Prosecution Closing Speech Day 1

Monday, 19 June 2023
(10.30 am)

(In the absence of the jury)

MR JUSTICE GOSS: The answer to the query from the juror is, yes, we will finish at 3.45 tomorrow, thank you very much.

Jury in, please.

(In the presence of the jury)

MR JUSTICE GOSS: We will finish no later than 3.45 tomorrow, members of the jury. But as far as today is concerned, as I've already said to you, it will be a normal sort of court day with the breaks mid-morning and mid-afternoon.

Yes, Mr Johnson.

Closing Speech by MR JOHNSON

MR JOHNSON: Thank you, my Lord.

Good morning, ladies and gentlemen. The beginning of the end, as far as I'm concerned, you'll be glad to know, and I'm sure you're glad that we're there as well.

Just before I start, what I would like to do is give you a few documents that we should have given you a while ago but which I hope hasn't impeded your progress through the evidence. It's just some indexes, or indices, for bundle 1 and bundle 2. You were promised these a while ago.

(Handed)

I think Mr Stansfield has left off the second page of bundle 2 for his Lordship. Bundle 1 is one page and bundle 2 is two pages. Three pages in total: bundle 1 is a single page, bundle 2 runs to two pages.

(Pause)

If you could just keep open bundle 1, please, and go to divider 8. Then the very last thing, also in jury bundle 1, please, but divider 3, this is a paginated version of the agreed facts. So we overlooked paginating the original version, I am afraid, but you may find that if Mr Myers wants to refer you to some of these during his speech, having page numbers will speed up the process slightly or if you between you want to refer each other

to things, then having page numbers always helps. So with our apologies for the oversight, hopefully this rectifies the position.

(Handed)

If you just look at agreed fact 13, it's been crossed through. And in case the eagle-eyed amongst you wonders why and asks the question, I'll give you the answer: it's because although it was read to you, it became irrelevant, so we've just crossed it through.

So that's the housekeeping done. That's the easy bit. Now you've got to sit there and listen to me.

It probably seems an awfully long time ago, that date in October when I stood here and introduced you to this case. I told you then that I was really only giving you an introduction and that I wouldn't go into very much detail, and you probably sat there and thought, oh yeah, he's been going on for days.

Well, the detail I gave you back then is nothing compared now to what you know about this case, is it?

And what I am going to say to you now will be a bit more detailed than what I said to you back then, because you understand now what really matters in this case and the detail does matter.

When we opened the case to you, we gave you a strictly chronological presentation. As we called the evidence before you, we gave you pretty much a strictly chronological presentation, with the exception of the case of [Baby K]. When Lucy Letby gave evidence, with the exception of me dealing with [Baby F] alongside the case of [Baby L], I dealt with things chronologically. And you've had 7 or 8 months of chronological presentation and indeed last Thursday his Lordship said to you that when he sums up the case he will likely to adopt a chronological presentation.

But our task at this stage is slightly different.

What we need to do is to draw together the strands of this case and, from our point of view, drawing together the strands of this case dictates a slightly different approach to a chronological presentation. What we want to do is to point out the similarities of some of these cases, which are separated by weeks or sometimes even months. We want to point out the evolution of Lucy Letby's murderous assaults on these children and we want to point out how calculating and devious she has

been. This will involve dealing with the cases in a slightly different order.

We suggest that Lucy Letby gaslighted the staff at the Countess of Chester Hospital, doctors and nurses alike, professional people with many, many years of combined experience. She persuaded them that what they knew in their heart of hearts to be utterly abnormal was just a run of bad luck. But we know, don't we, ladies and gentlemen, that laboratory-synthesised insulin ending up in the circulations of [Baby F] and [Baby L] wasn't just bad luck? And even Lucy Letby ultimately was prepared to accept that. I say "even" and "ultimately" because of what you know she wrote in her defence statement.

When I asked her about [Baby L] and the fact that there was insulin in his dextrose, her response was:

"I'd have to be guided by the expert evidence."

Well, we agree with that.

Last Wednesday, Lucy Letby called evidence from Mr Mansutti, picked from the obscurity of the antiquated cast iron plumbing system of the Countess of Chester Hospital, to tell you about incidents in areas of the hospital that aren't actually relevant, many of them, to what happened in this case. He told us about an occasion when a paper towel was forced down the plughole of the sink in nursery 4 and water ended up on the floor. That wasn't relevant to anything that happened to any of these children.

The fact that there may have been an occasion, a single occasion, apparently, when there was a back-up in the sink in nursery 1 doesn't explain what happened to the children in this case. If there'd been sewage on the floor at the time of any of these events, ladies and gentlemen, there would have been a record made at the time. Somebody would have remembered it.

Mr Mansutti couldn't tell us, could he, precisely when that incident happened? He thought it was some time in 2015 or 2016. His evidence isn't going to help you decide this case. It was a distraction.

He was called, we suggest, to seek to bolster the tattered credibility of Lucy Letby and you might ask yourselves why. It's a good question. One single word, a very short word: why?

You heard from Dr Marnerides that the liver injury to [Baby O] wasn't the result of misplaced CPR: somebody assaulted him and caused that liver haemorrhage and they injected [Baby O] with air.

[Baby O] didn't die by natural causes, did he?

And the circumstances of [Baby O]’s death, taken together with the insulin given to [Baby F] and [Baby L], have nothing to do with the drains. Please do not be distracted.

Lucy Letby got away with her campaign of violence for so long because people didn't contemplate the possibility, the remotest possibility, of a nurse trying to kill tiny babies.

When you first heard me describe back in October the facts of this case, you were probably thinking the same thing, but the insulin proves that somebody was trying to kill children, as does the case of [Baby O].

And it shows -- all those cases show the awful lengths to which that person was prepared to go.

I say "that person", ladies and gentlemen, because the similarities between many of these cases do show you, don't they, that it was a single person sabotaging children? And the coincidence of the presence of Lucy Letby on all these occasions shows who that person was.

On 14 March this year, Dr Brearey made one of his several appearances in the witness box to tell you about the collapse of [Baby O]. As part of the cross-examination, he was accused of having confirmation bias and of seeing fault in Lucy Letby simply because she was always there when certain events happened.

Lucy Letby had used ways of killing babies and trying to kill them that didn't leave much of a trace, certainly nothing that was spotted at the time as being significant. And her behaviour had persuaded many of her colleagues that the collapses and deaths were "normal". Many of them simply couldn't see the wood for the trees.

Several post-mortem examinations in isolation didn't raise the alarm because no one -- no one -- was contemplating the possibility of foul play. And Dr Brearey met the accusation of confirmation bias very well, we suggest. When it was put to him on behalf of Lucy Letby, he said this:

"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 to the point when the -- you know, and beyond when the [Surname of Babies O, P & R] 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, this all became very exceptional and then 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's nothing to do with confirmation bias, that's just statistically every time it happened, it became statistically more than probable. And that was raising our concerns to a point where, yes, that was -- that's when we escalated when we did."

Dr Brearey made the point later in evidence that same day that when these events were happening between June of 2015 and June of 2016, he and his colleagues didn't know that [Baby F] and [Baby L] had been poisoned with insulin. He didn't know what Dr Marnerides would say about [Baby O]’s liver either, did he?

Dr Jayaram, on 28 February this year, when giving evidence about [Baby K] and [Baby M], said this:

"This was an unprecedented situation for us. Nobody trains us to deal with this and, as I've mentioned before, we work within a certain rulebook and a certain playing field. We're not thinking could this be deliberate harm initially. These thoughts come into your head after a while and you put them away because it seems utterly preposterous. Then more and more happens. Then it's very easy sometimes then to start seeing things that aren't there."

A few days earlier on 22 February, dealing with [Baby M], he said:

"We're taught to think about common things, less common things, very uncommon things, rare things. In the rules of engagement by which we work, we do not generally consider unnatural causes or deliberate things and nothing like that at that stage was even being contemplated, it was simply an association, just as if there'd been any other member of staff or any other piece of equipment, that would have been commented on."

Ladies and gentlemen, you may feel that deciding whether or not, for no good reason, some of the doctors had it in for Lucy Letby is important. It was certainly suggested to some of them on her behalf. That's why we asked Lucy Letby questions about it on a case-by-case basis, because it's easy to make general

allegations, isn't it? What you are interested in, ladies and gentlemen, is evidence.

So that brings us to what I called the Gang of Four, the conspiracy theory. I'm not asking you necessarily to look now, but if you were to go to paragraphs 11 to 13 of the defence statement you would see a suggestion being made by Lucy Letby that the collapses and deaths that you have heard about were in some way the product of staff shortages or mistakes or, that in some way the doctors were insufficiently qualified.

When we asked Lucy Letby about this when she was giving evidence, generally speaking she said that the particulars of that were a matter for medical opinion.

Well, it's not for her to prove anything, but you have had no medical opinion to suggest that there were any serious shortcomings, have you?

If we, the prosecution, had called evidence about all the children that went through the Countess of Chester Hospital over this period, over that twelve-month period, and examined their care or looked at staffing ratios, that wouldn't have helped you decide what happened to the 17 children named in this indictment. The only thing or the only things that matter, ladies and gentlemen, is to concentrate on the issues in this case, concentrate on those 17 children, look at their problems and see where, if at all, there were shortcomings which might have explained their collapses or deaths, and that we have done together, haven't we? And we suggest that that was a very uncomfortable exercise for Lucy Letby, particularly when she was put on the spot time and time again in the witness box to explain, from her point of view, what she was saying were the shortcomings, not the generalities, the specifics.

What did she come up with? Well, I'll remind you.

In the case of [Baby A], it was a delay in inserting his long line to give him fluids. She also blamed Mel Taylor:

"... if we agree [as she put it] that the cause of death was an air embolus."

If we agree. Coming from the witness box:

"... if we agree that the cause of death was an air embolus."

Well, we do agree, ladies and gentlemen. The prosecution do agree. We'll agree with Lucy Letby on that.

[Baby A] didn't die of dehydration, did he? Because that's in reality what's being offered up as the shortcoming. He went without fluids for 3 or 4 hours. He did die of an air embolus but it wasn't Mel Taylor who supplied the air, was it?

[Baby B]. Lucy Letby could come up with no criticism of the care or staffing levels.

[Baby C], nothing.

[Baby D]. Again, staffing levels were irrelevant and the only criticism offered by Lucy Letby was the delay in giving her antibiotics. But [Baby D] didn't die from an infection, did she, ladies and gentlemen?

In the case of [Baby E], Lucy Letby's best effort was to suggest that there was "a delay in responding to [Baby E]'s bleeding". But of course that depends on what the doctors were being told at the time, doesn't it, and whether they were being told the truth by the designated nurse as to what was really going on? It also begs the question of why [Baby E] was bleeding in the first place, doesn't it? Again, staffing levels are irrelevant.

Staffing levels and mistakes had nothing to do with [Baby F]'s problems because somebody poisoned him deliberately.

With [Baby G], again, staffing levels were not relevant. Lucy Letby's best effort was to offer to blame her best friend, [Nurse E], for accidentally overfeeding [Baby G] before she changed her mind and said she didn't believe [Nurse E] actually had overfed [Baby G].

In [Baby H]’s case Lucy Letby questioned whether:

"... some of the drains were securely put in."

That was the way she phrased it. She also said there was potential incompetence. "Potential" and "potentially" are words that she uses very often, aren't they? Potential incompetence with where the drains were put in. Of course she isn't qualified to say, as it happens, and the doctors who actually carried out this exercise said there was no problem. The expert evidence called by the prosecution suggested there was no problem. And Professor Arthurs from Great Ormond Street, having looked at the radiographs, said there was no problem.

[Baby I]. Well, you'll remember there were four different events for [Baby I]. So far as the first on 30 September was concerned, Lucy Letby identified no issues. The second, 13 October, this is Lucy Letby's hawk-eyed spot of [Baby I]'s pallor in the gloom of nursery 2. Ashleigh Hudson got the blame for that one, for not

having [Baby I] on full monitoring for 48 hours after the antibiotics were stopped.

But when we looked at the charts, as a matter of fact [Baby I] had been off full monitoring for much longer than 48 hours.

With the third incident the following night on 14 October, no issues identified.

With [Baby I]'s death on the night shift of the 22nd into 23 October, she said that potentially medical staffing issues may have contributed. Dr Chang had been called away to the delivery suite and Dr Gibbs went home and returned within 30 minutes. The doctors weren't with [Baby I] throughout once she'd deteriorated. Well, we'll come to that, ladies and gentlemen, but given the opinion of Dr Marnerides, we suggest that that too is a non-starter.

In [Baby J]’s case, Lucy Letby could identify no shortcomings or errors other than to say it was a very busy shift.

[Redacted] [Baby L]. He was poisoned with insulin. No staffing issues there.

[Baby M]. Lucy Letby said that the unit was "very stretched" and that [Baby M] was not in a proper space. But like the others, there was nothing she could put her finger on.

With [Baby N] on 3 June, nothing. At handover on 15 June she said that the unit was very busy. But [Baby N] was due to go home, wasn't he, and later on in the shift she said, "There was an issue with intubation". Well, none of that deals with why [Baby N] needed to be intubated in the first place, does it, or why he was bleeding? Even less is it evidence of some sort of staffing or operational deficiency.

In the case of [Baby O], it was suggested by Lucy Letby that there had been an issue with the inadequacy of dealing with the concerns raised by Sophie Ellis overnight, though neither the charts nor the evidence you heard from those who were there suggested that there was a problem.

