

CONTENTS

[NURSE B] (recalled)

Examination-in-chief by MR DRIVER

Cross-examination by MR MYERS

Witness statement of [DR A] (read)

Witness statement of MS CAROLINE OAKLEY (read)

Witness statement of MS MELANIE TAYLOR (read)

Witness statement of [NURSE D] (read)

Witness statement of MS SOPHIE ELLIS (read)

Witness statement of MR STUART ECCLES (read)

Witness statement of DR ANAND KAMALANATHAN (read)

Witness statement of DR DANIELLE GARDNER (read)

Summary of interview with LUCY LETBY re [Baby K] (read)

Wednesday, 1 March 2023

(10.30 am)

(In the presence of the jury)

[NURSE B] (recalled)

Examination-in-chief by MR DRIVER

MR DRIVER: Could you once again state your full name for the record, please?

NURSE B: [Nurse B].

DRIVER: [Nurse B], you've been invited back this morning to assist in relation to your evidence about the care given to [Baby K] on 17 February 2016. I think you anticipated that?

NURSE B: Yes.

DRIVER: Thank you. Could you confirm that you were working a day shift starting at about 7.30 am on 17 February?

NURSE B: Yes, I was.

DRIVER: What was your status within the unit on that particular shift?

NURSE B: I was the shift leader.

DRIVER: What is your practice or routine in terms of the time for attending at work when working a day shift?

NURSE B: So the handover begins at 7.30 promptly, so I arrive 5 to 10 minutes prior to the shift beginning, and people huddle -- in the old unit we huddled at the nursing station prior to the beginning.

DRIVER: We've heard a little about this previously, but it's been a while now. So the handover responsibility and information from those who work the night shift to those working the day shift in this example would take place as a group activity --

NURSE B: Yes.

DRIVER: -- the huddle, as you've described it, not in one of the nurseries but in one of the common areas between the nurseries?

NURSE B: So at this time, 2016 -- sorry, this is...

DRIVER: We're in February 2016.

NURSE B: In February 2016, we gathered at the nurses' station as a team and then we went to a separate room on the unit for a full handover and you'd then receive a further handover at the cot side on the individual babies allocated to your care.

DRIVER: Can I break that down?

NURSE B: Sure.

DRIVER: Forgive me for being slow. So both shifts would come together at the nursing station?

NURSE B: The people that were coming on to shift would gather at the nurses' station. The people on the previous shift may still be giving care to their babies, so they may still be within the nurseries. There may be some at the computers doing their end of shift notes.

DRIVER: So that's the first phase of the handover process?

NURSE B: As it was, yes.

DRIVER: As it was. What would take place between those beginning their shift at the nursing station during this first phase of the process?

NURSE B: What would...

DRIVER: What information would be exchanged or what instructions would be given?

NURSE B: In the separate room are you talking about, sorry?

DRIVER: It may be me. I understood your evidence to be that those coming on to shift would huddle together.

NURSE B: Sorry, we're just in a group. We're chatting in general, we're not discussing work necessarily at that time.

DRIVER: Right.

MR JUSTICE GOSS: As I understood the witness, we have the huddle, then they go into a room -- these are the nurses coming on shift, is that the --

NURSE B: The safety huddle didn't exist then. The safety huddle exists now. We would gather at the nurses' station in 2016, everyone coming on to shift, and then go into a separate room.

MR DRIVER: So at that first gathering, would you as shift leader allocate babies to those who would be working the shift with you?

NURSE B: In the separate room, yes.

DRIVER: Right. And how and when would you receive the information to enable you to determine which of your colleagues should be designated to which of the babies?

NURSE B: At the full handover. You'd receive the baby list with all the details of the babies and then further information to follow.

DRIVER: Then, is this right, once the designation had been decided upon and communicated, your colleagues would go to their respective rooms for a direct handover and exchange of information with the nurse who had been allocated --

NURSE B: Correct.

DRIVER: -- their baby on the previous shift?

NURSE B: Yes.

DRIVER: You told us the handover formally took place at 7.30.

NURSE B: Yes.

DRIVER: And you'd arrive a little earlier to prepare for it?

NURSE B: Yes. Most would.

DRIVER: And did you do so on 17 February?

NURSE B: I did.

DRIVER: What is the first thing that you recall on that morning that brought [Baby K] to your attention?

NURSE B: A call from Lucy, a call for help.

DRIVER: Pause there. Where were you when you received the call for help?

NURSE B: At the nurses' station.

DRIVER: At approximately what time was it that you received the call for help?

NURSE B: Between 7.20 and 7.30.

DRIVER: And what stage in the pre-handover process had you reached when you received the call for help?

NURSE B: So no formal handover had taken place. I'd arrived early for shift. The day shift was starting to gather at the nurses' station. I had not received any formal handover at this point.

DRIVER: Where was Lucy Letby when you heard the call for help?

NURSE B: In nursery 1, at [Baby K]'s incubator side.

DRIVER: Having heard a call for help, what did you do?

NURSE B: I responded, I walked in.

DRIVER: When you walked into nursery 1, were there any other members of staff within nursery 1?

NURSE B: Not beside [Baby K]. I don't recall the other side.

DRIVER: Was Lucy Letby in nursery 1?

NURSE B: She was.

DRIVER: You have told us she was at [Baby K]'s incubator?

NURSE B: She was.

DRIVER: Did anybody else enter at about the same time as you?

NURSE B: Yes, Jo Williams and Dr Jayaram.

DRIVER: Are you able to recall, between the three of you, the order in which you three entered the nursery?

NURSE B: I believe they entered ahead of me. I don't know who was first or second, but I entered behind them.

DRIVER: Did anybody else enter at about the same time as the three of you, Dr Jayaram, Nurse Williams and yourself?

NURSE B: I believe Melanie Taylor did.

DRIVER: Did she enter before or after you or can't you recall?

NURSE B: Approximately the same time.

DRIVER: Thank you. Where did you go to?

NURSE B: Mel and I hovered at the doorway because we were coming on to the day shift. We did not know [Baby K] at this point because she'd been born in the early hours of the morning. Jo Williams, Lucy and Dr Jayaram had been there on the night shift, so they knew the full history, what care was ongoing, so they were better placed to deal with what was happening with [Baby K] at that point in time.

DRIVER: Thank you. And what was happening with [Baby K] at that point in time?

NURSE B: She was having bradycardia and a desaturation.

DRIVER: At the point of time that you first looked over to her incubator, was she receiving any treatment, was there any active response to that presentation?

NURSE B: Yes. Lucy was Neopuffing [Baby K] via her ET tube. She had an ET tube in situ.

DRIVER: Was that act of Neopuffing taking place simultaneously with the call for help?

NURSE B: I believe so.

DRIVER: What happened next?

NURSE B: Dr Jayaram and Jo were immediately at Lucy's -- at Lucy's side, at [Baby K]'s incubator, and it was noted by either Dr Jayaram or Jo -- you go through a process when a baby is on a ventilator, referred to as DOPE, which stands for displacement, obstruction, pneumothorax, equipment, to find out the quickest way possible of what is causing the issue.

So the displacement stands for, is the tube in the correct place, and it was noted that it wasn't in the place that it had been left in previously.

DRIVER: Can you recall, with the benefit of having refreshed your memory from your statement and the underlying notes, how it was in the wrong place, what had happened to it, was it too far in, too far out?

NURSE B: It was too far in.

DRIVER: It was too far in?

NURSE B: Yes.

DRIVER: Do you recall how much too far?

