

27 June 2023 (Day 137)

Defence Closing Speech Day 2: Babies A, B, C, D & E

(10.30 am)

(In the presence of the jury)

Closing Speech by MR MYERS (continued)

MR MYERS: Good morning, ladies and gentlemen.

Count 1. [Baby A]. [Baby A] was born, ladies and gentlemen, on 7 June 2015 at 20.31 hours, 31 weeks and 2 days' gestation, the second of the twins; [Baby B] was the first. His weight was 1,660 grams.

On 8 June, so a little under 24 hours later, at about 8.05, he was given a 10% dextrose infusion via the long line and at 20.26, or thereabouts, so about 20 minutes later, he collapsed. And sadly, he died at 20.58 that evening.

The experts, Dewi Evans and Sandie Bohin, say that an air embolus is the cause of his death and was the harm done. We start here, ladies and gentlemen, that in a case, the prosecution case, as heavily based on coincidence as this one is, we ask you, how about this for a set of coincidences: a baby collapses and dies, that baby is an intensive care premature neonate, very preterm, only 1 day old, so fragile.

That baby has been left without fluids for at least 4 hours because staff didn't have the time to feed him.

Left with a long line in the wrong place because the registrar who put it there was too busy to correct it, with, we say, a heart rate and a respiratory rate where the respiratory rate is not in the normal range and the two together are not behaving as they should do, without a nurse dedicated to monitoring him, although the guidelines in a case like this indicate that there should be, and collapsing within minutes, really, of the line being used to put fluids through.

So we ask at the outset, is all of that just a coincidence? That's the first case we come to, ladies and gentlemen, and for all the attempts or efforts of the prosecution to dismiss the suggestion of problems or sub-optimal care at the Countess of Chester neonatal unit, we say straightaway, actually, we have sub-optimal care, we have inadequate staffing and we have a collapse and death in front of everyone, and when Lucy Letby had done no more than be there really for minutes, 20 or so minutes, and no suggestion on the evidence that she had done anything physically to [Baby A] at all.

The risk of sudden and serious deterioration in [Baby A]'s case is the same as that for other babies on this unit, and I'm not going to repeat this, you'll be pleased to hear, every time we turn to one of the children, although I will identify where there are particular features that stand out. But it's a fact that on a neonatal unit the babies are there for a reason: many are preterm or very preterm and some have significant problems in addition to that, and you have heard many witnesses describe how they are at risk of deterioration and how that can be sudden and serious.

That has been the evidence from nursing staff in this trial over and over again -- and a good number of the doctors as well. That is why, or one of the reasons, it is so important for there to be careful treatment and monitoring by suitably trained and experienced staff.

So Mel Taylor was designated to look after both [Baby A] and [Baby B], both had UVCs, which makes them both intensive care babies. In fact, one of them with a UVC would take that over the limit, but they both did.

The prosecution have relied on the BAPM guidelines where they believe it will help them on the topic of band 4 nurses and stoma bags, and we'll look at that with [Baby J]. Not so keen, it seems, on the more fundamental issue of staffing members and intensive care, which is pretty basic. Those guidelines are there for a reason, ladies and gentlemen, and however anybody tries to justify this, by the afternoon of 8 June 2015 there should not have been just one nurse looking after [Baby A] and [Baby B].

If they'd had a nurse each, we could have confidence that the procedures regarding lines were done correctly and the monitoring was done correctly instead of having one nurse dealing with both and a doctor, David Harkness, who was stretched across multiple babies.

Warning signs. Before we come to fluids and lines, I'd like just to look at the observation chart at tile 28. So we'll put this one up. Thank you, Mr Murphy. There we are. You're familiar with these now, ladies and gentlemen.

Just take a look at that if you don't mind. Could we enlarge it so we can see the heart rate and the respiratory rate section, please. Thank you. We can see, if we're looking at 8 June, starting from 8 or 9 in the morning, I ask you just to look at where the respiratory rate is. You can see that.

Sandie Bohin, Dr Bohin, said it was stable and not escalating and not worrying. And we say, look, look at the evidence. This is one of the many examples when what is before your eyes is not what one or other or both of the prosecution experts will accept. We say, and you can look at the evidence, it isn't stable and it is escalating. And it doesn't matter that it pops up and down along the way, the direction is up throughout that day, right to the point of collapse, and Dr Bohin would not have that.

Now, this was the first chart you looked at, ladies and gentlemen, so it would have been more difficult for you to assess my questioning of her as to what that shows at that time, possibly, if you're not familiar with these charts. But you can consider what she says now and what you make of her refusal to acknowledge that.

Mel Taylor said there was nothing remarkable and she doesn't appear to have reacted to it in any way, and we ask or wonder how much attention she was giving to it because looking after two babies and, on the evidence, no doctor available immediately if she had wanted one leaves us wondering how close the attention was.

What is the point of the yellow? It's there for a reason. If we just look at the foot of the chart there is a guideline there. Can you just go down to the notes, please, Mr Murphy. Can you see there, ladies and gentlemen?

"White: continue obs as per frequency. First yellow: action and repeat. Second yellow: escalate senior nursing practitioner or SHO."

And we say that refers to the number of times something falls in the yellow.

In any event, it's in the yellow. Could we go back again to the first two bars, please, Mr Murphy. So that's the respirations. Now have a look at the heart rate. Does it move really at all? Given what you know about this case and what you've been told about heart rate and respiratory rates following one another, now what do you think when you look at that? I'm not asking you to become experts, I'm just asking you to think about what we have heard and what we have learned in this case.

When I questioned Dr Bohin about this on 26 October, she began by agreeing that heart rate should match respiratory rate, which we say is logical as well as medical. Then, as I went further, she then said, no, they didn't have to, which begs the question here why didn't they? We say what happened there, asking Dr

Bohin about heart rate and respiratory rate not matching, shows two things.

First of all, that she wouldn't acknowledge what is obvious, they should have matched, and secondly, we say, there is a problem: the heart rate should rise and it didn't.

UVC and fluids. The umbilical venous catheter was in the wrong position, so [Baby A] was taken off fluids whilst he waited to have it properly positioned and he received no fluids or dextrose for at least 4 hours.

And Dr Bohin, on 26 October, agreed this was sub-optimal. First case. First instance of acknowledged sub-optimal care from one of the experts, although we maintain there are more that would not be acknowledged.

That didn't change up to the point of collapse, the position of the long line. It is a risk, we say, if it is in the wrong place. David Harkness in evidence was satisfied that it was well placed and we say that is odd because that is not what the records indicate. It was not correctly sited and we can see that if we look, first of all, at the radiograph and then at the Dr Harkness' notes on the radiograph sticker. So could we look just at tile 156, which is the radiograph? Thank you.

It's the commentary, but this is 8 June 2015, 7.09.

Can we go down, Mr Murphy, please. We have the description there and the last bit is what's significant:

"The tip of the left-sided peripheral long line is projected over the junction of the innominate vein and the superior vena cava."

And they meet up at the top there, the superior vena cava comes into the top of the heart. So that was the item identified there. If we look at what Dr Harkness put on his notes at tile 145, please, down at the bottom, the bottom part of the chart, please. You'll notice a couple of entries but it's the one on the right:

"X-ray review."

Time of X-ray, it's 19.09 on 8 June. If we look down:

"Long line position: superior vena cava."

Comments:

"Long line at right subclavian SVC... [as read]"

Sorry, subclavian vein not vena cava, subclavian vein:

"... to be pulled back."

The subclavian vein is under the clavicle, the collarbone:

"... to be pulled back."

And across at 21.20, so this is after [Baby A] had sadly died, Dr Harkness puts down a reference about:

"Dealing with a long line in another patient with X-ray, so unable to action."

Can you see that? Meant to be pulled back, wasn't, because he was busy.

According to Dr Harkness, he said that the next day -- this is in evidence -- he chatted with his colleagues and they all decided it was perfectly placed.

That was decided afterwards with his colleagues. You know what Dr Evans says about that and the readiness to admit fault, but we were told they decided it was perfectly placed and he said:

"It's exactly where we wanted it to be."

So that's a change, isn't it, from what we see on the records?

It seems Dr Bohin was in a mood for change too because in examination-in-chief, which, as you know now, if you didn't before, is when one party asks their own witnesses the questions, so examination-in-chief is when the prosecution speaks to their witness, she said nothing critical about the long line and she said it was in a safe position.

So I took her to her report that she had written back in November 2020 where she didn't say that and I put to her on 26 October what her report said on this issue and she had said:

"The X-ray showed the long lines have crossed the midline..."

Or "the long line" it should be, but it says:

"... the long lines have crossed the midline. It was not within the heart but it was not in the best position."

The best position is the optimal position. Just look at the language, what it means, not in the optimal position is

therefore in a sub-optimal position. Her language: it was not in the best position.

She didn't mention that in her evidence until I took her there and, of course, that is why it was meant to be moved but couldn't be. I asked her about potential risks with a long line left too close to the heart and she said this:

"There is a BAPM recommendation about the care of long lines because of the risk of cardiac tamponade..."

Which you'll find from the glossary is a problem created when fluid accumulates in the sac encasing the heart. She said:

"If the tip touches the heart it can go through the heart muscle and cause a problem, so there are guidelines about that."

To be absolutely clear, she was confident in her evidence that it would have taken more time for a long line to move into proximity to the heart than this line had. So she said, there's no danger of this, it didn't have long enough.

Well, we note the facts which are that the line was too close to the heart, it was left there when it should have been moved, fluids were put down it, that very line, at about 8.05 and [Baby A] went into a fatal collapse within 20 minutes of that.

You may remember, for all the denials that the line had nothing to do with what happened, that we will not know and we will never know its final position or where the tip was because Dr Harkness removed it as soon as the collapse happened. So we won't know.

What about the events, how the collapse happened?

And we ask rhetorically: how is this Lucy Letby?

Handover had just taken place. Mel Taylor was sterile -- you know that means now gowned and gloved and ready to perform a procedure -- ready to set up the fluids, and Ms Letby helped her with that, and then she started her duties in front of Mel Taylor, right next or close to where David Harkness was attempting to put a line into another baby. So when did she do whatever it is she's meant to have done in that period of time?

And how? Seriously, how? Next to Mel Taylor and David Harkness. How, when? We can guess, can't we? No idea.

Mel Taylor said she was making notes and could see her, so let's not start watering down the significance of that. So what did she do, get a syringe and inject some air in front of everybody?

Nothing to support that suggestion, nothing consistent with that.

We got a little more evidence about the physical situation when Lucy Letby was cross-examined about this by the prosecution on 18 May. And she gave a clear account of the layout that wasn't challenged, no doubt because it's accurate, and this is what was said. The prosecution said:

"Question: Do you accept you were standing over [Baby A] at the time he collapsed?

"Answer: I accept I was within his cot space checking equipment, yes.

"Question: How close were you to him at the time he collapsed?

"Answer: I was in the close vicinity. I was checking equipment around his incubator.

"Question: Yes. Give us an idea in terms of this court. Could you reach out and touch him?

"Answer: I could touch the incubator, I'd have to open the doors to actually get into the baby, but yes I could touch the outside of the incubator.

"Question: Could you touch the lines?

"Answer: No.

"Question: Why not?

"Answer: The incubator was closed."

And that's where that went. And that's as far as we get. So actually, if that's right, if that's some physical impediment, so far as that suggestion is concerned, it doesn't appear anyone could have accessed this line without opening the incubator.

These are the kind of mechanical steps that would need to be taken for these attacks to take place that you would need to hear about in the evidence to see what it is that's meant to have happened and we don't have anything. We have allegations of harm bowled out there with no evidence and no facts in support and no idea what is meant to have happened.

You, we are sure, ladies and gentlemen, would regard that any collapse like this must be an awful event to deal with and, again, we don't overlook the tragedy of this. And you may agree you're not going to forget the most obvious details,

particularly if you're involved in it. It might be different if you're on the periphery or elsewhere, but if you're involved. If you had set up the line and put the fluids down it, if that is what you had done and [Baby A] was your baby, and collapsed minutes later, you're not going to forget that, are you? That's going to stick in your memory.

But here we encounter something rather strange when we come to the evidence of who did what. It may not have seemed all that striking when we dealt with [Baby A] as the first baby but we say it foreshadows something that's a little more unsettling as we have proceeded, you make of this what you will, but as we have seen how some of the accounts of some of the nurses and doctors in this case who were involved in collapses and who might even be expected to be called to account have changed. It's just how it is.

It might be expected to be called to account if blame wasn't being directed at Ms Letby but we're going to see something here that's happened elsewhere in this case, how accounts change at times like this, not always but sometimes, we get glimpses.

Ms Letby has always said it was Melanie Taylor who set up the line and connected the fluids and she only helped because she had just come on.

Melanie Taylor in her evidence couldn't remember which way round it was, couldn't remember if she had connected the line and put the fluids down it, she told us, and for the reasons I say or suggest to you, you may think that's strange given that she was involved and must have thought about this afterwards and continued to think about it.

After all, if we're going to judge witnesses by the same consistent standards as you're asked to, that's the sort of thing that the prosecution would have absolutely slated Lucy Letby for not remembering, wouldn't they?

Can you imagine if she had been the one to connect the line and they could show that and she'd been saying, "I don't remember it", you know exactly how that would have gone. A different approach for their own witness though, isn't it? Okay for Melanie Taylor to forget crucial matters.

Now, if it was Mel Taylor alone who was giving evidence on this we'd be none the wiser. We'd have Lucy Letby saying Mel Taylor did it, we'd have Mel Taylor saying, "I can't remember". But we also had [Nurse A] who saw the whole thing and she was able to give lots of details about this event, but in evidence before you to the prosecution she said she didn't know who connected it

either. That's where this began in her evidence. She said, "I don't know who connected it", back on 24 October.

But when it came to my questioning, I reminded her that she'd been interviewed by the police in January 2018 years ago and I showed her, that process we went through where the witness is reminded of their evidence on the screen, and I showed her a statement and what she said to the police and asked again if she could help us with who had connected the fluids. You know what the answer was? Looking at what she'd said back in 2018:

"It appears then that I was able to say it was Mel that done it."

That's interesting, isn't it? [Nurse A] was able to say a good deal about this incident, including, later on, adding details about a rash to [Baby A] that she didn't give at the time. We'll come to that. How did she come to miss that crucial detail, about who connected the line, how did they come to miss that to you when that's what she had said to the police in 2018? How did she come to leave that out? How on earth did Mel Taylor forget?

Well, Mel Taylor connected the line, ran the fluids down it, and 20 minutes later [Baby A] collapsed and we say that, on this evidence so far, there is absolutely no basis to find Ms Letby guilty of any offence against [Baby A], nor is there any clear evidence of any harm, which you have to be sure of. And it wouldn't be fair to convict her by just lumping everything together and saying, well, it must be her because she was there. But it doesn't end there, does it, because this count, like most of the others, is based firmly on the opinions of the experts that this is an air embolus and then you're expected to fill in the details and go, introduced by Lucy Letby because she was there. That's how it works.

So it was an air embolus. So we're going to look, ladies and gentlemen, at this point, at how this air embolus theory works in this case because it arises for the first time in the case of [Baby A] and is then relied upon in various forms after that. So I'm going to step out of [Baby A]'s case for a moment, if we could, and look at this theory. It's detailed stuff, I don't know about you, but where I'm standing, as it's been earlier, it's roasting in here, you may be very hot too, I don't know. It is hot, yes.

I'm going to ask you, as you have been doing, to listen as closely as you can. I know it's detailed. But this is meant to be reliable, scientific, medical theory underpinning the most serious allegations.

So what is the overarching theory of air embolus in this case? Ten or 15 minutes and then we'll get back to the actual facts with [Baby A]. Well, at the heart of it are Dr Evans and Dr Bohin. They're the ones, we say, pushing this with the prosecution, of course, who rely upon them. So let's look at them. Neither of them has clinical experience in identifying or treating air embolus, so they're not experts on that basis. Both of them could give an account of some time in their experience when somebody in hospital where they worked had one. That doesn't make you an expert. Neither of them are experts on that basis.

Both of them rely principally upon research, but this isn't a broad body of research, is it? It's quite clear they rely principally upon that article in a paper written by Lee and Tanswell over 30 years ago. That is the key piece of research they rely upon.

I asked them both at an early stage of their evidence what clinical features are used to support a diagnosis of air embolus. And I did that, ladies and gentlemen, so we could have something consistent to measure the cases against as we went through the evidence from that point on. That's why I asked them that, so we could try to pin down how do you identify an air embolus.

And the factors we received at the earliest stages were these. First of all, the presence of a IV cannula.

That was from Dr Evans. Secondly, a sudden and unexpected collapse; they both said that. Third, unusual skin discolouration. And be in no doubt, ladies and gentlemen, and you heard and saw this, both began -- began -- by relying on that very specific description in that paper by Lee and Tanswell.

Fourth, the presence of air in the great vessels.

Both of them cited that and are relying upon findings and opinions from Professor Arthurs, which we'll come to.

And then Dr Evans also at the outset said resuscitation is unsuccessful. They may have given different weight to different factors, but those were the five factors we were dealing with at the beginning. We will be looking at these. But apart from there having to be an intravenous entry point, we say not one of those criteria has been applied consistently by either of those witnesses across the cases under consideration in this trial, not one. And they have chopped and changed them as much as required to fit the available evidence. That is a criticism we have made of both of them from the outset and you can judge that

criticism by what you witnessed in the evidence and what we say were the extraordinary contortions they went through to try to fit the evidence into that theory. My word, it changed, we say.

I'm going to remind you, if you can endure it, of that description in that paper again because the prosecution addressing you last week in closing complained about what they described as the defence fixation with "a single description from a single case". Well, that's not our fault. It's not our fixation. We are not the ones who brought this up. It's from their witnesses that this is the key guideline to discolouration in cases of air embolus. All we have done is taken that and then shown how inconsistent that is.

Just to remind you, ladies and gentlemen, we find it at page 24946, Mr Murphy. It's the second page of this paper. It's actually got a bit of highlighting on. That's not ours.

You will remember in this study, 53 cases were looked at. In about five out of 53 the researchers, or rather the people writing the study, found discolouration and in one of them there was a description of a rash that is relied upon in this case in particular. Here it is. They list things associated with air embolus and in the middle of this article:

"Blanching and migrating areas of cutaneous pallor, [so areas on the skin] were noted in several cases and in one of our own cases we noted bright pink vessels against a generally cyanosed cutaneous background."

So a bluish skin background, bright pink vessels in one in particular, and some moving. Not a lot of detail there, but some moving it's put in several cases.

If we pull out and look at the table, just above that, you can see there, ladies and gentlemen, "Cutaneous signs", which is what we're talking about, is in 11% of those 53 cases, which is why we know it's five or six of the 53 cases. There you have it. That's it. That is it.

So it's not the most significant feature associated with air embolus on the research. It's in five or six cases out of 53. But it's a very specific description there. Only one case with that picture of the red vessels and the cyanosed background. We say, as a basis for convicting someone for murder or murders, or murders and attempted murders, it is tenuous in the extreme. It can't even be said, ladies and gentlemen, that the clinical circumstances of the babies in that study reflect those of the relevant babies in this case. We don't know to what extent this piece of research, plucked from 1989, is directly applicable to

this case, save that Dr Evans, Dr Bohin and others have made reference to it. It didn't come from us, not our fixation.

That's it. We can take that down, please, Mr Murphy. Thank you.

That, we say, meagre piece of research has carried us into pure guesswork at times in this case and the way the experts have changed their ground on it you can assess, but we'll remind you as we go through it.

Now, Professor Kinsey. This is connected, so following on with the quality of scientific evidence, how strong is it, ladies and gentlemen -- or rather scientific theory. Maybe, we say, recognising how lacking in expert quality the evidence of Dewi Evans and Sandie Bohin is on this topic, the prosecution attempted to drum up support from Sally Kinsey, who is a professor of haematology. And you'll remember her, I'm sure, if only because you'll remember all the diagrams that were put up and the discussion about ping-pong balls to describe how oxygen is carried by haemoglobin and it goes round the body.

She is a professor of haematology, but she's not, as she frankly conceded in cross-examination, an expert on air embolus. And she said the following things in answer to my questions on 29 November. She agreed she's never seen this phenomenon herself, although she's read about it in medical literature. She said air embolus does not feature in her expertise. She agreed that the diagrams and explanations adduced by the prosecution that dealt with circulation were standard images of how circulation and gas exchange work, they are of general application and not specific to air embolus.

She said that a haematologist is not the specialist who would deal with air embolus; she's the one they had. She said she was only here talking about air embolus because she had been asked to. Literally said that:

"I'm not an expert on it but I've been asked to, I'll have a go."

