

29 June 2023 (Day 139)

Defence Closing Speech Day 4: Babies J, L, M, N, O & P

(10.30 am)

(In the absence of the jury)

Housekeeping

MR JUSTICE GOSS: Mr Myers, the jury will be leaving at 3 o'clock this afternoon. I propose to have a shorter lunch break to try and make up some of the time that will thereby be lost from the normal court day, so we will have a 45-minute lunch break and then we'll just have one session until 3 o'clock.

MR MYERS: Yes. I wonder, my Lord, whether it is possible to consider starting at 10 o'clock tomorrow or whether that would create a problem with anybody. I'd be keen to have the time, if possible, to make sure I can deal with everything I'd like to, to try to make up for the lost time if that creates no inconvenience.

MR JUSTICE GOSS: Right. I'll check whether the jury can do that. Thank you very much.

(In the presence of the jury)

MR JUSTICE GOSS: Just before Mr Myers resumes, some timetabling issues. To accommodate one of you this afternoon we will finish at 3 o'clock, but in order to make up some of the lost time, I hope it won't cause undue inconvenience, we will only have a 45-minute lunch break. Would we be able to sit at 10 o'clock tomorrow morning? Would that cause any undue inconvenience to you? I'm anxious that Mr Myers completes his address tomorrow. 10 o'clock tomorrow? So be it. Thank you very much.

Closing Speech by MR MYERS (continued)

MR MYERS: Good morning, ladies and gentlemen.

[Baby J], count 13. We'll start there today. [Baby J] was born on 31 October 2015, 15.00 hours. She was 32 weeks and 2 days' gestation and she was 1.709 kilograms in weight.

We're looking at events, on this charge, on 27 November 2015 and you'll recall there are two pairs of events. It's the second pair that form the substance of the allegation. The first pair are at about 04.40 and 05.30, when she'd be in the care of Nicola Dennison, and she desaturated to 30 and then 50 -- or possibly 50 and then 30 depending on how we read the notes.

The second pair of desaturations were when she was in the care of Mary Griffith and that was at 6.56 and 7.24. Those were low desaturations associated with clenching of hands and stiff limbs and her eyes deviated to the left, if you recall. So it's the two pairs of events and the allegation relates to the second.

Dr Evans didn't identify a natural process for this, no particular harm mechanism was identified, but no natural process he said. Dr Bohin came to no major conclusion other than these were serious and unexpected deteriorations but she did not identify a natural explanation. So that's the state of the evidence on the experts.

We can start with the picture, ladies and gentlemen, we get of the Countess of Chester when it came to dealing with this situation with [Baby J] from [Mother of Baby J], who was [Baby J]'s mother. You'll remember [Baby J] had two stomas because she had to have it arranged that faeces, that would otherwise have travelled through her gut, could be recycled outside and it was an unusual situation, not the sort of thing that the Countess of Chester neonatal unit would usually deal with.

[Mother of Baby J] gave evidence about how [Baby J] was looked after and, when you bear in mind the prosecution position that Ms Letby is wrong to say this presented particular difficulties, you will want to keep in mind the evidence of [Mother of Baby J], who can be considered to be a fairly neutral witness on this topic.

Because [Baby J] had been looked after at Alder Hey at the time of her surgery and after her birth when it was apparent what problems she was encountering and [Mother of Baby J] was able to draw comparisons between the Countess of Chester and Alder Hey and it did not reflect at all well on the Countess of Chester. She gave evidence on 10 February and she told us about things like this.

She and her husband had to spend time dealing with the stomas when they were at the Countess of Chester in a way they didn't have to at Alder Hey. And the staff at the Countess relied on them to deal with [Baby J]'s day-to-day care when they were there. [Mother of Baby J] felt that at the Countess of Chester her questions were unwelcome in a way that she was unused to after being at Alder Hey. And when I asked her what she meant by that, she said it felt like, on occasions, the staff did not take her or her husband's concerns seriously when they raised them. She said that Alder Hey were extremely professional in the way they approached the stoma procedure. She said that as a contrast, ladies and gentlemen, to how things were done at the Countess of Chester:

"They were organised and everything ran smoothly with the stomas at Alder Hey."

By contrast she said staff at the Countess of Chester did not have the same confidence and ability when it came to the stoma bags. And she agreed with what she told the police in her statement, which was put to her, that:

"In hindsight I don't think the Countess of Chester was properly geared up or prepared for the level of care needed to deal with [Baby J] and her stomas and colostomy bag and recycling of faeces."

That is from [Baby J]'s mother, not just something that Ms Letby is saying.

She added that she didn't think the Countess of Chester had the resources or the expertise or the time to commit to [Baby J]'s needs and it's important -- this relates not just to the post-27 November incident, this is a general impression. When we say that the Countess of Chester was receiving too many babies at too high a level of acuity, we say that on the basis of evidence like this, ladies and gentlemen.

There were issues with weight gain and [Mother of Baby J] told us that weight gain was a problem and she complained about that and her complaints were not taken seriously. There were issues, we say, with infection and [Mother of Baby J] described an incident when she arrived at the hospital to find [Baby J] wrapped in a towel that was covered in faeces and they called a meeting with the consultant. And she talked about another time when she complained about the infection risk that would be created if [Baby J] was being bathed in the way the NNU wanted and she said her concerns were met with what she described as "pushback".

It's a relatively brief account from a mother of one of the children in the case of her experience at the Countess of Chester, but it is a direct contrast between there and a unit at Alder Hey that was able to deal with the complexities of [Baby J]'s condition. So it's no good pointing to the BAPM guidelines and saying: well, here we are, a band 4 can deal with this adequately. Band 4 nurses, as other nurses are, are very hard-working and very flexible. Very. But if the problem is greater than they can deal with, we end up with situations like this.

Dealing with the stoma bags was a medical condition that was unusual for the neonatal unit. Mary Griffith said it was unusual to be dealing with the stomas and she had been there and working there a very long time and she's a very experienced nurse. Even John Gibbs, when he gave evidence on 13 February, confessed it

was a challenge managing [Baby J]'s stomas, which was done mainly by the nurses. And a challenge because they rarely had babies on the unit with a stoma requiring recycling of feeds. It's not clear that the BAPM guidelines are actually talking about that.

As for Nicola Dennison, who is the band 4 nurse who was dealing with [Baby J] on this night, what she said on 14 February was:

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

In fairness to Nurse Dennison, you have it right from her there that this is unusual.

Let's turn to the actual allegations. I dealt with that as background because, first of all, it casts a light on the Countess of Chester neonatal unit and because it also casts a light on the position [Baby J] was in when we look at the collapses she experienced.

With this count, ladies and gentlemen, if it was needed, we now have evidence beyond debate that serious desaturations can come out of nowhere. And we have that because we have those first two at about 4.40 and 05.03 that are not and cannot be blamed on Nurse Letby. We have had months of people saying, yes, neonates can deteriorate suddenly and unexpectedly, and then debating with us or disputing with us in a given case that that is what happened on that occasion. And yet we definitely have it with [Baby J]: a well baby generally, in nursery 4, due to go home and out of nowhere, not something that can be blamed on Ms Letby, she goes and desaturates to 30 and 50, whichever way this goes, and we've seen that on Nurse Dennison's notes. We see it in the records of Dr Verghese, who I will deal with in a moment, and it's recorded on the apnoea and brady chart. It's there.

Dr Verghese suggested that he'd considered whether the first -- whether this first one was a false desaturation. He's not saying it was, it's just something he considered. Extraordinary, really, after months of evidence this is the first time that came up. But we can put that to one side because Nurse Dennison is very experienced and she knows what she's talking about and we've seen other occasions when the nurses have fixed the monitors. This wasn't that problem.

She had just finished feeding [Baby J] at the time, she's very experienced, she described [Baby J] being pale and mottled -- so

this isn't false, this is how she was -- and she required breathing support, which is one of the things Dr Verghese agreed is consistent with a genuine desaturation.

Given the fact she'd been fed on other occasions and handled without false desaturations, this is plainly a real one and nobody thought otherwise, but I deal with that because it came up in passing.

Dr Gibbs said these first two were very significant drops in oxygen. He never regarded them as anything other than genuine. And it is important, ladies and gentlemen, when we look at this that that first serious desaturation around 4.40 happens as Nurse Dennison is looking after her. And it seems to be after she'd finished a feed. It comes out of nowhere and may well have been done to the 30s. Right? That is important in this case, not just on this count when we're looking at what happens with [Baby J], but when we consider the capacity of babies to deteriorate and it's there.

I confirmed with Dr Gibbs and Dr Brearey, on 13 February in the case of Dr Brearey, that these two events were unexpected and unexplained and as unexpected and as unexplained as the later two, and he said they were. Dr Brearey said he could identify no cause for these first two incidents. And you'll realise the reason I'm making a point of that: that is to do with something that has nothing to do with Ms Letby and yet we have very similar incidents, no apparent cause, unexpected and sudden. It happens.

It also means doesn't it, ladies and gentlemen, that we know, whatever the experts go on to say about there being no explanation for the events, that there was something wrong with [Baby J] that morning? We know that as a fact before we come to the events that are blamed on Ms Letby.

The experts give no explanation for the events when Ms Letby was there and that's used to support an allegation of harm. Nobody gives an explanation for the events when Ms Letby isn't being held responsible. You see the symmetry between it. We say the clear unfairness -- and you see the way in which the allegation comes into being once Ms Letby is there. When she's not there the same thing is not an allegation. When she is there it becomes an allegation.

The events at 6.56 and 7.25, ladies and gentlemen. We have the notes of Mary Griffith, who was caring for her. Desaturations down to the 30s and then down to the 70s. We say that whatever caused these, and undoubtedly something was wrong with [Baby J] that morning, Ms Letby did nothing to harm her on the evidence.

There is no evidence of anything that could link to Ms Letby harming her.

Mary Griffith says she was there on the episodes and there is no evidence from her that Lucy Letby was there on either as they happened. She said she was in nursery 2 for the first of this second pair -- this is on 13 February she talked about this -- and was alerted when the alarm went off. She can't remember who else was there, let's not start guessing with the presumption of guilt, she can't remember, and on the 7.24 episode she was actually watching [Baby J] as the deterioration began.

There is no space for these allegations. I don't say that in a defiant way, it's just if we're looking at what we can be sure about, where is it? I asked her about what happened after the first part of this pair at 6.56 and Mary Griffith said:

"Answer: I didn't have many concerns about her [page 37, 13 February]. I was obviously watching her closely but she seemed to have stabilised.

"Question: Right. Did you remain with [Baby J] thereafter or did you leave the nursery for any reason?

"Answer: No, I stayed there because she'd had these dos and she was -- you know could go again and I stopped there until the day staff took over.

"Question: Was there another incident involving --

"Answer: Yes, there was.

"Question: All right. Did you make a note of that incident as well?

"Answer: Yes."

It could not be plainer: she is there watching over [Baby J] because of what happened. That doesn't prevent the allegation from being made, but it undermines it crucially.

She went on to describe the 7.40 incident and how Lucy Letby came into the room together with Caroline Oakley.

We say that in any ordinary situation that would have to leave somebody not guilty. You judge it. That's our submission. But that's it. We spent a lot of time investigating the possibilities of whether Ms Letby had moved from one nursery to another, a lot of hypotheticals going back over 7 years. That is

the evidence from the nurse who was looking after her, consistent with her notes.

The experts didn't identify a cause. They say there isn't a medical cause. This case is about proving harm so you can be sure, ladies and gentlemen, and they don't identify specifically any harm and you can be sure of this, that if either of those two thought they could, they'd have a go at it.

We say it's hardly surprising none is identified because we can see the conditions in which [Baby J] was, we can see how she deteriorated twice in the earlier part of the morning, and then again, maybe a little more dramatically but following on from it, later on. And Ms Letby is in a position where she's charged with this. And keeping in mind the burden of proof, it does look like it's rather being left to her to explain something that she probably wasn't there for, she may well not know about, and the experts can't, and that shouldn't happen. We don't have to provide an explanation.

Dr Bohin regarded infection as very unlikely, although she couldn't rule it out. And we do observe it wouldn't be surprising if there was infection at work here given [Baby J]'s particular condition and what we know about the unit and the stomas.

There's a radiograph, ladies and gentlemen, at tile 226, I won't go there right now, but it's described on the commentary as having:

"Interstitial shadowing consistent with infection."

And you may or may not recall that when Dr Evans gave evidence on 14 February I asked him about blood swabs that had been recovered and the -- they didn't -- the blood swabs didn't identify a relevant bacteria, but a swab taken from the area of skin around the central venous line grew a bacteria called *Klebsiella oxytoca*. Dr Evans agreed that is capable of causing infection in vulnerable infants.

And on 14 February, I asked him about whether one could rule out infection and this is what he said at page 91:

"There are lots of complicated issues with regard to this little baby. We know she had a surgical procedure, she has a stoma in line and she's got a Broviac line, in other words a central line in place, so all of these and she's in a baby unit. So all of these markers place her at some kind of risk. That's why my opinion is quite ambivalent in this particular case. I've heard the evidence from yesterday that local doctors were satisfied that they did rule out infection. From my perspective, 5 years

ago when I did this report, I wasn't so confident in ruling out infection. That's as far as I could go, really."

That's quite a concession from Dr Evans, you may agree, in the context of this case that he wasn't as confident as the treating doctors were in ruling out infection. That's probably as close to a concession as we're ever going to get in case from any of the medical experts. But he accepts that the bacteria recovered from the skin around the central line site was capable of causing infection in vulnerable infants.

Ladies and gentlemen, it doesn't take a great deal of time to deal with the case of [Baby J], and that's not said out of any disrespect to her or to you, but in this case there is such little detail, but the detail that there is is so clear, it's possible to deal with it in a fairly short period of time.

We have events that begin around 4.40, unexpected and serious, coming out of nowhere, and absolutely no basis and no suggestion Ms Letby is responsible for that; it happens with another nurse.

The experts cannot identify harm or a mechanism of harm in circumstances where one of them is ready to accept he cannot rule out infection. This is not attempted murder, we say, but it does go to show how empty the fact of being accused by the prosecution can be because they say this is attempted murder as much as they do everything else and that is what we're dealing with.

