

28 June 2023 (Day 138)

Defence Closing Speech Day 3: Babies F, G, H & I

(10.30 am)

(In the presence of the jury)

Closing speech by MR MYERS (continued)

MR MYERS: Ladies and gentlemen, we're going to move to the count of [Baby F], count 6. Before we look at [Baby F]'s case in particular, can I just say a little by way of introduction about the insulin counts in general because we have those on count 6 with [Baby F] and count 15 with [Baby L].

The prosecution have referred, more than once, to concessions from Ms Letby that she accepts the insulin analysis. As a starting point on her behalf, we do not accept that those concessions, so far as they can apply, and I'll come to that, establish that she has committed any offence. And we say that to do that, to establish the commission of an offence, where these counts are concerned, keeping in mind his Lordship's directions on the law, you must be satisfied so you are sure that the sampling and testing has been done properly and accurately, that goes without saying, and you must be satisfied so you are sure that Ms Letby deliberately introduced insulin with an intention to kill.

We know that the analysis has been explained. We know that. And you may well accept it. It is obvious that we can raise little by way of challenge to it and we accept that. But where somebody disputes guilt as firmly as Ms Letby does, we do, we say, at least need to check that the evidence stacks up. In that regard it is insufficient simply to rely upon concessions obtained from Ms Letby in the course of cross-examination to whether things are accurate when she can't possibly know herself that they are. She's just working with the same evidence as anybody else in terms of analysis.

We know that evidence at face value establishes how the testing was done and the results obtained and therefore what we do, and all we can do there, is to ask you to look closely at that evidence and satisfy yourselves that it is safe to rely upon, not by speculation but by logic and any inferences that follow from it. You're entitled to do that.

Can I make this clear: it is not agreed evidence. However much anybody would like it to be, it isn't. You've seen witnesses come and be cross-examined on these issues and that is why.

The defendant, Ms Letby, cannot test the samples because they were disposed of a long time ago. That can't be helped. That's how they were dealt with as part of the sampling and testing process. We cannot check that and therefore we are looking in the evidence at the way the sampling and the testing was done.

You will have seen, ladies and gentlemen, that the evidence has demonstrated in both counts, as it happens, that there have been bag changes when Ms Letby wasn't present, and the changing of lines and giving sets at the very least in the case of [Baby F], and with, it seems, insulin continuing throughout.

We say that is something that Ms Letby cannot be held responsible for realistically and we'll look at that and I'll explain why we say that. We say the fact is, on the evidence, that whatever has happened, there is no basis for saying this can only be her, though we do not and cannot identify an alternative in the event, as the prosecution put it, of a targeted attack. That's an expression they have used.

You will keep in mind as we go through these counts that she is seen to do nothing that possibly links her to what is alleged. And you'll keep in mind the prosecution have made, in particular, the suggestion that she has been involved in adding insulin to bags when they are already hanging or as they are put up, but in particular, as it was put in the case of [Baby L], going back and spiking it maybe three times. You'll want to think about how realistic that is.

Then where we say that unrealistic explanation can't be preserved, the prosecution switch to the possibility, and this is especially in the case of [Baby L], of sticky insulin, and we'll look at that. But we say these are the most contrived and artificial explanations, designed to make up for the fact that whatever has happened, the evidence does not work out in the way the prosecution would like it to prove what they need to prove, and you will have to consider this.

In closing, the prosecution said -- this is from 19 June:

"I don't know, because I'm not a fortune teller, whether or not you will hear any submissions questioning the integrity of the process or the validity of the results, but if you do, a careful consideration of his Lordship's review of this chapter of the evidence, we suggest, will leave you well placed to assess the merits of any such submission."

We're not sure what was meant by that. The prosecution know very well, as do you, that the process is questioned. This hasn't been dealt with by agreed facts or agreed evidence and Ms Letby does not accept she has done anything wrong. So we ask you to

look at all of the evidence on this issue, as you are entitled to and as we are entitled to ask you, and to reach your own conclusions so long as those conclusions are within the confines of the evidence and fair and reasonable conclusions to be drawn.

One matter, which we'll deal with, a striking matter, we say, is that neither [Baby F] nor [Baby L] come close to the serious problems that high doses of insulin like this are said to cause. Just think about that. I'll come back to it when we look at the evidence. But the expert evidence of Professor Hindmarsh was clear. And if insulin at high concentrations affects blood sugar and maintains it at low concentrations for a long period of time, that can be extremely damaging, if not lethal in the case of an adult, never mind a neonate.

In the case of [Baby F], there was a vomit at 1 o'clock in the morning on 5 August and there were raised respiratory and heart rate for some hours afterwards but, we say, nothing approaching what expert evidence has described with regard to high doses of insulin. And in the case of [Baby L], he only ever seemed to be in good health, save for the low blood sugar readings, which we say is extraordinary if he received such high doses of insulin but maintained such low blood sugar for such a period of time. We'll look at the evidence on that, as you'd expect, when we come to [Baby L].

All of that is before we come to what we say is an obvious question that arises with these counts, or obvious questions that arise, such as why only use insulin like this in these two cases if it is such a clever and undetectable method of causing harm? And if the intent is to kill, then why not do that if that is what has happened?

So there is a good deal to look at and consider, we say, ladies and gentlemen, and these counts don't use the -- and let's face it, this is the way they are being used -- short-cut to conviction that the prosecution are keen for you to do. We say the conclusions to be drawn from the evidence are not clear. The evidence does not have all the answers for what has happened and it cannot be used in that way, however much anybody is hungry for convictions in this case. The same rules apply, it's still necessary to look at it in the same way and ask the question: when faced with this evidence, are there explanations or are there possibilities that mean we can proceed on the basis of the presumption of innocence and apply that? Does that mean she is not guilty? Not to approach this as something which is simply set out to you with a presumption of guilt as if it can just be taken as a fixed fact that carries you straight to conviction, which is the way it has been presented.

There is a good deal to look at in these counts and we ask you to look at it, as we have throughout, with the presumption of innocence in mind and not the presumption of guilt.

So we start with [Baby F], ladies and gentlemen. [Baby F], you know, born on 29 June 2015 at 17.54, the second of the twins, 29 weeks and 5 days' gestation, 1.434 kilograms in weight.

From about 1.54 on 5 August 2015, he was recorded to have low blood glucose. That continued until 19.00 that day. An analysis of a sample taken at 17.56 that day returned insulin C-peptide readings of 4,657 picomoles per litre of insulin to 169 picomoles per litre of C-peptide, which you know from the expert evidence is a ratio which indicates, if accurate, that there has been the introduction exogenously of artificial insulin. You'll keep in mind those figures and just how high that is, 4,657 picomoles, four times higher, as it happens, than the dose that is said to be established in the case of [Baby L].

When we deal with this, ladies and gentlemen, however much I may refer to it or not, it may be helpful just to have open, to have at hand the Hindmarsh table, if you have it, which is behind divider 5 of jury bundle 1.

Unless necessary, it's not something I just propose to just go through, but because there's reference to events in this, you may want to have access to this and look at it as you listen to what we have to say about it.

It's important to keep in mind as we look at this -- you may have marked this on the table or not, you may want to, it's up to you, but to have a note of this somewhere -- the bag of prescription TPN that was hung by Ms Letby and [Nurse A], at what is said to be the start of this period, is hung at 00.25 on 5 August. We've seen that table, which is at tile 147. I don't ask to put it up now, we've seen it that many times. But 00.25 on 5 August is when a bag is hung of prescription TPN for [Baby F].

We also know, and it is helpful to have this in mind or recorded somewhere, that bag was changed to a TPN Maintenance bag, because the line had tissued, by Shelley Tomlins and [Nurse C] at 12 noon that same day. You see reference to that on that prescription for that, but those are the two key times.

Now, going through the material relating to this analysis, first of all, we cannot check the sample and we know why and that's just a fact, it's just the process. Unlike the case of [Baby L], we cannot and do not point to any issue with regard to the way the sample was taken. There is an issue in the case of [Baby L] and the prosecution have found it necessary to address you at

length about that, seeking to persuade you the sample was taken at 12 noon and not 15.45. I'll come to that when we come to [Baby L]. But no issue arises like that in the case of [Baby F]. We accept that.

We recognise, being realistic, you are likely to decide you can take the analysis as accurate. I know that. But there are just two points we make as you do that or as you consider that.

First, the analysis which we have, which gives us that ratio, those figures, is based on a sample that was taken at 17.56 on 5 August. So this was after the bag change, the second bag that was placed on around 12 noon that day and therefore did not come from the bag hung by Ms Letby and [Nurse A] and relates to a sample taken at a time when she was not on duty.

So the sample relates -- the analysis relates to the second bag. Now, Professor Hindmarsh in dealing with this said that it is reasonable to assume the amount of insulin in the first bag was similar to that -- sorry, the amount of insulin in the second bag is similar to that in the first, given that the same amount of dextrose was being used to counteract it and the blood sugar level remained relatively constant throughout. In other words, if you look at that table the readings are all in the same sort of bracket, this is what he said, and it's the same type of dextrose being used to deal with it, therefore the conclusion to be drawn is the level of insulin must remain similar or the same throughout that period. That's what he said.

We say that must be very approximate, it must be. Professor Hindmarsh accepted that blood glucose -- and this was in examination on 25 November, he accepted that blood glucose cannot establish the amount of insulin or the insulin/C-peptide ratio. You can't look at blood glucose and work out how much insulin is there, otherwise there wouldn't be a need to do the testing, would there? And although he says that the blood glucose to dextrose relationship was steady across the two bags, you might note when we come to the case of [Baby L] that the type of readings there don't seem all that different from those in [Baby F]'s case. We can look when we get there. They don't seem all that different.

But we know those are with a much lower level of insulin, so we do question, as we're entitled to -- it's a trial, we're allowed to do this -- we question whether the level of insulin from the continuing bag can be said to be the same as it was beforehand. We question the basis for that. It seems incredibly approximate.

The second matter we identify, and question, is, we say, the effect upon [Baby F]. We don't disregard the fact that he was unwell, that he vomited, and the prosecution identify, as

follows from what's been said about the question of half-life, that that comes some time about half an hour after that first bag is hung. It's at 1 o'clock on the 5th. That's right.

But we do observe this: it's significant, what happens and what doesn't happen when we come to consider what might be expected for the huge level of insulin disclosed by the analysis and, I suppose, the question of intent, although it's not accepted that Ms Letby has had anything to do with this.

When he gave evidence on 25 November, Professor Hindmarsh was asked to describe the dangers of very low blood sugar. He explained that the brain does store glucose as glycogen but this store will last only for 20 minutes and he said that when it is insulin that has produced very low blood glucose, this switches off the brain's ability to use other energy sources and therefore in that situation the brain is going to be susceptible to damage. Whether there is damage depends on the duration and depth of the hypoglycaemia.

This is evidence. However anyone reacts to this, this is evidence in the case and it's a matter for you, ladies and gentlemen, as you know.

He said that once we get down to 2.6 or 3, that's the blood glucose reading, there may be some cognitive interference in thinking, but going further down in terms of blood glucose there can be seizures, death of brain cells, coma and even death. This is his expert evidence. And we say it makes it surprising, we question, given that, that after 17 hours with [Baby F], we are told from the analysis of consistently high insulin and blood sugar readings as low as 0.8 and many below the 2.6 or 3 at which Professor Hindmarsh said we are entering territory of seizures, death of brain cells, coma and even death, we ask -- it's a good thing of course, but we ask -- how it is there is no physical impact on [Baby F] beyond a vomit early on and a raised heart rate and respiration for some hours but which came down to acceptable levels.

We don't invite speculation, we don't invite guesswork, but since you have to be sure of the basis for any conviction and since we challenge that Ms Letby is guilty, we have to look at what lies behind this and it is an observation we make that, fortunately, neither of these babies displays anything like the symptoms you might expect from what we have been told about the impact of this type of concentration of insulin and low blood sugar over a persistent period.

When asked about this, Professor Hindmarsh furthermore said:

"In addition to sweating or an increased heart rate, and the response is variable, the first presentation could well be and often is collapse and seizure."

You can evaluate that, ladies and gentlemen. A great deal is made of that, but that isn't what we have, fortunately. And we identify that is something we regard as a question, something worthy of consideration when weighing up, as it's put, the integrity of the material we are relying upon.

Ms Letby's actions in this context, what she did do and what she didn't do. [Baby F] received dextrose to correct low blood glucose. But it still remained low without mounting damaging effects, which we observe may be difficult to understand given the expert evidence, but then think of this: Ms Letby was involved in giving dextrose during the shift. We have that at 4.20 on tile 198. It's difficult, we observe, to see how anyone would be giving a dose of insulin with an intent to kill when they know that low blood glucose, which is something that will be tested for, will lead to dextrose being given to correct the problem.

And it's a strange intent to kill, we say, where the obvious remedy is inevitable and the person who we are told is alleged to have the intent is then involved in giving the remedy, as Ms Letby undoubtedly was. That brings us to the question then of what we can be sure about what did happen in the event that we can rely upon the analysis.

Who did it and how did it happen? The straight point on the evidence, we say, is that we do not know what has happened here or who is responsible insofar as this is deliberate, if this is, and these are matters for you to look at. The prosecution asked all the nurses to come and give evidence and they asked most of them if they'd administered insulin to [Baby F]. As it happens they didn't ask [Nurse B] or [Nurse C] but that's an oversight, we don't make any point of that, we are just observing it.

They wanted to make a point, didn't they, of how many people say they didn't give insulin to [Baby F] and narrow that down to Ms Letby, and all the witnesses have said no. Interestingly, we observe, they didn't ask any of the doctors at all on either of the insulin counts. We are not making an allegation but we observe that does show a tendency on behalf of the prosecution to put doctors in a place beyond criticism generally -- and you have seen that -- including a refusal to acknowledge medical mistakes that we say has more to do with an attitude of where the prosecution is based than the actual evidence.

Keeping in mind the burden and the standard of proof, we say there are four reasons why we cannot be sure, because we say

there's a lot we can't be sure about here. The weight of these counts, the weight comes from reliance upon the analysis and we recognise there are questions we can ask, but we may well get to the point that you find that established. We challenge it, we try to do so in a proportionate way to what we can say, but after that there is a huge gap as to what has happened and that gap is filled by, we make no apologies for saying this, the presumption of guilt that operates by saying: put it all together, it must be her. That's a very self-perpetuating way that this prosecution case works. In fact, if you strip that away and look at this through the presumption of innocence there are a lot of questions to ask and we say we are a long way from being sure. There's a number of reasons.

The first is there is no evidence that Ms Letby interfered with any bag of TPN. None. Blink, ladies and gentlemen, and you will miss that point. In fact you have to blink at least 22 times in this case to miss the point, at least 22 times or perhaps nearer 30 by the time we get to the end of it. But as you know, not one witness sees Ms Letby actually doing any of the acts that are alleged to amount to harm that are brought against her and the same goes for the insulin counts and that is no small matter, is it, because you know the insulin is stored in a fridge in the equipment room that is used by all nurses on the unit at any time to have a hot drink, to use their phones, to collect any of the many items of equipment or medication that are needed constantly and consistently on the unit and are stored in that room.

You've seen photos of it, it's full of all kinds of things. Anyone can go in at any time and the likelihood of being seen interfering with insulin or a TPN bag, or both, by someone coming in or passing would be very high and the risk would be obvious.

We say there would be nothing quick about what the prosecution allege. It involves getting a syringe, getting the keys, drawing up insulin, getting out a TPN bag or the TPN bag, and injecting it in without doing anything that arouses suspicion and without getting caught -- and potentially multiple times is how this allegation is now put. You'll remember in 2015 the syringes were not kept in the same room as the insulin and the TPN.

The prosecution have suggested alternatively that insulin was introduced when the bag was hanging. Think about that, hanging. Maybe to come up with something that sounds easier to do, but it isn't, is it? It still involves getting insulin from the fridge and the equipment room, getting a syringe or having a syringe, getting it in there, getting into the bag without detection, all of which is visible, when there's no reason for anybody to be injecting anything then into a hanging TPN bag. How on earth is

that going to happen? Who's going to do that? There's windows around the place, there are people everywhere.

If it sounds like I am just giving lots of reasons why she couldn't have done it, you're dead right, I am doing, because there are lot of reasons why this would go noticed, spotted and the risk is obvious. It's easy to make the allegations, ladies and gentlemen, but it would be quite difficult to carry this out.

You'll keep in mind, when we're looking at circumstances and the bigger picture, this isn't the only allegation where, on the prosecution accusations, Ms Letby must have done all kinds of things and not been seen. That applies to everything, everything, with just the same force as the prosecution rely upon the generality of matters and the similarity of matters in their case. We say it becomes increasingly unrealistic to maintain this as we go along event after event. So that's the first matter.

The second is that, as a matter of fact, and this is matter of fact, there is no exclusivity about access to that bag. Whatever has happened, it's a fact. It's not as if it's something that is only in Ms Letby's possession and therefore we know if something has happened she must be the one who has done something. She's not the only person with access to the bag that was hung at 00.25 or any other bag.

It's a prescription bag, prescription bags are ordered in the morning and brought to the unit around 4 to 5 pm. So the bag was there for about 3 hours before Ms Letby was even on duty. Once she's on duty, the bag was on the unit for over 4 hours before it was hung.

Again, I make it absolutely plain, this is not an invitation to speculate, speculation is wrong, but it's identifying where there are inherent weaknesses in the evidence that reduce the degree to which we can be sure of what is happening. We cannot identify anyone who interfered with the TPN bag, just like no other witness can. But this count is about you being sure that if the insulin was there it was Lucy Letby and only Ms Letby who did this. We make the obvious observation that there is nothing exclusive about access to that bag or any bag on the unit. Not exclusive to her. That's the point.

If there was, it would have been unnecessary for the prosecution to go through that process of bringing on so many people here and asking them, most of them, "Did you do it?" Wouldn't need to do that.

Third, we know that Ms Letby was not on duty at the time the bag was hung from which the sample was taken and was analysed and when low blood glucose was ongoing and had been ongoing for some hours. Let's move to one side for the time being the business of whether that analysis reflects how the bag was earlier on. Professor Hindmarsh has explained why he says it's reasonable to say that it does and I have dealt with that.

But what we do know is, after she had left the unit, insulin continued to be received or given to [Baby F] via a Maintenance bag that had been hung after she hadn't been there for some hours. We say, ladies and gentlemen, it is incredible, incredible, to maintain she is responsible for this and incredible for a number of reasons.

First of all, the evidence -- and this is in the case of [Baby F] in particular we're looking at -- is that the TPN bag, the line and the giving set were all changed around 12 noon. That is absolutely clear. It cannot, we say, sensibly be challenged and isn't challenged. That's at some point after Ms Letby had gone off duty.

After she had gone off duty it became apparent that [Baby F]'s long line had tissued and that seems to have been identified on Dr Saladi's grand round between 10 and 11 am on the 5th, certainly not before. And as you know now, that meant the long line had to be changed and in these circumstances, if the long line is changed, so is everything that goes with it: the long line, the TPN bag and the giving set.

Shelley Tomlins explained this on 23 November and was clear that there would be a new giving set:

"Everything is removed, the bag is changed."

This is clear evidence unchallenged. [Nurse C] on 24 November explained that:

"In these circumstances the long line has to be changed and everything with it: the long line, the TPN and the giving set."

The significance of that is obvious, isn't it, ladies and gentlemen? That's the evidence of the nurses and it's consistent with entries in the documents that we have that show the changes that were made and references to this in the note.