NURSE B: I'm sorry, I don't remember. I did see the statement this morning. It was over a centimetre, possibly 2 centimetres, which is a significant amount in a baby, particularly in a baby of [Baby K]'s size.

DRIVER: May I lead on -- your statement tends to suggest that as you recall it, it had moved from a point of 6.5 centimetres to 8 centimetres, which would indicate that it was further into her lungs by 1.5 centimetres.

NURSE B: Yes.

DRIVER: Does that accord with your recollection?

NURSE B: Yes.

DRIVER: Thank you. Was it adjusted back to the appropriate position?

NURSE B: It was, immediately.

DRIVER: So this was all at around, by now, 7.30 am?

NURSE B: Approximately.

DRIVER: Approximately. Which would have been scheduled handover time in any event?

NURSE B: Yes.

DRIVER: And so what happened next?

NURSE B: So I felt the best place to be at that point was to receive the handover with Mel, which wouldn't be normal practice, but I quickly realised that [Baby K] needed a lot of care and the best place would be to stay by Mel's side and we both received the handover on [Baby K]'s one-to-one care.

DRIVER: So whereas all things being equal, you as shift leader would have been effectively a supernumerary, because of the circumstances you --

NURSE B: I still was supernumerary. Mel had the one-to-one care, which is the correct standard. But when a baby is requiring a lot of care, sometimes they need two nurses to one. But I could have been free to go elsewhere if needed but at that point I was needed beside [Baby K].

DRIVER: So you exercised your managerial discretion to --

NURSE B: Yes.

DRIVER: -- lend support to Melanie Taylor --

NURSE B: Yes.

DRIVER: -- in the care of [Baby K]?

NURSE B: Yes.

DRIVER: Were you present at the cot side when the information was exchanged, the handover process --

NURSE B: Yes.

DRIVER: -- took place?

NURSE B: Yes, I received the full handover.

DRIVER: Which would have included [Baby K]'s immediate medical history from the night shift?

NURSE B: Yes.

DRIVER: And were you aware at that point that Dr Jayaram was seeking to communicate with Arrowe Park Hospital and/or the transport team to arrange for [Baby K]'s transfer out to a tertiary unit?

NURSE B: Yes.

DRIVER: Primarily, was your role in the hours that followed to assist and support your colleague Melanie Taylor to stabilise [Baby K] and prepare her for transport?

NURSE B: Yes. [Baby K], within those few hours -- I believe it was 12.40 she left the unit to go to Arrowe Park, I believe.

She needed more and more infusions, she was having low blood pressure, so she was needing extra and extra infusions as the morning went on, which requires a two-person check to make them up. It's very time-consuming. So instead of taking a nurse from another baby, I just stayed with Mel.

DRIVER: Thank you. If Mr Murphy will assist us to go to our presentation, we'll see where those events appear in the chronology, beginning with tile 131, please. If we just click to the second page, we don't need to go behind it, we can see here that if we did check the records that you and Melanie Taylor together recorded this event at 8.30.

Mr Murphy, tile 154. A further infusion at 09.45.

Tile 170, a further infusion at 10.50.

The next tile, Mr Murphy, 171.

NURSE B: That one is a change of rates. That's the same infusion at an increased rate.

DRIVER: You're quite right, thank you for that correction.

Tile 171, that's an additional infusion or is that a change of rate from --

NURSE B: That's going back to the first medicine. That's an increase in rate.

DRIVER: Thank you.

Tile 177, sodium chloride at 11.10?

NURSE B: Yes. All of these are because [Baby K] had low blood pressure.

DRIVER: Thank you. I think finally in this sequence of infusions to address that low blood pressure is tile 199 at 11.55, some sodium bicarbonate. Is that intended to address the same issue or a different issue?

NURSE B: No. That will be in relation to blood gases, blood gas results. That's not to do with blood pressure.

DRIVER: Thank you. But globally speaking, part of the same cares in order to best ready her for transport; is that right?

NURSE B: Yes. [Baby K] was deteriorating through the morning, so every blood test, every observation that was recorded that was abnormal. All of these medicines are working on different aspects of the care but all to try and improve the numbers in general.

DRIVER: I'm grateful. In addition, you and Nurse Taylor provided her with some medicines as prescribed and we can see them at our tiles 197 and 198.

197 is the provision of some medication and 198 is the administrative exercise of recording that fact, I believe. Is that surfactant, which we know a little about? It's intended to assist lung maturation; is that right?

NURSE B: Yes. Would I be able to see it, please?

DRIVER: Of course.

NURSE B: Thank you. Yes. So this is probably [Baby K]'s second dose of surfactant. I don't know whether you're allowed to tell me, but I would imagine that the night team had administered her previous dose. You give them approximately 12 hours apart, but you can give it sooner if needed.

DRIVER: We have heard some evidence about surfactant earlier.

Thank you.

NURSE B: tile 209, please. Perhaps click beneath to assist the witness. Can you help us understand this?

NURSE B: So this one was asked for by the transport team. So the transport team had arrived by this stage, and this is -- I don't want this to come out the wrong way. It might sound quite shocking to the court, it's almost a paralysing medicine.

DRIVER: To relax the baby?

NURSE B: To very much relax the baby to help with the ventilation and the sedation of the baby.

DRIVER: Thank you. That's at 12.30 in the afternoon.

NURSE B: tile 215, this may be just a recording of the event that we've just looked at at 12.30. Is it or is it something additional to that?

NURSE B: Sorry, I didn't note the time on the previous one.

DRIVER: 12.30 was the previous one and this is 12.42.

NURSE B: Um... It's given at 11.06, so the stop time on it is 12.30, but I started it at 11.06. I'd have to have them side by side to compare if you needed me to.

DRIVER: I don't think it's entirely necessary.

NURSE B: It's the same medicine anyway.

DRIVER: I'm grateful. So in addition to undertaking these necessary steps, did you at times support Melanie Taylor while she conducted all the observations and bedside monitoring that we've become accustomed to?

NURSE B: Possibly, but I think I was more -- Mel stayed by the incubator side recording the observations and I was able to then go and start doing the paperwork that was needed for a transfer, because that involved going out of nursery 1. So Mel stayed by her side and then I was able to support her in different ways.

DRIVER: Thank you. I think from time to time you actually did undertake some observations, no doubt because Nurse Taylor was entitled to a break.

NURSE B: Sure.

DRIVER: If we go to tile 128, please. We see the observation chart. We have them in paper form behind divider 14.

If you need to look, I think it's the other folder, the one with a number 2 down the spine. We won't dwell on this for very long, [Nurse B].

If we go to the bottom of the page, Mr Murphy, to assist the witness identify her initials.

Do you see it on screen?

NURSE B: Yes.

DRIVER: Can you see your distinctive [initials of Nurse B]?

NURSE B: Yes.

DRIVER: And if we go up the page, can we ascertain when that was?

NURSE B: 8.30 in the morning. So perhaps Mel was still receiving handover or... Yes.

DRIVER: That indicates that you undertook that observation?

NURSE B: It does.

DRIVER: Can you help me with this: this document, where's it kept? Where was it kept at 08.30 on 17 February? Where was it at hand?

NURSE B: It will have been at the incubator side. We've got stands with clipboards on, just right there.

DRIVER: So every baby's observation chart is clipped to that baby's cot or incubator?

NURSE B: Yes. Occasionally if the doctors are on a phone call to the transport team, if they're on the phone it's not inside the nursery, they may take it to the nursing desk, but that's as far as it would go.