[Redacted] Before we come to the break, perhaps we can start the next count, my Lord.

MR JUSTICE GOSS: Certainly.

MR MYERS: If I can just start with count 15, ladies and gentlemen, which is [Baby L]. This is the second, isn't it, of the two insulin counts we're looking at, as they're put? The first is [Baby H] on count 6.

[Baby L], born on 8 April 2016 at 10.13. Twin 1. Gestation, 33 weeks and 2 days. Weight, 1.465 kilograms.

Count 15 is based upon this, ladies and gentlemen: that there was low blood sugar recorded for [Baby L] over a period of about 53 hours; it is Professor Hindmarsh in particular who identified that as the likely period. That period runs from 10 am on 9 April -- or can be said to begin from 10 am on 9 April to 15.00 or thereabouts on the 11th.

A blood sample taken between 12 noon and 15.45, and there's a debate about the time it was taken, on 9 April brought back this

result: insulin, 1,099 picomoles per litre; C-peptide, 264 picomoles per litre. So again, that ratio would indicate, if accurate, that that is artificial insulin, exogenously introduced at the level of 1,099 picomoles per litre.

Before we actually come just to look at the detail of the charge, could I just swing us back into the real world and real life outside the unit at this point. It's easy here to look at everything as if it's happening in absolute isolation.

Real life, as in life outside work, was going on for Ms Letby, and everybody, throughout the whole time on this indictment. I'd like just to return to this, that we have a young woman, she says committed to her profession, everyone at the time took the view committed to her profession, and looking after [Babies L & M] as she looked after dozens or hundreds of babies over this period. Alongside that, she was seeing friends, going on holiday, going out, going to salsa, she had a win on the Grand National. Whatever stereotypes have been planted in your mind, that is not who she was then or how she was living. So we say it does matter to keep in mind, when you're hearing these dreadful allegations and the evidence on which they are brought, the person they are aimed at and what her life was.

And although the allegation is that she was excited or captivated or motivated, interested, in the things which we are dealing with in this case, we say that actually at this time it's very clear what her principal concern was and that would have been the fact she was moving house at this point.

If you look at a couple of the texts from the [Baby L] sequence, the messages, you see what her mind is occupied with. Could we go to tile 48, please? This is Lucy Letby on 8 April, 18.15, to [Nurse E]:

"Unpacking. Stuff everywhere lol. May do extra shift over weekend."

May we move forwards in these to tile 57, please.

Sophie Ellis now:

"How's the house, pal?"

Next tile, please, Lucy Letby:

"Feels a bit weird having a whole house [because she had been living in the accommodation before this] but it's good, thanks, although stuff everywhere as moved in properly on Tuesday and been at work Wednesday, Thursday and today. Doing tomorrow as an extra so I will see you tomorrow night. Won't be such an early

start for you now, back in Chester. Did I hear your grandparents are coming to see you?"

Just pausing there, there are lots of texts that we say, or messages, that have been taken out of the whole run of her messaging and you can decide what they go to show, whether they're taken out of context, whether they prove anything that's significant. But equally, this is the stuff that's on her mind at the time.

Tile 59, please, from, Sophie Ellis to Lucy Letby:

"Yeah, I bet it does. It'll feel more homely once you've sorted everything out. Jeez, 4 long days in a row. Are you okay?"

Remember what we heard about the fact Ms Letby was someone who was prevailed upon to work a lot? We had the agreed evidence of [Nurse A] that it wasn't really that surprising she was there when sick children were there because that's how flexible she was and what she was trained for.

Sophie Ellis:

"I know, yeah, and I don't have to pay for petrol. It's cost me a fortune. Yeah, they are [emojis]. Haven't seen them for a while. What's the unit like?"

These messages, where she's talking about the unit or children, are part of a two-way conversation with other nurses, as you'd expect of someone working in this environment, interspersed, sometimes at length, with things that relate to her life outside the unit. And we can see what must have been a major concern for her at this time.

So ladies and gentlemen, this is what's going on in her life at this point and she is occupied with that and, we say, not with trying to kill -- it sounds awful but this is the allegation -- trying to kill a pair of twins, who, as it happens, she cared for over a period of weeks and did so without any criticism that could be made of her, apart from the events, as we come to them in this trial, of the 9th and 10 April, when we say what was occupying her, as much if not more than anything else, was the move to new house.

Perhaps we can come and look at the detail, my Lord, after a break.

MR JUSTICE GOSS: We can do. You'll then have a slot to occupy about 1 hour and a quarters, because I'm condensing the lunch break and I don't want too long a slot after lunch because it's

a difficult time in any event. So I think it might help, while we are all still fresher, just to do another 10 minutes or so.

MR MYERS: I agree.

When we look now at events with this allegation, ladies and gentlemen, could I ask you, like we had in the case of [Baby H], to get the chart, the blood sugar chart, which is behind divider 6 in jury bundle 1 so you can make reference to it, if you need to, as we go along.

We will look at this at one point just to track the bag changes, but by all means you can refer to it as we go along as a guide.

When we looked yesterday at the case of [Baby H] on count 6, I made some general observations about the insulin counts and the defence's position on them and they apply in just the same way but I am not going to repeat all of them now because I am sure you remember them and they apply across both counts. In particular we urge you not to use these as a shortcut to conviction, which is, we suggest, the way they've been presented. It's a matter for you. Ultimately your approach to the evidence is a matter for you so long as it's within the directions given by his Lordship, but we suggest there is a lot to look at here as there is on other counts and it's important to consider every count separately because there are some very distinct features to different counts on this indictment.

It's not accepted that Ms Letby has committed this offence. It's not accepted that the evidence takes you there without proper consideration and consideration of its shortcomings, and we say they forestall, they cut out guilt, but that's a matter for you.

We say the evidence must do two things, just like we did in the case of [Baby H]. First of all, they must satisfy you, so you are sure, that the sampling and testing has been done properly and accurately. And it must satisfy you, so you are sure, that Ms Letby deliberately introduced insulin with intent to kill.

And you'll remember what I said yesterday, that it's not always going to be possible for someone to explain everything that happened, it's really not, that's why the law and the system works in the way that it does.

Therefore what's crucial isn't to guess or to speculate, but to see if you, if we, are sure that, whatever has happened, Ms Letby has done that with that intent. And if there are things that make you unsure, then we don't have to go further and start trying to guess, what's the alternative, what could have happened, it's whether we are sure about it that matters. Because it may not be possible to say, but that that doesn't

make somebody guilty. You know that, for reasons that are inevitable, because of the processing system, the samples aren't tested, so for that reason we look at the integrity of the process, recognising, as we said frankly yesterday, ladies and gentlemen, that you may well reach the point that you decide: well, whatever happened, we're satisfied with the analysis. But we still ask you just to look at factors that may have a bearing on that since you have to be sure of it. And there are two in the case of [Baby L] that we draw to your attention.

One of them is how the sample was handled and processed, and that is something we looked at in the evidence, if you remember, with the technicians. That's why we looked at it.

And the other matter, rather like in the case of [Baby F], is the condition here of [Baby L] and how consistent that is with what we might expect to have happened for such a high insulin reading.

So as to the handling of the sample, first of, all we know from Dr Anna Milan it should be in the lab at the hospital within half an hour, where it is spun and cooled. That's the guideline. On any view, whether the sample is taken at 12 noon or 15.45, it falls well outside that guideline because, as I'll remind you, it wasn't actually received until some time after 6 pm. On any view.

Now we recognise -- right at the beginning we recognise that, whatever the situation, the evidence, and Dr Milan was clear about this, is if there has been any deterioration in the sample because of delay, that probably would only serve to reduce the level of insulin. So the argument is, there we are, what are you complaining about, defence? It could only be better for you is really what that says.

You will have noticed that the prosecution were anxious to minimise, perhaps naturally, the period of delay in their closing submissions to you, and lest there be any uncertainty as to the way I described this yesterday, the defence say this sample was taken at 12 noon. The prosecution say they put the time nearer to 15.45, which of course reduces the delay.

We know on any event there was a delay because if we just look at the results sheet, which is at tile 190, please. If we look at the top you can see it says received. If we look down, you've got the top row and then the next row where you can see Dr Gibbs' name and then you've got a row below the second line. And in the middle we can see "RECV". Can we see? If we move to the right.

And Emma Lewis, who's the biochemist from the hospital, on 24 February, explained that is "received 18.26". The 8 isn't very clear. That's when it's received; that's page 16, 24 February.

So there's a delay, we know there's a delay, of some sort. The defence say nearer to 6 hours because it was taken at 12 noon. The prosecution preference is it was taken at 15.45, the sample. Therefore they say about a 2.5-hour delay, and we are told it doesn't really matter.

We note the prosecution spent some time dealing with this and when they were talking about it in submissions to you they said this, ladies and gentlemen, in their closing address last week, 19 June:

"We suggest that the audit trail for the blood sample is incontrovertible: it was [Baby L]'s blood which was analysed. After all, who else on the NNU could it have been from?"

To which we say, well, we don't know, although that might have struck you as a thought-provoking comment:

"It was [Baby L]'s blood which was analysed. After all, who else on the NNU could it have been from?"

Well, whatever the concerns of the prosecution, as a matter of fact and record we maintain it is 12 noon when the sample was taken and we maintain that for the following reasons and I will just set them out for you.

First of all, the evidence of their own witness, Dr Anthony Ukoh, on 15 February was that this sample was taken at 12 noon. He's the doctor. That's what he said. His note at the time he did the review out of which the decision to take the sample came -- his note which led to the sample being taken is at tile 101.

Just have a look at this, please. We can see 10.20 hours is when he was doing the review of [Baby L]. It was after this that he took the decision there should be a sample. If we scroll down to the second page it seems to be identified here in the plan. It's got, "For BM checks", blood sugar checks. Okay? "For blood sugar checks."

It's after this -- this is what precipitates the taking of a sample. We just identify it because Dr Ukoh says the sample is at 12, his note is certainly in advance of that. And we also know it was 12 because that was the note he wrote for himself on the back of the results sheet, which is at tile 111, so let's look at that next, please, Mr Murphy.

That's a helpful way of looking at this. Can you see, ladies and gentlemen, it's the same sheet, but you have got the back and front and PTO on it. You've got -- at the top, there we are:

"9 April 2016, hypo screen results, 12 noon."

12 noon, he explained, is a note made as to when the sample was taken. That's his evidence. That's the witness. So we say, straightaway, it's not much use trying to say it's 15.45, this is 12 noon.

The 15.45, in case you're wondering, we will be coming back to this sheet, I apologise for moving around, but let me just explain where 15.45 comes in. If we go to tile 190, please, which is the analysis of results sheet, if we look:

"Entered."

(Pause)

It's in paper, I'm grateful, 18025, but what I'm looking for is here. Can you see where it says, "Entered", ladies and gentlemen? I wanted to confirm this is right, and we've got:

"15.45, 9 April 2016."

Do you see the time there? Thank you, Mr Murphy, the cursor's there.

Emma Lewis, the biochemist, on 24 February, explained it had been said by the prosecution this is when the test was ordered on 19 June. Emma Lewis explained in evidence:

"I believe that is the time when the request was actually made."

In other words, when the request for analysis was made. That doesn't tell us the time the sample was taken, that's just when the request goes in for analysis. It's not a record of the sample being taken. That's why I've explained that. It's a record of when the request is made. So if a sample's been taken and is left lying around for some reason, that's not going to be entered until someone gets round to putting the request in. That's the point. That's why there's been a delay. It's taken at 12 and there was a delay, as Mary Griffith said, in podding it, she said, because of what happened with [Baby M].

We say the delay is lengthier than that. But so we're quite clear, the evidence on that 15.45 from Emma Lewis is that's the time the request is made. It does not follow that's the time the sample is taken.

As for the results sheet which we looked at at 111 -- I'm going to ask to go back to that, please -- it was said that a number of these -- the last two weren't verified until 11 April, so how could this be 9 April? Well, you can see, ladies and gentlemen, from the left-hand side, this is a sheet where material is being entered into it as we go along. Look at the left-hand side, there's dates when different results came in.

Just look at the -- Mr Murphy, the top row, please, on the left-hand side. Can you see how different dates have been entered and different results as you go along on the same piece of paper? It's not all at once. And the results came in, it seems, on three different dates.

And what Dr Ukoh has done is started to put them in or made a record, as we see in the handwritten note at 12 noon on 9 April, and put in the material there. And in fact if we go now to tile 190, you'll see that some of these results did come in on 9 April. If we scroll down a bit, please. There we are. That shows it. Do you see there were actually three dates?

9 April is when the first five come in. 11 April, the next two, and the insulin ones were on the 14th. The reason we know that's the order is because, if we just go to the next page, and this was pretty awful to try and look through, so if you need to look at this, ladies and gentlemen, it is better to go to the exhibit in the paper bundle.

If we scroll down, can you see the first ones: sodium, potassium, bicarb, urea and so on. We have "entered 9 April" there and then "verified 9 April" if you go right of it. Do you see 9 April? The first five are 9 April. Then we come down to cortisol and growth hormone, verified on the 11th. There we are. There's the cortisol and the growth hormone below that, please, Mr Murphy. There we are, verified on the 11th.

Can we scroll down to see what's on the 14th? It's the insulin and the C-pep that came in on the 14th. We did look at this in evidence. So we've got three different dates. So there were results that came in on the 9th and, if we now go back to that result sheet, tile 111, you can see now, we've got in results that did come in on 9 April, looking at the right-hand side, and as it happens the cortisol and the growth hormone were later, on the 11th, and they've been asterisked.

The reason I have spent time with that is there are results coming in on the 9th, for which there would have been a reason to make a note on the 9th. It's not that they all came in later.

So the evidence, ladies and gentlemen, that the sample was taken at 12 noon is clear. 15.45 simply comes from the sheet we

saw -- we can take those down, please, Mr Murphy -- with the date that the request for the analysis was made, combined, I suppose, with Mary Griffith saying that she took the bloods, she doesn't know when, but there was a delay in podding them because of what happened with [Baby M].

