

10 July 2023 (Day 145)

Judge's Summing Up Day 5: Baby Q, Other matters, Conclusion
Jury Deliberations begin

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Housekeeping

SUMMING-UP (continued)

(Jury bailiffs sworn)

(Jury in retirement)

Monday, 10 July 2023

(10.30 am)

(In the absence of the jury)

Housekeeping

MR JUSTICE GOSS: Mr Johnson?

MR JOHNSON: My Lord, just before the jury comes in, if I may, we have handed to your Lordship this morning hard copies of the documents for the jury, and if I could go through the formality at some convenient point of formally exhibiting all these documents, just in case there's something we omitted to exhibit during the course of the evidence. That will override any problem that might later occur if I've failed to do that.

MR JUSTICE GOSS: Thank you. Mr Myers?

MR MYERS: Nothing to add to that, my Lord.

MR JUSTICE GOSS: Thank you very much. I suggest we do that straightaway. They are to be distributed to the jury?

MR JOHNSON: They are.

MR JUSTICE GOSS: The other thing that will be distributed to the jury is sheets of labels which, I will explain to them in due course, are to go on their various documents, which will then be bundled up and taken to the jury room in a confidential bag, unique to each juror. That's the sort of housekeeping issue with which I'll deal at the end of my summing-up.

So you know what I'm proposing to do by way of timetable, I anticipate that I will have completed, to all intents and purposes, my summing-up before or around midday. I'm then going to ask the jury to put the labels on their documents in court, then to go for a short break, 20 minutes or thereabouts, as long as it takes for all the documents to be taken to their deliberating room, and also if counsel want to raise anything

that I have said this morning that requires any correction or anything like that so that we can deal with that, and then say a few more words and send them out -- swear the bailiffs and send them out to begin their deliberations.

(In the presence of the jury)

MR JUSTICE GOSS: Good morning, members of the jury. Each of you has been given, as I can see, a sheet of labels bearing your own name. When I complete my summing-up, which will be at around midday, I should imagine, I shall give you instructions as to what to do with those labels. So just leave them to one side for the moment, please, and I will resume my summing-up in a moment.

Before I do that, Mr Johnson is just going to distribute a set of final documents to you, which there's no need for you to look at, they are in a sense a formality, and he will explain to what they relate. It's by way of completion of the evidence.

MR JOHNSON: Yes, my Lord. This is simply formalising what we have in fact achieved during the course of the evidence. They are hard copies of lists of material in addition to what's on the sequence of events charts. So when the jury on their iPads go to the additional documents, they should find the documents that are listed in these lists.

MR JUSTICE GOSS: I am holding it up to show you.

MR JOHNSON: It's just if you can't find something, they're divided child by child, and if they're not on the list then you haven't got them, I'm afraid.

If I can go through the formality, my Lord: by agreement between the parties, on a belt and braces approach, exhibiting all these documents in these lists, that's a legal formality that's required, so I do that now. If I could ask Mr Stansfield to at some convenient stage give the jury a copy of one of each of these documents.

MR JUSTICE GOSS: Yes. The first is a schedule of the video evidence, so that's a reference document for you as well. It's entirely up to you where you put these. I'm going to make a suggestion about my legal directions and I'll do that now when you've received these.

MR JOHNSON: There shouldn't be any surprises in what you've just been given. It's just an easy ready reckoner list to cut down any time you may need to spend trying to find things, really. That's the only point.

(Pause)

MR JUSTICE GOSS: I don't know where you've put them my written legal directions 1 and 2. It's entirely up to you, but you might find it most convenient to put them with the indictment in your first jury bundle because they obviously relate, particularly legal directions 1, to how you approach the counts on the indictment.

If you do that then you each know where they are. So both sets of legal directions: the first relating to how you approach your decisions on the counts on the indictment and the second, the evidential directions.

(Pause)

SUMMING-UP (continued)

MR JUSTICE GOSS: The final count on the indictment, count 22: [Baby Q], attempted murder, 25 June 2016.

[Baby Q] was the 17th and last baby in this case and was born by emergency caesarean section at the Countess of Chester on 22 June 2016 at 04.09.

His mother, [Mother of Baby Q], had the misfortune of having a heterotopic pregnancy, a second baby being outside the womb and it having to be removed by surgery.

After 5 weeks in the hospital, [Baby Q] was delivered at 31 weeks and 3 days' gestation. He weighed 2.076 kilograms, 4 pounds 8 ounces. His tone was poor at birth, his Apgar scores were 4 at 1 minute, 7 at 5 minutes and 9 at 10 minutes.

Susan Dillon, the midwife present at the birth, noted that he was in good condition for his gestational age. He was taken to the unit at 04.23. There were no signs of infection.

Three days later, on Saturday, 25 June, [Baby Q] vomited fluid, desaturated and had bradycardia in an event at 09.10.

The prosecution case is that this was a consequence of liquid, and very possibly air, being injected down his NG tube causing splinting of his diaphragm and compromising his breathing, and although it cannot be discounted that he may have been developing mild NEC, that would not account for the sudden vomiting, desaturation and bradycardia from which he recovered.

The defence say that the possibility of developing NEC and the attribution of his collapse to an event unrelated to an act or acts of deliberate harm cannot be excluded.

Christopher Booth was [Baby Q]'s designated nurse for the long day shift of 23 June from 07.30 to 20.00, the day after he was born. [Baby Q] was on nasal CPAP, was coping well, self-ventilating in air, and he could confidently leave him off CPAP for a longer time. He obtained a lightly bile-stained aspirate at 09.00, as can be seen on the intensive care chart at page 3B in section 2 of your second jury bundle and so he, Christopher Booth, omitted enteral feeds. It was an unremarkable shift, he said, where [Baby Q] made good progress.

Tanya Downes, now a lecturer at Chester University, then a bank nurse working at the Countess of Chester, was the designated nurse for [Baby Q] for the night shift of the 23rd to the 24th. She remembered the shift as it was the night of the EU referendum.

[Baby Q] was self-ventilating in air. He'd passed meconium. As can be noted on the intensive care chart, copied as sheet 3B in section 22 of your second jury bundle, she aspirated 2ml of bile or bloodstained aspirate at 21.30, which she described in evidence as a coffee ground aspirate and for which she sought a paediatrician's review. She also noted that the stomach was not bloated and there were bowel sounds in all four quadrants.

At 23.30 she noted a new NG tube was inserted. She explained this involved removal of the old one and replacement. She was not asked about that but Dr Bohin said, as a matter of routine, any nurse would have checked for aspirates after insertion to make sure it was in the right place.

As noted on the fluid balance chart behind tile 61 -- the paper copy is on page 10 in section 22 -- she aspirated 1.5ml of bile at 04.00. She had no concerns during the shift.

After [Baby Q] had been discharged from hospital a month later, on 25 July 2016, she recalled him having to be readmitted to the out-of-hours clinic with gut problems. There had been a history of siblings, she said, having milk allergy problems.

[Nurse D] was [Baby Q]'s designated nurse for the day shift of 23 June. She noted that [Baby Q] appeared to have a cluster of a few bradycardias in the morning, but that seemed to be due to a loose ECG lead, as once it was replaced there were no further episodes of bradycardia. His observations were stable.

Samantha O'Brien took over as [Baby Q]'s designated nurse for the night shift of the 24th to the 25th. Behind tile 70 is her nursing note made at 05.25 on the morning of the 25th. He was stable, self-ventilating in air, and didn't have any increased work of breathing or respiratory distress.