DRIVER: And then it's brought back, no doubt?

NURSE B: Yes.

DRIVER: Thank you. I believe you also assisted in relation to entries on the fluid balance chart and the intensive care chart. Just for completeness, tile 129. It's another entry at 08.30, which tends to suggest that you were playing an active role at that point in time.

Do you see your initials to the left of the screen?

NURSE B: Yes. So I've done the full complete set of observations for ventilation, fluids and general observations at 8.30.

DRIVER: Yes. We can see the column on the left and the row on the right as well.

NURSE B: Mm-hm.

DRIVER: Thank you very much. Were you, during this shift, working under the guidance at times of a [Dr A]?

NURSE B: Yes, [Dr A], yes.

DRIVER: Thank you. Directing to an extent [Baby K]'s care until the arrival of the transport team?

NURSE B: Correct.

DRIVER: As we understand it, once the transport team arrived, they effectively assumed ultimate responsibility for the management of the baby thereafter?

NURSE B: They lead the care. Mel and I would still have been providing the care. If they requested a medicine it would still be us preparing and administering the medicine, completing the observations. But it's led, yes, by the transport team rather than our doctors once the transport team arrive.

DRIVER: And the records tend to suggest that, in addition to that which we've looked at, you also participated in the important function of communicating with [Baby K]'s parents?

NURSE B: I did, yes.

MR DRIVER: Thank you very much. Could you remain there and answer any questions that are asked of you?

Cross-examination by MR MYERS

MR MYERS: Just this, really, something about the handover and immediately after that. You were asked about what happened when you went into nursery 1 after Lucy Letby had shouted out for some help. Do you remember being asked that?

NURSE B: Yes.

MYERS: You were asked if there was anyone else there, and actually what you said was, "No one else beside [Baby K]".

By that, do you mean there was no one else that you saw where [Baby K]'s incubator was when you said "beside [Baby K]"?

NURSE B: Yes. Because there's two different entrances to nursery 1, as I'm sure you're all familiar with now, and [Baby K] was in the right-hand side, so I've gone in the right-hand door, so in my eyeline I'm focused directly on [Baby K] and her monitor. So there could have been other people on the left-hand side.

MYERS: That's what I wanted to check. What you're talking about is over where [Baby K] was?

NURSE B: Correct.

MR MYERS: Thank you very much.

MR DRIVER: My Lord, no re-examination. Does your Lordship have any questions for [Nurse B], who I think may be here for the final time?

MR JUSTICE GOSS: Right. No, I don't have any questions.

Thank you very much for coming again and giving further evidence. It is believed you will not be required again, but just in case you are required for some unexpected reason, would you please not talk to anyone about this case until it's all over?

NURSE B: Okay.

MR JUSTICE GOSS: Thank you very much indeed. Just remain where you are, you know what the procedure is now.

And you know what the procedure is, members of the jury, thank you. Just a few minutes, that's all.

(In the absence of the jury)

MR JUSTICE GOSS: I'm sorry if you were inconvenienced yesterday -- were you here yesterday as well?

NURSE B: I was.

MR JUSTICE GOSS: Well, I'm sorry about that.

NURSE B: Not to worry.

(Pause)

MR JOHNSON: While the screen is being removed, could I just explain what's happening today or rather not happening today?

MR JUSTICE GOSS: Yes. Is everyone content for this to be dealt with in the absence of anyone?

MR MYERS: Yes.

MR JUSTICE GOSS: It's on the record.

MR MYERS: It is. It's logistical rather than --

MR JUSTICE GOSS: It's administrative rather than substantive.

MR MYERS: Yes.

MR JOHNSON: We always bear in mind, of course, my Lord, that the purpose of expert evidence is to inform the jury of matters of which they are unaware or may be unaware. The issues, as they have crystallised in this particular case, are factual issues and inferences to be drawn from the facts rather than the medical data, if you like. Having discussed the position at some length with my learned friend last night, we offered to tender the prosecution experts lest it was thought there was any cross-examination that might be relevant to any issues, but we were not proposing to lead any evidence specifically from them and my learned friend has informed us this morning that that is not required, so we do not propose to call either Dr Bohin or Dr Evans.

Perhaps I can give just a very -- perhaps your Lordship would give an explanation to the jury as to the reasons for that.

MR JUSTICE GOSS: Well, I think it might be better, because you've engaged in the discussions with Mr Myers, if you could just briefly explain that the issues are factual in relation to this particular baby and it is agreed between the prosecution and the defence that there is no expert evidence that is required in relation to that.

MR JOHNSON: Yes. I will, if I may, draw the parallel with the third [Baby I] incident.

MR JUSTICE GOSS: Well, if Mr Myers is content with that.

MR JOHNSON: But just to make the point it's the same scenario, it's an issue of fact for them to resolve. If that's a problem I won't mention it.

MR MYERS: I understand why my learned friend says that in the spirit of assisting the jury. I'd ask if we could not to bring up other counts just in case anyone was to read into that some significance which goes way beyond what I know would be intended by saying that.

MR JUSTICE GOSS: That's why I said, just out of an abundance of caution, that's right. I think between you if you could agree an appropriate form of words.

MR JOHNSON: Yes. There is another issue that we need to resolve as well. Perhaps could we ask that we dispose of the reading now, then have the break, and sort this all out?

MR JUSTICE GOSS: Absolutely. I think, Mr Myers, I entirely understand what you're saying. The cautious approach is the right one in this case and, as I say, I think for the same reason it's best that you actually agree the form of words

between the two of you. Do that at the break and if you need slightly longer than 10 minutes, so be it.

MR DRIVER: My Lord, as to the reading, I am about to read, I think it's eight statements --

MR JUSTICE GOSS: Hang on, we'll just wait until the defendant is in place.

(Pause)

MR DRIVER: My Lord, I'm about to read a number of statements, many of them involve references to timed events, which are of course represented on our sequence of events presentation. If your Lordship prefers, when reading the sentences relating to those events, I will inform the court as to the corresponding tile number.

I'll be punctuating the statement a little, but --

MR JUSTICE GOSS: I think that will be very helpful. So if any juror wishes to make a note of that, they can make a note of it. It's entirely up to them. But rather than just reading them as a free narrative, so to speak, or an uninterrupted narrative, it's best to focus on the documents to link the two up, as you would if the witness was actually here giving evidence.

MR DRIVER: Quite. There's one statement from a Dr Kamalanathan, the editing of which has been an ongoing process. We've recently arrived at an agreed form. We'll print that off and read that after the short break.

MR JUSTICE GOSS: I don't know how long this reading will take, but I see there's a list of quite a few witnesses whose statements will be read. Whenever we have reached the point where you have read as many as you can read, that's when we'll have our break, whenever that is, and then we'll have a 10, maybe, 15-minute break if necessary, because it is, as I understand it, not anticipated that we are going to have a very full day.

MR DRIVER: Quite so.

MR JUSTICE GOSS: And as the jury will know, when we complete the evidence in relation to [Baby K], then we will not proceed with any further evidence in relation to the next baby.

MR DRIVER: Indeed. Thank you.

MR JUSTICE GOSS: We'll deal with that as and when it all arises.

MR DRIVER: I'm grateful.

MR JUSTICE GOSS: Thank you very much.

(In the presence of the jury)

Witness statement of [DR A] (read)

MR DRIVER: May I read some witness statements, please, beginning at page 20 of your Lordship's reading bundle with a statement from [Dr A], dated 2 October 2018, which reads as follows:

"I have been asked with reference to [Baby K] and in particular her care on 17 February 2016 [as read].

