

17 June 2024

Kate Tyndall (continued), Dr Sara Brigham (Obstetrician & Gynaecologist), Yvonne Griffiths

CONTENTS

MRS KATE TYNDALL (continued)

Examination-in-chief by MR JOHNSON (continued)

Cross-examination by MR MYERS

DR SARA BRIGHAM (affirmed)

Examination-in-chief by MR DRIVER

Cross-examination by MR MYERS

MRS YVONNE GRIFFITHS (sworn)

Examination-in-chief by MR DRIVER

Cross-examination by MR MYERS

Re-examination by MR DRIVER

Monday, 17 June 2024

(12.00 pm)

(In the absence of the jury)

MR JUSTICE GOSS: Can I add in relation to that, particularly members of the public who are attending, either present in court or attending remotely, that these reporting restrictions apply to them and there is to be no publication of anything in breach of any reporting restrictions, in particular in relation to identifying any of the children involved.

MR JOHNSON: Thank you.

(In the presence of the jury)

MRS KATE TYNDALL (continued)

Examination-in-chief by MR JOHNSON (continued)

MR JOHNSON: Welcome back, Mrs Tyndall. We had reached up to and including tile 98 and so you have then put in a marker, in effect, at tile 99 to denote the --

MR JUSTICE GOSS: I think we'll just pause for a moment because I haven't logged on yet to my iPad, so everybody can get on their iPads and get the documents they want to have in front of them.

(Pause)

Sorry, Mr Johnson. When you're ready.

MR JOHNSON: We see displayed on the screen at the moment tile 99, which if we went behind it would say no more than we see there.

We then move to tile 100, which is where you have put in Dr Jayaram and Dr Smith as the authors of clinical notes relating to [Baby K]'s desaturation and collapse.

TYNDALL: Yes.

JOHNSON: Thank you. We will be hearing from both of those gentlemen tomorrow.

Moving on to tile 101, this is the nursing note made by Joanne Williams, the designated nurse, relating to the same event; is that right?

TYNDALL: Yes, that's correct.

JOHNSON: We can see that this note, Nurse Joanne Williams' note, as indeed with Dr Jayaram's note, was made about an hour later or so?

TYNDALL: Yes.

JOHNSON: Moving to 102, please, do we then have a signed and countersigned prescription for morphine, signed by the registered -- sorry, the designated nurse, Joanne Williams, and also by Lucy Letby?

TYNDALL: Yes, this is the electronic prescription.

JOHNSON: Yes. At 103, if we could just look at that, please.

Again, please. Go to the original. If we look in the bottom left-hand corner of this document we see the column -- thank you very much. We can see the column runs from right to left on the screen as we're looking at it at the moment.

We see it's signed by Joanne Williams, but there will be evidence that that is not her handwriting at 03.50, relating to the administration of morphine.

TYNDALL: Yes.

JOHNSON: Thank you. At tile 104 this is another prescription chart, the infusion chart, timed the same at 03.50, for the morphine infusion?

TYNDALL: Yes.

JOHNSON: Then tiles 105 and 106 are entries made on a different child's chart by Lucy Letby and timed by her at 04.00 hours?

TYNDALL: Yes, that's correct.

JOHNSON: They are both for the child AR?

TYNDALL: Yes.

JOHNSON: And the child AR was one of the three that was in nursery 2?

TYNDALL: Yes.

JOHNSON: At 107 and 108 do we have two sets of swipe data, a minute apart, relating to Dr Lo?

TYNDALL: Yes.

JOHNSON: Followed at 109 by a prescription for phytomenadione paediatric, signed and countersigned by Caroline Oakley and Lucy Letby?

TYNDALL: Yes.

JOHNSON: At 110, the same information but in a different document, this time the computerised document; is that right?

TYNDALL: Yes.

JOHNSON: Then at 111, door swipe data concerning the entry of Joanne Williams, the designated nurse, from the labour ward into the maternity neonatal ward?

TYNDALL: Yes.

JOHNSON: And this again, just to remind people, I'm sure everyone remembers now, is mislabelled on the system, suggesting that going out of the NNU, but in fact it's the other way round?

TYNDALL: Yes.

JOHNSON: Thank you. At 112, please, at 04.30, heart rate, respiratory rate and temperature, together with the cot temperature and humidity recorded by Joanne Williams for [Baby K]; is that right?

TYNDALL: Yes.

JOHNSON: Another handwritten or hand-completed chart at the same time recording the neonatal fluid balance, also completed by Joanne Williams for [Baby K] --

TYNDALL: Yes.

JOHNSON: -- at tile 113?

Then at tile 114 the intensive care chart with ventilator and equipment settings recorded on it; is that right?

TYNDALL: Yes, that's correct.

JOHNSON: If anybody wanted to make a note we can remind them on Thursday last week, [Mother of Baby K]'s statement was read to the jury by agreement. She told the jury that at 04.31 there was a photograph that was timestamped at that time, so the [Baby K] family were on the unit at that time.

At tiles 115, 116 and 117 at 04.34, 04.35 and 04.38 are three separate documents annotated by Caroline Oakley and Lucy Letby for the child [redacted] in nursery 2?

TYNDALL: Yes.

JOHNSON: At 118, at 04.39, door swipe data for Dr Jayaram coming into the neonatal unit.

TYNDALL: Yes.

JOHNSON: At 119 and 120, two prescriptions for [Baby K], signed and countersigned by Lucy Letby and Caroline Oakley for gentamicin and one for benzylpenicillin?

TYNDALL: Yes.

JOHNSON: Followed at tile 121 with door swipe data for Dr Lo at 04.42?

TYNDALL: Yes.

JOHNSON: Then at 122, tile 122, at 04.45, the administration of the gentamicin to [Baby K], signed and countersigned by Caroline Oakley and Lucy Letby?

TYNDALL: Yes.

JOHNSON: Then at 123, 04.46, a minute later, Joanne Williams coming back on to the neonatal unit from the labour ward?

TYNDALL: Yes.

JOHNSON: Albeit recorded the other way round for the reasons we've already described.

At 04.48 did Joanne Williams update the nursing note?

TYNDALL: Yes. That's what time she started updating the nursing note.

JOHNSON: Thank you. If we just look behind the tile, please.

Can we see there that various information was recorded on [Baby K]'s admission to the neonatal unit, the fact that Registrar Smith had inserted a cannula, that a dextrose infusion had started together with morphine?

TYNDALL: Yes.

JOHNSON: That a bolus had been given to [Baby K] on intubation, septic screen, and other relevant information?

TYNDALL: Yes.

JOHNSON: At 125, 2 minutes later, is that when Dr Jayaram actually made the notes concerning events that had happened earlier on the shift?

TYNDALL: Yes, that's his update of everything that's happened between [Baby K] being born and that time.

JOHNSON: Yes. That includes the collapse at 03.50 or thereabouts?

TYNDALL: Yes.

JOHNSON: At 126, 127 and 128, do we have three separate updates made on the computer concerning benzylpenicillin and gentamicin, which had both been given at 04.40, as we have already seen, and 128, phytomenadione, which had been given at 04.20?

TYNDALL: Yes. So these are just the computer records for that administration.

JOHNSON: As we've seen often before, the same information recorded in different databases, either handwritten or computerised?

TYNDALL: Yes.

JOHNSON: At 129, at 04.57, a pathology sample was taken, is that right --

TYNDALL: Yes.

JOHNSON: -- on the order of Dr Smith?

TYNDALL: I think that's the time it's down as being received rather than taken.

JOHNSON: I beg your pardon, thank you.

Then at tile 130, at 5 am, and tile 131 at the same time, did Lucy Letby record entries on the chart relating to baby AR in nursery 2?

TYNDALL: Yes.

JOHNSON: Thank you.

At tile 132, 05.07, did Joanne Williams make a note in the nursing notes concerning her contact with [Baby K]'s parents?

TYNDALL: Yes.

JOHNSON: I think if we look there, we'll see reference to photos having been taken, which ties in with the evidence given by agreement from [Mother of Baby K].

At 133, 134 and 135, do we have a prescription, together with the updates on the computer, concerning morphine and sodium chloride --

TYNDALL: Yes.

JOHNSON: -- made and countersigned by Joanne Williams and Lucy Letby?

TYNDALL: Yes.

JOHNSON: At 136, at 05.30 that morning, and 137 and 138, do we have three separate charts into which data was handwritten by Joanne Williams for [Baby K]?

TYNDALL: Yes.

JOHNSON: Then at 139 a retrospective note made by Dr Lo, timed at on 05.40, concerning the fact that [Baby K] had been given Curosurf, which is the surfactant to help the lungs?

TYNDALL: Yes, which was given earlier in the shift at 02.45.

JOHNSON: Thank you.

At tile 140, is that the corresponding update on the computer record for the Curosurf?

TYNDALL: Yes.

JOHNSON: And then at 141 and 142, timed at 05.50, were a couple of pathology samples collected for analysis?

TYNDALL: Yes.

JOHNSON: Which, as it happens, if we click on either, Mr Murphy, we'll see that no pathogens were detected once the growing plates had been analysed --

TYNDALL: Yes, correct.

JOHNSON: -- or the dishes, the Petri dishes.

At tile 143, same time, 05.50, is there a note on the transfer team's handwritten notes?

TYNDALL: Yes, about handover from Dr Jayaram.

JOHNSON: Yes. We'll just look at this because this just pre-dates, by a relatively short period of time, the second incident, so this is a handover taken from Dr Jayaram at 05.50, discussing the time of "[query] night/day team", the fact that Dr Jayaram was keen not to miss a window of opportunity whilst [Baby K] was stable.

TYNDALL: Yes.

JOHNSON: The reason for the referral there, extreme prematurity, and the intention to ship [Baby K] out to a tertiary centre.

TYNDALL: Yes.

JOHNSON: That's 05.50. Tile 143.

At tile 144, this is an untimed entry. Why has it been put in at this point in the chronology?

TYNDALL: Because the transport team make a note at 05.55 that they have a UVC in situ and the note on tile 144 talks about a UVC being inserted by Dr Smith.

JOHNSON: Yes. So a UVC is a line that goes in through the belly button, through the umbilicus, into the veins, the venous system?

TYNDALL: Yes.

JOHNSON: Umbilical venous catheter is what the letters stand for.

UAC, umbilical arterial catheter, wouldn't pass so they couldn't get one in?

TYNDALL: Yes.

JOHNSON: At 145 do we then have a further note made by the transfer team at 05.55?

TYNDALL: Yes.

JOHNSON: If we could click on that, please, Mr Murphy, do we see there that Dr Jayaram had called them?

TYNDALL: Yes.

JOHNSON: That he, Dr Jayaram, had told them that baby dislodged the tube, is how it's recorded, and had to be re-intubated, now size 2.5 centimetres at 6.5 centimetres at the lips. They now have an umbilical venous catheter in situ but no umbilical arterial catheter. Then the pressure of the ventilation and then the words "Still not X-rayed".

TYNDALL: Yes.

JOHNSON: Then there's a record of the fact that various doctors were coordinating to arrange the transfer of [Baby K] from Chester.

TYNDALL: Yes.

JOHNSON: Five minutes later, at 146 and 147, are there entries in the baby AR in nursery 2 -- in AR's notes made by Lucy Letby?

TYNDALL: Yes.

JOHNSON: Followed at 148 by an update to the nursing record of [Baby K]; is that right?

TYNDALL: Yes. This is the electronic admission form that's completed for [Baby K].

JOHNSON: Okay. So if we just click on that, please, and if we could go to the original document, Mr Murphy.

If we run through this reasonably slowly, on the left hand half of the page we see Joanne Williams' original or an earlier note made between 04.48 and 05.07, don't we?

TYNDALL: Yes, so that's her nursing notes of [Baby K]'s treatment from the moment she was born until she started that note at 04.48.

JOHNSON: We've dealt with a lot of that material as we've gone through but she in turn will deal with that herself when she gives evidence, but just concentrating for now on the right-hand side of the page, please, which is getting ever larger and dominating the page, do we see that this was created by LL, Lucy Letby?

TYNDALL: Yes.

JOHNSON: The document was opened at 06.04?

TYNDALL: Yes.

JOHNSON: And it was closed at 06.10?

TYNDALL: Yes.

JOHNSON: We see information relating to [Baby K]'s mother and father.

TYNDALL: Yes?

JOHNSON: The date of [Baby K]'s delivery and the means of delivery?

TYNDALL: Yes.

JOHNSON: The time, just to the right there?

TYNDALL: Yes.

JOHNSON: The admission time to the neonatal unit?

TYNDALL: Yes.

JOHNSON: [Baby K]'s gestation at the time of her birth together with her weight?

TYNDALL: Yes.

JOHNSON: How she was transferred from the delivery unit or delivery suite on something called a Resuscitaire; is that right?

TYNDALL: Yes.

JOHNSON: That she came from ward 35, that she's extremely preterm, and then the observations that were recorded by the nursing staff at the time --

TYNDALL: Yes.

JOHNSON: -- or by the medical staff? The fact that the parents were interviewed by Joanne Williams and Dr Jayaram?

TYNDALL: Yes.

JOHNSON: The equipment explained by Joanne Williams. If we carry on, please, vitamin K had been given. There was an elective intubation. Further down, please. It goes on to another page.

If we start on the left, can we just move the page across a bit tot he left, please? Thank you. Then various pieces of information recorded there?

TYNDALL: Yes.

JOHNSON: We'll come to all that with the witnesses. So that's done between or closed down at 06.10, is that right --

TYNDALL: Yes, that's correct.

JOHNSON: -- having been started at 06.04?

The next tile is an X-ray, isn't it?

TYNDALL: Yes.

JOHNSON: If we could click on it and go to the X-ray itself, please, Mr Murphy, and scroll down, please. What we see here is a copy of the X-ray as it was taken at the time; is that right?

TYNDALL: Yes.

JOHNSON: It's been put into the sequence of events at tile 149 because of the time that's printed on to the X-ray itself, is that right --

TYNDALL: Correct.

JOHNSON: -- whether or not that time is actually correct; is that right?

TYNDALL: Yes. I just put in what -- with the date and timestamp on the material.

JOHNSON: Exactly. It's not part of your exercise to seek to rationalise it in the context of other evidence?

TYNDALL: No.

JOHNSON: So there may be other evidence that suggests this was taken a bit later than 06.07.23, but we'll come to that in due course. Not least because if we go to tile 150, please, we see mention of someone called Anne Kember who was the person who took the X-ray, who didn't come to the general -- this general area of the hospital until a minute after the X-ray suggests it was actually taken.

TYNDALL: Yes.

JOHNSON: If we look at the following tile, please, 151, here is Anne Kember actually coming into the unit with the mobile machine at 06.09.

TYNDALL: Yes.

JOHNSON: Is that right? So that's why, looking at these three tiles as an example, 149 to 151, it may be that they are out of sequence?

TYNDALL: It may be that the X-ray should be below the door swipe data.

JOHNSON: Exactly, it should be further on in the chronology.

Thank you.

152, please. This is the end time of those notes that we looked at before that were inputted by Lucy Letby concerning the admission of [Baby K] into the NNU?

TYNDALL: Yes.

JOHNSON: Then at 153, there's a further desaturation of [Baby K]; is that right?

TYNDALL: Yes.

JOHNSON: That is recorded at 154 in Dr Jayaram's notes.

If we just click on to the first one, please, his note records this as having happened at 06.15; is that right?

TYNDALL: Yes.

JOHNSON: As before, we'll come to that with him. Going to 155, please, Mr Murphy, do we have a note made by the transport team at 06.22 --

TYNDALL: Yes.

JOHNSON: -- saying that somebody called Dr Rath has spoken to Chester, Dr Jayaram is happy to wait as long as it won't be beyond 9.30 or 10 am so that the baby doesn't deteriorate; is that right?

TYNDALL: Yes.

JOHNSON: Just putting this into context, is the effect of this that the day transport team was going to pick up [Baby K] at the beginning of their shift rather than the night team at the end of their shift?

TYNDALL: That's how it reads, yes.

JOHNSON: Thank you. So 156, please, Mr Murphy. Joanne Williams took blood gases or blood for analysis by the blood gas machine from [Baby K], is that right, at 06.24?

TYNDALL: Yes.

