

30 June 2023 (Day 140)

Defence Closing Speech Day 5: Babies O, P & Q, Summary & Conclusion

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Closing Speech by MR MYERS (continued)
Discussion

Friday, 30 June 2023
(10.00 am)

(In the presence of the jury)

Closing Speech by MR MYERS (continued)

MR MYERS: Good morning. Ladies and gentlemen, we were looking at the case of [Baby O], which is count 20 on our indictment, and just to remind you again, there's really three times on that date that the evidence focuses on on 23 June: there's 13.15, which is the initial vomiting and abdominal distension; 14.40, when there was a profound desaturation and bradycardia and [Baby O] and was "mottled ++ with red abdomen"; and then a desaturation at 15.51, which led to CPR from which he couldn't be revived, sadly. That's what we were dealing with.

Yesterday, just before we finished, I was simply, by way of illustration, drawing parallels with the way that a baby may pass to one nurse, who looks after the baby, be passed to another one, and even though the pattern happens elsewhere without any blame apportioned, when Ms Letby is slotted into that pattern in a similar way then it's treated as a harm event. That's what we were dealing with and I was just looking at the symmetry with these when Sophie Ellis is in the middle, receiving the babies from different people and then passing the babies on to Ms Letby both times.

We had looked and considered the extent to which there was any change in [Baby O]'s condition overnight and there was some change, not enormous but some change, and, if you recall, enough for the registrar, Huw Mayberry, to be asked to come and take a look.

If we move to the time at 1.15 pm, [Dr A], on 15 March, spoke about [Baby O]'s condition at this time. We say that what he identified were factors that showed a developing problem rather than anything which shows that any type of deliberate harm had been done. From the blood gas he said that it appeared that [Baby O] may have been developing or indicated a metabolic acidosis. He had wondered if there was infection -- we are not

saying there was that but these were the thoughts that went through his mind.

The abdominal distension. He spoke about how a baby may take extra breaths that can lead to some distension, for example, when straining to pass a stool, which he described [Baby O] had done, and it is recorded on the intensive care chart that [Baby O] was on Optiflow at this time and had been for some time.

So if we're talking about mild distension, we say there's nothing really with his abdomen that can account for a collapse. And he didn't collapse at that time, of course. He didn't. We say even when we move forwards to the event at 14.40, the radiograph for that time shows only moderate distension. I'm going to come back to that in a little bit, ladies and gentlemen, about moderate distension there because the allegation is that, amongst various things that the experts discussed, excessive air was forced into him, so we'll see if it actually supports that.

It's important, we suggest, to keep in mind what [Dr A] said about the potential for a pre-term neonate to have problems after an initial 24-hour honeymoon period. In other words there can be a period when a baby can be relatively resilient and then, after that 24-hour period, any problems can take effect. What he said on 15 March was that:

"Preterm babies have a degree of resilience and it's commonly observed that babies you'd expect to have problems due to their prematurity or other circumstances often do well in the first 24 hours, so you have to be mindful that a deterioration may occur after that point."

Which we say is the type of period we're moving towards or into with [Baby O] when we say he did begin to deteriorate.

He was beyond that recognised period of resilience and we say that's relevant when we consider what happened and, again, the absence of anything that indicates Ms Letby did anything to him -- and you will remember, ladies and gentlemen, that at this point, in addition to working in the nurseries at a busy time of the day, she had a student nurse with her, Rebecca Morgan, who was in effect shadowing her. In fact she complained, didn't she, in one of the texts to one of her friends that she had her got her "practically glued to her", I think is the way it was put, I will remind us of the wording when we come to it. So not only is it the normal situation but there's actually someone there with her at this point. But we say this is where we get to at 14.40, with a gradual accumulation of problems for [Baby O] and into a period when [Dr A] recognises a neonate may develop problems.

This is where we get to when things escalate and go -- and become more pronounced.

The expert evidence as to what happens at this point and moving onwards is, we say, confusing. And if you have followed it during the course of the trial and taken notes, and you did that when we were dealing with [Baby O] and Dr Evans and Dr Bohin gave their evidence, we urge you to look at whatever notes you had or recollections you have or whatever guidance you have received from us, as far as you can, and from his Lordship when you receive it, but we say it is very confusing as to exactly what is meant to have happened. We add in brackets that's not surprising because, as you know, we say these are experts who are deliberately looking for things they can allege or mechanisms they can describe to support the allegations.

Dewi Evans has provided, at different times, various mechanisms. His first two reports, when we asked him about this in cross-examination, alleged an assault in the early hours of the morning that must have injured the liver, which hit a tipping point later that day. We say that what he was doing there was actually acknowledging that there were problems in that night shift, in the early hours of the morning, and trying to link them to the liver injury much later. That's why he did that with his tipping point theory but importantly he'd originally said in his reports "an assault in the early hours of the morning".

There was also, we say, quite a lot of uncertainty about what use he made of the mark that Dr Brearey described that was there for some time -- do you remember, the small 1 to 2-centimetre -- and there was some debate, is it a rash, is it a bruise. It was plainly a mark that came and went. It doesn't appear to have been a bruise and it seems that Dr Evans had taken that as a bruise at some point.

We did in addition, and perhaps inevitably, get to air embolus with Dr Evans. We usually did, didn't we, whatever was happening? And of course, he includes trauma done to the liver and that is a real issue to consider.

Dr Bohin gave us air down the NGT, air embolus, and potentially trauma, and however she approaches it, certainly we recognise what happens with the liver is something that has to be considered, whatever the experts say in fact. That has to be looked at.

I'll just deal briefly with the other mechanisms. Air embolus. If you can find in the evidence precisely how, where, when that was meant to be done, ladies and gentlemen, by all means make use of that. We suggest it's very unclear as to how that works. The prosecution, frankly, didn't appear to identify a place

because they -- we don't criticise them for this, this is the state of their experts' evidence -- but they concluded their examination of Dr Evans by saying that there were various timings, but the defence could look at them with Dewi Evans if we wished. Why should we descend to try or be expected to make detail, make sense -- to make sense -- of something the prosecution didn't?

You may remember that, "The defence can ask if they want to". Well, how can we? We don't quite know what he says happened or when and we didn't get that.

Post-mortem gas is something that is relevant in the case of [Baby O]. As we've had from Owen Arthurs, it's something to consider, the air in the great vessels, it is not conclusive, but the picture is largely the same as for [Baby A] and [Baby D] in terms of radiographs.

I am reminded, and I correct this, that Professor Arthurs did make reference to air in the bowel and in fact in the heart, so I correct what I said, if you remember, a few days ago about an absence of evidence of that. There was air he identified there.

But be that as it may, it is air in the great vessels that he focuses on and which he has drawn the comparisons with, with [Baby A] and with [Baby D].

And wherever we get to with that with Owen Arthurs, ladies and gentlemen, you know there are a number of explanations for air like that and they apply each time we come to this. They could be, Professor Arthurs says, gas introduced from outside, by accident or on purpose. It could be, less commonly he says, unusually post-mortem gas; that was his study that said in 25% of cases you could get this. And the strongest link he has identified on his actual research, in the academic sense, is the link with resuscitation, which is a common feature across all of them and, we say, is the most likely explanation for that same disposition of air that we see.

And it certainly doesn't look like the image that we have of an undoubted air embolus, which looks exactly like what you would imagine, with it branching out in different directions. We see that in the Lee and Tanswell paper and we saw that on the imaging of [Baby G] and none of them actually look like that.

So let's go back to discolouration. Again, there are many and varied descriptions for comparison, ladies and gentlemen. It was at this point of the case that there was the exchange with Dr Bohin where we were suggesting to her that we'd lost sight of any type of principled standard to apply and she, if you remember, said, well, it's rather like the business with

chickenpox: we all know what chickenpox looks like, so we can spot chickenpox marks. The point is that's right: we do know what chickenpox looks like, we don't have much to go on with what air embolus discolouration looks like, we can't do it, outside this paper. And we had reached at this point in the case a stage where -- and you'll have seen this on the evidence -- literally everything could be used by the experts if they wanted to say, "Ah, that is unusual", even if the clinicians hadn't identified it as unusual.

Now one person who did give a vivid description was [Father of Babies O, P & R], and good deal of reliance has been placed on that. It's a description he gave in his interview on 16 December 2019. Nobody expects him to make records like a doctor or a nurse so there's no point made about that at all. But let me start with what he said. He described the veins being bright blue and he indicated his left hand and he could see the veins, also like prickly heat. He said different colours but emphasised blue, bright blue, prickly heat, "It got worse then went down again".

And do you remember, he gave that description, "Like ET's stomach"? And if you know ET, you'll know what that means. He tapped his hands and said it went down, although that might have referred to the stomach. And nobody could doubt how vivid and upsetting that is, we say plainly linked to a swollen belly and the veins being blue. And [Baby O] was very unwell and there had been an issue developing, in one way or another, for some time and there, we say, would be bound to be discolouration.

And Samantha O'Brien, whose statement was read to you, could see that [Baby O]'s stomach was distended and his skin "a bluey colour". And we've heard that is symptomatic of desaturation in babies.

And Yvonne Griffiths' statement was read to you. She was with [Father of Babies O, P & R] as he was watching and, looking at all the evidence equally and with equal degrees of analysis, she didn't identify or describe anything odd about [Baby O]'s colour at all. None of that is to take issue with what [Father of Babies O, P & R] says, but what will strike a witness and the things that stand out may vary, mightn't they, in a particular situation and the shock and impact for him is enormous and he has focused upon the colours and the discolourations he sees.

The blue raised veins and the ET description may reflect a distended abdomen and issues in relation to that. We say that isn't something that is linked clearly to air embolus, not at all, and it's significant that the other clinicians present, notwithstanding the background in this case, and let's face it the witnesses all know it because it was talked about, they

haven't drawn distinctions from the colour of [Baby O] which stands out and which they have called especially unusual. And we say that is significant, that a natural desire -- there's every sense of sympathy with [Father of Babies O, P & R], every sense of sympathy, and the prosecution have seized upon his descriptions and used them as much as they possibly can. But we say we don't doubt he saw what he saw, but that isn't air embolus, you couldn't possibly base this on that.

[Dr B] said that [Baby O] was mottled when she first saw him at about 15.50 and she explained that is consistent with a baby with poor perfusion. That is important. Mottling is something that's sometimes used for air embolus by the experts in this case and sometimes not, but you know, ladies and gentlemen, you have probably developed a good knowledge of various areas of clinical observations if you didn't have them beforehand, but mottling is a sign of poor perfusion, not a sign of air embolus. So you have to be very careful with how that's used.

We come back again, as we move through the afternoon, as to how or when is Ms Letby meant to have done whatever was meant to be done with an air embolus? We know that the student nurse was involved with [Baby O] and with [Baby P] in this nursery. She told [Dr A] that, "My student is glued to me".

The closest we've come to any specific allegation is the period in which various medications are given to [Baby O], which means that his line is accessed, there's a run of them.

We'll look at them in a moment, but it happens around about 14.39, right up to the point of collapse at 14.40, and in various ways the suggestion has been made, or the implication made, that one of the last people or the last person to give medication before that collapse was Ms Letby, and we know she was involved in medication around that time. We have looked at this several times closely.

That point is not a good point. It isn't what the evidence is, so I'm just going to remind you because you can see who's accessing the lines immediately before this collapse and we say, on the evidence, it isn't Ms Letby.

We need to look first at the neonatal review because that sets it out in a particular way that, when we actually go through the evidence, we say is not accurate. So could we put up the neonatal review for [Baby O] at page 4, please, Mr Murphy? It's lines 92 to 97. In fact, let's go 92 to 100. There we are, thank you.

All right, ladies and gentlemen, if we look at this, this is from the neonatal review. The sequence isn't the same as this,

but we've got Melanie Taylor and Samantha O'Brien at 14.39 giving medication at line 92. And there's a second medication given at the same time; that's at 14.39. Then we have the prescriptions which duplicate it. That's the actual prescription just being updated at 95 and 96.

Here what happened -- I'm not suggesting this is on purpose, but the analyst has put at 97 at 14.40 Lucy Letby with Samantha O'Brien starting an infusion. You can see that, can't you, and that looks very much like it happens just before the collapse. We have been through this in some detail in the evidence and to see exactly how this works, we need to go to the sequence of events and not the neonatal review. So if we put that to one side, and I'm going to ask Mr Murphy, if he would, just to go to the sequence of events and start at tile 191. It's important to look here now at how these work.

So 14.39 is the first of those medications being given by Melanie Taylor and Samantha O'Brien. That's sodium chloride, flushing a line before the antibiotic, cefotaxime, is given. And if we can go to tile 192, please, Mr Murphy. The next one along. That's at that time.

Next, 14.39, there's swipe data for Ms Letby, and we'll just confirm where she's coming from or going to. So from maternity labour ward to the neonatal unit. So she's not even there on the position at this point, this is the evidence. If we come back out of that and let's carry on.

Then we come to the second medication, also at around this time, 14.40. Sorry, we come to the -- we've had the two medications, we come to the update on the computer. So that's for the first one and tile 195 please: update to nursing notes. Can we move on from there, please. So 196, an X-ray around this time. 197, please. Then the event at 198.

We then have, at 199, clinical notes by [Dr A]. Then if we move to 200, at 14.40, we have the neonatal infusion that begins post-collapse, in fact, at 14.40 with Lucy Letby and Samantha O'Brien.

If we go to [Dr A]'s notes, if we just go back, please, and open them up, and scroll down, it takes a little bit of careful reading here but this is dealing with what happened after 14.40:

"Called to see [Baby O] at 14.40. Desaturation, bradycardia, mottled. Bagged up and transferred to nursery 1 and continual Neopuff required in 100% oxygen."

It's got some statistics. The PEEP. Now:

"IV cefotaxime and 10ml sodium chloride bolus already given."

Can you see that? That's really important. "Already given."
That's the 14.39 ones:

"Further 10ml per kilogram [whatever] then intubation following and morphine."

The 14.40 infusion with Lucy Letby and Samantha O'Brien is what follows with the intubation. We see that. The cefotaxime and the sodium chloride are given beforehand and we can see "already given". That's what we have at 14.39. And we had this -- we went over this in evidence in fact.

It's important to keep this in mind because either the impression or the suggestion may be made, or has been made, sorry, that at 14.40 somehow Ms Letby was involved in what took place immediately before the collapse. She was not. We're not saying that what happened at 14.39 caused the collapse, although again you could be fairly confident what would be said about it if Ms Letby had been involved in that, but the fact is at 14.39 it is Mel Taylor and Samantha O'Brien accessing the line. And Ms Letby's involvement follows.

Can we move, please? Thank you, Mr Murphy. We can take the tile down.

Also alleged is air down the NGT. Again, we have the same questions, ladies and gentlemen. When? How? For how long? How is that done when there are other activities going on, when a student nurse is there involved with all of this? What we do have is the radiograph that was taken round about 14.40 or at 14.40. And we have the image of that at tile 197, so I'm going to ask Mr Murphy to put that up next because this was relied upon in particular by Dr Bohin to say that there's been an attack with air.

