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Tuesday, 14 March 2023
(10.30 am)

(In the absence of the jury)

MR JUSTICE GOSS: Yes, Mr Myers.

MR MYERS: My Lord, may I raise one matter with regard to Ms Letby before we commence today?

MR JUSTICE GOSS: Yes.

MR MYERS: In the past, Ms Letby suffered from optic neuritis, which is a swelling of the optic nerve and sometimes makes it a little bit difficult or uncomfortable to see. In particular it can cause sensitivity to bright light and make it hard to read.

Your Lordship may recall actually a while ago -- we remembered this this morning when we reviewed the position -- there was an enquiry from the jury about what was the Walton Centre and why was the defendant going there -- it was a long time ago in the case -- and in fact it was where she'd gone to receive treatment for this condition. We can deal with that in due course.

It's flared up in the last few days. She had wanted to go to hospital, which is what's happened in the past, but couldn't be taken there, although she was seen by a GP, we understand, at the prison, but no particular medication has been given, although in the past we understand she's had steroid drops.

In any event, it creates some discomfort in bright light at the moment, although she is able and ready, if she can, to continue, and therefore we don't raise any issue with the proceedings continuing, nor do we at this point request your Lordship to raise any issue or give any explanation to the jury and draw attention to it in that way, but because it is something which creates an issue for her and does affect the way she reacts to the light, it's something we thought was important to identify to your Lordship because you'll be looking at her and you'll see, perhaps, if there is a marked issue and we shall monitor the situation too. I know those who instruct me are going to make efforts on her behalf that she be seen by somebody as soon as possible, maybe even on Friday, along with the other assessment that's taking place, or at the weekend. But we thought it necessary to raise it and bring it to your Lordship's attention at this point. With your Lordship's leave, we'll see how we get on from here.

MR JUSTICE GOSS: Certainly. Thank you very much for bringing it to my attention, Mr Myers. I will obviously keep an eye on the defendant. If I can see that she appears to be having difficulty, I will break the proceedings off so that enquiries can be made. But she, I assume, has a very good relationship with the escorting staff and she will, I know, pass anything on to them, who will pass it on to you, who can pass it on to me. So everyone is aware of this difficulty and, should any problem arise, we'll deal with it as and when.

MR MYERS: Thank you.

MR JUSTICE GOSS: I will say nothing, do nothing, at this stage.

MR MYERS: We don't ask for that.

MR JUSTICE GOSS: Thank you very much.

(In the presence of the jury)

MR JUSTICE GOSS: There's a request that we don't sit beyond 3 o'clock this afternoon. Is it anticipated that that will cause any difficulty?

MR DRIVER: Absolutely not.

MR JUSTICE GOSS: There we are. That's it. No need to say any more. There we are. That answers the question.

Thank you very much. If there is any difficulty, I was going to say we'd have a slightly shorter lunch, but if we're not going

to have any difficulty then we'll just press on, usual mid-morning break, and then finish at 3 o'clock. Thank you.

Witness statement of MS AMY DAVIES (read)

MR DRIVER: My Lord, may I begin by reading some statements that we intended to read last week before circumstances caused us to have to adjourn. It's a statement of Amy Davies at page 27 of the first of two reading bundles that your Lordship has received.

Amy Davies made a statement dated 23 May 2018 regarding her involvement with a set of triplets born on 21 June 2016 at the Countess of Chester Hospital: "At the specified time I was working as a neonatal practitioner. I recall [Baby O], [Baby P], and [Baby R], and although I did not have any involvement in their care when they were first born, it was during the night of 21 June 2016 that I looked after both babies.

"I was working a night shift on 21 June 2016 and I was the designated nurse for [Baby O] and [Baby P]. During the handover I cannot recall any concerns or issues raised by the day staff. The care that I provided during that shift was very straightforward. Both babies were on CPAP and there were no concerns.

"When a baby is on CPAP, they obviously need that additional support, which makes them vulnerable, but I had no concerns about them. I have confirmed this by reviewing the notes made at that time, which also documents the babies were on antibiotics.

"I confirm that my initials AD are present at the bottom of the observation charts. Within [Baby P]'s notes I have documented that his cannula tissued during the night so it stopped working and this caused his arm to become swollen. As a result, the cannula was replaced with another and the replacement was uneventful. This is quite a common occurrence and I had detailed that it was a doctor who replaced the cannula.

"Both babies had blood gases to check that they were stable and the results confirmed they were. The triplets' parents visited and I updated them in relation to both [Baby O] and [Baby P] and I think the parents then returned to the ward for the night and I didn't see them again after that.

"I recall that [Mother of Babies O, P & R] was still in a wheelchair and recovering from her caesarean. I was happy with both babies during that night shift and I believe that they remained in nursery 1. From what I can remember, [Baby R] was in nursery 2, although I had no involvement with [Baby R] and I didn't look after the triplets again following that shift.

"I would have ended my night shift at 08.00 hours on the morning of the 22 June 2016, but I am unsure of the member of staff I handed over to.

"I worked the following night shift on 22 June 2016, but I did not look after any of the [Redacted] triplets.

I am unsure of when I next worked a shift at the Countess of Chester Hospital as I only work three shifts a week, but I believe it was after [Baby O] and [Baby P] had passed away."

Witness statement of MS CAROLINE OAKLEY (read)

MR DRIVER: The next statement to be read is at page 30, my Lord, a statement made by Caroline Oakley on 31 July 2018, which reads: "From accessing the computer system, Meditech, within the hospital, I can see that I worked a night shift on the 21st and 22 June 2016.

"On 21 June, the day the triplets were born, I came on duty at 19.30 hours. I was shift leader that night and I really cannot remember anything about them. From looking at the hospital records, Amy Davies was looking after [Baby O]. He was fine and was on CPAP and was stable and was nil by mouth.

"His parents had visited some time during the shift.

[Baby R] was also looked after by Amy on 21 June. He was also on CPAP and he was fine and stable. I don't remember anything else specific about that shift and the [redacted] triplets.

"On 22 June, I was the shift leader again coming on shift at 19.30 hours. I was in charge on the shift and I was working with Amy Davies, Sophie Ellis, Nicky Dennison and Val Thomas. [Baby O] was being looked after by Sophie Ellis on 22 June and he had obviously done quite well in the day as on the night shift he had come down from CPAP to Optiflow, which is less respiratory support. He was still on intravenous fluids, but had started to take a little bit of milk. This will have probably been just a tube up his nose and into his tummy.

"His antibiotics had stopped at 36 hours, so obviously he was clinically well, and his blood results were okay. I have made a note towards the end of the shift that his abdomen became distended and he was reviewed by Dr Mayberry and he said that clinically he seemed okay, so just carry on and monitor. I assume the request was made to Dr Mayberry by Sophie Ellis and she will have updated me as well, as I was in charge of the shift that night.

"[Baby P] was also being looked at on 22 June by Sophie Ellis. He had obviously had a good day shift because he had also gone down from CPAP to Optiflow (inaudible) some intravenous fluids and also started some feeds. His antibiotics had stopped and his blood results were okay. So overnight from 22 June into 23 June, both [Baby O] and [Baby R] were progressing well.

"For the night shift of 22 June, I was not the designated nurse for any of the triplets; I was the shift leader. So at the end of the shift on the morning of 23 June 2016, I would hand over to the morning staff and there was nothing of concern to comment on. [Baby O] did have a full tummy. Obviously it was enough of a concern for us to ask the doctor to conduct a review.

There was nothing with [Baby P] but we also thought [Baby R]'s tummy was full so we also requested a review on him.

"So obviously, there was something with the two with the tummies. I did not work the shifts on the 23rd and 24 June 2016 at all. By the time I returned to work, sadly both [Baby O] and [Baby P] had passed away. There is no further information I can provide in relation to the [redacted] triplets."

Witness statement of MS VICKY BLAMIRE (read)

MR DRIVER: Finally, my Lord, at this stage, may I read a statement from a Vicky Blamire. It's at page 34 of the bundle and it's dated 26 January 2018 and it reads: "I have been asked with reference to the care of [Baby O] and in particular 22/23 June 2016.

"I recall [Baby O] as he was one of three triplets who all appeared to be doing well. I was working a night shift on the 22nd into 23 June 2016 and it was a busy night shift. During the early hours of the 23rd I was asked by Nurse Sophie Ellis to do a nasogastric tube feed on [Baby O]. Sophie was the designated nurse for [Baby O] during this shift.

"I went into nursery 2 and no other members of staff were present. As I approached [Baby O]'s cot, I could see everything I needed for the feed was laid out ready. To do a tube feed all you require is the milk and a syringe. To conduct this feed you use the syringe to aspirate the nasal tube of the child, which indicates if any stomach acid or digested milk is still in the stomach, which will indicate the nasal tube is still in the stomach.

"To feed the child, you can either filter the milk from the syringe through the nasal tube into the stomach or place the milk on to a stand within the incubator and gravity will then feed it through the tube and into the baby's stomach.

"I noticed that [Baby O]'s stomach was distended (swollen) and told Sophie this. She told me that she was aware and had asked for a review by the paediatric doctor, but had been told to go ahead with the feed but closely monitor the stomach.

"I fed [Baby O] and remember him squirming a little as he was being fed. I will have signed for this tube feed on the feeding charts, which are kept on the end of the cots. I cannot recall how long this procedure took to complete. I had nothing further to do with the care of [Baby O] for the rest of the shift." My Lord, we now would like to call Dr Brearey, who has been in the building for some time now. As your Lordship may be aware, there is, for reasons unconnected to our trial, enhanced security in this building at the moment, which is causing a delay in the movement of witnesses. So as of the time Mr Johnson wrote me a note a minute or two ago, Dr Brearey was not outside.

MR JUSTICE GOSS: Do you have any indication, Mr Johnson, as to --

MR ASTBURY: I wonder if I can assist. Dr Brearey was asked to be brought up for 10.30, so my Lord may have noticed I have been bobbing in and out and there is no sign of him yet. In fact there are a couple of things I could probably read if that could assist to occupy a few minutes.

MR JUSTICE GOSS: If that doesn't cause any difficulty?

MR ASTBURY: It doesn't, no.

MR JUSTICE GOSS: All right. Let's await Dr Brearey as and when he can be -- no, he's not here. Right, please come forward, Mr Astbury, and read these statements to us.

Witness statement of MS YVONNE FARMER (read)

MR ASTBURY: Thank you. My Lord, they're in the new bundle that I hope is --

MR JUSTICE GOSS: I have it, thank you.

MR ASTBURY: Beginning with Yvonne Farmer at page 36.

Yvonne Rose Farmer, in a statement dated 13 March 2018, says this. I should describe, she is a nurse by profession. We have edited the statement down: "On 22 June 2016, I was working a long day clinical shift on the unit, which had commenced at 07.30 hours.

I recall looking after [Baby P] on this date and I think I also looked after one other patient.

"[Baby P] was in nursery 2. We call this our high dependency room and we have access to all the gases and equipment. During that afternoon, I remember one of my colleagues moving [Baby P]'s brother [Baby O] from nursery 1 to nursery 2. I recall this as nursery 1 was busy and, due to limited available bed spaces, we had to move babies around.

"I believe my colleague Sam O'Brien was [Baby O]'s designated nurse that shift and I supported her in moving [Baby O] whilst Sam was caring for another baby in nursery 1. [Baby O] needed a new IV site as well. I also assisted with [Baby O]'s drip and intravenous fluids whilst the cannulation procedure was conducted.

"We do share our workload and as a team we help each other where we can. My involvement has been documented by Sam and is visible within the nurses' records.

I also recall that [Baby O] had been on nasal CPAP and had been downgraded to high flow. The [surname redacted] babies were quite difficult to cannulate as their peripheral circulations were quite poor. This is common in premature babies but it is all dependent on the individual baby. From reading the notes, I can see that all three of the triplets had problems with their IV access.

"On 23 June 2016, I was working an 08.00 to 17.00 hours day shift and in a practice development role. Some time towards the afternoon, I was inside the office when I was alerted to [Baby O]'s collapse.

I am unsure who made me aware of the situation, but [Baby O] was in nursery 2 and was quickly transferred back to nursery 1.

"We make this decision as nursery 1 is a larger room and allows more staff to be involved and provides increased access to the babies. It also makes it easier in the event of a transport team assisting with the transferring-out of a baby.

"I made my way to nursery 1. As I entered nursery 1, I saw Lucy Letby, [Dr A] and [Nurse C].

I am unsure of whether any other colleagues were present. [Baby O] was being intubated and I cannot confirm whether I was involved in administering drugs but I was present in a support role.

"Any baby requiring resuscitation has cardiac massage and another member of staff manages their airway. Two more people are required to draw up and check the drugs and to document the drugs administered.

We have a written resuscitation drug pro forma so we know exactly the amount of drugs to give to the baby and in which order. We document the time we start resuscitation and the time we start cardiac massage.

This results in an accurate record of the procedure.

"The drugs are already in nursery 1 and we have a resuscitation trolley. On top of the trolley, or by the trolley, there is a sealed box containing all of the drugs needed along with the pro forma. All the items are within easy reach and these are kept separately from all the other drugs. Once the seal is broken, the drugs are in a set order. This negates having to search for the drugs required or having to leave the room. Once the box has been used for a baby, the box is returned to the pharmacy and is either destroyed or a new box is made up.

"We draw up the drugs. This involves two members of staff and we hand the drugs to our colleagues conducting the resuscitation. I don't know if it would have been Lucy or one of the doctors who administered the drugs to [Baby O]. With any resuscitation, a consultant is called and we ended up with three consultants present that shift. I know I stayed at the unit until approximately 17.30 hours. My colleague Yvonne Griffiths was still on the unit and she took over from me and I am aware that it was soon after I left that [Baby O] passed way.

"I do recall Dr Gibbs and [Dr B] both being in the room. It is possible that this is when I was called into the room as I do recall scribing at one point, but I cannot say for certain.

"On 24 June 2016, I was informed by a colleague that [Baby O] had passed away."

MR JUSTICE GOSS: That sentence you have just read, "It is possible that this is when I was called into the room", is slightly out of context now because of the editing that's taken place. But the point is she was in the room and she says she may well have been responsible for some of the entries on the sheet that we saw last week, but she hasn't been asked to look at the sheet and identify where her handwriting appears if at all?

MR ASTBURY: We think we know whose the handwriting is, but we'll come to that.

MR JUSTICE GOSS: Exactly, yes, so we'll deal with that. It just may have been slightly confusing that part. You will well remember that sheet you haven't looked at but you will remember I have looked at and you will have the opportunity to look at in due course.

MR ASTBURY: As my Lord reminds me, we didn't show it to the jury, but perhaps after the break I will bring it in and that can be done.

MR JUSTICE GOSS: We hadn't anticipated that our sitting last week was going to be curtailed as much as it was with the weather. You'll remember that we broke off at Thursday lunchtime.

MR DRIVER: Dr Brearey, please.

DR STEPHEN BREAREY (recalled)

Examination-in-chief by MR DRIVER

MR DRIVER: Could I invite you to state your full name for the recording, please?

BREAREY: Stephen Paul Brearey.

DRIVER: You're still bound by the oath or affirmation you took on your first visit to the court.

I would like to ask you, please, about the events of 23 June 2016 and your involvement with the baby [Baby O].

Firstly, can you confirm the nature of your duties or responsibilities on that particular day shift?

BREAREY: I wasn't the consultant of the week that week, but I was in a meeting on the neonatal unit on the morning of the 23rd, and that meeting had finished and I was passing through the neonatal unit and spoke to [Dr A], who was the registrar on the neonatal unit that day. He had just attended to [Baby O] and moved [Baby O] to room 1 of the neonatal unit and I offered to assist him with the intubation that he was planning at that time.

DRIVER: Thank you for that introduction. Before you became directly and personally involved in the treatment of [Baby O], did you appraise yourself of his relevant clinical history?

BREAREY: Yes, and [Dr A] gave me a handover of the background, yes.

DRIVER: Thank you. My Lord -- you and I need to raise our voices.

MR JUSTICE GOSS: Not you so much, but you're facing

MR Driver and you were dropping right away at the end of the sentence. I'm not being critical it's just it's difficult.

BREAREY: Thank you for reminding me.

MR JUSTICE GOSS: It's all right.

MR DRIVER: I was about to ask, given the break we had last week, if I could, through Dr Brearey, remind ourselves of the clinical history with reference to our carousel presentation very briefly.

MR JUSTICE GOSS: I think that would be helpful, just to refresh our memories. I'm sure you'll remember [Dr A] giving evidence last week and, you remember, he said he helped, as he recalled, pushing [Baby O] into the other nursery.

MR DRIVER: In fact, my Lord, [Dr A], when he last came to give evidence was about another baby, [Baby N], and [Dr A] will join us tomorrow.

MR JUSTICE GOSS: I'm sorry, I'm getting confused now. That illustrates how easy it is to get confused. So there you are, I need refreshing as well.

MR DRIVER: If Mr Murphy could take us to tile 4, please.

For this purpose, Mr Murphy, we will just use the second tile here without going to the original notes so as to give ourselves a reminder of the chronology.

Did you appraise yourself of the notes made by your junior colleague, Dr D, as to [Baby O]'s time and date of birth and condition in the first hours of life?

BREAREY: I did, yes.

DRIVER: And in a sentence or two, how would you summarise those facts?