JOHNSON: Then 157, at 06.25, again do we see Lucy Letby and Caroline Oakley making a note for [Baby K] concerning an infusion that she was receiving?

TYNDALL: Yes, of saline.

JOHNSON: At 158 to 159, did Lucy Letby record herself at 06.30 as giving a feed and taking observations concerning a child, GT?

TYNDALL: Yes.

JOHNSON: And at the same time at 160 and 161 and indeed 162, are there three separate sets of readings recorded by Joanne Williams for [Baby K]?

TYNDALL: Yes.

JOHNSON: At 163, 7 minutes later at 06.37 hours, and a couple of minutes later after that, did Lucy Letby, at times 163, 164 and 165, record herself giving medication to a child KC and the child GT?

TYNDALL: Yes.

JOHNSON: At 166 and 167 are there further records made by the transport team, timed at 06.45 am and 06.47?

TYNDALL: Yes.

JOHNSON: By this stage, 06.47 -- if we just click on it, please, Mr Murphy -- do we see that it was confirmed that [Baby K] was to be taken to Arrowe Park in Birkenhead?

TYNDALL: Yes.

JOHNSON: At 168, 169 and 170 do we have three tiles which relate to the children GT and AR, timed at 06.49 and 7 am, signed and countersigned by Lucy Letby and Caroline Oakley?

TYNDALL: Yes.

JOHNSON: Thank you.

Tiles 171 to 173. Do we have further door swipe data, each of those three relating to Dr Jayaram, timed at 07.19, 07.19 and 07.21?

TYNDALL: Yes, showing him entering into the neonatal unit.

JOHNSON: Yes. So we're now coming very close to the end of the night shift, is that right --

TYNDALL: Yes.

JOHNSON: -- which normally ends between 07.30 and 8 am? We come to the third and final event at Chester for [Baby K], which you have put into the sequence between 173, which is 07.21, and 175, which is 07.25.

TYNDALL: Yes.

JOHNSON: If we go to 175, please, Mr Murphy. Do we see there that you have transposed Dr Jayaram's manuscript into typescript and this is a further desaturation?

TYNDALL: Yes.

JOHNSON: Do we see at the bottom of the typescript there that the endotracheal tube, the ETT, had actually gone into 8 centimetres at the lips --

TYNDALL: Yes.

JOHNSON: -- rather than, as it should have been, 6.5 centimetres at the lips?

TYNDALL: Yes.

JOHNSON: Thank you. Was this event also recorded in the nursing notes by one of the day staff, Nurse Melanie Taylor, at tile 176?

TYNDALL: Yes.

JOHNSON: Again, we'll come to that in due course. If we move on to 177, please. These are going -- we're still with [Baby K]'s records and do we see that Lucy Letby was acknowledging responsibility for a saline infusion together with Caroline Oakley?

TYNDALL: Yes.

JOHNSON: Can we just look at the document, please, Mr Murphy? So this is at 07.30. So looking in the -- that's it, thank you. There we see the time recorded. Next to the time, immediately to the left, Lucy Letby's signature on top, Caroline Oakley's beneath. To the left of that the signature of the doctor, in this case Dr Jayaram, I think, who prescribed route intravenous, dose 7ml, and then we can see further to the left, a bolus, a 7ml bolus of normal saline, as it's described, on 17 February.

TYNDALL: Yes.

JOHNSON: Thank you. Going back to the carousel, please, Mr Murphy, at 178, 179 and 180, do we have three sets of data that were recorded by hand by Joanne Williams on the appropriate forms?

TYNDALL: Yes.

JOHNSON: Then at 181 have you recorded the handover from the night shift to the day shift and the fact that [Baby K]'s designated nurse became Nurse Melanie Taylor?

TYNDALL: Yes.

JOHNSON: Thank you. At 182 is there a record at 07.37 of the fact that an ambulance was booked at that time --

TYNDALL: Yes.

JOHNSON: -- to transfer [Baby K]?

TYNDALL: Yes.

JOHNSON: At 183 did Dr Jayaram update his notes at 07.50 that morning?

TYNDALL: Yes.

JOHNSON: At 184 was there a further X-ray of [Baby K]'s chest to confirm the satisfactory position of the ET tube?

TYNDALL: Yes.

JOHNSON: At 185 and 186 is there some door swipe data concerning Anne Kember, the radiologist?

TYNDALL: Yes, entering the neonatal unit, so the same issue with the timings.

JOHNSON: Exactly, thank you. So the combination of 184 through to 186, in effect, as you have just said, mirrors 149 to 151. So the time recorded on the image of the X-ray is in advance of when the radiographer is recorded by the door swipe data as actually coming into the unit?

TYNDALL: Yes.

JOHNSON: It might give rise to the inference that the clock on the X-ray machine is a bit fast. It might do.

TYNDALL: Might do.

JOHNSON: 187, please. In the transport team notes, the ambulance arrived for the team at 08.05?

TYNDALL: Yes.

JOHNSON: At tile 188, more morphine recorded for [Baby K], signed for by Melanie Taylor and [Nurse B]?

TYNDALL: Yes.

JOHNSON: At 189 the nursing notes were updated by Joanne Williams at the end of her shift?

TYNDALL: Yes.

JOHNSON: At 190, Dr Jayaram recorded coming into the neonatal unit at 08.29?

TYNDALL: Yes.

JOHNSON: At 191, 192 and 193, there are three sets of handwritten data recorded on the pre-printed forms by [Nurse B] for [Baby K]?

TYNDALL: Yes.

JOHNSON: Is that right?

TYNDALL: That's correct.

JOHNSON: At 194, at the same time, still 08.30, a neonatal infusion prescription chart signed by [Nurse B] and the lady who's now the designated nurse, that's Melanie Taylor?

TYNDALL: Yes.

JOHNSON: A blood gas record at 195, timed at 08.43?

TYNDALL: Yes.

JOHNSON: At 196 in the nursing notes, Nurse Taylor records the fact that she had taken a blood gas:

"CBG [capillary blood gas] remains poor and pressures [this is the ventilator] increased to 25/5."

TYNDALL: Yes.

JOHNSON: Thank you. We then see at 197 that the transport team actually arrived at Chester; this is at 08.50 hours.

TYNDALL: Yes.

JOHNSON: At 198 and at 199, we see other events recorded by Nurse Taylor, just after the transport team had arrived.

TYNDALL: Yes.

JOHNSON: Followed at 200 by the transport team's notes of the fact that they in effect took handover from Dr Jayaram?

TYNDALL: Yes.

JOHNSON: Is that right?

TYNDALL: That's correct.

JOHNSON: So we see the note says:

"At Countess of Chester Hospital. Handover from Dr Jayaram."

Then various pieces of information, which we have seen as we've gone through, together with some additional information there recorded.

TYNDALL: Yes.

JOHNSON: At 201, do we have the transport team's observations of [Baby K]?

TYNDALL: Yes.

JOHNSON: Heart rate, respiration, blood pressure, ventilator, rate of oxygen, amount of oxygen and pressure?

TYNDALL: Yes.

JOHNSON: At 202 at 09.15 -- if we just click on that, please, Mr Murphy -- they have recorded the team arrived at Chester, parents arrived from labour ward at the same time, and then the fact that they were, that is the parents, were updated by the medical staff.

Dr Kamalanathan examined the baby and various things are then recorded.

TYNDALL: Yes.

JOHNSON: Thank you. At tile 203 do we have Dr Jayaram's notes of those events?

TYNDALL: Yes, detailing the handover with the transport team primarily.

JOHNSON: So the counterpart to the transport team's notes in effect, but this time in the notes at the Countess of Chester, followed by four separate tiles, 204 to 207, which record the giving of surfactant at 09.20?

TYNDALL: Yes.

JOHNSON: And are recorded variously by Nurses [Nurse B] and Taylor and Dr Jayaram?

TYNDALL: Yes, they're just recorded in different documents.

I think Dr Jayaram's actually given the surfactant.

JOHNSON: Yes. At tile 208, do we have further observations taken of [Baby K] --

TYNDALL: Yes.

JOHNSON: -- at 09.30 that morning, and we see some of that information repeated in the transport team notes at tile 209 at the same time?

TYNDALL: Yes. I think they're recording them simultaneously at this point.

JOHNSON: Yes. At tile 210, the same time again, Nurse Taylor recording the fluids?

TYNDALL: Yes.

JOHNSON: That had been moved to the umbilical venous catheter?

TYNDALL: Yes.

JOHNSON: Then also at 09.30, tile 211, the intensive care chart equipment settings recorded by Nurse Taylor?

TYNDALL: Yes.

JOHNSON: Further blood gas record at tile 212 --

TYNDALL: Yes.

JOHNSON: -- timed at 0944? And that's also recorded in the transport team's documentation at tile 213?

TYNDALL: Yes.

JOHNSON: At tile 214 Nurse Taylor has recorded in the nursing notes at 09.44 that [Baby K]'s gases were worse, the results were worse?

TYNDALL: Yes, at 09.44 --

JOHNSON: Yes.

TYNDALL: -- and that the transport team consultant increased the rate as a result of that.

JOHNSON: Thank you. Then [Nurse B], at tile 215, records the fact that [Baby K] was given dobutamine and that in turn was also recorded on other documentation at tile 216 by [Nurse B] and Nurse Melanie Taylor?

TYNDALL: Yes, that's the prescription chart for the dobutamine.

JOHNSON: Thank you. Did Nurse Taylor also make a note in the nursing notes at 09.45, tile 217?

TYNDALL: Yes, this is basically her recollection of what's happened with the medication from the transport team.

JOHNSON: Yes, and the increase of a class of drugs called inotropes --

TYNDALL: Yes.

JOHNSON: -- which, the jury will hear in due course, are designed to keep blood pressure up in the patient?

TYNDALL: Yes.

JOHNSON: At tile 218, is there a record that another doctor, [Dr A], at 09.55, managed to insert an arterial line --

TYNDALL: Yes.

JOHNSON: -- into the radial artery?

And then at tile 219, at 10.00 am, more transport team notes recording the giving of the surfactant, the dobutamine, the fact of the arterial line having been inserted and a rate of fluids?

TYNDALL: Yes.

JOHNSON: Together with the fact that [Baby K] was being given 90% oxygen?

TYNDALL: Yes.

JOHNSON: At tile 220 do we have very similar information recorded in the Countess' notes by Nurse Melanie Taylor?

TYNDALL: Yes, on their fluid charts.

JOHNSON: Yes. At 221 is there a text sent by [Nurse E] to Lucy Letby?

TYNDALL: Yes.

JOHNSON: Could you read that, please?

TYNDALL: It says:

"Hope you had a good shift and are away in the land of Nod now."

JOHNSON: "Well away in the land of Nod."

Then at 222 to 224 are there three sets of notes made on the transport team documentation?

TYNDALL: Yes.

JOHNSON: Followed at 225 and 226, and indeed 227, which are all handwritten records made by Melanie Taylor of [Baby K]'s heart rate, the ventilation equipment settings and the fact that [Baby K] had been given a drug called heparin?

TYNDALL: Yes.

JOHNSON: Thank you.

At 228 at 10.40 did Nurse Taylor record the fact that nitrous oxide was being given to [Baby K] at that time?

TYNDALL: Yes.

JOHNSON: That was also recorded in the transport team notes at 229?

TYNDALL: Yes.

JOHNSON: At 230, Nurse Taylor recorded, at 10.40:

"Further gas improved, put on to nitric oxide by transport team at 10.40, in transport incubator. ABG [whatever that means] prior to transfer good."

TYNDALL: Yes.

JOHNSON: The transport team, 10 minutes later at tile 231, recorded the rate of the administration of nitric oxide?

TYNDALL: Yes, it increased from 10 to 20.

JOHNSON: Parts per million I think that is. Then at 232, also at 10.50, and indeed 233, are there more records of dobutamine and dopamine and the rate at which that was being administered to [Baby K], on this occasion made by Nurses Taylor and [Nurse B]?

TYNDALL: Yes.

JOHNSON: Thank you. 234, 235 and -- well, 234 first. The neonatal fluid balance chart for Chester recorded by Nurse Taylor?

TYNDALL: Yes.

JOHNSON: Then 235 and 236, also timed at 11 am, the transport team's notes about updating [Parents of Baby K]?

TYNDALL: Yes.

JOHNSON: Then [Baby K]'s vital signs?

TYNDALL: Yes.

JOHNSON: Together with the rate of nitric oxide and oxygen?

TYNDALL: Yes.

JOHNSON: At 237, at 11.10 hours, still in the transport team notes, as indeed is tile 238, concerns records made at 11.10 --

TYNDALL: Yes.

JOHNSON: -- which are recording what is being give to [Baby K] and in what quantities?

TYNDALL: Yes.

JOHNSON: Some of that material is also recorded at 239 on the Countess' documentation by Nurses [Nurse B] and Taylor?

TYNDALL: Yes.

JOHNSON: And the results of a blood gas record at tile 240 recorded by Nurse Melanie Taylor at 11.13?

TYNDALL: Yes.

JOHNSON: A corresponding entry in the nursing notes appears at 241, made by Nurse Taylor, saying:

"Blood pressure improved. Large base excess on gas. Full bicarb correction given."

TYNDALL: Yes.

JOHNSON: Then do we have a series of notes made by the transport team at tiles 242 and 244?

TYNDALL: Yes.

JOHNSON: They are the vital signs of [Baby K] together with the rates at which various drugs are being administered to her?

TYNDALL: Yes.

JOHNSON: Followed at 245 by a further X-ray report?

TYNDALL: Yes.

JOHNSON: This, the report that is, is given by Dr Wright, who is the consultant radiologist?

TYNDALL: Yes.

JOHNSON: Then at 246, at 11.30, hydrocortisone was given to [Baby K] and an X-ray was to be taken, as recorded by the transport team?

TYNDALL: Yes.

JOHNSON: At 11.30, tiles 247 and 248, did Nurse Taylor make further records concerning [Baby K]'s vital signs?

TYNDALL: Yes.

JOHNSON: And the rates of ventilation together with administration of dopamine, dobutamine and hydrocortisone?

TYNDALL: Yes, that have all been increased.

JOHNSON: Yes. Then there's a prescription for the hydrocortisone at 11.32 at tile 249 together with an untimed entry from Nurse Taylor saying that hydrocortisone was being given by a slow bolus.

TYNDALL: Yes.

JOHNSON: That is also recorded at 251?

TYNDALL: Yes, that's the computer history for the electronic medication.

JOHNSON: Thank you. Then the third dose of the surfactant for the lungs, the Curosurf, recorded at 11.40 by Melanie Taylor --

TYNDALL: Yes.

JOHNSON: -- at tile 252?

At tile 253, more transport team notes concerning infusions being given to [Baby K]?

TYNDALL: Yes.

JOHNSON: Another note concerning the Curosurf at tile 254 made by [Nurse B]?

TYNDALL: Yes. This is just on one of the paper charts.

JOHNSON: Yes. Then four separate tiles, 255 through to 258 inclusive, all transport team notes, all relating to the ventilation that was being given to [Baby K], the Curosurf in conjunction with that, her vital signs and fluids that were being administered by pump?

TYNDALL: Yes.

JOHNSON: At 259 and 260 do we have two consecutive tiles concerning the prescription for Curosurf?

TYNDALL: Yes.

JOHNSON: As indeed -- well, and then at 261 is the prescribed sodium bicarbonate that was being given to [Baby K], prescribed by [Dr A]?

TYNDALL: Yes.

JOHNSON: That's timed at 11.55, as indeed is tile 262, which is that information recorded on the intensive care chart by [Nurse B]?

TYNDALL: Yes.

JOHNSON: At noon, was [Baby K] moved to the transport incubator as recorded at 263 and 264?

TYNDALL: Yes.

JOHNSON: At 265 is there a prescription for adrenaline?

TYNDALL: Yes, but that's not actually given, as in it is recorded in 266, saying it was drawn up for transfer, but not commenced.

JOHNSON: Yes, thank you. At 267 and 268 and indeed 269, do we have more records made by the transport team concerning the fluids that had been given to [Baby K], her vital signs, and the fact that she was physically handed over to them from the care of the staff at Chester?

TYNDALL: Yes.

JOHNSON: At 270 and 271 is there a prescription for pancuronium that was administered at 12.30 hours?

TYNDALL: Yes.