This is the image. We can see the timing and the date. If we just scroll down we can see the gas there. This is at -- it's accepted this is 14.40 that this is taken. Can we scroll down to the actual note, please and just roll it down. This is the note that goes with it and we ask you to look closely at the description of distension. It's the fourth line down:

"Moderate gaseous distension of bowel loops throughout the abdomen."

Do you see that, ladies and gentlemen, "moderate distension"? Do not forget it's being said there's an attack here with an intent to kill. Professor Arthurs agreed with what the report says, on 16 March, when he was asked about this as moderate distension.

Pausing right there, Dr Bohin, when talking about the distension at this time, in evidence on 15 March, used words like "severe distension", "huge distension". She told you, in terms, that the radiograph of 14.40 revealed and we quote "a huge amount of gas in the abdomen". That is wrong. However she comes to say that, it is misleading because it is not a huge amount of gas in the abdomen. And given the mechanism she proposes, we suggest it's hard to see how that happens as a mistake or if she just misread this. But Professor Arthurs was very clear, this is moderate, and to say it's a huge amount of gas isn't right. We say straight: that is coming from a biased way of approaching this evidence.

Professor Arthurs agrees that the radiograph -- on 16 March agreed the radiograph can't show how the gas came to be there and he was dubious about Optiflow being an explanation. You may remember I asked him about that. We got as far as agreeing that CPAP belly could cause things like this, but he did take issue with my suggestion that Optiflow could have done it, I recognise that.

But, and this is crucial, when giving evidence on the same occasion, we say it's crucial -- you can assess it, ladies and gentlemen, it's a matter for you -- but he agreed that so far as this moderate degree of distension was concerned a radiograph like this might arise where there is no apparent cause. I'm just going to read to you -- this it's on 16 March at page 64. I asked him:

"Question: Is it the case that sometimes it might be encountered but no apparent cause is found? You may encounter images like this and there's no apparent cause?

"Answer: Yes, that's right. We know that tummies expand for whatever reason with some of these babies."

We have that certainly with [Baby I] in her history and it's important and, we respectfully observe, fair of him. It's the sort of thing a responsible, independent expert will do. He's been called by the prosecution, he's asked questions by both sides. We ask him:

"Question: Is it right you may get something like this with no apparent cause, in other words it can happen?"

"Answer: Yes, that's right."

That is a fair concession and we rely upon that.

We turn then to the third issue and the one -- it's a matter for you, ladies and gentlemen, but the one that we recognise is the one that is perhaps most likely to exercise considerations in [Baby O]'s case. We know that so I'll deal with that next.

There is injury, and plainly significant injury, to [Baby O]'s liver. A lot of the evidence in this case is upsetting, inevitably this no less than anything else that we have looked at. The issue is whether you can be sure that was done by Ms Letby to [Baby O] with the intention of killing him.

In their closing address to you the prosecution said:

"Before [Baby O] collapsed, Melanie Taylor had looked at him and thought that he didn't look as well as he had -- and you'll remember this bit of evidence, don't you, ladies and gentlemen?"

And then they said this:

"What she didn't know, and what you know from all the circumstances, is that [Baby O] by this stage had an internal bleed."

Now, we say that actually, there is no sufficient basis for that assertion at all. I'll explain why we say that. Just pinpointing, first of all, the time that comment relates to. On 9 March at page 61, Melanie Taylor in evidence described this conversation, where she said, "I don't think [Baby O] looks as well", and Ms Letby said, "I think it's all right". That conversation is happening an hour or two before the collapse. That's the collapse when [Baby O] is moved from nursery 2 to nursery 1, so that's the 14.40 collapse.

So that conversation is around 12.40 or 13.40. We ask rhetorically: the prosecution have decided the liver injury was done, therefore, between 12.40 and 13.40, at the latest, and we say on the basis of what? There is no clear evidence of when that was caused. There is no time attributed to it.

Dewi Evans, at one point, had suggested, if you remember, something had happened in the night that reached a tipping point later on and he was fairly imprecise. That leaves a pretty broad range to follow with Dr Evans as to when it could have happened, even including a period when Ms Letby wasn't there, although he retreated from that in evidence.

We say that no medical witness has identified that [Baby O] had sustained a liver injury by 13.40. If that's right, then this is a very approximate comment that is being made on the basis of insufficient or no evidence.

[Dr A] saw him, [Baby O], at 13.15 -- and we started with this this morning -- and he saw some abdominal distension and there were various issues and acidosis, but certainly nothing that led him to identify any internal injury. And we recognise an inevitable part of this case is -- and this is a reasonable observation, isn't it -- that if these things are happening, other people on the unit may not be looking for them. We can see that. We know you'll see that. All right? But certainly nothing at that point stands out in that way and no one has identified things like drops in blood pressure or changes in heart rate or anything which indicates an internal injury at that time.

And there's a reason why we are pursuing this point. We know a radiograph was obtained at 14.40. We've just looked at it.

Certainly on that nothing follows from that that has led anyone to say there's anything strange about the liver. Nothing. We say that the comments of the prosecution to fix the injury at that time is done for a particular purpose, we say it is, you've heard the question from the prosecution, why. Why did they say that? We say it's because it assists them in trying to move it away from a period when it could have happened during CPR. And we say that is one thing that follows whether that is the design in that comment or whether it's incidental, I don't know, I'm not trying to say, but a consequence of seeking to move the time of injury to between 12.40 and 13.40 is to move it away from when we say it was most probably caused.

And we say, ladies and gentlemen, that we cannot say how this was done, that CPR can cause it and could -- and I'm going to go through both of those because there's two questions. The first one is: can, in principle, CPR cause liver injury? The second is: could CPR have caused this injury?

Can it cause injury? Dr Evans and Dr Bohin flatly denied the possibility of this outright. We say that they have to be wrong about that because of course it could. And in fact Dr Evans provided, didn't he, in support of his position, the guidelines on neonatal life support that specifically direct the person giving CPR to be careful not to press too low because that risks damaging the liver? So it's very straightforward: you wouldn't have to have guidelines like that with that warning if it wasn't a possible danger. So it's a possibility we say, that's why the guidelines say that.

Dr Marnerides, the pathologist, was particularly dissatisfied and critical of me for seeking to establish that CPR can cause liver injury by talking about injury to [Baby P] at the same time as we were dealing with [Baby O]'s case. This was on 30 March.

Now, straightaway, can I identify, so you understand, we understand this reasonably, there's a big difference between the injury to [Baby P]'s liver and the injury to [Baby O]'s. I am not suggesting that they're anything like the same magnitude, of course they're not, we know that. But Dr Marnerides encountered no difficulty in accepting that what we have on [Baby P] could be the result of CPR. And we say, if that's right, looking at the location in general, then it is possible for CPR to cause injury.

We say it's very simple: can CPR cause liver injury? We say, on the evidence from [Baby P]'s case alone, it must be able to, to cause it. The magnitude is the second question, but can it do it? Yes, it can. We say the real issue is whether the injury in the case of [Baby O] could be from CPR. Is that possible?

The prosecution have pointed to how you can look at one count and apply evidence there to another. We say, if we take as our starting point [Baby P] and the principle that that can happen, then when it comes to the extent of injury we say, first of all, it is of little use Dr Marnerides seeking to introduce road traffic accidents, trampolines and bicycle accidents or pots following out of aeroplanes. That doesn't help us. They are extreme examples. He is a pathologist, he will see the worst and most extreme cases, and others that are not, but inevitably what he won't be seeing in the general run of practice is where injuries have been caused to livers and somebody has lived.

So he won't be able to tell us how little force it would take to cause an injury like this. That's the crucial thing. A pathologist can tell us how bad it can be but he will not be able to tell us how little the force could be and he can't. It is very important to draw the distinction between him picking the most graphic illustrations of what can happen but being also able to see how little it could take and we don't know. We suggest, ladies and gentlemen, it's going to take a good deal less force to cause an injury like that in a neonate than the extreme examples he was giving us, particularly since it's not combined, as far as we know, with any external injury or impact, or anything like that, which you may think is significant when we've had bruising elsewhere in other cases. There is certainly nothing there. How is that if we're talking about something which is the force of a road traffic accident?

If anybody did resuscitation with [Baby P], CPR, as the staff did on that resuscitation video -- and it's RG6 and you have a look at that -- you imagine somebody doing CPR on a baby weighing 2 kilograms in the way it's done on that video.

It is upsetting to see the haematoma and the extent of it. A lot of the haematoma is the spread after the damage has been caused.

What we asked Dr Marnerides -- and these are difficult things to deal with because it's upsetting material, but what we asked him and what we wanted to explore was: is it possible that CPR could do this? And I want to remind you of what he said after quite a lot of questioning on 30 March. We'd had the business about pots falling out of aeroplanes and it's possible -- or a pot in the desert next to somebody and it's possible it fell out of an aeroplane but not probable. Do you remember that? We're not suggesting anything like that.

But I asked him.

"Question: So that you understand, and I appreciate your position in this, Dr Marnerides, you don't accept the proposition that forceful CPR could have caused this injury in general terms. You don't. Do you agree it can't categorically be excluded as a possibility?"

What he said was this:

"Answer: We are not discussing probabilities here -- sorry, we are not discussing possibilities here, we are discussing probabilities. I cannot see how it is probable. Possible, it could be. But we need to understand that we are referring to -- when we discuss, we need to understand what we are referring to when we discuss possibilities and probabilities."

Because -- it had so many double faults I'm going to read that answer back to you again. He said this -- in answer to the question, "Can CPR be categorically excluded as a possibility", he said:

"We are not discussing possibilities here, we're discussing probabilities. I cannot see how it is probable. Possible, it could be. But we need to understand what we are referring to when we discuss possibilities and probabilities."

Now, we say, upsetting as this is, that that approach, we say, is wrong because this case, like any criminal trial, is about being sure. It's not about what is probable, it's not about "Is it a probability?", we say that is the wrong approach. We are talking possibilities. That is the question. And however reluctant he may have been, or anybody is, to acknowledge this fact, his evidence is:

"Possible, it could be. I cannot see how it's probable."

Right. Well, that is his evidence. Now, one of the reasons, one of the reasons we raise CPR or the question about -- so could it have happened? Yes, it could. Sorry. Could CPR do this? Yes, it

could in principle. And could CPR account for this? Yes, it could, it is possible.

One of the reasons we raise this or one matter we look at in conjunction with it is that telephone exchange. We'll have a look at that post-indictment schedule if we could, please, Mr Murphy, at tiles 111 through to 125, because we're not raising this in isolation in the sense that nobody could possibly raise a question about how CPR was done. This was a very, very tense, difficult situation. You heard a statement read from [Mother of Babies O, P & R], who described staff in a state of panic and uncontrolled as events unfolded with [Baby O]. That's the atmosphere.

And then we have this exchange where Ms Letby and [Dr A] are talking about a conversation with a doctor who I think was Dr Best, Dr Jess Best. We'll run through about 13 tiles. [Dr A] to Lucy Letby:

"Did J tell you what was wrong earlier?"

Can we go through these to 125, please? Thank you.

Ms Letby:

"Not really. We started talking but then people came into nursery and she dashed off."

Next, please, [Dr A] to Letby:

"I'm not sure where the information has come from. It seems that on the SHO grapevine somebody at LWH [Liverpool Women's Hospital] has said that one of the triplets was found to have a ruptured liver. J was upset that this may have been caused by her chest compressions."

114:

"Oh no, that's awful."

Letby to [Dr A].

115:

"No wonder she's upset. Were you able to reassure her?"

116, please. [Dr A]:

"We spent 20 minutes in a cubicle going over everything. The CPR was all at the 5th rib space, between the nipples. The DuoDERM on [Initial of Baby P] was high."

[Initial of Baby P] would be [Baby P]. We're not suggesting this is a ruptured liver in relation to [Baby P]:

"If there was anything it will have been due to fluid volume causing liver distension."

117, please. [Dr A]:

"I'm not sure I believe it."

118:

"It was a coroner's PM. It usually takes weeks to get any report."

Let's carry on to the end of this bit, please, 119. From Ms Letby:

"It seems a bit of a rumour mill has gone into overdrive. The boys were only returned today. Can't see how info would be out that quick."

120:

"No, me neither."

121:

"Not nice for J though. Can see how it could play on her mind."

[Dr A]:

"This has come at the end of a seven-day run for her."

A seven-day run:

"Not a good time."

123, Ms Letby:

"No. It's good that she felt able to tell you. "

124:

"I'm good for a hug and a chat. I think I helped", says [Dr A].

And then 125:

"She said she had spoken and cried on you and Huw and was feeling better for it", says Ms Letby.

Whatever has happened, it took 20 minutes to discuss how CPR was done. We looked at this in the course of the evidence. We say, at the very least, this raises the possibility that, amongst those dealing with this, injury can be caused by CPR. That's plainly something that she was concerned about, that J was concerned about in the circumstances that she was dealing with. We know CPR was performed on two occasions with [Baby O].

That is as far as we can take that. Ms Letby says, "I didn't do it". We do not have to explain how -- you understand that, ladies and gentlemen -- but we do actually ask you to look at that evidence. We don't shy away from it, because we'll know you'll want to, and it's important and it carries, in every sense, an impact, doesn't it? But we ask you, when you do look at it, to keep in mind that when it comes to CPR, we say, on the evidence that we've had, however reluctantly given, is it possible for CPR to cause liver injury? Yes, it is. Is it possible it could cause this injury? Yes, it is. And if that is right, and in the absence of other evidence, we would say, that could possibly mean that you can attribute it to Ms Letby, we are some way from being sure of that. If we're not sure, that is not guilty, however emotionally impactful that evidence is. But that's a matter for you, ladies and gentlemen. We've dealt with it in detail because we understand it's something you will want to look at in detail.

We were also, in the case of [Baby O], taken to a Datix form, do you remember, with reference to IV access having been lost and IO access, intraosseous access, being used. And that was on the theme by the prosecution that Ms Letby lays false trails, it's a deliberate lie designed to make it look as if an air embolus had been introduced, could not have been introduced because there was no IV access.

It's a theme the prosecution follows. And we say, as in other cases, it simply can't arise in this place -- in this case because if a form had been put in earlier in the day saying, "No IV access", then maybe someone who was sufficiently clever could be doing that to make it look like they could never have done anything to cause the collapse. But that form relates to events once the collapse had happened, if you think about it, because we're talking about the IO needle being used. That is after the collapse has happened. So whatever the state of IV access is at that time, and even if Ms Letby is wrong about it, it hardly provides her or anybody with the ability to say, "I couldn't have done it because we'd lost access". Because if someone's had access to it, it was before that point anyway.

And we do observe the reason we have that Datix form is because the prosecution have brought that up. That's why we're looking at it. We didn't.