There is a paper copy of the observations chart at page 2 in section 22. It's J24307. Nothing untoward is recorded in relation to his cardiorespiratory observations.

[Baby Q] continued on trophic feeds of 0.5ml every 2 hours, which he was tolerating. The fluid balance sheets are J24330 and 001, behind tiles 61 and 62, with paper copies at pages 10 and 11 in section 22.

There were intermittent moderate acidic aspirates, meaning the milk was partly digested at some feeds, which were returned, including a 3ml aspirate at 03.00 on the 25th. He was given nystatin, a standard precautionary medication against thrush given to babies of less than 32 weeks' gestation; J24189.

The blood gas results behind tile 79 recorded at 06.58 on 25 June were checked by the registrar on duty, [Dr D], for review, because the pH had dropped a little bit compared to the previous blood gas, which was done the previous morning.

Samantha O'Brien noted in the nursing notes behind tile 86, towards the end of her shift, after [Dr D]'s review, that the current management of care was to continue. Her general impression of [Baby Q]'s state of health during the shift based on her documentation was that he was stable throughout the shift. She had not documented anything that would alarm her.

[Dr D] confirmed that the blood gas sample was a little more acidic but was within acceptable limits.

The defendant took over as [Baby Q]'s designated nurse for the day shift of 25 June. [Baby P] had died the previous day and [Baby R] had been moved from the Countess of Chester.

The defendant was informed that [Baby Q] had had large aspirates overnight, so she would not call him as being in good condition. Mary Griffith also had a baby in nursery 2, YM. Minna Lappalainen was the shift leader.

The defendant recorded [Baby Q]'s vital signs for 08.00 on the observation chart, which is behind tile 88.

Tiles 97 and 98 are the vital signs and fluid balance charts, duplicates of what appear behind tiles 61 and 62. The paper copies are pages 10 and 11 in section 22. There are gaps in the entries at 09.00.

At about 09.10, [Baby Q]'s alarms sounded and he desaturated. Mary Griffith explained that before this happened, only her and the defendant had been working in nursery 2. She had been doing cares for YM prior to feeding him, with her back to the

defendant when the defendant, who had been dealing with [Baby Q], asked her if she, Mary Griffith, was staying in the nursery because she had to go into nursery 1 to see another baby. She was at that time also the designated nurse for baby BM in nursery 1, who was on hourly observations and there are entries on charts apparently initialled by the defendant for BM, J31674 and -- I think that may be 673 and 674, but certainly 674, including one at 08.30. It was normal practice to ask the remaining nurse in the room to keep an eye on another baby.

Shortly after the defendant had left the nursery and Mary Griffith was tube-feeding YM, [Baby Q]'s alarms went off. She looked over and saw his saturations had dropped. She could not abandon her baby mid-feed immediately and called for Minna Lappalainen, made her baby safe, and then went to [Baby Q] and sucked him out because he had vomited. She said Minna Lappalainen then started Neopuffing [Baby Q].

Mary Griffith's plan of locations is J24077 and she said she was at point A, [Baby Q] at point B and Minna Lappalainen's desk was at point C.

Minna Lappalainen remembered being called by Mary Griffith, who said there was an alarm going and [Baby Q] had been sick. She went to [Baby Q] immediately and could see he had been sick and there was mucus coming out of his mouth. She turned him on to his side, made sure his airway was clear and gave him oxygen.

Behind tile 101, J24314, the apnoea/brady/fit chart, was completed by Nurse Lappalainen. The paper copy is page 10 of section 22.

She recorded a brady of 98 and desaturation to 68 that lasted for 3 minutes intermittently. She wrote on that chart:

"Baby found to be very mucousy. Clear mucus from nasopharynx, oropharynx removed. Clear fluid +++. O2 via Neopuff given post-suctioning. [Dr A] was emergency called to attend. NGT used to aspirate stomach by Nurse L Letby."

In evidence Minna Lappalainen confirmed that there was some -- some fluid was coming out of the nose and the fluid was clear. There was no milk or particles.

The defendant's nursing note, which is behind tile 102, recorded that at 09.10 [Baby Q] had:

"Vomited clear fluid nasally from mouth, desaturation and bradycardia, mottled ++. Neopuff and suction applied. Registrar [Dr A] attended. Air ++ aspirated from NG tube."

Nurse Lappalainen said she was not overly concerned.

In her first interview on 5 July 2018, the defendant remembered being [Baby Q]'s designated nurse. When she came on duty she recalled he had a low temperature and was tachycardic. He was handling well and well enough to be left in the care of another nurse. She returned to nursery 2 after 09.10 to see [Baby Q] being attended to as he had vomited, was mottled and desaturated. She thought that Nurse Lappalainen was giving him Neopuff and that Nurse Griffith and a doctor may have been there too. She didn't think she had seen the vomit but she was told that he had vomited clear fluids.

Regarding the aspiration of air ++, she could not remember if that was something she or somebody else did. When asked about the air in [Baby Q]'s stomach, she suggested that babies sometimes gulp air when they vomit and she thought that an alternative for how air could get into a baby could be due to some sort of blockage in the bowel.

In the second interview on 12 June 2019, she recalled asking Mary Griffith to watch [Baby Q] in nursery 2 while she attended to another baby for whom she was caring in nursery 1. She accepted that [Baby Q] collapsed within minutes of her leaving nursery 2 and that he was stable when she left. She wouldn't have left him had that not been the case. She denied deliberately leaving the room to blame the collapse on other staff and explained that the baby in nursery 1 was due cares. She denied administering air via [Baby Q]'s NGT or otherwise acting in any way to cause the collapse.

In the final interview on 11 November 2020, she denied giving [Baby Q] anything that would have caused him to be sick and she said that babies could deteriorate at any time.

In her evidence to you the defendant said she noticed [Baby Q] was on the cold side, so she decided she would prefer for a doctor to see him before she fed him at 09.00. She was concerned about his temperature and needing his incubator temperature to be increased and his blood gas had not been as good.

She arranged with both Mary Griffith and Minna Lappalainen that she was going into nursery 1, where she went shortly after 09.00 and where, at 09.04, she assisted Minna Lappalainen with medication for baby JA. She was in there for a few minutes.

She was asked about entries on [Baby Q]'s fluid chart, J24307, which is behind tile 97 at 09, 00 when there should have been a two-hourly feed. Although fluids are recorded, the O2 and saturations are not recorded and the column has not been

initialled. She couldn't explain why she hadn't filled them in. It was a mistake, she said.

When interviewed, she had said her memory had been that she was going back to BM in nursery 1 to do cares. It was pointed out to her that BM did not need cares. She couldn't say for definite now what she was doing, but BM was an intensive care baby, so she wouldn't have left her for too long a period without checking on her. She denied that she had just sabotaged [Baby Q] and was looking for a reason to get out of nursery 2 when Mary Griffith appeared back in the unit.

She could hear something going on outside nursery 1 and could see Minna and Mary Griffith in there with [Baby Q]. She was informed by Minna that he had vomited and it was very mucousy. He was still receiving a bit of pressure from Neopuffs. She didn't help with steps to help [Baby Q]. She had no part in giving him oxygen via Neopuff after he had been suctioned.