JOHNSON: That fact was also recorded by Nurse Melanie Taylor in the nursing notes at tile 272?

TYNDALL: Yes.

JOHNSON: A blood gas result at tile 273?

TYNDALL: Yes.

JOHNSON: And those results recorded by the transport team at tile 274, timed at 12.40?

TYNDALL: Yes.

JOHNSON: At 275 what is the final -- in effect the final nursing note, which says, made by Melanie Taylor, made at 12.40, saying:

"Oxygen increasing throughout the morning. In 100% prior to transfer. Synchronising with ventilator. Satisfactory tidal volumes."

The fact that [Baby K]'s temperature had gone up, her heart rate was stable, she was on phototherapy, and that she was in an incubator with 80% humidity --

TYNDALL: Yes.

JOHNSON: -- and had been handed over physically at 12.40?

TYNDALL: And left the NNU at 12.40, yes.

JOHNSON: And that is also recorded by [Nurse B] at tile 276?

TYNDALL: Yes.

JOHNSON: The pancuronium recorded yet again by Nurses Taylor and [Nurse B] at tile 277?

TYNDALL: Yes.

JOHNSON: And then we have the transport team making a record at 12.50 after they had taken over [Baby K]?

TYNDALL: Yes.

JOHNSON: Reference to the fact that [Mother of Baby K] was about to be discharged and was going to Arrowe Park?

TYNDALL: Yes.

JOHNSON: They literally saw [Baby K] into the ambulance?

TYNDALL: Yes.

JOHNSON: And departed Chester?

TYNDALL: Yes.

JOHNSON: Thank you. At 279, further readings recorded by the transport team?

TYNDALL: Yes.

JOHNSON: And at 280, 281, 282, 283 and 284?

TYNDALL: Yes. They are all transport team observations and notes.

JOHNSON: Thank you. There's then a transfer letter, which is written in every case where an infant is transferred out of one hospital into the care of another, which sets out a summary of the position up to that point, is that right --

TYNDALL: Yes.

JOHNSON: -- written by Dr Smith, who was the registrar who had originally intubated [Baby K]?

TYNDALL: Yes.

JOHNSON: We'll come to that in due course.

At tile 286 is there a record of [Baby K] having arrived at Arrowe Park at 13.15?

TYNDALL: Yes.

JOHNSON: The jury may remember at 14.00 hours [Mother of Baby K] also followed her daughter.

Is there then summarised in this sequence between tiles 288 and 291 some further retrospective notes?

TYNDALL: Yes, this is just Melanie Taylor writing up her notes for [Baby K]'s treatment while she was her designated nurse.

JOHNSON: Thank you very much. Then we're almost at the end of this document now. Do we have a series of four text messages, three of which are outgoing and one of which is incoming, starting the same day, Wednesday, 17 February, at 17.48, with a text from Lucy Letby to [Nurse E]?

TYNDALL: Yes. That reads:

"25-weeker delivered, so fairly busy. How's your mum? x"

JOHNSON: Yes. And followed three and a half hours later by a further one.

TYNDALL: Yes. It reads:

"Everything okay? Not like you to not text back lol."

JOHNSON: Then did [Nurse E] text straight back saying:

"Oh sorry lol."

And then followed by a social message and then:

"25-weeker gone out now? x"

TYNDALL: Yes. And then Lucy Letby replies at 21.14, the start of the message is of a social nature, but then carries on with:

"Yeah, but not until 2ish and very unstable BP on quad inotrope. 31-weeker born at 7, vented, which I've got, but Chris off sick, so only me Amy, Sophie, Val and Angela with 13 babies and tonnes of ABX."

Which is antibiotics. She's back on shift in the hospital at this point.

JOHNSON: Yes. So that's the end of the 17th. We heard from [Mother of Baby K] on Thursday about [Baby K]'s progress at Arrowe Park. Does the next tile, 296, record the withdrawal of care from [Baby K] in the face of what was a desperate situation at 05.10?

TYNDALL: Yes.

JOHNSON: Then, at tile 298, [Baby K]'s death is marked and was recorded at 05.28?

TYNDALL: Yes.

JOHNSON: At 299, a few hours later, at 8.15, the death certificate was completed, and that was amended slightly a couple of days later. We'll hear from a doctor about this with the explanation it was originally:

"Cause of death: (1A) severe respiratory distress, (1B) severe prematurity."

And that was in effect reversed a couple of days later to "extreme prematurity" and "(2) severe RDS".

TYNDALL: Yes.

JOHNSON: We come finally to two tiles, 301 and 302. First, 301, please, Mr Murphy. Here have you recorded the fact that on 9 April, the same year 2016, there were events relating to [Babies L & M]?

TYNDALL: Yes.

JOHNSON: The jury will get a bit more evidence about that in due course, but on 29 May, so 6 weeks or so later, Lucy Letby was searching for [Mother of Baby I], who was the mother of [Baby I], who she had murdered. Then on Friday, 3 June, there was an event concerning [Baby N], followed on the 23rd and 24 June by the murders of [Babies O & P], followed on 1 September by a Facebook search history by Lucy Letby for [Mother of Baby G], the mother of [Baby G]. And then on 23 June 2017, so a year to the day after the murder of [Baby O], a search for [Surname of Babies O, P & R] made by Lucy Letby?

TYNDALL: Yes.

JOHNSON: And then another year further on, so in other words 2 years and 2 months after [Baby K] had been transferred out of the Countess of Chester, did Lucy Letby's Facebook account reveal the fact that she had searched for [surname of Baby K]?

TYNDALL: Yes.

MR JOHNSON: Thank you. We need to deal with the neonatal review as well, but it may be that that's an appropriate point, my Lord.

MR JUSTICE GOSS: That's a good breaking point. Thank you very much.

Could you be ready, please, members of the jury, to continue at 2.10? Just over the hour.

And remember and abide by your responsibilities as jurors: no research about anyone or anything, no communication by any means with anyone about anyone or anything to do with this case.

Thank you very much.

(In the absence of the jury)

MR JOHNSON: Whilst things are being tidied up, behind divider 60 of the jury bundle in hard copy there are two documents which haven't been properly redacted. Could we ask the court staff to substitute these two pages for the corresponding pages behind 6B, please?

MR JUSTICE GOSS: Yes. Mr Myers, you've seen this, have you?

MR MYERS: Yes.

MR JUSTICE GOSS: Are you agreeable to this being done?

MR MYERS: Yes, there's no problem with that.

MR JOHNSON: It's just personal details that they don't need.

MR JUSTICE GOSS: Thank you.

(1.06 pm)

(The short adjournment)

(2.10 pm)

MR JUSTICE GOSS: Two pages?

MR JOHNSON: Yes, my Lord, behind 6B.

MR JUSTICE GOSS: Yes, 17.02.07 and 17.03.00 I've changed those. Thank you very much.

Yes, jury.

(In the presence of the jury)

Mr Johnson.

MR JOHNSON: Thank you, my Lord.

If we could put away what we had before, please, ladies and gentlemen, and take up the large black file.

Mrs Tyndall, again, this is your work, isn't it?

TYNDALL: Yes.

JOHNSON: Thank you. If we look at the very first page, please, we see the case name, the exhibit reference, which is your initials followed by a number, the date of this, the most recent version of this. There have been other versions, haven't there, I think, along the way?

TYNDALL: Yes.

JOHNSON: At the bottom of the first page there is a key. It explains to us that if any entry is -- well, you explain it to us, please.

TYNDALL: So anything in yellow is the records relating to [Baby K]. Anything that's in blue type are records made by Lucy Letby or where she's been co-signing them.

Anything that's in italics relates to computer entries made, so there's no physical interaction with a baby.

If there's a question mark, it's because the person hasn't been identified.

JOHNSON: Thank you. Turning over then to page 2 of 10, please, do we have two versions of the floor plan?

TYNDALL: Yes. So the top one is as the -- where the babies were and their designated nurses at the start of the shift.

The bottom one is the layout of the nursery with the babies and their designated nurses at the end of the shift and therefore includes the admission of [Baby K] into nursery 1.

JOHNSON: Thank you. So moving over to page 3, let's just deal with the purpose of this document. Is it to give an easy ready reckoner to enable us all to see whether there are any records at any time relating to any of the other children, or any of the children indeed, in the neonatal unit during the course of this shift?

TYNDALL: So as detailed on the front, it includes all records made by Lucy Letby during the full shift, but for the other babies they start at midnight because [Baby K] wasn't admitted until just before -- well, 02.40 on the shift.

JOHNSON: Yes, okay. So at the time of the incidents that we will be concentrating on in the course of the evidence, can we see what, if any, other records Lucy Letby was making?

TYNDALL: Yes.

JOHNSON: And what was being done, if anything, with any of the other children in the unit?

TYNDALL: Yes.

JOHNSON: So given that that's the purpose and given that [Baby K] wasn't born, as you say, until just after 2 am, perhaps, my Lord, I can deal with the beginning of this document reasonably quickly.

Are the preponderance of the entries, which run from line 2 down to 44 on page 3, entries made by Lucy Letby?

TYNDALL: Yes, with some entries made by other nurses from midnight onwards.

JOHNSON: Yes. So far as the children in respect of whom Lucy Letby was making entries, we can see that they are AR, GT and KC.

TYNDALL: Yes.

JOHNSON: If we just turn back a page to page 2, we can see that AR and GT were in nursery 2?

TYNDALL: Yes.

JOHNSON: And Lucy Letby was the designated nurse for them?

TYNDALL: Yes.

JOHNSON: The child KC was in nursery 1?

TYNDALL: Yes.

JOHNSON: And was the primary responsibility of Caroline Oakley?

TYNDALL: Yes.

JOHNSON: Thank you. So at page 4, please, which is lines 45 through to 89 -- first of all, I'm sure it's obvious to all from what you've already said, but what's the point of the pink line in the middle, please?

TYNDALL: It's to show from that moment that there will be entries relating to [Baby K] because that's when she was born.

JOHNSON: Yes. So above the line, in other words prior to the birth of [Baby K], lines 45 to 65, do we have several entries made by Lucy Letby for the children AR and RN?

TYNDALL: Yes.

JOHNSON: And then several other entries made by a combination of people for some of the other children in the unit?

TYNDALL: Correct.

JOHNSON: So taking it up then at line 66, at 02.12 the birth of [Baby K] and a clinical note made by Dr Jayaram.

TYNDALL: Yes.

JOHNSON: Is it the case that in pretty much every, if not every, single [Baby K] line there will be a corresponding tile number or line in the sequence of events chart?

TYNDALL: Correct.

JOHNSON: Yes, okay. So we don't need to spend too long on dealing with them because it's simply a repetition of information we've already received.

Line 71 is the intubation of [Baby K] as recorded by Dr Jayaram?

TYNDALL: Yes.

JOHNSON: Line 77 is the admission of [Baby K] into the NNU?

TYNDALL: Yes.

JOHNSON: 78, Dr Jayaram's discussions with [Baby K]'s parents?

TYNDALL: Yes.

JOHNSON: 80 and 81, a clinical note regarding medication and observations?

TYNDALL: Yes.

JOHNSON: Then 88 and 89 are further medication and infusions?

TYNDALL: Yes.

JOHNSON: Otherwise, in that period of time, can we see that -- well, we can see -- so far as [Baby K] is concerned, first of all, none of those were made by Lucy Letby?

TYNDALL: No.

JOHNSON: Lucy Letby, on the other hand, if we concentrate on the blue script, at 02.14, 02.36 and 02.50 was making entries or doing things concerning the children RN and AR?

TYNDALL: Yes.

JOHNSON: Thank you.

Turning then to page 5 of 10, here for the first time on this page, which is lines 90 through to 138 we see the correspondence of entries made by Lucy Letby for [Baby K]?

TYNDALL: Yes.

JOHNSON: So they are in the yellow-shaded lines with blue typescript, so lines 122?

TYNDALL: Yes.

JOHNSON: 134?

TYNDALL: Yes.

JOHNSON: And 136?

TYNDALL: Yes.

JOHNSON: Thank you. We can see the event in respect of which the Crown make the allegation in this case at line 132; is that right?

TYNDALL: Yes.

JOHNSON: So concentrating on the time before that event, first of all, we see at lines 101, 106 and 107, 122 through to 128, and 130 to 131, incidents or events which have already been documented in the sequence of events chart?

TYNDALL: Yes.

JOHNSON: Otherwise we can see at 3 o'clock, just after 3 and onwards through to 03.30, Lucy Letby making entries or taking readings in respect of the children AR and GT?

TYNDALL: Yes.

JOHNSON: We can also see the balance of information there before line 132, which is recorded by Caroline Oakley, Sophie Ellis and Valerie Thomas?

TYNDALL: Yes.

JOHNSON: So concentrating on 132 then, please, after that event do we see that the first nursing note or nursing event is the medication that's given at line 134?

TYNDALL: Yes.

JOHNSON: Followed by an infusion at line 136?

TYNDALL: Yes.

JOHNSON: Do we see that in respect of both -- actually, 135 as well, I beg your pardon. But in respect of 134 and 136 both of those are done by Lucy Letby and Joanne Williams according to the record?

TYNDALL: Yes.

JOHNSON: 135, on the other hand, which is equipment settings and entries on the chart regarding medication, is an entry which is recorded under the -- I think under the initials of Joanne Williams; is that right?

TYNDALL: Yes.

JOHNSON: Whether the handwriting is all Joanne Williams' is something that we'll deal with in evidence.

At 137 and 138 are entries relating to other children at 4 am?

TYNDALL: Yes.

JOHNSON: Thank you. Page 6 of 10, please. Again concentrating first on [Baby K], do we see entries concerning [Baby K], all of which are in the sequence of events as well at 145 and 146?

TYNDALL: Yes.

JOHNSON: 148 to 150?

TYNDALL: Yes.

JOHNSON: 159 to 161?

TYNDALL: Yes.

JOHNSON: 164 to 168?

TYNDALL: Yes.

JOHNSON: 176 to 177?

TYNDALL: Yes.

JOHNSON: And 180?

TYNDALL: Yes.

JOHNSON: Many of those entries are also in blue type because Lucy Letby was a contributor to them?

TYNDALL: Yes.

JOHNSON: Otherwise, so far as [Baby K] is concerned, at 148 to 150, 164 to 165, 168, 176 to 177, and 180 are entries made by Joanne Williams and Dr Jayaram?

TYNDALL: And Dr Smith from pathology.

JOHNSON: You're quite right, thank you very much.

Apart from those, we can see that Lucy Letby was making entries for the child AR at 04.00 hours at 141 to 143?

TYNDALL: Yes.

JOHNSON: For [redacted] at 155 to 158?

TYNDALL: Yes.

JOHNSON: For AR at 173 to 175?

TYNDALL: Yes.

JOHNSON: Thank you. Otherwise on that page, other nurses are making entries relating to other children?

TYNDALL: Yes.

JOHNSON: At page 7 of 10, please, entries concerning [Baby K] predominate on the page between 185 and 190.

TYNDALL: Yes.

JOHNSON: Do we see three to which Lucy Letby made a contribution?

TYNDALL: Yes.

JOHNSON: And three others, Joanne Williams alone?

TYNDALL: Yes.

JOHNSON: 196 is Dr Lo?

TYNDALL: Yes.

JOHNSON: 201, 204 to 206 and 209 are medical records, the transport team or Joanne Williams with Dr Lo?

TYNDALL: Yes.

JOHNSON: At 219 and 221 do we have the admission record's start time and finish time --

TYNDALL: Yes.

JOHNSON: -- which is -- the printout of which is the document we looked at during the sequence of events review?

TYNDALL: Yes.

JOHNSON: Further down the page, at 223 to 229, are many entries relating to [Baby K]. They are made by Dr Jayaram, the transport team, Joanne Williams and a single one by a combination of Lucy Letby and Caroline Oakley at line 226?

TYNDALL: Yes.

JOHNSON: Otherwise on the page again other entries relating to other children?

TYNDALL: Yes.

JOHNSON: At page 8 of 10, again concentrating first on [Baby K], noting desaturation at 07.25 at line 253 midway down the page?

TYNDALL: Yes.

JOHNSON: Before that, two entries concerning [Baby K], both made by the transport team at 238 and 241?

TYNDALL: Yes.

JOHNSON: After that, Dr Jayaram's clinical note at line 254?