It may be that when all is said and done it causes you no concern that a sample that should be frozen or chilled and spun within about half an hour wasn't, we say, for 6 hours, or, even with the prosecution's assessment, at least a couple of hours. And we have acknowledged, we trust reasonably, how the experts have said this would make no difference. But it's been a point of contention. The prosecution have sought to establish it's 15.45, maybe in response to the defence questioning, but we say that there is delay in processing the sample and it's one thing to keep in mind when you come to assess how safe it is to rely upon the results.

The second aspect there is the condition of [Baby L], so perhaps I can deal with this before we take the break. Obviously, there was nothing wrong with him at all at the time. It's a similar situation to that with [Baby H] but even more striking because, apart from the apparently low blood sugar itself, there seems to be absolutely no sign of any adverse effect upon [Baby L], which we say is, as we said in the case of [Baby F], extraordinary given what we are told about the potential effects of high concentrations of insulin.

We ask how is this evidence of poisoning? Dr Gibbs described on 16 February how [Baby L] was, even at the height of this apparently insulin-heavy period, was:

"Lively, pink and appeared to be in good condition."

He was receiving dextrose, we know that, but still:

"Lively, pink and appeared to be in good condition. The low blood sugar was consistent, we believed at the time, with a growth-retarded infant."

There is another, we say, potentially significant anomaly and this isn't just picking things out to try and create issues, this is something which you may accept is directly on the point of the blood glucose, because when the analysis was performed the results brought back a reading of 2.8 for blood glucose, which is relatively healthy. Do you remember that? 2.8. I'm going to deal with the explanation for that and then look at what we have. 2.8, we observe, would be consistent with [Baby L] being fine. We say it would be potentially inconsistent with the type of insulin/C-peptide ratio we have.

Professor Hindmarsh was asked about this by the prosecution. He said the reason that the blood glucose was 2.8 is that this was from a plasma rather than a heel prick. So it's come out of the blood rather than just the usual heel prick which we have. A heel prick would be 10 to 15% lower. I'm going to unravel this in a moment. So a heel prick, which is what we normally get on the blood gas chart, would be about 2.4. Could we put up tile 191, please, Mr Murphy?

This is the analysis of blood glucose from the sample that was taken. Can you see, ladies and gentlemen, "Glucose, 2.8"? That would be we submit, completely -- that doesn't -- that's a relatively healthy reading and we've seen where the readings are.

Professor Hindmarsh said, yes, well, that will be higher, a heel prick would be 10 to 15% lower. So that would be about 2.4, okay? 2.4.

Now this is where we have got the table. From the heel prick, at the time the sample was taken, it should be about 2.4, from what Professor Hindmarsh says, but if we look at the table now -- let's take time to get our eyes in on the table. If we go, first of all -- we'll look at both times, but let's go first of all to about 12 noon, which is when we say the sample was taken, so we're looking at 9 April, 12 noon.

At that time, with 10% glucose, we have a blood sugar reading of 1.6. Do you see that, ladies and gentlemen? So we need to have the chart there: 12 noon, 1.6. So around that time, if the blood was taken there, that should be saying 2.4, not 1.6, because if the blood sample was taken then and it's 2.8, and if we make a 10 to 15% allowance for a heel prick, that would be 2.4. This isn't 2.4. Whatever lies behind this, the readings we're getting are lower than it should have been for what that sample is there.

And even if we look at or about 15.45, which is the bottom of the page, there's no blood gas reading at that point but it's bracketed by 2. At 15.00 you can see it's 1.5; do you see that ladies and gentlemen? If we go over the page to 16.00, it's 1.5 there as well. 15.00 is 1.5, 16.00 is 1.5 at a time when, even if the prosecution are right and the sample was taken at 15.45 and this is the blood glucose from the analysis, it should be 2.4 here. Same thing.

Whenever the sample was taken, making adjustment for the lab reading, it should be 2.4, we say, rather than the lower readings if this is right. But we have far lower readings than that, which is why we say it does raise a question about the

accuracy of the heel pricks for blood sugar readings. It must do because that should be higher.

When Dr Gibbs was questioned by me about the 2.8 on 16 February he said 2.8 would be an acceptable level but he thought he had a way of explaining that. He said the evidence was that since [Baby L] was receiving a relatively high volume of 12.5% glucose at this stage, 2.8 was still abnormally low, so he was saying, 12.5% glucose, too low. Well, you can see, actually, ladies and gentlemen, straightaway if you look at the chart, that he's wrong about that. Whichever time it was taken, [Baby L] was not receiving 12.5% glucose and he didn't receive that until 16.30. So that explanation does not account for a higher blood glucose level than we might expect.

And high-volume infusion via the long line of glucose, which would be more potent, didn't happen until [Dr A] put in the long line some time after 1 am on the 10th, and you can see on the 10th when the long line goes in: 01.30.

Because we cannot conduct our analysis, because Ms Letby says she did not do this, we have to look closely at this to see if we can be sure about it, and I'm endeavouring to do so, ladies and gentlemen, in a way that take account of the fact that, at face value, this analysis appears to be sound. And I may be appearing to select fairly small points to consider with it, I recognise that, but we submit they are still significant potentially. And we do not have an explanation ultimately for why the blood glucose reading on this chart, at the time we've just been looking at, is as low as it is when the analysis was 2.8 and, correcting it for the type of heel pricks we normally get, would bring it to 2.4 or thereabouts. And when we keep that in mind with the fact that [Baby L] appeared to be as well as he was over the whole period that we're looking at here.

My Lord, perhaps that's a point at which we can stop.

MR JUSTICE GOSS: Certainly. We'll have a ten-minute break then, members of the jury.

(In the absence of the jury)

MR JOHNSON: I would never interrupt my learned friend whilst he's speaking, but this is clearly an important point. It may be he's chosen not to deal with this issue, but the explanation given in evidence was the bolus at 15.40.

MR JUSTICE GOSS: Yes, right. At the very bottom of first page of the blood sugar readings. All right.

Thank you.

(12.05 pm)

(A short break)

(12.15 pm)

MR MYERS: My Lord, I should say I'm grateful to Mr Johnson for raising that matter and it is something that I omitted to deal with. What we say is pretty discrete on it, but perhaps I ought to while we are dealing with it now. I will do that.

MR JUSTICE GOSS: It's entirely up to you, Mr Myers. If you don't, I will be pointing out to the jury what the evidence is, which I shall be doing in any event.

MR MYERS: I know your Lordship will, but I'm grateful for the matter having been pointed out. It's something that I should deal with or should have dealt with.

MR JUSTICE GOSS: It's all right, you deal with it.

MR MYERS: I will, thank you.

(In the presence of the jury)

MR MYERS: Ladies and gentlemen, if we still have the table there, there's one matter I omitted to deal with and I'll take the opportunity to deal with it now before I finish with the table.

You'll recall this is something that was identified. At 15.40, can you see, ladies and gentlemen, it says:

"Bolus of 4.3ml 10% dextrose"?

This is at the bottom of the page for 9 April -- sorry, I should have said where we are. If we look on the chart, 9 April, 15.40, bottom of the first page.

There's a dextrose bolus of 10% that was given.

The prosecution made, with Professor Hindmarsh, the observation that that may or does account for the 2.8 blood glucose reading, more dextrose put in, that's why the blood glucose was higher.

It's important I just say the following about that because there's three points we make with regard to that. First of all, straight off, if the sample was taken at 12 noon, that's no explanation, obviously, because a dextrose bolus being given at 15.40 makes no difference. So if, as we say, it's 12 noon the

sample is taken, we have the difference between 2.8 and 1.6, which can't be accounted for.

Were you to find that you were satisfied it was taken at 15.45 or thereabouts, the question then is: what difference does this bolus make? We say the problem actually remains. If we look over the page at the 1.5 at 16.00, that is still too low, whatever's happened, for a reading of 2.8. It's still too low.

Our complaint is with what these figures are, that they are too low across the board, and in any event, if you look at the reading for 15.00, pre-the dextrose bolus, it's 1.5. And if you look at the reading for 16.00 after the dextrose bolus, it's 1.5. It's a little difficult to work out what effect that has had in fact and how those readings work because it remains low on either side of it and lower than it should be. But it's important that I give the position of the defence on that because that's something that was identified in the course of evidence.

Now, the next matter we were going to deal with, ladies and gentlemen, is that of the mechanism of delivery. So do keep the chart out because we'll be looking at it. What we say on this, bearing in mind how you have to be sure as to harm, is that when we come to look at what happens with the dextrose infusion bags -- and we say that on a sensible view Ms Letby simply cannot have interfered with them in the way alleged for this to be sustained against her unless we invent fairly artificial theories that don't reflect realistically what could have happened.

We know from Professor Hindmarsh the abnormal readings -- the first abnormal reading we have is that reading on the first page at 10 o'clock of 1.9. 10.00 hours. Therefore insulin has entered into the system at some point between the reading at midnight of 3.6 and that reading of 1.9.

You know the prosecution case is, well, Ms Letby's done that when she's come on duty maybe around about 9.30 or something like that, but it's within that period and it then continues according to Professor Hindmarsh for about 56 hours.

We know there are a number of bags that are changed throughout the course of this period. I am just going to remind you where we've identified them. The initial bag that was hung was at 12.00 hours on 8 April, so starting at the top, second row down, 12.00 hours on 8 April is bag 1. No one is suggesting there is insulin in that because, of course, what we have are reasonable readings for an infant who has hypoglycaemia, and no one is suggesting anything before midnight, so no insulin in that.

The next bag, there was some uncertainty about this, but we seem to have reached the position that round about midday a second bag did or may have done up. It seems to be, we're agreed, did, round about midday, bag 2, midday on 9 April.

If we go over the page to 16.30, ladies and gentlemen, a third bag, if we are up to three, is hung at about 16.30 and that's the one that was put there by Belinda Williamson, the bag that was put up at the time of [Baby M]'s collapse. And you know the evidence about the bag: she started again with a fresh bag, that's what she would expect to have done.

Next bag, ladies and gentlemen, so bag 4, is 2.30 to 3.00 on 10th April, or between 3.00 and 2.30 to 3.00 is when bag 4 goes in on 10 April.

There's another bag, it's on 11 April, and it's the bottom row where it says, "Started by Caroline Oakley/Samantha O'Brien".

So we're up to about five bags by that time and the period when Professor Hindmarsh is satisfied insulin has gone is at 15.00 hours on the last page, 15.00 on 11 April, which is where his lengthy period comes from, 50 plus hours, in the course of which there are a number of bag changes which Ms Letby is not involved in.

Let's consider now how realistic all of this is against what we have to be sure of or you have to be sure of. In setting the scene for their theory the prosecution began by pointing out how there had been an issue with [Baby L] being hypoglycaemic at the outset and that Ms Letby had made a point of questioning Dr Bhowmik, who was the doctor dealing with [Baby L], about the decision not to follow the hypoglycaemic pathway. You will remember there was an issue there that normally there's something called the hypoglycaemic pathway where they encourage the baby to have feeds, but the position with Dr Bhowmik was to go straight on to IV dextrose first. And the prosecution said this about that point:

"Nurse Davies [who was on duty with Ms Letby] said that the infusion therapy prescription sheet showed that she had checked what was being given to [Baby L], and in challenging Dr Bhowmik and documenting it, we suggest Lucy Letby was setting up an issue for [Baby L] in the sense she had identified an anomaly and had decided to use it as a cover to attack [Baby L]."

In other words, it's that theme that she says something about a child's condition as a kind of cover then for doing something about it. One of the prosecution themes, like talking about clotting issues in the aftermath of [Babies A & B], although we saw how that came about a couple of days ago.

We say the idea that somehow she picked on this and it's connected to cover for an attack with an intent to kill, which is the test, makes -- doesn't follow, doesn't make sense. Because [Baby L] being put on dextrose means that his blood sugars will be monitored closely and they should rise. And he's going to be a focus for observation on blood sugar, isn't he? He's going to be a focus. If Ms Letby is planning to do something with blood sugar, probably the thing -- if someone is planning to do something, you probably wouldn't bring up blood sugar as a focus with the doctors looking at it. You'd steer it away, you wouldn't raise it. They're saying it's done as cover, but given we know there are constant tests and the child is monitored, you're just talking about something that is going to be detected anyway. It doesn't create a cover at all unless you are going to do something truly dramatic and that didn't happen. [Baby L] was a well baby.

So we say, if we apply fair logic to this, in fact by talking about blood sugar or being involved in discussions about it, she's doing the exact opposite of what somebody would do who wanted to secretly interfere with it. This is drawing attention to what would be happening.

The next matter is the suggestion this happened at 9.30 in the morning or round about that time. We say there is a good deal of conjecture involved in that, a good deal of conjecture, too much. It's said by the prosecution: well, Mary Griffith was out of the room and you were on your own. First of all, at that time of the day in the unit, no one's going to be on their own anywhere for very long, we suggest. But just to have an idea of who is where and who is doing what around this period, I am going to ask Mr Murphy to help us with the neonatal review for [Babies L & M] and go, first of all, to page 2.

We can see here, ladies and gentlemen, how the nursery is set out with [Babies L & M] in nursery 1 with Mary Griffith, and Lucy Letby with two babies that she's looking after in there.

As for Mary Griffith's movements, if we go to page 3, this is the time we're looking at, we'll see at lines 34 to 39 where it is the prosecution is saying she's absent. This is where we have, in a way, a gap that is exploited for this round about 9.29 in the sense that -- or a time that's exploited. We have Mary Griffith and Angela McShane. We say that, given all we know, including how prescriptions are entered and the way the computers are used, this may be a precise time for when the entries are made. It isn't precise as to who is exactly where at the given period. It also covers a matter of minutes, but it's imprecise. We are not saying that goes to show the prosecution are wrong, it leaves it possible, doesn't it? It's possible. We

recognise that. It's possible. But it very much leaves open an awful lot.

But in fact it's not only Mary Griffith who is in and about nursery 1 at this time, and remember what Belinda Williamson says about it being "as busy as a bus station" and the time of day this is and the comings and goings. We also have Dr Ukoh working in and around that area. If we look on this page -- let's start with line 33, it's on there.