Give us something. She said there is little in the medical literature regarding cutaneous features of air embolus. She referred to Lee and Tanswell, with that particular description, and she also referred to a paper by an author called Garcia that dealt, make a note of this, with bubbles found in the blood of overweight adult deep-sea divers as a result of decompression.

This is before we get to the cats and the dogs and the rabbits. This is overweight adult deep-sea divers as a result of decompression, the bends in other words, something completely different.

We know this is the basis of her research because of the cross-examination. And she agreed that's no basis for drawing a consistent link between exogenously introduced air and skin discolouration. She agreed that. And that, ladies and gentlemen, is in fact the extent of where we get to with her as an expert on air embolus.

What did become apparent was that she had relied upon Dewi Evans and Sandie Bohin in what she said about air embolus, which we say, frankly, was a big mistake and it illustrates the circular way in which the prosecution evidence has fed upon itself amongst the experts in this case and you have seen that elsewhere.

You saw it when we came to Dr Marnerides and the extent to which he relied upon material that was given to him and it feeds back into the basis for his conclusions. It's a kind of self-perpetuating cycle once the theory of air embolus is introduced into this case. We say it's very difficult to actually find evidence of an air embolus being introduced but you can be in no doubt as to the effect of the theory being introduced into it and feeding itself through the experts.

In particular, she told you, she was struck -- just perhaps think about this -- by how closely the description by Ravi Jayaram had matched the description in the Lee and Tanswell paper, which is the one and only description in this case of that bright pink vessels and a generally cyanosed background. She was struck by how it matched it but then we got this: she'd thought that what Dr Jayaram had said had come from his clinical notes. Right? She was struck by how much his description matched that article and was struck by it in the circumstances where she thought it came from his clinical notes; cross-examination, 29 November, page 85, lines 22 to 25.

I went through that with her and you may have noticed her reaction, it's a long time ago, when it was pointed out to her that he didn't actually say that in the clinical notes. Ladies and gentlemen, you'll remember, he said nothing. Nothing. We're coming to that shortly.

We suggest she was visibly taken aback by that and, we suggest, became increasingly uncomfortable with what she'd been invited to do by way of giving expert evidence from that point onwards.

How this material feeds itself back into this case over and over again. You go back to the clinical notes on that first incident, and we're going to go and look at them in a minute, and you see if you can find any description in them. You won't. On [Baby A] you won't.

But at least Professor Kinsey was ready to acknowledge her limited knowledge and ready to concede she was no expert.

So comparisons on discolourations, ladies and gentlemen, we'll look at skin discolouration as we go along, but in general there are a number of problems with trying to make comparisons in this case. We say this applies generally.

First of all, this is across this case, there are many causes of discolouration in a baby. We're confident you'll understand that you can't just use any discolouration, however striking, and then say, air embolus. We began this case with a very specific description. Not our fixation, theirs, the experts.

Secondly, we don't have a precise record of any of the skin discolourations in this case, by which I mean a photograph, something we can actually look at and compare. We have nothing to assess and compare the masses of descriptions, so we can see if there's any uniformity with objectivity. We have individual descriptions but they vary a good deal even when talking about the same baby.

Third, the descriptions don't just vary between different witnesses. You have seen individual witnesses give different descriptions at different times or none at all. So we say this is no basis for trying to compare or say we're talking about the same thing.

Fourth, sometimes these descriptions have come months or years after the things they are said to describe and after the people who had given the descriptions have all spent, or many of them have spent, time discussing this, pooling descriptions and recollections and, you've heard this in the evidence, and I'll remind you of some of it, listening to other people's descriptions, goodness knows when in the context of what we're dealing with here. So the dangers of recollection being contaminated or influenced are obvious.

Many causes of discolouration, no precise record by which we can look at these and compare them, changes between individuals describing them, changes within individuals' own accounts describing them, and everybody talking about them. That doesn't, by the way, prove there must be something, which is one of the lines that was taken: oh, they're all talking about it. That doesn't. It doesn't prove it's an air embolus.

Now, the second fact, an unexpected and sudden collapse. That's how the witnesses put this at the start of the trial. It's two things. As for unexpected, ladies and gentlemen, that's something to weigh up in each case. We say that in general any

of these neonates had the medical potential to deteriorate suddenly and even dramatically, and we base that on the evidence of the witnesses.

In some cases we say the babies' medical conditions means there is no surprise there was a collapse. For example, we say that [Baby D] with pneumonia, who had persistent difficulties in breathing without assistance, comes into that category. And then sudden. Sudden collapse. We would say rapid collapse.

At the beginning of his evidence Dr Evans said it would take about 1 to 2 minutes for an air embolus to take an effect after being introduced. That is very rapid. It's bound to be, isn't it? It gets into the bloodstream of a baby.

It's going to be important, ladies and gentlemen, to keep that in mind when we look at how realistic it is to say Lucy Letby has injected air because time after time she is nowhere near to events at the time this particular mechanism is said to have been done. That isn't good luck or she's fortunate or she's somehow planned it, it just doesn't fit. And it had led to some extraordinary contortions in explanations from the experts as to how this could be done, I'll remind you.

The third matter, resuscitation being unsuccessful.

That was something Dr Evans stressed as an identifying feature. And that is consistent, isn't it, ladies and gentlemen, it's consistent with what you would expect of an air embolus and what we know for that matter. And what you'd expect if someone is -- it's a terrible thing to say, but if someone is trying to kill babies with it.

If someone is intending to kill babies, you would expect it will be unsuccessful resuscitation. Only four of the 53 infants in the Lee and Tanswell paper survived the event.

Now, the number of times air embolus is alleged in this case does not make sense, we say, when you consider that against the almost inevitably lethal outcome of it, given how often that doesn't happen here. You weren't given much information on how air embolus is meant to cause collapse or death. I did ask, ladies and gentlemen, Dr Marnerides, the pathologist, and either he couldn't say or he wouldn't say, but he just refused to give an explanation and said he is the pathologist, not a clinician. He couldn't tell you how it works, although he still gave evidence about it. We say not a very promising start if the prosecution pathologist is making pronouncements about a mechanism he's unable to tell us about.

In fact, Sandie Bohin said that if air gets into the veins it can end up in the right side of the heart and it causes circulatory collapse, it creates in effect a gas lock. So a bit of the heart where the air is meant to go out to the lungs, it blocks it there and it can't go through. That's one thing she described, the blocking of the circulation. It all sounds probably -- it may or may not sound technical, it sounds technical to me, but these things may matter.

The air is 78% nitrogen, it doesn't just go. That's why divers get the bends. It doesn't just vanish. You don't just get 78%, something with 78% oxygen (sic), we say, that causes a blockage and then it just goes.

That's why it is so lethal. It's important because it means that if it's interfering with circulation and causing a collapse, it is static, it's a blockage, and that should mean, we say, it should or could be visible on an X-ray taken at the time, including an X-ray in life if we begin to put all of this together. As you have been told, you can take the view across all this evidence in assessing the experts.

It's also important, isn't it, because if air embolus is lethal and gets into the right side of the heart and block the circulation, that's where you would expect to find it on a photograph post-mortem, surely.

You won't find air in the heart on one post-mortem photograph in this case.

So as to the suggestion that inability to resuscitate proves air embolus or is diagnostic, ladies and gentlemen, there are many circumstances, sadly, when resuscitation may be unsuccessful. One of them may be air embolus, but you can't put this into reverse and say because it was unsuccessful therefore it is an air embolus. That's back to front.

On the evidence in this case, as you've seen, the idea that air embolus or the theory that air embolus is something from which there can be no resuscitation cannot be supported because it then changes. It's just changed by Dr Evans in particular when we have a baby where there is resuscitation, jettison that bit of theory, press on with a new explanation.

Discolouration. We looked at that. Unexpected and sudden. We've looked at that. Unsuccessful resuscitation. We've looked at that.

What about air in the great vessels, which is the fourth key aspect that's relied upon? We've had evidence from Professor Arthurs, Professor Owen Arthurs, ladies and gentlemen. It's

accepted that air in the great vessels, the aorta or the vena cava, doesn't of itself diagnose a gas embolus. He recognises that, it doesn't do that, it might be but it could be post-mortem gas, it could be gas which occurs after resuscitation.

Post-mortem gas occurs naturally and very swiftly after death and resuscitation applies, as it happens, to every baby in this case where it's alleged they died of an air embolus and we have those radiographs.

Let's look a little bit more at this though. Owen Arthurs began saying it was unusual to find this air in the great vessel of a neonate. It sounded promising but we did look at the research behind that, didn't we? Professor Arthurs was not happy that I was criticising his research, you may have detected, but we are defending this lady on charges of murder and not here to compliment a prosecution expert on a study that was not published, it's not in published research, it's not been peer-reviewed -- this is what should normally happen with solid expert evidence. We can't say it's based on babies of the same extreme prematurity or the same circumstances as these and there had been no control of the various variables. It's a tiny pool of samples.

Professor Arthurs found 38 images to work with and of them he found eight with post-mortem gas, although he said that doesn't necessarily apply to this case. But "unusual" means post-mortem gas in 25% of the cases based on that research. We say that's hardly unusual, first of all.

But most crucially, really, when it comes to this point, he came on to regard very readily that the strongest link between gas in the great vessels after death and babies is where resuscitation had been performed, and you heard that. That's actually the strongest link and that's in properly performed and published research with other experts, and that applies to [Baby A] and that applies to [Baby D] and that applies to [Baby O]. That is the common feature. That's it actually. And it sits squarely in quality research, as in published with other researches, by Professor Arthurs. We don't need to resort to air embolus, the evidence of it being air embolus is not strong and it isn't the most powerful connection.

But we can go further, can't we, actually? Because we know, ladies and gentlemen, you know, what an air embolus actually looks like. You know that because of questions that we asked Professor Arthurs and items that we showed to him and he dealt with this. Do you remember the blood vessels, as tubes, coming out of them all over the place, like a tree, really, and if the heart is beating then the blood will go through those vessels and air can go throughout that system.

Owen Arthurs gave the example of dye being put into the bloodstream so you can see the circulation and the same goes for air.

We have an image of air embolus on that article by Lee and Tanswell, and we looked at it, at D16, please, Mr Murphy, so could we put that up. This is an air embolus. This comes from the Lee and Tanswell article.

It was that image on the top right-hand corner of the page which we have enlarged and put into a format that we can see clearly here.

Take a good look, ladies and gentlemen, because surely the obvious thing in this case, where there are radiographs and alleged air embolus, is to make a comparison with what we know an air embolus looks like. And you know what, that doesn't seem to have occurred to the prosecution or one of their experts until we did this. Or if it occurred to them, they didn't do it. Here it is, that's what it looks like. That shouldn't surprise you, that's what you'd expect. That's what an undoubted air embolus looks like and it's nothing like what we have in this case.

We also saw, as it happens, an air embolus on [Baby G] from when she had recently been born at Arrowe Park Hospital. We saw that at page 8139 of the exhibits and we showed this to Professor Arthurs. Page 8139. Now we know what we're looking for, you can probably see it anyway, even if we didn't have to identify it with Professor Arthurs. But you can see, as it appears on our image on the left-hand side, probably the right-hand side of the baby, you can see where the tube has gone in and you can see some loops, dark loops, and that's the air embolus in the liver area. Air in the liver, looking nothing like the images in this case, although a little bit more like the image in the Lee and Tanswell paper.

As Owen Arthurs explained on 3 February, what we have is a misplaced -- just ponder this -- a misplaced UVC, so that air has gone into the liver and caused a tree-like pattern due to the inappropriate positioning of the UVC. He accepted this was an air embolus from a connected -- where there'd been a wrongly connected or wrongly positioned UVC too low in the liver. It was there at this point, we looked at it, and it was there 45 minutes later. This is in [Baby G] in hospital, her heart beating, keep this in mind when it's suggested you can't see an air embolus when someone's heart is beating. You can see this one.

Forty-five minutes later, it's still there at page 8141. Just go to the next reference, 8141, please, Mr Murphy. There it is still. These are in sequence.

If you go to the exhibits, you don't have the exhibits in the numbers but we can follow them through and we went through this with Professor Arthurs.

This has a real significance in this case. We can see from Lee and Tanswell what an air embolus is meant to look like, and it really shouldn't come as any surprise and it's not just two lines of air static in one or more great vessels, it's a tree-like pattern because it's got there after the heart was beating air round the system together with the blood. That's how it works. And we can see it here in life on [Baby G]. So a couple of things follow from this -- thank you, Mr Murphy.

That was by accident by the way. A couple of things follow. It's no good saying it can't happen by accident. Air embolus can happen because of legitimate medical treatment, something that Dr Bohin accepted only reluctantly and Dr Evans was unwilling to accept at all.

We're not suggesting for a moment that every allegation of air embolus in this case is explained by a medical accident. We question and we challenge whether air was introduced in any of these cases. But it does remain a possibility, actually, doesn't it, from the evidence that if there had been an air embolus, it's entirely possible that one or more instances could arise from the course of sub-optimal procedures. It must have done there on [Baby G], one of the babies in this case.

But secondly, and importantly, this establishes that an air embolus, if there is one present, can be visible when someone is alive. So it's not right to take the line that it wouldn't be possible to see it on a radiograph during life because the blood is moving. It's not right, it doesn't follow that there cannot be an air embolus when the blood is moving. The whole point about an air embolus, of course, to some extent, is it acts as a blockage, it isn't moving. That's the problem. So it will show up, air shows up on a radiograph. And we've got it there. That is decisive.

It seems a small thing, something that just came up in the cross-examination of Professor Arthurs, but we say, ladies and gentlemen, it's crucial to keep this in mind in this case. This is stuff we have now, we have an image of air emboluses, I am not sure in the Lee and Tanswell whether that's in life or death, but in the case of [Baby G] it's in life.

Ladies and gentlemen, scientific medical evidence, we say, needs to be sufficiently reliable if we're going to rely upon it in a criminal trial, as we are in this case. And we say that in this case the scientific evidence in this area in particular falls far short of that. There is a lack of genuine expertise across the witnesses. There really is on the evidence. The research basis for the findings that you've been given is poor from the link between gas in the great vessels to the question of discolouration. And what guidance we have from the experts has been applied inconsistently throughout the case.

And it's no answer, we submit, to say that there are enough bits and pieces to put it all together and say it does the trick. It's not enough to say that. If there is a lack of expertise and a lack of scientific rigour, it can't be compensated for by taking what is, in the first place, inadequate knowledge and then just repeating it and applying it in this case over and over again. And we say: where is an image that looks like what we know an air embolus is in this case, apart from on one of the babies when she's at a different hospital?

Where? And there isn't. And this is an area, we say, where the evidence is so poor it cannot safely be used to support these allegations. Of course I'm going to go through them with you. But rather than seeing if the theory can be manipulated to keep the allegations going, just look to see how it has been used like that, just to prop them up. You'll just see that.

I'm going to return to [Baby A]'s case now. So that's general points about air embolus. We are confident, ladies and gentlemen, you'll understand the application of them to the other cases, the other cases where it arises as we go along.

We've already dealt, in fact, in looking at that with much that arises in [Baby A]'s case, but the question, first of all, of sudden and unexpected collapse. Because it was sudden and it was unexpected, wasn't it? But obviously, it's unexpected. If it was expected, someone would have stepped in to give him the treatment he required, like giving him fluids, which he didn't get, his dextrose, putting the line in the right place, paying attention to his elevating respirations and the heart rate remaining unchanged. We say no one appears to have been expecting anything, but given that, no one was actually doing very much. The failure to read subtle signs.

Inability to resuscitate. Well, sadly, that happens and happens with many conditions after a certain point.

We submit that doesn't prove air embolus. For the reasons we've said, that is a piece of back-to-front reasoning that is used over and over again when it suits the prosecution because, of

course, sometimes, despite that principle of air embolus, we find a baby is resuscitated.

Discolouration. Ladies and gentlemen, this is the crucial detail in [Baby A]'s case, we say, and unless this is something you can be sure of, there is no basis for air embolus here at all. The prosecution have recited descriptions of rashes to Ms Letby and to you, as they're entitled to, of course they can do that, but what they've done is to recite evidence that has been given by witnesses in this trial from that witness box and that's the only material they've gone to.

So you have had recited to you evidence from witnesses who have had years to think about this, to talk about it and for recollections to change. You can see that. So we say it is crucial, isn't it, to look at what was recorded at the time. And we haven't done that for a long time, although I've referenced it.

We say where -- you've got them, ladies and gentlemen -- where in the medical notes or the contemporaneous documents do we see any reference to any striking discolourations such as that described in the evidence in the case of [Baby A]? We start with [Baby A], in the case of [Baby A]. We don't. We do not.

That, we say, is extraordinary. If something is so unusual, in the way witnesses have later said it was, it is extraordinary that it should fail to be recorded by so many people on so many occasions. One of the roles that you have, ladies and gentlemen, even in a case as technical as this, is to apply your common sense to what you see and look at. It's not that lawyers don't have it, whatever views there may be, it's just that where you are, your task is to assess the facts. And there comes a point, doesn't there, when something becomes just unsustainable? How can it be said there were these striking discolourations with [Baby A] when so many people do not identify them at the time?

Caroline Bennion, who's one of the nurses who dealt with him, who was close up to him during resuscitation, describes nothing remarkable, an experienced nurse. So before we even come to the descriptions, nothing from her.

Mel Taylor who was close up during the resuscitation process, nothing remarkable.

David Harkness, the doctor responsible directly, gave very dramatic accounts in evidence and I asked him about it in cross-examination I said:

"Question: It's something you'd never seen before?

"Answer: No.

"Question: Unexpected?

"Answer: Yes.

"Question: And you've given us a description of the patches of blue, purple and red and white patches; that's the description, isn't it?

"Answer: Yes.

"Question: Personally striking?

"Answer: Yes.

"Question: It seemed to be linked to this, as you put it, unexpected deterioration.

"Answer: Yes."

That's on 20 October.

If that is right and if he's a clinician and able to put down in his notes all sorts of observations -- and you'll see them, ladies and gentlemen, at tiles 185 and 183, that's where his notes are, we don't need to put them up right now because the point is there's nothing to see on this topic. Lots of other stuff, not this.

Despite saying how striking, how it sticks there and the most lurid descriptions to you in evidence.

What about his statement to the coroner for the inquest in July 2016, so over a year later? No reference there either. How can you possibly not include this lot in a statement for a coroner if it's what you saw? And don't give us the, "Oh, I was just so surprised I didn't think of doing it", it's been a year that's gone by. He wasn't surprised to put down everything else he put down in his clinical notes, was he, just this most striking extraordinary thing. Incredible if he saw what he went on to describe years later, not incredible if it isn't what he saw.

[Nurse A]. Her evidence is a good example of how recollections shift, ladies and gentlemen. When she gave evidence to you on 24 October, she did give descriptions that were unusual, although not actually the same as the Lee and Tanswell one but there we are, but unusual. But it seems she had forgotten what she had said to the police in May 2018. You've had, you've been reminded of her descriptions, given in evidence.

What did she say when she first spoke to the police about this? I asked her about that in cross-examination on 24 October and I said:

"[Nurse A], when you made the statement to the police [this is on 18 May 2018], you said, 'He was centrally very pale and unusually his limbs were what I can only describe as white.'"

That's it. That's it. No blotches, no red, no purple:

"Centrally pale and unusually his limbs were what I can only describe as white."

"Question: And that's all you said about discolouration, [Nurse A], all you said?

"Answer: Okay.

"Question: You didn't mention an unusual discolouration, did you?

"Answer: It's not --

"Question: Or purple blotchiness or anything like that? You didn't.

"Answer: Okay.

"Question: And although on Friday you said maybe there was more discolouration on his torso, when you made the statement to the police back in 2018, 4 years ago, you said, 'Centrally he was very pale', and you've explained to us centrally means on the central part of the body; yes?

"Answer: Yes.

"Question: That's different from the description you gave us on Friday, isn't it?

"Answer: Yes."

She agreed, yes.

How on earth do we get from "centrally very pale and unusually his limbs were what I can only describe as white" to blotchiness or purple or red or goodness knows what else it was later on?

She went on, after she'd made that first statement to the police, to make another one later in which she said that she saw discolouration on [Baby B] and that was like the discolouration

on [Baby A]. But her actual account, her first account of what she saw, was:

"Centrally very pale and unusually his limbs were what I can only describe as white."

And she agreed in evidence what she said in evidence was different from that and not just a little bit different. For the purpose of the issue we all know we're dealing with here: totally different.

Ravi Jayaram gave the most striking descriptions of [Baby A] being "pale blue", of the colours "flitting", "moving round", "things he'd never seen before" in evidence on 24 October. And also in a statement to the police in 2017 he described:

"Unusual discolourations and flitting patches of pink areas on the background of blue/grey skin."