TYNDALL: Yes.

JOHNSON: Then a block between 259 and 262, the first of which is Lucy Letby and Caroline Oakley and the balance Joanne Williams?

TYNDALL: Yes.

JOHNSON: At 268, 270 and 271 the transport team, all with Dr Jayaram or an X-ray?

TYNDALL: Yes.

JOHNSON: Otherwise we can see about eight or so, maybe slightly more, maybe nine, lines of blue type in the top half of the

page, where Lucy Letby has made entries relating to the children GT, KC and AR?

TYNDALL: Yes.

JOHNSON: Then on the rest of the page entries being made by other nursing staff or medical staff relating to other children?

TYNDALL: Yes.

JOHNSON: Thank you. The final page, please -- the final page of records anyway, page 9 of 10. Three lines relating to [Baby K] after the day shift had finished. Line 283 first of all, the transfer team note at 8.05.

TYNDALL: Yes.

JOHNSON: Then at lines 288 and 289, at 8.10 and 8.14 respectively, an e-prescription and a nursing note written or noted by Nurses Melanie Taylor, [Nurse B] and Joanne Williams?

TYNDALL: Yes.

JOHNSON: Otherwise, records relating to AR, AE, SC and OC, which are some of the occupants of the ward at the time, all made by other nursing staff?

TYNDALL: Yes.

JOHNSON: Right at the end is what in effect is a reproduction of the second page, which is the population layout at the beginning of the shift and its corresponding -- the corresponding position at the end of the shift?

TYNDALL: Yes.

MR JOHNSON: Thank you very much. I don't know whether there are any questions. Yes, there will be some questions. Wait there, please.

Cross-examination by MR MYERS

MR MYERS: Mrs Tyndall, can I just check that you and also, ladies and gentlemen, you, have got open the page which shows the nurses and babies. So we're currently on page 10 of 10.

I just have a couple of questions about Caroline Oakley and the baby we can see whose initial is KC. So if we look at page 10, it's the same as page 2.

We've got Caroline Oakley as the designated nurse for KC in nursery 1 at the beginning of the shift, haven't we?

TYNDALL: Yes.

MYERS: She's also, as it happens, the designated nurse for [redacted] in nursery 1?

TYNDALL: Yes.

MYERS: When we look down to see the position at the end of the shift, again Caroline Oakley is still in nursery 1 as the designated nurse for both of those babies?

TYNDALL: Yes.

MYERS: And we know, of course, that by the end of the shift [Baby K] has also gone into nursery 1, allocated to Joanne Williams?

TYNDALL: Yes.

MYERS: All right, thank you. I'd like to go to page 5 if we could, please. So we're moving into the shift. When we get to page 5 -- and we'll follow it on paper at the moment -- I would like just have a look, if we could, at line 112. Just so that everyone catches up, page 5, line 112, which is an entry for 3.20 on 17 February.

Can you see that, first of all, Mrs Tyndall?

TYNDALL: Yes.

MYERS: I'll just check we're all there. Thank you. That's an entry relating to Caroline Oakley and KC; is that right?

TYNDALL: Yes.

MYERS: KC is one of the two babies who had been allocated Caroline Oakley; is that correct?

TYNDALL: Yes.

MYERS: The entry which you put in is:

"Intensive care chart: equipment settings."

That's the record type?

TYNDALL: Yes.

MYERS: And then:

"Activity summary. Entry made on chart regarding self-extubation."

Can you see that?

TYNDALL: Yes.

MYERS: We have a glossary that helps us with the meaning of terms that we see. It might be obvious what extubation means, but just to assist everybody, and it's behind divider 2, though you don't need to go there at the minute, behind divider 2 in the jury bundle, extubation means:

"To remove an endotracheal or a breathing tube from a person or body part, especially the trachea, after artificial ventilation."

I'm just saying that so we can follow what extubation means; it means the tube coming out.

This entry says it is self-extubation, doesn't it?

TYNDALL: Yes.

MYERS: That's with reference to baby KC?

TYNDALL: Yes.

MYERS: Can you assist us, when you put this record together, it might be apparent, it may not, but could you tell us where would that information have come from for that entry or what document?

TYNDALL: I believe from reading that, but I haven't got the records in front of me, that it's come from an entry made on the intensive care chart.

MYERS: Right. That's why it says under record type "Intensive care chart: equipment settings"?

TYNDALL: Yes.

MYERS: All right. We can leave open the paper, if we would, so we can refer to that, and I'm going to ask Mr Murphy just to put up on the screen the records relating to KC that we've been provided with and we've just given them the initial D1. Actually, could we go to page 3 in those records, first of all, Mr Murphy?

They actually have the exhibit reference LJK97 for anybody who wants to take the exhibit reference but we'll call it D1. It's a bundle of records relating to baby KC. His name has been redacted for the purposes of identity.

TYNDALL: Yes.

MYERS: This is KC's records. We can see, if we look at the nursing notes -- maybe if we just look down that page to the entry for 17 February, just scroll down a little further to 00.51, maybe back up, Mr Murphy, there we are -- we can see the initials CO. Do you see that?

TYNDALL: Yes.

MYERS: That's Caroline Oakley, isn't it?

TYNDALL: Yes.

MYERS: That's the nurse who was on duty. Just so that the members of the jury aren't mystified, this material relating to KC is not part of the overall material in [Baby K]'s records, is it?

TYNDALL: No.

MYERS: It's additional to that?

TYNDALL: Yes.

MYERS: Yes. But when you've been performing your task, Mrs Tyndall, of looking around what was going on in the nurseries you've had access to this material to enable you to compose this review?

TYNDALL: Yes.

MYERS: Can we move forwards then, please, to page 14, which takes us to the intensive care chart for KC. That page is fine to start with, thank you.

We've seen these in [Baby K]'s case. This is a standard form of chart for intensive care observations, isn't it?

TYNDALL: Yes.

MYERS: We have the time running down the column on the left or approximate time; do you see that?

TYNDALL: Yes.

MYERS: And then the nurse making the entry initials it on the far right?

TYNDALL: Yes.

MYERS: When we look down at the entries for 01 down to 07, and this is all for 17 February, the initials are -- they are the initials in fact used by Nurse Caroline Oakley, aren't they, you're familiar with those?

TYNDALL: Yes.

MYERS: And round about 08.00 we see a different set of initials, [redacted]?

TYNDALL: Yes.

MYERS: We'll come to who that is later. There's probably no dispute, that's [Nurse B]?

TYNDALL: Yes.

MYERS: So that's the right-hand side of that chart, as we've got used to seeing it, and can we just move across to page 15, which is the left hand side of the chart, and we're going to go down to where you got the information that we see at line 112. So if we go down to the foot of the chart, please, first, Mr Murphy, and we're looking for one of the CO entries and it's the third one along from the left but we might need to rotate this so we can see it. There we are.

I'm going to ask you to take time to catch up with where we are, Mrs Tyndall, if you need to.

TYNDALL: Mm-hm.

MYERS: Can you help us with what we have three lines down there? The cursor is just next to it for the KC chart.

TYNDALL: Do you want me to read out what it says?

MYERS: Yes, if you can say that.

TYNDALL: "03.20. Self-extubated ++, Neopuff ++, PEEP leading to BiPAP at 03.40."

MYERS: All right. The initials first of all next to that are consistent with the Caroline Oakley initials, aren't they?

TYNDALL: Yes.

MYERS: So is this where you got the entry for 03.20 for the self-extubation for KC?

TYNDALL: Yes.

MYERS: This isn't critical at all, but I'm just dealing with an extra piece of information. If we carry on looking down the chart that we've got open, the review, and if we come down to 03.40 in line 129, there is no entry there for what we appear to see on the IC chart, is there?

TYNDALL: You mean the entry of BiPAP at 03.40? No.

MYERS: Again, this is not critical as in critical of you.

TYNDALL: Yes.

MYERS: But actually, if we wanted to convey the rest of that entry initialled by CO, we would have an entry at 03.40, wouldn't we, for baby KC saying "Neopuff plus PEEP leading to BiPAP" and that would be at 3.40?

TYNDALL: Yes.

MYERS: And that's an entry made, so we can be clear, by Caroline Oakley so far as we can tell --

TYNDALL: Yes.

MYERS: -- dealing with KC in nursery 1 --

TYNDALL: Yes.

MYERS: -- at, as it says here, 03.40?

TYNDALL: Yes, between 03.20 and 03.40.

MYERS: Okay. All right, but leading to BiPAP at 03.40?

TYNDALL: Yes, yes.

MR MYERS: And that's the time we have. Well, we'll just make a note of that. That's all that I wanted to ask you about, Mrs Tyndall. Thank you.

MR JOHNSON: No re-examination, thank you, my Lord. Does your Lordship have any questions?

MR JUSTICE GOSS: I don't, thank you very much.

Thank you for coming to give your evidence, Mrs Tyndall.

(The witness withdrew)

MR DRIVER: My Lord, may I call Dr Sara Brigham, please.

DR SARA BRIGHAM (affirmed)

Examination-in-chief by MR DRIVER

MR JUSTICE GOSS: Can I just say for future reference, when an oath is being taken or an affirmation is being made, there shouldn't be any movement or conversation in the court. I think the gentleman who came in didn't realise that that was the case. I didn't want to interrupt the process at that point.

MR DRIVER: Could you state your full name, please?

BRIGHAM: Yes. I'm Dr Sara Anne Brigham.

DRIVER: Dr Brigham, could you, in a sentence or two, explain to the jury your current occupational status and your role?

BRIGHAM: So I am a consultant obstetrician and gynaecologist at the Countess of Chester Hospital.

DRIVER: Did you occupy that role back in 2016?

BRIGHAM: I did, yes.

DRIVER: You appreciate, Dr Brigham, that you've been invited here today to provide evidence in relation to a patient at the Countess, dating back to February 2016, by the name of [Mother of Baby K]?

BRIGHAM: Yes.

DRIVER: And in advance of making a witness statement, were you given the opportunity to review the relevant clinical notes relating to [Mother of Baby K]?

BRIGHAM: Yes, my statement was based upon the records, yes.

DRIVER: Thank you. Independent of those records, did you actually have a memory of [Mother of Baby K]?

BRIGHAM: I'm afraid I don't, no.

DRIVER: Does the same apply to her daughter, [Baby K]?

BRIGHAM: I'm afraid I don't.

DRIVER: May I reassure you that we will invite you to consider some of the detail of the clinical records, but it's not a memory test and you'll see the record on the screen as will we all.

BRIGHAM: Thank you.

DRIVER: Having reviewed [Mother of Baby K]'s notes, were you able to identify your role within the unit in the week of 15 February 2016?

BRIGHAM: I was, yes, I was the consultant obstetrician and gynaecologist of the week that week.

DRIVER: What did that entail?

BRIGHAM: So we undertake this week where essentially, along with the junior doctors, we are in charge of the labour ward along with midwifery team, but as well as that we look after any emergency gynaecology patients as well, so we are literally on the labour ward Monday to Friday, 9 am or 8.30 to 5.30 during the week.

DRIVER: As part of your duties and responsibilities, do you have responsibility for the management of high-risk pregnancies?

BRIGHAM: As consultants we will oversee those, yes.

DRIVER: Thank you. Having reviewed the notes, was it in that role that you came into contact with the patient [Mother of Baby K]?

BRIGHAM: Yes, I was asked to see her as consultant on the labour ward that week.

DRIVER: Thank you. Mr Murphy, could you put up tile number 9, please? Dr Brigham, if I could direct your attention to this presentation on screen. You'll soon become familiar with it. If Mr Murphy clicks on that tile, you will see behind that tile, Dr Brigham, there are some typewritten notes which themselves have been derived from the original material that you can now see on screen.

There should be a mouse on your desk, by which of course I mean...

MR JUSTICE GOSS: A mechanical one.

MR DRIVER: If you want to draw our attention to any particular detail, please do so.

So the document before us, I'm sure you're well familiar with documents of this ilk, records not in your handwriting, I don't believe, that at 11.30 somebody undertook an assessment of [Mother of Baby K] "as per the telephone sheet" is the language used there. Can you see that?

BRIGHAM: Unfortunately, I can't get the mouse to move the page down.

DRIVER: No, we just -- Mr Murphy will move the page for us. If you want to highlight any particular words at any time -- do you see the top line?

BRIGHAM: Yes.

DRIVER: "Assessment as per telephone sheet."

BRIGHAM: Yes.

DRIVER: In this context what is a telephone sheet?

BRIGHAM: So for any patient phoning the labour ward for any advice, a brief history will be taken by the midwives answering that telephone call and then when the patient then attends to the labour ward, they'll then add to that telephone sheet and then from there on then it goes into the healthcare records like this.

DRIVER: If Mr Murphy were to take us back to tile 6, we'll just briefly glance at the underlying document there, which I trust will be a note of a telephone conversation. The original document, please, Mr Murphy.

(Pause)

Let's go back to tile number 9.

(Pause)

So we are now at tile 6. Original document, please.

(Pause)

The first entry at 11.30. Would that be a note of an examination of [Mother of Baby K] on her presenting to the hospital?

BRIGHAM: That first entry was an entry undertaken by the midwife and, yes, she's taken a brief history and then undertaken an examination based upon what's documented here.

DRIVER: Thank you. If we scroll down to a note made by a Dr George -- do you remember Dr George?

BRIGHAM: I remember the name, but unfortunately I don't actually recollect the actual doctor.

DRIVER: If we keep going down we'll see that part of Dr George's note refers to a discussion with you. If we keep going down, please, Mr Murphy. Just above the hole punch:

"D/W Dr Brigham plus R/V by Dr Brigham."

Could you decode that for us, please?

BRIGHAM: Yes. The junior doctor discussed the patient with myself and then I subsequently reviewed the patient myself.

DRIVER: So R/V is --

BRIGHAM: Review.

DRIVER: Let's go back to the beginning of Dr George's note then and see what was the topic of discussion. Could you help us better understand this note, please?

BRIGHAM: Yes. So this patient was in her first pregnancy, she was 25 weeks' gestation, so 25 weeks into the pregnancy, and she was known to be Rhesus positive with a body mass index of 22. She presented with a history of vaginal bleeding and mucus, some abdominal pain, and feels tightening, so that's mild abdominal pains.

They started that evening, every 10 minutes, now worse. Then it mentions again the vaginal bleeding and mucus. No lower urinary tract symptoms, her bowels opened okay. Foetal movements noted to be good. No fever. No nausea, no vomiting.

DRIVER: Thank you. So concentrating on the blood loss, the abdominal pain and the sensation of tightening, what in your opinion are those symptoms indicative of?

BRIGHAM: I would certainly want to rule out preterm labour.

DRIVER: Thank you. Continue down Dr George's note, please.

Having been presented with those symptoms, what was the approach in response?

BRIGHAM: So I obviously reviewed the patient to assess for myself, but based upon the history and the examination findings I didn't repeat the vaginal examination because that had been

performed by the junior doctor, but I felt based upon that assessment that she was in preterm labour.

DRIVER: What does the phrase preterm labour mean in this context?

BRIGHAM: Labour occurring before 37 weeks' gestation.

DRIVER: Keep going down the page, please, Mr Murphy.

Does Dr George note a plan of action, as it were?

BRIGHAM: I think they do further down, after discussing with me, the plan was to give her some pain relief, to administer steroids -- steroids are used to reduce the risk of respiratory depression in preterm babies. To give some indomethacin, which is used to reduce the uterine activity. To give some magnesium sulphate -- magnesium sulphate has shown to be beneficial in babies born preterm as it reduces the risks of them developing cerebral palsy. We wanted to take a high vaginal swab because we know infection is a common cause for preterm labour so it's important to rule out infection. And then the plan was, because of the gestation, to arrange a transfer -- an in utero transfer of mum and baby to a tertiary neonatal unit.

DRIVER: Thank you. Let's recap on that. Some pain relief for [Mother of Baby K]. Some medication to, if possible, slow down the process. What was the underlying purpose behind that?

BRIGHAM: So that's essentially to get the steroids administered.

We give two doses 12 hours apart and, ideally, if a baby is then born the benefit is after 24 hours of a second dose. So the purpose of administering what we call the tocolytics, the indomethacin in this situation, was to slow down the uterine activity, the contractions, so that we can get the steroids on board to help mature baby's lungs.