BREAREY: [Baby O] was one of triplets born at 33 weeks and 2 days' gestation. They were born in relatively good condition for their gestation. [Baby O]'s birth weight was just over 2 kilograms, which is a good weight for that gestation -- and for being a triplet. They required, or [Baby O] required, CPAP

support in the first day of life, but his supplementary oxygen requirement reduced to air in that first 24 hours.

He received IV antibiotics and caffeine and, further to that, in the second day of life, he was weaned down to Optiflow support but still in 21% oxygen air. And antibiotics were stopped after 36 hours. All was generally good and going in the right direction for those first 48 hours. I think he established full enteral feeds within 48 hours as well.

DRIVER: Thank you. Mr Murphy, could you take us to tile 6, please, which, I anticipate, confirms the facts that you have just shared with us as to the feeding regime.

BREAREY: That's correct.

DRIVER: Then to tile 121, which will take us to a ward round at 09.30 on 23 June 2016. The jury, I'm sure, will remember Dr Cooke, who gave evidence last week. Did you learn that during that ward round it was noted that [Baby O] had a trace aspirate from his nasogastric tube?

BREAREY: Yes.

DRIVER: What was the nature of that aspirate?

BREAREY: I think she commented that there was some bilious -- there were some mild aspirates but some bilious.

DRIVER: Yes.

BREAREY: Nothing too worrying in that on its own in view of the rest of the examination and findings being unconcerning.

DRIVER: I think if we look at this, we can go to the original note if need be, but if we look at the line that begins with the letter F.

BREAREY: Yes. So the baby's moved up from 75 to 90ml per kilogram per day of fluid as is protocol, was receiving donor-expressed breast milk via NG tube, and trace of aspirates, so non-bilious, sorry, I do apologise for that.

DRIVER: Not at all, thank you. Then if we move forward in time to 13.15 hours, tile 168. [Dr A], as I've already indicated, will join us tomorrow to give evidence, but did you appraise yourself of his note --

BREAREY: Yes.

DRIVER: -- made when he was asked to see the patient at 13.15 hours?

BREAREY: Yes, I did, yes.

DRIVER: How was [Baby O] presenting in summary at this point in time?

BREAREY: Well, [Dr A] was asked to see [Baby O] because of a vomit and abdominal distension. He noted the amount of milk that [Baby O] was on and mentioned the trace of aspirate but no bile, one vomit post-feed, no blood, either orally or by rectum. There was a small meconium plug at the anus, presumably that's on his examination.

His heart rate and saturation levels were all within the normal range, 160 to 170 heart rate, and saturations of 100%.

Femorals were palpable, femoral pulses were palpable. The capillary refill time was less than 2 seconds. Again, normal range. His respiratory rate was 40 per minute, normal range. Temperature of 36.8, a normal temperature. But abdomen was distended.

Umbilicus was normal. There was no flare -- that's some redness around the umbilicus -- and no erythema.

DRIVER: Pausing there if I may, what's the significance or the point of that observation, the absence of flare or erythema?

BREAREY: With a vomit in a preterm baby and some abdominal distension, one of his differential diagnoses would be necrotising enterocolitis; I'm sure the jury have heard of it before.

DRIVER: They have, yes.

BREAREY: There are different clinical diagnostic criteria for necrotising enterocolitis, and some flare around the umbilicus or the tummy button would be one sign of necrotising enterocolitis. And there wasn't any evidence of that redness or flare in the tummy.

DRIVER: Thank you. Sorry, I interrupted you. Continue.

BREAREY: He noted there were no femoral umbilical hernias present, another cause for vomiting in a preterm baby.

The bowel sounds were normal, were active, in all the quadrants of the tummy. Again, reassuring for it not being necrotising

enterocolitis. And there was no enlargement of the liver, kidneys or spleen on his examination.

DRIVER: Thank you. There were some blood gas tests undertaken, I understand. If we could go to tile 172 and click on to the original document, Mr Murphy. I'm grateful.

In summary, what does this measurement report inform us of?

BREAREY: It shows that there's a mild metabolic acidosis.

DRIVER: Could you explain what that is to the jury, please?

BREAREY: So the pH of 7.201 is slightly lower than we'd expect a normal range to be for a preterm baby. The carbon dioxide level was slightly higher, but more or less acceptable for a preterm baby on Optiflow. You can't interpret the oxygen level in a capillary gas like this. The base excess and the bicarbonate levels were raised, suggesting there was a metabolic cause to the mild metabolic acidosis.

DRIVER: Could you explain the concept of a mild metabolic acidosis, please?

BREAREY: That would lean you more towards a problem that isn't ventilatory, like in a respiratory acidosis, the carbon dioxide level would be significantly raised. If the base excess and the bicarbonate are those levels, then the other category of causes would fall into things like infection or blood loss or fluid loss, that sort of thing, really.

DRIVER: So it's a pointer but not literally diagnostic of anything in particular?

BREAREY: Exactly, yes.

DRIVER: I'm grateful. If we can go back to our tile 168 for a moment to see [Dr A]'s plan. So the plan was?

BREAREY: To do the gas, which we've just talked about, and he was suggesting that if there was any temperature instability, apnoea or bradycardia, so if [Baby O] were to stop breathing or his heart rate was to drop somewhat from the normal range or if there was any blood from anywhere, really, then that would be an indication for an abdominal X-ray to look at his tummy in more detail and to consider giving fluid boluses, which would correct the metabolic acidosis.

DRIVER: Thank you. If we could look at some features of that plan in action. If we go to tile 180, I think we'll see a full blood count sample. Click on the original document, Mr Murphy.

So this is different to the last report that we looked at. How does it differ, Dr Brearey?

BREAREY: So this is a U&E result from the lab initially. It's showing a normal sodium level, a normal potassium level, the bicarbonate level is within normal range. Urea, normal. Creatine is slightly high by lab values but acceptable for a preterm neonate. And a bilirubin of 131, which I would have expected to be under the treatment line for jaundice.

DRIVER: So in summary, bilirubin apart, what do those results inform you of?

BREAREY: None of those results were concerning, in the normal range.

DRIVER: All within normal range?

BREAREY: Yes.

MR JUSTICE GOSS: When you say under the treatment line, that means it should have been --

BREAREY: No. There's a chart, which you may have seen, where you can plot the bilirubin level against time and there's a line, and if the level is above that then you give phototherapy or exchange transfusion if it's very high.

But because it's below the line the baby didn't need treatment.

MR JUSTICE GOSS: That's what I thought because Mr Driver thought that that was concerning. So it wasn't in fact -- there wasn't any jaundice to speak of? Not requiring phototherapy?

BREAREY: It was mild, not needing treatment.

MR DRIVER: Before we get to your direct involvement, [Dr A] having suggested that --

BREAREY: Sorry, just can I --

DRIVER: Please.

BREAREY: Because it just mentioned the CRP level being 1. So there was no evidence of infection on these blood tests either during this test and the full blood count result was similar. There was no concern about infection from the full blood count or the CRP.

DRIVER: Understood. Can I just ask you to consider X-rays, please. Firstly one at tile 197. If we look at Dr Wright's -- we don't need to go to the X-ray itself, Mr Murphy, if we just look at Dr Wrights' description or her radiology report, more accurately.

What did this reveal?

BREAREY: Well, I can go through her report if you like, but I think we agreed with this at the time, that the NG tube was in a satisfactory position with its tip in the stomach. There's a normal cardiac size and contour to the heart. Slightly increased lung density bilaterally, consistent with mild RDS. [Baby O] was on Optiflow at the time. Moderate gaseous distension of the bowel loops throughout the abdomen. No free peritoneal air, to indicate perforation, or intramural gas, to indicate necrotising enterocolitis. The appearance is non-specific, but NEC, necrotising enterocolitis, or mid-gut volvulus cannot be excluded.

DRIVER: The doctor referred to a subsequent image which --

BREAREY: Yes. So I think [Baby O] had had a previous X-ray and the degree of distension of the bowel loops was improved from that previous X-ray.

DRIVER: I think if we go to our tile 246, and look at the summary of Dr Wright's consideration here, this is post-intubation, so we have raced ahead in time a little.

BREAREY: This is 16.46, so this is after [Baby O] had had the bradycardia and desaturation and intubation. So it's an X-ray taken immediately after intubation to check the endotracheal tube position and it was reported that the endotracheal tube was in a satisfactory position, the NG tube should be advanced 10 to 15 millimetres, which seemed to be a little high in that X-ray. Normal cardiac size and contour. Mild bilateral changes of RDS, similar to the previous X-ray. The lungs appeared hyperinflated but there was no evidence of pneumothorax.

The bowel was considerably less distended by comparison to the previous image earlier in the day.

DRIVER: That was a reference that we saw, was it (overspeaking) --

BREAREY: On the previous one.

DRIVER: -- Dr Wright's last report?

BREAREY: Yes.

DRIVER: And no evidence of perforation or obstruction, and as you've already commented, no intramural or portal vein gas demonstrated?

BREAREY: Correct.

DRIVER: Let's return to the chronology at tile 188. If we stay with the outer tile. It just records your arrival or entry within the unit. Does that accord with your recollection of your movements that day? So it's about 4.30ish you were passing there -- sorry, 2.30ish.

BREAREY: It was earlier than that because I assisted with the intubation, which I think occurred around about 3, if I'm correct.

DRIVER: It's my mistake. I said 4.30 and I should have said 2.30.

BREAREY: Okay.

DRIVER: So you were on non-clinical duties, you told us?

BREAREY: Yes.

DRIVER: Teaching within the unit that day?

BREAREY: It was a meeting. Either way it wasn't clinical, yes.

DRIVER: And then if we go to the chronology at tile 199. Just to orientate themselves, go to the second tile there, which is [Dr A] recording that he, [Dr A], was called to see [Baby O] at 14.40 because of a desaturation, bradycardia and a mottled appearance.

BREAREY: Yes.

DRIVER: Please tell us your recollection of when you became involved in these events.

BREAREY: From my recollection, at some time between 14.40, when he had a desaturation, and about 15.00, 3 o'clock, when he was intubated. So at some time whilst [Dr A] was preparing and the nursing staff were getting the medicines ready for the elective intubation.

DRIVER: And how did you come across the situation and what did you do in response?

BREAREY: I was really supervising [Dr A]. He's a very senior registrar, so I didn't have any active role in the task.

We went through the intubation checklist prior to intubation, which is checking the equipment and the personnel and allocating tasks for each role in the intubation. I was leading the intubation but [Dr A] was the first intubator allocated and if he was going to have trouble then I'd step in to be the second intubator. And then we went ahead and intubated [Baby O].

DRIVER: Thank you. Could we go to tile 206, please? Just click first on the original document and then we'll return to this page.

Is that your handwriting, Dr Brearey?

BREAREY: It is, yes.

DRIVER: Are these notes written retrospectively and the notes were written at 18.00 or thereabouts on 23 June?

BREAREY: Yes.

DRIVER: They begin with the words: "On the unit and assisted with intubation by [Dr A] this afternoon."

BREAREY: That's correct.

DRIVER: So you told us that you supervised or were on hand to supervise [Dr A]'s elective intubation of [Baby O] --

BREAREY: Mm-hm.

DRIVER: -- which other information will tell us took place between 15.03 and 15.08 hours? So that's to fix it in time.

BREAREY: Yes.

DRIVER: Tell us about the intubation process, please.

BREAREY: Well, [Dr A] didn't have any problems intubating and we worked together to fix the tube in the correct position and I clarified that there was a good colour change on the capnograph, indicating that it was in the correct position and there was gas exchange going on.

And I listened to [Baby O]'s chest and there was good air entry on both sides. And it was -- we connected [Baby O] and the ET tube to the ventilator and started him on fairly normal ventilator settings for a preterm baby, really. The rate was 60 per minute. The inspiratory time on the ventilator was 0.4. The

pressures were 20/6. And the amount of oxygen he's in initially was 30% oxygen, so not having to work too hard to ventilate [Baby O] at this stage, and he seems relatively stable.

DRIVER: So successively intubated to enable a connection to the ventilator?

BREAREY: Yes.

DRIVER: But in terms of the degree or extent of ventilatory assistance, was that moderate?

BREAREY: Moderate, yes.

DRIVER: Next you have made a note of an observation you made.

Could you give us your recollection of that observation, please?

BREAREY: I noted during the intubation that [Baby O] had a rash on his chest, on the right side of his chest wall, exactly 1 or 2 centimetres in size. I haven't said the size there but I mentioned it in my statement. It was an unusual rash. It was initially -- it initially appeared like a purpuric rash.

DRIVER: Pausing there, Dr Brearey, you'll be more familiar with that term than most of us in the room. What do you mean by a purpuric rash?

BREAREY: I suppose most people might come across it when they're being warned what to look out for if children or babies have meningitis. So you talk about a glass test where you roll a glass over a rash and if it doesn't disappear, that means purpura because the little capillaries are broken under the skin and it is quite a worrying sign in a sick baby who presents to A&E, for example, with a temperature. So purpura in neonates is very, very rare and often babies are very ill when they have purpura.

So it was a little concerning and clearly noticeable. And I have made the point there of [Baby O] having good perfusion at the same time because you wouldn't expect a baby who is ill with sepsis, with purpura, to have good perfusion at the same time. It normally goes together that a baby has poor perfusion and a poor capillary refill time and that didn't seem to be the case with [Baby O] at that time. So that's why I mentioned it in the notes. It was unusual.

DRIVER: At that point in time did you form any view as to the possible cause for that presentation?

BREAREY: Well, we've talked about sepsis already, and I was aware that [Dr A] had already started [Baby O] on antibiotics, so been restarted on IV cefotaxime already to cover for infection. I'm not entirely sure at this point whether we had the blood test back that we've just discussed with the CRP being 1, but certainly I think most doctors in that position would want to -- would have infection as their sort of first suspicion of a cause for this rash.

DRIVER: Did you have that as your first suspicion at that point in time?

BREAREY: Initially, yes.

DRIVER: You have told us that you were not a consultant on call, but you were on hand, so you lent your assistance.

Can you recall who was the on-call consultant for the neonatal unit that week?

BREAREY: [Dr B].

DRIVER: Did you communicate with [Dr B]?

BREAREY: I did. I believe she was on the children's ward at the time when we intubated, so after I was happy that [Baby O] had stabilised after intubation, on my way back to my office, I stopped by to talk to [Dr B] to let her know that we had intubated [Baby O] and I think [Dr B] was about to do that as well anyway and give her an update around about the same time.

DRIVER: So [Baby O], having been connected to the ventilator, having intubated and then connected to the ventilator, more accurately, how was he, generally speaking, when you left and spoke to [Dr B]?

BREAREY: He seemed to have stabilised. We normally look to repeat a blood gas about half an hour after intubation to check that the numbers are all okay in terms of that.

So you don't have an immediate sort of definite idea, but there was nothing on the monitor or from the observations that were concerning at the point when he left at that time.

DRIVER: Thank you. Before we move on through the chronology of events, you posed the question to yourself as to whether or not the blood results had been received at this point and I think, if we go to tile 175, which is earlier in time to that which we've just looked at -- this is actually the taking of a sample rather than the results.

If we look at this document itself.

BREAREY: So the blood culture was taken on that day looking for infection. There was no evidence of infection on blood culture as well as the CRP result being less than 1 that we've spoken about already.

DRIVER: A culture taken at 13.39 that afternoon, but reported back in its fullness some 5 days later when no bacterial growth was discerned?

BREAREY: Yes.

DRIVER: So let's move back to the chronology of events, please.

So you having assisted or supervised [Dr A], having left that part of the unit, spoken to [Dr B], were you then called back at 16.30 hours?

BREAREY: Yes.

DRIVER: If we could go to tile 205, please. What was happening -- sorry, that doesn't appear to be the right tile. 225 perhaps. Go to tile 243, I'm told.

MR JUSTICE GOSS: It wasn't 206 because that was the next one, written in retrospect at 18.00.

MR DRIVER: 243, if we could click there, please. My note is in error.

Does this record, and if we go to your original, that you were called back to assist?

BREAREY: Yes. So I haven't included all of the background between that first paragraph and when I was called back to assist at 4.30, but from what I can gather from the notes, [Baby O] had a further deterioration on the ventilator, where he had a desaturation and a bradycardia on the ventilator that then prompted a re-intubation by [Dr A] and [Dr B], and then a further one secondary to that whilst on the ventilator. It was when they were assisting [Baby O] and managing [Baby O], the second of those re-deteriorations, that they called me to assist.

DRIVER: Thank you. Both [Dr B] and [Dr A] will give evidence, out of sequence, but they'll be coming shortly.

Let's go to your note then at approximately 16.30.

What was happening when you came back to the NNU?

BREAREY: Well, [Baby O] had effectively been resuscitated by [Dr B] and [Dr A] and in that resuscitation effort he'd received two doses of adrenaline and had had cardiac compressions, and on my arrival he had restored to a spontaneous heart rate, increasing to 140, and oxygen saturations in the 90s when I arrived.

DRIVER: Sorry to interrupt, but could you give us an overview then of his state upon your arrival?

BREAREY: So on my arrival, he had restored his spontaneous circulation and his oxygen saturation levels were normal from a point, when [Dr B] and [Dr A] saw him, where he was having a bradycardia and desaturations.

DRIVER: Thank you. So you were informed, no doubt, of his condition when they intervened, but at the time you arrived --

BREAREY: Yes.