That sounds amazingly familiar, doesn't it? That sounds a lot like the description in the Lee and Tanswell. It could almost have been taken from it. It could Almost have been taken from it:

"Patches appear to appear and disappear."

So his evidence to you and what he said to the police at an early stage of this investigation, very striking, very like the Lee and Tanswell article he'd read only a short time before.

And he said in answer to my questions on 24 October he'd never seen something like this before and it was extraordinary. And this is an experienced clinician trying to work out what has happened, he would have us believe.

Let me suggest to you, ladies and gentlemen, what is extraordinary about that description -- two extraordinary things in fact. First, that it made no appearance in his clinical notes at the time. They are detailed. They are full of details. You'll find them at tile 210, but no appearance there. Nor is there any reference to them in the lengthy statement he made to the coroner for the inquest in July 2015. How on earth can they be missed out? It's the first remarkable thing. Nothing in his clinical notes or the coroner's statement.

The second remarkable thing, and I have touched on this, is that it does seem to fit remarkably well with the wording in the Lee and Tanswell article that he read some months after this event, but before he made his statement to the police. We're hearing a lot about coincidence in this case, aren't we, ladies and gentlemen? You may agree that isn't a coincidence, is it? And we

suggest that the only reasonable explanation is that at the time he did not see what he later described. There is no way he would not include a description like that in the clinical notes. And what a coincidence that David Harkness didn't either. How could two, one very experienced, the other relatively experienced, clinicians both fail to do that?

It may be they were too busy talking about how the long line was well placed. But it's not in the notes, is it? And that is extraordinary and way beyond any inconsistency that Ms Letby has had fired at her and been hauled over the coals for in this case. It's way beyond missing out the word stained from "bile-stained aspirate" in paragraph 70 of the defence statement, isn't it? It's extraordinary. That's the bedrock for this. And it's not even there in the notes at the time or the coroner's statements.

Gas in the vessels, the radiographs won't tell us that, it doesn't even look like an air embolus and it could be resuscitation. And air bubbles in the histopathology by Dr Marnerides, this is some garnish provided to the prosecution case by Dr Marnerides. He's not an expert on air embolus, he can't say how they work. He pointed to tiny items in thin sections of material taken from the lungs which may or may not have been air or fat. And he pointed to a similar things thing in the brain which was most likely a bubble of air, although not 100% sure. And he conceded:

"This is not proof of an air embolus."

He said it was highly suggestive. We say that is pushing it. They are minuscule finding and it is no surprise that in fact Dr Marnerides readily accepted these findings did not show -- did not show -- there had been an air embolus in [Baby A]'s case and that, from a pathological point of view, the cause of death in [Baby A]'s case remains ascertained. That's on 26 March.

So [Baby A], ladies and gentlemen. We have to keep in mind who's proving what here and you need to be sure about these allegations. We say there is no fair or proper basis for an air embolus on the evidence of the experts. What we do have is undeniable poor care of a very fragile and premature neonate; you've seen what that consisted of. And we have circumstances in a busy nursery with people all about, no suggestion Ms Letby accessed the line at any point after Mel Taylor had used it to put fluid down the line that Dr Harkness had left in the wrong place. And that's the evidence on this count.

My Lord, can we pause at that point?

MR JUSTICE GOSS: Yes, certainly. Ten minutes then, please, members of the jury. (In the absence of the jury)

MR JOHNSON: My Lord, I don't want to pick up trivialities, and I hope that this isn't a triviality. But at page 29, line 16 of today's draft transcript. My learned friend said:

"You won't find air in the heart on one post-mortem photograph in this case."

You won't find it one, you'll find it on two. It's the evidence of Dr Arthurs on 3 February, relating to [Baby E], at page 69, and [Baby O] on 16 March at page 50.

MR MYERS: I'm grateful for that and I shall check that. Not because I don't accept it, but I just want to check.

MR JUSTICE GOSS: Do check it and then it'll be up to you whether you want to correct it or whether you want me, if it is correct, to correct it in due course.

MR MYERS: Yes. If that's something that is missed and incorrect then I would like it to be corrected if it makes a difference --

MR JUSTICE GOSS: Check it --

MR MYERS: Yes, I will (overspeaking) --

MR JUSTICE GOSS: (Overspeaking) with the assistance of those --

MR JOHNSON: (Overspeaking) it verbatim now.

MR MYERS: Thank you, my Lord.

MR JUSTICE GOSS: Thank you very much. Yes, we'll do that. Thank you very much.

(11.41 am)

(A short break)

(11.51 am)

(In the presence of the jury)

MR MYERS: Count 2, ladies and gentlemen. [Baby B].

[Baby B] was born on 7 June 2015 at 20.30. Again, 32 weeks and 2 days, the first of the twins and 1.669 kilograms.

On 9 June, just before midnight, she had a desaturation down to 75% and the CPAP prongs were dislodged from her nose.

Then, on 10 June, about 12.30, so half past midnight, a sudden desaturation to 50% and associated with the discolouration to the skin that is described.

Dr Evans and Dr Bohin identify, or say they identify, air embolus as the cause of harm. In [Baby B]'s case, we start or are asked to start with the statement that she was stable before her relatively brief deterioration around 00.30 on 10 June. Fortunately, it was a relatively brief deterioration. That doesn't underestimate the fact that any deterioration is a matter of concern, but with what we're dealing with in this case, it is relatively brief. It didn't involve her being intubated.

Can I say at the outset, ladies and gentlemen, the defence recognise on the evidence in the case of [Baby B] that there is no obvious medical condition or apparent or obvious sub-optimal care. That's recognised. We're not just saying it every time we come to a count that there is. Here we recognise that there is no obvious evidence of that.

But we also observe this: that in terms of what is alleged, that there was an attempt to kill [Baby B] with a lethal air embolus, not only is the evidence of that unclear, but it is so weak, we submit, it is no basis for being sure of what is alleged. And that's what matters. Because, as we have explained, and as you will understand, it may not always be clear exactly what's happened and we have to be careful, particularly in a case revolving around medical material like this, not to jump from saying, "Well, it isn't clear therefore guilty". If it isn't clear, it's therefore not guilty. Just some general points about [Baby B]'s condition before we look at the event itself. Her birth condition actually was relatively poor, she was the more poorly one of the two twins we heard. As it happens, we went through some of the material relating to breathing issues after the time of the event and this is in the additional material for [Baby B].

But we see that on 19 June, so this is some time later, there's an entry in notes by Nurse Caroline Oakley describing "fleeting desaturations and bradycardia". On 20 June, Nurse Kate Brammall describes apnoea and desaturations down to 70 or 80% and the heart rate drops, self-correcting.

And on 14 July, after discharge, we saw a note in medical records of an attendance at hospital where there had been issues with [Baby B] and she had been mottled.

Nobody's suggesting those have been caused by the event we're looking at here and they are not as serious. But we identify them because it shows, as with others, that there can be deteriorations for any number of reasons that may or may not be identified. In [Baby B]'s case, we know that she had also been going through a process of attempting to insert lines into her, rather as [Baby A] had. You may recall we'd asked questions as to what is the number of attempts it should be, the competent number of attempts it should be to insert a line, and it seems that up to three -- it takes as many as it takes, of course, but the aim is to deal with it in three. And Dr Harkness, we know there were five attempts by him on the line insertion chart in the additional material, but five attempts to insert a line before it happened. That's some time before the deterioration, we are not suggesting there's a direct link. It's just not very good, we say.

There were also attempts to insert a UVC on the 8th by Dr McCormack with difficulties, all of which are capable of putting a baby under stress.

Then we have an entry by Nurse Caroline Bennion at tile 31 in fact, let's have a look at that, at 3.28 on 9 June. So we've been going through the lines, the attempts to insert a UVC, and if we look at tile 31 on 9 June in the [Baby B] sequence. If we can enlarge that, please, we can see things there. This is during the night shift before the night we come to.

There is reference in Nurse Bennion's note to the left hand and arm looking puffy at 21.00 hours; that's earlier in the shift and the infusion stopped. Delays there. It says:

"[Baby B] appeared jittery at this point and BM and gas obtained."

We can see lactate is high at 4.1. She seemed to improve during the shift, the lactate dropped, the jitteriness settled, but "[Baby B] is very active". It doesn't sound like that was something that Nurse Bennion regarded as a positive thing, it's hard to tell, but that's where we get to. But again we are not suggesting this leads directly into what happens at the time we are looking at. But also, by the same token, it's consistent with what we know about the babies on this unit, that they can change and they can change rapidly. That's where we are.

What do Drs Evans and Bohin suggest was the cause for the event at 00.30 hours, which is the one we're looking at? In the case of Dewi Evans we have literally -- or we did literally go through all the options in the search for something that can support an allegation of harm. We can take the note down, please, Mr Murphy.

We had the suggestion that Ms Letby had or may have deliberately removed [Baby B]'s nasal prongs around midnight. That was something he put in his report, although he didn't seek to push that in here. This was early on and we were identifying these things to show the theme of Dr Evans coming up with whatever alternative he could find. That was one of them.

We had the suggestion from Dr Evans that [Baby B] had been smothered, literally just thrown out there like someone casting a fishing line. He didn't persist with that and there's no evidence of smothering and not a suggestion from anyone that they noticed [Baby B] being smothered. So maybe that's why that mechanism was also abandoned. Then we have air embolus, supported by Dr Bohin.

I'm going to pause on the topic of prongs because whilst that isn't something which is seriously alleged against Ms Letby, it has relevance elsewhere in this case about the way that these babies can interfere with breathing aids, tubes, items put on their faces, and we have heard evidence about that. [Nurse A] made the note about the prongs being dislodged shortly before midnight on 9 June. She was never in any doubt that was [Baby B]'s own doing. She was there, she'd know. But she described how the CPAP prongs are secured by ties on [Baby B]'s hat, but she said on 24 October it's not unusual for them to be knocked out by a baby from just moving or pushing them away. You may want to log that, about how these things move about or can be dislodged without anyone interfering.

What about air embolus? Before we come to look at how strong the evidence actually is, ladies and gentlemen, we say it's important to consider how unlikely that anybody, be that Ms Letby or any other nurse, deliberately injected or could have injected air into [Baby B]. And again, it comes to this: these allegations, these accusations, have to be placed within the real world. There's a place where this is said to be happening and you have to weigh this up in the context that you're looking at and nursery 1, where [Baby B] was, is a busy nursery.

[Nurse A] was working there, other nurses can come and go at any time as they require for equipment or medication. Belinda Williamson or Simcock talked about this and I reminded her actually on 16 November of what she'd said in a statement to the police on this. What she said to the police was this, ladies and gentlemen, back in February 2018, and I'm going to this because it helps paint a picture of what nursery 1 was like.

Just pausing, when we look at the layout -- the psychological trick that happens in this case, when we look at those layouts, it's very easy to see baby, nurse's name, arrow, and then we're

left with the sense that that's it, it's a sort of static situation, that's it, that's all that's going on. Of course it isn't.

There's people moving around, there's doctors coming and going, not all the time, but they are, there are nurses moving around, there's people in the unit.

As to nursery 1, what Belinda Williamson said to the police was:

"We have a number of drugs cupboards on the unit. There are four drugs cupboards in nursery 1 and a fridge in the sterile store opposite nursery 1."

She went on to say:

"All the cupboards are locked and the keys are held by the shift leader or another band 5 or 6 nurse."

And then she went on to say:

"As a result of the cupboards' location nursery 1 is constantly busy. I would liken it to a bus station, it can be so busy."

So that's from one of the witnesses who worked there, a prosecution witness, likening it to a bus station. It is very easy in our mind's eye just to think of it as just an empty space that looks like what it looks like on the layout with an arrow and a name or couple of names. "Like a bus station." It's a hub in there, people coming in and out whenever at any time.

I asked her:

"Is it right that in addition to whoever was caring for the baby or the babies, staff could be coming in and out at any time to collect items?"

And she agreed. But perhaps to balance some of the impressions created in this case, keep in your mind that description from a nurse who knew that unit well, that it was "busy or like a bus station in there".

For this allegation of harm to have taken place, Ms Letby or the person responsible would have to be close to [Baby B] at the time air is injected.

Remember, it's rapid. And of course she's not. She's not. She was assisting [Nurse A] in nursery 1, which is a normal thing for one nurse to do with another.

These things build up. Of course suspicion was raised because she was in there. But you have the reviews, you've seen the evidence: the nurses assist all over the place.

She assisted with TPN being put up at 00.05; that's at tile 213. She is hardly injecting air then. We don't accept she is at all, we don't accept it in any way, when I say that you'll appreciate I am just dealing with what it is the prosecution are saying.

[Nurse A]'s not going to miss that. And it's not going to take 25 minutes to take an effect, is it, if it's injected then in fact? It's quick, 1 to 2 minutes according to Dr Evans -- until, can I say, we came really to [Baby M]. We got some new developments at that point, which we'll come to. But it's quick. So that's not quick.

A blood gas taken at 00.16; that's at tile 20. No sign of any air embolus or deterioration then. Nothing immediately following it. No suggestion that Ms Letby is seen to have done anything at that point in any way or anybody else. And then at 00.30, [Baby B] desaturated dramatically, at which point Ms Letby was with [Nurse A] and not with [Baby B]. And nothing -- nothing -- to show she was, with witnesses there or a witness there, who knows who else, but certainly one. And nothing.

This must be one of the only cases where somebody can be in a situation so many times with nobody witnessing them doing anything and it being treated as totally okay to say, "Well, they did it". No one can tell us how, in what way, and it's not seen by anybody.

It is an explanation that has formed an allegation, ladies and gentlemen, unsupported by evidence.

The evidence of [Nurse A] was that Lucy Letby was actually standing with her checking medication at the time this happened, and that was on 24 October.

So she's with [Nurse A] at the time of the deterioration and that is it, and actually [Nurse A] said that she was keeping a particularly close eye on [Baby B] because of what happened when she knocked the prongs off and because of what had happened with [Baby A] and because she had a line in her. How much does it take to show how almost impossible -- there's no space to do anything unless we're going to invent one.

This is a situation where both Lucy Letby and [Baby B] are effectively under observation by [Nurse A] who went out of her way to say she was watching what was going on with [Baby B] because of her concerns.

Well, what is the evidence that these expert opinions are based upon that is meant to prove beyond reasonable doubt that this was an air embolus? Discolouration? I'll come back to that shortly. We say that is the only feature worthy of consideration. It is worthy of consideration, we recognise that. We recognise you'll want to consider it, not just dismissing everything. That is something to look at and I will come to that in a moment.

Rapid acting. Well, no, not if they're trying to pin this on Ms Letby because nothing happened rapidly when she was looking after [Baby B].

Inability to resuscitate? Well, you've heard what we say about that. We say it is significant. If an air embolus is introduced, it is invariably going to be lethal. You cannot have air embolus being introduced all over the place, as happened in this case with Dr Evans and Dr Bohin, and them not be lethal, least of all if they're introduced with an alleged intention to kill. Because -- I am not wishing to be insensitive, but if that is the intention, how difficult is it? What on earth is the difficulty if you can do it? If you can already do it. If it happened with [Baby A], why on earth wouldn't it happen every time? It's not going to take much, is it? A teaspoon, we were told.

[Baby B] made a swift recovery in fact. I remind you, 78% nitrogen. It doesn't just vanish, it stays there, we've seen that on images in this case, the image of [Baby G] in particular I'm referring to.

Air in the system. We do have a radiograph that was taken at 40 minutes after the deterioration. It's at tile 240, I wonder if we could put that up, please, Mr Murphy. There it is. Nobody suggesting air on that in any sort. The point has been made, you wouldn't necessarily get air in a radiograph in life even if an air embolus has been introduced. That may be so. But we know that you can as well from what we've seen with [Baby G] and from the medical logic of this, actually, but you can. And there isn't. There isn't. If there was, it would be identified. There isn't.

I put it down -- just to make the point, we have the image taken in the sort of period when, in [Baby G]'s case, there was still air on that radiograph at Arrowe Park, it was there for some time. It doesn't just go.

Can we take that down, please, Mr Murphy? Thank you.

Discolouration. I'm not going to keep repeating the points that we make, ladies and gentlemen, because they apply in case after

case. In [Baby B]'s case there was discolouration that struck those or some of them at the time as unusual. That's right. We ask, as we go through this, to keep in mind this is the only case, actually, where there is evidence from what was recorded that we say genuinely establishes that. We have [Nurse A]'s note of purple blotchiness with white patches, so she was able to describe that, no reason not to, when she came later to talk about [Baby A], and Rachel Lambie's note of purple discolouration with white patches. And then [Dr B] said when she came later she was told about purple blotching and it was on the right mid-abdomen and on the right hand when she got there. That's it.

So we are not disputing in this case there are those descriptions. But again -- and we make no apology for saying this, because it's where we started -- none of them fit that description in the Lee and Tanswell paper, which is the colour that we are told or that the mode of colour be flitting changes, the bright pink areas over the cyanosed blue background, none of them match that, we say. There's no real way of checking, is there? We don't have any images. But that is a precise description.

I remind you that babies can be discoloured for many reasons. We question why an air embolus should just cause discolouration such as the sort that was seen on this occasion. And this becomes guesswork, doesn't it?

We look at [Baby B] and say, "Oh, that's like [Baby D]", or, "That's like [Baby O]". How on earth can anyone say that? You look at the clinical notes if you like, ladies and gentlemen, we ask you to, we don't shy away from this evidence. I am talking about it now. You look at it and perform your own comparison as far as you can, particularly on the notes at the time. You'll see how approximate this becomes, even in the case of [Baby B]. What we're acknowledging is there's at least a record of something at the time, as there is in the case of other children, mottling or whatever it is.

One factor that we draw to your attention, particularly where Rachel Lambie is concerned, who's the doctor who attended at this point, she had been there -- you may think this is important -- when [Baby A] had collapsed, and what she said about [Baby B] was that was the only time she'd seen discolouration like that on [Baby B]. I asked about it on 24 October and she said she'd never seen anything like that before. That's interesting, isn't it, because that is a witness who has made a note at the time in the case of [Baby B], who was present for [Baby A] and [Baby B], and was clear that what she saw on [Baby B], whatever it is, we don't accept it's air embolus at

all, but whatever it relates to is the only time she'd seen that and she'd not seen that before.

So if anybody was in a position, in whom you could have some confidence to say it was like [Baby A], she is the witness, and she specifically does not. She says something quite contrary to that. That's the best evidence we have for making a comparison in this case, we say, from a witness who did make a note with [Baby B] and she doesn't liken it to [Baby A].

So what do we say about air embolus? We accept some of the witnesses describe a discolouration they considered striking, but there is no evidence to establish that is diagnostic of air embolus and no basis for saying it's the same as the others in this case. To state the obvious, if it needs to be stated, unfortunately whatever happened with [Baby B], whatever condition it was, was not fatal.

Whatever it was is not supported by evidence by way of an X-ray and an X-ray was taken over the relevant period and we say that is important. You can look at -- you've been addressed at length about circumstantial evidence but we say with regard to that, that involves also looking at what is missing that might otherwise be there that could give you some degree of certainty in what you're asked to find, and we say it is highly relevant that that is missing.

So nothing by way of any radiograph that fits with an air embolus, and we know that can be done, it's not there. I'm going to identify this. It's an unhappy detail that appears in some cases and something is made of this. I don't mean to be indelicate, but let's face it: no screaming, no crying, no distress. The reason I identify that here, and it applies to [Baby A] actually, is so much has been made as we go on in the case, as Dr Evans and Dr Bohin began to spread out and look for clues as to what they could rope into their ever-flexible air embolus theory, it morphed somewhere along the way into cries of distress. That wasn't anything they identified at the beginning of this case and it isn't anything we see in the first two cases.

So reliability and consistency is important, otherwise we are literally in the territory of experts who have got a free hit at making this stuff up as they go along and we say, without a moment's hesitation, there has been a lot of that with Dr Evans and Dr Bohin, there has been. You can see that on the evidence. It has just changed as required.

If distress was such a feature, why wasn't that identified right at the beginning when I asked them about it? That's why I asked, so we could have something to measure it against. Instead, it

just came up when it was a detail they could work into the story, work into the theory.

So as it happens no air on any radiograph and no distress. No principled basis, in fact, consistent, we say, with what happened to [Baby B] as being due to an air embolus. There really isn't. Plenty of evidence to support that she suffered a significant desaturation, and we say that is consistent with her prematurity, and fortunately there was a relatively -- relatively -- rapid recovery and that is it.

Afterwards, various things were identified by the prosecution, very much under the presumption of guilt head we say, just picking things out to which prejudice can be attached. For example, something was made of the fact that when we go to the neonatal review we have Ms Letby looking after [Baby B] up to and around 1 am that morning as if that was sinister. Another one of those examples where she is doing what other nurses do, helping a nurse, and in this case she had to help because [Nurse A] was looking after [Baby B]'s parents. [Nurse A] was the designated nurse, we went over this, she went to help or deal with [Baby B]'s a parents, so the nurse who continued to assist was Ms Letby. That's it. But it's used against her to shore up a weak allegation.

