

2 July 2024

Summing-Up (continued), Jury Deliberations & Verdict

Tuesday, 2 July 2024

(10.30 am)

(In the presence of the jury)

SUMMING-UP (continued)

MR JUSTICE GOSS: Good morning, members of the jury. I need to correct something that I said to you yesterday afternoon about an event description on the sequence of events relating to entering or leaving the neonatal unit, do you remember swipe cards and the like?

The situation is in fact set out in agreed fact 41, in section 3. It's on page -- well, I numbered the pages. It's page 13. I'll just read it through so that it's clear what it is:

"In February 2016 staff were required to swipe an electronic pass to enter the neonatal unit from a labour ward. However, the data collection from any such event was erroneously recorded as 'maternity neonatal to labour ward (in)' when it should have read 'labour ward to maternity neonatal (in)'. Exit from the neonatal unit into the labour ward did not require the use of an electronic pass and did not generate any records."

In other words, it was the doors or the door from the maternity ward into the neonatal unit. So if there is someone, a nurse or someone, clinician, coming from there, that's where the swipe data was the wrong way round; all right.

So I apologise if that caused any confusion to any of you who had spotted that what I was saying did not accord with what was in the agreed fact.

All right. Well, I'll return to my narration of the events.

[Mother of Baby K], who was now of course in labour, continued to be cared for at the Countess of Chester Hospital over the night of the 15th to the 16th. The defendant was working that night and was aware of the prospect of the birth.

On the morning of the 16th, your reference is tile 16 -- I'm not going to ask you to look at these tiles; I'm just reminding you of the relevant tiles -- [Nurse E], another nurse at the unit, messaged the unit at 09.02, enquiry:

"Did the 24-weeker come?"

To which the defendant responded, at 17.26, tile 18:

"No, it didn't come but 6 centimetres, so wouldn't transfer out. Imagine it'll have delivered today."

At 18.34, tile 31, so an hour before she came on duty, in response to an email from another nurse, Jennifer Jones-Key, who at tile 30 referred to a "mad day", the defendant asked:

"24-weeker come?"

To which the response from Jennifer Jones-Key, tile 33, was:

"No."

In fact, of course, as you know, [Baby K] was to be born during the following nightshift when the defendant was, again, on duty. The details of the staff on duty and the babies in the unit at the start of that nightshift are depicted in tile 36. You're familiar with it. You can refer to it, if you so wish.

The defendant was the designated nurse for two babies in nursery 2, AR and GT. Joanne Williams, a band 6 nurse, was the designated nurse for the other baby in that nursery and became [Baby K]'s designated nurse after she was born.

Dr James Smith, then a registrar and on duty on that night, now a consultant, said that as soon as he was notified that delivery was imminent, he asked for Dr Jayaram, the consultant on-call, to be called in.

Tile 49 is the relevant tile fronting the clinical notes written in retrospect by Dr Jayaram.

You will recall Dr Smith, who gave evidence before Dr Jayaram, talking you through those notes. He remembered [Baby K], as she was later to be named, but was simply recorded as "Baby [K]" on the notes at the hospital. She was born at 02.12 hours and weighed 692 grams. Dr Smith, Dr Jayaram, Nurse Joanne Williams and the defendant were amongst those present at the birth. There will be two teams, the gynaecological and obstetrics team and the neonatal team.

[Baby K]'s condition at birth was not unexpected for a baby of her gestation. She was given antibiotics to protect against infection and inflation breaths using a small mask to start her breathing. You will remember both Dr Gibbs and Dr Jayaram demonstrating the delivery of short puffs of air through a mask.

[Baby K] was breathing for herself at four minutes, as recorded in the notes of Dr Jayaram. Her heart rate was above 100 at two

minutes and 30 seconds of life and her oxygen saturation level was over 85% at six minutes, and that was said to be good, especially at her gestation.

Her Apgar scores, as recorded in the notes, were a good set. Dr Smith said being floppy at birth was nothing unexpected and being dusky was not unusual. Her sats -- that's oxygen saturation levels -- were above 90% and she was stable before she was intubated with an endotracheal tube.

About 20 minutes after birth Dr Smith succeeded in inserting a 2-millimetre tube at the third attempt at intubation, having been unable to insert a 2.5-millimetre tube. For a baby of [Baby K]'s size, the tube range was 2.5 to 2. If the larger one cannot be passed, the smaller tube is used, said the doctors.

Dr Babarao said it was reasonable and safe to use a 2-millimetre ETT if a 2.5-millimetre one will not pass.

The nursing notes, behind tile 66, written by Joanne Williams, who, as I've already said, became solely responsible for [Baby K], recorded the time of intubation as being about 12 minutes after birth. She described it as a team effort. The tube was secured at the lips and tied to a hat.

Dr Smith said that everything that happened was standard and there was nothing unusual. His memory was that there were no concerns. If he had seen any evidence of trauma, any bleeding or difficulty intubating, he would have handed over to the consultant, Dr Jayaram, who was there. There was no indication in the notes to do with any blood secretions or any indication of trauma, from what he could remember. Had there been, he would have handed over to the consultant.