DRIVER: -- he was in some (overspeaking) recovery?

BREAREY: Yes, they'd got him back again, yes.

DRIVER: So what happened next?

BREAREY: I noted a good colour change on the capnograph and he became stable enough to be put back on to the ventilator, this time at slightly higher pressures. So the rate was the same, 60 per minute. His inspired oxygen concentration was 100% this time, which is higher than previously, and the pressures were 32/6, so higher peak pressures on the ventilator, so needing to do more work at that stage.

DRIVER: Could you expand upon that again as to why the ventilatory support was enhanced?

BREAREY: Well, it's hard to say other than the fact that those ventilator pressures were needed to maintain [Baby O]'s saturations and observations.

DRIVER: Thank you. Could we go to tile 255, please. Could you explain to us the rationale behind the entries recorded here?

BREAREY: Okay. So on reassessing [Baby O] at that time, his perfusion wasn't as good as previously and we prescribed some dopamine, which is an infusion of medicine that raises the blood pressure. It's what we call an inotrope. So that infusion was started to help with his perfusion on the basis that his blood pressure might be a little low.

FFP is fresh frozen plasma and that was requested.

Again, if you're considering sepsis then sepsis can cause something called disseminated intravascular coagulation coagulopathy, which essentially means there is clotting abnormalities as a result, so FFP would be the treatment for that. So that was requested. It needs to be taken out of storage and brought from the transfusion lab. So sometimes there's a little lead-in before it's actually given.

I think [Dr B] and [Dr A] had tried to do some capillary blood sample gases but weren't able to obtain those because of [Baby O]'s poor perfusion. But looking at his condition at the time, I felt that it would be reasonable to give him a half correction of sodium bicarbonate on the basis that he's more than likely still got that metabolic acidosis that I mentioned earlier.

DRIVER: Let's go to tile 263, please, as to the short infusion of sodium bicarbonate to enable us to understand.

What's the purpose, the objective, of the introduction of that at this point?

BREAREY: Well, if a baby is acidotic then bicarbonate is essentially a base that corrects that acidosis. So that's the purpose of it, to increase the pH of the blood, and it's thought that the medication that we give, particularly things like dopamine, work better in a normal pH.

DRIVER: Thank you. Tile 263, Mr Murphy. Sorry, that's where we are. Tile 267.

MR JUSTICE GOSS: I think it may be 266.

MR DRIVER: Sorry, 266.

MR JUSTICE GOSS: They all appear on these notes -- this is just a continuation, they're put into the sequence at this stage, but I'm retaining the one note and following it down on that note. I'm not criticising it, but you'll see it's just all on the one note and these various events go through. It's just further down this note, the same note.

MR DRIVER: Quite so.

At 17.15 was [Baby O] baptised?

BREAREY: Yes.

DRIVER: How did he progress immediately thereafter?

BREAREY: His heart rate started to drop towards the end of the baptism. So as the baptism finished then we intervened and started chest compressions and CPR.

DRIVER: How significant a drop in heart rate is a drop down to the region of 60?

BREAREY: Well, less than 60 would be your criteria for starting chest compressions, less than 60 per minute.

DRIVER: Thank you. So chest compressions were started. Were you involved in the CPR?

BREAREY: Yes.

DRIVER: Can you describe the process to us?

BREAREY: Well, there is a standard neonatal life support process, so there will be three chest compressions to every one breath given through the ET tube at that time. That will continue with regular rechecks of the pulse and any effort at breathing that might have restarted. And then regular doses of adrenaline given during the resuscitation effort.

DRIVER: As to the adrenaline, [Dr A] will give evidence as to the precise timing of that. But in terms of [Baby O]'s general appearance within the context of CPR, obviously, how did it appear to be going from a respiratory point of view?

BREAREY: Well, we had a really good team that afternoon, working really well, and so the process of the resuscitation, I couldn't fault it, to be honest, really. Everything was going as you'd expect. Dr Gibbs joined us at one stage, another senior member of staff. So there were three consultants present and a senior registrar who was going to be a consultant later that year. So we weren't short of experience.

Paediatricians are quite humble people, but Dr Gibbs and myself are both advanced paediatric life support instructors. I'm a neonatal life support instructor.

[Dr A] and [Dr B] are very experienced. There was lots of years of experience in that resuscitation.

We were well supported by nursing staff and I thought clearly the process of the resuscitation and what we were doing was as I would have wanted or expected to happen. But we just weren't getting a response back in terms of [Baby O]'s condition that we'd normally expect from what I would consider to be a good quality resuscitation.

DRIVER: Could I invite you to further analyse that response, please? We can see from the note that Neopuff inflations were underway and that there was good chest movement.

BREAREY: Yes. So we're quite confident that the Neopuff was being used but the endotracheal tube was still in situ and seeing his chest rise clearly is reassurance that the breaths that we're giving are inflating the chest and causing gas exchange in the lungs.

DRIVER: Was that gas exchange further evidenced by a capnograph reading?

BREAREY: It was, yes.

DRIVER: So from that point of view, all was as one would hope in the circumstances?

BREAREY: Mm-hm.

DRIVER: But did it have the desired effect?

BREAREY: It didn't seem to be having the effect we would normally see from those resuscitation efforts, no.

DRIVER: What was the difference in [Baby O]'s presentation from that which one would anticipate you would "normally" see?

BREAREY: We'd normally see a response from heart rate initially, really, and the heart rate rising, and we didn't feel a pulse throughout this resuscitation. I've mentioned slightly lower down in the note that although the monitor was reading a heart rate between 40 and 200, he never had a palpable pulse. I believe I made a statement about this discrepancy to clarify this.

DRIVER: Could you explain that apparent discrepancy to us, please?

BREAREY: So there's different forms of cardiac arrest and the two main forms are cardiac arrest, where you don't have a pulse, either something we called asystole, where the monitor will have a flatline, or pulseless electrical activity, where the monitor might show some electrical activity in the form of a wave but there's no palpable pulse. So effectively, the electricity is going through the heart but it is not enough for the heart to stimulate a heartbeat and generate that pulse pressure.

From a practical point of view, it doesn't make a difference because you still need to carry on doing the CPR in the same way for both asystole and pulseless electrical activity.

DRIVER: And in [Baby O]'s case was there evidence on the monitor of electrical activity?

BREAREY: Yes.

DRIVER: However --

BREAREY: There was no pulse.

DRIVER: What, if any, investigations did you undertake to try and solve the problem?

BREAREY: Obviously, with a sudden deterioration like this, we'd want to exclude a pneumothorax, so we did a cold light investigation and there was no suspicion of pneumothorax on cold light examination.

DRIVER: And of course we've already considered abdominal X-rays.

Was there anything in any of those reports to suggest whether or not there was a pneumothorax?

BREAREY: From the chest X-rays, no.

DRIVER: You've noted the consultants in attendance and the family members in attendance also.

BREAREY: Yes.

DRIVER: If we go to tile 286, we'll see the next page of your note. Could you explain to us what happened next as recorded in the note?

BREAREY: Okay. So we'd been carrying on resuscitation for quite some time and it was starting to appear that there was no response to resuscitation and we'd been going for over half an hour since that baptism. I was aware that we hadn't had a blood gas for some time because previous attempts at blood gas had been unsuccessful because of the poor perfusion in [Baby O].

I was also aware of previous deaths on the unit and the importance for us to show that we were resuscitating effectively. I could see it clinically in front of my eyes that we were doing all those sorts of things properly, but sometimes having some blood tests help that and also a gas might help to help us in terms of our resuscitation as well, you know, if there were any specific abnormalities that we could correct. So I thought a blood gas would be helpful at this stage in proceedings.

We didn't have a problem with IV access because the dopamine had been given, the adrenaline had been given, so we had IV access. But the problem with the peripheral IV access is that you can't take blood out of a peripheral cannula very easily, the vein collapses and you interrupt the infusions that are going through. And it was day 3 of life so the umbilical cord was quite dry and would have been quite difficult to cannulate, which would be the normal thing we do in a newborn baby.

[Baby O] was 3 days old now and although [Dr A] had planned to put in a UVC prior to all these deteriorations, it can be a lengthy process and quite difficult to do at the best of times, even when someone is giving CPR. So I thought probably the best option at that time was an intraosseous blood sample.

DRIVER: Can you explain what that is, please?

BREAREY: So the bones in -- a lot of long bones are hollow and within the hard bone itself is blood marrow and blood; that's where your blood cells are made. And, more so in paediatric practice for babies that come collapsed to the A&E department or older children to the A&E department, if the medical staff aren't able to get IV access soon, then the intraosseous route is the preferred option for getting quick access so you can do blood tests and give infusions.

So intraosseous needles have been used for some time for older babies and children, but not too commonly used in neonates. Their use is recommended now in neonatal life support courses but that change happened after these events, so it wasn't in any of the textbooks for neonatal life support at the time when these events were happening, but all of us, as paediatricians, knew how to take an intraosseous sample at least.

So the intraosseous needle wasn't needed to assist with the mechanics of the resuscitation because those fluids and the drugs had already been given. It was really, hopefully, a confirmatory blood test or a blood test to guide us in the late part of the resuscitation.

DRIVER: Thank you. If anybody cares to note, the printout corresponds to -- Dr Brearey's handwritten note here is behind our tile 288, but we needn't go there, Mr Murphy, if we just stay with Dr Brearey's note.

Looking at the next -- forgive me. Dealing with this in stages, so the results, the data there, from the blood test, what did that inform you of?

BREAREY: The pH was just over 7, so [Baby O] still had an acidosis and it was still a metabolic acidosis. Importantly for

me, as a doctor, as part of a team, the resuscitation team, the carbon dioxide level was 7.06, which told me that we were effectively ventilating [Baby O]'s lungs and that was the same carbon dioxide level as [Baby O] had in his previous gas early in the afternoon before any of these collapses. So whatever the cause of [Baby O]'s collapse, it didn't seem to be respiratory in origin from this.

The base excess was raised, minus 17, which tells us about the metabolic cause for the acidosis. And the haemoglobin level was 86, which -- in retrospect, I was made aware of the initial post-mortem result, which suggested that there'd been a bleed from the liver into the abdominal cavity. And a haemoglobin level of 86 was less than the previous haemoglobin level from the lab tests, but it's still not a level that I would expect to be low enough to cause the collapses that occurred on that day.

For a well baby, not on ventilatory support, we wouldn't give a blood transfusion for a haemoglobin of 86. So clearly, there'd been some blood loss and some dilution of the blood from all the fluids we'd been giving as well, but it's telling me now that I don't think blood loss on its own was the cause for the collapse or the collapses that [Baby O] had that day.

DRIVER: Thank you. I am looking now to the next three lines of your note, how was [Baby O]'s abdomen during the resuscitation?

BREAREY: It was still distended, and again we're at the point in the resuscitation where we're trying to exclude rarities that might have caused this. Rarely, I have only come across it once in a career, rather than a gas leak that causes a pneumothorax when a preterm baby is being ventilated, sometimes there can be a leak into the mediastinum, which is the central part of the chest where the heart sits. That can be called a pneumomediastinum. Again, on a rare number of occasions, that gas can leak down into the abdomen and cause the abdomen to be distended, which can then splint the diaphragm and stop the baby from breathing properly.

So in attempts to exclude that, I inserted a small cannula into the lower right corner of the abdomen in case that would decompress any free gas that had collected, but no gas came out of the cannula, just a small amount of blood, which was sent for culture, which more or less excluded that fairly rare event.

DRIVER: Thank you. We're now at 17.43, you having returned to [Baby O] at about 16.30 or thereabouts. We know that your previous involvement with him was at 14.40, at which point you told us that you noticed a rash on the right side of his chest wall during your first attendance upon him. Was there anything of note on his skin at this second occasion?

BREAREY: That rash had disappeared, which tells me it definitely wasn't a purpuric rash because purpuric rashes don't vanish like that, they're around for a good few days afterwards, which is perplexing and I have never seen it before and I've not seen it since.

DRIVER: You told us earlier that purpuric rashes are the product of -- are infective in origin.

BREAREY: Mm-hm.

DRIVER: What, if anything, is the relationship between that origin and the duration of the presentation of a purpuric rash?

BREAREY: I don't quite get your question.

DRIVER: Purpuric rashes, you have told us, are infective in origin.

BREAREY: Or can be, yes.

DRIVER: Why is it that purpuric rashes don't disappear?

BREAREY: Well, there's rupture of the capillaries underneath the skin, so you know, it takes a while for that sort of thing to heal. It just doesn't vanish like that, really, in the space of an afternoon. You'd be seeing a purpuric rash for days and weeks afterwards usually before it fades completely and the skin heals.

DRIVER: Thank you. So you had inserted a cannula in, it's technically referred to as the McBurney's point to exclude or, if present, address this rare condition that you explained to us, but you were able to rule that out effectively. Then, please, could you describe to us the remainder of the attempted resuscitation process?

BREAREY: The parents were present for at least some of the resuscitation, but not all of it. I can actually remember seeing more of the grandmother than I can of the parents, just from memory, but they were updated by myself and the team throughout the resuscitation. And obviously, a very distressing time for everybody, really, the family and the team involved. But it became increasingly present at that time that we had worked really hard and just simply, and unusually, weren't getting a response to those resuscitation efforts and the team agreed that to continue resuscitation was going to be futile. That again was discussed with the parents and grandmother, and then we withdrew care and stopped our resuscitation efforts and passed [Baby O] to his mum.

DRIVER: Your note suggests that occurred after a full 30 minutes of attempted resuscitation.

BREAREY: At least, yes.

DRIVER: At least?

BREAREY: Yes.

DRIVER: We know that in time, [Baby O]'s case was referred to the coroner. Did you involve yourself with that process at all?

BREAREY: No. [Dr B] was the consultant of the week, so she spoke to the coroner afterwards.

DRIVER: But did you hold a debrief for the neonatal staff involved?

BREAREY: Yes, I did, yes.

DRIVER: What, if any, conclusions did you draw from this set of events?

BREAREY: I was... All these events in the trial, you know, are distressing for staff, but both [Baby O] and [Baby P]'s deaths were particularly distressing for those involved and equally so with me, really. But there was clearly some elements of the case that I was concerned about. All three triplets were born in such good condition and were following a path, healthy path, to growing and developing and hopefully going home, and you know, the deterioration of [Baby O] that day really came out of the blue as far as that was concerned and the fact that we had to intervene initially felt like a surprise and the fact that each time we tried to stabilise him and resuscitate him we got to a period of stabilisation and then he deteriorated soon afterwards. The fact that he had two desaturations and bradycardias on the ventilator is exceptionally unusual when we're so confident that things were fine with him.

The rash was unusual and like nothing I'd seen before or since, and we'd excluded as many, if not all, natural causes for him collapsing like this and I couldn't then, and I can't now, think of a natural cause for why these events happened.

DRIVER: Did those concerns prompt you to take a particular course in relation to reporting the events within the hospital system?

BREAREY: Yes. I intended to escalate it the following day, but [Baby P] had already started deteriorating and I was helping

with some of his care the following day already. We'd had -- so following [Baby P]'s passing, I attended the debrief for [Baby P]'s care the following day and I've worked quite closely with Dr Rackham, who was actually leading that debrief. He was the transport consultant who was present at the time.

DRIVER: From Arrowe Park?

BREAREY: From Arrowe Park, yes. Nurse Letby was present in that debrief. I asked her how she was feeling and I can remember suggesting to her that she would need the weekend off to recover from these traumatic events. She didn't seem overly upset to me in the debrief, or upset at all, and told me at the time that she was on shift the next day, which was a Saturday. I was concerned about this because we'd already expressed our concerns to senior management about the association with Nurse Letby and the deaths we'd seen on the unit.

So following the debrief, I phoned the duty exec on call in the hospital that evening, Karen Rees, she is the senior nurse in the urgent care division, who was on call. She was familiar with our concerns already and I explained what had happened and that I didn't want Nurse Letby to come back to work the following day or until this was all investigated properly.

Karen Rees said no to that and that there was no evidence. The crux of the conversation then went that I put it to her that was she happy to take responsibility for this decision in view of the fact that myself and my consultant colleagues all wouldn't be happy with Nurse Letby going to work the following day, and she responded, yes, she would be happy to take that responsibility.

I said, well, would you be happy with the responsibility if anything were to happen to any of the babies tomorrow then, and she said, yes, she would be able to take that responsibility. That's where the conversation finished.

DRIVER: For the sake of completeness -- sorry, I interrupted.

BREAREY: We had further conversations with the execs the following week when action was taken.

DRIVER: Sorry for interrupting. Tile 498 is a Datix form submitted by Nurse Letby but within which you're mentioned. If we go to the original form, please, Mr Murphy.

Are you familiar with the format of this document?

BREAREY: Yes.

DRIVER: In a sentence, what is its purpose?

BREAREY: So we have a Datix incident reporting system in the hospital, so this can be entered by any member of staff, clinical or non-clinical, if they feel an incident has happened, however small or large, and we had a very healthy culture in terms of incident reporting in the neonatal unit at the time. One of my jobs as neonatal lead doctor was to review these incidents and act on them appropriately in terms of learning for staff and to try and treat it as a sort of no-blame culture, if you like.

So the format -- do you want me to go through it? The name of the patient is [Baby O]. The location was on the neonatal unit in the urgent care division.