The prosecution picked out a message in the [Baby A] sequence at tile 337. I would like just to look at this. Thank you. There's a bit of jumping around here with this inevitably because we were looking at a couple of sequences. This was picked out as a message sent by Ms Letby to Ashleigh Hudson on 12 June at 10.08. And it says:

"It was awful. He died very suddenly and unexpectedly just after handover. Not sure why. It's gone to the coroner. [Baby B] went off Tuesday night and was intubated but back on CPAP now. They are querying a clotting problem. Very sad."

Pausing there, they would query it because there was antiphospholipid syndrome for both these twins if you remember. They would query it but that's what Ms Letby said at that point. And the prosecution in closing their case said on 20 June, having identified this:

"Lucy Letby fastened on to that as an explanation. We know from [Baby A]'s sequence at tile 337 they're querying a clotting problem."

The point being, as was made a number of times, that she was introducing ideas or conditions as cover for what the prosecution allege she was up to. And we saw that point being made many times. And this was seized on.

It's consistent with that theme, or one of the themes of the prosecution case, we say, where they look at what the nurses are talking about, seize on comments by Ms Letby, and then use them in whatever way props up or supports the allegation. In this case, as in others like it, saying: look how she's raising a false cover, what she's brought up.

Well, as ever, we have to look at the context. So just to see how clotting enters its way into this and where the idea comes from about querying a clotting problem, let's go back 2 days to 10 June, 10.09 in the evening, on the [Baby B] sequence at tile 349 just to see where clotting actually makes an appearance and how it comes into this.

So we are now 2 days before that message which the prosecution identified and it's a message from Lucy Letby to [Nurse A], 10 June:

"How is [Baby B]?"

Which isn't a surprising question given what had happened. This is actually a good example of how she cannot win, because of course, "How is [Baby B]?", no doubt could be identified as, oh, look, she's showing an interest in what happened. Not asking about [Baby B] would be considered perhaps as very odd, you're not bringing up something you were involved with. It works either way, doesn't it?

Anyway, "How is [Baby B]?", she asks [Nurse A]. In response, if we go to tile 350, [Nurse A] to Lucy Letby:

"Looks really good. Wanted her vented overnight but blocked her tube and happy on CPAP. Not that that means anything after last night!"

And the next message, please. [Nurse A] says:

"We also have a 30/40 800-gram and new 31/40 twins. T1 girl, T2 boy. Boy vented and in [Baby A]'s space. Other two new babies on CPAP."

Then we come to this at tile 352 when we're looking at where clotting problem start. Let's have a look, [Nurse A] to Lucy Letby:

"[Baby A]'s preliminary report: no gross abnormalities, so now bleeds, clots or line issues. [Baby B] all ultrasound normal. D-dimer result not significant, so no idea what's happened [as read]."

There we have [Nurse A] to Lucy Letby:

"So now bleeds, clots or line issues [as read]."

That's where clotting issues come into this. It isn't Lucy Letby generating clotting issues as some sort of cover when she talks to Ashleigh Hudson on 12 June or fastening on to something. It's her talking about something with another nurse that [Nurse A] told her about. It is, we say, an exchange that would be considered unremarkable in the case of any other nurse.

The prosecution do not raise suspicion against [Nurse A] for here -- for what we have here, do they? They don't raise it. She mentioned it soon afterwards. Again, just imagine if that message was the other way round. What would be said then? You know what would be said. As the prosecution said in closing, "You know what I'm going to say, don't you?" Yeah, we do: Lucy Letby, every single time.

Final point on this, ladies and gentlemen, with [Baby B]. I'll leave you with this: I'm going to ask Mr Murphy to take that down but to put up [Dr B]'s notes at tile 223, the clinical notes from [Dr B], the consultant. We leave you with this because we say this is an insight into the opportunistic way this prosecution theory of air embolus is constructed against Lucy Letby.

If we just enlarge -- these notes are made by [Dr B]. If we enlarge the lower half, please. You may remember this:

"Adrenaline not required."

She sets out the bolus that was given:

"Upon my arrival, purple blotchiness, mid-abdomen and right hand. Pink and active."

Can you see that? I don't know if you remember, what little insight into the prosecution and the experts we got with this; yes? Independent experts, objective, you can rely upon them, not taking a crack at any point they spot as it comes by. All right, let's put it to the test.

We all know what "pink and active" refers to, and [Dr B] said so in her evidence on 25 October. It describes [Baby B], pink and active. We've seen it.

That's a description for babies. After I'd finished cross-examining Dewi Evans about discolouration and what we say is the lack of convincing or consistent evidence, I sat down, and the prosecution got up because they're allowed to ask their witness

questions to, in effect, re-examine and deal with any fresh points or points arising. They came to this and, we say, offered a suggestion to Dr Evans, who we say had given very unimpressive evidence on discolouration. That's a matter for you, that's my submission, you'll judge him on the evidence, but we say it was unsatisfactory.

He was asked this by the prosecution:

"Question: The notes of [Dr B] that are on the screen at the moment, Dr Evans. If you just look, it was suggested that what [Dr B] had noticed was inconsistent with the article. In other words, the only part that was read to you was:

"'On my arrival purple blotching or blotchiness.'."

"Whatever that says halfway down.

"Answer: Yes.

"Question: But in the next line it says, 'Right mid-abdomen and right hand, pink and active'. Do you see that? [Dr B] interpreted her own handwriting for us this morning. That pink and active wasn't read to you. Do you see that?

"Answer: Yes, yes.

"Question: Is that consistent or inconsistent with the Lee and Tanswell."

Dr Evans immediately:

"Answer: It's a good point, actually."

It's a good point that pink and active is consistent with Lee and Tanswell? Not a good point, it is a ridiculous point. The sort of point you will grab at if you're interested in propping up an allegation on whatever basis you can come up with, whatever the facts. That is exactly what happened there. That is a direct hit of Dr Evans doing the sort of thing he was criticised for so severely by Lord Justice Jackson: working-up an explanation. So we spotted this a month or two before we came to that decision.

This is the same expert who you were being asked to rely upon across this case. But it didn't end there we say. When Dr Bohin came to give evidence I asked her about this and she agreed that pink and active describes a baby, not a rash, and that people in neonatal medicine do not describe rashes as pink and active.

Now, I pointed out what Dr Evans said and Dr Bohin's reaction was to say that was a mistake, and quite rightly, of course, I respectfully observe, his Lordship pointed out that it may be difficult for one witness to comment on what another witness has said, and with that we respectfully agree, that's right.

But now we have come to the end of the evidence you'll recall much has been made, after that point in the case, by the prosecution of how Sandie Bohin is involved for the purpose of peer-reviewing Dewi Evans, and there certainly has been no limit on her commenting on his opinions and findings elsewhere. It's what we're told she was here for. And we say, and you saw this unfold in evidence, that it is revealing that when we came to this point, we say her reaction was to excuse him by saying it was a mistake.

It's not a mistake to say that -- well, it may be a mistake to decide to say that, I suppose, a mistake for a supposedly independent witness to do that. But it's not what might be called an innocent mistake. We say it's patently obvious Dr Evans knew what he was doing and it's beyond an easy dismissal on behalf of somebody else suggesting there's anything mild about that. That is what we're dealing with and that is the sort of thing that the evidence you are asked to be sure about in the case of [Baby B] is based upon. It is the same experts making the same assertions in other cases where it may not always be as obvious how poor the basis for their findings is, but it just shows how little it takes and how they will use that evidence, we say, and that then is pre-eminently a job for you to assess.

You have to be sure of harm in this case and we say we are way away from that in the case of [Baby B] on the evidence.

[Baby C], ladies and gentlemen.

[Baby C], born on 10 June 2015, at 15.31, half past 1 in the afternoon (sic), 30 weeks and 1 day gestation, 800 grams.

On 13 June, so what we now know would be called day 4 of life, at 23.00, Sophie Ellis gave [Baby C] his first milk feed.

At 23.15, he collapsed. CPR started, but it couldn't revive him and it ceased at 45 minutes past midnight and, sadly, [Baby C] died at 05.58 on that morning of 14 June. That is count 3 on this indictment.

Dewi Evans identified no cause in his reports before the trial, but in evidence he said this was air down the NGT and then also said air embolus.

Dr Bohin identified no cause.

Dr Marnerides identified or suggested air in the abdomen, gaseous air, gaseous exogenous air.

We say at the outset, so many things that are wrong and unfair about this case generally are illustrated by this one charge, and we mean wrong and unfair from the position of where Ms Letby sits. If [Baby C] had been 1 gram lighter, he wouldn't or shouldn't have been at the Countess of Chester Hospital at all. That is before he became unwell, which we maintain he undoubtedly did on the evidence. His chances of survival were not good, we say, even before he became unwell. He suffered from infection, he couldn't be fed, he was producing black or dark bile aspirates regularly during his final 24 hours and he had pneumonia when he died. Those medical findings can't be contested, they're the evidence.

Whilst the experts identify harm being done on 12 June, when Lucy Letby was not on duty, they cannot convincingly identify what was done to him, we say, to cause him to collapse and die at the time when she was on duty on 13 June, although she wasn't designated. We say they have refused to accept that [Baby C] was as unwell as he obviously was. And finally, Ms Letby is being blamed for something where, yet again, on a careful consideration of the evidence it doesn't follow that she was even in the room at the time that any harm would have had to have been done to [Baby C] if the prosecution are right that harm was done.

[Baby C] had a number of serious risk factors from the outset: he was extremely low birth weight, only 800 grams, he was very premature, there had been intrauterine growth restriction, and what was called reverse end-diastolic flow, which interferes with blood flow pre-birth. He was regarded as a high risk of potential decline or infection or NEC or abdominal problems, NEC in particular. We recognise that.

His markers for infection are high in the days following birth. Respiratory distress syndrome, lung consolidation. These are all in the notes, ladies and gentlemen. Elevated lactate. His CPR was up to 23 in the clinical notes of Gail Beech at one point. Low platelet count. Persistent production of dark bile aspirates and pneumonia on post-mortem. And Dr Bohin talked about that in particular and I'll come back to that.

We say there are failures by the neonatal unit and these, ladies and gentlemen, are not accepted by any of the clinicians. These are not accepted, but these are failures, we say, that exist. We say he should have gone to a tertiary unit for investigation given his condition of the 12th into the 13th.

There was no examination by a consultant before the 13th. There was a failure to react to the bile aspirates, or even vomiting, that had taken place -- and vomiting took place on at least one occasion and maybe two, I'll show you. We say the evidence shows a general failure of medical and nursing staff to react to the problems or document them properly.

When you look at that, we say that all of that is circumstantial evidence that is perfectly capable of showing you there was sub-optimal care received by [Baby C] and it had an effect because that played a significant part in how ill he became. And when we come to Sandie Bohin you'll see how she talks about how the pneumonia that he had would have made him weaker and less able to be resuscitated. So this is all cumulative.

Joanne Williams was asked about this by me on 28 October, about the potential for [Baby C] to develop serious clinical difficulties unexpectedly or deteriorate rapidly. And I said to her:

"Question: I think you would agree that you can never be complacent with a baby of the size that [Baby C] was?

"Answer: Yes.

"Question: You agree with that?

"Answer: Yes.

"Question: And you've been through your observations, and I'm going to go to them with you, but do you agree that however stable he appears to be at any particular moment, you still have to keep a very close watch on a baby like [Baby C]?

"Answer: Yes.

"Question: Because even if there are indicators of stability, change can happen quite rapidly, can't it?

"Answer: Yes. Obviously, it's making sure. That's why we carry out our observations and it can sometimes be only subtle."

That was from Nurse Williams:

"Question: Yes, that's what I wanted --

"Answer: Subtle signs.

"Question: Yes, subtle signs, thank you."

Then my question carried on:

"Question: I think your view was that a baby the size of [Baby C], in his condition -- I think you way you expressed it was it could make you quite nervous, I don't mean that in a critical way, but nervous. Do you mean in the sense you have to keep quite alert and just keep a close eye on what's happening?

"Answer: Absolutely."

Right? Now, we say the prosecution approach in this case, although not limited to this count, is to minimise the problems and, so far as they can, to present this as a baby where all was well.

When they cross-examined Ms Letby on 18 May, it's one of the many occasions she was asked a question and asked questions in detail about something where you may have thought, well, she can't remember all the detail. But the prosecution took her through excerpts from [Baby C]'s history, but their cross-examination began this way, they asked her:

"Do you accept that [Baby C] progressed well, having been born in good condition?"

Can I say, the aim of this was to get her to say he was all right. That's the aim of this questioning by the prosecution, as if that can actually determine this, but that's where we were going:

"Question: Do you accept that [Baby C] progressed well, having been born in good condition?

"Answer: I can only go on what other people's notes were. I'd not looked after [Baby C] before.

"Question: Do you accept the evidence is that [Baby C] was doing well?

"Answer: I think there had been issues with his abdomen and things but --

"Question: He wasn't perfectly healthy, that's why he was in a neonatal unit, but there were no causes for concern, were there?

"Answer: Not that I recall, no."

That's what she said. And then that's treated, isn't it, together with everything else, that that shuts the issue off and there's nothing to see here, move on. We disagree entirely.

That -- by the way, that answer came from the woman, I don't mean to dismissive by saying that, who agreed with the prosecution when they wrongly said that both [Babies O & P] had been unwell when she handed them over. Do you remember that question was put to her:

"What happened with [Baby P]? Like his brother, [Baby C], they were both unwell when you handed them over, weren't they?"

And she agreed. And then, quite properly, the prosecution went on to point out that that was a mistake on their behalf, it wasn't both [Babies O & P] who were unwell, they meant to say [Baby N]. We'll come back to that. The reason I'm pointing this out is that even where there's no dispute that what they said was wrong, she went and agreed with it in cross-examination. She agreed with something the prosecution agreed afterwards was wrong. So there is no point taking answers she gave when she was manoeuvred into a position to say, "Do you agree this, do you agree that", and just assume that that is the end of the issue, which is what the prosecution would like to do. We say you look at the evidence if you would, ladies and gentlemen.

And let's see how [Baby C] was doing. We can start with the nursing note of Yvonne Griffiths, please, at tile 231. One of the strange things with the notes in the case of [Baby C] -- I just wonder if you could pull out for a moment, Mr Murphy -- so we can see the page, could you expand the lower part of that page?

It was actually -- it's a bit hard to see, but it's a right mess of notes here. We've got addendums on [Baby C] being put in on all sorts of days after the time that the deterioration and the death happened. It happened on the 13th and we've got people putting in notes around then and coming back and putting addendums in.

Yvonne Griffiths, which is the -- back to where you did go, please, Mr Murphy, on the right-hand side. Her note, which deals with events of the 12th, I think it had gone into someone else's notes originally, if you remember, but it doesn't find its way here until 14 June, a late addition of a note. It's actually poor record-keeping, isn't it? That is poor record-keeping.

This is a baby who died and notes relating to his condition, which was not good in the period leading up to death, the day before, had been put in the wrong patient's file. So no one's going to read these, are they, at the time it mattered, unless they go to the wrong patient's file if I understand this correctly?

Can you imagine what would happen if Lucy Letby had done that? A baby's died and it turned out she had been put relevant notes in someone else's file. Plausible deniability, or some version like that, cooking the notes, cooking the forms, goodness knows what.

If we look down here, it says:

"[Baby C] unsettled at times [halfway down]. X-ray of long line."

And:

"18.30 hours, bile noted on blanket. Nasogastric tube aspirated and 2ml of black-stained fluid obtained. Infant too unsettled for lumbar puncture. Plan to reassess later."

We say this is a significant period. This is 12 June and this is where a particular problem is beginning to emerge, though there may be signs before then when we come to the radiograph of problems.

12 June this is with Yvonne Griffiths, note in the wrong place, describing bile on a blanket and "2ml of black-stained fluid obtained".

The next place to go to, ladies and gentlemen, if we're following this through, is the IC care chart at tile 25, please. It's the right-hand side, if we could enlarge that. You can see, ladies and gentlemen, where Yvonne Griffiths has signed that, 12 June. You can see where she's signed that on the right-hand side, the YGs going down. It's the day shift. Can you see 08.00 it begins? If you let your eyes adjust on that.

A couple of things about Nurse Griffiths' note -- and don't forget she's one of the senior nurses on the unit. Right? Let's have a look at this for a piece of record-keeping. Keep in mind what capital would be made of this if it was LL who was in charge here or designated and not YG.

We can see at 09.00 she hasn't signed it, this is a senior nurse on the unit, something Ms Letby would be taken to task for. I'm not going to go through every single time we see these things, but it's important. So much of this has been made by the prosecution.

Something is entered at 12 o'clock, not signed there. But perhaps, more crucially, we know from the note that she put in the wrong place and brought across a day -- the day after -- later in the day after [Baby C] had died, we know from that note that at 18.30 there was bile on the blanket, which could be consistent with a vomit, and that's important because

vomiting bile is a red flag. There had been bile on a blanket and she'd aspirated 2ml of black fluid at 18.30. Okay? Where is that on this chart? A senior nurse, potential beginning of a serious problem. Nothing. It's not put there. No mystery, it's not there, it isn't.

As we carry on into that evening, dark bile continues to be produced. It's being produced across that evening. If we go to the next chart that would follow on at tile -- before we do that, just pausing there, while we're still on 12 June, can I show you next, ladies and gentlemen, the radiograph we've looked at, which actually is from about midday, 12.36. Probably taken, can you see where it's got "long line" at 12.00? Something about long line maybe in conjunction with that, I don't know, but a radiograph was taken at 12.36. So we are going to come out of this and look at that picture. Page 1996, please, Mr Murphy.

Now, this is the picture, the radiograph, that Dr Evans, Dr Bohin and Dr Marnerides have all said gives evidence of harm being done to [Baby C]. It's harm. It is, they say -- they regarded it as a suspicious event, which is air forced into the abdomen. That is their view, expert view. If we look at the commentary that goes with this, if we scroll down to the next page, 1997, this is the line:

"There is now marked gaseous distension of the stomach and proximal small bowel."

It might be all coming back, I don't know, but the whole point is -- another issue here is "proximal small bowel" means it hasn't gone all the way into the intestine. Something has happened which means the air that has gone in has stopped part-way through the bowel. This is important when we come to the question of whether there'd been a blockage there, which we spent some time looking at.

But let's just take this step by step. Marked gaseous distension of the stomach, something that all three of those key experts regard as suspicious and indicative of a harm event, one taken when Ms Letby was not there, playing no part in what happened. The timing of this is actually, it seems, a couple of hours before we get into the period where Yvonne Griffiths' observation about bile on the blanket or on the cot, which could be a vomit, and then dark bile commences at about 18.30. We suggest you, we, are doing a better job here at knitting this together than anybody was at the time.

But that's where we are there. Assuming that this isn't harm, and we don't suggest it was, it shows, doesn't it, this bit about the X-ray and what the experts said, beyond reasonable doubt, how wrong those three experts are capable of being on the

question of what abdominal distension is consistent with harm and what is not? Please carry that forward, ladies and gentlemen, as we begin to go into territory in a case where they are identifying gaseous distension that is a harm event all over the place. This is proof that they get it wrong. Of course we know, we say, the reason this never went on to that table and isn't in this case, you know what I'm going to say, because Lucy Letby wasn't on duty. You know what would have happened if this had happened and she was the nurse responsible for [Baby C] at this time, and that is all it has taken in this case for a number of the charges that you are dealing with. We'll continue moving through how [Baby C] was. I'd be grateful, please, Mr Murphy, if you could now go to the next sequence on the care chart at tile 44, please. At this point we are going through now from the night of what was the 12th into the 13th, into the 13 June, which is the day leading up to [Baby C]'s collapse and then, sadly, his death in the early hours of the 14th.

We can see throughout that day, under the output column, entries, certainly for bile, with different nurses. We've got JW, Joanne Williams, in the afternoon part of the day, looking after [Baby C]. Entries for dark bile there, haven't we? It may not be a lot but it's consistent, it's a tiny baby. And then it goes on to when Sophie Ellis took over, leading up to the time of the feed, and we have green bile at 23.00, which is just before his first feed. So this is the picture on that chart.

We submit to you, as we did to witnesses, that this is a genuine concern and the evidence of Dr Sally Ogden, who gave evidence on 27 October, and some of the nurses who gave evidence, was in agreement with that. And that dark bile accompanied -- thank you. Dark bile accompanied with vomiting, if it is, which happens at least once and maybe twice, if Yvonne Griffiths' record on bile in her notes is correct, bile on the blanket, that can be really serious.