In relation to her nursing note she had no recollections of aspiration via NGT and was told air ++ was aspirated from the NG tube. She said this wasn't a significant event and was something that they would deal with routinely. It needed intervention but it was certainly not on a scale of needing collapse and resuscitative measures. It wasn't serious.

[Dr A] was called to the unit at 09.17 because of the vomit and then desaturation and minor bradycardia. In his note, which is behind tile 103, he wrote that as a result of the bagging, [Baby Q]'s oxygen saturations returned to 100%, but he continued to require PEEP to hold his lungs open at the end of positive-end expiratory pressure -- I'm sorry, he required PEEP and because of that was moved to nursery 1 and then started on CPAP. As a precaution he was started on antibiotics.

Referring to his blood gas record, J24326, page 8, paper copy, section 22, his gas at 06.58 was a very acceptable gas.

The reading at 09.56, after the event, which [Dr A] thought was a venous and not a capillary gas, as recorded, was markedly different. The pH was lower, the carbon dioxide was higher, so this was a respiratory acidosis, he said. The base excess had increased to minus 6 from minus 2.8 and the lactate had increased from 1.2 to 4.

[Baby Q] was given sodium chloride at 10.10. That reduced his heart rate. He continued on CPAP with 25% oxygen. He was presumed at that time to have sepsis. The biochemical results that came back showed that [Baby Q] was a little dry and that may well have been partly responsible for his increased heart

rate in the range of 190 to 200, but it did not give any explanation for the vomit.

The blood gas readings at 11.12 will have been done within the unit and showed that his pH had then normalised, his carbon dioxide had come down to an acceptable level, his bicarbonate had changed slightly, his base excess halved, and he was down to 21% in oxygen. His glucose was very slightly increased but his lactate had come down slightly and it was pretty much the same as it was at 06.58 that morning.

The chest X-ray and report that was taken, timestamped at 11.52, that is behind tile 135, showed mild interstitial shadowing with a trace of fluid in the horizontal fissure. There was no focal collapse or consolidation, no suggestion of a large amount of foreign matter in his lungs, nor does it suggest that he had a chest infection or one was evolving, so nothing showing any responsibility for his collapse.

Dr Gibbs in evidence confirmed that [Baby Q]'s sudden deterioration at 9.10 was not in keeping with a little baby who was getting tired with their lungs slowly closing down because they are stiff.

The plan was to increase fluids. At 19.10, [Dr A] noted the gases taken at 18.22, which do not appear on the blood gas record and will have been taken from the paper slip produced by machine, were acceptable but he was retaining carbon dioxide and was starting to turn towards a more respiratory acidosis. He was looking tired whilst being on CPAP, so, having consulted with Dr Gibbs, it was decided to intubate him rather than wait. [Baby Q] was successfully intubated and placed on the ventilator. There was no sign of any infection taken at 20.25; that is behind tile 217.

[Dr D], the registrar on duty that night on the 25th/26th, examined [Baby Q] at 00.30. Her notes are behind tile 275. His gas was acceptable, he had no markers for sepsis, was very unsettled at times, but had no activities suspicious of seizures and his pulse was high, 194 beats per minute.

At 06.50 she was asked to see him because of his poor gas. The record is behind tile 109, paper copy at page 9 in section 22. The fifth entry includes a high PCO₂ reading, which she considered was a respiratory acidosis, which she resolved by adjusting the ventilator settings.

Nurse Amy Davies remembered that he was a bit restless and unsettled at the beginning of the shift, the night shift that is, and she got a doctor to review him, but said he was stable

throughout the remainder of that shift and gave no cause for concern.

[Dr A] returned to duty on the day shift of 26 June. [Baby Q] had dark green bile aspirates at 08.00, no normal bowel sounds and small loops of bowel were palpable, which was unusual. An X-ray taken at 05.04 that morning, J24299, showed to the radiologist a single loop of mildly distended bowel on the left side of the abdomen. [Dr A] felt it was on the right side and arrangements were made for [Baby Q] to be transferred to Alder Hey and [Baby Q] left the unit at the Countess of Chester at 18.20 that day.

Dr Benjamin Lakin, a consultant in paediatric critical care, including paediatric intensive care, at Alder Hey Children's Hospital stated in agreed evidence that, by reference to medical records, [Baby Q] was admitted to the paediatric intensive care unit for assessment because of concerns about his distended abdomen and deteriorating condition and the possibility of it being NEC.

The discharge letter from the Countess of Chester described the issue being a profuse vomit with desaturation. When assessed by Dr Holek, [Baby Q] was stable and did not require high levels of support on the ventilator or drugs such as inotropes to support his circulation and his abdomen was very slightly swollen.

These were all signs of a baby who was quite stable. Dr Lakin reviewed [Baby Q] on the evening of 26 June at 20.24 and found him to be very stable. He was assessed by surgical colleagues at 21.40, who felt she was stable but with some subtle signs suggestive of NEC. He was next reviewed at 14.24 on the 27th, after he had successfully been taken off the ventilator. He remained stable, his abdomen had returned to normal and his abdominal X-ray had also normalised. The decision was made to transfer him back to the Countess of Chester, to complete a course of antibiotics, and restart feeds at the end of the treatment period. He remained stable and his bloods were acceptable.

Dr Stivaros, a specialist paediatric neuroradiologist, said that the images taken at that time could be explained by [Baby Q] having suffered a significant hypoxic ischaemic event at the time.

In terms of [Baby Q]'s subsequent health, his mother said he was in and out of hospital many times, at least three times a year as an inpatient, with various infections, as he had a weakened immune system. He had some disabilities and, in August 2018, the paediatrician, Dr Howyada Isaac, in a witness statement dated

April 2020, said that his development was mildly delayed in August 2018.

He was, according to consultant paediatrician Katherine Davis, diagnosed with a mild right-sided weakness and developmental delay. He remains under her care and she would expect [Baby Q] to have a normal lifespan but it will be necessary to continue to monitor his development as he grows and to provide appropriate support as needed.

Professor Arthurs examined a number of radiographs of [Baby Q]'s chest and/or abdomen. Two relevant ones were taken at the Countess of Chester on 26 June, the day after the collapse and before his transfer to Alder Hey. One was stamped as having been taken at 05.05, which [Dr A] thought had been taken 12 hours later at 17.05, and that's the time I put in the narrative when I was relating to you the narrative about that. The other was taken at 11.58.

In the first, that's the one date stamped as being at 05.05, there was a single loop of dilated bowel on the right side, which was slightly abnormal and another area on the left side, which could be pneumatosis, which is gas within the bowel, which had gone up into the bowel wall. Both were the sort of mild features that radiologically could be early signs of NEC but they were not diagnostic of it and had to be correlated with his behaviour and clinical signs.

If the first image was taken at 05.05 and not 17.05 then the image at 11.58 showed an improvement. If the first image in time was the one taken at 11.58, which is a known time and an undisputed time and the other one was taken at 17.05 and not 05.05 then radiologically there was a deterioration. However, when [Baby Q] was X-rayed again at Alder Hey at 20.22 that evening, things were settling and, of course, clinically he was settled and had improved.

Whether [Baby Q] had NEC and, more specifically, whether NEC was relevant to the event at around 09.10 on the morning of the 25th was considered by both Dr Evans and Dr Bohin.