It means there is no way that what happens when Ms Letby was not on the unit can be blamed on a continuing dose of ever-diminishing bits of sticky insulin, which is the laughable -- I say why I use that word -- laughable theory used by the prosecution to deal with the obvious problem of Lucy Letby not

being there when dextrose bags were changed multiple times in the case of [Baby L]. And I say laughable because if you were watching Professor Hindmarsh, he laughed when I asked him about it. That's perhaps a matter of expert evidence and we'll come to that when we deal with [Baby L].

But look at what happened if you are in any doubt as to how unlikely it is that Lucy Letby could be responsible for what happened with the insulin in that bag. The prescription bag was removed and the line turned off. The bag was replaced with a fresh bag, a new line, a new giving set. But because there's no replacement bag of prescription TPN, the nurses used one of the stock Maintenance bags. That evidence again is absolutely clear. So it wasn't replaced with a bag of prescription TPN that had been prepared specifically for [Baby F], it was replaced with one of the stock Maintenance bags.

We say particularly telling, as we begin to put this together, is what Shelley Tomlins agreed about this. I asked her whether the reason they had to use a stock bag was because the line tissing was something that wasn't predicted, to which she said, "Exactly, yes". That is such an important aspect of this count so far as the defence are concerned because now we have a tissing of the line that happened hours after Ms Letby had gone off duty, that couldn't have been predicted and was not foreseen, and that led to a change in the line and the bag, and yet the blood glucose continues to drop once the new bag is put up and the sample taken at 17.56 identifies that high level of artificial insulin.

So the evidence is that the stock bag, if this is right, must have been contaminated with insulin. And that follows from the way the insulin continued throughout 17 hours. But we ask, I'm sure you're there already, how can Ms Letby be held responsible for that second bag on any fair or logical basis and the high level of insulin in a bag that no one could see would be needed that comes into play hours after she left the unit?

Whatever happens, however we look at this, we say, moving on, ladies and gentlemen, the case against Ms Letby becomes increasingly difficult to swallow when we look at the situation concerning Maintenance bags. This is like a series of Russian dolls of improbability here, it goes on and on, the contortions that are necessary to sustain this allegation. What's the next thing that comes up? Let's think about Maintenance bags. Because for those people or anyone committed to convicting Ms Letby, despite the completely unexpected nature of what happened, it is tempting to say she must have done a Maintenance bag too, she must have had that ready, lined up ready to go for this unpredictable, unforeseen event.

Of course, that begs the question, doesn't it, why, first of all? Why would she? A TPN bag lasts 48 hours. That's the evidence. We know that. The unit keeps up to five Start-up and five Maintenance bags at any one time and we've been over this evidence with Mr Allen, Miss Tomlins and Nurse Yvonne Griffiths. She was shown the picture of the list on the fridge and she was clear that whatever is on that list, the actual figure was five of both. Right? Five of both. Right? That's the evidence.

Then we were shown the requisition book, that book where you put in the chits of what you need to have replaced from items used relatively regularly on the unit to get fresh supplies. And you may not remember but we know two Maintenance bags were ordered on 17 July, the 17th -- and the date we're looking at, as you'll know, ladies and gentlemen, is round about -- is 5 August. So two bags ordered on 17 July, no more ordered until one on the 11 August, from which we say it's reasonable that the following follows.

First, that there were five Maintenance bags there on the 5th because there had been no need to order any more than the two that had been ordered on 17 July. If they'd be getting used up there'd be more orders. Seven weeks -- several weeks, sorry, after replacements are ordered on the 17 July no more were ordered so we take it those are topped up, so to speak.

Second, the bag ordered on the 11th, that's the first time anyone orders another bag, we say it follows that must be ordered to replace the one used by Shelley Tomlins and [Nurse C] on the 5th.

That follows. You can see the orders: two on the 11th, that's where we are at the time we get to 5 August; and then about a week later another bag is ordered. That is evidence that's it.

So the evidence indicates there are five stock Maintenance bags, which there should be because that's what they have on the unit. And if we are going to say they weren't, that is speculation, guesswork and contrary to the evidence.

So even if somebody had guessed somehow that a Maintenance bag might be needed for an unpredictable and unexpected event, which is pretty unlikely we say, they are not to know, are they, what bag would be taken? How are they going to know, if this is targeted attack, how are they going to know what bag is going to be taken? They'd have to do the lot to make sure there happened to be a stock bag for the unforeseen event of [Baby F] needing it.

You'll keep in mind, ladies and gentlemen, as [Nurse C] explained, that stock bags are not stored in any particular

order. So to contaminate one would be utterly random and no way of doing so in a way that would be targeted or meant to be used for [Baby F], or for anybody in particular. That would be utterly random, even if you did think of having one ready just in case -- and why anyone would think of just one just in case beggars belief.

It is, we say, therefore unreasonable to maintain Ms Letby put insulin, or anyone, in a Maintenance bag that they could have not foreseen would be needed because it shouldn't be, should it?

It's equally incredible to suggest that she, or anyone, had done this to more than one or all of them because that's obviously the way the mind will go next, won't it, in this Russian doll of improbabilities? Ah well, must have done all of them. Really? Where none of those spares, it seems, ladies and gentlemen, ended up causing blood sugar crashes with other babies on the unit. None. There is no evidence that any other baby was affected at this time and you can be sure that you would be told if there was. There is no other evidence that establishes that. We've had lots of documents from other babies at the time around the unit related to what's going on. The only evidence we have is of what happens with [Baby F] at this point.

We know the other bags could have been used in due course elsewhere. We saw that more Maintenance bags had to be ordered on later dates from the requisition book. But in addition to being incredible, this undermines the repeated use of the word "targeted attack". It cannot be targeted if someone doesn't know who's going to need it and it could have been given to anyone.

How on earth is this meant to work? So unless Ms Letby had a Nostradamus-like ability to read the future and predict a Maintenance bag would be needed for an unforeseen event and know exactly which bag to do so that when someone came to get the bag unexpectedly for the unexpected event they would go to the one bag that had been done. But for that this is completely unreasonable.

It becomes less and less likely that this could be done, and for a basis of being sure we submit it cannot be. This follows from the evidence: that first bag should have lasted 48 hours; events take place when Ms Letby wasn't there that are unpredictable and unforeseen; a random bag is taken from a stock; there is no way one bag has been done or all of them done. None of that makes sense.

This isn't a party game, ladies and gentlemen, of "Let's Get Letby". We're not playing that. We're not here to invent explanations that ignore the evidence or are designed, working on a presumption of guilt, to find a way through it. Whatever

happened with the TPN bag or TPN bags, there is, we say, no sensible way of claiming that Ms Letby can have been responsible for putting insulin in the second bag. She cannot have foreseen that, no one could. And we say if she may not be responsible for what happened with the second bag, start there. If she may not be, that fundamentally, fundamentally undermines the accusation that she put it in the first, or any one, unless we're going to have speculation as to lots of different people doing things.

If she didn't or might not have done the second that is no basis to convict on the first. That would be contrary to the whole way this prosecution case works and we would be entering very new and speculative territory.

One final detail: we know Ms Letby was caring for [Baby F] on other occasions. Amongst the many, we say, illogicalities and inconsistencies on this count, this is another one that goes against any reasonable view that there is an intent to kill at work here, putting -- looking at the other criticisms we make and putting this alongside it.

Putting it bluntly, despite all that is said about the capacity of insulin to harm and its lethality in high doses, this doesn't come close. This is nowhere near to what you would expect, we say, for an allegation of attempted murder. And connected with that, nor is it, when you consider the position Ms Letby was in with [Baby F], something the prosecution say she had planned, using the emotive expression, "a targeted attack".

We have seen, we looked at this in evidence from the charts, the TPN charts, the blood gas charts, that she was looking after [Baby F] on night shifts from 1 August, the 2nd, the 3rd, and then the 4th. Then a blood gas chart records her caring for him next on 8 August.

The fact is that there are multiple opportunities and she didn't take them. And we say that is because this is not something that she is intending and it is inconsistent with that.

On the other hand, given Ms Letby's work pattern generally and the evidence we have, there are many nights when she was looking after the sickest babies, so it follows, doesn't it, if something goes wrong or something happens she has a high chance of being there and getting the blame for that because she is there?

Just stepping back and looking at the situation with Lucy Letby and [Babies E & F], Ms Letby's evidence is that she believed she had a good relationship with [Mother of Babies E & F]. However everyone feels now listening to this, that is how she saw it at the time. We've looked at various evidence relating to searches

and documents. But I made reference to the diaries in this case. In fact further review establishes in the 2015 diary there's an entry for [Baby E] on 3 August, which is the day of her shift when she looks after him and we run into his deterioration that night.

Now, he was plainly on her mind. As it happens, and you may think this is significant, he is the only child noted in that 2015 diary, which we say fits no pattern at all consistent with these allegations. And revealingly, there is no entry at all for [Baby F]. So unless we're going to start inventing, "It may be this, it may be that", that doesn't sit well.

We know that Ms Letby searched for [Mother of Babies E & F] on Facebook and she did that a number of times, but you'll keep in mind she searched for many parents, some of whom are connected with babies on this indictment, there are parents of babies on this indictment who were not searched for, and there are parents of babies on the indictment who were not and parents of babies who were not on the indictment. Every permutation.

There is the card that was photographed that had been sent to her by the [family of Babies E & F]. The amount of this activity as a whole seems particular to them and to [Mother of Babies E & F] in particular, the interest there. And looked at through the lens of the presumption of guilt, which is the way the case is presented, you are invited to take the very worst interpretation.

But we say that doesn't follow, does it? Because it doesn't fit with patterns with other children, whatever entry we have in a diary, whatever searches there are, it isn't part of a pattern. It isn't consistent with that. But however it feels and sounds now, her evidence is that she felt close or had a good relationship with [Mother of Babies E & F] at the time and it is Ms Letby's way, we have seen from her use of Facebook in particular, to take an interest in people who she meets, who are on her mind, unrelated entirely with any allegation. That's just how it is. You may know people who are like that. They think of someone, they're interested in someone, they search for them, they look for them, they google them, they go on to the next one, boom, boom, boom, rapidly.

That photograph of the card sent by the [family of Babies E & F] to the unit that was taken by Ms Letby on 20 November at 3.40 am whilst at work, the fact of that photograph, ladies and gentlemen, when we step back, we say, doesn't prove anything. It's a card that had been sent to her place of work and which she photographed when she was at work there, not because she'd set it up for some delight that that gave her, which is the way it's been presented.

We'll look at this when we come to the card that she photographed and she sent to [Baby I], or her family, on the day of [Baby I]'s funeral. But it's a point we remind you of that photographing cards is one of the things that Ms Letby does, or she says she does, irrespective of this allegation and we actually saw some evidence that supports that and I'll come back to that when we look at the case of [Baby I].

When we come back to the case of [Baby F], ladies and gentlemen, when we look at the totality of the evidence there, however it is presented, however much the prosecution rely upon it, once you get down to the fundamental mechanics of what has taken place, we say it is impossible, there is no proper basis for being sure that Ms Letby was involved in doing anything to that second bag unless we perform contortions that are utterly unrealistic. If that is the case, we cannot be sure. We may not always be able to be sure but if that's where we get to, that is not guilty, it is not guilty.

I pause as I do, ladies and gentlemen, and then I'm going to turn to the case of [Baby G]. You can put the chart away, if you like, a good opportunity to do that.

(Pause)

With [Baby G], ladies and gentlemen, we're dealing with counts 7, 8 and 9 on the indictment. So [Baby G]. [Baby G], you may recall, was born actually at Arrowe Park Hospital. She was very, very preterm, extremely preterm, 23 weeks and 6 days. She was born on 31 May 2015, just before midnight, at 23.57, 23 weeks and 6 days, 535 grams. That's an extremely low birth weight.

The key events in the chronology are as follows, just to remind us all. Having been born on 31 May 2015, on 13 August 2015, she was transferred to the Countess of Chester neonatal unit. Whilst there, in the very early hours of the morning of 7 September 2015, [Baby G] experienced projectile vomiting and desaturation after feeding, that was followed by apnoea and desaturations and problems with intubation and ventilation, which went on for some time. It's in particular the projectile vomit and desaturation at -- I'm going to put this neutrally at this point -- between 2 and 2.30 because there is an issue, isn't there, on timing, but you know where we are, at or about that time that forms count 7. We say the evidence is very clear, we're talking 2.15 but, just putting it objectively, between 2.00 and 2.30 at this point.

On 8 September she was transferred to Arrowe Park Hospital and she remained there until the 16th and then on the 16th she was transferred back to the Countess of Chester. And on 21 September, around 10 am, there was an episode of -- with two

projectile vomits and a brief self-resolving apnoea and desaturation. That's count 8, that morning of 21 September.

Then that afternoon, around 15.27, there was apnoea, desaturation and bradycardia after she'd been left behind a screen with the monitor off; that is count 9. So counts 8 and 9 are on the same day: count 8 is in the morning with vomiting and count 9 is in the afternoon, the incident with her behind a screen and the monitor off.

It is important to keep in mind, we say, that where [Baby G] is concerned there was a far longer course of treatment and events that took place and a broader area of that outside the three events on the indictment, in particular that period at Arrowe Park before she came to the Countess of Chester.

There were also, we looked at this with the evidence of Sandie Bohin, records in the entries for events after 21 September, so after the events on the indictment, in particular events where vomiting was recorded, and I'll remind you of some of the evidence about that. That's, putting it as neutrally as I can, the chronology we're dealing with.

With regard to count 7, which is the incident between 2 and 2.30, the projectile vomiting, Dewi Evans said that is air and milk down the NGT causing abdominal distension, forced down it. And Sandie Bohin says it's excessive milk forced down the NGT.

And when we get to count 8, on the morning of 21 September, the mechanism given by the experts there -- Dewi Evans says that [Baby G] was given more than the recorded 40ml of milk and it was excessive and it was milk or milk and air. Dr Bohin says she was given more than the 40ml of milk, and you'll remember they say this is a mathematical calculation they were doing about the mathematics. I'll come back to that. More than the 40ml of milk, it was in excess, that that caused the vomiting. And the prosecution case, of course, is that these things are all being done with the intention to kill.

There are many areas of this case that are upsetting. It's invidious and impossible to begin to compare. It's all upsetting, it's all very emotive. Hearing about how poorly [Baby G] has been and the injury, the brain injury she sustained and the consequences of that to her and her family is desperately upsetting. It really is. It's heartbreaking. We're back in the position that every one of us here, we're all made of the same stuff, is going to be moved by it in the same way.

You'll understand, however much we're affected by it, that feeling, which is natural, doesn't establish what the cause is. It doesn't help us establish cause. And it certainly doesn't

help us establish whether or not we can be sure that Ms Letby did what is alleged against her. But you'll understand the obvious dangers when we're faced with something as moving as this. We just ask, with absolute respect to [Baby G] and her family, please don't do that when it comes to forming your conclusions here on these facts.

The expert Stavros Stivaros, who is the brain specialist who talked about the imaging, and we heard evidence read from him, said the scan, the scan, which identifies the injury, cannot determine a cause for the injury. Very careful not to link up the fact there is an injury, with, "Well, there we are, it's been done", as the prosecution say.

Nor did the brain scan show that what happened on 21 September contributed to any. We know that injury was first identified after the events of 7 September. So it seems to be connected with that period, doesn't it, of prolonged medical activity which began with the projectile vomiting, but then we have, it seems, hours of the ventilators not working properly and tubes being changed, and Alison Ventress in particular told us about that, none of which shows how the injury was caused.

The case against Ms Letby, we say, when we go to the evidence, we say the allegations are weak and actually when we get into the detail here they go to demonstrate shortcomings in this case generally because they provide very clear illustrations in different ways of how blame, we say, is placed improperly and unfairly on Ms Letby. We say that applies elsewhere in this case, but we say you can see it at -- it's certainly at particularly points on these charges of [Baby G] that you can absolutely see that happening.

With count 7, the projectile vomiting at or about 2.15 on the morning of 7 September, we say that Ms Letby cannot have done anything to cause this on the evidence. And with regard to the vomits in the morning of the 21st and the mild desaturation, all of which was brief and self-resolving in large part, we say that's part of an ongoing clinical picture for [Baby G], of vomiting, after the 7 September incident.

We say that the incident later that afternoon when [Baby G] had been left behind a screen with the monitor off is something she is being blamed for but for which she most definitely is not responsible. The evidence on that is compelling and it is shameful the way she is now being held responsible for something when we know, we know, more about the circumstances now than we ever did at the start of this trial thanks to the frankness, actually, of [Nurse B]. Maybe a little late in the day, but we got there. How would this look if she hadn't said what she said?

All right. Let's just start with an introduction to this. The margins of viability or the margins of survivability, ladies and gentlemen, is an expression that's been used by medics and the prosecution experts in this case. And we can see from the extreme prematurity and very low birth weight of [Baby G] she was in that perilous category when she was born.

She had many problems, she has a history of desaturations and problems throughout her time at Arrowe Park and before going to the Countess of Chester Hospital. That was something that I reviewed with Dr Bohin when she gave evidence about this. We actually looked at lots of the material that will be, I anticipate, in the additional section for [Baby G] because it wasn't material on the tiles, it was material from the exhibits with J numbers, and we went through the history at Arrowe Park.

To begin with Dr Bohin said that what we were looking at were just the sort of things one would expect to find in a premature baby, but actually that picture persisted right the way through, right up to the point of transfer to the Countess of Chester Hospital.

So it's not just that she was premature -- or rather it's not just the immediate consequences of prematurity. There were problems, we went through, right the way from 2 June -- she'd been born on 31 May -- 2 June right up to the transfer on or about 4 August. In fact you may remember the transfer was even delayed on 31 July because [Baby G] had desaturated to 42.1% as she was about to be transferred and she's 2 months old by then. These things are important because of the repeated assertion of how stable and how well the babies are doing and how that is used as a yardstick or a starting point to measure what happens with Ms Letby. If we're going to do that, let's be realistic about the conditions of babies like [Baby G].

Alison Ventress agreed in cross-examination on 1 December that infection is a concern with a baby like [Baby G]. It's a concern with all babies, of course, but it's a particular concern with a baby like [Baby G]. It's something to keep in mind when we look at the first incident in particular because you may recall there is a very high series of CRP readings that follow on from that within the 48 hours that follow. Very high.

Not only that, there are two other things we say that show she was prone -- two other things she was prone to illustrated by her history over the 2.5 months before transfer to the Countess of Chester. So this is whilst at the Arrowe Park Hospital.

First of all, abdominal distension. That was recorded on a number of occasions. We went through them, ladies and gentlemen. It happens over the period that she was there.

Secondly, blood secretions. Blood secretions. Given how much is made of this regarding entries in the clinical notes, in particular during the early hours of the morning of 7 September, it is really important just to keep in mind that this was something that also happened at Arrowe Park.

We saw -- I will give you note, I am not going to put it up, ladies and gentlemen, but it should be available. At page 4510, which is 14 June, we looked at this with Dr Bohin, there were bloodstained secretions from the ETT. Dr Bohin said that may be because she'd had a low platelet count but I took her to the records that showed [Baby G] had had a platelet transfusion 10 hours before.

If this sounds like just so much detail, you'll understand, ladies and gentlemen. If we're in a case where allegations are thrown out at Ms Letby, "Oh there was a secretion with the ETT, you did it", and literally that stuff came on the hoof during cross-examination, it's important to recognise, no, on the evidence this was going on before she ever went to the Countess of Chester Hospital. And then we have that on 14 June.

