to the events of the 5th into 6 September, which we've looked at in the course of this trial, but just to assist everybody by reminding them of this.

I am not suggesting this is something you have identified as suspicious, it's just what happens on these dates that I'm looking at now, so there's no misunderstanding.

It might assist if I refresh us all just by some references to the material we've seen. I wonder if we could put up page 13773, which is some notes by Dr Neame, who told us about this. We're going to look at this in the notes that follow.

If we look down towards the lower part of that page we can see an entry at 09.35. Can you see that?

BOHIN: Yes.

MYERS: Dr Neame described how at this time, on this page, and moving on to the next page, which is 13774, [Baby I] presented as a well baby. So we can move from this page to 13774.

At 9.35, [Baby I] was well. Do you see that, where it says "well baby" about four lines up from the bottom?

BOHIN: Yes, that was a ward round entry.

MYERS: It was. If we scroll down, we can see what happens 12 hours later. It's 21.00 now, so 9 in the evening:

"[Dr Neame] asked to see patient because of desaturations. Generally well today but increasingly frequent desaturations over the last hour, with associated bradycardia."

BOHIN: "No associated bradycardia."

MYERS: My fault:

"Increasingly frequent desaturations requiring intermittent..."

Is that...? What do you interpret that to be, "wafting O2" or "bagging"?

BOHIN: "Intermittent wafting O2."

MYERS: He makes the note that the -- if we look:

"On examination: alert, active, pink."

Down at the bottom. Then:

"Very frequent desaturations."

Do you see that?

BOHIN: Yes.

MYERS: The nadir, which he said means the lowest point, was 60%?

BOHIN: Yes.

MYERS: And a slight bradycardia he identifies there; do you see that?

BOHIN: Yes.

MYERS: If we move now as we carry on into the evening to page 13775, overleaf. And go down now to Dr Ventress' entry at 22.30. The second half of the page.

Thank you.

Looking at the section which begins 20 minutes after the feed at 22.20; do you see that?

BOHIN: Yes.

MYERS: There's profound desaturation down to 50%; do you see that?

BOHIN: Yes.

MYERS: Oxygen given to take it up to 100%; is that what the next bit means?

BOHIN: Yes, and the flow of the Optiflow was increased to 7 litres a minute from 6.

MYERS: So the treatment given there we see. I'd like to go to the next page to follow this through, 13776. From the top:

"Quiet, does cry when disturbed but not usual strong cry. Looks pale, slightly mottled."

There's a reference to mottling, as it happens, isn't there?

BOHIN: "Slightly mottled." But the perfusion is normal with a capillary refill time of less than 2.

MYERS: "Chest clear. Abdomen mildly distended but soft, veiny appearance."

Carry on down the page, please, to 1 o'clock in the morning. At approximately 23.15, [Baby I] had another profound desaturation to 50%. I'm not going to read through the whole of that page and the following page because I'm following the general course of this.

Can we move to 13778 next, please? 3.40 in the morning. You can see that, Dr Bohin?

BOHIN: Yes.

MYERS: So we're now about 18 hours after Dr Neame had said that she seemed a well baby in the morning of the day before, aren't we; yes?

BOHIN: Yes.

MYERS: Dr Ventress notes that she was:

"Crash called to the NNU at 3.20. [Baby I] had a profound desaturation on the ventilator and started to drop heart rate."

That's right, isn't it?

BOHIN: Yes.

MYERS: In fact, what we have is continuing issues with [Baby I]'s saturation and ventilation throughout the course of going into 6 September, don't we?

BOHIN: Yes, because [Baby I]'s got an infection and what you've shown over the series of entries is a baby with infection who is slowly deteriorating because of that infection. She had a septic screen very early on and was started on antibiotics, but continued to slowly decline and ended up on the ventilator.

MYERS: She went to Liverpool Women's Hospital, didn't she, at about 3 pm or thereabouts on 6 September?

BOHIN: Yes.

MYERS: No sign of any problem incoming at 9 o'clock on the morning of the 5th, was there?

BOHIN: No, she was well then.

MYERS: Yes. So you say she was well then. Whatever the reason, a baby can be well and still deteriorate dramatically without any obvious warning?

BOHIN: No, she deteriorated slowly because you've shown me a series of events over the subsequent 24 hours or so, where a number of doctors had been called to see her and each time because she's desaturating and becoming more unwell. So these weren't sudden catastrophic collapses, these were moderate events, which were treated appropriately. She went on to have another moderate event, but none of these were the catastrophic collapses that we saw later on.

MYERS: The desaturations down to about 60% that began at 9 o'clock were sudden, weren't they, 9 o'clock in the evening?

BOHIN: They were. She had an infection at that time. She was screened for an infection and treated for an infection.

MYERS: And within hours of that, the early hours of the next morning, she is then on a ventilator, isn't she?

BOHIN: Yes, she had an infection and deteriorated, so was put on a ventilator. That was the right treatment.

MYERS: Yes, and all of that is against a background where, up until 9 o'clock at night, there was no sign there was going to be any problem; that's the fact, isn't it?

BOHIN: Throughout the day prior to that, yes, she was well but she became unwell so at some point there has to be a marker where you start to become unwell and that was the marker.

MYERS: A baby like [Baby I] is, sadly, quite capable of declining very steeply if she becomes unwell?

BOHIN: Babies don't suddenly collapse and have a cardiac arrest for no reason like we saw in the subsequent events.

Babies can become unwell. There are usually warning signs and red flags that you respond to. Sometimes they become more unwell despite the red flags, but it's unusual to babies to suddenly have a collapse and a cardiac arrest. Very unusual.

MYERS: With 30 September, which I'm going to, event 1 as it's described, you said yesterday, as a starting point, that [Baby I] was in effect a well baby, with no respiratory symptoms, self-ventilating in air, gaining weight and the collapse was sudden and unexpected.

BOHIN: That's correct.

MYERS: That's what you said. Just to put matters in context, by saying she is well, really that means she's stable in the circumstances of [Baby I], doesn't it, rather than well in the sense of a healthy newborn baby?

BOHIN: Well, she was well for [Baby I]. She wasn't requiring any support, she had no respiratory symptoms, and by that time was in air and had been gaining weight. So she was well.

MYERS: You say no respiratory symptoms: you have said also today her lungs weren't normal.

BOHIN: She had chronic lung disease, so if you looked at her lungs under a microscope you would find that they were abnormal histologically. But in fact, in terms of how she manifested herself, she had no respiratory symptoms at that time whatsoever. So although she had mild chronic lung disease, it was not affecting her breathing at that time.

MYERS: But her condition means if there is a problem that has any impact on her breathing, that is likely to be magnified given her condition, isn't it?

BOHIN: Yes.

MYERS: As to the issue of gaining weight, we went through this with Dr Newby, Dr Bohin. I'm going to remind you of this, but we can go to the material if we need to. On 25 August 2015, [Baby I] was between the 9th and 25th centile. In fact, if it assists let's put up, please, page 13763.

If we look down towards the bottom of that page, we can see the fluid growth section. You can see there, Dr Bohin, it says, "Centile line, 9th to 25th"; do you see that?

BOHIN: Yes.

MYERS: Dr Newby gave evidence that when she dealt with [Baby I] on 26 August 2015, the weight was static. There was no material for that on the ward round. But can we move next, then, to 22 September, which is on page 14353.

We can see that although the month before, she was between the 25th and 9th centile, a matter of a week or so before the first incident we are dealing with, she's now on the 9th, isn't she?

BOHIN: She is, but at her birth she was on the 50th. So between her time at the Liverpool Women's Hospital and returning to the Countess of Chester, her weight had gone from the 50th to the

25th and then had subsequently gone from the 25th to 9th. So her lack of weight gain was not all at the Countess of Chester.

MYERS: But overall she is not gaining weight as she should be, is she?

BOHIN: No, but I've already discussed that. That's because she's been very ill on occasions, so she has not been fed.

MYERS: Yes. You told us yesterday she was gaining weight.

BOHIN: Well, she was gaining weight. Within the notes is a growth chart and after the growth chart there is a weight chart, which shows that she is gaining weight.

She may not be gaining weight as appropriately as one would like, and I've explained the reasons why that is, but she is gaining weight because her weight on this chart is 1.54 kilograms and that is above her birth weight. So yes, she has gained weight.

MYERS: But the fact is not gaining it in the way that you would hope in a healthy child?

BOHIN: But she'd been severely ill. She was very ill from birth and there were lots of stops and starts with feeds and nutrition. She was on a ventilator for a long time.

So babies will not gain weight if they are ill.

MYERS: Can we just look at the chart, please, which is at page 14146. This comes from [Baby I]'s records.

Just dealing with this, so we can understand what lies behind your observation that she was gaining weight. Do you understand that's why I'm looking at this?

BOHIN: Yes.

MYERS: We can see this chart says "Low birth weight growth chart" and it relates to [Baby I]. Can you see that at the top?

BOHIN: Yes.

MYERS: We're going to move to another chart in a moment. The top right-hand corner, there's a box with [Baby I]'s name in it. I'm just going to go down to the bottom, if I can, just to see which week we're dealing with as we approach 30 September. Thank you very much, Mr Murphy.

Pausing there, you'll be familiar with these charts, Dr Bohin, won't you?

BOHIN: I'm familiar with these charts. I'm not familiar with this chart. I didn't see that in the notes. I don't know where that has come from. I didn't see that in the notes.

MYERS: (Overspeaking) this has got the centile lines marked on it, hasn't it (overspeaking)?

BOHIN: Yes.

MYERS: And we look at it, ladies and gentlemen, we can see where they're written on. It's a little bit blurred, but for example, the 50th is right in the centre and it has a broken dotted line on it. Can you see that?

BOHIN: Yes.

MYERS: There we are, that's the 50th.

BOHIN: Yes.

MYERS: So the 99.60 or whatever, which is the top one --

BOHIN: Yes.

MYERS: -- is up there and the 0.4 centile is down at the bottom.

BOHIN: Yes.

MYERS: And this enables us to see whether a baby is staying on the same centile or moving across the centiles as a way of estimating assessing their weight, doesn't it?

BOHIN: Yes.

MYERS: Right. We are looking at really week 34, because if you look down at the bottom, 25 September -- can you see that?

BOHIN: Yes.

MYERS: Week 34 is the 25th, week 35 is 2 October. Just to be clear about the direction of travel, I'm going to ask if we could put up chart 15028. Remember week 34 is 25 September. It's actually the chart on the left-hand side that has items plotted on it, so let's, if we may, enlarge that one. We're going to make it a little bit bigger if we can. The bottom half. Thank you.

We can see, just looking at the overall picture, Dr Bohin, at the beginning [Baby I]'s plotted here between the 25th and 50th, isn't she, the first one we have for the Countess of Chester?

BOHIN: Yes.

MYERS: Although she began on the 50th at Liverpool Women's Hospital, didn't she?

BOHIN: Yes, she did.

MYERS: We've seen on the ward round notes where there's reference to when she goes to the 25th centile and then between the 9th and the 25th?

BOHIN: Yes.

MYERS: If we look at week 34, which is where we are, we can see by this point, at the start of that week, she's already dropped to the 9th, hasn't she?

BOHIN: She's on the 9th centile, yes.

MYERS: So relative to where she was before, her weight has dropped, hasn't it?

BOHIN: She's crossed centile lines, but she has continued to gain weight.

MYERS: She has, but do you understand gaining weight because she's being fed and putting some weight on and gaining the weight that it would be hoped a healthy baby would gain, you follow the difference between those, don't you?

BOHIN: Of course I do because I look after babies and I know why they don't gain weight. And one of the reasons they don't gain weight is you stop feeding them. So no one is going to gain weight if they don't have any calories in and there were lots of times when [Baby I]'s feeds were started and stopped and started and stopped and she was put nil by mouth and just given a 10% dextrose infusion, which contains no calories at all. So during those times she would not be putting on weight and if this graph was annotated and we added in when her feeds were stopped and started and stopped and started, I think it would be a truer picture.

MYERS: In any event, we can tell looking at this, how she goes from, on this one, the 25th down to the 0.4 centile by the time we get to between weeks 37 and 38?

BOHIN: Yes.

MYERS: That is very low indeed, isn't it?

BOHIN: Well, it's not the weight gain that one would like.

MYERS: If a baby isn't gaining weight in the way that one would hope she would, that would leave her much less resilient in terms of dealing with whatever health issues they have as they go along, won't it?

BOHIN: Not especially, no.

MYERS: Do you think that failing to gain weight doesn't weaken the baby in that way in terms of resilience?

BOHIN: Well, you'd like them to gain weight which is why you fortify their milk, but [Baby I] had lots of illnesses which stopped her from gaining weight, as I've already said, so I don't think that lack of appropriate weight gain makes you more vulnerable to developing illness.

It certainly doesn't make you more vulnerable to having a cardiac arrest.

MYERS: Well, 30 September, let's focus on that, that doesn't involve cardiac arrest, does it?

BOHIN: No.

MYERS: Thank you for showing us the charts, Mr Murphy. Take that down.

Let's deal back to 30 September. Your evidence, Dr Bohin, is that this involves, you believe, air being put down the nasogastric tube; is that correct?

BOHIN: Yes.

MYERS: Can you help us with any basis for how much air would have to be put down -- any basis in terms of research or data -- how much air would have to go down for that to happen as we see in this case?

BOHIN: No, no idea at all, and I don't think anybody has any idea. I can find no research papers. It's so variable -- it would be so variable depending on the size of the baby, whether the baby had been fed.

A stomach that has never had any milk in it will be quite small. You need to remember that the stomach is a muscle so it can stretch.

But it's a bit like a balloon the first time -- babies, when they're born, their stomach is very small and you give them a little bit of milk the first day and a bit more the next day and a bit more the next day in normal term babies and so their stomach stretches.

By the time they are many weeks old, their stomach can accommodate quite a lot of millilitres and in [Baby I]'s case she was on 50-odd millilitres of milk for each feed, so her stomach could accommodate quite a lot of millilitres. So to say how much air would be required, it's impossible to say because no one can possibly do those experiments.

MYERS: Does that go also for being able to estimate how long it would take to do that?

BOHIN: To put the air in?

MYERS: Yes.

BOHIN: Well, it would depend on the bore of the nasogastric tube, I imagine, the volume of air you try to put in and the size of the nasogastric tube that was placed. So a small nasogastric tube and a little bit of air wouldn't take as long as a little bit of air going down a large nasogastric tube. But that's just, to me, my own common sense. There's no science behind that and I know of no research.

MYERS: We know [Baby I] in fact was prone to abdominal distension throughout her life, wasn't she?

BOHIN: Yes.

MYERS: That's just, and I'm going to put it this way, an impression you form that the volume here means it must have been introduced externally?

BOHIN: Well, the X-ray showed massive gaseous distension in addition to the fact that, clinically, her abdomen was more distended than the staff had been used to, so there had been a change.

MYERS: Moving to 13 October, this is a date where your opinion is that both air embolus and air down the nasogastric tube play a part; is that correct?

BOHIN: Yes.

MYERS: When you dealt with this in your report, one of the factors that you focused on as a matter of suspicion here was that the apnoea alarm didn't sound, wasn't it?

BOHIN: Yes.

MYERS: Indeed that was the primary concern for focusing -- a primary concern for focusing on this, wasn't it?

BOHIN: On what, sorry?

MYERS: On this as a suspicious event.

BOHIN: Well, no, it was more the fact that she required resuscitation that made it suspicious. It wasn't just the fact that the apnoea alarm hadn't gone off: she'd been found in her cot motionless and blue.

MYERS: In your report, if we look, please, at -- it's difficult to read the pages because I've got red lettering over mine.

BOHIN: Paragraph?

MYERS: It's in your concluding paragraph 5.33. At the centre of the page it has a bullet point next to it. In the third bullet point down on the page after 5.33 starts, you say, dealing with 13 October:

"I agree with Dr Evans that the apnoea monitor must have been tampered with or switched off on 13 October."

BOHIN: Yes, that's correct. That was my opinion at the time because anyone with an apnoea alarm who is apnoeic, the alarm should go off, but actually having heard Ashleigh Hudson's evidence, it was clear that [Baby I] wasn't apnoeic but was breathing very slowly and she said in her own evidence that actually she was breathing enough to have not have triggered the apnoea alarm.

That information isn't available in the notes, so my original thoughts were, why didn't the apnoea alarm go off, and the only reason I could come to was that it was switched off. Now I know that [Baby I] was breathing, but just very slowly. That's explicable.

MYERS: I am now dealing next with the question of air down the nasogastric tube. This morning, you've explained to the jury how maybe there was one that wasn't recorded or an NGT could have been in place and there's no record of that. That's what you said, isn't it?

BOHIN: Yes.

MYERS: I would like to take you to what you said in your report at paragraph 5.12. In fact, there are two paragraphs 5.12. There's a bit of a numbering jump, but it's the second one.

BOHIN: I've only got one on mine.

MYERS: It appears twice on this. You say this:

"I do not think that [Baby I] had an NGT in situ prior to this event. She had been bottle feeding and therefore wouldn't have needed one. I could find no reference to an NGT being in situ in the nursing notes."

You go on to say over the page at 5.13:

"[Baby I] was therefore bagged using Neopuff without an NGT in place when she collapsed."

Just pausing there, nowhere there are you trying to suggest there might have been an NGT, are you?

BOHIN: Not in that report. There's no way of knowing whether there is or there isn't.

MYERS: At the time you did the report --

BOHIN: I couldn't find any evidence that one was in situ.

MYERS: And now you are endeavouring, I'm suggesting, to introduce the possibility of a nasogastric tube in your evidence now.

BOHIN: No, I'm just saying there is nothing written to say whether there was one there or not. My report suggests that because she was bottle feeding, she didn't need one clinically and therefore that was my assumption, that because I couldn't find any evidence that there was one there, one wasn't there, because she didn't need one clinically because she was being bottle fed. As I already said, usually, the nurses will leave them in for a few days before removing them to just be sure that babies have established bottle feeds.

MYERS: What you say in the report, and I am reading on to paragraph 5.12, having said there's no reference to an NGT being in situ you say this:

"[Baby I] was therefore bagged using the Neopuff without an NGT in place when she collapsed. This could in part account for the

vast amounts of air within the gut prior to an appropriately sited nasogastric tube."

BOHIN: Yes.

MYERS: So you accept that when it comes to abdominal distension, first of all there is no evidence of a nasogastric tube in place at the time, do you?

BOHIN: There isn't any evidence that one was in place, but as I previously said, the nursing staff were notoriously poor at recording nasogastric tube placements, removals, changes, lengths. Their documentation was very bad.

MYERS: Do you also accept that Neopuffing could account in part for, as it says in the report, the vast amounts of air within the gut?

BOHIN: In part, yes.

MYERS: Yes. So actually, it may be the case there is no question of air having been put down the NGT; do you agree?