[Baby Q]'s was the 27th case that Dr Evans reviewed in 2017. He said that although there were markers relating to his gastrointestinal system that [Baby Q] was unwell, namely a bit of bile coming up and he wasn't really tolerating his feeds, from 09.10 something totally different happened which could not be explained on the basis that he was sickening for some kind of gastrointestinal problem. He vomited clear fluids after being on virtually no oral feeds and the last entry of aspiration by the night staff showed nothing coming up in the tube. In addition to the vomiting, he also suffered a very significant deterioration,

his heart rate falling below 100 and his oxygen saturation dropping to 68.

It was not clear how to put it all together. He vomited, he was resuscitated very promptly, his oxygenation returned to normal. The suspicion regarding NEC was perfectly reasonable, as was keeping him off oral feeds and putting him on antibiotics used in cases of NEC and putting him on CPAP, as was later ventilating him and then, in due course, transferring him to Alder Hey.

Dr Evans deduced that [Baby Q] could not have vomited clear fluid or vomited anything at all unless quite a significant amount of some clear fluid had been placed down his NGT earlier before 09.10, with or without some air as well, to make him vomit and he would not have deteriorated in dropping his oxygen saturation and his heart rate unless his diaphragm had been interfered with. In other words, he was unable to breathe properly because his tummy was full of liquid and that is what led to the oxygen desaturation and to the reduction in heart rate. Once he had vomited, which was nature's way of unsplinting the diaphragm and making it easier for the resuscitation to be successful, he recovered.

In relation to the air ++ or +++, the earlier Neopuffing could be one of the explanations, although there was very little Neopuffing taking place, or as well as having some clear fluid put down his NG tube, he could have had some air inflated into the stomach as well. Air and liquid, as a matter of the combined volume, would add to the stomach distension and increase the risk of splinting the diaphragm. He said when babies vomit they do not swallow air.

In cross-examination he accepted that in his first report of 2017 he stated he believed that [Baby Q] was given a lot of air via his NG tube into his stomach and made no reference to fluid at all. In his second report, in 2018, he stated [Baby Q]'s deterioration during the early hours of the 25th was due to inappropriate care and believed he was given a lot of air via his NGT into his stomach. The aspiration of a lot of air ++ at 09.10 was noteworthy, that may have destabilised him.

It was put to Dr Evans that he had added fluid now to keep the allegation going rather than to simply reflect the facts. Dr Evans refuted that. He had stated in his report of 21 October 2021 that if [Baby Q] had vomited clear fluid he must have been given clear fluid orally, either in the form of water or a clear solution, such as saline from an intravenous bag. In addition, he received a lot of air as well. It is most likely this was administered via the NG tube. He also said that the evidence he heard from the people who were looking after him had been a

great help in forming an opinion regarding the accuracy of what happened at 09.10 on that day.

Having seen an X-ray report from Professor Arthurs that there was an abnormality, which radiologically may be reflecting NEC, he thought that NEC could not be ruled out but its presence or otherwise did not explain the destabilisation and drop in his saturations or why he was vomiting clear fluids.

The fact that he settled so promptly at Alder Hey suggested that NEC was not a feature that caused his deterioration at 09.10 that morning. If he was sickening from NEC from late Friday/early Saturday morning he wouldn't have settled as quickly. Once back at Chester on 28 June, they were able to introduce oral feeds and he did not have any further significant gastrointestinal problems until he was sent home on 25 July.

The other option is that his bowel problem post 09.10 could be the result of ileus, which is the intestines stopping working. [Dr A] said that on the morning of the 26th, the day after this incident, he was not hearing any bowel sounds. He was on ventilation and morphine, which can cause constipation and can interfere with bowel activity.

Dr Bohin commented on the clinical and nursing notes, including the defendant's description of the 09.10 event, the start of trophic feeds the previous day and the aspirates, observing that the aspirates were not excessive or uncommon for babies having feed intolerance, which she thought [Baby Q] probably had, and thought at this time his abdomen was soft.

She noted the two-hourly fluid entries -- J24431, behind tile 62, which is page 11 in section 22 -- in which the defendant had appeared to initial the 08.00 entries. No feeds were recorded for 09.00 when they were due.

On the accounts of the witnesses, Dr Bohin did not know where the +++ of clear fluid came from. [Baby Q] not having received any feeds since 07.00(?) and then only a tiny amount of milk. In relation to air, Nurse Lappalainen's Neopuffing was intermittent for 3 minutes, which was, in Dr Bohin's opinion, unlikely to have caused air ++.

She also noted the observation chart at J24307, which is page 22, showed an escalation of the heart rate and a commensurate rise in respiratory effort prior to 10 o'clock, which was an acute event occurring over minutes and within the previous hour and was not something that happened over previous hours before that or days. She therefore concluded that [Baby Q] had been given air down his NG tube, which had caused him to become distressed and caused the increase in heart rate and respiratory

rate and distended his abdomen so much that effectively the diaphragm squashed the lungs, which caused him then to decompensate and become mottled and desaturate and required resuscitation. The collapse was not consistent with anything that could reasonably be explained by some naturally occurring illness or condition.

In cross-examination, she agreed that if there was mucus +++ and if it had to be removed by suction or by pulling it out, it could actually interfere with breathing. However, she said that [Baby Q] was on a ventilator and babies on ventilators often create mucus and he'd never had a problem with mucus up until that point, so she didn't know why he would suddenly then produce mucus +++ that caused him to become mottled and desaturate in the way that he did.

She entirely refuted the suggestion that in the process of vomiting, or maybe immediately afterwards, a baby may suck in a lot of air and that could introduce more air into the baby, saying that was breathing and they wouldn't ingest any more air than through natural respiration. After a vomit, she said, you carry on breathing normally and she didn't think you would ingest more air by breathing normally.

In relation to the ingestion of air via the Neopuffing, she said that this was after the collapse and intermittent for 3 minutes and wouldn't account for air ++.

She accepted there were aspirates and a problem -- that aspirates can be an early indicator of NEC, but it was also consistent with other things such as ileus. She also said that temperature instability is not diagnostic of NEC, it can be artefactual or environmental. You can get it with infection but it does not give you the diagnosis of NEC.

In her opinion, [Baby Q] got better too quickly for it to be mild NEC. Children that have mild NEC are treated with gut rest, so you don't feed them, usually for around 10 days, and they are given three antibiotics empirically. You rest the gut for 10 days before very slowly reintroducing foods. [Baby Q] had conservative treatment, but also recovered, got off the ventilator, didn't have any more bilious aspirates, didn't have any bloody aspirates, didn't have any bloody stools. His gut was completely fine within 24 hours. That, for her, was not a baby that had mild NEC.

She thought he had an ileus because he'd been destabilised. He was on a very large dose of morphine, which could account for what was seen once he was ventilated.

The Alder Hey surgeons sent him back to Chester because he didn't have NEC. [Baby Q] was returned on 28 June, as I've already told you. The defendant was his designated nurse the following day, the 29th, and on the 30th.

Messages passed between the defendant and [Dr A] and other nurses, particularly from tile 239 onwards when she was enquiring of [Dr A] about what Dr Gibbs was asking about in relation to [Baby Q] being left unattended.

There is a sequence of messages in the post-indictment messaging sequence, including ones in which [Dr A] reassured her that the review found they, that's him and the defendant, both did everything well and had done a perfect job in response to her expressions of self-doubt in her abilities.

There was a reference to infection risk and the risk of air embolus and her reaction to being taken off nursing duties.