Of course, a baby doesn't just bring up dark bile for what is verging on -- what is a 24-hour period for no reason. And it should be a concern, shouldn't it? We shouldn't need experts to tell us that. It must be blindingly obvious.

Dr Ogden in her note on the morning of 13 June had marked "very dark bilious aspirates". And I asked her about that, about what that was. I asked her:

"Question: Do you agree that dark bilious aspirates are a cause for some concern?

"Answer: Yes.

"Question: In term of direction of travel, it's not such a great direction. If we're starting in a good place, it's not such a good place, is it?

"Answer: No, it's a concern that those are occurring at that time."

She was talking about in the morning.

Of course they carry on, don't they. I asked her if dark bilious aspirates were a red flag in terms of what needed to be done and what Dr Ogden said was:

"Answer: It was certainly a worrying sign that would need more investigation.

"Question: Just to help us with why it's worrying -- first of all, in a baby who may be at risk of NEC, it might be a sign of that, mightn't it?

"Answer: It could be, yes.

"Question: It could be a sign of some obstruction in the gut, couldn't it?

"Answer: Yes.

"Question: Whatever that is, or some other type of -- I suppose until you've investigated it, you don't know what the problem might be.

"Answer: No."

Well, we were getting there, ladies and gentlemen, in the evidence, with Dr Ogden at least, because our suggestion to you is that on all the evidence, it's a simple suggestion, [Baby C] merited closer care and investigation than he received.

Joanne Williams in her notes at 16.19 on 13 June, so getting into that afternoon, recorded how [Baby C] was, she identified aspects that showed he was stabilising but said:

"Do not want to push [Baby C]."

Dr Gibbs was cross-examined also about dark bile and vomit and he actually volunteered that intestinal obstruction could be one explanation on 1 November:

"Question: Bile plus vomit, dark bile plus vomit, is a red flag, isn't it?

"Answer: Bilious vomiting in a young baby, yes, may indicate intestinal obstruction, it may. It doesn't always but you have to consider the possibility."

He volunteered that, I hadn't even asked him that at that point. Not in that sequence of questions:

"Question: It may indicate intestinal obstruction. For that reason if a baby begins to vomit bile or dark bile you might even consider speaking to a paediatric surgeon, mightn't you?"

"Answer: I'd investigate the baby first and then talk to the surgeon."

So we have an X-ray showing, we say, how air in the abdomen didn't move beyond the small intestine. We went over the structure of the intestines with Dr Gibbs, who said they were open pipes through which air under pressure will move and it should keep moving. Of course Dr Marnerides later on said maybe not, that doesn't follow because there's a pyloric -- there's a valve there which could actually stop the air from moving.

Well, two points. He said that, he's the pathologist, he's the only person to say that but he said that. But secondly, if that's right, if that's right why doesn't that happen on all the other abdominal imagines we've been given if Dr Marnerides is right if that explains this? We should have loads, shouldn't we, if there's a valve there that stops it moving and we don't. It's just something he came up with. Why is it only in the case of [Baby C] that it's necessary to suddenly have a prosecution expert who explains, oh well, it doesn't always move through the system because it seems to have done elsewhere. If it's being forced in, why doesn't it? He says there's a valve there that would stop it. Well, we're going to come back to what Dr Marnerides says about gastrointestinal blockage after lunch, ladies and gentlemen.

But we have the picture developing and on top of that, you may recall, 3 days it seems without [Baby C]'s bowels even opening. The fourth day they didn't. They never did. He never even passed meconium. Something that seems to have caused no particular concern to the clinicians at the hospital.

Dr Bohin and her attitude on this case. She was firmly set against suggestions we made that there were significant problems with [Baby C]. Her view was that [Baby C] was managing well. So it follows it was of no concern to her in terms of relevance to what happened that he never left intensive care, that he never in fact breathed without support for more than a few hours, that his CPR levels at a certain point had risen, that he didn't open his bowels, that there was dark or black bile, that he appears

to have vomited at least once, and that black bile was produced consistently right up to the hour or so before death, and that he had pneumonia on post-mortem.

Her view is he was managing well. We say that's symptomatic of an attitude that is simply set against us. She had the gall to imply, and we say that, that where the nurses had recorded dark bile repeatedly they probably got that wrong, they could have got it wrong, that it was blood, like somehow that's meant to be better. How on earth is that better as it happens? But what a thing to say. She's not there. One minute we're being told these are experienced nurses who know what they're doing and they've recorded consistently dark bile, and Dr Bohin, rather than accept what the consistent records of the nurses say, rather than do that simply raised the possibility that we're dealing with blood actually instead.

That is an extraordinary dismissal of the evidence of the experienced nurses who were looking after [Baby C]. It also demonstrates again, rather like, "I don't see [Baby A]'s respirations rising", a determination not to accept what is before us in the evidence where that is capable of assisting the defence. That must be the explanation, displaying, we say, remarkable contempt for the nurses' ability to distinguish between dark bile and blood, like they wouldn't be able to tell the difference, but Dr Bohin, years later in this courtroom, can and tells us we possibly or probably got all that wrong.

You'll remember -- or you may not remember, I'll remind you, ladies and gentlemen -- in the case of [Baby Q], where there were three occasions when the nurses noted bilious aspirates, in due course he was sent for -- that was a cause of concern. It was a cause of concern. And talking about [Baby Q] in that case, Sandie Bohin was ready to say that it was right to take that seriously, and this is what she said:

"Because bilious aspirates can indicate serious gastrointestinal pathology in the case of the newborn."

So far as the defence were concerned, that wasn't as relevant in the case of [Baby Q]. But why not just say that then in the case of [Baby C] where it is relevant to the defence case? Why not say, "Bilious aspirates can indicate serious gastrointestinal pathology in the case of the newborn"? That's all we're asking. So it's evidence that can be given on [Baby Q] but doesn't apply when we're dealing with [Baby C].

I'll explain, ladies and gentlemen, just before we break, why it is that we make so much of this point. It's not because the defence are saying necessarily this explains what happened, although by the same token it may do. The burden isn't on the

defence to do that, the burden is on the prosecution and it never moves.

But why this is important is, first of all, if we are right that there was a problem with [Baby C] and one that was remaining, it does indicate complacency or missing it or a potential lack of care in the case of [Baby C], which is an important theme in this case generally. It may also contribute to his condition when he collapsed and couldn't be resuscitated. We say also it shows, this issue and their reaction to it on behalf of the prosecution experts in particular, shows their unwillingness to accept reasonable conclusions to be drawn from the evidence.

I'll just deal with Professor Arthurs if I may, my Lord, and then we can move on to the next part after lunch. Is that all right, ladies and gentlemen? So what Professor Arthurs said because what he said was significant, although perhaps not in the way that he thought.

I'm going to ask Mr Murphy if we could put up again the radiograph at 996. This is the one from 12 June and the one where we were investigating whether it shows or suggests an intestinal blockage because the air never got as far as the large intestine, it just went from the stomach and the small intestine.

Professor Arthurs was asked about this by the prosecution and the significance of there being no gas in the rectum. He agreed, as you look down you can see there's no gas down there. He said on 11 November:

"If you see where the legs are, you can imagine, if you imagine where the two legs are coming in, in between those would be where the rectum comes out, so an observation has been made there isn't any gas in that particular location. So that's relevant if [Baby C] were a newborn who had never passed any faeces, meconium, and that this was his first X-ray because that might suggest there's a blockage in the bowel."

Yes, say the prosecution.

Professor Arthurs said:

"As we know, that's not the case, so the presence or absence of gas in a baby who is passing meconium freely has almost no relevance."

In other words, Professor Arthurs was saying if a baby hasn't passed faeces or meconium this could be relevant, it could show a blockage, but his understanding was that plainly [Baby C] had been doing, so he said this is of no relevance. So I asked him

in cross-examination to explain whether this, what we're seeing, could be indicative of an obstruction or a twist and he said he didn't think it fitted the clinical scenario because he believed [Baby C] was 4 days old at this point and that for a baby who hadn't had his bowels opened for 4 days that would be in the clinical history, his point being that if a newborn baby had not had his bowels open for 4 days that might fit the clinical scenario of obstruction. But again, there's nothing in the clinical history saying he hadn't, so he didn't think that believed (sic) to [Baby C]. Well, he wasn't seen, of course, by a consultant until 13 June and whatever's written in the clinical histories, as a fact it seems, there is no record of him ever opening his bowels or passing meconium, so Professor Arthurs' interpretation or assumption about the clinical records was wrong.

He couldn't have looked at what the notes did or didn't show. At the time of that radiograph, [Baby C] was on day 3 of life, no record of bowels being open at any point up to then or indeed afterwards, and therefore on the evidence of Professor Arthurs, given [Baby C]'s clinical history, this is actually consistent with obstruction. He said it would be consistent but not in a baby that had passed faeces or meconium. Well, it is, isn't it? You may well think in any event to those treating him and looking after him, if his bowels had never been open, that would be an elementary clue to a problem, but it plainly wasn't.

After lunch, we'll have a look at what Dr Marnerides said on behalf -- when called by the prosecution on the subject of blockage and [Baby C]'s bowel. But my Lord, can we stop there, please, for now?

MR JUSTICE GOSS: Yes, certainly.

Ready to resume at just after 2.05, please. Thank you.

(1.04 pm)

(The short adjournment)

(2.04 pm)

MR MYERS: Ladies and gentlemen, I'm going to turn to -- on this issue of [Baby C] and whether or not there was a gastrointestinal blockage, let's look at the post-mortem evidence.

When Ms Letby was cross-examined about this by the prosecution, they said to her:

"Do you remember the evidence of Dr Marnerides, the pathologist, who said that the histology shows that [Baby C] did not have any bowel issue?"

And Ms Letby said yes.

And certainly so far as Dr Marnerides is concerned, that's right. That's one part of the post-mortem evidence from their expert witness, pathologist, who you'll keep in mind didn't see [Baby C] or perform the post-mortem on him.

Can I remind you of the agreed evidence from the pathologist who did perform the post-mortem? You may think this is significant. Perhaps this is one to turn to the agreed facts, please, ladies and gentlemen, which you'll have in jury bundle 1, divider 3. Let's have a look there and go to page 8, if you would, please, agreed fact 21.

These are the agreed facts, the agreed evidence relating to [Baby C] here, and you'll see, small 1, that George Kokai was the consultant paediatric pathologist who conducted the post-mortem examination at 10.00 hours on 16 June. He made a written report and significant is the entry under "abdominal cavity", which is the part of this agreed fact on this page. He recorded the following:

"All abdominal organs show normal anatomical position. Gall bladder, extrahepatic biliary ducts and pancreas are normal. The stomach, all loops of bowel and mesentery show normal rotation and pattern apart from descending colon, which crosses the midline into the right lower abdominal cavity and connects to the sigmoid colon, which is in a normal position. The serosal cover is thin, shiny and translucent."

Then Dr Kokai records:

"The stomach contains large amounts of bile-stained secretions. The remaining bowel is empty. The colon contains meconium."

You'll remember meconium is the substance in the bowel that is there that passes out in a newborn baby first before faeces passes through. So that's significant, isn't it, in light of other things that we've heard?

This is agreed evidence and we've heard a lot from the prosecution about the strength of agreed evidence. This is agreed evidence that:

"The stomach and the bowel loops are normal apart from the descending colon [which you saw is the lower part of the bowel,

the large intestine] crossing the midline into is the right lower abdominal cavity."

We looked with Dr Gibbs at that image of the bowel and where the large intestine almost goes round, rather like a square, going round the outside and coming down the left-hand side.

But this from the post-mortem:

"It crosses the mid-line into the right lower abdominal cavity."

This is agreed evidence from the pathologist who performed the post-mortem. Dr Marnerides refused to accept this. He also refused to accept where it says "the remaining bowel is empty". He says there is gas in the bowel.

Here, Dr Kokai says:

"The stomach contains large amounts of air and some bile-stained secretions, the remaining bowel is empty."

The reason I say he refused to accept this is that his evidence is that George Kokai regarded this as -- or this bowel was normal, was Dr Marnerides' way of putting it, it was normal. It was normal.

Well, you can read it, the language is plain. According to Dr Kokai this is not normal, that's how he puts it. So whatever Dr Marnerides means about normal, that isn't the language used by Dr Kokai.

As for the question of gas in the bowel or distended bowel, that is linked to a photograph Dr Marnerides has seen. It's not one of the ones, so far as I can see, that we have. But whatever he says he sees on that photograph, and indeed it may be this is how he says that it has been mistaken for the bowel crossing, because it's distended, but that isn't the evidence from the pathologist who conducted the post-mortem. It doesn't matter how Dr Marnerides explains around this, that pathologist looks at the physical structures, has described how it crosses and says that is not normal because he talks about "everything else is normal apart from". So it's not normal.

And the only place where he identifies air is in the stomach, ladies and gentlemen, and we do ask you to note this carefully:

"The stomach contains large amount of air; the remaining bowel is empty."

So whatever Dr Marnerides says about his views looking at other material afterwards, that isn't what the pathologist says, that

somehow there is a large amount of gas there. But of course that's significant because one mechanism that eventually Dr Evans came to, and which Dr Marnerides also refers to, is that gas was somehow introduced which caused the abdomen to distend and collapse to follow. But that's not what's found in the post-mortem.

This agreed fact, ladies and gentlemen, shows the importance of looking at the whole picture. Beyond the snapshot of the pathology from Dr Marnerides and the dark bile aspirates for 24 hours, we have bowels not opened, we have the radiograph with that curious feature of the air just stopping, we don't see it anywhere else, we have the post-mortem from Dr Kokai, and the opinions of John Gibbs and Professor Arthurs, actually, as to the possibility of blockage. We say that, in combination, that is powerful evidence, actually, from which you can conclude there was a blockage and there should have been investigations and something should have been done about it.

Dewi Evans. His position before he came here and gave evidence to you, based on eight reports over 5 years, was that whilst he was ready to identify deliberate harm by air being forced down the NGT on the 12th, which is that time when Ms Letby was not on duty, in his reports he hadn't identified specific harm and indeed he was in readiness to say that it may not be possible to say what caused [Baby C]'s collapse and ready to say infection could not be excluded. And nothing in his eight reports pre-trial over 5 years suggested air had been forced down an NGT. He just came out with that when he gave evidence when the prosecution were taking him through his explanations, just came out with it on the hoof, it might be said.

The prosecution in closing to you last week conceded that there could be criticism of Dr Evans for not putting in his report that opinion because there should be prior notice. But actually, it doesn't come down to some technical rule about what experts should put into reports, we say, and is far more significant than that.

This is to do with Dr Evans making up explanations as he went along. That's exactly what he did and he did that on this occasion. We say that is because he's biased and he's not independent and he's seeking to find theories that can support the allegation.

When I cross-examined him about this -- you may recall, you may not -- I asked him to tell you what the evidence was for air being forced in and the diaphragm being splinted by air being put down the NGT. This is on 1 November. I asked him repeatedly, what is your basis for saying that, because he'd only just said

it for the first time in evidence that day with the prosecution. He just kept on saying:

"Baby collapsed and died, baby collapsed and died."

Well, we know, sadly, that is what happened. But what's the basis? He kept repeating that until he eventually, suddenly, literally came out with air embolus. You may or may not remember it but he just came out with it there and then without identifying any evidential basis at all. That is what we are dealing with.

Nothing in his eight reports over 5 years and he comes out with air being forced down the NGT for the first time when the prosecution ask him questions. When I pushed him to explain what's the basis for that all he could do is turn round and say, "I think also there's an air embolus". Dr Bohin agreed that [Baby C] had pneumonia at the time his death. She agreed on 2 November that could have made him less responsive to resuscitation. She agreed the pneumonia was a contributory factor to death because it may have made him less responsive. But then I hit the brick wall when I suggested that that meant [Baby C]'s collapse and death might have been caused by something that might not have been fatal in itself but for the fact it was combined with the pneumonia, some problem with his condition plus the pneumonia meant he collapsed and couldn't be resuscitated. Our point was that if pneumonia made him more vulnerable, another medical problem could surely combine with that to cause death, even if it wasn't or didn't do that on its own, but she absolutely would not have that and we do not see why not on any logical basis, save that she would not agree with the suggestion we were advancing which raised the potential for this to be something other than harm, even though she didn't identify any mechanism of harm as it happens. She was set entirely against the possibility of an abdominal blockage, against what we say is the clear weight of that evidence and she preferred instead, and relied upon, Dr Sally Ogden's note of bowel sounds that showed there was no blockage, tinkling bowel sounds.

We say really this required proper examination and a proper review and all the signs were there that there was a serious problem with [Baby C]'s intestine and it should have been properly checked and the evidence, we say, supports that.

He was a very poorly little boy. We say he shouldn't have been at the Countess of Chester, he should have been transferred out with the problems that he had.

You've looked at this now, ladies and gentlemen, the record-keeping was sub-optimal. The accumulation of evidence, we say,

plainly indicated an intestinal problem and the failure to deal with that was plainly sub-optimal. We say he was unwell over the period of his short life and died with pneumonia and an underlying bowel problem that is consistent with all the evidence and the evidence of the post-mortem from George Kokai.

So there is no basis to be sure, no basis to be sure, that a non-medical explanation applies and that harm was done. And the two lead experts, one of them doesn't identify mechanism, Dr Bohin, and the other one, Dr Evans, literally came up with them as he went along, making them up on the spot.

We say that the evidence in this case goes further in exonerating Ms Letby when we look at what happened. This is the business of who was in which nursery at the time that [Baby C] collapsed. We say Sophie Ellis should not have been looking after [Baby C].

No matter how this is dressed up, how it's dressed up, whatever has been said about Ms Letby and her views about who should be doing what, Sophie Ellis was relatively inexperienced, she wasn't qualified in a specialty, and she was put in charge of a very fragile little boy. Plainly Ms Letby took exception to that in that she complained about it and you may think someone who takes their work seriously and appreciates the challenges of looking after unwell children may make an issue of that. [Nurse B] says it was all right because Mel Taylor was in that same nursery and on hand and that also, of course, she was available, although we point out if it takes up to three nurses to keep an eye on [Baby C] because the designated nurse is insufficiently experienced, which is what this comes down to, that is a very poor state of affairs indeed.

The desaturation and collapse in [Baby C]'s case, ladies and gentlemen, follows the one and only feed he received from Sophie Ellis around 11 pm. So again, we're in a position where there are striking coincidences in this case, not the ones the prosecution refer to but other ones. It's a feed, in fact, that isn't recorded in any chart, it's made a note of in her nursing notes, although when you look at them on tile 231 for your reference, they are confusing because they're spread across different entries and different times after the events.

One of them came some days after the events but we finally got to the point with Nurse Ellis where she was describing two episodes in her evidence and the picture painted by her was that she'd been out of the room on one occasion when Lucy Letby was in there and [Baby C] desaturated and that Ms Letby had been very close to [Baby C] on the second occasion when the collapse began that led to his death. So in other words, she put Ms Letby there at a time when she says she was not there at the time that

led up to that final collapse. That was the effect of the evidence of Nurse Ellis and you'll remember that was the version of events that the police followed when they interviewed Ms Letby and we've looked at that. I'll mention that again shortly.

She didn't say she was seeing Ms Letby do anything wrong but, not for the first time, as we see in this case, we see certainly the effect of this being that blame and suspicion are nudged her way. This time, certainly the nurse who is meant to be looking after [Baby C] and had fed him is instrumental in that, however that happens. It's her account that puts Ms Letby there.

Is that the only account? Because we need to look at all the evidence, don't we? Mel Taylor was on duty in that nursery with Sophie Ellis. When the prosecution asked her questions, she said she didn't know if she'd been in the nursery or not when [Baby C] deteriorated, but that Lucy Letby was already at the incubator when she approached and she didn't remember anyone else being there. This is the evidence she gave to you in the trial.

She said the only person she remembered there was Lucy Letby and she thought that Lucy Letby had inserted the Guedel airway. So actually, that has the effect, doesn't it, of coming alongside what Sophie Ellis was saying? Sort of backing-up what Sophie Ellis was saying.

Strange then, because we got to this when I cross-examined Nurse Taylor, strange that when she spoke to the police back in 2018, much closer to the time these events happened, she told them that when [Baby C] had collapsed she was pretty sure she was there and that she was feeding another baby. Why didn't she tell you that? And she told the police, get this, it was Sophie Ellis who called her over. And she had nothing to say to the police about Lucy Letby.

All right? So at the time she made her statement in 2018, she's there, and she has Sophie Ellis calling her over. That contradicts what she said in evidence to you. Why has she changed that account like that? Literally swapping Ms Letby for Sophie Ellis. Why?

