

14 February 2023
Baby J

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

Tuesday, 14 February 2023
(10.30 am)

(In the presence of the jury)

MR ASTBURY: I call Nicola Dennison, please.

MS NICOLA DENNISON (sworn)

Examination-in-chief by MR ASTBURY

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

DENNISON: Nicola Anne Dennison.

ASTBURY: And your occupation, please?

DENNISON: Nursery nurse at the neonatal unit, Countess of Chester Hospital.

ASTBURY: Were you employed in that capacity in November 2015?

DENNISON: Yes.

ASTBURY: How long have you, as a matter of interest, been employed at the NNU at Chester?

DENNISON: Since 1985, barring a couple of years.

ASTBURY: Right, thank you. We've heard that nurses are given bands by way of categorisation.

DENNISON: Yes.

ASTBURY: What band are you and would you have been in November 2015?

DENNISON: I'm a band 4 and I'm a nursery nurse, not a registered nurse.

ASTBURY: Thank you. You've been asked about your involvement with a baby named [Baby J], back in November 2015. Did you complete a series of night shifts towards the end of that particular month?

DENNISON: Yes.

ASTBURY: And did you care for [Baby J] on those night shifts?

DENNISON: Yes, I did.

ASTBURY: Do you have a recollection of [Baby J]?

DENNISON: Yes, I do.

ASTBURY: What do you remember about [Baby J]?

DENNISON: She was a nice little baby. She was lively, she was alert, she was engaging. She also had medical concerns, which is unusual for our unit. She had stomas, she had a Broviac line, and as a band 4 it was unusual for us to look after that, but she was a well baby going home with those medical conditions, so was at that point of almost being ready for home.

ASTBURY: Right. We've heard a little bit about stomas and Broviac lines. Did you have experience of stomas and Broviac lines?

DENNISON: Yes, I did.

ASTBURY: Were you comfortable dealing with both of those features?

DENNISON: Yes, I was. Can I clarify though that we didn't do anything with the Broviac line, it was just present.

That was cared for once a week on Friday and that was dealt with registered members of staff.

ASTBURY: Thank you. That's a Broviac line --

DENNISON: That's the Broviac --

ASTBURY: I think the stoma (overspeaking) --

DENNISON: The stoma needed regular care. Feeds every 3 hours and that was a normal part of her care and was going to be a normal part of her parental care at home.

ASTBURY: Okay. With that in mind, at the stage that we are discussing, at the end of November, were her parents involved in her stoma care and her cares generally?

DENNISON: Yes, during the day when they were present on the unit.

ASTBURY: Thank you. I'm going to ask you about two of those night shifts, one in more detail than the other, but if we begin -- if you look to the right there's a screen which I hope will help. Have you had the opportunity to refresh your memory from the notes that you prepared back in November of 2015?

DENNISON: Yes, I haven't actually looked at the computer-written notes for a while, but I've had opportunity to read my statement.

ASTBURY: When you made your statement, did you have a look at the notes at that stage?

DENNISON: Yes, I did.

ASTBURY: Hopefully these will assist you. If we go first to tile 68, please. You mentioned a series of nights.

I think you actually cared for [Baby J] on the 25th into 26 November 2015; is that right?

DENNISON: If you say so. Looking at my notes --

ASTBURY: Let's have a look at your note and it might, I hope, jog your memory. This is -- in fact, I think it's the note above, thank you. If we look at that first note, 08.07 on 26 November. Does that suggest that was when the note was started on the computer?

DENNISON: Yes. It would have been written retrospectively, so if I was busy on the night shift I would -- when everybody's come on and I can find a quiet corner, I would then write my notes retrospectively for the nights that were done.

ASTBURY: We have heard that the handover would take from 7.30 to 8 and then you would have the opportunity to sit down and make up your notes?

DENNISON: Yes.

ASTBURY: We can see there that in those notes your initials appear, ND.

DENNISON: Yes.

ASTBURY: And you've entered, speaking of [Baby J] I assume, "Observations stable".

DENNISON: Yes.

ASTBURY: "No desaturations."

DENNISON: Yes.

ASTBURY: "No obvious problems from the stoma fistula."

DENNISON: Yes.

ASTBURY: "Handles well and has tolerated bag recycling and (inaudible) changes."

And is that:

"Has passed urine and bowels opened"?

DENNISON: Yes.

ASTBURY: And:

"Fed four-hourly by mum."

DENNISON: Yes.

ASTBURY: I know you mentioned the parents were helping with cares in the day. Does that suggest that at that stage mum was also helping through the night shift?

DENNISON: (Reads sotto voce.) Reading the notes of the 26th, it says "in the evening", so...

ASTBURY: Let's go on to the next note then if that informs.

You've completed that immediately after the note above.

You finished that at 8.18:

"Mummy and daddy did feed and cares together last evening. Mum has provided cares with support from staff overnight."

DENNISON: So mum must have been rooming in that night.

ASTBURY: And, "Happy with the changes put in place yesterday", whatever they may have been?

DENNISON: Yes, I can't remember off the top of my head.

ASTBURY: That's the conclusion of your night shift, the 25th into 26 November, and you touched on the next note. Is it right that you handed over to Nurse Ashleigh Hudson for the succeeding day shift?

DENNISON: If it says so.

ASTBURY: Okay.

DENNISON: I can't remember.

ASTBURY: She's completed the next note, we've got the benefit of the notes, but you don't remember?

DENNISON: No.

ASTBURY: Okay. You worked a night shift again, did you, on the 26th into 27 November?

DENNISON: Yes.

ASTBURY: Can we go next, please, Mr Murphy, to tile 129? We don't need to go behind that. We've had the benefit of the swipe data. And we understand to enter the neonatal unit you'd swipe a card on the security door and that would admit you. At 9.17 (sic), would that be consistent with type of time you'd turn up for a 7.30 shift?

DENNISON: Yes, thereabouts.

ASTBURY: Move on please to tile 140. We've a representation of the start of that shift (inaudible: coughing) to look at, please. In the top we can see the names of those people who were working, names I suspect you will recognise, but if we can go

through them. Dr Brearey and Dr Gibbs were the consultants respectively for the week and on call overnight.

DENNISON: Yes.

ASTBURY: The registrar and the SHO, we understand they change from time to time, so they may not be -- do you remember either of those as a matter of interest?

DENNISON: Um... no.

ASTBURY: Okay. They are again respectively Dr Austin and Dr Verghese. Moving on to the nursing staff, the shift leader that night was Caroline Oakley. As far as registered staff were concerned, Lucy Letby, Mary Griffith and Laura Eagles. Then if we go to the fourth box, we can see there that there were two nursery nurses, yourself and a lady named Vicky Blamire.

DENNISON: Yes.

ASTBURY: Scrolling up again, we can see the allocation of the babies that night if it assists you. Can you see that?

Do you need it enlarged a little bit?

DENNISON: No, I can see.

ASTBURY: Importantly for yourself, nursery 4, [Baby J].

You are designated nurse for [Baby J] and a second baby with the initials NW.

If we look at the rest of the plan, we can see that Lucy Letby was next door in nursery 3 with two babies.

And again, we can see the rest of the allocations through nursery 1, nursery 2 and a couple of unconfirmed babies. Do you recall being based in nursery 4 that particular evening?

DENNISON: Yes. At the time I gave my first statement I was unsure whether I was in 3 or 4.

ASTBURY: Right.

DENNISON: Once I'd got over the panic of being interviewed and had chance to reflect, I can confirm that I was in room 4 that night.

ASTBURY: Okay. You touched earlier on the stage that [Baby J] had reached in her treatment. What does nursery 4 inform you about that?

DENNISON: Nursery 4 usually reflects on a relatively well baby with not complicated -- getting ready for home, not requiring a nurse at her bedside all the time. At night we would add -- I do normal nursery hours, we would put them into the dark and get them ready -- just generally getting them ready for home.

ASTBURY: All right. From the parental note, it seems that mum was helping with some feeding through the night. Would that have been with the same goal in mind?

DENNISON: Yes.

ASTBURY: All right. We can go next, please, I hope to refresh your memory, to the nursing notes at tile 161. Before we click them, do you have any independent recollection of the shift and how it unfolded with [Baby J]?

DENNISON: Yes, I do, because I'd had her several times over and on that final night what was unusual for [Baby J] was I wasn't getting much in the way of stuff into her stoma bag for what we call recycling, re-feeding, which was unusual for [Baby J]. She usually had good quantities and we were using able to re-feed the distal stoma quite easily.

She was growing and doing okay --

ASTBURY: Right.

DENNISON: -- and I wasn't getting very much in the bag and she was a little bit quieter than normal and I'd already asked the doctors to review her. They said she was okay and to carry on feeding and the night then progressed.

ASTBURY: Are you able to recall at what stage of your shift that would have been?

DENNISON: It was around and about midnight-ish.

ASTBURY: All right. We'll go to some specific entries that you have made on various forms in a moment but I wonder if we can go to that nursing note, please. Just have a quick look at that, reacquaint yourself, and I'll go through it if I may.

DENNISON: Yes.

ASTBURY: So:

"Observations within normal limits and normal for her pre each feed"?

DENNISON: Yes.

ASTBURY: "Handles well and has woken for each feed. Has taken all feeds very well and settled after each feed."

DENNISON: Mm-hm.

ASTBURY: Then you have made your note:

"Nil in bag to recycle at first feed of the shift. Air released and distal stoma redressed as a little bloody."

DENNISON: Yes.

ASTBURY: Is that the type of care that would be required for the stoma on a --

DENNISON: Yes.

ASTBURY: Was that on a regular basis or is that an unusual thing to have to do with a stoma?

DENNISON: It depends, really. Sometimes it's okay, sometimes it just needs a bit more attention. The only thing that was unusual for [Baby J] was on her actual stoma was she had a fistula, so not only was she losing contents from the top of the stoma, she also had a little unusual hole to the side where it joins the skin. So this sometimes made the bag care a little bit difficult because it was making the bag wet where it shouldn't be. So very often the bags would slip or need redressing more frequently than you would normally expect a stoma bag to be redressed because the fistula was causing this to be wet and slippery.

ASTBURY: So you had to presumably have a seal for the recycling bag?

DENNISON: Yes.

ASTBURY: And that was being interfered with to an extent by leakage from the fistula?

DENNISON: Yes.

ASTBURY: That was something everyone was aware of and was --

DENNISON: Yes.

ASTBURY: Was that being managed?

DENNISON: Yes, and -- well, they decided that she wasn't losing anything internally in her abdomen, that it was all coming out,

either across the skin and/or into the bag, so they decided it actually wasn't causing her a problem.

ASTBURY: Right.

DENNISON: It just meant she was losing from two places.

ASTBURY: Then you've noted that there were 33ml to recycle at midnight.

DENNISON: Yes.

ASTBURY: Is that you were saying was a little less than (overspeaking) --

DENNISON: Yes, I'm about 4 hours adrift.

ASTBURY: Right, okay. In what way?

DENNISON: So I have said I thought it was about midnight that I didn't get anything. Obviously it was earlier that I didn't get anything and then I had a healthy volume to be able to process and recycle at midnight.

ASTBURY: Right, okay. It's between 8 and midnight when you had that concern there wasn't much coming through?

DENNISON: There wasn't as much as normal, but then obviously she's passed some so I've got some to be able to recycle.

ASTBURY: So a more normal situation at midnight?

DENNISON: A more normal amount for her.

ASTBURY: All right. Now, things, I think, moved on because at 4 am you have noted that [Baby J] became unwell after her feed.

DENNISON: Yes.

ASTBURY: And you have noted there:

"Desaturated to the 30s initially."

So is that a very low saturation?

DENNISON: That's a low number, yes.

ASTBURY: "Not apnoeic but then required some Neopuff to recover."

DENNISON: Yes.

ASTBURY: We've heard Neopuff is a delivery of oxygen to help the baby.

DENNISON: Or it's a breath, so it can be with oxygen or air.

ASTBURY: Okay. Did you administer that?

DENNISON: I will have started it until somebody came to help, yes.

ASTBURY: And do you remember what was administered?

DENNISON: No.

ASTBURY: Okay.

DENNISON: I said in my statement that I couldn't 100% categorically say that I would have started it but that would be a normal process if you found a baby that required support we would instigate it and call for help at the same time.

ASTBURY: Thank you.

MR JUSTICE GOSS: Sorry, there's no punctuation there and the way that it was put by Mr Astbury reads:

"[Baby J] became unwell and desaturated to the 30s initially, not apnoeic but then did require..."

Should it be:

"Desaturated to the 30s. Initially not apnoeic but then did require some puffs"?

Or what is it? It's not particularly important but do you see the point? Does the "initially" relate to the saturation to the 30s or the apnoea?

DENNISON: I'm not sure.

MR JUSTICE GOSS: Right.

DENNISON: I'm not sure. I wouldn't be using a Neopuff on a baby that was not apnoeic. But I would say maybe she was pausing but hadn't actually gone past the allotted 20-second mark that would trigger it as an apnoea but had dropped her saturations and then had gone on to require Neopuff.

MR JUSTICE GOSS: The point is you Neopuff when the baby's apnoeic and that's what happened here?

DENNISON: Yes, or if she wasn't responding once you'd just touched her -- nudged her to bring her out of whatever episode is happening and if that didn't respond and the saturations remained low we would then use the Neopuff initially with a breath and then, if required, we can add oxygen into that as well.