BOHIN: No, I don't.

MYERS: So even though in your report you said there's no evidence of one, in fact you said you didn't think she had one --

BOHIN: Because she was bottle feeding.

MYERS: If you don't think she had one, it can't have been used to put air down, can it?

BOHIN: Somebody could have put one in.

MYERS: Right. Let's look at what you say about air embolus.

One moment, please.

(Pause)

Chest compressions can cause bruising, can't they?

BOHIN: They can in adults and older children, but I have not seen it in neonates.

MYERS: If they can occur in adults and older children, they can occur in neonates, can't they?

BOHIN: I have never seen it in neonates.

MYERS: You're talking about discolouration in the area of the sternum, aren't you?

BOHIN: It says to the right of the sternum. The staff described it, yes.

MYERS: So we're talking about an area, I'm indicating on me (indicating), but just to the right of the upper mid-centre of my chest?

BOHIN: Yes.

MYERS: Right. Which is the sort of area where compressions may take place, isn't it?

BOHIN: No.

MYERS: In any event, bruising can move from the point of the application of force, depending on how blood tracks, can't it?

BOHIN: It can, but it would also occur at the application of force. It doesn't just appear separate to the application of force.

MYERS: There's nothing distinctive in the colour of this bruising that marks it out for an air embolus, is there?

BOHIN: No.

MYERS: It's described by you as bruising; is that correct or am I misstating that?

BOHIN: A bruiselike discolouration.

MYERS: How long did that remain for?

BOHIN: Oh, I can't recall.

MYERS: Well --

BOHIN: Without looking at the notes, I can't recall.

MYERS: Let's see if we can find -- I'd be grateful if we could have some assistance here as to exactly where you identify a bruise or bruiselike mark near the sternum that supports your suggestion of air embolus. Can you help us with where we find that?

BOHIN: No, I can't remember which page that's on, I'm sorry.

She's got over 2,000 pages of notes. I can't possibly remember which page that's on.

MYERS: I'm trying to find that too, Dr Bohin.

BOHIN: I've written that both nursing and medical staff comment on a bruiselike discolouration to the right of the sternum. So more than one person has commented on it, but I don't know which page it's on.

MYERS: I'm just helping with that now. Well, we have, first of all, the nursing notes, page 14513, which is in the [Baby I] event 3 section at tile 40. This is an entry at 21.49. This is an entry more than 12 hours after the event, isn't it? Is that correct?

BOHIN: It's made at 21.49 on the 13th, yes.

MYERS: Yes. Event 2 is in the early hours of the morning, wasn't it, of the 13th?

BOHIN: Yes.

MYERS: Right, at about 03.20 am. The reference we have now is at 21.49, isn't it?

BOHIN: Yes.

MYERS: So about 18 or 19 hours later, isn't it?

BOHIN: Yes.

MYERS: And looking at the relevant part, if we look about two-thirds of the way down, we can see it's an entry by Ms Letby: And it says:

"Some bruising/discolouration evident on sternum and right side of chest..."

Can you see that?

BOHIN: Yes.

MYERS: "... [query] from chest compressions"; yes?

BOHIN: Yes.

MYERS: This is a bruising mark visible in that area about 18 hours or so after the events we're dealing with, isn't it?

BOHIN: Yes.

MYERS: And after there had been sustained cardiac massage, hadn't there?

BOHIN: Yes.

MYERS: It's not going to be an air embolus leaving a bruise 18 hours later, is it, Dr Bohin?

BOHIN: But she needed resuscitation because she collapsed.

MYERS: You are bringing into your evidence that discolouration is evidence of air embolus.

BOHIN: I'm saying it's consistent with, yes.

MYERS: This is not discolouration seen at the time your alleged air embolus is taking place, is it?

BOHIN: Well, I don't know because it's a retrospective note.

MYERS: This says "Written for care given from 19.45" at the top; do you see that?

BOHIN: Yes. So it's present then.

MYERS: Yes. This isn't talking about discolouration at the time of the incident, is it?

BOHIN: That note isn't from the time of the incident.

MYERS: I wonder if we could put up, please, tile 49 from this section, section 2, of the [Baby I] section, page 14381.

This is a note by Dr Neame who attended. We can see from 04.45. It says it is written in retrospect.

BOHIN: Yes.

MYERS: "Blepped at 03.23. Came to see [Baby I]."

He gives a description:

"On my arrival..."

Do you see that?

BOHIN: Yes.

MYERS: He talks about Neopuff ventilating; do you see that?

BOHIN: Yes.

MYERS: "Chest compressions ongoing"?

BOHIN: Yes.

MYERS: Pale; yes?

BOHIN: Yes.

MYERS: Floppy?

BOHIN: Yes.

MYERS: There is no reference to any kind of discolouration there, is there?

BOHIN: No.

MYERS: "Airway repositioned, double-handed jaw thrust. Chest movement. Stats: heart rate about 60 despite the above, therefore CPR continues."

That's correct, isn't it?

BOHIN: Yes.

MYERS: CPR meaning chest compressions, including chest compressions, doesn't it?

BOHIN: Yes.

MYERS: He talks about intubation?

BOHIN: Yes.

MYERS: I am just reading it in short form because we are looking for discolouration.

He talks about the ETT being entered?

BOHIN: Yes.

MYERS: "Equal air entry" -- is that "on auscultation"?

BOHIN: Yes.

MYERS: "CPR continued", that's the chest compressions continue, isn't it?

BOHIN: Yes.

MYERS: "Cold light negative. Dr Newby"-- I'm not sure...

BOHIN: "Contacted."

MYERS: Yes. Are we able to follow over the page, please, to 14382? Thank you.

Currently by this point on the ventilator with the volumes set out there; is that correct?

BOHIN: Yes.

MYERS: More statistics. The bottom point relates to medication, doesn't it?

BOHIN: Yes.

MYERS: Just go down, there's reference to an X-ray, then we have the end of the note, don't we?

BOHIN: Yes.

MYERS: Nothing there talking about discolouration around the area of the sternum?

BOHIN: No, there's not.

MYERS: No. The discolouration to the sternum is something that's identified later, I suggest, Dr Bohin, isn't it?

BOHIN: No one's mentioned it between that time and the previous entry you gave me.

MYERS: And that discolouration does not therefore link to any air embolus at the time, does it?

BOHIN: For me it does because, as I've already said, I have never seen bruising as a result of chest compressions in a neonate and I have attended many, many resuscitations.

I may have just been kind of unfortunate that it hasn't happened, but I have not seen it.

MYERS: So your evidence is that discolouration 18 hours later is consistent with air embolus; is that what you're saying?

BOHIN: No, it's noted 18 hours later. I can't say when it occurred, but it's first noted in the notes 18 hours later. That's not the same as when it first occurred.

That's when it's first noted.

MYERS: I'm going to suggest that's an example of you taking something you have seen in the notes and working it into the air embolus theory, isn't it?

BOHIN: No.

MR JUSTICE GOSS: Is that a convenient point? I was wonder whether it was.

All right. We'll have our ten-minute break now, members of the jury, thank you very much.

(In the absence of the jury)

MR JUSTICE GOSS: I didn't want to raise it in front of the jury, but if one goes to the note, there was the word "mottled" written by Dr Neame on the page. If you go up the previous page, just above the reference to the antibiotics, "mottled". Further down, under "MAP".

BOHIN: Yes, "mottled".

MR MYERS: I see that now, thank you. We can identify that.

MR JUSTICE GOSS: I'm just pointing it out because you did -- you referred to the antibiotics, but there was a reference to it there. I'm not saying it's significant or not. That's why I didn't raise it in front of the jury, but I was just pointing it out.

MR MYERS: I'm grateful for that and I will point that out.

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

(11.50 am)

(A short break)

(12.00 pm)

(In the presence of the jury)

MR MYERS: Could we put up page 14382 again, please? The top part of that page, Dr Neame's note. Returning to the note we've just looked at for 03.20. I was identifying what it said or it didn't say about discolouration.

It has been identified to me, and therefore properly I identify it to you, the word "mottled" appears above the (inaudible: coughing). Can you see that?

BOHIN: Yes.

MYERS: I'm going to carry on, if I could, please, down to page 14383, which is the next page. Just following through in fact, this is what we know to be the notes compiled for the grand round. Do you recognise them?

BOHIN: Yes.

MYERS: This is compiled -- this is dated 13 October, so some time that morning; do you see that?

BOHIN: Yes.

MYERS: We assume. It sets out what's happened. Under the problem list it says:

"Cardiac arrest overnight [query]..."

Then I'm not sure what the second word is:

"[Query] cause. Required compressions. Adrenaline."

Yes?

BOHIN: Yes.

MYERS: It says at that point:

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

It also refers to "recurrent abdo distension"; do you see that?

BOHIN: Yes.

MYERS: The reason I have gone to that is, having seen that, just to go to the next page, 14384, if we look underneath "on examination", it says:

"Abdo distended ++. Desaturation and brady on palpation. Firmer than yesterday. Bowel sounds present. Good air entry. Bilateral but squeaky. Air leak."

Then it says:

"Bruises right hand chest [query] from compressions."

Do you see that?

BOHIN: Yes.

MYERS: I point that out because this will be some hours later and there's a description there of bruises on the right-hand chest; do you see that?

BOHIN: Yes.

MYERS: Just so we have the available information for what that says.

I'm going to move to event 3 now, please, Dr Bohin.

For event 3, just to remind us all, there are actually two parts to this as it's set out. One is an abdominal distension round about 05.00, leading to a deterioration that required ventilation and resuscitation. Then some time after 07.00, maybe 07.30, significant desaturation and bradycardia. There's two parts to that.

Your evidence has been these are due to air down the NGT and air embolus; is that right?

BOHIN: That's correct.

MYERS: Just as a general principle, can I ask this: where we have two events, two deteriorations, that are relatively close together in time, do you accept that the first event may destabilise a neonate so that a second event is more likely?

BOHIN: It depends how they recover from the first event.

MYERS: Right. Before we look at what I want to ask you about, NGT and air embolus, I'd like to deal with something about the notes that's been raised with you. The nursing note relating to this we find at tile 174 in section 3 for [Baby I]. So could we have a look at tile 174?

If we go behind that. Have I got the wrong...?

Sorry, tile 74. That's my mistake. Tile 74. If we go behind that.

It's the second part down, which says:

"Addendum: 14 October 2015 at 08.43 by Lucy Letby."

The lower half on the right-hand side, please.

We can see that it says:

"At 05.00 abdomen noted to be more distended and firmer in appearance with area of discolouration spreading on right-hand side. Veins more prominent."

BOHIN: Yes.

MYERS: 05.00. That's a note that's been made retrospectively, isn't it?

BOHIN: Yes.

MYERS: Yesterday when you were asked about this, you said or agreed that there was no medical note corresponding with this.

BOHIN: That's correct.

MYERS: Right. Can we just have a look, please, at tile 79? Go behind that. This is the note by Dr Neame relating to this event, 14 October 2015 or a note made at 05.55; is this correct?

BOHIN: Yes, that's a note made at 05.55.

MYERS: That's also a retrospective note, isn't it?

BOHIN: It doesn't say it's retrospective, so I don't know.

MYERS: Well, do you agree it's most unlikely that's been made as we go along?

BOHIN: Of course.

MYERS: So that's made, on the face of it, after Dr Neame has dealt with the incident that he has been asked to attend to, isn't it?

BOHIN: Quite possibly.

MYERS: Yes. The point is, something's been made of the fact that there's a note by Lucy Letby which refers to an incident at 05.00 and then a suggestion somehow that there's no corresponding clinical note. Do you understand that?

BOHIN: If this note relates to that then, then I've missed it.

MYERS: All right. Because it sets out quite a lot of activity, in fact, in the period leading up to it being made at 05.55, doesn't it?

BOHIN: Yes.

MYERS: In which case, nothing to deal with there and I'll move on from that.

As to the question of air down the NGT, I'm not going to repeat the general questions about that that I've asked earlier. But in fact if we stay with Dr Neame's note, do you see about four lines down it he says:

"On my arrival Neopuffing..."

And he sets out pressures and oxygen?

BOHIN: Yes.

MYERS: He goes on to give a description of what's taken place.

He has "abdomen distended and mottled"; do you see that.

BOHIN: Yes.

MYERS: "Tender with" -- was that gurning or guarding?

BOHIN: Guarding.

MYERS: He describes what that means. He goes on to say:

"Neopuff pressure increased."

BOHIN: Yes.

MYERS: It's after that, if we look down, that the chest and abdominal X-rays are arranged, isn't it?

BOHIN: Yes.

MYERS: So in this case, given the course of events, we can't discount the effect of Neopuff being used in terms of contributing to any distension in the abdomen from air, can we?

BOHIN: There's a nasogastric tube to decompress.

MYERS: But still, it could lead to distension, couldn't it?

BOHIN: Not of that degree, no.

MYERS: The basis for air embolus, let's be clear about this, is it the discolouration, such as it is, and the veins being prominent that you rely upon, Dr Bohin?

BOHIN: It's not the veins, because that's a long-standing problem and is quite common in premature neonates that they have very little fat on their abdomen and so it's very common to see prominent veins. That's almost a normal finding in a baby of low birth weight. So, no, it's the distension -- it's the collapse and the discolouration.

MYERS: Well, I'm going to suggest to you there's nothing distinctive about any discolouration associated with this that marks it out for an air embolus, is there?

BOHIN: Well, that was my opinion.

MYERS: I'm not going to repeat the questions. We've got the point I made with you and what you say about that, Dr Bohin.

This is a more general question about events 2 and 3, the events of the 13th and 14 October. If we move forwards into the 15th, which isn't an event of suspicion, we see increasing further deterioration in [Baby I]'s condition, don't we?

BOHIN: Yes.

MYERS: Which led ultimately to her having to be discharged to Arrowe Park Hospital?

BOHIN: Well, it led to her being re-intubated because of a problem with the lungs.

MYERS: Yes.

BOHIN: And it was the cardiac arrest and ongoing ventilation that led to her being transferred out, not that particular event.

MYERS: But isn't it possible that what you've got is a deterioration over a period of time that results in her becoming so unwell she had to be transferred out on 15 October?

BOHIN: No, the plan was to transfer out on the 15th because this was a level 2 unit who don't routinely deal with long-term ventilated patients and she had had a cardiac arrest for which the team did not have an obvious cause.

So they were in liaison with a tertiary centre and, just before 4 o'clock on 15 October, there was another deterioration, which required re-intubation. But she was always going to be transferred out because it was their policy not to keep ventilated patients long-term.

MYERS: Could we look at the radiograph, please, on pages 14701 and 14702? This is a radiograph taken on 15 October 2015 at 15.31.

Can we scroll down to what Dr Wright, who's the radiologist, said about this? This is 15.30 on the 15th. Thank you.

It describes the position of the ET tube and the NG tube. There's nothing I'm drawing out from the top part of that, it's what's in the second part that I'd like us to go to:

"Right-sided long line in situ with its tip projected over the inferior vena cava at L1 level."

BOHIN: Yes.

MYERS: "There's been a marked interval change in the bowel gas pattern. No free intraperitoneal air noted. The bowel is centrally located with peripheral opacification compatible with ascites. Bowel wall oedema is also noted."

Ascites is fluid in the peritoneum, isn't it?

BOHIN: Yes.

MYERS: As it happens, that can be an early sign of NEC, can't it?

BOHIN: I have not seen ascites on an X-ray like that with NEC, no.

MYERS: Ascites may indicate an inflammatory process ongoing?

BOHIN: It might, but actually she didn't have ascites.

MYERS: But there may have been an inflammatory process ongoing?

BOHIN: I don't think there was.

MYERS: It says:

"Bowel wall oedema is also noted."

Is that liquid or fluid in the bowel wall or swelling because of --

BOHIN: That means actual thickening of the intestinal wall.

MYERS: With fluid?

BOHIN: Yes.

MYERS: Which again is consistent with an inflammatory process potentially, isn't it?

BOHIN: It may be, but of course the report on the X-ray needs to be taken in conjunction with the clinical findings.

So the clinicians will obviously take note of that and the fact that one lung was collapsed and the other lung was hyperinflated. But the bowel is decompressed because she's got a nasogastric tube in place, and yes, that X-ray does show that there may be ascites. It's compatible with ascites. It doesn't mean that she's got ascites. If that doesn't fit with the clinical picture, which it doesn't, then she didn't have ascites and didn't have ascites.

MYERS: She had deteriorated dramatically over a period of days, hadn't she?

BOHIN: She had had two events previously and had another deterioration that day, which led to her being re-intubated.

MYERS: Can I ask you to clarify something, please? Did [Baby I] have a collapsed left lung at the time she was transferred to Arrowe Park Hospital?

BOHIN: No, she was re-intubated.

MYERS: Can I just ask you to explain something in your report at paragraph 5.21? You're referring to events on 15 October and the re-intubation then, aren't you?

BOHIN: Yes.

MYERS: And you say something -- you say:

"It was appropriate to re-intubate [Baby I] at the time. The collapse of the left lung is most likely to be due to the ET tube being too long [and you put] +/- infection."

BOHIN: Yes.

MYERS: What does that mean?

BOHIN: Well, earlier [Baby I] had collapsed and -- well, she'd had a deterioration and at the time the team weren't sure why she had deteriorated. So it was completely appropriate to think that it might be an endotracheal tube-related issue so they took the old tube out and replaced it.

The X-ray after that replacement was that X-ray that you have just shown, which showed that one lung was white and was opacified, so that lung was collapsed.

The other lung looked like it was slightly larger than usual, which means that the endotracheal tube is preferentially ventilating one lung rather than two lungs, and that was why I said that the collapse of the left lung was most likely due to the endotracheal tube being too long.

MYERS: What does "+/- infection" mean?

BOHIN: There may be infection to play -- there may be infection as well to play in that. At that stage it wasn't known, but there may be and she was screened for infection.

MYERS: I'm going to move to the 22nd into 23 October 2015, which is event 4 or events 4. I'd just like to be clear about what you say is or may be the cause of this or these events. I'm looking at the final page of your report.

In your evidence this morning, Dr Bohin, you have said that this collapse or these collapses are due to air embolus, haven't you?

BOHIN: Yes.

MYERS: I want to understand. In the report that you wrote, you put:

"I agree with Dr Evans that the collapse on 22/23 October is likely to be secondary to an air embolus, but I also think [or 'say'] that there was exogenous administration of air into the bowel via the NGT and that neither of these was accidental."

Just so we know, in terms of your evidence now, what's happened to the suspicion that this was due to air down the NGT, which is what you said in your report?

BOHIN: I still think that's a possibility.

MYERS: On the basis of the radiograph at 00.23?

BOHIN: Yes.

MYERS: So your evidence in fact is that this is air down the NGT and air embolus?