I asked her and she was utterly brazen about it. That's how it is, she wouldn't give an explanation for how she came, in effect, to reverse this, we say, when she came to give evidence 4 years later, reverse who was there. But there is no doubt that in 2018, she told the police it was Sophie Ellis who had called her over and that she, Mel Taylor, was there and she didn't mention Lucy Letby at all. So whatever has gone on and however it happens, and there could be any number of reasons, and maybe we should not and we do not speculate, but she's changed that

account or the account has changed in a fairly significant way because it puts Lucy Letby into the position where she is in the room. That isn't what she said when she first spoke to the police. She reversed it round.

That's not the only evidence of this, fortunately.

Fortunately, we have the evidence of [Nurse B], which we say settles this, if that's necessary. She gave evidence on 31 October last year and what she said to you is fairly consistent with what she said to the police in 2018. I asked her about it. It comes to this. She had been dealing with a baby we've got initialled as JE in a different nursery with Lucy Letby. JE was Lucy Letby's baby.

Some time between 10 and 11, she was called to assist -- that was her recollection of time -- [Baby C]. So she'd been with Lucy Letby looking after JE, she gets called to assist with [Baby C].

She went to nursery 1 where Sophie Ellis and Mel Taylor were Neopuffing [Baby C]. No suggestion Lucy Letby was there. She wasn't because they'd been looking after baby JE elsewhere.

When asked questions by the prosecution, she made it clear that she and Ms Letby had been occupied in trying to find a doctor to do a septic screen for JE. That's what they'd been involved with. Ms Letby therefore is in no way near to nursery 1. And she described, [Nurse B] did, assisting Melanie Taylor and Sophie Ellis and she told the police that some time later she became aware that Lucy Letby was in the room. That's that. With [Nurse B] when it happened, which would explain why in Mel Taylor's original statement to the police Lucy Letby isn't there, she was with [Nurse B]. [Nurse B] went over to assist and at some point after that is aware that Lucy Letby has gone there too, but not in the room when it happened. That follows from what Mel Taylor first said to the police and how [Nurse B] has always described this.

So how Mel Taylor comes to change it years later so it has the effect of coming into line with what Sophie Ellis was saying and putting Lucy Letby there, pretty breathtaking, really, isn't it, how that has happened? You've seen that unfold in front of you.

The evidence, we say, taken as a whole puts Lucy Letby somewhere else when [Baby C] collapsed. It also shows how it can happen that witnesses change their accounts in the case of Mel Taylor, Sophie Ellis, no, she's always said, she wasn't there, but Mel Taylor's changed, as it happens, coinciding with this trial, with Sophie Ellis'.

None of this was unravelled before you in the review of the evidence from the prosecution. They, rather like the police in interview -- I am not being critical of them, the police are working with the evidence they have -- they proceed just on the blunt statement of Sophie Ellis without everything else and without regard to what [Nurse B] said or even Mel Taylor at that time.

You saw in the interviews, and it was in the [Baby C] interview at pages 11 to 17, how there's a whole series of questions of Ms Letby, all based upon the assumption that what Sophie Ellis said is right, even though it's inconsistent with what Mel Taylor was saying at that time and [Nurse B]. We've been through this, I'm not going to go back to it because you have the point, ladies and gentlemen, you have the references, but we say it's a feature of the interviews, the police are working with what they had, but actually it can lead to some unfairness is Ms Letby is being given facts that she is relying on as if they are established and then she is asked questions about them as the point of departure for that questioning, which is what was going on and that's how it's been used in the case. It can lead to unfairness, not because anyone's trying to be unfair with that questioning, but because it gets taken out of context and used to her disadvantage in this trial. That's where we say used in that way it becomes unfair.

So in conclusion, ladies and gentlemen, looking at the evidence, balanced, fairly, we say Lucy Letby was not there when whatever happened happened and that's based on evidence, unless we're going to just accept the fact that Mel Taylor can change what she said, however or why ever it happened.

There is no consistent medical explanation for what did happen on the 13th, although we say the evidence of failing in care is powerful and that [Baby C] was a very poorly little boy with pneumonia, with some sort of abdominal issue that was never fathomed, who became very unwell and you can see that happen over a period of time, and there is nothing, nothing, that establishes that Ms Letby was involved in harm, there really isn't, or how she could have been when we look fairly at the evidence.

I'm going to move now, ladies and gentlemen, please, to count 4, [Baby D]. [Baby D] was born on 20 June 2015 at 16.01. Her gestation was 37 weeks and 1 day, which makes her one of the older babies in this case and her weight was 3.13 kilograms.

She was born on 20 June at 16.01. On 22 June, at 01.30, she collapsed and there was discolouration associated with that collapse, but she made a good recovery.

An hour and a half later, at 3 am, she collapsed again and there was some discolouration associated with that collapse, although there was less discolouration that time, and she made a recovery. Then on 26 June, 45 minutes later, she collapsed, no significant discolouration identified, and she did not recover and she died at 4.25.

Dr Evans and Dr Bohin say that this was the result of harm inflicted with an air embolus or, I suppose, air emboluses because there's actually three collapses that we're looking at over a period of about an hour and three-quarters. That's nearly 2 hours and 15 minutes.

Well, as an introduction to this, fact: [Baby D]'s mother, [Mother of Baby D], her membranes ruptured 60 hours before [Baby D] was born.

Fact: in accordance with the hospital's own guidelines she should have been given antibiotics but they failed to do that. That is sub-optimal.

Fact: save for Dr Bohin, all witnesses who were asked agree that by 12 minutes of age [Baby D] was displaying signs of being ill or seriously ill.

You'll remember it's described at 12 minutes how she was floppy and appeared to be lifeless. Dr Bohin was inclined to blame or explain that on the way her father was holding her. You recall, she said parents/fathers can sometimes do that.

The evidence was absolutely plain and I'll remind you of it: this is not to do with the way [Baby D] was being held, it's another example of an obstructive response to what the evidence is from Dr Bohin. The evidence is very clear: [Baby D] was very unwell at 12 minutes of age, very unwell.

Fact: she should have been given antibiotics from that point, or as soon as possible afterwards, but that didn't happen for almost another 4 hours. That is sub-optimal. That falls below the appropriate standard of care.

Fact: maybe in consequence of all of the above, [Baby D] was born with pneumonia. Fact: [Baby D] was so ill that by about 10 pm that night she had to be ventilated to enable her to breathe properly.

Fact: she was on the ventilator for about 11 hours and the following morning she was taken off it. But then when you go through, and we went through the notes, there were continuing signs, various signs of respiratory difficulty during that day until she had to be put back or put on to CPAP.

Fact: she desaturated when taken off CPAP at about 7.15 that day; that's at tile 158, ladies and gentlemen. We perhaps don't need to go there, it's an entry I think by Dr Rylance.

Fact: measurements to monitor her condition indicate some deterioration later that evening, something ultimately recognised by those caring for her, I'll come to this shortly, something Dr Evans and Dr Bohin flatly refused to acknowledge.

She suffered a desaturation at 01.30, from which she recovered quickly, although the consultant in charge, ladies and gentlemen, Elizabeth Newby, was sufficiently cautious to say, and she said this when explaining the situation on 9 November to you, that:

"There was a low threshold to intervene by intubation and ventilation should things deteriorate from a respiratory point of view."

I'll come back to this in a moment but we say that's significant. After that first collapse, it was discussed between Dr Newby and Dr Brunton how to deal with [Baby D] and one of the things they discussed was what respiratory support she should have and the decision they came to was since she was saturating in 100% air on CPAP, that was fine as long as everything was all right, but there would be a low threshold to intervene if she deteriorated from a respiratory point of view; she said that on 9 November. That was the position around about 2 o'clock. All right? So that was the decision, that's what the plan was. At 3 o'clock in the morning, [Baby D] suffered another desaturation similar to the first from which she rapidly recovered. But at that point, this is on tile 236, Dr Brunton took the decision to take her off CPAP. And within half an hour of that, she collapsed fatally, after which, at her post-mortem, fact, she was identified to have pneumonia in her lungs with acute lung damage.

So ladies and gentlemen, on the evidence, very ill from the outset. Actually, by any ordinary standard, outside this trial, in this courtroom, where would you say a baby being born with pneumonia was healthy? Seriously? The things you or we are expected to believe. That must be unwell.

And the account given by [Mother of Baby D] of what happened leading up to her birth and at her birth was grim indeed and the descriptions of [Baby D] and how she was at 12 minutes after birth.

Whatever Dr Bohin had to say, we say deliberately to minimise the impact of that, but you'll be the judges of that, ladies and

gentlemen, Dr Rylance agreed that from the point that [Baby D] collapsed at 12 minutes, given the history of ruptured membranes and everything we know, the right course would have been to prescribe antibiotics immediately, she said that on 8 November, because, as she said, the purpose of antibiotics is to treat and reduce the risk of infection, and that didn't happen for hours.

So we say, again, that for a prosecution case that relies almost entirely on coincidence, it's a bit much if you're not asked to pay attention between the obvious link we say between the failure to give the mother antibiotics and the daughter antibiotics, the membranes having ruptured for 60 hours before birth.

The 36 hours during which [Baby D] was alive, on any sensible view again, we say, are characterised by respiratory problems. Ladies and gentlemen, if you're able to, you may feel you know the exhibits well and you don't need to, but you have all this material with you and you're able to look through and perhaps go from clinical note to clinical note as you scroll through the sequence or look at the nursing notes. You're probably familiar with the charts now. You have a look at that and see if this is a baby who is breathing in any way that you would consider, because you can now in light of all this, acceptable and problem free. Because again, I repeat what we said yesterday, please judge our submissions by the evidence.

If you look at the evidence and you're satisfied, "No, no, she's fine, she's breathing fine, I don't know what the defence are on about", that's the end of our point, isn't it? But if you look at the evidence from the time of birth to the time of death and you see there are breathing problems, that means the insistence by prosecution experts that, "There's no real problem, nothing to see here, there's nothing wrong", is wrong.

You can look at the whole picture in that way and we say it most definitely is wrong. And it is very unfortunate decision, perhaps, that after that second collapse when [Baby D] had already demonstrated, if we can put it that way, the condition she was in, they say she's under attack, I will come to that.

But if a baby like this has just collapsed twice but then been resuscitated pretty well it seems or revived, sorry, recovered, first of all, it is surprising she was taken off CPAP after what had happened and particularly so when Elizabeth Newby said that she had discussed this with Dr Brunton and there was a low threshold to intervene given that she was on air via the CPAP.

That's fine. But that would change if there was a deterioration in her respiratory state. That's what they agreed and there was change, but they didn't intubate, they simply took her off CPAP.

That's got to be pretty significant, hasn't it, for a baby like this then to not have breathing support at that point? And then the collapse, the final collapse, comes 13 minutes later.

Dr Marnerides did not perform the post-mortem, that was done by Dr Jo McPartland and her evidence was read to you and that was agreed fact 22. It followed [Baby C]'s and, again, I apologise about the picking up and the putting down of the files but it's perhaps worth going back to this, ladies and gentlemen, and we ask you to consider this when you're looking at the entirety of the picture later on.

It's at page 9 and it's agreed fact 22. There are a couple of matters here in addition to the post-mortem findings that you may find of assistance more generally in the case, ladies and gentlemen. We're going to come to that as we read through.

The first part of this agreed fact paragraph 22, page 9, identifies that:

"Jo McPartland, consultant paediatric pathologist, conducted the post-mortem [and the time and the place]."

And then extracts of the report are set out here and of significance, of course, is what we have under "Lungs":

"Patchy acute pneumonia, most prominent within one of the right lung samples. Hyaline membranes present, indicating diffuse alveolar damage."

She goes on to identify the rupture of the membranes, it says 36 hours before birth, but that of course was corrected:

"After that, the collapse of the baby soon after birth..."

So she didn't have any difficulty identifying that, only Dr Bohin did:

"... followed by continuing [continuing] respiratory problems and the histological pneumonia, which is quite convincing. I think it's likely that the pneumonia was already present at birth."

She deals with the disposal of the placenta, which she say is unfortunate. Then this:

"Although [Baby D]'s CRP was low, in early onset sepsis the sensitivity of CRP in detecting infection may be as low as 22% and therefore does not rule out infection."

Pausing there, this is agreed evidence. So it seems the business of CRP identifying infection is by no means perfect. It may not always reflect it. Then over the page:

"Microbiology tests were negative in this case but this is often the case after antibiotic treatment and does not rule out infection, which is histologically proven in the case."

Pausing there, ladies and gentlemen, keep that in mind if you are able to when other cases are identified and there are no microbiology tests indicating -- or there are microbiology tests which are negative but there has been antibiotic treatment. That's why they're negative.

She concludes here:

"Dr McPartland also recorded the following summary findings:

"'1. Early neonatal death after 36 hours of age.

"'2. A normal growth and developed baby girl with weight on the 91st percentile, length on the 25th percentile and head circumference on the 98th.

"'3. Acute pneumonia with hyaline membranes indicating alveolar damage.'"

Those are the findings from the pathologist who conducted the post-mortem.

Despite that, the opinion of Dr Marnerides is that this is air embolus. He preferred air embolus. We say I bet he did. He preferred air embolus. So in other words, despite the pathology of what there was, he preferred to go with Dewi Evans and Sandie Bohin about what there wasn't evidence of, we say. And he was clear when I asked him questions about this that whilst he accepted pneumonia was there and at one point had taken the view that it could be instrumental in death, in fact given the views of Dewi Evans and the other clinicians, he now came to the view that pneumonia could not account for this because [Baby D] was doing so well.

There you've got the mixture of how he takes clinical findings and then incorporates them with the pathology. So there is pneumonia but his view was:

"Taking in mind what the clinicians have said about how well she was doing, I don't see that that can explain it."

Well, that goes back to the question of you take a look. We submit to you, ladies and gentlemen, on this evidence, she really was not doing well with respiration.

What is the evidence of air embolus then? Dr Bohin on air embolus. Her view was that this couldn't be explained by infection, it had to be something "unusual and odd". And she went with Dr Evans with air embolus, relying upon discolouration, how suddenly this happened.

We pause there, suddenly? There's three. What's sudden about two and three, for example? How suddenly it happened and that [Baby D] had been distressed, which at this point, and for the first time in the case, Dr Bohin revealed was a sign of air embolus, not one we had had before this point -- as you have seen, the air embolus theory is nothing if not flexible -- and there was also air in the great vessels.

And so have we dealt with that, ladies and gentlemen. We know the description these experts started with as being the hallmark of air embolus, we know it. It's not our fixation with it, it's what they said.

When you look at the notes, nothing here matches it (inaudible) if anyone says unusual, odd, strange, it doesn't. Caroline Oakley, one of the nurses whose description of prosecution have relied upon, was pressed in examination-in-chief to enlarge upon her note. Can we put up the note, please, at tile 228? It's on the right-hand side of the long body of text.

Caroline Oakley documents in her note, ladies and gentlemen, the chronology in this case and you can see actually, as we go down, there's an entry for 01.30, which is the time of the first collapse, and then 3 o'clock and then 03.45. In the course of this she does identify discolourations to this extent. At 01.30, she puts, third line down:

"Discolourations to skin observed: trunk, legs, arguments, chin."

That's as far as that goes there.

And at 3 o'clock we can see under the second line:

"Skin discoloured again but less than previously."

And then 3.45:

"No discolouration."

That seems to be the way that this was. So that's what she said at the time. You may agree nothing there, actually, to identify or base a theory of air embolus, a finding of air embolus on, there's nothing, unless we're going to say any discolouration counts and we know neonates can be discoloured for any number of reasons and we have heard lots of descriptions in this case. That's the problem: we get descriptions that are then just applied to the theory because someone has decided it's going to apply about.

Now when Caroline Oakley was examined by the prosecution she enlarged upon what was in her note and she was questioned at length about it and she came up with expressions like "red/brown". She began to give some colours and red/brown is one of them I cross-examined her about that and pointed out that the red/brown she described in evidence wasn't in her note. And after we went round and round, and this is on 4 November, she ended up saying to me:

"I just remember the rash, I don't remember the specifics of it, I just remember it's an unusual rash."

Well, okay, great. You just remember an unusual rash. We say that is nowhere close to what you should require, ladies and gentlemen, for what the prosecution seek to prove.

And if that is what she really remembers then we do have another witness, however unwittingly, beginning to add detail years later that isn't here.

In her statement to the police, another witness who gave descriptions was Kathryn Percival-Calderbank. And in 2018 -- I'm going over these because the prosecution have given an account of these discolourations generally taken from the evidence of the witnesses but not what was said beforehand. That's what they've chosen to do, they've taken the evidence. That's fine, but we need to look at the whole picture for you to be clear how much certainty you can put on this.

In 2018 Kathryn Percival-Calderbank had said this to the police:

"[Baby D] changed colour. She'd been mottled over her trunk and legs and she'd seen that in the past with discolouration from circulation issues or sepsis but on this occasion it looked unusual."

She confirmed that on 9 November. So mottling, she had seen discolouration from circulation issues, but this looked unusual, but that's as far as that went. All right?

Now, when she came and gave evidence 4 years later, it appears that rather than, in the case of most witnesses, the common experience, which is that memory deteriorates, it had developed. It had developed and she said now:

"This seemed to be a larger, mosaic-type rash, a reddy/blue, reddy/brown colouring, vessels, oval-type markings on the skin, vessels of blood, whatever it was, they seemed to be meeting up on each other."

What an extraordinary and vivid description, yeah? Red, brown, mosaic, oval markings, meeting up with each other. How on earth does that compare with what she said 5 years before or 4 years before to the police:

"Mottled on the trunk and legs, circulation issues in the past, it looked unusual"?

That's as much as she gave to the police and 5 years later we have a very vivid, lurid description. "All those vessels", "all those vessels", how on earth did that not appear in the description to the police?

If there appears to be a theme developing, or if I sound at all repetitive with it, I'm sure you'll understand, I don't apologise for that, because this is what's happening. If it seems repetitive it is because it keeps on happening: witnesses who haven't said things at the time or not recorded them have then given striking descriptions in evidence to you years later.

It's almost as if in some cases they must have been speaking with people between the time of their first account and giving evidence to you. And I asked her about that, Kathryn Percival-Calderbank, whether the extra detail was something she might have picked up from what other people had said when she'd gone back and talked to them. And actually what she said -- this is her answer on 9 November -- I asked if that had happened and she said:

"I might have done but it's also my recollection."

We are interested in "I might have done", which was the first bit that came out, "I might have spoken to other people about it", because we say that is almost certainly what has been going on here, people sharing recollections. That must be the account -- explanation in some cases for accounts changing in the way that we see.

Dr Bohin gave evidence about the discolouration and I tried to get from Dr Bohin an understanding of just what discolouration we are dealing with. I'd be grateful if you can just let me

explain or repeat to you, ladies and gentlemen, how that piece of evidence went, just to remind you, because I'm going to suggest we were just locked in a never-ending circular, self-feeding theory here. Listen to this and, I'm sorry, it takes about a page, but let me you go through it. Question to Dr Bohin:

"Question: Discolouration. Discolouration can be caused by conditions other than air embolus, can't it?

"Answer: Yes.

"Question: There can be many reasons, can't there?

"Answer: Yes.

"Question: You don't actually know what the discolouration of [Baby D] was like, do you, you haven't seen it?

"Answer: No, I haven't.

"Question: You don't have a picture or a photograph, do you?

"Answer: No.

"Question: We have various descriptions from the witnesses dealing with this. You cannot say whether what one witness is describing they saw on one occasion with one child is the same as what another witness is saying on another occasion with another child. There's no way of knowing that, is there?

"Answer: No.

"Question: You cannot say or you do not say what discolouration is specifically distinctive of an air embolus, do you?"

That is by this point:

"Answer: No.

"Question: Or do you?

"Answer: No.

"Question: Right. So any discolouration then?

"Answer: No.

"Question: Come on, tell us then, which one?

"Answer: Sorry, which one what?

"Question: Help us, which discolouration indicates an air embolus?

"Answer: The discolouration described by the clinical staff, both the nurses and the doctors who saw [Baby D] with patchy discolouration that came and went is compatible with an air embolus, taking into account the clinical situation that we had."

Pausing there, I ask her to explain what the basis is and she comes to saying, well, it's based on the description given by the people, the clinicians. That is, I'm sure you can understand, entirely circular.

It's an air embolus because they're describing it and I'm using that now as the guide to it. She's not measuring it against anything that could assist with this.

I'm afraid with various variations, that's where we got to, over and over again, and indeed as more and more wider changing colours became identified as relevant discolouration.

Now, you will understand [Baby D] goes through three episodes, and again, I appreciate, it seems indelicate when what we're dealing with here is so sensitive, but I had to ask the questions, so I asked Dr Bohin about the question of fatality and if an air embolus can be fatal, and we say on the background it should be, how come there were two occasions when this was not fatal? You may remember these questionings that went on. How can that be? Contrary to what we expect of an air embolus, surely, they're meant to be lethal.