The general clinical picture, he said, was positive.

In his address Mr Myers was very critical of Dr Smith and the picture he painted of [Baby K]'s condition and the intubation, submitting that the doctors were minimising how poor [Baby K]'s condition was and, in effect, covering their own failings, including not passing a larger tube.

[Baby K] was admitted on a Resuscitaire into the neonatal unit at 02.40, tile 53. Her parents were spoken to, tile 54, and her recorded readings in the clinical notes, behind tile 55, were described as "good". That entry also set out the ventilator settings.

In the intensive care nursery, nursery 1, she was placed into an incubator in the position identified on the plan, to the right of the room as you walk in.

Again, said Joanne Williams, it was a team effort transferring into the incubator. You've seen the videos that were played to you of an incubator, the equipment and the alarms attached to them and which you can view again, if you so wish, when you are deliberating.

The alarms are configured, you'll recall from the video, for a neonatal profile. The settings can be adjusted by a nurse, but they should only be set within a clinically set range. There are two alarms: a monitoring alarm, which flashes yellow, and an emergency alarm, which flashes red. They have different sounds. An alarm can be paused for one minute and no longer. It can then be paused again. When the alarms are paused, a lamp on the machine will show a red light.

Now, that is but the briefest of summaries and you can, if you wish to be reminded of the details, watch the video again.

Dr Smith said that the blood gas readings at 03.03, which are behind tile 63, with a paper copy in section 6F of your jury bundle, were good. Taken collectively, they showed a good resuscitation and indicated the tube was acting perfectly normally and the baby was stable. She was given surfactant for her lungs because at her prematurity [Baby K] was not making enough.

It was prescribed at 03.00, tile 52, though Joanne Williams said prescriptions can be written retrospectively.

Mr Myers, referring to the evidence of Dr Babarao, said this was between 13 to 30 minutes late because it should be given in the first hour after birth; that's the surfactant. Dr Babarao said at that time, 2016, ideally surfactant should be given in the first hour of life after the tube is in, but then told you that current practice is different, because we are eight years later, and there is no necessity or urgency, he said, to intubate a baby.

An infusion of dextrose was set up at 03.00, a sample of blood for testing for sepsis was taken at 03.31, tile 88, and had no bacterial growth after five days. [Baby K] did not have any infection.

The most common problems and the highest risk for a premature baby is breathing difficulties, said Dr Gibbs. The more premature a baby, the higher the risk that the lungs are immature and particularly very stiff when they're small lungs. Dr Gibbs said that babies frequently display apneic episodes, that is cessation of breathing, but that you would be worried about an apnoea in a ventilated baby. A ventilated baby

shouldn't have a prolonged period of 20 seconds where they don't breathe because the ventilator is breathing regularly for them. If a baby is on ventilation and the oxygen level drops, as a desaturation in other words, you increase the oxygen level which should be at around 90%. The sats should be at around 90% plus. A level of 20% or less is a collapse.

Behind tile 58 is the observation chart for [Baby K].

The first entry's at 02.45 which were not signed, said Joanne Williams, in her handwriting. Those entries were not initialled. We've looked at that several times and you have the paper copy in your bundle, section 6, section D.

The defendant said she made those entries in the columns at the lower part of that chart and her not signing or initialing them was just an oversight on her part. She was involved with [Baby K] at that time, though of course she had no recollection of [Baby K] or any events with [Baby K] during the course of that night.

The remaining entries on the hour, up to and including 6.30, on that chart were initialled by Joanne Williams who confirmed those entries were all in her handwriting.

At 03.15 there were calls to and from the transport service because, of course, [Baby K] was to be transferred to a level 3 unit. Tiles 75 and 76 are the relevant tiles. At 03.15 and 03.30 the defendant was involved in giving medication to and taking observations on Baby GT, who was in nursery 2. That's tiles 82 and 83. She also witnessed the removal of 50 millilitres of morphine for [Baby K] on the drugs register with Joanne Williams at that time, tile 84.

Joanne Williams said they were getting a pre-made syringe of morphine from the stock in the locked fridge in the room opposite the nurses' station, the sterile store in the enlarged plan in section 4 of your jury bundle.

The observations on [Baby K] at 03.30, tile 85, behind which is the chart of which you have a paper copy in section 6D to which I have just referred, were noted by Joanne Williams. She said she would have checked the ET tube was properly in place when taking those observations at around 3.30.

Behind tile 86 is the fluid balance chart relating to the commencement of morphine at 03.30. The intensive care chart is behind tile 87. You have a paper copy in section 6F of your bundle and it contained a record of Nurse Williams' observations. She noted that there was a 94% leak on the ventilator. She would, she said, escalate that by drawing it to

the attention of medical staff, Dr Smith or Dr Jayaram. The clinical picture, however, was that [Baby K] was saturating well and clinically looked well, but there was a leak.