DRIVER: Thank you. There was reference a little higher up in the note to an Actim Partus test. Could you help us understand what that is?

BRIGHAM: An Actim Partus -- again, we use it in conjunction with the history and the findings. If it's positive -- it's not a particularly good test, but if it's positive then it suggests that there is a risk of preterm delivery.

It's better than -- the negative predicted value of this test is more reassuring in terms of the fact that it's got a higher negative predictive value but a positive Actim Partus test in

conjunction with the history and the vaginal examinations would suggest that this lady was in preterm labour.

DRIVER: Thank you. The final part of the plan of action, as it were, you told us was transfer in utero. Can you explain to the jury what you mean by that and why transfer was contemplated?

BRIGHAM: So Countess of Chester Hospital at that time was a designated as a level 2 neonatal unit, so we accepted babies born from 27 weeks' gestation. This baby was 25 weeks' gestation if it was to be delivered.

Therefore babies of this gestation are optimally delivered in a tertiary neonatal unit of which the Countess of Chester was not at this stage.

DRIVER: But in the Mersey and Cheshire region Liverpool Women's Hospital and Arrowe Park were?

BRIGHAM: They are level 3 neonatal units, yes.

DRIVER: Thank you. Final sentence there:

"Registrar to discuss with the cot bureau."

Could you explain to the jury what the cot bureau is and why such discussions were needed?

BRIGHAM: The cot bureau is a central team that will organise -- because we needed to arrange for a neonatal bed for the baby, should baby be delivered, but we also needed to arrange for a unit that could take mum as well because she hadn't actually delivered at that stage. So they will organise and coordinate a hospital where there's a bed for baby, should the baby be born, and also a bed for mum as well.

DRIVER: Thank you. So that was a job delegated to the registrar --

BRIGHAM: Yes.

DRIVER: -- whilst you went about your other duties with other patients, no doubt?

BRIGHAM: That's correct, yes.

DRIVER: Could we look at tile 12, please, Mr Murphy?

A brief description of the main features of a document that we're going to look at:

"Referring unit: Chester [you are the referring clinician].
Confirmed hospital: Preston [it says]."

We'll come to the original document in a moment:

"Non-completion reason: cancelled, patient unstable to transfer."

Then there's a time and date stamp.

If we look at the original document, please. We have [Mother of Baby K]'s personal details, some obstetric details there, 24 weeks and 6 days. The reason for indication for the requested transfer, "Threatened preterm labour". The fact that [Baby K] is a singleton, a single baby, not a twin or triplet. If we keep going down. There's a reference to the steroids. Keep going down:

"Non-completion reason: cancelled, patient unstable to transfer."

Could you expand upon that for us, please?

BRIGHAM: Before we put any of our mums in an ambulance we need to make sure they're not going to deliver in the ambulance and obviously it was a clinical decision and it was felt she was advancing in labour and therefore was unsuitable to put into an ambulance for an in utero transfer due, as I say, to the risk that she may deliver in an ambulance.

DRIVER: We can infer from the fact that these enquiries were being made that, in your clinical judgement, it would have been preferable for the baby to be delivered in a level 3 hospital as opposed to a level 2?

BRIGHAM: Yes.

DRIVER: But you've just alluded to taking into account the risk of a baby being born in the back of an ambulance. What would you prefer, delivery in a level 2 hospital or a risk of delivery in the back of an ambulance?

BRIGHAM: As in this case, delivery in a level 2 hospital rather than in an ambulance.

DRIVER: "Confirmed hospital: Preston."

What can you deduce from that?

BRIGHAM: When we're contemplating any in utero transfer we need to think about where we're transferring the mum and baby to and

even potentially if there was a cot available at Arrowe Park or Liverpool Women's Hospital, if we were concerned that the labour was progressing we would potentially still cancel the in utero transfer, again because of the risks of delivery in the back of an ambulance.

DRIVER: Is it right that the further apart the hospitals, the greater that factor is?

BRIGHAM: That's correct. Preterm labour is very unpredictable and so the mum can go from the early stages of preterm labour to be delivering within about 30 minutes.

DRIVER: Were there any features of [Mother of Baby K]'s presentation that would have caused you to fear a rapid progression?

BRIGHAM: I think the fact that she'd had some bleeding to me was concerning that there may be some bleeding behind the afterbirth and that can precipitate the delivery.

DRIVER: From your substantial experience, what effect, if any, on labour does the act of moving a mother from a bed to an ambulance tend to have?

BRIGHAM: Well, obviously as the cervix dilates up there is a risk that the waters can go and we know that baby was a breech presentation, and when babies are in the breech presentation sometimes they can start to deliver through an unfully dilated cervix, so they wouldn't have to get to full dilatation for delivery to start. That then results in baby's head becoming entrapped in the cervix.

DRIVER: Thank you. Could we go to tile 13, please. These are [Mother of Baby K]'s notes. Many of the entries were made by colleagues of yours, but the ones I'll take you to are where colleagues have made the note but there is a reference to you or reference to discussions with you.

If we can look at the original, please, and if we could scroll down, please. It's primarily the entry at 18.45, which seems to have been made by a colleague of yours by the name of Hawe, H-A-W-E. Do you recognise that name?

BRIGHAM: That was one of my colleagues.

DRIVER: And what was Dr Hawe's status back then?

BRIGHAM: He was a consultant obstetrician and gynaecologist and he was the consultant on call that night overnight, so he took over the labour ward from myself.

DRIVER: So we saw your earlier entries were daytime entries. Is there a shift pattern where effectively you hand over --

BRIGHAM: Yes, so about half past five in the evening we hand over to the overnight consultant on call.

DRIVER: Thank you. Your witness statement, having considered these notes of Dr Hawe's, records that:

"It was noted that [Mother of Baby K]'s CRP and white cell count were slightly elevated."

What feature of the notes informs you of that?

BRIGHAM: That was what was recorded by Mr Hawe in his documentation that evening.

DRIVER: Thank you. Can you explain to the jury what that means?

BRIGHAM: So CRP is a C-reactive protein and it's elevated in the presence of inflammation or infection. Inflammation and infection is often the cause of preterm birth.

DRIVER: So those clinical observations made by Dr Hawe don't prove the fact, but what are they consistent with?

BRIGHAM: Again, they would give us a reason why [Mother of Baby K] was in preterm labour.

DRIVER: Does it inform you at all about the imminence of the labour?

BRIGHAM: It's not very predictive of the imminence but again, with the whole clinical picture, putting all the pieces of the picture together, it would suggest that she was in preterm labour and because of either infection or inflammation.

DRIVER: Thank you. If we scroll down to the entry made at 19.00. What do you learn from that or what can we learn from that?

BRIGHAM: The repeat vaginal examination, she'd progressed from 2 centimetres to 4 centimetres dilated and the neck of the womb had come become completely thinned out, the membranes were bulging, so based upon that there was a risk that the waters could go at any stage.

DRIVER: So we're very much heading in one direction at this stage. The following day were you back on duty for 16 February?

BRIGHAM: I was, yes.

DRIVER: Thank you. Is it part of your role to undertake a ward round?

BRIGHAM: Yes. I do. Depending on other emergencies going on in the labour ward, that's one of the first things we try and do when we take over in the morning is to review all of the patients in the labour ward.

DRIVER: I'm grateful till 17, please, Mr Murphy. If we go to the original document, I think it will indicate that you saw [Mother of Baby K] at about 9.20 that morning.

(Pause)

Pause there, Mr Murphy. We can see that there are -- overnight, in the early hours of 16 February, there is a series of notes made in relation to [Mother of Baby K]. Would you have reviewed those notes as part of your preparation for the ward round?

BRIGHAM: I would, yes.

DRIVER: In a sentence or two, what did you learn?

BRIGHAM: So we'd noted that she was still on the treatment to inhibit the contractions, that we'd completed the steroids administration, and she was still on the magnesium sulphate for protection of the baby's brain.

DRIVER: The treatment to retard the contractions, to retard process, why not just continue with that indefinitely for weeks?

BRIGHAM: Because, as we discussed earlier, preterm birth occurs for a reason and if there is infection in the womb we don't want to keep the baby in that environment for too long because that in itself can cause -- increase the risks of cerebral palsy for baby. So it's about getting the steroids on board and then awaiting events.

DRIVER: By the time you conducted your ward round, to use your phrase, were the steroids on board?

BRIGHAM: They were, yes.

DRIVER: And the magnesium sulphate too?

BRIGHAM: Yes.

DRIVER: Thank you. Scroll down. Is that your handwriting?

BRIGHAM: No, that's -- I'm not sure whose handwriting that is.

I suspect that's one of the junior doctor's handwriting.

DRIVER: So is it a note of your examination though?

BRIGHAM: It's a note of our ward round, yes.

DRIVER: So you conduct the ward round, accompanied by junior colleagues, one of whom notes what's going on?

BRIGHAM: That's correct, yes.

DRIVER: Thank you very much. Is it in effect a summary of the page we've just looked at --

BRIGHAM: That's correct.

DRIVER: -- in a line or two?

BRIGHAM: Yes.

DRIVER: So what was the plan of action at this stage?

BRIGHAM: Because we'd administered the steroids and she was noticeably 6 centimetres dilated, so that's advanced in labour, the decision was not to continue with the treatment to inhibit the uterine activity and to await events.

DRIVER: And just let nature take its course --

BRIGHAM: Yes.

DRIVER: -- you having done as much as you could for the baby?

BRIGHAM: Yes, we had optimised baby as much as we needed to with the steroids and the magnesium sulphate.

DRIVER: Thank you. Tile 37, please, and the original document.

If we scroll down to 00.55 on 17 February, please. Go down, please, Mr Murphy. Keep going.

(Pause)

Through to 17 February, please.

(Pause)

Does that record the ringing of the emergency bell?

BRIGHAM: It does, yes.

DRIVER: Which I'm sure speaks for itself. If we continue to go down, please, is that a note made by your colleague Dr Ford?

BRIGHAM: That's correct, yes.

DRIVER: Was he a registrar at the time?

BRIGHAM: He had prior to this been undertaking a consultant locum in the unit, so he was about to start his own consultant post in the region. So yes, he was actually acting as a registrar that night.

DRIVER: You are off duty by this time?

BRIGHAM: I'm not sure whether I was on call, but I think I wasn't actually the consultant on that night, I don't think.

I don't recall.

DRIVER: But it would suggest -- the note at least would suggest that he'd discussed something with you?

BRIGHAM: I wasn't in the hospital.

DRIVER: From this note what can you discern?

BRIGHAM: I think the concern was that there was some -- she was noted to be fully dilated with the breech presentation, so the baby was coming bottom first, and there was some discussion about whether or not we should get the labour delivery going and break the waters and to allow her to actively commence pushing.

DRIVER: So at this stage you now contemplated advancing the labour?

BRIGHAM: That's it, yes.

DRIVER: Did you do so?

BRIGHAM: I think from what I can recall from the notes, her waters went spontaneously.

DRIVER: Thank you. Keep going down, please, Mr Murphy.

Is that --

BRIGHAM: Yes. At 01.52 her waters ruptured spontaneously and the fluid around baby was noted to be clear. So the reg and the team were contacted to come to the room for imminent delivery.

DRIVER: Thank you. We can see at 02.05 is that further encouragement of delivery, as it were?

BRIGHAM: Yes. The concern at that stage was that the uterine activity wasn't as frequent as we'd like, because the difficulty with a breech delivery, when baby is coming first -- is where baby's bottom is coming first is if the delivery is slow you can't put forceps on the baby's head because obviously that's coming last. So we wanted to try and get the uterus to contract as frequently as possible to help expedite the delivery. So the discussion that I had with Dr Ford was around starting a Syntocinon drip that causes the contractions to increase.

DRIVER: And we can see there, can we, that at 2.12 [Baby K] was born?

BRIGHAM: Yes.

DRIVER: Footling breech, which is a term for the direction, feet first?

BRIGHAM: Yes.

DRIVER: If we go to tile 47, please. Click on the original document, and we can consider a retrospective note written at 03.15 hours. Go down, please, Mr Murphy.

(Pause)

"Written in retrospect." What does this note tell us?

BRIGHAM: This is a record by the midwifery team and obviously at the time they are busy dealing with the delivery, assisting with the delivery, so this will be the events written retrospectively and they were written at 03.15.

DRIVER: Thank you. We mentioned earlier the white cell count being elevated as the CRP count. Was that ever investigated further, do you know?

BRIGHAM: I'm not sure, I don't know. I don't recall.

DRIVER: I won't go there then.

Just take the screen down, please, Mr Murphy. Let's take a step back. Could you give us your overview -- retrospective overview as to the events surrounding [Mother of Baby K]?

BRIGHAM: So [Mother of Baby K] attended the Countess of Chester Hospital at 24 weeks and 6 days in preterm labour, due to the gestational age it was discussed whether or not we should be

looking at an in utero transfer to optimise the delivery. However, due to the fact that she advanced in labour, the decision was made to not transfer her out in utero, which I believe was the correct decision to make, but baby was optimised as much as we could with steroid administration and magnesium sulphate. Baby was born with normal cord pHs.

DRIVER: Could you explain that?

BRIGHAM: Cord pHs is a measure of amount of acid in baby's bloodstream, so it's a predictor of foetal distress during labour. That shows there was no evidence of foetal distress, baby's distress, during labour.

DRIVER: We know from the chronology that [Mother of Baby K] presented in the afternoon of the 15th and the baby was born in the early morning of the 17th. With hindsight, would it have been possible to transfer [Mother of Baby K] out with the baby in utero?

BRIGHAM: I still believe that, given the fact that the cervix was dilated up and the membranes were bulging, that there was a risk that by undertaking in utero transfer we could have expedited the delivery in an ambulance potentially. So I still believe, based upon the clinical situation at the time, that it was the right decision not to transfer out.

DRIVER: So in essence it boils down to a clinical judgement?

BRIGHAM: It does, yes.

DRIVER: And do you stand by your judgement made at the time?

BRIGHAM: I do, yes.

MR DRIVER: Would you stay there and answer any questions, please?

Cross-examination by MR MYERS

MR MYERS: Dr Brigham, I just want to ask you about that.

I haven't got a lot to ask about. But with regard to the transfer that was something that, in an ideal world, you would have wanted to take place?

BRIGHAM: I would, yes.

MYERS: You've explained there were concerns at the speed at which labour was proceeding which meant it could be very risky

to spend [Mother of Baby K] in an ambulance to Preston when the baby might be born on the way?

BRIGHAM: That's correct.

MYERS: I just want you to help us with when the decision was taken not to send her to Preston and can we go to tile 13, please, Mr Murphy. Go to the note behind the cover, please.

These are notes for 15 February, Dr Brigham, at about 15.00 in the afternoon. If we scroll down below where we've got the stamped examination, just to the entry below that. Can we just stop there. It says -- is that:

"Registrar re-examined to..."

What's the next word, please?

BRIGHAM: I believe that says "to continue". I'm not sure what they mean there.

MYERS: "In agreement. Plan: discussed with Dr Brigham, decision made not to transfer. NNU here aware."

And the relevant -- the patient is debriefed about that and the room is prepared; is that correct?

BRIGHAM: That's correct, yes.

MYERS: So it was 15 February -- is it 15 February when [Mother of Baby K] first presented with the beginning of labour?

That's right, isn't it?

BRIGHAM: That's correct.

MYERS: The plan at an earlier time on 15 February had been to transfer her to a tertiary unit, hadn't it?

BRIGHAM: That's correct.

MYERS: But we can see, certainly some time between about 3 and 3.30 pm that afternoon, the decision was taken not to transfer her; that's right, isn't it?

BRIGHAM: That's correct.

MYERS: As it happens, hindsight being a wonderful thing, [Baby K] wasn't born for another 35 hours or thereabouts, was she?

BRIGHAM: No.

MYERS: So in fact, there would have been time, had that decision not been taken, to get her to Preston safely, wouldn't there?

BRIGHAM: I don't think we could say that because she was lying in a bed. The act of transferring her across to a trolley and into an ambulance may have caused the membranes to rupture. There was some change in the vaginal examination findings from when she first initially presented. We know that in term labour we expect progression of at least half a centimetre an hour, but preterm labour can go from 2 centimetres to fully dilated within half an hour. So based upon the fact that there was change from when she initially presented to this repeat examination, things can change very, very quickly. And as I mentioned before with a breech vaginal delivery the cervix doesn't need to be fully dilated for baby to start to deliver.