[Mother of Babies O, P & R] described how upset Ms Letby was after the death of [Baby P]. We say that is normal. It's what you'd expect. She was involved in looking after them, after their deaths, the triplets, [Babies O & P], with the memory boxes and [Father of Babies O, P & R] described that, but then again she's the designated nurse. There's nothing odd or suspicious about that.

Naturally, attention moves to her behaviour later on with the note. You know, the note where we can see, reading across it, on what looks like the anniversary of their birth, she's thinking of them. And in fact we have had in evidence, I omitted this, reference to her looking at the [Family of Babies O, P & R] on Facebook, that is one of the searches, on 23 June 2017. Again, effectively the anniversary, isn't it?

There are two ways of -- many ways of looking at that. There is the way the prosecution say, which is in some way that shows or is indicative of her having killed them, putting it bluntly. That's the allegation. That's what they're saying. We say it doesn't get close to proving that. It really doesn't. It may well show that on the anniversary of their birth it is something that she remembered and in her state of mind, that is consistent, we say, with the distress she was experiencing, of which there is no doubt, it is not misleading, she was deeply distressed over this period as she looked back at what happened.

So how is that meant to indicate that she's done something to harm them as opposed to anguished at the thought of what had happened? And that's how it reads, particularly when you put it in the context of her frame of mind at that time.

There are often a number of ways of looking at the pieces of evidence in this case, particularly those pieces, and quite a big difference applies to whether one approaches it looking at it through the lens of a presumption of guilt or the lens of a presumption of innocence. The presumption of innocence would mean that if there is any other explanation, other than what the prosecution say, then that's the one to go with and there is, most definitely. Nothing about those establishes guilt.

You will have to decide that ladies and gentlemen. You understand these are submissions we make from the defence position. But there is no set script to that. There's no set view. We say to you all of that and the note writing is of a piece with the distraught condition she was in at that time.

We'll move next, ladies and gentlemen, to the case of [Baby P], count 21 on the indictment. First of all let's start with the details with [Baby P]: [Baby P] was born on 21 June at 14.23, 33 weeks and 2 days. He was the first of the triplets and his weight was 2.066 kilograms.

The key events that we'd looked at collectively on this count are as follows: on 23 June, so this is the day when, tragically, [Baby O] died, on 23 June at 18.00, the clinical notes record a mild abdominal distension with [Baby P]. He was in the care of Ms Letby that day, who had with her the student nurse, Rebecca Morgan. Care was handed over to Sophie Ellis.

During the night shift of the 23rd into 24 June, he produced large milk aspirates and then large air aspirates. You've probably seen these documents so often you can probably almost see them in your mind's eye as you look at them with those entries in them, with the large milk ones on the first page of the feeding chart and then the large air ones with the small bit of milk on the second page. That's overnight.

The doctor was called for a clinical review, that's Huw Mayberry, but he didn't make it to the nursery before he was called away again, so there was no review of [Baby P], although there was meant to be one, because they were too busy.

If we move forwards then into the morning of 24 June 2015, at about 9.40 [Baby P] had apnoea, bradycardia, desaturated and was mottled with a distended abdomen. And this happens in the nursery just after Dr Ukoh had reviewed him.

Then at 12.28 that day, there was a further desaturation and bradycardia. That is the point at which [Dr B] says a tube was dislodged. We'll look at that.

A right-sided pneumothorax was eventually identified. Treatment for that commenced. And then at 15.14, so quarter past 3 almost that afternoon, there was a collapse and cardiorespiratory arrest, during which you may recall [Baby P] received significant doses and infusions of adrenaline. Notwithstanding that, he couldn't be resuscitated and he died at 16.00 hours. So that's the course of events when we come to [Baby P].

What the experts say about this I'll deal with as I go through it because on this count there's a lot of detail from them which casts light potentially on how events went. We say there are two very specific issues to keep in mind with [Baby P]. The case against Ms Letby revolves around the desaturation, the event at 9.40 in the morning: apnoea, brady, desaturation, mottled with distended abdomen. The case around her revolves around that in particular.

The first question to keep in mind is whether it can be established, so that we or you are sure, that she did attack [Baby P] in some way so as to cause that initial deterioration.

The second issue really that emerges on the evidence, we say, is whether she dislodged the breathing tube at 12.28. It is something that [Dr B] describes, you remember. Those seem to be the two key issues.

There may be other matters that you look at or you consider important. That's entirely for you, ladies and gentlemen. But whilst plainly addressing you on behalf of Ms Letby, we are trying to impose some structure on what we're going through here, so this can be looked at in detail and in an ordered fashion.

Ms Letby is clear she is responsible neither for the death of [Baby P] or what happened at 09.35 or 09.40. We say, I'm going to give you the detail in this shortly, it is important to appreciate how the prosecution's own expert medical evidence shows that death was probably caused by a pneumothorax sustained by [Baby P] as a result of the resuscitation procedures after the 9.35 deterioration. And I'm going to remind you of that evidence -- there's so much evidence, I've got every bit written down in front of me here and I struggle to keep track of it. But that's really important when we consider what the charge is here, of murder.

We say that evidence about what happened is important because it doesn't just answer the question of why [Baby P] died, but also because, once you see that bad management or bad treatment or failings in treatment by the hospital may be to blame for what happened, you will at least be more alert, ladies and gentlemen, to the possibility of efforts to shunt blame Ms Letby's way again.

I'm going to deal first, actually, with the issue of the medical treatment that [Baby P] received and then we'll come to the question of what the evidence is that can establish that Ms Letby is responsible for all of this beginning in the first place and we say it certainly doesn't, but we'll look at that.

The medical treatment. There's two parts to this really. The first, we say, is that the pneumothorax that [Baby P] undoubtedly had was caused by the resuscitation response, in particular the ventilator pressures. Secondly, there was then a failure to identify and treat that as rapidly as should have happened.

So I'm going to deal with that first because we say it's important you have in mind the gravity of those mistakes before we come to look at the way things are being said against Ms Letby, then you have a bit of context about some of the things we say about those allegations.

Dr Bohin, on 23 March, gave evidence about [Baby P] and she dealt both with the final collapse and death and the question of what lay behind the deterioration at 09.40 in her opinion. At this point I'm just going to go to the collapse and the death, as you know. These are, we say, the key points from what she said. 23 March, page 61:

"The chest X-ray taken at 11.57 should have been done sooner."

There was a chest X-ray taken, it was taken at 11.57, "It should have been done sooner", and that's the chest X-ray, ladies and gentlemen, that revealed a moderately large right pneumothorax. That's the first thing: "Chest X-ray should have been done sooner."

She said, page 62:

"The pressure [Baby P] had been put under on the ventilator after the 9.40 event was high for a baby like [Baby P] and that may have caused the pneumothorax."

She said, page 70:

"Even after the chest X-ray had been delayed until 11.57, from the notes it appears that it was not reviewed until 12.30."

She said that attention should have been paid to the pneumothorax sooner to prevent complications and, she gave the example:

"... to make sure that it did not become a tension pneumothorax."

She said the pneumothorax may have contributed to the collapse prior to its being discovered. By "the collapse prior to being discovered", we're talking about the 12.28 deterioration, the one which [Dr B] blames on a tube dislodgement. Right? There's going to be a picture that emerges here in a little bit, ladies and gentlemen, not an unfamiliar one.

But actually, the prosecution's own expert evidence is that pneumothorax that was delayed (sic) late, wasn't reviewed until 12.30, so hadn't been reviewed until after the tea break desaturation, that might have contributed to that collapse. And that is the collapse, the one where [Dr B], the consultant in

charge, is keen to blame it on a dislodged tube, patently nudging it Ms Letby's way, and then the prosecution took their lead from her and called it the tea break dislodgement, didn't they, or tea break desaturation?

Well, if [Dr B] is right, ladies and gentlemen, you will want to see, when we come to them, what she said about such a significant event in her notes, won't you? Because we know that tube dislodgements are noted in notes, we have seen that elsewhere, and we can expect to see that if she's accurate in what she is telling you and we will take a look in a little bit. You may even want to see whether it features in the notes of [Dr A] who was there and did deal with this in some detail. They're important sources, aren't they, of corroborative evidence to see how much reliance we can put on what the responsible consultant said.

We say that, on the expert evidence, 12.28 should be called "the failing to react to the pneumothorax desaturation", not "the tea break desaturation", because that is the expert evidence, failing to react to the pneumothorax. And at the conclusion of her report, and as she accepted in evidence, Dr Bohin had said this -- she accepted this in evidence:

"My impression of the care afforded to [Baby P] after the collapse on 24 June [that's the collapse in the morning] is that it was muddled. There were unacceptable delays in the recognition and treatment of the pneumothorax, the ventilatory strategy used and the use of a high dose of adrenaline infusion was unusual."

I'll come back to that.

Switching to Dr Evans, and he'd given evidence on 22 March. When the prosecution asked Dr Evans:

"What was the cause of events with regard to [Baby P]?"

And this is looking across what happens that day, Dr Evans said the only thing he could think of was that he'd suffered complications from the pneumothorax.

He also said, 22 March, page 157, that he could:

"... identify no natural cause of death."

But he said in cross-examination that the pneumothorax was most likely the consequence of resuscitation, and that's resuscitation following the 09.40 event, and specifically the pressures during intubation that followed, which could or would overinflate the lungs. That's how it happened. His view, ladies

and gentlemen, again this timing is important, was the pneumothorax will possibly have increased significantly between 11.57 and 12.40. So this fits together in fact with what Dr Bohin said, what we prefer to call, on the basis of the expert evidence, the "failing to react to the pneumothorax dislodgement".

And Dr Evans' view, as he gave in cross-examination on 23 March, in his three reports pre-trial, and he didn't disagree with this in evidence, was that death was the result of complications from the pneumothorax. That's on 23 March he gave that evidence. And that's what he had said in his three reports pre-trial.

So on the question of causation on the charge of murder, ladies and gentlemen, we say that whatever happened at 09.40, and we'll have to look at this of course, but we say that there's nothing to suggest [Baby P] would not have been stabilised at that point and that on the basis of the evidence, particularly that prosecution expert evidence, ironically on this occasion, death was in all likelihood the consequence of poor medical procedures after that.

We say therefore it's little wonder, for example, that Dr Brearey refused to accept the extent of the harm done by his team, or the potential extent of it, and his unit when I asked him about the management of the pneumothorax and the consequences of not managing it on 22 March, and he would not acknowledge any issue with the delayed chest X-ray or ventilator settings or a problem caused by a delay in identifying the pneumothorax or, for that matter, the doses of adrenaline. We say it is no surprise once you have that background, or that part of the foreground, in sight that blame has headed in the direction of Ms Letby.

We said at the start of our submissions to you, ladies and gentlemen, on Monday, that this case is a prime opportunity to hide poor performance and bad outcomes and we say that is what is happening now with this.

Before I come to the 9.40 collapse, can I just remind you, there's been reference to it in what we've said, without a doubt [Baby P] received doses of adrenaline during resuscitation that were much higher or higher, you pick the word, higher than he should have had. Do you remember we went through this and certainly it appears to be double the intended dose. That is an error.

Dr Bohin agreed that too high a dose can cause lactic acidosis, although she pointed out [Baby P] already had it, so it's difficult to work out to what extent adrenaline would have made a difference. On 23 March we talked about this. She accepted

that once that happens there are an increased likelihood of issues, side effects. Lactic acidosis is potentially one side effect of excessive adrenaline, but she was keen to point out that didn't mean it happened in this case, which is as far as we got with that. So I'm not suggesting she agreed it was made worse by the adrenaline, she didn't. We got to the point that it could be but it would be difficult to tell since he had lactic acidosis anyway.

All we can do, ladies and gentlemen, is point again to something that was not done correctly, and that was a mistake on the mathematics -- and it's mathematics that the people who deal with this type of procedure would be doing all the time. Remember, we went through it with Dr Rackham. All right?

I'm going to move then to really the question that comes first in time, which is: does the evidence establish, so we can be sure, that it's Ms Letby that caused the collapse at 09.40?

We can keep in mind the state of the medical evidence on what followed. The allegation is based upon the theory, the opinions, of the experts, Dr Evans and Dr Bohin, that the 9.40 collapse was caused by air down the NGT. They both get there in different ways. The destination is the same, the journeys are different.

The prosecution have maintained that [Baby P] was already unwell when he was handed over to Sophie Ellis the night before; do you remember? They say, in effect, Ms Letby had sabotaged him. And the experts certainly begin by basing their assertion, we say, on that radiograph that was taken at 20.09 on 23 June. Certainly Dr Evans did unashamedly, so let me deal with him first.

Dr Evans. His view was that the radiograph at 20.09 indicates that gas was in the system that is instrumental in the collapse at 09.40. It is, we say, unbelievable that an abdomen splinted with gas sufficient to cause a collapse should not do that at the time you have it on the radiograph, but should have done so, with a kind of delayed effect, 13 hours later.

Dr Evans had a solution to that, and you'll remember the solution, I suspect, when I remind you of the words he used. That was on 23 March of [Baby P]:

"I think he had an extra dollop of air in the morning of the 24th."

Right?

We say that is as absurd as it sounds. So Dr Evans, this prosecution expert, says we have a radiograph at 20.09, almost there, it's like one dollop short of splinting the diaphragm.

It's like everything minus a dollop, and that's there throughout the night and then the necessary dollop is given the next morning. You heard it, ladies and gentlemen. You can decide how convincing it is, it is a matter for you. We say it's utterly unconvincing but it's a classic example of trying to work up the explanation with the available evidence, isn't it? I mean, if that diaphragm was being splinted or almost splinted, there'd be some fairly dramatic reaction at that point you may think. And the suggestion of dollops being given later on... It's something done for the convenience of the explanation, we say.

Dr Bohin was a little more difficult to pin down on this issue. We put to her that her report suggested that the excess gas she is referring to was gas that was seen on the radiograph from the night before the collapse, in other words what Dr Evans was saying. I went through this with Dr Bohin and she eventually said on 23 March: well, that was poor wording on my part. In other words she's agreeing, yes, it may look like in my report I was saying that, but I don't mean that not now, not when I'm giving evidence. "Poor wording on my part", is what she said.

But you see, ladies and gentlemen, if there was sufficient air to splint the diaphragm that wasn't there the night before, she then was presented with the problem of explaining where the air had come from that caused such a collapse, because there's no radiograph that can explain that, there's nothing taken that morning that show air could have done that. She began vaguely, we say, by saying air had been added in the morning. I pointed out to her the examination by Dr Ukoh at 9.35 which noted moderate distension and various other findings but nothing that we said indicated a splinted diaphragm. Undaunted, ladies and gentlemen, Dr Bohin's answer was this:

"Hmm, Not when he examined him, but 10 minutes later this baby has a cardiac arrest and has a distended abdomen, so I've put two things together and I think the most likely cause is that this baby has splinted his diaphragm and decompensated at that point."