"I do not recall [Baby K] or her parents and it is likely that I never met them. I was working a day shift on Wednesday, 17 February 2016." The next part of the statement takes us to a specific clinical note, which, with Mr Murphy's assistance, we can go to at tile 156, thank you, which is timed at 09.55 hours on 17 February.

[Dr A]'s statement reads:

"At 09.55 hours on 17 February 2016, I have endorsed the clinical notes of [Baby K] with reference to a procedure I have completed. I have inserted an arterial line into the radial artery in [Baby K]'s right wrist, which I have connected to an arterial circuit for use in blood pressure monitoring and blood sampling in preparation for monitoring whilst on the neonatal unit and would likely be used following transfer.

"A very slow infusion of necrodised(?) saline was run to prevent the blood clotting within the line. The line would stay in situ for as long as it worked.

I have recorded [Baby K]'s blood pressure, which was visible on the monitor when the pressure monitoring circuit was connected, was 30/25. The main arterial pressure was 27." That concludes [Dr A]'s statement.

Witness statement of MS CAROLINE OAKLEY (read)

MR DRIVER: The next statement to be read is from a Caroline Oakley, dated 11 April 2018. It reads:

"I have been asked for my recollections of a baby by the name of [Baby K], who was born at 25 weeks' gestation on 17 February 2016 at 02.12 hours.

"She was admitted into the neonatal unit at the Countess of Chester Hospital a short time later. I was working a night shift on the 16th into 17 February 2016 and was on duty in the NNU when [Baby K] was admitted.

I can start by saying I have absolutely no memory of [Baby K] or that night shift. Anything that I am about to say is taken from the off-duty roster and the nurses' notes on the Meditech system, which I have had the opportunity to view, and not from my memory.

"On 16 February 2016, I started my shift at 7.30 pm and I was the shift leader. Joanne Williams was also on the night shift and she became the designated nurse for [Baby K] when [Baby K] was admitted to the unit.

I know this because Joanne is the nurse who updated Meditech with [Baby K]'s care.

"Also on duty were Lucy Letby, Sophie Ellis and Val Thomas. The consultant was Dr Ravi Jayaram and Dr Smith was also on duty, but I have no memory of him.

I have no memory of how many babies were on the unit that night or where they were situated and Meditech does not record these details.

"[Baby K] would definitely have been in nursery 1 with Joanne, but I don't know if any other babies or members of staff were in there. I have not made any notes on Meditech in relation to [Baby K] because I was not caring for her, so I can only repeat what Joanne has written as I have no memory of [Baby K] or the shift.

"The notes state that [Baby K] was admitted at 02.40 hours in fair condition, intubated at 12 minutes of age, and was attached to the ventilator, which is all standard practice.

"The notes also query a dislodged ET tube and she was re-intubated by Dr Jayaram. She was screened for infection and given IV fluids as she couldn't feed herself. [Baby K] was also given morphine and antibiotics. The notes show that [Baby K] had two intubations due to apnoea and desaturation, colour loss.

[Baby K] was then started on dopamine. The treatment charts show that I signed with Joanne for a number of standard medications." Pausing there, our presentation does evidence that Caroline Oakley co-signed for a number of standard medications and they can be at, Mr Murphy, if you would, at tile 37.

NURSE B: 03.00 hours the neonatal infusion prescription chart shows an infusion of dextrose. At tiles 72 and 73, please, Mr Murphy, at 04.20 hours, it shows the provision of phytomenadione and the corresponding administrative exercise. That's 04.20 hours on the 17th.

Tiles 79 and 80 at 04.40 hours are for the antibiotics gentamicin and benzylpenicillin. Tile 82, 04.45, again gentamicin. Tiles 86, 87 and 88 record the administrative exercise of updating the records as to the provision of those medicines.

On tile 109 at 06.25, there's an entry on the infusion chart in relation to the giving of saline.

NURSE B: tile 117 at 07.30, towards the end of the shift, Nurse Oakley again makes a further contribution to that infusion prescription chart, again in relation to saline.

Returning to Nurse Oakley's statement, she states:

"I have no memory of the desaturation event at 02.50 hours, so I cannot make any comment on it. I am told Joanne left the unit to update [Baby K]'s parents shortly before the event, but again I have no memory of this so I don't know who was looking after [Baby K] in Joanne's absence.

"Regarding the ET tube, which possibly dislodged whilst assisting [Baby K] with her breath, I do not know what size the tube was, but from experience I would expect it to have been a size 2 or 2.5. I do know of incidents in the past where a tube has slipped, but I don't know if this is what happened on this occasion.

I also know of occasions in the past where we have been in receipt of faulty equipment, such as ET tubes, and we've had to send them back to the supplier, but I cannot say if any of the equipment used on this occasion was faulty." Witness statement of MS MELANIE TAYLOR (read)

MR DRIVER: The next statement to be read is that of Nurse Melanie Taylor. For reference, Nurse Taylor -- sorry, this statement is dated 1 May 2018, I should have said.

Nurse Taylor has made nursing notes which are -- and I won't go to them, but if anyone cares to note, they are on our presentation behind tiles 116 and 137. They are the retrospective notes that you're very familiar with -- the likes of which you're very familiar with, I should say.

Nurse Taylor says:

"I have been asked to comment on baby [Baby K] and her care on 17 February 2016. I recall [Baby K] as she was born at 25 weeks, which is very premature. She had been looked after by Joanne Williams since birth and I took over from Joanne for the day shift at 07.30.

I had a verbal handover with Joanne in nursery 1 and then took over the care of [Baby K], assisted by [Nurse B].

"[Baby K] was being transferred to a specialist neonatal unit due to her prematurity. My role during her time in Chester was to stabilise [Baby K] and prepare her for transport. Shortly after taking over care of [Baby K], her ET tube had slipped, which caused her to have a loss of colour with her heart rate and saturations dropping.

"I can't recall exactly who adjusted the ET tube for [Baby K], but when this happened her saturations improved.

During the morning, I checked [Baby K]'s blood gases." She provides the times of those checks and I'll provide you with the corresponding tile numbers. She checked [Baby K]'s blood gases at 08.45, which is at tile 133; at 09.44, which is at tiles 150 and 152; and at 11.13 hours, which is at tile 178. So 08.45, 09.44 and 11.13 hours:

"On each occasion the results were poor. The blood gases I took at 12.30, just before her transfer, had improved. Throughout the morning, [Baby K]'s ventilation requirements were increased as a result of poor blood gases and increased oxygen requirements.

"The transport team arrived mid-morning and worked alongside us to prepare and stabilise [Baby K] for transfer." She then gives evidence about medication. We've already seen some of this:

"At 08.30 hours [this is tile 131] [Baby K] was given a dopamine infusion at 10 micrograms per kilogram per minute to try and reverse her low blood pressure.

However, this appeared to have no effect. Because there was no effect, at 09.45 hours [tile 154] she was given a dobutamine infusion at 10 micrograms per kilogram per minute to again try to reverse her low blood pressure.

"At 10.50 hours [tile 170] both were increased to 20 micrograms per kilogram per minute. [Baby K]'s mean blood pressure was still too low, so she was prescribed hydrocortisone..." The fact of that prescription is recorded at tile 187:

"... which was administered by me through an intravenous bolus. I recall this helping her blood pressure improve." The next sentence relates to an entry at tile 197.