MYERS: All right. So your view is, come what may, that was the right decision?

BRIGHAM: Absolutely, yes.

MYERS: But a tertiary unit is the type of unit that is specialised to deal, if possible, with a baby like [Baby K]?

BRIGHAM: When we're looking at optimising preterm deliveries of this gestation, a tertiary unit is optimising it along with the administration of steroids and magnesium sulphate, which we were able to do in Chester.

MR MYERS: Thank you, Dr Brigham.

MR DRIVER: My Lord, I don't have any re-examination. Does your Lordship have any questions for Dr Brigham?

MR JUSTICE GOSS: I don't, thank you very much.

Thank you for coming and giving your evidence. It's complete and you're free to go.

(The witness withdrew)

MR DRIVER: The next witness to be called has special measures in place.

MR JUSTICE GOSS: Shall we have a break then? I think that's the easiest thing. We'll just have a ten-minute break then and we'll continue. I'll explain to you about the special measures when you return. They're not dramatic or anything.

(3.22 pm)

(A short break)

(3.33 pm)

MRS YVONNE GRIFFITHS (sworn)

Examination-in-chief by MR DRIVER

MR JUSTICE GOSS: Just before Mr Driver introduces the witness to you, the special measure that was referred to before we broke off is a screen. It's very common now for witnesses to give evidence screened from others in court. The purpose of a screen is simply to ensure that the witness has the best opportunity to give their best evidence. Giving evidence is a very stressful experience, as you'll appreciate, and it's stressful enough for people who aren't familiar with courts to come in, but even people who are familiar with courts can be stressed out when they have to give evidence in a case. So the reason is simply to try and make the witness feel as relaxed as is possible.

So you attach no significance whatsoever to the fact that any witness is screened from you. You treat the witness in exactly the same way as you treat any other witness: you listen carefully to what she says and you assess her as you would any other witness. All right?

Thank you.

MR DRIVER: Could you state your full name, please?

GRIFFITHS: Yvonne Griffiths.

DRIVER: And your occupation?

GRIFFITHS: I'm a registered nurse.

DRIVER: Do you fulfil the role of a ward manager?

GRIFFITHS: I do presently.

DRIVER: Within the Countess of Chester Hospital?

GRIFFITHS: Yes.

DRIVER: Mrs Griffiths, you have made a long witness statement which provides an overview of the structure of the neonatal unit at the Countess of Chester Hospital from a nursing and a ward manager's perspective. I'm just going to take you to a few of the topics dealt with in that long statement, so we're not going to go over all the ground.

Firstly, I'm going to ask you about the hierarchy of nurses within the neonatal unit. To assist you and us all, if we open that white file that's in front of you, and there are several coloured dividers there. Behind divider 3 is a document entitled "Lucy Letby agreed facts". It's paginated. I would like you to go to page 4 of that document, please.

I'm going to read into the record agreed fact number 12 entitled "Nursing staff":

"The paediatric nursing staff worked on a rota within a day/night shift system, which typically consisted of (i) a ward manager, (ii) senior neonatal practitioners (shift leaders, band 6 and R23 enhanced neonatal trained nurse), (iii) neonatal practitioners (band 6 without R23 enhanced qualification or a band 5 nurse and (iv) nursery nurses (band 4 nurses)."

They are, I'm sure, terms that you are well familiar with. Does that statement of fact accurately reflect the hierarchy within your unit?

GRIFFITHS: Yes.

DRIVER: Could you just decode "R23 enhanced neonatal training" for us? What does that mean?

GRIFFITHS: As a nurse on the neonatal unit it's extensive neonatal unit training, because it is very specialised, so within a year of a nurse joining our team we would ask them to join a foundation course and after 2 years they would then do a quality and speciality course. Then there is a new course that was out, which is the R23, so that's just an enhanced neonatal course that -- you have to do the other two courses before you can actually do the R23 and that just gives the nurse additional skills to cannulate, to interpret blood gases, so they're very, very experienced nurses once they've done this course.

DRIVER: Thank you. Other than the nurses described at 12(iv), the band 4 nurses, are all the other nurses registered nurses?

GRIFFITHS: Yes.

DRIVER: How does that differ from your band 4 colleagues?

GRIFFITHS: Band 4 colleagues -- they joined us when I first started and so they do not become part of the register of the NMC but they do have extensive training also. But they're just limited in what they can do. So they're not able to look after

any ITU or high dependency babies, so they're more the special care babies that we have on the unit.

DRIVER: And what's the NMC?

GRIFFITHS: The Nursing and Midwifery Council.

DRIVER: Thank you. That agreed fact refers to a rota and shift system. Could you concentrate on the shift patterns for me, please? Typically what do the shift patterns consist of?

GRIFFITHS: We work a twelve-hour shift so they would start at 7.30 in the morning and ending at 8 o'clock in the morning.

And then also 7.30 pm until 8 am. So it's a twelve-hour rotation of days and nights.

DRIVER: What happens within the unit at the point of the shifts beginning and ending? What's the process there?

GRIFFITHS: The process in the time here that we're talking about, we did ask parents to leave, just for that thirty-minute handover. So at 7.30 we'd ensure that no babies were having feeds at that time so that time could be designated to that thirty-minute handover between shifts.

DRIVER: Could you explain to the jury what would take place during the handover? What is the handover period?

GRIFFITHS: So at handover the oncoming nurses would have a summary of all the babies presently on the unit and then they would be allocated specific babies to their skill set.

And then they would go to the bedside and have a handover report at the bedside, using the records at the side of the bed.

DRIVER: Thank you. You know that in this trial we are focusing on a baby by the name of [Baby K] who was born extremely prematurely and was housed briefly in nursery 1 at the Countess of Chester Hospital. So it's that nursery and that set-up within it that we are primarily interested in.

In terms of nursing levels, what types of nurses and how many would be designated to work within nursery 1?

GRIFFITHS: I was responsible as the deputy manager at the time to coordinate staff for each shift. So we would ensure that we always had two band 6 nurses who had the quality and specialty on a shift. And they would primarily look after the ITU babies. We also had nurses that were in training, as I mentioned the foundation course and the QIS course, so they would work

alongside more experienced staff to gain that skill set. But people would have to have the QIS course to work within the ITU space.

DRIVER: Thank you. I would like you now to assist us in relation to the process through which a neonate, a newborn baby, was admitted into the neonatal unit from the labour ward, the labour suite. For a baby like [Baby K], whose delivery was known to be imminent, at what point in the process would your colleagues become involved in the care of that baby or be present with that baby's mother and the delivery?

GRIFFITHS: Obviously any higher-risk delivery where we know we would be needed, the sooner we know that baby is on CLS the better. So we would go and hopefully meet the parents prior to and explain our role once the baby was born. And also to get some maternal history that may help us with the baby being born. We would also ensure that the baby was in the closest area to the neonatal unit so that if they did need transferring it would be quite close and we'd also have Resuscitaires in each room so we would ensure that the Resuscitaire was stocked for a preterm delivery.

We'd also ensure that the consultant was either present or would be easily able to come to the delivery room.

DRIVER: You made reference to the CLS; is that the central labour suite?

GRIFFITHS: Sorry, yes.

DRIVER: When a high-risk baby like [Baby K] was expected, would members of your team be present at the delivery?

GRIFFITHS: Yes.

DRIVER: Would that include doctors as well as nurses?

GRIFFITHS: Yes.

DRIVER: So would there be in effect be two teams there, one team of obstetricians for the mother?

GRIFFITHS: Yes, for the mother.

DRIVER: And paediatricians for the baby?

GRIFFITHS: Yes.

DRIVER: You made reference to a piece of equipment called a Resuscitaire; what is that?

GRIFFITHS: It's an overhead heater. So the baby would be placed on a Resuscitaire and it would have open sides so that the medical team could have access to the baby, but it also had a heat source to ensure that the baby didn't get cold and it would also have oxygen so that we could deliver oxygen to the baby under pressure.

MR DRIVER: My Lord, in due course we'll play the jury a Resuscitaire video, but it might unduly delay Mrs Griffiths if we were to play it now.

The Resuscitaire would be taken to the central labour suite?

GRIFFITHS: It's already there.

DRIVER: It's already there. Is it a movable object?

GRIFFITHS: Yes.

DRIVER: Would it be within the Resuscitaire that the newborn travelled from the labour suite to your care at the neonatal unit?

GRIFFITHS: Yes.

DRIVER: Upon arrival, would the baby be transferred from the Resuscitaire into the incubator?

GRIFFITHS: Yes.

DRIVER: And again, my Lord, the jury will see an incubator in due course.

Upon admission into the unit, could you help us with regards to the paperwork, the record-keeping in relation to the baby?

GRIFFITHS: We'd have an admission sheet that we could pre-fill in some areas prior to the birth and that would be the mum's blood group, if there were any issues in pregnancy, if the membranes had ruptured prior to. So some of the data we could populate prior to the baby being born. Once the baby was born there would be very specific questions, so the Apgars, anything that we needed, any resuscitation would be on there, and the temperature of the baby on transferring.

DRIVER: Mr Murphy, could you put up the document behind tile 53?

I'm not going to take you to the detail, Ms Griffiths, because you didn't actually have any hands-on dealings with [Baby K], did you?

GRIFFITHS: No.

DRIVER: This is the neonatal unit admission form for [Baby K]. Is that the pro forma document you were just describing to us?

GRIFFITHS: Yes.

DRIVER: If we could scroll down, there isn't an awful lot on it, so it gives the members of the jury some idea as to the type of information recorded there. So they are typed fields alongside which the doctor, I think in this case, adds some detail; yes?

GRIFFITHS: Yes, I think it's nurse/doctor, it's combined, yes.

DRIVER: Combined nurse and doctor, thank you.

So the baby, having been brought in in a Resuscitaire, transferred to an incubator, the notes are made as we go along. Where are those notes kept, physically speaking?

GRIFFITHS: Initially, the notes would be at the bedside or the cotside. We have a portable trolley with a clipboard, so just for easier access because you can imagine it's a very busy time, a time of a baby being born, and you need to document as things happen. So once you weigh the baby you can document on the sheet. So this admission sheet normally would stay with the baby until the nurse finishes her shift and then it would be filed in the baby's notes.

We wouldn't have the baby's notes initially, we would have to order them from the front desk and then go and collect the folder to put all the documentation in. So it's not always filed completely in the notes at the time of birth.

DRIVER: The information contained within this document and its like, does that information also get copied elsewhere into a different form of record?

GRIFFITHS: This would then -- we have a computer system -- at the time it was called a Meditech computer system, so that was where we had our nursing notes, so we would use the information that was on any of the admission sheets to populate the admission on the computer system.

DRIVER: Mr Murphy, could you go to tile 66, please? If we go to the original document, please. This is something we've already looked at, I think.

We can see "note" there at the bottom of the page, thank you, next to the initials JW.

GRIFFITHS: Yes.

DRIVER: "Williams, Joanne RGN." Do each of your colleagues have a unique set of initials or mnemonic attributed to them?

GRIFFITHS: Yes.

DRIVER: And do you each have your own password or passcode to get on to this system?

GRIFFITHS: Yes.

DRIVER: Can it be shared amongst you?

GRIFFITHS: No.

DRIVER: We can see on these notes, on this side of the page at least, they are made by Joanne Williams. Is she a band 6 colleague of yours?

GRIFFITHS: Yes.

DRIVER: But if we look at the other side of the page we'll see notes made under the initials LL.

GRIFFITHS: Yes.

DRIVER: Lucy Letby?

GRIFFITHS: Yes.

DRIVER: Are they the notes that would have been transposed from the written admission document into this computerised version of [Baby K]'s (inaudible) notes?

GRIFFITHS: Yes.

DRIVER: So for example, parents' name --

GRIFFITHS: Yes.

DRIVER: -- and the details of delivery and the like? Thank you.

That's enough of that screen, Mr Murphy.

Still on the topic of record-keeping and nursing notes, would babies such as [Baby K] be the subject of almost continual observations?

GRIFFITHS: Yes, definitely.

DRIVER: What is observed, what is recorded?

GRIFFITHS: When a baby is transferred we have a Philips monitor that we will plug in, so ECG leads, so that would monitor the heart rate and any respirations and importantly a saturation monitor as well. That would be on either of the limbs and that would give us a reading.

Once we had any lines we can then do any blood pressure via the umbilical lines.

DRIVER: Thank you. If we could go back into that white file and look behind divider 6D, I'm sure you're well familiar with these charts.

GRIFFITHS: Yes.

DRIVER: Can you help the jury? What information is plotted on these charts or graphs?

GRIFFITHS: You can see that we tend to do hourly observations on an ITU baby. The first, the yellow, line indicates that if the observations breach into that area then we would have to escalate that because, obviously, that's a little bit higher than or lower than we would normally expect. Anything in the white is what we would normally expect. So you've got the heart rate, which is the first block, and a baby's heart rate is always twice what an adult heart rate is. So you can see that running around about 140, 160, which is normal.

Respirations are always that little bit higher as well. It looks like there's been a circle and a star, so I presume that's based on the baby being ventilated, so we would set a pressure on the ventilator, so to give 60 breaths a minute, and we would make sure that baby was breathing 60 breaths a minute.

DRIVER: I wonder if you would deal with the processes rather than the detail of this baby.

If we go overleaf in the file, please, behind 6E, we see a different type of chart, being the intensive care chart. What's this document used to record?

GRIFFITHS: So this is an ITU chart. It's only used in the ITU room. This will tell us what ventilation the baby was receiving and the rate and the oxygen and any comments at the bottom, and then also would have a part for the fluids that the baby was receiving.

DRIVER: Together, would those two documents combine to represent the majority of the observational record-keeping --

GRIFFITHS: Yes.

DRIVER: -- at regular timed intervals?

GRIFFITHS: Yes.

DRIVER: With a baby as extremely premature as [Baby K], that would be on at least an hourly basis?

GRIFFITHS: Yes.

DRIVER: Thank you. Could you help us with the protocols in relation to the administering of medication? If Mr Murphy would take us to tile 63, please.

What are the rules controlling this process?

GRIFFITHS: Any medication -- yes, it's -- two registered nurses would have to administer medication, so whenever -- we always have to base it on the weight of the baby so we're always guided by a formula and any guidance on the fluids. We have a fluid regime, so day 1, day 2, how many millilitres per kg you'd actually give the baby.

DRIVER: Thank you. If we look to the right of our page, underneath the patient name, there we see a column entitled "given by". Where there's entries there, is it right that we'll see two sets of signatures?

GRIFFITHS: Yes.

DRIVER: Does that mean that both the nurses actually give the baby the medicine?

GRIFFITHS: They actually calculate the medication together, so they do two separate calculations, come together to make sure they came up with the same calculation, then with the infusions they would go to the pump together and then just set the rate and double-check it and sign the form.

DRIVER: Does that, in effect, provide a safety net against human error?

GRIFFITHS: Yes.

DRIVER: Thank you. Finally, and a completely different topic, you were asked by an officer, I understand, to mark a plan to

indicate a door known as the maternity labour ward doors by the lift.

GRIFFITHS: Yes.

DRIVER: If Mr Murphy could put up the exhibit YG20, please.

You recognise this as a plan of the unit?

GRIFFITHS: Yes.

DRIVER: Did you endorse with a circle in the smaller of the two plans -- do you remember doing this?

GRIFFITHS: I do, yes.

DRIVER: What does that represent?

GRIFFITHS: That is the access to the delivery suite, not from the neonatal unit, but the other access off the main corridor by the lifts.

MR DRIVER: Thank you. Could you remain there and answer any questions.

Cross-examination by MR MYERS

MR MYERS: Mrs Griffiths, back in February of 2016, which is when we're looking at in particular, you were the deputy ward manager in the neonatal unit, weren't you?

GRIFFITHS: Correct.

MYERS: And you were a band 6 nurse?

GRIFFITHS: Yes.

MYERS: I've got questions about some general areas that I'd like to ask you about and we'll be looking at a few documents.