MR ASTBURY: So you have put there:

"Colour looks poor, pale and mottled."

DENNISON: Yes.

ASTBURY: That's an observation from 4 am?

DENNISON: Yes.

ASTBURY: And:

"Doctors informed and examined her"?

DENNISON: Yes.

ASTBURY: Now, that coincided with a feed at 4 o'clock?

DENNISON: Yes.

ASTBURY: Do you remember whether that feed was completed?

DENNISON: Not sure. I'd have to look at the feeding chart.

ASTBURY: Shall we have a look, please, at this stage the charts that you completed that night. If we can go first to tile 153. These are all in -- these documents we're about to look at are behind divider 13 in jury bundle 2 (inaudible) second one, 16280.

This is an observation chart which you will be more than familiar with, I'm sure --

DENNISON: Yes.

ASTBURY: -- and we're becoming increasingly familiar with.

I want to ask you, please, just about the entries -- we can see the dates across the top and in slightly darker pen we can see entries at 20.00 hours, 24.00 hours, midnight, and 04.00 hours, presumably into the 27th when we look at the dates.

DENNISON: Yes.

ASTBURY: If we scroll down to the bottom, do you recognise your initials at the bottom of those columns?

DENNISON: Yes.

ASTBURY: Are they the three in the slightly darker pen that I've drawn your attention to?

DENNISON: Yes.

ASTBURY: So we can see there, if we scroll back up, the general observations of heart rate, moving down, respirations and then temperature. Are the three readings you took all within the parameters that are considered safe and normal?

DENNISON: Yes.

ASTBURY: Scrolling down a little bit more, we can see that [Baby J]'s saturations were 100, 98 and 100 respectively.

If we go down a little bit further. We can see, as you pointed out earlier, nil and nil for the recycling at 8 pm when you first came on duty.

DENNISON: On shift, yes.

ASTBURY: But then we can see 33 at midnight, as you put in your notes. Then at 4 am, 40. So is that what you would hope to be seeing again?

DENNISON: Yes.

ASTBURY: All right. You then described [Baby J]'s stools, I think, as loose and yellow; is that right?

DENNISON: Yes.

ASTBURY: You have said "no" as far as a new bag was concerned, that wasn't necessary at that stage. Is that right?

DENNISON: Yes. On my middle one, I'd got some leakage.

ASTBURY: Right.

DENNISON: There's a Y there. That indicates that there was some leakage. So I obviously hadn't changed the bag, I was obviously able to clean it and contain it.

ASTBURY: Right.

DENNISON: Because we try and change the bag the least amount of times as possible because it irritates the skin.

ASTBURY: Okay.

DENNISON: So if we can not change a bag, it's preferable.

ASTBURY: So that gives us an idea of the stoma care over those 8 hours?

DENNISON: Yes.

ASTBURY: If we move on, please, to [Baby J]'s feeding chart at tile 142. So that's the 4 am feed which we were dealing with a moment or two ago. Is that your signature on the right-hand side?

DENNISON: It is.

ASTBURY: We've got:

"Passed urine and bowels open."

Working our way backwards, the route being B for bottle, is that?

DENNISON: Yes.

ASTBURY: 70ml?

DENNISON: Yes.

ASTBURY: Does that [Baby J] had --

DENNISON: She completed her feed.

ASTBURY: Was that completed before she fell ill or did she return to it after the doctors had seen her?

DENNISON: I think she had part-way, then was seen, then I was allowed to finish the feed.

ASTBURY: So whatever it was, the doctors were content for her to finish --

DENNISON: Yes.

ASTBURY: -- what she'd started?

DENNISON: Yes.

ASTBURY: All right. If we go back, please, to tile 142, we'll just look at the feeding chart for the first part of the shift. I think the last two entries on the right show the 8 o'clock and midnight feeds that [Baby J] was due.

DENNISON: Yes.

ASTBURY: We can see expressed breast milk, some donor breast milk and some fortifier; is that right?

DENNISON: Correct.

ASTBURY: Feeding normally?

DENNISON: Feeding normally and the -- on the right-hand side, where it says "bowels open", that indicates that the re-feeding of the distal stoma was working well as well because we were actually getting stools in her nappy as well as in her bag.

ASTBURY: There's two parts?

DENNISON: Yes. So what we're collecting, what we are re-feeding is obviously going through and going through regularly because she's had her bowels open most nappy cares.

ASTBURY: So despite that concern at 8 o'clock, certainly nothing to cause you to stop feeding [Baby J]?

DENNISON: No.

ASTBURY: And things were clearly remedied between midnight and 4 am?

DENNISON: Yes.

ASTBURY: Just for the sake of completeness, please, tile 154.

We've just gone to tile 154, that was the feeding after midnight. I don't think we need go to that.

After that 4 o'clock feed, do you remember where you were?

DENNISON: No.

ASTBURY: All right. Did anything else happen with [Baby J] during the course of that shift while you were still caring for her?

DENNISON: While she was still under my care, but not necessarily me in the room with her at each time, I know she had another episode where my colleague Mary had to attend to her and had

documented that she had lost colour and again needed some intervention. She desaturated but I wasn't present at the time.

ASTBURY: Okay. Can we go, please, to -- I want you to just have a look at tile 160, please. It's described as an apnoea/brady/fit chart. We can see [Baby J]'s name on the top. Those two signatures, do you recognise those?

DENNISON: They are both mine.

ASTBURY: So we've got two entries there, one at 4.40 and one at 5.03?

DENNISON: Yes.

ASTBURY: The first time at 4.40, do you remember both of those incidents?

DENNISON: I don't remember the second one.

ASTBURY: Well, let's just deal with the one you do remember. Is that the one you were describing to us when you weren't in the nursery?

DENNISON: I think one must have been when I was part-way through a feed when she became unwell and I held off feeding and got the doctors to review her and the carried on.

Whether she became poorly again after that...

ASTBURY: Do you think that might be an entry concerning the 4 am incident?

DENNISON: Yes, I think... Yes, maybe.

ASTBURY: Okay.

DENNISON: I'm not sure.

ASTBURY: All right. Just tell us about the incident you can remember then for now.

DENNISON: I know I attended an incident with [Baby J] where she'd lost colour and was desaturating and where she needed to be repositioned and then have Neopuff. But it's so long ago now it's just difficult to recall exactly what timings and exactly when.

ASTBURY: Okay. Have you had the opportunity to refresh your memory from your statement this morning?

DENNISON: I've looked at my statement this morning, but I had two statements for that baby. The first one was the first time I had ever been in a police station and was quite sort of anxious and didn't really know what was going to be asked of me. For the second one, I have had more time to reflect and I was able to make a few changes -- like in the first statement I was unable to confirm whether she was in room 3 or room 4, but I knew which position in the nursery she would have been in. But I just find it really difficult to recall, to be perfectly honest.

ASTBURY: Okay. Let's just deal with what you can remember for now then. You remember an incident where there was -- you tell me: you went to Mary Griffith in nursery 4; is that right?

DENNISON: I think I wasn't present at the time for one of those but Mary had answered the alarm. This looks like I've joined Mary who was already attending because I'm almost certain that Mary attended that alarm. But it looks like I've assisted her because I've signed the chart, but I might not have been the initial attender for the incident.

ASTBURY: Okay. Do you remember where you were?

DENNISON: No. As a nursery nurse, non-nursing member of staff, we are the ones that do the washing, the stocking up and various things, and many of those items are off the unit. So I could have been doing any of those duties.

But if I was going to be leaving the unit and not in earshot of the baby's alarms, I would have said on passing, can somebody listen out for [Baby J], I'm leaving the unit to do the washing or leaving the unit to go to the bathroom or I'm going to get some milk out of the stores, can -- whatever.

ASTBURY: Okay.

DENNISON: Then I would, in passing, ask somebody to listen for [Baby J]'s alarms.

ASTBURY: So you had left [Baby J] for a reason in --

DENNISON: Yes.

ASTBURY: Would you leave a baby -- does that assist you with the condition [Baby J] was in when you left her? Would you leave a baby who was, for example, still poorly or displaying any of the symptoms --

DENNISON: If she was desaturating or alarming, I wouldn't have left the unit at that time, so she was obviously in a stable pattern.

ASTBURY: Okay. I think you touched on it before, but just describe the nursery at night when you may have cause to leave a baby.

DENNISON: Babies who are in nursery 4 are usually getting ready for home or are on the end of their NICU journey. So we would try and replicate what a parent would do at home: lower lighting, less noise, no radios, and things like that, door partially ajar, so that the general noise of the unit corridors going by won't disturb that patient. And there isn't necessarily a nurse member sitting in that nursery overnight, but within earshot of any alarm that may still be present.

ASTBURY: Do you know how you became aware that Nurse Griffith was, presumably, at [Baby J]'s cot side --

DENNISON: She may well have shouted for support.

ASTBURY: Okay. When you went in, can you remember whether anyone else was in there?

DENNISON: No, I can't.

ASTBURY: Is that no one else was there or you just can't remember?

DENNISON: I can't remember, but I don't think anybody else would have been in there. Mary would have answered the alarm call because nobody else had answered it, ie I wasn't in the room or in the immediate area, so anybody would answer an alarm call if it was going on for any length of time. So that would have been answered and then she may well have shouted for help and if I'd come back from whatever I was doing at the time would have then gone on to answer Mary's call.

ASTBURY: Do you remember how long -- what was Mary doing when you went in?

DENNISON: I think she was just repositioning [Baby J], moving her, waking her up, moving the blankets so you could have a look at her properly.

ASTBURY: Okay. Go back to your nursing notes, please, tile 161.

If we just scroll down a little bit, please, we got as far as "Doctors informed and examined her":

"Further episode just after 5 am again requiring oxygen, though no apnoea this time."

DENNISON: Yes.

ASTBURY: Does that help you with what Mary Griffith was doing when you went in?

DENNISON: That would have been -- if there's no apnoea you probably wouldn't have Neopuffed at that moment. That would be if she'd desaturated, she would just be stimulating her, waking her, having a good look at her, removing the blankets, check she was breathing and that she'd got good colour.

ASTBURY: Okay:

"Decision made to screen [Baby J]. Taking cultures from both venous and Broviac line."

Who would make that decision?

DENNISON: The doctors on the back of having lost colour.

ASTBURY: "Doctors requested the 04.00 hours recycle is done."

Which I think we've just looked at on the observations chart. That was completed?

DENNISON: Yes.

ASTBURY: And we've seen the result of that, a further 40ml given without any issues. What's that reference to -- is that the entry we saw on the observations chart?

DENNISON: Yes.

ASTBURY: Okay:

"Stools at stoma site loose yellow. In the nappy, soft yellow stool with some form."

Is that correct?

DENNISON: Yes.

ASTBURY: What does "form" mean?

DENNISON: It means it's not as loose and sloppy as what we're getting in the bag, so it's very liquidy what we're getting in the bag, but by feeding it back through the distal stoma the gut then has a chance to process that, to get the additional nutrients to help the baby grow, because babies with stomas don't tend to grow terribly easily, terribly well.

ASTBURY: Right.

DENNISON: So they're given -- this is why we re-feed, they're given a second opportunity to absorb those nutrients, so once they've got all the nutrients out of it and have taken the excess liquid out of it, what comes out of the other end in the nappy is a normal poo for a baby, so it's soft and firm rather than, you know, sort of like with substance, rather than just liquid.

ASTBURY: Is that what that note means?

DENNISON: Yes.

ASTBURY: Thank you.

DENNISON: Which means the stoma's working well at that point.

ASTBURY: "Has passed urine (inaudible: coughing)."

DENNISON: Yes.

ASTBURY: "At that stage [Baby J] moved into nursery 2 for closer observations and a plan to omit the 8 am feed and run fluids via the Broviac line"?

DENNISON: Yes.

ASTBURY: Again whose decision would that have been?

DENNISON: Doctor's decision.

ASTBURY: And to commence cefotaxime and teicoplanin?

DENNISON: Yes.

ASTBURY: Both of which are antibiotics, we understand.

DENNISON: They are, yes.

ASTBURY: Thank you. At what stage was, do you recall, [Baby J] moved into nursery 2?

DENNISON: She moved into nursery 2 shortly after that second episode, after 5 o'clock, so somewhere between 5 and 6 she was moved into room 2. The thought was she was potentially had an infection, so she was moved to nursery 2 where we have an upgraded monitoring system in there and the lights would have been up and she would have had just general better observation, not in the dark and going-home room.

ASTBURY: Did you continue to care for [Baby J] once --

DENNISON: I didn't. Once she was moved across she then became nil by mouth and went on to fluids and was deemed to be perhaps not as stable as we were thinking. She then had a registered member of staff, but I'm not sure who took over her care.

ASTBURY: All right. Did you personally have any more contact with [Baby J] for the remainder of that shift?

DENNISON: Only for my own interest, just to see she was okay.

I popped in and out of the nursery on several occasions.

Also I did some of the running, the fetching and carrying for the registered member of staff so they didn't have to leave that area. So if they wanted some water to flush the line, I was free to go and get that for example. But I didn't do any more formal cares overnight for her.

ASTBURY: Are you aware of her progress for the remainder of the shift?