If we can scroll down.

MR JUSTICE GOSS: First of all, the date. Go up to the date. The reported date is 30 June. The opened date is 1 July.

BREAREY: Okay. So that would have been reported then a week after.

MR DRIVER: Yes. If you could direct Mr Murphy to scroll down.

BREAREY: So the risk grading is a near miss. "Actual harm" is none. "Potential for harm" is high potential harm.

I think that the first two of those are recorded by the person reporting it and then the potential for harm is an automatic thing that comes out on the system.

I haven't seen this. I can't recall reviewing this Datix. I might have done.

DRIVER: If we go to incident investigation, there's a reference to your name, Dr Brearey.

BREAREY: Annemarie Lawrence was the risk facilitator for us at the time.

It says, "Reviewed in the NNIRG meeting", that's the Neonatal Incident Review Group, by myself, Eirian Powell, who's the neonatal unit manager, Annemarie Lawrence I have mentioned, Ailsa Simpson was a senior nurse, and Gemma Webster was a pharmacist. It says: "SB [that's me] wishes amendment to incident form.

Patient did not lose peripheral access. Intraosseous access required for blood samples only."

DRIVER: Is that just you correcting part of a narrative?

BREAREY: I haven't seen the actual report.

MR JUSTICE GOSS: If you go back up, I think you'll see reference to that further up.

BREAREY: "Description." It says: "Infant had a sudden acute collapse requiring resuscitation. Peripheral access lost. Intraosseous access required. Resources not available on unit.

"Action taken: staff obtained equipment from children's ward. Delay in this happening due to staff being needed for infant care needs. LP needle utilised as time delay in obtaining." So what I didn't mention in terms of getting an intraosseous sample is that the most common way of doing that in older children and term babies is something called an EZ-IO device. Prior to that, it was literally a big needle with a bit of a screw -- and this sounds brutal, sorry, but you screw it into the shinbone of the baby. Obviously it's a resuscitation situation. If you haven't done it before, that can be quite daunting for staff, whereas an EZ-IO needle is easier to do. It just resembles a mini hand drill with a magnet on the end of it where the needle sits on the end of it.

So you literally just -- you just put it up against the baby's skin, where it ought to go against the bone, and just press the button and it drills through to the core of the -- middle of the bone for you. So the neonatal unit didn't have an EZ-IO device on the neonatal unit -- and I don't think many neonatal units in the country at that time would have had EZ-IO devices to use, although most paediatric A&E departments probably would have done, which is why the doctors were familiar with them.

So from my recollection, when I said let's do an IO, I think somebody might have gone to look for the EZ-IO device, which would have been on the children's ward, and from my recollection I said, don't worry, we can just use a needle, which was adapted, a short LP needle, which I've used before in previous haematology jobs in babies, this sort of size (indicating), and I put the needle in because I think it would have been quicker than waiting for the EZ-IO device, really.

So there was no delay and there was no problem with IV access, it was only for a blood sample. So it wasn't really an incident, to be honest, because we just got on and did it anyway.

DRIVER: So is it accurate or inaccurate to assert that peripheral access was lost?

BREAREY: That's inaccurate, untrue.

DRIVER: And so was there at all relevant times intravenous access to [Baby O]'s circulation?

BREAREY: At least one and sometimes two, at times two. I think it's recorded in the notes somewhere that a second IV access was obtained in the record.

MR DRIVER: Thank you. I have no further questions. Could you remain there, please?

MR JUSTICE GOSS: You're going to be more than a few minutes, aren't you?

MR MYERS: More than that, my Lord, yes.

MR JUSTICE GOSS: We'll have our break then now, members of the jury. The usual 10-minute break.

(12.05 pm)

(A short break)

(12.17 pm)

MR JUSTICE GOSS: Mr Driver, I notice the family are not here.

MR DRIVER: Thank you for that.

(Pause)

MR JUSTICE GOSS: Can I just check, is everybody here who wants to be here? Thank you very much.

Cross-examination by MR MYERS

MR MYERS: Dr Brearey, I just want to ask you about the process of CPR first. I'm going to ask Mr Murphy to put up on our screens a chart that we have at tile 227. It records various things.

(Pause due to technical difficulties)

MR MYERS: One moment, please, Dr Brearey. We can see this says "Neonatal unit resuscitation record". You are familiar with this form, are you, Dr Brearey?

BREAREY: It was a form we created that year as a result of the large number of resuscitations that we had that year, to improve the recording of drugs given, yes.

MYERS: Right. It's not just drugs given, it also records chest compressions, doesn't it? And so we can all tell why I say that, if we look at the column to the left, the top row has got "Chest compressions started" in bold print, hasn't it?

BREAREY: Yes.

MYERS: So this can be used to record when the chest compressions commenced? Is that how it works?

BREAREY: Yes.

MYERS: There's two occasions during [Baby O]'s resuscitation when chest compressions took place; is that right?

BREAREY: Well, if that's what the chart is saying.

MYERS: Were you present on both of those occasions?

BREAREY: As I say, on the first occasion I was called to assist and arrived just as compressions had stopped and he had recovered.

MYERS: So 16.19, if that's accurate, is the first time that we have chest compressions certainly so far as this records it; is that right?

BREAREY: As far as that records it.

MYERS: From your recollection, you would have arrived some time after that had stopped or just stopped?

BREAREY: Yes.

MYERS: And you were present on the second occasion at 17.16, weren't you?

BREAREY: Yes.

MYERS: So you can't help us -- so far as the first occasion, from your own knowledge, you can't help us with how long that lasted for, can you?

BREAREY: The first one, no.

MYERS: As for the second one, 17.16, did you say that you did that?

BREAREY: Did what?

MYERS: Did you do the chest compressions at 17.16, the second batch?

BREAREY: Well, we were a team, and it was going on for a period of time. I can't remember exactly. I can remember doing compressions at some stage, but we rotate relatively -- you know, after a short period of time because it's different to sustain high quality compressions for the whole duration of a resuscitation like that. So I would have done some but not all of them.

MYERS: Do you know how long it went on for the second time?

BREAREY: Well, it says it started at 17.16.

MYERS: Yes.

BREAREY: And we finished at 17.47, was it, something like that?

MYERS: That's the end of it, yes.

BREAREY: Yes.

MYERS: So it went on throughout the whole of that period?

BREAREY: Yes.

MYERS: 17.16 to 17.47?

BREAREY: Mm-hm.

MYERS: With different people doing that?

BREAREY: Yes.

MYERS: The chest compressions are done by applying pressure, I'm just showing on my body, but you're the expert, you might be better to tell us yourself. Where do the fingers go on the baby?

BREAREY: It's in the sternum, which is the bony part, the middle part of the chest, below the line of the nipples, but on the very -- so on the lower third of the sternum, effectively.

MYERS: You know you did it at some point?

BREAREY: Mm-hm.

MYERS: But you can't be sure who did it when; is that right?

BREAREY: That's correct.

MYERS: At the time it takes place, and again I've said this before, I repeat it now, I don't mean any insensitivity by asking questions like this, we all know what we're dealing with but I do need to ask some technical questions. At the time it takes place, was [Baby O] removed from his incubator so there's freedom of movement?

BREAREY: As far as I can remember and -- I'm pretty sure he was in his incubator but you can take the top off the incubator and the sides can come down. The level of incubator can go up and down according to whoever's operating. So I think that was happening. At least the top was off, the sides might have been down as well so we could access [Baby O] appropriately.

MYERS: That's what would have happened during the CPR that you were involved with; is that right?

BREAREY: Yes.

MYERS: Next I would like just to look at the note, the second page of the notes that we've looked at with you so far, Dr Brearey.

BREAREY: Could I just comment on that record as well? I don't know who filled it in. I don't know whether it's got a signature. This is really a replacement to the aide-memoire we would normally use to record in our notes. So I think the note-keeping is definitive whereas this is an aide memoire for that. I'm assuming because they've ringed the number 3, they mean that the 17.16 start of compression was underneath the 3 rather than underneath the 2, because the timings align then, don't they? Because it looks like then chest compressions started at 17.16 but adrenaline was given at 17.26 but that isn't right because the first episode needed two doses of adrenaline and then chest compressions started at 17.16.

MYERS: So it should move one further along in fact and that's why the 3 has been ringed?

BREAREY: Yes. Whoever did it, presumably that was the reason.

MYERS: We can see the timings so we certainly know the order in which thing happened if those timings are accurate.

BREAREY: Yes, but as I say it's an aide-memoire document, it's not definitive as the notes would be.

MYERS: There's a lot going on whilst this takes place, isn't there?

BREAREY: Exactly, and I don't know who's completed this.

MR JUSTICE GOSS: It says underneath: "Neonatal unit resuscitation record to be completed by any member of staff during resuscitation."

BREAREY: Exactly, because you don't know who's available and obviously the priority is providing the care and resuscitation, and sometimes if there aren't numbers - - there did seem to be numbers that day -- it can be a relatively junior member of staff.

MR MYERS: Thank you.

MR JUSTICE GOSS: And maybe different people?

BREAREY: Maybe.

MR JUSTICE GOSS: I'm not a detective, but if you go down to the sodium chloride at 16.47, and then 17.17, whoever's writing the number 7 there, it's not written in two different forms, the 7.

BREAREY: No, it looks different.

MR MYERS: So this would be something that different people have access to as it goes along?

BREAREY: Yes.

MYERS: There's also the practice or there has been a practice of people writing things down on bits of paper that are available whilst it takes place?

BREAREY: The idea of this form was to avoid that.

MYERS: All right. Next I wanted to go to the second page of your notes that we were looking at, which are at tile 268. I'll just check that's the correct reference.

286, sorry.

I am just going down to look at where the entry says: "IV cannula inserted at McBurney's point to try to decompress abdomen. Small amount of blood."

BREAREY: That's correct.

MYERS: McBurney's point, is that on the left or the right-hand side of the abdomen?

BREAREY: It's the right.

MYERS: The right?

BREAREY: Yes.

MYERS: We know the liver is on the right-hand side of the abdomen -- well, in fact it goes across, doesn't it, the top of the liver?

BREAREY: Mm-hm.

MYERS: Is avoiding the liver something that's important to do when you insert a cannula or aim to insert it into that area?

BREAREY: Yes, but I was nowhere near the liver.

MYERS: Right. Where it's got a small amount of blood from it, where does the blood come from?

BREAREY: Presumably bloodstained serous fluid in the peritoneum.

MYERS: But do you have any idea -- was that something you'd be expecting to find or not?

BREAREY: Um... I think given the resuscitation and the point in the resuscitation we were, then it wouldn't be unusual for some blood to be there, but it wasn't overly concerning. A lot of blood didn't come out. Just a small amount of blood in that position wouldn't be that surprising, no.

MYERS: When you say, "Bearing in mind the point in the resuscitation that you were at", not everyone may follow what you mean by that. What do you mean by that?

BREAREY: Well, he had a distended abdomen, we'd been doing CPR for a prolonged period of time. Some of his tissues or organs might have been hypoxic in some way. There might have been a small amount of bleeding from the gut. You know, it's difficult to hypothesise where that small amount of blood would have come from. Obviously, in retrospect, after seeing the post-mortem results and seeing that there was a ruptured subcapsular haematoma, that's probably the most likely place where the blood came from, is that ruptured subcapsular haematoma of the liver.

MYERS: I am just going to pause there so we can keep track of this. We have heard already in this case with regard to [Baby O] that one of the findings after he died was that there had been a haematoma, there'd been a bleed of some sort to the liver and we'll hear more about that. We have mentioned that before so I am just making sure we can all keeping track of what you're referring to by the subcapsular haematoma. That's whatever it was that was the bleed to the liver?

BREAREY: Yes.

MYERS: When you refer to it's not -- it may not have been the words you used, so forgive me, but not a surprising or it's something you might expect to find after this stage of the resuscitation, when talking about the blood are you referring to the fact that because of resuscitation it's possible that there may be some bleeding internally because of the efforts being made?

BREAREY: Potentially, yes, or the lack of oxygen to the tissues (overspeaking). It's impossible to say with any certainty.

MYERS: It's possible -- sorry?

BREAREY: Looking at -- McBurney's point is -- if you draw a line between the umbilicus, the tummy button, and the bony prominence, the iliac crest of the pelvis, the McBurney point is two thirds way along that, so it is quite low down on the right-hand side of the tummy. Even looking at the final X-ray, which did appear to show a slightly enlarged liver, putting a needle in that point in the abdomen was nowhere near where the liver was.

MYERS: So your opinion is if it's picked up the blood or the blood it picked up might have tracked there from somewhere else but not that the needle has gone into an organ?

BREAREY: It wouldn't have gone into the liver.

MYERS: All right. But your view is that haematoma, we are talking about the subcapsular haematoma, that might have ruptured during resuscitation efforts?

BREAREY: It might have done.

MYERS: I want to turn then to other matters. That's what I wanted to ask you in fact about the clinical side of this. But there's other things you told us about, Dr Brearey, that I want to ask you about, just for a little bit more information.

We know, and you have referred to it, that by this time on the unit, so far as you and some of the consultants were concerned, there's a link between the presence of Ms Letby and events that took place.

BREAREY: All the consultants.

MYERS: All the consultants knew at this point, did they?

BREAREY: Yes.

MYERS: Right. And that's based on the fact, as it seemed to you or them, that she'd been on the unit at the time of potentially significant events? That was the unifying feature, wasn't it?

BREAREY: That was one of them, yes.

MYERS: That was one of them? All right. We'll see what others there are.

When Dr Jayaram gave evidence back in -- the last time, which was 28 February, he referred to the fact that he'd been careful, in effect, to avoid confirmation bias. That's an expression you're aware of, isn't it, confirmation bias?

BREAREY: Yes.

MYERS: Confirmation bias, and I'll ask if you agree with this, give a different explanation if you want to, is the tendency to focus on information that tends to support an existing opinion or belief, the tendency to focus on that rather than other factors. As a definition, do you agree with that?

BREAREY: Well, it's a tendency to try and confirm your beliefs --

MYERS: Yes.

BREAREY: -- with preconceived ideas.

MYERS: And you tend to fix upon those things which meet those beliefs and maybe not things which would steer away from them?

BREAREY: Being aware of confirmation bias is very useful because then you can try and avoid it as best you can.

MYERS: You can try to.

BREAREY: We try to be as objective as possible.

MYERS: I'm afraid you'll have to speak up, Dr Brearey. We were just getting to grips with confirmation bias and I'd suggested a very basic definition and you were just explaining or agreeing, to this extent, it's the tendency to see things which back up what you might already think?

BREAREY: That is bias, yes.

MYERS: You said that you are aware of that so you try to avoid it?

BREAREY: Yes.

MYERS: Although, of course, sometimes someone may not even know when they're doing it?

BREAREY: Some may not.

MYERS: Now, after the death of [Baby D], which was back at the end of June 2015, it's after that, isn't it, that you first performed a review of any common features and first identified that Ms Letby had been on duty on the incidents you were looking at?

BREAREY: I didn't identify it. Eirian Powell identified it when she did a staffing analysis after the first three deaths in June 2015.

MYERS: Is that something you'd asked her to do?

BREAREY: No.

MYERS: Was it something you were actively interested in knowing whether there was any unifying factor?

BREAREY: That was the purpose of the meeting.

MYERS: Yes. So Eirian Powell, who we have met once, relatively briefly, in this case, she in effect was the nursing manager for the unit?

BREAREY: She was. So we had a meeting, I can't remember whether it was late June or early July 2015, with the director of nursing, then Alison Kelly, and the head of risk, and three deaths in a short period of time were a concern, but at the same time statistically if we had no more deaths that year, it would still be within the normal range for our unit's mortality rates. And Eirian Powell looked at all the possible things that might be common to these deaths that can be looked at, which was more than just a staffing analysis. She did the staffing analysis and associated that link, but she also looked at which incubator spaces the babies were in, whether they had been on certain pumps, you know, any factor.

We looked at microbiology, any factor that might be a common link between all of them and there didn't seem to be anything like that. It was my job prior to the meeting to sort of correlate the clinical care reviews and look at whether there were any links in terms of that that might explain the deaths.

MYERS: All right. It's from that point, the end of June 2015, that certainly you have or had identified to you the presence of Ms Letby on three of those events?

BREAREY: That's correct. I think my comment in the meeting at the time was, "No, it can't be Lucy, not nice Lucy".

MYERS: We'll come to your views on that in a little bit.

BREAREY: Well, it wasn't my view, it was my view at the time.

MYERS: All right. Dr Jayaram also was party to that, wasn't he, to that knowledge at that time?

BREAREY: Dr Jayaram wasn't at the meeting, but obviously he was the clinical lead at the time.

MYERS: Yes. So you'd have shared that with him soon afterwards?

BREAREY: I shared it with all my colleagues because it was a meeting about the deaths in the neonatal unit.

MYERS: So everybody knew that, to that extent at least, Ms Letby was an object of interest from June -- by everyone I mean your consultant colleagues knew by June 2015 that Ms Letby was a subject of interest?

BREAREY: I certainly emailed Dr Jayaram. I can't remember emailing my other colleagues, although we might have discussed it, I can't remember.

MYERS: You remember emailing Dr Jayaram?

BREAREY: Yes.

MYERS: When I asked you, "Did you share that with Dr Jayaram", your immediate response was to say you shared it with all your colleagues.