BOHIN: Yes.

MYERS: And is that on event 1 of event 4 or event 2 or events 1 and 2?

BOHIN: Both.

MYERS: So on both occasions you're saying there has been someone deliberately putting air intravenously and into the NGT?

BOHIN: I can't be clear of which one of those -- whether both of them occurred on both events or one occurred on each of the events. But the way that [Baby I] presented is compatible with both air embolus and exogenous air down the nasogastric tube.

MYERS: You've heard the evidence of Nurse Hudson, haven't you, about how she checked the abdomen when [Baby I] first collapsed?

BOHIN: Yes.

MYERS: And she identified no sign of distension or swelling?

BOHIN: That's correct.

MYERS: I want to ask you about what you say about air embolus here. When you were giving evidence about this, you said it's air embolus because the event was sudden and unexpected, [Baby I] had been unsettled and agitated. She was in, you said, severe pain, there was distension of the abdomen and collapse, and there was mottling.

That's what you said, wasn't it?

BOHIN: Yes.

MYERS: Can you help us with how distension of the abdomen is supportive of air embolus?

BOHIN: Distension of the abdomen is not supportive of air embolus but it is supportive of exogenous air down the nasogastric tube.

MYERS: It also follows a period after which air had been administered to [Baby I] as part of the support she was given, doesn't it?

BOHIN: But she had a nasogastric tube in place, which should decompress the bowel and would not cause that extent of bowel dilatation.

MYERS: I'm not going to go back to Nurse Hudson's evidence, I've asked you about that. I'll stay with the other points I'm asking about air embolus.

Crying and distress, Dr Bohin, are highly subjective to gauge, aren't they?

BOHIN: Yes.

MYERS: We've heard the evidence of Nurse Hudson. Whatever the reason for that, it is very speculative, isn't it, to jump from that to saying that must be because of an air embolus?

BOHIN: What was described was something over and above normal crying in a baby. Nurse Hudson gave a very clear description of inconsolable crying and, for me, that is very unusual in a baby and indicates that they are in significant pain. There aren't many things that will cause that, but air embolus is one and, along with the other clinical findings here, it's compatible with air embolus and I think it was air embolus.

MYERS: Well, I take issue with you on that, but I'm not going to repeat the questions.

As to the nature of the collapse, [Baby I] made an extremely good recovery very rapidly from the first deterioration, didn't she?

BOHIN: Yes.

MYERS: Which is not consistent with the effect of an air embolus, isn't it?

BOHIN: It can be because it depends on how much air has been injected.

MYERS: And as for discolouration, I dealt with that when we began the questioning and I'm not going to repeat that now (inaudible: coughing) the points are that we make, Dr Bohin.

It's entirely possible, isn't it, that for a baby who had been as poorly as [Baby I] had been, the cumulative effect of successive episodes meant that she was far more likely to deteriorate, sadly, and die in the way she did on 23 October, doesn't it?

BOHIN: No, I don't agree with that.

MYERS: And a baby who has undergone successive incidents like that will be weaker and less able to cope with the impact of a collapse and more likely, sadly, to die, and that's the fact of it, isn't it?

BOHIN: No, it's not, I'm afraid. She recovered from that first event and was so well that she was extubated. That didn't show a child that was in any way weakened or compromised.

Illness in neonates is -- there is no cumulative effect which means that there is then a tipping point, and you can't cope anymore. It doesn't work like that.

The fact is that she was successfully resuscitated after that first event and that didn't in any way weaken her, meaning that with the next event she was more likely to succumb, so I'm afraid I can't agree with that.

MYERS: I suggest you, in fact, cannot with any certainty identify any particular mechanism for how she came to die.

BOHIN: Yes, I think she had an air embolus.

MYERS: And that is something that I suggest you have put together out of available pieces of evidence, Dr Bohin.

BOHIN: That's not the case.

MR MYERS: Thank you.

MR JUSTICE GOSS: Thank you.

Re-examination by MR JOHNSON

MR JOHNSON: Just a couple of issues, please, doctor.

Towards the beginning of the questions that you were asked on behalf of Lucy Letby, you were asked about two separate occasions on the 5th and 6 September --

BOHIN: Yes.

JOHNSON: -- if you remember that.

BOHIN: Yes.

JOHNSON: As a matter of fact, it's right, isn't it, that those were dealt with in your report from paragraph 4.12 onwards?

BOHIN: Yes.

JOHNSON: And why didn't you flag those up as being incidents of concern?

BOHIN: Because she had an infection, she had clinical signs of an infection, she had a high white cell count, a high neutrophil

count, which is compatible and indicative of a bacterial infection, and a high platelet count of 906, which you see where there is a lot of inflammation.

JOHNSON: And so by comparing those to the incidents that we've focused on here, in other words 30 September, 13 October, 14 October and the 22nd into 23 October, is that comparing like with like?

BOHIN: No, I felt that [Baby I] had an infection at this point and also the X-ray taken around that time showed gas within the centre of the abdomen, which we have seen, but there was no evidence of NEC and there wasn't huge gaseous dilatation. So infection was the cause of that deterioration, so it wasn't a suspicious event to me, so there was no need to flag it as one.

JOHNSON: But the lead-up to those events and the recovery from those events, were they typical of infective events?

BOHIN: Yes. She continued to be unwell for a while and required intubation. She then became unwell whilst on the ventilator. So as I mentioned, she was known to have an infection, she was being treated for an infection, and had a very rocky time for a few days until the antibiotics controlled the infection and then she recovered.

JOHNSON: And are they characteristics that we see with any of the four events that you have told us about in your evidence before cross-examination?

BOHIN: No. In the other events, she's collapsed and been resuscitated and either recovered very quickly or, sadly, on the last event was unable to be resuscitated.

This event, where she had an infection, presented very differently and she recovered very differently.

JOHNSON: Is that the very reason why you have highlighted the four events that you have as being suspicious?

BOHIN: Yes, because they stood out.

JOHNSON: Secondly, the nasogastric tube point. I'm referring here to the questions that you were asked about your analysis, such as you were able to analyse the notes, concerning whether or not [Baby I] had a nasogastric tube on 13 October; all right?

BOHIN: Yes.

JOHNSON: The issue being, if she didn't, how did the air get into her stomach? And I think you told us, when I was asking you

questions, that it is a matter of seconds for someone who knows how to do it to get a nasogastric tube into the stomach of a small baby.

BOHIN: That's correct.

JOHNSON: And it can be removed equally quickly?

BOHIN: That's correct.

JOHNSON: As a matter of fact, at page 25 of your report, and it's paragraph 5.33, this also deals with the point that was suggested to you that you are a mere cipher for Dr Evans, did you confront the apparent -- the issue -- it's the third or fourth bullet point --

BOHIN: Yes.

JOHNSON: -- did you confront this issue and summarise your position?

BOHIN: Yes. I stated --

JOHNSON: Can you tell the jury what you said, please?

BOHIN: "I disagree in part with Dr Evans about the cause of the collapse on 13 October. As no nasogastric tube was present prior to the collapse, the amount of gas within the abdomen could be secondary to resuscitative bagging via face mask prior to intubation. Having said that, the appearances are gross and in excess of what I would expect to see after a period of bagging. I would agree with Dr Evans that exogenous administration of air into the bowel via the nasogastric tube is, on the balance of probabilities, the most likely cause."

JOHNSON: Yes, thank you. So is what you are saying there that there's no evidence on the face of the records to say that there was a tube in place?

BOHIN: That's correct.

JOHNSON: But getting the air in via that means is the one you favoured as a matter of opinion?

BOHIN: Yes.

JOHNSON: Can I deal finally with the weight issue that was raised with you. Can I ask Mr Murphy to put up on the screens pages 15029 and 15030 in the medical records.

I don't know if we can put them side by side, the two pages, if that's possible, or one above the other.

All right. Sorry. As usual, I didn't give Mr Murphy any advance warning of what I'd ask him to do.

This actually is a simple plot of [Baby I]'s weight, isn't it?

BOHIN: Yes.

JOHNSON: We can see along the west/east axis at the top of the graph "day 1" and the date above it; is that right?

BOHIN: Yes.

JOHNSON: So day 1 is 7 August and this runs to day 53, which is 28 September?

BOHIN: Yes.

JOHNSON: Here we have a fairly linear progression of [Baby I]'s weight. If we go on to the next page, please, Mr Murphy. Obviously, that one runs into the second one.

BOHIN: Yes.

JOHNSON: So it's taken up at the point the first one left off and we can see the continuation of that weight gain. Most markedly we see between about the 13th/14th -- it's actually from 10 October onwards, isn't it?

BOHIN: Yes.

JOHNSON: There's quite an increase. Did that, as a matter of fact, coincide with [Baby I] first being removed from the Countess of Chester and then subsequently returning?

BOHIN: Yes, partly that time. It covers that time. She wasn't actually at the Countess of Chester.

JOHNSON: Now, of course the point you've accepted is one has to look at the centiles; is that right?

BOHIN: Yes.

JOHNSON: So it's not simple a matter of looking at this graph and saying that she's gaining weight so that's all fine, because you would hope that if a child remains on the same centile, she would gain weight more quickly; is that right?

BOHIN: That's correct, but premature babies invariably cross centile lines at the start, so when she was born, she was on the 50th centile at 27 weeks' gestation. All babies lose a bit of weight, but premature babies will often cross centile lines before they settle on a line and grow along that centile line. So it was no surprise that she dropped from the 50th centile, but thereafter she didn't grow appropriately but she's been ill. This graph shows that actually she did gain weight, so her weight wasn't completely static.

JOHNSON: Yes. Is that really a graphic, literally in a graph, representation of the point you were making before?

BOHIN: Yes.

MR JOHNSON: Thank you. Does your Lordship have any questions?

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

Thank you, Dr Bohin. That completes your evidence in relation to this part of the case, but you'll be coming back to give further evidence. So please don't talk to anyone about anything to do with the case.

Thank you very much.

(The witness withdrew)

MR JOHNSON: I'm going to deal with the interview summaries now, my Lord, and pass to you a copy, if I may.

MR JUSTICE GOSS: Thank you.

(Handed)

Summary of interview with LUCY LETBY re [Baby I]

(read)

MR JOHNSON: The usual warning applies to this, ladies and gentlemen. It's a very short summary of some very long interviews.

On 4 July 2018, the interviewing officers followed the relevant medical notes from the outset. Of the first incident, on 30 September 2015, Lucy Letby had no independent recollection and relied on the entries in her notes. She recalled a conversation with [Baby I]'s mum about her abdomen. Lucy Letby didn't know whether she'd noticed [Baby I]'s abdomen or whether [Baby I]'s mum had highlighted it to her.

Lucy Letby had noted that [Baby I] appeared generally pale, but she wasn't concerned about [Baby I] being pale as she was often paler in colour. Lucy Letby could not recall how she became aware of [Baby I] vomiting at 4.30 pm or who put out the crash call.

Regarding the incident of 13 October 2015, Lucy Letby did remember this event when [Baby I] was found apnoeic in her cot. She and Nurse Hudson went into the nursery and put the light on in the nursery for something. She explained that the lights weren't switched on in the nursery at night.

Lucy Letby looked over at [Baby I] and noticed that she was paler in colour and her face was pale. Lucy Letby and Nurse Hudson went over to [Baby I] and pulled the covers off her and undid her babygro to check her torso in order to check her colour centrally. [Baby I] was shallow breathing and gasping, the apnoea alarm had not activated as they are programmed to alarm if a baby has not breathed for 20 seconds. If [Baby I] had gasped once every 20 seconds or more, the apnoea alarm would not have gone off.

I think in that context the "or more" is probably more than one gasp every 20 seconds rather than a gasp more than every 20 seconds.

She could not recall having treated [Baby I] up to that point of the shift and Lucy Letby started to give Neopuff ventilation and a call for help was made.

That interview continued the next day on 5 July 2018. The questions moved on to 14 October 2015 and Lucy Letby said she did not remember the shift.

From the notes, she agreed that she had been [Baby I]'s designated nurse.

In relation to the events of 22 October 2015, Lucy Letby had no recollection of specific events but did remember [Baby I] dying. Lucy Letby had a general recollection of [Baby I] coming and going to and from other hospitals and then coming back to the Countess of Chester, then needing to go back to another hospital.

There was a feeling on the unit that [Baby I] was being returned to the Countess of Chester too quickly and before she was ready and the transfer process itself was a lot for the baby to undergo and quite stressful for the baby.

When interviewed again on 11 June 2019, Lucy Letby agreed that she had sent a sympathy card to the [Family of Baby I]. She

couldn't go to the funeral and it wasn't often that the nurses would get to know a family as well as they did with the [Family of Baby I]. It was suggested to Lucy Letby that she send a card via one of the other nurses who had gone to the funeral. She had taken a photograph of the card and she -- sorry, she had taken a photograph of the card that she had sent to the [Family of Baby I].

Of the incident on 13 October 2015, Lucy Letby denied injecting air into [Baby I]'s stomach and indicated that she aspirated air from the stomach. During the first collapse, Lucy Letby recalled that [Baby I] was in a cot, not an incubator, she was in the cot space right near the nursery entrance and Lucy Letby agreed that it would have been harder to see whether [Baby I] was pale without the light on.

Lucy Letby could not remember at what point they had put the light on, whether it was before or after they saw [Baby I]. Lucy Letby did not exactly recall the order of events but thought that both she and Ashleigh Hudson were in the nursery together and put the lights on as they went into the room. She thought she and Ashleigh Hudson were at the doorway when she spotted how pale [Baby I] was and that they just put on the lights.

She could not remember why she'd gone in and turned them on. She could not recall whether [Baby I] was examined prior to putting the lights on.

Lucy Letby wondered whether she, that is Lucy Letby, had seen something in [Baby I]'s colouring that Ashleigh couldn't as she, Lucy Letby, was more experienced. She added that the nursery was never that dark that you wouldn't be able to see the baby at all and there was always a level of light for that reason.

[Baby I] was often a pale baby, but despite the canopy there was enough light from the corridor to see as [Baby I] was still facing outwards towards the door and there was still light coming in from the main corridor. There was always a degree of natural light that would be on the cot and it was not completely covering [Baby I] so that she was completely out of view.

Lucy Letby could not remember if [Baby I] was wearing a babygro. It was possible she was wearing one with a cardigan. If she was dressed that way, you'd still be able to see her face and her hands.

In relation to the incident of 14 October 2015, Lucy Letby denied causing [Baby I] any harm. In relation to the incident of 22 October, she denied causing [Baby I] any harm.

When interviewed again on 10 November 2020, Lucy Letby denied having administered air to [Baby I].

Lucy Letby was asked whether she recalled [Baby I]'s feeding tube being out of position and coiled up on 13 October 2015. She did not, but she agreed that it would not be a common event.

In her texts to [Nurse A] after that shift, she agreed that she'd described [Baby I] as "not good" and that she had asked to care for [Baby I] again the next night for continuity. Lucy Letby explained it was quite common, if on shift, to keep the same baby for continuity of care. She said she would have been a little bit disappointed that there was no continuity, but it did happen and the nurses would not always have the same patients.

Lucy Letby was asked why she had searched for [Mother of Baby I] on Facebook and she said she didn't know and she didn't have any recollection of doing it.

MR JUSTICE GOSS: Right, thank you.

That's just a summary so that you have in mind what was said in the interviews. You'll get much more detail and indeed get written records of the relevant parts later on in the case.

MR JOHNSON: Thank you. We are going to move on now to [Baby J]. It may make more sense, if your Lordship would approve, to just take an early lunch and start early.

MR JUSTICE GOSS: I think so. We're on to the next baby.

There will be further evidence, as before, in relation to some of the babies.

MR JOHNSON: Yes.

MR JUSTICE GOSS: Particularly from the pathologist so far as [Baby I] is concerned. But otherwise, that's it. All right?

So is 1.45 too early for you?

MR JOHNSON: Not for us, my Lord, we're happy to do that.

MR MYERS: However the court wishes to deal with it, my Lord.

MR JUSTICE GOSS: We'll just have the usual hour then and sit again at 1.45. If we finish a little earlier this afternoon, so be it. I think it's not a time that -- there's not much you can do in the one hour apart from having something to eat and drink if you want to.

Thank you very much.

(In the absence of the jury)

MR JUSTICE GOSS: Mr Myers?

MR MYERS: My Lord, when we turn to the sequence of events for [Baby J], your Lordship will see there is a large amount of messaging material in that. Aware of the matter that was raised earlier, we just point out that the bulk of that is there because the prosecution wish to include that. I think there's one text that we put in. It's there by agreement, but I wouldn't want the court to think that the defence had in some way flooded the sequence of events with texts. We certainly haven't done.

MR JUSTICE GOSS: No, I'm not seeking to attribute fault, blame or anything else to anyone. If it's agreed between you, it goes in in that way and it'll be up to Mr Johnson the extent to which he wants to refer to any texts (overspeaking) if it's there.

MR MYERS: (Overspeaking) I felt it best to say that.

MR JUSTICE GOSS: It's occurred to me that we've heard a lot about NEC during the course of this case and I've reminded myself what the glossary tells us about NEC.

It's helpful but it's not comprehensive in that sense.

It may be occurring to the jury in relation to some of these babies, where NEC has been raised as a suspected problem, that it would be helpful to know whether NEC -- particularly as far as the defence is concerned, whether they are asserting that NEC played any part in any of the collapses or conditions of the babies. Because it gets raised time and again, suspected NEC, but then I think in relation to [Baby I] we know that [Baby I] never had NEC at any time.

MR JOHNSON: (Inaudible: no microphone).

MR JUSTICE GOSS: That's what I think we're going to need to know: whether you can have had NEC and leave no sign of having had NEC --

MR JOHNSON: Dr Marnerides will deal with that.

MR JUSTICE GOSS: I'm not being -- I'm just putting it out there now. I'm not asking anything is specifically done now, but it's something that is going to have to be addressed quite clearly for the jury so they can understand it.

MR JOHNSON: Yes. I think the position, as I understand it at least, is it's only in -- well, clearly in [Baby J]'s case, she did have NEC, we know that. So far as other children are concerned, my understanding of the medical position is that it's only in a case where one has had an autopsy one can say --

MR JUSTICE GOSS: One can say one way or the other. All right. I'm flagging it up for you to bear in mind.

MR MYERS: Yes. It follows from that, of course, it isn't always possible from the defence perspective, and we say more generally but I'll limit what I say to the defence, to identify cause, but there may be any number of features that have played a part in the course of a child's health in the hospital. Your Lordship raises, if I may say, a perceptive point, the question of whether NEC can arise and whether it can be dealt with and not leave signs later on if it has been, in which case, of course, pathology may not assist with that depending on whether or not Dr Marnerides or the evidence establishes that if NEC has played a part then there must be signs of that at the conclusion. These are matters that we can deal with as we get there.