The best Lucy Letby could come up with in the case of his brother, [Baby P], was that there were "potentially issues with chest drains but I cannot say."

Then finally with [Baby Q], there was nothing.

So much for staffing shortages and incompetence. So where is the evidence of the shortcomings alleged in the defence statement? Where is the evidence of the suggestions being put to the

doctors on behalf of Lucy Letby? From what shortcomings were the Gang of Four trying to deflect? What was their motive, the Gang of Four, for scapegoating Lucy Letby? She didn't give you specifics. She hasn't told you the evidence for her theory.

It's no answer for the defence to say that she, Lucy Letby, is not qualified to say, because she is the one who is making the allegation. Just as we make the allegation here, we produce the evidence, the evidence is tested.

As his Lordship told you last Thursday, and you have in writing, the questions asked by counsel are not -- as much as we would like them to be, the questions we ask are not the evidence. That applies to us both.

Lucy Letby has to prove nothing. There is no burden on her, but there is, as a matter of fact, no evidence to support her allegations.

We've seen it put, haven't we, ladies and gentlemen, with enthusiasm to several of the medics that they are in some way part of a conspiracy to convict the innocent Lucy Letby? And it's been suggested that these people have invented evidence to persuade you that ultimately she is guilty. And when you are considering whether that suggestion has any credibility, you might ask yourselves the question: why would the doctors do that?

One advantage you have had is seeing many of these alleged conspirators over and over again. Do you really think that Dr Brearey, Dr Gibbs, [Dr B] or Dr Jayaram would say things they knew were not true to get Lucy Letby convicted?

When you're considering that question, you might like to pose yourself this question: what did the doctors say that wasn't true? What did they actually say that wasn't true?

I put their important accounts to Lucy Letby as we went through each case individually. It may be that I missed it if she told us, but I suggest that there was very little, if anything, that she positively said was not true in what they, the doctors, had said. All she did say was that she had not seen what they say they saw. [Redacted].

But the Gang of Four didn't do a very good job in scapegoating Lucy Letby, I suggest, because at the time they missed the evidence of the insulin poisonings, that disconnection in the ratio between C-peptide and insulin. So it's a conspiracy to scapegoat her where they, the conspirators, have actually missed the best bit of evidence. Astonishing.

All the clues in the insulin cases point in one direction, don't they? And she's sitting at the back of court. All the evidence suggests that the consultants at that hospital didn't even know about the wildly out of kilter ratio between insulin and C-peptide when they blew the whistle.

Was that turning up just a bit of good luck from their point of view or does it prove in effect what we allege, that she was responsible?

There's a very serious point in all this, ladies and gentlemen. Why, if there's no evidence to support it, is Lucy Letby so fixated on seeking to persuade you that there is a conspiracy amongst the doctors? Is it an attempt to divert you from what really happened, like the evidence from Mr Mansutti?

Lucy Letby, we say, put a lot of effort into trying to pull the wool over your eyes. You'll remember what she spent a lot of the day on 2 May, the first day she gave evidence, telling you all about: isolation from her friends or her "family on the unit" as she described them. That was her explanation for writing things like:

"I am evil. I did this. I killed them on purpose because I'm not good enough."

That was her explanation for writing a letter or a note to the [Babies O, P & R] triplets on their birthday.

And we never did get an explanation for why it was addressed to [Baby R] as well, did we, even though she was asked the question?

I'm not going to spend time now addressing you about Lucy Letby's notes. We will come back to them at the end when we look at what she did before she left the unit at the end of June or the beginning of July 2016, although, having said that, I'm not going to spend a lot of your time looking at Lucy Letby's notes. There are more important things in this case.

Part of the truth, though, came out eventually. On Friday, 9 June we established that Lucy Letby was not isolated. So 5 weeks after she had put that forward as an explanation she had to admit, didn't she, that she was still in contact with the people she had originally told you she had not been allowed to contact and she had not contacted? Even though she knew what we had from her phone she did actually repeat the lie before I actually dealt with the detail briefly.

But then we went to the spreadsheet and the lie was exposed, wasn't it? Do you remember it being suggested to Dr Jayaram, "You think that just" -- I'm paraphrasing what was put to him:

"You think that because you're a doctor people would just accept what you say"?

We saw that in the witness box from Lucy Letby. She thought that if she said something often enough, whatever the evidence is, you will accept it.

You might want to bear that in mind, ladies and gentlemen, when you're considering anything else that she has said at any point of this case.

We suggest that Lucy Letby is an opportunist. Some of the children she targeted were sick but they would have recovered, but she used their vulnerabilities to camouflage her attacks.

Fortunately, in this desperately sad and tragic case, fortunately her perception or, rather, misperception of some of these children's vulnerabilities became a feature which was going to give her away. She thought that the [Babies A & B] twins had an inherited blood disorder from their mum, so she thought she could get away with killing [Baby A] and trying to kill [Baby B] in June 2015, and if she'd stopped there she probably would have got away with it, wouldn't she?

But she Googled haemophilia and used the information to inform her attack on [Baby N] a year later in June 2016, and again she'd have probably got away with it if she'd stopped there.

Other children were perfectly healthy and would have thrived if she'd given them a chance. Her ignorance of C-peptide and the ratio between it and naturally produced insulin led her to think that she could get away with poisoning [Baby L] and [Baby F]. What she didn't know was that that disconnection in the ratio between C-peptide and insulin leaves a biochemical footprint or fingerprint, which proves foul play. And she'd have got away with that as well, ladies and gentlemen, if the police hadn't, as a matter of precaution, referred the cases of [Baby L] and [Baby F] to Dr Evans.

You'll remember he didn't see the cases until significantly after many of the others in this case.

As the suspicion of the consultants grew, Lucy Letby was taken off night shifts and there were no unexplained deaths at night. She went on holiday to Ibiza in June 2016 and when she got back she embarked on a killing spree: [Baby P] and [Baby O] murdered in quick succession, followed by an attempt to murder [Baby Q],

all within 3 days of her return to work. And when she thought she was rumbled, or at least that the suspicions were growing significantly, she did her best to create the impression that the neonatal unit was dysfunctional by putting in false Datix sheets.

I will return to them. But you will remember, won't you, the [Baby O] one, dated 30 June, that Dr Brearey said, in effect, was a lie?

You'll remember the JA Datix sheet put in the same day, referring to a missing bung on a line that in a text message she said created the danger of an air embolus. What a thing to be pointing out just as you feel that you have been rumbled for administering air to these children, ladies and gentlemen. Get your defence in first. That's exactly what she was doing, isn't it?

The effort that Lucy Letby put in on 30 June has continued through this trial, hasn't it, with the non-specific and general suggestions of incompetence or short-staffing, but for the reasons I've explained, despite her saying there were problems, there is no evidence of there being problems.

I said earlier that we're not going to deal with the cases chronologically and the reason for that, we suggest, is that there are things that are beyond any sensible debate, things that we suggest you are very likely to accept.

Starting with things that are agreed, or at least are not disputed, can be very revealing, not least because you can take them into account when considering cases further down the line. So I'm going to start with things that we suggest fall into that category and see where they lead us in terms of interpreting the rest of the evidence in the case. I will start by, in effect, taking five cases together.

We are going to start with the cases of, as I said earlier, I think, the [Babies E & F] twins, the [Babies L & M] twins and [redacted]. [Babies E & F] and [Babies L & M] were two sets of twins born several months apart. Their cases have important similarities: one of each pair was poisoned with insulin. So unless you conclude that that poisoning was accidental, a possibility that we suggest you can dismiss, unless you conclude it was accidental, you know that somebody was trying to kill them. The other twin in each pair was attacked with air. What are the chances of that, 7 months apart in the same unit?

[Redacted] So looking at [Baby E], the twins were born on 29 July 2015, which was Lucy Letby's day off. Between then and the events you've heard about, Lucy Letby had looked after [Baby F]

several times. By the events that we are concerned with, both twins were doing well.

You'll recall that [Mother of Babies E & F] was an inpatient at the hospital as well and it seems like a long time ago now, but it was 14 November last year that [Mother of Babies E & F] gave evidence. She started with the events of 30 July 2015 when she had been able to visit her sons and have a cuddle with [Baby F].

[Mother of Babies E & F], we suggest, was a very, very important witness in this trial and she told you a number of very, very important things. What she said was that providing milk to her sons was top of her agenda. She felt it was the only thing she could do for her boys. She said that on 3 August, 21.00 hours, she went down to provide that milk. She said that when she entered nursery 1, [Baby E] was crying and it was like nothing she had heard before. To quote her, she said:

"It was horrendous. More of a scream than a cry."

You will remember [Baby I] and [Baby N], won't you, ladies and gentlemen, and that look of shock on Dr Loughnane's face when she saw she had written "screaming" of [Baby N] on 3 June 2016.

[Mother of Babies E & F] said that there was blood round [Baby E]'s mouth. You'll remember what I described more than once as a goatee beard type image on that picture.

Lucy Letby told [Mother of Babies E & F] that the blood had come from the nasogastric tube and the registrar was on his way. On his way.

Lucy Letby told [Mother of Babies E & F] to go back to the post-natal ward and by 21.11 hours [Mother of Babies E & F] was back on the post-natal ward. There's no room for misunderstandings here, is there, ladies and gentlemen?

This is a head-on credibility contest between [Mother of Babies E & F] and Lucy Letby. That's why Lucy Letby's lies about something as trivial as her social life are so important.

A full-on, head-on credibility contest. And you can be sure that Lucy Letby is lying about this incident, can't you? Because plainly, as any parent will understand, the provision of milk, food, to a newly born infant is important. And 21.00 hours was [Baby E]'s feeding time. If we just look at tile 121, please, of the [Baby E] -- you've got this in hard copy as well, haven't you?

"Crying like nothing I'd heard before. It was a sound that shouldn't have come from a tiny baby. It was horrendous, more of a scream than a cry."

You may think, ladies and gentlemen, and we invite you to conclude, that [Mother of Babies E & F] would have a very good reason to remember this: it was the night her son died.

Either [Mother of Babies E & F] saw blood or she didn't, she got it wrong. Why would she make it up? If [Mother of Babies E & F] saw blood at 9 pm then Lucy Letby's nursing notes are false. You've got them, ladies and gentlemen, in a hard copy behind divider 5 of jury bundle 2. Either Lucy Letby told [Mother of Babies E & F] that it was the nasogastric tube which had caused the blood or she did not.

Why would [Mother of Babies E & F] make that up?

Dr Bohin told us that the records show that the nasogastric tube that was in place on 3 August was the same one that had been inserted on 29 July, so the same tube had been in for several days, and that was never disputed.

Well, Lucy Letby would have known that at the time, wouldn't she? So why did she say that it was the nasogastric tube that had caused the bleed if it was the same one that had been in there for so long? The answer is it was a panicked reaction, told to a mother who knew no better, and it was designed to cover her tracks.

When you're considering whether or not [Mother of Babies E & F] is accurate about that, ladies and gentlemen, bear this in mind: when Lucy Letby was struggling in interview to explain why it was that [Baby N] was bleeding, and we will come to this, there's a 1ml bleed that she wrote on a chart that she never escalated to anybody. So she was being asked about that in interview for [Baby N] and she came up with the same line under pressure from the police. Can I ask you just to go to the [Baby N] interviews, please? It's in jury bundle number 2, interviews bundle number 2. About halfway through.

This is really important to the case of [Baby E].

It may seem an absurd thing to say, but I'll explain why. So being asked about this 1ml bleed, so a small bleed, for [Baby N]. Page 10, [redacted]. A few lines down, and you can see a response:

"If the tube's been -- the NG tube's been inserted forcefully it can cause a bit of trauma going down. I wouldn't say it's common, but it can happen."

Then towards the bottom.

"Question: But in your experience that has caused, in the past, bleeding, has it?

"Answer: Yeah, it can do yeah.

"Question: Is that bad bleeding or just a small amount of blood?

"Answer: No, just a small amount.

"Question: Right, okay. Such as 1ml?

"Answer: Yeah, I wouldn't expect any more than that."

Now, this is really important, ladies and gentlemen.

It's important because -- remember what [Mother of Babies E & F] was actually describing. She was describing a small amount of blood around the mouth, wasn't she? Do you remember that?

If [Mother of Babies E & F], as Lucy Letby would have it, was really down there at 10 o'clock, [Baby E] was producing lots of blood by 10 o'clock, 22.00 hours. So under pressure from the police to produce an explanation for blood with another child, blood in a child with haemophilia, blood that hadn't been escalated to the medical staff, she came up with that as an explanation under pressure on the night of 3 August 2015, the pressure of a mother arriving with milk, and a child with a small amount of blood around its mouth like [Baby E] had, she came up with the same explanation. That is why Lucy Letby falsified the nursing notes for [Baby E]. That's the evidence.

We suggest that you can be sure, you can be absolutely sure, that [Mother of Babies E & F] is telling the truth because what she saw and heard caused her such concern that she rang her husband. The phone records prove that she made a call, don't they? They don't prove what's in the call, of course they don't, but they prove that she made the call. If I just remind you of tile 122, please. This is a call at 21.11, 4 minutes and 25 seconds.

[Mother of Babies E & F] told you what she said to her husband, and [Father of Babies E & F] told you what she said to him. Have the [Parents of Babies E & F] made that up to get Lucy Letby? Because that's the choice. Are they in on it? Are they a sub-gang of two or are they telling the truth?

