

21 March 2023

Baby P

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Tuesday, 21 March 2023

(10.30 am)

(In the presence of the jury)

DR HUW MAYBERRY (recalled) (via video link)

Examination-in-chief by MR DRIVER

MR DRIVER: Members of the jury, you'll note that Dr Mayberry is on screen.

Good evening, Dr Mayberry. Can you hear me? We couldn't hear your reply, Dr Mayberry. We saw your lips move. Try again. Can you hear me?

MAYBERRY: Yes.

DRIVER: And I can hear you.

MAYBERRY: Good.

DRIVER: Dr Mayberry, when you last gave evidence you told us about your responsibilities in relation to the baby [Baby O] on a night shift that began on 22 June 2016. Today, we'd like to

ask you questions in relation to his brother, [Baby P] or [Baby P].

Is it right that your next shift at the hospital was for a night shift that began on 23 June 2016?

MAYBERRY: Yes.

DRIVER: We know from evidence that between those shifts, sadly, [Baby O] died. Were you aware of that fact before your shift began or not?

MAYBERRY: I was made aware of it during a discussion with one of my colleagues, Dr Jessica Burke, who'd informed me about what had happened.

DRIVER: Was that a discussion within the workplace as part of the handover or was that a discussion elsewhere?

MAYBERRY: It was inside the workplace. Both the paediatric and the neonatal handover occur in one of the rooms in the paediatric ward and it was there where I had the discussion with Dr Burke.

DRIVER: Thank you. Was, in effect, Dr Burke handing over her responsibilities to you and updating you on relevant developments?

MAYBERRY: It was before the main part of the handover. I think Jess had wanted me to know before proceeding with the main part of the handover.

DRIVER: I understand. As part of the handover proper, were you informed of any changes in the planned management of [Baby O]'s brothers, [Baby P] and [Baby R]?

MAYBERRY: Yes. So Jess had told me that the other two patients, [Baby P] and [Baby R], had been reviewed by Dr Gibbs and he had started -- he'd done a septic screen or initiated a septic screen on the children because of the concerns about the deterioration of [Baby O] and had reviewed them not long before evening handover.

DRIVER: Could you just remind us of the timetabled time for that doctors' handover as opposed a nurses' handover. What does time the medics' night shift again?

MAYBERRY: I can't remember the exact times at the Countess of Chester. I think it was -- it was between 8 and 9 o'clock, but I think it was normally around 8.30 to the best of my recollection.

DRIVER: Thank you. I wonder, Mr Murphy, could you put up tile 134, please? If we could look at the original note.

MR JUSTICE GOSS: Just to set everyone's minds at rest.

There was a fault in the system, there was no fire alarm, no proper fire alarm, so don't be concerned that we should be evacuating, we shouldn't.

MR DRIVER: I'm grateful.

Dr Mayberry, can you see the clinical note on screen?

MAYBERRY: Yes.

DRIVER: Thank you. We'll see that it was timed at 18.00 hours, signed off by Dr Burke. It begins with the words:

"Reviewed -- Dr Gibbs."

It would seem from the chronology that you provided to us that this was the review of [Baby P] and indeed [Baby R] made by Dr Gibbs shortly after [Baby O]'s sad demise.

Having re-read that note, does that accord with the verbal appraisal that you received from your colleague, Dr Burke?

MAYBERRY: Yes.

DRIVER: It would seem that the baby had been tolerating nasogastric tube feeds and there was a plan put in place. In short, is the first point of that plan to take bloods from the baby and to screen those samples for full results?

MAYBERRY: Yes.

DRIVER: The second part of the plan, is that the introduction of antibiotics?

MAYBERRY: Yes.

DRIVER: Was it your understanding that this was a precautionary measure, made because of [Baby O]'s unexpected demise?

MAYBERRY: Yes. So normally, at the time -- if you're worried about sepsis in twins, or triplets in this case, if one of them became unwell, then you would initiate a septic screen on the remaining children.

DRIVER: Is that effectively an established and widely embraced protocol in relation to all multiple pregnancy children?

MAYBERRY: Yes, it was at the time, although I've sort of moved out of this area of paediatrics subsequent to this.

DRIVER: I'm sure it's not controversial. I think your statement suggests that it was actually part of national guidance in this regard.

MAYBERRY: Well, I believe it was at the time, yes.

DRIVER: I'm grateful. In any event, they were the steps and they were the reasons behind those steps taken in relation to [Baby P].

In addition to that, were you informed that there was to be an adjustment in the feeding regime for [Baby P]?

MAYBERRY: So the initial discussion was that [Baby P] would continue having nasogastric feeds, but if there were to be any concern overnight, then the feeds should be stopped and fluids should be started -- sorry, intravenous fluids.

DRIVER: I'm grateful. Were you appraised of any decision-making as to the quantity of feeds to be continued for [Baby P] at that point or not?

MAYBERRY: I don't recall, sorry.

DRIVER: Very well. So having been told of the change of management plan and the fact that Dr Gibbs was steering this course as a precautionary measure, did you attend upon [Baby P] or did you go about other business at that point?

MAYBERRY: I initially had a phone discussion with one of the nursing staff who had told me that they'd had some higher volumes of aspirates from the nasogastric tube.

So normally, before they gave more milk down the nasogastric tube, they aspirated the tube to see how much feed remained in the stomach. They told me that they were having a few millilitres of aspirate, and at that point I, out of an abundance of caution, made a decision that the best thing to do would be to go to the neonatal unit and see how things proceeded, how [Baby P] was.

On arrival at the neonatal unit, just after I had walked through the doors, the emergency bleep went off with a call to, I think it was A&E resus, and so at that point I had to immediately go and attend to another child who was in an emergency condition.

At that point I had to make a decision and while normally having aspirates from a nasogastric tube on a child that you're feeding is not by any means an unusual step to see, I thought the safest plan would be to ask the nursing staff to move [Baby P] on to IV fluids.

DRIVER: Thank you. Could I invite you to break that down and assist us as to when these events occurred? From memory, approximately how far into your shift were you when you had that telephone conversation?

MAYBERRY: This was straight after evening handover to the best of my recollection.

DRIVER: So approximately what time of night?

MAYBERRY: I'd have thought about 9.30.

DRIVER: Thank you. Can you remember who initiated that communication, you or your nursing colleague?

MAYBERRY: I believe it was my nursing colleague.

DRIVER: Do you remember how they caught your attention?

MAYBERRY: I think they had given -- to the best of my recollection, it was a normal bleep that they had bleeped me on.

DRIVER: To which you responded, I take it?

MAYBERRY: Yes. And at that point I made the decision to go the unit.

DRIVER: I know it's a lot to ask, but can you remember the identity of the nursing colleague you spoke to at this point?

MAYBERRY: I think it was Belinda Simcock to the best of my recollection.

DRIVER: The report you received, you've just told us, was to the effect that there'd been a small amount of aspirate withdrawn from [Baby P]'s digestive system; is that correct?

MAYBERRY: Yes.

DRIVER: Are you able to help as to quantity with any more precision?

MAYBERRY: I believe the phrase that was used was that [Baby P] was having some increased aspirates from his nasogastric tube.

DRIVER: Thank you. Were you informed of the nature of the aspirates, whether they were milky, bilious or what?

MAYBERRY: I was told that they were milky.

DRIVER: Thank you. The withdrawal of a milky aspirate from the system of a neonate, in isolation would that be a matter of particular concern or not?

MAYBERRY: Not in isolation, no.

DRIVER: What are the potential causes of a failure to fully digest a feed?

MAYBERRY: There are many causes. For a lot of children it can be normal and it's part of having reduced movement through their gut of feed. Some children may have reduced movement of milk through their gut for other reasons, so if you're worried about them having an infection or having something like necrotising enterocolitis -- however, to the best of my knowledge, and this is probably something that I've gained more knowledge about following -- in subsequent years, nobody really knows what a large volume, as it were, of aspirate is, and practice varies across the United Kingdom as to how often people check aspirates, when people check aspirates and what people would do about large levels of aspirates.

DRIVER: Thank you. I wonder whether we could take down the note from the screen so we can see Dr Mayberry again.

Apologies for that, Dr Mayberry, my oversight.

MAYBERRY: No problem.

DRIVER: So to summarise the answer you just gave, in isolation ordinarily this might not be a matter of concern, but of course we know that you knew that [Baby P]'s brother [Baby O] had died in the very recent past.

MAYBERRY: Yes.

DRIVER: Did that fact operate on your mind when deciding how to respond to this telephone call?

MAYBERRY: Yes, because I was worried about how [Baby O] had deteriorated and, not having an adequate answer at the time for the reason why he had deteriorated, I felt the best course of action to do was to stop feeds at the time and put him on IV fluids. I had a very low threshold in my mind to do that.

DRIVER: A very low threshold and was that an adjusted -- downwards adjusted threshold because of [Baby O]?

MAYBERRY: Yes.

DRIVER: So your management advice was to withdraw all nasogastric feeds and to place [Baby P] on a regime of, the notes suggest, 10% dextrose intravenously; is that correct?

MAYBERRY: Yes.

DRIVER: Just to recap on your evidence, you were telling us how you went to the neonatal unit to effect this plan; is that correct?

MAYBERRY: Yes.

DRIVER: But however, before you actually got to [Baby P]'s cot side, there was an emergency elsewhere that caused you to go back from where you came from, effectively?

MAYBERRY: Yes.

DRIVER: Did you return to the neonatal unit during the course of that shift?

MAYBERRY: I don't recall if I returned just before evening handover -- before morning handover for that shift.

I may have done. I certainly do recall at one point, at about 4 o'clock in the morning, I rang the neonatal unit from the resus department in accident and emergency, where I was dealing with another sick child, because I hadn't heard back if there had been any further progress with [Baby P]. I was informed that he was doing well and that there were no concerns from the nursing staff about his condition at that point.

DRIVER: Thank you. So to piece the chronology together, you'd gone to the NNU intending to attend upon [Baby P], an emergency caused you to go to the A&E resus, and did that emergency keep you there for several hours?

MAYBERRY: Yes.

DRIVER: You next communicated in relation to [Baby P] at about 4 am, when you made a phone call to check on his progress?

MAYBERRY: Yes.

DRIVER: What information did you receive during that second [Baby P]-related telephone call?

MR JUSTICE GOSS: He said, "I was informed he was doing well and there were no concerns".

MR DRIVER: Thank you, my Lord.

MR JUSTICE GOSS: No need to go over it again.

MR DRIVER: Was there anything in particular, Dr Mayberry, that you might assist us with in relation to his nasogastric tube?

MAYBERRY: Do you mind... I'm sorry, do you mind clarifying that a little more, sorry?

DRIVER: Certainly. Your statement, and I am sure this is not controversial, suggests that you were informed, and you directed, that his nasogastric tube should be left on free drainage. Does that accord with your recollection?

MAYBERRY: Yes.

DRIVER: And the purpose of that?

MAYBERRY: The purpose of that would be to drain off any fluids or air within his tummy, which might be accumulating.

DRIVER: Thank you. So having been so appraised by a telephone call, were you assured and satisfied with the continuing management of [Baby P]?

MAYBERRY: Yes.

DRIVER: Did you hand over responsibility to medical colleagues at the end of your shift?

MAYBERRY: Yes.

DRIVER: And do you recall that? Do you recall who you spoke to and what, if anything, in particular, you suggested?

MAYBERRY: I will have to refer to my statement, sorry. I believe I spoke to the consultant who was on during the day and the medical registrar who was on during the day to inform them --

DRIVER: Again, I'm sure it's uncontroversial. Your statement suggests you spoke to Dr Gibbs directly and asked him to see [Baby P] as a first priority. Does that --

MAYBERRY: Yes.

DRIVER: -- accord with your recollection?

MAYBERRY: Yes.

DRIVER: Does that conclude your involvement with any of the [Surname of Babies O, P & R] triplets?

MAYBERRY: Yes.

MR DRIVER: I'm grateful. Could you remain there and answer any questions asked of you?

Cross-examination by MR MYERS

MR MYERS: Dr Mayberry, you've explained to us that there was a particular concern to monitor [Baby P] closely because of what had happened with [Baby O]; is that right?

MAYBERRY: Yes.

MYERS: In fact, on the night shift that you were working, you were contacted about [Baby P], weren't you?

MAYBERRY: As I've said previously, yes.

MYERS: You did set off to go to examine him in the neonatal unit, didn't you?

MAYBERRY: Yes.

MYERS: But you never actually examined him at all, did you?

MAYBERRY: No.

MYERS: What you're telling us about him is based upon telephone calls, maybe two or so telephone calls, with nursing staff, isn't it?

MAYBERRY: Yes.

MYERS: And you never got as far as being able to make any clinical notes in the records for [Baby P], did you?

MAYBERRY: No.

MYERS: And the reason for that is that you were called away because you were required in a different part of the hospital, weren't you?

MAYBERRY: Yes.

MYERS: Which, as it happens, is the same reason that you'd been unable to make the note with regard to [Baby O] the night before, although you had actually seen [Baby O]; is that right?

MAYBERRY: Yes.

MYERS: You can't give us any first-hand knowledge as a doctor of how [Baby P] was presenting that night, can you?

MAYBERRY: No, apart from -- not first-hand knowledge, no.

MYERS: The first thing that was brought to your attention, you tell us, is a telephone call from one of the nurses to -- was that to tell you that [Baby P] had produced a few millilitres of milk; is that correct?

MAYBERRY: A few millilitres of milk had been aspirated from his nasogastric tube, yes.

MYERS: Thank you. So there's a phone call of a few millilitres of milk aspirated from his NGT. Your recollection, Dr Mayberry, is that you received that phone call not long after the handover that had taken place; is that correct?

MAYBERRY: Yes.

MYERS: So you think maybe round about 9.30 in the evening, something like that?

MAYBERRY: Yes.

MYERS: You also say that you recall it was Belinda Simcock.

There may not be much that turns on this but just as a matter of record, it may be Belinda Simcock was not actually working that evening. Might it have been Kate Percival-Ward, as she was, or Sophie Ellis, who contacted you, or is it just too difficult after this period of time to be sure?

MAYBERRY: My recollection was of Belinda Simcock, but if she was not working that evening then obviously that's an incorrect recollection.

MYERS: All right. We can check that. I don't anticipate anyone would expect you to recall precisely who now.

That's not a criticism: some time has gone by.

A few millilitres of milk being aspirated from an NGT may not be a concern; is that your opinion, Dr Mayberry?

MAYBERRY: I think... It's my opinion now that having aspirates from an NGT would be considered, in many cases, normal.

MYERS: When you say "a few millilitres", what figure did you understand "a few millilitres" to be?

MAYBERRY: I don't recall at the time what my opinion of what a few millilitres was at that time.

MYERS: But to assist us in any event with this, as you sit there now, what do you consider "a few millilitres" to be, what quantity of millilitres?

MAYBERRY: Five, 10ml.

MYERS: And if the quantity becomes larger, depending on how large it is, is that likely to be more of a concern?

MAYBERRY: At the time I would have said yes. And now I would have said it's not possible to say.

MYERS: In any event, when you say a few millilitres you say up to -- did you say up to 5 or 10ml, something like that?

MAYBERRY: I believe so, yes.

MYERS: All right. I just want to show you a feeding chart that we have. It's tile 24. This should come on your screen. We'll just open it up so you can see it.

I'm going to enlarge the readings we have in the lower right-hand corner. We have the timings and I can tell you what the timings are when we get there, Dr Mayberry.

MAYBERRY: Sure.

MYERS: It's difficult to see so I'm going to ask if we can enlarge the top -- the bolder entries to the right-hand side, thank you.

First of all, can you see the third column from the right with writing has got:

"DEBM NGT 15. 136. 14ml R."

Can you see that, Dr Mayberry?

MAYBERRY: "DEBM NGT 15ml" -- and what was, sorry, the other thing that you were asking about?

MYERS: I'm just checking. Below that it says "136". The cursor is on the screen there. And below that it says "14ml"; do you see that?

MAYBERRY: Yes.

MYERS: We know that is an entry for 8 pm, for 20.00 hours, on that evening. The next entry that you can see to the right of that, where we have the running total below DEBM of 151, the cursor is there, that is at 22.00 hours. Can you see that?

MAYBERRY: Yes.

MYERS: Then the final entry on the right-hand side at 00.00 hours is for 20ml that was aspirated. Do you see that?

MAYBERRY: Yes.

MYERS: First of all, from what you tell us, is it right that you didn't know about the 14ml that had been aspirated at 20.00 hours?

MAYBERRY: It would have been, to the best of my recollection, before my handover and I don't recall being handed over the 14ml of aspirate.

MYERS: You mean you don't recall being told about that at the time of handover?

MAYBERRY: No.

MYERS: The 20ml to the right-hand side, once that aspirate had been produced -- obtained, [Baby P] was made nil by mouth.

You can see it says "stopped" on the total column.

Can you see that?

MAYBERRY: Yes.

MYERS: That happened at midnight, not 21.30.

MAYBERRY: Okay.

MYERS: But whatever your recollection, do you agree 20ml is a substantial quantity of milk to have been aspirated from [Baby P]'s NGT?

MAYBERRY: Yes. It's a reasonable amount of milk to aspirate.

MYERS: It's significantly more than the figure you give us as what you believed a few millilitres to be, isn't it?

MAYBERRY: Yes.

MYERS: But from what you tell us, you never realised that in fact it was 20ml that had been aspirated at that time; is that correct?

MAYBERRY: To the best of my recollection, yes.

MYERS: And do you agree that 14ml being aspirated at 20.00, followed by a further 20ml aspirated at midnight, may be a cause for concern?

MAYBERRY: It's a... It's a difficult question to answer. There's many things to take into account as opposed to looking at a single number of aspirates in that chart on its own. The chart says that the child is opening their bowels and passing meconium, which would suggest that they're having ongoing gut transit. So aspirating 14ml in that context is slightly offset by the fact, you know, the child is opening their bowels.

So on its own as a number, yes, it's a reasonable amount, but there is enough during the day to suggest that this child is moving -- their gut is moving and therefore a suggestion that their gut is healthy.

MYERS: But 14ml followed by 20ml may be something that is clinically significant in a bad way, mightn't it?

MAYBERRY: In terms of an evidence base for knowing how much you can aspirate off somebody's nasogastric tube in relation to their feeds and what that means, there isn't a very good evidence base for saying how well that correlates with disease in newborns and in children in acute and critical care.

MYERS: You explained that as part of the plan on handover, it had been decided that if there were any concerns overnight [Baby P] would be made nil by mouth; is that correct?

MAYBERRY: Yes.

MYERS: And [Baby P] was made nil by mouth, wasn't he?

MAYBERRY: Yes.

MYERS: So it follows, doesn't it, that the aspirate that was reported to you was potentially a cause of concern?

MAYBERRY: It was a cause of concern for myself as I mentioned earlier on, yes, because of what had happened with [Baby O] and not knowing why he had deteriorated.

MYERS: At the time he was made nil by mouth, you had no idea of the actual volume of the aspirate, did you, accurate idea?

MAYBERRY: I did not, no.

MYERS: Can I just ask you something that follows that and I'm going to ask Mr Murphy to put up tile 237, please. This is a continuation of that chart into the early hours of the morning, Dr Mayberry, so you can understand what we're looking at.

You can see there the chart as it carries on and I'm just going to look briefly at the entries under "output" towards the bottom of the chart, a couple of entries in particular. If you look where it says -- under the word "output", you have the line for aspirates and if you look four columns along you'll come to -- it says "25ml air".

MAYBERRY: Yes.

MYERS: Can you see that?

MAYBERRY: Yes.

MYERS: That is entered at -- that's the column for 04.00 that morning. So this comes 4 hours after [Baby P] had gone nil by mouth after the 20ml of milk.

MAYBERRY: Yes.

MYERS: Your evidence to us is that around 4 o'clock, you rang the NNU and were told there were no concerns and that [Baby P] was doing well?

MAYBERRY: Yes.

MYERS: From that, does it follow it was never brought to your attention that 25ml of air had been aspirated from his NGT after he'd been made nil by mouth?

MAYBERRY: That's correct, yes.

MYERS: We can see, if we go right of that, under the column for what is actually 07.00, a further 5ml of air was aspirated from the NGT and 2ml of milk. Can you see that?

MAYBERRY: Yes.

MYERS: Again, that wasn't something that was brought to your attention, was it?

MAYBERRY: No.

MYERS: And at no point did you have the benefit of examining [Baby P] yourself before you handed over; is that correct?

MAYBERRY: That's correct.

MYERS: Do you agree that 25ml of air being aspirated after he'd been nil by mouth for 4 hours may be something that could be a cause of concern?

MAYBERRY: It could be, yes.

MR MYERS: I'm not asking you to go beyond that, Dr Mayberry. That's what I wanted to ask you.

Thank you for answering those questions.

MR DRIVER: If Dr Mayberry could be put back on screen.

My Lord, I have no re-examination for Dr Mayberry.

Does your Lordship have any questions for the witness?

MR JUSTICE GOSS: I don't, but will we be linking to Australia again?

MR DRIVER: We don't expect so.

MR JUSTICE GOSS: Dr Mayberry, that completes your evidence.

Thank you very much indeed. It's not anticipated that you will be required to give any further evidence in this case, so we will not be having to link up to you in Australia again. Thank you very much for making yourself available to give evidence at various stages during the course of this trial. In a moment we will sever the link. Thank you very much indeed.

MAYBERRY: Thank you.

MR DRIVER: Mr Astbury will call the next witness.

MR ASTBURY: My Lord, I'm afraid we're going to need to reconfigure the court for this particular witness.

MR JUSTICE GOSS: Yes. It's the three-minute break, not the ten-minute break. Thank you.

(Pause)

MRS KATHRYN PERCIVAL-CALDERBANK (recalled)

Examination-in-chief by MR ASTBURY

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

PERCIVAL-CALDERBANK: I'm Kathryn Leslie Percival-Calderbank.

ASTBURY: You have given evidence before. You know I'm going to ask you to keep your voice up if at all possible please and remind you that the microphone, unfortunately, doesn't amplify your voice, it simply records it. If you can stay as close as you can to it.

PERCIVAL-CALDERBANK: Okay.

ASTBURY: You have previously described yourself, I think, as a senior nurse practitioner?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: Could you remind us, please, of your experience as a neonatal nurse?

PERCIVAL-CALDERBANK: I qualified as a general nurse, then as a midwife, then went into neonatal nursing, where I did subsequent courses and then did an enhanced nursing practice course within the neonatal unit.

ASTBURY: So when did you qualify as a nurse?

PERCIVAL-CALDERBANK: In 1985 -- 88.

ASTBURY: When did you enter into the neonatal field?