On 17 June, page 4282, the ETT is blocked by an old clot or secretions and on 19 June, page 4536, we have pink bloodstained secretions on suction. And on 29 June, page 4315, we have fresh blood on suction after a desaturation down to 50 and a bradycardia of 65 beats per minute. And ladies and gentlemen, at Arrowe Park Hospital that was diagnosed in the notes as "probable pulmonary haemorrhage". All right? Dense stuff.

We went through it with Dr Bohin before we actually went to the events, but it is important, we say, if we're going to start from a level playing field in assessing what we find with [Baby G] as we go forwards into how she did at the Countess of Chester Hospital.

I'll turn then, ladies and gentlemen, before we break, if I may, to count 7. So we're dealing now with the first of the [Baby G] allegations. Now we do say at 2.15 on 7 September, and we say that because that's consistent with the evidence and that's really the way this case was presented at the beginning, up to the point that it became increasingly apparent with the evidence of nurse Ailsa Simpson that the prosecution were going to have to shift the timings a bit to get round the problem created by the fact that she said she was with Ms Letby in the minutes, several minutes, before the period of vomiting, almost giving Ms Letby an alibi in that way.

The allegation on count 7 is an allegation that Ms Letby force-fed milk to [Baby G]. That's the allegation. There is, of

course, no evidence she did that. You're entitled to look at all the circumstances and draw reasonable inferences, but outside applying the usual presumption of guilt, it is very difficult to see what the basis for guilt is meant to be apart from the fact, of course, she was on the unit and it happened.

The allegation is force-feeding milk or doing something to cause desaturations as the morning proceeded, and we ask, how, what opportunity? The allegation has developed in the course of the trial that she somehow made her have bloodstained secretions at least at some point whilst resuscitation was taking place. With all the medical staff there? How? How? Why is that different from other bleeds or secretions that [Baby G] had before she was at the Countess of Chester?

The allegation also is that air -- the allegation developed into the forcing of air down the NGT, maybe residual from the alleged attack at 2.15 or even maybe during the course of the treatment because, you'll remember, we have the 100ml aspirated at about 6 or 6.15 in the morning. Ms Letby is blamed for that too, 100ml. After [Baby G] had been watched by staff giving her intensive treatment for hours after she had been repeatedly, as it happens, bagged and Neopuffed and her abdomen wasn't actually noted as distended, not in the notes, until 6.10 am, which was after she'd been having air pumped into her on and off for hours as part of a response to deterioration. But that's worked its way into this amorphous allegation.

I start with the allegation at the point that it's said that she had force-fed milk down the NGT. That may be an appropriate point to stop, my Lord, looking at the time.

MR JUSTICE GOSS: Certainly. We'll have a ten-minute break then, please.

(11.40 am)

(A short break)

(11.50 am)

MR MYERS: Ladies and gentlemen, I was going to turn to what's said and what happens with 7 September, so the allegation that Ms Letby had forced milk down the NGT.

Obviously, the key matter for you, bearing in mind what has to be proved and his Lordship's directions, are that the prosecution prove, so you can be sure, of the causing of harm with the intent, which is the intent to kill for attempted murder. So that's the case, whatever I say about the facts. But it is significant, we say, the way in which certain aspects on

this allegation have changed since the start of the trial. That is significant.

So I'm recognising it's still a question of how they proved the allegation. The way it changes in the course of a case is not a defence, I'm not suggesting that, but we do say it shows a lot about where we have to be unsure about what's being alleged.

Dr Evans and Dr Bohin based their opinion, certainly before the trial, that air or air and milk had been forced down the NGT on this fact, that there had been a projectile vomit and that [Nurse E] had aspirated [Baby G]'s stomach before the 2 am feed. That was a fairly key way in which they had come to allege or propose a mechanism of harm that they did. I want to focus on that first because, before they gave evidence in this trial, both Dr Evans and Dr Bohin based this allegation on that belief that [Nurse E] had aspirated the stomach contents prior to feeding and the prosecution case was based on that. That is what this was based on. In other words, that the stomach had been empty before the 2 am feed and excess milk must have been introduced deliberately: we know it's empty because [Nurse E] would have aspirated it. That was the assumption, would have taken milk out.

If you are in any doubt about that, what the prosecution said in opening to you on 11 October when dealing with this was the following:

"At 2 o'clock in the morning on 7 September, [Nurse E] aspirated the NG tube. So she drew up to see if there was anything in [Baby G]'s stomach. She checked that there was no residual milk [that's the important point], she checked the positioning of the tube and then she fed a sleeping [Baby G] 45ml of milk through the tube."

So it was alternate, bottle, tube, bottle, tube, and this was the tube:

"When she had drawn up the aspirates she found minimum aspirates of a quantity that was not sufficient to prevent feeding and meant importantly, before she was fed, [Baby G]'s stomach had been empty, pretty much empty."

That assertion that the stomach was empty was based on the assumption that [Nurse E] had aspirated the contents prior to the feed. That's how this came into being at that point.

It'll help if we have the key entry on the feeding chart before us, ladies and gentlemen, so I'm going to ask Mr Murphy if he'd put up tile 75 from the [Baby G] sequence. You're familiar with this, ladies and gentlemen. It's the entry by [Baby G] for 2

o'clock -- thank you. A 45ml feed via the NGT. And of course, this becomes significant shortly, but a pH of 4.

Now, when we came to the evidence of [Nurse E] on 2 December last year, we discovered that the assumption that she had emptied the stomach before feeding was wrong. The assumption upon which this allegation had been based in that sense was wrong.

[Nurse E] made it clear in her evidence she would not have emptied [Baby G]'s stomach. That's something that would only be done routinely with smaller babies. She said she would have taken just enough to check the pH but not empty the stomach. So this is utterly different from the way it had been assumed this had happened up to this point, up to the point [Nurse E] gave evidence.

She said -- this is all on 2 December, page 78 that she didn't recall aspirating [Baby G] around the 2 am feed, there was no way of measuring if there was undigested feed there, with bigger babies who appear stable, and this is [Baby G]:

"You wouldn't aspirate at every feed, you would work on the assumption that milk for earlier feeds had been digested, but if something has changed so that milk was not being digested, new milk would go on top of undigested milk."

That is absolutely not the way that the experts had thought this would have happened. They'd said the stomach had been emptied first, and it's not the way this was opened to you, understandably, the prosecution relying on what their experts said and their understanding of the evidence. But this is a crucial difference because the way this began was that the stomach was empty, we take that as given, and so a lot of milk must have been pushed in to cause the projectile vomiting.

Suddenly now, after [Nurse E]'s evidence, that all falls apart because there could be any amount of milk in [Baby G]'s tummy, so it would take less. This is milk from earlier feeds, so when she comes to the 2 o'clock feed, that could have gone in on top of milk from earlier feeds. I make that quite clear, the allegation originally was that there would have been no milk from earlier feeds because the stomach would have been aspirated. No. [Nurse E] was clear. It doesn't follow at all. When she put that milk in at 2 o'clock there could have been milk there. There could be undigested milk if something has changed for whatever reason, you wouldn't know. So suddenly it no longer follows, does it, that if there's a projectile vomit on that basis it's milk being forced in after 2 o'clock?

This we say, ladies and gentlemen, created a fundamental problem for the prosecution and their experts because up until this point it had been presumed that what you're looking at here was the only milk that could have been in [Baby G]'s stomach prior to the projectile vomit. And on the evidence of [Nurse E], that presumption, that assumption, is not well made: there could have been milk there from previous feeds and this could have been sitting on top of it.

Now, that can't be helped, that's really the purpose of a trial, isn't it? That's why we do it, to test assumptions and assertions and this one failed. That's the process working properly.

But what we are critical of is the way then that the way the allegation was put morphs and, we say, on an unjustified basis it changes, doesn't it? Because the reaction of the experts, and in due course the prosecution who follow them, is to switch attention to pH now. We've moved to pH. Let's have a look at how this was done. This actually came out of something we say that happened towards the ends of [Nurse E]'s evidence. At the conclusion of her evidence and at the conclusion of any witness's evidence his Lordship is quite entitled to ask questions to deal with any matters that he has identified that you would be assisted upon to get further material from. And he did that on this occasion. I just mention it respectfully, it's 2 December. Just so we can follow this through.

It's strange reading out what his Lordship says, but the transcript is this. The question from his Lordship to [Nurse E]:

"Question: Just this, about not knowing whether any of the previous feed of the 45ml had been digested."

And it was the 45ml feed before this, that's the point:

"Question: Does the pH figure that that you took at 2 o'clock give you any information or not about that?"

[Nurse E] said:

"Answer: Not really because if the milk is in the stomach you'd have some kind of acid reaction anyway regardless of how much milk was there.

"Question: Yes, so there's simply no way of knowing?

"Answer: No. The baby may vomit if there's more milk there than they can cope with but if there's no vomit you wouldn't know."

So she was saying the pH there doesn't help us with whether or not there was already milk in the stomach when she did this feed. That was her evidence. And that's where we got to.

So end of that issue on the face of it. No. No. The issue was seized upon by Dr Evans and then Dr Bohin when she came to give evidence, both of them saying now that low pH meant acid and therefore no milk in the stomach. I don't know if you recall all of this, ladies and gentlemen.

So what they did is to then, you might say, switch the line of attack. We're no longer talking about a stomach would have been empty because you wouldn't feed without emptying it, that has gone, that failed. We now have: ah, no, no, the stomach was empty because we have a pH of 4, which means it's acid which means there was nothing in there at the 2 o'clock feed and therefore anything excess has been forced in after that rather than this on top of old milk. That isn't of course something that had been dealt with in the reports but they're entitled to react to the evidence as it develops, we recognise that.

But they would not accept that a pH of 4 meant the stomach might have milk there and Dr Bohin was particularly vigorous in her resistance to that. When she was asked about it by the prosecution, looking at this, she said:

"Yes, that's acidic. We know that [Nurse E] -- she told us, that was her signature."

Sorry. She was asked:

"Question: That's [Nurse E]?"

"Answer: She told us that's her signature."

"Question: Is that pH value of 4, so an acidic value, consistent with there being a large amount of undigested milk in the stomach?"

"Answer: No it's not. Milk is neutral and gastric contents are acid. A pH of 4 is very acidic. If there was undigested milk or milk in the stomach that would buffer or neutralise the pH and you'd expect the pH to be higher than that."

You see that, ladies and gentlemen? In other words she was saying, ah, no, a pH of 4, we know that's an empty stomach, or pretty much empty, because pH 4 is acid and if there was milk in there we'd have a higher pH. So looking at the pH we can still say the tummy is empty.

And in cross-examination with me she absolutely would not accept that a pH of 4 meant there could be milk there in any significant amount, rubbishing the evidence of [Nurse E], as it happens, who had said the opposite in answer to his Lordship's questions and mine. But that isn't the first time she brushed aside what experienced nurses have to say when it didn't fit in with the impression or her version or how she wanted to describe what happened.

You'll recall I reminded you yesterday what she had to say about the dark bile aspirates with [Baby C], clearly recorded as that, to which she said, no, the nurses could be wrong, it could be blood. Remember? They got it wrong. She wasn't even there. We say this nurse did not get that wrong.

However, there is a way of looking at this. We know, whatever Dr Bohin says, that she is not right. She's not right and what she has said is literally blown out of the water by the evidence in the case of [Baby P], which demonstrates there can be significant quantities of milk and the pH can still be acidic. I'm going to come to that in a moment, but just so we are absolutely clear, the point is this: we had started with it being said that at the time we're looking at that stomach must have been empty and therefore a projectile vomit has to be that more milk was forced in after that 45ml. [Nurse E] ended that by saying it doesn't follow the tummy was empty. Fine. We then switch to saying, from the experts: yes, it was empty because it's pH 4, that's acid, there couldn't have been milk in when she out that 45ml in. Right? That's where we got to with the experts: disregard what the [Nurse E] says, it would have been empty.

No. If we put up tile 24 from the [Baby P] sequence, which is his fluid chart. You'll probably remember it when we see it, ladies and gentlemen. Just enlarge the bottom part. Let your eyes zero in on this, ladies and gentlemen. Remember what we're dealing with here now.

I'm going to ask you to look at this, keeping in mind Dr Bohin's expert evidence and her stalwart refusal to agree with my suggestions to her that you could get an acid pH and still have a substantial body of milk in the stomach. If we look here we can see, can't we, at 20.00, with Sophie Ellis actually aspirating, there's 14ml of milk and a pH of 3, so actually more acidic than we have with [Baby G] and 14ml of milk and that's at 20.00.

At 24.00, the pH 3 continues. At 24.00 we've got 20ml and a pH of 3. There we are. It's there. That's it. That's the purpose of a trial. Dr Bohin is wrong. Wrong. Yet she would not accept it in cross-examination. And the reason she wouldn't is because she

didn't want to say something, we say, or give ground on something that could possibly assist the defence. It's for reasons like that, on the evidence, that we say that, yes, whilst Dr Evans quite blatantly, in our submission, is working up explanations to maintain the allegations based on the theory of guilt rather than the facts, we say Dr Bohin is quite ready to do the same sort of thing, albeit with a great deal more subtlety.

But tile 24 on the [Baby P] sequence does not in any way sit with what she was saying with what we have on the tile that we're looking at, tile 75, with [Baby G]. That was tile 24, [Baby P], ladies and gentlemen.

Go back to [Baby G]. We can take that down, please. It shows us, putting aside the comment I make upon the experts, and you'll assess that -- that's comment from the defence, you'll assess that on the evidence -- but it also shows there can be a substantial volume of undigested milk with an acid pH. So on any view when [Nurse E] came to do the feed at 2 o'clock there is no basis for saying that [Baby G]'s tummy was empty and the only thing in it at that point onwards was 45ml unless somebody forced more in. That's why this undermines that allegation. Whichever version we go with as to the basis for saying it was empty, they both fail.

But at the same time when we're looking at [Baby G] we have an issue with infection which we say is significant because you will want to wonder what condition she was in generally and the CPR for [Baby G] rose. I'll give you the figures and I'll give you the tiles but we don't need to put them all up, but I'll say it in case anyone should wish to reference this.

At 3.59 am, so an hour and a half maybe after this, an hour and three-quarters, [Baby G]'s CRP was 1; that's at tile 89. At 2.18 pm, that day, it had gone up to 28. So we're going into the realm where that is an inflammation that is consistent with an infection. By 22.53, so shortly before 11 o'clock that same day, it was up to 106. And by 9 September, referred to in her discharge letter from Arrowe Park, page 7304, it was up to 218. That is a huge CRP reading. The 1 at tile 89. The 8 is at tile 186. 106 is at tile 350. And then we had the discharge letter at page 7304 with a CRP of 218. Those are facts, ladies and gentlemen, and we say, however we try to talk about the exact start of a 48-hour period, that is a powerful coincidence, isn't it?

Really, however we look at this, the vomit started after a period of infection. When I was talking about 24 to 48 hours, Dr Bohin was quick to point out it's not absolutely precise. Well, we agree, bit of give and take. So if we go with what Dr Bohin

said, this vomit coincides with the start of a period of infection or certainly high CRP readings, which is consistent with infection, and we say the facts speak for themselves. That's not a coincidence.

But over and above that, let's come back to the point of Ms Letby. That deals with the experts and what we say are the flaws in the mechanism. But what about the allegation she did something? If we look at the timings, ladies and gentlemen, and the prosecution have used the charts on the neonatal review to see if there's a possibility the timings could be made to fit so that Ms Letby could have done something she shouldn't do. It's incredibly speculative. You have heard what we have to say about the neonatal review and the extent to which you can use those documents.

[Nurse E] said feeding could take from 10 to 25 minutes, fairly approximate. Ailsa Simpson, who was the senior nurse on duty that night, added this, which you may want to keep in mind generally, that the computerised prescription entries don't establish -- do establish a precise time, that the nurse checking it can do that at a computer on the nursing station. So the point being Ailsa Simpson, who says she was at the nursing station with Lucy Letby in the period just leading up to the vomit and at the time of the vomit, could well have been there dealing with prescriptions. She says she was there. She's a prosecution witness. Let's not lose sight of actually the narrative here: I was there with Lucy Letby for minutes, some time before the vomit and then we both went.

Her evidence on 2 December, however much games are played with the timings, is that she was at the nursing station for 5 to 10 minutes with Ms Letby before hearing the vomit and the two of them went over. That leaves vanishing amounts of time between when [Nurse E] would have finished the feed and any opportunity. If a feed takes from 10 to 25 minutes, and if Ailsa Simpson's at the nursing station for 5 to 10 minutes and if the vomit is round about 2.15, any time around there, there is no opportunity for Ms Letby to have done what is alleged. That is where we get to. That's the point of all of this. There just isn't.

It doesn't really matter how we try to move things round to go to the neonatal review, say, oh look, Ailsa Simpson's doing something a bit later, maybe it all happened at 2.30. That isn't the way this went and that isn't what took place. Even the sequence of events records this at 2.15. We know this is at 2.15.

And however we try to position the time, we know on the evidence of the prosecution's witness that Ms Letby is there maybe up to 10 minutes before this happened. Okay? If we are engaged in

trying to squeeze a possibility of convicting someone by looking for or creating cracks in evidence, I suppose we can always do that, we can always do that. If we're in the business of being sure, we're way away from that here.

When you look through the notes, when you look at the material with this, ladies and gentlemen, you'll see that there is a clear sequence, a feed round about 2 o'clock. [Nurse E], when asked about this, said she would have left, this is on 2 December, maybe at 2.05 or 2.10. The vomit is round about 2.15. And for 5 or 10 minutes beforehand Ms Letby was with Nurse Simpson. And whatever's done about trying to look for gaps, that is Nurse Simpson's recollection. It's a narrative, she knows what happened.

The case advanced, didn't it, as we went along because we moved then on from the mere fact of a vomit and how that happened and whether the tummy was empty to look at other aspects and other allegations made. We say we see this elsewhere. We're told that there was bleeding that [Baby G] experienced, bloodstained secretions and Dewi Evans said we've seen this before with [Baby E]. We haven't seen that before. [Baby G] is not bleeding like [Baby E] in any way.

What we have seen from evidence relating to the period before she went to the Countess of Chester was that she was prone, certainly on several occasions, to some type of bloodstained secretions. We went over that with Dr Bohin, that's clear. And therefore when we're dealing with a bloodstained secretion or fluid at the time of the first intubation, we ask you to keep in mind there's no active bleed seen, this is nothing like [Baby E], bits of blood in secretions, and no concern of any underlying problem.

Well, covering all bases, the prosecution have also gone for abdominal distension now at 6.15, not ones to leave any stone unturned. And perhaps we could put up, please, tile 107, which are Alison Ventress' notes. If we can go to page 2 to home in on what we're looking at. In fact, if we go up a little bit, could we go to the first page to assist everyone? It's my fault, sorry, ladies and gentlemen, racing to the second page. Could we go to the first page, Mr Brearey -- sorry, Mr Murphy -- just so we can be clear? Tile 107.

Alison Ventress was involved in the resuscitative efforts for [Baby G] as you know, ladies and gentlemen. I'm just going to scroll down because it's a particular timing which we're looking at. Could you go down the page, please? This sets out everything that happened. On to the next page if you could. Here we are.

Just to help you, ladies and gentlemen, we've moved on to 6.05 in the morning because there's a prolonged period that the medical staff were dealing with [Baby G] and you may remember Alison Ventress working out what the problem was because the ventilator didn't seem to be working. She actually had to change the ventilator. You may well question, goodness knows, what the effect of all this was when we consider the long-term situation. Cause isn't established from what Dr Stivaros said, but the point is there is a very long period in which [Baby G] was encountering difficulty with breathing.