Where's Dr Ukoh at the beginning of the period we're looking at? With GT, who's in nursery 1 at 9.15. Right? So this is the morning ward round. 9.15.

If we move forwards, please, page 4, line 48, we get to 9.45, so move on half an hour, with TSB still in nursery 1.

Now, someone may say, well, how can you say he's still in, he might have gone. He might have gone, he might have stayed. He's working his way, we're going to see, through the babies in that nursery. He's there at 9.15 with GP, he's there at 9.45 with TSB, and if we look at 10.20, at line 63, please, he's now actually dealing with [Baby L], as we know, because this is the point at which he identifies the need for the blood analysis.

So we have the three babies in that nursery in succession, over the period we are looking at, being dealt with by Dr Ukoh. We don't see him, you can look at the review, dealing with other babies in other nurseries.

We have heard a lot about circumstantial evidence and we say, in a way, this is powerful circumstantial, evidence for the defence, isn't it, because the reasonable inference to be drawn is that the person who is in there, or a person in that nursery over this period, is Dr Ukoh because he's dealing with the babies in there.

So the claim that we can say with some certainty that Lucy Letby is on her own in that nursery is speculation. It certainly doesn't follow from the evidence directly and if we're looking at what might follow indirectly, it's certainly not the only inference to be drawn, although we say it's chosen because it does fit, of course, with the theory of guilt.

Actually, from what we understand, Dr Ukoh is there dealing with a succession of children and people are coming and going. That's 9.30 and what we say about that.

There are other problems, ladies and gentlemen, with the allegation against Ms Letby in this way because, and we'll come to sticky insulin in a little bit, but putting that to one side

for a moment, this involves Ms Letby putting insulin into every bag that is put up, doesn't it, this allegation, unless we have some very, very sticky insulin?

It certainly involves her, we've had the suggestion, nipping over and spiking the bag three times in the middle of everything. And you can weigh up literally how realistic that is: where it comes from, the syringe, visible to people, what if anyone asks what she is doing, what if anyone asks. That is, we say, a contrived and artificial theory designed to get round the problems by the serial bag changes.

You'll remember, ladies and gentlemen, dextrose is kept in nursery 1 so whoever's doing this would have to keep on getting insulin from somewhere and bringing it in. It's kept in a different place, isn't it? To say nothing of the business of somehow managing to add it to a bag that's already hanging. That's the first -- the sheer mechanics of what's being suggested, we submit to you, is unrealistic.

Next we have the likelihood that Belinda Williamson hung a fresh bag at 16.30. We know that Mary Griffith had been preparing a bag, but because of what happened with [Baby M], she stopped. We looked at this in evidence on 16 February. The likelihood is, the proper practice would be that that bag gets thrown out and a fresh dextrose bag is used.

That makes sense, doesn't it, because if a nurse is going to put his or her name to the medication or fluid given they have to be sure it's been made up correctly. We know that, that's proper. So how on earth, if that's happened, do we get insulin going in there?

Third, we say, as we said yesterday, this can't be explained by saying somebody has done a job lot of dextrose bags. Because no doubt that's where the web next goes to. We are going to go through each option and come up against a wall and it finds its way to an alternative suggestion.

Putting aside the lack of evidence of a wholesale quantity of bags having been done in this way, and we know there are about 15 bags of dextrose kept in there, it's commonly used, isn't it? How is Ms Letby going to predict the ones that are going to be used? How? Because these aren't specific to any baby and they're used frequently and it's certainly not the case that other babies have been identified, when people have gone back and looked at this, who appear to have had rogue bags of insulin coming out of this in this nursery or thereabouts, even though dextrose is relatively regularly used.

And the only possible explanation, if this is bags having been done beforehand, because of what we're told is a targeted attack, is you'd have to do the lot. You couldn't just do one or two and hope they were picked. So that can't be that way.

We know Ms Letby isn't there on the 10th or the 11th as this carries on, with at least up to two further bag changes. So where do we get to? We get to sticky insulin. Sticky insulin. A way of sticking the allegation together with sticky insulin.

This applies with giving sets were not changed and the evidence there is mixed. Mary Griffith, when she talked about the bag change that would have taken place at 16.30 on 16 February, seemed to be clear, a giving set would be changed. Belinda Williamson, on 16 February, had no idea if it would or wouldn't. And Ms Letby when she was cross-examined on 5 June said not changed every time, but accepted it could be changed. So it could be changed or it could stay the same, not changed every time.

There's a lot of bag changes over the 56 hours. And we say that to suggest that there is sufficient insulin from any one of them to keep sticking but to keep delivering is unlikely in the extreme. When Professor Hindmarsh was first asked questions about the topic on 24 February, and it was explained to him there was a question about whether or not giving sets were changed, but considering the position of sticky insulin his initial response was a smile and he said, "Yes, that's a tricky one now". "Yes, that's a tricky one now." And then I cross-examined him about that on 24 February and I was asking him whether it would ever run out or do we simply have an inexhaustible supply of sticky insulin for days? I said:

"Question: I'm going to ask, surely that must run out at some point? There can't be an inexhaustible supply of sticky insulin over a period of about a day and a half running through this, can there?"

And we say, with a wry smile, he said:

"Answer: That's correct.

"Question: Right. Is it the case that sticky insulin could be operative over a certain period potentially?

"Answer: I don't think anybody's actually done those kind of studies, to be honest. I think the answer is we simply don't know."

Then at the end of questioning him, we got to this point -- 24 February, page 97:

"Question: If we're working with the question of insulin being added in some way or getting in there in some way, would that be more consistent with it being added to the bags as we go along rather than an ever-diminishing supply of sticky insulin coming off the plastic?"

So which of these two is the more likely for what we have: an ever-diminishing supply of sticky insulin or this having to be spiked? He said:

"Answer: Yes. If you were just relying on the sticky insulin, you would have to probably come back a bit on your infusion rate because you would probably be overdoing it in parts. So yes.

"Question: So sticky insulin may account for some aspect of it but over time it would really require additional insulin being required as we go along to maintain those levels?

"Answer: That is what I would view as correct, yes."

So even if we run with the sticky insulin theory, which is sticky and tricky, Professor Hindmarsh accepted that we would still require additional insulin to maintain those levels. So that theory is weak -- I don't say that critically of Professor Hindmarsh -- but in any event it does not get away from the problem, as he said, that additional insulin is required. And for this allegation, however it is approached, to be sustained, it requires interference, really, we say, with each bag that is hanging. It is impossible to see how that could be done when there are so many bag changes from a random supply of bags and when Ms Letby simply wasn't there to do that. That is why we come back to saying this is a question of being sure, not, can we find a way, working with this and taking a prejudicial view, can we find a way of saying this could be guilt? It's a question of can we be sure. And in other words, are there things here which raise real questions -- we say not just real questions, they make it extremely unlikely unless, as we said yesterday, she has an ability to predict what's going to happen that gets beyond anything that you could expect anybody to have.

There is an amount of paperwork associated with [Babies L & M] and the points we have made generally in this case about paperwork applies in their cases generally and specifically. Ms Letby, you have heard, says that she accumulates paper, it's nothing to do with harm, and we say that is utterly sustainable given there is no direct link between the paper she accumulates and harm that is done. It's not exclusive to that, it doesn't follow any kind of pattern.

However the paperwork strikes you, ladies and gentlemen, we submit it has nothing to do with the intention that is being alleged here, whatever her reason for accumulating it. And whilst we recognise you are bound to want to look at it and weigh it up, we say that that's different from using it to speculate, to fill gaps in any shortcomings of the evidence that we have.

We say the key factor here and what we need to look at closely, given what you have to be sure of and his Lordship's directions, is whether the evidence can make you sure that she has done harm as alleged. We submit that she cannot physically be responsible for what has happened when we look at the whole period over which this has happened, not unless we are going to allow for the unlikelihood of repeated spikings of dextrose bags, maybe even when she wasn't there, which we say, respectfully, is absurd. And we keep in mind what Professor Hindmarsh has said, that even if sticky insulin could account for any of this, there would still have to be, to some degree, insulin added to maintain the levels we are dealing with.

We remind you also how unlikely it is, and illogical, that this is down to somebody trying to do the harm that is alleged with the intention that's alleged. We have this distinction in the figures of insulin between [Baby F] and [Baby L]. This appears to be about a quarter of what happened, in [Baby L]'s case, and that makes no sense at all, from 4,000-plus down to 1,099 picomoles. It's utterly inconsistent, when we look at that, with somebody with a deliberate intention to harm, however this has come about, and we need to -- that's why we ask you to look closely at all the evidence here because, as we have said from the beginning, there's nothing that's a done deal about this at all.

[Baby L], fortunately, was never anything other than a premature baby who did well -- this is in terms of medically -- given his prematurity and low birth weight. And after this period of 2 days when we have this analysis, but for that he was presented as a baby with hypoglycaemia, otherwise unremarkable in that sense, and his clinical course proceeded successfully over the following weeks until he was discharged on 3 May 2016, having been looked after by Ms Letby on various occasions over that period -- 16 April, 17 April, 24 April, 25 April -- and having been on the unit on many more occasions when the twins were there, all of which is utterly inconsistent with somebody who is intending to kill one of these twins by means of a targeted attack or any other way.

We'll look next, ladies and gentlemen, at [Baby M], [Baby L]'s twin. This is count 16 on this indictment. [Baby M], born on 8 April 2016 at 10.14, twin 2. 33 weeks and 2 days, a weight of

1.74 kilograms. The event we look at is 9 April at 16.02 when he had an episode when he was apnoeic, there's desaturation and bradycardia, and he required CPR for 25 minutes but made a rapid recovery.

This is a case where the experts, Dr Evans and Dr Bohin, propose a mechanism of harm. They say that that is by air embolus. We'll have a look at this.

Some basic facts about the situation when we come to [Baby M]. He is in nursery 1. We finally established that he had been put in a corner because the nursery was full, and we've heard how that isn't ideal because there's always meant to be space in the nursery, but he was there and we know that's how it was and he was close to his brother and in there on this day with Ms Letby and Mary Griffith, but of course whoever else comes and goes, it's a busy place.

One of the issues in [Baby M]'s case is that the collapse that he has is said to come out of nowhere. There are some indicators that he had some health issues, but certainly, we can all recognise, it's something that appears to be out of all proportion to how he presented when he had the collapse. We can see that and that's one of the points the prosecution point to.

We'll have a look at whether there were any indications in his condition to show that everything was not well, but before we do that, again we ask you to keep in mind the fact of a sudden or unexpected collapse, if that's what it is, is something that can happen, and we've just seen this morning, literally about an hour or so ago, how that happened in the case of [Baby J], although we recognise not as pronounced as what happens in the case of [Baby M], we know that. But certainly the fact that a collapse is sudden or unexpected does not of itself prove that harm was done.

Here again we have Ms Letby doing nothing with [Baby M] at the time he deteriorates. We'll look at the timings in a moment. She, from the descriptions we have, including that from Mary Griffith, was on the other side of the nursery. There are people about. She had participated in the giving of antibiotics to [Baby M] about 15 minutes before the collapse. That has become the focus, really, that's become the focus.

Dewi Evans and Sandie Bohin, we say, have done their best to work around this state of affairs by efforts to describe, at this point of the case, not how quickly air embolus works, but how slowly it can work, as the air takes its time to creep down the tube to coincide with a figure of, let's say, 15 minutes, which we say, ladies and gentlemen, is unbelievable. We're

talking about very narrow tubing, about 0.4ml in volume. I'll come to the evidence shortly.

This is tubing that is designed to make sure that whatever goes in goes in quickly. It's the same tubing that's used to put adrenaline in when it gets to where the T-piece is, the three-way tap. It's meant to be quick. It's not meant to take 15 minutes; it's immediate.

The reality of the situation -- if we just put up tile 83, please, Mr Murphy, to see how the nursery was set up this day. I think we saw it earlier under a -- this is the [Baby M] sequence, thank you. This is a busy day. Okay? It's really busy and you can picture the scene with all the types of people who would be there, now we're familiar with how this unit is. For all that Ms Letby's focus is alleged to be on doing harm, she actually had a job to do. We know she did that, in the eyes of people around her, excellently, competently. She had issues of her own at work to deal with. We looked in evidence about how the baby GT had been keeping her busy. She had work to do. It wasn't an idle time. And not much time to interfere with air emboluses elsewhere as this takes place.

A lot has been made of Ms Letby's involvement in the care of [Baby M], including the delivery of the prescription, the antibiotics at about 15.45. It's important, isn't it, to ask whether that is significant when we look at the way business is being done on the nursery that day. We say it's absolutely not. She's been, as usual, picked out for something that is utterly conventional and normal for the nurses on that nursery. And as I've said before, you certainly don't have to take my word for it, I'd ask you to look at the evidence.

So we're going to go to the neonatal review and keep in mind how Ms Letby is being identified for assisting on one occasion -- on one occasion -- at 15.45, we say plucked out artificially when we know nurses assist in that way, and that's followed by utterly artificial contortions by the experts to explain how a slow-moving air embolus can work, just to try and get round the timings, because 15.45, collapse at 16.02, it's about a 15-minute delay not the 1 or 2 'minutes we had at the beginning of the case.

So the neonatal review. Could we start at page 3, please? Thank you. Lines 25 to 32. This is earlier in the day now, between 9 o'clock and 9.11, and we have Ms Letby assisting Ashleigh Hudson with babies. Certainly not all in nursery 1. Okay? Assisting with other children. Totally all right. Totally what happens.

Can we go next to look at lines 34 to 39, please, on page 3? Thank you. All right. We've seen this earlier, haven't we? Mary

Griffith now assisting in another nursery round about these times, we don't know precisely when. We looked at this earlier: a nurse assisting another nurse. Totally conventional. Totally normal.

Go next, please, to page 5, lines 89 to 93. We now have Ms Letby, with assistance, caring for the child she's designated, TSB, with other people helping her, certainly Mary Griffith is in that nursery. So this way round is fine, this way round Mary Griffith is not a murderer or an attempted murderer, but it's different when Ms Letby does whatever everyone else is doing.