Is Lucy Letby telling the truth when she says that [Mother of Babies E & F] came down at 22.00 hours? Well, [Mother of Babies

E & F] told you that after the 21.00 hours event, the next time she went down was when the doctors were working on [Baby E], trying to save his life. Is she wrong about that?

Of all the things in your life that you remember, ladies and gentlemen, I hope none of you have ever been in that position, but you might just remember, mightn't you, seeing your son in a terminal decline?

And if [Mother of Babies E & F] is telling you the truth then Lucy Letby's notes are a lie, her account is a lie, and we suggest there can be only one sensible reason why she would falsify the nursing notes. It's not a case of a mistake creeping in, is it, or, to use her phrase, an error? This is a fundamental difference between [Mother of Babies E & F]'s compelling account and the lying written record made by Lucy Letby. That's why we say this is a head-on credibility contest, it's a choice. It's a binary choice: [Mother of Babies E & F] is lying or Lucy Letby is lying. No room for mistakes.

Go to tile -- well, it's actually on that same tile there. Do you see the next call there at 22.52? A call to [Father of Babies E & F]. This was the call from the midwife. Do you remember being told that a message had come up from the ward and [Mother of Babies E & F] was so upset by what she heard that she asked the midwife to use her phone to phone [Father of Babies E & F]? You can see it's a long call, 14 minutes and 30 seconds.

Just park that time in your head if you would, 22.52, and go to tile 128. Click on that, please.

Scroll down, please. Sorry, it's the next -- further down, please.

Just before 23.00 hours, here is Dr Harkness' note.

He times it at 23.00 hours. Obviously he's not using a stopwatch. This is the beginning of the final dramatic collapse of [Baby E] and it coincides, doesn't it, with that telephone call made by the midwife to [Father of Babies E & F]?

If we look at tile 153, please. The family communication note is what I'm interested in, please.

If you read down about five lines:

"Both parents present during resus. Fully updated."

There's also somewhere a message about the midwife, I've lost it. It may be on the other side of the page.

(Pause)

There is there -- you'll be able to find it when you look, as always when I'm standing here I can never find exactly what it is I want. There is in there a reference to having contacted the midwife, called the midwife.

So the bits of the jigsaw all fit, as with all jigsaws they only fit one way, and the image on the jigsaw corresponds to the account given to you by [Mother of Babies E & F] and it completely undermines, we suggest, Lucy Letby's version of these events.

So we suggest that Lucy Letby was interrupted by [Mother of Babies E & F] at 9 pm and she then worked on creating the impression that [Baby E] was ill and she used her friend Belinda Williamson to make one of the notes in the chart to give the impression that this was all something that Belinda was involved in as well, and she called Dr Harkness and for a short time [Baby E] recovered.

Then, once Dr Harkness had left, she attacked him again and, as [Baby E] entered his final collapse, somebody rang the post-natal ward to call [Mother of Babies E & F] and so upset was [Mother of Babies E & F] by what she heard that she called her husband.

If you agree and you're sure that's right then it's clear evidence of falsification, isn't it, in those notes? And why would she, Lucy Letby, have done that if [Baby E] died from natural causes? It's powerful evidence, isn't it, independent of the medical evidence, powerful evidence that Lucy Letby murdered [Baby E]?

When [Mother of Babies E & F] caught Lucy Letby red-handed, she didn't realise what was going on, of course, but her natural instincts told her that something was up, and in that respect [Baby E]'s case has similarities with [redacted].

Dr Harkness was the person who had to deal with the consequences of Lucy Letby's sabotage and he gave evidence on 17 November and he gave us, in effect, a chronological framework, didn't he, for what had happened? He told us about the handover and the time that that takes, that he and Dr Wood were covering the shift, and that they would have spoken to the nurses.

And although his note is timed at 22.10, he accepted under cross-examination that he was probably on the neonatal unit from about 21.30.

If you think that those times are important, we're not suggesting they are, we're not suggesting they aren't, but if you think that they are you might want to look at tile 125 of [Baby E]'s sequence, please. That's the fluid balance chart. If you look at the 22.00 hours column, so it's in the bottom right-hand corner there, you will see that Lucy Letby has written, "15ml fresh blood". I say she wrote it because Lucy Letby accepted in evidence that it's her writing.

But we suggest that she had manipulated circumstances so that this was an entry that was signed by Belinda Simcock or Belinda Williamson, as she's now known, and the point of that, and this is where other cases become relevant, isn't it, the point of doing that is to dissociate herself from this event if anyone ever goes back to look at the paperwork.

So just as in other cases, either that she wrote data and didn't sign it or got someone else to write things at the time she was doing things, and when on 24 May this year she was asked about that apparent anomaly, she said of that entry "15ml fresh blood" that:

"I assume it came after Belinda's documentation."

That was the evidence she gave. So she got Belinda to sign an entry and then adds to it. You'll remember this in the context, won't you -- do you remember HS, the child in a different nursery when [Baby I] collapsed for the final time on the 22nd, midnight on the 22nd and 23 October, HS, the child who was going to Stoke? After, in that case, Chris Booth had signed the infusion, timed at 23.00, she altered the time to 24.00.

This is where you put all the little bits, all the bits and pieces together, ladies and gentlemen. It's utterly obvious, isn't it, what's going on here?

What Lucy Letby did here was sabotage [Baby E] after Belinda Williamson had written her entry. She puts it in under Belinda Williamson's initials so that it looks like Belinda Williamson is involved as well, so what could possibly be wrong about this? There's somebody else there when this happens when you look at the notes.

Although Dr Harkness was persuaded in cross-examination that his note at 22.10 was really for events from about 21.30, you may think that that note there, timed at 22.00, makes that concession dubious to say the least. A reason why Lucy Letby needs Dr Harkness to be there earlier is that she needs an innocent reason for omitting the feed at 21.00. She needs to get the doctor in there earlier as a reason for omitting the feed at 21.00, which in turn undermines [Mother of Babies E & F]'s

evidence. So if you're looking for why Lucy Letby is doing this, that is the reason. She was caught sabotaging [Baby E] by [Mother of Babies E & F] and this is what she does, this is what she did, we suggest, to cover herself.

When he arrived at 22.10, Dr Harkness was told by Lucy Letby that 30 minutes earlier there had been a dirty aspirate. If he was there at 22.30 then you can see why Lucy Letby's so keen to put the aspirate at 21.00 hours, which is when [Mother of Babies E & F] is there.

You can see how all the bits fit together, can't you?

We then have the sudden large bloodstained vomit and a 14ml aspirate, apparently -- so not 15, a 14ml aspirate -- which had been taken at about 22.00 hours.

That's what caused Dr Harkness to suspect that there was some sort of gastrointestinal bleed. But when he examined [Baby E], all the signs were good. His bowels had been opening, his CRP was less than 1, his sats were good, his other vital signs were good and he was in air.

And on examination, [Baby E] was pink and lively.

You'll remember during cross-examination it was suggested to Dr Harkness that he was "out of his depth".

Do you remember that being put to him? Do you remember his reaction? He was insulted by that, Dr Harkness.

Dr Harkness said that he was discussing things with [Dr C], the consultant who was on site, and when you're considering whether Dr Harkness was really out of his depth, ladies and gentlemen, you might want to remember what Drs Brearey and Jayaram said about the level playing field: we don't factor in, they were saying, the possibility that a nurse is actually trying to sabotage children. None of these doctors suspected sabotage, did they? They were all looking for a natural cause for what was going on. There was no natural cause because there was no level playing field.

23.00 hours. Dr Harkness was called back by Lucy Letby. [Baby E] desaturated to 70% and there was further blood coming up the nasogastric tube. [Baby E] was breathing for himself and crying. He had to be given 100% oxygen. But as Dr Harkness said, and I quote him:

"Something was interfering with the oxygen getting into his bloodstream."

Dr Kinsey's explanation for the mechanics of air embolus, the blockage caused by the bubble:

"Something was interfering with oxygen getting into his bloodstream."

Dr Harkness planned to intubate [Baby E], and whilst that was being organised there was a further sudden deterioration at 23.40, and in between times, it was Lucy Letby who had been looking after [Baby E]. You will remember what Dr Harkness described he saw:

"A strange pattern over the tummy area, over the abdomen, which didn't fit with the poor perfusion. In between the chest, the upper legs, the rest was still pink, but there were these kind of strange purple patches that appeared over the outside of his tummy."

Do you remember Dr Harkness was moving his hand as he was describing that to you? He went on to say:

"There were patches in one area, then there were some in the other. Some of it was still nice and pink but it was certainly unusual and not fitting with a baby that had completely shut down or poor perfusion."

(11.49 am)

(Audio feed lost from court)

(11.50 am)

(A short break)

(12.05 pm)

MR JOHNSON: I think I just quoted to you what Dr Harkness actually said about what it was he saw. You will remember that he was saying in terms that this was not something he had ever seen outside the context of the babies in this case and he was drawing a comparison with what he'd seen with [Baby A].

He said that what he'd seen were patches that were no smaller than 1 to 2 centimetres. One of the strange or unusual things about what he saw was that it didn't remain constant. He was cross-examined, you will remember, about differences in his description of what he'd seen in [Baby A]'s case and what he saw in [Baby E]'s case and he said this in response:

"It was something that was so unusual that it's hard to give a clear description."

The point here, ladies and gentlemen, is we have a doctor saying, "This is something I had not seen before", and that's the important -- the precise way he described it isn't so important, is it? What he was saying was that he was seeing the same thing again: the same thing that he'd seen with [Baby A] he was seeing with [Baby E].

An interesting feature is that if you go to Lucy Letby's interviews, she describes what she saw in [Baby A]'s case very similarly to the way she describes what she saw in [Baby E]'s case.

You'll remember how traumatised Dr Harkness was by what he'd seen. You'll remember him describing the effect it had on him, how he had to have time off work.

He'd never seen a baby bleed the way [Baby E] did.

On the other hand, if we go to tile 253, we can see how Lucy Letby felt about it. It's the same day that [Baby E] died:

"One of those things."

Nothing to see here, that's the message, isn't it, ladies and gentlemen? Nothing to see here. Remember me saying about her gaslighting her colleagues, persuading them that the wholly abnormal was in fact normal?

Moving away from that text, please, it was suggested to Dr Harkness that he'd been influenced by discussions he'd had with others. He denied it. And even Lucy Letby doesn't put him in the Gang of Four. Was Dr Harkness a liar?

Do you remember the evidence of [Dr C], the consultant, who said that when she arrived at [Baby E]'s side at a later stage:

"[Dr Harkness had told her] in quite a lot of detail about some very dark purple patches he'd seen on the abdomen and the unusual appearance of these"?

She said that when he, Dr Harkness, had spoken to her, he'd told her in "quite an animated fashion because it was quite an unusual appearance".

So if Dr Harkness is lying about this, [Dr C] is supporting the lies, isn't she? What are the chances of that, ladies and gentlemen? How far does this supposed conspiracy go?

I'm not going to invite you to go there because this all takes time for me to keep referring you to documents, but can I give

you some references. Do you remember I said what Lucy Letby actually said is quite similar? If you go to [Baby E] 8, [redacted], you will find, I'm not asking you to do it, but you will find Lucy Letby describing a patch of purpleness on [Baby E]'s abdomen that was "not something normal for a baby to have".

That's what she said. You can check it. She said it was on his right-hand side by the belly button and she went on, two pages later at [redacted], to say that she asked for Dr Harkness to review [Baby E] again after the discolouration and in evidence on Friday, 5 May she said there was:

"[A] red sort of horizontal banding across the abdomen, just around the area of the umbilicus."

So, ladies and gentlemen, if it's true, and Lucy Letby appears to be conceding that it is true, that [Baby E] did have strange discolouration on his abdomen, why was Dr Harkness being taken to task for saying it?

Is it all to create in your minds the impression that in some ways the doctors are bad, that they're all ganging up on Lucy Letby?

We invite you to conclude that that was all, in effect, a gratuitous attack on Dr Harkness' integrity.

It feeds into the general theme that Lucy Letby is being scapegoated for other people's incompetence and malpractice. And the point of the attack, we suggest, was to try to persuade you that in some way Dr Harkness is prepared to make things up which implicate Lucy Letby in the most serious crime. But the problem with the attack is really he was saying in his way what she was saying in her way in interview.

At 23.45, [Baby E] was intubated as an emergency.

The capnograph told Dr Harkness that the tube was in the correct place, and the discolouration on [Baby E] remained. In cross-examination it was suggested to Dr Harkness he should have intubated [Baby E] before that time and he was accused of incompetence for delaying the blood transfusion. But the truth, ladies and gentlemen, is that it was Lucy Letby harming [Baby E] and because she was the cause and because she wasn't letting on what she'd done, the doctors were never going to be able to save him.

You will remember that [Dr C] arrived at 00.25 on 4 August, had a discussion with Dr Harkness at the cot side, and they then moved from the cot side over to review the X-ray on the computer and to review the blood results, and even if you don't remember

it, you know what happens next, don't you? They move away to a computer, either at the nurses' station or in nursery 1, and we know it's just round that little wall in nursery 1, and it was at that point that [Baby E] deteriorated for the final time.