We can see at 6.05 it says "profound desaturation" and if you keep moving down you'll find an entry:

"Dr Brearey called in urgently. NG aspirated as abdo appeared very large. Around 100ml aspirated."

Can you see that, it's in the centre of the page? That's what I'm looking at. The suggestion is made, well, it's a direct accusation, that that -- and this is something that's come up in the course of evidence as we've gone along: Lucy Letby, something happens, she did it, guilty. This is the mechanism.

The accusation is that that is something she did. In the middle of all this, hours of resuscitative assistance, either something residual from what happened at 2.15 or something that is alleged to have been done as this was ongoing. Realistically, is that really realistic? Well, what did Alison Ventress say? She was clear that this was -- as clear as she could be that this relates to air; okay? That's important because the allegation first of all is it's all to do with forcing milk in, but she said this on 2 December:

"At this point the NGT is aspirated."

And the question was:

"Question: It was aspirated and there was 100ml aspirated."

"Answer: Yes."

"Question: Which, to the best of your recollection, is most probably going to be air because if it was anything other than that you'd have said?"

"Answer: Yes."

I asked her that and she said yes. Okay?

Now, Dr Brearey made his first appearance in the trial at this point. You weren't familiar with him. You perhaps would not have

known where he slotted into everything that's happened on that unit or what a senior position he occupies and how much responsibility he must bear for what happens on his unit. You didn't perhaps have all of that in mind when he began to give his evidence. But he, when dealing with this, said he assumed it was fluid. Assumed it was fluid. We say that is extraordinary. There's no basis for that assumption. No note at the time suggests that.

We say he knows very well the significance of that and we say -- and we challenged him about saying this was fluid. We say this is opening his account in evidence before you, ladies and gentlemen, with a quick shot at Lucy Letby by supporting the excessive milk theory. That's why he just came out with fluid. It's not realistic to claim it was fluid. How on earth, for example, is 100ml of milk going to be there hours after a projectile vomit, with no distension being seen, until about 6.10? Not until then.

You can see the note is right in front of us:

"NG aspirated as abdo appeared very large."

This has been going on for hours. If the abdomen had appeared very large before then we would know. It's not something which was just held back and a note was just made. Large abdomen, aspirate. A large abdomen, it follows, round about this time. The suggestion by Dr Brearey: this could be fluid. Yeah, I bet he made that suggestion. There's no basis for it to be fluid anyway. How would that get there? And Dr Ventress saying, as far as she could think, it's air not fluid and she linked it to the breathing support which had been going on.

You can go through this note if you want, ladies and gentlemen. I asked her about it. I said:

"Question: In any event, when you noticed [Baby G]'s abdomen was large, that struck you as something that could happen by air going into the stomach rather than the lungs?

"Answer: Yes.

"Question: And that's what you thought with your clinical experience at the time?

"Answer: Yes. That was just after she'd had a period of IPPV via the face mask.

"Question: That's right, we see that."

You can see it right there, ladies and gentlemen, about six lines above it:

"Question: And the point is [I asked] it was after that period you noted that her stomach being -- her abdomen distended, didn't you?

"Answer: Yes.

"Question: Is that right?

"Answer: Yes."

Wow. If Dr Brearey's right, it didn't leave much time, did it, for Ms Letby to nip in in the middle of all this treatment and start doing things with milk, which is unsupported, or with air, which couldn't have happened. These are little glimpses sometimes. What he said, we submit, is completely inconsistent with the evidence, but they're more than that, they're little glimpses of a mindset at work here and that was opening his account, we put it, with a nudging of blame, knowing very well which way it's going when he starts talking about fluid, we submit. We challenged his about it being fluid and he was adamant.

If we move on, if we move on we'll see reference to "bloodstained fluid in oropharynx" and the evidence was that there was blood at this point. There'd been trouble getting air in and Dr Ventress had worked her way through the process, including changing the ventilator until she discovered there was a problem with a clot or blood at the end of the ETT. This clot, you can see actually if you look up there, ladies and gentlemen, just after the time 06.10, can you see:

"Thick secretions ++ in mouth. Blood clot at end of ETT"?

Can you see? This is the point when having spotted that, she took it out. [Baby G] then receives or continue -- she receives breathing support, she'd had it at other points, going on and off the ventilator. The ETT is taken out, she is given breathing support, her abdomen at that point, not before, at that point is spotted to be enlarged after the breathing support and there's a clot on the ETT. And that, if you carry on reading, was changed. You can see further down after the 100ml aspirate it says:

"Re-intubated at 06.15 with a size 3.5. Tight fit."

And we moved on from there and actually things improved then. Got to the bottom of it.

We say that speaks for itself, blood clot on the ETT explains this. That's why air isn't getting through and that's what the problem was and that would have interfered with [Baby G] receiving oxygen for quite some time given how long this process was of changing ventilators.

When giving evidence Dr Brearey, we say, did his best to say a blood clot could not have blocked the tube and interfered with airflow. He wouldn't have it. And again we suggest to you that can only be done to raise somehow suggestions or support suggestions that Ms Letby is involved in some way given what we know. Because it's extraordinary that he would not accept that a blood clot could interfere with the flow, or block it, of air. Why on earth wouldn't he? We know it can. And we say the inference to be drawn is that is an accidental error in his evidence.

In cross-examination Alison Ventress agreed that what we have here -- this had interfered with the flow of air and that once the tube with the clot had been removed, the problem was resolved. That was the evidence on 2 December from the doctor dealing with this.

Not only did Alison Ventress accept a blood clot was responsible for blocking this, or the removal of it resolved the problem, but Dr Bohin had agreed that clots like this can stop a ventilator from working when I asked her about an incident on 7 June when [Baby G] had desaturated at Arrowe Park and a clot was found on the end of the ETT. This was the additional page 4282, ladies and gentlemen. It's from when [Baby G] was at Arrowe Park. Dr Bohin said:

"She desaturated because the ventilator was unable to push gas into her lungs because of the clot or secretions, or a mixture of both, at the end of the tube. So if you're not ventilating then you will desaturate."

Some that's a very sudden thing, that's a very sudden event. That's on 13 December. That's her evidence on that.

We say a number of things follow. It appears there would have been a long period with lack of oxygen due to a clot blocking the ETT. That is contrary to maintaining a healthy condition for [Baby G], isn't it? We say that Dr Brearey's attempt to say a blood clot would not have caused the blockage, as he insisted on 12 December, is wrong. We say, more importantly, he must have known that. And we say that what we have here, looking particularly at this extract and the use the prosecution have sought to make of it, is yet again something happening as part of the clinical history with a baby, a patient, on this occasion a clot blocking the ETT, and it being taken out of context and

used to prop up allegations against Ms Letby, which also takes us away, and your focus and everyone's focus away, from the failure to ventilate [Baby G] properly over a period of hours.

We will move next then to several weeks later, to 21 September, 10 am in the morning, count 8. This is the projectile vomiting in the morning. Nurse Letby made a reference to it on her notes and we've got them at tile 48 so I wonder if we can put that up please.

Can we go down to the -- I'll check I've got the right reference. This is [Baby G] sequence 2, sorry, Mr Murphy. That's my fault, sequence 2, tile 48. We're looking at the top left. Here's the note that actually this incident is based upon.

A couple of weeks later, 12.47 the note is, 21 September, by Ms Letby:

"Written for care given from 08.00."

We go through the usual figures:

"[Baby G] appears pale. Temperature 36.4. Hat in situ and well wrapped. NG tube feed (EBM) given at 9 o'clock as [Baby G] asleep and due immunisations. 10.15, x2 large projectile milky vomits. Brief self-resolving apnoea and desaturation to 35% with colour loss. Tube aspirated. 30ml undigested milk discarded. Abdomen distended. Doctors asked to review. Low temperature."

And we move on from there. All right. An allegation you can be sure of: she did this on purpose to kill [Baby G]; yes? You may think, just as a starting point, if that's right, given all that's been said about Ms Letby, what an extraordinary thing to put in your own nursing note, your attempt to murder somebody, particularly when you bear in mind a theme of this prosecution case throughout is that when Ms Letby is doing this, her preference is to get other people to deal with it. Yes? That's one of the hallmarks, do you remember? If she's not there, guilty. If she is there, guilty. If someone else deals with it, guilty. Whatever way round we are, it's guilty. Yes?

This is her putting a note in with the baby she's looking after. Where is the document fraud, the cooking of the notes that's meant to go with this and everything like that? It isn't, is it? We'll come to one issue with temperature in a little bit, but as a starting point it's strange to be so frank if trying to kill a child, particularly for someone who the prosecution say does so many other things to hide their tracks.

Dr Evans and Dr Bohin say, well, it's simple arithmetic, this is similar to 7 September. Dr Evans says air had been forced into

the abdomen, Dr Bohin says: well, it's a projectile vomit and the only projectile vomits are the 7th and the 21st so these are suspect. We say this is an incredibly weak basis.

Can we move to the feeding chart, please, which is at sequence 2, tile 47? These are the feeds that morning. Both Dr Evans and Dr Bohin, when they came and gave evidence, said that this is a simple arithmetic which leads them to believe this is overfeeding. We say it's not arithmetic, it's assumption and guesswork. There's a 45ml feed at 6 am. There's a 40ml feed by Ms Letby at 9 am and 30ml is aspirated from the stomach, we've seen from the notes, after the projectile vomits.

45ml at 6 am, 40ml at 9 am and 30ml from the stomach after the vomits. And what they're saying, ladies and gentlemen, what the experts are saying is no more sophisticated than this: that seems a lot after feeding. That's what lies behind "it's a matter of simple arithmetic". It's certainly simple but there's no arithmetic to this at all. We don't know how much of the 45ml feed at 6 o'clock was still in the stomach. We don't know what quantities were in the vomit. We don't know. So please don't be drawn into thinking there's some arithmetic here that shows an assault has been committed, it's not a simple matter of arithmetic. That doesn't support this.

Dr Evans saying air in the abdominal area supports this. No assessment of the extent, just something Dr Evans has taken from the overall descriptions and worked into his evidence. I just pause here to remind you of something that Professor Arthurs said about [Baby G] and the air in her stomach because he studied a very large number of radiographs from Arrowe Park and the Countess of Chester and, ladies and gentlemen, on 3 February he said that:

"As a general point the abdominal radiographs with [Baby G] demonstrate multiple episodes of small and large bowel dilatation which were treated as presumed sepsis and settled with supportive management."

And he said:

"There are several episodes of acute abdominal distension with bowel dilation on abdominal radiographs, including at Arrowe Park."

He went on to say:

"In my opinion, it's highly unlikely that the mechanism [that's force-feeding with air or milk] accounts for all the episodes of bowel distension in two different hospitals."

In other words, if you have the same thing going on on different occasions at two different hospitals, that underlines this is probably or entirely possibly down to [Baby G]'s condition and how she is, not because of what someone is doing. He is saying this is what we find with [Baby G], whichever hospital she's in.

The suggestion, particularly from Dr Bohin, that what we have on the 7th is similar to the 21st and what we have on the 21st is similar to the 7th, so it's a pattern. Well, it's not, is it? There are obvious differences. There is no evidence of the same force or distribution. We've seen the photographs and descriptions of how dramatic it was on the 7th. That doesn't apply to this occasion. That's not similar. We can't say it's the same amount of milk, we can't quantify it.

The 21st, the one we're looking at now, was brief and there was a relatively swift recovery. The 7th was very different: [Baby G] was unwell and, whatever happened, it went on for a long time. We can't even say the vomits are the same. You can't just say what happened on the 21st is the same as what happened on the 7th, therefore they're both attacks.

Actually, again, ladies and gentlemen, on the 21st, there was some evidence of infection, although not as pronounced, and we heard from Dr Fielding who said a loose green stool was passed 10 minutes after this vomit. In cross-examination he said whether this shows she was unwell depends on the general history of the child but he noted her temperature had dropped to 36.2 about 17 hours before and her CRP on the morning of the 21st was 18 and so it's raised. It's consistent with being a little unwell.

Faced with that, what do the prosecution do when they ask Ms Letby about temperature and Ms Letby says there's a low temperature? She said that could be relevant. And we have an allegation that she had cooked the notes. Remember? Cooking the notes. So let's have a look at this piece of cooking of the notes that applies to Ms Letby to support her defence. It's at tile 46 in this sequence please Mr Murphy.

We can enlarge the lower part so we've just got the temperature in. If we look at the LLs at the bottom, it's possibly the first one, just to the right of the cursor. And if we move up, we can all follow this, ladies and gentlemen, can you see what look like two dots there on the temperature column? Yes?

The prosecution made a lot of the fact that there are two dots at the 09.00 reading, saying in some way you're inventing what you're saying about temperature. We say it's not a good point, is it, because, first of all, other nurses have done the same, twice. Just go along, left of that point. We can see multiple

dots on other occasions. We can see, two columns to the left of where we are, someone's put what look like two dots in there. Go further left, four or five columns. Looks like two dots. Yes?

So if that's right, yet again, we've got Ms Letby being criticised for something that in fact others have done on the very same chart. But even more than that, if she is meant to be cooking the notes to pretend that there's low temperature, look where the dots are. How's that Ms Letby pretending this is low temperature?

If you go back, please, Mr Murphy to the column we were looking at, the 09.00 column where we started. Stay on the temperature, if you would, please, just that first column we looked at with Lucy Letby' name at the bottom of it. That's it. Look where the dots are. If we go up from the LL at the bottom to the right of the cursor there. All right. How is that cooking the books on temperature, on low temperature with this genius nurse? Yeah? It's not. It's in the white. The low temperature comes from entries when you look at it that include entries other people have put in. That's why Dr Fleming agreed with that. That's what Ms Letby is refers to amongst what she deals with later on. It's not a good point, we say respectfully, not being rude to the prosecution. I just mean, evaluating it analytically, as we are meant to, it's not something that only she has done and it doesn't even do what it is alleged to have done.

Thank you, Mr Murphy, we can take that down.

Finally on this particular allegation, Dr Bohin and her assertion that the only projectile vomits were the 7th and the 21st, which is when Ms Letby was on duty. And actually I dealt with this right at the beginning, if you recall when we were looking at the chart. I'd gone through with Dr Bohin the period after the 21st, going into October in fact, when [Baby G] demonstrates a propensity to vomit quite a lot and she made the point: yeah, but those are the only projectile vomits. She said to me when I was suggesting that [Baby G] had become someone who vomited a lot:

"I'm sorry, I don't agree with that because [Baby G] had two episodes of projectile vomiting on 21 September and she had projectile vomiting on 7 September. There were no other episodes recorded of projectile vomiting."

We know she's wrong. On 15 October, and we looked at this on the first day I was speaking to you, ladies and gentlemen, in the nursing notes of Ashleigh Hudson, it's page 7477, but we don't need to put that up, there's reference to projectile vomiting, Lucy Letby not on duty. Dr Bohin is wrong. She just said:

"Well, sorry if I made a mistake. I made a mistake."

Yes, it's that easy making accusations of people in support of an allegation of attempted murder:

"If I made a mistake, I made a mistake."

Just like that. From the prosecution's supposedly independent expert witness. There's rather a lot at stake with just making a mistake, isn't there?

One incident on that morning of 21 September, members of the jury, taken out of context being used to blame Ms Letby.

But that's not the only incident this day, is it? And this takes me to the final count where [Baby G] is concerned and that's the event some time around about 3.30 in the afternoon of 21 September. You know the one I'm going to talk about because you can picture this one a bit easier. We can imagine the scene.

What is Ms Letby meant to have done? What is the allegation? If this -- how is someone to defend themselves against something if things just move around all the time? What is the allegation, that she interfered in some way with the monitor? We know that [Baby G] was left on her own behind a screen without a monitor on. When they opened the case the prosecution said this -- this is the allegation as it began:

"On the second occasion, count 9, in the afternoon, when she was behind a screen, somebody switched off the monitor when [Baby G] collapsed."

We know who somebody is when that's said:

"Somebody switched off the monitor. Dr Gibbs didn't, [Baby G] didn't do it, and she was discovered by Lucy Letby."

There is a common theme running through all these cases, isn't there? That last bit we agree, yeah, there is, the common theme of blaming Ms Letby where other people have or may have made mistakes, that is a common theme.

Due to the frankness of [Nurse B] we now know that the doctors responsible created this situation. We do. We've had her evidence on this. It's not challenged.

John Gibbs and David Harkness. Yet again, we have clear evidence, ladies and gentlemen, in this trial of how something has gone wrong and Ms Letby is blamed. If it hadn't been for the frankness of [Nurse B] maybe we'd just be left with the usual

shield wall of denials when we suggest that others may be responsible.

So what did [Nurse B] say? She had told us, didn't she, that when she heard the case opening she realised the prosecution were wrong to blame Ms Letby for switching off the monitor because there's something she had kept quiet about, but she didn't want to keep quiet about any longer. She knew what had happened, she hadn't given the detail to the police, and when she was interviewed by them in 2018, and I asked her about this, she said:

"At that point [they] would have to ask Drs Gibbs and Harkness to establish what happened."

That's how she had left it at that point. We say it's strange for her to do that and it may illustrate a problem, it may, of nurses and junior doctors not wanting to push the blame on to more senior colleagues or doctors, but to her credit, when it came to the period before giving evidence, she told us what did happen.

Let's look at this. Dr Gibbs and Dr Harkness had struggled to fit a cannula to [Baby G] that afternoon, seven attempts on this baby. We have heard a lot about how stress can lead to desaturation, haven't we, how the events can cause that to happen? Seven attempts across the couple of them.

Dr Gibbs accepted on 14 December that this could be what caused her to desaturate and the bradycardia afterwards. At that point this count is over, ladies and gentlemen, we say to you. It's a matter for you, but that's it once we have that, that their actions, albeit for a clinical purpose, could have caused this to happen. We know handling can do that.

They are both in a hurry, we know why that is, and they rush off -- I'm going to come to [Nurse B]'s evidence -- without telling her, without telling anyone, leaving [Baby G] on her own behind a screen, and leaving the monitor off. That is the evidence and the reasonable conclusions to draw from the evidence. That's what happened, that's what the doctors didn't do, which is why they had to go back and apologise to [Nurse B] that afternoon for leaving without telling her or anyone, for leaving [Baby G] on her own behind a screen, and leaving the monitor off.

She is crystal clear about that. Dr Gibbs was direct on that point. He said:

"If that is what [Nurse B] says, then that is what happened."

So it's no good the prosecution, or anyone, shuffling away from that. She's a witness who's been relied upon in detail throughout and on this her evidence is crystal clear.

We saw how Dr Gibbs dealt with it and accepted what [Nurse B] says. Dr Harkness, what a display that was. Going through what she had said, he just kept saying, "I don't remember I don't remember I don't remember". Maybe he doesn't. Maybe he doesn't remember, ladies and gentlemen. Maybe rushing off and leaving babies behind screens who desaturate without the monitor attached and having to go back and apologise to a nurse is something he doesn't remember. That's one option. Or he did and he doesn't want to say. But neither, you may think, is particularly impressive. He didn't deny it, did he? We have heard what the prosecution say about witnesses who don't deny things, but he certainly didn't want to admit it. Very poor treatment leaving a baby like that after that treatment to desaturate without the monitors on or when she desaturates without the monitors on. I'm not suggesting that they knew that would happen.

A high-risk baby with a difficult cannula fitting and after that they apologised, on the evidence of [Nurse B], which can't, we say, seriously be challenged and isn't. But the point, of course, to borrow from what you heard last week, is you know what I'm going to say, who gets the blame? Who's being charged with attempted murder for this?