PERCIVAL-CALDERBANK: In about 1994 or 1995, I think it was.

ASTBURY: I think you said you became a band 6, which we have heard is the senior band within the unit. When do you think you achieved that status?

PERCIVAL-CALDERBANK: Um... I...

ASTBURY: You don't have to be precise, it's just to give us an idea of your experience.

PERCIVAL-CALDERBANK: Probably 1998, something like that.

ASTBURY: I think you mentioned some additional courses as well; have they been since?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: We know that you were employed at the neonatal unit at Chester back in 2015 and 2016. You've come along today to assist with your recollection of a night shift on the 23rd into 24 June of 2016; is that right?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: All right. You've prepared a statement for that purpose; is that right?

PERCIVAL-CALDERBANK: Yes, that's correct.

ASTBURY: You've had the opportunity to refresh your memory from the statement?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: I'm going to ask you in particular, please, about your treatment of a baby by the name of [Baby O]. But in fact -- well, in fact [Baby P]. But as it happens, I think you were designated nurse for [Baby O] on that particular night shift; is that right?

PERCIVAL-CALDERBANK: Yes. I was looking after [Baby O], who had unfortunately died that afternoon.

ASTBURY: So we know he passed away probably but a couple of hours before you came on shift --

PERCIVAL-CALDERBANK: Yes.

ASTBURY: -- but responsibilities continue?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: And you were allocated those responsibilities as his designated nurse on that shift?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: That shift would have started, we've heard, about 7.30 in the evening; is that right?

PERCIVAL-CALDERBANK: That's correct.

ASTBURY: I'm going to ask you, please, just to look at our representation, if you would, of the shift, which in fact probably won't help you. Do you have a recollection of starting the shift? I'll take that back. Do you have a recollection of starting that particular shift?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: And the handover?

PERCIVAL-CALDERBANK: I just know that I was handed over to look after [Baby O] and to help sort out all the subsequent paperwork that was required to deal with the event.

ASTBURY: As a band 6 did you have any additional responsibilities on that particular night shift?

PERCIVAL-CALDERBANK: No.

ASTBURY: Have you had the opportunity -- I'm going to move on to [Baby P] now -- in respect of [Baby P] to refresh your memory from the notes made on that shift?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: Have they assisted you in the course of preparing your statement?

PERCIVAL-CALDERBANK: Yes, they did.

ASTBURY: Do you recall, perhaps based on the notes, who was [Baby P]'s designated nurse during that particular night shift?

PERCIVAL-CALDERBANK: The nurse was Sophie Ellis.

ASTBURY: Do you recall at any point [Baby P] being brought to your attention?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: Why was that?

PERCIVAL-CALDERBANK: Because it was noted that he had large aspirates and also there was concern with his stomach becoming distended.

ASTBURY: Why was that brought to your attention?

PERCIVAL-CALDERBANK: Because I probably -- because I was the senior nurse and if I was sitting down doing paperwork, because

Sophie was a junior nurse, she would ask assistance from senior nurses.

ASTBURY: Okay. So in the first instance when that was brought to your attention do you recall what you did?

PERCIVAL-CALDERBANK: I'm aware that at one time -- I don't know whether she called me or that I had gone into the room, but we had a look at him to see what he was looking like and he was to be reviewed by the doctors.

ASTBURY: Do you remember roughly what stage in the shift that was?

PERCIVAL-CALDERBANK: I don't. I think it was quite early on, but I'm not sure what time.

ASTBURY: Okay. Do you recall, having gone to look at [Baby P], anything about his presentation or appearance?

PERCIVAL-CALDERBANK: He was a well baby, but I have noted that his abdomen was quite distended, so I aspirated his nasogastric tube.

ASTBURY: Was that the first time that you went to see him?

PERCIVAL-CALDERBANK: No, I had seen him during the shift.

ASTBURY: Okay. So just working through, so not too far into your shift you were asked to see him. Is that the point when you asked for him to be reviewed?

PERCIVAL-CALDERBANK: Well, because of his -- when Sophie had remarked that his aspirates were large and of partially digested milk, so because we had -- because of the picture of what had happened to [Baby O], so we were being more cautious, I suppose, to be more aware that -- to make sure that [Baby P] was well looked after.

ASTBURY: We've heard that they were identical triplets.

PERCIVAL-CALDERBANK: Mm-hm.

ASTBURY: So is it the case that what had happened to [Baby O] was of particular concern in those circumstances?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: And that perhaps a more cautious regime was being adopted than otherwise would have been the case?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: You mentioned that you aspirated air from [Baby P]. Just explain that to us, please.

PERCIVAL-CALDERBANK: When babies have a nasogastric tube, that's the way that we would feed them if they were unable to feed for themselves, because I know that he was on full feeds, he had previously been on an infusion of fluids, but as he became well we increased -- he was started on feeds.

ASTBURY: Okay. I'm just going to ask you, please, with what you told us in mind, to look at the screen to your right.

Mr Murphy, put tile 238 up, please.

These are Sophie's notes, but it's a reference to you, so I'm just going to ask you to quickly look at the entry or the addendum that's made in those notes, please. That's exactly it, thank you, Mr Murphy. If you could enhance that a little, please, so we can see it.

So we are becoming familiar with these notes. I'm just going to ask you -- you may be asked about other entries, but I'm going to ask you about the addendum there that's timed at 06.39 by Sophie Ellis, that abdo has been soft and non-distended, that 25ml air was aspirated by -- is that senior nurse practitioner?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: Kate Ward, as you were then?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: And NGT placed on free drainage?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: When you tell us about the occasion you aspirated [Baby P]'s tummy, is that the occasion you were talking about?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: Now, that, we believe, is recorded on the neonatal feeding chart; would that be right?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: I'm going to ask you to look at that next, please, which is behind tile 237. This is the form that is post-

midnight. I'm going to draw your attention to those entries towards the bottom left-hand corner of the form, please.

We can see in the aspirates row, fourth entry along, 25ml of air. That's recorded, I think, at 4 am.

PERCIVAL-CALDERBANK: Yes.

ASTBURY: Would that be consistent with your recollection as to when you actually came round to undertake that --

PERCIVAL-CALDERBANK: As far as I'm aware, yes.

ASTBURY: I make the point this is midnight onwards. Were you aware that there had been aspirates from [Baby P]'s tummy before midnight in the earlier part of the shift?

PERCIVAL-CALDERBANK: Yes, I had.

ASTBURY: Were they drawn to your attention?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: Do you recall a decision being made to place [Baby P] nil by mouth?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: There is a further entry timed at 7 am we can see on the form, which speaks of another 5ml of air and 2ml of milk. Do you have any recollection of that event?

PERCIVAL-CALDERBANK: No.

ASTBURY: All right. We can see from the observations chart -- and I can take you to them if I'm asked to -- at the time [Baby P] was self-ventilating in air.

PERCIVAL-CALDERBANK: Yes.

ASTBURY: He wasn't receiving any breathing support. When you took the -- when you withdrew the 25ml of air, was that at all a feature that was on your mind?

PERCIVAL-CALDERBANK: No. No, just that he... I'd been... I think I'd been called by Sophie to have a look at him. He looked like he had quite a large stomach, so I said, "Let's aspirate his tummy and see what's happening", and noticed that I drew back 25ml of air. I know there isn't on there, but we were also checking to see whether the aspirates -- were they milk or were

there other concerns such as were they bile-stained or anything like that in case of that as well.

ASTBURY: You can be taken to it, if necessary, but they're described before midnight as milky aspirates.

PERCIVAL-CALDERBANK: Yes.

ASTBURY: Does that accord with your recollection?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: And a pH of 3 during of course of those aspirates.

In your experience, are there -- I made the point he was self-ventilating in air. Are there causes in your experience for that sort of air to accumulate in the tummy?

PERCIVAL-CALDERBANK: Sometimes if you have a baby that you've had to bag for ventilation, the nature of the way that you bag a baby, sometimes the air is forced into the stomach.

ASTBURY: That's the Neopuff device?

PERCIVAL-CALDERBANK: The Neopuff device, yes. Or if you have got a baby that's on CPAP, which is another -- or a non-invasive form of ventilation, that sometimes causes babies to get a bloated abdomen.

ASTBURY: Why was it important in this case to remove the air from [Baby P]'s tummy?

PERCIVAL-CALDERBANK: Because he looked uncomfortable or sometimes it makes it uncomfortable and it can cause pressure on their lungs because they're actually trying to -- you know, it's like if we had a fizzy drink and we got a load of the bubbles from the fizzy drink, you want to expel it and get rid of it because it's uncomfortable.

ASTBURY: And we have heard that the tummy is under the diaphragm.

PERCIVAL-CALDERBANK: Yes.

ASTBURY: And it is the diaphragm that expands and contracts the lungs up (sic)?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: All right. Do you know why it was you that was asked to aspirate the air?

PERCIVAL-CALDERBANK: I don't. I don't know whether Belinda, who was the shift leader, was around at the time or busy herself, but I was asked just to come -- would I come and review, which is normal practice.

ASTBURY: So the other senior nurse on the shift with you was Belinda?

PERCIVAL-CALDERBANK: Simcock.

ASTBURY: Having aspirated [Baby P]'s tummy, did you see him again at all that night? Did you continue to keep an eye on him?

PERCIVAL-CALDERBANK: I might have popped in just to check was he okay, how was he, but I don't really know, I've got no real recollection. But I probably did because I would have done that.

ASTBURY: Okay. In your statement you express a view of how [Baby P] was towards the end of the shift. Do you recall how you assessed him to be at 7 o'clock?

PERCIVAL-CALDERBANK: He seemed comfortable and settled and seemed like a well baby.

ASTBURY: Now, come the end of the shift, of course, we've heard how the handover takes place and the nurse designated in [Baby P]'s case will succeed Sophie.

PERCIVAL-CALDERBANK: Mm-hm.

ASTBURY: Who is responsible for the allocations for the oncoming shift?

PERCIVAL-CALDERBANK: The shift leader.

ASTBURY: You weren't shift leader on that night shift?

PERCIVAL-CALDERBANK: No.

ASTBURY: Did you play a part in allocating babies to nurses?

PERCIVAL-CALDERBANK: I didn't but I'd be asked if I'd got any opinion.

ASTBURY: And do you recall having an input on that particular shift?

PERCIVAL-CALDERBANK: Yes, I felt that because of what had happened previously that it was important that Lucy was given

some support because she'd been allocated to go back into the special care nursery to look after -- I don't know whether...

I think it was [Baby P], to look after him, and by putting Chris Booth, who was another senior nurse, within that nursery to look after [Baby R] but to support Lucy in that instance.

ASTBURY: So some extra support alongside the senior nurse --

PERCIVAL-CALDERBANK: Yes.

ASTBURY: -- which we know Chris Booth is and was?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: All right. What were -- you told us that you considered [Baby P] at that point at the changeover to be settled and improved; would that be right?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: Were there any ongoing concerns for [Baby P] when you were making those sort of decisions?

PERCIVAL-CALDERBANK: It was just because of what had happened previously.

I know that he and his sibling [Baby R] had been screened in view of -- and commenced on antibiotics in view of what had happened with [Baby O].

MR JUSTICE GOSS: She didn't actually say improved, she said, "He seemed comfortable, settled and a well baby".

MR ASTBURY: That was a slip of the tongue. Having seen the tummy and the aspiration earlier -- if that was wrong of me, I apologise.

We have heard that [Baby P] was in nursery 2, so still requiring (inaudible) a high dependency (inaudible).

PERCIVAL-CALDERBANK: Mm-hm.

ASTBURY: Was there anything troubling you about -- you told us that [Baby P] was to be allocated to Lucy. Was there anything troubling you at the time about Lucy and working at the higher end of the nursery spectrum?

PERCIVAL-CALDERBANK: I had been asked by my manager or, I don't know if anybody else, other band 6s, that if there was any incidences, such as in intensive care that -- to try and not put

people back in there too often, to try and move them out of areas and to do -- for support and to help their mental health, really.

ASTBURY: Okay. Had Lucy Letby expressed any views about working in either the intensive care end or the -- I hesitate to say it, the less intensive care --

PERCIVAL-CALDERBANK: I had asked her -- at one point, I had allocated her to an outside nursery rather than in intensive care when she came in, not on this shift but on another shift, an earlier time and she'd expressed that she was unhappy at being put in the outside nurseries, expressing that she felt it was boring and she didn't want to feed babies, she wanted to be in the intensive care nursery.

ASTBURY: Okay. Not on this occasion?

PERCIVAL-CALDERBANK: No.

ASTBURY: On another occasion that you recall?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: All right. Did anything strike you about Lucy Letby on those occasions when she was in one of the outer nurseries, as you called it?

PERCIVAL-CALDERBANK: If there was anything going on within nursery 1, we found that she would migrate to -- as we would all do in order to go and help, but she would definitely end up back in nursery 1 to assist with people.

ASTBURY: We've heard that it's all hands to the pump when there are emergencies or things are occurring in any nursery.

Is there any reason why that stood out to you at the time?

PERCIVAL-CALDERBANK: It was more because we were worried for Lucy's mental health because of -- you know, it can be upsetting, it's emotional, and sometimes exhausting as well at the end of the day, at the end of your shift if you're constantly put in that stressed situation all the time.

So sometimes it's good to come out of that environment and be in the outside nurseries.

ASTBURY: Do you remember any specific conversations with Nurse Letby in those sort of circumstances?

PERCIVAL-CALDERBANK: I had had an argument where I had asked her to go out -- I had put her in an outside nursery and she was quite upset that I said, "No, I would like you to go out into the outside nurseries to look after certain babies".

ASTBURY: Do you remember when that took place?

PERCIVAL-CALDERBANK: No.

ASTBURY: Do you remember, in relation to the events we've been discussing in June 2016, whether it was around that time or was it --

PERCIVAL-CALDERBANK: It was before that.

ASTBURY: Okay.

MR JUSTICE GOSS: Can you be any more specific than just "before"?

PERCIVAL-CALDERBANK: It was within the period of this -- of --

(11.38 am)

(No video feed from court)

(11.39 am)

MR JUSTICE GOSS: Thank you. Could we rewind on that?

MR ASTBURY: Apologies for that. We have others dialling in and following things. I think the last question I asked you was how that particular conversation had resolved itself.

PERCIVAL-CALDERBANK: Basically, Lucy, she went into the outside nurseries, but she was not happy with the decision.

ASTBURY: Okay. You were telling his Lordship that you can't help us with when that took place?

PERCIVAL-CALDERBANK: No, unfortunately not.

ASTBURY: Obviously, you concluded your shift round about 7.30 when the handover had taken place. Did you work the next night, commencing the 24th?

PERCIVAL-CALDERBANK: Yes, I did.

ASTBURY: Did you learn of [Baby P] having passed during the course of the day?

PERCIVAL-CALDERBANK: Yes.

ASTBURY: Bearing in mind what you told us about what you saw of him during the course of the previous night shift, what was your reaction to that?

PERCIVAL-CALDERBANK: We were very shocked to hear what had happened to him because that was not what we had expected after leaving the shift that morning.

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

Cross-examination by MR MYERS

MR MYERS: Mrs Percival-Calderbank just a few questions, please, if you'd help. Dealing with the topic you were asked about at the end, about where Ms Letby worked or where she liked to work, it is right, isn't it, she made it plain, she did prefer to work in the intensive care aspect of the operation, didn't she?

PERCIVAL-CALDERBANK: She did, yes.

MYERS: And I know you said that she'd said something about being unhappy in the outside nurseries, that it was boring. Was she conveying that she just felt it was her job to be in the intensive care rather than things like feeding, that was just how she looked at that?

PERCIVAL-CALDERBANK: I don't know.

MYERS: All right. Did she actually use the word boring?

PERCIVAL-CALDERBANK: Yes, she did.

MYERS: Is that what she said?

PERCIVAL-CALDERBANK: Yes.

MYERS: She was quite clear about her preference to work in intensive care, wasn't she?

PERCIVAL-CALDERBANK: She was.

MYERS: She wanted to do that?

PERCIVAL-CALDERBANK: Yes.

MYERS: But the instance you have told us about, which may have been some time before this, you can't remember when, although

she made it plain where she preferred to work, she did go where she was put in fact, didn't she?

PERCIVAL-CALDERBANK: She did, yes.

MYERS: She did that. Something you described is that there were times when she would end up back in nursery 1 --

PERCIVAL-CALDERBANK: Yes.

MYERS: -- and you were talking about how in fact everybody certainly would be ready to help --

PERCIVAL-CALDERBANK: Yes.

MYERS: -- when there was an issue. Was it the case that she was particularly keen to assist so far as you could see?

PERCIVAL-CALDERBANK: Yes.

MYERS: And she would be there very quickly if an issue arose?

PERCIVAL-CALDERBANK: Yes.

MYERS: You're being asked these questions, so we don't miss the point, in the context of this trial and these allegations, but in fact the concern amongst you and your colleagues at the time was that it can be very stressful in that setting working for prolonged periods in the intensive care, can't it?

PERCIVAL-CALDERBANK: Yes, it can.

MYERS: And the issue, the worry was that it might be unsettling for someone's mental well-being to keep on doing that; is that the point?

PERCIVAL-CALDERBANK: That's correct, yes.

MYERS: So for that reason, amongst those of you in charge of these things, some of you felt she should spend more time away from the intensive care; is that correct?

PERCIVAL-CALDERBANK: That's correct.

MYERS: But she didn't really want to hear that, she wanted to do the intensive care?

PERCIVAL-CALDERBANK: Yes.

MYERS: All right. Just a couple of questions then about the shift that we're actually dealing with now, the night shift with [Baby P].

Were you called by Nurse Ellis to see [Baby P] on a number of occasions in the course of that shift from what you can remember?

PERCIVAL-CALDERBANK: No. I think I was only called once. I don't really actually know when I was called in.

MYERS: All right. Was it you that aspirated the 25ml of air at 4 in the morning?

PERCIVAL-CALDERBANK: It was, yes.

MYERS: So you were certainly called round about that time?

PERCIVAL-CALDERBANK: Yes.

MYERS: Is that because Sophie Ellis was concerned that you check what the situation was with [Baby P]?

PERCIVAL-CALDERBANK: Yes, she was concerned so she just asked me to assist.

MYERS: We know that he had been made nil by mouth round about midnight, we know that from the records. When you went to see him at about -- would that be about 4 in the morning, something like that?

PERCIVAL-CALDERBANK: I presume it must have been yes.

MYERS: You have made reference to his abdomen appearing quite distended.

PERCIVAL-CALDERBANK: Yes.

MYERS: Is that something you noticed about his stomach at that point?

PERCIVAL-CALDERBANK: Yes. When I was observing him, yes.

MYERS: You hadn't been called to see him earlier than that from what you can remember; is that correct?

PERCIVAL-CALDERBANK: No.

MYERS: So this is the first time you'd seen him and seen what looked to you like quite a distended abdomen?

PERCIVAL-CALDERBANK: Yes.

MYERS: And it was when you saw that that then the air was aspirated from him?

PERCIVAL-CALDERBANK: Yes.

MYERS: You've been asked about what could the cause of that air be and you have told us, well, sometimes Neopuff or CPAP, that kind of breathing support, that can lead to air getting into the belly and expanding it, can't it?

PERCIVAL-CALDERBANK: Yes, it can.

MYERS: On this occasion we know, and we've confirmed this, [Baby P] wasn't receiving any additional breathing support. We know that, he was breathing in air unsupported. So would you agree that 25ml of air in those circumstances could be something to be a matter of concern potentially?

PERCIVAL-CALDERBANK: It could be.

MYERS: Do you recall whether you or anyone else looking after [Baby P] or on the unit made contact with the doctor after that air had been aspirated?

PERCIVAL-CALDERBANK: I don't know. I think he was -- he had been informed.

MYERS: You think the doctor had been informed?

PERCIVAL-CALDERBANK: Yes.

MYERS: Right. When you get to the end of the shift, you described [Baby P] as being settled.

PERCIVAL-CALDERBANK: Yes.

MYERS: The word "improved" made an appearance in the questioning. In fact, when you made your statement to the police, do you recall saying that by the end of the night you thought that [Baby P] had got past the worst bit and that he would start to improve?

PERCIVAL-CALDERBANK: Yes.

MYERS: Do you remember saying that?

PERCIVAL-CALDERBANK: Yes, I do.

MYERS: So the word "improved" did feature in your statement?

PERCIVAL-CALDERBANK: Yes.

MYERS: What were you meaning when you said he had got through the early part of the night:

"We thought he had got past the worst bit and that he would start to improve"?

What were you getting at when you say that about the end of the shift?

PERCIVAL-CALDERBANK: Because we've put him nil by mouth and sometimes we put babies nil by mouth if they're not -- if they haven't digested their milk, it's been too much for them to digest. So by putting them nil by mouth and putting IV fluids and giving them a rest, that sometimes settles their stomach, then you can start to recommence feeds and that's how -- what we felt he would be doing.

MYERS: That's the direction you thought he would go in?

PERCIVAL-CALDERBANK: Yes.

MYERS: All right. We know he went nil by mouth at about midnight, didn't he?

PERCIVAL-CALDERBANK: Yes.

MR MYERS: Thank you, Mrs Percival-Calderbank.

MR ASTBURY: My Lord, nothing arising. Does my Lord have any questions.

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

MR ASTBURY: We don't think Nurse Percival-Calderbank will be back.

MR JUSTICE GOSS: That completes your evidence. Thank you very much for returning and giving further evidence in this trial. It's not anticipated that you're going to be required again, but just in case for some unexpected reason you are required to come and give further evidence, would you please not talk to anyone about this case until it's all over?

PERCIVAL-CALDERBANK: Yes.

MR JUSTICE GOSS: Thank you very much indeed. Remain where you are for the time being, please. We'll take our ten-minute break

now and then the next witness will be in place for when we recommence in 10 minutes.

Thank you very much.

(11.48 am)

(A short break)

(11.58 am)

MR CHRISTOPHER BOOTH (recalled)

Examination-in-chief by MR ASTBURY

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

BOOTH: Christopher Neil Booth.

ASTBURY: Thank you. You have given evidence before. Can I remind you, of course, you're still bound by the affirmation or oath that you took at the outset.

And you have come along to assist with your treatment or your knowledge of three triplets, [Baby P], [Baby O] and [Baby R], born at the neonatal unit in Chester in June 2016?

BOOTH: Yes.

ASTBURY: Thank you. You provided a statement dealing with all three and can I just reassure you that the jury have heard your evidence in relation to [Baby O], which was read to them last week by agreement, so I'm going to ask you, please, to concentrate today on [Baby P].

BOOTH: Okay, yes.