BREAREY: I didn't say when. I can't remember when I shared it with all of them, but over the course of the rest of the year, I would have shared it with them at some stage.

MYERS: I'm not disputing that is a focus of concern for you, Dr Brearey.

BREAREY: Well, the deaths and the collapses were a focus of my concern.

MYERS: I do suggest that once Ms Letby had been identified as somebody or a factor that was common to those, there was

naturally a bias against her in terms of how she behaved was interpreted; do you agree or disagree?

BREAREY: I disagree.

MYERS: Right. We know, and you touched on this in your evidence, there's no formal complaint made to the police at any point right up to the period we're dealing with, with [Baby O], is there?

BREAREY: Well, identifying the cause for death is quite important in identifying concerns. And the process of identifying the cause of death is a long process. You know, the coroner's inquest that occurred for some of these babies that died in June didn't complete until later on in 2016. There's learning from every case that we reviewed and that's normal. You know, there's no one episode of care in the NHS where everything's completely perfect and we would pick up learning points from each episode, but they were just learning points, they didn't explain why these babies collapsed always.

But that was my job. My job wasn't to identify the cause of death, that was the sort of coronial process, if you like, for inquests and the like. But my job was to try and improve our practices and over the course of that year our practices did improve and get better. TranscriptWiki Transcripts Revision history Change password Log out RexvsLucyLetby They were already good before this all started and our results in a number of factors would back that statement up. But as the year went on and more events happened, then more suspicion arose, yes.

MYERS: Yes, I'm looking at the question of suspicion. If someone close to you was attacked or hurt unlawfully by somebody, Dr Brearey, and you believed you knew the identity of that person, you'd contact the police and give it to them, wouldn't you?

BREAREY: If I saw an act happening, yes.

MYERS: And if you believed you knew the identity of the perpetrator?

BREAREY: If I saw that act happening, yes.

MYERS: Yes. And if -- maybe not as dramatic as that. If someone were to burgle your house, heaven forbid, but if they did and you believed you knew the identity of the perpetrator, you would be ready to report that to the police?

BREAREY: Yes.

MYERS: Or of they stole your car?

BREAREY: Yes.

MYERS: And if someone hurt one of the babies on your unit and you believed you had the identity of the person responsible, you'd report that to the police too, wouldn't you?

BREAREY: I think you're making this a little bit more simplistic than it actually was because it's not something that anybody wants to consider, considering that a member of your staff is harming babies. And actually, the senior nursing staff on the unit didn't believe this could be true up until the point when the -- you know, and beyond, when [Babies O & P] died.

But the year was spent for predominantly myself and Dr Jayaram, but also my colleagues, with increasing suspicion with every episode, and none of us wanted to believe it either. But the fact that things in terms of practices were going from good to better, the fact that we were working on a very good unit that normally had very good results, and this all became very exceptional, and then when we stopped to take a step back and think about it, the nature of these collapses, as you've heard this morning already, the unexpected nature of them, the lack of response to resuscitation, the unusual rash that had been noted on a number of occasions, and each time the association with Nurse Letby -- and that is nothing to do with confirmation bias, that's just statistically every time it happened it became statistically more and more improbable and that was raising our concerns to a point where, yes, that was... That's when we escalated when we did.

MYERS: I'm not disputing with you the question of suspicion at all --

BREAREY: The other thing to say as well is that nobody was flagging a concern to us from outside the hospital. The coroners, the pathologists, the neonatal network, MBRRACE reports come back a year or two after the actual -- that's the national mortality reporting for women and babies. That comes back 2 years later, which is all very unusual in some ways for the NHS, where you tend to get a lot of pressure to do things and act on things, and yet we were getting this mortality this year, and there wasn't any red flags being alerted outside the trust or within it.

So I was very keen to take another opinion, get somebody without any confirmation bias, and that's why we had a review of the deaths that had occurred up and through 2015 and that review took place in February 2016 eventually, with an external neonatologist from Liverpool Women's Hospital, to review all our

reviews and to review the cases and provide some sort of external sense to things for these cases.

MYERS: Twelve months, approximately, is the period of, certainly for you and Dr Jayaram, suspicion, about Ms Letby, isn't it, from [Baby D] to [Baby O]?

BREAREY: Well --

MYERS: It is, isn't it?

BREAREY: No, 12 months of knowledge of her association with these cases.

MYERS: Increasing knowledge or suspicion then? Put it that way.

BREAREY: Well, knowledge of an increasing association, yes.

MYERS: And the reason I'm going to suggest nothing was actually done about it, so far as she is concerned, is because you appreciate that, apart from her being present on the unit or apparently present at the time of potentially relevant events, that was as far as that went. That's as far as it got so far as she is concerned?

BREAREY: Certainly that was a major factor but I have just talked to you about the increasing evidence of worry and that was really put down on paper during that review in February 2016, where it was noted that the majority of cases where the babies collapsed occurred at night, where less staff and parents were present, in the early hours, that a lot of the deteriorations were sudden collapses.

MYERS: That's an example I am going to suggest of confirmation bias in the sense that you're identifying factors that linked in some way to Ms Letby. That's what you were naturally doing, isn't it?

BREAREY: Ms Letby wasn't mentioned in that meeting until the end of the meeting and all those observations were made by Dr Subhedar, a senior neonatologist from Liverpool Women's Hospital, who made those observations before I even brought up the fact that there was an association with Nurse Letby.

MYERS: Your interpretation of that and the factors you're picking out and the way you say that feeds into your suspicion is part of the confirmation bias in having decided it's to do with her in the first place.

BREAREY: Dr Subhedar didn't have any confirmation bias because he didn't know the association at that time and he still came up

with those factors that we included in the reports that were common to all the cases.

MYERS: But he's not drawing a link to Nurse Letby in the way you are, Dr Brearey.

BREAREY: No, because we're in court now, aren't we, and a lot more has come to light since then.

MYERS: And from what you were saying, did you contact the police in February 2016 when you did that review if it took you to the place you tell us it took you to?

BREAREY: It didn't take me to that place immediately and it also didn't exhaust the avenues within the trust of escalating my concerns. So following that thematic review, I completed the report and sent it to the director of nursing and also the head of safety and quality, who's the director of nursing, and the medical director of the hospital, asking for an urgent meeting with them along with Eirian Powell, the neonatal unit manager. That was my escalation following that meeting.

MYERS: One thing, for instance, you didn't look at closely, I'm going to suggest to you, is the question of the acuity of the babies who were being brought under the unit and a significant increase in the numbers of high acuity babies over the period. That wasn't the sort of thing you were focusing on, was it?

BREAREY: Well, in my opinion, and was backed up from the BadgerNet data that we all use in the country for neonatal care, there wasn't a significant increase in acuity and, anyway, you could argue it's either a chicken or egg. You know, I'm sure you'd want to argue that an increase in acuity caused all these cases, which personally I find completely unfeasible. Or you could argue that the cases themselves created an increasing acuity in the unit because of the more intensive care we were providing in the unit because of the sudden collapses, which I think is much more likely.

MYERS: Do you agree that increases in acuity could be a relevant factor?

BREAREY: I don't think it was a relevant factor in these cases.

MYERS: Well, I'm going to suggest to you that's one example of the type of bias that I'm suggesting took place taking place.

BREAREY: I would be quite happy to take that criticism from an expert witness who is experienced in neonatology.

MYERS: Right. So you are not able to tell us then whether you considered high acuity as relevant?

BREAREY: It was considered as part of it, yes.

MYERS: And quite simply, it's not something you regarded as significant?

BREAREY: If you look at all the cases I don't think there was a single case in any of the ones we reviewed at that review in February where there was a lack of staff that had any significant effect on the cases.

MYERS: So you disregard any question about staff numbers playing any part to do with any element of care?

BREAREY: In any of these cases there was not a single episode that we reviewed where a lack of staff contributed to the outcome of the babies.

MYERS: So not high acuity, not any problems with staff. What about any sub-optimal performance by any other member of staff on your unit? Is that something you identified and actioned?

BREAREY: Would you like to define how you (overspeaking) suboptimal --

MYERS: I'm just asking you, did you do that. Anything below understand outside the guidelines and not done in the right way?

BREAREY: If you're saying optimal means perfect I'd say things aren't always perfect. But I don't think our practices and our care that we were receiving (sic) was any different than it would have been in any other local neonatal unit in the region, and probably the country.

In fact, in some ways it was a lot better.

MYERS: I'm going to suggest to you didn't go about looking for sub-optimal performance in any way with regard to anyone else. You were interested in establishing the link between Ms Letby and the events we are looking at in this case.

BREAREY: I would completely disagree with that because in every case we identified elements of care that could be improved on. What I'm saying is those elements of care would not have affected the very tragic results that occurred with these babies.

MYERS: That's your view on that.

BREAREY: My view on it is that we identified areas that could be improved on, but none of them had an effect on the final outcome.

MYERS: I'm going to suggest to you that the possibility of it being down to one person in the way you were suspecting is something that is attractive in the context of confirmation bias rather than looking for problems like acuity --

BREAREY: Absolutely not.

MYERS: -- or sub-optimal performance.

BREAREY: Absolutely not. I'd much rather not have to sit here today and talk to you and have something that we could get our teeth into and improve in terms of patient care.

But as I say I was very happy that the care and the team that was working were excellent.

MYERS: I make it plain, Dr Brearey, that I'm not challenging that you had the suspicion that you've described, that's not what I'm challenging. But what I do want to suggest to you is that the reason that the police were not contacted at any point during the period with these babies in the unit that we have been looking at is because you appreciated that, beyond Ms Letby's presence on certain occasions, there was nothing to get beyond that.

BREAREY: The reason we didn't go to the police was because we wanted to escalate this appropriately within the structure of the hospital rather than directly going to the police ourselves without the support of the medical director and the executives in the trust.

MYERS: You'd go to the police if your car was stolen and you knew who did it, wouldn't you?

BREAREY: As I say, I don't think that's the correct analogy.

MYERS: And if you believe that somebody's harming babies on your unit on your watch, if you believed that for sure, then you would be able and you would have acted on that?

BREAREY: I try to act on facts rather than belief --

MYERS: Right.

BREAREY: -- and that's what I was doing.

MYERS: Yes. I am not going to challenge that. It's a question of belief, not facts?

BREAREY: I was acting on facts.

MR JUSTICE GOSS: Not belief?

BREAREY: Not belief.

MR MYERS: Well --

MR JUSTICE GOSS: That's what he said.

MR MYERS: Yes. You have suspicion, but the reason you didn't contact the police is that there was no basis for that to say someone had done something wrong?

BREAREY: Of course there was a basis, but we were trying to escalate appropriately to our executives at the time with the facts that we had at the time.

MYERS: Nothing would stop you, or any of your colleagues, raising it, in effect blowing the whistle, at the point you wanted to within the NHS if there was a good reason for doing that, would it?

BREAREY: Well, there was a very good reason to escalate to our executives because of the facts of the case that I have just talked about: the association with Nurse Letby, the nature of the collapses, the fact that they're happening suddenly overnight and the lack of response to resuscitation and the rashes.

MYERS: You make it sound as if the executive you have referred to, Karen Rees, wasn't really that concerned by your concerns.

BREAREY: No, because she believed that Nurse Letby couldn't have done this.

MYERS: And you believed otherwise?

BREAREY: I didn't believe, I was worried about the facts of the case -- all the cases.

MYERS: And if you were anxious about the babies on your unit with the solid facts that you say you had, then the next obvious thing to do would be to escalate it, for example, to the police, wouldn't it?

BREAREY: No. It would be to talk to the executives, to try and confirm the correct plan of action going forward. I've not gone

to the police before with concerns about multiple deaths on a neonatal unit and I'm not sure many neonatal leads have done. It needed executive support and that's what we were after.

MYERS: You don't even -- we went to a Datix form. That Datix form is about intraosseous needles, isn't it?

BREAREY: Yes.

MYERS: You ended up saying it's not really an incident at all, was your evidence on that.

BREAREY: Well, no.

MYERS: It just doesn't raise any issue regarding Lucy Letby, does it?

BREAREY: No.

MYERS: There's not even a Datix form submitted about her, about your suspicions.

BREAREY: Are you expecting me to Datix the fact that I'm worried that a nurse might be harming babies on the unit?

MYERS: Somebody might expect, if you had 12 months thinking that, you might do something, Dr Brearey.

BREAREY: I was doing as much as I could do at the time.

MYERS: Dr Rackham, was he a consultant who came to deal with the transport and assist late in the resuscitation?

BREAREY: Yes, he's a neonatologist.

MYERS: I am looking at the question of confirmation bias still, so we keep focus on this. In fact, in the review that took place, he commended Lucy Letby for her work during the resuscitation, didn't he?

BREAREY: Yes.

MYERS: I've got the statement that you made to the police here about this in November 2017. I just want you to have a look at page 39 where you make reference to this.

It's going to be shown to and you his Lordship and the barristers, the lawyers.

Just have a look to yourself, please, where we have: "Following these deaths Dr Rackham led a debrief. " If you just read that and the lines that follow it.

(Pause)

Have you read that to yourself?

BREAREY: Yes.

MYERS: You mentioned about how Nurse Letby was. What you were dealing with here was you told the police in 2017 that Dr Rackham had led the debrief and he commended Nurse Letby. You then said to the police this: "I had a conversation with Nurse Letby suggesting she should have the weekend off and not return to work but she refused. I expressed my concerns to Karen Rees who was the duty manager that day but without success.

Karen Rees gave me the impression..." Well, she didn't agree with you and she didn't think it was a reasonable request to make.

BREAREY: Yes.

MYERS: "Completely subjectively, on the morning [Baby O] died I was just passing through the unit and I walked past Nurse Letby she was upbeat, happy and more confident than normal. She said, 'Hello, Dr Brearey', and looked me in the eye very confidently." That's something you saw fit to put in your statement to the police, didn't you?

BREAREY: Well, it was just what happened.

MYERS: Yes, but that's an example of you, for instance, interpreting her walking past, being as you describe, you say upbeat, happy and more confident, and picking that out as something worthy of comment in a police statement; yes?

BREAREY: Yes.

MYERS: And, no doubt, I'm going to suggest, if she'd walked past you and looked the other way with a stony face, that would find its way in as well? If she'd looked away from you that would appear there, wouldn't it, interpretation of things in a negative light because of confirmation bias, Dr Brearey?

BREAREY: I suspect the police in the interview had asked me whether I'd had any dealings with Nurse Letby that day and that's simply what I said. I have not put any relevance on it at all.

MYERS: I suggest you are. You're making it sound that there's something odd about how she behaved. You disagree with that?

BREAREY: Yes.

MYERS: All right. You have told us about early 2016 and the review you did and Eirian Powell putting together a report into the moralities of babies. She did that in advance of the review in February 2016, didn't she?

BREAREY: Yes.

MYERS: She identified who had been present at the time of various incidents, didn't she?

BREAREY: Yes.

MYERS: She documented the names of doctors in that review but you told her you didn't want it to include doctors, didn't you?

BREAREY: I can't recall that.

MYERS: Are you saying you didn't do that or you just can't recall?

BREAREY: I can't recall it.

MYERS: Do you recall whether the column which had details of doctors that were present was removed before being sent to Alison Kelly, the head of nursing?

BREAREY: I don't recall that. I would have been more than happy for all the doctors to be included in that.

MYERS: When Eirian Powell pointed out that Melanie Taylor was the next most commonly present nurse after Lucy Letby, was your reply, "Yes, but she's nice"?

BREAREY: I can't recall that either. It doesn't sound like anything I would have said, to be honest.

MYERS: It wouldn't be very fair, would it?

BREAREY: Actually, my response to Nurse Letby's association back in June 2015 when the association was made with her was, "Not nice Lucy". You can come out with an immediate comment which doesn't really necessarily correspond to anything meaningful.

MYERS: We're going to get more dates in the chronology as we go along, I'm not expecting you to recall all dates. But can you just help us with? The Countess of Chester neonatal unit was

redesignated from a level 2 to a level 1 on 7 July 2016, wasn't it?

BREAREY: No.

MYERS: What date do you say that happened?

BREAREY: Well, first thing to say, it was our decision to do it, do the change, based on a pure decision in terms of looking after staff and their welfare because everybody was very stressed and upset by all these events. That's the reason we reduced the number of cot spaces from 16 to 12 capacity and reduced the gestational limit from 27 weeks to 32 weeks.

MYERS: It's the date I'm after at the moment, Dr Brearey.

BREAREY: I'm only saying this because you've said level 1 and level 2. We still maintained the high dependency cot spaces in the unit, which doesn't make -- wouldn't make us a level 1 unit. So actually we were somewhere between a level 1 and level 2 unit and actually those changes were made to look after staff at the time and just to take a bit of pressure off everybody whilst events settled down a little, which they clearly did because there were no more events after Nurse Letby left the unit.

MYERS: Yes, but it raised the -- the minimum age of gestation became 32 weeks, didn't it?

BREAREY: Well, most of the -- a large majority of the cases in this trial are babies over 32 weeks.

MYERS: Yes, but the demands across the unit change. You note the unit didn't take babies under 32 weeks after it was redesignated.

BREAREY: It was the staff during doing the same job and there were no sudden collapses. And as I have said --

MYERS: But --

MR JUSTICE GOSS: Just let him finish.