Let's turn, ladies and gentlemen, to counts 10 and 11. [Baby H]. [Baby H] was born on 22 September 2015 at 18.22. 34 weeks and 4 days, 2.33 kilograms.

Key events. Not all of them, but key ones are as follows. She didn't receive surfactant until 11.30 on 24 September, so about 41 hours after birth, I think. Yes. A long delay.

By that time chest drain 1 had been inserted and that was inserted by Dr Harkness on 24 September at 10 am, so actually just in advance of that surfactant. A case perhaps of coming too late, wasn't it, because a chest drain had gone in by that point? That was on the morning of 24 September.

Chest drain number 2 is inserted at 3 o'clock in the morning of 25 September, inserted by Dr Ravi Jayaram. Chest drain number 3 was inserted, almost 24 hours later, at 2.15 on the morning of 26 September by Dr John Gibbs. An hour and 7 minutes after the third chest drain was put in, at 3.22 on 26 September [Baby H] experienced a profound desaturation down to 30%. That's count 10. Then the following morning, 00.55, on 27 September, desaturation into the 40s, and that's count 11.

Dewi Evans, in terms of what is the medical explanation for this, it is unexplained, he says. Sandie Bohin, unexplained, although harm is, of course, proposed of some sort, but no medical explanation given.

We have an explanation, don't we, ladies and gentlemen? The defence certainly do. It's a matter for you whether you agree. They were under no burden to prove anything. But we say this is a case where the evidence reveals serial sub-optimal care. Those failings and shortcomings are, we say, clearly linked to problems experienced by [Baby H]. There is no evidence of Ms Letby doing anything wrong at all, but she gets the blame for what happened.

Sub-optimal care. Dr Evans absolutely would not have that there was sub-optimal care. Dr Bohin was more frank, although perhaps sometimes a little slow to be as frank in evidence as she was in her reports, but we were able to take her to them and then we got to frankness. We did have to go to the reports from time to time. But there was significant, we say, sub-optimal care in [Baby H]'s case, both -- in six individual areas but then, when you total this up -- I'll go through it now. About five areas, actually.

First of all -- first -- there was the late delivery of surfactant up to 36 hours post-birth. Late delivery. Dr Bohin agreed that appropriately timed surfactant -- appropriately timed surfactant can reduce the risk of pneumothorax. We know [Baby H] had to have three chest drains eventually. Dr Bohin went on to agree that late provision of surfactant will have made the initial pneumothorax worse. She said that on 24 January.

So we can see, ladies and gentlemen, right away, that sub-optimal care has had a damaging consequence given what happened with the pneumothoraces or the first pneumothorax.

One, late delivery of surfactant up to 36 hours post-birth. Way too late. It should never have been missed.

Second, she accepted, again on 24 January, unacceptable -- page 70 -- unacceptable delay in intubating on the morning of 24 September. That's what she said in her report. In evidence she was a little slow to accept her own opinion but she did eventually say it was a delay.

Third, a butterfly needle inserted after the deterioration whilst on the ventilator at 10.05 on 24 September was left there. You saw that needle coming into [Baby H]'s chest. She agreed, Dr Bohin did, that this is a needle with a sharp tip that can tear delicate lung tissue and it was still there about

an hour and 20 minutes later. In her report she had that leaving needles -- I'm quoting from it because this was put to her in evidence. We did hear this. She said that leaving the needle in the chest is dangerous, and she accepted that in her evidence before you, and that this could have contributed to subsequent pneumothoraces. Dr Bohin agreed this was sub-optimal practice because it's hazardous.

Four, as we go into the evening of 24 September, so this is the evening after the first chest drain had been fitted in the morning by Dr Harkness, [Baby H] continued to experience desaturations and she was struggling against the ventilator. Nothing to do with Nurse Letby. The opinion of Dr Bohin was that it would have helped if [Baby H] had been sedated. I'm not suggesting in itself in any way that is sub-optimal, it's just something else, isn't it, it just keeps coming?

Dr Jayaram attended at about 1.50 am on 25 September and some time passed before he inserted chest drain 2, even though he inserted needles on a couple of occasions first. The opinion of Dr Bohin was that it would have been better to proceed to inserting the second chest drain sooner than actually happened; it should have been done straight after the needle had been inserted.

Now, across those five issues there's a range of how bad it is. Not giving surfactant for 36 hours or thereabouts is bad. We all know that now from this case. That's a huge delay.

Leaving the butterfly needle -- sorry, it's a delay which Dr Bohin linked to damaging consequences, given what happened with the pneumothoraces, so there's a clear link there.

Leaving the butterfly needle inserted is hazardous because it can tear lung tissue and her view in her report was that that could have contributed to subsequent pneumothoraces. Those are bad.

Other matters. The delay in intubating on the 24th was unacceptable. Failure to sedate on its own probably would be unremarkable, but it just adds to the picture. And then delaying with the insertion of the second chest drain again was not the optimal way of proceeding with Dr Jayaram. But we already have undoubted sub-optimal care, taking us up to the period where the allegations then start against Ms Letby.

I said six areas, then said five areas. Of course, the sixth area is what happened to the fitting of that second chest drain and what happened once it was fitted. Do you remember the issues about where it went in, how it moved around, how it wasn't secured properly? That's hotly contested by Dr Jayaram and the

prosecution, so we'll look at that evidence. But before we get to that, ladies and gentlemen, we have a catalogue of sub-optimal practice that made [Baby H]'s position sequentially worse with her desaturation repeatedly and her treatment not being the standard it should have been. And it's that positioning of the second chest drain and the failure to secure it adequately that we say takes the sub-optimal up to six or even seven items on the evidence. It makes it unrealistic and unfair, really, putting the emphasis on the fact that [Baby H] improved at Arrowe Park after she was moved there. Not surprising, is it, a tertiary centre like that? Of course she improved there. And that list about babies that improve when they leave the Countess of Chester. There's a very good many reasons why, and we say they are not to do with Ms Letby, and this is a clear example of how things could only have got better once she was removed from the Countess of Chester.

I'm going to start, if I may, before we break, ladies and gentlemen, just to identify what we'll deal with. This is event 1 at 3.20 am on 26 September 2015. Just to remind you, this is the first event. This happens about an hour and a number of minutes after the third chest drain had been fitted. You can imagine what the strain of that must have been on this little baby.

No cause is identified by the experts, although the prosecution -- the prosecution, not the experts, have sought to make use of what [Baby H]'s father said in his statement to the police in May 2020, if you remember, about mottling running out of skin towards her fingertips. That was read to you in January. They've taken that and endeavoured to put this under their list of discolouration. It doesn't match any description of air embolus, whatever her fingers were doing, and you know that if it possibly could, there's two people who would have been the first people to get there and tell you about it -- yeah? -- or suggest it. One of them is called Dr Evans and the other is called Dr Bohin.

They would have seized on that enthusiastically, and not undermining the seriousness of the incident that [Baby H] was involved in, there is nothing remarkable about that discolouration from any other witness recorded at that time. That has been an absolute non-issue in this case until the prosecution just spot something in a witness statement that was read about colour. Bang, in the list, "that's discolouration". There's loads of discolouration on the unit. It's an utterly irrelevant one. That's why it's important to look at those lists with a great deal of caution, ladies and gentlemen.

Perhaps before I go into any further detail there, that might be an appropriate point to stop.

MR JUSTICE GOSS: Certainly. Right, we'll break off for lunch. Could you be ready to start at no later than 2.05? That's just an hour and 5 minutes.

(1.00 pm)

(The short adjournment)

(2.04 pm)

MR MYERS: Ladies and gentlemen, it occurred to me as I was about halfway through my sandwich that we're about halfway through the period in which I plan to deal with the submissions on behalf of Ms Letby and it's concentrated material and it's hard to concentrate on and we, and everyone in court, are grateful to you for focusing upon it. It's hard and the detail keeps accumulating as we go along, I appreciate that.

But it is necessary to look at the detail because it matters, actually, particularly where so much is based upon circumstantial evidence and supposed, alleged similarities and generalities, but we do appreciate it and I hope you understand why it is necessary to look at the detail this way. We are grateful to you for focusing upon it. It's concentrated and it can be very hot, at least I find it very hot. So we'll see how we get on.

We were looking at the first of the [Baby H] events and that's at 3.20 on the morning of 26 February 2015. No cause proposed by the experts, and of course we don't have to find an explanation, but we do suggest, on all the factors which we have with [Baby H], that by this time there was a build-up of so much that had happened to her and, we also say, possibly the effect of a badly placed chest drain, which was the second one, that this may well have contributed to the collapse that she had. There must be, we say, a cumulative impact on [Baby H] for everything that's happened.

You'll recall at least one, if not more, of the nurses saying something even like a nappy change or a heel prick or just handling can cause one of the babies to desaturate. Well, goodness, [Baby H] had been through an awful lot more than that by the time we come towards 3.15 on 26 September. She had just had a third chest drain -- just, about an hour beforehand -- a third chest drain inserted. That is very unusual. It must be a huge stress on a baby.

When Alison Ventress gave evidence on 19 January, I did ask her about this and I began by saying to her:

"In fact, if we look at the days leading up to the event at about 3.20 on 26 September, there's a good deal more than just suction, nappy change and blood tests that have happened, isn't there?"

And she agreed and we went through it. There had been multiple desaturations -- this is a period not involving any allegation against Ms Letby -- multiple desaturations, including in the hours leading up to this event, some of them profound, suffering for prolonged periods of time with pneumothorax or tension pneumothorax. She'd had three chest drains inserted and Dr Ventress agreed that one would be quite an event for a baby; three would put a lot of pressure on a baby. The third one went in little more than an hour before this happened and, of course, butterfly needles on various occasions.

And this is where we got to in conclusion with Dr Ventress. I asked her:

"Question: So although we have no trigger identified at the note -- we understand why you put that there --

"Answer: Yes.

"Question: -- the reality is she had been through an awful lot of medical activity, hadn't she?

"Answer: Yes.

"Question: And it is quite conceivable that a baby under that much intervention, having gone through what she had gone through, could suffer quite a significant collapse?

"Answer: Yes.

"Question: So cumulatively, over 3 days, it could be said that that did contribute to what happened?

"Answer: Yes. And babies do desaturate for reasons that we don't identify."

So that's just the cumulative effect of everything.

Then we come to consider the effect or possible effect of the second chest drain, the Dr Jayaram chest drain. We say this is another aspect of care, of poor care, and it may well be significant, remembering there's no burden on the defence to explain.

In closing their case, the prosecution apologised to you, really, on our behalf for the time spent asking questions about

the chest drain. Do you remember? They said it was unfortunate, unfortunate, that we had to have time questioning about the position of the chest drains before we got to the evidence of Owen Arthurs because he saw no problem with the position. Do you remember that's the way our case on this was dismissed before you'd actually heard nit explained to you?

We say the prosecution are wrong to take such a dismissive approach to actually matters of evidence -- we've had a lot of evidence on this -- and we say they are wrong because there is evidence that there were problems with chest drain number 2 and we say they are wrong about what Professor Arthurs actually said if we look at all of his evidence. We'll remind you of some of the other things that he said.

Before we do that, can I just look at what we learned about where a chest drain should go. We know now, we didn't beforehand, a chest drain should go in what's called the fifth intercostal space. You count down the ribs and there it is. I can't count on mine, but there it is, that's the fifth intercostal space. That's why, in their notes, Drs Harkness, Jayaram and Gibbs made reference to that, although you may recall Dr Jayaram got that wrong because he put it through the eighth one. That's the point.

Dr Bohin was clear that the fifth is the right place and it is put in the fifth to avoid other structures inside the chest where there could be a problem if the chest drain makes contact, and that includes the heart and the vagus nerve. And there can be a danger of bradycardia or desaturation if it comes into contact with either. I'll remind you of the piece of evidence relating to that shortly.

But Dr Jayaram didn't put it in the eighth -- sorry, didn't put it in the fifth, he put it in the eighth and that's wrong. We can see the right place, ladies and gentlemen, if we look at the chest drain inserted by Dr Harkness around 10 am on the 24th. That's at radiograph 12658, please, Mr Murphy.

We can see that butterfly needle sticking in there at the top, the bright light at the top. I think I'm right about that, I'll be corrected if I am not. In any event what I'm asking you to look at is the pigtail drain that we can see -- thank you. That's at or around the fifth intercostal space.

We can see where Dr Jayaram put his at tile 75. This is at 4.37 on the 25th. All right? Here we are, tile 75. There it goes. Spot the difference. The guidelines are clear. Dr Bohin accepted that Dr Jayaram's placement of the chest drain was not in accordance with the guidelines. There's two issues with Dr Jayaram's chest drain. One is where it has gone in, which is

round about the eighth intercostal space, and the other is, perhaps in connection, where the tip ends up in the course of all this. You can see where it is right now.

In any event, Dr Bohin accepted that the placement was not in accordance with the guidelines, and even though we say she did seem to make some excuses by saying there was already a drain in that position, therefore justifying what Dr Jayaram had done, she had to backtrack and agree with me when I pointed out that if we look at what Dr Gibbs did when he put the third chest drain in, that didn't seem to be a problem. Can we just look at tile 229 before we come back to tile 75, just jump across to 229, if we could, because this is where Dr Gibbs put his drain at 2.30 on the 26th. There we are. So no need to put it as low down as Dr Jayaram did. You can see the third drain. This is the one that Dr Gibbs had put in.

If you want to check the time -- could we scroll down, Mr Murphy, so we can be reassured as to the time. We can see it at the top, actually. There we are: 26 September, 2.30. And that was when the third drain had gone in. And as we are looking at that, look how the Jayaram drain has moved now, tickling its way or moving on its way, whatever it's doing, inside the cavity there in a way the others don't. All right, thank you.

If we go back to tile 75, please. This is the Jayaram one. Dr Bohin went on to accept that the tip of the chest drain here is not in an optimal position. And on 24 January she was asked about this and agreed it may come into contact with structures like the heart or the vagal nerve and it was sub-optimal and we say that is bad.

But it wasn't just put in the wrong place, it wasn't secured properly. It moves about, ladies and gentlemen. It may be because of how the baby moves or how the baby is handled or maybe because it isn't secured. But if you want to see how it moves, and we watch it, I'm going to go through a series of these radiographs with you -- by all means feel free to make a note, but you may have this already, but I'll give you the reference and the time and the date. So we're going to start here. T75, which is 4.37 on the 25th. 25 September.

Next, 14.53 on the 25th. So tile 137, which is 14.53, 10 hours later. That's where it is there. T137 next. There we are. Can you see? If we could see, Mr Murphy, the timings as we go there, just so we can all be reassured and I can check we've got the right one. Can you see at the bottom, ladies and gentlemen, 25 September, 14.53? You can see how the Jayaram drain has now moved up inside the chest cavity.

Next could we go to tile 12670, which is at 17.25. Sorry, page 12670. It may also be at tile 158, Mr Murphy. There we are. 17.25. Difficult to see, but we can see where it is, but it appears to have moved in some way. It's not sticking in as it was.

If we move forwards to 22.56 that evening, a little before 11 o'clock, we can go to tile 200. It's gone back down again. Can you see that, moving around? The other one isn't moving.

We go next, please, to 2.30 on the 26th at the time Dr Gibbs had fitted his and this is tile 229. Back up again. Then we move forwards a bit to 19.17 the following evening on the 26th. Just carry on, please, the following evening at tile 381. A slight movement across there away --

(2.16 pm)

(No audio feed from court)

(2.17 pm)

MR MYERS: -- they are not moving like that.

Now Professor Arthurs -- and you can see how close that comes to the midline where the heart -- not on this one, but on other ones -- where the heart and the vagus nerve are.

What Professor Arthurs said, bearing in mind the prosecution apologised and said it was unfortunate we questioned him about this, we say his evidence makes little difference to what we have here. In general on this topic -- and we can take this down for a moment, please, Mr Murphy -- in general on this topic it is important, isn't it, to keep in mind how expert evidence applies to the expertise -- the quality applies to the expertise of the expert on that topic and Owen Arthurs on 3 February had said in his report -- he acknowledged he said in his report written before the trial:

"Whether a drain can cause clinical complications, such as episodes of desaturation or bradycardia, is outside my area of expertise and I defer to the neonatologist experts regarding whether [Baby H] suffered more or fewer than expected of those episodes than any other baby".

So first of all, he's not an expert on the effect of the position on the chest drain and he defers to the neonatologists. The view of the expert neonatologists or paediatrician in the case of Dr Evans was set out in the joint report, accepted in evidence by Dr Evans and Sandie Bohin, and it was confirmed, I think by Dr Bohin, that they'd said the apparent mobility of the

chest drain tip may have resulted in complications, including episodes of desaturation and bradycardia.

That's in general. Put in brackets the fact that when asked about this, Dr Bohin said, "Ah yeah, but not on this occasion, to be fair". That's what she said. It doesn't mean we're saying she was being fair but, so you have it, that's what she said, that:

"It can result in complications, including desaturation/bradycardia."

But she qualified that by saying "but not here". But on this point, and with regard to tile 229, please, Mr Murphy, tile 229, which is the position as it was put in by Dr Gibbs -- sorry, the position after Dr Gibbs had put in the third drain and we can see where the thin Dr Jayaram drain is at this point.

On this one, 3 February, Professor Arthurs was asked about this and I asked him:

"Question: When you were asked about this image, Professor Arthurs, what you said about it was, 'It looks like it's touching the heart', about the second chest drain.

"Answer: Yes.

"Question: 'It may be several centimetres away.'. It follows from that that it may be several centimetres away, it may not be several centimetres away; do you agree?

"Answer: Yes.

"Question: This can't tell us precisely how close it is to the surface of the heart or whether it's actually touching?

"Answer: Yes."

So it can't tell us, it could be several centimetres away, it may not be, it follows it could even be touching, ladies and gentlemen, so I suppose in that sense the prosecution were right to say our questioning was unfortunate, insofar as it's unfortunate for them. But that, you may think, is an important part of Professor Arthurs' evidence. And it's not right to seek to dismiss it as if we have wasted everybody's time by dealing with it when we look at it in its entirety.

If you want an opinion outside the hospital, and outside the experts in this case, we can see what Dr Soni was told by the doctor from Arrowe Park Hospital on the morning of the 26th

around 11 am. Could you put up, please, tile 341 please, Mr Murphy. Tile 341.

It's the second point. From Dr Soni, the note by Dr Soni, 11.54, 26 September 2015, speaking to...

"Discussed with Dr Rath, consultant neonatologist at Arrowe Park."

Looking at her condition. But look at the -- if we come down to the second point, please:

"Possible cause for cardiac arrest..."

So this is after event 1 with [Baby H]:

"Possible cause for cardiac arrest could be that a drain is too close to the heart and touching pericardium. Can pull drain out if too far in. Shouldn't be close to midline."

Okay? There it is. Evidence from someone else.

It moves. It's around the area of the midline. That can create problems. You saw the photograph that shows its position barely an hour before this episode.

We can take that down, thank you, Mr Murphy.

That's dealing with its movement inside the chest, but the question also -- we say this is a very badly fitted drain, and we say that on the basis of the evidence, but it wasn't just moving on the inside. We suggest it wasn't in the right place, it moved in the chest in a way that could trigger a brady or a desaturation, and it wasn't secured properly so that's a third problem.

We know it wasn't secured properly because Dr Gibbs had to secure this at 17.45 on the 25th. So it had been fitted late at night and some time during the following day it was secured. We see that in the notes from [Nurse D] and I'd like us to look at those, please, ladies and gentlemen. They're at tile 144. I wonder if we could go to that.