Okay? In other words, all right, yeah -- it's like a game of chess with check, check, check, moving around. It's not the night before. Okay, it's not the night before. Well, it can't be that morning because he's examined by Dr Ukoh at 9.35. Hmm, no, it can't be. Ah, what's happened is, in the 10 minutes after that, the baby has splinted his diaphragm and decompensated at that point, which seems to be getting close to rather what Dr Evans said, but a good deal more than an dollop of air going in. That seems to be that all the air is put in, sufficient to splint the diaphragm, after the medical examination whilst Dr Ukoh is in that room, in the 5 minutes or so between the end of the examination and the collapse. There is no other explanation

that goes with what Dr Bohin said when we go through her evidence and she was adamant by this point that what happened the night before is not what she means is responsible for the morning.

The reviews with Dr Ukoh are ongoing in that nursery. Christopher Booth, on 21 March, had said the collapse happened pretty much straight after the review of [Baby P] with people in the nursery. We have a continuous line of events here, ladies and gentlemen, from this point and we say that, on any sensible view, again, there is no opportunity for this. Whatever's happened there is no opportunity.

The evidence of who exactly was in that nursery varies across the witnesses but it seems to be the following people: Anthony Ukoh and Christopher Booth, obviously Ms Letby, for the student nurse Rebecca Morgan, the evidence is less clear as to whether she was there or not, but there are people around. And we say, both in terms of the time available, whatever method is meant to have been used at this point, and with people in the nursery, it is implausible in the extreme that there's been some sort of attack in a five-minute period, putting sufficient air down an NGT to cause his diaphragm to splint.

We say the more likely position, and the more reasonable one, is that [Baby P] had been all right at the handover at 8 pm the night before but had deteriorated during the night, we see the milk not being digested and it being aspirated in quite large volumes. Then we see air being aspirated from his stomach, getting into the morning, and this continues into the 9.40 review.

My Lord, I just want to check, what time is convenient for the court? I can continue for a little while.

MR JUSTICE GOSS: Well, perhaps I'll ask the jury. Do you want a break now or do you -- yes.

MR MYERS: Thought so.

MR JUSTICE GOSS: It may be that we'll have two breaks during the morning session then.

MR MYERS: Yes. I can say --

MR JUSTICE GOSS: Because thoughts have been going through my mind about next week, obviously, and I'm wondering -- we'll try it with two breaks today and see how you get on in the morning with 10 o'clock starts or we'll stay at 10.30 next week with one break.

MR MYERS: I should say if it assists, my Lord, I should finish in good time today. So a later start would not have interfered with that in fact, so I apologise for the earlier start.

MR JUSTICE GOSS: It doesn't matter, we've started, but we'll have a break now.

(11.11 am)

(A short break)

(11.21 am)

(In the absence of the jury)

MR MYERS: My Lord, did you wish for another break? Because if you do, could you indicate the time? Did you say you wanted two breaks in the course of the morning?

MR JUSTICE GOSS: Yes, if you want to have a break or if you want to have an earlier lunch, it's entirely up to you.

MR MYERS: Thank you. Whatever suits your Lordship.

MR JUSTICE GOSS: It was getting quite hot in here but it feels a bit cooler now I've come back in. We'll see. I'll keep an eye on the jury and see how they are. If you think it would be appropriate to have a break at any time, just say, you just choose it.

MR MYERS: Thank you very much.

MR JUSTICE GOSS: It's much better, you'll know what's a good point and what's a bad point. I don't want to repeat yesterday.

(In the presence of the jury)

MR MYERS: Ladies and gentlemen, we say that in reality now, putting to one side the allegation of sabotage the night before, that in reality there was no significant problem with the care of [Baby P] or his health before the handover to Sophie Ellis. So just to have a look at the evidence on that, during the day of the 23rd, Ms Letby and Rebecca Morgan, as it happens, had been involved in [Baby P]'s care. And Rebecca Morgan, the student nurse, was involved in that up until she finished, which we established was around about 7 pm. And when we looked at the observations in the care charts, we could see where she had written the entries in and sometimes they'd been co-signed with Ms Letby, sometimes they hadn't been, but we established she was certainly involved in the entries and with the care.

I'm going to ask if we can put up the fluid chart at tile 24, just to see the entries up to 18.00, if we can just go into that. If we could open the chart, please, Mr Murphy. Thank you.

We're perhaps sufficiently familiar with this to work with what we see here. We've got RM, Rebecca Morgan's initials, for [Baby P] for 08.00, 10.00, 12.00, 14, 16. And she confirmed in fact that is her at 18, although part of that isn't completed. But that's her doing the form. So she's involved with that certainly up to 18.00. It's not entirely clear who it is that's doing the actions, so I'm not going to suggest that's absolutely clear, but the two of them appear to be involved.

When she was asked about the 18.00 column on 22 March, the question I asked was:

"Question: Well, actually there's another column we've seen, 18.00, the next one along to the right. Again, is this your handwriting, where we've got EBM NG 15 121 [as read]?"

"Answer: Yes.

"Question: That's your writing at 18.00. There's nothing in the aspirates, in fact, on that occasion is there?"

"Answer: No.

"Question: Does that mean maybe [Baby P] wasn't aspirated at that time for whatever reason?"

"Answer: No. I would have always checked the aspirates before we gave a feed."

But this is just dealing with the situation as we're going that evening and who it is that's looking after [Baby P] and who's involved.

There was a review noted up by Dr Cooke but by Dr Gibbs at 18.00 and that is at tile 134, so could we have a look at that, please, Mr Murphy.

It's the top half of this page:

"18.00, R/V Dr Gibbs."

But it's Dr Cooke who's filled this in. Nothing particularly dramatic or of concern but attention has been drawn to four lines down:

"On examination: abdomen full mildly distended."

Can you see that? So an abdominal X-ray was ordered. You can see under the plan, "Abdo X-ray", but I'm taking time to go over this with you, ladies and gentlemen, so you can put into context the allegation that there was some sort of sabotage that happened. Easy to say. This is what we have.

It seems the X-ray may have been delayed if that's what triggers where we come to next because we do have a radiograph that was taken at 20.09, so it's actually taken after handover, and that's at tile 173. And this now is the one that Dr Evans is referring to about there being gas the night before that was topped up by a dollop after about 13 hours. You know what we say about that. But if we go to tile 173 we have that radiograph.

Do you see, ladies and gentlemen? 20.09 on 23 June. As to what we make of this, the evidence of Professor Arthurs is important. Dr Evans said on 23 March -- in fact, can we scroll down to see the writing beneath it, Mr Murphy? I'd better make sure we've all had that too. Thank you.

This is the relevant bit for our purposes:

"Gas-filled bowel loops throughout the abdomen, through to the lower rectum, with no evidence of obstruction and no plain film signs of perforation."

Thank you. If we go back now to the image, I'd be grateful, just up the page. Dr Evans said the air on the radiograph was excessive and he even went so far as to say that he listened to Owen Arthurs' evidence and Owen Arthurs had said this was excessive. He said Owen Arthurs had said it was excessive as well.

Owen Arthurs, when he gave evidence on 16 March, didn't put it that way. In fact, he said no more than moderate dilation. What he fixed on was:

"The pattern was quite unusual, extending all the way to the rectum."

But just taking the points as we take them. First of all, the expert evidence of the radiologist -- sorry, the radiographer, was that this was not excessive, but the pattern was unusual. And he agreed, we say significantly, as he did in the case of [Baby O], that:

"There may be no readily identifiable cause for this."

This is on 16 March in cross-examination. The question was:

"Question: Are we in the position again that, when we come to consider the range of other possibilities, first of all this may be dilatation for which there is no cause that can readily be identified?

"Answer: Yes, that's possible.

"Question: That's possible. Because I'm going to suggest that, as we have seen sometimes, babies' stomachs dilate or their abdomens dilate just in the course of their treatment; is that correct?

"Answer: Yes, it's possible."

This is, you may agree, significant stuff. It may be not what everybody wants to hear. Anybody, for instance -- the prosecution don't rely upon that, they don't go to that. Well, they're the prosecution. But you have to decide, not anyone else, not how anyone reacts or what they think, it's your opinions, ladies and gentlemen, that matter. That's from Owen Arthurs.

In answer to the question:

"Question: Whether babies stomachs may dilate when talking about this or their abdomens dilate just in the course of their treatment; is that correct [as read]?

"Answer: Yes, it's possible."

Also, you remember, Professor Arthurs said he would expect this gas to pass through a baby in about 1.5 hours, not 13 plus a dollop. This isn't going to be there, we say on the basis of that, the following morning, this isn't causing splinting of the diaphragm or anything like it. No such description at the time. If we look at tile 178, we've got [Baby P]'s blood gas for 20.27 on the 23rd. Can we scroll down a little bit, please? There we are, you can see where Sophie Ellis has signed it, 20.27. There's nothing at this point significant there. This isn't a baby that's being sabotaged. That's the allegation being made to support this count to obtain a conviction in part, but that is evidence of no particular problem at 20.27, which would be extraordinary if this is doing anything to harm the baby, to harm [Baby P].

The observations, if we want to see them, at 20.00 and 22.00, could we go to tile 22, please, Mr Murphy.

This covers the period of the 23rd into the 24th, if you look at the top. I wonder if we can just see the initials at the bottom just for a moment, Mr Murphy, if you could go down there. If we

look down you can see where Sophie Ellis has been signing for this. We might need to enlarge it a little bit, please. There we are. Go to the right-hand side, in fact.

We see those -- this is the chart which is a little difficult to follow at first with what is where. We've got Rebecca Morgan signing and then Sophie Ellis. So we can see the night shift and, if we scroll up, we can have a look now to see if these are the readings of a child who has been sabotaged.

The suggestion is, from Dr Evans, that something happened overnight that took a dollop the following morning are utterly, we say, unsustainable, the suggestion this is sabotage is unsustainable, but it was made.

What does happen, ladies and gentlemen, we say, is that [Baby P], having been handed over in good condition to Sophie Ellis, does begin to deteriorate overnight. Sophie Ellis' note is at tile 169, I wonder if we could put that up, please.

Could we go up to the top, please? Thank you. This is a note at 01.31 in the morning. If we just read down through the body of it, we've seen the condition that [Baby O] was in at the handover. It says:

"Cares taken over for night shift at 20.00. Safety checks completed."

And so on:

"Philips monitoring in situ. Apnoea alarm now in situ as on caffeine. Observations have been within limits."

So it starts off well enough:

"Did have one desat into 80s and 1x brady into high 90s. Self-corrected. No intervention required."

Pause there. If you remember what has been said about self-correction and the evidence of Elizabeth Morgan, which may well be right, we're not disputing it, it's agreed evidence, but we do see nurses sometimes wait before they step in, and then a baby may self-correct. That's what appears to have happened at this point.

So at this point no particular issue. However, as we move on -- and you will recall the charts maybe, ladies and gentlemen -- there is a 14ml part-digested milk aspirate gained at 20.00. That was recycled, the feed continues. Then we see at midnight:

"20ml part-digested aspirate gained. Abdo full but soft."

Dr Mayberry was informed. You may recall, it may be later on, but Dr Mayberry was meant to come and review [Baby P], wasn't he, but he didn't because it was busy. That's just how it was. But that tells a story, a small part of it maybe.

[Baby P] was made nil by mouth, in fact, at midnight, you can see it says after:

"Reg Mayberry informed. Planned to put nil by mouth."

And he was made nil by mouth. That is not a good direction of travel.

There's no record of air being aspirated from the NGT during the night -- during the first part of the night up to midnight but air does begin to appear in the records by 04.00. I wonder actually, though it's not on the list, Mr Murphy, whether we can put up tile 237, if it's possible to get there. We will be going back to tile 169.

Just to remind us all, ladies and gentlemen, we're getting more and more familiar with these, but we can see at 04.00, 25ml, that's air. And there was more air on there at 07.00 and a little bit of milk.

We've had evidence, haven't we, about whether or not, had there been air there earlier, it would have been taken out when the milk was taken out because you keep going until nothing else comes out. It's a little difficult to tell if it was or it wasn't, really, on the evidence, you may think, but certainly there's air being extracted then which, you may think, going back to Dr Evans, makes it all the less likely there's air in there overnight waiting for a dollop the following morning. That is unsustainable, we submit.

But things are changing, [Baby P] is nil by mouth, producing air, and this is 8 hours after the handover by Ms Letby. There's been no significant deterioration by this point.

Kathryn Percival-Calderbank, who was on duty at this time, the senior nurse, gave evidence on 21 March. She was involved in the aspiration or aware of the aspiration of the 25ml from the stomach and she said that [Baby P]'s abdomen appeared quite distended around this time; that's 04.00.

If we go back now to the nursing note of Sophie Ellis at tile 169, please. If we scroll down, can you see the note at 06.39? It says:

"Abdo has been soft and non-distended. 25ml of air aspirated by Senior Nursing Practitioner Kate Ward."

That's Percival-Calderbank. Sophie Ellis is saying abdomen soft and non-distended. The evidence, it has to be said, of Kathryn Percival-Calderbank was when the 25ml was aspirated from the stomach, at that time -- this is page 40 -- his abdomen appeared quite distended around this time. There is a conflict between them. We're not saying necessarily anything follows from that but we cannot help but observe if there'd been a conflict like that involving an entry by Ms Letby and a senior nursing practitioner, you know how that would play out ladies and gentlemen. You do, we say.

This is the position, this is the direction of travel then as we come to the following morning at 9.25. And then we have the ward round where Dr Ukoh -- if we go to tile 134, again, please -- where Dr Ukoh reviews [Baby P].

Just scroll down to the lower half of the page. There we are. It's the timing, really. This is the next clinical review, Dr Mayberry not having done one, 9.35 this happens, and we know that within 5 or 10 minutes of this there is then a desaturation. And we will hear what the experts say about that and their different explanations for how it is a harm event.

We say there is no proper basis, first of all, to say there is sabotage the night before. That's not supported by this evidence, we say it's contradicted by it. And we say that you can see a deterioration in [Baby P]'s condition which is consistent with what happens shortly after this review.

Now what happens after that is the ventilation with pressures that are too high and the pneumothorax and the failure to take the chest X-ray in time and the failure to identify this in time and the failure to deal with it in time, all of which play a part in, according to the experts, the collapse or are likely to play a part in the collapse at 12.28 and are likely to contribute to, if not explain, the sad death of [Baby P]. We've been through that, that's why I dealt with that first so you can see what this leads into. You can see why there's some explaining to be done at this point -- I mean as we move forwards into an investigation and trial.

What about the tea break dislodgement then? Because enter [Dr B] at this point. Not so much involvement with her in the case in this way up to now, but she gave very striking evidence, you may feel, when we came to [Baby P]. It became very dramatic indeed, you will remember it:

"Got to get [Baby R] out, it's the only way he's going to live."

And things like that and we then had described to us the tea break desaturation.