If we go next please to lines 123 and 124 on this page. Page 5. Down at the bottom, here -- now, if it said Lucy Letby rather than [Nurse B], we suggest this would be treated as a matter that would be highly suspicious because we have [Nurse B] coming to a nursery where she isn't a designated nurse for that child and looking after a child who has a collapse later that day. I wonder what would happen, I know we are not meant to speculate but you'll understand why I am saying this, if we had Lucy Letby there rather than [Nurse B]. [Nurse B] has actually gone away from the nursery where her designated baby is and has actually come to nursery 1 because that's actually, ladies and gentlemen, what happens.

And then if we go to page 6, lines 167 and 170, we've got Ms Letby and Mary Griffith, prescriptions with baby GT, who is one of the babies Ms Letby was looking after -- because that's what they do, ladies and gentlemen, they help one another.

So when we move forward to page 7, lines 209 and 210, please, 15.45, Ms Letby assisting Mary Griffith in the nursery where she's been working with [Baby M], let's start with that. But for these allegations, but for a presumption of guilt, there is absolutely nothing odd about that at all. It's what happens.

You can look at the whole 12 pages if you want to, you'll see her activity is consistent, we say, is consistent with what you see generally with nurses on the neonatal reviews.

Thank you, Mr Murphy. I'll move to the expert evidence with Dewi Evans and Sandie Bohin.

In their reports, and we asked some questions about this, one of the mechanisms considered was that [Baby M]'s collapse was as a result of airway obstruction. Airway obstruction, so smothering or doing something to a tube. In their evidence they had both dropped that and stayed just with air embolus, probably because it was increasingly obvious how absurd it was to suggest that Ms Letby is smothering [Baby M] in a nursery full of other medics and people coming and going. But certainly it seemed to be worth

consideration in the reports. They stuck with air embolus. They say there's no medical cause to explain what happened in this case with [Baby M] and on that basis what's left is air embolus.

Sandie Bohin on 23 February said in evidence to the prosecution -- we say it reveals quite a bit about her thought process:

"I had to find some way to explain the collapse."

"I had to find some way." We say, no, you don't have to find some way. In medicine it's acceptable to say you cannot find a cause, that it's unascertained, you don't know, as has happened actually in some other occasions although, we submit, all too rarely. It's not acceptable to find something, in this case air embolus, because you feel that there's an obligation to do that.

As to the condition of [Baby M], can we put up Mary Griffith's notes, please, at tile 191, Mr Murphy? From the [Baby M] sequence. Sorry, tile 91. Just enlarge the Mary Griffith entry there. This is a note by Nurse Griffith at 8.11 on 9 April, "Initially fine".

At 12.15, if you look into the body of the note, about four or five lines down, the first sign of any problem:

"Stomach distended and increased work of breathing."

Now, these things, it seems, are treated as nothing wrong, no sign of anything. That's a sign of something, isn't it? It is in other cases. Mary Griffith went on a break, [Nurse B] took over. There's a slight rise in temperature during that period. And when Mary Griffith returned at 1 pm, she learnt that [Baby M]'s nasogastric tube had aspirated 5ml and there had been undigested milk. We can see it referred to there.

Later, around 2.30, 1.5ml of bile aspirate. The time of 2.30 came in the evidence but we can the reference here:

"1.5ml of bile-stained aspirate was produced."

And which we say is a surprise because a bile-stained aspirate may be a sign of a problem and is unexpected surely. It's a snapshot isn't it? But when we're being told there's nothing wrong, it's okay, it's fine, he's not actually. He's not. This isn't fine, that's why it's being recorded. People may say it's fine now, but it shouldn't have been fine then we say. Subtle signs. Sudden collapses. Unexpected. As a concept, witness after witness is ready to accept that. When we're faced with the reality of subtle signs in a neonate, in an intensive care unit,

whatever their condition, on a neonatal unit, it seems to be that it doesn't apply any longer.

The doctor was called because of a concern, this is where we see, "Shown to reg", can you see?

"1.5ml and bile-stained. Shown to reg."

The registrar isn't named. That's okay in this case, it's not Ms Letby. But shown to the doctor. That is because of a concern.

But at 15.00 he was not doing as well as he was at 10.25 and Dr Ukoh had reviewed him and he's made nil by mouth.

Can you see, if we keep reading on, the aspirate is:

"... 1.5ml, bile-stained, shown to reg and baby put nil by mouth."

You may think that isn't a great direction of travel but if you do, you're at odds with witnesses who said there was nothing really wrong with him.

If we look at tile 6, which is the blood gas readings -- I'll ask Mr Murphy to put that up, please. If we look at 18.00 on 8 April, so the fourth line down, and then 9 April, 16.22, there's no blood gas readings taken actually. Maybe that's one of those things, but that is a period over which we have seen, during the course of Mary Griffith's shift, [Baby M] is deteriorating, actually, on the evidence.

When it's said by the experts, or the prosecution relying upon them, there's nothing wrong -- it was said at one point, "There's no need to have done a blood gas because there's nothing wrong", that's such a circular argument. How do you know there's nothing wrong unless you do the blood gas? He's certainly not doing as well as he was at the start of that day, from what we've seen, and ending up nil by mouth.

Even if we accept that, nevertheless what happens with [Baby M] just after 4 o'clock is still a significant escalation or deterioration, even with the problems beforehand. That does not come close to making Ms Letby guilty of anything. We have to be sure of a deliberate intention to kill and therefore we need to be clear about the mechanism and how that's meant to work. And that is where what is said about air embolus comes in.

That's what I'd move to next, but I'm just wondering, my Lord, whether this is the point to take a break because then we would continue after a shorter lunch break.

MR JUSTICE GOSS: Certainly. We'll resume then at 1.45, please, members of the jury.

(1.00 pm)

(The short adjournment)

(1.45 pm)

MR MYERS: Air embolus, ladies and gentlemen, the mechanism proposed by the experts in the case of [Baby M], Dewi Evans and Sandie Bohin. They pointed to, between the two of them, discolouration, the rapid onset and collapse of [Baby M], and sudden recovery after 30 minutes of resuscitation.

So we start with discolouration. Both of them ended up saying, in effect, that whether or not we can rely upon discolouration, of course, depends upon the evidence of Dr Jayaram because he is the sole witness to give significant evidence of discolouration, remembering that we're dealing with, now, 9 April 2016.

His notes, we don't need to put them up, are at tile 182. It is with a sense of déjà vu that you'll approach them and look in there for signs of discolouration and find none.

The description makes an appearance in his statement to the police 17 months later, having described it in interview to them shortly before that. But it's not the delay that matters before it comes out, it's the fact it's not in those notes, isn't it? We say it is unbelievable. There is no way he would fail to miss the discolouration if he saw it at the time. If we think through what he's described by this point, what he says he had seen with [Baby A] and heard about with [Baby B], what's been talked about on the unit, he and Dr Brearey with their suspicions starting as early as June 2015, what is meant to have happened with [Baby K] in February 2016, and here we are here with significant clinical findings that would go to support, given his description later, the type of lurid descriptions from that paper that he'd read before he went to the police, but after the time of [Baby A] and [Baby D] and these, it seems, he wrote them at the end of this period, in 2016, June 2016. But they're not there, even though he'd agreed by this time it was "all eyes on Letby".

Not a case of the penny dropping later by now, is it? Not by the time that we get to April 2016. If he saw them, he would be the first person to write them down. They are not there. Just like they are not there in his notes for [Baby A] on 8 June 2015 and not in that statement to the coroner on 24 July 2015. And we have no reference to discolouration in the notes for [Baby M] 10 months later.

That's why we say with that list you were handed you can approach it with a very good deal of scepticism. We say if the discolouration was there, it would have been in his notes and indeed he would have been the first person to have noted it and he didn't because it wasn't.

It would seem that by this time unusual rashes would be something of interest on the unit, whatever the reason for them. We know a number of people are present during [Baby M]'s collapse: [Nurse B], Mary Griffith, Belinda Williamson, Dr Ukoh. None of them give any description of any type of significant discolouration, nothing to support what Dr Jayaram says.

Mary Griffith actually said she saw no unusual marks or discolourations on the skin. She'd been looking after [Baby M] that day.

[Nurse B], you may think a pretty observant nurse, on the ball, she hasn't volunteered seeing anything unusual. And trying to suggest that [Baby M]'s in a corner and it's not well lit hardly counts, does it?

And Dr Ukoh, who was close to [Baby M] throughout, you may think could not have missed this if he was displaying the colourations that Dr Jayaram describes. And we've got his notes, Dr Ukoh's notes, of this incident at tile 149. I wonder if we could have a look at that, Mr Murphy.

Bearing in mind we've had descriptions from Dr Jayaram of the blotchiness/pinkness appearing and disappearing, Dr Ukoh is dealing with this, these are his notes later on, he's had time to process it. There's one particular description here from Dr Ukoh of [Baby M] and it is about the fourth line down:

"Pale ++."

There it is. I am not going to say any more about that. Thank you, Mr Murphy.

Rapid onset. A lot of things can be rapid with neonates like this.

Sudden recovery. We say, yes, he was resuscitated, he continued to be unwell and have apnoeas and desats over the day or so that followed but he did make a good recovery. We say at the same time, if he did, how do we have an air embolus that can cause a collapse like that that vanishes within 30 minutes if there can be such a good recovery? But there's a bigger problem we say -- actually, those are significant problems and the discolouration, we say, forms no basis for what is alleged, but

there's a further problem: air embolus is fast-acting once it's in the bloodstream. We know it would be very, very rapid indeed.

Ms Letby and Mary Griffith administered antibiotics at 15.45 or thereabouts and that is the end of contact. There's nothing else that can be alleged in terms of going over and doing something. That's the time we start from and that has created, we say, a big problem for the prosecution and the experts because if air has gone into the bloodstream it should be very, very rapid, not 15 or 16 minutes.

So that is why we took a deviation in the evidence, if you remember, into what were called three-way taps and the empty spaces in the tubing. Remember we've got the valves, the little entry areas for the catheters to enter in. And we have the idea that an air embolus is put into a tube that is not much wider than a couple of strands of thick cotton and that then there would be a period of time for it to move along before it could enter the system.

We are not told how much air could cause this collapse. With Dr Evans we investigated this on 23 February. He had done some research into it. The empty space we're talking about is something like 0.35 to 0.4ml. That's tiny, a very narrow bore. If you were to inject 1, 2 or 3ml, which are the figures for lethality when we have been looking at dogs and rabbits, I think, with Dr Bohin, that would be immediate collapse because it's straight in, isn't it? It's bigger than the space it has to travel through, so it's straight in.

So the allegation is intending to kill. Somebody doing that isn't going to play around with minuscule quantities if that's what's going on, not if they've done it before, not if they know what they are doing; they'd put in enough to do the job.

Half a millilitre is in. Let's just think about this. How's somebody going to put such a tiny amount in, 0.4ml, that it takes -- and that seems to be what we're talking about, that T-piece, that it's going to take 15 minutes to go through it with the infusion going in. The idea is that it has come in and it is carried in on the infusion that's coming in. But that little space it's going to carry in on is about 0.35 to 0.4ml, so if you put anything in that's bigger than that, it's going to fill that space and go straight in anyway. And anything smaller than that is minuscule. How's someone going to measure that or know? How are they going to calculate this?

The maths don't really help with the experts because that space is so small, when we step back and think about this, even a minute quantity will be in rapidly which is what we have with adrenaline. That's the point. It's a completely artificial

exercise, designed to try to get round the fact that that 15 minutes between Ms Letby assisting Ms Griffith and the collapse prevents the experts from being able to rely upon the air embolus theory in the way they would wish to. That is what was going on there and that is why we've had to contort our way through those tubes and it doesn't make sense even when we do that.

When it passed, we say with [Baby M] there were scans, he was discharged from hospital without concerns, fortunately.

We've heard about the scans, but there's no suggestion, thank goodness of any harm, any long-term consequences. So fortunately it seems neither [Baby L] nor [Baby M] appear to have suffered any long-term consequence for what is alleged, which we observe in passing with relief, but note is extraordinary for two alleged attempted murders with the methods that are said to have been used. But it's not extraordinary if that hasn't happened.

And dealing with [Baby M], in conclusion, we observe that the basis on which air embolus is brought is utterly unrealistic. It really hangs on a piece of evidence of discolouration that is incredible and contortions involving tubes and empty spaces that mathematically make no sense and were designed to deal with the problem of Ms Letby not being there, not doing anything at the time, the problem that causes. There is no proper basis, we say, to be sure there and very good basis not to be sure.

Ladies and gentlemen, I turn now to counts 17, 18 and 19, which are the counts concerning [Baby N]. [Baby N] was born on 2 June 2016 at 13.42. 34 weeks and 4 days' gestation, and 1.67 kilograms in weight.

He had haemophilia, his factor VIII levels were too low. The events that we deal with, 3 June, which is count 17, the first one, and that is at about 01.05 or 01.07 in the morning on 3 June. If you remember, [Baby N] was screaming or crying and he desaturated. He responded to facial oxygen within minutes, fortunately, and made a swift recovery.

Dr Evans says that is due to an air embolus. Dr Bohin says it's due to the infliction of a painful stimulus.

Let's look at the facts of each one as we go along rather than just giving a chronology there. The other event is 15 June. So we've got 3 June, the screaming episode, and then we have 15 June with the desaturation at 7.15 in the morning and then a further desaturation later that afternoon at 2.50, which was event -- count 19. But I'll come back to those in more detail as we go along.

Haemophilia. [Baby N] had haemophilia, which was unusual in the Countess of Chester Hospital. We know now from Professor Kinsey, who gave evidence on 7 March, that because of his haemophilia [Baby N] was more likely to suffer a bleed from trauma -- and that doesn't mean intentional harm, but from trauma, from physical contact, than babies who do not have that condition. And in the event of trauma, [Baby N] was more likely to bleed more profusely or heavily because the blood would not clot as it would in a baby without that type of haemophilia. We were told that on 7 March.

She was very clear and very firm about those points. And of course they are not insignificant when we consider a case where there was so much intubation that took place, we say. She explained that any process involving instrumentation had the potential to cause trauma and therefore bleeding and she said this in this way -- she was asked:

"The process of using a nasogastric tube or an orogastric tube [down the oesophagus], we know the difference between those procedures now. Is that capable ever of causing bleeding?"