Dr Babarao said that a leak of 94 is very high and one would want to check and find out why. He agreed it was theoretically possible that the baby was working for herself, but, he said, it was a snapshot in time and one needed to look at the whole clinical picture.

He also said that a size 2-millimetre tube would not have caused a leak. There had to be something else. He also said that surfactant is currently given through even thinner catheters than 2 millimetres.

Joanne Williams confirmed that she was doing a lot of things at 3.30. A lot of the entries are recorded as being at 3.30 and you heard evidence that this was the approximate time within a margin of recorded times. She confirmed they were not all precise times. She then went, after completing those documents, to update [Baby K]'s parents. She said that [Baby K] would have been stable and oxygenating at that time, otherwise she would not have left the unit. She would, she said, not be gone for long.

Dr Jayaram said that, in relation to the leak, her respiratory status was stable. They were not having difficulties with ventilation or her needing more and more oxygen or an increase in pressures so they would not re-intubate, unless they needed to re-intubate, because that was a procedure that was not without risk.

The leak itself in isolation was not clinically significant in terms of [Baby K]'s ventilation.

At 03.31 and 03.35 there were communications with the transport team relating to preparations for [Baby K] being transferred to Arrowe Park Hospital. That's times 89 and 90.

Dr Jayaram was called back by the transport team at 03.41, time 95, during which he was told the plan for [Baby K]'s transport and it was noted that he was "agreeable totally with it". That was the note made by the transport team in relation to that conversation.

Dr Jayaram said that he was sitting at the desk where it says "Nurses' Station" on the plan, with his back to the wall of nursery 1. Joanne Williams had told him she was going to update [Baby K]'s parents. He thought he had probably just spoken to the transport team. Joanne Williams told him that Lucy Letby was babysitting, that is supervising, when the named nurse was

called away. That was the phase they would use for it so that someone was supervising the baby. Dr Jayaram set he felt uncomfortable because of the previous unusual incidents with babies and the association with Lucy Letby being present. He needed just to go into the nursery to reassure himself that everything was okay and to prove to himself that he was being ridiculous.

So, about two and a half to three minutes later, he stood up and walked in through the entrance closest to the nurses' station, went round the small wall in the nursery and walked towards the incubator. He saw on the screens that [Baby K]'s oxygen saturations were dropping.

They were in the low 80s and going downwards. The defendant was standing next to the incubator at point B on the plan, to which you were referred, facing in his direction. She didn't have her hands in the incubator.

As he approached, he said words to the effect, "What's happening?" and she looked up and said, "Oh, it looks like she's desaturating" or words to that effect.

The alarms, which are set to sound usually if the sats fall below 90% and alarm immediately, were not sounding. He didn't look to see whether the button that caused the alarms to be suspended was pressed, but saturations were going down and continued to go down.

He accepted, when he was questioned, that in an interview by the police on 4 April 2018, he said three times that he could not remember whether the alarms were sounding. He told you that what he could say was that it was not an alarm sounding that prompted him to go into the room.

I draw your attention to my legal direction in relation to how you should approach an inconsistency in what a witness says about an event at different times.

Dr Jayaram said he looked at [Baby K]. Whereas previously her chest had been moving up and down, her chest was not moving well. The ventilator was still working but her chest wasn't moving as it should have done and he disconnected [Baby K] from the ventilator and tried to hand ventilate her through a T-piece, but she didn't pick up and there was no colour change on the colorimeter.

Dr Smith remembered the event. He was out of the room at the time. He entered the room at this point and saw Dr Jayaram on the right-hand side of the incubator trying to bag [Baby K] by the ETT; in other words, give puffs of air. He was not

successful. Dr Jayaram removed the ET tube as it was not doing its job. He then ventilated [Baby K] through a small mask. She picked up extremely quickly. Within a few breaths, her colour improved, her saturations improved and he could see that her chest was moving normally. He said that there had been a significant ventilation problem for longer than 30 seconds, probably 30 to 60 seconds, given her saturations were down in the 80s, no longer than two minutes, and it takes 30 seconds to start to desaturate. So those were the time brackets and time limits.

There wasn't, he said, a massive plug of mucus in the tube. In 2021 he said to the police, when interviewed, that he hadn't checked the tube. Another inconsistency to which Mr Myers referred.

It is possible, said Dr Jayaram, for a baby of this age and condition to move their own tubes, but he has never seen it in babies of this gestation. She was not a very active 25-weeks gestation baby. It was possible but improbable that [Baby K] dislodged the tube herself because of the condition she was born in and the tube was secured as securely as they can. The tubes are secured in a fairly robust way with both a clip that holds it in place with a rubber flange and tape around them and tied in as well. The tube was a good way down the trachea so it would take quite a lot of movement from a baby to dislodge a tube. The diameter of a tube would have no bearing on how easily it could be dislodged. He, Dr Jayaram, didn't believe the leak itself was significant at all with regard to this deterioration.

He thought it was while he was bagging [Baby K] and her saturations had picked up that Joanne Williams returned to the nursery but he couldn't say for sure.