Let's look at the evidence, ladies and gentlemen. [Dr A] talked about the deterioration at 12.28 when he gave evidence on 20 May (sic). He agreed, page 100, it may have been from the pneumothorax that had not at that point been identified or dealt with. He made absolutely no reference to a dislodgement of the tube. That's interesting, isn't it? We'll look at his notes. They're pretty detailed and he didn't mention a tube dislodgement.

In fact, he did mention something, so the tube was in mind. What he said was that he'd removed it and I asked him about this, page 99:

"Question: You removed the tube, in fact, didn't you?

"Answer: Yes, I did.

"Question: But it's difficult to recall from this passage of time whether or not that tube was checked for secretions; is that correct?"

He'd made some reference to secretions:

"Answer: It may well have been checked, it's certainly not recorded here. I suspect the tube was removed and put down on the trolley where all the intubation kit was. The priority was to get the next tube in, to secure the airway.

"Question: The poor colour change on the capnograph, does that suggest a problem with the breathing process for [Baby P], putting it at its simplest?

"Answer: It suggests there's not the -- not the required amount of carbon dioxide passing back up through the tube, whether that's through blockage or poor effort."

He wasn't sure, but he talked about blockage. He didn't talk about the tube having moved, and we'll see his notes in a bit, but nothing about a dislodgement from [Dr A]. We know at this time he had not yet identified a pneumothorax. We know from the expert evidence what is very probably contributing to this desaturation, to this problem.

So despite what [Dr B] later says about a tube being dislodged, the tube is seen and removed by [Dr A] who gives no description about that. And you may think if there'd been a dislodgement, that is a prime person who would. We can look at his notes just

to satisfy you if you'd like, ladies and gentlemen. They're at tile 420.

Can we go to tile 295, first? This is the second page, sorry. It's in two different tiles. You know what's going on with [Baby P]'s lungs at this point but if we scroll down the page we'll get to 12.28. All right:

"12.28. Desaturation bradycardia. CPR commenced. Poor colour change on ET capnograph. ETT removed and bagged."

That's what he described. Nothing about a dislodgement or anything like that. If we go over the page then, which is where we need to go to, that's it thank you. To page -- tile 420:

"Re-intubated 3.50."

Then there's the details there:

"Adrenaline infusion commenced."

And so we go on. These are detailed notes, absolutely no reference to tube dislodgement.

And we can see the chest X-ray, it says at 11 -- at 12.30 and this is when it is reviewed, at 11.57, the chest X-ray wasn't reviewed until 12.30. So this desaturation has happened in that period of time. It should have been reviewed. The pressures should have been lower in the first place, but they having been too high, it should have been reviewed. It wasn't.

This is over the very period that [Dr B] went on to say there'd been a tube dislodgement and we know where that takes this case. When one of the consultants says that, we know where that goes. And this is where the right-sided pneumothorax is found. So that's [Dr A] on this.

Let's see what [Dr B] says. If we can go to tile 625 please.

These are notes that she wrote later that evening, so there is, it seems, time to reflect upon the day and consider what had happened. So she wrote these in knowledge of what had taken place:

"Written retrospectively from 9.30 am."

She describes being called to the nursery -- I'm going to summarise but we can read it through. That's the 9.40 incident. There's dropping sats and heart rate and, just a few minutes earlier:

"Briefly seen [Baby P] and D/W [discussed with] registrar."

Can we just carry on down a little bit. So this is:

"[Discussed with] registrar. To do a gas."

I can't decipher everything, ladies and gentlemen, but we know what we're looking for:

"Full blood check. CRP. Shortly after this [Baby P] deteriorated."

Okay? If we carry on down here, something about the bag, IV access, lost -- not flushing. Actually:

"IV access lost -- not flushing. Airway maintained with Neopuff bag whilst getting intubation ready. Few attempts at IV access unsuccessful. [Dr A] arrives took airway from Dr Ukoh. Dr Ukoh inserted IO needle."

If we can carry on, please. This is as we go into the afternoon, in fact, with the adrenaline being given:

"[Dr A] and I were present with [Baby P] throughout the day."

It says:

"For detailed notes in management and resuscitation please refer to [Dr A]'s note entries."

Can we just go over the page, please, to see what follows:

"I spoke with Dr Rackham at 10.30 and updated about [Baby P]. Was advised they would enquire whether a bed was available and also to try to arrange to take [Baby R] at the same time or unit (parents' requested this so they can be together). Spoke to Dr Rackham again at 1 pm..."

So this is after -- it's well after 12.28 and so on.

It's a long note. I think it may go to a third page, in fact. Let me just check. That's it, 2 pages. There we are, a third. There we are.

You won't find tube dislodgement anywhere in there. Anywhere. And she made such a lot of it in evidence here on this trial for Ms Letby. And of course, if you are persuaded by what [Dr B] said, then there's an explanation for what happened that doesn't involve sub-optimal performance, does it? It doesn't involve medical -- it dovetails neatly with this prosecution and it's all Ms Letby's fault, but if you go to the material here, you

won't find tube dislodgement. You'll find [Dr A] wondering is it blocked and you'll find the late identification of a pneumothorax that caused a collapse, but not a tube dislodgement. And that's not an accident, ladies and gentlemen. You've seen that happen here. You make of it what you will, it's a matter for you, but we say that tea break collapse, when you look at all the evidence, should simply be called "the unidentified pneumothorax collapse" because that's what the evidence establishes.

Even more surprising, you may think -- we can take that down, thank you, Mr Murphy -- even more surprising in the circumstances is, [Dr B] having told us that certainly by this time or around this time she was aware of Nurse Letby and suspicions being upon her, there is not even a Datix report, for example. We're back in that territory, aren't we? Not only is it not in the notes, but there's no complaint, there's no issue raised about it.

She was a little reticent to explain how she did know about this and had she spoken with her colleagues about it. And she began, when I asked her about it on 21 March, by saying, do you remember, that there had been flippant comments about it and then she withdrew the word flippant. That was the first word she went for, but she withdrew that. I asked her:

"Question: Which consultants were these that you were sharing these comments with? Who were you talking to about this?"

She said, page 148 on 21 March:

"Answer: I wouldn't want -- I don't exactly remember to be able to give you the names."

"I wouldn't want -- I don't exactly remember to be able to give you the names", is how she put it. There aren't that many, are there? Not hard for you to tell you who.

Well, as Dr Evans said, we tend not to spread news about the mistakes we make.

Just another couple of points with [Dr B], ladies and gentlemen, because she had a lot to say on this episode and directed, in fact, at Ms Letby. That was a direction of travel of her comments. Do you remember the comment about Ms Letby having said about, "He's not leaving here alive", and [Dr B] gave a very dramatic account of that event when she gave evidence and told us there was a point when Ms Letby turned to her and said "He's not leaving here alive, is he?"

And the prosecution say two things. First of all, this was unnecessary because [Baby P] was doing so well and, secondly, it reveals what Lucy Letby had planned or done. We say neither of those actually reflects the situation.

Whatever is said now about how well [Baby P] was doing, the evidence of [Dr B] in fact was that she was very worried herself and that she felt out of her depth, whether or not there had been a good gas. And we know this because when she gave evidence on 21 March, talking about how she felt around 12 noon, she said -- and she was becoming very animated in this:

"Oh the transport..."

She was talking about her thoughts:

"'Oh, the transport team are going to be here soon', almost thinking out loud, more than anything else, and I'm literally sort of counting the minutes before they arrive, just desperately wanting this baby to get better, and thinking, you know, there's something -- you're just totally out of your depth, can't think what's going on, maybe someone else can come, and Staff Nurse Letby says, 'He's not leaving here alive, is he', which I found absolutely shocking at the time and I just turned around and said, 'Don't say that, he has had a good gas.'"

First of all, from that evidence, the impression was not that [Baby P] was doing brilliantly at that time or doing well or was stable, it sounds like she was worried to death about the situation -- and of course this is during the period of the undiagnosed pneumothorax and she was feeling totally out of her depth.

And as for what Ms Letby said, well, it's a matter for you, ladies and gentlemen, and what you make of how Ms Letby expresses herself. You may form the opinion she has a tendency to say or do things that reflect the emotion of the situation as she believe it requires. We have had that with her being inappropriately upbeat sometimes with some parents, maybe misgauging it, people can do that. Turning round and saying something like this maybe utterly consistent with that, may be consistent with social awkwardness or saying something inappropriate. It doesn't prove murder, which is what is being alleged here.

And you may think if Ms Letby is as smart and as in control as the prosecution would have you believe and if she has, as it was put, done this or was planning it, the last thing she is going to say to the consultant in charge is, "He's not leaving here alive". She's simply saying what it seems were the anxieties in

people's minds at that point as the medical staff were failing to identify and react to what had happened.

And of course it culminated, the evidence did, with [Dr B]'s dramatic account of hoping that [Baby R] could be taken away at the end of the incident. And she said to you, ladies and gentlemen:

"I just remember thinking at the time [this is when Dr Rackham came later that afternoon] the sobbing -- dad was there and sobbing, stood next to [Baby P], and literally begging Dr Rackham, 'Can you please take him', and even though I didn't beg, I said it to Dr Rackham in a more professional. Way in my mind and heart I just wanted him to leave because I thought that's the only way he's going to live."

Do you remember that? That was a high charge of emotion when she said that. In effect, they're both begging Dr Rackham, "Take him, it's the only way he'll live". Yeah? And naturally, the prosecution identify that because that sounds a very striking piece of evidence.

But that's just not right. The process concerning [Baby R] didn't come out of what was going on with [Baby P] at this time. We've actually just seen it in the note from [Dr B]. What was going to happen with [Baby R] had been decided earlier that day. If we just go back, please, to tile 672. It's page 2 of the tile, please, Mr Murphy.

(11.54 am)

(No audio feed from court)

(12.03 pm)

MR MYERS: -- ladies and gentlemen, the sort of things we have criticised this unit for are set out and laid bare in what happens there on this evidence.

I'm going to turn now to the final count on the indictment.

It doesn't matter, we say, ladies and gentlemen, how many counts are brought against somebody, it doesn't prove the case just because there's lots and lots of things said about it. We need to look at them closely and see what emerges. There may be things that repeat that you identify and that you rely upon on one view, some things you identify where you say, well, that may be relevant from the prosecution's point of view, and there are things where you say, that may be relevant from the defence's point of view, we recognise that, but it involves looking at them individually and most definitely not working on the basis,

oh, there's a lot of stuff here therefore... We are confident you know how unfair that would be.

Count 22, [Baby Q]. My Lord, I just wonder, so we all know, using an expression I've used today, the direction of travel, I anticipate I should certainly be able to deal with [Baby Q]'s case before lunchtime, and I wonder whether we could break then and then I can conclude my submissions after lunch. This will probably take us to approaching 1 o'clock, something like that.

MR JUSTICE GOSS: All right. Are you happy to go on until close to 1 o'clock and then have the lunch break?

MR MYERS: It might fall just a little short of that.

MR JUSTICE GOSS: That doesn't matter, I'm not worried about falling short, I'm just worried about another 50 minutes or thereabouts for the jury without a break.

MR MYERS: We can always have a break.

MR JUSTICE GOSS: No, I'm just checking.

MR MYERS: Thank you, my Lord.

[Baby Q]. Born on 22 June 2016 at 4.09 in the morning, and weighed 31 -- at 31 days and -- at 31 weeks and 3 days' gestation and just over 2 kilograms, 2.076 kilograms in weight.

The episode, the event we're looking at, is on the morning of 25 June at 9.10 in the morning, when the records describe:

"Vomiting clear fluid nasally and from mouth. Desat and bradycardia. Mottled ++. Neopuff and suction. Air ++ aspirated from NGT."

We'll have a look at what these things mean when we come to the evidence.

Dr Evans proposes fluid down the NGT, and maybe excessive air, but fluid. And Dr Bohin proposes excessive air down the NGT.

In this trial, ladies and gentlemen, we dealt with a variety of incidents. Very different factually, many of them, very different issues come up, which is why it's important to regard them, obviously together, but also on their own facts. We do not disregard the importance of any episode experienced by a baby on the neonatal unit, but we do say this must surely be an event that has been taken out of all proportion and context when it finds its way into this case as an allegation of attempted

murder. That's what we're measuring this against, an intent to kill in some way.

This is the note of -- if we could put up tile 103 from the [Baby Q] sequence, please. This is the note of [Dr A] that morning at 9.17:

"Called to neonatal unit at 9.17. Desaturation. Had just vomited."

Then it says:

"Desaturated to low 60s. Minor bradycardia. Bagged via Neopuff circuit in [whatever] on 100% oxygen. Soon returned to 100%. Confirmed required for PEEP. Moved to nursery 1 and commenced on CPAP. UVC in situ."

And then there's some readings and we move on. That's his note of this incident:

"Desat and vomit. Desat to the low 60s. Minor bradycardia. Bagged via Neopuff and soon returned to 100% oxygen."

The note that we have in Ms Letby's records is at tile 143. Let's have a look at that next if we may. On the left-hand side, just enlarge the large entry on the left. You'll remember Ms Letby said it wasn't there at the beginning of this and we'll look at this shortly, but this note completed -- written between 12.53 and 13.04, written for care given from 08.00. So far as the incident is concerned it says:

"09.10. [Baby Q] attended to by Staff Nurse Lappalainen. He had vomited clear fluid nasally and from mouth, desaturation, bradycardia, mottled ++. Neopuff and suction applied. Registrar [Dr A] attended. Air ++ aspirated from NG tube."

Thank you, we can take that down.

This isn't to diminish anything but that is it, that is this attempted murder. Okay? That's it. Not projectile vomiting -- issues develop later as we go into the evening when [Baby Q] became tired and there's a specific diagnosis associated with that and we'll have a look at that a little bit later. Again, we emphasise we don't disregard natural concerns, but it is an event, we say, that is unremarkable in itself and it was not regarded at the time as particularly serious by anyone dealing with it. Nowhere close to some of the other matters we're dealing with, not that that indicates what has happened in terms of the allegation.

But when Nurse Lappalainen was asked about this on 3 April, she agreed [Baby Q] stabilised relatively quickly from the episode and then we had this:

"Question: And although you kept and would have kept a watchful eye on him, it wasn't the type of incident that you were overly concerned about once it had been dealt with?

"Answer: No, I wasn't overly concerned, but I wanted him to be checked out as well, yes.

"Question: And after that, as you have said, there's no specific incident that took place that you dealt with thereafter?

"Answer: No. I had to take care of other infants and the ward."

That's it. There's a real danger that when it is taken and brought into this trial and the label "attempted murder" is attached to it, it may be regarded as more than it is, ladies and gentlemen. There must be, on a unit like this, all sorts of events in a 12-month period of a similar magnitude to something like this. So why is this one here? To borrow a formula we've had elsewhere in this trial, I think you know the answer to that. Yes? I think you know. This is here because the nurse on duty at the time was Lucy Letby and therefore she becomes the explanation for what has happened, even if there is no evidence of her having done anything at all to cause this to happen.