The sentence reads:

"Curosurf is used to improve the compliance and oxygenation of the lungs. During my time with [Baby K] she was given two doses of Curosurf via her ET tube, although I did not give these to her. She was also given two saline boluses and bicarbonate boluses." Those events are recorded behind tile 198:

"At 12.30, prior to transfer, [Dr A] gave [Baby K] 100 micrograms per kilogram of pancuronium, which is a muscle relaxant, which had been requested by the transport team." We've already looked at that at tiles 209 and 215:

"I drew up an adrenaline infusion at a dose of 100 nanograms per kilogram per minute, but did not give this to [Baby K]. This was given to the transport team should they have needed it during the journey." That is recorded at tile 203:

"All medication was double-checked prior to being given to [Baby K]. The transport team began giving [Baby K] nitric oxide through her ventilation, which improved her blood gases prior to transport." That fact is recorded at tile 167.

"At 12.40 hours, the transport team took [Baby K] and transferred her to Arrowe Park Hospital." We have already seen that at tile 213, members of the jury:

"I had nothing further to do with [Baby K]'s care after she was transported." Witness statement of [NURSE D] (read)

MR DRIVER: The next statement, and it's page 25, my Lord, is a statement made by [Nurse D] on 23 July 2018:

"I have been asked with reference to baby [Baby K] and in particular her care on 17 February 2016 [as read].

"I was working a long day shift on this day and started work at 07.30 hours. I was not directly involved in the care of [Baby K], but having reviewed the electronic prescription notes, can see I was involved in checking and signing for [Baby K]'s medication, as detailed below." This is behind 187:

"11.32 hours, hydrocortisone sodium injection co-signed by Mel Taylor. Behind 197 at 11.45 hours, poractant alfa lung surfactant co-signed by [Nurse B]. I have reviewed the nursing notes and can state that other than what I've detailed above, I

had no other involvement in the care of [Baby K] that day."
Witness statement of MS SOPHIE ELLIS (read)

MR DRIVER: Sophie Ellis, at page 26, is irrelevant, my Lord, so I invite you to go to page 27, please.

Sophie Ellis made a statement dated 11 September 2019. She states that she'd been asked about her recollections of events during a night shift between 16 and 17 February 2016 and her recollections of baby [Baby K]:

"I cannot recall the shift or anything significant occurring. I can see from the medical records that I was on duty overnight that night, but I have no recollection of this. From reading the notes, I can see there were only two shifts documented, a night shift when [Baby K] was born and the following day shift when she was transferred to Arrowe Park Hospital. The night shift would have been between 19.30 hours on the 16th and 08.00 hours on 17 February.

"I think that [Baby K] was born in the early hours of the morning. I can't remember who was on duty that night, but from the notes I can see that a nurse by the name of Jo Williams was allocated to look after [Baby K] and that Lucy Letby did [Baby K]'s admission on 'Badger', which is a national neonatal system where all of the babies' details such as parents' details and admission observations are inputted.

"I can't remember where I or anyone else were working that night and this wouldn't usually be documented in the notes. I don't recall which nursery [Baby K] was admitted to, but if a baby required intensive care they would be in nursery 1 as there is more equipment in there and it is a bigger nursery. I can see from the medical records that [Baby K] was on a ventilator and needed help with respiratory support.

She was quite unwell, so I would say that she would definitely have been in nursery 1.

"I cannot recall any of the babies I worked with that night, but I was a relatively junior nurse at the time so I would have been allocated to care for the low-dependency babies. These babies would usually be in nurseries 3 and 4, maybe nursery 2.

"The nursery that the babies were admitted to would depend on how busy the unit was. I think I only ever worked in nursery 1 with support, but I don't recall working in there on that particular night. I was not aware of [Baby K]'s desaturations during that night, but I can see from the notes that there was a query around an endotracheal, ET, tube that had become dislodged quite a few times. This can happen if the tube has not been

secured properly or if [Baby K] was moving around and could have caused her to desaturate, but I do not remember any of this happening.

"The endotracheal tube is attached to the ventilator. The tube goes into the neonate's mouth and inflates their lungs. It sits above their carina so that it can equally inflate their lungs. A doctor performs the intubation.

"The tube is usually secured with a harness. At Chester they used a little plastic board that goes across the baby's mouth. The ET tube went through the middle of it and there were ties at the side of the plastic board which would tie on to their hat.

"If a baby is very active, they can sometimes dislodge the tube or, if they are being moved, for example if their head is being turned, the tube can become dislodged. It can also happen if their harness isn't tight enough.

"[Baby K] was born at 25 weeks' gestation and was only little, but in my experience this could occur even in a baby who was a few hours old. Sometimes they can move around enough to dislodge the tubes as they can be quite agitated.

"The indications that a tube has slipped or become blocked would be if the baby's oxygen requirements go up significantly, if they start desaturating or if their entry isn't equal. If you suspect that a tube is blocked or dislodging or dislodged, you bag the baby with Neopuff and use a CO2 detector, which is placed on the end of the ET tube. When you bag the baby, if it has a positive colour change and turns yellow, this indicates CO2 in the lungs, but if it doesn't change colour or if the colour change is not as good or as strong as it has been previously, this may mean that the tube has slipped or become blocked. You can also check the tube to ensure that it has remained where it was secured.

"The tubes are marked in centimetres. When a baby is intubated you look to check what measurement it is at the lips. An X-ray is then carried out to ensure that the tube is sited correctly and, if it is, you stick at that measurement. For example, for [Baby K] it may have been 8 centimetres at her lips. If it was then at 9 centimetres when checked then obviously this would mean it had slipped.

"The ventilator shows how much oxygen a baby is using. There are different settings on the machine relating to things such as tidal volumes and minute volumes. If this goes out of normal ranges, an alarm may activate. I'm not familiar with the ventilators at Chester as I didn't really use them much.

"The Phillips machine monitors the oxygen saturations. You can set parameters on this. When the saturations go below 90, a low grade alarm will sound.

It depends on what parameters have been set, but if the saturations go really low, for example below 80, a loud alarm will sound. I am not aware of any alarms going off on the night shift of 16 February to 17 February 2016.

"Designated nurses remain near to the baby's bedside to monitor. They might go to the other side of the room, but with [Baby K], as she was so unwell, I wouldn't expect them to move far from her bed space.

"Reading from her notes, [Baby K] became unwell quite quickly and needed nitric within the first few hours.

This is a vasodilator, which helps gases exchange. If a baby had a high oxygen requirement and their saturations are still not brilliant, they may go on to nitric.

"As a nurse if I was concerned that an ET tube had become dislodged or blocked or if a baby needed more oxygen, their oxygen saturations weren't good or they needed a high amount of oxygen to maintain their saturations, I would notify the doctor and they would come and have a look.

"I would expect a doctor to be in the room or on the unit, especially if there was a new admission. If it was discovered that an ET tube had slipped it might be pulled back to where it was or removed and the baby would be re-intubated. I may have observed colleagues carrying out clinical interventions in relation to [Baby K] while she was on the ward, but I can't recall this and I cannot see my signature on any of the paperwork relating to [Baby K].

"As a junior member of the team I had a preceptorship within the first year of qualifying as a nurse [which is a structured start for a registered nurse, I understand, my Lord] but I can't remember who that was at Chester. You don't always work with your preceptor, your instructor, you just have regular meetings to check how things are going. I have been a registered nurse for 5 years now and have experienced ET tubes becoming dislodged or blocked with secretions on a few occasions in babies I have been caring for.

I can't remember how many times but it does happen.