ASTBURY: And we will zoom in, in particular, on your day shift of 24 June 2016. We've heard about the triplets, their weights, their condition at birth. So I'm going to ask you, please, firstly to look at -- I think you may have seen this before -- on the screen to your right our representation of the shift that day. It's tile 257 first, please, Mr Murphy.

This is our list of clinicians and nurses on duty.

I'm going to concentrate for your purposes, please, firstly on the two consultants, Drs [Dr B] and Brearey who were on duty that day, the registrar, [Dr A], and indeed Dr Ukoh, from whom we've already heard as well.

We see at the bottom Dr Cooke. Do you have a recollection of those three in particular working that day?

BOOTH: The two registrars, yes. And Jessica Burke, yes.

ASTBURY: Right.

BOOTH: My recollection is a bit sketchy about Katarzyna Cooke.

ASTBURY: Not an issue. If we move on then to the nursing staff, please. We can see alongside Lucy Letby and yourself, also on duty are [Nurse D], Mary Griffith, Yvonne Farmer was on the unit with a student nurse by the name of Rebecca Morgan. If we scroll down a little further, there might be some more names, please. We can see two nursery nurses working long days, Janet Cox and Angela McShane.

If we go to the next page, please, the allocation of various babies. If we can enlarge it a little bit, if that's possible, please, to assist Nurse Booth. Simply for these purposes to draw out, if we look at the box in the centre at the bottom of the page, which represents nursery 2, we can see that you were allocated -- that's [Baby R], in fact.

BOOTH: Yes.

ASTBURY: And Lucy Letby alongside you in the same nursery, [Baby P].

BOOTH: Yes. I do recall that, yes.

ASTBURY: Thank you. When you took over the care of [Baby P] that morning, do you recall anything of significance being mentioned during the course of the handover?

BOOTH: From memory, no, not really, other than the babies had been quite stable overnight. I think [Baby P] had just recently stopped feeds because his abdomen was a little bit distended and he had a large gastric aspirate --

ASTBURY: Right.

BOOTH: -- so his feeds were stopped.

ASTBURY: That was brought to your attention?

BOOTH: Yes, yes. But [Baby R], who I was looking after, was very stable.

ASTBURY: Of course, you'd have known about [Baby O] from the day before --

BOOTH: Yes.

ASTBURY: -- having been on duty. We've heard that during the course of the handover, a sheet would be prepared summarising the position for each baby. Is that a fair summary of what the sheet would show?

BOOTH: Right.

ASTBURY: A handover sheet?

BOOTH: Yes.

ASTBURY: You're familiar with handover sheets?

BOOTH: Yes.

ASTBURY: I'm going to ask you to look at a particular document for me, please.

My Lord, the jury have seen before some handover sheets. These are those relating to [Baby P]. If I can pass them forward, please.

My Lord may want to see them first.

(Handed)

Nurse Booth, I would like you to look at these documents, please. Can you confirm that this, according certainly to the date and the name on the top, is the handover sheet from the start of that particular day shift?

BOOTH: Right, okay, yes.

ASTBURY: That's the document we're talking about?

BOOTH: Yes.

ASTBURY: You can probably also see, just for the sake of the record, there's some handwriting both on the back and on an additional piece of paper.

BOOTH: Okay, yes.

ASTBURY: My Lord, this time we have some clean copies to show by way of the screens without the highlighting on the last occasion and also having been edited appropriately. So I'm going to ask

Mr Murphy, so everyone else can see them, to put up the three-page bundle, please, for [Baby P].

I'm conscious that the jury didn't see the last --

MR JUSTICE GOSS: No, I saw them.

MR ASTBURY: Might this be an opportune moment for them to see certainly these documents and they can be shown the others at a more appropriate time?

MR JUSTICE GOSS: Yes, certainly.

MR ASTBURY: I wonder if Mr Stansfield could take those documents, you having identified them, Nurse Booth.

Thank you.

MR JUSTICE GOSS: Just before they are handed over, and you are obviously going to ask some questions about these documents, first of all, the front sheet, as you will see, is typed. It's a table, essentially, which is created with references to the various babies that are in the care of the unit on the shift that is being handed over. So you just can see what it says about various babies there.

On the reverse of that sheet, if you'd turn it over, please, there is -- you can see it's then turned upside down -- some handwriting. Now, is that your handwriting or any of it?

BOOTH: No. It's not mine.

MR JUSTICE GOSS: That's all I wanted to ask, thank you.

Then on the next sheet, there again is some handwriting.

BOOTH: Yes.

MR JUSTICE GOSS: That's all there is on that sheet of paper, the top right-hand corner of one side.

BOOTH: Yes.

MR JUSTICE GOSS: Is any of that your handwriting?

BOOTH: No.

MR JUSTICE GOSS: All right. I think we'll just establish that so when you look at it, you know what it is, and then we'll look at it on the screen. Thank you.

MR ASTBURY: These are the originals, not the edited versions that we can see on the screen.

MR JUSTICE GOSS: Yes, right.

Please don't try and assimilate every detail, you can't spend time reading it now. These are documents to which there will be reference, I imagine, during the course of the evidence. It's just to familiarise yourself with the layout of the document so you can see it and you can see what the handwriting is. Thank you.

(Pause)

Whilst that's being done, Mr Astbury, I can see the J number at the top. They have another number as well, don't they? Did they have another reference when we have referred to them earlier?

MR ASTBURY: These are the original numbers, but this is a sanitised version, in effect, with the editing and highlighting removed. My Lord will remember from the last occasion.

MR JUSTICE GOSS: What are the original numbers? Those are the J numbers? They don't have any other reference numbers?

MR ASTBURY: Yes. They form part of a larger exhibit which we will come to (overspeaking) PMB/4.

MR JUSTICE GOSS: Exactly. That's what there's been reference to before?

MR ASTBURY: Yes. They are amongst other papers which have been collectively given the exhibit reference PMB/4.

MR JUSTICE GOSS: So these are from PMB/4?

MR ASTBURY: Yes.

MR JUSTICE GOSS: Thank you.

MR ASTBURY: PMB/4 being the same reference given to the similar document in respect of [Baby O] which the jury haven't seen yet but my Lord has.

MR JUSTICE GOSS: Exactly.

(Pause)

Are these documents on the iPad as well or not?

MR ASTBURY: They will appear in this form on the iPad, so that's why there's been a short delay.

MR JUSTICE GOSS: They will in due course, but at the moment -- it's only because I find it easier to read on the iPad than from the screen, I find it clearer on my particular screen, but they will in due course be on the iPad?

MR ASTBURY: Yes.

MR JUSTICE GOSS: So at the moment don't try and find them on the iPad.

Right. Back to Mr Booth, please.

MR ASTBURY: This is a type of document, we've heard, that is produced at every handover; is that right?

BOOTH: It is, yes.

MR JUSTICE GOSS: Do you want the witness to have the document?

MR ASTBURY: No, I'm going to move on to the shift itself.

Just one question about the generic position: what would ordinarily happen, in your experience, with a handover sheet once the shift had come to an end?

BOOTH: Usually, they should be thrown away in the confidential waste, but -- speaking honestly for myself, sometimes they are, you know, I've taken them home, you know, in my uniform and left them in my uniform pocket. But technically, they should be destroyed in the confidential waste on the unit at the end of the shift.

ASTBURY: Why should they be destroyed in the confidential waste?

BOOTH: It's confidential information.

ASTBURY: So on those occasions when you've absentmindedly taken them home, what have you done with it?

BOOTH: I have brought it back and then destroyed it on my next shift.

ASTBURY: Could we go back to the shift then, please? I'm sorry, there was a delay there when we introduced those documents. Do you have any independent recollection of the shift as far as [Baby P] was concerned?

BOOTH: I do in that it was so very busy and quite traumatic and it was -- matters escalated so quickly because his condition deteriorated.

ASTBURY: You told -- we looked at the plan earlier, both boys were in -- both [Baby P] and [Baby R] were both in nursery 2?

BOOTH: Yes.

ASTBURY: They were the only two babies in nursery 2; is that your recollection?

BOOTH: That's my recollection, yes.

ASTBURY: Would you, from time to time, leave the baby in nursery 2?

BOOTH: On a day like that when [Baby P] was so sick, there wouldn't be an opportunity to really leave the nursery without a member of nursing staff -- obviously you'd have to have toilet breaks, but someone would cover for you.

But there wouldn't be the opportunity -- indeed, you wouldn't want to leave a baby as sick as that.

ASTBURY: You told us that [Baby R] was better.

BOOTH: Yes.

ASTBURY: Had there been occasions when you were able to leave [Baby R]?

BOOTH: That's right. [Baby R] was stable, he was fully monitored, he was receiving antibiotics, and he was in the far end of the nursery, and he could be observed -- on the old unit, you have probably seen the layout, the rooms are quite small, so we had the opportunity to observe [Baby R] whilst we were working with [Baby P].

ASTBURY: Okay. When you -- you described [Baby P] as being poorly during the course of that shift. When did you first become aware of that?

BOOTH: I think it was during the doctors' ward round when the doctors were actually commencing the ward round. They would have been to see [Baby P] and [Baby R] first and it was then that he'd had his first sort of acute episode where he collapsed.

ASTBURY: When you say the time, was the ward round still going on or had the doctors moved on? Can you recall?

BOOTH: They were in the room at the time, I remember that. The doctors were in the room examining the babies and this happened whilst the doctors were in the nursery.

ASTBURY: Okay. When you say "this happened", tell us what happened from your perspective.

BOOTH: My exact -- I can't give you an exact recollection, I just know that he became bradycardic and his oxygen levels dropped and his heart rate fell, so he needed resuscitating.

ASTBURY: Okay. We've heard that sats dropping or bradycardia to an extent is not altogether unusual in neonates; is that right?

BOOTH: There's varying degrees. Babies do from time to time drop their saturations and pick themselves up. But if they drop to a certain level, we consider it a more profound event where we have to intervene.

ASTBURY: On this occasion you said that resuscitation followed, so it's clearly beyond that which you would normally expect?

BOOTH: Yes, definitely.

ASTBURY: How were you alerted to what was happening with [Baby P]?

BOOTH: I think we were just in the room at the time and we were just aware of the monitors going off and as I say, the rooms are quite small, so there was no need for anyone to be alerted or anyone to be called because all the necessary people were already in the room.

ASTBURY: You said "we and all the necessary people". You said the doctors were on the ward round. Do you remember which doctors were there when this happened?

BOOTH: There was Dr Ukoh, he was a locum registrar, and [Dr A] was around. And late in the day, I know [Dr B] was involved as well.

ASTBURY: Any other nurses in the room at the time?

BOOTH: Myself and Lucy Letby. There was a student nurse, Becky Morgan, who was sort of... I'm fairly sure she was under the sort of scrutiny of Lucy, she was working alongside her --

ASTBURY: Right.

BOOTH: -- as a student.

ASTBURY: Okay. Did you go to [Baby P] when it became apparent that he was suffering this collapse?

BOOTH: I would have assisted. What actions I did exactly, I can't tell you.

ASTBURY: Do you remember anything about his appearance when he had that first collapse?

BOOTH: Um... Dusky, mottled, yeah. He was just...

ASTBURY: We've heard that earlier in the day, so in the early hours, there'd been a distension to the tummy. Is that something you noticed at any time?

BOOTH: Um... Throughout the day, yes.

ASTBURY: Can you remember at what stages of the day that struck you?

BOOTH: I can't exactly. I can't pinpoint a time.

ASTBURY: That first collapse at the ward round. We've heard that took place round about 9.30, the ward round, and we've heard from Dr Ukoh as to the time of his note. Does that accord with your recollection for that first event?

BOOTH: Yes.

ASTBURY: We've then heard there were further collapses involving [Baby P]. Do I take from what you've said that you don't remember them individually --

BOOTH: No.

ASTBURY: -- and distinctly?

BOOTH: Not distinctly, no.

ASTBURY: All right. So what is your recollection through the course of the day then? After that initial collapse was, for a time, [Baby P] stabilised?

BOOTH: Um... The whole day was quite overwhelming. He did rally, I think, on three occasions where his spontaneous circulation did return and he seemed to recover. But then with each subsequent collapse, it became more difficult to resuscitate him. Unfortunately, the final one in the afternoon -- he couldn't be resuscitated --

ASTBURY: Okay.

BOOTH: -- sadly.

ASTBURY: So you told us Dr Ukoh was there round about 9.30.

You have told us that [Dr A] was around, I think you put it.

BOOTH: Yes. And [Dr B].

ASTBURY: Do you remember any other doctors during the course of the day coming to assist?

BOOTH: Dr Brearey. He would have done an echocardiograph. And I know [Dr B] was liaising with the tertiary unit.

ASTBURY: Yes.

BOOTH: She was trying to secure a transfer for him to go to a tertiary unit. The tertiary unit consultant made his way over, Dr Rackham.

ASTBURY: We're going to hear that he arrived about 3 o'clock if that assists you with timings.

BOOTH: Yes.

ASTBURY: Did the number of doctors present during the course of the day strike you at all?

BOOTH: It was fortuitous that they were all around at the time because it was a case of all hands on deck and we could get as much expertise in where it was needed to try and help [Baby P]. But yeah, it was good that there was so many doctors around.

ASTBURY: Do you recall any other nurses that were present during the course of the shift? We've been through the list.

Any involved --

BOOTH: Yvonne Farmer was helping. We were having to draw up special drugs called inotropes to support [Baby P]'s blood pressure and that takes two people to draw up and administer. Yvonne was helping, helping us both drawing up medications.

ASTBURY: "Both" being you and Lucy Letby?

BOOTH: Yes, that's right, yes.

ASTBURY: Do you remember Rebecca Morgan, the student, assisting at all?

BOOTH: She was involved in [Baby P]'s care at the beginning of the shift. Although I think, to be fair, she wasn't used to this sort of situation. I think she was quite overwhelmed and overcome --

ASTBURY: All right.

BOOTH: -- and became quite upset.

ASTBURY: Do you recall during the course of the day the need for intraosseous needles having to be deployed?

BOOTH: Yes.

ASTBURY: Do you recall at what stage that took place?

BOOTH: Exactly -- not exactly what time, no.

ASTBURY: Upon the arrival of Dr Rackham, did events continue in the same way? Did anybody take charge in particular?

BOOTH: I think it's fair to say that with Dr Rackham being a neonatologist and an expert in his field, he did sort of orchestrate things and become like the team leader.

I think it's fair to say he had expertise, you know, that perhaps our consultants didn't possess. And yes, he did become team leader.

ASTBURY: Do you recall the course of the resuscitation after he arrived?

BOOTH: Unfortunately, I'm fairly sure that was, sadly, the final collapse of [Baby P] shortly after Dr Rackham arrived.

ASTBURY: We've heard that that, tragically, was unsuccessful, that final resuscitation.

BOOTH: Yes.

ASTBURY: Do you recall what you did after [Baby P] had passed away?

BOOTH: I think we were all in a state of shock, but I think we had already brought [Baby O] in his cooled cot into the nursery so he could be with his brothers, with the parents' consent, obviously, so that they could be together before -- when it is known that it's futile, really, with [Baby P], that he wasn't going to make it, so we had [Baby O] in the nursery as well. So it was all about supporting the parents, which Lucy took charge of.

ASTBURY: Your recollection is you brought [Baby O] into nursery 2?

BOOTH: Yes, after I spoke with the parents, obviously. I only did it with their consent.

ASTBURY: Of course. [Baby R] was still in nursery 2 at this point?

BOOTH: Yes, he was.

ASTBURY: How was [Baby R] towards the end of your shift?

BOOTH: Thankfully, he was incredibly stable. I think it's fair to say he was fine. He'd been put on triple antibiotics as a precaution. He was nil by mouth. He was on a drip. He was in his incubator and it was agreed that he would be taken to the tertiary unit.

ASTBURY: Okay. What was the feeling about [Baby R] at that point, the two triplets having passed away so suddenly? Were there any concerns for [Baby R]?

BOOTH: Fearful, yes. Really fearful. This is -- we thought it can't possibly happen again. You were just terrified it could happen again.

ASTBURY: Did you notice anything about [Baby R] that caused you any concern?

BOOTH: He did have a slight distended abdomen, but nothing of any concern, it wasn't tense or loopy or discoloured, it was just a little bit distended, nothing more than that.

ASTBURY: Is that something you'd noticed earlier in the shift?

BOOTH: Yes.

MR ASTBURY: Thank you, Nurse Booth. I have no more questions, but if you could wait there, please.

Cross-examination by MR MYERS

MR MYERS: Mr Booth, were you in nursery 2 at the time of [Baby P]'s collapse that morning?

BOOTH: I would have been, yes.

MYERS: And at that time you were caring for [Baby R]; is that correct?

BOOTH: Yes.

MYERS: In terms of the other people that you can remember that were there, Lucy Letby was there; is that correct?

BOOTH: Yes, that's right.

MYERS: There was also a student nurse with her, Rebecca Morgan?

BOOTH: Yes.

MYERS: From the best of your recollection, was Rebecca Morgan there as well?

BOOTH: Um... I can't recall her being there, but I know from the details presented before me she was there.

MYERS: Just to assist with that, you've described that she'd been involved in the cares for [Baby P] at the beginning of the shift.

BOOTH: Because her signature was on the observation chart.

MYERS: That's right. Yes, we have seen that. So you have seen her signature on the observation chart. We believe we have seen that at 09.00 or thereabouts that day so she would have been there dealing with, certainly around that time?

BOOTH: Yes.

MYERS: Dr Ukoh was present as well looking at [Baby R]; is that correct?

BOOTH: Yes.

MYERS: And then it was whilst you were all there, after the original review of [Baby P] a little earlier, that he deteriorated suddenly round about 9.40/9.50?

BOOTH: I agree with that, yes.

MYERS: Do you recall whether Nurse Letby went for help at that point or do you not recall specifically what she did then?

BOOTH: I think, because the room was full of the people we needed, that negated the need for calling for assistance because everyone was already there.

MYERS: So we have the picture, of course, we know there had been a review of [Baby P] with Dr Ukoh round about 9.30 to 9.40,

something like that. This collapse that happened followed pretty much straight on from that with the people still in the nursery, didn't it?

BOOTH: Yes.

MYERS: Going to the end of the day next, that's what I'd like to ask you about. You brought [Baby O] into the nursery so he could be with [Baby P] at that point; is that correct?

BOOTH: Yes.

MYERS: We know that, sadly, [Baby O] had died the day before.

BOOTH: Yes.

MYERS: That was a decision that was taken so the family could be together, tragic as the circumstances were?

BOOTH: Exactly. Exactly, yes.

MYERS: And that's something which you, with the family, would have considered as part of the appropriate course to take; is that right?

BOOTH: It felt appropriate at the time and -- yes.

MYERS: Because time spent assisting the parents or trying to assist the parents, even in these terrible circumstances, is part of your role, isn't it?

BOOTH: Exactly, yes.

MYERS: And it's something that follows, we've heard something of this, a set pattern, a set protocol. The bereavement checklist is followed, isn't it?

BOOTH: Yes, we do have that, yes.

MYERS: And you had assisted with bringing the family together in the way you described, hadn't you?

BOOTH: Yes.

MYERS: Then, as the designated nurse, it would fall to Nurse Letby to deal with those aspects of the bereavement checklist that are part of this; is that correct?

BOOTH: Definitely, yes.

MYERS: Things like what's called the bereavement packs, the memory box, things like that?

BOOTH: Yes.

MYERS: All right. You've described it as a very difficult and sad day.

BOOTH: It was traumatic, yes.

MYERS: And from the time of [Baby P]'s collapse at about 9.40, there were a number of medical staff with him and tending to him throughout, weren't there?

BOOTH: Yes. The nurse -- he wasn't left by them, the members of the medical team, throughout the whole of the day.

MYERS: And you were working alongside Nurse Letby, giving her the support that you could in the efforts to care for [Baby P] and to save him; is that correct?

BOOTH: Yes.

MYERS: You were able to do that because [Baby R] was stable, so you could support Nurse Letby?

BOOTH: Exactly, yes.

MYERS: So you worked closely with her that day?

BOOTH: Yes.

MYERS: And she was doing as much as anyone else to do all she could do to help [Baby P], wasn't she?

BOOTH: Without a doubt, yes.

MR MYERS: Thank you, Mr Booth.

MR ASTBURY: My Lord, no re-examination. Does my Lord have any questions?

Questions from THE JUDGE

MR JUSTICE GOSS: You said that members of the medical staff were there throughout the day?

BOOTH: Yes.

MR JUSTICE GOSS: Was that continuous, there was always a doctor at all times throughout the day shift so far as you can remember?

BOOTH: Yes, definitely, yes. We had two consultants present, plus two registrars, at least one SHO, senior house officer, so there would have been a doctor present throughout the day in the nursery.

MR JUSTICE GOSS: Thank you. I have no further questions, thank you very much.

MR ASTBURY: We don't expect Nurse Booth back as things stand.

MR JUSTICE GOSS: Thank you for coming and giving evidence again today. That completes your evidence. It's not anticipated that you will be required again, but just in case would you please not talk to anyone about anything to do with this case until it is all over?

BOOTH: Yes, of course.

MR JUSTICE GOSS: Thank you very much. Please just remain where you are and we'll have a few minutes by way of break for the court to be re-arranged.

(In the absence of the jury)

MR DRIVER: My Lord, with Mr Myers' consent, may I just address the court as to some timetabling matters?

MR JUSTICE GOSS: Yes, certainly.

MR DRIVER: It's now approaching 12.40. We have two statements to read to the court, one from Dr Cooke and, I'm pleased to say, additionally one from Yvonne Farmer, who was on our list of witnesses to be called today.

That's no longer the case, we've been able to agree an edited version of her statement to read, thus saving some time.

It might be convenient for us to do that reading between now and the lunch break and then begin the next two witnesses immediately thereafter.

MR JUSTICE GOSS: Fine. Are you content with that, Mr Myers?

MR MYERS: Yes, my Lord.

MR JUSTICE GOSS: If the public could leave the court for a moment so Mr Booth can leave the courtroom in a moment and then we'll continue with that.

(Pause)

MR ASTBURY: My Lord, while we have no witness in the witness box, now might be the time to allow the jury to see the originals of the day before, 23 June, which they haven't seen.

MR JUSTICE GOSS: Certainly. Take the screens down, please.

(Pause)

(In the presence of the jury)

MR ASTBURY: My Lord, in a moment my learned friend Mr Driver will read some more evidence, but I just wonder whether now was an opportune moment for the other handover sheet, which the jury saw on the screen, but not physically, whether now might be the time to just to take them --

MR JUSTICE GOSS: Relating to [Baby O]?