In his notes, written in retrospect at 4.50, behind tile 100, Dr Jayaram noted that the oxygen saturations dropped to less than 40. They weren't as low as that when he walked in, but they dropped quite rapidly. This was a life-threatening level, if not dealt with quickly, because the heart rate will slow down, then circulation of blood through the lungs slows down, so you get into a vicious cycle of deterioration.

There was consensus between Dr Jayaram and Dr Smith that the tube had been dislodged.

Dr Jayaram said he was extremely uncomfortable with what he had seen. He didn't want to think the unthinkable, which was the expression that he used.

He was cross-examined at length about why he didn't take further action as a result of what he says he had seen, informing

hospital managers and going to the police. Mr Myers submits that his evidence is not worthy of belief because he didn't do those things.

Dr Jayaram accepted that, in retrospect, he should have acted on what he had seen. What he did do was to discuss the incident with his colleague, Dr Brearey, and add it to the list of concerns. They had already not been believed by managers when they had raised concerns in relation to earlier events. He wanted to follow the process and didn't want to engage in conversation with the defendant about the event.

Joanne Williams said that when she came back into the unit the alarms were going off in nursery 1.

Dr Jayaram and Lucy Letby, the defendant, were in the room. She didn't remember what was being done. The door swipe data shows that she re-entered the unit at 03.47, tile 98. That is an entry to which agreed fact 41 applies. In her nursing note, behind tile 101, written between 04.48 and 05.07, she noted:

"Tube removed and re-intubated on second attempt by Registrar Smith with 2.5 ETT measuring 6.5 centimetres at the lips. Air entry clear and equal. Large amount of blood-stained oral secretions."

She said, because she has written that, she must have seen it. She said she didn't feel qualified to answer whether a baby of 25-weeks' gestation could dislodge a tube because at that time she did not have much experience of 25-weeks' gestation babies.

[Baby K] was prescribed and given morphine at 03.50, tiles 102 and 103. The defendant was involved in that.

At 04.00 the defendant was taking and noting observations on her designated baby, AR. That's tiles 105 and 106. Thereafter, she was involved as a co-signer with Caroline Oakley, the shift leader, for medications for [Baby K]. Lines were inserted, including an umbilical venous catheter, UVC, medication was given and observations of [Baby K] were undertaken.

An X-ray of [Baby K] was taken by Anne Kember, a radiologist, tile 149. The sequence of events at the time attributed to it was at 06.07. A portable radiographic machine was used on which the clock was said by Anne Kember in her agreed evidence to be inaccurate. The door swipe data showed her entering the unit at 06.09, tile 151. So the image must have been taken at some time after that. The ET tube was in a satisfactory position but required advancement and there was shadowing in the left lung.

At 06.10, tile 152, the defendant was completing the admission record for [Baby K]. Shortly thereafter, at 06.15, there was another desaturation, tiles 153 and 154. Dr Jayaram made notes about this event at 07.50.

They are behind tile 154. Her sats dropped quite suddenly. He remembered there was a second desaturation. The X-ray showed the ET tube was well into the trachea and hadn't gone into one lung so there was air able to go into both lungs. You have the notes behind tile 154. The UVC was properly sited. He tried pulling the tube back but that made no difference.

[Baby K] was extubated and re-intubated by Dr Smith with another 2.5 ET tube.

Dr Jayaram thought at the time that the desaturation was clinically explainable because there was some haziness on one lung field and gas evidence of respiratory acidosis, meaning that the acid levels had gone higher, suggesting that she was not being ventilated as well as she could be, and when she was re-intubated she became stable. There is no evidence of the tube having been moved.

There was a further desaturation at the end of the shift, tile 175. Dr Jayaram's notes, behind tile 176, are the notes made by Melanie Taylor, who was coming on shift, the dayshift, and was to become shift leader.

Dr Jayaram told you he was reliant on his notes for the detail of what happened. There was a sudden drop in blood pressure, then in saturation levels and her heart rate dropped to below 100, which was low for a neonate of that age. They started hand-ventilation and heart compressions. It was found that the ET tube had migrated from 6.5 centimetres at the lips to 8 centimetres; in other words, it had gone further in, and had to be withdrawn. Then, when that was done, the heart rate picked up.

[Nurse B] came on duty as the nursing shift leader that morning. She recalled getting to the unit at about 07.25. She heard the defendant shout for help from nursery 1. She followed Joanne Williams and Dr Jayaram into the room. She saw the defendant had her hands in the incubator and appeared to be Neopuffing [Baby K] via an ET tube. She, [Nurse B], stayed in the doorway. The tube, she said, had gone in further than it should have. The event ended and [Baby K] was placed back on the ventilator.

That the defendant was in nursery 1 at that time is not challenged, but of course her evidence is she has no recollection of any events during the course of that shift.

[Nurse B] and Melanie Taylor, as you can see from the sequence of events, were then involved in the medication for and treatment of [Baby K] intermittently, pending [Baby K]'s transfer to Arrowe Park.