Dr Bohin -- this is where we get to the wildlife. Dr Bohin sought to deal with the fact that [Baby D] suffered two non-fatal collapses despite the theory it should be fatal by talking about studies with dogs, piglets and rabbits. None of that was very conclusive.

None of it gave any specificity to how this is meant to work, it didn't answer anything. But she was simply saying the facts and the figures there show it can be variable.

But ladies and gentlemen, you have nothing to assist you and we have nothing to assess that with. All we have is a baby who had three collapses, two of which mercifully weren't fatal and one of which, sadly, was.

We say none of that fits with where we began. And vague assertions about dogs and rabbits, how does that give us any confidence as to what is meant to happen with a baby here?

Even the question of distress, even within this one case is just endlessly variable; okay? Discolouration is different on all three of these occasions. Why if it's meant to be the same thing? Why? The consequence of what happens is different every time. Why? If it isn't just a baby getting more and more poorly, which is what we say this is, and then a questionable decision about taking her off breathing support, we say that's the answer, but if it isn't that, then why does it keep changing, the discolouration, if it's meant to be the same thing? Why isn't it the same thing that happens each time? And even the theory of the baby being distressed which appeared for the first time here changes, because for the first one of these events there's no record of distress by [Baby D]. For the second one there was distress, but that appeared to stop when taken off the CPAP, and Dr Brunton's view was that it was the CPAP which had been upsetting her, which is why he took her off it. So that was the explanation from the clinician, nothing to do with distress because of an air embolus or any distress that he thought extraordinary. She was upset with the CPAP, he took her off it. Third occasion, no distress. Okay?

None of them are coherent or consistent: (inaudible) discolouration on the first episode, a bit on the second, not on the third, which is fatal. No distress on the third, which is fatal. How does any of this stack up? We say it doesn't, it simply doesn't. The reason we're in this position and the reason I am going through this with you like this is because we have experts knitting together bits of available detail to meet the allegation.

Now, finally on this area, the question or the suggestion this is an unexpected collapse. Dr Rylance agreed that infection is the leading cause of death in neonates and it can develop very quickly. And Dr Newby, I asked her about how quickly babies can deteriorate and she agreed, rapidly. And it was agreed that a baby who is unwell can have sufficient reserves to keep going for a while and then they reach a point when they cannot maintain their level of functioning any longer and at that point they can deteriorate rapidly. And that's actually something [Dr A] later acknowledged when we came to the case of [Baby O]. He talked about how it was possible for a baby to do well for the first 24 hours after birth but then deteriorate when the initial reserves began to run out. Such a lot of information in this case from different parts of it. But actually one thing which can assist is you can find material in one part that casts a light on another part.

We've seen -- we started with the fact, that whatever's said about [Baby D] being well all day by Dr Bohin, Sarah Rylance, who saw [Baby D], said that by 7 pm, while stable, she wasn't a

healthy baby. She wasn't a healthy baby. That directly contradicts what the expert says who has been pushing air embolus, said that on 8 November.

As we move along with the blood gas picture, there was a deterioration. If you put up tile 30, please, Mr Murphy. If we look down at 1.14, please.

Dr Brunton -- if we look at 1.14, there we go, we can see, the pH has dropped down to 7.2. And looking across there, the opinion of Dr Brunton was that the picture was not as good as it had been earlier, and indeed Dr Newby, 9 November, had said the readings deteriorate at 23.52 and 01.14. They may seem to be subtle changes, but there's a reason we have these. And the evidence from the clinicians is they're not so good.

Caroline Oakley, in her note at 174, had indicated they were satisfactory but in evidence when they were put to her, what we have here, she was actually good enough to accept these were not as good as they were earlier, which again you may think is interesting. If Lucy Letby had got something like that wrong in a nursing note, there'd be deep criticism of it.

Caroline Oakley in her note says they were satisfactory but agreed they actually weren't as good as earlier and Dr Newby was clear with the deterioration.

Putting this all together with the picture with the breathing difficulties, this is not a baby who was doing well. She had struggled to breathe and was showing signs of acidosis before we get to 01.30. That is there, that is on his evidence. If anyone thinks about that, wherever the emotions take us, and they're powerful emotions in this case that affect all of us, we can all feel that. Wherever they take us, that's the evidence. It could well be taken, the view, that the two deteriorations, 1.30 and 3 o'clock, indicated problems in themselves.

If we go back to Caroline Oakley's note at tile 228. Enlarge that and come down to the final part of this. At 03.45, do you see:

"Monitoring alarming, [Baby D] desaturated and then became apnoeic. Called Staff Nurse Letby to help."

Let's pick this up from there. This final collapse happens, we can see from Caroline Oakley's note, at a time when Lucy Letby isn't there and at a time when Caroline Oakley is there. And if you remember, Caroline Oakley, between the second and the third collapse had decided to do [Baby D]'s cares. How wise that was having just come off CPAP, who knows, but it was a caring thing to do.

She did her cares in between [Baby D] coming off CPAP at 3 o'clock -- between then and 3.45. She was with her, [Baby D] collapsed, she called for help and it says here specifically, "Called Lucy Letby for help".

Yet again we have the position where in that period leading directly up to this, looked at in this way, with this nurse, Ms Letby is being held responsible for something where on the evidence she simply is not having involvement with that baby at that point. And we submit there is no evidence that she did anything to cause this.

You have to consider this against how an air embolus is meant to act again. She's not seen to be interfering in any way. There are times when she gives assistance during the evening, as nurses do with one another.

Various points have been identified, but nothing that is linked to or identified to doing harm and staff are about during the period. And in this final period a focus on [Baby D] with Caroline Oakley doing feedings and cares and fully occupied with her, we say, up to what must have been the point of collapse and calling for Ms Letby to help.

So again, again, what is meant to have happened? I'm not asking that as general suggestions, I'm not inviting theories, we've had a lot of those, we've had too many of those. I'm asking that to make the point. Nothing. Nothing that's identified. You're told you can be sure, you have to be sure. Of what?

There's such a blunt point to be made in this case and it seems so insensitive, but it's a point I have to make because actually, blunt or not, it's important and it really stands out in [Baby D]'s case. It's this, and it may have struck you already: we're looking at intention to kill. Right? Let's come back to this, as I said I would where we could as we go through. Intention to kill from somebody who, the prosecution allege, plainly knows what they're doing. Because by this point it's already happened. With air embolus we're told. If that's right, it's not -- this is what I mean about being blunt, but I'll be blunt -- it's not going to take three goes, is it? It's not going to take three goes.

Just think about that, it will be one shot, sudden, rapid and fatal. Unless we're going to just modify the theory to support the allegation. And there's no basis to do that.

[Baby D] was an unwell baby, there were obvious failings in her care, to her mother and to her. She was born with pneumonia and she died with pneumonia and to suggest that means she did not

die of pneumonia is utterly unrealistic with a baby that, from birth to the point she died, was unwell. That's why she was here, that's why she couldn't breathe properly unaided for most of the time, that's why she needed breathing support. There were people there throughout. There is no evidence of Ms Letby doing anything remotely linked to harming her. And we say she cannot have done so in a situation and with the circumstances that we are dealing with. And she wouldn't have done so and she didn't do so. And you are being asked, ladies and gentlemen, to convict her, to be sure, on the basis of a theory that has, by this point of this trial, already been reframed and recast, however required, just to fit in with the evidence that we have. Inconsistent, no coherent principle, and not based on any thorough or proper research or experience. That's why I took the time this morning just to go back over the absence of that in this case.

My Lord, the next count to deal with is count 5. I wonder whether now is the time to take a break.

MR JUSTICE GOSS: Certainly. A ten-minute break, please.

(In the absence of the jury)

MR JUSTICE GOSS: Mr Johnson, I'm just wondering, could you tell me on what day it was of the trial that Dr Marnerides gave evidence about [Baby D]?

MR JOHNSON: The 29th and 30 March.

MR JUSTICE GOSS: Day 97? Thank you very much, Mr Maher. Day 97, thank you.

(3.08 pm)

(A short break)

(3.18 pm) (In the presence of the jury)

MR MYERS: Count 5, ladies and gentlemen, [Baby E].

[Baby E] was born on 29 July 2015 at 17.53, so 7 minutes to 6 in the afternoon. He was 29 weeks and 5 days' gestation, the first of the two twins, [Baby F] was his brother, and he was 1.327 kilograms in weight.

On 3 August 2015, during the shift going from that evening into the night, he bled at various points. At 23.40, there was a desaturation and bleeding continued, and with a further collapse round about 00.30 or thereabouts, and he died in the early hours of the following morning, 01.40.

Dewi Evans, Dr Evans, says that death is due to air embolus and trauma causing haemorrhage, and Dr Bohin says death is due to air embolus and, I put question mark trauma, she wasn't so clear about that. But it was there.

A lot of emotional pressure for everybody with all of these counts on this indictment and no less with this one. Enormous pressure. A traumatic event. Terrible for [Parents of Babies E & F]. You will feel for them very strongly. Remember what I said at the beginning about how natural it is to feel like that and how could we do anything other than feel like that with them and for them?

You know that makes it very important to look at the evidence as objectively as you can because, as a starting point, the way anyone feels in terms of emotional reaction does not make anybody guilty of anything. And we will look closely at what [Mother of Babies E & F] said and we will deal with that respectfully and sensitively, as sensitively as we can.

There are particular issues to consider in [Baby E]'s case. I'm going to look at it with this structure in mind, although there may be some deviations along the way. First of all, whether [Baby E] received the care he required as his condition deteriorated late that night and into the early hours of the morning. Straight question: did he get the care he needed? Whatever was going on -- remember what we say about blame in this case and which direction it's going in and the reticence in some quarters to accept it? So, did [Baby E] get the care he required?

Secondly, we'll look at whether the evidence shows Lucy Letby attacking [Baby E] around 21.00, which is the starting point presented to us by the prosecution. Attacking him. Third, we'll look at whether [Baby E]'s condition is as described by [Mother of Babies E & F] to the police at around about 21.00.

Fourth, we'll look to see whether the theory, the allegation, that [Baby E] died because of an air embolus is supported by the evidence because crucially that's the prosecution case.

And then also we'll look to see what evidence there is of an attack causing trauma upon which you can be sure as opposed to a bleed that developed in some other way. We don't have to say how the bleed happened. I don't say that to be belligerent or difficult, it's the law -- quite rightly, if I may respectfully observe -- that we don't have to, we may not be able to.

What has to happen is the prosecution make you sure of harm and they propose two mechanisms, so you need to look at the evidence

of that and you, ladies and gentlemen, will keep in mind throughout, of course, that there was no post-mortem in this case of all cases, a case where the issues so badly require that for resolution given what's said. There was no post-mortem.

And we repeat what we say and said yesterday: there is one person who carries the disadvantage that goes with that and she's sitting in the dock. We say that that absence has left the way open for the prosecution and their experts to make all sorts of suggestions. So first question: did [Baby E] receive the care he needed? We say no, he didn't. Actually, he didn't.

I'm talking about the bleeds in particular. The failure to react to the bleeds, the failure by Dr Harkness and [Dr C], the consultant, is obvious we say. The GI bleed, the gastrointestinal bleed had either been identified or strongly suspected by David Harkness at about 20 to 10 on 3 August. It had been. Can we put up tile 128, please, Mr Murphy, from the [Baby E] sequence.

Here we are. This is the first note and you'll remember we went over with Dr Harkness when he would have attended on the unit, and I will come back to this, but it's probably about 9.30 he could have been there to have done all this and then made this note. But anyway:

"Asked to see patient re gastric bleed."

So he goes through all of this, he does the examination, no wounds to the throat. You remember that was something that was floated, one of the many theories in this case. No evidence of that. Can we go over the page, please, just to see his conclusions? And we can see there:

"Suspected GI bleed [query] cause."

Which is consistent with what he saw. He prescribed ranitidine, which is something prescribed to reduce acidity, to assist with a situation like this. That's why he prescribed it at this time.

We say that in fact, from this point, given the bleeding which had commenced, it was obvious that a transfusion would be required, and certainly by the time we get to 23.00, if we scroll down a little bit further, we can see there, 23.00:

"Further gastrointestinal blood loss."

Nothing about "from the throat", by the way, nothing at all from the clinician, a suggestion thrown out there by the prosecution, put into that pattern. It's not:

"Further GI blood loss. 13ml bloodstained fluid from NGT."

Right? Even here, no action, no action for a transfusion. It says, "For elective intubation with drugs", but that didn't happen for some time. That was delayed for another 45 minutes. We say Dr Harkness did not act as he should and, if he wasn't out of his depth, then what did he think he was doing? He knew he was dealing with a gastrointestinal bleed, or a suspected one, that's what the notes say, that's why he prescribed ranitidine. A straightforward medical fact, again something Dr Bohin stubbornly refused to acknowledge in her evidence, we say, that this is a bleed that is causing a serious deterioration and we went on to say that is the cause of death. She would not have that.

It was at least 45 minutes to intubation. Dr Harkness told you that it took time to get the drugs ready. It took time to get to the truth on that didn't it because in fact we discovered, eventually, intubation drugs are kept on the unit ready to go. He said it took time to get the drugs ready to excuse the delay in intubation. Shelley Tomlins said they have them ready to go and when we came to Yvonne Griffiths, who showed us the fridge and items in the fridge, she pointed out where ready to go intubation drugs are kept up on the top shelf of that fridge. They're ready to go. He's not right, unless you just want to let that one go, ladies and gentlemen, that's a matter for you.

Substantial and ongoing blood loss. No transfusion. No note preparing transfusion up to this, no cross-matching, the things which you'd expect to happen as preliminaries to prepare for a transfusion. And [Dr C] didn't get to the neonatal unit for about 1.5 hours after she was first told about the bleed. She got there at about 12.25 or thereabouts.

Now, when I cross-examined her on 16 November, to her credit, we say, it's a matter for you, she agreed this was a serious situation by 10 pm and a very serious situation by 11 pm that was now a medical emergency. She agreed.

She should have been there before she actually arrived at 00.25 and she agreed that, she agreed she should have got there sooner and she wished she had. That's what she said, "I wish I had". The only, certainly senior, doctor to accept responsibility in that way for anything in this case. Of course if there's nothing to accept responsibility for, why should any of the others, but we say there is plenty, unfortunately. The reason she should have got there sooner, ladies and gentlemen, is of course she was overall responsible for what was happening with [Baby E]. We say, it's not accepted, it's a matter for you, but this is obviously sub-optimal care. You have the evidence. You don't get admissions the full way from doctors in this case on that issue,

we say you're not going to get it, and you'll keep in mind what Dr Evans said about the reluctance of doctors to admit the mistakes they make. This isn't a criticism of all doctors, but we say it does apply here, the situation in general.

Keep in mind, ladies and gentlemen, [Baby E] and [Baby F] were at a high risk of problems. That's the overall nature of the evidence, including the opinion of Dewi Evans.

Belinda Simcock or Williams or Wilkinson -- Williams, sorry -- a nurse for over 20 years, her view is a baby like [Baby E] carried a significant risk of mortality, sadly. Because they were premature with twin-to-twin transfusion syndrome and reverse end-diastolic flow, they shouldn't really have been at the Countess of Chester but they were there because they had run out of cot space at Liverpool Women's Hospital. Well, the different levels of unit exist for a reason, don't they? We say [Baby E] shouldn't have been here. It may not be anyone's fault that he was there, but it's illustrative, we say, of the difference in the levels of care that exist for a reason.

And when things went wrong with [Baby E], as they did, the medical staff at the Countess of Chester, it seems for the whole of the paediatric unit, A&E and the neonatal unit, consisted of Chris Wood, who was a GP doing a four-month paediatric placement as a relatively junior doctor, David Harkness, the registrar, and [Dr C], who was in hospital accommodation but didn't come to the scene until after [Baby E]'s collapse at 23.30 -- 23.40 sorry.

We say it's not extraordinary he became unwell: his blood sugar struggled. It raced to a high level throughout, despite attempts, we say, by some witnesses to play that down, but we went through this, you may recall. With [Nurse B] I went through showing how the insulin had been given to him, the insulin in the case of [Baby E]. He was on and off insulin throughout the four-day period in the neonatal unit, maybe because his body wasn't producing enough or maybe because he was under stress because of another underlying problem. [Nurse B] volunteered stress as a cause of high insulin before I asked her a question about it. By stress we mean physical which can lead to things like acid production. You don't have to just take that from me, I am not asking that you would, [Dr C] accepted that this could be a cause of high blood glucose and that stress can raise acid levels and high acid levels can cause ulceration and bleeding. So if you're looking for an explanation for a bleed that does not involve Ms Letby, we say you have it there.

Plainly, Dr Harkness considered this may be due to acid, or could be, as per his notes and the prescription for ranitidine. But of course a shield wall of denial goes up when the defence

join the dots and actually make the suggestion that that could be consistent with this gastric bleed or some other unidentified cause but not Ms Letby and that the failure to act swiftly and appropriately was a mistake.

We do -- you may, you may struggle to understand how Dr Bohin could not concede that at the very least bleeding was a cause of death. She wouldn't. We say that is a good example of her stubborn refusal to accept what must be a reasonable possibility. There was profuse bleeding on top of 25% blood loss. It's distressing talking about this, I know that. We have to when we're considering an expert who won't accept that blood loss, bleeding, was a cause of death.

We say the evidence is clear and that tragically [Baby E] did bleed to death when he was not in the right place, where the doctors failed to react appropriately and in time and, most unhappily and surprisingly, delayed a blood transfusion for which we never really got a good reason. But everybody here could see that this required a blood transfusion. I don't know, you may be doctors and nurses, for all I know, I don't know. But even if you're not, it speaks for itself.

Of course this is one of those cases where having dealt with this as he did, or rather as he didn't, David Harkness has gone on to provide the prosecution with descriptions of discolouration to the police and to you that in themselves are different, different from what he said in evidence, from what he said to the police, and both of which do not reflect what he put in the notes at the time. Familiar territory.

The second point I said we'd look at, ladies and gentlemen, whether the evidence shows Lucy Letby attacking [Baby E] around 21.00. Let's start with this first attacking him. In opening on 11 October last year the prosecution said this before you had heard the evidence:

"[Mother of Babies E & F] interrupted Lucy Letby who was attacking [Baby E]."

That sounds pretty definite, doesn't it? What did you think that consisted of? Well, wherever we get to with the evidence and with [Mother of Babies E & F]'s evidence, that isn't the description she gives and that isn't the evidence. The evidence does not show Ms Letby attacking [Baby E], however many times that is said, we say doubtless for the effect it has upon you and whoever is listening, it doesn't do that. It's a highly charged description, highly emotive, and has been pushed from the start.

[Mother of Babies E & F] in her evidence said Lucy Letby wasn't even beside him, she was working at a workstation and [Mother of Babies E & F] just walked in. Her evidence was she walked into the nursery, which would be unexpected, whatever the milk times are, generally unexpected and indeed anybody can walk into that nursery, "Busy as a bus station", Belinda Williamson said, a prosecution witness, unchallenged on that.

And when [Mother of Babies E & F] gave evidence on 14 November, she said she was busy doing something but she wasn't near [Baby E]; page 19. So yet again, someone appearing unexpectedly to find Lucy Letby not causing harm. That is the evidence. So that is where we get to on Lucy Letby attacking or an attack ongoing, being interrupted, [Mother of Babies E & F] interrupting Ms Letby who was attacking [Baby E]. The evidence is she was busy doing something but she wasn't near [Baby E].

Next point, the condition that [Baby E] was in when [Mother of Babies E & F] came downstairs and as described to the police later. You'll look closely at what [Mother of Babies E & F] said, ladies and gentlemen, and we'll be careful with the way we deal with this and sympathetic. Okay? It doesn't mean disregarding any shortcomings in the account when look at carefully.

The prosecution, we say, have done their best to turn this part of the case on this part of the count into what they have called a binary choice -- you heard them use that expression last week -- meaning either Lucy Letby is lying or [Mother of Babies E & F] is lying.

We say they haven't done that by accident. That is done deliberately. Who's the liar? It is done deliberately to put the defence, and to put you, in a difficult position because no one is going to want to say that [Mother of Babies E & F] is lying and no one is saying that she is lying. So can we get that clear straightaway? That's language used by the prosecution to characterise this situation when they say this is a binary choice.

The question is: what degree of accuracy can we place on everything that is said? And I don't say that in some mealy-mouthed fashion because we need to look at this and see whether or not the way it was described, as [Mother of Babies E & F] told the police, as she discussed it as she's given evidence to you, fits with everything we know at the time because you have to assess this. That's different from a question of lying, so perhaps can we take the heat out of that by saying this is a question of accuracy and reliability.