MR JUSTICE GOSS: Exactly. That's the reason I was raising it. I was putting you on notice, but I just thought it would be helpful because the jury are receiving a vast amount of detailed evidence about a number of medical conditions and just some -- it was occurring to me whether I was going to say something at or around this stage in relation to what the structure of my summing-up will be by way of reassurance, I hope, to them. I think I will do because otherwise it may just become rather overwhelming for them.

MR MYERS: The situation sometimes arises that the defence say "in which a specific cause cannot always be identified".

MR JUSTICE GOSS: Exactly, I understand that, yes.

I understand your point and obviously it's a completely different approach from your point of view.

MR MYERS: Thank you, my Lord.

MR JUSTICE GOSS: Well, thank you very much.

(12.48 pm)

(The short adjournment)

(1.45 pm)

(In the presence of the jury)

MR JUSTICE GOSS: Mr Johnson.

MR JOHNSON: My Lord, [Baby J], please.

MR JUSTICE GOSS: [Mother of Baby J]. [Baby J] is the baby.

MR JOHNSON: Sorry, I beg your pardon. [Mother of Baby J].

[MOTHER OF BABY J] (sworn)

Examination-in-chief by MR JOHNSON

MR JOHNSON: Nice loud voice if you would, please.

Could you tell the jury your full name?

MOTHER J: [Mother of Baby J].

JOHNSON: And [Mother of Baby J], are you the mother of [Baby J]?

MOTHER J: I am.

JOHNSON: And was [Baby J] born at 3 pm on 31 October 2015?

MOTHER J: She was.

JOHNSON: Was she born at the Countess of Chester Hospital?

MOTHER J: She was.

JOHNSON: Is your husband [Father of Baby J]?

MOTHER J: Yes.

JOHNSON: Without going through all the detail, was your pregnancy a difficult pregnancy?

MOTHER J: Yes.

JOHNSON: And were you originally pregnant with twins?

MOTHER J: I was.

JOHNSON: And as a result of an operation that you had to have at a hospital in London, was the consequence of that that one of your twins was lost?

MOTHER J: That's right.

JOHNSON: Was the plan to have your child in Liverpool or elsewhere?

MOTHER J: In Chester.

JOHNSON: In Chester. What was the plan? How did the birth come about?

MOTHER J: So after the treatment in London at 17 weeks, they had planned to give me a caesarean section at 34 weeks.

Unfortunately, my membranes started to rupture around about 30 weeks or there was an issue -- there was some leakage at 30 weeks. So then I was in and out of the hospital.

MR JUSTICE GOSS: I think two things. Could you pull the microphone -- sit a little nearer to the microphone and could you please keep your voice up as well. Thank you.

It's a big room, this.

MOTHER J: So I was in and out of the Countess of Chester Hospital for about 2 weeks prior to having [Baby J], but that was then by emergency section --

MR JOHNSON: Yes.

MOTHER J: -- at 32 weeks and 2 days.

MR JUSTICE GOSS: Sorry, again. Do you want the loop?

Can you hear?

(Pause)

MR JOHNSON: So far as your perception was concerned, albeit it came about as a result of a C-section, did the birth proceed satisfactorily?

MOTHER J: Absolutely, yes. [Baby J] was born in the afternoon by caesarean. She appeared to be extremely well with her early term, and yeah, they showed her quickly to us from over the screen. She was breathing well, they weren't concerned, and they whisked her away to the neonatal unit, I believe.

JOHNSON: Yes.

MR JUSTICE GOSS: Sorry to interrupt you.

MR MYERS: I apologise, [Mother of Baby J]. There's an issue with being able to hear properly in the dock, as your Lordship can

see. I believe the headphones that Ms Letby has got have static on them and therefore there is no sound coming through them.

(Pause)

Thank you, my Lord.

MR JUSTICE GOSS: Is there still a lot of static? I think rather than spending a lot of time over this --

MOTHER J: I'll try and speak louder.

MR JUSTICE GOSS: Don't shout, but I'm now speaking quite loudly. Can you do the same?

MOTHER J: I'll try, yes.

MR JUSTICE GOSS: We'll see.

MR JOHNSON: Okay.

MR JUSTICE GOSS: Ms Letby didn't hear that, but if I could perhaps summarise it. She was saying that born at 32 weeks and [Baby J] appeared to be extremely well, no problems that you were aware of?

MOTHER J: No.

MR JUSTICE GOSS: I've summarised it. All right?

MOTHER J: Thank you.

MR JOHNSON: Were you taken down to the neonatal unit to see [Baby J]?

MOTHER J: I was, but that was much later in the day.

JOHNSON: About 7 o'clock or thereabouts?

MOTHER J: Yes, between 7 and 8 pm that evening.

JOHNSON: Did you see [Baby J] when you got there?

MOTHER J: I did, yes. She was in room 1, which is the intensive care room at Chester. She was in an incubator and, yes, she appeared to be doing well, although I was there for about 10 minutes and she produced a little bit of brown bile from the mouth, and then we called one of the nurses over and then they started to investigate what was happening.

JOHNSON: Yes. Was the outcome of that that [Baby J] was taken over to Alder Hey by ambulance?

MOTHER J: That's correct, yes.

JOHNSON: Were you told the reason for that at the time?

MOTHER J: We were told that they... Um... That they had concerns about her bowel at that time, yes, because they'd started to do some X-rays and communicate with Alder Hey and share those X-rays. So yes, they had their suspicions that they had identified something on the X-ray.

JOHNSON: Was the upshot of it all that you found out that [Baby J] had something called NEC or necrotising enterocolitis?

MOTHER J: Yes, that was discussed afterwards, but a perforated bowel was also what was identified.

JOHNSON: Yes. Did [Baby J] have to spend a period of time at Alder Hey, where she had surgery to deal with that issue?

MOTHER J: Yes. She had emergency surgery at Alder Hey the day after she was born on 1 November, around about 9 am in the morning.

JOHNSON: Did she also have something put in called a Broviac line?

MOTHER J: She did, yes.

JOHNSON: So far as [Baby J]'s bowel was concerned, was it in effect cut?

MOTHER J: Yes. Yes, they cut the bowel, they removed about 1 centimetre of the bowel and said that that was quite a little amount of the bowel to remove for the concern that they had with the perforation. They then made the decision to give [Baby J] two stomas, which is where the bowel protrudes from the body, and it allows the bowel to rest after the surgery. Then after that, they then reconnect the bowel after a certain period of time.

JOHNSON: So the jury haven't really heard anything about this sort of thing before. A stoma is where the bowel in effect exits through the abdomen?

MOTHER J: That's correct.

JOHNSON: Then there is an entry point as well, so there's an exit and an entry?

MOTHER J: Absolutely.

JOHNSON: So faeces comes out of the exit?

MOTHER J: Yes.

JOHNSON: And was what you had to do eventually is you had to recycle the faeces?

MOTHER J: Yes.

JOHNSON: And the purpose of that is to ensure that the second part of the bowel grows at the same rate as the first part?

MOTHER J: That's correct. That's what we were told, yes.

JOHNSON: Were you shown how to do that at Alder Hey in Liverpool?

MOTHER J: Yes.

JOHNSON: I think you've already told us that [Baby J] was at Alder Hey for about 10 days. She returned, I think, to Chester on 10 November; is that right?

MOTHER J: Yes.

JOHNSON: Generally, first of all, how much contact did you have with [Baby J] once she'd been returned to Chester?

MOTHER J: Very frequent contact with [Baby J]. Mostly in the daytime because there wasn't really the space to stay on the ward.

JOHNSON: Were you expressing milk for [Baby J] or was she taking donor milk?

MOTHER J: It was a combination of the two, so I was expressing and we were taking some of the donor milk because I couldn't produce the quantity required.

JOHNSON: Did you fairly quickly establish a routine?

MOTHER J: I did, yes.

JOHNSON: Was [Baby J] progressing well?

MOTHER J: Absolutely.

JOHNSON: And did she in effect cascade down from room 1 to 2 to 3 to 4?

MOTHER J: Yes, over a four-week period she progressed to room 4.

JOHNSON: So that four-week period essentially coincides with November?

MOTHER J: Yes.

JOHNSON: Were there any issues as far as you were concerned?

MOTHER J: There were issues with weight gain. So we expected [Baby J], based on what we'd been told at Alder Hey, to be increasing her weight on a weekly basis and that wasn't happening.

JOHNSON: Right. Did that concern you?

MOTHER J: It did.

JOHNSON: Did you articulate or communicate your concerns to the staff at Chester?

MOTHER J: Frequently.

JOHNSON: And how did you feel your concerns were received?

MOTHER J: Um... not very seriously. They weren't overly concerned.

JOHNSON: How was the stoma management going?

MOTHER J: We had quite a lot of challenges with the stoma management, but there are two different time periods for that.

JOHNSON: Yes. Well, take us through the initial stay at Chester then or the beginning of the -- once you'd returned from Liverpool on 10 November, what were the issues immediately following that?

MOTHER J: So in terms of the stoma management?

JOHNSON: Yes.

MOTHER J: So I would say that the faeces that [Baby J] was producing, there was a difference in consistency compared to what we'd seen when we were at Alder Hey for the 11 days, and we'd been informed by the dietician at Alder Hey that if there was a change in consistency then that should be communicated because it was very important to monitor what was going in in

terms of feed and then what was coming out in terms of faeces because that's how they measure the -- those were the metrics that they used to analyse what was happening, really.

We didn't see that same approach at Chester, and the management of the stoma -- we spent quite some time managing that ourselves throughout the daytime and it was going quite well for the first 4 weeks, but after that, we started to have some challenges.

JOHNSON: What I want to do, if we may, [Mother of Baby J], is just deal with in more detail what happened in November, leading up to 27 November.

MOTHER J: Okay.

JOHNSON: So, so far as that period of time was concerned, so in absolute date terms the 10th through to 27 November, were there any major problems with the stoma as far as you were concerned?

MOTHER J: No. The only thing I would say is that the bags, the stoma bags, that we were putting on to [Baby J], they should have been lasting between -- well, when we were at Alder Hey they said they'd last for a day, I think between 24 and 48 hours they said they'd last. And at Chester, prior -- for that period, they were probably lasting between 12 and 18 hours, so under what we were expecting.

What I would say is we were -- during that period I was actually trying to breastfeed [Baby J], but because of the stoma bags, whenever we tried to do that, the bag would then leak and cause quite a lot of issues with breastfeeding. But we were at a stage where we could try that because she was doing so well.

JOHNSON: Were relations between you, your husband and the staff at Chester good or what?

MOTHER J: I would say that the approach by the staff at Chester was a very different one to the one that we saw at Alder Hey. We felt a little bit like if we asked questions, that they weren't received so well, whereas at Alder Hey it was a very inclusive communication path, whereas I didn't -- [Father of Baby J] and I didn't feel the same about the communication at Chester.

JOHNSON: We know, as a matter of record, that at about 7 o'clock in the morning on 27 November, [Baby J] collapsed.

MOTHER J: Mm-hm.

JOHNSON: And I just want to deal, if we may, with what happened in the 24 hours or so prior to that collapse.

MOTHER J: Yes, sure.

JOHNSON: By that stage of [Baby J]'s stay at Chester, were you staying overnight at all at the hospital?

MOTHER J: So the plan was for me to stay overnight for a couple of nights because she was in room 4, we were really excited about getting her home and other than the weight gain issue she was doing extremely well. They'd taken her off the heart rate monitor, all of the monitoring systems, she was free from them. And yeah, I was staying at the night-time to see if I could manage the daytime cares, which was doing the stoma bag and the feeds and caring for [Baby J] in the daytime and seeing if I could manage that at the night-time as well. So I stayed over and got involved in the night-time process.

JOHNSON: Okay. So in effect, is this you having a dry run for taking her home --

MOTHER J: Yes, absolutely.

JOHNSON: -- with the back-up of the hospital if there were issues?

MOTHER J: Yes.

JOHNSON: So can you remember now which the first night was you stayed in the lead-up to the events of the 27th?

MOTHER J: The 25th.

JOHNSON: Is that into the 26th?

MOTHER J: Yes.

JOHNSON: Okay. So you'd stayed that night. Did you remain there all day on the 26th as well?

MOTHER J: I think so, yes. I'd made some notes of all the feeds and the cares that I was doing for [Baby J], so I think I was there throughout that day.

JOHNSON: What did cares involve?

MOTHER J: So cares involved feeding [Baby J], changing her nappy, and then replacing -- well, attending to the stomas. One was to recycle the faeces and the other was to empty the bag and also deal with the bag and the consequence of the bags, you know, not adhering to [Baby J] very well.

That was quite a lengthy process, so about an hour to just deal with the bag.

JOHNSON: An hour how many times a day?

MOTHER J: Three, well, three-hour blocks.

JOHNSON: Yes.

MOTHER J: So... You would literally do the process and then you'd be back at the beginning of it. So at least four -- three/four times during the twelve-hour window I was there in the daytime.

JOHNSON: Okay. Did there come a stage on the 26th when you went home?

MOTHER J: Prior to...

JOHNSON: Prior to [Baby J]'s collapse.

MOTHER J: Yes. Yes, I stayed at home that night.

JOHNSON: So you'd stayed the night of the 25th into the 26th, you'd been there all day, you went home on the 26th intending to return on the 27th?

MOTHER J: Yes, absolutely. I was there every day from 8 o'clock.

JOHNSON: Any particular reason why you picked 8 o'clock as your time of arrival generally speaking?

MOTHER J: Because that was after the handover and the staff preferred for parents not to be on the ward when there was a handover of shift.

JOHNSON: So you were intending to go at or about 8 o'clock on the morning of the 27th?

MOTHER J: I arrived at 8, so I would leave about 20 to.

JOHNSON: Yes. What was the first you heard of an issue involving [Baby J]?

MOTHER J: I received a telephone call from a withheld number, basically informing me to get to the hospital very quickly because she'd collapsed.

JOHNSON: Let's deal with that. Can you remember roughly what time that call was received?

MOTHER J: I'm trying to think. Maybe about 7.10.

JOHNSON: So shortly before you would have left anyway or...?

MOTHER J: Mm.

JOHNSON: Okay. So you were told that [Baby J] had collapsed; is that right?

MOTHER J: Yes.

JOHNSON: And in effect get here as quickly as you can?

MOTHER J: Absolutely, yes.

JOHNSON: And is that what you did?

MOTHER J: Yes.

JOHNSON: Were you with your husband?

MOTHER J: I was, yes.

JOHNSON: What did you see when you got to the hospital?

MOTHER J: When I got to the hospital, [Baby J] was in a half incubator, so a hot cot, in room 2, which is the high dependency unit, and she was connected back up to a monitor and she looked very floppy. She was very pale, yellowy in colour, and not very responsive.

JOHNSON: How did this event come to you in the sense of what impression did you get as to what had happened?

MOTHER J: We were totally and utterly just shocked because prior to this, she was extremely well, you know, she was coming home, we were preparing for her to come home and look after her in the evening. Everything, other than the weight gain, was fine.

JOHNSON: Did you speak to Dr Gibbs in the aftermath of [Baby J]'s collapse on the 27th?

MOTHER J: Yes. [Father of Baby J], my husband, he spoke to Dr Gibbs and had some lengthy conversations with Dr Gibbs. I think I just joined in, you know, a bit later in the conversation.

JOHNSON: Yes.

MOTHER J: I was next to [Baby J] and very stressed by what I was seeing and experiencing.

JOHNSON: Do you have a clear memory of how [Baby J] developed during the 27th once you'd got to the hospital, how her condition developed?

MOTHER J: How it progressed after the collapse?

JOHNSON: Yes.

MOTHER J: Um... Yes, I mean, the nurses that were on that shift, you know, led the care. We stayed over that night at the hospital and she recovered quite quickly. It was established there wasn't an infection, that wasn't the cause, and the cause was unknown at that stage.

JOHNSON: As you recall things, how quickly was [Baby J] back to the way she'd been when you'd left her on the night of the 26th?

MOTHER J: Probably -- I think by the afternoon of the next day, she was back up to full feeds.

JOHNSON: Since then, has [Baby J] had problems from time to time in hospital, in the immediate few weeks after that?

MOTHER J: In the immediate few weeks?

JOHNSON: Yes, so going from 27 November through to the end of the year. In that period of time, did [Baby J] have at least one other episode?

MOTHER J: Yes, there was another collapse on around 16 December, I think it was.

JOHNSON: Yes.

MOTHER J: After the first collapse -- sorry?

JOHNSON: No, no.

MOTHER J: After the first collapse, that's when we really started to see some issues occurring with the stoma and the bags. The bags were being washed off very, very frequently, so literally you would put a bag on, a stoma bag on, and it could be, you know, a couple of hours before the next feed, it would have come off, because babies are moving and the stoma wasn't performing as it should have been performing.

There were things happening to the stoma where it effectively had stopped working as a stoma. There was a small fisture (sic) in the side of the stoma close to [Baby J]'s skin, so then the faeces was coming out of the fisture as opposed to the top of the stoma.

JOHNSON: All right. Did all those circumstances together mean that [Baby J] was transferred out of Chester?

MOTHER J: So after the second collapse, there were concerns that when they pressed [Baby J]'s abdomen, she winced and was feeling pain, so they were concerned that there may be something to do with the stoma that needed to be investigated, so they then moved us to a surgical hospital.

JOHNSON: And did [Baby J] have the operation in effect reversed?

MOTHER J: She did, yes.

JOHNSON: So her bowel was in effect sewn back together and obviously the stoma was closed?

MOTHER J: Yes. Both stomas closed, bowel reattached.

JOHNSON: And in due course she went home?

MOTHER J: Yes. 5 January, home.

MR JOHNSON: Lovely. Can you just wait there, please?

There may be some more questions for you.

Cross-examination by MR MYERS

MR MYERS: [Mother of Baby J], I'm just going over the same sort of topics.

MOTHER J: Okay.

MYERS: There were various anxieties during the pregnancy, weren't there?

MOTHER J: Yes.

MYERS: But certainly, so far as you could tell, when it came to [Baby J] being born on 31 October, things seemed to be all right at that point, didn't they?

MOTHER J: They did, yes.

MYERS: Thanks. Was it later in the evening of that day that you were told by the staff looking after her that she was bringing up brown bile?

MOTHER J: Well, I saw the brown bile when I went down to see her and then I said, "She's bringing up some bile from the mouth".

MYERS: So you pointed that out to the staff in fact?

MOTHER J: Yes.

MYERS: This is staff at the Countess of Chester, isn't it?

MOTHER J: Yes.

MYERS: When you pointed that out to them, they then became concerned, didn't they?

MOTHER J: Yes.

MYERS: And in fact, it's a rather disconcerting detail, but I think concerned enough to call for a priest at one point; is that right?

MOTHER J: Um...