Your attention was drawn by Mr Myers to tile 211, the intensive care chart, and the handwritten unsigned entries during this period on the left side of the page written by Melanie Taylor. That's where you have to turn the page round. You have a copy of it in section 6E of your bundle. The defence say that it's not unusual for entries not to be signed. There are a few entries with some alterations written by Melanie Taylor at that time. You can see the nature of those discrete entries whilst [Baby K] was being stabilised and prepared for transfer and after handover to the transport team, and Melanie Taylor didn't give evidence before you and wasn't asked about anything obviously therefore in relation to that.

Now, these two events, the second and third events, are not the subject of any charge, as you well know.

The prosecution say that they were evidence of further occasions when the defendant interfered inappropriately with [Baby K]'s ET tube, causing deterioration, and which required actions to stabilise her and are part of the whole picture of the events of that shift after [Baby K] was born.

Dr Kamalanathan, the consultant paediatrician on the transport team, received the handover of [Baby K] from Dr Jayaram at 09.00. The UVC was lying low but acceptable for the purpose of transfer to Arrowe Park.

An arterial line was established, medication was administered and she was transferred to Arrowe Park, arriving at 13.15. It was an uneventful transfer.

Dr Babarao confirmed that [Baby K] was a very sick child and that even if she had been born in a level 3 unit, she could still have been unwell.

Sadly, [Baby K] died at 05.28 on the morning of 20 February after treatment was withdrawn. No post mortem examination was conducted and the cause of death was certified as extreme prematurity and severe respiratory distress syndrome, tiles 298 to 300 in your sequence of events.

A neonatal mortality review carried out by a panel, of which Dr Babarao was a member, at Arrowe Park, concluded that death could potentially have been avoidable had [Baby K] been born in a level 3 unit, reference being made to "suboptimal care". However, Dr Babarao explained that the review did not have the

notes from the Countess of Chester and he now had more information about why [Baby K] was delivered at that hospital, including the fact that the level 3 hospital to which she would have had to be taken, which was going to be Preston and not more local to Chester, and they were only aware of one accidental extubation when the transport team were there and did not have the complete clinical picture. In any event, [Baby K] was, as you well know, delivered at the Countess of Chester.

The issue in this case is whether, at around 03.45, the defendant attempted to murder her.

When interviewed in 2018 the defendant said that they were aware in the unit that [Baby K] had died after she did die on 20 February and she confirmed in her evidence that they learnt that a few days after she had been transferred to Arrowe Park, so obviously at around the time that [Baby K] sadly died.

At 23.56 on 20 April 2018, two years after [Baby K] died, the defendant conducted a Facebook search for "[Surname of Baby K]", tile 302 on the sequence of events.

She told you she had no recollection of doing this or why she did it. She said she often searched for people on Facebook and you have on the last pages of the sequence of events the details of searches of the parents of other babies in respect of whom she has been convicted of murdering or attempting to murder them.

The defendant was 26 years old at the time of the events. She is now 34. She denies she did anything to [Baby K] intending to harm her and did not attempt to kill her and does not accept that she ever intended to hurt or harm any baby in her care. She recalled seeing [Baby K] in nursery 1 but did not recall any incident around 03.45 in nursery 1 or any incident when Dr Jayaram was standing there. She does not accept the incident described by him happened. She has no recollection of being asked by Joanne Williams to look after [Baby K] or of any times when the records shows she was involved with [Baby K]. It would be common, she said, to help other nurses. There was fluidity in the movement of nurses and because of the need to co-sign for certain medications and to assist with taking observations and the like.

She was arrested three times and interviewed under caution about these events as set out in section 4 of the agreed facts, which are numbered 19 to 22 in your bundle. The first time was in July 2018, a few months after the Facebook search for "[Surname of Baby K]". She was provided with a bundle of medical records before the interviews and said that she was reliant on those

records as she had no recollection of any of the events of that shift.

The record of what she said in the 5 July 2018 interview is in section 7 of your bundle. The record of interview or interviews on 12 June 2019 are in section 8 and the record of the interviews on 10 November 2020 are in section 9. You have seen and you will have access to see those interviews again, if you so wish.

She was cross-examined about her answers. In the first interview she was asked, on page 4 in section 7, about what caused concern for [Baby K] at the 3.50 event and she said:

"I believe her ET tube had slipped."

She knew that, she said, from reading the notes Melanie Taylor had made. Those notes related to the event at the end of the shift, the third event. Both counsel have addressed you in relation to that and what she said in interviews and I'm not going to repeat their respective submissions.

In the second interview she agreed that if there had been any issues with [Baby K]'s ET tube, Joanne Williams would have remained with her.

In relation to the last event, she agreed that at the time of the last event [Baby K] was paralysed. She told you she did not agree that [Baby K] was paralysed at the time of the first event, although she wasn't sedated. She said that if she had noticed [Baby K]'s observations were declining or if she had seen the tube had slipped, she would have summoned help. She was not agreeing that any such event had occurred; she was trying to be helpful and fill in the gaps. She didn't recall any such event. She didn't know why the monitor would be silenced and, again, her answer to the question on page 8, "Do you remember why you wouldn't react to the drop in oxygen levels?" of, "Possibly wanting to see if she self-regulated. We don't normally intervene straightaway if they weren't dangerously low". She said that, again, she was trying to be helpful answering in that way. She remained steadfast that she had no recollection of any such event.