The deterioration, ladies and gentlemen, took place at about 9.10. Looking at the mechanics of this, Mary Griffith was looking after [Baby Q] from about 7.45. We say that there simply is no opportunity for Ms Letby to have done this -- sorry, Lucy Letby was looking after [Baby Q]. Mary Griffith is in the nursery. My mistake. But there is no opportunity to do this or to force whatever it is that is said to be forced down the tube.

You're familiar now with the layout of the nursery. It's visible to people, it's a relatively busy time of the day. How is something meant to have been done, for instance, that creates a reaction that takes place within a particular time? How do you control that? If somebody forces somebody into a baby, vomiting could be very quick, it could take time. We've not been told. But you may recall this allegation involves the suggestion that Ms Letby had set this up, she'd done something seen by nobody, left the nursery to go and look after her baby in nursery 1, and then came back when this happened.

How that is meant to have been managed, calculated -- how do you put something down a baby like that and then know what time you have to do what? We can all come up with guesses and suggestions, we've had no guidance on that. It's rather like the

business about the air down the NGT. How much does it take, how long, how quick does splinting of the diaphragm happen. According to Dr Evans, on one view, on the last count, almost 13 hours, until you put the last dollop in that is.

So far as [Baby Q] is concerned that morning, there were some aspects of his condition -- leading up to the event at 9.10 there were some issues lurking as it happens. There had been bile during the day of 23 June, bile aspirated with blood that evening. Aspirates during that day and the night that followed. Perhaps we could just look at those, they're on tiles 61 and 62.

Samantha O'Brien was looking after [Baby Q] on the night shift and if we look down to the lower right-hand part of the chart for the night hours, this is for the shift from the 24th into the 25th with Nurse O'Brien looking after [Baby Q]. At this point minimal aspirates but if we go to tile 62, which follows on -- that might be my mistake.

It's the next feeding chart that I'm looking for, Mr Murphy, if you have that.

(Pause)

It's page 4 in the paper bundle. I wonder if we could reach for that, ladies and gentlemen. Sorry, Mr Murphy, I must have given you the wrong reference, I've got it down as tile 62. Take the paper bundle if you would, ladies and gentlemen, let's have a look in there. We're there now. It's on the screens. Thank you.

If we look there we can see aspirates carrying on in the morning with Nurse O'Brien from the night shift into the morning and I've identified it, ladies and gentlemen, these are small, subtle points you may think, you may think they don't amount to very much at all, that's entirely for you. They follow a period of some bile being produced. What Nurse O'Brien said about this when giving evidence on 3 April was that it was, as we go from the 24th into the 25th, it was "more than she would expect". She said that overall this was more than she would have expected.

MR JUSTICE GOSS: If you're looking in the paper bundle, it's not page 4, it's the very last page.

MR MYERS: Oh right.

MR JUSTICE GOSS: Yes. It's J24331 and I've written tile 62 at the top of that.

MR MYERS: Is it tile 62?

MR JUSTICE GOSS: Yes, it is tile 62.

MR MYERS: There we are. One way or another we get there. Thank you.

The point is, ladies and gentlemen, they may seem small matters, but because so often you're being told there's nothing wrong, the baby is very stable, the baby is fine, there's nothing to see, that's not entirely the extent of it. There are some issues with [Baby Q] and that feeds into what happens later on when we know he's transferred with a diagnosis of probable NEC, as it happens, and we'll get there, we'll get to that.

But Nurse O'Brien said this isn't -- this is more than you would expect with such tiny amounts being fed to [Baby Q]. You see those 0.5ml amounts going in on the NGT and yet when you see what's being produced by way of aspirates, it's quite a lot more. That's why she said it's more than you would expect and his blood gas as at 7.30 was not as good as before.

If we go to tile 70, please, Mr Murphy. If we go down there to the bottom of the entry on the right-hand side, the last entry:

"Capillary blood gas carried out this morning. Result not as good as previous, however acceptable. Seen by [Dr D], to continue."

All right, not as good, acceptable, but that indicates, doesn't it, the way things are there and the direction of it? So nothing dramatic, we don't suggest that.

But important for what happens next -- we can take that down, thank you very much, Mr Murphy -- because we come next to the point when Ms Letby goes to nursery 1 to look after the other baby that she was caring for. She's explained she hadn't fed [Baby Q] that morning, that she was concerned he should be reviewed given the aspirates overnight, and there are aspirates overnight, and Nurse O'Brien has said it's more than you would expect, and therefore she felt, if the ward round is taking place round about 9 o'clock, and there were doctors there, she would wait for that, let them review [Baby Q], and in the meantime she would check on BM in nursery 1, and she would have to do that.

This isn't, for example, her going off to a nursery where she had no commitment whatsoever: she had a baby BM in nursery 1, so she asked Mary Griffith to look after [Baby Q], and that is completely natural, ladies and gentlemen. The suggestion is this has all been set up and we've explained to you how unlikely that is and how on earth do you calculate that. And she went to nursery 1.

Let's go to the neonatal review on the screens for [Baby Q] just to see what happened and follow this through. The layout is at page 1. Just enlarge that please, Mr Murphy, thank you.

So we have Ms Letby in nursery 2 with Mary Griffith, with [Baby Q] and YM, and also she had a baby in nursery 1, BM, and [Nurse B] was in there as well. And you can see that one of the babies [Nurse B] was looking after is JA. So Ms Letby, having gone there, using what we have available as best as we can -- can we go to page 3, lines 62 and 63. And we see, having gone there, round about 9.04 or at 9.04, she's involved in giving a prescription to JA. Again, this is why we spent time looking at these. This is natural. The minute it's got the name Lucy Letby to it it's as if a kind of light comes on and a huge amount of prejudice is sent straight into what we're looking at. But she does what the nurses do to assist one another and then it's whilst she was there that [Baby Q] became unwell.

Well, as you know, we've said to you, ladies and gentlemen, she can't really win. If she goes off and leaves a baby in someone else's care and there's a problem such as this, that's her fault. If someone else goes off and leaves a baby in her care and there's a problem, as with [Baby I] at the end, the event that mirrors precisely what had happened with Ashleigh Hudson about an hour beforehand, that's her fault. If she hands a baby over to somebody else and, some time later, there's a problem, as happened with [Baby N], when he was fine, he's handed to Jennifer Jones-Key and he became very unwell about 5 hours later, that's her fault. And there doesn't even have to be evidence that she's there, the second pair of events with [Baby J], and that's her fault.

The event that follows, we've seen the nature of it and fortunately there was a fairly swift recovery until about 10 hours later, actually, when [Baby Q] began to get tired, and we'll look at what that led to shortly. But as to what it is -- and thank you for putting those up, Mr Murphy, we can take them down. As to what it is that Ms Letby is alleged to have done on this occasion, it depends a little bit on which expert you ask. If you had asked Dewi Evans at any time up to 2021 what had happened, he would have said, given what he put in his reports, the three of them up to that point, this was air being forced down the NGT. But, as you know -- and I was criticised for not identifying this, but we -- it's been corrected -- he did by the time of a fourth report say that it was fluid.

Dr Bohin seems to have stuck with air down the NGT, although she did make comments about the fluid that came out being inexplicable. Right. We're going to have a look at the fluid. It's on these small details that a great deal hangs in this case. A great deal hangs.

Fluid. So you can understand the point I wish to make, ladies and gentlemen, we say this is mucus, it's plainly mucus from the descriptions that are given when you put it together. That will block the way that [Baby Q] was breathing and that can have led to a desaturation at this point. Not air, not milk, it's not some unknown fluid, it is mucus. So you know where we're going with what I'm looking at.

Dr Bohin was doubtful about that, that it was mucus, and we're going to go to the evidence. Bear in mind she was doubtful about mucus on 6 April. We say it's very clear. And we do ask this question: is she reluctant to concede mucus because that actually provides an explanation? Because she was asked on 6 April:

"Question: You agree, whatever lies behind it, if it is mucus +++ and if it had to be removed by suction or pulling it out, that could actually interfere with breathing, couldn't it?"

And she said:

"Answer: If it was, yes, it could."

Right. So we got that far. Mucus could interfere with it. So what's the fluid? Let's have a look what people say. So we're going to rattle through some documents, ladies and gentlemen. Mr Murphy's ready to go. Thank you.

[Dr A]'s note, first of all, tile 103. We saw this earlier:

"Called to the NNU. Desaturation. Had just vomited."

Now, he explained, of course, this is something that he was being told. He wasn't there, but that's what we have there. He puts in "vomited". That's what he's been told. A letter has been -- attention has been drawn to a letter at tile 310, that he'd sent, a letter, a discharge letter, when [Baby Q] was moved to another hospital, tile 310, where he uses the expression "profuse vomit". Just scroll down, if you would, please, Mr Murphy. Go over the page, actually. There we are. Can you see there, ladies and gentlemen:

"Profuse vomit with desaturation".

A great deal's been made there. The prosecution have said, "Look, [Dr A] said 'profuse vomit'." Well, [Dr A] doesn't know, [Dr A] is using or paraphrasing words that were given to him in a letter he's writing, so he cannot tell us what this is. Yes, somebody has said to him or said something, but he didn't put "profuse vomit" in the notes, as it happens, but this is word

from reported events. We've seen what Nurse Letby put in her notes -- I'll remind you again -- it's at tile 143, but remember she's in the bracket of someone who was told about this just after it happened, but tile 143. Thank you.

This says:

"Attended by Staff Nurse Lappalainen. He'd vomited clear fluid nasally and from mouth."

That's what we're looking at there:

"Desat, bradycardia, mottled, Neopuff, suction, air".

Of course, the order of that is going to be significant, isn't it? Neopuff before air. Just take note of that, if you would, ladies and gentlemen.

Actual evidence of the vomit came from Mary Griffith and Minna Lappalainen. On 3 April, in answering questions to the prosecution, Mary Griffith said that all she'd said was that [Baby Q] had vomited and Minna had started Neopuffing and she gave no more description than that. The person who gives detail of what this vomit was, the person who was there and dealt with it, was Minna Lappalainen, and she recorded this on that apnoea chart, which is at tile 101, so this is the evidence from a senior nurse at the time dealing with [Baby Q]. Dr Bohin was not there.

"Baby found to be very mucousy. Clear mucus from nasopharynx/oropharynx removed. Clear fluid ++. Oxygen via Neopuff given post-suctioning. [Dr A] emergency called to attend. NGT used to aspirate stomach by Nurse Letby."

I seem to recall Ms Letby wasn't sure that she had done that, but that's the note made by Dr -- sorry, by Nurse Lappalainen.

Probably the best and the most accurate record on this -- and she was questioned to establish what lay behind this on 3 April:

"Question: What did you see when you got to his cot?

"Answer: He'd been a little bit sick and there was clear mucus coming out of his mouth.

"Question: And in the next column have we got your note of what you saw, what -- [this is about the chart] -- what you found and what you did about it?

"Answer: Yes. It's just when there is a baby being sick -- and actually I went to him and attended him. Yes, he was being sick, but he was mucousy.

"Question: I'll let you read it for us."

She read out exactly what we have in the note here and she was asked:

"Question: Can we break that down, please? Very mucousy. What does that mean in this context?"

And she said:

"Answer: It's just the volume of clear mucus was just a large amount because it was coming outside of the baby's mouth.

"Question: And when you say 'clear mucus from nasopharynx/oropharynx --

"Answer: Basically, some of it was coming through the nose, because there's obviously a common channel in your pharynx, and also from the throat and then into the mouth.

"Question: And when you put 'clear fluid +++' what is that?

"Answer: The clear fluid means the mucus that I'm clearing, what I am clearing is clear, there's no feed in it, no milk, there's no other particles in it, just clear fluid, like saliva."

That was what she was asked in chief, that's when the prosecution ask questions, and we say this could not be plainer. This is mucus. And in cross-examination, she was asked:

"Question: Ms Lappalainen, you describe in the comment section that the baby was found to be, you put it, "mucousy/clear mucus"; do you see that?

"Answer: Yes.

"Question: Do you recall whether there was vomit as well or was that not vomit or do you have no recollection as to that?

"Answer: I can only recall clear mucus, like saliva.

"Question: And so where we've got the 'clear fluid +++' that you were asked about, is that a reference to the mucus that you saw?

"Answer: It is, yes.

"Question: Was that mucus that you also removed?

"Answer: Yes."

How Dr Bohin can have decided to take issue on whether that is mucus is mind-boggling because the evidence is absolutely clear. Why she took issue on that, when we all know mucus can, in light with her answer, provide an explanation for the desaturation, you may draw your own conclusions, ladies and gentlemen. But she wasn't ready to accept the clear evidence of Nurse Lappalainen and nor do the prosecution.

What we do have evidence of, ladies and gentlemen, as we go forwards in time with [Baby Q] is NEC. It's not for the defence to set out to prove one thing or another, you know that. But it is clear in this case that [Baby Q] became or was becoming unwell at some point, and we say as a result of early stage NEC, or he might have been. And again, you have been asked by the prosecution, and we agree with this, to look at all the evidence relating to a baby time and time again.

Look at the evidence if you would, ladies and gentlemen, when you come to it. [Baby Q] was at risk as a premature baby of NEC; it's something they're all on the lookout for. There'd been 2ml of bile with bile around 21.30 on 23 June. That's in the paper file in the care chart. There was a concern at the time. There are aspirates, not a lot, but perhaps more than expected during feeding.

Vomit and deterioration on the morning when Ms Letby was the designated nurse, a vomit we have established, we're talking clear fluid, we're talking mucus that had to be cleared, and a lot of it. I should say I've moved on rapidly to this and didn't deal with "air +++" but that is because by this point in the trial we have seen, repeatedly now, that when a Neopuff is used like this, that can put air into a baby. There's no way of distinguishing that from anything else.

Going into the night -- we can take the tile down, please, Mr Murphy. Thank you. Going into the night, [Baby Q] became tired, he was unsettled, and by the morning of the 26th he had produced bilious aspirates. Now, although you've been invited to take a broad look at the evidence on each of these counts across the evidence, form a general view, you haven't been taken yet to what [Dr A] identified, which we say is quite important, so we'll go and have a look at this.

But that morning, his temperature was unstable on the 26th. There were no audible stomach sounds where there should have been. You may remember [Dr A] describing there was bile in the OGT, orogastric tube, on palpation, he could see that, and he could feel swollen bowel loops, and an abdominal X-ray revealed

dilated bowel loops. We had a bit of a debate about what time the X-rays were taken, but we get there that by 11.58 there's an X-ray and also at 5.05.