BREAREY: As I've said, the staffing did not have a significant effect on the events that happened before that change.

MR MYERS: But you are not taking the same volume of babies at the same acuity, are you, as a fact?

BREAREY: That's true.

MYERS: That's true?

BREAREY: Yes.

MYERS: Because the unit is then taking babies from 32 weeks and above, not 27/28 weeks and above.

BREAREY: Although we would still stabilise babies less than 32 weeks for the last 6 years, of which nothing's happened to those babies born less than 32 weeks because you can't predict birth sometimes and babies are born less than 32 weeks in your unit because that's the nature of obstetrics and maternity.

MYERS: I'm not trying to be rude, but I've asked three times now that the age of gestation that the unit is then able to take babies, save those that are born when it can't be stopped, is 32 weeks?

BREAREY: Yes.

MYERS: That's what had changed, isn't it, from 27 up to 32?

BREAREY: Yes.

MYERS: And the other thing that I asked you is: what is the date when that took place?

BREAREY: That was early July 2016.

MYERS: I had suggested the 7th.

BREAREY: I can't challenge, that I haven't got the date.

MR MYERS: Now, finally -- my Lord, I'll be about 2 or 3 minutes.

MR JUSTICE GOSS: Please carry on.

MR MYERS: 2017. We are going to get more dates and more events as we are going along, but let me deal this, having asked about the police. 2017 is when eventually you sit down with the police to discuss these matters; that's correct, isn't it?

BREAREY: Yes.

MYERS: There are two meetings. One that you weren't at, one that you were at.

BREAREY: Yes.

MYERS: There's a meeting on 27 April 2017 when Dr Jayaram, Dr Holt, Ian Harvey, who was the medical director, and Stephen

Cross, who's the director of corporate affairs, met someone called Nigel Wenham; that's right, isn't it?

BREAREY: Yes.

MYERS: 27 April 2017. Nigel Wenham is a police officer who's a member of what's called the Child Death Overview Panel?

BREAREY: CDOP, yes.

MYERS: CDOP. Well, if I'd started with "CDOP", everyone would be thinking, "What's he talking about?" So CDOP is the Child Death Overview Panel?

BREAREY: Yes.

MYERS: That meeting is in April 2017. Then there was a meeting that you did attend, a further meeting, on 15 May 2017; that's right, isn't it?

BREAREY: It may be. I don't know what the meeting was.

MYERS: It's a meeting where there's you, Dr Jayaram, Dr Holt, Nigel Wenham, again, from CDOP, and a police officer, Paul Hughes, who became the senior officer in charge of the investigation at that time.

BREAREY: That's correct.

MYERS: There's just one particular issue I want to deal with on that. The meeting covered a number of topics arising out of the concerns at the unit; that's correct, isn't it?

BREAREY: Mm-hm.

MYERS: In the course of that meeting, the police present were told about what was described as unusual rashes that were seen; that's correct, isn't it?

BREAREY: Yes.

MYERS: And there was reference made, I think by Dr Jayaram, I can show you the notes if it assists, to air embolus being something that has crossed your minds or been a concern; that's right, isn't it?

BREAREY: He mentioned it during the meeting, yes.

MYERS: He did mention it during the meeting and this was with the police officer Paul Hughes and Nigel Wenham being present.

BREAREY: Mm.

(Pause)

MR MYERS: One matter I'm just trying to unravel, my Lord, before I conclude.

MR JUSTICE GOSS: Yes.

(Pause)

MR MYERS: I can leave it at that for now. There's nothing else I need to raise at this point. Thank you, my Lord.

MR JUSTICE GOSS: Thank you very much.

Re-examination by MR DRIVER

MR DRIVER: Two brief matters, I hope, my Lord.

Dr Brearey, you were asked about your suspicions, beliefs and knowledge of facts in the year between the death of [Baby D] in June 2015 and the death of [Baby O] in 2016. In that 12 months or so, did you know as a fact that two patients within your unit had returned blood results that showed abnormally high blood insulin together with a low blood C-peptide level?

BREAREY: I didn't know that, no.

DRIVER: You were asked about the extent to which you considered the part that increased acuity and/or sub-optimal performance may have played in the collapse and, in some cases, deaths of babies on the unit. You're coming back next week, I believe, Dr Brearey, to give evidence in relation to [Baby P].

BREAREY: Yes.

DRIVER: If, upon your return, anyone were to ask you specific questions about specific cases in that regard, would you be in a position to answer those questions?

BREAREY: In terms of staffing and acuity?

DRIVER: And sub-optimal performances.

BREAREY: Of course, yes.

MR DRIVER: Thank you.

MR JUSTICE GOSS: Are you saying that on the basis that before Dr Brearey returns he is told, "These are the cases I want to ask you about", or just a sort of clean sweep of any case?

MR DRIVER: It's a general invitation.

MR JUSTICE GOSS: A general invitation, right. You're content to do that?

MR MYERS: I can make it plain now, rather than going through this. Where we have said there is sub-optimal performance, we have dealt with that with the experts who have reviewed all of this. It's not something where I'm going to go through each one of those with Dr Brearey for the reasons we've put in our cross-examination to him, which is -- I'm not trying to be rude to Dr Brearey, but the examination (inaudible) us making responses on the basis of where we are now and what we're talking about now.

The independent assessment, insofar as there is one, we suggest, comes from the experts and we have been through it with them. We don't expect Dr Brearey -- and we don't seek to put to Dr Brearey points for him to comment on in that way as one of the treating physicians who's involved in these issues. So that's raised now, but it's not something we're going to be doing, we've done it with the experts.

BREAREY: Can I just make one fact that I haven't mentioned before in terms of staffing levels? Because they obviously relate to staffing during the different acuity.

Obviously, the more staffing you have, the more likely you are to meet standards, national standards, BAPM standards, which is the National British Association of Perinatal Medicine, which may have been discussed already, I don't know. But it was noted that our staffing levels were less than BAPM standards during this period when the College reviewed our care in September 2016.

It was also noted in that report that this was similar to other units and, actually, at the time when these events happened our staffing levels were better than all the other local neonatal units in the region.

Yes, all those units didn't reach BAPM standards, but actually ours was closer to the BAPM standards than every other local neonatal unit in Cheshire and Merseyside at the time. Obviously, all those units weren't having the same mortality problems as we were.

MR JUSTICE GOSS: Thank you, Mr Myers.

Well, you'll be coming back next week and if anyone wishes to ask you any questions, you'll answer them.

BREAREY: Okay, thanks.

MR JUSTICE GOSS: Thank you very much. That completes your evidence for now. So you're free to go, obviously.

I know that this is a day upon which resources are even more stretched, so your presence in a hospital will be more useful than it will be here. Thank you.

(The witness withdrew)

MR JUSTICE GOSS: As far as this afternoon is concerned?

MR DRIVER: It may be prudent for us to return -- to have a shorter lunch than usual.

MR JUSTICE GOSS: That's what I was going to ask because we've got another doctor, who is better off not being here or certainly completing their evidence today.

I don't know how long you need for lunch or would like to have for lunch. Is 40 minutes sufficient or would you like to have longer? Do you need to go out and purchase something? Shall we say 1.55 then? Is that all right? Nearly 45 minutes if you go now.

Thank you very much. Don't worry if you're not quite ready at 1.55, but if you can be ready at 1.55 that would be very helpful. Thank you.

(1.13 pm)

(The short adjournment)

(1.55 pm)

[DR B] (recalled)

Examination-in-chief by MR ASTBURY

MR ASTBURY: Could I ask you to state your name for the record, please?

DR B: [Dr B].

ASTBURY: Thank you. You have given evidence before, so you know that I'm going to ask you to keep your voice up --

DR B: Okay.

ASTBURY: -- if at all possible, please.

It's some time since you have given evidence. Can I simply remind you that you're bound by the affirmation that you took back on 25 October last year. Thank you.

You've prepared a statement and come along to assist today with your involvement with a baby by the name of [Baby O], also known as [Baby O] at the time.

You've prepared accordingly, am I right? Now, as it happens, we've heard from Dr Brearey this morning and we'll hear from [Dr A] tomorrow. So I'm proposing simply to ask you about your involvement with [Baby O] on 23 June 2016.

In preparing your statement, did you have access to your notes that were made at the time?

DR B: Yes, I did.

ASTBURY: So you would have been aware on the afternoon of 23 June, can I put it simply this way, of [Baby O]'s clinical course that day?

DR B: Yes.

ASTBURY: And again, without delving into the detail, you were aware of the occasions when [Dr A] was called to see him?

DR B: Yes.

ASTBURY: Were you aware that [Dr A] had intubated [Baby O] during the course of the afternoon?

DR B: No, I was not. I have deferred to my statement. So I had seen [Baby O] -- can I look at my statement to refer to?

ASTBURY: We will go to it if necessary --

DR B: Yes, so the exact dates -- I'm just referring to when I saw him on the morning rounds. So just to put it in perspective, we operated what we called a paediatrician of the week at the time, which meant that we did our ward rounds on the neonatal unit on a Sunday and a Wednesday.

ASTBURY: Yes.

DR B: So the Wednesday morning, I had seen [Baby O] on the ward rounds, and there's my note entries and my statement relating to

that as well. I did not see him on the rounds the following day and I believe the doctor did the ward rounds that day. On that afternoon, I think it's 15.40 or 15.51, one of the times, I was walking towards the neonatal unit.

So how it works is, obviously there was one consultant who covered both the wards and the neonatal unit, and if there was a sick baby or an unwell baby, you would be called away and you would prioritise where the workload was, and I hadn't been aware that [Baby O] had become unwell.

ASTBURY: I'm going to ask you to pause there, doctor. Just to assist you by way of orientation -- I'm sure I can do this, there's no challenge to this -- you saw [Baby O] on your ward round of 22 June?

DR B: Mm-hm.

ASTBURY: Were you the consultant of the week that particular week?

DR B: Yes.

ASTBURY: And you were in the unit or certainly in the hospital on duty on the afternoon when he saw [Dr A] on a number of occasions?

DR B: Yes.

ASTBURY: I was hoping to focus in on the point that you'd started to tell us about, which is when you were on the unit and -- were you speaking to [Dr A]?

DR B: So we were actually -- when I came out of the ward I was going towards the neonatal unit and [Dr A] was coming downstairs and was -- started walking along with me and he started to update me what had happened in the previous couple of hours.

ASTBURY: I'm going to ask you to pause there. A note is being taken of what you say, so if we can take it in bite-size chunks. I think you had an idea of roughly what time this took place?

DR B: So I think I've put in my notes, it was about -- I want to say 14.40, but I would like to confirm that from my statement.

ASTBURY: Well, I'm told I'm okay to lead from your statement.

Your recollection was the conversation took place about 15.50 that afternoon. We've seen the presentation before. If we go to the presentation, please, Mr Murphy, and we go to tile 214.

If you go back to your recollection for a moment, please.

DR B: Yes.

ASTBURY: You were telling us about a conversation you were having with [Dr A].

DR B: Yes. So basically, this is -- is this data from when I have documented or is this when I'm walking down the corridor with [Dr A]?

ASTBURY: I'm wondering whether the timing of the bleep data -- we have heard about the bleep system that's in the hospital --

DR B: Yes.

ASTBURY: -- and in the context of this particular afternoon, whether that assisted you with when you might have been having the conversation with [Dr A].

DR B: Yes, yes, that's right. So his fast bleep actually went off as he was mid-sentence, telling me that [Baby O] had been intubated and we didn't get very far into what had happened in the previous couple of hours and we both ran literally across the corridor into the unit.

ASTBURY: Right, I was about to ask where you were when this conversation took place. You can obviously remember you weren't in the unit.

DR B: No, but I was walking towards the unit. So there's a corridor that then leads to the neonatal unit door that you go in and then go into the neonatal unit. And [Dr A] joined me, because he was coming from upstairs. I had just gone, just to check everything was okay, because I hadn't been round there in the daytime, I'd been on the children's ward. It was then that [Dr A] started to update me about what had happened in the previous few hours. As far as I can remember, he could only get in that he'd had to intubate [Baby O] who had suddenly become unwell. Then his crash bleep went off and we both ran into the unit.

ASTBURY: Okay. If we look at the next few tiles, please, Mr Murphy, we can probably see -- do you remember the swipe data system that was in place --

DR B: Yes.

ASTBURY: -- where you have to swipe your particular card to go through a particular door?

DR B: Yes.

ASTBURY: We have, I think, three tiles. I don't think we need to look behind them. Maybe just the third one, Mr Murphy.

On that third one at 15.53 --

DR B: Yes.

ASTBURY: -- that one shows you entering the actual neonatal unit.

So again, I hope that assists you with the timing --

DR B: Yes, you're right.

ASTBURY: -- of what went on. Now, do you have an independent recollection of what you came across when you entered the unit?

DR B: I do. From what I can remember when I walked in, [Baby O] was being bagged by the nurse. Obviously, my recollection of all the readings that I have put in my statement is from the statement itself, but his saturations were very low and he looked very unwell.

I have written -- what I recall is he was just generally very mottled and looked really, really sick.

ASTBURY: We can go to your note in a moment. It's not a memory test but I'm just interested in what you can actually remember --

DR B: Which was a shock from my recollection of him the previous day. And obviously, generally, if -- so the registrar and the SHO would have gone round in the morning and if there are any unwell babies -- and at the time, because there was only one consultant covering the two sides, if a baby was unwell and consultant presence was needed, they were informed and I hadn't had any information and, assuming that all had gone well, there were no poorly babies on the unit on that morning.

And generally, whenever we had time, you would just go across to the neonatal unit and just make sure that everything was running smoothly and that had been my purpose when I had been going there.

Obviously when I walked in, [Baby O] was being bagged and -- do you want me to carry on?

ASTBURY: If we pause there. I just want to ask you a couple of questions about what you have said already. You went to the unit

and a nurse was bagging [Baby O]. Do you remember who that nurse was?

DR B: No.

ASTBURY: Did you take a history from the nurse who was present as to what had happened?

DR B: I don't exactly recall, but that would have been the question, "What happened?"

ASTBURY: Okay.

DR B: And from my statement, I can recall -- because this was 6 years ago, so I don't remember the exact conversation.

There are some images which are engraved in my head, and I'm sorry if I cry, so you'll have to excuse me. And one of them is him just being lifeless and mottled and the question would have been, "What happened?"

ASTBURY: Okay.

DR B: You know from my statement, I can recall that they said, "Oh, he suddenly dropped his saturations", and this was how he is.

ASTBURY: Okay. You mentioned his appearance. You also said that you were shocked given what you'd seen the day before.

Could you just expand on that for us, please?

DR B: When I'd seen him the day before on the morning rounds, he -- from my notes and from my recollection there was nothing untoward. He was a 33-weeker, one of the triplets who had progressed quite well. He had needed some initial support for his breathing, had been on CPAP, and I'd reviewed his gases, I'd seen him. He was progressing quite well and I'd asked if he could be changed to Optiflow and if we could start feeds. And I know from the notes that they'd weaned the Optiflow, he'd gone from oxygen into air, and they'd started the feeds and gradually increased them and he was fully fed.

So this was a baby who was progressing very, very well. When I had seen him, I had no reason to be worried about anything, and this was a shock that was completely unexpected.

ASTBURY: Okay.

DR B: I didn't know about -- from what had happened from about 1 o'clock onwards, so I think it was probably more unexpected from that point of view.

ASTBURY: If we go to your notes, which is the next tile in fact, Mr Murphy, at 218.

So do you recognise the handwriting, doctor?

DR B: Yes.

ASTBURY: Is that yours?

DR B: Yes.

ASTBURY: Is that your note?

DR B: Yes.

ASTBURY: Thank you. I'm going to go through that with you if I may. You have made the point that it is timed at 6.15 that afternoon but written retrospectively from 3.50 pm --

DR B: Yes.

ASTBURY: -- which is consistent with the times we've just looked at. You were with [Dr A] updating you about [Baby O]'s condition. He'd been intubated. Is that "around 3 pm"?

DR B: Yes.

ASTBURY: And that was when the fast bleep went off. You arrived, did you, to find [Baby O] was being bagged and you put there, "Sats at 35".

DR B: Yes.

ASTBURY: What can you tell us about that figure?

DR B: So that's a very, very poor oxygenation because normally we would expect babies to saturate in the high 90s, 94, 95. And 35 is very, very poor.

ASTBURY: Okay. "With" -- is that --

DR B: Bradycardia means his heart rate was low as well.

ASTBURY: Thank you.

DR B: Initially, when somebody's oxygen levels drop, a normal reaction is that your heart rate goes up to try and compensate,

to improve the oxygenation. And if that doesn't happen over a period of time, your heart, because it's not getting oxygen either, starts to drop, which again is a very bad sign.

ASTBURY: Notwithstanding that, you've got -- is that: "Good air entry on auscultation"?

DR B: Yes. So I would have straightaway gone in -- because this baby was intubated, so when they are being bagged you can listen in and I could hear that the air was moving on auscultation. But his oxygen saturations weren't coming up. So if you're delivering breaths and you're delivering oxygen and you're bagging through a patent tube, you would expect that baby's oxygen levels and heart rate to respond and come up.

ASTBURY: Yes.

DR B: What I have said is: "Good air entry on auscultation. Saturations not improving." Do you want me to carry on?