We start here -- we may need to go over the page. Just below that, it's the bottom one, please, thank you. All right. So this is an addendum put in at 20.31, so at the end of her shift, but you can see it deals with events in the afternoon:

"Went up to Cestrian to update mum at 16.00 whilst Dr Harkness carried out [and can we move on, please] a head scan."

Just when you look at this, I would like you to keep in mind what's gone on with the drain and what would be said if Lucy Letby had been on duty and done this note, just what would be made of this. She's nowhere near at this point:

"At 16.21 [Baby H]..."

So she's just left [Baby H], a couple of minutes, 20 minutes before:

"At 16.21 [Baby H] started to desaturate. No air entry heard. ET tube suctioned. Help summoned from colleague. Crash call placed for paediatricians. No secretions obtained on suction. [Baby H] bagged with Neopuff. No colour change on capnograph. Still no air entry so ET tube removed. Doctors arrived. [Baby H] being bagged with Neopuff, spontaneously breathing, 30% oxygen with saturations 100%."

That's quite an incident isn't it? She's re-intubated. We carry on down the page. Just about halfway down, can you see -- halfway down towards the end of one of the lines it says:

"Second chest drain noted to be in a different position and 'holes'..."

And "holes" is in quotes, eight or nine lines up from the bottom:

"Second chest drain noted to be a different position and 'holes' close to chest wall. Further Tegaderm applied and chest drain tubing position altered. Both chest drains bubbling ++ during re-intubation but only occasional movement since. Dr Gibbs used cold light to chest wall as he thought there was a slight re-accumulation. No signs with cold light."

And we know in fact that at this point and after this Dr Gibbs then went on to secure that chest drain because it wasn't secure.

A number of matters from that, just pausing there, as a snapshot of what has gone on 9 or 10 hours before the third drain goes in and [Baby H] desaturates.

First of all, this is unexpected, isn't it? We've heard a lot about how unexpected events indicate someone attacking a child, that's one of the links. Well, this must have been unexpected because she went off and left [Baby H] and this happened. When we come to the chest drain, it's leaking through a hole in the chest, and it was enough in fact to wet and stain the bed, and it had been moving and it was fixed by Dr Gibbs.

Now we've seen how -- where Dr Ventress later that evening had to reposition a chest drain and in passing the prosecution just suddenly put it out there: you interfered with that, you've done that. But this drain was not well secured. Even after this it moved and we have it moving here and this can't be blamed on Ms Letby.

If we carry on, just to the handover:

"Handed over to night staff."

Last line:

"Desaturation at 19.00 to 56%."

This isn't anything that can be blamed on, at this point, Ms Letby. We have a handover and we have a desaturation to 56%. Precisely -- this should be in one of those lists you've been given except it won't fit in there because it goes with [Nurse D], doesn't? It's something there happening at handover and later on we have allegations being put to Ms Letby that she is sabotaging when it comes to her, sabotaging when Dr Ventress had to reposition the drain again later that evening. All connected, we say, with Dr Jayaram's badly fitting and badly positioned chest drain on the evidence, ladies and gentlemen. And all features here which relate or are similar to events later on.

Now, again, pieces of evidence the prosecution have used to try to support this event. The parents had just left, they tell us, with the [Baby H] event. We're coming to Ms Letby. The prosecution have endeavoured to use what [Father of Baby H] said to the police in his statement in May 2020 that was read to you on 18 January.

[Father of Baby H]'s evidence was that he and [Baby H]'s mother had been there until about midnight when they left. Pause a minute. The event with [Baby H] happens hours later, 3.20 in the morning, after a third chest drain has been fitted. So the key event we're dealing with doesn't happen just after the parents have left. And if there is a suggestion that what Alison Ventress was dealing with is what that relates to, could I just put up tile 210, please.

This is the notes from Dr Ventress, just if we look at that, where she had to adjust the second chest drain. These notes were made at 23.50, which means what you see there is being dealt with up to that time when she then makes the record. These problems therefore happen before midnight, as it happens, which certainly, on the agreed evidence, of [Father of Baby H] would be before the parents had left. It becomes terribly approximate, but it's just something which is thrown out there in passing

and, however we look at it, it's unrelated, we say, to what happens at the time of the event we're actually looking at.

So we can take that down Mr Murphy, but what we have, ladies and gentlemen, on the evidence -- on the evidence and you've just been through this review patiently with me for pour which I'm grateful -- but we have evidence of serial sub-optimal care and you'll recall Dr Bohin agreed the positioning of that chest drain ultimately was not optimal.

From the point that surfactant was unjustifiably delayed, or improperly delayed, right up to the failure to insert the second chest drain properly, all of which is perfectly capable of having a very adverse effect. And there's a lot of evidence of that and, put in the balance, what evidence is there of actually Ms Letby doing a single thing wrong during all of that? What is there?

We come to the second event with [Baby H], which is the following night, 27 September at 00.55. We say, again, Ms Letby has no involvement and no opportunity really to be involved in this.

There was a lot of involvement with [Baby H] on the night that we've just looked at, the 25th into the 26th, but that's because she was [Baby H]'s designated nurse, so that's hardly surprising. It's very different picture actually on the second event that's alleged against her, the 26th into the 27th. Could we put up the plan, please, for that evening which is at page 2, thank you, of the neonatal review? So on this evening, the second event, [Baby H] is in nursery 1, designated with Shelley Tomlins. And nursery 2 is where Lucy Letby was based. Obviously nurses, all of them, can move about as required but that's where she was based.

The notes of Shelley Tomlins identify a series of events but can we just start by seeing the last time that we have involvement with [Baby H] by Ms Letby. That's at page 3, line 82. This is the last time we have the blue and yellow together. This is at 22.38. Keep that in mind, 22.38, so some time before the actual alleged event. Thank you.

The event itself is described by Nurse Tomlins in her notes at tiles 436 and 442. I won't go there in fact, but it would appear [Baby H] was with her -- in fact, let's have a look because this may be important given what's been said. Could we go to tile 436, please?

We have a number of events, in fact, that evening. If we just start at the top we've got a note here made at 22.53. Just

looking into the first part of that note, ladies and gentlemen, the first paragraph, you can see it says:

"Around 20.30 [Baby H] had profound desat and brady."

Do you see that? I'm going to remind you the event which is blamed on Ms Letby is at 00.55. But at 20.30 we have profound desat and bradycardia, nothing to do -- nothing alleged to Ms Letby (sic).

If we move on 21.45 in the next entry:

"Desaturation to 40% despite good air and positive entry."

There we are, thank you. Again nothing alleged there against Ms Letby.

On to 00.55, you can see just this at the bottom of this note:

"00.55. Profound desat."

This one is blamed on Ms Letby, we say randomly, although it may be the worst of them all, that's why.

We carry on I think to page 442, tile 442 to carry on with the note, please, thank you. You'll notice it doesn't appear that Miss Tomlin was anywhere other than, from the notes, with [Baby H].

Next:

"03.30. Profound desaturation to 60s."

This isn't part of the case against Ms Letby. It just goes on and on.

So there's a series of them -- thank you, Mr Murphy -- a series of them throughout that evening. We say what happens at 00.55 is plainly part of the course of [Baby H]'s condition. The evidence of Ms Letby being there is very thin and I'm going to come to Matthew Neame because that's really where we seem to get to on this. That's the evidence there of what happened.

Shelley Tomlins appears to have been there on these occasions, so how Ms Letby's meant to have gone in and done anything is difficult to see.

Matthew Neame made two notes for attendances and they were timed 21.15 and 01.30. Ms Letby was asked about this in examination, cross-examination. The prosecution pointed to evidence by Matthew Neame where he'd said that Ms Letby had been present on

both times he had gone there and that he had spoken to her. But, as ever, it is important to look at the full picture and the full extent of the evidence. I asked him about that on 23 January. And he said a number of things that he hadn't said originally.

He said he recalled a number of nurses being present on the second occasion, so this is the -- when he attended at 01.30, which is the time of the -- or about the time of the key event. A number of nurses being present on the second occasion but not the first. He had also told the police in his statement in July 2019 that Ailsa Simpson was there on the second occasion. He was wrong about that, but the point is I brought that out to demonstrate how wrong people can be. He told the police Ailsa Simpson was on duty, she wasn't.

In his statement to the police he never mentioned Shelley Tomlins being there at all, although he knew her and we know she was there throughout, so he put one nurse there who wasn't there, didn't make reference to the designated nurse who was. And he went on to accept that on his first attendance it could have been Shelley Tomlins who told him what had happened, not Lucy Letby.

When Ms Letby was cross-examined about this, what was put to her, and to you listening, was that Matthew Neame said it was her he had spoken to and that is where he began. But when he was questioned later he agreed he put Ailsa Simpson there when she wasn't there, he couldn't remember Shelley Tomlins, though he did know her, but he agreed it could have been Shelley Tomlins who told him what had happened. Doesn't sound like he was really that clear when it came down to the identity of who was doing what.

And on such small things and such fragile recollections, charges of attempted murder, like this one, rest. In the absence of any other evidence showing involvement by Ms Letby and with a baby who had been subjected to the care that [Baby H] had and was already that evening going through a series of desaturations. No cause identified, members of the jury, no mechanism of harm on any of these occasions, multiple failings in care, and no evidence, we say, that comes close to putting Ms Letby in a position of doing anything wrong.

And really, as I said right at the beginning of this, what the submissions are that we make measure them against the evidence. You look for where the evidence is that compellingly shows you, so you can be sure, that she caused the problems for [Baby H].

And whilst we don't have to prove anything, our submission to you is the evidence demonstrates quite the opposite and that

there were very serious failings in care, serial sub-optimal care. That will have destabilised her very badly. And Ms Letby? Nothing.

Ladies and gentlemen, we move now, come now to count 12. And as you know this is a lot of material here. Okay? Count 12 is the allegation in the case of [Baby I], but an allegation that has rolled up within it multiple allegations over quite a period of time. And, as I have done, I will go through these and try to go to the key point that we've been dealing with and what we say about them to assist you.

[Baby I] was born at Liverpool Women's Hospital on 7 August 2015 at 20.47. She was 27 weeks' gestation, so extremely premature, 970 grams in weight. And she remained there until 18 August when she was transferred to the Countess of Chester Hospital.

What I'll do is, rather than simply going through and summarising the events, we'll look at the summary of each one as we come to it so we can keep focussed as we go along.

But some preliminary points about [Baby I], ladies and gentlemen. [Baby I] was very small and she was a fairly fragile neonate throughout her life. Very preterm, very poorly. Capable, it seems, of deteriorating from almost nothing. And I say that because we have, for example, the evidence from Nicola Simmons, a nurse from Liverpool Women's Hospital, who dealt with [Baby I] on 6 September after her transfer there. This was read to you.

I pick this because this is something describing [Baby I] before any point that anything is being alleged about Ms Letby. If I pick something that said how much trouble she was having in the middle of the episodes we're looking at, no doubt it could be said, "That's what's being done to her". So this is before then.

She said:

"[Baby I] had a profound bradycardia upon positioning. This in itself is not uncommon for a small sick baby upon repositioning. For a tiny baby like [Baby I], just moving her from one incubator to another, as we had to, may have triggered a desaturation and a bradycardia. The movement upset could have been created by as little as moving her arm so we can get access for a line insertion."

Okay? So let's get real. We're dealing with an incredibly fragile neonate. We're dealing with somebody, a baby, who was very unstable. She required an enormous amount of support.

We went through and have looked at and considered various aspects of her. She had regular desaturations, some very

serious, and needing a significant degree of support. One feature of [Baby I] was she had regular abdominal distension, which was marked, and it could persist even after treatment and support. I don't expect you, ladies and gentlemen, to be able to remember the massive number of statements that have been read to you in the course of this case, but when we were dealing with [Baby I], we had a lot of statements read as well as evidence given, and so many people spoke, the nurses spoke about [Baby I] always having a big tummy, a tummy that would distend, numerous investigations. That includes statements, ladies and gentlemen, from [Nurse C], [Nurse A], David Harkness, Laura Eagles, who said [Baby I] always had a big tummy, Shelley Tomlins, Chris Booth, who spoke of numerous investigations into a distended abdomen.

And Sandie Bohin agreed that throughout [Baby I]'s notes there were problems that were consistent and which recurred, including desaturations, abdominal distension on a variety of occasions and mottling.

She was regularly described with veins over her abdomen, in particular sometimes over her body. And these things matter if we're trying to find a stable starting point to start judging or assessing events where Ms Letby is said to have done things that reveal themselves in the way [Baby I] presents. But outside those allegations, this is how she could present: she regularly required breathing support and she's often described in the statements, ladies and gentlemen, as mottled.

The statement of Shelley Tomlins. There's a description:

"Like corned beef, purplish-white, blotchy. Some babies look like that all the time and for some it can be a sign they are unwell. "

Gosh. Imagine that being given as a description for one of the events Ms Letby is blamed for, or even imagine Ms Letby being on duty when that's a description that's given, then she would be blamed for it, wouldn't she, we suggest.

There were regular concerns about NEC and infection and breathing problems, so really serious problems. And all of that, ladies and gentlemen, is combined with and, we say, associated with a continual and worsening failure to gain weight, something that Dr Bohin largely regarded as irrelevant to what we were dealing with, but when we went through this with Dr Elizabeth Newby on 1 February, we saw that [Baby I] started her life somewhere around the 50th centile, which is acceptable, in the middle of where everyone is. By 25 August, so before any allegations, she'd dropped to somewhere between the 9th and the 25th. And by the 22nd she was down to the 9th. And by 20

October, she was on the point 4 centile, which is the lowest there is.

We say her ability to withstand problems that she could have experienced quite naturally as a cause of her condition would have reduced and reduced over time.

All right. Let's have a look at some of the dates that arise.

The first date, ladies and gentlemen, we go to is 23 August. It's not one of the dates of the events, but you're probably familiar with the significance of this now. It's not in your sequence of events, but it's an event where there was abdominal distension identified, and identified by the experts in this case, Drs Evans, Bohin and Marnerides, to such a degree that they identify it as a harm or an event that is consistent with harm. Okay? This is one of those events like [Baby C] on 12 June.

In other words, we say, you can be very confident that if Ms Letby had been on duty on that day she would be facing trial on this along with the other charges but she isn't on duty then, so she isn't being prosecuted for it.

A harm event according to the experts -- and this is right from the start of the events we're looking at and it tells us three things. It tells us, first of all, how readily the experts will claim events are suspect, and to some extent that's what they're here for, they're to look for it (sic), I suppose to that extent it's very important they're there doing it, but they're certainly ready to identify them even where they're not.

It shows that events that are put before you rely heavily upon the presence of Ms Letby. Otherwise why isn't this there? But also, and importantly, it shows -- and please keep this in mind, ladies and gentlemen -- this is something that happened on 23 August, which is actually a sad, but natural, part of [Baby I]'s condition if we work on the basis there isn't really harm that was done here, the experts have got that wrong. This means, this level of distension, and this level of concern, is actually a natural part of her condition.

So all the time when we go on to people alleging air down the NGT or other dates on the basis of abdominal distension, we have hard proof the experts can be completely wrong about that and you should have little confidence in it.

Not everyone is going to want to hear that, ladies and gentlemen. Okay? Not everyone's going to react to that in the same way. You decide that. But if you're looking for a guide as to whether you can rely on the experts' ability to safely

identify where harm was done from the state of [Baby I]'s abdomen, they can't. They got it wrong. And if Ms Letby had been a duty this would be something else to deal with but it isn't because she wasn't.

Dr Marnerides, when questioned about this on 30 March by me, agreed that having identified 23 August as a harm event and where air forced into [Baby I]'s abdomen, that was where his consideration of what follows began. In other words, that kind of cast the die. Having seen that, having decided that, he then began to look at what followed with that in mind. You can see the dangers of that. Then, as he begins to factor in the views, do you remember, of the clinicians, that includes views by Drs Evans and Bohin.

That's not the only event, ladies and gentlemen, with [Baby I] where there is serious deterioration that cannot possibly be blamed upon Ms Letby. The next is on the 5th and 6 September. I'll deal with this briefly because it's not on our indictment but, please, just keep it in mind. We have an eighteen-hour period on the 5th and 6 September where [Baby I] deteriorated suddenly and dramatically from being a well baby at 9.35 am on the 5th, according to Dr Neame -- 5 September a well baby at 9 am. Carried on until about 9 in the evening when there was a desaturation to 60%, bradycardia requiring oxygen. Then, as the hours go, by more desaturation, abdominal distension, mottling, into the next day, and she was transferred to Arrowe Park at 15.00, which is then actually where we pick up with that section of the statement that I read to you at the beginning from Nurse Simmons about how [Baby I] could desaturate literally by moving an arm. Okay?

That is serious. We're told it was down to infection, but it shows how quickly she could desaturate, how quickly she could become seriously unwell, so it is no good, we say, starting from a position that a witness can come along at the beginning of any one of the half-dozen dates we're going to look at now and say [Baby I] was doing brilliantly. [Baby I] was not doing brilliantly. She wasn't doing well and her capacity to deteriorate dramatically and suddenly is marked.

The first event, 30 September 2015. This involves a feed at 4 o'clock in the afternoon, 16.00, followed by vomit and desaturation and bradycardia at 16.30. And then a little later, at 19.30, apnoea, desaturation, bradycardia, she was given a Neopuff and air was aspirated. Across this period Dr Evans says this is air down the NGT and Dr Bohin says the same.

We had quite some time -- I'm going to ask Mr Murphy to put up tiles 61 and 62, one goes into the next. We had some time talking -- Ms Letby being questioned about whether a review had

really happened at 15.00 that afternoon. Okay? This is that one. It's difficult sometimes to keep track, but if your minds go back to those questions -- can we just scroll down? It's towards the bottom of the page. Pull out for a moment. This is at 13.36. And if we go to the following page it starts 13.36 and then we have a note now:

"19.31. Reviewed by doctors at 15.00 as [Baby I] appeared mottled in colour with distended abdomen, prominent veins."

All of which we now know, ladies and gentlemen, keep in mind, are characteristic of [Baby I] by this point. Point 1.

And amongst various things -- do you remember I said they never actually asked Dr Hunt whether she attended or not, the prosecution, but one thing they said was there was no review at 15.00, there was no conversation with the mother about that, the only conversation was in the morning, and we have a note and the number of ways they say it is false and that is one of them. This is 25 May and the prosecution said to Ms Letby she was lying about a fictional review at 15.00. All right? So focus on that, 15.00 with [Baby I]. You'll remember Ms Letby had been talking about [Baby I]'s mother at some point and they were saying this whole thing is made up.

And to support that the prosecution refer to a statement from [Mother of Baby I] that they said contradicted this and that there was no meeting at 15.00 with the doctors or anything like that. All right? That's the issue. I'm just picking this as one small thing before we look at the events.

The agreed evidence of [Mother of Baby I], [Baby I]'s mother, had been read to you. She wrote a couple of statements that were read. Let's actually see what was said. We've been through weeks with it being left this is a lie, there was no review at 15.00, nothing like this happened. The agreed evidence of [Mother of Baby I] -- there were two statements read on 25 January to you. The extract I'm going to refer to in the first one said:

"I was just changing [Baby I]'s nappy prior to leaving for the day when a nurse called Lucy (at the time I didn't know her name but I now know it to be Letby) came on duty. It would have been around 3 pm. Lucy came over and said that she thought [Baby I]'s stomach looked swollen, to which I agreed, but [Baby I] appeared okay in herself."

She goes on to describe the hospital calling later on.