In the final interview, in 2020, relating to the last incident about which [Nurse B] gave evidence, she said she did not recall that evidence and she had no idea what caused the tube to be dislodged; maybe it wasn't secured appropriately.

She was asked about the messaging between her and [Nurse E] at 21.14 on 17 February and on 18 February, pages 3 and 9 in section 9, and said she vaguely remembered the message she sent. It's

behind tile 295, referring to a very unstable BP on quad inotrope because [Baby K] was so tiny and should have been one-to-one, possibly two-to-one, nursing care and obviously she wasn't.

Elizabeth Morgan, who is a nursing advisory consultant and whose evidence was read to you as agreed, said, having read the medical and nursing notes for [Baby K] and the related interview transcript and a number of external sources of literature, that in her professional experience it is possible for an endotracheal tube to become dislodged in an unsedated or active baby or where securing ties have become loose.

Where a baby is sedated or is paralysed, this is less likely to occur accidentally. In her experience, she said it's very unlikely that a nurse would leave the bedside of an intubated neonate, unless they were very confident that the endotracheal tube was correctly positioned and secured, the baby was inactive and they would be away only briefly. She would expect the nurse to inform a colleague who would remain in the vicinity they were leaving to alert them the baby was unattended at that time and to ensure that they would attend the baby if an alarm should sound.

Given the gestational age of the baby, in her professional experience, when observing a falling oxygen saturation level in a baby of this age and gestation, it will be standard good nursing practice to immediately attend the bedside to actively observe the baby, ascertain any cause for the change in oxygen levels and to take corrective action, calling for help to alert other staff members of the situation, if necessary.

A series of checks would be carried out immediately to ascertain why the oxygen level had dropped, for example has the tube become blocked or dislodged, has the baby developed a pneumothorax or has there been an equipment failure. She said she did not believe that it would be normal nursing practice to wait and see if the baby self-corrected at this gestational age, given the lungs are so immature and the risks associated with unplanned extubation. The incident should also be reported verbally to the designated nurse on her return and recorded in the nursing records or charts by Lucy Letby.

When cross-examined about this, the defendant said that was Elizabeth Morgan's opinion. She couldn't say whether it was right or wrong. She referred to her experience of working at Liverpool Women's Hospital and on the unit and said the common practice that was done by the nurses was that you would not automatically put your hands in the incubator to start doing something because babies often self-correct and that applied to a 25-week gestation baby on a ventilator as well.

Well, that completes my review of the evidence.

You'll appreciate that it is no more than a review.

It's for you to decide what is and is not relevant and whether there's a conflict in the evidence which you consider it is important to resolve in reaching your verdict in this case, who is truthful and reliable about the evidence that they have given on the topic and the significance to be attached to any piece of evidence in the context of all the evidence, applying the directions of law that I have given you.

You have heard the respective arguments yesterday and I'm not going to repeat them. You will have them well in mind when you are deliberating on your verdict in this case.

How you conduct your deliberations is entirely a matter for you. You should respect each other's opinions and value different viewpoints that are expressed. Everyone should have a chance to speak. You should listen to one another and no one should be or feel pressured. You are under no pressure of time. If at the end of the court day you are still deliberating, you will be brought back into court and, after I've given you a short further direction, I'll send you home and you will then resume your deliberations on the next working day.

Do not, under any circumstances, make your own enquiries about anything to do with the case or talk to or communicate with anyone in any way, even with each other, about the case, except when you are all together in the room in which you are deliberating as a group.

You have known from the outset that those are the golden rules, your responsibilities in relation to this case, or one of the golden rules. You must not conduct any research and you must only talk about this case, I emphasise, when you're all together in the room.

Some of you, I understand, are smokers. There will be smoke breaks to enable those of you who want to smoke. There will be a maximum of two per day and they will be short, just enough time for anyone to smoke.

One of the jury bailiffs will escort those wanting to smoke to an appropriate area. Another bailiff will remain in your retiring room with those who do not wish to smoke. When you are separated, none of you, be you a smoker or someone remaining in your room, should discuss anything about the case because you're not all 12 together hearing what is said about the case. Your request for a smoke break should be written on a note and handed

to the jury bailiff, or one of the jury bailiffs, outside so that it's known there's going to be a break.

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

The foreman will also inform the court when you have reached your verdict and deliver it on your behalf when you are brought back into court for that purpose. You can agree to select a different man or woman to be your foreman at any time before your verdict is delivered.

It's up to you how you organise yourselves, but you will know from attending groups and meetings that you need someone to act as a foreman in order to control the discussions.

Of course take with you your iPads, all the documents, the files, with which you've been provided and any notes that you have made. You will -- I'm just going to check with counsel about the laptop. Is there going to be a laptop or is it --

MR DRIVER: No, it's all on the iPads.