DENNISON: She became very, very unwell right on handover, between sort of 7 and quarter past, after which we had to get a consultant in to see her. She required further resuscitation -- and she did need a lot of resuscitation on that occasion.

ASTBURY: Right.

DENNISON: And the consultant did the work with her. We also queried whether she had fitted and she had medication accordingly for that as well.

ASTBURY: Just to complete your shift in a way, can we go, please, to tile 211 and have a look at the entry you made there.

Just the entry there at 07.50, so in fact a little earlier than you made your more detailed retrospective note that morning:

"Between 07.50 and 07.54, daddy enquired. At last pm had been informed that there was no stool to recycle at the first feed and that she was checked again after the feed. Informed him she had fed well and was very settled at the time of his call."

Do we assume from that that the call came before 7.15 because you then go on to describe what happened --

DENNISON: Yes, sometimes we can add several times or even open without filing them, so I would have -- so that would have been

the first part of my night and how it would have gone. Then I would have finished off with the final developments at 7.15.

ASTBURY: "At 07.15, Staff Nurse Laura Eagles called parents and informed them of the later developments this morning"?

DENNISON: Yes.

MR ASTBURY: Thank you. I have no more questions for you, but if you could wait there a moment.

Cross-examination by MR MYERS

MR MYERS: Could I just ask you, first, do you recall whether it was particularly busy that night or do you have no particular recollection of that?

DENNISON: I don't have any particular recollection. As I was around in nursery 4, I might not even know what was going on in other rooms.

MYERS: Say if you don't recall these things by the way, but do you recall whether the doctor or doctors were required during the night for any other incidents on the unit?

DENNISON: I have no idea.

MYERS: Do you recall a pair of twins being brought in a bit later on in the morning, about 6 o'clock?

DENNISON: I have no idea.

MYERS: That's all right. I'm going to ask you first then about where [Baby J] was at the beginning of the shift and the reason for that.

DENNISON: Okay.

MYERS: It might help us if we have a plan out of the nursery.

We've got a plan of the way the neonatal unit is set up.

You'll find it in one of the files, which should be near to where you are -- we can assist, so if I can ask Mr Murphy to put up the plan of the unit. Thank you, he's ahead of me. We've got it on the screen, actually.

[Baby J] was in nursery 4 at the start of the shift, wasn't she, Nurse Dennison?

DENNISON: Yes.

MYERS: And that's where you were looking after her?

DENNISON: Yes.

MYERS: Is this right, that there's almost a route through the nurseries on the way home, if you like to think of it that way?

DENNISON: Some of them skip some of the rooms, but yes, they tend to be admitted into room 1 or are frequently admitted into room 1 and make their way round. Nursery 1 is normally your intensive care, with some high dependency.

Nursery 2 would very often be high dependency. And 3 and 4 is special care and getting ready to go home.

MYERS: Right. Is there any significance -- first of all, do you remember which position [Baby J] was in in nursery 4?

DENNISON: On the right as you walk in through the door.

MYERS: So we can all see this plan. If we imagine walking in through that door, so we are standing in the doorway, you being on the right as you are looking into the nursery?

DENNISON: Yes.

MYERS: And was she in the first position on the right?

DENNISON: Yes.

MYERS: The one nearest what we know is a window?

DENNISON: No, it's... Well, it is a window, it's a window into a corridor and there's cupboards underneath.

MYERS: Yes. So if we look at the doorway at nursery 4, above it we can see a pale grey bar that's been put on the wall, drawn on the wall --

DENNISON: Yes.

MYERS: -- on the plan. Can you see that? The cursor is on it actually. Mr Murphy is moving that little arrow round it.

DENNISON: No, that's the window.

MYERS: That's what I was going to ask you.

DENNISON: Sorry, that's the window.

MYERS: That's the window into the corridor, isn't it?

DENNISON: Yes.

MYERS: And --

DENNISON: Can I just say that door swings the opposite way.

MR JUSTICE GOSS: You're not the first person to point out the inaccuracies of the plan.

DENNISON: So basically the door swings that way (indicating) because a baby on an alarm would be where you can glance through an ajar door and you would be able to see her monitoring without disturbing the patient.

MR MYERS: That's it. So we've had that, as his Lordship says, the door is actually the other way.

DENNISON: Swings the other way.

MYERS: So you go in and [Baby J] was in that first position on the right-hand side --

DENNISON: Yes.

MYERS: -- nearest to the window that looks into the corridor?

DENNISON: Yes.

MYERS: And you were just saying why a baby on monitoring is put in that position. Could you just explain that in a bit more detail?

DENNISON: She will have had a monitor either on a locker top beside her or on the bottom of her cot, depending what equipment she'd got around her. So you could have the door partially ajar, you could have the lighting down, but when you're walking past the corridor, you can glance in, check the monitoring is okay without actually disturbing her and doing unnecessary disturbance to a child who's prepping for home.

MYERS: Does it also follow, because the baby's near the window and the doorway -- first of all, it's quick to get to the baby if you need to; is that right?

DENNISON: It's more for observation.

MYERS: Right. You can also get some light coming into the cot in that position, can't you?

DENNISON: From the doorway.

MYERS: From the doorway. And from the window?

DENNISON: From the corridor. We do have blinds on the window so I can't say whether the blinds were down or not. Just because there's a window doesn't necessarily mean you could see through.

MYERS: But the purpose of having a baby in that position is so you can see the monitor easily from the corridor?

DENNISON: Yes.

MYERS: And so you get the light through the doorway and through the window so you can see the baby?

DENNISON: Yes.

MR JUSTICE GOSS: I think she's just qualified that by saying you wouldn't get light through the window if the blind was down (overspeaking) but you rolled all that up into one.

MR MYERS: If the blind is up then light comes in through the window, doesn't it?

DENNISON: Yes, but we may have the blind down at night to stop too much light getting to the baby.

MYERS: Yes, that's right. Could I just ask you to have a look at your statement, please, at page 2693. I'm not expecting you to find 2693, it will appear on the screen in a moment when Mr Murphy's found it for us.

If you take a look, it should be just for you to see, Mrs Dennison, and his Lordship and the barristers.

Can you see the first paragraph that says "on reflection now"?

DENNISON: Yes.

MYERS: "On reflection I can now confirm the night shift..."

DENNISON: Yes.

MR JUSTICE GOSS: So this is the second statement?

DENNISON: I was just going to say, this is the second statement, once I'd had chance to process in my head.

MR MYERS: What you say is this, just looking at that paragraph:

"[Baby J] was in nursery room 4, situated in the first cot or incubator on the right-hand side as you enter the room."

Don't you?

DENNISON: Yes.

MYERS: "Prior to this, she was moved from nursery room 3 from the exact same cot position and into nursery 4 in preparation to be for discharged"; yes?

DENNISON: Yes.

MYERS: "The reason I am sure of [Baby J]'s position is because any baby with unusual difficult or complex needs is always placed near to the window and the doorway..."

That's what you say, isn't it?

DENNISON: Yes.

MYERS: Then you give the reason for that as follows:

"... so the staff can see and reach them quickly should there be a need."

DENNISON: Yes.

MYERS: So it is to help with observation of the baby, isn't it?

DENNISON: Yes.

MYERS: Yes. Thank you very much for that, Mr Murphy.

Just to help us all picture it, I'm going to ask if we can put up page J124, which is a photograph of the corridor, just so we can all see it, Mrs Dennison.

We've just seen the plan, so hopefully that's in our minds, but do you recall this is the scene?

DENNISON: Yes.

MYERS: But obviously when there's babies and staff, there's people moving about and it's occupied, isn't it?

DENNISON: Yes.

MYERS: The desk at the front right, is that the nurse -- what we've called the nursing station?

DENNISON: Yes, it is.

MYERS: And in fact, as we look at the windows and going up the corridor, are those nurseries 2, 3 and 4?

DENNISON: Yes.

MYERS: There's an example of the blind down on one window, isn't there, nursery 2?

DENNISON: Yes.

MYERS: And then blinds up on nursery 3 from the look of it?

DENNISON: Yes.

MYERS: We can't tell with nursery 4.

DENNISON: I think it looks about halfway.

MYERS: All right. But that's the arrangement as we go up the corridor?

DENNISON: Yes.

MYERS: The same principle applied, did it, with the cots in each nursery that the first one on the right is nearest to the window?

DENNISON: Yes.

MYERS: And that assists with observation?

DENNISON: Yes.

MYERS: Thank you. We can take the photo down, thank you very much.

You described to us that after [Baby J] had been moved, she went to -- she was moved to nursery 2 from nursery 4?

DENNISON: Yes.

MYERS: And that was because, amongst other reasons, it was thought potentially she had an infection, potentially?

DENNISON: Yes. The thoughts were she was acting like a baby that could have an infection.

MYERS: You made a comment with regard to nursery 2 about there being upgraded monitoring and the lights up.

DENNISON: Yes.

MYERS: Could you explain just so we can have a little more detail?

DENNISON: So we have larger monitors in there, known as Philips monitors, that we could put ECG leads on, which is over and above and extra from the light probe monitor that she would have had in room 4.

MYERS: When you say the lights are up, what were you describing then?

DENNISON: They just would be fully on, so she could be seen and monitored at all times.

MYERS: Because nursery 2 is a higher level of care, isn't it?

DENNISON: Normally, yes.

MYERS: Thank you. I'm going to move next to your involvement with [Baby J] that evening, Mrs Dennison.

DENNISON: Okay.

MYERS: The only thing that you had identified as unusual prior to the events we're looking at was the way that the stools or the faeces didn't seem to move through her in the way it normally did at one part of the shift --

DENNISON: Yes.

MYERS: -- in the early part of the shift.

DENNISON: That's correct.

MYERS: One concern that you had was whether the stools, I think you put it this way, were stagnating inside her body; is that something that bothered you?

DENNISON: That's a possibility.

MYERS: Although, as we move on, it seems that it began to work better?

DENNISON: It worked better.

MYERS: Yes. It is difficult, isn't it, going back without the notes to remember exactly what happened and when and with who, would you agree?

DENNISON: Totally.

MYERS: Yes. Would it follow that what you've put into the notes, as much detail as you've put there, is probably about as accurate as you can be as you go back now?

DENNISON: It's what I would have said at the time.

MYERS: I'd just like to look at the notes and at the apnoea chart and just see exactly what they can tell us, if that's all right. Thank you. So I am going to ask Mr Murphy, first of all, to put up tile 161. We're looking at the entry that you made the following morning at 07.37. We've just seen this, Mrs Dennison. I'm going to go straight down about eight lines where it says "shortly after the feed". Can you see that?

DENNISON: Yes.

MYERS: Let's see what you wrote actually at the time:

"Shortly after the feed at 04.00 hours [Baby J] became unwell and desaturated to the 30s."

Then there's been a query about what the word "initially" applies to:

"Initially not apnoeic but then did require some Neopuff to recover. Colour looks poor pale and mottled. Doctors informed and examined her."

Then we have:

"A further episode just after 5 am again requiring O2, though no apnoea at this time. Decision made to screen [Baby J], taking cultures..."

So that's the passage we're looking at.

DENNISON: Yes.

MYERS: The first thing is, does that describe two separate events in effect?

DENNISON: Yes, it does.

MYERS: If we look at the first part of that:

"Shortly after the feed at 4.00 hours, [Baby J] became unwell and desaturated to the 30s."

You've been asked questions about how the feed went.

Can you assist us with whether you had completed the feed and then she desaturated and became unwell or whether it was part-way through? Just from looking at what that says.

DENNISON: If it's "after the feed", I would say the feed had been completed.

MYERS: Right. So certainly from the note, that appears to be what's happened?

DENNISON: Yes.

MYERS: So the feed was completed and she became unwell and desaturated. If we carry on, that event finishes with the line:

"Doctors informed and examined her."

Can you see that?

DENNISON: Yes.

MYERS: Do you recall whether the doctors were informed and examined her after both events or just at that point from your recollection?

DENNISON: I would think initially after the first event.

MYERS: Yes.

DENNISON: Because later on, I've then said that the recycling from the stoma is done, so I would have possibly held off the stoma recycle. We tend to do the bag changes and the nappy changes at the end of the feed so they can be as comfortable as possible for as long as possible when they've got a stoma because they get gas in there. So to keep that down, I would do that after the feed is done. If she'd had an unwell episode, I would have left that for the doctors to decide whether I re-feed that stoma or not. I have put that the 4 o'clock recycle is done, so that would have been the doctors' request that that would have been carried out.

MYERS: Putting this together, for the first episode, the doctors are informed and examine her, and then another episode and again the doctor or doctors attend?

DENNISON: Yes.

MYERS: That's probably what happened?

DENNISON: I would think so.

MYERS: Right. Do you use a swipe card to come on and off the unit when you leave the unit?

DENNISON: Yes.

MYERS: We've got swipe data that we've seen and, just to cut through it, certainly what we have doesn't suggest you'd come back on to the unit between 3 to 5 o'clock.

DENNISON: But if I left my swipe at the desk, I can buzz and somebody could let me in and out of the unit.

MYERS: So you can't be sure where you were at that time?

DENNISON: No.

MYERS: Anyway, you were with [Baby J] on the first event, that's right, isn't it?

DENNISON: Yes.

MYERS: For the second one you believe you were not with her?

DENNISON: I believe I joined Mary.