That's the first statement from her, talking about something involving Lucy and 3 pm, and Lucy saying [Baby I]'s stomach appeared swollen. But if we go on to the second

statement -- remember, it's being said the whole thing about 3 pm is just fabrication:

"On this day [she said, talking about this day] it would have been around 12 noon to 12.30, I would only be away for 30 minutes. The first time I recall seeing Lucy that day was around 3 pm, 15.00, when I was changing [Baby I]'s nappy. Lucy walked in and went and stood by the window. She would have been stood approximately 6 feet away from where I was stood with [Baby I]. I remember Lucy looking over and saying, 'I have noticed her belly is distended today, I'll go and get the doctor to come down and check her'. I remember agreeing with her and thinking her stomach did look veiny and swollen."

Lies apparently:

"I was still with [Baby I] when a female doctor came and checked [Baby I] over. She checked [Baby I]'s stomach and said it seemed soft to touch but they'd keep an eye on her. Due to her not showing any concern I left shortly after 3 pm. I have no recollection of seeing any particular member of staff that day apart from Lucy."

Now we have spent a lot of time, before the defence have had the opportunity to stand up and address you on behalf of Ms Letby, with Ms Letby being hauled over the coals about a fictional review at 15.00 and being told that's a reference to [Mother of Baby I]'s statement and how this doesn't dovetail with it all and how she's made it up and she's lying. Well, we have just had a look there at the agreed evidence that you weren't taken to a the time those things were being said, which has [Mother of Baby I] describing what we have here. That's what happened.

If she got that wrong, that's a good guess by Ms Letby at the time she made those notes. Well, it's not, is it? That's what happened. My word, we spent a lot of time with the prosecution trying to show, oh you're lying, you're making stuff up. It happened. [Mother of Baby I]'s mum (sic) remembers it and she talks about it in a statement which wasn't read to you.

Naming doctors: oh, you've not named the doctors. Plausible deniability. Murder. Really? They don't always name doctors. If we look at the tile from the [Baby C] sequence. Tile 112, please, Mr Murphy. This is a tile -- a note at 16.19 by Nurse Williams. If we look in here we'll find -- there we are, second line down:

"After discussion with Registrar Ogden on ward..."

I've got the wrong one, I apologise. I am actually looking for tile -- [Baby M], sorry. [Baby M], tile 148. A cross-reference, ladies and gentlemen.

Mary Griffith, 9 April 2016, fifth line up. It starts, ladies and gentlemen:

"Next feed the aspirate was 1.5ml and bile-stained. Shown to reg and baby put nil by mouth. Nasogastric tube on free drainage", and so we go on.

Sorry about the mix-up, I went in the wrong direction. This is where we are going.

I'm having to deal with these things because these are accusations that are thrown out in the course of cross-examination and, for all we know, and I don't know what you think, you may have thought, "Yes, that's compelling, she's not given the name of the registrar, that's really bad". You may have thought that, you may not. I don't ask, I'm not entitled to know, but I have to deal with that possibility.

So many things are thrown at her that others do that, unless you apply a presumption of guilt, simply do not go to prove what they're said to prove. So a little time before we actually get to the events, just dealing with two of the things that were thrown out there: that she'd made up a review at 15.00, with [Baby I]'s mum there and a doctor. She didn't. It's in the statement of [Mother of Baby I]. And that she sticks down entries without doctors' names because that is to do with hiding what is going on and that isn't what happens, it happens elsewhere. You'll probably find other examples.

So 16.00, ladies and gentlemen, the first event. We can take that down, please. It happens at 4 o'clock, during the day. There goes the night-time theory at this point, remember, about night-time and it being quiet? That one went fairly early on in the case.

Vomit, desaturation and bradycardia, like others in this case. Coming in the course of this. But we say nothing in itself suspicious. Lucy Letby calls for the doctors, calls for them in good time, plenty of opportunity to stabilise, and that's what happens. There we go, 4 pm.

In fact at the time there were various concerns as to her health. Dr Harkness said there was some concern as to NEC. Owen Arthurs said on the radiographs there's an indication of NEC. We're not required to say what it was, we may not be able to. What we're looking at is: is this something which makes us sure

that harm had been done to [Baby I]? And not at all, we say. Sadly, this is what happened and would happen.

The later event at 1930 took place at handover as Nurse Butterworth came in. We ask, or raise, the question in passing: what is it Ms Letby's meant to have done? We know the allegation is she forces air in. That's the allegation, she forces air in, because air was taken out.

Right. Bernadette Butterworth told us about the use of Neopuff. The facts of these sometimes come back as you begin to go into them. You may recall this one because this is the one where [Baby I]'s tummy expands as the Neopuff was used on her.

And Nurse Butterworth told us about the use of Neopuff and that even over a short period that could make the abdomen inflate as you watched and she described that graphically and explained how that happened and how they needed to Neopuff [Baby I] and it was only after that that the abdomen extended and the air was aspirated. And we can see her note at tile 94 of the first [Baby I] sequence. That was it I think. Tile 94, sequence 1:

"During handover [Baby I]'s abdo had become more distended and hard, she had become apnoeic and bradycardic and sats had dropped. IPPV given and, despite a good seal with Neopuff, there was still no chest movement. Aspirated NGT: air +++."

And in her evidence she described [Baby I]'s abdomen getting more inflated as they used the Neopuff and she said this about it when questioned. She was asked by me:

"When handed over..."

I asked her about the handover. She said:

"When we handed over we were having handover she would have become the desats and bradycardia that would have happened. We then would have gone in to give the Neopuff [as read]."

Although I put it the other way round:

"We started the Neopuff and obviously we are putting, like, air into her tummy and sometimes the tummy can increase if you are Neopuffing and become hard. Sometimes that can push up the diaphragm if the tummy is that full of air."

Just listen to this ladies and gentlemen if you would kindly. And you are. But how important is that:

"Answer: If you're Neopuffing it becomes hard and sometimes that can push up the diaphragm if the tummy is that full of air.

"Question: That's helpful. That's what I wanted to ask if I may say. That's the order in which it took place?

"Answer: Yes, it would have. Whether she desatted first or bradycardic, those two things would have happened first.

"Question: But as for the abdomen becoming more distended, was that something you could actually see happening as the Neopuffing was taking place?

"Answer: Yes, I think I could.

"Question: And that's why you then asked Lucy Letby to get the air out by aspirating?

"Answer: By aspirating.

"Question: And you recall that some air and some milk came out at that point?

"Answer: Yes."

Crucial evidence we say, ladies and gentlemen, as it happens, that breathing support can cause abdominal distension in a baby who was prone to that as it happens. And here with nothing more than a Neopuff. And that is something that can be applied across this case where you find it appropriate to do so. But that's it actually happening there and then.

We'll turn to event 2, ladies and gentlemen, with [Baby I], and we'll start upon this and then at an appropriate point may we stop, my Lord? This is one which we could say is one of the factually vivid allegations, isn't it? Something we've looked at and probably can envisage, ladies and gentlemen, and this is the deterioration at about 3.20 in nursery 2 when Ashleigh Hudson had been caring for [Baby I]. It's the one at the door, what could Ms Letby see or not see, that one.

The harm alleged from the experts or by the experts, from Dewi Evans, is air down the NGT and air embolus. Dr Bohin, air down the NGT, maybe, not too sure, and air embolus. Okay?

Just at this point in time, ladies and gentlemen, just putting together everything that was happening, this is event 2 at 3.20 on 13 October. We'll then come to event 3, which is on the morning of the 14th. And then actually, when we went to the evidence, deterioration continues, stops a bit, then on the 14th it goes into the 15th and [Baby I] became unwell, Ms Letby isn't charged with anything then, and she ends up having to be transferred to Arrowe Park on the afternoon of the 15th, at that

point with suspected NEC. But no one's suggesting that accounts for anything at the beginning of this. I'm just saying that's how it went. Not even that, by the way, if it was suspected, if it was NEC, can be blamed on Ms Letby.

We say to some extent, whatever's happened, this series of allegations can't, events 2 and 3 -- well, if you start at one end, yes, maybe you say, there we are, Ms Letby must have done something. If you start at the other end, on the 15th when she had to go to hospital and she deteriorated overnight and nothing was alleged against her over that, the night of the 14th into the 15th, well, maybe that shows what was going on and it all building up to that. It depends on which way you look at it to some extent.

If we look at the whole picture we say there is a bit of artificiality in sub-dividing it, really, into three bits. Event 2, when it started, that's Lucy Letby. Event 3, as it was ongoing on the morning of the 14th, that's Lucy Letby. At the end of it, as we go into the 14th into the 15th and [Baby I] becomes unwell and goes to the hospital elsewhere, that's just left. We say that's the key to it: she was very unwell and that's where we ended up.

One of the topics which has, at points, perhaps been difficult to define how it applies is the question of experience and staffing, something the defence have identified, and there's no doubt there were clear staffing pressures over this period when the hospital was taking on more babies and babies with higher needs. We've had that from many practitioners.

One of the issues, we say, is that when that happens inexperienced people may be put in positions where more experience is required and things like monitoring may not happen as they should be done.

When we come to what was happening with [Baby I] and antibiotics at this point, we say we do actually have a very clear example of the wrong approach to monitoring going on. Whether that then feeds into what happens is a matter for you, but I'm going to identify it because we're not saying these things without evidence in support of them. We say it can't be disregarded. Ashleigh Hudson was the designated nurse for [Baby I] on this night. And Ms Letby says, well, she was quite inexperienced to be looking after [Baby I], who needed close monitoring to look for any changes -- and we know in these babies the changes can be rapid and they can be subtle.

Ms Letby explained that Ashleigh Hudson wasn't monitoring [Baby I] as she should have been because she was on antibiotics and the monitoring wasn't being done properly and she was criticised

severely for that as if it was something without any basis. It was dismissed, but in fact the evidence of Dr Newby on 1 February was that a baby on antibiotics should be monitored for heart rate and respirations, not because everyone's bored and they've got nothing else to do, but because if that's the condition of the baby, it's serious: they're on antibiotics, watch them. Watch them.

We left that with a suggestion, it seemed, that the antibiotics had been stopped 48 hours before the incident anyway. That seemed to be a suggestion that we stayed at. That's not right, that's wrong.

[Baby I] was on antibiotics up to right up to the time of this. There should have been monitoring. I'll just quickly run through the tiles that show this. Can we have at look them from the sequence 2, Mr Murphy, tile 11.

So we've got 12 October -- and don't forget, ladies and gentlemen, the event we're looking at is at about 3.20 on the 13th. So 12 October, there we are. Antibiotics at 7 in the morning.

Tile 21, please. Later on that day, 4.20 on the 12th, antibiotics.

Tile 40, please. Antibiotics literally hours before the collapse.

So they weren't stopped well beforehand: she's on antibiotics over this period. This isn't good. She's having to receive medication, she's meant to be monitored. We can see where the monitoring of heart rate and respiration stops if we look at tile 14. So we've got this going on right up to the time shortly before this collapse and on tile 14 you can see there where respiration and heart rate cease to be monitored. You can see they cease to be monitored from about 9 pm on the 10th. This is wrong. Simply it's wrong. Whatever else this takes us, this is wrong. We have had the evidence from Dr Newby: on antibiotics they should be monitored for heart rate and respiration. Antibiotics had not been stopped 48 hours before the events, they are going on right the way up to it, she's not being monitored properly.

That means, doesn't it, that as it happens, though again, you can miss this when you blink, vital signs in this sense were not being monitored in the hours before the collapse, so we don't actually know -- we have heard lots about how, oh, they were stable, their obs were good, all that sort of thing. We can't really say that here because we don't have it and we should have.

Could I stop there, please?

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

(3.09 pm)

(A short break)

(3.20 pm)

MR MYERS: Ashleigh Hudson had been away from nursery 2 for, what, maybe 15 minutes, something like that, having asked one of her colleagues to keep an eye on [Baby I]. She wasn't sure whether it was Lucy Letby or Caroline Oakley.

When she comes back, no one is in the nursery, but she walks over to the nursery, and she seems to go there with Ms Letby, or a point comes when she is in the room and Ms Letby is in the doorway, not in the room. It's a small room, ladies and gentlemen. [Baby I]'s cot is feet away. Ashleigh had her back to [Baby I] -- she had come in with the milk and it seems actually she hadn't looked at her.

There was certainly enough light for Ashleigh to read the name on the bottle, check the serial number, and draw milk into a syringe. And Ms Letby described standing at the door and she looked across and she said she remarked that [Baby I] looked pale or a bit pale, and Ashleigh who hadn't looked, really, until they turned the lights on saw that and they see how badly [Baby I] is doing. And she's gasping intermittently, so the apnoea alarm hasn't sounded, and we take it from there. That's it.

You'll look at the points here and the evidence closely. It comes from Nurse Hudson: she hadn't looked at [Baby I]. Her attention was on the milk, although feeding wasn't for hours away, which is a strange feature, actually. If you care to look you will see she is on feeds intermittently and there wasn't a feed due for some time, but that's the situation.

Ashleigh Hudson embarked on a lighting reconstruction 5 years after the event. She went back to the scene with the police and photographs were taken. Evidence that we say is entirely manufactured -- I don't mean that in a pejorative or a negative sense, unwittingly, but it's being made for a purpose, isn't it, as part of this investigation?

Nurse Hudson and the police came up with a room so dark you would be able to tell nothing about the baby even if you were monitoring him. That's so dark, actually, when you look at that

photograph, it would be hard to even put the milk into the bottle, measure it out, read what's there, but those are the photos that were taken and Nurse Hudson picked the very darkest one. We looked at that. Remembering back 5 years.

Well, the evidence of Nicola Dennison, who gave evidence on the [Baby J] count -- and we'll talk about that probably tomorrow -- talked about how the nurseries are arranged so you can see the children that you are looking after. Babies who present the greatest concern were placed, by comparison with nursery 4, in nurseries 2 and 3, and nursery 2 is where [Baby I] was. And that's illuminated by light from the door and the window and it is easier to see. We say that Nicola Dennison's evidence creates quite a different impression from that of that Ashleigh Hudson and her photo selection with the police 5 years later. But it is consistent with what you might expect, because it's fairly pointless having nurseries like these if you can't actually see the babies by looking into them.

When she was asked questions Ms Letby answered at one point:

"I had more experience so I know what I was looking for."

Then she said, "or looking at", and the prosecution seized on that, and the fact that she did what might be described as a double fault at that point, questioned what she'd just said.

In fact, if we just strip that down to the basis of what was said, ladies and gentlemen, it's the type of issue pre-eminently for you to assess, isn't it? Do the words make a difference? Someone who is experienced, we say, knows what they're looking for. You may recall the point at which this happened, the ninth day of evidence, the fifth day of cross-examination, at a point where, we say, Ms Letby was very tired and was finding it increasingly difficult to concentrate. You may remember that session as we went along it. And it was in those circumstances that she said this.

I don't really make excuses because on her behalf we say to you there's no real distinction between "what I was looking for" and "what I was looking at". It's a kind of point that came out of it because of the way it was seized on and that's as far as that goes.

There's a very big window, isn't there, right next to nursery 2, set in the wall and right next to the nursing station, literally looking into where that cot is. In addition to being an opportunity for light to enter the room, even if it's on dim, it also gives anyone on the outside an opportunity to look in. And you may think that's a very odd place for someone to commit an

offence of attempted murder in those circumstances like that, even if they were minded to, which we say Ms Letby wasn't.

But however dim it is, it is unrealistic to suggest it's so dark in that nursery that it's impossible to see what one of the babies looks like. It's the type of suggestion which is attractive set against the allegation and the suspicions in this case, but it's not very realistic, we say, if you consider the situation and what was meant to be done there.

But that type of area isn't a matter for expert evidence, certainly not a matter for what I say or anyone else says about it. Where you come to on that is entirely within your province because this is the sort of thing you can weigh up well, ladies and gentlemen, together considering the evidence.

What about the mechanisms in this situation that are alleged to have been used? Dr Evans, in his first few reports -- we looked at this with him -- suggested air had been forced down the NGT. There is a problem here with the air down the NGT theory, which became apparent in the period before the trial when the experts identified there was no NGT. So option number 1, which they had gone with, air down the NGT, sort of fell apart at that point to begin with.

In fact what Dr Bohin went for was this:

"Starting with air down the NGT, there was a problem because there didn't appear to be an NGT in at the time."

In her report Dr Bohin had said:

"I don't think [Baby I] had an NGT in situ prior to this event."

So that's pretty plain. However, in evidence we got to the point where it appears she was suggesting that maybe the attacker, and you'll remember this, had darted in, carried a spare NGT that they had whipped out, put down, forced in air, and then vanished, carrying it around, a mobile NGT to pop in when required and then take it out.

Given that air embolus is also suggested, we are not told whether the whipping out of the NGT was done at the same time as the air embolus, whether it was done beforehand. You may wonder what on earth is being suggested with an alleged murderer running round switching between modes of attack like this and if that's realistic or does it not rather reflect the determination of the experts to come up with something, anything, that they can work into the available evidence?

All done, by the way, with an open door and people able to look through the large window from the nursing station and into whatever it is that is happening there.

What's the evidence of air embolus? There's precious little, ladies and gentlemen, for air down the NGT because there wasn't one. There wasn't, unless we go with Dr Bohin's whip it out, pop it in there in front of everybody or nobody, or whatever, and have a go and then vanish with it, like you carry it around with you for that purpose.

Air embolus. It seemed to be the basis, when we got down to this with Dr Bohin, was discolouration of the sternum. Remember? She is -- she relied upon that with air, embolus that there was discolouration over the sternum. And we say that Dr Bohin is demonstrably wrong to rely upon that.

[Baby I] underwent protracted CPR after this event and what was seen hours later was bruising. If you look at the notes -- and perhaps just make a reference, ladies and gentlemen, if you care to, to tile 49 of the [Baby I] 2 sequence, the notes of Dr Neame, he makes reference to the CPR and -- although reference to [Baby I] being pale and that there was some mottling, but that's that. No discolouration that stands out.

Lucy Letby's notes from later that day, tile 40, refer to some:

"Bruising evident on the sternum and right side of the chest [query] chest compressions."

Okay? The bruising that Dr Bohin was talking about is what we see recorded in the clinical notes at tile 143. So let's have a look at this. It's from a ward round the next day, 13 October. If we just -- we can see reference to:

"Cardiac arrest overnight [query] compressions."

If we just keep going down and see what's at the top of the next page. Thank you:

"Bruises [bruises] right-hand chest from compressions."

That's it. We looked at this with Dr Bohin. That's it. This isn't discolouration from an air embolus. It is what it says, it's bruising. An air embolus doesn't cause bruising. Doctors are perfectly capable of identifying the difference. This is bruising from chest compressions and this is an attempt by Dr Bohin to use, we say, the available evidence to sustain a theory that is unsustainable. That's it. You won't find discolouration anywhere else, that's what she was referring to near the sternum, that's it.

And part of what we have to be sure about in this case is the mechanism, don't we, that harm was done and we need to look at the basis for that. We submit that there is no clear basis that can sustain what it is that's meant to have happened. Air embolus? No. NGT? No, unless we invent someone using one in a mobile fashion in the most improbable of circumstances.

Event 3, the morning of the following day. Take that down, please, Mr Murphy, thank you.

14 October. At 5 o'clock in the morning, [Baby I] had a distended abdomen with discolouration on the right side and deterioration requiring ventilation and resuscitation. And then again at 7.30, at handover, she desaturated with bradycardia and discolouration. And Ms Letby was her designated nurse, by the way, as we know, on this shift at this time leading up to the handover.