Professor Kinsey said:

"I think any instrumentation, so ie putting something external into that area, has the potential for causing trauma and hence bleeding."

That's her evidence, page 61.

We say that becomes significant when we get to the events in this case, particular those on 15 June.

The Countess of Chester, you may think surprisingly, did not have factor VIII on birth and failed to make this arrangement even by 15 June, which is 2 weeks after [Baby N]'s arrival there. You may think it would have been obvious and sensible but it wasn't done.

Professor Kinsey said it would have been good practice for the unit to have factor VIII in stock even if it's not given to the baby from birth and you may think that is obvious, but that isn't what happened.

The allegation on 3 June at about 1.02, or whatever time we're looking at, probably when we look at the door swipe data you'll see 5 minutes past or 7 minutes past. This allegation Dr Bohin says physical trauma, some kind of pain; Dr Evans, an air embolus, by the time of his third report.

Was Ms Letby even there? What is the evidence of this? She wasn't in the nursery where this took place and we know that the incident must be some time just before 1.07 because if we look at tile 173 from the [Baby N] sequence 1, we've got Dr Loughnane's door swipe data. So she -- if we can go into that just to satisfy us all that's her coming into the unit, though it obviously is. Could we just click on the tile, Mr Murphy? Thank you. So labour ward, in, to neonatal, in. So she's coming in at 01.07.

No one is actually saying Ms Letby is there, nothing to put her there. Christopher Booth, who was the designated nurse, said that as a matter of practice when he went on his break he'd have asked a nurse in the nursery to look after [Baby N] and those nurses working there have been asked and none of them have a recollection that it's them, so we're in that territory. But at the same time nothing identifying that Ms Letby is there, and there's a question whether she was even on the unit, because if we look at tile 175, please, and we'd better go into it to check which way this is going and make sure I've got it right. There we are, maternity neonatal entrance doors, in. So this would appear to be she's coming in at 01.15. So whether she was even there at the time might be a moot point. It's not long after the time this is meant to happens, it's entirely possible she wasn't there.

The nature of this desaturation, why should it be an allegation? Could we put up please tile 174 which are Dr Loughnane's notes. Could we go into those, please? You see here she had come on at 01.07 and within a couple of minutes she is making her note. Thank you:

"1.10. Desat, unsettled, got upset. Looked mottled and dusky."

That's it ladies and gentlemen for discolouration:

"40% oxygen. Screaming."

That's a feature that is fastened upon:

"Sternal recession, poor trace on sats probe. Pink. Attempts to settle, crash bleeped away."

And he was settling by that point, though still crying. But that's it really. That's it. Nothing, we say, remarkable about this, which is why, as it happens, Dr Evans hadn't included it in his initial report as an air embolus, that only came in his third report on [Baby N].

No significant discolouration, nothing, and really a matter of minutes at its height and then pink and then we move on to the

record of recovery. It has to be, we observe, without making light of it, but it must be one of the faster air emboluses in the history of air emboluses. It's literally whoosh, that's it. Don't forget we began by saying how catastrophic they could be. Dr Evans had begun by saying resuscitation was something that might fail or would fail and it generally does when we actually go to the literature. This is an extraordinary situation for an air embolus, not even the discolouration we have been asked to look for.

We say it's plainly not an air embolus and if we might be right about that, not only does that end the question of air embolus on this count, but it also goes to show how unreliable these diagnoses are from Dr Evans, in particular, and we say also from Dr Bohin.

What does Dr Bohin say about this? That it was the infliction of a painful stimulus. Pausing there, the allegation, and what you have to be sure of, is an intent to kill. Okay? That's not accepted at all, but is this anything like an intent to kill by the infliction of a painful stimulus?

[Baby N] was haemophiliac and at this point he is not receiving factor VIII. There is no blood, there is no sign of injury. Dr Bohin's response to that, as we say, is her way, which is to dismiss sometimes what those on the scene have done, and we have seen that, was to suggest that there had been no examination of his mouth, so as if a doctor missed it. No examination of his mouth? He's meant to be screaming the place down. If there's blood, and we have heard about Professor Kinsey and the blood that would flow or could flow, any blood, you might think the doctor would have spotted that.

That is Dr Bohin, in the moment, throwing that out there on 2 March as a way of trying to prop up what she is saying, in effect saying: I know it doesn't show any injury, doesn't show any blood, maybe the doctor missed it. Well, if [Baby N] was crying for upwards of 20 or 30 minutes, you're hardly going to miss blood from the mouth, are you? He's been examined and there's not a touch of that.

Again, not only does that fail to support the allegation on this count, but it also, we say, casts a light on the reliability and the credibility of a witness like Dr Bohin if she is ready to say things like that to shore up that theory. That is from the evidence and you can measure what I say against that, ladies and gentlemen.

On the question of screaming, Dr Evans said that there were a couple of papers that positively supported screaming as evidence of air embolism. When we went through those with Dr Evans in his

evidence it became apparent that they deal with situations that are absolutely nothing like we're looking at here. [Baby N] recovered from crying within -- recovered from the episode within minutes. It plainly wasn't lethal, thank goodness, nothing close to it.

The other cases, the two cases, that Dr Evans talked about when relying upon crying were monumental in terms of what happened, with older babies being killed, in one case by a host of bubbles, and absolutely no similarity to what we're dealing with here, nothing at all like this, and lethal.

Those are such poor opinions, but not just poor because they're not well supported by the evidence, but poor because they are a good example of both these experts doing what we have put to them repeatedly, which is looking for ways to find mechanisms that prop up the allegation rather than sit with the facts. And you can judge that, but that's nowhere near to a properly made-out mechanism or an intent to kill.

We move forwards, ladies and gentlemen, to 15 June. It begins, for the purpose of the allegation, at 7.15 in the morning, count 18, when after a night -- and we'll look at the night in a moment -- of some issues with [Baby N], there was a profound desaturation at about the time that Ms Letby had come on to the unit. So of course, the link is made. We'll come to that. That was followed, some time after about 8.05 or 8.06 by attempts to intubate, and the identification of blood in the oropharynx, if you remember. That's with [Dr A].

As to that, Dr Evans found it difficult perhaps to know what to make of the collapse at 7.15, but said the bleeding is due to trauma in the upper airways. And Dr Bohin said this is down to most likely inflicted trauma to mouth or the oropharynx. That's what is said there.

Then there's a later event that day at 14.50, count 19, when there was a profound desaturation and 3ml of blood were aspirated from the NGT and then that is followed by multiple attempts to intubate. And it would seem the expert opinion for the first part of that day carries over to that, that there's been some sort of attack which has caused this.

Those are the three counts -- we've looked at the first one already. Those are counts 18 and 19. But leaving nothing to chance, the prosecution also point out a desaturation at 19.40 that evening when Dr Potter and his team had turned up. That's not a specific allegation on the indictment but it's brought in as part of everything and you know why we say it is brought in like that because it happens and who is there at the time? Ms Letby. She is not seen to do anything, she has no part in

anything in terms of doing any harm, but she's there when it happens and we have had some witnesses saying they were there, other witnesses saying they weren't there. The implication is: well, there we are, she could have done it behind everybody's back at about 19.40 when they're all waiting to start their important work with [Baby N], just nipped in and did something unidentified. We'll go through this though.

Remember when we began at the start of this week and I looked at that table with you, table CEH16, the staff presence table with all the crosses and we looked at where there would have been gaps by the end of this trial, certainly in a couple of places. And I'd made the observation that, in the case of [Baby N], what we've seen happen is an effort made by the prosecution and by the witnesses, the experts, to establish a point of harm outside the night shift when Jennifer Jones-Key was looking after [Baby N].

The prosecution saying [Baby N] was unwell or he'd been sabotaged when he was handed over. Setting it all up, yeah? And then the experts, we'll remind you of this, saying, yes, however things were during the night, there's a break at about 7.15 and it's all change then, it's different, and that fits in with the allegation that Ms Letby is there in the morning and she's done something.

Well, we say, based on the evidence that on the 14th, the day before all of this, [Baby N] had been doing well in the care of Ms Letby and when he was handed over to Jennifer Jones-Key at the end of Ms Letby's shift he was well.

It's going to be important, we say, to keep in mind the note of Nurse Jones-Key and what she said about it. The note is at tile 141 in the second [Baby N] sequence. I'd be grateful if we could go there, please. We start above that, in fact, please, but we need to go to the larger entry above it.

A note at 05.51 by Jennifer Jones-Key. I'm going to look at the whole of the note because it's so important to the allegations being made and what we say about them:

"At start of shift baby nursed in incubator with eye protection in situ. SBR repeated at 21.00. Result 150. Lights stopped. For repeat in morning."

We don't say that is relevant:

"Baby demand bottle feeding on expressed breast milk. Taking good amounts on own bottles. Baby very unsettled early part of night."

We'll come back to that:

"I noticed that, just after 01.00 feed, baby looked very pale, mottled and veiny, abdomen slightly bigger. Seen by NNU Nurse Belinda Simcock, advised to place baby on saturation monitor. Reviewed by paed. To be watched for an hour. After 30 minutes noted to be having desaturations to low 80s. No intervention required but quite frequent. Rest of observations within range. Reviewed by [Dr A] and for septic screen. Cannula inserted into right hand and bloods taken for CRP, blood culture and FBC..."

Is that cefotaxime? Anyway:

"IM cef given by NNU nurse. Baby looked worse this morning and cap refill 3 secs. Reviewed again by paed. Placed into 25% ambient oxygen and nil by mouth."

And there's reference to dextrose commencing and then:

"PU, BO. No contact from parents."

If we look at the next entry to put this in situ with what happened next after that night, there we are, at 8.19 -- we'll come back to this in a little bit:

"At 07.15 baby crying and dropped saturations. Seen by NNU Nurse Lucy."

Then we're into that desaturation then and what follows. Could we just put back then the first part of the note, Mr Murphy, and I'm going to remind you of what Jennifer Jones-Key said. This is on 3 March. This part of the allegation is what we see here in effect is because [Baby N] had been sabotaged in advance by Ms Letby, one of those things identified at the beginning about whatever she says, whatever happens, this self-serving method of allegation will just change to fit in:

"Question: I'm going to go through the events that you've described and ask you to help with some of the details. If we take this from the handover on 14 June from Lucy Letby [this is cross-examination], from that point [Baby N] was stable and he seemed to be doing well, didn't he?"

"Answer: Yes."

"Question: And there were no concerns about him, were there?"

"Answer: No."

"Question: We've seen your note and we'll take another look again in a little bit. You've said he was a little unsettled after handover through to midnight."

Pausing there, "a little unsettled", in case you wonder, when it says "very unsettled", is how the prosecution put it after questioning Jennifer Jones-Key when she was first giving evidence and she agreed, and that's at page 75, lines 5 to 8.

So I carried on:

"Question: You said he was a little unsettled after handover through to midnight?

"Answer: Yes.

"Question: That wasn't any significant concern, was it?

"Answer: No.

"Question: And as you've described to us, and as we've seen, at 9 o'clock that evening he took a full feed from the bottle, didn't he?

"Answer: Yes.

"Question: I think in your experience that suggests that he was a well baby and hungry?

"Answer: Yes.

"Question: We'll put the note up so you can refer to it if it helps, Mrs Jones-Key, as we go along, feel free to."

We looked at the note and at the entry that said:

"I noticed that just after 01.00 feed baby looked very pale, mottled and veiny, abdomen slightly bigger."

That was drawn to her attention. She said yes. She was asked:

"Question: So is that the time at which there first appeared to be a deterioration in [Baby N]'s condition?

"Answer: Yes, it was.

"Question: All right. So he'd been fine for 5 hours after you'd taken over from Ms Letby?

"Answer: Yes.

"Question: About 1 o'clock he deteriorates and actually, just in summary, that remained the case throughout the rest of the shift, didn't it?

"Answer: Yes.

"Question: And his condition didn't seem to get any better, did it?

"Answer: No."

So that's 5 hours after handover. Whatever is said about unsettled, he was feeding well, he was doing the things that a happy and healthy baby would do at that point, and the assessment of the nurse looking after him was that he was well and hungry. The deterioration begins 5 hours after she had taken over.

That is an end to the sabotage theory, we say. Ms Letby had done nothing to make [Baby N] unwell prior to this shift. He became unwell during the shift. We have it. But we also have a clear example of the way this case works in bringing allegations against Ms Letby, and as we go through this, and you'll have it on your sequence of events, ladies and gentlemen, you'll see from this note, and documented in [Dr A]'s notes, and he gave evidence about this, how [Baby N] deteriorated and became unwell that night. Jennifer Jones-Key took that from 01.00. We can see how matters go.

Interestingly, do you see at one point it says:

"Reviewed by paed. To be watched for an hour."

And then about eight lines down:

"After 30 mins, noted to be having desaturations to low 80s. No intervention required."

Do you see that on the note? [Redacted]. We had the agreed evidence read to you of Elizabeth Marshall who said the proper process would be to intervene or to help, certainly not just to stand there and watch.

That may very well be the textbook approach, we're not disputing that, that's why it's agreed evidence, and this isn't the only occasion. As you'll see, in reality the nurses will sometimes wait. Jennifer Jones-Key described this and she said they may tickle their feet to get a reaction but it's not a medical emergency. She said they may wait for 30 seconds to self-correct, maybe tickling their feet, it's not a medical

emergency. And you've got a reference to that here and that's what I asked her about on 3 March with that.

More mottling as the night goes on. [Dr A] at tile 184 in his medical notes for 03.45, so we need to scroll down. He's dealt with other matters there but 03.45 describes five episodes, desaturations noted. He talked about this:

"Five episodes whilst on [maybe -- is that monitor?]."

But anyway five episodes. Mottling, he'd had, but had resolved. At 05.15 he described the persistence of mottling, which is nothing to do with air embolus of course. And by 05.30, [Baby N] had been made -- thank you, there we are:

"Mottled appearance persists, coming and going."