MYERS: You joined Mary. Do you recall the alarm sounding on either of those events?

DENNISON: No.

MYERS: You don't?

DENNISON: No.

MYERS: Do you recall any point when Mary attended and the doctors came very soon after her?

DENNISON: I think we would have just called the doctors because she'd had yet another episode.

MYERS: Right. If I describe a situation where the alarm goes off and then Mary attends with doctors almost at the same time, does that match with anything you recall or not?

DENNISON: I can't say that I remember that.

MYERS: All right. When [Baby J] was moved to nursery 2 after the second episode, was it Mary then, so far as you know, who took care of [Baby J]?

DENNISON: I'm not sure who took over her cares.

MR MYERS: Thank you, Mrs Dennison.

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

Questions from THE JUDGE

MR JUSTICE GOSS: Only this. It's just to -- could you put up tile 162, please, Mr Murphy, which is the apnoea/brady/fit chart that you were asked about.

DENNISON: Yes.

MR JUSTICE GOSS: You have completed all the handwriting that's on that document?

DENNISON: Yes.

MR JUSTICE GOSS: Can you now recall whether you will have completed those two entries at or around the time of each event or later in the shift when you made up your nursing note?

DENNISON: No, they would have been done at the time and I will have done the first one and I probably have written up the episode that Mary attended on the second one, so while I will have done the documentation for that second episode...

MR JUSTICE GOSS: So the first episode, which you say you were present at --

DENNISON: Yes.

MR JUSTICE GOSS: -- you have written "yes" to an apnoea, brady, duration 3 minutes, 100% Neopuff?

DENNISON: Yes.

MR JUSTICE GOSS: Then the second event at 05.03, no apnoea, desat to 30s?

DENNISON: Yes.

MR JUSTICE GOSS: Two-minute duration?

DENNISON: Yes.

MR JUSTICE GOSS: 100% oxygen and then facial?

DENNISON: Yes. So because she wasn't apnoeic, she was actually breathing, but obviously not efficiently enough. But instead of actually doing positive breaths with the Neopuff, just turn on the oxygen so that the breaths that she's making for herself, she then takes as extra oxygen and that will bring her saturations up by herself rather than us doing a physical breathe for her.

MR JUSTICE GOSS: All right. If we go back to the previous tile, which are your nursing notes that you say you wrote in retrospect at the end of the shift, can you see:

"Shortly after the feed at 04.00 [that's the first incident], [Baby J] became unwell and desaturated to the 30s"?

DENNISON: Yes.

MR JUSTICE GOSS: So that's the first event, whereas in your apnoea chart you have put it for the second one.

DENNISON: I may have got my saturation numbers perhaps not quite right. But she did have Neopuff on that one.

MR JUSTICE GOSS: Right.

DENNISON: The further episode at 5, no apnoea, and she didn't have a Neopuff. That would have just been the facial.

MR JUSTICE GOSS: Right. So that's it. You think in these notes you may have got that muddled or...?

DENNISON: Maybe just the saturation numbers. This is where we're talking about the punctuation, whether the "initially"

was not apnoeic but may have become apnoeic to require the Neopuff. Whereas the second one, she wasn't apnoeic, but she probably had desaturated and just needed additional oxygen to aid her own respiration rate but didn't actually need physical breaths from the Neopuff. So we use the same piece of equipment but we can use it in two different ways.

MR JUSTICE GOSS: Right.

DENNISON: We can use it as a facial mask providing oxygen or we can actually use it with a seal, giving positive breaths.

MR JUSTICE GOSS: Yes. And you press it to give the breaths?

DENNISON: You press it to give a positive breath.

MR JUSTICE GOSS: Thank you. Do you want to ask anything?

Re-examination by MR ASTBURY

MR ASTBURY: In light of those observations, would the history at the time have been related to the doctor who attended and you described treating [Baby J] as a result?

DENNISON: I don't understand the question.

ASTBURY: So would the doctor who came along to treat [Baby J] be told what had just happened?

DENNISON: Yes.

ASTBURY: So it would have been related to the doctor at the time?

DENNISON: Yes.

MR JUSTICE GOSS: That's all, thank you very much.

This witness isn't required again?

MR ASTBURY: No, not anticipated.

MR JUSTICE GOSS: Thank you very much for coming and giving evidence this morning to us. You're free to go. Just in case, and it's not anticipated this will happen, but just in case you do have to come back at any stage, I can't think you will, would you not talk to anyone about anything to do with this case until it's all over?

DENNISON: Okay.

MR JUSTICE GOSS: Thank you very much indeed.

MR DRIVER: My Lord, the next witness, Dr Verghese, is immediately outside the court.

MR JUSTICE GOSS: Good, thank you very much.

DR KALIYILIL LUKE GEORGE VERGHESE (sworn)

Examination-in-chief by MR DRIVER

MR DRIVER: Could you state your full name, please?

VERGHESE: It's Dr Kaliyilil Luke George Verghese.

DRIVER: Dr Verghese, do people occasionally refer you to by the name of George?

VERGHESE: Yes, they can call me George.

DRIVER: Dr Verghese, as part of your training and as a senior house officer, did you do a six-month or so spell at the Countess of Chester Hospital between September 2015 and March 2016?

VERGHESE: That's correct.

DRIVER: Were you, do you recall, on duty on the night of 26 November into 27 November 2015?

VERGHESE: Yes, that's correct.

DRIVER: As you appreciate, I'm going to ask you questions about a patient by the name of [Baby J]. You have previously made a witness statement to the police in this regard. Prior to doing so, were you given and did you take the opportunity of refreshing your memory from the clinical notes written about that patient?

VERGHESE: I did.

DRIVER: Have you refreshed your memory from those notes again more recently?

VERGHESE: Yes, I have today.

DRIVER: We'll return to the notes in due course, but leaving them aside for a moment, do you actually remember the patient [Baby J]?

VERGHESE: I can't say I definitely do. I think I remember the night because it was a busy night, but I can't say for definite that I have full recollection.

DRIVER: Thank you. Leaving aside [Baby J], who we'll return to and focus upon in due course, was there anything exceptional about that night that caused it to lodge in your memory?

VERGHESE: I think, but I don't know whether it fits with the records, there were two twins born at home who were quite premature, who then needed a lot of intensive support that day. Normally, you'd be with the consultant with the sickest patient but I remember Dr Gibbs was with [Baby J] and I was with others because it was a busy shift.

DRIVER: Thank you. I am now going to draw your attention to that screen to your right where we have a presentational sequence of

events, a timeline, which also contains the actual notes made contemporaneously.

If we could begin, please, just to help the doctor orientate himself, with tile 158, Mr Murphy, which simply informs us that the swipe data records tend to suggest that you were moving within the unit at 04.10 that morning.

Tile 165, Mr Murphy. Well, 164. We can see at 05.03 -- if we click on that data behind tile 164 to begin with, so we know whereabouts within the hospital Dr Verghese was moving. We can see that according to the data, your swipe passed through the neonatal entrance doors into that part of the hospital.

Having refreshed your memory from the clinical notes that you wrote shortly thereafter, do you recall whether you went there as part of your routine or if you went there in response to a request to do so?

VERGHESE: Sorry, I don't directly remember the events, but from my notes I've put there that I was asked to see the patient, so it wouldn't have been a routine call/visit.

At that time of day, in a night shift, it would have been because I was asked to attend.

DRIVER: Let's click behind that tile and go to the doctor's own note. That, you've just described, is the ATSP note, shorthand for "asked to see patient".

VERGHESE: That's correct.

DRIVER: We can see the date 27 November 2015 and we can see the time at 05.15. Is that the time of your attendance, initial attendance, or is it the time of the writing up of the notes?

VERGHESE: That's a good question. I wouldn't be able to say.

I don't know.

DRIVER: Thank you. Do you recall whether you attended upon this patient once during that shift or more than once?

VERGHESE: I can only see one entry in the clinical notes. I may have been there with a senior, but if I was with a senior they would have documented or I would have documented on their behalf and I can't see any other entry by myself other than this.

DRIVER: Thank you. Moving on through the notes, and we'll consider the entries in your first paragraph that come before the O/E abbreviation for "on examination". In general terms and

knowing your own working practices as I'm sure you do, what would be the source of the information, the data and the description that is in this opening paragraph of yours?

VERGHESE: Okay. So everything prior to that OE abbreviation would be a record given by the nursing staff who were present, to kind of relay the most recent events as to why a patient might need seeing or has deteriorated.

DRIVER: So this in effect is the basis on which you were briefed as to the situation --

VERGHESE: Yes, that's correct.

DRIVER: -- that caused them to call for you to see patient?

VERGHESE: Yes.

DRIVER: And were you told therefore, reading through your note, that the patient, [Baby J], had had two profound desats?

VERGHESE: That's correct.

DRIVER: Then you better describe them individually. The first, to 30s, does that explain the degree to which she desaturated?

VERGHESE: I guess there would be objective numbers, but it may not be a true reading, as alluded to in my statement, and on the kind of qualifying criteria of my notes for each desaturation.

DRIVER: Thank you. I'll invite you to expand on that in a moment. First to 30s:

"Being handled during stoma cares."

Two related questions: why would you have noted that it happened while she was being handled due to stoma cares and, secondly, could you expand upon your notion of the true reading or not?

VERGHESE: Okay. So the sats monitor is measuring your oxygen levels in the bloodstream. It's an optical probe that has to have good contact with the skin. The machine would normally show you a signal strength to say that you have a good signal. So if there are any movement artefacts or any interference potentially, that desaturation or apparent desaturation on the monitor might not be true, hence it was then potentially trace related. Could there be a bit of doubt that that first desaturation was maybe not a desaturation at all but just because she was moving, wriggling while having her cares done? Could that have been why the monitor alarmed?

DRIVER: Picking up on your use of language there, we have on the one hand a true saturation, a true reading, and on the other, I think the phrase you used was a trace related.

VERGHESE: Yes.

DRIVER: And that is to convey the question of whether or not the probe is properly attached to the baby and therefore providing a reliable and accurate reading of the saturation levels?

VERGHESE: Yes. I guess I would say that it's an objective marker, but the second statement where she wasn't handled and then the rest of the clinical history given by the nurses is enough of a clinical concern, regardless of the desaturation, that further steps need to be taken.

DRIVER: As we've already established, you're receiving this information verbally from the nurse, you weren't present when either of these readings were taken?

VERGHESE: No, that's correct.

DRIVER: But you're just approaching with a degree of caution because she was being handled at the time?

VERGHESE: Yes, just that first statement, yes.

DRIVER: But by way of distinction, the reported second event was a desaturation to the 50s, which in your opinion would seem still profound?

VERGHESE: Yes.

DRIVER: And on this occasion, you established that the baby, as reported by the nurses, was not being handled at that point?

VERGHESE: Yes.

DRIVER: And so what conclusions did you draw from that?

VERGHESE: Again, it could still be trace related. So if the baby moved of her own volition, potentially that could lead to the monitor alarming and saying there was a desaturation, but it's more the things afterwards that probably are definitive -- kind of would give me concern. They said that the nurses had to intervene and give some respiratory support, that the baby was pale and mottled afterwards and was working hard with her breathing. Those are all -- would make me concerned that these were potentially true desaturations. If they were trace related, she should be absolutely fine, she shouldn't have an abnormal colour, she shouldn't be working hard with her breathing, so in

the context it probably -- at least one of those was significant.

DRIVER: Thank you. Let's continue through the information provided to you. Her heart rate?

VERGHESE: Yes, that's an abbreviation, HR.

DRIVER: Take us through that note. Did that attach to the first of the profound desats, the second, both, or aren't you sure?

VERGHESE: I assume from my notes it would be from both of the desaturations. The heart rate remaining above 100, I guess, doesn't tell you -- it just shows that they weren't incredibly sick as in peri-arrest. Your heart rate would go up with a stress response so if it had gone up and it was above 100, that wouldn't tell me that they were sick or not, just that they weren't then peri-arrest and that they had desaturated and then become also then profoundly bradycardic or low heart rate. So it's a qualifying statement, but I don't think it tells you whether they're sick or not.

DRIVER: Could you define peri-arrest for us?

VERGHESE: Someone who is about to lose cardiac output and then need full CPR, cardiopulmonary resuscitation. So if your body doesn't have enough oxygen, then eventually your heart rate will drop and then fail.

DRIVER: You then noted, as reported to you, the other indicators that you've told us caused you concern, namely -- what's the first word?

"Since then pale and mottled."

So a reference to the baby's poor perfusion?

VERGHESE: Yes, that's correct.

DRIVER: "Increased work of breathing"?

VERGHESE: Yes.

DRIVER: And you contrasted that, did you, as reported to you, with the presentation prior to these profound desats?

VERGHESE: That's correct.

DRIVER: You read them to us and tell us what, if any, significance you attach to them.

VERGHESE: Just that she had been settled during the night prior to these events. She had not had any desaturations to that point. She had been feeding well and at that time there had been no kind of prior nursing staff concerns.

DRIVER: Thank you. So does that conclude the part of your note that records the information provided to you by the nurses or nurse who had requested your attendance?

VERGHESE: That's correct.

DRIVER: Thereafter do we go to your observations and examination of the baby?

VERGHESE: Yes.

DRIVER: How was she?