MR ASTBURY: Yes. This is the handover sheet and associated paperwork from [Baby O]. It went on the screen but the original was not passed round.

MR JUSTICE GOSS: All right. It's the same sort of document, but just so that you know, this is the notes relating to [Baby O] and you looked at the notes relating to [Baby P], as I did. But I looked at this previously.

This is the one I have seen before.

MR ASTBURY: My Lord, the intention is to exhibit it as PMB/4, not individual (inaudible: coughing) with my Lord's leave.

MR JUSTICE GOSS: So the typed handover sheet and then handwritten notes again.

(Pause)

Mr Astbury, my note is that this is the -- the reference for this is KDH/2A.

MR ASTBURY: Yes. They have been presented in such a way to try and attach to a particular baby. They were all together and we think properly they should be exhibited as PMB/4.

MR JUSTICE GOSS: All right. So what were referred to, and I don't know if you were taking note of this or not, but I obviously did, KDH/2A, the notes that were shown to Melanie Taylor, Nurse Taylor, these notes (indicating), form part of PMB/4, but they are different notes. So these two sets of documents and other documents form PMB/4.

MR ASTBURY: Yes. My Lord, the reason we're doing it as PMB/4 --

MR JUSTICE GOSS: There's no need to explain to us. I'm sure it'll all become clear. For the moment, just so there's no confusion, these are the notes that Melanie Taylor looked at and spoke about.

(Pause)

Witness statement of DR KATARZYNA COOKE (read)

MR DRIVER: My Lord, members of the jury, may I read two witness statements, please. The first is a statement made by Dr Katarzyna Cooke, dated 8 March 2018. The jury will recall the earlier evidence of Dr Cooke in which she informed us of her professional status within the Countess of Chester as of summer 2016 and her professional development since then.

So if I --

MR JUSTICE GOSS: And your comment on the quality of her handwriting, shortly before --

MR DRIVER: Shortly before I couldn't read her handwriting, yes, quite so.

MR JUSTICE GOSS: I'm trying to put it -- you'll remember Dr Cooke, I'm not being discourteous to her, but she spoke with an Eastern European accent.

MR DRIVER: She told us she was Polish and she remembered the Brexit referendum date.

If Mr Murphy could put up tile 64, please.

MR JUSTICE GOSS: This is the 8 March 2018 statement?

MR DRIVER: It is, thank you.

If we could click on the note. I'm grateful. If I now read from the statement:

"On Thursday, 23 June 2016, I remember that I was involved in the morning ward round and conducted a review of [Baby O] and

[Baby P]. The babies were two of a set of triplets, their brother being [Baby R].

"The morning ward round is a routine process which is conducted every day, whereby we assess all the babies in the unit and decide a management plan. The nurses are kept up to date with any changes in the plan. They flag up any concerns re patients' handover from the previous shift or current ones."

My Lord, moving to page 7 of the reading bundle:

"I have reviewed the notes shown to me in relation to [Baby P], the brother of [Baby O]. [Baby P] was reviewed at 10.00 hours on 23 June 2016 during the ward round, approximately 30 minutes after I had conducted [Baby O]'s review.

"From the notes, I can see that he was a good birth weight for a premature triplet. He had the same problems as [Baby O]: he was on CPAP due to apnoea and he had also been commenced on antibiotics as a routine precaution. The antibiotics were stopped and he was doing a little better than his brother as he was breathing unassisted in air.

"[Baby P] was establishing his feeds on donor milk and he had been tolerating them well. On examination, there were no remarks and a similar plan was implemented to that of [Baby O]: to continue establishing [Baby P]'s feeds and to complete baby checks along with a cranial ultrasound review when appropriate.

"I have documented that [Baby P]'s abdomen appeared full, but this is also subject to whether a baby has just had a feed, therefore we are required to look at the bigger clinical picture. His observations were normal and there were no concerns. [Baby P] was breathing unassisted with no sign of respiratory distress, which is really good for a baby of his gestation.

"He had active bowel sounds and no aspirates and I would describe him as a well baby at that time."

If I could ask Mr Murphy to move to tile 134, please. Returning to Dr Cooke's statement, she states:

"Dr Gibbs was the on-call consultant that evening and conducted a thorough review of him [[Baby P]] and I was completing the writing for him. It doesn't seem like there were any concerns or any dynamic changes from the review in the morning. Dr Gibbs did decide to commence [Baby P] on antibiotics and he requested an abdominal X-ray as a precaution and to rule out NEC.

"The next entry I have documented is at 18.00 hours, which is way beyond the time when everything had happened that day with [Baby O]. I am aware that Dr Gibbs reviewed the surviving triplets post-[Baby O]'s collapse. I later documented in the notes that [Baby P] is stable and continuing to breathe unassisted, tolerating his feeds well, and is active upon handling.

"Dr Gibbs notes that [Baby P] had a normal breathing pattern and his abdomen is full, mildly distended but without tenderness, and active bowel sounds. [Baby P] appeared to have redness at the base of his umbilicus. This may have been due to scratching caused by his nappy or cord clamp. This could have been a genuine concern but it is unlikely in a well baby. It is not an uncommon finding as the clamp on the umbilical cord is made from plastic and, when tucked inside the nappy, due to a premature baby's fragile skin, it could have caused scratching.

"In cases of multiple pregnancy, whereby something has happened to one of the babies from a medical perspective we would have an extremely low threshold for review and very close monitoring of other siblings. Dr Gibbs also made the decision to do a full blood count along with bilirubin and started him on second-line routine antibiotics.

"In consideration of [Baby P]'s belly button and to cover every eventuality, [Baby P] was prescribed flucloxacillin, which was a standard treatment of a suspected infection within the umbilicus. It is also documented that an abdominal X-ray was requested. These actions are precautionary measures taken, especially in view of [Baby O]'s collapse. It is to anticipate the problems and be able to act on it early enough to avoid long-term issues.

"The following day, Friday, 24 June 2016, I was working at the Countess of Chester Hospital and I was either on call again or holding the bleep for the neonatal senior house officer. I certainly recall working with the registrar, Tony Ukoh, as he was my senior that day.

"There is no record of my name on the medical notes for [Baby P], but I think I assisted with CPR on [Baby P] following his collapse. From what I can recall, [Baby P] experienced desaturation and bradycardia. This would not resolve, so we continued on to CPR. I think I was performing cardiac massage until a number of seniors entered the room and they took over. This recollection is from my memory alone.

"The deaths of both triplets was the first time I had seen a neonatal death in my whole career and therefore it has left a lasting imprint on my memory. I would describe it as quite

striking. [Baby P]'s death was unexpected, especially as I do not recall any concerns raised by nursing staff, nor the night team of doctors on call. This recollection is from memory alone."

That concludes that aspect of Dr Cooke's evidence.

She made another statement, which is at page 11, dated 18 May 2018, which states during the time she worked at the Countess of Chester Hospital she had some involvement with the care of a set of triplets born on 21 June 2016.

She repeats that on Thursday, 23 June, whilst working at the Countess, she completed the morning ward round within the neonatal unit and, at approximately 09.30, she conducted a review of [Baby O]. I am looking at page 3 of 4 at 13. It is largely repetitious, but she states:

"I conducted an examination of [Baby P] at approximately 10.00 hours during the morning ward round of 23 June 2016. This was about 30 minutes after my examination of [Baby O] but was 24 hours prior to [Baby P]'s collapse and subsequent death.

"When I complete the morning ward round, I review each baby in a very systematic manner. I review the nurses' observations, respiratory support, fluids and cardiovascular concerns. I then go through the medication prescribed to the baby and any concerns in relation to sepsis. I believe at the time, and considering my qualification grade of being a doctor, I did not miss anything and everything was correctly documented.

"Now, due to my neonatal experience and having worked in this area a little longer, I know that if there was any acute problem or change, [Baby P] would not have presented in a normal, reassuring way. To my knowledge, there is nothing from either my recollection of memory or any notes that would concern me at that time in relation to the examination of either [that is to say [Baby O] or [Baby P]] baby."

My Lord, is that a convenient moment or would you like me to read the next statement?

MR JUSTICE GOSS: I think if we just read the next statement, it'll only take a few minutes. We'll run slightly beyond 1 o'clock, but we'll still have the hour for lunch.

Witness statement of MS YVONNE FARMER (read)

MR DRIVER: Yvonne Rose Farmer made a statement dated 3 March 2018 stating that she qualified as a nurse in April 1997 and in October 2000 she returned to the Countess of Chester Hospital

and stayed within the neonatal unit at this hospital until the present day.

At page 16, my Lord. She asserts that:

"I am a band 6 nurse and I work clinically, but part of my job is referred to as practice development, but it is a role as an educator and concerns the development of the unit within guidelines, introducing new equipment and training our staff to use the equipment. I would describe being an educator as a role I have grown into."

At page 17, and if I could ask Mr Murphy, with my learned friend's agreement, to put up J23866, which is a nursing note which corresponds to the entry within the statement that I'm about to read:

"On 22 June 2016 I was working a long day clinical shift on the unit, which had commenced at 07.30 hours. I recall looking after [Baby P] on this date and I think I also looked after one other patient.

"Halfway through my shift, [Baby P] was doing really well on CPAP, so we stepped him down on to high flow. Again, this is humidified gases, but it is a flow and the infant does most of the breathing. Respiratory-wise, [Baby P] seemed to be doing okay and we checked the gases once the respiratory support had been changed. These results appeared good and so he was left on this flow. [Baby P] started off on a flow of 5 litres and this was reduced to 4 litres at 16.00 hours that day.

"[Baby P] was nil by mouth. Again, this is quite common as you are supporting the work of breathing and you don't want to compromise this by filling their stomach with milk. He was on intravenous fluids via a cannula line in his hand or foot. Again, this is the normal practice of administering intravenous fluids.

"During this shift, we conducted hourly checks on the cannula site and I noticed that there was tissing (the site was becoming blocked) and instead of the fluids travelling via the vein, the vein breaks down and travels via the tissues.

"A cause of this is due to prematurity. As the vein is so narrow, it breaks down and causes local swelling, so the cannula is removed and a new one inserted into another vein, but there is no permanent damage caused. There are signs you look out for. Symptoms include redness, swelling or if the baby appears to be in any pain.

"I had informed the doctor about the tissing but, as we were busy at the time, no one could replace the cannula straightaway. As a result, I had been asked to start some feeds so they could reduce the amount of intravenous fluids.

"During the afternoon, one of the consultants sited a new line, recommenced intravenous fluids and continued with a small amount of feeds. Again, this is calculated on the weight of the baby to a ratio of millilitres per kilogram and [Baby P] was given 75ml per kilogram. [Baby P]'s cannula was later changed and he was showing signs of toleration with no vomiting and his stomach was not distended, so we were happy to continue with the feeds.

"During the shift and over the evening, those feeds were increased. We look for signs that the baby has opened his bowels and that the digestive system is working. I was happy with [Baby P]'s progression. He was a little quiet but some babies are quieter than others. Respiratory-wise he was doing quite well and he was starting to absorb some feeds. His antibiotics were stopped because his blood cultures were negative and the markers we look for in relation to infection were okay.

"[Baby P] was doing quite nicely. However, we are never complacent with premature babies as there is always an element of risk of infection."

That concludes the relevant parts of her statement, my Lord.

MR JUSTICE GOSS: Yes. Thank you very much. We'll break off now, members of the jury. Could you please be ready to continue at 2.10, which is just over an hour? A few minutes over the hour. Thank you very much. Please remember your responsibilities as jurors not to conduct any research or communicate with anyone about anything to do with this case.

(In the absence of the jury)

MR DRIVER: Just to inform the court, having just reduced to a couple of minutes that which might have taken 30 or 40 minutes, it may be that we finish a little earlier this afternoon.

MR JUSTICE GOSS: Don't worry about that at all, Mr Driver.

Thank you and Mr Maher very much.

Can I just explain about the transcript issue whilst we're here? On the transcripts that were sent through, Wednesday the 15th, in other words last Wednesday, was Day 88, and that was marked on the preceding day's work.

The day of the snow was not a sitting day as such -- it was a sitting day, but no transcript was produced for that day.

MR JOHNSON: Yes.

MR JUSTICE GOSS: So all the days apart from that Friday were sequential up to that date. Wednesday 15th, Day 88. When we got to Thursday, it's Day 90.

MR JOHNSON: Yes. That's because it was pointed out to the transcriber that a day had been overlooked, which was the previous Friday.

MR JUSTICE GOSS: Exactly, but I'm not going to renumber my days going back to -- to renumber those because it's just too difficult, but that, I assume, is what happened.

MR JOHNSON: It is. That's the inference I had drawn.

MR MYERS: I should say, if it assists, we were in contact with the people who produce the transcripts because we'd identified there'd been -- the days that the case has been listed didn't tally with the days on the number of days and it was apparent that on the day that the court sat but no evidence was called, which you'll recall is 10 March, no LiveNote transcript was prepared for that day, and so they'd continued from the Thursday and then picked up the numbering again when we returned, but had omitted in the run of it the day when we had sat and so that was identified and that was corrected. In fact it makes a difference -- if there is no change of numbering it makes a difference to 2 or 3 days, that's all, and then we all meet up again after that.

There was one day where they hadn't recorded the actual day of the trial that it was correctly and that's how that came about. So the extra -- they moved the numbers forwards to accommodate the fact that if the days on the LiveNote transcripts are to actually tally with the days recorded of the trial sitting, the two tally. And that means that we move forwards with no transcript on 10 March, which is why there's a difference between the number of transcripts and the number of days sitting, the one day. That's how that came about, my Lord.

MR JUSTICE GOSS: Thank you very much. So it's between the 11th and the 20th?

MR JOHNSON: I have actually put it in an email which your Lordship's clerk has.

MR JUSTICE GOSS: That's fine, thank you. That's what I assumed would happen, it had been picked up.

So are we all going to -- if we need to refer to a particular day, are we going to renumber those days between...

MR JOHNSON: It would only actually involve renumbering the Friday, which had no number, and then the Tuesday and Wednesday. It's only renumbering 3 days.

MR JUSTICE GOSS: Well, we'll do that. I don't want the transcripts resending out.

MR MYERS: The way it follows now, my Lord, or should follow, is that -- yes, Day 86 is 9 March. We then have Day 88 is the 14th. And there is no transcript for Day 87 -- oh, Day 87 is the 14th.

MR JUSTICE GOSS: I think we all know what the issue is.

Thank you very much.

(1.12 pm)

(The short adjournment)

(2.10 pm)

(In the presence of the jury)

[DR B] (recalled)

Examination-in-chief by MR ASTBURY

MR ASTBURY: Good afternoon. Could we start with your full name, please, again for the record?

DR B: I'm [Dr B].

ASTBURY: You'll remember, [Dr B], I'm going to ask you to keep your voice up and generally in the direction of the microphone, which of course doesn't amplify, it only records.

You came along last week to assist us with your treatment of a little boy called [Baby O] and you've come along today, as you know, to assist with his triplet brother, [Baby P] --

DR B: Yes.

ASTBURY: -- known as [Surname of Babies O, P & R] on the medical records.

You, I think, first met [Baby P] during the course of a ward round on 22 June 2016; is that right?

DR B: That's right.

ASTBURY: Thank you. I think that took place at about 11.45 am?

DR B: Yes.

ASTBURY: And you were paediatrician of the week?

DR B: Yes, that's right.

ASTBURY: I'm going to ask, please, it's not on our carousel, but if Mr Murphy can put up J23840, please.

(2.11 pm)

(No video feed from court)

(2.12 pm)

MR ASTBURY: Hopefully you recognise the writing?

DR B: Yes, that's right, that's my handwriting.

ASTBURY: Thank you. That's your note of the ward round on that particular occasion?

DR B: Yes.

ASTBURY: You have noted there triplet 1, as we know [Baby P] to be.

DR B: Yes.

ASTBURY: And you have noted the problems as they were considered to be at the time?

DR B: Yes.

ASTBURY: And then you've made a note of the various categories that we're becoming familiar with.

DR B: Yes.

ASTBURY: We can see there that [Baby P] had been screened and was receiving antibiotics. If we can scroll up and look at your examination, please. I don't think we need to go into too much detail on this, simply to identify it.

We can see that abdo was considered soft at that point.

DR B: Yes.

ASTBURY: You have made other notes. Was he on breathing support at that stage?

DR B: No, he had been taken off. Had been on -- so he was on CPAP at the time, at this point in time when I saw him.

What I'd asked for -- so you know where it says "U&E plus gas and trial of Optiflow"? So I had asked if we could step -- as a step-down approach in weaning ventilation, change him to Optiflow from CPAP. So at the time when I saw him, he was on CPAP, and I'd asked for that to be changed to Optiflow.

ASTBURY: Is that a positive step for a baby in [Baby P]'s position?

DR B: Yes, that's a positive step. So basically, CPAP is a form of non-invasive ventilation, which gives pressure and aids ventilation. Optiflow is just some flow with humidity. And as a method of non-invasive ventilation, it's a step down towards -- the next thing that would happen is you would wean the Optiflow and then take them off, which is what happened with him.

ASTBURY: Thank you. We saw yesterday, indeed I should tell you this, we've already heard in this case from [Dr A] and a number of other doctors who treated [Baby P] on the day we're about to deal with, so we won't need to go through those notes. In fact, we also heard as a matter of fact Optiflow came to an end around about 6 am on 23 June.

DR B: That's right.

ASTBURY: The jury, I'm sure, will remember. Just looking at those notes, and bearing in mind the stepping down of the ventilatory support, what's your assessment, please, of [Baby P] or what was your assessment of [Baby P] during the course of that ward round?

DR B: So from looking at the notes, it looks like I am fairly satisfied with his progress. He is one of the triplets and he is progressing as we would expect him to. He is on CPAP, we are planning to change his fluid, we're giving him antibiotics which we plan to stop, his examination is unremarkable. I've asked for some blood tests to check his kidney function, a blood gas, and wean down his ventilation and I am predicting that things will go to plan and there wouldn't be any problems with moving him on to -- out of the ventilation, introducing feeds and spending a period of time on the neonatal unit, what we call feeding and growing and establishing feeds --

ASTBURY: Right.

DR B: -- before being discharged.

ASTBURY: You mentioned blood gases. I wonder if I can ask Mr Murphy to go to tile 178, please. I'm going to look at blood gas record, please, because you -- part of your plan was, I think, to take another blood gas record; is that right?

DR B: Yes. So one of the things, if I could just clarify at the beginning, is in my statement I have mentioned that I have reviewed his gases, which I have not documented here, but as part of the review I would have looked at his observations, his temperature charts, whether he'd opened his bowels, passed urine, what his temperature stability had been, whether he'd had any periods of dropping his oxygen levels or heart rate. I would have looked at the blood gases that had been done before, which, although I have not documented, forms part of seeing the patient.

ASTBURY: Okay. So as of the 22nd, having completed your examination and made your plan, all that information would have been in the mix and under consideration when you decided on the progress?

DR B: That's correct.

ASTBURY: Thank you. If we can look at those blood gases because there's one -- if we look at 22 June, just below -- the first of the hole punches on the page, we can see there's one at 12.17, not long after your examination of him.

DR B: Yes.

ASTBURY: Is there anything, and again I don't think we need to go into detail, you may be asked if it is necessary, is there anything that stands out on that particular blood gas reading at 12.17?

DR B: No, this is what I would call an excellent gas.

ASTBURY: We can see there's a note suggesting progress on to Optiflow; is that right?

DR B: That's right.

ASTBURY: And as it happens, we have another blood gas in the afternoon, which the entry suggests is once [Baby P] is already on Optiflow. Again, bearing in mind the change in ventilation,

is there anything we need to have our attention drawn to in that particular blood gas reading record?

DR B: No. Again, this is an excellent gas, very similar to the one done at 12.17, and does not raise any concerns and looks like everything is going in the right direction. His ventilation has been weaned to Optiflow and he seems to be managing very well with that change.

ASTBURY: Thank you. You next considered, certainly for the purposes of your statement, and I don't think we need to go to it, as it happens we've just seen it, you then considered the examination undertaken by Dr Cooke, is that correct, on 23 June?

DR B: Yes.

ASTBURY: Did anything concern you from that particular examination on reviewing the notes?

DR B: No.

ASTBURY: Next, please, could I ask Mr Murphy to go to tile 63.

No, that wasn't in fact what I was hoping to go to.

It'll be 64, please, Mr Murphy, my error.

If we scroll halfway down, I hope. Scroll down, please. We can see there at -- just keep going, please.

It's not a note that you completed, doctor, but we can see after Dr Cooke's examination, it would appear that you've looked at what's called a CRUS, a cranial ultrasound scan.

DR B: Yes.

ASTBURY: And can you tell us, please, what you have noted as a result of the scan?

DR B: That says:

"Normal appearance, no [something] haemorrhage or dilatation."

ASTBURY: Is that "evidence of"?

DR B: So that's evidence of -- that the cranial ultrasound was normal, showing no features of concern.

ASTBURY: Thank you. So you're able to satisfy yourself that all was normal in that regard?

DR B: Yes.

ASTBURY: Thank you. We've heard already from you about events during the course of that afternoon and early evening on 23 June. We've also heard this morning, and you comment on it in your statement, Dr Gibbs reviewed both [Baby P] and [Baby R] after the death of [Baby O] that particular evening and you have seen those notes. Was there anything -- we're not going to go to them -- that stood out to you having seen those particular notes?

DR B: No.

ASTBURY: Any concerns?

DR B: No.

ASTBURY: Moving on then, please, to 24 June, were you present at the morning handover?

DR B: I was.

ASTBURY: This would have been the morning after [Baby O] passed?

DR B: Yes.

ASTBURY: What time would that handover normally take place?

DR B: 8.30 in the morning.

ASTBURY: Do you remember having any conversation with Dr Mayberry, who had been the night registrar?

DR B: So this is part of my statement. I don't remember it exactly now, but as I've mentioned in my statement, Dr Mayberry had said in the handover that he had been asked to review [Baby P] overnight and felt that he had some abdominal distension and had, as a result of that, stopped his feeds and started him on intravenous fluids.

ASTBURY: Right.

DR B: He was already on antibiotics from the evening before when Dr Gibbs had reviewed him after [Baby O] sadly passed away. Both [Baby R] and [Baby P] had been screened and started on antibiotics, more as a precaution, just to make sure that we were covering them for infection.

ASTBURY: We've heard, I think this morning, that the consideration is the fact that they are triplets --

DR B: Yes.

ASTBURY: -- so there is the potential for similar features to arise in siblings who are born in that way?

DR B: That's right, yes.