After the defendant was taken off nursing duties, she registered a grievance with the trust on 7 September. She said she didn't know what to do. She was precluded from contact with all but a few work colleagues and the events were having a massive impact on all her life. It was emotionally difficult and she felt very lonely.

When asked about a note on an annual leave request form, page 48 of the images, which was found in a desk at Mostyn Lodge where she had been working up to her arrest, she couldn't remember when she wrote it. It was not all at the same time. It was what she did, she said, she writes down a lot of things.

The names on that note were people who were important to her at the time. She was fighting for her career and wanted someone to help her. She couldn't cope with it. She only ever did her best.

I've already referred you to the agreed facts of her arrest in July 2018, June 2019 and November 2020.

Searches of both her home in Chester and the home of her parents in Hereford were carried out in the early hours of July 28 (sic) and then further -- there were further searches on the 10th to 11 June 2019 as detailed in section 6 of the agreed facts in your first jury bundle.

The details of the interviews conducted after her respective requests are set out in section 7 of the agreed facts.

In section 8 you have the index of the images within the search presentation, the presentation itself being in the additional documents section of the post-indictment sequence of events, the

last sequence of events on your iPads. I'm not going to take you to it, you can remind yourselves of any images that you wish to in your retiring room.

There were various papers, all now collectively in the exhibit reference bag NAC2. You have images of the writing on them to which reference has been made. In particular, the "not good enough" note and phrases, "I killed them on purpose because I'm not good enough", "I am a horrible, evil person".

The defence invite you to find that these were the writings of a hard-working, committed person, written for herself, who wanted to excel at the job that she was clearly very good at and was distraught at what was happening, being wrongly targeted and blamed, they submit, for a system that failed and the faults of others and for which she bore no responsibility.

The prosecution agree that they are the writings of a troubled person but they say they refer to certain babies and people and were being written by someone who was troubled by the terrible things that they had done and were being investigated and she was in part confessing to what she had done.

There is also a 2016 diary with entries in April on the 8th and 9th relating to LD, long day, and "twins" and "resus", and on the 23rd and 24 June to LD and references to "J and E", and on the 25th to M; the images are exhibit 12.

In an Ibiza bag underneath the bed in bedroom 2 were handover sheets for the period 23rd to 28 June 2016, some with handwriting on the back, which appear to relate to resuscitations; PMB4.

In a Morrisons bag there was documentation relating to "Twin 2 [Surname of Babies L & M]", that's [Baby M], and 31 nursing handover sheets that related to a total of 17 babies, 13 of which were for babies who are named in the indictment.

The four (sic) babies for whom there were no handover sheets were [Baby A], [Baby C], [Baby D], the subject of counts 1, 3 and 4, who all died in June 2015.

The total number of handover sheets seized from both addresses was 257, of which 21 involved babies in this case, four in the Ibiza bag and 17 in the Morrisons bag.

The various documents seized in the searches were the subject of questions in the interviews, termed as overarching interviews. The last section is in your second jury bundle, the interview bundle.

The first and second interviews were on the 3rd and 5 July 2018. They were after she had been arrested for the first time. In relation to the note, NAC10, the sheet of paper filling both sides, which you'll remember having seen, she said she wrote these things in July 2016 because everything got on top of her after she had been removed from the unit and she was going to have to redo her competencies and her practice might not be good enough. It made her feel guilty and really isolated and she was blaming herself.

She went to a GP and was given antidepressants. She wrote about killing herself because her practice hadn't been good enough, but she never made any mistakes. She thought the police would be involved and she would lose her job, which she loved. She was panicking. She felt she was being victimised by the consultants, Ravi Jayaram and Stephen Brearey. She thought the nurses were a good nursing team. She thought she wrote these things down as a way of getting it on paper and it helped her process it a bit more.

Despite what she had written, she had not killed them on purpose. She felt if her practice had not been right then she had killed them and that was why she wasn't good enough. She was very career focused. She wrote, "The world is better off without me", because she had disappointed people. She wrote, "I am evil, I did this", because that was how it had all made her feel at the time.

That year had been difficult because they were seeing more babies with complex needs, chest drains, stomas, and quite a few extremely premature babies with congenital abnormalities, a lot of twins and then triplets. She thought staffing levels were quite poor at times, with an inadequate skill mix sometimes.

She was doing a lot of additional shifts and overtime and didn't think a lot of support was being offered. She said she didn't have any paperwork or medical records relating to any of the allegations for which she had been arrested at home, but might have inadvertently taken some handover sheets home.

She was interviewed again 11 months later on 10 June 2019. She said handover sheets should ideally be placed in the confidential waste bin. The handover sheets that were found at her home had inadvertently been taken home in a pocket. She didn't keep them for any specific reason. They were kept in a folder in a spare room because she didn't know how to dispose of them.

Sorry, there may be a technological problem. I'll just have to pause there.

(Pause)

I'm sorry, there will now be a short break in my summing-up because it's going to need investigating, but I have very nearly finished. So would you please just go into your room and you'll be brought back in when you're ready.

(11.28 am)

(A short break)

(11.34 am)

MR JUSTICE GOSS: The issue is resolved. What I'll do is I'll just go back a few sentences and resume from the interviews that took place on 10 June 2019, a year after the first set of interviews.

She said handover sheets should ideally be put in the confidential waste bin. The handover sheets found at her home had inadvertently been taken home in a pocket. She didn't keep them for any specific reason. They were kept in a folder in the spare room because she didn't know how to dispose of them. She hardly ever looked at them. She hadn't got a shredder.

In her evidence she did confirm that she had a shredder which she had bought between 5 April 2016 and her first arrest in 2018, which was shortly before she was first interviewed. She only shredded bank statements, she said. The handover sheets and notes were insignificant and she had forgotten she had a shredder when she was interviewed. It was an insignificant item.

When asked about [Baby M]'s blood gas records, exhibits 7 and 8 in the case, which was found in the Morrisons bag, she said it was one of many she took home. It was an error on her part that it wasn't shredded. She accumulated paper which she accepted she moved around with her. The sheets had no meaning at all to her, they were just pieces of paper she had difficulty in throwing away.

In the 2019 interviews she referred to her support network of colleagues who I identified earlier in this summing-up last week: [Dr A], [Nurse E], [Nurse A] and Minna Lappalainen.

She confirmed her status as a band 5 nurse, her experience, and having started on the unit in January 2012, and the courses she had completed including being trained to give babies medication via a long line, Broviac line and umbilical venous catheter, UVC, for the safe administration of boluses.

She didn't recall any specific training about insulin. She said she learned through experience. She had no had training about air embolisms and was not really aware of them and had heard of them more from an adult perspective. She could not think of special training in any dangers if things were done incorrectly apart from being mindful not to leave a line open.

In the final interview she was asked about her personal diaries. She made reference to the collapses of babies in the diaries because it was a way of thinking things through in her own time, expressing thoughts on paper. She thought she started documenting names after concerns had been raised in February 2016 that there had been a rise in the mortality rate. She was asked about the note in the diary KL4, in which she had written "Kill me". She wrote that because sometimes she wished she was dead. She had lost everything, wasn't working on the unit, and hated working in the office.

In her evidence she said that on 26 June 2016 she liked all the doctors at the hospital. She was worried that she was in trouble because she had made a mistake in relation to [Baby Q] and was very upset and worried but didn't realise there were serious concerns about her.