VERGHESE: So based from my notes, rather than recollection of the events, she was alert, her heart sounds -- that's the HS and then it's a diagram for 1 and 2, so normal heart sounds with no murmur. "Femorals x2", so that would be her kind of pulses, checking in the groin area, they were good volume. And her cap refill, which is one marker of her perfusion to her skin, where you put your finger on the skin and then take it away, was less than 2 seconds, which again was normal. So from a (inaudible) of her -- her cardiovascular status, she seemed to be stable.

I then proceeded to document my findings of the respiratory examination. That's where then the first kind of abnormalities were detected.

That sign for an arrow upwards and then RR is increased respiratory rate, so she was breathing fast.

Also I have then documented her work of breathing. One of the markers of respiratory distress is subcostal recession, just sucking in, drawing in the rib muscles underneath the bottom rib, and so that was just a marker that she was working harder.

I have then said she's got good air entry, so bilateral is both sides of the chest, and there was no added sounds to suggest a pneumonia or an air leak or something like that from clinical examination.

DRIVER: Thank you. So mixed indicators there, some negative, some otherwise?

VERGHESE: Yes. I would say generally, one of the most sensitive markers of someone becoming unwell is that their respiratory

markers would go up, would be one of the first things to go. You may be seeing -- you're seeing the start of a decline.

DRIVER: Then you turned your attention to her abdomen, did you?

VERGHESE: Yes, that's correct. So then it's a wee diagram of the tummy. Slightly different for her than the normal patients on that unit was that she had stomas, so intestines that were drawn up to the skin, because of previous bowel surgery. Then I've documented that her abdo or abdomen was soft, it wasn't painful, so non-tender, there was no masses that I could feel, her bowel sounds were normal, so that would be active. And there was no overlying skin changes that you might get with some surgical tummy complaints where the abdomen might become discoloured.

DRIVER: Putting them together, that was a satisfactory examination, was it, or satisfactory results upon examination, I should say?

VERGHESE: Of the abdomen, yes. The nursing -- I think it had been noted earlier in the week that she potentially had a fistula, so a small tract that shouldn't be there, in the front of the stoma. And I think the nursing staff -- it wouldn't have been noted by me, but me putting that would have been a nursing note that it was maybe bypassing more than previously, so maybe more liquid coming out of this fistula. Of that clinical examination, the only thing of concern was her respiratory findings and then the nursing report prior to my attendance.

DRIVER: So putting all that together, does your next note tell us that you queried the possibility of infection?

VERGHESE: That's correct.

DRIVER: And acting upon that, did you discuss with a Dr Austin -- is Dr Austin the registrar at the time?

VERGHESE: That's correct, yes.

DRIVER: You discussed with Dr Austin whether or not the baby should undergo a septic screen?

VERGHESE: That's correct.

DRIVER: And then you set out your plan. Take us through your plan, please.

VERGHESE: So again, [Baby J] was slightly different. Few of our patients would -- because of the recent surgery where she may have then had to be on artificial feeds through her venous system, she had a central line, so it would be a bit of plastic

that would be sitting in one of her larger vessels and it would be there for several weeks or several months. So normally, when you're doing a septic scene or an infection screen for a baby, you would put a new line in, a peripheral line, but the risk with something like that is that if there's a bit of plastic sitting in someone's body for a long period of time, it can become infected. So one of the sources for a potential infection, if it was infection, could be that it was coming from the central line, so hence why I have documented that we needed to take blood cultures both from the central line and also from a peripheral site as well. So that was the first step.

DRIVER: Thank you. So the potential site of infection there, you have just explained to us was the plastic itself, you contemplated --

VERGHESE: Yes.

DRIVER: -- and you wanted to investigate?

VERGHESE: I guess it's twofold: it changes where you take the sampling sites from and it also changes what antibiotics you give her because if it was a central line infection, the bugs can adhere a lot to the plastic line, it can be difficult to treat, so it would change what antibiotics you give the patient as well.

DRIVER: Thank you. You included in your plan, at point 2 a lumbar puncture.

VERGHESE: That's correct.

DRIVER: Which is a form of -- a more invasive form of testing for infection. I think you have looked further into the notes and you know that your senior colleague, Dr Gibbs, saw [Baby J] later that morning at 07.35; is that correct?

VERGHESE: Yes, that's correct.

DRIVER: Considering all that together, do you think that [Baby J] did actually undergo a lumbar puncture or not?

VERGHESE: I don't know. You'd have to have a look at the notes of the lab to know when her lumbar puncture was received.

But I know in Dr Gibbs' notes following mine, it says "LP later", and generally, because it is quite an invasive procedure and sometimes patients can decompensate when they're having a lumbar puncture, because as a neonate they might be being curled up into a foetal position, they might have desaturations of

their own. It was felt that with her work of breathing, it wasn't a safe time to do a lumbar puncture.

The lumbar puncture itself doesn't change the immediate treatment, it would still have been the same antibiotics, it just helps to guide the treatment down the line in terms of the duration of antibiotics and things like that. So it's always a risk/benefit and at that time it would have been felt the fact she was too unstable to have the lumbar puncture, we didn't want to worsen her clinical condition.

DRIVER: Thank you. At point 3, did you suggest that she should be -- intravenous antibiotics should be introduced into the patient?

VERGHESE: That's correct, after my discussion with Dr Austin, IV antibiotics -- and then I think in Dr Gibbs' notes he qualifies later which antibiotics.

DRIVER: We saw them yesterday, thank you. Then you made a plan as to some amendments to the feeding regime; is that correct?

VERGHESE: That's correct. Just if someone's working hard with their breathing and you don't know which way they're going to go, potentially you might need to support their breathing, you might need to intubate them and put a tube into their lungs and have a machine breathe for them. So there would be an increased aspiration risk if they have had recent feeds. That would be one reason and the other reason is if there is a lot of work of breathing, if your tummy becomes full or distended, it give less room for the lungs to inflate. So in her case where she's working hard with her breathing, the safest thing to do is to it make her nil by mouth, to stop feeds, and start fluids through the drip instead.

DRIVER: Thank you. That was the plan. Let's now consider what actually happened. If we could go to tile 170, please, Mr Murphy, and the documents beneath.

Does that accord with the plan that you drafted that morning?

VERGHESE: So that definitely is the -- from the documentation, the culture from the central line and that was taken, it says there, or documented on the form at 06.09.

DRIVER: Go to the next tile, Mr Murphy.

VERGHESE: That would have been -- that wasn't documented. It would have been standard practice to check (inaudible) infective markers and her inflammatory markers, so things like the full blood count and the CRP were taken that same night at 6.09.

DRIVER: That was ordered, it would seem, looking at the right side of that document, by your colleague Dr Austin with whom you'd be discussion [Baby J] and the issues at hand?

VERGHESE: I assume so. I can't recollect how they reported or how you ordered blood tests in Chester, but from that, yes.

DRIVER: Thank you. We know, and you've confirmed, that you're satisfied that Dr Gibbs prescribed the particular antibiotics that were deemed appropriate for [Baby J] that morning.

VERGHESE: I think off the top of my head it's my name on the electronic prescription, but it was him who suggested which antibiotics.

DRIVER: Let's go to tile 208. That might help us one way or the other. This is Dr Gibbs' clinical note. If we go down, this is the note you made reference to. Keep going down, please, Mr Murphy.

We can see there as part of his plan, as he confirmed to us yesterday, he indicated which antibiotics he deemed appropriate.

VERGHESE: That's correct, yes.

DRIVER: But you --

VERGHESE: I think I actually prescribed them after he'd asked what he wanted.

DRIVER: I'm grateful. If we go to tile 219 and 220, please.

These speak for themselves. They are a representation of nursing notes that demonstrate the nurses administering the drugs that you had prescribed in conjunction with Dr Gibbs.

Was it any part of your function to seek to discover the cause of the presentation that you were asked to come and consider?

VERGHESE: Um... I think I'm medically trained, I've never been forensically trained, so it would be looking for medical causes of a deterioration. In someone who's already on a unit and we've established the kind of greatest risk is infection or sepsis, and so it's making sure that they are stable, in a suitable place, and whether they require any other support, and then are you covering or investigating for infection and treating appropriately.

DRIVER: If there's any risk of infection, do you err on the side of caution?

VERGHESE: Yes, completely, with patients of this age group, their immune systems are very immature so they can decompensate very quickly. Unfortunately, the tests that we do at the time can't confirm infection, it's normally a few days down the line that you can maybe draw those conclusions, because even when you're doing those blood tests that were taken -- or marked as Dr Austin earlier, they can be normal in a patient who has sepsis. Some of those markers have a lag of 24 hours. So those first blood tests could be normal.

That's why we repeat them 24/36 hours down the line, so it would be a few days after you are building up the picture and you notice on that blood culture from the central line there is no growth after 5 days, so you only get that information kind of drip-fed to you down the line and id of putting all the pieces of the jigsaw together to find out what was the reason that she decompensated that first time I was called to her.

DRIVER: Did you continue to monitor the results a few days down the line or did that responsibility move to other colleagues?

VERGHESE: I don't think it's myself directly. I don't think I can see myself having put any entries after that date, so I would think it would have come through to other colleagues during the daytime.

MR DRIVER: Thank you very much. Could you remain there and answer any further questions.

MR JUSTICE GOSS: How long are you likely to be?

MR MYERS: I think probably about 10 or 15 minutes, my Lord.

MR JUSTICE GOSS: Are you happy to continue?

VERGHESE: I am, yes.

MR JUSTICE GOSS: Let's do that. We're going to have the break a little bit later. I'm anxious to complete this witness if possible.

Cross-examination by MR MYERS

MR MYERS: My Lord, yes.

Dr Verghese, we've seen two entry data slides, one of them for about 4.10 in the morning. That was the first one. Can we look at T158, please, so there can be no question.

Do you see, Dr Verghese, there, 4.10, that swipe entry data?

VERGHESE: Okay. Where is that for, sorry?

MYERS: For coming on to the unit.

VERGHESE: Okay.

MYERS: We also -- that's 4.10. We also saw at tile 164 swipe data for you coming on at 05.03. Sorry, that's the maternity ward. Can we look at T157 then, please?

04.09. That swipe data is for the maternity neonatal entrance doors.

VERGHESE: Yes, it seems to be.

MYERS: So 4.09. We also saw the data for 05.03 at tile 164.

That's maternity neonatal entrance doors, in.

VERGHESE: Yes. It seems to be the same for both.

MYERS: So we would seem to have you coming into the neonatal unit at 4.09 and 5.03?

VERGHESE: Yes.

MYERS: It might be very brief at 4.09 because there's the maternity ward at 4.10, we saw.

VERGHESE: I didn't see the maternity ward, but yes, that would be how you'd enter the maternity ward via the neonatal unit sometimes.

MYERS: When we look at your notes, and we're going to come back to them in a moment, we can see that there's two desaturation events that were described to you, weren't there?

VERGHESE: Yes, that's correct.

MYERS: Did you attend on two different occasions in response to those events?

VERGHESE: I don't believe so. As I say, I don't have a direct recollection of the events, but if I had entered -- attended them at two separate times, I would have normally documented the two separate events. Also there would have been a plan or something written from the first one, even if it was a watch and wait or -- I don't believe so from the notes.

MYERS: So your assessment of this is you will have attended on the one occasion?

VERGHESE: Yes.

MYERS: I'll come back to that.

As to the desaturation readings that you have been telling us about, Dr Vergheese, is what you're saying that the numbers alone do not necessarily indicate a desaturation at all?

VERGHESE: Can you just repeat that question once for me?

MYERS: Is your evidence that the number, the reading alone, does not necessarily indicate a desaturation?

VERGHESE: That's correct, yes.

MYERS: Right. Is it your evidence that you need to see if there are other indicators present which would demonstrate desaturation?

VERGHESE: I think it's about building a picture, so I think it would be a brave person, if there was clinical concern, irrespective of the later findings, that they mention the desaturations, I don't know because it wasn't the case with this one, but you may have to still treat that all the same, if it was just based on the desaturations alone and nothing else that came afterwards in terms of there being signs of her being unwell.

MYERS: You said when you were looking at the two readings that certainly the second one gives you concern because, first of all, she's not being handled. And you said also because of her being pale, mottled and requiring respiratory support.

VERGHESE: Yes.

MYERS: So if a baby is pale and mottled and needed respiratory support, that would tend to show it was a genuine desaturation?

VERGHESE: Probably.

MYERS: Probably. Let's look at your notes then, please, Dr Vergheese, which are at tile 165. Your recollection, you have said to us, is that you attended [Baby J] on one occasion.

We've seen you come into the unit at 5.03. You're nodding. You have to say yes or no.

VERGHESE: Sorry, yes.

MYERS: Or no if you want to. Your notes are made at 05.15, aren't they?

VERGHESE: That's correct.

MYERS: Does that suggest it's probably retrospective after you've dealt with whatever had to be dealt with?

VERGHESE: It may -- probably. As I say, I don't recollect the events, but it may be that I did all of that assessment and then have written the notes afterwards.

MYERS: And certainly you took a history from the nursing staff who were present, didn't you?

VERGHESE: Yes.

MYERS: And the nurse or nurses described two profound desaturations; yes?

VERGHESE: That's correct.

MYERS: They were clear that these are both desaturations, weren't they?

VERGHESE: Both episodes, they've said they had to give respiratory support, they felt these were true desaturations.