MR JUSTICE GOSS: All the material has been loaded up on to the iPad?

MR DRIVER: I believe so.

MR JUSTICE GOSS: So you'll be able to -- the videos and everything should be on the iPad if you want to look at any of those.

If there is anything upon which you need assistance, either by way of clarification or direction or being reminded of a particular piece of evidence, then write your question or request down on a paper, hand that to the bailiff to give to me. Do not talk to the bailiff about your question or anything about the case.

You have my written legal directions. You should follow them. If anyone is not following the legal instructions or refuses to deliberate or relies on other information, other than the evidence that has been put before you in this case, so is not acting in accordance with their jury oath or affirmation to try the case on the evidence, the court must be told straightaway by sending me a note. You act as a collective group. You are there to ensure that due process is carried out and each member of the jury acts in accordance with their oath or affirmation. Don't

leave it until after the deliberations are over because then it will be too late and the matter will be outside my control.

I'm not anticipating there will be any such event, but I'm just telling you that is what should happen in the highly unlikely event of that happening, that is what should be done, send me a note.

All right. I'm just going to check --

MR DRIVER: My Lord, we've compiled a list of the visually recorded and documentary exhibits loaded additionally on to the iPad.

MR JUSTICE GOSS: That will be helpful so that you do know what's on the iPad. Thank you very much.

Mr Myers, you wanted to say something?

MR MYERS: There is one matter, my Lord. It relates to one issue in cross-examination of the defendant --

MR JUSTICE GOSS: Yes.

MR MYERS: -- which we'd raised earlier, about one of the babies who isn't a baby that Ms Letby is charged with.

MR JUSTICE GOSS: Yes.

MR MYERS: And it's Baby KC.

MR JUSTICE GOSS: Yes.

MR MYERS: I don't want to stray into an area which your Lordship may need to direct the jury on, but of course the jury have heard questions about that and we make the point that is not something that forms part of this case and is something that should be disregarded by them.

MR JUSTICE GOSS: Thank you, Mr Myers. I have deliberately not referred to that particular piece. You will remember the question that was put by Mr Myers in relation to Baby KC when that arose --

MR MYERS: By Mr Johnson.

MR JUSTICE GOSS: Mr Johnson, sorry, about Baby KC. Sorry, that was a complete slip of the tongue, for which I apologise, and, as I said to you, you have it in writing that the proposition that's put in a question by an advocate is not evidence, unless

it's agreed to by the witness. It wasn't agreed to by the witness. It's not evidence in the case.

All right.

MR MYERS: I am grateful, my Lord. Thank you.

MR JUSTICE GOSS: So you should ignore that.

If you focus on the evidence that you have in relation to [Baby K] in this case and this particular charge. Thank you, Mr Myers, for reminding me of that.

MR MYERS: Thank you, my Lord.

MR JUSTICE GOSS: All right. Just wait for a moment. Just gather all your bits and pieces together because you're going to have to carry them out with you. You should have the sheet of paper now.

When the ushers have been sworn to act -- when the two ushers have been sworn to act as your jury bailiffs, would you please leave the courtroom, take with you everything with which you have been provided and commence your deliberations.

As I say, when there are breaks, I've told you what will happen in relation to the breaks.

Just wait there for a moment. Yes.

(Jury bailiffs sworn)

MR JUSTICE GOSS: Well, you have heard that the ushers -- now your bailiffs -- have said they're not going to speak to you; you mustn't speak to them. All right. So each has heard the other receive that direction.

Please gather your things and follow the bailiffs.

(The jury retired to consider their verdict at 11.27 am)

MR JUSTICE GOSS: Mr Murphy, just before you go, the jury have taken their iPads. Are there chargers in the room for them?

MR MURPHY: There are, my Lord, tested this morning.

MR JUSTICE GOSS: Good. So they will be able to keep them charged. Thank you very much indeed.

I'll say that the court will not sit between 1 o'clock and 2.10 in any event.

MR JOHNSON: Thank you.

MR MYERS: Thank you, my Lord.

MR JUSTICE GOSS: All right. Thank you very much.

Mr Myers, will someone --

MR MYERS: Yes, my Lord.

MR JUSTICE GOSS: Would you take the defendant down, please.

MR PILLING: Your Lordship, can I ask you a question about the reporting restrictions?

MR JUSTICE GOSS: Yes.

MR PILLING: It's just for clarification about the order made at the Court of Appeal in April of this year and under section 4(2) of the Contempt of Court Act and just the particular wording of the order, just seeking a bit of clarity on that. The order says:

"The publication of any report of these appeal proceedings [that is Lucy Letby's application for leave to appeal against conviction] is postponed until the conclusion of the retrial or until further order of the Court of Appeal Criminal Division or of the trial judge presiding over the applicant's retrial."

There are three options there.

MR JUSTICE GOSS: Yes, there are, and the status quo is that there is prohibition on the reporting in relation to that and I'm not -- are you applying for me to make an order removing it?