What are the chances of that, it being at precisely that moment? [Baby E] collapsed for the final time at about 00.25. CPR was started, drugs administered, [Baby E] was given a blood transfusion at 00.50, and as CPR was given, blood came from his nose and his mouth, the like of which Dr Harkness had never, ever seen before. But after 10 minutes, spontaneous heart rate returned. You've heard that before, haven't you, in several cases, not least perhaps most dramatically [Baby C]? But unhappily, [Baby E] didn't survive.

You will remember that [Dr C] advised against having a post-mortem, a decision or advice that she plainly substantially regretted, you may think, when she gave evidence. And she made the point in the witness box that with NEC a child's observations deteriorate over a longer period of time than happened with [Baby E] and that the normal X-rays that were taken of [Baby E] were not consistent with NEC. No one now, as far as we understand, seriously suggests that [Baby E] did have NEC.

[Dr C] also discounted stomach ulceration on the basis that if a child died from a natural blood loss she'd have expected to see a more gradual deterioration, not these cliff-edge type deteriorations that [Baby E] had, and that if it was gradual blood loss, as you would expect in a case of stomach ulceration, the heart rate would go up and the blood pressure would go down, and that was not what was happening with [Baby E].

She, like Dr Harkness, said she'd never seen bleeding like this before in a small baby and she said that, other than [Baby E]'s blood glucose, which had normalised in the lead-up to the events of this shift, there was nothing in his observations to suggest that he was unwell in the sense of there being a cause for the bleeding and collapse.

The expert evidence is a big help, ladies and gentlemen, to you, we suggest, in determining what happened. Importantly, and in the absence of a post-mortem examination, it excludes the possibility of [Baby E] having died from natural causes.

Professor Kinsey excluded the possibility of there having been a congenital bleeding disorder and you will remember what she said about [Baby F], I am sure. The fact that he is [Baby E]'s identical twin, the fact that she'd looked at [Baby F]'s blood results and could therefore exclude the possibility of there being a congenital bleeding disorder. [Baby E] was bleeding from

the throat, just like [Baby C], like [Baby G] and like [Baby N] all did – [Baby C] was before [Baby G], [Baby N] was later.

Dr Arthurs told us that the imaging didn't really help with what happened to [Baby E] and went on to say that the absence of air in the great vessels didn't make a difference in determining the issue of air embolism because images are not taken in the acute resuscitation period and therefore you would not expect to see air.

He also said that because very few babies die of air embolus there isn't a great deal of imaging -- no imaging records really to compare against.

Dr Evans was taken to task for having suggested in one of his earlier reports that perhaps the nasogastric tube was used to cause an injury to [Baby E], the very thing that [Mother of Babies E & F] says Lucy Letby said to her on the night, ironically. He said that when he had seen a tube before the trial started he'd rejected that himself as a theory, but that didn't stop him being criticised for having raised it in the first place.

And the important point being made by Dr Evans was that the bleeding was not the result of some natural or innocent phenomenon. In answer to questions about stress, Dr Evans said it doesn't turn up out of the blue on day 5 or 6 of a child's life, and you will remember the evidence of [Nurse B], who said that [Baby E] had been out during the day having skin-to-skin contact, and you'll find that in the nursing notes with his mum for most of the day before he died. So that is not stressful for a little baby.

Dr Evans referred to the graphic description given by Dr Harkness of flitting patches of discolouration and told you that, in his view, that was clear evidence of air in the circulation. And if [Baby E] was caused a bleeding injury or had air in his circulation, we suggest there's only one person that can have been responsible.

So far as [Baby E]'s bleeding was concerned, Dr Evans thought it had to be the result of trauma and pointed to the fact that neonatal units are full of bits of equipment such as suction tubes or introducers which might have been used, and he was cross-examined at some length about that and it was suggested that there was no evidential basis for saying that an introducer had been used. Well, the evidential basis, ladies and gentlemen, is the result of whatever it was that happened that was not a natural event.

We say something was used. This was no naturally occurring bleed. Many other children in this case had inexplicable bleeds somewhere in their throats or coming up from below the vocal cords; that's a phrase you're now very familiar with in this case. And as I say, the most obvious other cases, [Baby N], [Baby C], [Baby G] and one I missed out from my earlier list, I think, [Baby H] as well. So you have a list there of five children of these 17 where this unusual sign was spotted.

Dr Bohin gave you a more important detail. She began by reminding us that [Baby E] was being fed normally up until 21.00 hours on 3 August, in other words the time that [Mother of Babies E & F] went down to the unit.

Dr Bohin described [Baby E] as being "incredibly stable"

and reminded us that on Dr Harkness's first examination of [Baby E], his abdomen was soft, non-tender, non-distended, with normal bowel sounds. And thereafter the blood gas results had shown a decline.

When she was referred to the feeding chart, the one I put up on the screen for you earlier, and the reference to the mucky aspirate, Dr Bohin said it usually refers to a sort of brownish-green aspirate, so that's stomach juices plus any milk that may have been in the stomach abdomen maybe containing bile and flecks of blood. Altered blood goes brown, so it makes a kind of brown -- I guess that's why it's termed "dirty".

In the context -- then she was asked:

"In the context of a baby who's been fed twice at 5 and 7 pm, been fed 2ml and on each occasion there'd been a minimal aspirate, what view do you take of his record that at 9 pm, before he'd been fed, there was a 16ml aspirate?"

So this is the disconnect, isn't it, ladies and gentlemen? At 5 and 7, we've got minimal aspirates. 9 pm, 21.00 hours, the critical time when [Mother of Babies E & F] is there, a 16ml aspirate. What Dr Bohin said was:

"It just struck me as being really odd and out of keeping with what had gone before. Clearly, you don't just take the volume of aspirate in isolation, you have to link it to his clinical condition, which had been fine. And he had shown no signs of any gastrointestinal disturbance. He had tolerated those feeds up to that point and had had no aspirate at all. So I was just at a loss to explain where this 16ml had come from, despite having had no aspirate before and having had nothing in his tummy for 2 hours."

[Baby N] vomits clear fluid, a child that wasn't being fed at all. [Baby G], a projectile vomit round the cot on the floor, on the chair, and the feed -- the full amount of the feed being aspirated.

It's all the same thing, isn't it, ladies and gentlemen?

These are not isolated freak incidents, this is a pattern of behaviour, all down to Lucy Letby.

This is where you are entitled to go beyond where the experts can go. They've told you, haven't they, "We look at the cases in isolation"? You don't have to do that. You can look at all the evidence. You can make findings of fact as to whether someone's lying or someone's telling the truth, and it all has a part to play in the decision, doesn't it?

Dr Bohin agreed with Dr Evans that this was a case of air injected into [Baby E]'s circulation together with some kind of injury to cause the bleeding and she said this:

"Haemorrhage of this magnitude in neonates is vanishingly rare."

Vanishingly rare:

"Babies do sometimes have gastric erosion and ulceration but it does not result in haemorrhages of this fashion."

That's the way she put it.

Insofar as intravenous air was concerned, Dr Bohin's view was that the purple patches on the abdomen didn't fit with any explanation other than air embolus. It was put to Dr Bohin that in addition to an increased risk of NEC, reverse end-diastolic flow could put a baby at risk of "other abdominal issues". That was how it was put in cross-examination. She said not that she knew of and that if any specific issues were to be suggested then she would be able to answer.

Well, no other specific issues were put, ladies and gentlemen. So yet again, we suggest, this is an example, as we suggested at the beginning with Lucy Letby's defence statement, make general allegations, look at the specifics. It's no good saying, well, the care wasn't up to it. You tell us where it came up short and we'll answer.

Dr Bohin rejected the suggestion made in cross-examination that stress could have caused excess acid in the stomach, which in turn would have caused the bleeding.

So the prosecution position is this, ladies and gentlemen: all [Baby E]'s signs up to and including the start of the night shift on 3 August were normal, he was making good progress. Yet within an hour of Lucy Letby taking over at 20.00 hours, thing had taken a turn for the worse.

What are the chances of that? In itself it doesn't prove, of course it doesn't prove, that Lucy Letby sabotaged him, but when you look at it in the light of all the other cases, where the arrival of Lucy Letby coincides with the unexpected decline of a child, we say things go beyond the reach of innocent coincidence.

Her encounter with [Mother of Babies E & F] gives you more than a big clue of what was really going on. At 21.00 hours [Baby E] was bleeding from his mouth and when he died 3.5 hours later he was bleeding profusely. When he first collapsed, he was exhibiting an odd skin discolouration that Dr Harkness had only ever previously seen with [Baby A].

[Baby E]'s final collapse was at a time when [Dr C] and Dr Harkness were discussing what to do and were consulting [Baby E]'s records to make their decision.

What were the chances of that happening at precisely that moment? Again, taken in isolation, it would tell you nothing, but this is the point about circumstantial evidence, isn't it? You don't just look at one strand, you look at the combination, you look at how these telltale signs run across the cases. That's the power of the evidence.

These rapid collapses and deaths always happened when Lucy Letby was in close proximity. There are no innocent reasons for [Baby E]'s collapse and death, even looking at his case in isolation. But when you take it with his brother's case and look at their cases with the [Babies L & M] and the case of [Baby K] and with the others, the responsibility of Lucy Letby for what happened becomes even clearer.

It's taken me quite a long time there to go through [Baby E]. I won't take that long to go through them all, so if you're worrying about that, I'll do my best, but it's important because this is the beginning of the process, isn't it?

So moving on to [Baby F], Lucy Letby knew what the effects of neonatal hypoglycaemia were. She told the police in interview and she told you in evidence.

Importantly, she also told the police and you that at the time of these events she did not know about C-peptide. Therefore, if you are sure that it was she who poisoned the bag or the bags of

TPN, we suggest that you would have little difficulty in concluding that she intended to kill [Baby F]. And you will not forget, not least because I won't let you forget, that by the time [Baby L] was poisoned, the level of insulin in [Baby L]'s blood was double what it was in [Baby F]'s blood. So the poisoner had failed to kill [Baby F] and 7 months later, by the time we get to [Baby L], the level of insulin in the blood is twice what it was for [Baby F]. That tells you a lot about intention, doesn't it?

Now, [Baby A]. His death had nothing to do with what was in his dextrose bag. I'm skipping about a bit, I'm back to [Baby A] just to make a point. For reasons that you will understand, we suggest that Lucy Letby knew that it was nothing to do with what was in the bag. But you will remember that when she was interviewed about [Baby A], she said or she asked -- sorry, when she was interviewed about [Baby A] she told the police that in the aftermath of [Baby A]'s collapse she had asked for the bag to be kept. Do you remember that? It's the dextrose bag for [Baby A] back in June -- I'm jumping about quite a lot here -- back in June 2015.

You will remember she said she labelled it, I think, and put it in the sluice room and her friend [Nurse A] was asked about that and she confirmed that Lucy Letby had asked for the bag to be kept. And there never was an examination of the bag, was there?

That, you may think, is quite important because a child -- this is [Baby A] -- was attached to a bag, he died within a short time, and the bag was never examined. That would give or could give, if you were determined to injure a child, give you perhaps a degree of confidence that if you tried it again, no one would actually examine the bag.

She knew no one would examine it. And when she was being -- when Lucy Letby was being interviewed about [Baby F], back to [Baby F], we suggest in effect she taunted the police, saying, "Have you got the bag?" I'm not saying that's the exact phraseology or the tone in which she said it, but she repeatedly asked the question in interview, "Have you got the bag?" because she knew, didn't she, that the police didn't have the bag. And she thought that the fact that they didn't have the bag would give her a free pass. But she was wrong because what she didn't know was about C-peptide.

Professor Hindmarsh told us, Professor Peter Hindmarsh, you'll remember, told us that the relative consistency of the blood sugar levels in [Baby F] through 5 August meant that it was legitimate to infer that there was a consistent level of insulin being administered to him throughout the day when the TPN was

running from 00.25 when that was noted by Lucy Letby on 5 August.

So we heard, you will remember, quite a lot from Dr Milan about the quality-assured procedures at the lab at the Royal Liverpool University Hospital and that the results of her or her lab's blood analysis were reliable. You will remember that in evidence Lucy Letby herself appeared to accept that there was insulin in [Baby F]'s TPN bags.

Now, the bag which was hung by Lucy Letby was produced in the aseptic unit at the Countess of Chester Hospital on 4 August. We can see the prescription for it at tile 144, please. There you see the original signed by Dr Beech and then Dr Wood underneath and you can see Lucy Letby's by now familiar handwriting and signature.

It was back on 29 November last year that we called Ian Allen from the lab to give evidence and he was the man who was in charge of the unit at the time. Do you remember him explaining the painstaking and deliberate way in which the bags were produced? And he made it clear, didn't he, that there wasn't the slightest chance that any insulin was put into [Baby F]'s bespoke bag of TPN in the pharmacy? And that wasn't challenged on Lucy Letby's behalf.

So, ladies and gentlemen, you can be sure that when that bag went up to that unit, it was not contaminated.

If you're in any doubt about that, we invite you to consider four points. First, we invite you to re-watch the video which shows the painstaking procedure in the aseptic unit and bring back to mind the evidence of Mr Allen.

Second, remember what happened to [Baby E] 24 hours before [Baby F] was poisoned. [Baby E] had been murdered. What are the chances of his twin being attacked by a poisoner and the poisoner not being the same person who attacked [Baby E]? In other words, do you really think it's a realistic possibility that either two people were independently attacking children in the neonatal unit and they both just happened to have selected both twins or do you think it's a possibility that it's a matter of chance that [Baby F] got insulin the day after his brother was murdered?