The contents of some of the emails were pointed out to her and she accepted that she was having "a meltdown ++".

She was referred to the note behind tile 107 in the post-indictment sequence of events, an SMS timed at 23.29 on 27 June 2016, with no named recipient. The note reads, "Death x2". She said there were things she needed to document for babies that she had been caring for when she next went back to work, that she hadn't documented so far.

In messages to [Nurse E] she referred to the risk of air embolus and thankfully her submitting a Datix report. That report related to baby JA and was made on 1 July 2016. She wrote:

"Upon administering IV medication via UVC, the port on one of the lumens was noted to not have a bung on the end and was therefore open. Registrar informed. Lumen not accessed. Bung added and line labelled 'not to be used'."

She denied that she was covering herself for any suggestion of accidental air embolus and said it was simply what she found and felt it needed to be documented. She also referred to tiles 234 and 239 and denied she was getting her defence in with her friends.

She was asked about the conspiracy by the four consultants who she believed had apportioned blame on to her to cover failings

at the hospital and confirmed that she was not relying on individual failings because that was above her pay grade. Rather, she was asserting that the nursing staff acuity wasn't quite right and she didn't think that some of the babies had adequate care over a period of time and there was nothing she wished to add.

She was asked why on 25 June 2015, over 2 minutes from 21.50, she searched for [Mother of Babies A & B], then [Mother of Baby D] and [Father of Baby D]. She said the connection was that they were babies that had died or had been seriously unwell. She said that she searched for [Mother of Baby I], then [Father of Babies E & F] and then [Mother of Baby H] over 3 minutes from 01.16 on 5 October 2015 for the same reason and they were on her mind.

She didn't say that to the police when she was interviewed because she couldn't recall why she had looked at some of them. She denied that she was checking up on her victims. [Baby I] was still a patient at the hospital on 25 June, but they were on her mind.

In relation to her searches on Thursday, 5 November 2015 for [Mother of Babies E & F] at 23.40, [Mother of Baby G] at 23.41 and [Mother of Baby I] at 23.44, she denied having read [Surname of Baby G]'s name from one of the seven handover sheets with that name on it and said they were all on her mind at that time. All the parents of the babies for whom she searched were on her mind. She often thought of [Mother of Babies E & F].

She was asked why, in the note purported to be written to the [Surname of Babies O, P & R] triplets, she wrote to all three of them. She said she couldn't recall why she wrote to all three when [Baby R] was not dead.

I return to where I began and refer you to my legal directions 1, but I will not go through them again, and I've asked to you put them with the indictment for your assistance.

You have there set out in legal directions 1 what you must do and not do and what you have to reach conclusions upon, the importance of reaching decisions on all the evidence, and determining in relation to each alleged offence whether you are sure of the defendant's guilt or not.

You also have my legal directions 2 in relation to the evidential matters, including the defendant's character, inconsistencies between her evidence and her defence statement, inconsistencies in the evidence of any witness, the effect of delay and expert evidence.

You have to consider the evidence relating to the collapse of each child, their condition in the period leading up to the events, the nature of the collapse, its features and consequences as described by witnesses, as well as what the defendant has said and done, be it in messaging or in person, before, during and after any event, including her enthusiasm to be in nursery 1, the taking and retention of hospital documents, and Facebook searches, and what she has said at various times of the investigation about what she has done. Where there are conflicts in versions of events, words or actions that you consider significant, you have to decide whether resolution of those conflicts assists you in reaching conclusions in relation to the offence under consideration and, if they do, where that leads you.

If you are sure that two of the babies, [Baby F] and [Baby L], had Actrapid, manufactured insulin, inserted into the infusion bags that were set up for them 8 months apart in August 2015 and April 2016 respectively, and you are sure that was done deliberately, you then have to consider whether that may have been a coincidence, two different people independently acting in that way or were they the acts of one person and, if so, who.

You have to be sure that the child whose case you are considering was a victim of an intentional harmful act or acts of the defendant and, if it was, what her intention was at the time. She, of course, denies that she ever did anything wrong.

Although you have to decide on the evidence in each child's case, there were certain common features, as listed by Mr Johnson. This is the part of my first legal direction relating to circumstantial evidence and coincidence.

The defendant was on duty on every occasion an event occurred. There were ten babies who collapsed that had good air entry into their lungs but their saturations were dropping. Mr Johnson gave you the lists and invited you to write them down.

Five of the babies, if you accept the evidence of [Mother of Babies E & F], had unusual bleeding, some in their throats, which was seen by medical staff.

Eight of the babies demonstrated discolouration, which was seen by doctors in more than one baby and unique in all their experience. The defendant said that in many of the cases she either did not see the discolouration or there was no discolouration to be seen.

Eight babies suffered unexpected life-threatening collapses and then recovered very quickly, which was very unusual and could not be explained in medical terms.

Another feature common to events concerning five babies is that they occurred within a few minutes of their designated nurse going on a break or leaving the room.

In [Baby P]'s third event the defendant who was his designated nurse was in the room, but the doctors were out of the room.

As I have just reminded you, when [Baby Q] collapsed, the defendant had gone to another nursery.

Four of the premature babies were heard to be screaming or crying uncharacteristically at the time of their collapse.

In the cases of two babies another nurse was worried about them, but the defendant reassured them just before they fatally collapsed.

There were seven babies who collapsed shortly after their parents had left the nursery.

Four babies recovered quickly from collapses when they were taken to other hospitals.

There were three cases where it is alleged the defendant participated inappropriately in post-death bereavement procedures.

There was one baby, [Baby O], who sustained an impact injury to his liver that, on the pathological evidence, was a consequence of the application of considerable force.

The prosecution say that this is not a series of unconnected events and, when put in the context of the expert and medical evidence, the administration of insulin and the finding of air in the great vessels in some babies and the post-mortem evidence of Dr Marnerides and all the other evidence, you can be sure that the defendant committed all the offences upon which you are trying her.

The defendant denies she committed any harmful act. She was, I repeat, hard-working, dedicated and caring. She never falsified records and there is evidence of which you were reminded of other nurses failing to complete some entries on charts. Anyone can make mistakes or fail.

Her keeping of confidential documents had no sinister purpose, nor did her searches on Facebook, which she ultimately said in evidence she only made because she was thinking of the families at those times. Her handwritten notes were something she did as a habit and were a product of despair.

The defence say you cannot be sure that in any case she murdered a baby who died or that she attempted to murder any baby who survived. Some of those babies were very premature and at high risk of sudden collapse. The evidence upon which the experts rely in relation to air embolus, they say, is based on theories and not well-established medical knowledge. There have been inconsistencies in accounts and, it is submitted, the experts have lacked independence and reliability.

Well, that is no more than the barest summary of the respective arguments, which, as you know, took 4 or 5 days in each -- as far as each side was concerned to put those arguments before you.

Shortly, it will be for you, on all the evidence that you have heard, to perform your task of reaching verdicts on the 22 alleged offences charged on the indictment.

So I come back to where I started this morning, the labels that you have. This is, I'm afraid, a rather tedious administrative job you're going to have to do. Would you please put the labels on each of your files that you have, your notebook and any loose papers? They will then, for each of you individually, be placed in large confidential bags and, during a break that we're going to have now of about 20 minutes, they will be taken to your room.

When you return to court, I will have a few more things to say, but very few. The ushers will then be sworn to act as your bailiffs and you will begin your deliberations. So please just stick labels on the documents.