MR PILLING: I think I am, yes.

MR JUSTICE GOSS: Well, look, I shall let you think about it. I mean, we are at a stage, Mr Pilling, that -- anyway, I'll leave it at the moment and wait and see whether you do actually make that application or not.

MR PILLING: So the position could be that you don't, then we have to wait until the Court of Appeal --

MR JUSTICE GOSS: No, you won't.

MR PILLING: We won't.

MR JOHNSON: It may be that if the issue is what's the position once the jury has returned its verdict, then --

MR JUSTICE GOSS: We'll review it. That's it. All right.

Good. If you want to do it now, that was --

MR PILLING: No.

MR JUSTICE GOSS: All right. We're alert to that. Thank you for raising it. I was aware of that, but at the moment the prohibition stands.

MR PILLING: Of course.

MR JUSTICE GOSS: Right. I don't think there's anything else, Mr Myers and Mr Johnson. Thank you very much.

Would you take the defendant down.

(11.31 am)

(Short Break)

(3.10 pm)

MR JUSTICE GOSS: Mr Johnson and Mr Myers, I'm told that the jury has a verdict.

If I could just say to the members of the public who are in court: the verdict is to be taken in silence.

There is to be no disturbance of any kind. If anyone misbehaves, I'm afraid they will be removed from the courtroom. Thank you. I'm not suggesting anyone will, I'm just saying that is the situation.

Yes, would you bring the jury in, please.

(The jury returned into court at 3.12 pm)

THE CLERK OF THE COURT: Will the foreperson please stand.

Mr Foreman, will you please answer my first question "yes" or "no". Members of the jury, have you reached a verdict upon which you are all agreed?

THE FOREMAN OF THE JURY: Yes.

THE CLERK OF THE COURT: Do you find the defendant Lucy Letby guilty or not guilty of attempted murder?

THE FOREMAN OF THE JURY: Guilty.

THE CLERK OF THE COURT: You find her guilty, and that is the verdict of you all?

THE FOREMAN OF THE JURY: Yes.

THE CLERK OF THE COURT: Thank you, please sit.

MR JUSTICE GOSS: Thank you, Mr Foreman. Thank you, members of the jury.

Mr Johnson, obviously a sentence is going to have to be passed.

MR JOHNSON: Yes.

MR JUSTICE GOSS: But it is not possible for that to be done today for various logistical reasons.

MR JOHNSON: Right.

MR JUSTICE GOSS: I would propose that, unless either you wishes to make alternative representations, the sentence hearing be on Friday of this week, Friday morning.

MR JOHNSON: Very good.

MR MYERS: Very well, my Lord.

MR JUSTICE GOSS: There is, I believe, a victim personal statement from [Mother of Baby K].

MR JOHNSON: There is.

MR JUSTICE GOSS: If I could be given the reference. It needn't be done now, but when the court closes.

MR DRIVER: Would your Lordship like a paper copy?

MR JUSTICE GOSS: Well, if I'm just given the reference in the case system, I'll be able to read it.

Any documents that you are going to want me to look at, Mr Myers?

MR MYERS: I don't anticipate there will be, my Lord. If anything arises, I shall make sure your Lordship has them in good time.

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

Lucy Letby, will you stand. Having been convicted of this offence of attempted murder, you will obviously have to be sentenced for it. That sentence hearing will take place on Friday morning and you will be here for that hearing on Friday morning. Obviously you are serving a life sentence in any event.

Would you take her down, please. 10.30 on Friday.

(In the absence of the defendant)

MR JUSTICE GOSS: Members of the jury, thank you very much for your care and attention to that case. As you knew from the outset, when you were asked to complete the questionnaire, you knew what you were going to be in for and you have, if I may say so, very assiduously and diligently performed your role as jurors in this case.

You know from that document that I provided you with at the very outset what your responsibilities are for the remainder of your life so far as not disclosing to anyone anything that was said during the course of your deliberations in relation to your verdict, but you may talk about your experience as a juror of course to anyone who may be interested in it.

The whole criminal justice system in relation to serious offences, those that are tried in the Crown Court, depends upon members of the public dutifully performing their role as jurors; that is, sitting in judgment on fellow citizens. Jurors up and down the country are required to do this and the system, as I say, cannot continue unless people like you do what you have done in this case carefully and methodically, sifting through the evidence and determining what is the appropriate verdict according to law.

We pride ourselves on that in this country and thank you very much for playing your part in the system. It will no doubt be an experience you won't forget, but thank you very much indeed. You will not be required to perform any more jury service insofar as this service is concerned.

Thank you very much indeed. As far as the sentence hearing is concerned, that will take place at 10.30 on Friday morning. You may be here if you want to be here, but I think there'll be other avenues for you to be able to watch it, if you want.

All right. Thank you very much indeed. Please go with the ushers and they will tell you what happens hereafter in relation to other matters. Thank you.

(In the absence of the jury)

MR JUSTICE GOSS: All right.

(3.20 pm)

(The court adjourned until 10.30 am on Friday, 5 June 2024)