So it would follow, ladies and gentlemen, that if you agree with that then the murderer has to be someone who was working on both night shifts. And to get to the bottom of that, I'm not asking that these are put up now, but if you look at tile 115 in the [Baby E] sequence, and tile 101 of the [Baby F] sequence, that gives you the staff lists for each shift.

There are only three people who were working both shifts.

Valerie Thomas, who was a nursery nurse and therefore would never have been in nursery 1 when [Baby E] was attacked and wouldn't have the keys for the locked fridge.

The second person is Belinda Williamson/Belinda Simcock. She was working both shifts and she was a person selected -- do you think it's a matter of chance now thinking about this? -- to make that note at 22.00 hours for [Baby E]. An interesting coincidence. Well, she was working -- she was also working when [Baby L] was poisoned.

The third person who was common to both shifts was Lucy Letby, who of course had been [Baby E]'s designated nurse and who, from the signature it is clear, hung the bag for [Baby F].

So to comes down to a choice between two, doesn't it, ladies and gentlemen? Belinda Williamson or Lucy Letby. And that's where you factor in [Baby L] and [Baby M]. [Baby M] also attacked with air like [Baby E], [Baby L] poisoned with insulin like [Baby F], and [Baby L], as we will see, got more than one bag of poisoned, in his case, dextrose.

There's nothing random, ladies and gentlemen, about what was going on in that neonatal unit. These are not random poisonings. And when you take that into account, and when you take into account all the other evidence from all the other cases, it's obvious, isn't it, who was responsible? There's only one person who could be responsible.

[Baby F]'s TPN bag was delivered by a pharmacist to the unit at about 4 pm on 4 August and it was stored in the locked fridge. Only one set of keys for the fridge and only the registered nurses were entitled to have the keys. And in the fridge with the TPN was that little vial of insulin.

You can look at it if you want, I'm sure you remember it -- it's probably difficult to see from there -- that tiny, tiny vial of insulin (indicating).

So the bag was poisoned by someone who had access to the fridge and was also done some time after 16.00 hours on 4 August. Just looking at this single case in isolation, there is a limited number of candidates, isn't there? And we heard, I think from all of them, and we suggest you can dismiss the possibility that anybody else other than Lucy Letby poisoned that or those bags.

One of the questions might be posed to you is: well, how was it done? Well, we don't have to prove how it was done, ladies and

gentlemen, because the evidence shows that it was done. But we all saw the debunking of the so-called tamperproof port myth, didn't we, when Mr Allen showed you exactly how the supposed tamperproof port can be bypassed? It can be opened and resealed contrary to what Lucy Letby said at page 5 of the [Baby F] interviews. Anyone who wanted to could inject about 0.6 of 1ml of insulin into that bag, and somebody did precisely that. That tiny, tiny quantity, tiny quantity of insulin had potentially fatal consequences.

What mental intention goes with doing that deliberate act of poisoning? Put yourself in that position.

You'd never do it, of course. What is the state of mind that does something like that? [Redacted]. This was a targeted attack and it just happened that the target of the attack was the twin of the child who died under the care of Lucy Letby. That is no innocent coincidence and it's not the result of some conspiracy between the doctors or anybody else at the Countess of Chester.

You will remember that in cross-examination Lucy Letby would not be drawn on the question of whether [Baby F] was targeted, but we know from the evidence of multiple witnesses that insulin is never put into a TPN bag. The fact that there had been insulin in this TPN bag was spotted in 2018 by Dr Evans when he was conducting his review and he told you that the case of [Baby F] was referred to him because that of his brother [Baby E] was suspicious, and Dr Evans' conclusions were in effect confirmed by both Dr Bohin and by Professor Peter Hindmarsh.

Professor Hindmarsh told you that the half-life of insulin is 4 minutes, so to achieve -- do you remember this? To achieve a steady state, as he put it, of insulin takes about 24 minutes. I'm not sure I really understand the mechanics of it. I think the important point is it takes 24 minutes to get to the point of the steady state.

The first contaminated bag was recorded by Lucy Letby as having been hung at 00.25 and it's the tile we just saw, tile 144. At tile 161 there is a note that [Baby F] vomited at 01.30, so an hour and 5 minutes later.

Do you remember Professor Hindmarsh telling us that vomiting is a sign seen in the young which is associated with hypoglycaemia, low blood sugar? He told us that the body's first line of defence against hypoglycaemia is to produce adrenaline and the heart rate goes up. If you look at the observations chart for [Baby F] -- and it's tile 143, please, if we could just look at that -- we can see that sudden rise in heart rate at 1 o'clock, 2 o'clock, 3 o'clock.

We also know that by 01.54, [Baby F]'s blood sugar level was dangerously low at 0.8. Anything below, I think, 2.4 is regarded as a problem. This was a life-threatening situation for [Baby F].

The stock bag -- do you remember there was a replacement of the bag at about midday that day? And the stock bag had about the same amount of insulin in it. That was connected to [Baby F] after Lucy Letby had gone off duty. She'd have gone off at whatever time it was, 8 am, 8.30, whenever it was she would have left, and that stock bag was undoubtedly hung at about midday.

But the important point, of course, is that -- do you remember Claire Hocknell, the analyst's evidence? She told you that she had reviewed the records for all the other children in the unit on 5 August. No other child in that unit was receiving TPN.

So one child receiving TPN. How often was the stock being rotated? Do you remember that evidence? I think we produced the stock book for you, actually, should you ever want to see it. You heard some evidence from Yvonne Griffiths about this, about the turnover of TPN stock bags in the ward, and it was a very low turnover.

So taking 5 August as our reference date, one bag had been supplied to the unit on 30 June. One bag on 16 July. Two bags on the 17th. Then after this incident, a single bag on 11 August.

You've seen the layout of the fridge, haven't you?

The first bag, the bespoke bag, was contaminated. Easy to do the same thing to the stock bag at the front of the fridge. And it was only ever going to go to one child, wasn't it? But it's so sly, isn't it? Because it's going to be connected to that child at a time when the poisoner isn't there. What does that tell you about the mindset of the poisoner?

This is why it was a targeted attack. We will come to the point a bit later in the next case, [Baby L].

You know that the insulin was put in while the bag was hanging for [Baby L]. But what better way for a poisoner to cover their tracks than to leave a replacement bag in the fridge to be used by an unsuspecting colleague, a member of her "family". It shows a degree of cynical, cold-blooded planning, doesn't it? Because not only would it thwart the remedial step of replacing the bag, it would also divert suspicion on to somebody else and deflects suspicion from Lucy Letby.

The question of whether it was legitimate to infer the insulin contamination in the first bag, so the bespoke bag, from the

results of the blood tests taken from [Baby F] at 17.56 when he was on the second bag, was also explored with Professor Hindmarsh, wasn't it? And he said that it was legitimate to infer from the insulin and C-peptide results from the blood sample that the level of contamination in both bags was about the same.

So that tells us quite a lot as well, doesn't it, ladies and gentlemen? It tells us that whoever poisoned [Baby F] gave it some thought because they put the same amount into the replacement bag as well that might have been used. So when you're thinking about whether or not this is a conspiracy by the Gang of Four, whether you're thinking about whether or not staffing levels had anything to do with this or even the drains or the sink in nursery 1, we invite you to bear all that in mind.

When she was interviewed, Lucy Letby told some interesting lies about [Baby F]. You know that she has an exceptional memory for the details of these cases. She corrected me several times when I got the detail wrong, didn't she?

I don't mind that, I do get things wrong. No doubt in due course you'll be told that I've got some of the details of what I'm saying to you now wrong and you can be the judges of that. If I have, I apologise and it's not deliberate. But Lucy Letby, she's right on it, isn't she, right on the detail of this case?

And yet in interview with the police in 2019, she claimed that she wasn't aware of there having been any concerns about [Baby F]'s blood sugars. If you're looking for the reference -- I'm not asking you to look at it now because it takes too long, but at page 15 of the [Baby F] interviews, you will find that. And you know that she was lying about that because of the text message she sent to [Nurse A]. Can we go to tile 222, please? This is Lucy Letby to [Nurse A].

223, please. 224. 225. 226. As I said to you before, in interview she was asking the police whether the bag had been kept or had been checked. She knew what the answer would be.

On the second occasion she was interviewed, she repeated that question. She was taunting the police.

It's page 16 of her interviews, [Baby F] 16. When she came back for her final interview in November 2020, the police broke the news of C-peptide to her. You'll find that at page 22.

Lucy Letby's obsessive and surreptitious following of [Mother of Babies E & F] on the internet was never satisfactorily explained, was it? She undoubtedly poisoned [Baby F], who just

happened to be the twin of the baby she'd murdered the previous day. Cold, calculating, cruel and relentless.

I'm going to move on now, my Lord, to the [Babies L & M] twins to draw the parallels between their cases and the cases of [Babies E & F]. I can certainly use the 7 minutes, but if we have an early break --

MR JUSTICE GOSS: I think we will break off there. I'm just going to confirm, we do have to have one and a quarter hours, don't we? One and a quarter hours required? All right.

Well, if I say 2.05 then, 1 hour and 10 minutes.

That gives people time. Then we'll break off again at a convenient point, Mr Johnson, and have one final session after that for today. All right? Thank you very much. Because it is hard work, concentrating on all this.

(In the absence of the jury)

MR JUSTICE GOSS: I think this is an opportunity to clarify, actually, how long the breaks need to be in fact.

I obviously will have reasonable breaks, but I don't want them to be unduly long because I think most people find an hour or an hour and 5 minutes to be adequate for a midday break, so to speak. Is that all right for you?

MR MYERS: Yes, I'm in the court's hands, my Lord.

Certainly an hour would be helpful. After that, whatever is convenient.

MR JUSTICE GOSS: We'll say an hour and 5 minutes for lunch breaks in future, but I do think that we have to have 15 minutes' break in the mid-morning and mid-afternoon sessions.

MR MYERS: We agree, my Lord, thank you.

MR JUSTICE GOSS: And we won't go on significantly after 4 o'clock. If it needs another 5 minutes or so, obviously, Mr Johnson, we won't break off then. I'll just leave it to you to indicate.

MR JOHNSON: I'm sure someone will give me a nudge if I get too enthusiastic.

MR JUSTICE GOSS: If necessary, I'll point out where we've got to. Thank you very much then. 2.05, please.

(12.56 pm)

(The short adjournment)

(2.05 pm)

(No audio feed from court)

(2.08 pm)

MR JOHNSON: You remember I said I wanted to deal with the [Babies L & M] boys next because of the similarities that I explained to you. I'm going to have to deal with each separately, obviously, because otherwise it gets a bit too complicated -- for me, anyway.

On Friday 8 April 2016, at about quarter past 10 in the morning, [Mother of Babies L & M] told us that she gave birth to her twin boys. Lucy Letby was present at the birth and when [Baby L] was admitted to the neonatal unit at 10.30 that morning, he was "generally well", but his breathing rate was a little elevated, which we heard is not unusual for a premature baby. His low blood sugar was a problem from the beginning and, again, you heard from more than one witness, I think, that that's not particularly unusual for premature underweight babies.

You will remember that Dr Bhowmik told us about the calculation of the fluids that she prescribed to [Baby L], but she didn't recall discussing it with the nurses.

She didn't monitor the time that the infusion started and Dr Bhowmik couldn't really remember anything that wasn't in the notes.

But if we look at tile 13, please --

(2.09 pm)

(Video/audio feed lost from court)

(2.10 pm)

MR JOHNSON: -- and tile 13 shows us Lucy Letby's nursing note, which was written at the end of the shift. You can see the time, 17.42.

This particular note relates to the time at which Dr Bhowmik prescribed dextrose and continues:

"Myself [it doesn't appear on that screen but it appears in the original note] and Shift Leader A Davies have discussed this

with Registrar Bhowmik as it doesn't follow the hypoglycaemia pathway."

You will remember in that context, ladies and gentlemen, the evidence of Eirian Powell on 27 April this year when she said that Lucy Letby would not shirk to challenge a doctor if she thought a mistake had been made.

Amy Davies didn't recall this conversation, although Amy Davies did confirm that usually milk would be given as a first resort under the pathway.

Nurse Davies said that the infusion therapy prescription sheet showed that she had checked what was being given to [Baby L] and, in challenging Dr Bhowmik and documenting it, we suggest that Lucy Letby was setting up an issue for [Baby L] in the sense that she had identified an anomaly and had decided to use it as a cover to attack [Baby L]. You'll remember I suggested as much to Lucy Letby when I was questioning her.

The night shift of the 8th into the 9th was a shift on which Tracey Jones was the nurse looking after [Baby L] and you will remember her probably as the highly qualified agency nurse. Although she was operating as a band 5 at Chester she was in fact qualified as a band 8A, which is apparently beyond any of the nurses that we have heard from from the hospital itself.

She took over [Baby L]'s care that night and recorded that [Baby L]'s blood sugars improved to the extent that the monitoring was discontinued, and you'll find that at tiles 53 and 55.

Tracey Jones told us that she didn't change any IV bag for [Baby L], so she didn't change the dextrose, and so it follows that the bag that was put up by Lucy Letby during the day shift, when [Baby L] was admitted, was the same bag that was running through the night shift and was still running at the beginning of the day shift.

So we come to the day shift of Saturday, 9 April.