ASTBURY: I'll assist you, if I may. You have then noted that the ETT was removed and [Baby O] was re-intubated --

DR B: Yes.

ASTBURY: -- by [Dr A] with a size 3 at first attempt.

DR B: Yes.

ASTBURY: Do you recall, it doesn't seem to be in your note, what [Baby O]'s reaction to that was?

DR B: I don't exactly recall, but what I would say is that if [Baby O] had resisted or we had had to do a forced -- because when babies are active, they resist by breathing or breathing against or showing some movement, which can make intubation a bit challenging. Babies who, what we call, are completely flat, you know, their oxygenation and heart rate will just lie there and you can do anything to them. So that, from my note and from my memory -- there was no time literally to say, "Well, let's get some drugs", and basically he was flat as it is.

So the intubation, first attempt -- again, [Dr A] is a very experienced registrar, he's very good at what he does. Secondly, it doesn't seem like there was a situation where we had problems intubating him.

ASTBURY: Okay. But despite that, by 16.15, you are recording again bradycardia with desaturation. So this is after the second tube --

DR B: Yes.

ASTBURY: -- has been placed?

DR B: Yes.

ASTBURY: So does that rule out any problem with the ventilator itself or certainly the tube?

DR B: Yes. So this is re-intubation and this probably is -- the second intubation or re-intubation would have been done just in case: yes, I can hear the air entry okay, but because his saturations aren't coming up, I'm going to give this the benefit of doubt and re-intubate just in case. Because there's no 100% guarantee, if I can hear good air entry, there can't be a problem with the tube.

So in between that time, with first attempt, what I have not written, but I'm assuming his saturations would have come up and his heart rate would have come up as well and then he drops again with heart rate dropping again to 60 and saturations dropping to 50%.

ASTBURY: Okay. 50%, what would you say about that level? You told us about 35 --

DR B: Very poor. Very poor.

ASTBURY: He was hand ventilated using the Neopuff; is that right?

DR B: Yes. So we would take these babies off the ventilator and then you would manually give breaths while watching the baby and seeing if their chest is moving, and obviously looking at the monitor if the heart rate and the saturations are coming up, that manoeuvre.

ASTBURY: Yes. Do you recall who was hand ventilating on that occasion? No? Now, the heart rate you have recorded at 60 and we've heard from other witnesses, correct me if I'm wrong, that's the point at which it's dangerously low and chest compressions become necessary?

DR B: Yes.

ASTBURY: And you have put on the next line that that in fact is what commenced at 4.30 pm or 16.30 on your note?

DR B: Yes.

ASTBURY: We've also heard that there's a set protocol for the purposes of resuscitation. Is that, given the situation which had now arisen, what kicked in at that point at 4.30?

DR B: Yes.

ASTBURY: Hence your note about adrenaline. Is that bicarbonate being administered?

DR B: Yes.

ASTBURY: You've put there that [Dr A]'s entry, or you've inferred there, correct me if I'm wrong, is more detailed in this regard; is that right?

DR B: Yes. So basically, going back, I have made the retrospective note at 6 o'clock. The resuscitation drugs are given at certain times and somebody's responsible for recording the first adrenaline given at this time, second, third, however many. And at that point, that record -- so we were probably all documenting similar things because there were quite a few people who had been involved. So I didn't translate all that in my documentation, saying that [Dr A]'s entry notes... and in the resus chart which would have the exact timings and dose of those drugs that were given.

ASTBURY: We're expecting [Dr A] tomorrow, so I'm not going to take you to that note, but others may.

Your next entry deals with a left great saphenous cannulation; is that right?

DR B: Yes.

ASTBURY: Just tell us about that, please.

DR B: So basically, earlier in the day, when [Dr A] had reviewed [Baby O] about the abdominal distension and a blood gas that had been done, which was not very good, he had cannulated [Baby O] and started him on intravenous fluids and organised an abdominal X-ray. So [Baby O] had one intravenous access.

ASTBURY: Yes.

DR B: When children or babies become unwell, we are mindful of trying to get more than one intravenous access for various reasons. One is if you lose that one then you've got nothing. Secondly, we have to give multiple drugs, not all of them are compatible with each other and sometimes you think, well, okay, if I can use this one for this and that one for that -- so I think we were all very conscious that we had just one

intravenous access for [Baby O]. So quite a few people were trying -- I think I've put, maybe not here, but in my statement, [Dr A] tried a few times, so he would have been at one end, and normally just one person would try at a time and once I'd seen him have a couple of attempts -- I think I've put three attempts -- I started at the -- because I was at his foot end. So I tried the -- the saphenous vein is a big vein in your lower leg, just by the ankle.

ASTBURY: Yes.

DR B: And one of the things with big veins is you can -- it looks like I didn't get a lot of flashback, there was a little bit of blood probably because his circulation was so poor. When I flushed it, the cannula flushed, so that IV access was secured.

ASTBURY: I was about to ask you about that next entry. So were you satisfied that that was a functional intravenous access?

DR B: So I've said, "Not bleeding back much". That means that -- so when you cannulate -- the saphenous vein is a big vein, so normally in a child who has good circulation, blood literally flows back and drips and we have to be sort of -- you have to press on the top to stop the blood from coming, but this did not happen. So there would have been a flashback and I could see that a little bit of blood was coming through, but I didn't feel that at that time the priority was collecting blood.

And sometimes if you move things around too much you can actually lose the access and I was conscious that this was a precious access and I needed to save it for administering medication rather than getting blood.

And you can check -- if you're not in the vein, you get a big swelling at the end, so I would have flushed it and checked that it's going where it needs to go.

And if I wasn't in the vein, it would have been obvious that I was not in the vein and there was a swelling proximal to where I had cannulated and the cannula would have been taken out.

ASTBURY: All right. So you satisfied yourself that --

DR B: Yes. There would have been other people around me, it's not just one person, because when you flush, other people are looking as well just to confirm that we are happy with this.

ASTBURY: I was going to ask you, after the word "flushed", is that "fine" in brackets?

DR B: Yes. So I have confirmed that it flushed and it flushed fine.

ASTBURY: And then you indicate -- is that "dopamine commenced"?

DR B: Yes.

ASTBURY: If we scroll down a bit further please, Mr Murphy: "Three attempts at capillary gas unsuccessful." Just explain that to us, please.

DR B: Yes. In the first instance, if we had managed to get some blood from the cannulation, that would have been checked for a venous gas. This again -- capillary gases are -- with babies we -- there are little lancets that you pierce their heel with and then you squeeze, and little drops of blood come out that you collect in a little capillary. It looks like his perfusion was so poor that there was no blood from --

ASTBURY: So not even the prick with the pin was producing any blood?

DR B: No.

ASTBURY: "[Dr A] [is that], Dr Brearey and myself present at resuscitation from 4.30 pm onwards"?

DR B: Yes.

ASTBURY: "When Dr Brearey arrived, I went and discussed with..." Is that Dr Rackham?

DR B: Yes.

ASTBURY: From transport?

DR B: Yes.

ASTBURY: So just explain to us then, was that, for the time being, your involvement in what was going on?

DR B: So basically, at this time -- so when I've said about 4.30, this is the time when we'd given the adrenaline, the bicarb, we had an IV access, we'd started the dopamine and at that time he was put back on the ventilator. I had asked for Dr Brearey to come -- I think this is mentioned later on, I can hold on and come back to it later. But my main purpose of asking for him -- the things going through my mind was what had caused his sudden collapse, what had happened. One of the things I was thinking was: can it be something to do with his heart? Dr Brearey has a specialist interest in cardiology and we often ask

for his help when we suspect underlying cardiac problems, to do echocardiograms. That's why I'd asked for Dr Brearey to come down and assess whether - - and I haven't documented --

ASTBURY: Let's deal with that now.

DR B: Yes.

ASTBURY: Did that happen?

DR B: That did happen. So Dr Brearey came down. We had a discussion, and again I have not documented that in great detail here, but I have done in my statement.

Dr Brearey -- obviously, I think you probably already know that Dr Brearey had been present earlier on when [Dr A] had intubated, so he had supervised that intubation. I didn't know that at the time when Dr Brearey came down and I was explaining to him what had happened. He assessed the baby and his opinion was that this wasn't a cardiac cause for this collapse and he didn't feel that an echocardiogram was required.

ASTBURY: We've heard a little bit about the process of differential diagnosis. Is this working through the possibilities if it's simply -- to eliminate them?

DR B: Absolutely, yes. And because Dr Brearey was there as an overseeing consultant and the registrar was there, we had a discussion about thinking about different differential diagnoses and one of the outcomes of the discussion was: let's discuss with a tertiary centre neonatologist, give them an update on what's happened, ask if they have anything else to advise that we haven't thought of or done, and also given that [Baby O] has become so poorly, would he be transferred to a tertiary neonatal unit.

ASTBURY: So twofold, really. Advice, if they can offer anything different, and also the possibility of a transfer if it became necessary?

DR B: Yes.

ASTBURY: Do you remember going away to speak to Dr Rackham?

DR B: Yes.

ASTBURY: Do you remember where you'd have gone to do that?

DR B: As far as I can remember, I went to -- I think it's called the resource room. So as you enter the doors there's a room to the right and that was probably the -- usually the nurses would

go there for their breaks, the doctors would as well. It was relatively further out and you can close the door. So there's other parents, patients, everywhere else, including at the reception of the nursing station. So I didn't want to have that conversation in the middle of the unit, so I think that's where I went.

ASTBURY: That would have afforded some privacy?

DR B: Yes, yes.

ASTBURY: All right. Following your conversation with Dr Rackham did you go back into the unit?

DR B: Oh yes, yes. I never left the unit. So this is within the unit.

ASTBURY: (Overspeaking).

DR B: Yes, to nursery 1, yes.

ASTBURY: And what was the situation when you went back the second time?

DR B: I'll have to go back on to...

ASTBURY: Pause there, doctor. Can we have tile 316, please? I think you made a note of what you saw the second time you saw [Baby O].

DR B: Yes.

ASTBURY: So this is timed at 7 o'clock, but again would that be written in retrospect when the opportunity arose?

DR B: Yes.

ASTBURY: So: "Neonatal consultant gave an update. Dr Rackham agreed with..."?

DR B: That's "management".

ASTBURY: "... so far"?

DR B: Yes.

ASTBURY: And, "Advised to try for..."?

DR B: "Central access."

ASTBURY: We have heard about UVC and UAC: "He agreed to get an update for [is that] bed state for transfers"?

DR B: Yes, "transfer and call back".

ASTBURY: You returned to the resuscitation and again you've put: "For details and times, refer to Dr Brearey's notes and chart."

DR B: Yes.

ASTBURY: So just from recollection, do you recall what was unfolding when you went back to the nursery?

DR B: Yes. I think he'd probably done the same thing. So I remember going in and the resuscitation rounds of adrenaline and bicarb being done again.

ASTBURY: You say again. Had there been an improvement in [Baby O]'s condition before you left?

DR B: Yes. So between the time -- so when I said -- when [Dr A], Dr Brearey and myself were there after the re-intubation and that episode of desaturation and bradycardia, we'd put him back on the ventilator and he appeared to be stable, if you can use the word, which was why I thought: well, okay, we've got this moment now, let's sort of go back and have a re-think, we've considered different things and let's run it past another consultant.

ASTBURY: All right. When you came back things had deteriorated again?

DR B: Yes.

ASTBURY: What was happening when you came back?

DR B: So he was receiving doses of adrenaline every 4 minutes and we also gave him some bicarbonate. During this time we had also thought about could he have a pneumothorax, so we cold -- used a cold light to check for that because we couldn't really understand why these collapses and crashes were happening. It's not something I'd seen happen so suddenly in a baby, literally so quickly one after another. It just seemed like whatever we gave him was having no effect.

ASTBURY: Okay. With the resuscitation process being the protocol that it seems to be, would you have expected a response from the measures that were being taken?

DR B: In the first place, I couldn't explain why he had crashed in the first place. Generally speaking, if...

I'm trying to answer this as best as I can. So normally, if you revive a baby with ventilating them and supporting their breathing and their circulation with fluids, trying to improve their perfusion with dopamine, the answer is, yes, I would have expected a response from the medication that he was receiving.

ASTBURY: Before you'd gone to speak to Dr Rackham, you'd seen that improvement?

DR B: Yes. So that was the third time or the second time. He did that once and then [Dr A] intubated him. Then he went again. Then we re-intubated him. Then he went again and then he had stabilised three times and this was the fourth time.

ASTBURY: You mentioned a cold light test. We know that's only an indicative test, but what did that show or not show?

DR B: The cold light test is to check for -- so we are going through different --

MR JUSTICE GOSS: I'm sorry to interrupt, we've had this evidence and it's not been challenged.

MR ASTBURY: Sorry. What was the result of the cold light test (overspeaking) --

DR B: It was negative. The cold light is to check for a big air leak that can compromise a baby suddenly and might be one explanation --

ASTBURY: Was there any evidence on the cold light test?

DR B: No.

ASTBURY: Was at one point an intraosseous route sought?

DR B: Yes. So when we were trying to get a capillary gas -- so the venous cannulation did not give us the blood test, the heel pricks weren't giving us any blood, and we wanted to know the blood gas. So the blood gas gives us quite a lot of information about the oxygenation, perfusion and guides on what other resuscitative measures may be helpful. So Dr Gibbs was there and he used an intraosseous needle, which is --

ASTBURY: We have heard that's a needle into the shinbone, in this case, to obtain blood from within the bone.

DR B: Yes.

ASTBURY: Just to be clear, the purpose of the intraosseous needle was what, to obtain what?

DR B: To get some blood because there was no other way we could get any blood from him.

ASTBURY: At the time that was undertaken you have told us there were two intravenous points of access. Were they still operable?

DR B: Yes.

ASTBURY: And was there, at another point, an attempt to reduce the distension of [Baby O]'s stomach by use of a -- entry via the McBurney's point, we've heard it called?

DR B: Yes. These are now, we are trying to think -- one of the differentials was his abdomen was grossly distended and we know that when there is a lot of air or gas in the abdomen it pushes the diaphragm up and that compromises the breathing and can compromise the heart.

So another was, well, if we reduce this abdominal distension, will that help? So Dr Brearey then took a cannula and inserted to see if there was a massive air leak or if the bowel had perforated and all the air had leaked out and that had distended the abdomen to the point that it was compromising his cardiovascular status. And he inserted the little yellow cannula lower down on the right side of the abdomen.

ASTBURY: Did it relieve the distension?

DR B: No. He just got a little bit of blood that was -- there was nothing.

ASTBURY: And did the attempts to resuscitate by way of adrenaline and chest compressions continue?

DR B: We did however many rounds, I think there were four or six. There was a period of time, again, that I've documented in my statement, when he was again stabilised a little bit and there was a discussion about baptising him and whilst he was being baptised he became severely bradycardic again and resuscitation attempts were commenced yet again and I think he received another four rounds or however many from, I think, 5.15 until 5.45.

ASTBURY: Okay. Scroll down to the rest of the note, please, Mr Murphy.

You spoke to both parents regarding what was unfolding?

DR B: Yes.

ASTBURY: You remember them being present?

DR B: I don't.

ASTBURY: You've noted there the use of the intraosseous needle --

DR B: Yes.

ASTBURY: -- and Dr Gibbs, and the further adrenaline, which sadly had no effect. Is that a note to say that resuscitation was discontinued at 17.47?

DR B: Yes.

ASTBURY: Your final note on the page is the leaving of a message with contact details with the coroner's office; do you recall doing that?

DR B: No, I don't.

ASTBURY: Do you remember attempting to contact the coroner's office the following day?

DR B: I don't. I got a call from -- I remember speaking to somebody in that same room. I don't think I contacted them, I think they called back, so I must have had the message to call them back.

ASTBURY: Right.

DR B: Again, it's documented in there, but I do remember going in there and speaking to someone the following day.

ASTBURY: Did anything unusual happen while you were on the phone to the coroner?

DR B: The following day?

ASTBURY: Yes.

DR B: I think it did. Again, I haven't gone through that statement in detail.

ASTBURY: You're going to come and give evidence separately about [Baby P].

DR B: Yes.

ASTBURY: Just to conclude your evidence with regard to [Baby O], what was it that happened when you first tried to speak to the coroner the following day?

DR B: I haven't gone through [Baby P]'s notes in detail and I don't want to say the wrong thing, but I... [Baby P] again crashed that many times, I don't know whether one of those was when I was speaking to him.

ASTBURY: Okay. All right.

DR B: But I would need to check my notes on that.

ASTBURY: We can maybe return to that when you come back to tell us about [Baby P].

Could we finish, please, with tile 477, just for the sake of completeness? We can see there two notes in that regard. At 7.30 pm, so a couple of hours after [Baby O] had passed, you spoke to his parents about a coroner's post-mortem. It's at 2.25 and you have recorded speaking to someone called Chris from the coroner's office and providing the relevant details.

DR B: Yes.

MR ASTBURY: Thank you. [Dr B], I have no more questions.

If you could wait there, please.

Cross-examination by MR MYERS

MR MYERS: [Dr B], just a couple of points, if I may, just with regard to how [Baby O] looked when you first saw him.

I'm going to go to the first of the notes that we have, the clinical note. It's at tile 218. This is a note that you made in retrospect, [Dr B], at 6.15 pm.

DR B: Yes.