ASTBURY: Had [Baby P], do you recall, been changed to intravenous feeds as opposed to bottle feeds or milk feeds?

DR B: So he had been changed, so his feeds -- he was only having nasogastric feeds during the course of the previous evening when Dr Mayberry was asked to review him overnight there were some concerns that he'd had short episodes of desaturations and bradycardias as well as some abdominal distension. So I think more as a precaution, given what had happened with [Baby O], Dr Mayberry rightfully decided to play it safe and stop the feeds and put him on intravenous fluids, taking into account that his -- he was already on antibiotics. He also notes that despite these episodes of brief dips in oxygen and heart rate, he remained in air, so Dr Mayberry wasn't concerned and didn't think about putting him back on any form of assisted ventilation and was satisfied that just stopping the feeds and managing it that way was the right thing to do, which I agreed with when I briefly reviewed him the next morning.

ASTBURY: So at that point you've just confirmed for us that [Baby P] remained breathing for himself in air?

DR B: That's right, yes.

ASTBURY: Dr Ukoh, I think you just mentioned, took a review at 9.30 that morning?

DR B: That's right.

ASTBURY: Did you play any part in that review?

DR B: My part in that was -- so that morning wouldn't have been one of the days where we undertook morning ward rounds. However, when Dr Ukoh was reviewing [Baby P], I came and sort of cast an eye on [Baby P], just to make sure he was okay and I don't remember noting anything unusual.

I have seen Dr Ukoh's note entries, so at the time he was still -- [Baby P] was still in air, his abdomen was a little bit distended, he was on antibiotics. As far as I can remember there were no major concerns as such -- he was on caffeine as well and I suggested to Dr Ukoh that we undertook some investigations just to screen for a few things. Those have been listed: there was a blood count, which is just to check his blood cells; a CRP

to check for infection; a kidney function test to make sure his blood salt levels were okay; a blood gas; and an ammonia, which is basically a test that is done, a blood test, which we send on ice to check for metabolic disorders.

I think this was from the background of [Baby O] having passed away the day before, so this is just thinking beyond, "Is there anything else we should be looking for", and as part of that I'd asked for, while we're doing bloods, can we do this as well.

ASTBURY: Do you recall how that particular examination of [Baby P] came to an end?

DR B: I did not examine [Baby P], so there is no note for me saying that I have examined him. Dr Ukoh has and from the note entries, I have written -- I think while I was seeing him, I was either -- I don't remember this exactly -- either asked by one of the nurses that there was a phone call from the coroner about [Baby O] or I was bleeped, I don't remember, because the previous evening I had left my contact details on the answer machine about [Baby O]. So at about around the same time I have been asked to go to -- there was a resource room in the neonatal unit where we would take phone calls, which would be out of hearing.

ASTBURY: Just break that down then. Having been present at [Baby P]'s examination by Dr Ukoh, you then had cause to go to the resource room, was that?

DR B: Yes.

ASTBURY: To make a phone call?

DR B: Yes.

ASTBURY: And your recollection of who that phone call was to?

DR B: Again, this is from note entries. In my note entries, I have written that I was on to the phone to the coroner and, again, I have been asked this by the police, as to why I remember the conversation, and I have replied that I do not remember what exact conversation I had with them. However, it would have been to do with a summary of the unexpected events from the day before with [Baby O] and my filling in the coroner -- either the coroner or the coroner's officer, because I think you can confirm that from my statement who I spoke to because this is documented in the notes. I updated them on the previous day's --

ASTBURY: Okay. Well, rather than concentrate on what exactly you were telling them, what happened while you were on that phone call?

DR B: Yes, so I was asked to come and quickly review [Baby P] during that.

ASTBURY: And why was that?

DR B: Because, again, he'd suddenly become unwell and that was literally just 10-15 minutes after I'd seen him.

ASTBURY: Okay. We've heard that was the start of a series of difficulties for [Baby P] throughout the day; does that accord with your recollection?

DR B: Yes.

ASTBURY: Did you make a note of your involvement through the course of that day later on that evening?

DR B: Yes.

ASTBURY: I'm going to ask you then to look at that note, please, doctor, to assist you. It's tile 625.

It's quite a long note. I've gone to this tile because it's where all the notes are. But for the jury's help, it's spread out through the chronological order but I have gone straight to this so that we can take it through.

You've written -- just identify that is your note?

DR B: Yes.

ASTBURY: We should do that first, thank you. You have put:

"Written retrospectively from around 9.30 am."

You were called to nursery 2 because [Baby P] was unwell; is that right?

DR B: That's right.

ASTBURY: You have noted that Dr Ukoh and Nurse Lucy were present; is that right?

DR B: That's right.

ASTBURY: Anyone else present when you got there?

DR B: As far as I remember, no.

ASTBURY: Then you have noted that [Baby P] was dropping his sats, that's the saturation levels of oxygen in his blood, and his heart rate had dropped as well?

DR B: Yes.

ASTBURY: Is that right?

DR B: Yes.

ASTBURY: "Just a few minutes earlier I had briefly seen [Baby P] and discussed with registrar to do..."

And I think you have listed those tests you have already very helpfully told us about, I'm not going to go through those again:

"Shortly after this, [Baby P] deteriorated, Dr Ukoh started to bag and [you have put, is that] intravenous access x1 lost as not flushing"?

DR B: That's right.

ASTBURY: Can you explain that, please, to us from your recollection?

DR B: So basically, when I was called in to see, which was quite a shock, I saw that his saturations -- I don't remember the exact numbers, we would probably have to go back to the charts to look at that. His heart rate was dropping and his saturations were dropping. In my statement I think I have written that his sats were low and the heart rate was around 80, which is quite alarming because with any heart rate drop to 60, we start CPR, which is cardiopulmonary resuscitation. One of the first things you want in a child is you want to look at the airway. So you look at if they are dropping their oxygen levels, you start assisting them, which Dr Ukoh does, so he gets the Neopuff and starts to bag with -- assisting that, and I look for intravenous access.

He had one cannula in place, [Baby P], and as the further resuscitation comes and follows, that was lost fairly quickly because, shortly after this, his heart rate dropped to 60 and we started cardiopulmonary resuscitation and as part of cardiopulmonary resuscitation one of the drugs that's given is adrenaline. So the first --

ASTBURY: I'm going to ask you to pause there because, if it assists you, we've seen [Dr A]'s note and he confirms that the

heart rate was down to, as you said, 80, and sats were down to 60%, which you're right, is in your statement. I think you were about to tell us that the heart rate dropped still further; is that right?

DR B: That's right, yes.

ASTBURY: So your recollection of how long it was before that took place, roughly?

DR B: It probably wouldn't have been very long. Maybe within a couple of minutes.

ASTBURY: Okay. We've heard it before, but you tell us what happens when it drops to 60 or below?

DR B: Yes. If it drops to 60 or below, we commence cardiopulmonary resuscitation, which starts off by external cardiac compressions. So because the heart output is not enough to oxygenate, you assist by cardiac compressions and you give medication to improve the heart rate and the medication that's given is adrenaline.

ASTBURY: Okay. Pausing there, did adrenaline start on this occasion?

DR B: The first entry, as far as I can remember, is at 9.55, the first adrenaline.

ASTBURY: How was that administered?

DR B: The first dose was intravenous. So normally, we would give the adrenaline and then you would flush it to make sure that it goes into the -- because it's only a small dose, it's 0.1ml per kilogram, so he would have had 0.2ml, which literally -- you need to give a bit more fluid to make sure it goes in the system. And the cannula... When I say it flushed, there's a swelling that comes up at the end of it, which tells you that you can't use it anymore because it's not going in the vein, the cannula has tissue, is the word that we use, so the IV access is lost.

ASTBURY: Having commenced the resuscitation procedure that you have told us about, access is vital?

DR B: Access is vital, absolutely, yes.

ASTBURY: So were you able to administer more than one dose of adrenaline via the intravenous line that was eventually to block?

DR B: No.

ASTBURY: So what did do you then?

DR B: We then proceeded -- at this point [Dr A] had also come. So this now becomes more than one people (sic).

So one person is looking after the airway --

ASTBURY: I am going to interrupt you again, I am sorry. Do we take it from what you have said [Dr A] wasn't there to start with?

DR B: He wasn't there to start with but then he arrived and took over the airway management over from Dr Ukoh. He put the Guedel airway in and started bagging and we were getting ready for intubation. Around this time the adrenaline was also given, the IV access is lost, and Dr Ukoh and I moved to this end to start --

ASTBURY: Someone is taking a note of what you say, so I'm going to ask you to slow down. Lots going on at once.

DR B: Yes.

ASTBURY: [Dr A] has taken over the airway?

DR B: That's right.

ASTBURY: He's introduced a Guedel airway, which we've heard about before?

DR B: Yes.

ASTBURY: Preparations are being made for intubation?

DR B: That's right.

ASTBURY: And in the meantime, drugs are being administered, initially via an intravenous line, but then that line is lost; is that right?

DR B: That's right.

ASTBURY: Okay.

DR B: So in the first instance, both Dr Ukoh and I attempted to re-site an intravenous line, which is through -- which is inserting a cannula. I do not recall how many attempts, but normally in a very sick baby or a child, we would not spend too long before moving to an intraosseous route, keeping in mind

then when a baby collapses circulation is very poor and obtaining intravenous access can be very challenging. However, it is very important to have some kind of an access and an alternative to intravenous access is intraosseous access.

ASTBURY: We have heard that's through the bone in the leg, into the bone marrow within.

DR B: Yes.

ASTBURY: And that enables intravenous drugs --

DR B: Intraosseous, yes.

ASTBURY: Sorry, intraosseous as it then becomes. Can we return to your note so you don't have to try to remember too much because I think you have made a note as to what unfolded with the intraosseous access. If we can go down, please.

You have then noted:

"Airway maintained with Neopuff whilst bagged whilst getting intubation ready. Few attempts at IV access unsuccessful. [Dr A] arrived and took over airway from Dr Ukoh. Dr Ukoh and I inserted an intraosseous, [is that] needle"?

DR B: That's right.

ASTBURY: "First in left (Dr Ukoh)..."

Is that his action?

DR B: Yes.

ASTBURY: "... and then the right (by myself)."

Is that right?

DR B: Yes.

ASTBURY: "Heart rate falling."

Then you put:

"Adrenaline was given via intraosseous access."

Is that right?

DR B: That's right.

ASTBURY: Then:

"Intubated successfully at first attempt by [Dr A]."

DR B: That's right.

ASTBURY: So scroll down a little further, please. You have then put that:

"[Dr A] and I were present with [Baby P] through the day. For detailed notes on management and resuscitation, please refer to [Dr A]'s note entries."

DR B: That's right.

ASTBURY: So that presumably is for times and quantities and the like?

DR B: That's right.

ASTBURY: Okay. Whilst the drugs are being delivered via the intraosseous route, did resuscitation continue?

DR B: Yes. So again, I have not made detailed notes here, but with the -- I think he had at least four collapses.

He had three or four doses of adrenaline and a sodium chloride bolus before the return of spontaneous circulation --

ASTBURY: Well, again, if it assists you, it was not too long after 10 o'clock that [Dr A] notes that [Baby P] stabilised.

DR B: Yes.

ASTBURY: Once that first collapse or the emergency had passed of that first collapse, did you then go to contact somebody else?

DR B: Yes. So as I've written here as well, after this happened, this was now beginning to really concern me, that it was very similar to what had happened the day before. We had stabilised [Baby P] and I went away to speak to the neonatal transport team consultant, Dr Rackham, who is the same -- so it can be a different person, but it happened to be Dr Rackham who had been the same consultant that I'd spoken to the previous day for [Baby O].

ASTBURY: Was intravenous access, [Baby P] now -- the emergency having passed for now, was intravenous access regained?

DR B: Yes. So again there is a detailed note of that in my notes. I'll just clarify here, basically, very shortly after [Baby P]'s passing, [Dr A] and I sat down and discussed the

chronology of events and when -- what happened and just to make some sense of what had happened and I wrote my statement with times and what had actually happened in my statement very shortly after. So in that, I have made a note that once [Baby P] was stable, [Dr A] managed to site an IV access. I think one was on the right side and a short while later on the left. So not long after the first resuscitation, he had a -- one intravenous access and then, after that, two intravenous accesses, plus an intraosseous access.

When babies, or even older children, are unwell, it is recommended that they have at least two intravenous accesses, one, because multiple medication can be needed, and two, you have a back-up in case one stops working.

ASTBURY: Okay. Shall we return to your note, then, if we may?

I think you've made a note that you spoke to Dr Rackham at about 10.30 and updated him about [Baby P], you were advised that they would enquire whether a bed was available and also to try to take [Baby R] to the same unit was the plan. That was the parents' request so that they could be together; is that right?

DR B: That's right.

ASTBURY: You then go on to talk about speaking to Dr Rackham at 1 pm, but picking up about what you were saying about the times and sitting down with [Dr A], [Dr A] has recorded another desaturation and bradycardia at 11.30, involving [Baby P].

DR B: That's right.

ASTBURY: And a serious one; is that right?

DR B: That's right.

ASTBURY: Do you have a recollection of that second collapse?

DR B: Yes, I do. The second collapse, again, the oxygen saturation dropped and the heart rate dropped and he needed full resuscitation with adrenaline, bicarbonate and sodium chloride boluses.

ASTBURY: Okay. Which we've heard are the standard resuscitation drugs in these circumstances?

DR B: That's right.

ASTBURY: And we've also had the explanation as to what each is designed to do. Having collapsed at 11.30, is it right that spontaneous circulation returned as soon as 11.36 with [Baby P]?

DR B: Yes. So I think -- was this the time that he only needed one dose of adrenaline?

ASTBURY: Yes, I think.

DR B: Yes. One of the things which was -- again, I don't have my statement in front of me, but I recall -- was it at this time that it says he was very vigorous and breathing against the ventilator, so he was given some morphine --

ASTBURY: Right.

DR B: -- which again is -- so when you have a baby who is sick, who has sort of gone downhill and gradually become unwell to the point that you have intubated and ventilated them, they don't bounce back that quickly that in 5 minutes they'll be wanting to get this tube out, "I don't want this anymore". So that's basically the baby complaining that they don't like the tube down their throat, which is why we've gone and given him some morphine to sedate him.

ASTBURY: Okay. Can we break that down? 11.30, collapse requiring -- again, was there --

DR B: Cardiopulmonary resuscitation.

ASTBURY: Thank you for saying that. To such an extent that he required the full resuscitation programme, if we put it that way?

DR B: Yes.

ASTBURY: Those drugs that you have told us about, the first dose is being administered?

DR B: Yes.

ASTBURY: Six minutes later, you have spontaneous circulation again?

DR B: Yes.

ASTBURY: And how soon after is the baby effectively complaining about the intubation?

DR B: Around the same time. So what I have noted in my statement is that [Baby P] fighting the ventilator and breathing against the ventilator. When babies are being ventilated artificially with an endotracheal tube and we are giving them artificial ventilation, it's not ideal that they should be breathing

against the ventilator, so we then have to take measures to try and stop them breathing or synchronise with the ventilator somehow.

ASTBURY: I think you were, and I'm sorry for interrupting, telling us that it came as a surprise that he displayed that behaviour --

DR B: Yes.

ASTBURY: -- so quickly afterwards?

DR B: Absolutely, yes.

ASTBURY: Just explain to us why that was such a surprise, please.

DR B: Because basically, if a baby -- the first collapse was unusual. There was no reason for him to have suddenly dropped his oxygen levels and his heart rate. There had been nothing to suggest that. We had taken the necessary measures and resuscitated him and were still trying to work out what had actually happened, which was -- when you're thinking, "I don't get what is going on here, I need to discuss this with someone", and that someone at that moment in time is a tertiary specialist, which is why I'd gone and spoken to Dr Rackham, you're asking yourself, okay, I've done ABC, the baby is now stable, I don't understand what's going on, I need to speak to someone else and use their expertise, to include their advice in this.

So that's all going on and then while -- there's no reason again for him to collapse a second time, but it happens, and then he comes back very quickly and not only does he start breathing again, he's very vigorous, he's breathing against, he's kicking and he's complaining, which means that whatever event happened was a short period and then his circulation was back and he was --

ASTBURY: It's a very rapid recovery from a very low point?

DR B: Yes.

ASTBURY: How did [Baby P] appear in that period then when he was resisting the ventilator?

DR B: So he was -- what babies then do is you see them moving their arms and legs and they're trying to breathe and gag. And they open their mouths and you can see that they are appearing distressed from the intervention that...

ASTBURY: How would you have described -- it's a snapshot, I suppose, but how would you have described generally [Baby P]'s condition at that moment in time?

DR B: At that moment in time I would have thought, well, okay, he's come back quite quickly -- and I think one of the things is you -- what you do is very mechanical in that time, you deal with each situation as it's happening and you're trying to count -- because the only thing in your mind at that point is, how do I make this baby better, what do I do, and what do I have to do? So when a baby collapses, you give them adrenaline, you do CPR, you do the intubation, you've done that. Then if it happens again, you do the same thing again. So you're countering or trying to deal with every problem as it happens.

So at this point in time I see a baby who's come back very quickly, who's vigorous, but he's not -- I'm not in a place to say, well, okay, you're vigorous, you don't like your tube, I'm going to take the tube out.

I can't do that, I have to leave that tube in because this baby is having these collapses that I don't understand. So I then have to find a way to try and sedate him so he doesn't fight the ventilator.

ASTBURY: Okay. I think the medication that was given to [Baby P] at that stage was pancuronium; is that right?

DR B: Did he not have morphine before that? Because I think at one point he had 100 micrograms per kilogram of morphine first and then he had the pancuronium.

ASTBURY: Did that have the desired effect?

DR B: Yes. With the pancuronium, what the pancuronium does is it just stops them moving, it paralyses you. Basically it's a drug that paralyses you. That means that you can control the baby's breathing completely. They do not move, you breathe for them, you basically have to make sure that the ventilation settings are optimal and you can anticipate that the baby is not putting in any effort, but that also means that you have control over their breathing and by ventilation you can't cause any harm.

ASTBURY: Right. What I would like you to look at next, please, if we can go back to tile 178, you comment on a blood gas record that was taken not too long after this episode at 12.08.

DR B: Yes.

ASTBURY: If we can scroll down, please, I'm going to ask you to look at the penultimate entry on that particular line.

DR B: The 12.03 gas, this -- I remember being very pleased with this gas when I saw it because this had come after a few very poor gases. There's one that's not here which was a 6-point-something as well which is in my statement and it's in another gas record but that's not been entered here.

So the 12.03 gas, the pH of 7.32, which is very good. A CO₂ of 3.33, which is low normal, which means we are ventilating him well. A PO₂ of 5.72 is the capillary gas; that doesn't worry me. Base excess is minus 11.4, which is quite high, and this was a problem that we, as you can see from the previous gases as well, that's been progressively rising so this is metabolic acidosis, which means that the tissues are being deprived of oxygen, and that is producing the lactate which -- despite us having given him quite a few doses of bicarbonate and he went onto a bicarbonate infusion as well later on. That is minus 11.4, but to me that was -- I remember breathing a sigh of relief, phew, because by this time I'd spoken to Dr Rackham a few times, they were on their way and I am thinking, okay, we've paralysed him, we've got control of his ventilation, we've done a gas, the gas is good, so yes, we are dealing with the metabolic acidosis and, fine, the transport team are going to be here soon, we're going to be okay. I just remember that sort of sigh of relief at that point.

ASTBURY: Bearing in mind in his recent intubation, what does that gas, if anything, tell you about the effectiveness or otherwise of his ventilation?

DR B: That it is effective, that his ventilation is working.

So he has been paralysed now, we have sort of dealt with the fact that he was fighting the ventilator. We don't know why it's happened still. We are just, as I said, trying to deal with the problems as we are facing them, not quite understanding why these collapses have happened. But where we are from his airway/breathing point of view, I am reasonably satisfied, circulation I'm not very happy with, with the base excess of minus 11.4, but I feel like we're getting there, things are getting better and under control.

ASTBURY: Had you carried out any cold light tests during the course of the two resuscitations?

DR B: Yes, we had, and the cold light hadn't indicated that there might be a pneumothorax or an air leak.

ASTBURY: But I think that changed with an X-ray taken at 11.57; is that right?

DR B: That's right, yes.

ASTBURY: Go to tile 400, please. We can see there the time and date on the X-ray. I suspect the clue is in the question. What can you see there, on that particular X-ray?

DR B: Particularly in that chest X-ray we can see a right-sided pneumothorax, but it's not a tension pneumothorax. So the baby is intubated, I can see an endotracheal tube, I can see that there is a rim of air on the right side, you can see the lung margins, and you can see the air.

ASTBURY: Thank you.

DR B: However -- so pneumothorax is an air leak. Sometimes in babies who are otherwise not unwell, we can see small air leaks, but if the -- so a tension pneumothorax is when you get a large amount of air on one side and it pushes the heart to the other side. That is an acute emergency that you have to do something about.

ASTBURY: Is that the case here?

DR B: No. So this was not a tension pneumothorax, there was no mediastinal shift, which is why at the time, given with what had happened, we decided not to do anything.

There was no mediastinal shift, there was an air leak, but that changed with the next collapse because when we move on, when he deteriorated again, one of the first things we thought about was: well, yes, it wasn't a tension pneumothorax then, but has it become one now?

We needed to deal with that, so we then went on to do a needle aspiration to relieve that.

ASTBURY: In [Dr A]'s note that third deterioration took place at 12.28?

DR B: That's right.

ASTBURY: Again, in the timeline, does that accord with your recollection?

DR B: Yes, it does. I do remember exactly what had happened at that time as well. So with that gas that we looked at, we were sort of -- [Dr A] and I, I think, both breathed a sigh of relief. We were in nursery 2. It's an L-shaped corridor, [Dr A] and I walked down to the kitchen -- there's a little kitchen just as you enter the neonatal unit -- to make a drink. And I remember putting the kettle on and [Dr A] and I were talking

through -- when you are just trying to get your head round what's actually happened, talking out loud, thinking out loud.

I don't think we got very far. So literally, I don't think the kettle had even boiled, where somebody shouted from the end of the corridor, "Can you please come now", so both of us were out of the room when that collapse happened.

ASTBURY: Was there anyone left in the room when you went out?

DR B: Yes. As far as I can remember, Staff Nurse Lucy Letby was there with him all of that time.

ASTBURY: Anyone else there when you left him?

DR B: I don't remember.

ASTBURY: Do you remember who called you back?

DR B: No, I don't even know if I saw the person because I think we were in the kitchen and somebody just shouted -- because it was literally shouting distance, so they would have gone to the end of the corridor and shouted us because they knew where we were and we just came running back.