The first thing I want to ask you about is the type of babies that you were looking after. You may remember the prosecution, when you were asked questions a few minutes ago, described [Baby K] as a high-risk baby. You went on to say, "Almost continual observations are required". Do you remember saying that, almost continual? Why is it necessary to have almost continual observations for a baby like this?

GRIFFITHS: Because they're so fragile so we need to monitor them closely.

MYERS: It's the case, isn't it, that even when apparently stable you have to watch them to make sure they don't deteriorate?

GRIFFITHS: Yes.

MYERS: Because fragile as they are, they can deteriorate, can't they?

GRIFFITHS: Yes.

MYERS: And when that happens, it can be quite rapid, can't it?

It's tempting to nod, but you have to say yes --

GRIFFITHS: Yes.

MYERS: -- unless you want to disagree, in which case say no.

But yes, it can be rapid. Bradycardia, with which we know from our glossary means the slowing down of the heart, that's something that can happen to a neonate without any warning sign necessarily; do you agree?

GRIFFITHS: Yes.

MYERS: So you have to keep observations on them to watch out to see if it happens?

GRIFFITHS: Yes.

MYERS: And that's one of the reasons that they are attached, when necessary, to the type of monitors that we've talked about?

GRIFFITHS: Yes.

MYERS: Likewise, desaturation, which we know is a drop in the oxygen saturation in the blood, that is not uncommon in a neonate, is it?

GRIFFITHS: Correct.

MYERS: And if there is a desaturation, sometimes it can begin to drop quite rapidly, can't it?

GRIFFITHS: Yes.

MYERS: Would you agree it's possible to go from the mid to high 90s down to the mid to low 80s within seconds?

GRIFFITHS: Yes.

MYERS: Can handling a fragile neonate be a source of destabilisation to them?

GRIFFITHS: We try not to handle them frequently, so it's a hands-off technique, that's why we have the monitor to monitor the readings.

MYERS: But can handling therefore sometimes cause physical stress in a neonate?

GRIFFITHS: Yes.

MYERS: If one of the babies does, for instance, appear to be desaturating -- I'm not talking down to 70 or 60 but maybe into the low 90s or into the high 80s or the mid-80s -- may a nurse wait, first of all, to see if the baby self-corrects?

GRIFFITHS: I think you always have to monitor the baby and look for the skin colour.

MYERS: Right. So if you are monitoring and looking for the skin colour you may do that, but wait to see, first of all, does the oxygen correct itself whilst you're watching?

GRIFFITHS: Yes.

MYERS: But inevitably, if the baby doesn't correct then you need to make an intervention?

GRIFFITHS: Correct.

MYERS: Which may be giving oxygen yourself to the baby? That's one, isn't it?

GRIFFITHS: Yes.

MYERS: Or if there are serious concerns at what's happening, a nurse may then call for help?

GRIFFITHS: Yes.

MYERS: And as matters escalate, it may be that a doctor is bleeped to assist as well?

GRIFFITHS: Yes.

MYERS: I'm going to ask you a little bit about the duties you have been telling us about with the nurses. You described to us about the handover procedure that takes place and that takes place at the beginning of each of the shifts, doesn't it?

GRIFFITHS: Yes.

MYERS: I know this is a day-to-day occurrence for you, but to those people who aren't familiar with it I want to help with the timings again. The shift formally starts at 8 o'clock in the morning and 8 o'clock in the evening doesn't it?

GRIFFITHS: 7.30.

MYERS: 7.30, right. Between 7.30 and 8, is that the handover period?

GRIFFITHS: Yes.

MYERS: And that's the period in which the nurses who are coming on will be told which babies they're being allocated to; is that correct?

GRIFFITHS: Yes.

MYERS: And they will get a briefing first of all in a central area --

GRIFFITHS: Yes.

MYERS: -- telling them about that; is that right?

GRIFFITHS: Yes.

MYERS: And then in the handover period they will then go to the rooms and the cotsides for a briefing as to the baby in situ; is that right?

GRIFFITHS: Yes, the shift leader will give an overall and then they'll go back to the bedside and have a handover from the nurse.

MYERS: And that's a handover from the nurse who's been looking after that baby?

GRIFFITHS: Correct.

MYERS: So in fact during a handover period there will almost be double the normal number of nurses -- well, you'll have the shift who come off and the shift who are going to come on, won't you?

GRIFFITHS: Yes.

MYERS: So it's quite a busy time; is that right?

GRIFFITHS: Yes.

MYERS: I'm going to ask you about the type of tasks that the nurses undertake with the babies -- not so much the tasks themselves but how they organise themselves. Some of the tasks that the nurses deal with, they can deal with with their allocated baby in the nursery themselves, can't they?

GRIFFITHS: Yes.

MYERS: Some of the tasks require two nurses, don't they?

GRIFFITHS: Correct.

MYERS: Giving medication is one of those, isn't it?

GRIFFITHS: Yes.

MYERS: So in that situation the nurse will find another nurse who is available to assist them in that process?

GRIFFITHS: Yes.

MYERS: And sometimes if a nurse has got a duty that takes her to one baby in one nursery or one baby in part of a nursery, might he or she ask another nurse to look after one of their other babies if necessary?

GRIFFITHS: Sorry, can you repeat that?

MYERS: Yes. If a nurse has got more than one baby to look after and they have to focus on one of them, or maybe even leave the nursery altogether and deal with something else, will they ask another nurse to look after their baby whilst they're away?

GRIFFITHS: Usually you wouldn't leave unless the baby was stable to leave and then you'd just mention to the nurse around, usually the shift leader, that you needed to leave, could they keep an eye out for the baby.

MYERS: So sometimes, do you agree, you'll find a nurse looking after a baby that he or she hasn't been allocated to but because they've been asked to do that?

GRIFFITHS: Only for short term.

MYERS: But that can happen, can't it?

GRIFFITHS: Yes.

MYERS: And does it sometimes happen that a nurse who's looking after a baby that they weren't allocated to may make an entry in one of the charts when they've conducted observations for that baby?

GRIFFITHS: Yes, particularly if it's a very busy shift and there's not very many nurses on a shift, we could have four or five -- well, five nurses on a shift and if we have an admission then everyone pulls together and will do part of the documentation.

MYERS: So what we might see when we look at those type of charts, you may see the initials for the nurse who is allocated to a baby and then maybe in a run of those initials there might be another set of initials in there and then it carries on?

GRIFFITHS: Correct.

MYERS: The reality is the way the unit functions relies to some extent on nurses being able to help one another in what they're doing?

GRIFFITHS: Correct.

MYERS: I'm going to ask to look at a document that we've got called the neonatal review and it will be in one of the files. It might be in the large black file in front of you, the A3 file. I'm going to ask you, ladies and gentlemen, if you could go to it as well, please. I'm only going to go to several examples that I'm going to suggest is the type of thing I've been talking about just so we can see it on paper.

We've seen this document already in the trial, we and the jury, Mrs Griffiths, but it should say at the front of it "NN review schedule: [Baby K] (exhibit reference KLT41)". If you just look at the first page, I want to make sure that is the right exhibit. Does it say KLT41?

GRIFFITHS: It does.

MYERS: Thank you. If we go to the second page, which you were looking at there, it shows us who was allocated or designated for each baby in the nurseries at the start of the shift. That's on page 2. You can see that, can you, Mrs Griffiths?

GRIFFITHS: Yes.

MYERS: And then at the end of the shift we have the picture in the lower of the two plans and the principal difference is the addition of [Baby K], you'll see, in nursery 1.

GRIFFITHS: Yes.

MYERS: All right. I'm just going to go to a handful of entries and the first one and it may help -- I don't know, if we can put these on the screen, Mr Murphy, so you can underline them. I'm going to ask us all please to go to page 13 and just look at lines 14 to 19 -- sorry, page 3, lines 14 to 19. You might want to keep your fingers, ladies and gentlemen, on the plan so you can refer back to where the nurses were allocated as we go along.

If we look at those entries what they show us is between 10.11 and 10.19 pm, medication is being given and the system updated with regard to baby GT; can you see that?

GRIFFITHS: Yes.

MYERS: If we just flip back to page 2 -- leave on the screen what's there, please, Mr Murphy -- if those of us looking at paper look at page 2, we can remind ourselves that GT was in nursery 2 and was one of the babies allocated to Lucy Letby. Can you see that, Mrs Griffiths?

GRIFFITHS: Yes.

MYERS: Before we go back, if we look at the same plan, we can see that Nurse Sophie Ellis has babies in nurseries 4 and 3, doesn't she?

GRIFFITHS: Yes.

MYERS: So if we now go back to page 3, with the lines we're looking at, can you see that we've got baby GT and the medication that's being dealt with being tended to by Lucy Letby and Sophie Ellis --

GRIFFITHS: Correct.

MYERS: -- across the range of those entries there, haven't we?

GRIFFITHS: Yes.

MYERS: As you've described to us, that's two nurses being engaged in the giving of medication?

GRIFFITHS: Yes.

MYERS: Which is what's required, isn't it?

GRIFFITHS: Yes.

MYERS: And so far as Sophie Ellis is concerned, we have Nurse Ellis coming from her duties in one or two other nurseries to assist with a baby who's in the nursery that Lucy Letby is working in?

GRIFFITHS: Yes.

MYERS: There's nothing unusual or strange about a nurse going from one nursery to another to assist a nurse in that way, is there?

GRIFFITHS: No.

MYERS: I suppose from what you've said we would have to assume that the babies Nurse Ellis has left behind are stable, that's right, isn't it --

GRIFFITHS: Yes.

MYERS: -- and/or being looked after by another nurse that she's asked to keep an eye on them?

GRIFFITHS: Yes, the babies in the outer nurseries are more stable.

MYERS: They are more stable, yes.

Can we drop down on the same page, please, Mr Murphy and Mrs Griffiths, to line 31, I'm simply giving some examples, this exercise can be repeated across the whole of the neonatal review, but I'm not going to do that.

Line 31. If we look here now at 00.06, medication being given to baby GT, and this time it's Nurse Caroline Oakley assisting Lucy Letby.

GRIFFITHS: Yes.

MYERS: If you want to see where Caroline Oakley has come from, just look back at the page before, Mrs Griffiths, she was allocated to babies in nursery 1, wasn't she?

GRIFFITHS: Correct.

MYERS: Nursery 1 is the intensive care nursery, isn't it?

GRIFFITHS: Yes.

MYERS: So we assume that the babies at the time she left them were stable --

GRIFFITHS: Yes.

MYERS: -- and/or another nurse is looking after them while she is away?

GRIFFITHS: Yes, often medication is drawn up in the intensive care room and then the medication trolley taken to nursery 2.

MYERS: Right. But the picture of one nurse helping another with tasks like this is not unusual, is it?

GRIFFITHS: No.

MR JUSTICE GOSS: Does there have to be a co-signer?

GRIFFITHS: There does.

MR JUSTICE GOSS: There have to be two?

GRIFFITHS: Has to be, yes.

MR MYERS: Can we go to entry 43, the same page, a little lower down, please. If we look there we can see at about 00.50 in the morning, 00.51, for baby KC, there's a nursing note. It says:

"The nursing note entry regarding cares attended to by SN Letby."

Then it has Caroline Oakley and Lucy Letby written down as member of staff. Can you see that?

GRIFFITHS: Yes.

MYERS: Now, we know that KC is in nursery 1 with Caroline Oakley. So does that suggest that at that time, 00.51, Ms Letby is assisting Caroline Oakley in nursery 1 with baby KC?

GRIFFITHS: It suggests, yes.

MYERS: All right. Can we go over the page, please, to page 4, and look at entries 56 and 57. Just for the -- we can take note as we do so that that last entry, ladies and gentlemen, Mrs Griffiths, the one on line 43, took place before [Baby K] had come to nursery 1. [Baby K] came to nursery 1 a little after 2 o'clock. The one we've just looked at was at 00.50.

Something slightly different we're looking at here with lines 56 and 57. At 01.45, for baby RB, at the same time entries for feeding charts and the IC observation chart. The member of staff is Valerie Thomas. First of all, you see what I'm identifying?

GRIFFITHS: Yes.

MYERS: As it happens, the baby RB was in nursery 3, one of Valerie Thomas' babies?

GRIFFITHS: Yes.

MYERS: The reason I identify this is there are two charts being completed at 1.45. Could you help us with what it is that's taking place when we see one nurse apparently doing two things with one baby and two charts like that?

What is taking place?

GRIFFITHS: Usually, a baby is due a feed -- it looks like the baby potentially is due a feed at 2 o'clock so you would start that feed a little bit earlier and you would do observations. So you would do the temperature, heart rate and then you would then do the feed.

MYERS: So there might be a number of tasks associated with the entry at 1.45?

GRIFFITHS: Yes.

MYERS: But of course that doesn't mean therefore that all of those tasks are either done or completed bang on 1.45, does it?

GRIFFITHS: No, it seems like that's the time she went to the cotside to start the feed.

MYERS: It may be, if a nurse is engaged in feeding and cares for the baby and checking the readings, that might take 15/20 minutes?

GRIFFITHS: It just depends on what needs to be done at the same time.

MYERS: All right. But as it happens, just to assist us with this, Mrs Griffiths, where we see timings on these charts, unless we're dealing with a form which has a computer-populated timing, sometimes they will be approximate, won't they?

GRIFFITHS: Yes.

MYERS: Or they may refer to an event or events that took place over a period of time?

GRIFFITHS: It depends. If the baby was apnoeic then that specific time would be recorded. So there are different things that we do record.

MYERS: So we can follow exactly what you're saying, you said if a baby is apnoeic, that time would be -- you'd expect that to be specific?

GRIFFITHS: Yes.

MYERS: In other words, if a baby has stopped breathing at a particular time, you'd expect that record to be particular about that time?

GRIFFITHS: Yes.

MYERS: But if it's something like feeding or filling in the observation chart and the time for that, that may be more approximate?

GRIFFITHS: But not much out. Minutes.

MYERS: No. When we look at the IC chart -- I'm going to ask -- if we just look at section 6E in the white file, please, ladies and gentlemen. So we go behind divider 6E. We looked at this briefly a little earlier, Mrs Griffiths.

(Pause)

When we look down the timings on the left-hand side, can you see they all say 03.30 and then 04.30 and then 05.30 and 06.30 under the "fluid requirements" section?

GRIFFITHS: Yes.

MYERS: Do you agree what's happened there is those reflect one-hour periods within which certain activities will have been started or completed?

GRIFFITHS: Correct.

MYERS: It's not suggesting, is it, that it's exactly the hour or every half hour that those things are taking place?

GRIFFITHS: With the IV fluids, yes, it would because you need to get a correct reading of that hourly volume.

MYERS: But with other tasks it might be within that hour period, mightn't it?

GRIFFITHS: No, we try and get it as close to that time, so if it is 11.30. if you were 5 minutes either side -- we wouldn't expect that to be 40 minutes.

MYERS: If it was at 11.50 that a task was undertaken, where would that -- let's say if a task was undertaken at 05.50, where would you expect that to be included in a chart like this?

GRIFFITHS: I don't think a 05.50 would be, I think they would wait until 6. They would actually go to the -- it's a process of observing the baby and then recording -- I think this at 3.30, it sounds like that's when the baby was admitted, potentially, and so that's when we started the clock so therefore it was an hour after.

MYERS: That's why it's half hour brackets, isn't it?

GRIFFITHS: Yes.

MYERS: Because [Baby K] was admitted on the half hour so we've got half hours --

GRIFFITHS: Yes.

MYERS: -- of the brackets for the tasks that take place?

GRIFFITHS: Yes.

MYERS: Does that give us necessarily the precise time that the matters that we're looking at on it all took place?

GRIFFITHS: Yes, it's a new baby that's arrived, so they would really be looking at the regular observations.

MYERS: So where we see 03.30, does that mean that the 10% dextrose was given at exactly 03.30?

GRIFFITHS: I presume that's when the actual syringe was set up in a syringe driver.

MYERS: In the white file if we turn then, please, to divider 6C, please, ladies and gentlemen, and you too, please, Mrs Griffiths. We've got the white file before us and we've got the chart on the screen. Can you see the first entry is for 10% dextrose? Do you see that?

GRIFFITHS: Yes.

MYERS: "Route: IV." There's a squiggle for the doctor who's prescribed and then it's given by -- and there's two signatures. Can you see that?

GRIFFITHS: Yes.