MYERS: Or asked if you wanted [Baby J] to be christened?

MOTHER J: Yes, that question was asked, yes.

MYERS: Christened by a priest. That's where I got the priest from.

MOTHER J: Sorry, I didn't get -- yeah.

MYERS: That's all right. Thank goodness that wasn't necessary.

MOTHER J: Yes.

MYERS: And she was transferred to Alder Hey Children's Hospital in the early hours of the Sunday morning, wasn't she?

MOTHER J: Yes.

MYERS: That's 1 November?

MOTHER J: Yes.

MYERS: I'm going to ask you some questions about Alder Hey and the way that they cared for [Baby J] whilst she was there.

MOTHER J: Okay.

MYERS: How long was [Baby J] in Alder Hey for as well as you can remember?

MOTHER J: I think it was 11 days.

MYERS: Right. It was whilst she was there, as you told us, she had the operation which created two stomas?

MOTHER J: Correct.

MYERS: As you are more familiar with this than many of us here, just so we can follow, one of the stomas is at a slightly higher point in the abdomen, is that right, and does that receive faeces or at the same point?

MOTHER J: I think that they were actually at the same point, yes.

MYERS: But faeces comes out of one of them; is that right?

MOTHER J: That's right, yes.

MYERS: Then what has to happen is that's in a bag and then it has to be transferred across to the other stoma for it to be put back into the abdomen?

MOTHER J: Yes. There's a hole in the top of the other stoma and you use a syringe with a tube, and the tube would then be inserted into the top of the hole in the stoma, and then you would recycle the material back in so that the bowel then grew at the same time, so she was effectively still pooing into a nappy.

MYERS: So the person doing that is, in a way, filling in for the gap that's in the abdomen to help it go across?

MOTHER J: That's correct, yes.

MYERS: And that bit is going on outside the body?

MOTHER J: Yes.

MYERS: When you were at Alder Hey, did they show you and your husband how to do this?

MOTHER J: That's correct, they did, yes.

MYERS: Did they seem to have a good idea of how to do it themselves, to put it that way?

MOTHER J: They were extremely professional in the way they approached that procedure.

MYERS: Did they seem to be organised in what they were doing with it?

MOTHER J: Yes.

MYERS: And as far as you could feel, everything ran smoothly with [Baby J] and the stomas at Alder Hey, didn't it?

MOTHER J: Yes.

MYERS: Did the staff at the Countess of Chester seem to have the same confidence and ability to deal with stoma bags?

MOTHER J: Um... I would say they -- no.

MYERS: Right. When you got to Chester, were you told by a consultant, [Mother of Baby J], that this could be a bit of a roller coaster?

MOTHER J: Yes.

MYERS: That's something they actually said to you when you got there?

MOTHER J: Yes, but I can't recall the time period when that happened. I think that was after the first collapse.

MYERS: I'm seeing if I can help with that.

(Pause)

Did the doctor who said that say it could be a roller coaster on the unit and babies could go up and down?

MOTHER J: Yes. But I think that was after the second collapse because why would he have said that?

MYERS: The staff at the Countess of Chester, did it strike you, didn't seem to be geared up or prepared for the level of care that [Baby J] actually needed so far as stomas and the bags were concerned?

MOTHER J: Alder Hey contacted Chester to ask if they were able to perform the procedure and they said yes.

MYERS: Alder Hey told you Chester could perform the procedure?

MOTHER J: Yes.

MYERS: Right.

MOTHER J: They checked with Chester and they said that they could do the recycling because, if they couldn't do the recycling, we wouldn't have been able to go back to Chester.

MYERS: But when you got to Chester did it seem, by comparison with Alder Hey, that they were geared up to deal with this?

MOTHER J: Not as well as Alder Hey.

MYERS: I'm going to ask, actually, if we can be assisted by seeing something in your statement. It's at page 2644, Mr Murphy. I2644. So [Mother of Baby J] can see it and his Lordship and the barristers, and whilst Mr Murphy finds that, you made a statement on 25 March 2019 to the police, didn't you?

MOTHER J: Yes.

MYERS: All right, thank you. We're going to go to page 9 of 14. You'll see it on the screen, just near to you. I'm going to ask if we can go down to the paragraph below that. All right. I'm going to have a look through.

Can you see a paragraph that begins "in hindsight"?

MOTHER J: Mm-hm.

MYERS: Did you tell the police that:

"In hindsight, [you] didn't think the Countess were properly geared up or prepared for the level of care needed to deal with [Baby J] and her stomas and colostomy bag and recycling of the faeces"?

MOTHER J: Reflecting on the experience, yes --

MYERS: Yes, all right.

MOTHER J: -- compared to Alder Hey's experience.

MYERS: Yes. And did it strike you, I'm just looking a couple of lines below that, comparing the two of them, that they didn't have the resources or the expertise or the time to commit to [Baby J]'s needs?

MOTHER J: Yes.

MYERS: Right. One of the things I want to ask you about -- we can take that down for the moment, Mr Murphy -- is this: at Alder Hey, they showed you, didn't they, how to use the bags and help [Baby J]?

MOTHER J: Yes.

MYERS: Did it seem to you, to some extent, the staff at the Countess of Chester were relying on you to do that rather than them?

MOTHER J: I think it was a time-consuming process and we were keen to make sure [Baby J] got better quickly, so we offered our support.

MYERS: Right. Just as a general point, did they seem to know what to do with the bags themselves?

MOTHER J: Yes.

MYERS: But did they rely upon you for a lot of the day-to-day care of [Baby J] when you were there?

MOTHER J: Yes, although with the bags, what I would say was it was an ever-moving picture because of what was happening with the stoma and that made it very, very technical to be able to replace the bag. And without the skill of my husband, who's an engineer, I wouldn't have been able to position the bag in the correct place because it was very -- it was all very specific based on the size of the stoma. So I think if you didn't have a lot of experience in that area, nurses included, you would find that challenging.

MYERS: Right. You were asked a little early in the questions from the prosecution about relationships with the staff and the approach at the Countess of Chester as opposed to the approach at Alder Hey.

MOTHER J: Yes.

MYERS: Do you remember being asked about that? And you said you felt as if questions -- you said -- were not received so well.

MOTHER J: Mm-hm.

MYERS: Do you mean not received so well at the Countess of Chester?

MOTHER J: Yes.

MYERS: What did you mean by that, what sort of thing do you mean?

MOTHER J: So concerns maybe would have been a better word.

If we raised concerns to the Countess of Chester, I didn't feel like on occasions they were treated very seriously.

MYERS: Right.

MOTHER J: I didn't feel like they took that information and they then took that to the correct levels or interactions with Alder Hey, which we'd been told if there were any concerns, to go back to the experts in terms of the stoma care.

MYERS: And the experts were at Alder Hey?

MOTHER J: In terms of the stoma care.

MYERS: You also mentioned about weight loss and your concern about that.

MOTHER J: Yes.

MYERS: First of all, from what you could tell with your involvement, was [Baby J] gaining weight as she should have been or was she not?

MOTHER J: She was not.

MYERS: She was not. Did that cause you concern?

MOTHER J: It caused us concern because we'd been guided by Alder Hey of what we should be expecting to see. And actually, Chester also had a guideline that they were working to and they weren't seeing that either.

MYERS: No. Did you raise with Chester your concerns?

MOTHER J: Frequently.

MYERS: Frequently. How did you feel that was received?

MOTHER J: Not met with the amount of -- not met with any changes, really, any -- you know, not taken very seriously.

MYERS: Right. Were you aware of what prescriptions [Baby J] was meant to receive and when she was meant to receive them?

MOTHER J: At the time --

MYERS: Yes.

MOTHER J: -- very much so, yes. We're a long way off now!

MYERS: I'm not going to ask you to recall precise times. But knowing that, did you ever find yourself having to prompt staff at the Countess of Chester when she was meant to be receiving drugs?

MOTHER J: [Father of Baby J] more so than me was very much on high alert in terms of what should happen and when and what had been prescribed. I would say things changed after the first collapse. You know, we were much more concerned with the care because things were missed.

MYERS: Yes. Were you aware at any stage of having to prompt staff that [Baby J] was due to be given drugs at particular times?

MOTHER J: [Father of Baby J] did the prompting.

MYERS: But you were aware of that happening?

MOTHER J: Via [Father of Baby J], yes.

MYERS: All right. I just want to ask you something about infection. With a baby like [Baby J] who's got stomas, is there a potential increased risk of infection from what you understood and what you'd been told?

MOTHER J: I don't think I can answer that question.

MYERS: All right. Let me ask this: was there ever any incident that caused you particular concern or incidents that caused you concern given [Baby J]'s position with the stoma bags and any possible risk of infection?

MOTHER J: There was a general concern that she had a Broviac line and that needed to be treated and cleaned on a weekly basis.

MYERS: Right.

MOTHER J: And I guess for anybody who knows anything about infections, as we all do, especially after a pandemic, you know that if you're dealing with faeces and there are open entrances into a body, then they are susceptible to infection, an increased risk of infection.

MYERS: Was there ever an occasion when you saw her with faeces and not appearing to get the care that she needed to tidy that up?

MOTHER J: Yes.

MYERS: I put it that way. What happened on that occasion, can you tell us?

MOTHER J: On that occasion, I arrived at the hospital, [Baby J] was -- it was about 8 o'clock in the morning. [Baby J] was -- her waist, her bottom was wrapped in a towel, covered in faeces, and at that point I just said to a nurse, "What would you do in my situation? If you were a parent in my situation now, how would you deal with this?", and we called a meeting with the consultant.

MYERS: So there was faeces visible, was there?

MOTHER J: Yes.

MYERS: And just with a towel wrapped round it?

MOTHER J: Yes.

MYERS: Okay. Was there an occasion when you were concerned about a bath that she was being given with a Broviac line?

MOTHER J: There was an occasion where -- the procedure in room 4, before the children went home, they like them to have a bath. Yes, there was a discussion that took place over that occurring because I thought it was high risk because [Baby J] wasn't the same as the majority of the babies that were in that unit.

MYERS: When you raised those concerns, how were they dealt with?

MOTHER J: Pushback.

MR MYERS: All right. Thank you for dealing with my questions, [Mother of Baby J].

MOTHER J: Thank you.

MR JOHNSON: Does your Lordship have any questions?

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

Thank you very much, [Mother of Baby J]. That completes your evidence so you're free to go or stay as you wish.

MOTHER J: Thank you.

(The witness withdrew)

MR JOHNSON: Kate Tyndall, please.

MRS KATE TYNDALL (recalled)

Examination-in-chief by MR JOHNSON

MR JOHNSON: Welcome back. For the sake of the recording, would you identify yourself, please?

TYNDALL: I'm Kate Tyndall, intelligence analyst.

JOHNSON: Thank you. Mrs Tyndall, we're moving on now to the sequence of events in relation to the case of [Baby J]. Do we see at the first tile the record of [Baby J]'s birth --

TYNDALL: Yes.

JOHNSON: -- at 15.00 hours, born at 32 weeks plus 2, by C-section, weighing 1.709 kilograms?

TYNDALL: Yes.

JOHNSON: Her Apgar scores are recorded as 5 at 1 minute, 9 at 5 and 10 at 10 minutes.

TYNDALL: Yes.

JOHNSON: Then 10 minutes later at tile 2, do we have a record of her admission to the neonatal unit?

TYNDALL: Yes.

JOHNSON: Thereafter, are there some notes made by Dr Chang at 16.30 hours?

TYNDALL: Yes.

JOHNSON: We'll let Dr Chang deal with those. Followed by her record, that is Dr Chang's record, a communication that she had with [Mother of Baby J] and [Father of Baby J].

TYNDALL: Yes.

JOHNSON: Followed in turn at tile 5, timed at 17.10, by a nursing communication of -- sorry, a nursing record of communication with the [Family of Baby J]?

TYNDALL: Yes.

JOHNSON: Thank you. Just dealing with that, because Sophie Ellis isn't giving evidence on this count, that note records, I believe, the fact that the parents had been congratulated and updated regarding [Baby J]'s condition.

There was a picture either taken or given and then hand expressing was explained and demonstrated to [Mother of Baby J], and the family were shown round the unit.

TYNDALL: Yes.

JOHNSON: Thank you. Tile 6. Does that record the fact that between 31 October at 17.10 and 04.00 the following morning, [Baby J] remained in the neonatal unit?

TYNDALL: Yes.

JOHNSON: Tile 7. At 06.25 on the morning of 1 November 2015, [Baby J] was transferred to Alder Hey?

TYNDALL: Yes, she was transferred at 4 am, but the record was made at 6.25.

JOHNSON: I beg your pardon, thank you. Is there then an incoming text message from [Nurse E] to Lucy Letby that appears next in the schedule?

TYNDALL: Yes.

JOHNSON: Does that start with some social interaction?

TYNDALL: Yes.

JOHNSON: It's then followed by [Nurse E] saying:

"The baby we sent out has had surgery this morning and got stomas, not aromas, as my phone thinks."

TYNDALL: Yes.

JOHNSON: Presumably a reference to autocorrect.

TYNDALL: Yes.

JOHNSON: At 23.11 that same day, the Sunday, did Lucy Letby send [Nurse E] a message?

TYNDALL: Yes:

"Poor baby, probably does have an aroma as well."

And then the rest of the message is of a social interaction.

JOHNSON: And do the records then show that [Baby J] remained at Alder Hey between the 1st and 10 November --

TYNDALL: Yes.

JOHNSON: -- and was readmitted to Chester on Tuesday, 10 November at 18.15?

TYNDALL: Yes.

JOHNSON: By coincidence, the nurse that admitted [Baby J] was Lucy Letby?

TYNDALL: Yes.

JOHNSON: Tile 12 are nursing notes made by Yvonne Griffiths recording the transfer; is that right?

TYNDALL: Yes, recording the transfer back in and [Baby J]'s condition as she came back into the hospital.

JOHNSON: Thank you. Then what we see next at tile 13 is a text message sent by Lucy Letby, this is a matter of fact, sent while she was working this particular shift, wasn't it?

TYNDALL: Yes.

JOHNSON: Can you read it to us, please?

TYNDALL: It says:

"It's chaos here and I've just had a row with Caroline O."

Presumably Caroline Oakley.

JOHNSON: Yes. A minute later, did [Nurse E] respond:

"Eek, why is it chaos and why you had a row?"

TYNDALL: Yes.

JOHNSON: And do we then have, at tile 15, Dr Hunt or Dr Beebe's medical notes recording the fact that [Baby J] had been returned?

TYNDALL: Yes.

JOHNSON: I don't think we need to go into details, but those notes record [Baby J]'s condition at the time and something of the history; is that right?

TYNDALL: Yes, that's correct.

JOHNSON: There's then tile 16, recording the continuing stay of [Baby J] between that stage at 20.00 hours on 10 November through to 05.00 hours on the morning of 26 November?

TYNDALL: Yes.

JOHNSON: So just to put that into context, we're now -- well, in fact, some text messages have then been inserted, haven't they? These fill a lot of that time; is that right?

TYNDALL: Yes. There's a selection of text messages that have been put in that are -- well, that have been chosen in this period of time --

JOHNSON: Okay.

TYNDALL: -- that reference [Baby J] in particular.

JOHNSON: Yes. So the fact is that many of these messages refer to [Baby J]?

TYNDALL: Yes.

JOHNSON: All right. We begin, I believe, at tile 17 on 10 November, the time 21.17, quite a long message from Lucy Letby to [Nurse E].

TYNDALL: Yes.

JOHNSON: Could you take us through that one, please?

TYNDALL: Yes:

"D [that's the name of another baby on the unit] really sick on triple inotropes. Just left with transport. I've got baby in 2 on CPAP with no access and [Baby J] just got back from AHCH [which is Alder Hey Children's Hospital] with leaking stoma. Broviac needs fluids setting up, et cetera, and [Nurse A] doing eff all. Caroline saying she has a headache so she can have C [another baby] and sit down as much as possible, et cetera. When I asked her to do something she was moaning and then was chatting about [Baby I] funeral when trying to handover so said could she ask Mary about it after as loads going on and not really the time when parents around, et cetera. She said, 'It's not all about you, I'll talk to whoever I want to, and don't speak to me like that', so said, 'That's a bit unreasonable', and walked off."

JOHNSON: Okay. That was to [Nurse E]. Did [Nurse E] respond:

"Oh Jesus! Is [Nurse A] in charge? Have you spoke to Caroline again? What do they think is the matter with D?"

TYNDALL: Yes.

JOHNSON: And that's another child, isn't it?

TYNDALL: Yes, D's another child.

JOHNSON: Then Lucy Letby response to that enquiry?

TYNDALL: "[Nurse A] in charge and has done nothing, just chatting with all the parents. Kate B stayed late to wait until D [the baby] went and [Nurse A] just watched. Mary has helped me, thankfully. Sepsis with D. C [a different baby] still the same. No, haven't seen Caroline and don't want to. Everyone peeing me off. Must be this thyroxine lol."

JOHNSON: Did [Nurse E] spend:

"Why the hell is [Nurse A] doing nothing if there's stuff going on? Surely Caroline having C shouldn't be seen as an easy job if done properly. Place is a nightmare! Have you got [Baby J] too then?"

TYNDALL: Yes.

JOHNSON: Did Lucy Letby respond?

TYNDALL: "God knows, as C kept Kate busy last night, desats et cetera. Yeah, I've got [Baby J] and one on CPAP. Needs admitting, fluids doing, etc, showing parents around, giving breast pump etc. [Nurse A] and Caroline chatting in 1 and I'll say something I regret if I go in."

JOHNSON: Okay. Then [Nurse E] responded:

"Nothing like a bit of team spirit. Wonder who I'm on with tomorrow."

Did Lucy Letby respond?

TYNDALL: "Laura in charge. Yvonne F, Minna, Jo early/late, Nicki and Sian. Sorry about my rant."

JOHNSON: [Nurse E] responded:

"No worries. I wonder who I'll get."

TYNDALL: Yes.

JOHNSON: Is there then a response from Lucy Letby at 26?

TYNDALL: "Just really gets me down at times. It's like no one cares and just wants the easy life."

JOHNSON: And then [Nurse E]:

"I don't remember it being like that not long ago"?

TYNDALL: Yes.

JOHNSON: Did she send a further message saying:

"Ok. Don't know why I've been so busy, just having J, but I have lol. You've just got [Baby J] tonight."

TYNDALL: This is a different day now.

JOHNSON: We've moved on a day. That's my mistake. This is 18.28 on 11 November.

TYNDALL: Yes.

JOHNSON: So presumably a reference to J in the next message?

TYNDALL: I presume so, but it says:

"Is he still on CPAP? That's cool. Quite like recycling once get into it."

JOHNSON: Then were there messages exchanged between Lucy Letby, [Nurse E] and Susan Letby, which were all social messages essentially?