ASTBURY: When you came running back, what did you find?

DR B: So as far as I can remember, he was desaturating and his heart rate was dropping and his oxygen levels were dropping as well. And it looked like this child who had been paralysed with pancuronium had dislodged his ET tube. And one of the problems with pancuronium is whilst it's very good in controlling the ventilation, the baby can't do anything for themselves, so if the tube becomes dislodged for any reason -- and it is unlikely, unless -- because the baby is not moving, they are not breathing so unless something really untoward happens, you wouldn't expect that tube to dislodge, which was why I think we had sort of walked away from it, thinking, well, you know, he's now not going to breathe or fight the vent, we have a few minutes to think about is there anything we are missing or, you know, what we need to think about.

So we came back to find him crashing, that's the term you would use, and when we checked, the tube had dislodged.

ASTBURY: Do you happen to recall who was in the room when you went back?

DR B: I don't have a vivid memory but I do remember Lucy was at the bedside of the baby. She would have obviously asked somebody to call us.

ASTBURY: Okay. Were you given any explanation as to what had happened when you got back?

DR B: To be honest with you, I don't remember asking for one.

That wasn't my priority at the time.

ASTBURY: What was it that caused you to believe that the problem was the tube?

DR B: So the baby's connected to the ventilator, you are giving them breathing through the ventilator. If their oxygen levels start to drop, then the first thing you think about is, is the ventilator and the tube doing what they're meant to be doing? Because in a paralysed baby, it's the tube and the ventilator doing everything, the baby can't do anything. So you're basically -- literally one of the things -- first things you think about -- and if you're not supplied with oxygen through the ventilator for long enough, it's only a matter of time before your heart gets deprived of oxygen as well and starts dropping as well.

So the first thing you go to in a baby who's paralysed and starts to drop their saturations is, "Is there a problem with the tube?"

ASTBURY: Okay. Did you examine the tube?

DR B: I must have had a listen, tried to bag and checked if either there was no air entry or the chest wasn't inflating, but that decision was probably made quite quickly that the tube wasn't in anymore. Yes, I think I've written the capnograph wasn't changing colour.

That's one way of finding out.

ASTBURY: What happened then to the tube?

DR B: We removed that tube and [Dr A] re-intubated him.

ASTBURY: For a third time, was cardiopulmonary resuscitation recommenced?

DR B: Yes.

ASTBURY: What happened this time? Can you recall?

DR B: This time, as well, he received multiple doses of adrenaline, sodium chloride, sodium bicarbonate. We also commenced him on adrenaline infusion. I think this was -- around

this time, 12.20, was around the time to, give him a constant supply of -- either at this time or maybe a bit later on he went on two more infusions of dopamine and dobutamine to, again, improve his circulation and his cardiac contractility.

ASTBURY: Okay. Were any measures taken regarding, at this stage, the pneumothorax that you'd seen about --

DR B: Yes. Again, with the -- you'll have to go back to the statement to consult with the time. So one of first things we then also thought about with this collapse once the ventilation had happened was to needle the pneumothorax, the right side. The needling of the pneumothorax is that you insert a cannula and allow the air to come out. So that's an emergency procedure, which always should be followed by inserting a chest drain. However, a chest drain insertion is an aseptic and a fairly sort of lengthy procedure. It's not a -- in an emergency, it's a procedure we call needle thoracocentesis. So you put a needle in and you allow the air to escape. So if there is a tension pneumothorax that's causing a massive compromise, it will release the air and allow the lung to expand and then you go back and insert a chest drain properly, which is what was done.

ASTBURY: In the context of what was happening around this time, we've mentioned 12.28, do you remember at what stage that needle was introduced to, as it were, first aid the pneumothorax --

DR B: Um...

ASTBURY: -- or would you be reliant on [Dr A]'s note for that?

DR B: I would be reliant on my statement and his notes because we both did them in conjunction -- at the time when this was happening everything was happening in quick succession so thinking --

ASTBURY: Who inserted the needle?

DR B: [Dr A]. So basically, the first thing to do would have been to secure the airway. Needle thoracocentesis wouldn't have been a primary procedure. So you intubate the baby again, a baby who's paralysed is not breathing, you -- you tube them again and then the first thing you do is a needle thoracocentesis to release the air and then go from there.

ASTBURY: I'm going to ask Mr Murphy, please, to go, I think, I hope I'm right, to tile 435, please. This is [Dr A]'s note on this point. I'm going to ask you to have a look at this, please. You can see at the top the reference to the re-intubation that you told us about.

DR B: Yes.

ASTBURY: It's just that second paragraph down, please, beginning "Chest X-ray".

DR B: Yes.

ASTBURY: Does that suggest a chest X-ray was taken -- is that at around 12.30?

DR B: That's right.

ASTBURY: Do you recall that taking place?

DR B: Yes. That would have all been happening in that time, yes.

ASTBURY: I'm sorry, it's not your writing, but are you able to read what --

DR B: Yes.

ASTBURY: Is that "right-sided lateral" --

DR B: "Right-sided lateral pneumothorax decompressed with 24-gauge Jelco at second to third intercostal space/mid-clavicular line at 12.40."

I think it says "2 to 3", but you might have to ask.

ASTBURY: Just dealing then with that paragraph, doctor, we've looked at the X-ray that was taken at 11.57.

DR B: Mm.

ASTBURY: You tell us that you recall that chest X-ray being taken around 12.30?

DR B: No, I don't. The timeline, I am not going to be precise about. The timeline of the X-ray machine is the most accurate one because it records the time when the chest X-ray is taken. Yes?

ASTBURY: Or should do?

DR B: Which... It should do, yes. Whatever time we have here, I have or [Dr A] has approximate times because these are -- we have gone back and thought about, okay, we would have done this around this time.

ASTBURY: Okay. Well, I'm going to go back to your note now, please, at 625. We can scroll to the point that we'd reached in your note.

We had got, I think, to the bottom of the page, certainly on to the next page. You'd spoken to Dr Rackham, you told us, around 10.30, but on a number of occasions; is that right?

DR B: Yes, I did. I haven't documented them all but I spoke to him a few times.

ASTBURY: Do you recall the resolution of the resuscitation that began at around 12.28 that we've been discussing?

DR B: Do I recall the resolution as in return of spontaneous circulation?

ASTBURY: Yes.

DR B: Yes.

ASTBURY: Okay. How long, from recollection, do you recall that taking?

DR B: I think it lasted several minutes and he probably needed a good few doses of adrenaline from what I can remember.

ASTBURY: So that's a third resuscitation during the course of about 4 hours?

DR B: Yes.

ASTBURY: Okay. Moving on then in the timeline, if we may, and returning to your note:

"Spoke to Dr Rackham."

Is that about 1 pm?

DR B: Yes.

ASTBURY: "Updated about frequent collapses with desats and bradys on ventilation and possibly pulmonary hypertensive episodes."

Is that right?

DR B: That's right, yes.

ASTBURY: Just explain to us a pulmonary hypertensive episode, please.

DR B: I was discussing with Dr Rackham -- so when I spoke to him at 1, this would have been -- did you say the fourth or the third?

ASTBURY: The third was at 12.28.

DR B: Yes. He must have recovered from this and by this time I was obviously becoming extremely worried and again revisiting, are we missing something here, is there something else we can do, and I spoke to Dr Rackham again. Pulmonary hypertension is a condition where -- which babies can develop in which you can intermittently have periods where lung pressures go very high and oxygenation is compromised. So we are thinking here of every box that we can that might explain why these collapses are happening. And one of the possibilities Dr Rackham suggested was -- "Is he going into pulmonary hypertensive crisis?" was one differential. And he suggested to try and get an echocardiogram to see if that's the case.

ASTBURY: Okay. That will be the way, would it, to determine whether that was the problem or not?

DR B: Yes.

ASTBURY: Did you succeed in getting an echocardiogram?

DR B: Yes. I spoke to Dr Brearey, he is one of our colleagues who has a specialist interest in cardiology, to come and do an echocardiogram. Dr Brearey did and excluded pulmonary hypertension and, basically, I think I have written he had mild tricuspid regurgitation, which is nothing to be concerned about.

ASTBURY: All right. Let's pause there. You're quite right to say that's the rest of your note and I just wanted to deal with that first. You've then put:

"Already on dopamine and adrenaline infusions"?

DR B: Sorry, where are we now?

ASTBURY: After you have said --

DR B: Yes, "Already on dopamine and adrenaline infusions".

ASTBURY: "Due to frequent deterioration..."

Is that dobutamine?

DR B: Yes, "dobutamine prepared". So all these drugs augment each other and do slightly different things. So dopamine is good

for children who have poor peripheral circulation. So he had already been on that.

Adrenaline, because it improves cardiac contractility and again maintains blood pressure and improves perfusion. So he was already on that. And then again, he obviously went on and had another collapse despite being on this. So one of the things Dr Rackham suggested was to add in dobutamine, which again has a special effect in improving heart contractility because we were having frequent episodes of his heart rate going down as well.

So he was -- yes, he said, start him on dobutamine as well and get an echo done to see what is going on.

ASTBURY: And you put here:

"Dr Brearey performed an echo that showed mild tricuspid regurgitation."

DR B: Yes.

ASTBURY: Anything to worry about with that?

DR B: No.

ASTBURY: And, "Good cardiac contractility", is that?

DR B: Yes, the heart -- he could see that the heart was contracting well, so obviously at the time when Dr Brearey did the echo his heart rate was good and, from what he could see, there was no reason for a pulmonary hypertensive crisis to be causing this problem.

ASTBURY: You have then put -- is that, "Continue on dobutamine"?

DR B: Yes.

ASTBURY: HCO_3 , that's bicarbonate, is it?

DR B: Yes.

ASTBURY: "Infusion..."

DR B: "... commenced over 6 hours. Full correction as per advice from Dr Rackham."

So looking at his blood gas pattern one of the things that we could see was that we gave him multiple doses of -- so normally, there is a formula we calculate of how much bicarbonate a baby needs so when you get the full -- from the formula when you get

the full dose, you halve it and give it over half an hour and that's it.

So he'd had quite a few doses of that.

He was collapsing repeatedly and every time we did a gas, the acidosis was worse. So it wasn't something we were getting on top of.

Persistent acidosis is not good for the heart because it has a negative effect on cardiac contractility. So we were trying to counter all these things and when I would have been speaking to Dr Rackham, I would have been giving him the gases and the metabolic acidosis worsening.

So another thing that he suggested was put him up on a continuous infusion of full correction over 6 hours, which is what he is on now.

ASTBURY: And that's to correct that acidosis that was proving tough to shift; is that right?

DR B: Yes.

ASTBURY: All right. Let's go on in your note, please.

DR B: Sorry, say that...

ASTBURY: If we can go on with the note, please. Mr Murphy is just going to scroll down for us again in a moment, thank you.

Your next note is about Dr Rackham, but between that phone call and 3 o'clock, I'd just likes to discuss that period with you, please.

DR B: Yes.

ASTBURY: After those measures suggested by Dr Rackham, how was [Baby P] up until about 3 o'clock?

DR B: So between this time I think there is one gas at least.

So he was relatively -- I think we also gave him in this time some metronidazole to cover for necrotising enterocolitis.

Dr Rackham also asked to give him a start dose of hydrocortisone just in case there might be an element of what we call adrenal crisis. So we took a cortisol level and gave him that and again these are all the differentials going through everybody's mind.

So very sick babies, the adrenal gland produces a very important hormone, cortisol, which helps us fight stress and sickness. If a baby is not producing that in the right amount then that can be the cause of collapse, so we did that blood level and gave him some hydrocortisone. We also give him some metronidazole.

Both of these were given through the intraosseous route.

He had a gas -- I'll have to ask you to check the time -- of 7.25, which is not great, but still --

ASTBURY: Just pause there. We'll put it up for you if that helps. Everyone will have seen it, it's the last one on the sheet, sadly. It's at 13.38.

DR B: Yes.

ASTBURY: It's the last venous sample entered on the record.

That's the one you were trying to remember?

DR B: Yes. This is a pH of 7.25, which is borderline normal/okay/acceptable. His carbon dioxide levels are fine, which means that his ventilation is not an issue.

His oxygen PO₂ is fine, but his acidosis is worse. So his base excess is minus 13.8 and his lactate is 18.5, which is extremely high and worrying.

So this is all metabolic now. Breathing-wise, we've got control, it's just his circulation is that poor and there is that much acidosis around that it's causing him -- his body to produce a large amount of lactate and his acidosis.

ASTBURY: You mentioned a number of things. Is it also right that [Baby P] received a dose of Curosurf, surfactant --

DR B: Yes.

ASTBURY: -- during the course of the afternoon as well?

DR B: Yes, yes.

ASTBURY: And do you recall [Dr A], once it was considered appropriate, you told us you couldn't do it in an unstable baby, but did there come a point when [Dr A] felt able to do something with that temporary needle that you told us about to drain the pneumothorax?

DR B: Yes, so between the time of -- after the collapse at 12.30 and re-intubation, in the period of stabilisation that followed

[Dr A] successfully sited a chest drain and there was an X-ray confirming that that pneumothorax has resolved.

ASTBURY: Okay. [Dr A]'s note was that that was at 3 o'clock.

Does that accord with your recollection as best you can remember?

DR B: I don't recollect the exact times, but...

ASTBURY: Let's have a look at -- I would like you to look at two X-rays, please. If we go first to tile 434.

If we actually look at the X-ray, please.

Unfortunately, not timed or dated, this one, doctor, hence my reservation earlier --

DR B: Yes.

ASTBURY: -- but we saw [Dr A]'s note. Is this before the drain was fitted?

DR B: The drain is in situ now. So this tube that's coming in (indicating) is the drain and you can see that the pneumothorax has resolved. The endotracheal tube is in and the lungs are inflated.

ASTBURY: Okay. I'd like you to look at another X-ray, please, which is tile 574, which is timed.

DR B: Yes, that's a pigtail.

ASTBURY: Just comparing the two, I'm not going to go back to it, the difference there is the pigtail, is it?

DR B: Yes. So that's the one that takes longer to insert and you need a field of aseptic area and it takes a good half an hour to insert. So this would have happened --

ASTBURY: That's 3.36 and would be consistent with [Dr A]'s note that it was put in at or around 3 o'clock --

DR B: Around that time, yes.

ASTBURY: All right. With apologies to Mr Murphy for skipping around, can we go back to 625, please.

I want to pick your note up at 3 o'clock, please, which I think is on the third page, if I remember rightly:

"Dr Rackham arrived with..."

Is that the transport nurse, in effect?

DR B: Staff nurse, SN is staff nurse.

ASTBURY: "... with transfer team at 3 pm as chest drain was being inserted and fixed."

So again, consistent with [Dr A]'s note. And then sadly:

"Shortly thereafter, [Baby P] deteriorated again."

DR B: Yes.

ASTBURY: Do you recall where you were when that happened?

DR B: I was in that room, speaking to Dr Rackham, giving him -- I had spoken to him on a good few occasions during the day and I remember he was just standing opposite me and there were quite a lot of people in the room, but I don't recall who else was there. I was speaking to him and giving him handover on the events through the day --

ASTBURY: Okay.

DR B: -- and [Baby P] started to deteriorate again, oxygen levels dropping, heart rate dropping, and full cardiac resuscitation was started again.

ASTBURY: I hope this doesn't sound a daft question, I appreciate you were in the room, but how were you alerted to [Baby P]'s sudden deterioration?

DR B: It would have been either the alarms going off or -- because we were in the room, so it would have been pretty much in front of us.

ASTBURY: Right, okay. You mentioned that the resuscitation procedure began again.

DR B: Yes.

ASTBURY: This time we've heard it went on for some considerable time.

DR B: Yes.

ASTBURY: But sadly, on this occasion, it was not successful?

DR B: No.

ASTBURY: We heard this morning that, having arrived during the course of this, Dr Rackham took control of the situation; is that your recollection?

DR B: Yes.

ASTBURY: And beyond assisting him, did you have any other interaction with [Baby P]?

DR B: No. I think one of the things he added was -- we doubled the dose of adrenaline, so he had instead of 0.1ml per kilogram, 0.2ml per kilogram. Another thing Dr Rackham added was: is there a possibility that he could be having seizures, so let's give him a loading dose of phenobarbitone. So we gave him that. Another thing, because of the persistent bradycardia, adrenaline wasn't touching him, his adrenaline infusion had been doubled. We -- sorry, just one second. Yes, atropine is another drug that we don't use very commonly for resuscitations, but he just said to give him a dose of that, so we tried that as well but it didn't do anything.

ASTBURY: It wasn't successful?

DR B: No.

ASTBURY: All right. Okay. Before we move on to the remainder of your note, can I ask you this: you told us -- you've given us an idea of who was there throughout the afternoon and at particular times. Any conversations with any of those people that stick in your mind?

DR B: So one conversation that sticks in my mind is, you know that, when was it, just after the 12 o'clock gas, the 7.32 one. So we had that gas and after that -- so how we have the old neonatal unit, this was nursery 2, and then there's nursery 1, which is a bigger room. So I remember going there, to nursery 1, and there were a few nurses present there, including Staff Nurse Lucy Letby. And I remember -- so when you face one wall, there's a clock in front and I remember looking at that clock and it was going just past 12. And I just said, "Oh, the transport team are going to be here soon", almost thinking out loud more than anything else, and I'm literally sort of counting the minutes before they arrive, just desperately wanting this baby to get better and thinking, you know, there's something -- you're just totally out of your depth, can't think what's going on, maybe somebody else can come and help.

And Staff Nurse Letby says, "He's not leaving here alive, is he?" which I found absolutely shocking at the time and I just turned round and I said, "Don't say that, he's had a good gas."

And I just remember that's just -- all these years on, what, 7 years on, 6 years on, that moment is still very much alive in my mind and I said this and I left the room, but found that very -- because, yes, you know, we have babies -- all through our careers we see babies who are very, very sick, who are very, very unwell, and with some of them who have followed a course and have become progressively unwell, even when we know that their chances are survival are very poor, personally, for me, that's something I would never let myself think because it's that hope that makes you keep trying. So I just found that very, very -- I don't even know if I was upset, I think I was just shocked at the time, I was just shocked.

ASTBURY: Okay. Just pausing there then, you remember the time roughly?

DR B: It was just between 12 and quarter past because he had just had this gas, I'd had the gas and I'd come out of that room and gone to another room.

ASTBURY: This is the gas that you have described to us as being --

DR B: The 7.35 or 7.321.

ASTBURY: The one that you were pleased with?

DR B: Yes.

ASTBURY: So how would you describe [Baby P] -- albeit relative to what had been going on, but how was he at the moment that conversation took place?

DR B: At that point in time, since that morning, he was the best you could call him. We'd managed -- this was a kid that had had a good gas, he was ventilated, he was stable, the transport team were on their way, so I thought we were winning and found no reason for this comment, really.

ASTBURY: Okay. Through the course of the afternoon any other conversations with anybody that stick in your mind?

DR B: So after [Baby P] passed away, we -- so we have through -- when you go through to the labour ward, which is literally a connecting door from the neonatal unit, Lavender Suite, where the parents were. So myself and Staff Nurse Lucy Letby went down there and I went to speak to the parents.

I remember feeling -- you know, when you just feel, "I don't know how to face them, I don't know how to say this". So I went

there and the parents were sitting there and I told them that [Baby P] too was going to need a post-mortem.

Staff Nurse Letby was behind me against the door, against a shelf, and again one of the things that I found unusual was -- she was almost sort of very animated in that she was saying to the parents, "Do you want me to make you a memory box, a memory box for him, you know like I did for [Baby O] yesterday?" And I just remember thinking: this is not a new baby, this is a dead baby, why are you so excited about this?

ASTBURY: Why do you use the word "excited"?

DR B: Because that's how she was. She was just, "Do you want me to make you a memory box?" Like you make -- you know, babies upstairs get these, what do you call them, bounty packs or whatever, you know, newborns, they get this from the hospital or someone where they have different little things. And the parents were like, "Yes, please, that would be nice, thank you", and I found that very inappropriate, the way it was said.

ASTBURY: Not what was said?

DR B: No, not what was said, there was nothing wrong with the content of it, it was just how it was said.

ASTBURY: Okay. So dealing with the period after [Baby P] had passed away, can we just conclude your note, please? If we can turn back to that, please. You've reiterated:

"For detailed notes on resus, please refer to [Dr A]'s notes. At around 4.30 [is that] spoke to Chris at the coroner's office..."

DR B: Mm.

ASTBURY: And then:

"... the senior coroner's officer, Christine Hurst."

Scroll down, please, Mr Murphy. Thank you.

You have noted that it was agreed that both triplets' deaths -- and you have quoted:

"... unexplained and would require a coroner's post-mortem"; is that right?

DR B: That's right.

ASTBURY: You then put the contact details for Christine Hurst and also her home number, which has been obviously taken out,

and that she could be contacted over the weekend if needed; is that right?

DR B: Yes.

ASTBURY: Then you have noted that [Baby R] was transferred to Liverpool Women's Hospital. Anything you can recall about that process of [Baby R] being taken?

DR B: Yes. So I just remember thinking at the time I remember dad was there and he was absolutely sobbing, stood next to [Baby P], and literally begging Dr Rackham, "Can you please take him?" And even though I didn't beg, I said to Dr Rackham in a more professional way, in my mind and heart I just wanted him to leave because I thought that's the only way he's going to live.

ASTBURY: You thought that?

DR B: Yes, I thought that.

ASTBURY: And Dr Rackham agreed to take [Baby R]?

DR B: Yes, he was very good about that, yes.

ASTBURY: And then you put that you spoke to them, the parents, about the post-mortem, sadly a conversation that you had already had on 23 June after [Baby O]'s death?

DR B: Yes.

ASTBURY: And they wished for [Baby O] and [Baby P] to be transferred to the mortuary for the weekend:

"I informed them, as per discussion with the coroner's office, that both triplets would be transferred to..."

Is that Arrowe --

DR B: Alder Hey.

ASTBURY: Sorry:

"... Alder Hey on Monday when various specimens for testing for infection, genetic and metabolic conditions would be taken and they would be returned to the parents by the end of next week for funeral arrangements."

And then you carry on with the arrangements for more time with [Baby O] and [Baby P] if they wished. Perhaps we don't need to -- if we scroll down a bit more. You gave dad your secretary's number so you could be contacted if necessary and

also for the parents to call if they had any questions and you'd arranged to meet them.

That, I think, concludes your note with your signature, doctor; is that right?

DR B: Yes.

MR ASTBURY: Thank you. I have no more questions, but I don't know whether that's...