Do you see mottling here? By 05.30, the decision had been made for [Baby N] to be made nil by mouth. That is an obvious clinical marker of a worsening condition.

So that takes us now to what the experts said about these events, so we can take this down, please, thank you, Mr Murphy.

Dewi Evans on 7 March, it was a little confusing because in his report, pre-trial, he was asked about this, he had said:

"[Baby N] had sustained trauma to the back of his throat in the early hours of 15 June prior to the doctor being asked to see him at 01.45."

He'd said that in more than one place in that report. In evidence to you he said he meant that although [Baby N] had been unwell from around 08.00 he'd had the trauma from around 08.00. You'll have to weigh that up. But that's what he said in his report, he had linked the trauma to the trouble starting during the night shift. We say he had changed that by the time we got to the evidence here to separate trauma from trouble during the night.

Dr Bohin, also on 7 March, took a more nuanced approach. She said things were not right at 1 o'clock but it was from 05.15, with the lengthier capillary refill time, that the deterioration had worsened. But what she would not accept, when we put it to her, was that there was a continuing series from 1 o'clock, getting worse in the night, having deteriorations, building up to the profound one at 07.15.

She would -- she did not accept that that formed a continual worsening, that what happens at 7.15 -- in other words, she is saying that's different. We say, no, it's not, that's just

making space to move it along to when Ms Letby is there. That's what we say and that is something for you to consider.

But let's turn to the 7.15 event, ladies and gentlemen. What isn't immediately apparent from Jennifer Jones-Key's note, but we dealt with this in evidence on 3 March, she described that by 7 am further desaturations had been commencing again. She said:

"He settled down once we commenced fluids, but from about 7 o'clock onwards he was having more desaturations."

So that's really leading right into the period at 7.15 when there's the big one we've seen on the notes. And that is in the period before Ms Letby came on to the unit, more desaturations from 7.15 onwards. How anyone can just draw a line and say, right, what happens before Ms Letby is there is one thing, what happens when she turns up we're going to treat that totally differently, we ask you, how can that be done?

What happened next you have heard from the evidence. Some things Jennifer Jones-Key remembers from the note, some things independently, but she was clear about this: she was in the nursery feeding a baby. Lucy Letby came on to her shift. We know from the door swipe data that she enters at 7.12 at the earliest, that's at tile 137, but 7.12 is the earliest. She goes over to the nursery where Jennifer Jones-Key was. She says that she was somewhere around the entrance to it, Ms Letby does. Jennifer Jones-Key says she's feeding a baby. The alarm sounds and Lucy Letby walks over, she remembers that.

We point out on the evidence there is no indication or sensible opportunity for Ms Letby to have done anything to cause this. We've had a whole night of mounting problems. No evidence of her doing anything wrong, but we are here now having to defend the position because of the presumptions that are made when she is there.

We say that what then follows from 7.15 onwards is the continuing problems and mounting problems from the deterioration that, without a doubt, had begun at about 1 o'clock in the morning.

We come to the question of blood seen by [Dr A] round about the time of an intubation or, rather, attempted intubation at about 8.05 or maybe a couple of minutes after that. This comes next. But actually, before we get to that, there's quite a lot of activity between the desaturation at 7.15 and the attempted intubation. I'm going to ask if we could put up tile 141 again, please, which is the -- and the second part of Jennifer Jones-Key's nursing note. It's the lower part. We can put the whole

thing up. Thank you, Mr Murphy. So it's the lower part, sorry, my fault.

So this is carrying on:

"7.15. Baby crying, dropped saturations. Seen by Nurse Letby. Neopuff given. [Dr A]. Noted to be mottled all over body and blue in colour and cold to touch. Decision made to transfer to nursery 1. NG re-sited [that's nasogastric tube]. Re-sited in nostril with acid reaction. At handover baby dropped saturations again and required Neopuff. Care handed over to NNU Nurse Lucy."

Now, one observation we make for you to consider is this: we do not accept that Ms Letby has done anything or did anything to cause any bleed to [Baby N]. We say there is a real question about at which point did [Dr A] see the blood in his mouth during the intubation process. Do you remember? There's a question, was it before or afterwards or do we simply not know?

We question that there was blood there beforehand from the material that we have. We say it doesn't establish that. We do note this in the light of the evidence of Professor Kinsey who had said that any instrumentation could cause a bleed in a child with hemophilia, like [Baby N], and that that could include NGTs being used. That in the period between this collapse and blood first being seen, whatever precise point that was, Nurse Johnson (sic) has re-sited an NGT. We can see that. We don't accept that the note establishes when the blood is seen. But it would be strange for anyone to ignore that after the time we spent on the medical evidence in this case because if we're looking for an explanation of blood prior to intubation, we have one. If we want to consider the evidence that we've had, we've had one. Why we should just automatically leap to saying, "Well, Ms Letby must have done something", in the midst of a process where there's a lot of people involved, because we have him being moved, we have him receiving drugs -- we'll come to that in a moment -- we have him being looked after in a place that's busy with people about him. There's no suggestion she did anything there but we do have this.

Now, what we have looked at in the evidence and focused upon, and we looked at this as well actually, but what we've focused upon is the question in any event of whether it can be said with any certainty that blood was there before the intubation. Because we say that the most likely explanation for blood in the oropharynx were the multiple attempts at intubation with the laryngoscope that failed. That must be the most likely. But also to be considered is the alternative proposition which it was there beforehand.

We say there are three reasons, if we come to this, as to why the evidence does not support blood being there beforehand. First, and as we've just said to you, it's difficult to see how something can have been done to [Baby N] at around 7.15 that led to blood only being seen when [Dr A] came to intubate a little after 08.05 that is by way of a deliberate attack. It is very hard to see how that could be the case.

Secondly, we say, the clinical notes themselves do not establish the point at which blood is seen and, thirdly, in fact, the evidence of [Dr A], including taking into account what he'd said to the police before the trial, means that there is no certainty from him as to when the blood was seen.

So first, the question about whether something could have happened at 7.15 that led to blood only being seen after 8.05. [Baby N] is a haemophiliac. If he, or indeed any child, received an injury to the mouth or throat that causes a bleed, if that's what this really was, you would expect that that would be seen sooner, it wouldn't take 45 minutes, if there's some kind of blood flowing. He's very little, there are tubes there, there are all sorts of things going on. To suggest it's just missed is unrealistic.

And combined with that, yet again, despite the activity we have, we have Miss Butterworth and Lucy Letby administering medication from 08.00 to 08.06, pre-intubation, a number of medications. No opportunity to attack in the way that is alleged.

If we look at the clinical notes to see if they show that blood was there before intubation and we'll start please with Nurse Letby's, if we could, which is tile 151, please. Just looking at this particular issue at this stage, ladies and gentlemen, as to whether this is decisive in any way. It's a note by Ms Letby at 13.53 on 15 June dealing with care from 07.30 up to 13 -- in fact, it's completed at 14.10. So from 07.30 to 14.10. And the key point is this, four lines down:

"Decision made to intubate. Drugs given as prescribed. Unable to intubate. Fresh blood noted in mouth and yielded via suction ++."

We understand you're here to assess this case against Ms Letby and therefore you'll assess what she says, like any other witness, and you'll put it into the balance and you'll bear in mind the criticisms the prosecution make and their case and what they say about her documents. But certainly, on the face of this, nothing here suggests that blood is seen before the process of intubation. It simply doesn't. And in fact if we follow the order of events it's:

"Unable to intubate, fresh blood noted in mouth."

We can look at [Dr A]'s note, which is at tile 157 in this sequence. The note is made at 08.00 it says. There we are. It says 08.00, in fact we've got the timing of the intubation drugs being given there at 08.00, 08.05, 08.06, thank you. Then it says this:

"Attempted intubation x3..."

It gives the statistics of what was used:

"... using neck roll and laryngoscope blade. Blood present at oropharynx. Unable to visualise trachea inlet. Suction did not clean the view."

We say that is open to whichever interpretation you want to. We don't say it proves one thing or another, but we need some accuracy and it's open to either interpretation, but we ask you to keep this in mind as you look at this and what we would say is good practice.

We went over the process of intubation with [Dr A] when he gave evidence on 6 March. We went over the view, how it must be visible, you must be able to see what you are doing before commencing, you don't just stick a tube in where you can't see and hope for the best. In other words you're hardly going to have three goes at intubation if there's blood in the way and you can't see it to do it. That would be reckless. That would be very poor practice. If blood obscures the view, you are not going to have a shot anyway and so we say that if [Dr A] embarked on intubation, he must have been able to see the way to start with, and that would suggest that the blood would have come along after the process had started.

As for his evidence, to start with, his position was he believed the blood was there as he was attempting insertion number 1. In cross-examination I asked him to refresh his memory from what he'd said in his statement to the police and reminded him:

"Your recollection back in [and this is on 6 March, pages 73 to 75] 2018 was that you weren't sure if the blood was your fault when you used the blade inadvertently or if it had been present before attempting to intubate."

And he said yes.

Overall his view was that he felt it was there before, that's his view now, looking back, in fairness, but actually when we go back to his statement, he wasn't sure whether it was there or whether it was his fault when he used the blade inadvertently.

We say, bearing in mind that we need to be sure on these matters, we need to be sufficiently clear, but the notes certainly don't establish that blood is there beforehand and that when you consider the situation it is improbable that he would embark upon an intubation if he couldn't see the way. If there's blood there that stops it, you're not going to start, it wouldn't happen, and the interpretation that makes the greatest sense and the greatest medical sense is that this is blood that would have come about as a result of the attempted intubation. That would certainly be consistent with what Professor Kinsey said about how easily and readily [Baby N] would bleed.

So ladies and gentlemen, we're finishing a little early, it's warm, there's a lot of detail again, I know that -- I'm just saying for all of us, trust me, there's a lot to deal with -- but we have a final part to deal with, with [Baby N]. We should be able to deal with that before we conclude.

MR JUSTICE GOSS: Certainly, thank you.

MR MYERS: Count 19. So we move into the afternoon now of 15 June, the same day, but moving through the afternoon.

The way the evidence came out here, and we're not saying this to be difficult or critical, it can be difficult to organise everything when there's so much material and it's ongoing, but it seems to be what's happening is, as we come to 14.50, there's an episode where blood is spotted. A 3ml aspirate of blood, you'll recall on those records, is spotted around 15.00 and there's an incident with [Baby N] at that time, in conjunction with that, having a profound desaturation. This seems to be that it's following on from what had happened earlier, but because it's a specific allegation, Ms Letby has done something. Okay? Has done something. And following through from what the experts have said, it must be some sort of attack or something different from earlier because it's a separate count. It's a little difficult to unravel, we say, but certainly the event is clear and that's what happens at 14.50 with the desaturation and 3ml of blood being found.

Dr Saladi describes blood at 14.50. Interestingly, for all the doctors who attempt intubation in the period that follows, and there's about six or seven of them, five or six of them, he seems to be the only one who identifies blood. The others talk about swelling -- you'll remember Dr Huw Mayberry and his vivid descriptions of the epiglottis and we saw an illustration of it and he explained, although we're years later, how there appeared to be some sort of swelling there. But he didn't describe blood. He didn't describe seeing blood there.

Therefore it is strange, if Dr Evans and Dr Bohin are correct, that there is some sort of wound that's been inflicted in that way, deliberately, that there isn't more blood, we observe. There certainly was blood round about 14.50 when Dr Saladi does the examination and that aspirate is removed, but there's then a succession of doctors dealing with this, and mostly what they describe is swelling.

What the cause of that is, we say, frankly, is unclear, isn't it? It could be swelling from the morning, it could be from the attempted intubations in the morning, it could be getting worse as the day goes on and more people are having goes at intubating [Baby N].

Certainly Dr Bohin was definite that inflicted trauma to [Baby N]'s mouth, throat, or oropharynx was the cause of his problems that day. But the point is no baby in the Countess of Chester can have had more doctors looking into his or her throat in the space of about 8 hours than [Baby N] had that day with laryngoscopes, with illumination. And, save for Dr Saladi, we don't have descriptions of fresh or flowing blood or any identified trauma. We've got swelling but not identified trauma.

And as for the doctors who dealt with this, it is worth revisiting that list by [Dr D], which is at tile 420. We've seen this but this sets out people who were involved in attempts to intubate: Dr Mayberry, Dr Saladi, [Dr A] had earlier in the day of course, [Dr D], Dr Brearey, the anaesthetic team were called, I think it was Dr Campbell who was involved with that, so a number of people. You can see the note made by [Dr D] where it says "myself":

"Cords seen by [a word] anterior and obstructed by red swelling inferior to epiglottis."

Swelling. So for all that this is proposed to be trauma that is caused and trauma that would have caused bleeding, there are no signs of any kind of wound or damage like that inside the throat, that's the point, and he was well inspected by many doctors.

I'm going to move forwards, ladies and gentlemen, to follow this through to 19.40, which is the desaturation later in the evening when medical personnel arrive from Arrowe Park. You might remember things had become quite desperate at the Countess of Chester and there were talks of getting a theatre ready to perform an emergency tracheotomy because they could not intubate [Baby N] and they'd settled for a laryngeal mask as a way of helping him with breathing as they decided what to do.

We say it's unsurprising, sadly, that [Baby N] desaturated at 19.40 after the kind of day that he had had. This isn't an allegation, I remind you, on the indictment but it's something that is sent Ms Letby's way because she was there. But he'd had a very long day and had been through a great deal.

And in fact in evidence Dr Gibbs described how a poor fit with a laryngeal mask may mean he didn't receive the oxygen he needed. But however it worked, when Dr Potter and his team from Arrowe Park walked in, they walked into the midst of an escalating emergency situation. And you'll recall, for all that there had been the problems all day at the Countess of Chester, he intubated [Baby N] in the immediate aftermath of the desaturation in one go and there was no swelling and certainly no blood that he could note.

I'm going to deal with this because we ended up focusing on this and we say it's important because it just goes to show again the difference between, we say, someone who was equal to the task of looking after a child who presented particular difficulties and a large number of people who we say were not.