You will remember that Mary Griffith was the designated nurse for both [Babies L & M] twins on that shift and they were both in nursery 1. If we look at tile 88, please, we can see there were four children in nursery 1: the [Babies L & M] boys and two others who were both being looked after by Lucy Letby.

Mary Griffith told us in cross-examination that it was a busy shift in nursery 1. Quite how that bears on the issue of insulin finding its way into [Baby L]'s bag of dextrose will be for you to decide, but we suggest that if people were very busy it might mean that they are not in a position always to monitor what

somebody else, and in particular somebody like Lucy Letby, was up to.

If you look at the neonatal review, which is in the black file, you will see that Mary Griffith was certainly out of the room at about 9.30, so in other words about an hour and a half after the shift started, because she was with Angela McShane in nursery 4, administering medications to the children in there.

You will remember the evidence we heard from a number of different witnesses that medications were always given by a registered nurse, so it would follow, we suggest, that it was Mary Griffith actually administering medicines in nursery 4 at 9.30.

That means that Lucy Letby would have been alone with [Baby L] in nursery 1 at that time. And if you put that together, we suggest, with the evidence of Professor Hindmarsh, who said that it would be by about 9.30 that somebody put insulin into [Baby L]'s dextrose bag -- before we get to when the insulin went in, I'm going to deal with the evidence which proves, we suggest, that [Baby L] was poisoned.

Mary Griffith remembered that [Baby L] had low blood sugars. If we go to tile 97, please, we can see that she took a blood sample from [Baby L] at about 10 o'clock for serum bilirubin and blood sugar and she was shocked, she told us, by the coincidence of an increase in the amount of dextrose that was being given, the increase of the dextrose with the reduction, with a drop in [Baby L]'s blood sugar because the opposite should have been true because his blood sugar had regularised overnight at about midnight. Here he is being given more sugar, yet the blood sugar is decreasing.

As with [Baby F], what we suggest is the irrefutable evidence or the fingerprint of poisoning comes from the disparity in the ratio of the levels of C-peptide and insulin.

One issue that we spent quite a lot of time dealing with in evidence was the time at which Mary Griffith took the blood sample from the lab. Do you remember that? This was the one where the podding of the sample was delayed because of [Baby M]'s collapse. The issue in evidence became: was the blood sample taken at about midday or was it taken at about 15.45 or thereabouts?

It's an important point in the case of [Baby M] as well, so not just [Baby L] but [Baby M] as well, for reasons that we will come to.

In order to work out when the sample was taken from [Baby L], we have to look at the evidence given by several witnesses and what is contained in the documents that were created at about this time. So that you understand where we're coming from, ladies and gentlemen, we suggest that the blood sample which showed that [Baby L] had been poisoned must have been taken at about 15.45.

In other words, about 15 minutes or so before his brother collapsed and had to have CPR.

Although she said that she couldn't remember the time that the sample was taken, Mary Griffith did say that when it was taken it would have been treated as urgent. She also remembered that when it was taken, she had been distracted by an emergency with [Baby M], and we know what time the emergency was with [Baby M], it was about 16.00 hours; that's tile 160.

So that evidence in itself suggests that the sample was taken between 15.45 and 16.00 hours. Mary Griffith said that the blood was put into a vial, a small tube, and an envelope, both of which were labelled. She explained that the printing of the labels is an automatic process which is initiated by the order on the computer and that the labels are important because you need to get the right tubes to take the sample in because the chemicals -- the reagents, as they call them -- in the tube have to be the right ones for specific tests. So the tests have to be ordered, that determines the tubes which the blood goes into, which in turn is what is required. So it follows that the nurse needs to know what the test is or what test is to be conducted by the lab so that he or she, the nurse, can use the proper tube.

Emma Jane Lewis, who is a consultant biochemist at the hospital told us how the requesting system works.

What she had to say supports our contention that this sample was taken at about 15.45 because she said that when a request for a test is made, it's logged in the hospital system. If you go to your divider 2, please, ladies and gentlemen -- bundle 2, jury bundle 2, it's divider 15, page 18025. I think this is also at tile 190, but it may be easier to see on the document.

That's quite a busy page but what you see -- Mr Murphy is ahead of me and he's highlighted the relevant entry -- you can see the request for this test was entered at 15.45, which is the time we suggest is about the time it was taken.

That process of entering that information into that database initiates the production of the labels, which is a prerequisite for the taking of the test because it determines, as I say, the

type of tube into which the blood is decanted to send for testing.

So we know from that timestamped evidence that Dr Ukoh ordered the insulin C-peptide test at 15.45.

If we put that information alongside the evidence of Mary Griffith, that the podding of the blood was interrupted by the collapse of [Baby M], you know to an accuracy of 15 minutes or so when the blood sample must have been taken, because its processing and analysis were interrupted by Lucy Letby's attack on [Baby M].

So just going back to what happened earlier that morning, if we go to tile 101, please, or in the paper documents -- thank you. Dr Ukoh had examined [Baby L] at 10.20. He took us through the notes. In relation to the tube feed, [Baby L] was getting a dose -- sorry, in addition to his tube feed [Baby L] was getting a dose of 10% dextrose through a cannula because his bloods were low. And Dr Ukoh decided to increase the dextrose dose.

He said that he needed to be informed if the blood sugars remained low.

Because the levels of [Baby L]'s blood sugar were so low, he ordered the blood test. If we go to tile 111, please, and go back two pages in the paper documents to 17998, we'll get to the same material.

When Dr Ukoh was pointed to that, he thought, didn't he, that 12 noon was a reference to the time when the blood sample was taken? So this is where the confusion arose. I'm dealing with the issue of the confusion.

We say Dr Ukoh cannot be right about that because the computerised timestamped form proves that he ordered the test at 15.45. And that, as I've said, would have been the prerequisite for the tubes, et cetera. So with regard to Dr Ukoh's handwritten note that you can see there, we say that's a red herring and I'll give you a number of reasons why noon is a red herring here.

First of all, we know that this information was written at a later date, it wasn't written at the time.

Because Dr Ukoh told us by reference to the front of the form that it was his handwriting on the front on the 11th and 12 April. In other words, a couple of days after this blood test was ordered.

The second reason that this is a red herring is that the cortisol and the growth hormone readings on the back of the form at 998, which are there with the asterisks, were not actually verified until 11 April from the lab, so they weren't available, in other words, on 9 April.

And third, the PTO on the front of the form at the bottom must have been written at the same time as the material on the back of the form, otherwise why would you write PTO on the front, and therefore, at the time that Dr Ukoh was making his entries on the 11th or 12 April.

So far as the timing of the blood sample is concerned, this form, we say is a complete red herring.

The final piece of evidence that points to the blood sample being taken at 15.45 is the coincidence of the administration of the bolus of dextrose given by Lucy Letby and Mary Griffith at 15.40. I don't know if we can find page 17948, please. There it is.

You can see the bolus of dextrose given at 15.40.

It's below -- you can see "Time infusion started" in the second to right-hand column. The third one up is 15.40.

It's a 4.3ml 10% dextrose bolus, given at 15.40, prescribed at 15.35 by Dr Ukoh. And that coincides, if you remember, with the raised level of the blood sugar in the lab sample. So do you remember, there's a slight anomaly between the blood sugar levels going through the day and the one that went to the lab? The one that went to the lab was slightly -- the blood sugar level was slightly higher and Professor Hindmarsh told us that the reason for that, what appears to be an anomaly, it's not an anomaly at all, it's accounted for by the administration of this bolus at 15.40. So in other words, just before the sample was taken. So all the evidence, ladies and gentlemen, we suggest, points towards this blood sample having been taken by Mary Griffith at about 15.45.

Going to page 18025, please, in those documents, which is back to where we were before, Dr Gibbs helped us with this and he told us what you already know: the high insulin level in conjunction with the low C-peptide is in effect a fingerprint of the introduction of manufactured insulin. In other words, somebody poisoned [Baby L].

He told us that the low blood sugar level should have meant that [Baby L]'s insulin level was low too because the body, if it's producing its own insulin, automatically cuts off if the blood sugar level gets low. And you will remember that Dr Gibbs drew

conclusions about what was going on at the time and it had never occurred to him at the time that somebody had been giving insulin to [Baby L] and he'd never, Dr Gibbs that is, received the lab results. They went a few days later to the junior doctors, who didn't appreciate their significance.

Well, those results were also tested too by Dr Milan from the lab at Liverpool. She gave evidence on 20 February. She confirmed that the samples were properly labelled, that this was a check which was done more than once during the process, the machinery was checked and calibrated daily and the staff were properly and fully trained. The processes are overseen and checked by the manufacturers and by UKAS. The machine's results are then reviewed by a human biochemist and [Baby L]'s blood sample was received in Liverpool on 11 April.

The levels were C-peptide 264 millimoles and 1,099 picomoles of insulin. And she produced another document which you have as 26995 with the results and made the same point that Dr Gibbs made about the disconnect between -- in the ratio between C-peptide and insulin and she said in no uncertain terms the only way you can get a pattern like that is if insulin is given to the patient.

Dr Sarah Davies, another scientist who obtained the results in Liverpool and sent them to Chester, phoned them through because they were so unusual. Dr Milan confirmed that a failure to deal with things as they should have been -- do you remember her being asked about the stability of the analyte? In other words, the thing to be analysed. And she told us that if it hadn't been put on ice properly, that would have reduced the reading for the insulin because that's not as stable, but it wouldn't have reduced the reading for the C-peptide. So the result would have been even more marked if that had an effect on the result. So you can discount that, we suggest, as being a problem.

You may remember Dr Gwen Wark. She was one of the few people with a Scots accent who gave evidence in this case. She was a director of the UK National External Quality Assessment Service and, summarising her evidence, she told you that the lab at Liverpool was performing very well.

So we suggest that the evidence on this point is really all one way: you can discount as a possibility that these lab results are in any way misleading.

As I've already said, the amount of insulin in [Baby L]'s blood was more than double what had been found in [Baby F]'s blood, and that, we suggest, speaks volumes. We suggest that the person who poisoned [Baby F] must be responsible for poisoning [Baby L]. The idea that there were two separate people in this

neonatal unit separately spiking fluid bags is so improbable that it can be discounted as a reasonable possibility.

[Baby F] had survived, so the poisoner, Lucy Letby, upped the dose for [Baby L]. As I've said before, what clearer evidence of an intention to kill could you have?

The next question then, ladies and gentlemen, is: when did the insulin go into the bag? Well, we say it was put into the bag after it was hung and this is why it was -- one of the reasons why it was a targeted attack.

[Baby L], as I've already said, had had the same bag of dextrose running from about midday on the previous day and it ran until about midday on 9 April. If you go to jury bundle number 1, please, behind divider 6, you will find the table to which Professor Hindmarsh referred when he gave evidence.

If you can look at that and we can put up tile 10 in the [Baby L] sequence, please. This shows the hanging of the bag. You will remember that there was a slight doubt about whether it says 12.00 hours or 12.10. It doesn't really make any difference. You can see that Lucy Letby's initials -- sorry, signature appears next to it. That shows that she was responsible for or took co-responsibility for hanging the bag. So that's on the 9th.

What we see above it is the previous bag that was hung the previous day at midday. Do you see that at the top, right at the top? Signed and co-signed by Lucy Letby and Nurse Davies.

Looking at the table that you have behind divider 6, ladies and gentlemen, Professor Hindmarsh told us that the first bag, the one hung on 8 April, was not poisoned before the reading taken by Nurse Tracey Jones at midnight on the 8/9 April. You see that just above the thick black line about halfway down the table. The reason it wasn't poisoned before then is that if you look at the blood sugar readings, they're following a general upward trend, which wouldn't have been the case if there had been insulin in the bag on 8 April.

So far as the blip in that process is concerned, that's at 16.00, you can see there's a reading of 5.8.

That coincided with an upping of the dose. So that's what Professor Hindmarsh told us.

According to the evidence of the -- the uncontroverted evidence of Professor Hindmarsh, it must follow that insulin was put into the first bag some time between midnight, which is that reading of 3.6 at 24.00 hours, and 10 o'clock, 10.00 hours on the 9th.

Making allowances for the half-life of insulin, which I referred to earlier, that pushes the time back 24 minutes. So insulin went into the bag some time at or before 9.36 if that blood sample at 10 o'clock is an accurate record of the time it was taken. Okay? With me so far? So it didn't go in on the 8th, it went in some time between midnight at the beginning of the 9th and about 9.30 on the 9th.

So given that it actually went into a bag that was hanging on the cot or the incubator, it has to have been a targeted attack, doesn't it? That child, [Baby L], was deliberately selected by the poisoner for that insulin.

So it's not a random poisoning. And it must also follow, mustn't it, that whoever is responsible was on duty between midnight and 9.30? And that significantly reduces the possibilities. You are entitled, when you're looking at the answers, what answers you think can be drawn from this sort of evidence, to look at what was going on with [Baby F] as well. So put them together and see where the coincidences coincide.

You'll want to ask yourselves whether the person who poisoned [Baby L] is a different person to the poisoner of [Baby F]. We say it must have been the same person.

You'll bear in mind, won't you, that whoever -- if it is the same person, they'd got away with poisoning [Baby F] at this point, 9 April. So they would be pretty confident, wouldn't they, that they'd hit on a reasonably secure way of trying to kill babies, a way that was not being picked up by the hospital, just so long as it wasn't done too often?