MR JUSTICE GOSS: Yes. We'll have a break. Can we start again at 20 to, so in about 8 minutes? Will that be sufficient time for you? I'm anxious that this witness completes her evidence this afternoon.

(In the absence of the jury)

MR JUSTICE GOSS: I don't know how long you'll be, Mr Myers, but I don't think it would be appropriate to start another witness this afternoon, Mr Driver.

MR MYERS: No, I think not, my Lord.

MR JUSTICE GOSS: [Dr B], we have a sort of eight-minute or so break now. Do you wish to leave the court room for any purpose or are you happy to remain there?

DR B: Could I go to the toilet?

MR JUSTICE GOSS: Yes, I thought you might want to do that.

That can certainly be arranged. I will rise and someone will escort you from here and bring you back again.

(3.32 pm)

(A short break)

(3.41 pm)

(In the presence of the jury)

Cross-examination by MR MYERS

(3.41 pm)

(No audio feed from court)

(3.42 pm)

DR B: The hospital wasn't able to cope with a baby like [Baby R] because they were completely normal, well triplets whom we were expecting to run a normal course. I was just extremely worried that I did not understand what had gone on in the previous 2 days and it certainly -- whatever had happened, in my mind, wasn't normal. And at that point in time, I just wanted [Baby R] to be in a safe place.

MR MYERS: Because, as you say, "That's the only way he's going to live"?

DR B: That's... That's how I felt, yes.

MYERS: Because of the danger posed by Nurse Letby?

DR B: Yes.

MYERS: Right. So that would be crucial -- if you really thought that at that time, it would be pretty crucial for you to take action then. If you think it's necessary for children to be removed from the hospital to save life, surely you regarded it as critical to take action then, didn't you?

DR B: Yes.

MYERS: So did you call the police?

DR B: No.

MYERS: You've just told us you thought it was necessary for a child to be removed so Nurse Letby couldn't hurt it, haven't you? If you really thought that I'm going to suggest you would not have hesitated for a moment from calling the police.

DR B: At that point in time I felt the right way to deal with it would be to raise it at the right forums with the related colleagues, to raise concerns with them was the way I thought about it. So I went back and spoke to my colleagues and also spoke to the neonatal ward manager and raised my concerns.

MYERS: Your suggestion to us, if what you're saying now is right, is that you had thought she had deliberately harmed or perhaps deliberately harmed two of the babies in the unit in the last -- in that day and the day before.

DR B: What I knew was that what had happened to these two babies was not normal from a medical point of view to explain what had happened. I had my doubts about what had happened and wanted to discuss them with my colleagues and raise it at the right forum.

MYERS: If you really thought this, if you really thought this nurse had been hurting or even trying to kill children, you would have been yelling that from the rooftops, wouldn't you?

DR B: I can just repeat the same thing I have just said.

MYERS: But what about all the other babies in your care -- in her care on that unit from that moment onwards?

DR B: So I did raise that in that Monday meeting and said exactly that same thing.

MYERS: You didn't go directly to hospital management and raise anything, did you?

DR B: Not to the hospital management, but to our clinical lead and the neonatal lead and the neonatal nurse manager as the next people to raise my concerns with, so we could collectively deal with this situation.

MYERS: You didn't even put in a Datix report suggesting that a nurse was hurting babies, did you?

DR B: No, I did not.

MYERS: No. Are you seriously suggesting that you thought [Baby R] needed to go because his life was in mortal danger from a nurse that then you were okay with being left on the unit? Are you seriously suggesting that?

DR B: I have just explained to you what I thought and what I did about it.

MYERS: Well, I'm going to suggest to you that what you said at the end of your evidence then was something you came up with to dramatise the situation for the benefit of the jury and these proceedings, [Dr B].

DR B: No. I have just honestly said how I felt. That is true, that is honestly how I felt at the time. I have no intention of dramatising anything. It's tragic enough as it is.

MYERS: And if you had seriously thought a nurse was harming children and it was necessary to remove them to protect lives, you would most definitely have raised that with the police, wouldn't you?

DR B: I did raise it with the relevant people as soon as I was able to. I did not think at the time that that would be appropriate action to take.

MYERS: Now, at the time, you were aware, when we get to 24 June 2016, you were aware, weren't you, that already Nurse Letby was a focus of interest in connection with her presence on the unit at the time of deaths on the unit?

DR B: I don't quite know how to answer that question. I would not agree with that statement. [Baby O] and [Baby P]'s deaths were the first time that I came across this situation face to face, becoming aware that this was the case.

When I think back, and I've gone back and thought hard about this, did I know that she had been involved, the answer is no.

MYERS: Did you know that from July or June, late June/early July 2015, Dr Brearey and Dr Jayaram had decided that she was a person of interest because she had been present on the unit at the time of deaths that had taken place?

DR B: No, I didn't.

MYERS: They didn't share that with you?

DR B: No.

MYERS: Do you think as a clinical matter, if two doctors think somebody is a danger to other children or a potentially relevant factor to their harm, in your view as a consultant, should they share that information with other colleagues caring for children on that unit?

DR B: Yes.

MYERS: As of October 2015, were you aware of an email identifying higher mortality rates?

DR B: I don't remember exactly that but I do remember the data being presented that our mortality rate had been higher and we were an outlier but not in the context of any physical harm being done by a particular member of staff, no.

MYERS: Did you know that by that time, there were concerns with regard to Lucy Letby being present, it was said, at the time of mortalities?

DR B: Again, I've gone back and thought about it long and hard and I'm going to be completely honest: what I had overheard was that there had been situations where babies had been poorly and Lucy had been present. Now, that can be, you know, I can be the consultant on call and I can have 10 poorly babies. That doesn't mean much more. But other than that -- so I have known this since 2016 because of how things have happened. But before that,

I genuinely had no reason to believe before [Baby O]'s and then [Baby P]'s deaths.

MYERS: I'd just like you to be shown page 166 from the statements. It's page 36 of the statement you made.

It's for [Dr B], his Lordship and the barristers. It will come up on your screen, [Dr B].

If we scroll down, please, to the bottom of that page. The final couple of paragraphs. Thank you.

Just remind yourself, if you would, please, of what it says from "in July 2015" and just to the end of that page.

DR B: Yes. So --

MYERS: I'm just asking you to read it to yourself, first, and then I have a question.

DR B: I've read it because I've written it.

MYERS: And you have read the bottom paragraph too?

DR B: Yes.

MYERS: Right. From October 2015, towards the end of October 2015, at the latest, you became aware of concerns with regard to Lucy Letby being present at mortalities, concerns about that, didn't you?

DR B: No, I didn't, I don't say that there. So this has been taken from a timeline sheet that was done. I do not say that I was aware. I have said:

"Four further deaths occurred between August and October and I'm aware that on 23 October 2015 an email was sent relating to..."

I wasn't part of this email circulation.

MYERS: All right. The email related to mortality rates and responded to concerns regarding when Nurse Lucy Letby had been present? Are you saying you were unaware of that?

DR B: To this day I have not seen that email or was not part of that circulation list.

MYERS: And we've heard that there was something that was called a thematic review or a review undertaken in February 2016.

DR B: That's right.

MYERS: Were you aware of that?

DR B: I was present at that review.

MYERS: Right.

DR B: I was present at that review and I have read through that. It looked at the mortalities and the causes and there was no conclusion from the thematic review, until I left it, suggesting that Lucy was the common denominator.

MYERS: And Drs Brearey and Jayaram were involved in that, weren't they?

DR B: I remember Dr Jayaram and Dr Subhedar being there.

I don't remember Dr Jayaram; he might have been.

MYERS: You would have known very well at the time that is taking place, talking with them, [Dr B], that there is a focus on Lucy Letby as being present at the time, allegedly, of deaths. You must have known that?

DR B: I did not.

MYERS: They didn't talk about it, with you?

DR B: No.

MYERS: So as of February 2016, you'd have absolutely no reason from your knowledge of that unit to suspect Lucy Letby of anything?

DR B: No.

MYERS: She was an excellent nurse actually, wasn't she?

DR B: I would not say that. She was just another nurse.

MYERS: Just another nurse?

DR B: She was another nurse who did what other nurses do like other doctors do.

MYERS: You tell us that you knew nothing about her from the suspicions between Drs Brearey and Jayaram from June 2015? You didn't know that?

DR B: No.

MYERS: Nothing was said to you and you didn't pick up any information from an email being sent in October 2015 about a possible link between her presence and mortalities?

DR B: No.

MYERS: Although you went to the thematic review in February 2016, where certainly Dr Jayaram was also present, nothing came up then that put her under your attention?

DR B: No, because I actually went through that thematic review yesterday and I was reading through it. And from reading through it, they could not identify any reason from looking at that that would explain the increase in mortality rates. That's up until when I was at the meetings.

MYERS: [Dr B], it's not just reading through it, it's talking with your colleagues about what's going on. They must have said something to you.

DR B: I have no reason to lie, Mr Myers.

MYERS: But it must have come up in conversation. You say it didn't?

DR B: That... I've just answered that question.

MYERS: All right. Please help us with this: if we get forward then to February 2016, months after the suspicions in June 2015 of Drs Brearey and Jayaram, if by February 2016 they still had these suspicions you would expect, as a matter of clinical practice between fellow consultants, that they would raise that with you, wouldn't you?

DR B: Yes.

MYERS: You say they didn't?

DR B: No.

MYERS: All right. When do you say is the first time that it was drawn to your attention, if it ever was, that there was said to be a link between Nurse Letby and mortalities on the unit?

DR B: When [Baby P] died.

MYERS: So up until that point you'd heard nothing at all?

DR B: Nothing that would link deaths with Lucy.

MYERS: The actual event that we're dealing with, 24 June -- sorry. Did you hear gossip, comments, finger-pointing, about Lucy Letby?

DR B: Yes, but vaguely.

MYERS: Yes, vaguely?

DR B: Nothing concrete implicating deaths or raised mortality rates, no.

MYERS: By "yes vaguely", do you mean chit-chat between the consultants?

DR B: Just flippant comments about babies becoming poorly on her shift but nothing that made me think -- I'm being completely honest under oath here.

MYERS: Flippant comments?

DR B: Not flippant. I think flippant is the wrong word. So comments suggesting that there may be something going on but nothing I personally had any experience of or nothing that I saw as evidence to convince me that anything was going on.

MYERS: Wouldn't you be worried if there were comments being made about something going on which involves harm to children on your unit?

DR B: It wasn't in the harm way. Like I said to you, how I perceived it, if I'm a consultant -- this is something we have in the medical profession, being called heavy-footed is the word. So a certain doctor or certain nurse tends to become associated with -- on their shift it's really busy, you get crash calls to ED, you get crash calls to labour ward, they have really busy and difficult shifts. That's something that's very well-known within our profession. I more so, in my mind, associated that those comments were in the lines of that.

MYERS: When did you first start hearing flippant comments in relation to Lucy Letby and whatever was happening?

DR B: Vaguely in the few months before, but nothing that I was worried about that this was related to increased mortality.

MYERS: I'm not going to ask you to repeat what was said in the flippant comments --

MR JUSTICE GOSS: Mr Myers, can I correct you? She actually said flippant was not the right word. She used that word but then she

said, "No, that's not the right word", so to keep repeating it back to her is not appropriate.

MR MYERS: I focused on the word that she used, my Lord.

MR JUSTICE GOSS: But then she said that was not the appropriate word.

MR MYERS: All right. Very well, my Lord.

Who was making these comments?

DR B: Um... Other junior doctors, some consultant colleagues, but again, not in a way that would make me think that anything untoward in the way of harm being done was going on.

MYERS: When you say consultants, can you give us the names of the consultants who were making these comments?

DR B: Um... (Pause). I wouldn't want -- I don't exactly remember to be able to give you the names and say that, probably because, again, those same consultants would say to me, "Oh, you were on call? Well, that's to be expected. You can't have a quiet on-call, can you?" So to me, that is something like that. Yes, my on-calls are busy, I get sick kids. To me, this was no different to that, so I didn't take it in a way -- I would like to think I don't do harm on my on-calls, so...

MYERS: With regard to 24 June, do you actually remember exactly who was where on that unit during the course of the whole day?

DR B: So you'll have to remind me of the days. 24 June is [Baby P]?

MYERS: 24 June is the day when [Baby P], sadly, died.

DR B: Yes. So I just remember -- again, we are talking about 6 years ago now -- I just remember Lucy and Dr Ukoh being in that room when I ran in. And if you were to ask me for the rest of the day, I don't have memory of exactly who was where. I remember [Dr A] being there because he and I did a lot of things, I remember him inserting the cannula, the chest drain, the IV, I remember me and vaguely Dr Ukoh inserting the IO.

I remember Dr Brearey being there. Then I remember Dr Rackham being there.

MYERS: Do you remember any of the senior house officers being present?

DR B: No.

MYERS: Is that to say they weren't or you just don't remember?

DR B: I don't remember. There were a lot of people in that room. I'm sure there were.

MYERS: A lot of people?

DR B: A lot of doctors and medical staff.

MYERS: In where, sorry?

DR B: Nursery 2.

MYERS: Yes, throughout the day?

DR B: Yes.

MYERS: And you don't remember who they all were?

DR B: No.

MYERS: I would like to look at the blood gas which you showed us, which is on 23 June at 20.27. I'll give you the reference for that. Tile 178, 20.27.

DR B: Yes.

MYERS: If we look at that, that's something -- would you regard as a good blood gas at that time, the night before the shift?

DR B: Yes.

MYERS: So that's just shortly after the handover to Sophie Ellis, isn't it? Well, we know it's just after the handover time on the neonatal unit, isn't it?

DR B: Yes.

MYERS: As it happens we know Lucy Letby handed [Baby P] over to Sophie Ellis. And at the time of that blood gas at 20.27, that's a good blood gas?

DR B: That's right.

MYERS: Right. We can take that down, please.

You've told us that Huw Mayberry reviewed [Baby P] overnight?

DR B: Mm.

MYERS: Do you know whether he saw [Baby P] or not?

DR B: I can only go from the statement that I have made.

I do not recall -- so this would have been at the morning handover. I would have assumed that Dr Mayberry would have written in the notes, but he hasn't documented in the notes. You might be able to confirm that from the nursing notes whether he physically reviewed [Baby P] or not. I think in the nursing notes it said that Dr Mayberry reviewed and noted abdominal distension, apnoeas and bradycardias and then asked him to be placed nil by mouth, commenced on intravenous fluids, and...

MYERS: So you assume he would have made an entry in the notes?

DR B: Yes, I assumed he would have made an entry in the notes and I couldn't tell you for definite whether he physically reviewed [Baby P] himself or not.

MYERS: [Baby P] was a baby about whom, understandably, there was real interest to ensure he didn't have the same difficulties as his brother, wasn't he?

DR B: Yes.

MYERS: You say that he'd reviewed him overnight and there was abdominal distension and feeds were stopped?

DR B: Yes.

MYERS: That's what you understood the position to be?

DR B: Yes.

MYERS: Were you aware also of reported desaturation and bradycardia, albeit short-lasting?

DR B: That's right.

MYERS: Were you aware of milk being aspirated in any significant volume?

DR B: Not that I know of. However, brief periods of desaturations and bradycardias we do see commonly in a premature baby as long as they are what we call self-correcting and of brief duration. They are usually not of concern. If they become more frequent then the things that we would think about are infection and that would have been considered and he was on intravenous antibiotics. The other thing would be, is there a problem with their breathing, is there a problem with -- sometimes when they are being fed they can have gastro-

oesophageal reflux disease and when the milk refluxes that can give them brief periods of desaturations and bradycardias as well. So depending on how frequent they are, how long they're lasting, what intervention is needed, they are managed accordingly.

MYERS: Were you aware of milk aspirates of any significant size overnight?

DR B: No.

MYERS: Were you aware of air being aspirated to any significant volume overnight?

DR B: No.

MYERS: Or any volume overnight?

DR B: No.

MYERS: If we look at the note -- well, I can summarise it -- of Dr Ukoh the following day, there's reference at 9.30 to [Baby P] being mildly pale --

DR B: Mm-hm.

MYERS: -- having moderate abdominal distension, being slightly mottled.

DR B: Yes.

MYERS: And by that time he was nil by mouth as well, wasn't he --

DR B: Yes.

MYERS: -- and had been since midnight; that's right, isn't it?

DR B: That's right.

MYERS: So however we look at it, none of that is an improvement on the night before, is it?

DR B: No.

MYERS: And in fact, concerns sufficient to make him nil by mouth suggests that he's not doing as well as he was doing at the time of the handover, doesn't it?

DR B: It seems to me that -- I think the threshold for intervention was lower in [Baby P] as compared to what we would

do with another baby behaving the same way given what had happened with [Baby O] the day before.

MYERS: Given the concerns with [Baby O]?

DR B: Given the concerns with [Baby O]. So I think the threshold for placing him -- because we have babies, when their feeds are going up quickly, they can develop a little bit of abdominal distension. Again, the fact that he was still in air, he wasn't needing any extra intervention, he was -- another time with another baby you might have the same thing, you might have want to -- okay, let's continue with the feeds and see for a bit longer or -- I think there is some subjective variation on how to manage a particular baby and there's not a right or a wrong way.

So I think given the circumstances, the right decision was taken in placing him nil by mouth and placing him on intravenous fluids. Yes, Dr Ukoh's entries do not make [Baby P] out to be a very well and vigorous baby. However, they still do not explain why 10 minutes later he crashes, stops his heart and his breathing.

MYERS: If we look at the position from how it had been at the time of handover, the milk aspirates plus air aspirates plus nil by mouth plus how he presented in the morning when Dr Ukoh saw him, all of those are potential causes for concern, aren't they?

DR B: They are potential causes for concern which were all being addressed. They do not explain why he crashed and collapsed 10 minutes later.

MYERS: We understand the challenge that is posed in looking at why things happen as they do, but I am asking you to help us with what we can actually see and be sure of as we go along. And one thing we can be sure of is there has been a deterioration in [Baby P]'s condition from about 8.27 the night before, hasn't there?

DR B: Yes, it looks like those things have been noted.

MYERS: When we looked at the blood gas record a little bit later that morning -- again, if we have tile 178, if we could put that up, please. And if we look at 9.51 on what is actually 24 June, can you see it's actually in the second half of the chart?

DR B: Yes.

MYERS: Can you see that?

DR B: Yes.

MYERS: Certainly by 9.51 that is not a good blood gas reading, is it?

DR B: That's the time of his first collapse.

MYERS: It is. And that's not a good reading?

DR B: No.

MYERS: And as it happens there are no readings between 20.27, just after handover the night before, and 9.51 the following morning, are there?

DR B: No.

MYERS: If we go from the collapse, just after the first collapse, there were already a number of doctors on the unit, weren't there, when that happened?

DR B: When the first collapse happened?

MYERS: Yes.

DR B: So there was Dr Ukoh, there was myself. I don't remember anyone else being there before the collapse.

MYERS: Do you remember if [Dr A] was on the unit at that time or not?

DR B: No, [Dr A] was called later on. I don't know how he was called. He wasn't meant to be there but he joined us during the resuscitation, so he wasn't there at the start.

MYERS: You had reviewed [Baby P] along with Dr Ukoh, hadn't you, round about 9.30?

DR B: Why.

MYERS: And Dr Ukoh had remained in the nursery after you had gone to the resource room?

DR B: Yes.

MYERS: Was it Nurse Letby who came to ask you to come from the resource room?

DR B: I don't remember who it was that called me.

MYERS: Was it a nurse who came there to fetch you to come to the nursery?

DR B: I don't remember.

MYERS: How did you know that you needed to go to the nursery?

DR B: I would have been in the resource room on the phone and somebody would have come to tell me to go to nursery 2.

I do not recall who that was.

MYERS: Right.

DR B: That's all I can say.

MYERS: You don't recall if it was a nurse or who?

DR B: No, I don't.

MYERS: If we move forwards I just want to ask you something about what you said about fighting the ventilator and matters to do with that. That's the next thing I'm dealing with.

You have put this around about 11.36. We've got your notes, the ones you made, and for our reference, we don't have to go to them, but just so we can all keep track and the jury, tile 625 is where your notes are.

I am not asking you to look at anything, this is just for reference.

But also you made notes together with [Dr A] afterwards to establish the chronology, didn't you?

DR B: Yes.

MYERS: His notes are at tile 295. So for anyone who wants to confirm in those we can. Actually, do you agree nowhere in your notes does it suggest that at some point [Baby P] was vigorously fighting the ventilator? It's not put in that way, is it?

DR B: Yes. So I did try to clarify that in the beginning.

What I did do -- and with hindsight I should have documented these in the notes, but the events through that day happened in quick succession rapidly, one after the other. My handwritten notes were more general, not pertaining to exact timings of what was done when. It was only afterwards that I sat down and looked at the chronology of events and their times.

At the time, I thought that I will put these into a dictated statement form because I knew there was going to be a coroner's

PM and an inquest so that these were all there. What I should have done with hindsight was also written a retrospective note in the handwritten notes, which I did not do. But I did spend quite a lot of time confirming the times when I wrote that statement, which was within a few days of -- while all these events were still fresh in my mind and I can only apologise for that.

MYERS: When we look at the clinical notes that you wrote, they were written on 24 June at 7 pm. As it happens, in your mind at that time would be your feelings about what had happened with [Baby R] and how he should leave the unit.

That's right, isn't it? You'd had that thought by then if you're right.

DR B: Yes.

MYERS: Yes?

DR B: Yes.

MYERS: Now, you do go into five pages of notes in that note at 7 o'clock, don't you?

DR B: Sorry, I go into?

MYERS: There are five pages of clinical notes at 7 o'clock that you write. We know [Dr A] writes a lengthy note.

The first thing is do you agree -- certainly there's no reference there to particularly vigorous movement by [Baby P]? Do you agree with that?

DR B: Yes.

MYERS: Now, you've pointed out, well, he seemed to be very unwell with the collapses and then, round about 11.36, he seemed to be moving vigorously --

DR B: Yes.

MYERS: -- and fighting the ventilator.

DR B: Yes.

MYERS: By 11.36, he had had a number of boluses of adrenaline, hadn't he?

DR B: Yes, the exact number you will have to -- so he had three or four at the 10 o'clock one and then just the one at 11.30.

MYERS: Let's have a look at tile 385, which is a list of the boluses of adrenaline that he received. We can just scroll down. This lists adrenaline and other drugs that are given in the course of this day. But if we stop there -- thank you, Mr Murphy -- can you see, [Dr B], we've got 09.55 adrenaline, the first dose, 10.02, 10.08 and then 11.30?

DR B: That's right.

MYERS: So that's four doses of adrenaline by the time we're coming up to 11.36; is that correct?

DR B: Yes.