You may wonder why you have to do this and other people can't do it. It's because these are your confidential documents. They will be destroyed at the conclusion of this case.

(Pause)

Put them on the schedules you've just been given this morning as well. It's just for the avoidance of any doubt or difficulty. As I say, what will happen is you just leave them all piled up on your respective desks. Each of your documents will be put into an individual bag, individual to each of you, and will then be taken to the jury room and placed there in the retiring room, where you can open the bag, the bag will be sealed.

(Pause)

I'm going to say a few more things about the tablets and what's going to be available to you in your deliberating room. What I'm

going to do now is -- because once I do send you out to begin your deliberations there are strict procedures that have to be followed, I'm going to just, as I say, say but a few words, but they are important words, that I want you to have in mind when you do go out to start your deliberations.

We're going to have a twenty-minute break to enable all these to be collected up, transferred and so on, and it'll be a sufficient time for you to be taken from the room behind here and to have some refreshment before you come back in, in about 20 minutes, if you so wish, and obviously a comfort break if you want it. There are facilities as part of your retirement room for comfort breaks during the course of the day.

Have you all finished? That was very quick and efficient, if I may say so. I'm going to ask you now to leave the courtroom, it'll be a twenty-minute break, have some refreshment if you want it, and then return. Everything will have been removed from your desks by then.

(In the absence of the jury)

MR JUSTICE GOSS: It will be about 20 minutes. Would it be possible for the defendant to remain there or will you take her downstairs? You can stay up here, can you? All right. We'll let you know when the court is ready to continue. Thank you very much indeed.

Are there any matters that anyone wishes to raise?

MR JOHNSON: No, thank you.

MR MYERS: There's one matter, but perhaps I can inform your Lordship in the way that we have done and we can raise it with your Lordship if appropriate, but at least it gives your Lordship to consider it. It's a matter entirely for your Lordship.

MR JUSTICE GOSS: Thank you, that's very helpful. I entirely agree, that's the best way of dealing with it. I'll address it when the moving of the jury's documents has been completed.

MR MYERS: If your Lordship sees fit. It's entirely a matter for your Lordship. I'm going to send the matter through first before your Lordship says anything upon it.

MR JUSTICE GOSS: That's very helpful. Thank you very much indeed.

(11.57 am)

(A short break)

(12.46 pm)

MR JUSTICE GOSS: Thank you, Mr Myers. Yes, I am going to say something straightaway in relation to the matters that you raised.

MR MYERS: We're grateful. Thank you, my Lord.

MR JUSTICE GOSS: It won't be in the format you've done it, but it'll be done in an appropriate way, addressing what you said.

MR MYERS: Thank you.

MR JUSTICE GOSS: Can I just raise one other matter before the jury come in? I don't know whether you've seen the jury room AV instructions or not.

MR MYERS: No.

MR JOHNSON: No.

MR JUSTICE GOSS: This is a document that are the written instructions prepared by Mr Murphy about how to connect the iPad to the screen and then other instructions asking the jury to plug their iPads into charging boxes for overnight charging. You're welcome to look at it, but it is as neutral as that.

MR MYERS: We accept that, of course, my Lord.

MR JUSTICE GOSS: Thank you very much.

MR MYERS: Just for your Lordship's information, it was apparent, almost inevitably, there are two items that we will need to add to the exhibits. It doesn't prevent matters from proceeding now. That's in hand. One is photographs of a house, the other is related to social media material. They will be added to the bundles and it just requires two additions to the exhibit list the jury have, which they will receive fairly shortly. But it was apparent they were absent and therefore it's important to rectify that as soon as possible.

MR JUSTICE GOSS: Of course. If you're content for the jury to --

MR MYERS: Yes.

MR JUSTICE GOSS: There is one other thing in relation to sitting days from now on.

(Pause)

MR MYERS: My Lord, Mr Johnson reminds me it may be helpful for me to let the jury know that they will be receiving these so they're formally exhibited as part of the process that began this morning so they have it before they retire. I'll simply say it in the most neutral fashion.

MR JUSTICE GOSS: You do it in the way that Mr Johnson did just so they are not taken by surprise when two more documents arrive.

MR MYERS: I'll let them know, thank you, my Lord.

MR JUSTICE GOSS: All right, an addition to the list.

MR MYERS: An addition to the list.

MR JUSTICE GOSS: Jury in, please. Thank you.

(In the presence of the jury)

MR JUSTICE GOSS: I'm sorry that was longer than anticipated. It was actually a bigger job doing everything than had been anticipated.

I've been asked to remind you, and do remind you, that in relation to the list to which the prosecution referred and that I summarised shortly before we broke off, the defence submitted that they were not similar, the events, in that the features differed in relation to at least some of the descriptions and that they did not establish the patterns the prosecution said they did, and that you have to consider whether the factual basis for any event relating to any baby on any given list had been established in evidence to the necessary standard before you could rely on it as an event. All right? So I do that.

Mr Myers has got one -- there is no criticism of anyone involved in relation to this as you'll appreciate there is a vast amount of material in this case. There are going to be two items that need to be added to an exhibit list. Mr Myers will just explain this. It's not going to stop us from proceeding but he will just explain.

MR MYERS: Thank you, my Lord.

Yes, in addition to the list that you have, ladies and gentlemen, there will be two further exhibits to be added to it that we've had in evidence, but it's important that I identify them so you have all of that before you retire. You'll remember what they are.

The first one is photographs of Ms Letby's house that were introduced when she gave evidence, so that will be added to the material that you have and on the list.

The second item is that schedule of social media material, you will remember, that came in towards the end of the evidence and she was asked questions about that by the prosecution and by the defence.

They will be added to the list, my Lord, and the jury will have those shortly.

MR JUSTICE GOSS: In the list form, not the --

MR MYERS: They'll have access to the exhibits and they'll also have them on the lists too (overspeaking) --

MR JUSTICE GOSS: You'll have them on the list and they'll be on the iPads --

MR MYERS: Yes.

MR JUSTICE GOSS: -- so you then have the reference to be able to locate them on the iPads if you want to, the pictures of the house for argument's sake. I'm just saying that. All right.

When you do go to your deliberating room in a moment, Mr Murphy will be able to assist you at any time if any technology problems arise. But he's already linked an iPad to a large screen in the room so that if you wish to put up a document on a large screen that you can all be looking at at the same time for group reference or discussion, that can be done. It'll obviously be much easier saying, "Let's all look at document behind tile so-and-so", if it goes up on the screen and you can all see what it is, and that will make life easier, we hope, in relation to this.

There will be spare iPads in the room if you need any. If the iPad that you're using malfunctions and you want a replacement, it'll be there. All you do is log in with your own personal details and you'll have another iPad that you can use.

If you do need any technical assistance then please tell the jury bailiff. There will always be a jury bailiff outside your room and he or she will then accompany Mr Murphy into the room, who will come in, deal with the technology issue that has arisen, and the usher will stay with you whilst Mr Murphy is there. You must not discuss anything about the case whilst they are in the room. Your deliberations are confidential to you and, as you know, there is a lifetime confidentiality in relation to

your deliberations, no disclosure to anyone. I shall remind you about that at the very end of the case in any event.

If you have any questions that require you to be brought back into court, you do not need to bring your iPads with you. It's only when all 12 of you and no one else is present in the room that you should discuss anything about the case.