MYERS: And one of the things you've identified to us is that if respiratory support is required, that tends to support it being a true desaturation?

VERGHESE: Probably, yes.

MYERS: The first one is down to the 30s, yes, and that happened whilst being handled?

VERGHESE: That's correct.

MYERS: The second one was down to the 50s and that wasn't whilst being handled?

VERGHESE: That's correct.

MYERS: Were you familiar with [Baby J] as a baby on the unit?

VERGHESE: As I said before, I don't think so. I don't have any other entries from it. We maybe would have discussed her on a daily basis on a kind of pre-ward round meeting and things like that.

MYERS: Are you aware she was a baby who, because of her stomas, had to be handled regularly?

VERGHESE: To be fair, it'd be -- it wouldn't be my medical expertise. It would be more of a nursing thing as to how to care for patients with stomas in terms of what is needed from that point of view.

MYERS: When you attended -- sorry, where it says:

"Heart rate remained..."

Is that --

VERGHESE: "Greater than."

MYERS: "... greater than 100. Both episodes required bagging."

And it says:

"Since then pale and mottled with increased work of breathing."

Is that correct?

VERGHESE: That's correct, yes.

MYERS: I would like, just with what you have said, to look at the nursing note that was made by Nurse Dennison, which is at tile 161, keeping in mind what you've said about the overall circumstances. If we just enlarge down at the bottom, please, Mr Murphy, the same entry.

Can you see about eight lines down, it begins:

"Shortly after the feed"?

Do you see that?

VERGHESE: I do.

MYERS: Take your time just to read down.

VERGHESE: Yes, I've not read this before so just give me one minute.

MYERS: It's an entry by Nurse Dennison on 27 November 2015, made at 07.37.

(Pause)

VERGHESE: What was your question again, sorry?

MYERS: First of all:

"Shortly after the feed at 4.00, [Baby J] became unwell and desaturated to the 30s, initially not apnoeic but then did require some Neopuff to recover."

VERGHESE: Yes.

MYERS: "Colour looks poor, pale and mottled."

Are you aware Nurse Dennison is an experienced nurse?

MR JOHNSON: This is not a legitimate line of cross-examination.

MR JUSTICE GOSS: Well...

MR MYERS: Well, the question about pale and mottled and colouring, the doctor has said that we'll look at all the circumstances that go with it, and actually that's what I'm keen to identify.

MR JUSTICE GOSS: Well, yes. The doctor has said that he was told that the baby was pale and mottled.

MR MYERS: And factors like pale and mottled are factors that are consistent with a genuine desaturation, aren't they?

VERGHESE: Possibly.

MYERS: Possibly, right. Are you aware whether or not [Baby J] has a history of constant desaturations while being handled for her stoma care?

VERGHESE: As I said, I didn't know her regularly so I wouldn't have known. Could you remind me of the question you just asked?

MYERS: Are you aware whether or not [Baby J] had a history of desaturations while being treated for stoma care?

VERGHESE: No.

MYERS: Are you aware whether or not this is an exceptional desaturation for [Baby J]?

VERGHESE: What does exceptional mean in the context?

MYERS: Was in unusual for her to desaturate like this? Were you aware of that?

VERGHESE: I wouldn't know.

MYERS: You wouldn't know. So that might be part of something that forms the clinical picture of how significant it is, wouldn't it (sic)?

VERGHESE: Yes, if there was always a habit for it.

MYERS: We can see there the reference to the 30s. Can we go back to your note now, please, Dr Verghese, at tile 165.

I am being clear here, at the time you were told the first episode was down to the 30s, weren't you?

VERGHESE: Yes, that's correct.

MYERS: And you were told a second episode was down to the 50s?

VERGHESE: That's from the notes, yes.

MYERS: Yes. A sign or initial sign that a baby is unwell is if the respiratory markers go up, isn't it?

VERGHESE: Yes, that's correct.

MYERS: And, for example, saturations dropping to the 30s and requirement for bagging or Neopuff would be an indicator of respiratory markers going up, wouldn't it?

VERGHESE: Can you say that again once more?

MYERS: Desaturations going down to the 30s and a requirement for Neopuff is a sign of respiratory markers going up?

VERGHESE: So I guess I would say that the Neopuff being required is subjective. It would be the person who's caring for them at the time feels that it's required. It's not an objective marker. But yes, that someone feels that they need to give it would be of concern.

MYERS: And if the drop to 30s is genuine, that's a sign that a baby is unwell, isn't it?

VERGHESE: Yes, but again as I say, whether it was trace related or not or things like that, then it may introduce a bit of doubt.

MYERS: Yes. If there's a desaturation combined with paleness and mottling, that may be a sign that the baby is unwell as well, couldn't it be?

VERGHESE: Yes.

MYERS: Do you recall whether this was a particularly busy shift, Dr Verghese?

VERGHESE: If it's the night I'm remembering then it was, yes.

MYERS: Can I just check one thing before I move to that, dealing with your note still in fact. I am sorry to go back to it. Can we scroll down a little bit, please?

There we are, thank you.

You make a note there, is that "increased" -- next to the image of the chest area. Is that "increased subcostal recession"?

VERGHESE: It's "Increased respiratory rate" and then a full stop.

And then "subcostal recession", full stop.

MYERS: "Increased respiratory rate. Subcostal recession"?

VERGHESE: Yes.

MYERS: That also indicates some issue with being able to breathe and take in oxygen potentially, doesn't it?

VERGHESE: Not necessarily to take in oxygen, but yes, that they're having to work harder than normal.

MYERS: Which is another sign, potentially, of a baby being unwell?

VERGHESE: Correct. It could also be that your work of breathing can go up after a feed as well, so you know, it's a mixture of is it transient, if you have a feed it might come up. For them, for a baby the most exercise they would do when they are well is a feed, so it would be common that they might have markers of respiratory distress after a feed for a short period of time and then it settled down.

MYERS: Do you think all of this is due to a feed?

VERGHESE: No.

MYERS: You didn't think it was due to a feed, did you?

VERGHESE: No, but I do notice the discrepancy. I had put there about handling with cares and I note the nursing note says it was with a feed.

MYERS: You thought this might be infection or sepsis, didn't you?

VERGHESE: Correct.

MYERS: As to how busy the night was, did you have to attend other babies on the unit for whom calls went out for help that night?

VERGHESE: So again, I may be wrong, but if I remember rightly, that was the night when two 32-weeks twins were born at home in the community and brought in my ambulance, of which one of them had a congenital malformation and required intubation.

MYERS: Did you deal with that?

VERGHESE: I would have to -- as I say, I can't directly remember the events so I'd have to look at the notes of those other children to see whether I was involved.

MYERS: Was Dr Gibbs there to deal with that as well?

VERGHESE: Again, I'd have to look at those specific patient notes to see whether he was involved. But as I was saying before, if it's the night I remember, normally if there's one sick kid, both the registrar and the consultant and myself would all be there with the patient. And I don't remember being with Dr Gibbs while he was assessing [Baby J] because there were other sick patients that needed my care at the time.

MYERS: I'm going to ask if you can be shown page 8 of what's called our neonatal review. I'll let Mr Murphy take time to get there. It's just a record of events on the unit at the time. It's not is something you're expected to know, Dr Verghese, you won't have seen it before, but I'd just like us to look at page 8 of that review.

If we look over towards the right-hand side, you'll see a box where it says "Babies whose location is unconfirmed"; do you see that?

VERGHESE: Okay, yes.

MYERS: They've been put with initials so the identities of babies who are not actually part of this trial are dealt with sensitively.

VERGHESE: Okay.

MYERS: [redacted] were both admitted at 6.10 and 6.30.

VERGHESE: Sorry, the [redacted] there is not [Baby J], is it?

MYERS: No, no, it's a different --

VERGHESE: It's another baby with the same initials, same date?

Okay.

MYERS: Yes. Does it fit in with when it was that the twins came on to the unit, about that time?

VERGHESE: Again, I don't have direct recollection of the timing of the events, but that would make sense if they were both the same -- if it was twins that same day.

MYERS: Whilst we're dealing with this page, could we pull out and have a look at the entry for nursery 2. Can you see the initials DM and it's next to Mary Griffith from 21.45 hours? Do you see that?

VERGHESE: I see it, yes.

MYERS: Just having seen that, I want to take you to some notes relating to DM --

VERGHESE: Okay.

MYERS: -- who was with Mary Griffith from 21.45. Mr Murphy, could we put up 30078, please?

These don't relate to [Baby J], they relate to the baby DM. Is that your writing, Dr Verghese?

VERGHESE: That is my writing, yes.

MYERS: It's a note you make at 03.20. I want to identify this.

It says "Asked to see patient" -- is that "two desats"?

VERGHESE: That's correct.

MYERS: One to the 50s; yes?

VERGHESE: Mm-hm.

MYERS: And is that the time it would have happened, 22.20?

VERGHESE: I assume so from that entry.

MYERS: And one to the 60s --

VERGHESE: Yes.

MYERS: -- at 22.45? It seems to say "1.5h [or 1.3h] after feed".

VERGHESE: Yes.

MYERS: "Angry at time."

VERGHESE: Yes.

MYERS: Do you have any independent recollection of coming on to the unit at some point that night or early morning to deal with a baby other than [Baby J]?

VERGHESE: I don't recall the events, no.

MYERS: But just so we can get context, it's not unusual for you to be called to the unit to deal with desaturations or in response to desaturations of babies who are in care there?

VERGHESE: Correct.

MR MYERS: Thank you, Dr Verghese.

Re-examination by MR DRIVER

MR DRIVER: I wonder, Mr Murphy, whether we can go back to the population of the unit plan, please, and the box to the right that Mr Myers invited the witness's attention to.

You were taken to part of this plan that records that at 06.10 and 06.30, two babies, one with the initials [redacted], one [redacted], were admitted into the unit. You've made repeated mention to the event when two twins, born, your recollection, at 32 weeks in the community -- one of them with a congenital malformation, according to your evidence, that required intubation -- were brought on to the unit. Why does that stick in your mind?

VERGHESE: So normally, premature babies are born in hospital. So at 32 weeks, to be born at home is quite -- can be quite scary, you don't know what condition they're going to come in to you at. Then also patients born with congenital malformations as well, so a cleft lip is visible, that as well, I think, just maybe would stick in your head a bit more that night. And you'd sometimes remember a consultant coming in or things like that for a very sick patient. So I think it was just a combination of all those things.

DRIVER: Was this an urgent event, the arrival of these twins?

VERGHESE: From what I remember, yes. The paramedics brought her kind of through the delivery unit and straight into the neonatal ward.

DRIVER: And can you remember where within the neonatal ward these babies were taken?

VERGHESE: Generally speaking, the sickest babies would go to nursery 1; that would be the intensive care. So I could only think that they would have both been admitted to nursery 1 to be stabilised and then assessed.

DRIVER: And according to the document that your attention was drawn to, these events took place at 06.10 and 06.30.

If we could go back, please, just to remind ourselves of the chronology with [Baby J], if we could go, please, to tile 165 and the note behind that.

Your note -- your examination of [Baby J] took place at 05.15. If we go to tile 197, please, and click on to that. It records Dr Gibbs' note that we looked at earlier to confirm the antibiotics, a note written at 07.35 about events at 06.56 and 07.24.

VERGHESE: Mm-hm.

DRIVER: Putting that chronology together, your examination of [Baby J], the admission of these two babies who share a last initial and then Dr Gibbs' examination of [Baby J], does that assist you as to whether it was the same night or not?

VERGHESE: I'd have to see the notes of those other two to be sure.

It's suggestive but I wouldn't say definitely.

MR DRIVER: Thank you. If you can't help us any further, then so be it.

Does your Lordship have any questions for the witness?

MR JUSTICE GOSS: I don't, thank you, Dr Verghese. That completes your evidence. Thank you very much for coming and giving it. Not required again?

MR DRIVER: Not required again.

MR JUSTICE GOSS: All right, thank you very much.

(The witness withdrew)

MR JUSTICE GOSS: I'm sorry that we've sat later and you've seen the doctor leaving as quickly as he can. He's not been well, that's why I was anxious for him to complete his evidence as quickly as he could. There was a risk he would have to leave the court as an emergency. So that's why I was keen to get him through as quickly as possible. Do you want a break now? Does anyone want a comfort break, I'm thinking? Yes. We will just have a ten-minute break and then we'll see where we get to around 1 o'clock. We'll just have that ten-minute break, thank you.

(12.28 pm)

(A short break)

(12.38 pm)

MR JOHNSON: My Lord, Dr Dewi Evans, please.

DR DEWI EVANS (recalled)

Examination-in-chief by MR JOHNSON

MR JOHNSON: For the sake of the record, would you identify yourself, please?

EVANS: Dr Dewi Evans.

JOHNSON: Thank you. In the case of [Baby J], you have written several reports; is that correct?

EVANS: I have.

JOHNSON: Was your first sift report dated 16 November 2017?

EVANS: Correct.

JOHNSON: Was your more substantive review 31 May 2018?

EVANS: Correct.

JOHNSON: Did you then produce some further reports dealing with several issues, some of which we won't deal with today?

The third report was 17 October 2021.

EVANS: 24 June 2021. Then 17 October 2021, yes.