This has been whilst I have been working in Leeds, not in the Countess of Chester.

"I didn't look after many poorly babies at the Countess of Chester due to the unit being downgraded from a level 2 to a level 1 in 2016 and, prior to that, I wouldn't have taken those babies. If I had, I would have been working with someone else. I worked at the Countess from the middle of January 2015 to July 2017.

I was a student there before that." And then she goes on to explain where she has worked since her qualification. She's currently a band 5 nurse.

MR JUSTICE GOSS: This statement, as you said, was made in September 2019, so she started nursing in 2014? Witness statement of MR STUART ECCLES (read)

MR DRIVER: Yes. Thank you.

Finally for now, please, if I may, my Lord, at page 33 of the reading bundle we have a statement from a Stuart Eccles, who is a clinical engineering manager.

His statement is dated 10 July 2018, and he makes a statement about equipment. He says:

"The neonatal unit at the Countess of Chester Hospital uses two different types of monitors.

Nurseries 1 and 2 use a Philips MP30 neonatal monitor while nurseries 3 and 4 use a Masimo Radical-7 monitor.

The Radical-7 monitor is portable and can be used throughout the ward while the Philips MP30 is wall mounted." Then he describes each of the monitors in turn, beginning with the Philips. He says:

"There are normally three to four monitors within nursery 1, the intensive care, and a further two monitors within nursery 2, the high dependency. The monitors in nursery 1 are generally on standby when not being used. This is to allow quick use of the monitor should a baby require it rather than waiting for the monitor to go through the 10 to 15-second start-up process.

"The monitors in nursery 2 are generally turned off unless needed as this is a more controlled environment with staff having more time to get a baby set up. The Philips neonatal monitors are standalone devices and are not networked in any way. They are capable of being networked, but the Countess of Chester Hospital choose not to do this. They also do not go to a central monitoring system.

"The monitor allows trend data to be captured over a period of time, but the Countess of Chester Trust utilises the nurses' observation charts over the trend data. In other words, the nurse will complete their observation charts from the data the monitor is providing and their observations of the patient.

"The monitor has a number of different options as to what can be monitored, such as arterial pressure, temperature, saturation, ECG, which is electrical activity within the heart, pulse and respiration rates.

The condition of the baby and what is needed to be observed will dictate what the machine will be asked to monitor. You could observe one or all of the above functions if required.

"The touchscreen display of the monitor can then be customised to only show the readings from what you are monitoring rather than having a very busy screen with information that isn't required. Once the monitor starts being used without all of the observation leads plugged in, a visual prompt will appear in the top left corner of the screen, scrolling through a check of the monitor, updating the user of what is not attached.

"When the monitor is first turned on, it will automatically default to neonatal values, giving the user typical, pre-programmed values of a neonatal baby, for example, a typical heart rate range of 110 to 165 beats per minute.

"Based on the care needs of that baby, the nurse or doctor can then adjust this range to be specific for the care of that baby. Monitors on the neonatal unit automatically default to neonatal settings, which cannot be changed. Other monitors in use through the trust can be changed for the care of different patients, for example adults, paediatrics or neonatal. Once the profile is selected, the monitor will automatically give the user the default settings for the patient type selected.

"Once ranges have been set, alarms can then be set.

If the baby's monitor readings go outside of the set range, it triggers an audible alarm, prompting staff to attend to the baby. If the ranges were set to the extreme, for example the lower rate of 15 and upper rate of 250 beats per minute, then the alarm would never sound, despite the baby's heart dropping to dangerously low levels.

"The display on the Philips MP30 neonatal monitor is touchscreen. The display will show the actual reading from the patient along with the upper and lower limit set by the nurse or doctor.

"The monitor display screen will give the user visual prompts of medium and emergency alarms within coloured boxes at the top of the screen. It is possible to deactivate the alarms on the Philips MP30 neonatal monitor for 1 minute, using the alarm pause button on the touchscreen. This will then give a visible countdown display at the top of the screen.

"Once the 1 minute has expired, the alarms will reactivate. If the user wants to further silence the alarm they can press the alarm pause button again, which will give a further 1 minute of alarm silence, but this can't happen until the previous 1 minute has expired.

"If the user presses the pause alarm button again within the 1 minute time frame, the alarm will no longer be paused and will begin to sound again. This will generally be used by staff who have responded to the alarm and wish to silence the alarm whilst dealing with a medical issue.

"It is possible to pause monitor alarms in anticipation that treatment for the baby is likely to trigger the alarms. Again, this is only for 1 minute.

It is possible to silence an alarm by using the silence alarm button on the touchscreen display. The visual alarm indicators at the top of the screen will display despite the alarm being silenced.

"The neonatal configuration settings of the Philips MP30 monitor have 'alarm reminder' enabled, which means that the user will be reminded at regular intervals that the alarm has been silenced." That concludes the relevant parts of Mr Eccles' statement.

My Lord, could I ask that we have a short break at this point in time and I will conclude with the reading of two statements, the transport team and a doctor at Arrowe Park.

MR JUSTICE GOSS: Yes, certainly. We'll have our ten-minute break then now, members of the jury. It may be slightly longer than 10 minutes, but it'll be 10 to 15 minutes, I anticipate.

(11.42 am)

(A short break)

(12.08 pm)

Witness statement of DR ANAND KAMALANATHAN (read)

MR DRIVER: My Lord, the next statement to be read is an additional statement to the existing bundle, which I hope Mr Worthington has handed up, at page 44 onwards.

It's a statement of a Dr Anand Nathan Kamalanathan, dated 18 June 2020. He is a neonatal paediatrician and states:

"I joined Arrowe Park Hospital as a consultant neonatal paediatrician in March 2011. As part of the consultant role at Arrowe Park, I cover the regional neonatal transport team, providing medical cover for three days a week.

"Cheshire Police have requested a statement concerning my involvement in the care of a baby by the name of [Baby K], whom I transferred from the Countess of Chester Hospital to Arrowe Park Hospital on 17 February 2016.

"I have had the opportunity to read the transport records. I am able to provide a summary of what happened and my role in transferring this baby.

"I would have been on site at the transport team base at Liverpool Women's Hospital at around 8 am when I would have found out about this impending transfer." He gives some history of [Baby K]'s medical records:

"Mum's membranes had ruptured and she went into spontaneous labour. Mum had received two doses of antenatal steroids. [Baby K] was born by footling breech and needed stabilisation soon after birth. She needed airway support, intermittent positive pressure ventilation (IPPV) and intubation." Then he returns to the narrative of the events of the day:

"We probably reached the Countess of Chester Hospital just before 09.00 hours. This is the time from being at the base, 0.800 hours, calling an ambulance, arrival of an ambulance. And then the journey time in the ambulance, which would have probably been blue lights, from Liverpool to Chester.

"The next entry in the case notes is at 09.00 hours when I have documented that I received handover from the consultant at the Countess of Chester Hospital, Dr Ravi Jayaram. I introduced myself to mum and dad, who were on the unit at the time, and then went to examine [Baby K].

"From the records, I can see that I found the endotracheal tube to be at 6 centimetres at the lips.

I noted that the UVC was low lying and based on the measure at the umbilical stump. I have also made an entry and I have looked

at the X-ray, which would have corroborated the ET and UVC position.

"The UVC position was acceptable for the purpose of transfer. [Baby K] was on inotrope medication through the UVC. I did not think taking the UVC out appropriate as that would compromise her clinical condition. The team at Arrowe Park Hospital could identify an alternative access after transfer, ie a peripheral long line.