How you conduct your deliberations is entirely a matter for you. You should, of course, respect each other's opinions and value any different viewpoints that you each bring to the case. Everyone should have a chance to speak. You should listen to one another and no one should be or feel pressured.

You are under no pressure of time. At the end of the court day, which will be at 4 o'clock each day, you will be brought back into court and, after giving you a short further direction, you will be sent home and you will then resume your deliberations on the next working day at 10.30. So that will be the court days hereafter.

When you are not deliberating, your retiring room will be locked and no one will be able to enter it, so it will be exactly as you leave it when you resume the next day and no one will see anything that's there, any notes that you make or anything that is written there.

Do not under any circumstances make your own enquiries about anything to do with the case or talk or communicate with anyone in any way -- and that is even with each other now -- except when you are all together in the room in which you are deliberating as a group of 12 and after you have been brought back into court and I have sent you out to deliberate on your verdicts again. Do you understand that?

So even when you're waiting to come into court, assembling in the morning and you all happen to be together, don't say anything about the case itself.

When you leave court at the end of a court day, end of discussion about the case completely, no reference to anything to do with the case.

All 12 of you must hear what is said by any one of you at any time about the evidence in the case and your decisions in relation to the case.

I remind you of your legal responsibilities as a juror that you received on the first day of trial and which I have repeated to you ad nauseam, I appreciate, during the course of the trial.

But you will appreciate the significance of it and the seriousness of this case.

Smoke breaks. You will be able to have five-minute smoke breaks, one mid-morning and one mid-afternoon. One of the jury bailiffs will escort those wanting to smoke to an appropriate area, and if there's anyone who doesn't want to smoke and wants to go out and be with the smokers, they can if they so wish. Another bailiff will remain in the retiring room with those who do not wish to smoke or go out with the smokers. When separated, it follows from what I have just said, be you a smoker or remaining in your room, you must not discuss anything about the case. When you do want a smoke break, just write it on a note, then knock on your door and give it to the jury bailiff and then the smoke break will take place. All right? One morning, one in the afternoon, of your choosing so far as the time is concerned.

It may be helpful, if you have not already done so, to select a foreman -- that person can, of course, be a man or a woman -- who can organise and lead your discussions, ensuring that they are focused on the evidence and the law and that everyone has a fair opportunity to express their opinions at any time.

The foreman will also inform the court when you have reached your verdicts and deliver them on your behalf when you are brought into court for that purpose. You can, if you so wish, agree to select a different man or woman to be your foreman at any time before verdicts are delivered. It doesn't have to be the same person for the whole period of your deliberations. What you do and the decisions you make in your deliberating room are entirely for you.

If you do need assistance then write your question or the assistance you require down on a piece of paper and ask the jury bailiff to give it to me. Do not talk to the bailiff about your question or anything to do with the case. That again follows from what I've said about not talking to anyone about the case.

If, after you have been deliberating for a considerable time, you are unable to reach unanimous verdicts, I shall call you back into court and give you further directions, but, as you know, from my directions of law, your verdicts should be unanimous verdicts on each count on the indictment.

You have my written directions and you should follow them. Although it is a matter for you, you might find it helpful to begin by reminding yourselves of my first set of written legal directions and applying the sequential questions as a template to guide your discussions on the evidence and your conclusions of fact. You may want to select someone to write down key points

or conclusions that you reach. It's entirely a matter for you how you want to conduct your discussions.

If anyone is not following the legal instructions or refuses to deliberate, I'm not suggesting anything like this will happen, but if this were to happen, or relies on other information outside of the evidence so that juror is not acting in accordance with their jury oath or affirmation to try the case on the evidence, the court must be told straightaway. A note should be written, handed to the jury bailiff and brought in to me. That's an exceptional eventuality, but that's the procedure to follow should that highly unlikely event occur.

When you reach your verdicts on all counts on the indictment, your foreman should inform the jury bailiff and you will be called back into court. The clerk of the court will then ask your foreman to stand and he or she will then be asked on each count whether you have reached a verdict and then whether you find the defendant guilty or not guilty. That's just the procedure that's followed so that you know what will happen. It's relatively straightforward in procedural terms in this case because the charges are clear, what has to be proved, and there are no alternative verdicts or anything like that. All right?

Thank you very much. That completes my direction to you. I'm going to ask you now to retire and commence your deliberations. Obviously, it is the normal break time for refreshment. You have, I believe, brought some refreshment with you. That will be available there for you and then I will next see you, I anticipate, at 4 o'clock. All right? Thank you very much.

When the ushers have been sworn to act as your jury bailiffs, would you please go to your retiring room and commence your deliberations?

(Jury bailiffs sworn)

By way of assistance to all concerned, the pattern will be, assuming that the jury take more than today to reach verdicts in this case, on succeeding days and today the court will not sit between 1 and 2 o'clock. There will be no need for the defendant to be brought up for a 1 o'clock adjournment. The court will simply not be sitting. You will be informed when the defendant is to be brought up on each occasion apart from the start of the court day. Thank you very much.

(Jury in retirement)

(1.04 pm)

(Adjournment)

(4.00 pm)

(In the presence of the jury)

MR JUSTICE GOSS: As I said I would, I bring your deliberations for today to an end now and in a moment you'll be able to leave this courtroom and building and go home and be ready, please, to continue at 10.30 tomorrow morning. In the meantime, as I directed you earlier today, do not talk to anyone, including each other, about anything to do with this case until you have come back into court at 10.30 and been taken from here back to your retiring room and continue your deliberations as a jury of 12 people all together in your jury retiring room. All right? Thank you very much indeed.

I discharge the ushers from their oaths to keep you in a retiring room and you are free to leave this courtroom and I'll see you at 10.30 tomorrow morning.

Thank you very much.

(In the absence of the jury)

MR JUSTICE GOSS: Mr Johnson, Mr Myers, I formally put on the record something that did happen this afternoon, which was that Mr Murphy's assistance was required because there were two documents, I think it was, that were not behind the tiles that they should have been. They had been part of the presentation, but they were not available on the iPads that were available to the jury, something that I actually have encountered during the course of this trial, that for some reason they didn't get uploaded. So I gave permission to Mr Murphy to upload those documents for the jury's benefit and that has been done. I take it, Mr Murphy, that has been done or is being done?

MR MURPHY: It's in progress, my Lord.

MR JUSTICE GOSS: It's in progress, all right. But they are documents that are in evidence.

MR MYERS: Of course.

MR JUSTICE GOSS: There's nothing untoward about it, but I didn't want to waste time and let Mr Murphy get on with dealing with that.

MR MYERS: Thank you, my Lord.

MR JUSTICE GOSS: Thank you very much. There's nothing else?

MR MYERS: No. I know that Ms Santolini would be due to see the defendant if she could remain downstairs after the court rises.

MR JUSTICE GOSS: Certainly. Does anyone else want to see her?

MR MYERS: That may happen, but certainly there will be a visit from someone.

MR JUSTICE GOSS: These are different staff who haven't been here. Ms Santolini, who is a nurse, will see the defendant at some time before she is taken from this building, please. She knows, I take it, that the court is rising now?

MR MYERS: Yes.

MR JUSTICE GOSS: So she should make her way there as soon as possible.

MR MYERS: Thank you, my Lord.

MR JUSTICE GOSS: Thank you very much.

(4.05 pm)

(The court adjourned until 10.30 am on Tuesday, 11 July 2023)