MYERS: Which is designed to assist his heart and make his heart strong and therefore restore circulation, isn't it?

DR B: That's right.

MYERS: If we look at the -- there's also -- in addition to boluses of adrenaline, he was actually prescribed adrenaline intravenously, wasn't he?

DR B: That wasn't until later on. That starts at about between 12.20 and 12.30, after the third collapse.

MYERS: Let me just confirm something for you because there's a chart that keeps a records of intravenous adrenaline and that's at tile 386. Let's have a look at that, please.

Pause there. If we look down on the left-hand side below the column that's headed "Administration", where it says "doctor's signature", do you know who that is?

DR B: No. It says "JB" as initials.

MYERS: Yes.

DR B: I don't know.

MYERS: All right. In any event, this appears to record, if we look up at the top -- it's for adrenaline, isn't it, this sheet? Let's start with the basics.

DR B: That's an adrenaline infusion, yes.

MYERS: It says "adrenaline double" in brackets. It says "time started" and a first dose at 11.30; do you see that?

DR B: Yes. Can I explain that a little bit?

MYERS: Yes, please do.

DR B: I think in my statement I was asked to look at this again why these entries are timed here. There are nursing notes which give more -- because, mind you, this would have been prescribed by a doctor. However, the infusions are prepared, put up and commenced by the nurses. So the time might have been 11.30, but I remember, once I was asked to look at it again, going back and checking the nursing notes as to when the adrenaline infusion was actually commenced. So if you wouldn't mind reading into that, and you can probably countercheck against the nurses' entries, but I think it was a bit later than 11.30, although I...

MYERS: Are we to take from that that there was only ever one infusion of adrenaline from what you're telling us, however it looks?

DR B: Yes, it would have been one infusion of adrenaline started from 11.30 onwards, which would have been following my discussion with Dr Rackham. So this is the second collapse now at 11.30 and after this the plan was made to start him on the adrenaline infusion, which was later on doubled. So --

MYERS: And do you say -- can you recall what time that happened around?

DR B: The doubling?

MYERS: When the infusion began; can you help us with that?

DR B: I think from what -- I don't have the statement in front of me, maybe if I did --

MYERS: We'll go there, I'll go there in a moment, actually.

DR B: Because I looked at different nurse entries and when the infusions were actually put up and I seem to think it was around 12.20 when it was actually started. However, it would be good if you could --

MYERS: If we look at tile 292, just to assist you, [Dr B].

These are notes by Nurse Letby. If we can go to the left-hand side, please, Mr Murphy, and scroll up so we can see into the body of this. We'll come to the adrenaline in a moment.

We've got 11.30 -- could you scroll up a little more in case anyone wants to see what came before. Thank you, that's great. We can see a timing at 11.30 where it says:

"CPR for 6 minutes, loaded with panc."

Which you said is a sedative; is that correct?

DR B: Yes, that's a paralysing agent.

MYERS: Paralysing agent. Going down below that, 12.28, and then it says:

"Further collapse. Resus as documented in notes. Adrenaline infusion commenced."

You are saying it may be 12.20, but that's 12.28?

DR B: Yes.

MYERS: And then 12.47, the adrenaline infusion doubled at that point?

DR B: Yes.

MYERS: All right. So the infusion -- you say the notes are correct on that and it's round about 12.28 the infusion commences?

DR B: Yes, along with dopamine.

MYERS: Along with dopamine, all right. Thank you. That's just to show that.

So where it says 11.30 on the written prescription, that's not right, in fact?

DR B: Yes. The doctor would have prescribed that, asking for it to be started. From the time that a doctor prescribes it, a nurse would prepare it because for an adrenaline infusion, you have to prepare the adrenaline in a solution, and then work out the dose. So the nurse would check it, then another nurse would countercheck with her and then put that up. And in an ideal world, it should go up as soon as it's written up for, but there can be delays depending on what else is going on.

MYERS: In any event, by the time we get to 11.36, [Baby P] had received four doses of adrenaline by bolus. And in fact it is quite possible that if he has received that and if his circulation is restoring, he may react in fact to the intubation that he is subjected to? That could happen, couldn't it?

DR B: Sorry, can you repeat the question? In what sense?

MYERS: If he's received four boluses of adrenaline as we get to 11.30, and his circulation has restored, his circulation has improved, his circulation is restored, it's entirely possible that he may then react to being on an intubator and struggle against it?

DR B: Okay, so the first three doses of adrenaline were after the first collapse. Then there is a time period of over an hour and a half. The re-intubation happens when he's almost completely -- so when [Dr A] has re-intubated him he has not documented that there was any resistance to intubation. And it was only following his adrenaline dose and return of circulation and connecting to the ventilator that he's noted to be vigorous and fighting against the vent.

MYERS: It doesn't note, in fact, that he is vigorous and fighting against the vent anywhere, does it?

DR B: No, it doesn't. However, I do put it in my statement that that's -- so we wouldn't normally -- so paralysing a baby is not something we would normally do. It's not procedure. Giving morphine is. You give a sedative and you try and keep them calm. We wouldn't think about giving a baby pancuronium unless there is a good reason to do so. And I would have discussed with Dr Rackham and we would have -- "Yes, he's fighting against the ventilator, he's breathing, he's already on the morphine", "Okay, given what's going on, let's take that control by giving him pancuronium and paralysing him".

MYERS: The point I'm just investigating, quite simply, doctor, is that you've said to us, well, he seemed to make a very good recovery round about 11.36 or thereabouts, so good he was fighting against the ventilator. I'm just suggesting to you, if his circulation has been restored to some extent by then and he becomes aware he is on a ventilator, he may well react to the ventilator.

DR B: Yes.

MYERS: And his circulation and recovery is due, at least in part from what we see, to the adrenaline and the treatment he's been given?

DR B: Yes.

MYERS: Right. You went on to say that round about this point, you felt a degree of relief that things were better at this point?

DR B: With the 12 o'clock gas.

MYERS: We come to the 12 o'clock gas, yes.

DR B: Yes.

MYERS: But I would like to be quite clear what you mean by better. I'm going to suggest this: what you mean by better is that he was stable whilst you were waiting for Dr Rackham to come.

DR B: Yes.

MYERS: Can I be clear, that's what you mean, isn't it?

DR B: Yes.

MYERS: Not that somehow everything was all right and -- you weren't out of the woods at this time, were you?

DR B: Absolutely not, no.

MYERS: You were waiting for transport to come to take him to a tertiary unit for more intensive care; is that correct?

DR B: Yes.

MYERS: In fact, even in that situation with the blood gas -- and if we could just put up please again tile 178.

If we look down at the blood gas round about -- is it 12.03 or 12.08, it could be one or the other, it's the penultimate entry --

DR B: Mm-hm.

MYERS: -- you identify for us there that whilst there is some improvement in some regards, there is still, it appears, a metabolic acidosis component to what is taking place?

DR B: That's right.

MYERS: So the relief you felt was that he was in a stable enough condition for onward transport, hopefully; is that correct?

DR B: Yes.

MYERS: The pneumothorax, I'm going to ask you about that next.

The pneumothorax is identified. We've seen it's on an X-ray that's actually taken at 11.57. That's when it's identified first on an X-ray.

DR B: Yes.

MYERS: In fact, that wasn't identified -- that X-ray wasn't seen by the clinicians until some time shortly after 12.28, was it? Am I correct about that? When do you say you were first aware there was a pneumothorax?

DR B: I couldn't tell you the exact time. I couldn't, I don't remember, except for what's in the notes entries.

MYERS: Because there had been a cold light test at some point hadn't there --

DR B: Yes.

MYERS: -- and nothing had been identified then? But we know that certainly by 11.57 there was a right-sided pneumothorax.

DR B: Yes, which wasn't a tension pneumothorax, which wasn't life-threatening or any emergency to drain. And even after it was identified initially, we decided to not intervene given that things were stable. It wasn't until the following collapse that we decided to do the needle thoracocentesis, just to anticipate in case the pneumothorax had expanded and worsened -- the needle and then followed by the chest drain.

MYERS: Yes. But as it happens, as long as that pneumothorax was there and not being dealt with, that can compromise the process of respiration, can't it, can make it more difficult for the baby?

DR B: It shouldn't have any significant problems if it's not a tension pneumothorax. It wasn't a tension pneumothorax.

MYERS: Do you say that any other kind of pneumothorax simply does not create any respiratory problem for the baby at all?

DR B: So we have babies that have been identified on the unit, or even upstairs, who can have small air leaks and they can be otherwise reasonably well in themselves and we don't necessarily intervene unless there is an element of respiratory compromise because there is good evidence to show that small air leaks can reabsorb without any active intervention if these babies are just managed by leaving them alone. So putting a needle in is not the answer to treat every pneumothorax.

MYERS: Just to help us with some timings, I'm going to look at the notes of [Dr A] that we saw in fact with [Dr A] yesterday and you're aware of. I'm going to ask if we can put up tile 295.

If we scroll down towards the bottom because we're moving through the course of the day down to where it says 12.28, these are [Dr A]'s notes. It refers to saturation and bradycardia. Just to keep track with your evidence, this is the point where you say you believe a tube had moved or been dislodged.

DR B: Yes.

MYERS: That's what you say at 12.28?

DR B: Yes.

MYERS: We'll come back to that in a moment. We have here:

"CPR commenced. Poor colour change on ET capnograph. ETT removed and bagged via Neopuff."

Then over the page, carrying on down... I'll find the next one. This is the section to look at. It moves on to say how [Baby P] was re-intubated, adrenaline -- I'm not going to read through all the statistics and the descriptions. If we go down, we can see, where there's a break in the line, it says:

"Chest X-ray at 12.30. Right-sided lateral pneumothorax."

Do you see that?

DR B: Mm-hm.

MYERS: That appears to be the first time that you, the clinicians dealing with this -- that a pneumothorax is identified at 12.30.

DR B: No.

MYERS: Is it not?

DR B: No. What this is saying that -- I couldn't tell you the exact time the pneumothorax was identified because it's not been documented. What this is saying is that at 12.30, after [Dr A] had done what he had done, we made the decision that, given this deterioration and needing the re-intubation, the chest X-ray that had identified a right sided-lateral pneumothorax was decompressed with a 24-gauge Jelco, given the position -- so that was the time that we decided, well, okay, yes, it was not a tension pneumothorax, there was no mediastinal shift, but given this episode, let's go for needle thoracocentesis and then a chest drain.

That's how I see it.

MYERS: You can't tell us when it was you first became of the pneumothorax?

DR B: I would like to say normally what we would do is these are portable X-rays and what tends to happen is they come in with the machine and we can usually view the X-rays on the machine. For babies who are very sick, that's what we tend to do. We would look at the X-ray as soon as it's taken on there and then later on on the screen.

However, given that we acted on it at 12.30 and it happened at 11.57, at that time, it couldn't have been that the X-ray was reviewed there and then and the needle happened there and then. The two are two separate things. So I think that thing was parked at the back, we knew about it, we decided not to needle or insert a chest drain, but then when this collapse happened we went ahead and did that.

MYERS: It would be a relevant finding to record in the notes when it was you found the pneumothorax?

DR B: Yes, it is.

MYERS: And you are saying that isn't apparent from the notes?

DR B: No, it isn't.

MYERS: And I am suggesting a pneumothorax can have an effect that could play a part in [Baby P] finding it more difficult to breathe. That must follow.

DR B: I've already answered that question.

MYERS: You say it has no effect or a minimal effect?

DR B: A minimal effect. It wasn't a tension pneumothorax.

MR MYERS: There's a lot of material I'm having to deal with, my Lord. I can continue but I'm aware of the time.

MR JUSTICE GOSS: Not if you're going to be more than 15 minutes or so.

MR MYERS: It may be in that region, it could be a little bit more. I don't want to delay everybody or make them even hotter, I suspect, than they already are in the baking conditions that I'm experiencing out here.

MR JUSTICE GOSS: Would it cause inconvenience if we sat on?

If it does, just say yes.

MR MYERS: I've been reminded there may be re-examination.

MR JUSTICE GOSS: All right. Would it cause you great difficulty to come back tomorrow?

DR B: No.

MR JUSTICE GOSS: You've got a clinic or something?

DR B: I would prefer to finish today if I can because I've had to move quite a few things. I would appreciate if that could be...

MR JUSTICE GOSS: Is it going to cause anyone real difficulty? Please don't feel...

(Pause)

Are you sure? Let's press on then.

MR MYERS: Very well.

I'm not going to go through all of your notes, [Dr B], I'm not going through all of [Dr A]'s. The fact is, in neither set of notes is there any reference to a tube being dislodged, is there? You can check if you like. If I'm wrong, please correct me.

DR B: If you go back --

MYERS: Yes.

DR B: -- [Dr A]'s notes, the previous page to this, when it says the capnograph not changing colour --

MYERS: Let's go back to that then, please.

DR B: -- that to me is a dislodged tube.

MYERS: Well, hang on. Tile 295, please. To remind you, [Dr A] has been asked questions about this and given evidence on it and I'm not going to quote his evidence back to you, I'm just dealing with what you say.

We have:

"Desaturation and bradycardia. CPR commenced. Poor colour change on ET capnograph. ETT removed and bagged via Neopuff."

DR B: Yes.

MYERS: It doesn't say anything about a dislodged tube.

DR B: So poor colour change. So "capnograph" is the little --

MR JUSTICE GOSS: We know what it is.

DR B: So when it stops changing colour in a baby who's not breathing for himself, for any baby that I'm asked to see, to me that is a misplaced or a dislodged tube, and I will take that tube out and replace it.

MR MYERS: Or a blocked tube?

DR B: Or a blocked tube, yes.

MYERS: With secretions?

DR B: Yes. So that would be for [Dr A] to look at and say, when it was removed, what it showed.

MYERS: So that doesn't automatically follow that is a dislodged tube, does it?

DR B: No, it doesn't automatically follow.

MYERS: No, and nowhere in your five-page set of notes do you suggest in the notes made at the time this is a dislodged tube, do you?

DR B: I can't remember exactly what I have written, but if that is the case, then yes.

MYERS: Is that a detail -- as you've looked back, is that something which you have put there because to you it makes sense with the picture of what you think was going on rather than something that actually happened?

DR B: No, I just made an observation at the time. Mind you, when I was going through literally every -- trying to deal with every action with a reaction that it needed, I was just dealing with things as they were happening, I wasn't going round thinking, "Somebody's doing this, I need to undo it". I wasn't. So when I came, I found it highly unusual that a child who had been paralysed -- their tube was dislodged and I have made that observation.

MYERS: I'm suggesting to you, [Dr B], that there is no dislodged tube at the time because, if there was, that would have been put in the notes, not things that came later, but in the notes. We disagree on that.

DR B: We disagree on that because the fact that it's not there doesn't mean it didn't happen.

MYERS: Your recollection is that you'd gone off to get a cup of tea or get a drink from the kitchen?

DR B: Yes.

MYERS: Do you remember that, that detail?

DR B: I remember walking down and then running back.

MYERS: And do you remember where everybody else who'd been involved with this was within the nursery at this point or not?

DR B: No.

MYERS: When this was ongoing, you've told us about an exchange between you and Nurse Letby, things that were, you say, said by her or something that was said by her. Do you remember telling us about that?

DR B: Yes.

MYERS: And you've said she' said, "He's not leaving here alive, is he"?

DR B: Yes.

MYERS: First of all, is that the precise words or is that casting your mind back at the time you were asked to recall this, something along those lines?

DR B: As far as I remember, that was how it was.

MYERS: Do you recall telling the police it was a comment along the lines of, "He's not leaving here alive, is he"?

DR B: Yes.

MYERS: Yes, along those lines. Now, as it happens, he had been struggling, hadn't he?

DR B: Yes.

MYERS: He'd had to be given resuscitation on one or more occasions by this point, hadn't he?

DR B: Yes.

MYERS: And he'd had to be given adrenaline?

DR B: Yes, for which we couldn't understand the whats and whys of.

MYERS: And you were very concerned as to whether or not he'd be stable enough to make it on to the transport, weren't you?

DR B: At that point, no.

MYERS: Well, you've told us that after the first -- after four collapses and -- at least four collapses and three to four doses of adrenaline, this was --

DR B: No, he'd only had two by this time.

MYERS: But you were concerned about events the day before with [Baby O], weren't you?

DR B: At that point in time, as I've said before, I was not thinking about [Baby O]. So as this day was progressing, my mind was miles away from what had happened the day before because you can't focus on a sick kid, managing what you're managing, trying to think, and likening it to anything that had happened the day before. At that point in time, my focus was: this kid has gone off out of nowhere; we've brought him back once; then he's gone briefly the second time; he's come back again; I don't know what's going on with him; he's stable at the minute; I'm hoping we can get him out and get him better. That's where I was.

MYERS: At the time of this comment you were worried, weren't you?

DR B: Yes, of course I was worried, yes.

MYERS: And in fact, you've said to us, just as you were leading up to what you say Nurse Letby said, you said it went like this. You said:

"The transport team are going to be here soon. I was desperately wanting the baby to get better."

Feeling totally out of your depth, wanting someone else to come. Those were your words.

DR B: Yes.

MYERS: Feeling totally out of your depth?

DR B: Yes, because I didn't know what had prompted and caused those collapses in a baby who at 9.30 was reasonably stable and

went on and had a cardiac arrest 10 minutes later. That's just not something I have seen in the 17 years of my consultant career.

MYERS: And you were concerned?

DR B: Yes, I was concerned.

MYERS: And maybe all she was doing was making it plain that she's concerned?

DR B: I can only speak for myself.

MYERS: But it's simply expressing a concern that actually isn't that different from your concern, [Dr B].

DR B: I can only tell you my perception of how I perceived the comments.

MYERS: Do you think there's a danger here, because it's Lucy Letby we're dealing with, things she's said or done being taken out of context and being made to sound quite a lot worse?

DR B: I found it highly unusual, given the circumstances and the fact that we are in these situations in different times of having really sick babies and kids, but making such comments is not something we do.

MYERS: You may have regarded it, however it was said, as an inappropriate comment.

DR B: Yes. That's my personal opinion.

MYERS: All right. But you agree at this point, certainly in your mind was a real anxiety of what was going to happen to [Baby P]?

DR B: Yes.

MYERS: Right. When it comes to Nurse Letby assisting with the memory box and events towards the conclusion of this, [Dr B], it had been an incredibly distressing day so far as you could tell for everyone involved in it, hadn't it?

DR B: Yes.

MYERS: And it fell to Nurse Letby to assist the family with what happened after a bereavement had happened because she was the designated nurse?

DR B: Yes.

MYERS: You've described how she seemed to be, I think you put it, excited, "Do you want me to make a memory box?"

Shall I do this for you? Shall I do that for you?"

That's right, isn't it?

DR B: Yes.

MYERS: That's how --

DR B: "Shall I do it the same way like I did for [Baby O] yesterday?"

MYERS: Yes, all right. Not the way you would have gone about it if you were in that position; is that what you're suggesting?

DR B: Yes.

MYERS: But entirely possible she's going about it in an upbeat way, which, trying to be upbeat, you regard as inappropriate?

DR B: Yes.

MYERS: When you say "excited", that could be something she's doing just to try and sound better than it actually is?

DR B: Yes.

MYERS: There's a good deal of criticism directed towards Ms Letby, directly or indirectly. I want to give you the opportunity to comment on some evidence that we have had, [Dr B]. All right?

During the course of looking after [Baby P], did you have any kind of infection yourself? Were you coughing?

Were you spluttering? You smile, you know what I might be raising.

DR B: Yes.

MYERS: It's comments from the statement of [Mother of Babies O & P].

DR B: Yes.

MYERS: You know the passage I'm referring to perhaps:

"[Dr B] was coughing and spluttering and going out for a smoke and never washing her hands."

DR B: I think that happened once. It wasn't more than once as far as I remember. Yes, it did happen once and it's not something I'm proud of. No, I did not have an infection. I wasn't unwell at the time. I did cough, I had gone out for a cigarette, came back, didn't wash my hands. I don't remember doing it, but I must have coughed and then gone to the child again, so yes.

MYERS: All of which are particular things she may have focused upon, but you would say that hardly sums up the whole degree of your effort to help [Baby P], does it?

DR B: Yes, absolutely. But they were very right in observing that and it was wrong of me to do what I did.

MYERS: Right. But it's entirely possible to pick on little things like that -- I'm not being difficult with [Mother of Babies O & P] when I say that -- but pick on one or two items. But the reality is, in fact, your efforts were directing at looking after [Baby P], weren't they? And in fact, all those people dealing with [Baby P], from what you could see in the course of this, were all doing their best to look after him, from what you could see?

DR B: Yes.

MYERS: And that goes for Nurse Letby, doesn't it?

DR B: Yes.

MR MYERS: Yes. Thank you, my Lord, I'm grateful we could sit late.

MR JUSTICE GOSS: Thank you, Mr Myers.

DR B: Thank you. Thank you, everyone.

MR ASTBURY: My Lord, there is nothing in re-examination, thank you, unless my Lord has anything.

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

Thank you very much, [Dr B]. Stay there. Will [Dr B] be required again?

MR ASTBURY: Possibly. I'm sorry to put it so opaquely.

MR JUSTICE GOSS: It doesn't matter. In those circumstances, please don't talk to anyone about anything to do with this case.

All right? You'll obviously be notified as and when if you are required.

Thank you very much.

All right, members of the jury, thank you very much indeed today for going the extra 12 minutes. 10.30 tomorrow morning.

(In the absence of the jury)

It is very warm in here, Mr Myers, and it feels very airless as well.

MR MYERS: It often seems to strike at this point in the day as well, which is where I'm often located.

MR JUSTICE GOSS: It is uncomfortably hot, even for people who like it warm.

MR ASTBURY: Can I apologise for the alarm, deliberately set after 4.30?

MR JUSTICE GOSS: Not a problem, Mr Astbury. Thank you.

Mr Myers, will someone...?

MR MYERS: The timing is a little too tight this afternoon.

MR JUSTICE GOSS: No one will be able to come down and see Ms Letby now. Thank you very much. So your transport arrangements can go ahead, thank you.

I'm sorry if I caused confusion about the possibility of another witness. I had anticipated we would be the rest or most of the rest of the afternoon with [Dr B]. It's just the earlier comment from Mr Driver that I was becoming rather confused by.

MR MYERS: Crossed wires, my Lord, but there was no difficulty created by that. Thank you.

MR JUSTICE GOSS: Please remain where you are, [Dr B].

Thank you very much indeed. I will rise. Everyone else will leave the court and then you'll be escorted from the courtroom.

(4.45 pm)

(The court adjourned until 10.30 am on Wednesday, 22 March 2023)