Dr Evans says this is air down the NGT. Dr Bohin, air down the NGT and air embolus. We have air emboluses literally coming in everywhere from the experts from this point on in this case. Nothing happens almost without an air embolus -- well, it does on some of them but it's pretty common now. You'll see when we go along.

The events here consisted, we say, of a mass of evidence where they really blur from one to the next, with the common feature being the presence of Ms Letby. If you actually look at the evidence, and keeping in mind, particularly the allegation that an air embolus -- 05.00, Ms Letby's note which is at tile 40 describes:

"Abdominal distension with prominent veins."

That was a feature. Well, that's not unusual for [Baby I] in this case. Nor is abdominal distension unusual.

Abdominal distension is key to this allegation. Abdominal distension is key to [Baby I]'s condition from the statements that were read, from 23 August, the harm event that isn't, with significant distension. Okay? It's what happens with [Baby I]. That doesn't mean somebody can't have done harm, we know that, but just to say there is an abdominal distension and therefore that raises a likelihood or that you can be sure of harm, no, not in the position we are dealing with.

There was discolouration on the right side of the abdomen, but we say that alone, or even in conjunction with the distension, is no basis for saying an air embolus and distension has nothing to do with an air embolus anyway.

That largely is the evidence there. There's a point about Matthew Neame's notes, 05.55, and it's got in Nurse Letby, that at 05.00 the event happened and she called the doctor. But that's not very probative of anything apart from he got there sometime after he called her (sic), there was a lot to do and then he wrote his notes up.

I do ask you to keep in mind at all times the unpalatable and unhappy allegation, but to measure it against this -- and I said we would: intent to kill, an intent to kill. It's not -- how on earth is it? How's it meant to have been done and why does it not succeed?

Then at around 7.30, further desaturation, bradycardia at handover. Nurse Tomlins was there taking handover, it happened in front of them standing there -- and don't forget there had been care for [Baby I] in the period since the collapse when Dr Neame had attended, I am not suggesting all the time, I'm not suggesting it's physical impossibility for anyone to have done anything. I am not trying to be unrealistic in that way.

But again, it's the power, isn't it, of, as has been said earlier, circumstantial evidence. It all mounts up. We keep on having situations where we don't have Ms Letby doing anything that she shouldn't do. And in front of everybody, a busy time of day, [Baby I] desaturates and becomes bradycardic, which can happen if an arm is moved in the wrong way according to the nurse from the hospital, Liverpool Women's Hospital or Arrowe Park, on the 5th or 6 September.

It's the importance of -- sadly, we are not dealing with, for instance, a 2-year-old toddler in robust good health. This is nothing like it. [Baby I]'s weight has been diminishing, there have been a series of incidents, a large number of which cannot be blamed on Ms Letby, and it gets worse over time as her resources are depleted and so when something goes wrong it gets worse.

Her abdomen on this occasion was large and veiny. All right. Well, maybe if that had never happened before it might be remarkable, but it had and, ladies and gentlemen, we suggest it isn't remarkable.

Discolouration identified, slightly grey and darker than the rest of her body around her abdomen, but certainly nothing to match what is to be expected from air embolus or, let me say, what was to be expected of it at the start of this trial. By this time in the evidence, really, we're going to the point when the experts have jettisoned any principled application of a

theory and you saw it happen when we got to discussions about chickenpox and things like that.

Do you remember Dr Bohin saying it was like chickenpox? (Inaudible) chickenpox, it's like that with air embolus. How does she know that? Where has that come from? That's literally a theory invented in the course of this case for the purpose of sustaining this prosecution because we didn't start with that.

We've been critical of the theory of air embolus. We are also critical of what's said about air down the NGT with such abandon whenever there's an abdominal distension because that's being trotted out to you, ladies and gentlemen, like there's some principled theory it's based upon. Putting aside how unlikely it is for someone to keep on varying methods of attack, what evidence do we have about how it's done? How long it takes? How long does it take? How long does it take to distend an abdomen to a certain length? At what point does the diaphragm get splinted? What other things can happen to the air? How long can it remain there without passing out?

We've got some instances where there's a radiograph at one point and over 12 hours later there's allegations that there's some episode that happens because of it. I think that happens in the case of [Baby P]. The night before there's some distension on a radiograph, the next morning there's all the aspirates during the course of the night, and the next morning you remember Dr Evans saying:

"It just took a dollop more air to take him over the line"

What, from the radiograph from over 12 hours beforehand? It's not just air embolus which is a theory that's been put together for the purpose of, we say, in large part, supporting a prosecution, you think back to any principled description of how air down an NGT is meant to be used. It's trotted out like it's the answer. How? How is it done? How long does it take? How long does the air stay there for? How quickly does it happen?

Because if it would happen quickly, if enough air is put in to splint a diaphragm -- and if it does splint a diaphragm, surely that's going to have an effect very quickly, why don't we have it happening quickly like that, with someone being seen to interfere and the baby then going into arrest or unable to breathe? We don't have it, do we? We just have it as a concept.

Event 4, the 22nd into 23 October, the night that [Baby I] dies. So the 22nd into 23 October, there are two timings to this event, two very similar deteriorations, and that's really significant we say. Because two very similar deteriorations but two different people. Okay? Two different people.

23.57. There's a desaturation and CPR is required with an abdominal X-ray taken at 00.23 which shows some distension. Then 01.06, there is a desaturation and CPR from which, very sadly, [Baby I] did not recover.

Dr Evans says air down the NGT and air embolus. Dr Bohin says air down the NGT and air embolus. This is desperately sad, so much about this case is desperately sad. This is no different. But we start with an event at 23.57, where [Baby I] is being watched over by Ashleigh Hudson, who has been watching over her in the period leading up to her becoming unwell, and that rooting thing and getting upset and not settling and then going into a collapse. She's with her. She sees it as it happens. Nobody has done anything to cause that to happen. It doesn't suggest there's a period she wasn't there: she's been with [Baby I] and it happens as she watches, crying loudly and relentlessly, Ashleigh Hudson isn't sure why.

Then we have a similar event at 01.06 when it seems Ms Letby is there. And the only difference really is the event with Ms Letby comes after what [Baby I] has been through after she'd been with Ashleigh and, of course, the crucial ingredient, Ms Letby is there.

What is she meant to have done, first of all? If we take this event as it's presented from the beginning at 23.57, what? There is absolutely no opportunity and no evidence unless we invent situations that are a million miles from the evidence. This is important because we say the second collapse comes about in really just the same way and starts in the same way, even down to the same sort of crying as there was on the first one when [Baby I] was with Ashleigh. So if we find or agree that Ms Letby is not or might not be responsible for the first -- and we say the evidence, actually, makes it most unlikely that she could be -- then what is the basis for saying she's responsible for something that is so similar that happens again within about an hour or so? Particularly after everything [Baby I] had been through with CPR and a ventilation which starts and then stops. How on earth does that translate into Ms Letby now being responsible for something when this began in the way it did?

At this point [Baby I] was a very poorly baby and I mean before we go into this particular night and it would be nothing but complacent to treat her as anything other than that. This is the point when her weight is down to the 0.4 centile and her system would have been under terrible stress. There's a note by Dr Gibbs, which is in the pages at 4927, that we saw with Dr Gibbs. I wonder if we could just put that up, please. It's down in the bottom -- there we are -- in the distinctive handwriting. We'll be coming back to this in a little bit, but could we just

enlarge the lowest part, please. It's a note made at the review on 9 November.

Can you see just this, a comment here, six lines up:

"Poor response to second resuscitation might have been due to heart being compromised by previous collapses."

It's hard to... Anyway, previous collapses. Do you see that? That's the point. She was very weak by this point. Air down the NGT. What's the basis for that? It seems the experts point to the radiograph at tile 116. Tile 116. In fact, that's a radiograph that was taken -- we don't need to go there -- at 00.23. Okay? We need to keep in mind the timings, ladies and gentlemen, because we have a collapse at 23.57, so 3 minutes to midnight. Twenty-six minutes later, there was a radiograph taken and then another collapse, and the experts rely upon that radiograph to say, "Look, the abdomen's distended".

Somehow, in the course of all of this, it's then said that must be Ms Letby's fault. The abdomen only became distended in the response to that first collapse, as it happens, and that's on the evidence. Ashleigh Hudson was asked about this and about what was in her note at tile 91 of the [Baby I] 4 sequence. Let's have a look at this detail. The detail matters.

Tile 91. Just enlarge the main body, if you would, on the right-hand side, and scroll it down so we can go up the page. This is Ashleigh Hudson. In fact, we need to look at the other page, Mr -- or the top just to see who writes the note, please, just so we've got it. Okay, Ashleigh Hudson, 03.39 on the 23rd. We can move across, please, and now have a look at the top because this is so important. 23.57, [Baby I] is unsettled due to hunger, rooting. She's with Ashleigh Hudson, okay? We can see what happened. We can see the treatment. We see Neopuff is applied. We know about Neopuff from a number of people and, most graphically, today, from what we looked at with Bernadette Butterworth.

We carry on down here. Look at what we have just towards the last couple of lines, and Ashleigh Hudson was asked about this in evidence and agreed with it:

"Prior to ventilation [Baby I] had become more alert and crying Abdo soft [abdo soft!] and non-distended prior to resuscitation."

That's what we're looking for. Right there is the answer to a distended abdomen on the radiograph at about 23 minutes past midnight. It's there in front of us -- doesn't stop this accusation being brought. I suppose that's why we're having a

trial: to look at it. There it is, as Ashleigh Hudson said. She checked at the beginning of this. It's there, it's in the evidence, her abdomen was not distended at 23.57. It became distended during resuscitation. We know why. It's in there. An utterly false basis to say air has been forced into anybody. That is demonstrably wrong with the experts, although they're still ready to support the allegation with this.

And actually, it makes absolutely no sense because you'll remember the medical decision was to take [Baby I] off the ventilator at this time. You may question that, but that's the decision Doctors Gibbs and Chang reached. How could that happen if she's got a diaphragm being splinted at the same time? How could she have been so well, as they thought she was, or capable of coming off it and being allowed to recover if she's in the middle of a "diaphragm being splinted" moment, which she plainly wasn't? But the key detail is there's our answer to distension. It wasn't that she had something that distended her abdomen and caused a collapse, the distended abdomen comes after the (inaudible) due to resuscitation.

All right, that's that. Air embolus, then, next. Air embolus. They don't stop, do they, the prosecution experts? Let's go with a -- that one fails, we'll have a different theory. Air embolus, once, twice. How? Was it done in the middle of resuscitation? We don't know. Was it done after resuscitation when she was with Ms Letby, yeah? That's the implication, isn't it? When she went through exactly the same deterioration, really, that she'd gone through an hour beforehand with Ashleigh Hudson, but in the case of Lucy Letby that would be an air embolus then?

Doctors Bohin and Evans make a lot of the distress by [Baby I] on this occasion and about the cry that Ashleigh described. Well, the cry both times, both times. We've already said to you, ladies and gentlemen, one of the prime things we have to say about this part of the theory about distress. It's not something that was given to us at the start of this case as a sign of an air embolus, it's something that appeared in the course of the [Baby D]'s case, working its way in because she'd been distressed on one of the occasions, although not the one in which she collapsed and died. But it found its way into the theory and we went on from there.

The experts had referred to it, we went to look at it in their reports where they talk about it, but we say that is still something they'd worked into during the course of this, during the course of the events that take place. We see it on -- and if it was something that was a principled element of air embolus, it's something that they would have reached for at the very beginning when we asked them to set it out. They didn't.

And how is this -- is this an air embolus at 23.57 from which there's an extraordinary recovery or is this an air embolus at 01.06 or both times? We just don't know, do we? Pausing there, we do observe this. This is the point. This little scene plays out, if you remember, between Dr Gibbs and Dr Chang with the pros and the cons. Do you remember that, about, "Do we take [Baby I] off the ventilator, do we leave her on the ventilator?" Pros and cons. I was interested in the cons. There was silence from Dr Chang at that part and we didn't get any.

If we look again at that note from the debrief by Dr Gibbs at page 4927, Mr Murphy. Could we go to that page? 4927. Just look in the body of this, ladies and gentlemen. In fairness to Dr Gibbs, he writes this, doesn't he? It's the second or third paragraph down:

"Accept that removing [or something] ETT after first collapse might have not helped."

Right? "Might have not helped." That's a more precise detail of what could have contributed to the overall situation than anything the experts have contributed, we observe, ladies and gentlemen. "Might have not helped". Well, we don't propose to set out how or why what happened happened because we don't have to. I don't say that being belligerent, it's just because we don't because it's not always clear, is it?

Again, really, apart from the card, there I would leave it on [Baby I], apart from items that were thrown out there in the course of cross-examination, documents in an attempt to support what we say is a weak allegation, tragic as it is. One of them included an entry on tile 179. It's to do with changing a timing. It says 1.25 on tile 179. Do you remember this? We were asked, "Look, is that you? You've changed it where it says '1.25, sodium chloride'"; yes? 1.25.

Let's cut straight through it, really. I mean, first of all, we know nurses do change things. Ms Letby -- it becomes a criticism. But if you don't mind me saying this, so what? What does this prove? How does this have anything to do with anything, apart from they've cast around for something where there's been an amendment on a document at a relevant time and reached for it as some kind of vague -- that it's got something to do with the allegation. This all comes after what we're dealing with, not before, not during. What does it have to do with anything? I'm only picking it because it was put there before you and we say it's got nothing to do with anything here. It's the type of thing that's thrown at Ms Letby and at you and at us in the course of the questioning.

Likewise page 3 -- the baby HS. Do you remember the baby HS who was going to Stoke? Ms Letby was looking after HS in nursery 2 and there's the question about, "When did the 10% glucose infusion start? Were you cooking the notes? Were you laying false trails?" What that came down to was an infusion chart at page 34542. Scroll down, please, Mr Murphy. There we are, 34542. Do you remember this, where it looks like a time has been changed or amended to -- from whatever time to 24.00? We see that.

That's kind of thrown out there like, "Ah, look at this, hey", and everybody's like, "Oh yeah". Oh yeah, what? Okay, what is this meant to establish? How is this something done deliberately rather than correcting a mistake? [Baby I]'s collapse -- she'd been in the care of Ashleigh Hudson at 23.57 and we know Lucy Letby comes to help then. So we know where Nurse Letby was at about 24.00. This doesn't change anything.

Now, if a time had been changed that put her some distance away from nursery 1, let's say at 23.50, trying to sort of say, "Look, I was nowhere near, I've changed it to a time before anything happened", okay, there might be some merit in that suggestion. What's the point? What would be the point of changing it to the time when you know, and everyone knows, where you are if it's something that's done deliberately, ladies and gentlemen? What's the point of creating an entry that would -- deliberately, this is, rather than a mistake -- that puts you somewhere after the collapse? Slightly misses the point doesn't it? We don't say there's any point at all. We apologise for dignifying these questions by dealing with them now, but we have to because these are the sort of things that got thrown out as we went along, we say to compensate for the shortcomings in the evidence that actually matters, and you can decide that.

Ladies and gentlemen, I just conclude with the image of the card. We can take that down, Mr Murphy, thank you. [Baby I]'s funeral was on 10 November 2015 and various staff members went to that. Ms Letby couldn't, she was working at the time, we've got the shift pattern. She sent a card and we've seen images of the card that she sent and they were taken at 7.34 on 10 November in a location at the south corner of the Women's and Children's Building and that coincides with them being taken whilst at work.

She says some -- one of the things she does, photographs cards, photographs cards that are nothing to do with this case. And in fact, amongst the images recovered from her phone by the police was that at D29. I wonder if we could just put this up, please, Mr Murphy. Actually, if we go to page 33734, not this one because that is the [Baby I] one. Sorry, I apologise.

Just enlarge this. This is on the same section on the phone: Roger, Tash, someone else, "Congratulations". This is another photo, it's in the same sequence, a photo she took for people she says are friends of hers. Taking a photograph, one of the things she does. People have idiosyncratic things they do, whether it's accumulating paper, the way they use Facebook, the clothes they wear -- I'll pick something that doesn't apply to Ms Letby. People have ways they do things. One of the things she does is photograph cards, photographing a card that's received from the [family of Babies E & F], she photographed a card she sent to the [Baby I] because she couldn't go to the funeral. A number of other staff went. She's photographed a card from some friends of hers, that's actually found in the same exhibits.

There's a particular picture of Nurse Letby that has been pushed to you throughout this case, but I'll leave you this afternoon with a more revealing picture, we say, of what was happening here and that's the evidence of Lucy Beebe or Hunt if you remember. She had been called to give evidence during the [Baby I] counts and she gave evidence of finding Lucy Letby crying. This isn't a misleading impression, she came upon her crying, and what she said -- she describes 27 January. Ms Letby wasn't making a particularly big deal, but she was saying, "Why is it always me? Why is it always me?" We say that she's failing at something that she wanted to do and it's a rare but genuine insight into how things were for her.

I said to Dr Beebe:

"I think you told the police that, looking back, given what was happening, it seemed a pretty normal reaction to you, how upsetting it all was?"

And she said, yes, it's a pretty normal reaction and a glimpse of the person then and how she was feeling then, which is a million miles from the way that she is being portrayed to you now, ladies and gentlemen.

My Lord, I wonder if that's a good point to stop.

MR JUSTICE GOSS: Yes, certainly. If that completes --

MR MYERS: It does.

MR JUSTICE GOSS: -- that section. Thank you very much.

All right, members of the jury, 10.30 tomorrow morning, please. Remember your responsibilities.

(In the absence of the jury)

MR JUSTICE GOSS: I'm very conscious, Mr Myers, that you're focused on your address to the jury. What I shall do is I'll have another look tonight -- I'm sorry to keep sending you revised versions, but I'm just trying to refine it, anticipating -- I don't know whether Mr...

MR MYERS: We will respond, my Lord, this evening to that.

MR JUSTICE GOSS: If you could. I think it'll just be helpful because I anticipate that you are not going to complete your address much before the end of Friday's court sitting day.

MR MYERS: Yes.

MR JUSTICE GOSS: You'll occupy nearly all of Friday?

MR MYERS: It's entirely possible. I'm endeavouring to make sure I complete it within that time because it would be helpful to do that and we anticipate we will do, but it may take a lot of Friday to do that.

MR JUSTICE GOSS: Exactly. Any time after 3 o'clock that you complete that, I'm not going to start a summing-up. That will be helpful, I think. When we get to Friday, I think it would be helpful for you to know and for me to know.

MR MYERS: Yes, and I apologise for the delay.

MR JUSTICE GOSS: No, I've said you've got enough on your mind without worrying about --

MR MYERS: Yes. I should say I am assisted, and ably, but as your Lordship understands, ultimately I bear responsibility, therefore it can't come to your Lordship, notwithstanding the assistance I receive, until I have applied myself to it.

MR JUSTICE GOSS: Any time --

MR MYERS: We shall do that.

MR JUSTICE GOSS: -- before -- well, before we sit tomorrow morning. That will be fine if that's convenient.

Visit?

MR MYERS: Yes, please, my Lord. Thank you.

MR JUSTICE GOSS: I should actually say -- the defendant needn't be present for this -- it's just in relation to the direction, that in response to the prosecution suggestion about witnesses, other than those screened, I'm going to say something about,

"These are witnesses who gave evidence either from other parts of the country or from abroad". I'm not going to put it in the written direction, I'm just going to -- at around that point say "other witnesses' convenience and good reason", no significance whatsoever in relation to that. So that's just allaying the fears of Mr Astbury.

(4.03 pm)

(The court adjourned until 10.30 am on Thursday, 29 June 2023)