What do we go with? Well, on 14 November [Mother of Babies E & F] began on this part of her evidence saying that:

"I could hear my son crying. It was like nothing I'd heard before. I walked over to the incubator to see he had blood coming out of his mouth and I panicked. I was panicking because I felt like there was something wrong."

Well, she dealt with where Ms Letby was and whatever is happening here, we say at this point there is no basis for linking whatever is happening here to the bleed and death later because David Harkness saw [Baby E] directly after this and found him to be fine and settled. No suggestion by him or anyone at that point of blood or crying horrendously.

Now, as to the accuracy of the account, screaming.

All right? Screaming. Horrendous is the way [Mother of Babies E & F] described this. And we say however that is, however that recollection works, it cannot have been like that.

It cannot have been for this reason. There weren't just two people in that neonatal unit and a baby. All right?

It's not [Mother of Babies E & F] and Ms Letby and corridors of empty space and [Baby E]. It's full of people, actually, and people coming and going. We have to keep coming back to the fact this is happening in the real world on a relatively busy unit, whatever time of day and night -- and this isn't, if it makes any difference, right in the middle of the night, it's a fairly busy time, you may think, round about 9 o'clock, if that's the time we're talking about. You will remember the evidence of Belinda Williamson which I took you to earlier.

That piece of evidence is important and the descriptions of other nurses as to of how busy nursery 1 was. They are important generally in this case and of course important in the case of [Baby E] because it makes it less likely that someone has the risk or the opportunity to harm, as it's alleged [Baby E] was harmed, if they can be caught in the act like that. And it's also important when a witness describes, as [Mother of Babies E & F] does, hearing something she says she heard and screaming like she says it was. It's a straightforward point.

How on earth is that not going to raise the concerns of other people who will say, "Yeah, I heard the most horrendous screaming, I went along, it's the night that [Baby E] was bleeding," and so on? We hear things of other nurses who are aware of what happens in other counts. It is striking. There is nobody else describing what [Mother of Babies E & F] describes in terms of screaming at that point and we say it is

unrealistic, in terms of accuracy, what happened, that it can have been in the way that she is describing it, whether [Baby E] was upset or not -- he may have been, but screaming horrendously like that is not anything that anybody else suggests took place and it's difficult to see how that could have gone unremarked in this case.

But it's not just with the screaming, let's look at the bleed. We know there are issues with the timing and there are matters to look at with that and the question of bile, the bile-stained aspirate, what was there at 9 o'clock, what was there later. We recognise those points.

But as to the nature of the bleeding, [Mother of Babies E & F] began this part of evidence by saying that:

"[Baby E] had blood coming out of his mouth."

That's how it began. In fact it became apparent on further questioning that it isn't blood coming out of his mouth. We had this:

"Question: Did the blood go anywhere else apart from on his chin?

"Answer: It was on his -- a little bit.

"Question: A little bit on the lip?

"Answer: And underneath.

"Question: Just so we can be quite clear, you're not describing something where there is blood coming out and it's going on his clothes or over the bedding or anything like that?

"Answer: No.

"Question: It's that you could see certainly what looked like blood, you'd say it was blood, but you could see it round about his chin, in that area like we saw on the picture?"

And you've seen that picture and [Mother of Babies E & F] said yes.

Pausing there, the description "he had blood coming out of his mouth" is graphic and in fact on further questioning that isn't what was going on in the sense of blood just coming out of his mouth or coming over the place.

And [Mother of Babies E & F] agreed, 14 November, page 40, lines 1 to 2:

"It was not completely fresh."

That what's she agreed. So, we observe, not something that necessarily goes to an ongoing bleed or something that's linked to 1.5 hours later. So what was it? What was it?

We've seen described this smudged patch around the face there, around the lips. In her statement to the police she had said it wasn't thick blood. And reading from the statement and putting this to [Mother of Babies E & F], I asked her:

"It wasn't around his bottom chin..."

I read from the statement:

"Question: It wasn't around his bottom chin and the bottom lip?

"Answer: It wasn't thick. It's difficult to explain what it was. It's like a dribble pattern on his skin. It wasn't completely fresh.

"Question: Is that what you described, what you saw?

"Answer: [And she nodded and said] Yes, a dribble pattern, not completely fresh."

However we approach this, and we approach it sensitively and respectfully, that's different, isn't it, from the initial description:

"Screaming horrendously and blood coming out of his mouth"?

It is different, it's not the same and it certainly doesn't create the -- doesn't sit with the same impression.

I suggested, "Could it be aspirate?" She disagreed.

But nowhere, and this is the importance now of beginning to pull things together and taking a broader view, nowhere is there any other evidence -- in particular, nowhere from any nurse or doctor at the time is there any suggestion that round or about 21.00 [Baby E] was screaming in a way described or bleeding in the way [Mother of Babies E & F] described at the start of her evidence. There isn't.

If we go to the neonatal review please at page 2, line 33. I'll check I'm in the right place here.

This is the neonatal review. Can we go in fact to page 3, line 35? We might need to go back, Mr Murphy, I just want to check something. Yes, that's right.

The page we've just seen -- put that back.

I apologise for jumping around, ladies and gentlemen, I wanted to make sure I was in the right place, I am.

Page 2, line 33. You may already see where I'm going with this from the timings and who's doing what. Just go back a page, Mr Murphy. Thank you.

21.00 in fact. We've got Lucy Letby and Caroline Oakley involved or, first of all, Ms Letby at 21.00 dealing with [Baby F] and also, look at that, Caroline Oakley, 21.13, involved in a prescription for [Baby F], who we know is in the proximity of [Baby E]. This is contemporaneous or closely contemporaneous with what [Mother of Babies E & F] is describing.

If we go now over the page, please. Still there, 21.13, okay? Lucy Letby and Caroline Oakley observations on [Baby E] at 21.15.

This is just an example -- thank you, Mr Murphy -- but that's another nurse involved in the care in and around that nursery at a time that [Mother of Babies E & F] is describing screaming horrendously and blood. That's why I'm saying this isn't about lying or a binary choice, and it's open to you, and you, no one else, you to draw your fair conclusions from this. But the graphic description we have, we suggest, does not fit well with other people being about the place and being involved with these babies at that time who see nothing that coincides with this.

We can move from that and we're going to move next to what happened when -- the point of [Mother of Babies E & F] leaving, a conscientious mother and anxious. And she says: well, I left because somebody in a medical position said to go. She left, didn't raise anything with anyone else on the unit, and if she had been told a doctor was coming, why not wait for that? There is an issue here, isn't there, about whether a doctor was there or not. There is an issue. David Harkness agrees that the timings and the making of his note at 22.10 means that he must have been on the unit from about 21.30 at the latest; he said that on 17 November. And when he got there he saw a dirty aspirate which may have contained flecks of blood and bile.

And he -- his evidence, and he was asked about this in cross-examination, was he couldn't remember whether he saw [Mother of Babies E & F] around that time or not. He did see her but he

cannot recall the precise time. That is his message -- sorry, that is his evidence.

And without door swipe data it's difficult to be sure exactly where he was at what time. That is door swipe data that coincides precisely with the point we're looking at. The description that [Mother of Babies E & F] gives, this is something you'll have to weigh up, with what you would expect then to follow if she saw that. Would she just go? She said she did. You may accept that she did. Would she raise anything with another member of staff? You might think she would do that but nothing happens. She left.

And when [Father of Babies E & F] gave evidence he said that his wife had told him, and this is the way he put it:

"They told me to leave."

They told me to leave. They told me to leave.

Is that just something he said because someone giving evidence may just pick that expression and not mean it or does that reflect what he was told? We say that is capable of fitting with others being present. And it doesn't fit, if there's a they, with what [Mother of Babies E & F] said.

The prosecution point to and [Mother of Babies E & F] points to and [Father of Babies E & F] points to a phone call at 21.11 for 4 minutes and 25 seconds, and we don't doubt that [Mother of Babies E & F] is anxious and worried. We don't challenge that, that she rang her husband. They say they both talked about bleeding in that phone call.

We raise the possibility of whether details have been transferred from one call to another, that bleeding had happened later and maybe that's been translated to this phone call and that is rejected by [Mother of Babies E & F] or her husband. So that's where we get to with that.

The later phone call is ascribed to a phone call involving a midwife, someone else, when news came through to [Mother of Babies E & F] later on. That phone call was for 14 minutes and 30 seconds of, we're told, someone calling [Father of Babies E & F].

Well, it would be helpful, wouldn't it, it would be helpful with this difficult area of evidence if there were some way of having an independent guide to what had happened, what condition [Baby E] was in and how [Mother of Babies E & F] was, over and above the fact we have no other witness on the unit describing what [Mother of Babies E & F] said? I've identified that.

It seems the first person -- a person, if not the first person -- that [Mother of Babies E & F] spoke to after being downstairs was the midwife, Susan Brooks. I don't expect her evidence to leap out right now, but it's agreed evidence. Her statement was read to you on 15 November. It made reference to a note she made. I'm going to put that note up, but keep in mind all you know about [Mother of Babies E & F], your assessment of her, what it is she said she saw, what you might expect her to say or how she would express herself if things were as bad as they were described to you.

I'm going to ask if we could put up page 33405, thank you. The top part:

"Care since 20.00 hours."

This is from Susan Brooks:

"[Mother of Babies E & F] was postnatally well. I had given her some medication and she asked me to let her know if there was any contact overnight from the neonatal unit as one of the twins had deteriorated slightly at that time."

Okay? And we say, come on, that's not consistent with the gravity of what has been described in evidence. This is from the time and we know what it is because it's there.

It's a matter for you, ladies and gentlemen. If the situation was as it was certainly initially described in evidence to you, seriously, would it be down there if [Mother of Babies E & F] had said he had deteriorated slightly? Okay? We say that is inconsistent with later descriptions.

You have to weigh this all up. This is pre-eminently for you. But it is the best independent guide. It may be the only independent guide you're going to get and you'll have to decide what weight you give to it, but please don't ignore this, together with the fact that nobody else on that unit is talking about screaming or being horrific or blood flowing or anything like that. We've even got another nurse pretty much around that time in that nursery, no blood, nothing coming from [Baby E]'s mouth, all that stuff about bleeding from the throat. No, that's never seen. And in the note near the time, we have "deteriorated slightly". That is evidence and that's agreed evidence that was read to you. And you have heard about agreed evidence from the prosecution and it's no different when it applies to the defence.

We can take that down, please, Mr Murphy.

I want to look at the prosecution and their experts and the question of air embolus next. Dewi Evans, air embolus and injury inflicted with an item from the unit, and Dr Bohin, air embolus.

So is the suggestion or the theory that [Baby E] died because of air embolus supported by the evidence?

That is the prosecution case. So let's see if that applies. Dr Evans and Dr Bohin point principally to the account of discolouration given by David Harkness, and that's what this allegation in this case, the allegation of air embolus, is based upon principally when we come down to it. So where do we get to with David Harkness and discolouration?

His clinical notes, we can perhaps put them up for this time at tile 204, please, Mr Murphy. Thank you. This is made at 01.45:

"Sudden deterioration at 23.40."

We have:

"Poor perfusion, colour change on abdomen, purple discoloured patches. Intubated as an emergency at 23.45."

In fact, matters proceeded from there. That's the description there.

Dewi Evans accepted, on the basis of the description in the notes alone, he wouldn't suggest an air embolus.

And certainly Dr Bohin accepted poor perfusion is consistent with hypoxia, which is consistent with blood loss.

Dewi Evans, as it happens, in the first of the two reports he wrote, didn't suggest air embolus because at this point this is not evidence of air embolus, we say.

However, there are two further sets of descriptions from Dr Harkness. There's a description he gave in evidence to you, 7 years after the event, that is significantly different from his clinical notes and far more lurid, and a description to the police in his interview and the statement he made 3 years after the event, which is also different from his evidence and these clinical notes.

In his evidence, in particular, he talked about, on 17 November:

"... strange patches in one area and then another, different sizes, changing where they were."

Okay? Don't forget this comes after what he says he had seen in the cases of [Baby A] and [Baby B], although, as it happens, he made no note of. So if we've got patches appearing or disappearing in some way or mobile, and we all know the significance of that now by the time David Harkness came to give evidence to you, and we say made his statement to the police, everybody's got the significance who's been talking on that unit of mobile patches. But we don't have anything mobile here, do we? Not on the document that counts, not on the notes. That is very surprising, we say, particularly if he was alert to this because of what he says he saw with [Baby A] and [Baby B].

And in his statement to the police in 2018, which I'd read to him, it included descriptive features like "a strange discolouration over his body" and reference to a rash that "appeared on his chest and then a path (sic) somewhere else". So we've got strange discolouration over the body, a reference to a rash that appeared on his chest and then maybe a path -- or appear maybe -- appear somewhere else. And in evidence, strange patches in one area, then another, different sizes changing where they were.

But the crucial difference, and one that won't be lost on you, is the question of mobility. That is what comes out of the Lee and Tanswell article, that isn't what's in this note, but that's what appears. Very mobile evidence, that, isn't it? That's what appears in the statement to the police and in his evidence to you.

David Harkness reached for the formula, "It's like the rash on [Baby A]". Well, you know what he said about that in his notes and what he said about that in his statement to the coroner, which was nothing -- did I mention [Baby B]? It's [Baby A] that I refer to, that's my mistake.

Then we come to the actual -- and that's the key evidence, by the way, the key evidence relied upon for air embolus in this case. That is it: the mobile colours, mobile in a way that wasn't described in the note at the time and a note that even Dr Evans said he wouldn't have based air embolus upon that.

So we take it he bases it upon the changed account that came later. We can take that down, Mr Murphy, thank you.

We come to the actual collapse and death. We have a description at 00.36. As David Harkness and [Dr C] stood at the end of the incubator, [Baby E], according to David Harkness, collapsed in front of them:

"In front of our faces as we stood there".

This part of the incident doesn't involve any discolouration at all, as it happens. No evidence of anybody interfering with [Baby E], and we have Dr Harkness, [Dr C], Chris Wood, Belinda Simcock and Ms Letby all present. But where has the attack happened in those circumstances and with [Baby E] collapsing "in front of our faces as we stood there" by David Harkness' account? Where has it happened?

What does happen when they start CPR is [Baby E] bleeds -- and I'm not going to go through that awful detail out of respect to everybody because we've been there, we understand it, it's awful. We say that none of that fits with the collapse triggered by an air embolus; it does fit with heavy bleeding. The only person then who disputes that, that heavy bleeding is linked to death, seems to be -- is Dr Bohin.

Well, what of trauma then? As opposed to a bleed that developed some other way, what of trauma? Because in the absence of air embolus, or maybe in tandem with it, Dewi Evans turns to an attack with an implement. For two of his reports Dr Evans said [Baby E]'s sudden demise was the result of an acute GI haemorrhage:

"I am at a loss to explain the cause of the haemorrhage. This isn't typical of NEC. In the absence of a post-mortem, it's not possible to say whether [Baby E] sustained trauma to the upper GI system."

That's right, ladies and gentlemen, and we say that's where this should end. Then, in the third report, Dr Evans suggested an injury caused by thrusting in an NGT. You'll remember this. An NGT is a very narrow flexible tube. An NGT would never be capable of doing what Dewi Evans alleged and, in fact, he withdrew that suggestion in his report made a few weeks before this trial began in September 2022.

So we've gone from him saying [Baby E]'s demise was the result of an acute GI haemorrhage, "I'm at a loss to explain the cause" in reports 1 and 2. In report 3 that changes to an injury caused by thrusting an NGT. That is dispensed with. We say you can see him involved in conjuring theories to support the allegation rather than reflect the facts. But having rejected the NGT theory, he didn't stop there. You may recall he arranged for the police to bring him an introducer, like he doesn't know what one is, but he arranged for them to bring him an introducer.

Having set that up, we got served with the following part of a report or a statement only weeks before the trial and it said this:

"I have not seen any statement noting the presence of an introducer. Therefore my opinion regarding a potential cause of his trauma must remain speculative. I believe that it is reasonable to contemplate the possibility if a member of staff recalls that a redundant introducer was present around the time of [Baby E]'s haemorrhage, I believe it is an option that is worth exploring."

"I believe it's an option worth exploring." An option worth exploring? When we accuse him or other witnesses, prosecution witnesses, of seeking to work up an explanation, work up an explanation to meet the allegation, "I think an option worth exploring" comes close to that, we say, ladies and gentlemen.

The whole point is we are not to speculate, we are directed not to speculate, and how we're meant to be approaching this on "let's look at an option worth exploring", goodness knows. Are the police meant to go out and look for a witness to volunteer that? And nobody did, of course. But it gives away what's going on when Dewi Evans, in particular, where this is concerned, presents himself or is presented as any kind of independent or objective expert, and we say we can see there he's taking up a role of investigator, creator of theories, and coming up with speculative ways of hunting for evidence in search of a conviction.

There were obvious failings in care in the case of [Baby E], ladies and gentlemen, in reacting to a clear medical emergency. And we say, as a result of that, [Baby E]'s bleed ran out of control and he died. The evidence of air embolus is fanciful and is based upon Dr Harkness' shifting descriptions and no amount of shifting was described in the notes at the time, though he described a rash that was appearing or in some way moving later. And that is that.

There is no post-mortem and there is no examination identifying a wound to the mouth or throat, and Lucy Letby's getting the blame, despite having seemed to have done nothing close to an attack at any point, and we say no realistic opportunity for an alleged air embolus to have been delivered at the end. There just isn't enough and it's wrong to proceed on the basis there is if there isn't.

Tomorrow, ladies and gentlemen, I'll turn to the case of [Baby F] and then some of those issues relating to [Babies E & F] and documents that arise in their case. We've heard the question of the card that was sent. In fact, I want to go back and revisit an entry in the diary to look at, but I'll deal with that more generally when we deal with [Baby F] and look at the case at the conclusion then tomorrow.

My Lord, that's as far as I go this afternoon.

MR JUSTICE GOSS: Thank you very much.

Thank you, members of the jury. 10.30 tomorrow, please. Remember your responsibilities.

(In the absence of the jury)

MR JUSTICE GOSS: You won't have had time, I know, Mr Myers, because you've been otherwise engaged, just to check the evidence in relation to that matter that arose this morning. Can that be done overnight?

MR MYERS: Oh yes.

MR JUSTICE GOSS: The other thing is this, just so you know, I asked, and I was helped by Mr Maher, about what the evidence of Dr Marnerides was in relation to the abnormality to which you referred in agreed fact 21. I've got the evidence-in-chief but I haven't managed to look at the cross-examination yet.

MR MYERS: Very well.

MR JOHNSON: I've got it. I can put it in writing and circulate it.

MR JUSTICE GOSS: I've got the evidence-in-chief. Basically, he said it wasn't an abnormal finding. He said it's perfectly normal.

MR MYERS: Yes, he did.

MR JUSTICE GOSS: But you made the point to the jury that it wasn't normal, there was an abnormality here.

MR MYERS: Yes, I did, my Lord, and the point made comes from the agreed fact and it's very clear in the way that I put this. If we look at what Dr Kokai says, he says:

"The stomach or loops of bowel and mesentery show normal rotation pattern apart from the descending colon."

In other words that is not normal. That's why he says "apart from".

MR JUSTICE GOSS: Yes. I suggest you look at what Dr Marnerides actually said in his evidence and when he also went on to explain that even if there was any abnormality there -- and he doesn't put it in these terms -- the only thing you could have then would be a volvulus and there was no volvulus and there was

nothing on post-mortem examination that revealed any abnormality.

MR JOHNSON: And there's meconium in the colon, which is critical.

MR JUSTICE GOSS: Yes, exactly, so I think that will need to be revisited as well. If not by you, it'll be revisited by me.

MR MYERS: Yes, well, I can look at that, my Lord, I'd be grateful for the opportunity to do so. In fact, the other matter -- we are looking at that. There were two matters raised with regard to that. We believe the first one does not relate to gas in the heart, but I'll check that. Maybe the second one does, but the first one -- and we can't identify that but we'll continue just to check.

MR JUSTICE GOSS: I'll leave that with you, I'm not rushing you. It's only before we get to Friday afternoon that I want this sorting out.

MR MYERS: It has to be accurate, my Lord.

MR JUSTICE GOSS: Yes, exactly.

MR MYERS: I've certainly approached this in a particular way, but I'll go back and look at the evidence and make sure it's in line with that.

MR JUSTICE GOSS: Thank you very much. All right. Does someone want to go down?

MR MYERS: Yes, there will be a visit, my Lord, please.

MR JUSTICE GOSS: A visit, please.

(4.10 pm)

(The court adjourned until 10.30 am on Wednesday, 28 June 2023)