TYNDALL: Yes.

JOHNSON: Followed by a message sent by Lucy Letby to [Nurse E] at 18.14 at tile 31?

TYNDALL: Yes:

"No, which is another thing that peed me off as [Baby J] had only come back at 6.30 so had to do paperwork, show parents round, stoma needed new bag, fluids putting up, etc. Then on top J was having cannula, etc. Yvonne G said she only gave Mary one so should she could do ABX [which I think is antibiotics]. Does baffle me sometimes. Yeah, I'll keep an eye as know him and think he might tire. Hopefully not. Y."

JOHNSON: Do we then move 2 days to Friday, 13 November?

TYNDALL: Yes.

JOHNSON: Did [Nurse E] at 13.47 send a message:

"Hey, how's your day? Didn't get [J] back today with him going to MRI. [Nurse A] didn't think appropriate, so got [Baby J] and transfer with cleft lip/palate."

TYNDALL: Yes.

JOHNSON: Did Lucy Letby respond to that?

TYNDALL: Yes, with:

"Ah okay. So has a 6 got him? Did the twins come back? I'm okay, thanks."

JOHNSON: And [Nurse E] said:

"Yes, [Nurse C]. Yep, yesterday and then had two back today."

TYNDALL: Yes.

JOHNSON: We move on again then, over the weekend, to Monday, 16 November.

TYNDALL: Yes.

JOHNSON: We start with a message at tile 35, sent by Lucy Letby to [Nurse E]?

TYNDALL: Yes, asking:

"How often should Broviac be hep locked?"

JOHNSON: The response from [Nurse E] was:

"Once a week. It (inaudible) be done with the saline and 3ml of heparin. Why?"

TYNDALL: Yes.

JOHNSON: And a further message:

"I got [Dr A] to prescribe it for every Friday."

TYNDALL: Yes.

JOHNSON: There was a doctor working at the hospital at the time called [Dr A]; is that right?

TYNDALL: Yes.

JOHNSON: Lucy Letby responded to that?

TYNDALL: "They've documented once a week for [Baby J] on a Sat. Just wasn't sure if needed to be more frequent."

JOHNSON: [Nurse E] responded:

"Ah, okay. Once a week if been done properly and once week for thorough clean and new dressing."

Did Lucy Letby respond?

TYNDALL: "Cool."

JOHNSON: Thank you. That's Monday, the 16th. Moving to Tuesday, the 17th, do these messages start with a message being sent by Lucy Letby at 20.45 to [Nurse E]?

TYNDALL: "Ha ha, god yeah, down in 1! Jean not most reliable either. She told me Sian had restarted monitoring on him but neither of them documented it on obs chart and no apnoea chart, despite Jean saying and writing in notes that had been given oxygen, etc."

JOHNSON: And [Nurse E] responded:

"This is why 4s either shouldn't take them or be heavily supported. Kate hadn't allocated Jenny. [Baby J] back tonight. Don't think she was comfortable with it but Jenny had a moan when came in so got changed."

TYNDALL: Yes.

JOHNSON: Did Lucy Letby respond to that?

TYNDALL: "Kate B? Don't blame her. Who changed it?"

JOHNSON: [Nurse E] responded:

"Kate W said something and Kate B changed it. I don't think Mary happy having her either as (inaudible) allocated (inaudible) first and Jenny said she would countersign anything Mary did as she'd had her last night."

TYNDALL: Yes.

JOHNSON: A further message from [Nurse E] at 17.32, tile 45, saying:

"Just a lot going on this morning with B's discharge and liaising with stoma nurses, etc, plus dealing with safeguarding lol. All go! Oh and Kate Bissell has raised about Jenny having [Baby J] as looks like she's been doing the re-feeding."

TYNDALL: Yes.

JOHNSON: Did Lucy Letby respond to that about 37 or so minutes later?

TYNDALL: Yes, with:

"Ah, keeping you busy! Has B gone? That's good, glad Kate has done that. Was talking about it with Minna and don't think it's right."

B being the name of a baby.

JOHNSON: Did [Nurse E] respond:

"Yeah, you discharged her. No, I know."

TYNDALL: Yes.

JOHNSON: Did Lucy Letby then respond at 20.00 hours?

TYNDALL: "Glad B gone. Does Jenny not have [Baby J] tonight?"

JOHNSON: And [Nurse E] responded:

"No [laugh out loud]"?

TYNDALL: Yes.

JOHNSON: And then Lucy Letby to [Nurse E]?

TYNDALL: "Did Kate speak to Eirian then? As Yvonne G approved it. Bet you are pooped."

JOHNSON: And did [Nurse E] respond:

"Yvonne G approved it? Didn't realise that as Kate spoke to Yvonne and Eirian on phone when they were together today at study day"?

TYNDALL: Yes.

JOHNSON: Lucy Letby to [Nurse E]?

TYNDALL: "Yes, Belinda didn't think it was right but was struggling with allocation and as only three trained, so asked

Yvonne G, who was in office, and she said okay to have [Baby J] and TPN babies as would be supervised. Just off to salsa."

JOHNSON: Did [Nurse E] respond:

"Ah that's interesting as don't think she's said that to Eirian"?

TYNDALL: Yes.

JOHNSON: And the text at 54 from Lucy Letby?

TYNDALL: "I best she's got wind of Eirian not thinking it's right and now backtracking!"

JOHNSON: The following day, on Thursday the 19th, is there a series of four messages passing between [Nurse E] and Lucy Letby, essentially in the same vein, talking about Eirian and [Nurse B]?

TYNDALL: Yes, and Jenny having [Baby J].

JOHNSON: Yes. Moving on to 59, Monday, 23 November. Did [Nurse A] send Lucy Letby a WhatsApp message saying:

"Poor C. Good re D. How's [Baby J]? Wish I wasn't off. Feel so freaking useless"?

TYNDALL: Yes.

JOHNSON: And did Lucy Letby respond to that enquiry?

TYNDALL: Yes. With:

"She's good I think. In 4. Doing well with feeds. Hoping to get home soon."

JOHNSON: Yes. Was there then a further message from Lucy Letby but this time to [Nurse E]?

TYNDALL: Yes. This is on the 25th at 23.00.

JOHNSON: So we've skipped 2 days?

TYNDALL: Yes.

JOHNSON: Thank you.

TYNDALL: "Went to Las Iguanas. Was really nice. At salsa had 3 missed calls. They don't know how to give immunoglobulin and I was last person to give so just phoned and told them. Caroline

said it's mad. Ravi is there. What a nightmare. It's all getting they'll have to send babies out??"

JOHNSON: Did she send a further message an hour and 21 minutes later, so Thursday, 11 November?

TYNDALL: Yes:

"Fuming actually that they phoned me that late because they can't find a policy and that they obviously aren't being supported by Eirian, et cetera. Hope you sleep well."

JOHNSON: Did [Nurse E] respond to that towards the end of the shift, just before -- although neither of them may have been working at this stage, but at 6.59 saying:

"Gosh. Shouldn't they ringing somewhere like the Women's and getting a policy sent over or something than ringing people at home? Caroline was on phone to transport about half 8 trying to get that baby sent out cause we'd closed. I think it's all terrible!?"

TYNDALL: Yes.

JOHNSON: And do we then pick up where we had left off before that series of text messages? We'd left off at tile 16 and we're starting now with the day shift on 26 November 2015?

TYNDALL: Correct.

JOHNSON: So this now is in effect the detailed representation of [Baby J]' care in about the 24 hours or so prior to her collapse?

TYNDALL: Correct.

JOHNSON: So starting at tile 65, do we have a record of the nursing handover at which [Baby J]'s designated nurse was Ashleigh Hudson?

TYNDALL: Yes.

JOHNSON: At 08.02, tiles 66 and 67, do we have prescriptions for breast milk fortifier and sodium chloride oral supplements?

TYNDALL: Yes.

JOHNSON: They are signed and countersigned by Ashleigh Hudson and Belinda Simcock?

TYNDALL: Yes.

JOHNSON: At 08.07, was there a nursing update on the computer made by Nicola Dennison?

TYNDALL: Yes, for the night shift.

JOHNSON: Yes. So she'd been the nurse on the previous night shift, recording:

"Observations stable. No desaturations, no obvious problems from the stoma fistula. Handles well and has tolerated bag recycling and changes. Has passed urine and bowels opened. Fed four-hourly by mum."

TYNDALL: Yes.

JOHNSON: And then at 69, 08.15 hours, do we have Ashleigh Hudson's record of [Baby J]'s vital signs?

TYNDALL: Yes.

JOHNSON: Followed by a further update made in the nursing record at tile 70, timed 08.17, made as before by Nicola Dennison?

TYNDALL: Yes.

JOHNSON: Recording the fact that:

"Mummy and daddy did feeds and cares together last evening. Mum has provided cares with support from staff overnight. Happy with the changes put in place yesterday"?

TYNDALL: Yes.

JOHNSON: At tile 71, has Ashleigh Hudson annotated the feeding chart?

TYNDALL: Yes.

JOHNSON: At tile 72, do we have, timed at 10.30 hours on 26 November, Dr Ladde's medical notes concerning an examination of [Baby J]?

TYNDALL: Yes.

JOHNSON: Could you just take us through -- as Dr Ladde isn't a required witness for this, could you take us through your transposition of her handwritten notes?

TYNDALL: So it says:

"Corrected 35 plus 6."

In the actual original notes, there is a lot of [Baby J]'s previous clinical history, which hasn't been transcribed here. Then we've got:

"On examination, V [for ventilation] self-ventilating in air. Handling well. AF soft. Pink, well perfused. No respiratory distress. Bilateral equal air entry. Abdomen soft. Mum says mild distension soft abdomen. Stoma looks healthy. Fistula on left lateral aspect. Plan: 60ml per kilogram of expressed breast milk plus donor from bottle. If increased distension to inform."

Then there's notes of the observations from the observation chart.

JOHNSON: You just dropped your voice there.

TYNDALL: Sorry. Then there's a record of [Baby J]'s vital signs at that point.

JOHNSON: Thank you. At tile 73 do we have an incoming message to Lucy Letby from [Nurse E] timed at 11.40 to this effect:

"Hey, you okay? Sorry if text a bit early this morning [laugh out loud]"?

TYNDALL: Yes.

JOHNSON: Did Lucy Letby respond about 4 minutes later?

TYNDALL: Yes, with:

"Sorry I've not long got up. Just can't believe that some people were in a position when they don't know how to give something, what equipment to use and not being supported by manager. Staffing really needs looking at. Who else was on? You must be knackered."

JOHNSON: Do we then have two of the standard three sets of observations recorded at tiles 75 and 76 at noon on the 26th --

TYNDALL: Yes.

JOHNSON: -- records made by Ashleigh Hudson? Then followed by more messages, first between 12.05 and 12.24, Lucy Letby and [Nurse E] in contact with general social messaging?

TYNDALL: Yes.

JOHNSON: Then by Lucy Letby at 12.24, tile 78, sending a message to Jennifer Jones-Key?

TYNDALL: Yes:

"Sounds like you had a pretty mad day."

JOHNSON: Jennifer Jones-Key responded:

"Horrific. Got home at 10.45."

TYNDALL: Yes.

JOHNSON: Then was there a response to that from Lucy Letby at tile 80?

TYNDALL: "Wow. It's just not manageable with staff we have. I had Caroline ringing me at 11 pm."

JOHNSON: So then a message, a further message, a text from Lucy Letby to [Nurse E] this time?

TYNDALL: Yes:

"Fairly surely only 3 trained when I looked unless they've got anyone."

JOHNSON: Then going back to the Lucy Letby/Jennifer Jones-Key conversation, did Jennifer Jones-Key send two messages, a minute apart, the first:

"Nope. Why? I put you had said no on the sheet."

Then:

"To be fair there were seven of us yesterday as Laura clinic and me parentcraft and still wasn't manageable."

Did Lucy Letby respond to those messages?

TYNDALL: Yes:

"They were needing to give immunoglobulin but weren't sure how/what equipment to use and they had traced that I was the last person to give it."

JOHNSON: Yes.

TYNDALL: Then follows that with:

"It's a nightmare, isn't it?"

And then:

"Especially with no management."

JOHNSON: Then we've got a series of messages here, two from Jennifer Jones-Key to Lucy Letby. Tiles 87 and 88 are at 12.28 and 12.29, the first saying:

"Yeah. They were going to phone you or Yvonne, but thought they would [have] done it earlier."

Followed by:

"It is. TC full. Five admissions and a sick 32-weeker."

TYNDALL: Yes.

JOHNSON: Did we then put in a tile to record the fact that there were continuing messages between Lucy Letby and [Nurse E] about work but none which mentioned [Baby J]?

TYNDALL: Yes.

MR JUSTICE GOSS: I'm going to interrupt there, Mr Johnson.

I see that we've got more and more messages. This is nothing but messages coming up.

MR JOHNSON: Yes. It's time for a break.

MR JUSTICE GOSS: We'll have a break.

(In the absence of the jury)

MR JUSTICE GOSS: I haven't gone -- I was just scrolling through and --

MR JOHNSON: There are a lot.

MR JUSTICE GOSS: I was well into the hundreds.

MR JOHNSON: I'm not sure about that, but the advantage of having them on paper is I can see exactly what --

MR JUSTICE GOSS: I know, but it's much more difficult when you're trying to follow them on the screen.

MR JOHNSON: Yes.

MR JUSTICE GOSS: No criticism of Mr Murphy, but he was having difficulty keeping up with you.

MR JOHNSON: Sorry.

MR JUSTICE GOSS: If you want us to look at these, or anyone wants us to look at these, you'll have to dwell a little bit more on them rather than skipping through because it's not always easy to follow because there are messages going from different people.

MR JOHNSON: Well, it's when different people are involved.

Our recollection of why a lot of these are in doesn't necessarily accord with my learned friend's.

MR JUSTICE GOSS: I'm not going to -- the point is they're in by agreement?

MR JOHNSON: Yes.

MR JUSTICE GOSS: And if we're going to have reference to them, we might as well have proper reference to them rather than skimming through, because it's just not possible really to absorb the information. All right, thank you very much.

(3.00 pm)

(A short break)

(3.10 pm)

(In the presence of the jury)

MR JOHNSON: We had got to tile 91, which we can see records the fact that there were social messages between Jennifer Jones-Key and Lucy Letby at 12.21 on the 26th.

A minute later, did Lucy Letby send a further message to Jennifer Jones-Key?

TYNDALL: Saying:

"Can't contact Yvonne G when on hols. Eirian should always be contactable. We don't seem to get any support and girls last night shouldn't be in a position where they don't know how to give something or what equipment to use."

JOHNSON: Then did Jennifer Jones-Key respond:

"She would probably say they shouldn't give it but you can't do that"?

TYNDALL: Yes.

JOHNSON: Is there a further message back from Lucy Letby?

TYNDALL: "Do you know why she didn't come in to help?"

JOHNSON: And did Jennifer Jones-Key then say:

"Mel couldn't get hold of her. We tried from 4. She phoned back about 9. I said the girls were handing over and she sounded surprised. [Nurse B] spoke to her then. Steve B said no to transfer but Ravi and Eirian said yes."

In that context, is that Stephen Brearey, one of the consultants?

TYNDALL: Yes.

JOHNSON: And obviously Ravi Jayaram is one of the others?

TYNDALL: Yes.

JOHNSON: Did Lucy Letby respond?

TYNDALL: "I think she should have come in seeing as you'd tried everybody else."

JOHNSON: Did Jennifer Jones-Key respond:

"Oh agree, and we should [have] been able to get hold of her"?

TYNDALL: Yes.

JOHNSON: Did Lucy Letby then send a further message?

TYNDALL: "Ah well. Hopefully be bit calmer for me tonight lol."

JOHNSON: Then did Jennifer Jones-Key send a message saying:

"Should be as a few going home. 3 downstairs ready for TC when space"?

Do you know what TC means in that context?

TYNDALL: I presume it's the transitional care.

JOHNSON: Yes:

"C not vented anymore."

Did Lucy Letby respond:

"Good"?

TYNDALL: Yes.

JOHNSON: And then Jennifer Jones-Key:

"We were fine until the 5 admissions came together and it sends you over edge. TC very heavy and no back-up"?

TYNDALL: Yes.

JOHNSON: Lucy's response, please?

TYNDALL: "Yes, it's tough."

JOHNSON: And Jennifer Jones-Key:

"Don't think people realise what it's like"?

TYNDALL: Yes.

JOHNSON: And then, "Probably not", said Lucy Letby?

TYNDALL: Yes.

JOHNSON: Followed by social messages.

Then at 4 pm, [Baby J]'s heart, respiratory rate and temperature are taken and recorded?

TYNDALL: Yes.

JOHNSON: Together with the neonatal feeding chart at tile 107?

TYNDALL: Yes.

JOHNSON: There's then a series of messages, this time with [Nurse E] rather than Jennifer Jones-Key?

TYNDALL: Yes.

JOHNSON: Starting with a message from [Nurse E] at 108, timed at 17.16, saying:

"U well rested for work?"?

TYNDALL: Yes.

JOHNSON: Did Lucy Letby respond?

TYNDALL: "Yep. I've had a chilled day and slept well so I'm ready lol."

JOHNSON: [Nurse E]:

"Raring to go, eh? Are you going to say something to Caroline about being rang so late on day off? I bet they wouldn't ring Laura with something like that. She'd go ape."

TYNDALL: Yes.

JOHNSON: Did Lucy Letby respond?

TYNDALL: "Ready to face anything, ha ha. Yeah, I think I'll ask why they phoned and if they had tried transfusion, Women's, etc, as I said on phone that I will tell them what I did but they need to be happy and check it against something. When I phoned, first thing Caroline said is, 'Where are you?', so Minna and I wonder if she was half-hoping I'd say that I'll pop in and show them."

JOHNSON: There's then a record of a prescription of sodium chloride oral supplements, for [Baby J] --

TYNDALL: Yes.

JOHNSON: -- at 18.15 hours?

The text conversation continued with a text from [Nurse E] at 18.16, tile 113?

TYNDALL: Yes.

JOHNSON: "Sound like! It's rather presumptuous and cheeky to think you weren't doing anything. Wonder if they did check against anything."

TYNDALL: Yes.

JOHNSON: Did Lucy Letby respond?

TYNDALL: "It's all a bit odd as the main problem was they didn't know what giving set to use. Well surely if you phoned transfusion they would soon be able to tell you that or Women's -- and when I last did it there was a policy and we phoned pharmacy for advice, so I don't understand why when busy they spent time looking up who had last given it, et cetera."

JOHNSON: It's followed by some social messages between Lucy Letby and Minna Lappalainen?

TYNDALL: Yes.

JOHNSON: Then the text conversation between [Nurse E] and Lucy Letby resumed, tile 116, at 18.32:

"It is bizarre. It wouldn't occur to me to ring someone up late at night xbox [as read]."