So here we have a gap of 7 or 8 months between the poisoning of [Baby F] in August 2015 and the poisoning of [Baby L] in April 2016.

Now, Lucy Letby came on duty on 9 April between 7.30 and 8 am, and you will find that in tile 88. She knew [Baby L] had a naturally occurring hypoglycaemia because of her conversation with Dr Bhowmik, which was recorded in the nursing notes, and therefore he was a perfect target, wasn't he? And she had also by that stage introduced the spectre of a naturally occurring issue and a failure to deal with it in accordance with the pathway or the protocol. That's in the nursing note.

The insulin that poisoned [Baby L] was put into more than one dextrose bag and the staff who were on duty at the time, and at the time [Baby F] was poisoned, have all told you that they were not responsible. Because there was insulin in more than one bag, something you might be asked to consider is whether these bags

were left randomly by someone other than Lucy Letby and it just happens that [Baby L] got them.

Well, there are many reasons why we suggest you can exclude that as a possibility. The most important is the one I've already given you, that the first poisoning was done while the bag was actually hanging. The second is that the second bag he got went to him as well.

So let's just look, if we can, back at that chart that I was referring to before, the chart that was referred to by Professor Hindmarsh. So we know that there was insulin in the bag by 10.00 hours on the 9th and we know that Lucy Letby was in the room. We also know that Mary Griffith was not in the room because she was in nursery 4, giving medication to children there.

Mary Griffith had not been working when [Baby F] was poisoned.

The second bag that was put -- there was a second bag given to [Baby L]. That's four lines up from the bottom of the table. It's the one at midday. So that was poisoned as well.

A third bag was given to [Baby L], which you see over the page. It's the one that appears in the table at 16.30 because that's the time in the records, but you know as a matter of evidence that that bag was changed at about -- sorry, yes, at 16.30. You know that that was being put together because it was a more concentrated bag. You know that that was being put together at about the time that [Baby M] collapsed, and therefore Mary Griffith went back to [Baby M] and two other nurses took over the preparation of the 12.5% bag.

Somebody also spiked that bag. You may think, when you think about it, that that bag was in all likelihood spiked whilst it was hanging as well, because if, as Belinda Williamson told us, everything had to be changed because Mary Griffith was interrupted and they started with a fresh bag, then it would mean that after that bag was hung it must have been spiked.

Of course Lucy Letby was there at that stage and we suggest that the evidence shows that, given that she was the person that spiked the bag at 9.30, it doesn't take much to infer that she must also have been the person that spiked the bag some time after it was hung at 16.30 and certainly by the time -- yes.

Further bags were hung on the 10th at 02.30 and on the 11th at 01.45. We can see that as that period went -- so looking down the blood sugar column, which is the third from the left, we can see that once the 15% bag went up at 02.30 or 03.00, there was a general upward tick in the blood sugar levels. That is accounted for by the fact that it was the giving set that had previously

been used with the contaminated dextrose that was leeching, in effect, insulin as the new bags were put up. Do you remember? We had some evidence about whether giving sets are changed and whether they're not changed. But as Professor Hindmarsh explained to us, an explanation, and a reasonable explanation, for these results is that there was insulin that had stuck to the plastic of the giving set, that even though the bag was changed for bags that didn't have insulin in, the insulin was still coming off the giving set and therefore in ever-diminishing quantities, but it was still affecting the blood sugar results.

So the fact that Lucy Letby wasn't there after about 8 pm, we suggest, doesn't exculpate her at all. And the fact here, if you think about it, if you go back to the beginning, it has to have been someone that was on the ward in the room, we say, at about 9.30 on the morning of the 9th, and that inevitably is Lucy Letby.

So just step back, ladies and gentlemen, we say, and ask yourselves: did somebody do this to frame Lucy Letby? Because that's the only alternative, we suggest, to her being the person who is responsible.

And if Lucy Letby didn't do it then whoever did it also targeted [Baby F] and they also targeted Lucy Letby to take the blame. It must be, mustn't it? We suggest that is not a reasonable possibility given everything -- this is why all the other cases are so important as well, isn't it? Look at all those coincidences as well.

It just doesn't work.

If the aftermath of this poisoning on the night shift of the 9th to the 10th, Tracey Jones was [Baby L]'s designated nurse. She continued to document the blood sugars. She denied being the person responsible. She in reality, we suggest, is the only other reasonable possibility. It wasn't suggested to her that she was the person responsible.

Dr Gibbs got involved during the day shift on Sunday the 10th. He examined [Baby L] at about 10 am and, as I say, what happened thereafter is all explicable by insulin having come off the giving set. So that's [Baby L].

[Baby M]. On 8 April, like his brother, born in good condition. He was crying, good Apgar scores, breathing for himself. Within a short period of time admitted to the NNU with his brother and within a few hours he was having his observations taken every 2 hours and was breathing for himself in air. The picture of health.

Overnight on the 8th to the 9th, like his brother, cared for by Tracey Jones. If you look at the observations chart you will see he was doing just fine.

Saturday the 9th, the day his brother [Baby L] was poisoned, was an averagely busy shift according to [Nurse B]. And we say the fact that his twin [Baby L] was poisoned puts what happened to [Baby M] into sharp relief. And we invite you to think of [Baby M]'s case in this way: on the one hand, what are the chances of a perfectly healthy baby boy who had no significant problems collapsing out of the blue in an extreme way?

The doctors you have heard from all suggest not very big.

On the other hand, and you can go a stage further that the doctors are not entitled to go, what are the chances of this happening at the same time that his brother [Baby M] was being poisoned? And what does the fact that both boys were under attack at the same time tell you about the identity of the attacker? So we're back to the two attackers against one attacker conflict, if you like. You can exclude, can't you, the possibility that more than one person is responsible for all these things?

So putting it in a nutshell, we say that the poisoning of [Baby L] helps you to decide whether there was an innocent reason for [Baby M]'s collapse. It also helps you decide who was responsible. We suggest that at the same time you're entitled to look at the cases of [Baby E] and [Baby F] and what happened to them. And this is the strength of circumstantial evidence, isn't it? It's often referred to in a disparaging way as if, "Oh, it's only circumstantial evidence". Not at all.

Circumstantial evidence can be very, very powerful, can't it? This is one of those cases where it is very, very powerful.

Fifteen minutes after the blood had been taken from [Baby L] for testing, and at about 16.00 hours, [Baby M] suffered a profound collapse -- you'll find it at tile 145 of his sequence -- from which he made a miraculous recovery -- how many times have you heard that in this case? -- holding on to the ET tube, having been lifeless moments before. At that time he was in nursery 1 with [Baby L], but you shouldn't make the mistake of thinking he was an intensive care baby, ladies and gentlemen. [Nurse B] said:

"He was a well baby who did not need full ECG monitoring."

According to Ashleigh Hudson, at the time of [Baby M]'s collapse, Lucy Letby was asked what had happened and Lucy Letby said, "We don't know, he suddenly collapsed.

No warning". So a precipitous and unadvertised collapse, entirely out of keeping with any natural process.

If we go to tile 88, please. 10.25, Dr Ukoh examined [Baby M] on a standard ward round that morning.

This was at about the same time he'd examined [Baby L].

Whilst [Baby L] had had low blood sugar, for [Baby M] it was an unremarkable examination, and in particular you will note that his abdomen was normal.

The next time Dr Ukoh noted seeing [Baby M] was his collapse that afternoon. There was an issue with -- as the day went on, there was an issue with aspirates and a slightly distended abdomen and you will remember that [Nurse B] obtained an acidic aspirate at 12.30 and discarded it as it was not of any great concern and she told us that at 12.30 [Baby M] was well.

At 14.30, Mary Griffith aspirated some bile-stained fluid and showed it to the registrar. This was an additional concern to a degree and Dr Ukoh confirmed it.

But just pausing there, a bile-stained aspirate. Echoes perhaps of [Baby E]. [Baby M] was made nil by mouth, he was put on to dextrose, but nothing suggested he was likely to become seriously unwell. His nasogastric tube was put on to free drainage.

At 15.30, [Baby M] was put on to an infusion of 10% dextrose; that's tile 127. That too was signed by Lucy Letby and, on this, occasion Mary Griffith. He didn't get a bag of dextrose with insulin in, another reason why we say the attack on [Baby L] was targeted.

You will remember that this was at about the time that Mary Griffith was asked to take blood from [Baby L], so this is 15 minutes before the computerised order for the blood test for [Baby L]. So at this time Mary Griffith would have had other things on her mind. She was co-signing for [Baby M]'s infusion but she was about to take the blood sample from [Baby L] and then she was going to have to prepare a 12.5% concentrated dextrose solution for [Baby L].

So while Mary Griffith had those things on her mind, Lucy Letby was responsible for this infusion. You will not have forgotten, ladies and gentlemen, that according to the agreed evidence of

[Mother of Babies L & M], so [Babies L & M]'s mum, she, her husband and other family members had been visiting the twins that afternoon and she said this:

"About 10 minutes after we left the boys, a nurse called Yvonne came running up. She said I had to go back down and took me down on the wheelchair. I asked why and she said she'd explain downstairs. When we got there, one of the doctors was pressing our [Baby M]'s chest."

"Ten minutes after we had left the boys." So [Baby M] had gone from being well, to quote his father, "absolutely fine", to a life-threatening collapse and emergency CPR. His parents were praying and crying. Do you remember those words of one of his parents in their statement?:

"I was praying to my God."

Unbeknown to them, while [Baby M] was being resuscitated, [Baby L] was being poisoned with synthetic insulin and had been suffering from very low blood sugar for quite some time. Both were in the same room at the same time, and of course so was Lucy Letby. That is why you can dismiss as a possibility the idea that this is all just unlucky, innocent coincidence.

Belinda Williamson heard the alarms from [Baby M] and went into nursery 1, where she saw Mary Griffith and Lucy Letby -- and you'll remember Mary Griffith had been the sterile nurse preparing the dextrose infusion.

Belinda Williamson said that as she went in, Mary Griffith had her back to [Baby M]. Mary Griffith distracted by the preparation of this 12.5% infusion.

Who was behind her? [Baby M] and who else? You know the answer to that, don't you?

Belinda Williamson said she put out the call for assistance and informed the "in charge", then took over doing the fluids with Ashleigh Hudson. She couldn't remember whether or not the giving set was changed and confirmed that it wouldn't have been unusual to use the same giving set. This is for [Baby L], of course. She did not add insulin.

Mary Griffith said she was preparing the new dextrose bag for [Baby L], and Lucy Letby told her there was a genuine event that needed "to be sorted", was the way she put it, and Mary Griffith asked for a resus call to go out and was then relieved by Belinda Williamson.

[Nurse B] arrived, followed by medical staff, and the resus started at 4.02. It's recorded on the paper towel -- the paper towel, exhibit 7. The paper towel that found its way, as if under its own steam, back to Lucy Letby's home address and ended up in a supermarket bag under her bed. It "came home with me". Sounds like a dog following on behind, doesn't it?

These are inanimate objects. And the explanation? "I collect paper."

How long has Lucy Letby had to come up with a reason? Here we are now, 7 years later. The best reason is, "I collect paper".

"But I didn't know it was there." How do those ideas go together? Avid collectors are usually sad old men like me, most collectors know what they've got in their collection, don't they? It's nonsense, isn't it, ladies and gentlemen? Absolute nonsense.

[Nurse B] told us that she was in nursery 1, in the middle of the nursery, facing [Baby M]'s incubator, talking to Lucy Letby when things happened.

She couldn't remember Mary Griffith being there, but she did remember Mary Griffith being there slightly later.

Belinda Williamson said that she was talking to Lucy Letby too whilst Lucy Letby and Mary Griffith were doing medications.

So you've got a lot of different accounts, but somebody sabotaged [Baby M], didn't they? He wasn't breathing. A crash call went out. Yet another case where a child was being bagged, there was chest movement, there was good air entry into his lungs, but his saturations didn't respond. Almost a signature of many of these attacks, isn't it, ladies and gentlemen?

CPR was started. [Baby M]'s heart rate and sats remained low. The resuscitation moved into giving drugs. Six doses of adrenaline. Six. Dr Jayaram told us that there was an issue with blood perfusing the lungs to pick up the oxygen. Do you remember the gas exchange diagrams that Professor Kinsey explained to us as to how the mechanics of it all work? And it is a signature, isn't it, of the consequences of many of these attacks? And Dr Jayaram arrived, [Baby M] was receiving CPR led by Dr Ukoh. The protocol was well underway. He had pulseless electrical activity. In other words, the monitor was detecting some electrical activity in the heart, but the medics couldn't feel a pulse, at the very edge of life. And the overall resuscitation took 30 minutes with no spontaneous response. The longer a resuscitation goes on, the less likely it is to have a good outcome, and 20 minutes is the usual watershed, according to Dr

Jayaram. He said it was unusual to get a positive response after the amount of downtime [Baby M] had had. And Dr Jayaram had what he termed as "the difficult conversation" with the [Parents of Babies L & M], and [Baby M] suddenly recovered.

A miraculous recovery. CPR was stopped.

Do you remember what Dr Jayaram said? You might have forgotten:

"I wasn't sure what we'd done to suddenly make him better."

He couldn't explain what had caused the collapse and why [Baby M] suddenly got better. And you'll remember Dr Gibbs' evidence, won't you, about that inexplicable partial and temporary recovery of [Baby C]?

We will come to [Baby C] in due course.