"I have documented that [Baby K]'s oxygen requirement had gone up to 90%. At this time [Baby K] was ventilated with high ventilator settings. She had received two doses of surfactant and was requiring high amounts of oxygen.

"I make a plan to start her on inhaled nitric oxide.

This was started at 10 parts per million at 10.40 hours and increased to 20 parts per million at 10.50 hours.

Inhaled nitric oxide is normally used between 0 and 20 parts per million. I started at the halfway mark, 10 parts per million. I did not see an immediate response and hence went up to 20 parts per million within 10 minutes, as described above.

"At this point I took the opportunity to speak to mum and dad again to share my concerns about what [Baby K] was having. There were two problems: one was getting oxygen into [Baby K]'s blood, oxygenation; the other was maintaining blood pressure. [Baby K] was now on two medications to support her blood pressure. The next step that I took was to increase the dobutamine. I gave another medication called hydrocortisone, which is a steroid, used to support blood pressure.

"The next documentation is at 11.15 hours and there is a note that the oxygen saturation is between 84% to 92% and it keeps swinging. I have documented that the blood pressure (mean) is 21.

"Subsequent management included the following.

I have given a dose of pancuronium, which is a muscle relaxant. This works in improving oxygenation as lung tissues become more compliant and baby is not fighting the ventilator. I asked for a sodium bicarbonate infusion to correct the acid load. The effect of inotropes on the heart muscle is better with a normal blood pH. Sodium bicarbonate infusion aims to correct acid-base imbalance.

"We have documented a gas at 12.40 hours, which showed a pH of 7.396, which is normal. PCO2 was 4.19.

This is a reducing trend for PCO2."

MR JUSTICE GOSS: That's carbon dioxide.

MR DRIVER: Indeed, thank you.

"I cautiously dropped the amount of oxygen we were giving her as the oxygen level in the arterial blood was high and her oxygen saturations were 97%. At that time we made the decision that this was the best we could get at the Countess of Chester. We made a plan to transfer at around 13.00 hours. We had been at Chester for nearly 4 hours by that time.

"The pre-transfer gas at Chester was at 12.40 hours.

We would have started off some time after reviewing that gas. We would have used a blue light ambulance from the Countess of Chester Hospital to Arrowe Park Hospital, which roughly takes about 15 to 20 minutes. Allowing another 5 minutes to get the baby from the neonatal unit to the ambulance and another 5 minutes at the other end, I would say that transfer would take 25 to 30 minutes at a minimum.

"The transport team included myself and the nurse, who would have transported [Baby K] in an ambulance from the Countess of Chester to Arrowe Park Hospital. I have documented that I have had a discussion with Arrowe Park Hospital, which means that I have spoken to the team at Arrowe Park to tell them the situation of the baby.

This enables the other team to be prepared with the appropriate equipment and medications and gives them an estimated time of arrival.

"I can see from the medical records that the nurse documented that we arrived at Arrowe Park Hospital at 13.15 hours, following an uneventful transfer and that ET and lines remained in place during transfer. We informed parents that we had arrived. I gave a handover to the medical and nursing team and that the nursing staff were preparing all infusions.

"Once we arrived at Arrowe Park Hospital, I would have handed over to the medical and nursing team.

I don't recall any of the medical team that I handed over to, but it would have been the registrar and consultant on call.

"[Baby K] was still unwell when we arrived at Arrowe Park Hospital. Nothing had changed during the transfer.

The transfer was uneventful, but [Baby K] was sick. After handing over to the team at Arrowe Park Hospital I don't think I had any further involvement in [Baby K]'s care.

There are no entries by me in the records at Arrowe Park."
Witness statement of DR DANIELLE GARDNER (read)

MR DRIVER: Finally as far as witness statements are concerned, my Lord, may I read a statement of Dr Danielle Gardner, which is at page 39 of the reading bundle. The statement is dated 24 April 2018, which states:

"I am a paediatric cardiologist working within the cardiology department at Alder Hey Children's Hospital." She was, at the relevant time, at Arrowe Park, however. The statement goes on to say:

"The neonatal unit at Arrowe Park Hospital provides full level 3 neonatal intensive care for extreme premature babies born from 23 weeks onwards. The unit provides high-frequency oscillation and ventilation and total body hypothermia using nitric oxide.

"Babies born at other hospitals who require level 3 care would initially be stabilised at that hospital and then transferred to Arrowe Park Hospital for more specialist treatment.

"I have been asked to comment on the baby [Baby K] and my care of her while she was at Arrowe Park Hospital. On Friday, 19 February 2016 at approximately 9 pm, I started a night shift at Arrowe Park. At the start of my shift I will have had a handover from the day's registrar. On this occasion Dr Babarao was still present due to the current condition of [Baby K].

"Dr Babarao and I discussed everything he had done for [Baby K] during that day and the discussions he had had with her parents, that her condition was clinically deteriorating gradually and she was not responding to the care he had instituted and there was the possibility that she was going to die. There was the possibility that we would stop intensive care." My Lord, the contents of the statement correspond to entries on our presentation at tiles 235, 237 and 238:

"Dr Babarao and I discussed whether I was comfortable to complete this unsupervised and I advised him I would call him if I had any issues. My first entry on the clinical notes for [Baby K] was at 23.20 hours on this day. I documented the fact that [Baby K]'s care was continuing. From the update by Dr Babarao there had been no significant changes.

[Baby K]'s oxygen saturations were low. A review of her chest X-ray showed the ET tube had come slightly higher than what was

documented but was still working. Her blood pressure was low and every time she was handled, her blood pressure dropped.

"Dobutamine was added to try and raise her blood pressure, but it was felt that her blood pressure drop was due to her being handled and her blood pressure was naturally rising. Due to [Baby K]'s metabolic acidosis, she was given a sodium bicarbonate infusion to run continuously. She was given a half correction over 30 minutes to try and correct her gas and then the infusion was run from that point.

"[Baby K]'s parents were updated and she had been baptised. I continued to care for [Baby K] and next updated her clinical notes at 03.15 hours on Saturday, 20 February 2016. This update was me completing a full daily review of [Baby K], documenting her diagnosis, background and prognosis.

"[Baby K]'s respiratory saturations had dropped slightly. She was on a reasonable amount of ventilation with 100% oxygen and 20 parts per million nitrate and her oscillator was wobbling her, ie working appropriately.

"Her blood pressure had become worse and her dobutamine intake had been increased to maximum. She was given a bolus of fluid to try and increase her volumes and blood pressure, which had raised slightly.

"I noted that [Baby K] was very oedematous. Her sugars were running high, which is not unusual as a stress response, and her sodium levels were high.

[Baby K] was neurologically sedated. Her haemoglobin had dropped, so a transfusion was ordered. Her infection markers were normal. I then revisited and reviewed her current medication.

"The plan for [Baby K] moving forward was to continue with her current care. The adrenaline syringe had expired, but I made the decision not to change the syringe as I felt this could cause [Baby K]'s blood pressure to drop to such levels that it could be catastrophic. [Baby K]'s mean blood pressure was now 16 to 18. Her sats were between 50% and 70% for over 2 hours. I updated [Baby K]'s parents with the current situation and advised them that it was unlikely that [Baby K] was going to recover and they were aware that [Baby K] was likely to die soon and we were heading towards a point where intensive care would be withdrawn if she deteriorated any further.