Or just X?

TYNDALL: Yes.

JOHNSON: More social messages followed by more messages from [Nurse E] to Lucy Letby between 119 and 122?

TYNDALL: Yes.

JOHNSON: The first saying:

"Jenny kept going on and on yesterday about how difficult it is for the nursery nurses having four babies sometimes and TC blah, blah, blah. I don't think she quite gets what we do extra to them! It's all feed-related stuff really that they're juggling."

And:

"It's obviously tricky at times when got breastfeeders, but Christ no one's going to die from a crack [it says] handed breastfeed, are they?"

I imagine that should say cack-handed.

TYNDALL: Yes, and she corrects that in the next message.

JOHNSON: "Well maybe a crack-handed, but not cack-handed!"

Then there's more social mentions followed by a response from Lucy Letby to [Nurse E]?

TYNDALL: "She text earlier with a full breakdown of the day and that TC was very heavy and no support. As you say, they are essentially well babies that need feeding support and, yes, that can be hard work, particularly throwing parents into the mix, but it's not like having responsibilities for sick babies, medications, et cetera."

Then a message straight after:

"Although a crack-handed feed could be quite dangerous!"

JOHNSON: Then followed by more social messaging --

TYNDALL: Yes.

JOHNSON: -- involving first Lucy Letby and [Nurse E], then Lucy Letby and Minna Lappalainen and [Nurse E]?

TYNDALL: Yes.

JOHNSON: Then we have some swipe data showing Laura Eagles and Mary Griffith at between 19.11 and 19.17?

TYNDALL: Yes.

JOHNSON: A message from Lucy Letby at 19.17 saying:

"Off to the madhouse."

TYNDALL: Yes.

JOHNSON: And a response from [Nurse E] saying:

"Let me know what it's like."

Followed by more door entry data, so more of the nursing staff arriving for the night shift of the 26th into the 27th.

TYNDALL: Yes.

JOHNSON: It's obvious from that sequence that there isn't actually a record of Lucy Letby's pass being used, but it may well be that she went in with one of her colleagues because at tile 136 she sent a message to [Nurse E] saying:

"New baby vented. I've got nursery 3."

TYNDALL: Yes.

JOHNSON: Did [Nurse E] respond to that by saying:

"It's Laura in 1 then or have they got another nurse in?"?

TYNDALL: Yes.

JOHNSON: And Lucy Letby said:

"Laura in 1 but we have got Mary too."

TYNDALL: Yes.

JOHNSON: And [Nurse E]'s response:

"Ah, better then. Wonder who I'll have tomorrow."

TYNDALL: Yes.

JOHNSON: We come then to the shift in question. As always, if we click on the tile we see first the medical staff.

The paediatrician of the week, Dr Brearey. On call was Dr Gibbs. The registrar was Dr Rhiannon Austin. The night senior house officer, Dr Verghese. And the shift leader of the nursing staff was Caroline Oakley and we then see that the other three more senior nurses were Lucy Letby, Mary Griffiths and Laura Eagles.

TYNDALL: Yes.

JOHNSON: The nursery nurses were Nicola Dennison and Vicky Blamire.

TYNDALL: Yes.

JOHNSON: If we just scroll down, we see that the reason that Nicola Dennison was [Baby J]'s designated nurse was that she, [Baby J], was in nursery 4?

TYNDALL: Yes.

JOHNSON: There was one other child in nursery 4 also being cared for by Nicola Dennison?

TYNDALL: Yes.

JOHNSON: There were two children in nursery 3, both being cared for by Lucy Letby?

TYNDALL: Yes.

JOHNSON: Two children in nursery 2, one of whom was being cared for by Caroline Oakley, the shift leader, and the other by Mary Griffiths?

TYNDALL: Yes.

JOHNSON: In nursery 1, two children both being cared for by Laura Eagles?

TYNDALL: Yes.

JOHNSON: In transitional care were two children being cared for by Vicky Blamire?

TYNDALL: Yes.

JOHNSON: And there were two other children, at the bottom right of the graphic, whose location cannot be confirmed from the records; is that right?

TYNDALL: Yes.

JOHNSON: One of whom was being cared for by Vicky Blamire and of the other there is no record?

TYNDALL: Yes.

JOHNSON: No available record. So in a nutshell, [Baby J] in number 4, Lucy Letby in number 3?

TYNDALL: Yes.

JOHNSON: Right. So do we start the shift with two charts filled in by Nicola Dennison in respect of [Baby J] at 8 pm --

TYNDALL: Yes.

JOHNSON: -- recording her vital signs, together with the feeding data?

TYNDALL: Yes.

JOHNSON: Is there then an update to the nursing notes made by Ashleigh Hudson, who had been the daytime nurse for [Baby J]?

TYNDALL: Yes.

JOHNSON: We'll just deal with that because Ashleigh Hudson won't be giving live evidence. Could you take us through Nurse Hudson's notes, please?

TYNDALL: "Written for care taken over at 08.00 hours. Emergency equipment, alarm limits and feeds checked. Observations satisfactory as charted. Tolerating four-hourly feeding times. PTB [which I think stands for 'put to breast'] twice today as charted. Broviac remains in situ. Exit site pink and well perfused. Dressing is clean and dry. Proximal and distal stomas both pink and well perfused. Fistula on proximal stoma remains. Parent think it looks bigger. Tissue is well perfused and clean. Will monitor. [Baby J] appears to be in no pain or discomfort. Good amounts recycled today. Gastric fluid recycled at 16.00 hours. More watery than usual. Chalky yellow in colour. [Query]

less digested than usual. Advised parents to observe stools for changes. Discussed this with nurse in charge, Caroline Bennion. Passed urine. Bowels open."

JOHNSON: Thank you. Is there then at tile 144 a prescription for breast milk fortifier?

TYNDALL: Yes.

JOHNSON: At 145, a record of the fact of the fortifier being given to [Baby J]?

TYNDALL: Yes.

JOHNSON: At 146, Lucy Letby -- there's a tile covering the period 19.36 through to 22.53, recording the fact that Lucy Letby was sending and receiving text messages and none of them mentioned [Baby J]?

TYNDALL: Correct.

JOHNSON: We then go to midnight, so we're moving on about 3 hours and to 147 and 148, which are the vital signs and the feeding chart, both completed by the designated nurse, Nicola Dennison?

TYNDALL: Yes.

JOHNSON: At tiles 149 and 150, the prescription of and administration of the sodium chloride oral supplements for [Baby J]?

TYNDALL: Yes.

JOHNSON: Do we see that, so far as they are concerned, the principal signer of the record is Lucy Letby and the co-signer Mary Griffith?

TYNDALL: Yes.

JOHNSON: We then move on almost 2 hours to some door fob data, 01.57 hours. Lucy Letby coming through the entrance doors to the neonatal unit.

TYNDALL: Yes.

JOHNSON: Followed by similar data, 1 hour 50 minutes later, at 03.47 hours?

TYNDALL: Yes.

JOHNSON: Followed by the designated nurse, Nicola Dennison's record at tiles 153 and 154 of [Baby J]'s vital signs together with her feeding data?

TYNDALL: Yes.

JOHNSON: That's at 04.00 hours. There's then some more door data relating to entries into the maternity ward and then the neonatal unit of Dr Verghese?

TYNDALL: Yes.

JOHNSON: Two entrances of Dr Austin -- sorry, one of Dr Austin?

TYNDALL: Yes.

JOHNSON: And then Lucy Letby again coming into the neonatal unit at 04.29?

TYNDALL: Yes.

JOHNSON: It's quite some time since we looked at much door data, but essentially is the system that to get into the unit, you need a pass, to get out you can just press a button?

TYNDALL: Yes, some doors have got passes, some have just got buttons.

JOHNSON: You wouldn't necessarily be recorded going out even if you were going out alone?

TYNDALL: Yes.

JOHNSON: At tile 160 at 04.40 that morning, is there a chart, which I think we did see towards the beginning of the trial last year, but we've not seen for a long time, so if we go and have a quick look at this. This is what's referred to as an apnoea/brady/fit chart. There we see what is Nicola Dennison's signature in the signature column. There are two events recorded at 04.40 and 05.03. Apnoea on the first occasion but not on the second. Heart rate down to 100 on the second occasion accompanied with desaturation into the 30s. The durations of each of those events at 3 and 2 minutes respectively. And the measures taken, Neopuff on the first occasion, facial oxygen at 100% on the second.

TYNDALL: Correct.

JOHNSON: We won't go back to that, but those two events as recorded there are separately recorded in their respective tiles, I think; is that right?

TYNDALL: Yes.

JOHNSON: So the first at tile 160, the second at tile 162?

TYNDALL: Yes.

JOHNSON: If we go to 161, we have Nurse Dennison's written record in the nursing notes of the first event?

TYNDALL: Yes.

JOHNSON: Just as we will see in a moment at 163, her written record in respect of the second event. But dealing with the first, is that her -- she will come in due course to deal with this, but is that her written record that we see on the screen there?

TYNDALL: Yes.

JOHNSON: Going back then, the next tile is what we've already seen, namely the apnoea and desaturation and bradycardia at 05.03?

TYNDALL: Yes.

JOHNSON: Then at 163, Nurse Dennison's note in the nursing record?

TYNDALL: Yes.

JOHNSON: Followed by, at the same time, 05.03, do we have Dr Verghese's door swipe data, suggesting that he came into the neonatal entrance at 05.03?

TYNDALL: Yes.

JOHNSON: Then in turn, by his clinical note, his medical note, timed at 05.15?

TYNDALL: Yes.

JOHNSON: Dr Verghese again is coming to give evidence about this, so we'll leave his note for him.

At 166, door entry data for Caroline Oakley, timed at 05.41?

TYNDALL: Yes.

JOHNSON: Further door data, albeit this time into the maternity ward, for Dr Verghese, timed at 05.51, tile 167?

TYNDALL: Yes.

JOHNSON: Followed by two more sets of door data, first for Dr Rhiannon Austin at 05.56 going into the neonatal unit?

TYNDALL: Yes.

JOHNSON: And then Laura Eagles at 06.06?

TYNDALL: Yes.

JOHNSON: At tile 170, there is a record of a blood culture being commissioned, a specimen being collected for that purpose?

TYNDALL: Yes.

JOHNSON: And then a further pathology sample at tile 171 under the name of Dr Rhiannon Austin, and in that you set out the results of the analysis?

TYNDALL: Yes.

JOHNSON: Again, we'll deal with that with the medics.

Moving on to 172, please, do we then have an untimed entry made by Nicola Dennison concerning recycling of the stoma that she had been performing that night?

TYNDALL: Yes. It also makes mention of [Baby J] being moved into nursery 2.

JOHNSON: Then you have recorded the fact of [Baby J] being moved from nursery -- to nursery 2 from nursery 4 between 06.09 and 06.17?

TYNDALL: Yes, although there's no time on the entry, we just know there's a text message coming up that gives some indication as to when it was.

JOHNSON: Thank you. So just going back to the door entry data then, at tile 174, Dr Verghese went from the neonatal unit through to the labour ward?

TYNDALL: Yes.

JOHNSON: That was followed by a text message sent by [Nurse E] to Lucy Letby, asking whether she'd had a good night?

TYNDALL: Yes.

JOHNSON: Another movement of Dr Verghese at tile 176?

TYNDALL: Yes.

JOHNSON: Then Lucy Letby's response to the enquiry from [Nurse E], set out at tile 177 and timed at 06.28?

TYNDALL: Yes. It reads:

"No, [Baby J] in 2, screened, had profound desats and just got 32-week twins born at home, one with cleft lip, and only 5 staff!"

JOHNSON: Did [Nurse E] respond:

"Oh shit! 5 staff on today you mean?"

TYNDALL: Yes.

JOHNSON: And did Lucy Letby confirm that in her response?

TYNDALL: Yes:

"Yeah, 5 today."

JOHNSON: And [Nurse E] then responded:

"We closed again then?"

TYNDALL: Yes.

JOHNSON: Just to get a bit of context to that, that means closed to new patients rather than closed?

TYNDALL: Yes, I believe so, yes, to new admissions.

JOHNSON: Yes. At 181 through to 184, do we have a series of door swipe data relating to the movements of Dr Gibbs, Nurse Nicola Dennison and Dr Verghese?

TYNDALL: Yes.

JOHNSON: Then at 185, timed at 06.40, [Nurse E]'s message to Lucy Letby saying:

"Jesus! This will be an interesting allocation then! We closed then?"

TYNDALL: Yes.

JOHNSON: Did Lucy Letby respond?

TYNDALL: "Yeah, closed. Trying to get someone in. Cleft baby being tubed, I think."

JOHNSON: And [Nurse E] responded:

"What a bloody nightmare"?

TYNDALL: Yes.

JOHNSON: Then:

"Please tell me Alisa's not in charge today"?

TYNDALL: Yes.

JOHNSON: Followed by Lucy Letby's two responses?

TYNDALL: "You are having twins until we can find someone."

And:

"And sorry but yes. Why?"

JOHNSON: Is that followed by [Nurse E]'s question:

"What, the one that's being vented?"?

TYNDALL: Yes.

JOHNSON: And did Lucy Letby send two messages then?

TYNDALL: Yes. The first one saying:

"They are holding off at mo."

And the second one saying:

"It's all a bit tits-up."

JOHNSON: And did [Nurse E] respond:

"Sounds it. God, I really don't want to come in now."

Then:

"Shit. If it gets vented, I have not had one on my own or even been near one for nearly 5 months"?

TYNDALL: Yes.

JOHNSON: Do we then have a tile marked at 196 with denotes a desaturation of [Baby J]?

TYNDALL: Yes.

JOHNSON: At 197 we have Dr Gibbs' notes for that event, which he will deal with when he gives evidence.

TYNDALL: Yes.

JOHNSON: 198. Do we have a retrospective nursing note signed both by Mary Griffith and Lucy Letby?

TYNDALL: It's created by Mary Griffith, but it refers Lucy within the text.

JOHNSON: I've misread that then. Lest I have misled anyone let's just look at how it appears so that no one gets the wrong impression as a result of anything I've said. Can we look at the original, please, Mr Murphy?

So this is a note timed at -- made at 7.11 but the time referred to is 06.56; is that right?

TYNDALL: Yes.

JOHNSON: Is this where it says:

"[Baby J]'s monitor went off at 6.56, myself and L Letby attended"?

TYNDALL: Yes.

JOHNSON: Then it sets out what happened?

TYNDALL: Yes.

JOHNSON: Okay. If we could return to the carousel, please, Mr Murphy. Tile 199 is some door entry data relating to Laura Eagles?

TYNDALL: Yes.

JOHNSON: At tile 200, the neonatal infusion prescription chart records the administration of sodium chloride; is that right?

TYNDALL: Yes, signed for by Lucy Letby and Mary Griffith.

JOHNSON: Thank you. And reference made in the nursing notes to this event as well at tile 201, made by Mary Griffith?

TYNDALL: Yes.

JOHNSON: Then at the time that the notes, or some of the nursing notes, were made at tile 202, the time itself being 7.11, but the entries being the ones we've just been looking at?

TYNDALL: Yes.

JOHNSON: So retrospective entries made at that time but to or in respect of events earlier.

At tile 203 is there a record made by Laura Eagles and/or Nicola Dennison concerning a telephone call made to [Baby J]'s parents?

TYNDALL: Yes, I believe it's made by Nicola Dennison recording the fact that Laura Eagles has called [Baby J]'s parents.

JOHNSON: It may well be the telephone call that [Mother of Baby J] told us about earlier this afternoon.

At 204, timed at 07.20 and at 205, at the same time, do we have two parts in effect of the same chart recording fluids that were administered to [Baby J]?

TYNDALL: Yes, the first one is the prescription, the second one is the entries on the chart.

JOHNSON: Thank you. Again, is one of those signed by Lucy Letby?

TYNDALL: Yes.

JOHNSON: Do we then have the second of two events, timed after 07.20, but just before or at 07.24?

TYNDALL: Yes.

JOHNSON: Again, these are covered, as we can see in the next tile, 207, by Dr Gibbs' clinical notes?

TYNDALL: Yes, and 208.

JOHNSON: And 208, thank you. Again, we'll await Dr Gibbs to elucidate that material.

At 209, is this an update made on the computer towards the end of the night shift by Nicola Dennison?

TYNDALL: Yes, this is her record of everything in the night shift.

JOHNSON: Yes. Do we have an entry made slightly later but relating to events at 07.40 by Mary Griffith --

TYNDALL: Yes.

JOHNSON: -- at tile 210?

Then at 211, timed at 07.50, Nicola Dennison's notes concerning contact she'd had with [Baby J]'s parents?

TYNDALL: Yes.

JOHNSON: Thank you. At 212, 07.58, some door fob records concerning Laura Eagles?

TYNDALL: Yes.

JOHNSON: Then at 8 o'clock, tile 213, the feeding chart entries made by Mary Griffith?

TYNDALL: Yes, it's a note just saying she's gone nil by mouth and that they have moved from the feeding chart to the fluid balance chart.

JOHNSON: Thank you. Then at 214, a record of the handover between 7.30 and 8 am?

TYNDALL: Yes.

JOHNSON: For this day shift, the designated nurse was Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: Is there then a series of records concerning various drugs that were given to [Baby J]?

TYNDALL: Yes.

JOHNSON: And these entries span the tiles 215 to 224?

TYNDALL: Yes.

JOHNSON: Some are for antibiotics, others for sodium chloride.

TYNDALL: Yes.

JOHNSON: And a final one for phenobarbital?

TYNDALL: Yes.

JOHNSON: At 225, 8.30 am, [Baby J]'s heart rate and other vital signs and data recorded?

TYNDALL: Yes.

JOHNSON: At 226, a chest X-ray reported on by Dr Boothroyd?

TYNDALL: Yes.

JOHNSON: Then at the end of the shift, so far as Lucy Letby is concerned, tile 227, which is a record of a door swipe data entry, timed at 8.55, relating to Lucy Letby using her pass at the neonatal entrance door?

TYNDALL: Yes.

JOHNSON: At 228, do we have a note timed at 09.00 made by Mary Griffith concerning the administration of the antibiotics that we had seen in that series of tiles a few minutes ago being prescribed?

TYNDALL: Yes.

JOHNSON: Then at 229, the fluid balance chart?

TYNDALL: Yes.

JOHNSON: And a record made by Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: 230, timed at 09.30, the observation chart recorded by Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: Then at 231 and 232, Dr Chang's clinical notes recording her examination of [Baby J] at that time?

TYNDALL: Yes.

JOHNSON: At 233 to 235, over a ten-minute period, were there some further text messages between Lucy Letby and Mary Griffith?

TYNDALL: There's two with Mary and one with [Nurse E].