MYERS: Which is what you'd expect for a medication or something like this, isn't it?

GRIFFITHS: Yes.

MYERS: Then it says:

"Time and date started 17 February 16."

And it looks like 03.05 or something like that.

Do you see that?

GRIFFITHS: Is it the first line, 03.00?

MYERS: 03.00. Not 03.30, is it?

GRIFFITHS: No.

MYERS: So that's the actual record on the infusion chart as to when that dextrose was given or started, isn't it?

GRIFFITHS: Yes.

MYERS: If we go back to what we were looking at, the chart behind divider 6E, and it's on the screen to help us, do you see now that it's 03.30 what it says for the dextrose there?

GRIFFITHS: Yes.

MYERS: So that's what I'm getting at when I'm saying these things are not precise to the minute, are they?

GRIFFITHS: Sorry, but it does actually say the total infused is 0.3ml for that 03.30. So potentially 1.7ml per hour and it's actually infused at 0.3.

MYERS: That's how much you say may be there?

GRIFFITHS: At the 3.30 reading.

MYERS: Yes.

GRIFFITHS: Yes.

MYERS: But that doesn't actually tell us the time at which that dextrose infusion commenced, does it?

GRIFFITHS: No, but I think when you're actually getting the dextrose out and signing, you will sign and then take it to the

bedside and, you know, it just depends but that would have been an actual reading at 3.30.

MYERS: All right. I want to ask you some questions, if I may, please, before I finish with some of the areas on the unit and a little bit of administration.

If we stay with the white file, please, ladies and gentlemen, Mrs Griffiths, we've heard a little bit about controlled drugs on the unit. If we go to divider 5 and open it up and look at the photographs behind divider 5, photograph 5, which is at the centre of the top line on that page, is a view from within nursery 1. Can you see that?

GRIFFITHS: Yes.

MYERS: We've looked at these already. To the right of that photograph there's a large white cupboard, isn't there, on the wall?

GRIFFITHS: Yes.

MYERS: Above a blue tray?

GRIFFITHS: Yes.

MYERS: Is that a cupboard in which certain controlled drugs are kept?

GRIFFITHS: Correct.

MYERS: And that means drugs which can be given only on prescription; is that correct?

GRIFFITHS: Yes.

MYERS: Also, while we're looking at that picture, just below and to the left of that cupboard is a black screen, isn't it?

GRIFFITHS: Yes.

MYERS: And is that one of the terminals that nurses can use, for instance, to access the Meditech system?

GRIFFITHS: Yes.

MYERS: And can the nurses also use that to enter in details of prescriptions that are being administered?

GRIFFITHS: Yes. We have a paper copy and also we have one on Meditech.

MYERS: Right. Staying with this page and the pictures, if we go down to the bottom left-hand image, that's an image of what we know is the nursing station, so it's photograph 1 in fact, bottom left.

GRIFFITHS: Yes.

MYERS: And to assist you, Mrs Griffiths, you can see the photographs are orientated on the plan in the centre of the page so we can see the direction of view. Can you see that?

GRIFFITHS: Yes.

MYERS: So photograph 1 shows the nursing station, doesn't it?

GRIFFITHS: Yes.

MYERS: There's another screen, another terminal, there, that can be used to complete Meditech records, isn't there?

GRIFFITHS: Correct.

MYERS: And also to enter in the details for prescriptions; is that correct?

GRIFFITHS: More I think prescribing prescriptions but, you wouldn't use the nurses' station to administer.

MYERS: But to enter details, you wouldn't enter them there?

GRIFFITHS: No.

MYERS: You'd use nursery 1 for that?

GRIFFITHS: Or the portable. We have carts on wheels, so we would use those.

MYERS: Thank you. As it happens, if we're dealing with questions relating to morphine -- morphine is a controlled drug, isn't it?

GRIFFITHS: It is.

MYERS: But actually that isn't kept in the cupboard we're looking at there, is it?

GRIFFITHS: What's that, sorry?

MYERS: Morphine.

GRIFFITHS: Morphine?

MYERS: On the unit at this time?

GRIFFITHS: No, we have morphine syringes in the refrigerator.

MYERS: Yes. Is morphine a drug that is kept in the refrigerator for use whenever it's required?

GRIFFITHS: Yes, made up in syringes.

MYERS: Made up in syringes, ready in that way. It may be difficult casting your mind back to exactly --

GRIFFITHS: We don't have that luxury anymore.

MYERS: No, but I'm going to help you and the rest of us with where the fridge is in which the morphine syringes were kept. If we go behind divider 4, just before this one, if we look at the plan of the neonatal unit we can see where the nurses' station is and it's pretty much in the centre of the green area on the plan. Can you see that?

GRIFFITHS: Yes.

MYERS: Then if we drop directly down, 6 o'clock down from there, we can see, going past the words "nursing station", we come to an area called "sterile store"?

GRIFFITHS: Correct.

MYERS: There's a grey box marked "med cabinet"?

GRIFFITHS: Yes.

MYERS: Is that where the fridge was where the morphine syringes were kept?

GRIFFITHS: Yes.

MYERS: You told us about administering medication. I just want to ask you a little bit more about that, please, Mrs Griffiths. Unless what's been given is a vitamin, it has to be two band 5 nurses at least who deal with giving medication, doesn't it?

GRIFFITHS: Correct.

MYERS: The reason it's two is, first of all, to check that it's the right dose; is that right?

GRIFFITHS: Yes.

MYERS: There are a number of items to be checked. The right dose is one of them. You have to be sure it's the right patient?

GRIFFITHS: Yes.

MYERS: The right route, for instance IV?

GRIFFITHS: Yes.

MYERS: And of course the right drug?

GRIFFITHS: Yes.

MYERS: And it's all recorded?

GRIFFITHS: Yes.

MYERS: It's recorded on an electronic format on the computer system, isn't it?

GRIFFITHS: Yes.

MYERS: You've talked about the terminal in nursery 1, for instance, that the nurses would use to enter in details of prescriptions. Is what happens that the nurse will enter in those details as they're dealing with the prescription, as they're giving it?

GRIFFITHS: We have to have up on the screen the actual prescriptions so the nurses do know what to actually administer.

MYERS: Yes. They'll put in the details of the patient and their own details, won't they, into the prescription on the screen?

GRIFFITHS: The medical team would do that, yes.

MYERS: The nurses will open it up and put in the entry for when the medication is given; is that correct?

GRIFFITHS: Yes.

MYERS: Just as an example, I'm going to ask if we could put up tile 120. It's also at page 2 behind 6A for those who have their white bundles.

(Pause)

This is just so we can familiarise ourselves with what these look like, Mrs Griffiths. This is the computer record for a prescription; is that correct?

GRIFFITHS: Correct.

MYERS: For medication?

GRIFFITHS: Mm-hm.

MYERS: I'm not looking at everything on here, but we can see, where it says "patient", it relates to "Baby Girl [surname of Baby K]"; yes?

GRIFFITHS: Yes.

MYERS: If we want to see what the medication is, if we drop down a few lines below the grey bar we can see this is benzympenicillin, sodium. And then injection?

GRIFFITHS: Yes.

MYERS: Again to be clear, I'm picking this as an example, not to make any particular points about the care of [Baby K], it's just so we can familiarise ourselves with how this record is constructed. It has the dose beneath that, doesn't it?

GRIFFITHS: Yes.

MYERS: Is it the doctor who will have set out what the dose is going to be?

GRIFFITHS: Correct.

MYERS: So we can see dose, we can see route, and frequency.

Then it actually has "Start", and this says 17 February 2016, 03.45.

GRIFFITHS: Yes.

MYERS: Does that suggest that's when the prescription was made out by the doctor?

GRIFFITHS: Correct.

MYERS: That doesn't necessarily mean that's when it was given, but that's when the prescription was made out?

GRIFFITHS: Yes.

MYERS: As you said, the importance of going through it this way is to make sure when the nurses come to deliver the medication it's exactly what it should be?

GRIFFITHS: Correct.

MYERS: I'm just going to ask to scroll down to a section called "administration history detail". Here we are, thank you. On this entry we can see 17 February, it says 08.00, and then it says 17 Feb, 04.40. Do you see that?

GRIFFITHS: Yes.

MYERS: I'm just going to point out some further details, then I'll ask you the questions. It says:

"Given: yes. Dose: 17.3."

GRIFFITHS: Correct.

MYERS: That refers to the dose as prescribed by the doctor that we saw at the top of the form, doesn't it?

GRIFFITHS: Yes.

MYERS: Where it says 17/02, 17 February, 04.40, that's actually the time at which it was administered, isn't it?

GRIFFITHS: Yes.

MYERS: Then we can see who's been involved in administering it.

First of all, we have a user. Can you see that moving from left to right, "user"?

GRIFFITHS: Yes.

MYERS: It's got N.LETL; that's Nurse Letby's detail, isn't it?

GRIFFITHS: Yes.

MYERS: Because there have to be two nurses for medication, we see, beneath what we've just been looking at, "co-signer". Can you see that?

GRIFFITHS: Correct yes.

MYERS: That is N.OAKC, which is Nurse Caroline Oakley?

GRIFFITHS: Yes.

MYERS: These details are put into the form ongoing as the medication is given, aren't they?

GRIFFITHS: Yes.

MYERS: By the nurses, that is. So drawing that together we can see this benzylpenicillin was given at 04.40 by Nurses Letby and Oakley?

GRIFFITHS: Yes.

MYERS: Whenever medication is given, it will be given in accordance with a computerised prescription like that, won't it?

GRIFFITHS: Yes. If it's a brand new delivery and we needed to get the medication in and the baby is not on the system sometimes we would prescribe it on a paper chart.

MYERS: But if it's something when you're recording it in accordance with the prescription then it will be like that?

GRIFFITHS: Yes.

MYERS: One final matter, please, and I can conclude. It's something completely different. It's about how you report incidents on the unit. So a different topic briefly.

Is there a formal system that's available to nurses and doctors to report any oversight or error in the clinical environment?

GRIFFITHS: Yes.

MYERS: What's that system called?

GRIFFITHS: It's a Datix system on a computer.

MYERS: Yes. That enables doctors or nurses to record any matter of concern that occurs during the course of their duties, doesn't it?

GRIFFITHS: Yes.

MYERS: It could be anything from simply not having enough syringes to conduct they think is inappropriate or raises a safety hazard?

GRIFFITHS: Correct.

MYERS: The process is done online, isn't it?

GRIFFITHS: Yes.

MYERS: I'm just going to ask Mr Murphy to put up D2, which is an almost blank Datix form so we can see this. Do you recognise this form from your duties on the unit?

GRIFFITHS: Yes.

MYERS: It follows a standard format, doesn't it?

GRIFFITHS: Yes.

MYERS: So someone who's identified an issue of concern or that needs to be noted can go into the system and make an entry like this?

GRIFFITHS: Correct.

MYERS: I'm not going to look at every detail, it's here now as D2. The first thing is we can see a section for name and reference. Is that name and reference of the person making the record or the complaint?

GRIFFITHS: "Current approval status."

MYERS: Do you see:

"Name. ID. Reference. Reported date"?

GRIFFITHS: Yes.

MR JUSTICE GOSS: Have you ever completed one of these?

GRIFFITHS: Yes, I have, but I'm just wondering what the question is. Are you asking --

MR MYERS: Who fills in the first part under name and reference? That's my fault.

GRIFFITHS: The person completing the form.

MYERS: So the person raising the issue?

GRIFFITHS: Yes.

MYERS: So they would fill in that. The next section down, location, there are some details here from a redacted form, but the location is the place where the matter that's being raised took place, isn't it?

GRIFFITHS: Correct.

MYERS: Then coding. If we look at what's in there where it says:

"Clinical incident, neonatal unit. Equipment problem: malfunction or unavailable."

In that section there are a number of possibilities for the type of complaint that's being made, aren't there?

GRIFFITHS: Correct.

MYERS: This relates to a partially completed form I should say, Mrs Griffiths. The form can be used to report anything, can't it?

GRIFFITHS: Yes. There's a different pick list and you select.

MYERS: This is one of them?

GRIFFITHS: Yes.

MYERS: If we scroll down to the next section, risk grading, the person raising the issue can put down their assessment of risk; is that right?

GRIFFITHS: Correct.

MYERS: Including harm and the potential for harm?

GRIFFITHS: Yes.

MYERS: And then at the bottom of that page we've got the details for the incident date, time and description?

GRIFFITHS: Yes.

MR MYERS: My Lord, I'll be about 1 minute. Can I conclude?

MR JUSTICE GOSS: We're way over time now; it is just that I said we wouldn't go beyond 4.30.

MR MYERS: I am aware, I should say --

MR JUSTICE GOSS: I know we've got to go today

(overspeaking) --

MR MYERS: (Overspeaking) because we have got witnesses for tomorrow.

MR JUSTICE GOSS: I don't know how long any re-examination is going to take.

MR DRIVER: Less than 5 minutes.

MR JUSTICE GOSS: All right.

MR MYERS: There we are. I'll be about 1 minute.

MR JUSTICE GOSS: We'll press on. It'll be quarter to five.

MR MYERS: The form runs to eight pages, we are not going to go through all of those, but once a complaint has been put into the system with this, it's then reviewed at various levels, isn't it.

GRIFFITHS: It is.

MYERS: And on the same complaint those people engaged in the review can put in further details or findings that have been made, can't they?

GRIFFITHS: Correct.

MYERS: Because it's not just to make complaints about things, it is to learn or correct processes, isn't it?

GRIFFITHS: Correct.

MYERS: As well as to investigate matters of concern?

GRIFFITHS: Yes.

MR MYERS: With apologies to your Lordship and the jury for running over, my Lord, those are the questions that I have to ask.

MR JUSTICE GOSS: There is a good reason.

MR MYERS: It's tomorrow's witnesses.

Re-examination by MR DRIVER

MR DRIVER: Thank you. Three short points.

The Datix form that is on the screen now, does it include an option for serious crime?

GRIFFITHS: No.

DRIVER: Secondly, you were asked about the appropriateness or otherwise of a nurse remaining passive and awaiting to see whether a baby who was desaturating self-rectified.

Is that an approach of blanket application or would it depend on the clinical circumstances and the particular traits of the baby?

GRIFFITHS: Yes, it depends. If you know the baby and that's what they often do and they pick up then that's different, but a brand new baby, you would need to be aware of any desats or bradys.

DRIVER: And what significance, if any, would you attach to the baby's gestational age?

GRIFFITHS: Yes, you would really be wanting to watch that carefully and you would intervene.

DRIVER: A baby with a gestational age of 25 weeks and a few days, where would that sit on the spectrum of caution?

GRIFFITHS: Very high.

DRIVER: Thank you.

A separate topic, the handover process. How is the information relating to the baby -- how is it exchanged, is it written or is it --

GRIFFITHS: We do have a written form so that all the babies are on there and then the nurses would make notes pertinent to the baby that they were allocated.

DRIVER: Would there also be a dialogue between --

GRIFFITHS: Yes, at the bedside.

DRIVER: (Overspeaking) handing over at the bedside? Would it follow then that at the time of handover, you would expect the nurse who's about to knock off shift to be at or around the bedside of the baby she (overspeaking) looking after?

GRIFFITHS: Definitely, yes.

MR DRIVER: Does your Lordship have any questions for the witness?

MR JUSTICE GOSS: I don't. Thank you very much.

Thank you very much. That completes your evidence.

Would you just remain there for the time being, please?

I'm sorry we've overrun today and I hope it doesn't cause any undue inconvenience to anyone or any arrangements you have, members of the jury. I'm sorry that I said we would always finish by 4.30, but there is a very good reason: the witness is

simply not available after today so that's why we have to finish her today.

All right? Thank you very much.

Please remember your responsibilities as jurors, which will be ingrained into your minds, I sincerely hope: no communication with anyone by any means about anyone or anything to do with this case and no research about anyone or anything to do with this case.

10.30 tomorrow morning, please. Thank you very much.

(In the absence of the jury)

MR JUSTICE GOSS: Do you want to go down?

MR MYERS: We would be grateful we could, my Lord, please.

MR JUSTICE GOSS: A legal visit if possible, please.

MR MYERS: Thank you.

(4.42 pm)

(The court adjourned until 10.30 am on Tuesday, 18 June 2024)