JOHNSON: I always make a mistake with this. Thank you. Was there a final --

EVANS: 21 October 2021.

JOHNSON: Thank you very much. Just to reset our minds so far as the chronology is concerned, I'd like to go to your report of 31 May 2018, please. Do you there reproduce various uncontroversial facts, namely that [Baby J] was born at 15.00 hours on 31 October 2015?

EVANS: Yes.

JOHNSON: Her birth weight was 1,709 grams?

EVANS: Correct.

JOHNSON: When she was born, she was 32 weeks and 2 days' gestation?

EVANS: Yes.

JOHNSON: And you then gave this particular case your reference 14, and it follows from what you've told us before that means hers was the 14th case that you reviewed?

EVANS: Yes.

JOHNSON: As part of -- in order to carry out your review, did the police send you copies of medical records from the Countess of Chester Hospital?

EVANS: Yes.

JOHNSON: The Royal Manchester Children's Hospital?

EVANS: Yes.

JOHNSON: Alder Hey Hospital?

EVANS: Yes.

JOHNSON: And those records included X-rays?

EVANS: Yes.

JOHNSON: Did you note the fact that [Baby J] was admitted at birth to the Countess of Chester but within a few hours was transferred to Alder Hey Children's Hospital in Liverpool?

EVANS: That's correct, yes.

JOHNSON: There she had the bowel operation that we've been told about?

EVANS: Yes.

JOHNSON: She returned to the Countess of Chester on 10 November?

EVANS: Yes.

JOHNSON: And do you then reproduce various excerpts from the notes?

EVANS: I do.

JOHNSON: In particular, 16 November, recording the fact that she was producing:

"... greenish output, loose in consistency, from her stoma"?

I think that's your paragraph 9.

EVANS: Yes.

JOHNSON: Her weight had increased?

EVANS: Yes.

JOHNSON: And you move on to your paragraph 10, 26 November, where you summarise the position that [Baby J] was well?

EVANS: Yes.

JOHNSON: There was no respiratory distress?

EVANS: Yes.

JOHNSON: She was in air with oxygen saturations of 100%?

EVANS: Yes.

JOHNSON: A normal heart rate?

EVANS: Yes.

JOHNSON: And a respiratory rate of 45?

EVANS: Yes.

JOHNSON: Do you next record:

"Two profound desaturations at 05.15 hours"?

EVANS: Yes. 05.15 was the time when the documentation was made, yes.

JOHNSON: Were you referring there to Dr Verghese's notes, which we've seen on screen a few minutes ago?

EVANS: Yes, I was.

JOHNSON: Do you then move on to note the two further episodes of desaturation which were attested to yesterday by Dr Gibbs?

EVANS: I do, yes.

JOHNSON: You record the fact that on those two subsequent occasions, either side of 07.00 hours, stiffness -- the stiffness that [Baby J] exhibited and, to use the phrase used, I think, by Dr Gibbs yesterday, the fisting --

EVANS: Yes.

JOHNSON: -- description of her clenching her fists?

EVANS: Yes.

JOHNSON: And took 10 minutes to settle on the first occasion and 3 to 4 minutes on the second occasion?

EVANS: Yes.

JOHNSON: You record the treatment that she was given; is that right?

EVANS: Yes.

JOHNSON: And the fact that after each episode, her perfusion seemed to return to a satisfactory position?

EVANS: Correct.

JOHNSON: You record also the fact that a swab was taken from the central line?

EVANS: Yes.

JOHNSON: And do you move on at your paragraph 19 to summarise the position so far as blood tests were concerned?

EVANS: Yes. There were a number of blood tests around this time and the important ones were that the tests one carries out to

look for infection were all normal. Her white count was 12.6, normal. The neutrophil count, which is the type of white cell that increases with infection, was 3.6, that's normal as well. In other words, it was not increased. And the CRP, we've heard a lot about, again that was less than 1. So the markers of infection were all indicative of no infection.

JOHNSON: Did you record the fact at your paragraph 21 that a swab was taken from the central line site at 16.00 hours on 28 November?

EVANS: Yes.

JOHNSON: What was the upshot of that, please?

EVANS: It grew this organism called *Klebsiella oxytoca*, which is a rather peculiar organism, and that is it. Then there were further -- yes. That is what was isolated in the -- when they looked at the result, yes.

JOHNSON: Did you review the observation charts, so those charts with which we are now very familiar, with the yellow bands on the upper and lower limits of normal respiratory rate, temperature and the like?

EVANS: Yes, I did. Yes, I did, and again, my paragraph 25:

"The heart rate measurement, respiration, temperature range were all within normal values. No increase in temperature [which you would expect in infection] and she was in air throughout..."

In other words, she was not requiring additional oxygen. It's a good sign:

"... and her oxygen saturation was excellent at 98 to 100%."

So all was well.

JOHNSON: Yes. Did you isolate at your paragraph 26 the result from the blood sample taken, in effect, between the two latter episodes involving Dr Gibbs, the blood taken at 07.00 hours on 27 November?

EVANS: Yes.

JOHNSON: Are these, or at least some of these results, the things that can take a long time to isolate in a laboratory or are these results that exclusively are reportable very quickly?

EVANS: Most of them can be reported quickly. Again, the CRP of less than 1, normal. White cell count of 8.1 and a neutrophil

count of 2.7, so that's satisfactory. Then the blood gas values, which are done on the neonatal unit, that was normal. So all those results were satisfactory.

JOHNSON: I think Dr Verghese has told us that the sample that's in effect grown in the lab or tested in the lab over a period of days returned nothing untoward. Does that account with your reading of the records?

EVANS: I'm not too sure where the Klebsiella was obtained from but that was his evidence, yes.

JOHNSON: I think the Klebsiella was obtained the following day, on the 28th --

EVANS: Yes.

JOHNSON: -- we've already established that -- with a swab.

EVANS: Yes.

JOHNSON: Thank you. I want to move on to your observations section, please, Dr Evans, which is paragraph 44. There you referred again to the initial problem that [Baby J] had with intestinal obstruction.

EVANS: Yes.

JOHNSON: You moved on to consider at your paragraph 45 the circumstances of [Baby J]'s collapse.

EVANS: Yes.

JOHNSON: What did you observe particularly, dealing with the first pair of collapses, if I can put it that way, at around 5-ish in the morning and the second pair at around 7-ish in the morning?

EVANS: Right. Well, the first pair of collapses were unexpected. That's the first thing. Because as we've just heard, she was nice and stable before that. So that's the first point.

The second set of the events was more serious, in requiring more in the way of resuscitation, but again, were unexpected. I note that the markers of inflammation were normal, which would tend to rule out infection. So we'd had two pairs of events within a couple of hours which were unexpected, unusual, but from which she recovered.

Her second pair of events -- this coincided with what the doctors described as a seizure or a fit. And she was described

to have clenched hands, stiff limbs, eyes deviated to the left on two occasions. So these are characteristics of a seizure or a fit. This is what occurs -- sorry, this is indicative of something going wrong with your brain. In other words, a seizure is indicative of some abnormality of the brain.

My opinion was that [Baby J]'s brain was deprived of oxygen for a sufficient length of time to cause brain hypoxia, in other words loss of oxygen to the brain, causing the fit. And I continued by saying she's never had any subsequent seizures, so there is no evidence of her having an inherent predisposition to epilepsy.

Epilepsy occurs in children, but if her seizures were due to an epileptic focus, then she would have had seizures in future. But this, as far as we know, as far as I know, was the only occasion when she had seizures and that the cause of this was the hypoxia, the lack of oxygen to the brain.

JOHNSON: So, so far as the hypoxic incident that had caused those seizures was concerned, could you identify any natural process that might have caused that?

EVANS: No, I couldn't. I couldn't. There was no reason why she should suddenly become hypoxic. I won't go over the conditions that Dr Gibbs and Dr Brearey ruled out, but seizures can occur because of low glucose, they ruled out that, low calcium, they ruled that out, a brain haemorrhage, they did an ultrasound scan, they ruled that out. Therefore they ruled out these conditions and they were also -- I was here listening to their evidence yesterday. In their opinion, infection was not a feature, was not the cause of her seizure round about 7 am on that morning.

JOHNSON: If infection had been the cause of her rapid decline, would she have recovered as quickly as she did?

EVANS: I don't think she would. We've dealt with infection in this trial on a number of occasions and babies who develop an infection usually recover over a period of days. First of all, they develop features of infection, such as increased temperature, increased respiratory rate, but they do not recover this promptly.

MR JOHNSON: Thank you, Dr Evans. Would you wait there for some further questions, please?

MR JUSTICE GOSS: Mr Myers, you're likely to be more than 5 or 10 minutes, I assume.

MR MYERS: Yes. I'll be more than that, my Lord.

MR JUSTICE GOSS: I know it's been a very short episode, this, but it's much better to have the cross-examination of a piece.

MR MYERS: Yes. It enables me to consider it and maybe thereby shorten it in fact.

MR JUSTICE GOSS: I think for all sorts of reasons it's better. So we'll break off now, members of the jury.

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

Thank you very much indeed.

(12.57 pm)

(The short adjournment)

(2.00 pm)

(In the absence of the jury)

MR JOHNSON: My Lord, just as a matter of information, once we have called Dr Bohin, we will recall Mrs Hocknell just to deal with the issue because the anonymisation policy has come between the issues and -- well, the evidence and its perceptibility. So we'll call her to confirm various facts which are obvious from the records, which the defence have had for a long time, that underpin the neonatal review.

MR JUSTICE GOSS: I was going to say, I'm sure it could be capable of resolution, that.

MR JOHNSON: Oh, it is, it is.

MR JUSTICE GOSS: Absolutely, we'll deal with that.

Thank you.

(In the presence of the jury)

Cross-examination by MR MYERS

MR MYERS: Dr Evans, could you please take a look at paragraph 53 of the report we've just been looking at, the report of 31 May 2018? Are you there, paragraph 53?

EVANS: Yes, I am, yes.

MYERS: Thank you. With regard to 27 November, the day we're looking at, at the time of the report, certainly, you said that:

"One cannot rule out the presence of infection despite the normal inflammatory markers, CRP and neutrophil, at the time of the collapse."

That's right, isn't it, that one cannot just rule it out for sure?

EVANS: Yes. There are lots of complicated issues with regard to this little baby. We know she's had a surgical procedure, she has a stoma in line, and she's got a Broviac line, in other words a central line, in place.

So all of these -- and she's in a baby unit. So all of these markers place her at some kind of risk.

That's why my opinion is quite ambivalent in this particular case. I've heard the evidence from yesterday that local doctors were satisfied -- that they did rule out infection.

From my perspective, 5 years ago when I did this report, I wasn't so confident in ruling out infection.

That's as far as I could go really.

MYERS: One other matter I would like to confirm. The bacteria that was identified was *Klebsiella oxytoca*; is that right?

EVANS: Yes, and the clarification was there because, and I don't think I made it clear this morning, there were two results regarding -- around the time. The *Klebsiella* was grown from the central venous line site, in other words from the skin around the site. That grew *Klebsiella*, and I don't think I made that clear this morning, earlier. And whereas the culture from the blood itself after 5 days did not grow anything. So just to clear up those two points.

MYERS: All right. But *Klebsiella* is capable of causing infection in vulnerable infants, isn't it?

EVANS: Oh yes, yes, yes.

MR MYERS: Thank you, Dr Evans.

MR JOHNSON: Does your Lordship have any questions?

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

Thank you very much, Dr Evans. That's it in relation to this stage.

(The witness withdrew)

MR JOHNSON: Dr Sandie Bohin, please.

DR SANDIE BOHIN (recalled)

Examination-in-chief by MR JOHNSON

MR JOHNSON: Would you just confirm your identity for the sake of the recording, please?

BOHIN: I'm Dr Sandie Bohin.

JOHNSON: Have you written two separate reports in the case of [Baby J]?

BOHIN: Yes.

JOHNSON: Thank you. I'd like to concentrate, if we may, on the report of 23 March 2019. Did you there set out the material that you received in order to reach the conclusions that you express in writing?

BOHIN: Yes.

JOHNSON: Does that material include copies of the medical notes from the Countess of Chester, from Alder Hey and from the Royal Manchester Children's Hospital?

BOHIN: Yes, it does.

JOHNSON: And did you also receive, as part of the material sent to you by the police, the witness statement of Dr Dewi Evans dated 31 May 2018?

BOHIN: Yes, I did.

JOHNSON: Did you set out the chronology of [Baby J]'s life up to the event with which the jury is primarily concerned on 27 November?

BOHIN: Yes.

JOHNSON: And did you note that following the surgical intervention at Alder Hey in Liverpool -- I'm looking at your paragraph 6.6 now -- [Baby J] subsequently made good progress and was stable?

BOHIN: Yes.

JOHNSON: That on 26 November she was well and all recorded observations and vital signs were normal?

BOHIN: That's correct.

JOHNSON: That she was tolerating feeds and her ileostomy was working well?

BOHIN: Yes, that's correct.

JOHNSON: Next in your paragraph 6.7, did you note the two desaturations that occurred earlier on the morning of 27 November --

BOHIN: Yes.

JOHNSON: -- at around 5 o'clock?

BOHIN: That's correct.

JOHNSON: The jury have heard the evidence today about those.

BOHIN: Yes, that's correct.