During the resuscitation, Dr Jayaram noticed skin discolouration. [Baby M] was generally pale. There were patches and blotches of very bright pink or certainly more obviously pink on his torso that flitted around, appearing and disappearing. Dr Jayaram said this, direct quotation:

"Because [Baby M] was darker skinned, it was more obvious. He was generally pale, which one would expect in a cardiorespiratory arrest. There were patches of very bright pink, or certainly more obviously pink because it was on a darker skinned background, on his torso that flitted around, these sort of pink patches for want of a description, better patches. They would appear and disappear and then other ones would appear and disappear. I noticed them on his abdomen because that's the most obvious bit of his body that you could see because the rest of his body had people covering his chest doing CPR. I noted them sort of when I got there during the start of the resuscitation. I can't comment on how long they continued to be there. Once circulation was restored and his heart rate came above 100 they vanished. I had never seen this before [Baby A]."

When she was asked about it in interview, Lucy Letby said this -- and you'll remember I asked her about it in cross-examination as well. I'm not going to ask you to find the reference now, but if you want to make a note it's page 5 of the [Baby M] interviews.

She suggested that the lighting in nursery 1 wasn't very good in that corner spot and perhaps that was the reason why she didn't spot what Dr Jayaram did spot.

Well, I've got two words for you to bear in mind when you're thinking of that as an explanation, ladies and gentlemen: [Baby I].

You'll remember what happened to [Baby I] in nursery 2 on 13 October and the fact that Lucy Letby claimed to be able to see in very poor lighting when it suited her. And we will get to [Baby I] in due course.

Dr Jayaram made the point that [Baby M]'s collapse was not typical of any normal infective process. It was similar to what he'd seen with [Baby A], both in terms of the discolouration and in terms of how he collapsed, the lack of there being a reason.

He explained that at the time he was operating within certain rules of engagement. You'll remember the cross-examination, I'm sure. He had never seen this before these cases.

Do you remember he was asked -- in answer to a question, he asked a question, and his question was this:

"Are you suggesting that I didn't see it and am perhaps confabulating it?"

That's doctor or lawyer speak for making it up.

Well, what is Lucy Letby's case on whether or not Dr Jayaram is making things up? One minute you may think she has it one way, another minute perhaps she has it another. You will be the judges of that.

It was said that if this was what came back to Dr Jayaram on behalf of Lucy Letby:

"If you'd seen a rash that looks the way you've described it to us on [Baby M], you would have recorded it."

So in other words, because he didn't write it down, he must have made it up. Another time he was accused of seeking to create "dramatic detail" by using the phrase "physical chill" by describing how he felt when he later found a paper on air embolism.

Well, ladies and gentlemen, we suggest that not only is Lucy Letby prepared to kill babies, or try to kill them, she is also prepared publicly to trash the reputations of responsible professional people in an effort to get away with it.

As he was being resuscitated, [Baby M]'s blood gas was measured at 16.22 hours by [Nurse B]. She used the machine, she took the printout, she entered the data on the sheet and threw away the

printout in the secure rubbish. And that printout was found under Lucy Letby's bed. "I collect paper." What a bit of paper to add to your collection.

So ladies and gentlemen, you can see immediately the parallels, can't you, with what happened to the [Babies E & F] twins? Is it an innocent coincidence, or when you factor in that [Baby L] and [Baby F] were being deliberately poisoned, does it point that the fact that, first, someone was sabotaging all four and, secondly, that Lucy Letby was the saboteur? Yet another collapse just after the family had left, just after the interested observers had left, just when Lucy Letby was unsupervised and got the opportunity.

What are the chances of that pattern of collapses happening time and time again just when people have left the room or are being distracted?

My Lord, there is a little more I want to say about [Baby M], but I just have my eye on the clock.

MR JUSTICE GOSS: Yes, certainly, if that's as good a point as any, we'll have our break then. We'll just have a ten-minute break, members of the jury, not such a long remaining session. We'll finish at 4 o'clock or shortly thereafter, so this will be a short session after this.

Thank you.

(3.12 pm)

(A short break)

(3.22 pm)

MR JOHNSON: So after the collapse of [Baby M], we move into the night shift of the 9th into the 10th. [Dr A] told us about his involvement at 21.35 that evening.

[Baby M]'s collapse had been at about 4 pm, about 16.00, so about 5 hours later or so.

He said that there was -- so we have this dreadful collapse, six doses of adrenaline, 30 minutes of downtime, an inexplicable recovery, and by 21.35 there was a plan to take out [Baby M]'s ETT. Evidence of a truly astonishing recovery, every bit as astonishing, we suggest, as the collapse.

At midnight, the morphine was stopped following a good gas and [Baby M] had been settled all evening. The tube was taken out,

he was put on to BiPAP within 12 hours of this brink of death collapse.

Samantha O'Brien and Laura Eagles respectively were the nurses who looked after [Baby M] on the night shift and the following day shift, and by the time they were involved there was no cause for concern for this child who'd had such a devastating collapse.

On the day shift of the 10th, Dr Gibbs examined [Baby M] and although at the time he queried NEC and sepsis, he said that they could be excluded by the subsequent investigations, and by that day shift the only problem [Baby M] had was slowing in his rate of breathing, which required a dose of caffeine.

What you did hear, however, from Professor Stavros Stivaros was that [Baby M] had suffered a brain injury when he was sabotaged by Lucy Letby. Of course, Professor Stivaros didn't say when he was sabotaged by Lucy Letby, that's the bit I have added, but as a result of this incident [Baby M] suffered a brain injury.

It's perhaps no wonder if he'd suffered a brain injury that he wasn't in absolute tip-top condition over the next 24 hours; he'd had a very, very close brush with death.

In the days that followed, he no longer needed any stimulation for his breathing. Well, we had expert evidence from both Drs Evans and Bohin. They both told you that before his collapse at 16.00 hours, [Baby M] was breathing unassisted in air. He'd been taken off enteral feeds because of the bile-stained aspirate I told you about. The blood test and the observation chart provide no evidence to suggest that he had any form of infection. His collapse was as precipitous and dramatic as those of many of the other children, as was his recovery, and at the risk of boring you, I remind you that that is a fairly typical picture in these cases.

As Dr Evans said, the small bile-stained aspirate at 14.30 was not a marker of impending collapse. Dr Bohin added that babies of this gestation being taken off feeds is a very common occurrence and subsequent investigations revealed there was no gastrointestinal issue. Dr Bohin also said that the recovery was as perplexing as the collapse. The recovery tells you that it wasn't an infection-related collapse. It was suggested that the lack of blood gases in the hours before [Baby M]'s collapse meant that he might have had an infection, so this was a child presenting no signs of concern at all, therefore they were not taking blood out of his heel, and therefore it was being suggested, on behalf of Lucy Letby, that means you can't exclude infection.

Well, Dr Evans said that's simply not true, he was self-ventilating in air and there were no significant concerns, no reason to do a blood gas, and we know the subsequent tests exclude infection. Both Dr Evans and Dr Bohin told us that in their view this was a case of air embolus. Both explained how it could be that you wouldn't necessarily need to be literally at the side of the child at the moment he or she collapses to have been responsible for injecting the air.

And this is part, we say, of the evolving means of attack by Lucy Letby. She'd started with [Baby A] literally standing over him and injecting him as he collapsed, and then things -- she modified her behaviour.

You will remember that on 23 February Dr Evans was asked where the air goes, as if being able to answer or not answer that question necessarily determines the issue of whether or not this was an air embolus, and you were treated to a very, very long answer.

This was an issue taken up by Professor Arthurs or taken up with Professor Arthurs, on 16 March. And the implication being made by the questions was that because there was no evidence of air in the X-rays then that couldn't be the cause -- an air embolus couldn't be the cause of the collapse.

Professor Arthurs disagreed with that. He referred to tiles 192 and 238 in the [Baby M] sequence and, unlike the images in the cases of [Baby A], [Baby D] and [Baby O], who you'll remember all showed those air bubbles in the prone child, overlying the spine in the great vessels, he made the point that because the images of [Baby M] were taken in life and because the blood is circulating so quickly, with an active circulation in a living child you would not expect to be able to see air on an X-ray.

In answer to a question asked by his Lordship, Professor Arthurs said this:

"Most of the illustrations we have of air embolus in newborn babies in the literature are of those babies who have died of a massive air embolus. If it happens that you have the X-rays sufficiently close to when the incident occurred, it's possible you could see that. The main take-home message I think from the X-ray is that if you don't see air, it doesn't mean there wasn't an air embolus. These are not things we come across very commonly in paediatric radiology."

So to wrap all that up, ladies and gentlemen, [Baby L] was attacked first. As with the case of [Baby F], the evidence relating to the lab-related blood testing procedure is clear. We suggest that that the audit trail for the blood sample is

incontrovertible. It was [Baby L]'s blood which was analysed. After all, who else on the NNU could it have been from? Who else could it have been who was having their blood tested for insulin and C-peptide?

I don't know, because I'm not a fortune teller, whether or not you will hear any submissions questioning the integrity of the process or the validity of the results. But if you do, a careful consideration of his Lordship's review of this chapter of the evidence, we suggest, will leave you well placed to assess the merits of any such submission.

We suggest there's another point to bear in mind.

The presentations of both [Baby L] and [Baby F], together with the blood gas readings from the ward, supports the allegations we're making that there's only one conclusion to be drawn from this chapter of evidence: there was, as I said at the very beginning of this case, a poisoner at work. During the evidence no challenge was raised to the accuracy of the lab's findings.

The second point to note is that, just like [Baby F], [Baby L] was deliberately targeted specifically. We know that from a combination of the lab's findings and the evidence of Professor Peter Hindmarsh that [Baby L] was specifically targeted because blood (sic) got into a bag which was hanging after it was hung and afterwards it got into at least two further bags.

You've heard from all the nursing staff that were on duty at the relevant time and each other nurse has denied that they did it. It's not been suggested either by Lucy Letby in evidence or to any of the witnesses when they were cross-examined that they could or might have poisoned [Baby L]. And therefore the denials of all the other potential culprits have gone uncontradicted. This is where we suggest that all the circumstances surrounding the poisoning of [Baby F] also have to be considered.

Putting [Baby F]'s and [Baby L]'s cases side by side, we respectfully suggest that [Baby F]'s poisoned with two bags because the giving set had to be changed with TPN and so insulin sticking to the plastic cannot be the explanation for his continuing hypoglycaemia. In [Baby L]'s case, at least two bags were poisoned. We can see from the table that I was referring you to earlier that once the 15% bag was connected, things began to improve. So it must follow, mustn't it, so far as the 12.5% bag was concerned, either it was contaminated or the giving set that had been used for the 10% bags wasn't changed, so the insulin continued to run, unsticking itself from the plastic? But whichever possibility is correct, both are consistent with Lucy Letby being responsible.

As I said to you at the beginning of the case, I think, Lucy Letby and Belinda Williamson were the only two members of staff who were present in the neonatal unit when both [Baby F] and [Baby L] were poisoned. Belinda Williamson wasn't the person who was taking the resus notes for [Baby M] home. At the risk of repeating myself yet again, you can dismiss the possibility, can't you, that two murderers were working in the same unit at the same time? So it follows, we suggest, that Lucy Letby has to be responsible for what happened to [Baby L] and [Baby F], particularly when you factor in all the other evidence linking her to these cases.

And Lucy Letby knows that as soon as you conclude that [Baby L] and [Baby F] were poisoned, you will conclude that she must have done it because of the way she dealt with the issue in her defence statement. In the case of [Baby F] she said:

"Because I know I didn't do this but am being blamed for it, I cannot accept that the material readings and measurements over the relevant period or the blood analysis are necessarily accurate."

In the case of [Baby L] she said:

"I do not understand why [Baby L]'s insulin results were at the level they were. Also I do not understand how the results can have been so abnormal and yet there was no immediate investigation into this, therefore I am unable to accept the accuracy of these tests."

Well, she has rowed back from that in evidence because she realises that to deny that [Baby F] and [Baby L] were poisoned will make her look silly, but accepting it also causes her a problem, doesn't it? And you will want to listen very carefully, we suggest, to how the defence seek to pilot Lucy Letby out of that particular creek.

By now, ladies and gentlemen, you'll have worked out, I'm sure, if you hadn't before, why we started with these four cases. Because if you conclude that Lucy Letby murdered [Baby E], tried to murder [Baby F] and tried to murder the twins [Baby L] and [Baby M], then it puts all the other cases into a very clear context, doesn't it?

[Redactad]

MR JUSTICE GOSS: Right, members of the jury, that's it for today. 10.30 tomorrow morning, please. Remember we'll finish earlier tomorrow afternoon. Thank you.

We're going to have an hour and 5 minutes for lunch, that's the sort of compromised situation we reached after you went out at lunchtime today, so we'll try and keep progress.

(In the absence of the jury)

MR JUSTICE GOSS: Will anyone be wanting --

MR MYERS: Yes, we'd like to, my Lord.

MR JUSTICE GOSS: I just think it's worth checking.

MR MYERS: Yes, we're grateful, thank you.

MR JUSTICE GOSS: We can have the situation that you will always want to unless you indicate otherwise.

MR MYERS: It's helpful to check because the situation changes.

MR JUSTICE GOSS: Exactly. I think I'll do it each day if I remember and, if I don't, please remind me.

MR MYERS: I will.

(4.10 pm)

(The court adjourned until 10.30 am on Tuesday, 20 June 2023)