JOHNSON: Sorry, you're quite right. The first, was Lucy Letby saying:

"Hope you aren't too late leaving. Thank you for all of your help."

And a return message:

"Thanks for your support."

TYNDALL: Yes.

JOHNSON: And Lucy Letby sent a message to [Nurse E] saying:

"Well, I would say have a good day. Hopefully they'll get someone sent out. What a pile of shite. Very disappointed with Eirian and I'd already said to Caroline when allocating maybe not to give you twins as she was heading for vent and lots going on (you were originally in 2) but oh well. See you later. Hope you get to eat at some point."

And then at 236, at 10 am, the fluid balance chart data filled in by Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: At 237, 10.23 hours, Lucy Letby texted Jennifer Jones-Key, saying:

"Wow, it turned manic. Left at 9.15 but others still there."

TYNDALL: Yes.

JOHNSON: Did Jennifer Jones-Key respond?

TYNDALL: "Warned you lol. Don't know what it is. It seems to be pear-shaped. Hope you're okay."

JOHNSON: Did Lucy Letby then respond at 239:

"[Baby J] went off then had 33-week twins born at home, 1 vented on handover plus a mountain of antibiotics. Eirian working clinical"?

TYNDALL: Yes.

JOHNSON: Followed by:

"Just feel bad on the girls walking into that. Only 4 plus 1 on then, 3 plus 2 tonight."

TYNDALL: Yes.

JOHNSON: Then at 241, timed at 10.30 am on the 27th, did Ailsa Simpson record [Baby J]'s vital signs?

TYNDALL: Yes.

JOHNSON: Is that followed in the sequence at 242 and 243 by two messages from Jennifer Jones-Key to Lucy Letby?

TYNDALL: Yes:

"Not like [Baby J]. But you can't allow for ones that just come. Good, she may realise what it's like now."

And then follows this with:

"Don't, it's been like that every shift so we've all had it."

JOHNSON: Did Lucy Letby then send a message to Jennifer Jones-Key at 10.34, tile 244, saying:

"[Baby J] fitting. May end up tubed. I don't know if she'll stay all day. She said she'd come until found cover but there literally isn't anyone. She didn't speak to anyone or offer to take over from night staff just started doing the ward care antibiotics, which I know is important, but felt when all that's going on, she could have taken over and helped out a bit more clinically rather than second checking antibiotics."

TYNDALL: Yes.

JOHNSON: That may be a reference back to Lucy Letby saying Eirian was working clinical.

TYNDALL: Yes.

JOHNSON: 245. Did Jennifer Jones-Key respond to Lucy Letby at 10.42 hours?

TYNDALL: Yes:

"Just setting off for Sheffield so may not reply. You need some sleep. That's not like her at all. Wonder if something happened."

JOHNSON: Yes. And then was there a further follow-up?

TYNDALL: Yes, saying:

"IVAB [which I assume is IV antibiotics] should be last. Our babies are first and they seem to be getting ignored at the moment. She should be relieving staff. She may realise what it's like."

JOHNSON: Did Lucy Letby send one back at 10.53, tile 247, saying:

"Thinking maybe sepsis. It's all just -- and I know everyone's trying their best but doesn't feel like Eirian is particularly pushing for help from elsewhere or mucking in herself. Oh well, we can only do our best. Have a good day. In bed now. Least I live so close!"

TYNDALL: Yes.

JOHNSON: Then tile 248 at 11 am, do we have a fluid balance chart filled in by Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: Followed half an hour later, at tile 249, by [Baby J]'s vital signs?

TYNDALL: Yes.

JOHNSON: At tile 250, a cranial ultrasound report for [Baby J], timed at between 11.55 and 11.59?

TYNDALL: Yes, that's the time of the images.

JOHNSON: Yes, thank you. At noon, the fluid balance chart completed by Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: At tile 252, 12.15 hours, Dr Chang prescribed a blood transfusion?

TYNDALL: Yes.

JOHNSON: 253, observations taken?

TYNDALL: Yes.

JOHNSON: Timed at 12.30?

TYNDALL: Yes.

JOHNSON: 254, the blood gas is recorded?

TYNDALL: Yes.

JOHNSON: Both by Ailsa Simpson. At 255, is there a text message from Jennifer Jones-Key to Lucy Letby?

TYNDALL: Yes, it says:

"Oh, okay. Can you let me know how she is later. Yeah, I totally agree and more staff will just go off sick."

Then the rest of the message is social in content.

JOHNSON: Yes. At 256, was a blood cross-match sample collected?

TYNDALL: Yes.

JOHNSON: Followed at 257, timed at 13.00 hours, by the neonatal fluid balance chart?

TYNDALL: Yes.

JOHNSON: Followed again at 258, timed at 13.20, by Dr Chang's clinical notes concerning Dr Brearey's review of the cranial ultrasound that had been taken of [Baby J] at just before noon?

TYNDALL: Yes.

JOHNSON: At 259, timed at 13.30, further vital signs recorded?

TYNDALL: Yes.

JOHNSON: 260, a record of the product which was used as part of the -- as the blood transfusion?

TYNDALL: Yes.

JOHNSON: 261, the neonatal fluid balance chart data recorded, timed at 14.00 hours?

TYNDALL: Yes.

JOHNSON: Then at 262, Dr Wright's report of an ultrasound taken of [Baby J], this one an abdominal ultrasound?

TYNDALL: Yes.

JOHNSON: At 263, is there a message sent by [Nurse E] to Lucy Letby?

TYNDALL: Yes:

"Jesus Christ! Gonna quickly get something to eat. Bernie's come down and taken A [that's a baby]. Transport just arrived for E and taking mine be after. I've got C as well. Eirian done all the antibiotics with Belinda and made cups of tea which no one

has really had time to drink apart from her. Trying to get a bed for [Baby J]. Hope you're sleeping well."

JOHNSON: Thank you. Were [Baby J]'s vital signs then recorded at tile 264?

TYNDALL: Yes.

JOHNSON: And then there are some clinical notes at 265, timed at 14.30, made by Dr Neame --

TYNDALL: Yes.

JOHNSON: -- concerning a discussion he had had with Mr Makin, who was a paediatric surgeon?

TYNDALL: Yes.

JOHNSON: That paediatric surgeon had reviewed the abdominal X-rays of [Baby J]?

TYNDALL: Yes.

JOHNSON: And advised what's described as conservative management?

TYNDALL: Yes.

JOHNSON: At tile 266, timed at 14.41, did [Nurse E] send a message to Lucy Letby saying:

"Oh, and Tony Chambers and some woman turned up earlier!"

TYNDALL: Yes.

JOHNSON: And then is there a record in the clinical notes made by Dr Brearey, tile 267, timed at 15.00 hours, concerning a discussion that he had had with Dr Wright concerning the ultrasound scan of [Baby J]'s abdomen?

TYNDALL: Yes.

JOHNSON: At 268, the fluid balance chart data recorded by Ailsa Simpson at 15.00 hours?

TYNDALL: Yes.

JOHNSON: 269, [Baby J]'s vital signs data recorded, timed at 15.30?

TYNDALL: Yes.

JOHNSON: Blood transfusion started at 16.10 hours, tile 270?

TYNDALL: Yes.

JOHNSON: At 271 and 272, both are observation records made by Ailsa Simpson concerning the blood transfusion that was being given to [Baby J]?

TYNDALL: Yes.

JOHNSON: Followed at 273 by a pharmacist with the surname Harwood, who has recorded the fact that [Baby J] had had a dose of teicoplanin?

TYNDALL: It says she had a loading dose but no further doses were prescribed --

JOHNSON: Yes.

TYNDALL: -- and to consider adding them.

JOHNSON: Thank you. So then at 274 and 275, more blood transfusion observations recorded by Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: At 276, the fluid balance chart readings recorded?

TYNDALL: Yes.

JOHNSON: At 277 and 278, more blood transfusion observations recorded?

TYNDALL: Yes.

JOHNSON: At 279 the fluid balance chart timed at 18.00 hours?

TYNDALL: Yes.

JOHNSON: And then a message sent by Lucy Letby at 280, timed at 18.06, sent to [Nurse E]. Can you help us with the content?

TYNDALL: "Gosh, it's mad! At least things are moving in right direction. Is it bit calmer now? Still only 5 tonight? Hope Tony got stuck in and helped out."

JOHNSON: Then do we have further observations concerning [Baby J]'s blood transfusion timed at 18.10, tile 281?

TYNDALL: Yes.

JOHNSON: The record of the fact of some social messages passing between Lucy Letby and her mum?

TYNDALL: Yes.

JOHNSON: At 283 and 284, prescriptions for cefotaxime and sodium chloride?

TYNDALL: Yes.

JOHNSON: The fluid balance chart record at 285, timed at 19.00?

TYNDALL: Yes.

JOHNSON: Together with [Baby J]'s vital signs at the same time?

TYNDALL: Yes.

JOHNSON: Then the sequence concludes with three tiles, tiles 287 through to 289, and the record made by Ailsa Simpson?

TYNDALL: Yes.

JOHNSON: Thank you. We can deal with those in due course if they become relevant.

At 290 was there a handover to the night shift of the 27th into 28 November?

TYNDALL: Yes.

JOHNSON: Was the designated nurse for [Baby J] on this shift Lucy Letby?

TYNDALL: Yes.

JOHNSON: Did Lucy Letby record [Baby J]'s vital signs and the data for the neonatal fluid balance chart at 8 pm?

TYNDALL: Yes.

JOHNSON: Those are tiles 291 and 292. Did Lucy Letby receive some text messages from [Nurse E] between 20.03 and 20.52?

TYNDALL: No, the first one is from [Nurse E] at 20.03. The next two are Mary Griffith.

JOHNSON: Thank you. Could you talk us through those?

TYNDALL: The one from [Nurse E] reads:

"Will you put [my] half hour tea break in the time owing book?"

And then the one from Mary Griffith reads:

"How are things tonight? Is [Baby J] all right? Eventually left at 9.45 this morning, getting home at 10.30. Home you have a better night."

And then corrects this with:

"That should have read 'hope you have a better night'."

JOHNSON: At 9 pm, did Lucy Letby record [Baby J]'s vital signs and the data on the fluid balance chart?

TYNDALL: Yes.

JOHNSON: Jennifer Jones-Key then sent Lucy Letby a message saying, "Hope you're okay"?

TYNDALL: Yes.

JOHNSON: Further vital signs recorded at 22.00, tile 299?

TYNDALL: Yes, I think that's actually out of sequence.

JOHNSON: I think it is.

TYNDALL: Yes, it is out of sequence.

JOHNSON: We just need to correct that.

TYNDALL: Yes.

JOHNSON: Anyway, before that happened then, do we have text messages between Lucy Letby and [Nurse E] and Lucy Letby and Mary Griffith?

TYNDALL: Yes.

JOHNSON: We'll have to take this a bit more slowly because there's more than one conversation going on.

The first is from Lucy Letby to [Nurse E] and this is presumably a response to the earlier text from [Nurse E] saying:

"Will you put [my] half an hour tea break in the time owing book?"

Did Lucy Letby respond:

"Will do"?

TYNDALL: Yes.

JOHNSON: [Nurse E] then responded:

"Ta. Would have defo forgot by time came back."

TYNDALL: Yes.

JOHNSON: Did Lucy Letby then send a text to Mary Griffith at 21.30 hours? It's tile 302?

TYNDALL: Yes. It reads:

"You must be tired. Thanks for staying. Twins went to Arrowe so unit bit nicer. Still busy as only 5 on. [Baby J] quiet but hasn't done anything else abnormal and X-ray etc okay. Had a blood transfusion. I have her and your favourite baby!! He was screened today for high O2 requirement."

JOHNSON: And then did she send a further one saying:

"Ha ha, yeah"?

This is to [Nurse E]?

TYNDALL: This is to [Nurse E], yes.

JOHNSON: In response to:

"Would have defo forgot by time came back."

"Ha ha, yeah."

"Least you went out with a bang"?

TYNDALL: Yes.

JOHNSON: Did [Nurse E] then respond:

"Oh yes, [laugh out loud]"?

TYNDALL: Yes.

JOHNSON: And some social messaging from someone called Lorna Fisher to Lucy Letby?

TYNDALL: Yes.

JOHNSON: At 22.00 hours, fluid balance chart data recorded by Lucy Letby?

TYNDALL: Yes and the observations which were out of sequence.

JOHNSON: That's it, thank you.

Then at 22.33, did [Nurse E] send a message to Lucy Letby saying:

"Hope your night is better than last night"?

TYNDALL: Yes.

JOHNSON: Then at 23.00 hours, do tiles 308 and 309, have both [Baby J]'s vital signs and the data on the fluid balance chart?

TYNDALL: Yes.

JOHNSON: Those records completed again at midnight at tiles 310 and 311?

TYNDALL: Yes.

JOHNSON: There's some social messages recorded in the 15 minutes between midnight and 00.16 at tile 312?

TYNDALL: Yes.

JOHNSON: Followed by the fluid balance chart data completed again at 01.00 hours --

TYNDALL: Yes.

JOHNSON: -- at tile 313? And at 02.00 hours, tile 315, together with the observations at tile 314?

TYNDALL: Yes.

JOHNSON: At 316, [Dr A] examined [Baby J]?

TYNDALL: Yes.

JOHNSON: And again, he will be coming to tell us about that, so I'll leave his notes to him -- sorry, he isn't coming, I beg your pardon, that's my mistake.

Let's go back to that, please. I was reading from the wrong list.

Can you take us through [Dr A]'s notes, please?

TYNDALL: I am afraid there's some words in this I can't read because his writing is quite challenging. So:

"Asked to see patient re stoma output. Dark green liquid per [something I can't read] sediment [again I can't read that] but different to usual yellow transitional stool. On examination, pink, well perfused [then a little symbol which might mean zero or nil] temperature instability."

JOHNSON: "No temperature instability."

TYNDALL: "Heart rate 140. Reg heart sounds 1 plus 2 plus 0. Pulses normal. No respiratory distress. Vesicular sounds all zones. Abdomen SNT. No blood PO/PR. 60ml effluent collected. Impression [something I can't read] due to current antibiotic regime of teicoplanin and cefotaxime. Plan: (1) not to recycle current stoma output, (2) replace with 0.9% sodium chloride over 6 hours, (3) continue to slowly increase feeds based on total volume of 165ml/kg/day to achieve full feeds by 18.00 today, (4) 8 micrograms per kilogram of teicoplanin prescribed daily."

JOHNSON: Thank you. Do we then have a prescription for cefotaxime at 245?

TYNDALL: Yes.

JOHNSON: And Lucy Letby and [Nurse D] signed and co-signed for the administration of that?

TYNDALL: Yes.

JOHNSON: And the data on the neonatal fluid balance chart recorded at 03.00 hours?

TYNDALL: Yes.

JOHNSON: Tile 318, a prescription and then the infusion chart for the sodium chloride at tiles 319 and 320?

TYNDALL: Yes.

JOHNSON: Followed by vital sign data recorded at 04.00 hours, tile 321 --

TYNDALL: Yes.

JOHNSON: -- by [Nurse D]?

At 322, Lucy Letby and [Nurse D] at the same time signed and co-signed the neonatal fluid balance chart?

TYNDALL: Yes.

JOHNSON: The same form filled in an hour later at 05.00, tile 323?

TYNDALL: Yes.

JOHNSON: Followed by a nursing note update made by Lucy Letby at 05.06?

TYNDALL: Yes.

JOHNSON: Does this read:

"Written for care given from 20.00 hours to present. Emergency equipment checked. Fluids calculated. [Baby J] nursed in an incubator. Observations within normal range. Shallow breathing observed at times. [Baby J] pink and well perfused. Initially nil by mouth. Commenced enteral feeds and can increase as tolerated as per [Dr A]. Expressed breast milk given via NG tube. Minimal aspirates obtained. Abdomen soft and non-distended. IV fluids 10% glucose via Broviac. Dressing clean and clear. 60ml obtained from proximal stoma at 02.00 hours. Bile appearance. Registrar [Dr A] reviewed [Baby J]. Losses discarded and volume to be replaced with 0.9% saline over 6 hours. Commenced at 03.30 via Broviac. Proximal and distal stoma pink and active. Bowels not opened. Urine passed. Antibiotics given as prescribed. [Baby J] handling well."

Then:

"Parents had [Baby J] out for cuddles and pleased she's starting feeds. They are happier this evening and standard care being given to [Baby J]. Resident on the unit overnight"?

TYNDALL: Yes.

JOHNSON: Then observations taken at 06.00, tile 326, and the fluid balance chart at the same time?

TYNDALL: Yes.

JOHNSON: At tile 328, the infusion prescription chart, signed and co-signed by Lucy Letby and [Nurse D] relating to the sodium chloride infusion?

TYNDALL: Yes.

JOHNSON: A review by [Dr A] at 7 am --

TYNDALL: Yes.

JOHNSON: -- relating to the stoma output and the replacement of some light green aspirates; is that right?

TYNDALL: Yes.

JOHNSON: And his examination of the stoma?

TYNDALL: Yes.

JOHNSON: At 07.00 was the fluid balance chart completed?

TYNDALL: Yes.

JOHNSON: And then the final three entries for this chart, the nursing notes completed by Lucy Letby at 07.31, concerning an update being given to [Parents of Baby J] by [Dr A]?

TYNDALL: Yes.

JOHNSON: And then finally, the final note she made that is, concerning:

"A loss of 57ml obtained from the stoma at 6 am, plus leakage of the bag, bile stained."

And the fact that [Dr A] had been informed of that and the advice he had given?

TYNDALL: Yes.

JOHNSON: Then the very final entry, it's tile 333, made at 07.40 by [Dr A], concerning a discussion he had had about [Baby J] with a doctor at Alder Hey who had given -- who had made the suggestion that [Baby J]'s enteral feeds should be restarted and her, that is [Baby J]'s, aspirates should be observed --

TYNDALL: Yes.

JOHNSON: -- together with some advice about the stoma.

TYNDALL: Yes.

MR JOHNSON: Thank you very much.

My Lord, that's the conclusion of that sequence.

MR JUSTICE GOSS: It's not, there's a whole lot more messages, but we'll save those until Monday.

MR JOHNSON: Yes, it's the way it's been printed, it lulled me into a false sense of security.

MR JUSTICE GOSS: All right, thank you.

Members of the jury, 10.30 on Monday then, please.

Remember your responsibilities not to conduct any research about anyone or anything to do with this case and not to communicate with anyone outside your number when you're all together. So don't talk to anyone by any means about this case. Thank you very much. 10.30 on Monday.

(In the absence of the jury)

MR JUSTICE GOSS: Will anyone want to see --

MR MYERS: Yes, we'd like to, my Lord, if that's possible, please.

MR JUSTICE GOSS: Right. Thank you very much.

(4.09 pm)

(The court adjourned until 10.30 am on Monday, 13 February 2023)