JOHNSON: Did you next note two further desaturations, so this is now your paragraph 6.8, at 06.56 and 07.24, as the times are recorded?

BOHIN: Yes.

JOHNSON: What in particular did you note about those events?

BOHIN: They seemed to be different to the previous two in that there were clear signs -- although there was desaturation which was similar to the previous two episodes, on this occasion there were signs of seizure or fitting and that it was noted, depending on whose notes you read, that her limbs were rigid.

Particularly, there was clenching of her fists and, on the second occasion, eye deviation, which is very characteristic of a neonatal seizure.

But the thing that was concerning for me was that she required quite a lot of bagging and resuscitation with the Neopuff, so 16 minutes with the first episode and 8 minutes with the second episode before she recovered.

So she hadn't had seizures before, and yet here we've got two profound desaturations associated with seizure activity, which took a long time for her to recover from.

JOHNSON: Did you note the appearance of an X-ray?

BOHIN: Yes. She did have a chest X-ray taken that morning and that showed some non-specific changes on the X-ray, which may be consistent with infection. She also had an abdominal X-ray, which didn't -- wasn't helpful and didn't show anything untoward.

JOHNSON: Did you also note the taking of, and culture from, a skin swab from around the area of the Broviac line?

BOHIN: Yes. A swab was taken from the skin around the central Broviac line and that was taken on 28/11, which is the day after, and having reviewed the notes again this week, I think that was taken and it was nothing to do with the events of the desaturation because she also had a swab taken the previous 7 days before. So I think it was probably the policy in Chester to routinely take swabs of the Broviac site every week. I can't guarantee that, but there was no clinical reason to take a swab the week before and this particular swab wasn't taken at the time of the desaturations.

JOHNSON: Is it right to say that the culture taken from the blood from the Broviac line didn't grow any pathogens?

BOHIN: That's correct.

JOHNSON: What does that mean in language that I can understand?

BOHIN: A Broviac line is a big piece of plastic that goes into a big central vein in the chest and it is tunnelled under the skin, as we saw from the video, to try and reduce infection because central lines are accessed frequently to give drugs or fluids and are at risk of having bugs going from the outside directly into a central line and that's right next to the heart.

So if that plastic becomes infected in any way, the person with the line is likely to become very unwell and if anyone is suspected of having an infection, you would normally take blood both from the central line, out of the little tap that's on the end of that line, and also take blood from a peripheral vein and compare the two, because sometimes you may get bugs from the blood taken from the central line and it's not necessarily from the blood itself but actually the plastic of the line is impregnated with bugs. So it's usual practice to take blood cultures from two sites.

Here, they didn't do that, they just took it from the central line, but in any case it was negative so it means neither the blood nor the plastic was infiltrated with bugs.

JOHNSON: Dealing with your opinion, please, Dr Bohin, and taking up your report at paragraph 7.2, could you explain to us what conclusions you drew from the circumstances as have been established by the evidence?

BOHIN: [Baby J] was a well baby. She was ready to go home.

Babies who are ready to go home do not have major desaturations which lead to prolonged resuscitation with Neopuff. If that were the case, the medical team wouldn't be making them ready for home. These were completely unexpected and she required the Neopuff ventilation for a long time in actual fact before she came round and was well again and I just thought that seemed extremely unusual, just the speed of the collapse, the longevity of the resuscitation and then the fact that she seemed to recover really quite quickly afterwards. They were just unusual for me.

I felt that infection wasn't responsible for that because that isn't the way that infection plays out, and so having looked at other things that may have caused this, I didn't really come to any major conclusion other than these were serious and unexpected deteriorations.

JOHNSON: Just in terms of -- just taking you up on your remark that this isn't way that infection normally plays out, in what respect?

BOHIN: Well, [Baby J] was a patient, because she had the stomas and because she had a Broviac line, who was at risk of infection. But looking at her observation in the days prior to this event, and even on the day of this event, her temperature was stable, her heart rate was stable, her respiratory rate was stable and she was tolerating her feeds. And babies who are kind of brewing an infection tend to exhibit subtle abnormalities in some or all of those things, particularly intolerance of feed, which just shows you that all isn't well, really, and that you need to keep a special watch on them.

And she didn't exhibit any of those things until she had her desaturation, which can be a feature of infection, but then having resuscitated her, she was then better and seemed to be back to normal, that isn't a feature of an infection because by the time she was clinically well and what the medical team have described as back to her normal self, she hadn't even received her antibiotics at that point.

JOHNSON: So would you exclude infection as a reasonable cause for what happened to [Baby J]?

BOHIN: Yes, I excluded infection. I don't think that was the cause of her collapse.

MR JOHNSON: Thank you. Would you wait there, please?

Cross-examination by MR MYERS

MR MYERS: Dr Bohin, having looked at the material, you identify no obvious cause for collapse; that's correct, isn't it?

BOHIN: It is.

MYERS: Do you agree that however the indicators may be sparse or lacking, one cannot rule out the presence of infection despite normal inflammatory markers?

BOHIN: The inflammatory markers, the first one, showed a CRP of less than 1 and it's routine practice and recommended practice to follow -- repeat those inflammatory markers at 24 to 36 hours. Her subsequent inflammatory markers were also low. So nothing is ever 100% in medicine, but it makes infection very, very unlikely as a cause for her collapse.

MYERS: But no cause identified?

BOHIN: There was no cause identified.

MR MYERS: All right. Thank you, Dr Bohin.

MR JOHNSON: Does your Lordship have any questions?

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

See you again.

(The witness withdrew)

MR JOHNSON: Could I recall Claire Hocknell, please? And can we supply your Lordship with a copy of this statement after the hearing?

MR JUSTICE GOSS: Yes, later today, yes.

MRS CLAIRE HOCKNELL (recalled)

Examination-in-chief by MR JOHNSON

MR JOHNSON: Welcome back, Mrs Hocknell. Hopefully, somewhere is the neonatal review. Thank you. For the recording, would you identify yourself, please?

HOCKNELL: Claire Hocknell.

JOHNSON: Thank you. If I can invite the jury to go back to the big black file, please, and to what at the moment is the final page.

Mrs Hocknell, following the evidence this morning of Dr Verghese, were you asked to go back to the medical records relating to the two children [redacted], whose initials appear in the babies whose location is unconfirmed box in the bottom right-hand corner of the graphic?

HOCKNELL: Yes.

JOHNSON: Thank you. If we can deal with those two children, please. You have, and of course the defence also have had, access to the unedited records of these children insofar as they relate to any of the events that feature in the evidence; is that right?

HOCKNELL: Yes.

JOHNSON: Can you confirm, first of all, that those two children [redacted] are twins?

HOCKNELL: Yes, that's correct.

JOHNSON: Did you look at the records of, first, the baby [redacted]?

HOCKNELL: Yes.

JOHNSON: And did you confirm the following facts from those records? First, is this a boy or a girl?

HOCKNELL: It's a girl.

JOHNSON: She was born at 05.56 hours?

HOCKNELL: That's correct.

JOHNSON: On 27 November 2015?

HOCKNELL: Yes.

JOHNSON: She was admitted to the Countess of Chester Hospital at 06.10?

HOCKNELL: Yes.

MR JUSTICE GOSS: So not in hospital when born?

MR JOHNSON: No.

The next line in the records reads:

"Born at home. Breach. Known cleft lip. [Query] palate."

HOCKNELL: Yes, that's correct.

JOHNSON: Do the nursing notes for that young lady confirm that she had had CPR in the ambulance?

HOCKNELL: That's correct.

JOHNSON: That she was:

"... placed into incubator by night staff, baby continued to have a high O2 requirement, was apnoeic"?

HOCKNELL: Yes, that's correct.

JOHNSON: And did you find some retrospective notes made in respect of this little girl by Dr Verghese at 09.35 hours later that same day?

HOCKNELL: Yes.

JOHNSON: Looking at those notes, did they say, amongst other things:

"Informed by labour unit 32/40 twins..."

So premature twins:

"... SROM at home."

HOCKNELL: Yes.

JOHNSON: Spontaneous rupture of membranes, I think we have heard that in [Baby D]'s case:

"Coming in by ambulance. Paramedics delivered [redacted] at home, breach presentation."

HOCKNELL: Yes.

JOHNSON: "On examination no heart murmur, cleft lip plus palate."

HOCKNELL: Yes.

JOHNSON: Had Dr Verghese also noted "Dr Gibbs, consultant present"?

HOCKNELL: Yes.

JOHNSON: A decision was made to electively intubate with sedation drugs, intubated at 08.25 with a size 3 tube, 7.5 centimetres at lips?

HOCKNELL: Yes.

MR JOHNSON: Thank you. I don't anticipate there will be in questions.

MR MYERS: No questions.

MR JOHNSON: If any further detail is required in due course, then we will agree it amongst ourselves.

MR JUSTICE GOSS: Well, that evidence confirms what one had thought was likely to be the case, that [redacted] are the twins to whom Dr Verghese referred.

MR JOHNSON: Yes.

MR JUSTICE GOSS: Born 32 weeks, premature, at home, one with the unfortunate lip problem, and so he was -- that's why he remembered that night.

MR JOHNSON: Yes.

MR JUSTICE GOSS: All right. It just clears up a mystery.

I don't think you need to worry about the details in relation to those babies or that baby, you haven't heard about the other one. That's it. So [redacted] were those twins?

MR JOHNSON: They were.

MR JUSTICE GOSS: Thank you very much.

(The witness withdrew)

MR JOHNSON: Can I deal with the interview summary?

MR JUSTICE GOSS: Certainly. I don't want to sound opaque about this, but is there any more evidence to be read or anything now?

MR JOHNSON: No. Ah yes, there were two witnesses on a list that we provided you with some time ago, but on reflection, on both sides, we don't think that either of them advance either case.

MR JUSTICE GOSS: That's all right. I was just checking, that's all. I'm not questioning anyone.

MR JOHNSON: No, no.

MR JUSTICE GOSS: I get sent a list of who's likely to be giving evidence each day and there is reference to the reading of a statement, but obviously it's not considered relevant now, so it's not going to be read.

MR JOHNSON: It might be difficult to believe, but we do try and cut things down!

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

MR JOHNSON: So [Baby J]. When interviewed on 5 July 2018, Lucy Letby recalled [Baby J] as she'd arrived with a Broviac line fitted and with a stoma. They didn't have babies with Broviac lines or stomas on the unit very often and it was unusual to have a baby with [Baby J]'s level of care on the unit.

Lucy Letby remembered [Baby J]'s parents too as they had lost [Baby J]'s twin in utero. Lucy Letby didn't clearly remember a series of collapses in the early hours of 27 November 2015. She was not [Baby J]'s designated nurse, although she did administer medication shortly after midnight.

In the interview of 12 June 2019, Lucy Letby was reminded of the notes of [Baby J]'s care and that on 27 November 2015 she'd signed for the administration of some of [Baby J]'s medication. [Baby J]'s designated nurse had been Nicola Dennison, who was a nursery nurse.

Nicola Dennison would only have been authorised to administer certain oral medication, thus explaining Lucy Letby's involvement. Lucy Letby didn't recall whether she'd been present when [Baby J] collapsed. She thought that it was Nicola Dennison who had called her.

Finally, during the interview of 10 November 2020, Lucy Letby accepted that she'd searched for both of [Baby J]'s parents once on Facebook. However, she could not remember having done so. She was also asked about messages that she'd sent to some of her colleagues about [Baby J]. She said that couldn't remember who told her that [Baby J] had been fitting and maybe had sepsis.

My Lord, that concludes the evidence in the case of [Baby J]. We will move on tomorrow to take two cases out of turn. For good reasons we can't immediately deal with the case of [Baby K], who would be the next child in the chronology. Her case is in

February 2016. So we're moving on to [Babies L & M]. That will be as from tomorrow morning with your Lordship's approval.

MR JUSTICE GOSS: I've said that if we finish in relation to a child on a particular day, given, as you know, there has to be a change of the people who are interested and who want to be here to hear the evidence relating to their child or children to be here, so that will be it for today.

You'll appreciate we've made better progress in terms of time now and so [Babies L & M] will be the rest of this week, I assume?

MR JOHNSON: They will, and into next week. We anticipate that we'll finish their cases by the end of next week.

One of the cases is another insulin case. They take a bit more time -- or can do.

MR JUSTICE GOSS: Well, we don't want to go over all the evidence relating to insulin again.

MR JOHNSON: No, no.

MR JUSTICE GOSS: That's before the jury and it's really the issue of -- well, what the issue is in relation to an insulin case.

MR JOHNSON: Yes.

MR JUSTICE GOSS: Right. Thank you very much. So another early day for you, members of the jury. 10.30 tomorrow morning, please.

I'll remind you again, because I haven't reminded you very recently, of your responsibility as jurors not to communicate in any way with anyone about anything to do with this case and not to conduct any research in relation to anyone or anything to do with this case by any means. All right? Thank you very much indeed.

10.30 tomorrow morning.

(In the absence of the jury)

MR JUSTICE GOSS: Mr Myers, yes?

MR MYERS: Yes, we'd be grateful to have the opportunity to speak to Ms Letby. Thank you, my Lord.

MR JUSTICE GOSS: Yes, certainly. Thank you.

(2.31 pm)

(The court adjourned until 10.30 am on Wednesday, 15 February 2023)