We'll look at that, including what Dr Bohin had to say. It is worth considering, we say, Dr Potter, who gave his evidence in a very straightforward, matter of fact kind of way, and we say, and you may remember him being there, he was trying not to be critical. I'll remind you of some of what he said, but he plainly seemed to be, at the very least, surprised that there was this problem. You'll know that one issue that arose was maybe the swelling had gone down by the time Dr Potter got there because of drugs [Baby N] had been given. I'm going to come to that.

But I will just remind you, first of all, of Dr Potter's expertise because he gave an opinion and gave evidence and then Dr Bohin later on gave her opinion on it. So we can see who the expert is here.

Dr Potter's expertise in this area was evident from his evidence to the prosecution. He was their witness and they asked him about this on 6 March. It's important and I'm going to remind you what he said. He said:

"Answer: I'm a consultant paediatric anaesthetist.

"Question: Thank you. Did you become a consultant paediatric anaesthetist back in 1996?

"Answer: I did, yes, 1 April.

"Question: Thank you. We'll put that date aside for a moment. Was that at Alder Hey?

"Answer: Yes.

"Question: And have you worked there ever since?

"Answer: I have.

"Question: Do you have a particular interest in your practice?

"Answer: My particular thing is paediatric intensive care."

So very much the man for the job you may think:

"Question: Thank you. Do you have particular experience with airway difficulties?

"Answer: Yes, I do. Of the group of consultants on the intensive care unit I have the most experience of airway problems.

"Question: Are you talking about Alder Hey amongst that group?

"Answer: Yes.

"Question: How many paediatricians are we talking about?

"Answer: I think it's 10 or 11 full-time."

So an expert in paediatric intensive care, anaesthetics, with particular ability with the children, the sort of children we look at here, paediatric intensive care. The most experienced of airway problems. A genuine expert in terms of what he does, not just what he calls himself.

He explained modestly that [Baby N] presented a fairly unremarkable case for intubation, this is his evidence, and something he managed with relative ease. Nothing like as complicated as he'd been led to believe before seeing [Baby N]. And although his view was that for a doctor without his experience it might have presented challenges, and he described actually how the anatomy of [Baby N]'s voice box was slightly unusually shaped, which might have made getting a line of sight more difficult, he added that he was surprised that there'd been such difficulty intubating [Baby N] by so many doctors, and he said this:

"Because [he] thought the Countess of Chester doctors were pretty competent."

Pretty competent. That says something, doesn't it? It means also that this was something they should be able to do but maybe not as competently as he could. We say Dr Potter was careful about his professional colleagues when set against the ease with which he did this, but it does perhaps give a picture of different abilities at different levels of care.

Dr Potter rejected flatly the suggestion that had been made by Dr Gibbs at first that dexamethasone at 17.45 and adrenaline at the time of the collapse could have reduced the swelling, because that was one of the ways in which there was a kind of workaround that was introduced for the doctors on the neonatal unit, that the drugs given from 17.45 onwards would have reduced the swelling. And he was adamant, and you know his expertise, that that is not what would have reduced it.

So this came down to a question of skill and experience. He had it and the doctors at the Countess didn't. And you may have thought that would be the end of the matter. But no. Dr Bohin comes, in effect, we say, you can judge it, to the rescue. She didn't accept the opinion of the highly qualified and experienced Dr Potter. Dr Bohin is a neonatologist, she has experience. She is not, we say, nor has the evidence suggested, someone with his experience of intensive care with airway problems in children like this paediatric intensivist in this fashion, the most experience of airway problems. She doesn't. This is his thing.

But, and you heard this, with her knowledge of remedies for children who bark like seals -- do you remember that about croup and her knowledge of how anti-inflammatories work or anti-allergens work with peanut allergies, she was ready to take him on and say, no, I think the drugs would have worked, it's just down to the medication.

Well, there's actually a straight clash between those two prosecution witnesses on this and we say it's not insignificant. He's absolutely clear the drugs from 17.45 are not the reason he could intubate, they will not have changed the swelling. She's absolutely clear that he is wrong. He is the expert who does this and she is not. But what she says kind of rose out of the Countess of Chester doctors, doesn't it? It does, because it's getting back to saying, well, Dr Potter could only do it because it was easier. It's nothing to do with lack of skill and that feeds back into the case when we consider are they equal to the task and why did [Baby N] desaturate at 19.40 in the way he did?

We say she stepped well outside her area in dismissing his opinion and well into the area of assisting the prosecution on that point.

My Lord, I could make a start on the next --

MR JUSTICE GOSS: By all means. 3 o'clock is the cut-off point.

MR MYERS: Thank you. Again, by saying I can make a start, I'm not dealing lightly with the enormity of what we're dealing with, but I know we -- having said 5 days, I want to be there. I should say, I've got to a point, Mr Murphy, where you may be having to freestyle with some references. If we do, it's from the [Baby O] sequence, but there won't be many in the next 10 minutes, there may be one.

I'm going to start with a reference, Mr Murphy, if we could, which is tile 89 from the [Baby O] sequence. Whilst you're looking for that, I was going to introduce it.

[Baby O], ladies and gentlemen, we know -- I say [redacted]. [Baby O], and I apologise now at the outset if I confuse the names. I will try and stay with [Baby O]. Again, I mean no disrespect if I get the surname wrong.

On 21 June, triplets were born, [Babies O, P & R]. [Baby O] was born at 14.24. He was triplet number 2. 33 weeks and 2 days' gestation and a little over 2 kilograms and 220 grams. That's on 21 June.

23 June, which is the date for count 20 on this indictment, is at 13.15 there was vomiting and abdominal distension.

At 14.40 there was profound desaturation and bradycardia accompanied by "mottled ++ and red abdomen".

At 15.51, he desaturated to the 30s with bradycardia and CPR then followed on a couple of occasions after that, on two occasions after that, but he could not be brought back to a level at which he could sustain life and, very sadly, he died at 17.47 that day.

Dr Evans has proposed or attributed this to an air embolus that caused collapse, plus some sort of trauma that caused bleeding and will have destabilised him. Dr Bohin puts vomiting and abdominal distension due to air down the NGT, the collapse at 14.40 due to an air embolus, and was a little more ambivalent over the deliberate trauma, though she did consider that as well. You know where we're talking about the trauma, we're talking about that injury to the liver which was identified on post-mortem.

I'm going to start, if I may, with the night of the 22nd into 23 June. This is when Nurse Ellis is looking after [Baby O]. We have a couple of notes dealing with that shift. We say he was

well at the time of handover. When we look at this, a few items stand out. At this point he's tolerating feeds well if we look at the bottom:

"Part-digested milk aspirates under half the feed volume four-hourly. Abdo full but soft."

If we move on to 06.41. We have:

"TPN stopped as reached full feeds of donor-expressed breast milk. Tolerating well. Antibiotics stopped, blood cultures negative. Cannula removed. Gas completed. [There was a] Slight raise in lactate and Registrar Mayberry was informed."

We move on to the end of the shift:

"Abdo looks full, slightly loopy. Appeared uncomfortable after feed. Reg Mayberry reviewed. Abdo soft. Does not appear in any discomfort on examination. Has had bowels opened. Continue to feed, but monitor."

So that's the note from the night shift. We looked at this in evidence. During the night of the 22nd into the 23rd, which we're dealing with here, [Baby O] experienced some issues, some -- we looked at it -- whilst in the care of Sophie Ellis. That's why he was reviewed by Dr Mayberry. But no note was made by Dr Mayberry.

Lucy Letby was his designated nurse for 23 June and at 13.15 he became unwell. We ask this as we begin to look at this count: why is it that when [Baby N] became unwell with Jennifer Jones-Key at 01.00 in the morning the prosecution are ready to blame that on Lucy Letby's care of him up to 8 pm the night before, but when [Baby O] becomes unwell with Lucy Letby at 1 pm in the afternoon, we are asked to ignore how he was when Sophie Ellis looked after him up to 8 am?

We see the inconsistency, almost like a mirror image there. On both occasions we have a baby who becomes unwell after being handed over from one nurse to another and after a similar amount of time, and in fact the only difference is that whereas [Baby N] had been well when Lucy Letby handed him over to Jennifer Jones-Key, we know that [Baby O] had been experiencing some problem when Sophie Ellis handed him over to Lucy Letby.

So there's quite a big inconsistency in what can happen and what's said about it before we commence. We also ask, why is it all right for a doctor to attend but make no note in the case of [Baby O], but highly suspicious for a doctor to attend but make no note in the case of [Baby I]? Do you remember the 15.00 review? No note -- we looked at this with Dr Mayberry. There was

no note made here and there was no note made there in the [Baby I] case. And it's said, "Well, because you didn't identify the doctor, Ms Letby, and you made it up". But yesterday we had a look, didn't we, at [Mother of Baby I]'s evidence? And we saw that, when you go to that, she describes a doctor coming for a review at 15.00.

So we have a similar thing, don't we, but a different approach to it? In this case, no note. That's fine, it's Sophie Ellis. With Lucy Letby and [Baby I] it's not, it's a critical factor. We say different standards, ladies and gentlemen, for different people.

If we apply the same standards to the case of [Baby O], we say that Lucy Letby could not be blamed for what happened at 13.15, at the very least, notwithstanding there's an examination of [Baby O] by Dr Cooke at 09.30 where we accept he didn't appear to have any evident problems.

Staying with the issue of how different people are treated differently in this case, there is a striking similarity with [Babies O & P] that the prosecution -- that has not been identified. For both [Babies O & P], their problems start on the shift before Lucy Letby comes on duty, however small they may be.

In the case of [Baby O], we have the changes in his condition, we have seen here; they're moderate but they're there. In the case of [Baby P], we have the question of large milk aspirates at 20.00 and 24.00 and then large air aspirates around 04.00. Do you remember? 25ml that we say cannot sensibly be linked to Ms Letby, however creative anyone gets.

We're not making any allegations here, we're just showing the inconsistencies of the approach because the common feature is Sophie Ellis. If we were to switch what I'm going to say now, Sophie Ellis for Lucy Letby, you'll see the point. Sophie Ellis is the night nurse both times. Samantha O'Brien hands [Baby O] to Sophie Ellis on the 22nd, before this. So Samantha O'Brien, Sophie Ellis, Lucy Letby.

It's Lucy Letby who hands [Baby P] over to Sophie Ellis on the 23rd. So Lucy Letby, [Baby P], back to Lucy Letby. On both counts, therefore, Sophie Ellis is looking after the children and on both counts they're handed back to her, back to Lucy Letby by Sophie Ellis when they both deteriorate, and in the case of [Baby P] within 2 hours.

In a case where we're looking at patterns, we just observe -- making no accusation, we're simply trying to show the inconsistencies of this kind of approach, that for both children

Ms Letby is literally left holding the baby after Sophie Ellis has been in charge on both nights and where there have been issues of some sort on both nights but there have been different nurses handing the baby to Sophie Ellis before that point.

We should recognise there were issues on those nights because the doctors were informed on both nights of issues and changes in the babies' conditions. You can imagine --

MR JUSTICE GOSS: Well, how much longer?

MR MYERS: I'm virtually there, my Lord. This was it.

MR JUSTICE GOSS: Good. Sorry, I was just getting a little concerned you were gathering another head of steam.

MR MYERS: I was about to say it.

MR JUSTICE GOSS: I'm sorry, but --

MR MYERS: Simply this, simply this. If it was Lucy Letby who was in the position of Sophie Ellis on those two night shifts you could imagine what would be said if she was the common feature about both nights. That's the point. I'll pick it up in the morning, but that was it, my Lord.

MR JUSTICE GOSS: I'm sorry I interrupted you, but it was difficult to tell because you were joining up quite a few things.

All right, members of the jury. 10 o'clock tomorrow then, please, when Mr Myers will complete his address to you, I hope.

(In the absence of the jury)

MR JUSTICE GOSS: I did cause to be sent what I hope will be the final version --

MR JOHNSON: Which I at least have had an opportunity --

MR JUSTICE GOSS: I know you won't have done, Mr Myers.

MR MYERS: A very brief one, my Lord.

MR JUSTICE GOSS: I've essentially incorporated, not verbatim, but incorporated the suggestion that was made by you.

MR MYERS: I'm grateful. There was one other matter, but it's entirety for your Lordship. I did see this and I had the opportunity to look at this briefly before coming into court. May I just raise it now?

MR JUSTICE GOSS: Certainly, please do, yes. It'd be helpful.

MR MYERS: Then your Lordship has it. On the direction of the experts, this is page 4, and to some extent we are of course, as we always are, in your Lordship's hands on in. It's where your Lordship talks about -- directs the jury, I should say, on how they do not have to consider expert evidence in isolation and each expert was giving opinions purely from the viewpoint of their own specialised knowledge, each was careful to confine their opinions to conclusions they could draw from their own specialism.

We understand, of course, at that point your Lordship is setting out the process upon which they're embarked. There is an issue with the experts as to the extent, of course, to which they have confined themselves to opinions within their own specialism. The point we had raised, but it's entirely a matter for your Lordship, was that we were anxious that it did not appear that there was a settled view that they have to a man and a woman --

MR JUSTICE GOSS: I understand what you're saying because the criticisms that you've made in relation to -- a profession of having an expertise that you have challenged that they do actually have.

MR MYERS: We have. In fact, it came up then but it's come up in the submissions we've just been making, but it's featured elsewhere as we've gone through it and we were anxious that -- this isn't the purpose of it, we know that, but one does not know how a jury will react to what they receive in hard copy if they go back and look at it and if it appears that it's conveying that they have confined their opinions, we don't ask your Lordship to make comment one way or another but --

MR JUSTICE GOSS: No. I will add -- I have in mind what I'm going to add to make it plain that this is an expectation rather than an achievement.

MR MYERS: Yes.

MR JUSTICE GOSS: All right?

MR MYERS: Thank you.

MR JUSTICE GOSS: Some experts did, some didn't.

MR MYERS: Yes, they did.

MR JUSTICE GOSS: I don't want to get into the business of me saying who did and who didn't.

MR MYERS: No.

MR JUSTICE GOSS: Yes?

MR MYERS: There will be a visit, please. We're grateful.

(3.05 pm)

(The court adjourned until 10.00 am on Friday, 30 June 2023)