Dr Arthurs, Professor Arthurs, talked about those abdominal X-rays. He identified features consistent with NEC. He seemed to get a bit worse on them and then got a bit better, it was less so by the time he'd been moved to another hospital when he went to Alder Hey. His view was that this could be early stage NEC that had resolved or was resolving. He took that view, that was possible, that is what we suggested to him. That was the diagnosis of [Dr A], who's an experienced doctor, who dealt with this, and saw the bile and palpating the abdomen and the bowel loops. It was something that Dr Bohin would not agree with. Let's just have a quick look at where the diagnosis is set out by [Dr A] to remind you, ladies and gentlemen. It's not on the carousel, not on the sequence of events, but we have it -- we looked at it at pages 24199 and 24200.

I won't read through all of this, but this is the morning of the 26th, so we've had the episode on the morning of the 25th. [Baby Q]'s stabilised, becomes tired that night, the night is up and down. By the time we get to the morning, we have the findings, which I have summarised for you, but there's a lot of investigation. And we go over the page, we can see the diagnosis that's reached on the basis of all of this and there you have it, ladies and gentlemen, in the centre of the page. Above "plan" we've got there:

"Probable NEC. Bell's stage 2."

And you remember the Bell's stage of different features that help you identify NEC.

Owen Arthurs, and, it has to be said, even ultimately Dewi Evans agreed this was consistent with early stage NEC. [Dr A] identified this as probable NEC. Dr Bohin refused to accept this and we say, not for the first time. We say -- it's a matter for you -- but taking a very high-handed approach to the evidence of those actually dealing with the babies at the time. And it seems to be whenever she did that and dismissed it, that seemed to send things -- lend support to the prosecution by dismissing that it was mucus that could have caused a blockage when we can see there is that evidence, and we say that by dismissing what we have here is developing early stage NEC, but those dealing with [Baby Q], particularly [Dr A], made that diagnosis. Thank you, Mr Murphy.

Attempted murder. An intent to kill [Baby Q]. As with the other charges on this indictment, ladies and gentlemen, you have to be sure of what is alleged. We don't say that as some awkward test.

That is the law. But we say, as with other ones, you have very good reason not to be, and we ask with this one, which is the one I'm looking at with you now, where is the evidence that gets close to that?

Please keep in mind that note from Minna Lappalainen, which is compelling, really, as to what had happened. Someone hasn't forced mucus down [Baby Q], have they? That's what it is. It's not a vomit of milk or something else, it's mucus that he's produced. Other people are around, even another nurse in the same room. What on earth is she meant to have done? No evidence of an attack or anything done with an intention to kill and clear evidence of early stage NEC. And then, even after the return from the other hospital, [Baby Q] returns to the unit and, until she leaves the unit, Ms Letby is there without incident and without anything happening to him.

My Lord, I wonder if this might be a suitable point to stop. If we had a shorter lunch, I could finish after lunchtime.

MR JUSTICE GOSS: Yes.

MR MYERS: If that's suitable to your Lordship and the ladies and gentlemen of the jury. It would assist me just to take a break, whatever time we start, because then I can conclude.

MR JUSTICE GOSS: Absolutely. That's not a problem for me, certainly, I hope it won't be for you. Shall we resume at 1.40, please? That's just over the hour, nearly an hour and 5 minutes.

MR MYERS: I won't be long into the afternoon, my Lord. I won't be a great deal of time, but a break would help.

MR JUSTICE GOSS: Don't protest too much, to quote Shakespeare.

MR MYERS: I'll stop protesting.

MR JUSTICE GOSS: Thank you very much. 1.40 then, please.

(12.38 pm)

(The short adjournment)

(1.40 pm)

MR MYERS: Ladies and gentlemen, we are very grateful for the close attention you have given to this case and to what we have had to say on behalf of Ms Letby at the end.

It's taken some time and it is detailed because there has been so much to consider in this trial and because the detail is

important. And even taking the time we have taken, I have taken, we've looked at only a small part of the evidence in this case, ladies and gentlemen. We, the defence, have endeavoured to look realistically at enough of it for us to provide you with a reasonable summary, whilst setting out the case for Ms Letby.

This is the case from the defence perspective, just as last week, you heard the case from the prosecution. There is so much material in this case, it is difficult to refer to all that can be relevant and I'd be here talking for a good deal longer than I have been. And it isn't difficult for someone to pick out one item or another and give prominence to that, depending upon which position they are coming from. That is why, ultimately, the decision about what evidence is important and where it takes the case is for you. It's not for me or the defence, it's not for the prosecution, with respect to his Lordship, as he has directed you, it's not for his Lordship, it's not for anyone outside your number.

We are bound to say that you will be able to assess the way the evidence is used and where it has been used to undermine Ms Letby. And where that applies, please use your knowledge of the case and your knowledge of the evidence, together with the proper directions from his Lordship, to form your own opinions.

You have spent so long with this case, looking at this evidence, and we entrust you, with a proper analysis of it, that we know you will perform because you have put an enormous amount of your time, in all sorts of circumstances, over the last 9 months of your lives into this, and this is for you now.

The detail and being able to see it in a fair and balanced way and from the perspective of the defence, ladies and gentlemen, we say, is crucial for this to be a fair consideration of the case. In this case the dangers of being influenced by factors that are not fair, we say, are clear and they are substantial: emotion, suspicion, judging Lucy Letby by standards that are not applied to anybody else, unrealistic standards, and a reliance upon the fact that she was on the unit as proof of far more than that fact can possibly amount to.

We recognise, ladies and gentlemen, the evidence comes in many forms and some of the non-medical aspects will raise genuine questions for you, such as the Facebook searches and the handover sheets and the cards photographed. But even there, we say, the patterns that should exist if the prosecution theory is correct do not: they are incomplete and inconsistent. We say that is because they do not go to support what is alleged.

You, ladies and gentlemen, will decide what is important, but we maintain that it is the medical evidence that is crucial because

it's that upon which the allegations of harm are based and upon which, ultimately, you have to be sure, insofar as those allegations can be proved, and it addresses what did or didn't happen in the cases we are looking at, or it fails to.

When you come to the medical evidence, ladies and gentlemen, we ask you to keep two things in mind. First, that the lead clinicians, certainly from the Countess of Chester Hospital neonatal unit, are not neutral, disinterested parties, they are deeply involved in what happened, and we say that at times they have said things deliberately to prejudice Ms Letby's position. You will assess that and I'll return to the topic of the Countess of Chester Hospital shortly.

But you've also had a huge body of expert evidence and, ladies and gentlemen. However this is approached, this is a prosecution case that relies fundamentally upon the evidence of its experts, and you have seen that. Assessing this will be a matter for you. But we say, from an assessment of the evidence, that to a great degree this has come from two witnesses who we say are not experts in key areas of what they have held forth upon and whose evidence, we say, has proved to be partisan and has been directed towards supporting a theory of guilt rather than working with the facts.

Leading the way and leading the expert evidence in this prosecution case, and it would appear in the course of the investigation, is Dr Dewi Evans, an expert witness who has been criticised severely, we say, by a judge of the Court of Appeal for behaving in the type of way that we have challenged him over in the course of this trial in front of you for months.

We say his reports and opinions have led the way for other experts to follow, and the prosecution still support him and base their case upon him. That, we say, is incredible. But be in no doubt, his evidence, we say, is at the core of the expert evidence you have been asked to rely upon by the prosecution, and they continue to embrace his evidence and rely upon it to the very end.

Reliance by the prosecution upon Dr Bohin is no remedy. You have seen how she has approached this case and I say you -- and I repeatedly say you, because it is your opinion that matters, not anyone else, it doesn't matter what they think. This is the strength of the system we have: wherever it takes us in this case, you are (sic).

And we say Dr Bohin has been capable of being highly partisan, reflecting many of the elements of the approach of Dr Evans, albeit more cautiously. And even when we come to a witness such as Dr Marnerides, he is guided inevitably, as he has accepted in

many cases, not all but many, by the findings of these two witnesses and so the expert evidence in this prosecution case feeds upon itself.

Looking at the case more broadly, trying to deal with this case by taking shortcuts through the evidence would be deeply unfair. Now, of course, you are entitled to look at similarities and look at the cases in general and you are directed about that and we recognise that. Some of the events you are dealing with do have similarities and you can take that into account, whichever direction that takes you in, but there are many differences too. And the particular facts of each of the counts on this indictment, ladies and gentlemen, need to be looked at carefully because what happened and questions as to the medical condition of the babies and questions of medical failings, when they arise, are distinct to each.

These are the most grave allegations. Each one needs to be considered with care, each one with care, and we are confident you would not take any other view given the enormity of what this trial is about.

When we come to the basis of the case, ladies and gentlemen, you have seen over and over again how the mere presence of Lucy Letby alone really has become the sole explanation for what has happened and how her name has been used as if that alone explains what has happened, sometimes, apparently, without the need for any other evidence at all, save presence and an event taking place.

One thing that is constant throughout this whole case, above all else, is the fact that Ms Letby was not seen to do any of the acts alleged against her. You've been directed on circumstantial evidence and you're able to construct your opinions from that, but it is crucial to keep that in mind. And when we say the acts, we mean the acts, not standing nearby, not something having happened that can be incorporated into an allegation, the acts.

That is crucial to keep in mind. It isn't all that you have to look at, it isn't the answer to everything, we're not saying that, but in a case where you have been asked to look at coincidence by the prosecution, that has to be the coincidence above all others, doesn't it? It has to be, every time. And we say there is a reason for this coincidence, for the fact there is no direct evidence of her actually doing any of the acts alleged against her -- and we say the circumstantial evidence doesn't get us there, but we're talking about the direct evidence -- and that reason, however unwelcome it may be in some quarters, is that she did not do this. It cannot keep happening like that if she did.

And in a case in which you have been asked to look at coincidences, ladies and gentlemen, we urge you to keep this one in mind too, that between June 2015 and June 2016, the neonatal unit at the Countess of Chester Hospital took more babies than it would usually care for, and it took babies with greater care needs, on the evidence. We have heard that repeatedly.

In that same year there was an increase in the number of deaths and, we are told, the type of collapses we have been looking at in this trial. Those two facts are connected we say.

What didn't change was Lucy Letby. Ms Letby had been a neonatal nurse for years. That was what she was dedicated to. She cared for hundreds of babies. She didn't suddenly change her behaviour in 2015 to 2016. What changed was the babies cared for on the unit in terms of their numbers and their needs and, we say, the inability of this unit to cope.

But nobody is going to come here and admit that to you, are they? "One tends not to spread news about the mistakes we make." The one thing we can agree is accurate from the lead prosecution expert in this case:

"One tends not to spread news about the mistakes we make."

For each of these cases, ladies and gentlemen, we ask you to consider the circumstances in general, and these are things we ask you to look at each in case, whether you can be sure of the allegation in terms of how realistic it is that Ms Letby would, or even could, have done what is alleged in the circumstances and we say it never is, and in terms of the intent alleged, which is equally improbable for the reasons we have been describing to you as we have gone through the evidence at the conclusion of the case.

But also in each case we ask you to consider whether it is possible that the medical condition of the baby whose case you are considering could account for what happened and/or whether failings in medical care could possibly account for what happened because we say -- and this is a matter for you entirely, but we say these are significant factors across these cases. And we say there is powerful evidence of one or the other or of both on various occasions.

You have seen and heard the evidence, members of the jury. No one or not many people are going to turn round and say, "Yes, we got this wrong". A few exceptions have. That is not going to happen, so you have to assess it. But we say we have identified failings in care, serial failings in care, on the evidence. And I'm going to identify some that we can, and you may not have

believed it before this trial began, but at the very least this includes [Baby A] and the delay in fluids and the line that was placed too close to his heart, not in the best position and not moved, and, sadly, he died when that line was used while still in the wrong position.

[Baby C] and failure to react to 24 hours of dark bile-stained aspirates and who didn't open his bowels for the 4 days of his life. No one will admit any fault there. We ask you to look closely at that evidence.

[Baby D] and the failure to give her or her mother antibiotics when it is recognised that that should have been done. [Baby D] who was born with pneumonia, lived during her brief life with pneumonia, and died with it, having breathed without support for very little of her time.

[Baby E] and the failure to intubate or give a blood transfusion in time, despite a medical emergency.

[Baby H] and serial failings in her case, serial failings: a 30-plus-hour delay in giving surfactant, delays in intubation, a butterfly needle left in a hazardous position, the delay in inserting that second chest drain and how it was placed through, we say, the wrong part of the chest wall. And it was, we've seen the guidelines, we've heard about them: insecure and with a tip that you can see moving about within the chest cavity on a series of radiographs over a series of days, able to make contact with the heart and the vagus nerve, and able to trigger desaturation or bradycardia. And the experts have accepted that; what they won't accept is that it happened on these occasions.

[Baby J] and poor management of the stomas. Infection risk.

[Redacted].

[Baby N]. Failure to have factor VIII ready when he'd been identified as a haemophiliac and, we say, the serial inability of medical staff to intubate in circumstances where a more adequately experienced professional encountered no difficulty and that professional, Dr Potter as it happens, was clear in his evidence, talking about something he does for a day job, that that was not down to a reduction in swelling.

[Baby O] and the question of the liver injury, a matter that is not accepted and is hotly contested, we recognise that.

Uncontested, really, when we come to it is [Baby P] and the delay in taking a chest X-ray, the failure to identify a pneumothorax and to take action, that led even Dr Bohin to conclude in her reports as follows:

"My impression of the care afforded to [Baby P] after the collapse on 24 June is that it was muddled. There were unacceptable delays in recognition and treatment of the pneumothorax, the ventilatory strategy used, and the use of a high-dose adrenaline infusion was unusual."

And mistakes -- an initial event with ventilation that caused a pneumothorax, we say. Mistakes with the initial event, ventilation, causing a pneumothorax and then getting the doses of adrenaline wrong. That led even Dr Evans to conclude, in his three pre-trial reports, that death was the result of complications from the pneumothorax.

That captures so much in this case when put together with the other material. We're not identifying these as an excuse. They play a part when you weigh up the cause in this case. They also play a part when you weigh up the question of blame in this case. Because, for example, as we've been looking at this morning, when all of that went wrong with [Baby P], all of that, who gets the blame? And on what basis? Bases like the dislodgement of a breathing tube. That is undocumented where you'd expect it to be documented, if it really happened, and which coincides with the very point when failings in medical care were having a critical impact on [Baby P]'s condition.

Don't let this be played down or for it to be conveyed that somehow it doesn't matter. Even looking at those matters that cannot be disputed, which is most of what I have just identified to you, in this one unit over 12 months we say these are occasions where we together in this trial have been able to identify sub-optimal care. We do not know what errors in monitoring or observation have played a part, we can only get as far as the evidence gets us, we cannot or must not speculate, but what we know is awful in any ordinary situation looking at that.

We say that we collectively have got far enough to show that there was a terrible failing in care in that unit that has nothing to do with Ms Letby and that impacts upon one or more of these accounts in various ways. But the person in the firing line for blame now is her and you have seen how it has been stirred up and launched in her direction and supported by evidence in key areas that has been sometimes inconsistent and sometimes incredible.