MYERS: I know you are casting your mind back now and you began by trying to recall things as well as you could before you had the notes and you described that when you came back to see [Baby O] after the bleep had gone off and you were with Dr Brearey, you made reference to him looking mottled, is the way you put it.

DR B: Are we talking about the initial 3 pm note or...?

MYERS: Well, I'm just looking first of all at this one.

If we look here, from 3.50, which is when you first went back with [Dr A] --

DR B: [Dr A]? You said Dr Brearey.

MYERS: My mistake, with [Dr A]. 3.50. You said you'd gone back with [Dr A] and [Baby O] was being bagged --

DR B: Yes.

MYERS: -- and he was generally mottled.

DR B: Yes.

MYERS: If we look at the note here, you can probably read it yourself, but it says: "Written retrospectively from 3.50. Was with [Dr A] who was updating me about [Baby O]'s condition, had been intubated at 3 pm." You recite that: "Arrived to find [Baby O] was being bagged."

DR B: Yes.

MYERS: And you move on then and there's never any reference to him being mottled?

DR B: No, there isn't.

MYERS: We looked at a later note that you made later on.

We can go to it if you want to but it was at tile 316.

A few hours later and again no reference to any mottling then.

DR B: Yes.

MYERS: Just to cut through all of this, I have looked in the your statement as well to the police, which is dated 22 November 2017, and you go into quite a lot of detail there but there's no description about mottling there either. I'm just wondering whether, doing the best you can, mottling is something that appears but might not have been there at the time, appeared in your recollection but might not have been there at the time.

DR B: Okay. So I will expand on that a little bit. Mottling is a general term that is used when babies are very poorly perfused. Okay?

MYERS: Right.

DR B: So when the circulation becomes poor, the supply -- the body tries to preserve the blood supply to the vital organs and

takes it away from the skin, which is not a vital organ, and that leads to mottling.

MYERS: Right.

DR B: It is a sign of very poor circulation. While I have not mentioned the word "mottling", I think there is enough evidence there, by not being able to bleed a baby after stabbing them several times, to show that their circulation was very, very poor. So I think when I say mottling, it's the poor circulation, so one of the things that sticks in your mind is, well, the circulation is -- this baby is having a circulatory collapse.

MYERS: That explains it, I just wanted to be clear when you were saying mottling exactly what you were referring to.

It has a significance here and you have explained that, poor perfusion, which is what you'd expect of a baby in circumstances like this. You're nodding. You're agreeing, I take it?

DR B: Yes, sorry. Yes.

MYERS: The other matter I'd be grateful if you'd help with is this. We know that the actual process of CPR was performed on [Baby O] on two separate occasions that afternoon. I'm going to ask Mr Murphy to put up tile 227, which is a document that records when it took place.

We know from the note that you made that we've just looked at, [Dr B], that you'd recalled that external compressions commenced at 16.30. That's your approximate recollection. We can see, if you look on this chart, that we've got, "Chest compressions started" -- do you see it says 16.19? If you look at where it says "chest compressions started" at the top?

DR B: Yes.

MYERS: And it's got a record there?

DR B: Yes.

MYERS: I'm not raising any point about the fact it says 4.30 in your note and 4.19 here, that's not the point of my question. But I just wanted to ask if you could help us with how long that went on for, if you have any recollection of that particular session of chest compressions?

DR B: All I will say to you is when people who are directly involved in the resuscitation are not -- so there is a person assigned to time and document. And the start and stop times, however precise they can be, are documented by that person. So

once you've got a scriber assigned, my timings might not have been precise because that wasn't my job. But I couldn't say to you exactly how long. However, within a few minutes, his circulation did return, his heart rate was re-established, and he was -- we did manage to connect him back to the ventilator and that would have only happened after some degree of stabilisation had occurred.

MYERS: So maybe a matter of minutes, but you couldn't say how many?

DR B: No.

MR MYERS: I'm not going to ask you to guess then. I just wondered if it was something you could remember. That's all I wanted to ask. Thank you, [Dr B].

MR ASTBURY: I have nothing, my Lord. Does my Lord have any questions?

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

You will be required to give evidence again, [Dr B], but thank you very much for coming to give evidence this afternoon. Please don't talk to anyone about anything to do with this case until it's finished.

Thank you very much. Remain where you are, please.

I think there were -- I don't know who was going to be reading statements. Will there be any difficulty in -- rather than the disruption of the jury leaving the court and the witness leaving the court, would there be in difficulty in your remaining here for the 5 or 10 minutes it'll take to read these?

MR ASTBURY: It might take a little longer, my Lord.

MR JUSTICE GOSS: Will it?

MR ASTBURY: I think.

DR B: I'm fine with waiting.

MR JUSTICE GOSS: Are you sure? Is there any difficulty about anything being said in any of these statements that should not be heard by the witness? In other words, it might be prejudicial or corrupt your recollections or something.

I'm just looking at the statements I've got. Most of them are scored through.

MR ASTBURY: Yes. There's three nurses and two doctors left. Fairly short statements. I'll do them as quickly as I can.

MR JUSTICE GOSS: I was trying to save a bit of time, but I'm wasting it by conducting this exercise. So we'll just carry on. Are you all right with that?

MR MYERS: Yes, my Lord.

Witness statement of MS SAMANTHA O'BRIEN (read)

MR ASTBURY: My Lord, the next statement is Samantha O'Brien, who appears at page 51 of my Lord's bundle. She in a statement dated 10 May 2018 says this: "Between January 2016 and July 2017 I worked as a band 5 nurse within the neonatal unit at the Countess of Chester Hospital in Cheshire.

"I confirm that I was designated nurse for [Baby O] during my long day shift on 22 June 2016.

[Baby O] was in nursery 1 along with one of his brothers, but I can't be certain whether he was with [Baby P] or [Baby R].

"During my shift [Baby O] was progressing well and there were no issues." My Lord, I'm not going to go to it, but if anyone wants the note of that day shift it appears behind tile 48 in our sequence.

MR JUSTICE GOSS: Thank you.

MR ASTBURY: She adds: "I also believe I was designated nurse for [Baby R] that day.

"The following day, 23 June 2016, I was working a long day shift on the neonatal unit and I was the designated nurse for [Baby R]. Lucy Letby and her student nurse, Rebecca Morgan, were the designated nurses for [Baby R]'s brothers, [Baby P] and [Baby O].

"I recall all three triplets being in nursery 2 at the start of the shift. I was not continuously in nursery 2 as I believe I was also allocated a baby in another of the rooms. As nursery 2 is not intensive care, there is no requirement to remain in the room and the unit is small enough to hear if the alarms activate.

"I recall, as I entered nursery 2, that [Baby P] and [Baby R]'s incubators were on the right side of the room and [Baby O]'s cot was on the left side by the window.

I don't recall there being any issues raised in relation to any of the triplets during the morning handover.

"At some point during the afternoon, I can't be more specific, I recall that Lucy had requested a review of [Baby O] by the doctor. From curiosity, I asked Lucy her reason for this and she explained that [Baby O] had blew his tummy up. I could see [Baby O] but other than his stomach may have appeared slightly distended, there was nothing else that was visibly apparent to me.

"I was outside of nursery 2 when I saw that [Baby O]'s incubator was transferred to nursery 1. I am unsure of the staff who moved [Baby O] but confirm it would have been two nurses.

"It was at this point I glanced at [Baby O] and saw that his skin appeared a bluey colour. I'm aware this is symptomatic of desaturation in babies. I knew that [Baby O] was placed on a ventilator and stabilised.

I recall the triplets' parents being on the ward at this point and I took them into nursery 2 where they had cuddles with [Baby R].

"I was aware that my colleagues were focusing on nursery 1 and I was either spoken to discreetly or I went into nursery 1 to see what was happening. It was at this time that the parents were informed that [Baby O] had deteriorated and they were taken into nursery 1.

I then assisted in drawing up the drugs required in [Baby O]'s resuscitation procedure. I was working alongside Yvonne Farmer while drawing the drugs up and when she left I was later assisted by Melanie Taylor.

"Sadly, [Baby O] continued to deteriorate and he tragically passed away. I am aware that he was baptised but I have no further recollection of this taking place.

"I had no involvement in the aftercare with the [Surname of Babies O, P & R] family. I did attend a debrief which was led by Dr Brearey and took place during the same shift."

Witness statement of MS Yvonne Griffiths (read)

MR ASTBURY: The next statement, please, my Lord, is from Yvonne Griffiths and appears at page 54 in the bundle.

It is dated 26 March 2018 and she says as follows: "I am currently employed as the ward manager at the Countess of Chester Hospital in Cheshire. I have been asked to provide any

information I can offer in relation to a set of triplets born on 21 June 2016.

"I confirm that I was on duty on 23 June 2016.

I was office-based that day but obviously if my colleagues on the unit needed assistance, then I would support them. 23 June was the only date that I worked during the specific period involving the [Surname of Babies O, P & R] triplets.

"The triplets, [Baby O], [Baby P] and [Baby R], were in nursery 2 and were stable at that time, with Lucy Letby being the designated nurse for [Baby O] and [Baby P]. Lucy also had a student working with her as well and I believe that Rebecca Morgan was allocated the care of [Baby R] that shift.

"The [Surname of Babies O, P & R] triplets were classed as IT because they had lines in and possibly oxygen. [Baby O]'s cot was positioned first on the right as you entered the room and he was the baby we transferred into nursery 1 when he started to deteriorate. We only have one emergency admission space that we can transfer a baby into and as we were busy with patients, we did have to move a baby from nursery 1 to allow [Baby O] space in the room.

"When [Baby O] was in nursery 1, his cot was opposite the door. The medication cupboard that's used for resuscitation procedures is kept in nursery 1 and the drugs have to be checked by two members of staff.

"I remember being alerted to [Baby O]'s collapse as I was walking through the unit and I could see a lot of activity in nursery 2. I saw the staff were focused around [Baby O].

"We were very busy at that time so we moved the more stable baby out of nursery 1 and transferred [Baby O] to nursery 1. My only involvement at this time was to assist with moving equipment and ventilators.

"All the medical/nursing team were involved with [Baby O] and I recall [Baby O]'s father who was also present and looking very distraught. My role at that point was to support the father as there were enough people present to draw up the medication. Sometimes too many people can be more of a hazard in that situation.

"I remember supporting and holding the father's hand and discussing things with him as he was witnessing everything that was happening at the time with [Baby O].

I know Karen was also on the ward, but I don't recall her being in a wheelchair, I also remember Karen's mother being around.

"Dr Gibbs and Dr Brearey were also present with [Dr B], who spoke with the parents. It was unusual to have the three consultants present at the same time.

Unfortunately, when [Baby O] did die, the nurses were very busy caring for other babies on the ward, so I took the parents into the family room and sat with them with [Baby O] in his cot.

"I remained with the family for quite a long time that day. My duty that shift ended at 5 pm but I stayed until the night staff came on duty and handed over the care to them as, in a situation like that, I did not want to just leave.

"[Baby O] was later taken through to nursery 2 to be with his brothers and family and we ensured they were the only babies present in that room at that time to respect the parents' privacy." That concludes her statement, my Lord.

Witness statement of DR JOHN GIBBS (read)

MR ASTBURY: The next statement comes from Dr Gibbs and it begins at page 63 of my Lord's bundle.

MR JUSTICE GOSS: Thank you.

MR ASTBURY: Dr Gibbs, in a statement dated 10 September 2018, says this: "[Baby O] was the second of three triplets born on 21 June 2016 at 33 weeks' gestation. He was born under the care of one of my consultant colleagues, [Dr B]. I had no involvement with his care until the evening of 23 June 2016 when I was the consultant on call for that evening and night covering the neonatal unit and paediatric ward.

"I went to the neonatal unit at around 17.00 hours on 23 June 2016. I cannot recall exactly what time I went to the unit, nor is this recorded in [Baby O]'s hospital record. When I arrived on the neonatal unit, [Baby O] was extremely ill and was receiving cardiorespiratory resuscitation directed by two of my consultant colleagues, [Dr B] and Dr Steve Brearey. Other junior doctors were involved as well as a number of the nurses on the neonatal unit but I cannot recall exactly who else was involved at that time.

"I had only peripheral involvement since the resuscitation was already underway when I arrived on the neonatal unit and this was being led by [Dr B] and Dr Brearey. These two colleagues, plus nurses and junior doctors, recorded their involvement in [Baby O]'s medical record but there was no need for me to make

an entry in that record since I did not have a significant involvement with [Baby O]. Instead, as the consultant on call for the neonatal unit that evening, I directed my attention to [Baby O]'s triplet siblings, [Baby P] and [Baby R]." In respect of [Baby O], my Lord, that concludes Dr Gibbs' statement.

Witness statement of DR SUDESHNA BHOWMIK (read)

MR ASTBURY: If I can move next, please to, Dr Bhowmik at page 67. Dr Bhowmik says this in a statement dated 4 January 2018: "I am currently employed as a consultant paediatrician at Arrowe Park Hospital. From March 2016 through to September 2016, I was working as an ST8 registrar within the paediatric department at the Countess of Chester Hospital. This was my final year as a trainee before qualifying as a consultant.

"On 23 June 2016, I was on call and working a long day shift and had worked within the children's ward. At 16.30 to 17.00 we had the usual handover and I recall the on-call consultant, Dr John Gibbs, was also present but unusually no one representing the neonatal unit had arrived. We made our way across to the unit and entered the intensive care room (room 1) to find the resuscitation of baby [Baby O] taking place.

"From referring to the medical notes, [Dr A], consultant [Dr B], consultant Dr Stephen Brearey and Dr Kath Cooke were present.

There were also nurses around the baby but I do not remember who.

"We had arrived towards the end of the resuscitation attempt and I took over from [Dr A] and conducted the last series of cardiac compressions before, sadly, death was pronounced. Dr Gibbs and I immediately examined the other two siblings who were in the HDU room (room 2).

As a preventative measure, samples of bloods were sent to the laboratory to look for infection markers and both babies were placed on antibiotics.

"We had no concerns for either of the siblings at this time and I had no further involvement within the neonatal unit for the remainder of this shift."

Witness statement of MR CHRISTOPHER BOOTH (read)

MR ASTBURY: My Lord, next, please, is Christopher Booth.

In a statement dated 15 March 2018, he says: "I have been asked to provide any information in relation to my involvement with a

set of triplets born on 21 June 2016 at the Countess of Chester Hospital.

"On Thursday, 23 June 2016, I was working on a long day shift, beginning with the handover at 07.30 hours that morning. I believe that on this day [Baby O] was in nursery 1, however I am only surmising this as the triplets were quite new admissions and usually triplets on day 1 or day 2 would be placed in nursery 1.

This room is the main admission and intensive care nursery. I know that [Baby P] and [Baby R] went into nursery 2 at some point but I cannot confirm which day." He then confirms that the map that, my Lord, is in jury bundle 1 is an accurate representation of the unit.

I don't think I need to refer to that again for now.

MR JUSTICE GOSS: No, thank you.

MR ASTBURY: "I can't confirm the position of [Baby O]'s cot in nursery 1 and cannot recall whether I was a designated nurse for any of the triplets on 23 June 2016.

"Sadly that day, [Baby O] had some abdominal distension and he rapidly deteriorated and later suffered a cardiac arrest. My only involvement with [Baby O]'s care was during his resuscitation procedure whereby I was working in a supportive role and checking drugs.

"It is standard practice that two registered nurses check the drugs as some of the drugs we administer are quite complex and not straightforward. The drug volume provided is calculated against the baby's weight.

However, I don't specifically recall who I checked the drugs with during this situation.

"I cannot recall whether I had any contact with the [Surname of Babies O, P & R] family after [Baby O] sadly passed away. When it became apparent that [Baby O] was not going to survive, the mood among staff was understandably sombre and we were all shocked and disappointed.

"[Baby O] had looked like a triplet that potentially was going to sail through. He was a good size and not even that premature. It was so unexpected that he just suddenly collapsed with no indication that would happen and so it caught us all by surprise.

"As a precaution both [Baby P] and [Baby R] were placed nil by mouth with a possible cause being sepsis and they were both commenced on antibiotics and put on to drips.

[Baby P] and [Baby R] were both okay overnight." That concludes insofar as [Baby O] is concerned Nurse Booth's statement.

My Lord, there's one more statement to read, but that can be done in the morning.

MR JUSTICE GOSS: Certainly. I don't want to cause any difficulty. It's 3 o'clock then, members of the jury.

We'll break off there. It's almost all that was going to be dealt with today in any event. That's it for today. 10.30 tomorrow morning. Thank you very much.

Please remember your responsibilities as jurors. No communication with anyone by any means about anything to do with this case other than when you are all together and any communications that you have between you should be confined to what I call administrative matters, nothing to do with the case itself or any of the evidence in the case, I'm sure you understand what I'm talking about. So by all means communicate but nothing to do with the evidence in this case unless you're all together and can hear what the others are saying.

Thank you very much.

(In the absence of the jury)

MR MYERS: We'd be grateful if we could have a visit with Ms Letby, my Lord.

MR JUSTICE GOSS: Yes.

If you just wait there, please, [Dr B] and the rest of the court will go. Perhaps some of the lawyers may still be lingering but you'll be told when you may leave the court.

DR B: Okay, thank you.

MR JUSTICE GOSS: Thank you very much.

(3.02 pm)

(The court adjourned until 10.30 am on Wednesday, 15 March 2023)