"I discussed this plan with Dr Babarao, who agreed it was an appropriate course of action. I continued to care for [Baby K]. I next updated her clinical notes at 05.10 hours. Prior to this

update I had been discussing with the nursing staff about phoning [Baby K]'s parents to come to the ward. They had gone to a parents' lounge off the ward for a rest.

"Just as we ended our conversation, [Baby K]'s parents came on to the ward. [Baby K]'s parents asked me if now was the right time to withdraw intensive care for [Baby K]. I advised them that this was the right time.

Her blood pressure was 15 with saturations of 46%.

I discussed with the parents what options of withdrawing treatment were available. They decided that they wanted to hold [Baby K] whilst her treatment was withdrawn and they went into a family room for [Baby K] to be brought to them.

"[Baby K]'s infusions and ventilation were disconnected and she was wrapped in blankets. [Baby K] was manually bagged via her ET tube and taken to her parents, who had cuddles with her before asking for her ET tube to be removed. I then left [Baby K] with her parents to allow them to have further cuddles with her.

"I went back into the bedroom to examine [Baby K] and noted that she had no heart rate, no pulse, no respiration effort and no movement. I certified the time of death for [Baby K] at 05.28 hours.

"I noted on the records that the cause of death was extreme prematurity, leading to severe respiratory distress syndrome. I discussed a post-mortem with the parents and they decided they did not want [Baby K] to have a post-mortem.

"At 08.15 hours I completed the death certificate for [Baby K], noting the cause of death as (1A) severe respiratory distress and (1B) extreme prematurity.

"On 22 February 2016, Dr Babarao endorsed the clinical notes, reissuing the death certificate but switching the cause of death to (1A) extreme prematurity and (2) severe respiratory distress syndrome. The cause of death remained unchanged but was just presented differently.

"On 1 March 2016, the clinical notes of [Baby K] were endorsed at 14.30 hours, stating a debrief meeting took place. I cannot recall attending this meeting despite my name being on the list of attendees. A debrief meeting is standard practice following the death of a baby and takes place to ensure that everything was done appropriately as well as an opportunity for anyone to raise any concerns.

"After this debrief, I had no further involvement with [Baby K]." That concludes the reading, my Lord.

MR JUSTICE GOSS: Mr Johnson.

MR JOHNSON: Thank you, my Lord. Normally at this change we would call Dr Bohin and Dr Evans.

MR JUSTICE GOSS: Yes.

MR JOHNSON: Following discussions between the parties, ladies and gentlemen, in almost every case that you have considered so far, expert evidence has been called by the prosecution from Dr Evans and Dr Bohin, and in some of the cases you've also heard from other experts.

Expert evidence is admitted in a criminal trial to help you understand or to inform you of medical or scientific matters which may fall outside your experience, but which relate to things that either the prosecution or the defence, or both, say you should take into account when assessing the evidence as a whole.

The issues in [Baby K]'s case are such that it is agreed that there is nothing that either Dr Evans or Dr Bohin can say which would add to the evidence you have already heard and therefore we are not going to call them at this stage.

MR JUSTICE GOSS: Right. I hope you understand that. This, of course, is an allegation of attempted murder. The act is a specific act that is alleged and you have heard a lot of evidence about that. So it's agreed between the parties, for good reason, that there's no expert evidence that could assist you in relation to that, therefore none is going to be placed before you.

The consequence of that is, Mr Johnson, that we are now at the interview summaries and then at the end?

MR JOHNSON: Yes.

MR JUSTICE GOSS: But I have the interview summaries, for which I thank you. You know the process now. You get a summary of what the defendant said in relation to this when she was questioned by the police.

Summary of interview with LUCY LETBY re [Baby K] (read)

MR JOHNSON: As always, ladies and gentlemen, you'll get the full interviews, or the edited full interviews, in writing in due course, but this is just while you have the facts in mind and

you know what the issues are or where the lines between the parties are.

During the interview of 5 July 2018, Lucy Letby said she recalled [Baby K] only because she was a tiny baby and was 25 weeks' gestation and the Countess of Chester Hospital would not usually have babies of [Baby K]'s age and weight on the unit.

She said that [Baby K] would have been ventilated due to her age and Lucy Letby did not remember the ET tube slipping, nor did she remember any subsequent collapses by [Baby K] during the remainder of the shift.

Lucy Letby said that she would have to look back at the notes to see why she was in the nursery with [Baby K] and what other babies she'd had to care for that shift.

In the interview of 12 June 2019, Lucy Letby was informed that Joanne Williams was [Baby K]'s designated nurse and she agreed that she thought Joanne Williams would not have left [Baby K] to update the parents unless [Baby K] was stable and her ET tube was correctly positioned.

Lucy Letby did not remember being left alone with [Baby K] in nursery 1 and Lucy Letby could not remember being at [Baby K]'s cot side or [Baby K]'s saturations falling. Lucy Letby said she could not remember whether the alarm was silent, although she agreed it should have been sounding if [Baby K]'s saturations had fallen into the 80s.

Lucy Letby denied dislodging [Baby K]'s ET tube and she explained that [Baby K]'s tube had slipped earlier in the shift and had already had to be replaced.

Lucy Letby said tubes could slip if they weren't secured properly in the first place or if there was any tension on the tubing on the ventilator.

Lucy Letby had no recollection of the tube slipping and stated that she would have raised the alarm if Dr Jayaram hadn't walked in if she'd seen the saturations dropping or that the tube had slipped.

Lucy Letby thought it possible that she was waiting to see if [Baby K] self-corrected and she explained that nurses didn't always intervene straightaway if levels were not "dangerously low".

When further interviewed on 10 November 2020, Lucy Letby did not have any recollection of [Baby K]'s tube slipping at 7.30 am on 17 February 2016. Following further questioning from the police,

Lucy Letby suggested that maybe the tube had not been secured properly. Lucy Letby denied having done that deliberately and again suggested that the tube may not have been properly secured.

It was pointed out that there were no problems with the tube either in transport or at Arrowe Park and Lucy Letby suggested that the transport staff or the Arrowe Park staff may have re-secured the tube.

Lucy Letby agreed that she searched for [Baby K]'s mother on Facebook after this, but could not remember having done so. She explained in her text messaging later that she was complaining that the unit had been understaffed at the time of [Baby K]'s admission.

So that's the summary. As your Lordship has already said, that is in essence the evidence in the case of [Baby K] or the count of [Baby K].

MR JUSTICE GOSS: Yes. You'll recall last week, it was anticipated that we would reach this stage some time today and, as you know, we don't start on another baby because of the arrangements that have to be made. So that is it for today. It's a shorter day. Tomorrow, 10.30, we will start on the next baby. Thank you very much.

Please remember your obligations as jurors: no discussion with anyone at all about anything to do with this case other than when you're all together in a private place and can hear what is said by any one of you by all the other members of the jury, and no research about anyone or anything to do with this case.

Thank you very much.

(In the absence of the jury)

MR JUSTICE GOSS: Mr Myers, I take it that someone --

MR MYERS: Yes, we would like to see the defendant if we could, my Lord. We'll be able to see Ms Letby at some point, it'll be either one side or the other after lunchtime. It may have to be after lunchtime, but as long as she doesn't go before we've seen her.

MR JUSTICE GOSS: I think the officer in charge is familiar.

So whenever it is possible, either before or after, but not to be taken until someone's been to see her, thank you very much.

MR MYERS: Thank you, my Lord, I'm grateful.

(12.38 pm)

(The court adjourned until 10.30 am on Thursday, 2 March 2023)

4 6 8 11 13 15 17 19 21 23 25