When I say that, ladies and gentlemen, think if you would, please, about discolouration in this case, how accounts have varied, not just across the witnesses but from the same witness or where a witness has described nothing remarkable at the time in circumstances that make such an omission as extraordinary as

the discolouration those witnesses would later claim to have seen.

[Redacted].

Think, if you could, just as an example, of how, for example, Melanie Taylor and Sophie Ellis have placed -- it's a matter for you how much reliance you put on this -- placed Ms Letby in a position with [Baby C] on count 3 that actually effectively swaps her for the position of Sophie Ellis on the account originally given by Melanie Taylor to the police. Sophie Ellis, to be fair, has been consistent that she wasn't there. But Melanie Taylor's account changed and came into line with that. And both, in evidence here, are inconsistent with the account that has always been given by [Nurse B], which actually has Ms Letby elsewhere at the crucial time.

That is the evidence. However anyone feels about it, that's the evidence on that. Think of how Ms Letby is the one blamed now, even after the evidence we've had for [Baby G] being left behind a screen without a monitor working, after Dr Gibbs and Dr Harkness had gone without telling the nurse and after those seven attempts at cannulation. And Dr Gibbs does not dispute that on the basis of [Nurse B]'s evidence and Dr Harkness says he simply doesn't know, he can't remember.

We know she did not do what was alleged at the start of this, that seven attempts at cannulation could well have triggered the desaturation, and that the reason [Baby G] was found at the time that she was was because it was Ms Letby who raised the harm, and she is being tried for attempted murder for having an intent to kill in those circumstances.

Think of how many of the events in this case do not, we say, begin to fit with an intent to kill, whatever the offence alleged, and that applies equally, we say, to those counts relating to [Baby F] and [Baby L], counts 6 and 15.

If this was such an effective and secret method, these are the insulin counts, why was it not used elsewhere and why not with devastating effect here? And why not in increasing doses rather than a diminishing one, a reduction to 25% from the first to the second on the analysis, if that is correct? You were asked what better evidence of intention could there be, by the prosecution, on the basis of an increase. Well, what better evidence could there be that this is not about an intention when you look at that significant decrease, whatever has gone on there?

And how, ladies and gentlemen, was any of this meant to have been done? Sometimes the unit was quieter than others, but at others these allegations are attached to circumstances that make

an attack, we say, unbelievable and sometimes when Ms Letby is elsewhere and sometimes when the timings cannot really fit at all, for example with [Baby M] that we looked at yesterday. That's just one example. Or where she is in full view of other people who are there, like with the [Family of Babies A & B], like with this morning, when we were looking at the cases in the nurseries and particularly with [Baby P].

Once you begin to question, and we do ask you to question how any of this was done in reality, instead of an allegation thrown out verbally, we say that you will see how unrealistic it is, and all of that before we come to consider fairly what we described right at the start of our opening to you, ladies and gentlemen, which was dozens and dozens of alleged incidents of force-feeding, of pushing air down tubes, injecting air down tubes, of spiking insulin bags repeatedly, performing assaults with unidentified objects in a unit where anyone can walk into any room and any moment, and they do, and where for nearly 12 months we are told Ms Letby is under suspicion by an ever-increasing number of doctors. And not one occasion when there is evidence of her doing one of the harmful acts alleged against her.

We say that when you consider the evidence in this case and the intent that is alleged on each count, it is a case that has been constructed out of unrealistic allegations, factually. Much of the evidence has proved to be incomplete, inconsistent or absent when one comes to look at the allegations that have to be proved, and in many cases the allegations rely upon inconsistent standards, you have seen that over and over again, and we say, and you will have to assess, as you do all things that we say, partisan and poorly reasoned expert evidence.

We say the whole prosecution case is driven by a relentless presumption of guilt that has acted to compensate for gaps in the evidence, is capable of being deeply emotive and desperately prejudicial.

It is easy to lose sight of the reality of the person at the centre of this and in many ways there's only been focus on a particular characterisation of her, the person we say the prosecution have endeavoured to create in front of you in pursuit of their case. You need to look at the evidence, if you can, to reconstruct the person she was at the time, not the person she's been made in the last 7 or 8 years, but the person she was when you measure these allegations and the enormity of them against her.

Dr Hunt, we mentioned this yesterday, talked about how she said:

"I remember Lucy in the kind of the step down from the ITU, high dependency unit rooms, crying, with another nurse, I don't remember which other nurse. It was very much along the gist of, 'It's always me when it happens.'"

A normal reaction in the circumstances. That's not been done to create a misleading impression. That is evidence from the time from how she was.

That note, "Not good enough" it says, doesn't it? For all else it contains, that is how it's headed. Just for her, that's not a defence statement, it's not written for anyone else. "Not good enough." We say that is an insight into a genuine state of mind because this is clear, isn't it: Lucy Letby wanted to be good at what she did, she wanted to excel at it.

If we go back to the person that she was, not the kind of caricature that has been created by the use of words before you, you've heard witnesses who talk about her at the time. Eirian Powell in particular but others. She wanted to be good at what she did. She wanted to excel at it and, judging by all we have heard, that's how it was. And then this happened. So it's little wonder that she was distraught and the evidence of that is painfully clear and in no way artificial.

So ladies and gentlemen, when this woman is left in your charge, we would ask you to keep that in mind, not the picture conjured by the prosecution in this trial out of words and descriptions, not an impression formed out of how they treated her over weeks of questioning before you -- this is for you, other people's reactions don't matter, you -- how she was treated over weeks of questioning in a way they treated nobody else, measured by standards that have been applied to nobody else. Please keep at the forefront of your minds the person she was at the time these events were happening, not what she has been reduced to now.

I am saying this on her behalf because it needs to be said because absolutely no one else is going to say it. She was hard-working, she was deeply committed, she had a happy life, she loved her work and she was there much of the time, because she was committed, because she loved being a nurse, and so she was there at the time these incidents happened, and for a system, a system that wanted to apportion blame at a time when it failed, she was the obvious target, on the evidence not because of what she was seen to do, oh no, on the evidence because she was there.

We ask, ladies and gentlemen, entrusting her to you, for fairness and balance and a realistic assessment of the evidence in this case, based, we ask, and we are confident you will apply, upon a presumption of innocence and not a presumption of

guilt. And if do you that, you will reach the right verdicts, ladies and gentlemen, and we say that the right verdicts are verdicts of not guilty and those are the verdicts we ask you to return.

MR JUSTICE GOSS: Thank you, Mr Myers.

Mr Johnson, Mr Myers, there are some matters that I want to address, including my second set of legal directions. I'm just wondering whether -- I don't know how long this may take. I'm just thinking of the convenience of the jury. I'm going to ask them to retire at this stage. Perhaps the best thing is just to ask them to go into the room at the back at the moment and we'll see where we are.

MR JOHNSON: Yes.

MR JUSTICE GOSS: All right, members of the jury. I'm conscious of the fact that you started earlier this morning, but as you know, we are approaching the penultimate stage, which is my summing-up, which I've already indicated to you is going to take, I'm afraid, more days. You're going to have to listen to my voice for days next week. It's a four-day week next week. I will not complete it in the sense that I will not be sending you out on Thursday afternoon. It'll be early the following week. All right?

But I just want to clarify -- because you know you're getting another set of written legal directions. Can I just ask, have you still all got your first set of legal directions? I think when I start my summing-up, be that this afternoon or on Monday morning, we'll just do a bit of bookkeeping, so to speak, and tidy up and make sure we've all got the right documents. All right? Thank you very much indeed. Would you then go into your room? The usher will bring you back into court when you're needed again, thank you.

(In the absence of the jury)

Discussion

MR JUSTICE GOSS: If I could deal with the legal directions. You got yet another version, I'm afraid, yesterday. I assumed that, as far as you were concerned, was acceptable, Mr Johnson?

MR JOHNSON: Yes, I think your Lordship sent the message that silence was --

MR JUSTICE GOSS: Yes, it was. I just wanted to make sure -- and I couldn't see any more typing errors or grammatical errors there. So that will be -- I'm going to give a copy now to the

clerk. Please, copies for the jury. These are the second set of legal directions.

Are there any matters you want to raise, Mr Johnson?

MR JOHNSON: There are several matters arising out of what my learned friend has said, but I thought that the best way of doing that was to give your Lordship a document and my learned friend, obviously. That's mostly done, but it's not completed. I can certainly disseminate part of it which deals with --

MR JUSTICE GOSS: No. Really, this is why I was speaking with careful language, just to see whether the jury -- that's why I should say that they should go out there for the moment.

MR JOHNSON: It's not something I'll be able to complete because it's got to be referenced with transcripts and everything because, as -- well, we're suggesting there are a number of significant things that have been said which do not reflect the evidence --

MR JUSTICE GOSS: All right.

MR JOHNSON: -- and need to be resolved.

MR JUSTICE GOSS: I was reluctant to start, in any event, summing-up, even with introductory remarks, which is what I could have done this afternoon. They've been listening many days now.

MR JOHNSON: Two weeks, really.

MR JUSTICE GOSS: I think I'll send them home and tell them to come here on Monday morning. The only thing I'm querying, and I might ask the usher to ask the jury before they are brought back in, is whether, as far as their ability to concentrate is concerned, whether they feel it would be better to start slightly earlier and have two breaks before the lunch break or whether they would rather stay as we are at 10.30 and just have the one break. So I don't know, but I was just detecting after about an hour, an hour and a quarter, some of them looked like they might want a break and that might be another way of doing it.

Would you mind doing that, asking the jury so that I can take it from there?

MR JOHNSON: There's another issue that's bubbling away, which I don't anticipate for a moment is going to cause any controversy, but we're acutely aware of the potential for a complete disaster in the sense of the jury being given access to digital material

in retirement that has not been given in evidence. We know that Mr Murphy's kept a very careful digital audit of precisely what they've been shown. And over the last 2 weeks, on this side, we have made what we feel are comprehensive efforts to identify every last piece of information. It's all been scheduled and we have passed the schedule over and we understand that, for obvious reasons, consideration of that schedule hasn't yet been achieved.

So that's something, first of all, that's something that's going to have to be done. But secondly, what we are going to propose in any event -- so we would propose that that is agreed so that there is a clear record of precisely what has gone in. It'll have to be done before the jury goes out, we query whether it has to be done before your Lordship starts, probably not. And what I would propose to do as an absolute double belt and braces would be to somehow identify the digital file to which the jury has access through the iPads and to formally exhibit all the material on that file. So even if there is a document on the file that hasn't formally been exhibited in the trial, the fact that the jury has access to it in retirement doesn't have the catastrophic consequences that otherwise it could do.

Now, that will require somebody from the defence accessing the file with the assistance of Mr Murphy and just checking it against the index. So I'm hoping, by various routes, to achieve absolute certainty that for some technical reason these proceedings aren't compromised.

MR JUSTICE GOSS: The likelihood is, barring some unforeseen event arising between now and a week on Monday, that that stage will be reached on Monday week.

MR JOHNSON: Yes. Oh, I would anticipate so.

MR JUSTICE GOSS: Okay, that's fine, thank you. That raises another matter that I was -- links nicely to another matter.

In my jury bundle 1 index I have tab 9, a table of Facebook searches, June 2015 to June 2016. I don't seem...

MR JOHNSON: I haven't actually got it. Mine's blank as well as it happens.

MR JUSTICE GOSS: Yes. I haven't got it. Is that the defence one? Is that --

MR JOHNSON: Yes.

MR MYERS: Yes, it is, my Lord.

MR JUSTICE GOSS: D27 is that?

MR MYERS: I'll just check.

MR JUSTICE GOSS: You know, with the digital case system I struggle sometimes, especially when there's so much material on it now. I tried to find it there, but I couldn't.

MR MYERS: Yes, it's meant to be bundle 1, table 9. Sorry, divider 9. D27. But D27 is a reference that we have with Mr Murphy, D simply means the material introduced by the defence, so D27 is the 27th. They were all handed out, but if it's the case that your Lordship doesn't have a copy, a copy I'm sure could be provided to your Lordship.

MR JUSTICE GOSS: If I was given it, I just can't find it. It's probably my fault.

MR MYERS: I'm sure we can arrange for your Lordship to be provided with a copy.

MR JUSTICE GOSS: If you could, please, because obviously I shall want to refer to it.

(Pause)

That's good, I'm glad I asked. We will sit the hours we've been sitting up to now and not a 10 o'clock start. Thank you very much.

Right. Apart from the matter that you've already referred to, is there anything else you want to say?

MR JOHNSON: No, thank you.

MR JUSTICE GOSS: Is there anything, Mr Myers, you would want to say?

MR MYERS: We would like to see Ms Letby if we could, please.

MR JUSTICE GOSS: Certainly. I'll have the jury brought back into court and ask them to be here at 10.30 on Monday morning.

(In the presence of the jury)

MR JUSTICE GOSS: Thank you for your patience and thank you for addressing the issue that I asked of you: 10.30, we will stick to the normal court sitting times and probably not going much beyond 4 o'clock on any individual day in any event, but 10.30 starts, mid-morning break, lunch and so on. All right? That deals with that. But I'm not going to start this afternoon.

You've had a long week, listening to a speech, and mine is a form of address in that it's a single voice, obviously, speaking to you. And as I will tell you on Monday morning when I start, it's going to be very detailed and very dense, providing you with a chronology of events and some references, and I'm not going to give you any more documents apart from some directions of law that relate to certain aspects of the evidence and I will highlight those and you'll have copies to go with your other directions of law.

But I think that otherwise, you should have, each of you, all the documents with which you've been provided, you should have all your own notebooks and everything like that, and if you need more notebooks for when I'm summing-up to you, simply ask the usher and you'll be provided with more paper, big or small, whatever is more convenient for you. Whether you take any notes, entirely for you. I'll explain all that to you on Monday morning.

Thank you. It's an early finish for you, but please be ready to continue at 10.30 on Monday morning and, of course, continue to observe your responsibilities as jurors. As you will well understand, we are now entering a very critical phase of this case -- every phase is critical, but for something to go wrong at this stage would be a disaster for all sorts of reasons. Thank you.

(In the absence of the jury)

MR JUSTICE GOSS: Someone is going to come and visit the defendant. Thank you.

I'm just wondering, Mr Johnson, whether we should sit at 10 o'clock on Monday.

MR JOHNSON: That's probably a good idea.

MR MYERS: It probably is.

MR JUSTICE GOSS: Officer, actually, the court will sit at 10 o'clock on Monday. The jury will not be here, will be ready to start at 10.30, but the court will be sitting at 10 o'clock. Thank you very much.

Mr Myers, I don't know whether there's a spare copy of that document from somewhere.

MR MYERS: Mr Maher is going to check it's the right iteration before it comes to your Lordship.

MR JUSTICE GOSS: Thank you very much.

MR MYERS: We can deal with that this afternoon, my Lord.

MR JUSTICE GOSS: Thank you.

(2.32 pm)

(The court adjourned until 10.00 am on Monday, 3 July 2023)