Prosecution Closing Speech Day 2

Tuesday, 20 June 2023
(10.30 am)

(In the presence of the jury)

Closing Speech by MR JOHNSON (continued)

MR JUSTICE GOSS: Mr Johnson.

MR JOHNSON: Welcome back, ladies and gentlemen. I'm going to move on to [Babies O, P & R]. When I've said what I have to say about them, I'll then go back to the beginning to [Baby A] and deal with the babies that we haven't dealt with so far. So that's the mid-term forecast.

The reason I want to deal with [Babies O, P & R], and in particular with [Baby O], at this stage is because of the uncontroverted evidence of Dr Marnerides, the pathologist. I will come to the reasons why we say that Lucy Letby accepts his evidence in a few moments, but if, like her, as we suggest she has, you accept what Dr Marnerides said about [Baby O], then you can be sure that he was murdered.

The only question then would be: who was the murderer? Somebody inflicted a really serious injury to [Baby O]'s liver, didn't they? The likes of which Dr Marnerides said you only see in road traffic accidents, bicycle accidents or trampoline accidents.

That was really a graphic way of him describing for all our benefits the sort of impact that is required to inflict that sort of injury. You've got the pictures if you really need to look at them, but I'm sure you all remember them without having to look at them: the full-thickness bleeding right through the substance of [Baby O]'s liver.

That injury, together with the lacerations -- do you remember Dr Marnerides talking about lacerations in the surface and he showed us on the photographs? That full-thickness bleeding together with the lacerations in the surface of the liver. They are the best evidence you could ever have, really, we suggest, of someone having inflicted a forceful, violent injury on a very, very small child.

I want to start with Lucy Letby's letter or note to [family of Babies O, P & R]. This is your exhibit 11 if we can put it on the screen. This is classic reading between the lines, isn't it, ladies and gentlemen? What we suggest -- if you want, you can look at this yourselves in due course, but we suggest that it's obvious that this started off, this blank Post-it note started

off as a blank Post-it note, but then with a note that Lucy Letby wrote to those three boys. Then she filled in the gaps with all sorts of other things.

But the note reads as follows:

"[Babies O, P & R]. Today is your birthday but you aren't here and I'm so sorry for that. I'm sorry that you couldn't have the chance at life you should have and for that pain that your parents must experience every day. We tried our best and it wasn't enough. I don't know if many people will think of you today or any day, but I do, and I hope [and perhaps it says 'I will'] always remember because you should be. I can't do this any more. I want someone to help me, but they can't, so what's the point in asking? Hate my life."

So that's what started off, we suggest, on this piece of paper, because adding that note into jumbled writing that was already on the paper, we suggest, isn't a sensible suggestion.

That was written on their birthday. Obviously, it wasn't written while she was in Ibiza, so it has to have been written -- and from the context, therefore it has to have been written mid-June 2017 or mid-June 2018.

But interestingly, it came from her handbag, so it's something that she'd kept. Lucy Letby had been in Ibiza and got back shortly after the birth of [Babies O, P & R] boys, and the text messaging shows us that she was very excited at the prospect of seeing them. Unfortunately for them, her objective was going to be to kill at least two of them, and on Wednesday, 22 June, which is tile 24 in the [Baby O] sequence, she said she'd be "back in with a bang". And within 72 hours of that text, two of [Babies O, P & R] were dead, and she'd tried, we say, to kill [Baby Q].

Dr Gibbs, you will remember, when he gave evidence about [Babies O, P & R], was challenged on what he did about his concerns about Lucy Letby. It was suggested to Dr Gibbs that if his concerns had been genuine concerns he would have reported them to the police. But he said more than once, you will remember, that he never actually saw Lucy Letby do anything untoward and if he had done, he would have gone to the police.

Can you imagine, ladies and gentlemen, going to report your suspicions to the police in these circumstances? The first question would be: well, what have you seen actually happen? He's an intelligent man, he knows that question would be asked, and he's not prepared to make stuff up, is he? It tells you quite a lot about Dr Gibbs.

He also said, did Dr Gibbs, that he was genuinely concerned and that the appropriate way of escalating those concerns within the hospital was followed. And in answer to a direct question in cross-examination when he was challenged about this, Dr Gibbs said this:

"The death of the two of [Babies O, P & R] was the tipping point for realising that something very abnormal and wrong was happening on our neonatal unit."

And he was pressed again on the fact that he hadn't reported things to the police. Do you remember what his reply was to that? This in some way explains our approach to this address to you. His reply to that was:

"Well, at that stage I didn't know that two children had been poisoned with insulin."

It's really important, that, ladies and gentlemen.

But he was pressed further in cross-examination and he said this:

"At the time of events that I have never seen in my career before, that were unusual and unexpected. As I keep saying, it was those events that worried us most. That's what raised the concern. Then in medicine it's not an exact science, you can't always explain everything, which is highly unsatisfactory, so yes, just occasionally a patient dies and, despite extensive investigations and even a post-mortem, you can't be sure what's happened, but this was happening again and again on our unit over that year and that cannot be just coincidence or just bad luck. There must be a cause. And that's when we began to realise who was involved with these babies, looking at each nurse, each doctor, and then there was one common cause that was identified."

Ladies and gentlemen, the great advantage you have is you know that two children were poisoned with insulin. You know who was involved in hanging the bags.

You know that that same person falsified the records in many of these cases. These are all things that were not apparent at the time.

[Mother of Babies O, P & R]'s evidence was the first that you heard relating to her sons. As I said, they were born on midsummer's day, 21 June 2016, so 7 years ago tomorrow. All were good weights, they were 33 weeks and 3 days' gestation, they went into nursery 1 and all went well at the birth and the following day, the 22nd, all went well that day as well.

What [Mother of Babies O, P & R] told you in her agreed statement was confirmed by other witnesses, including [Dr D] and Kate Bissell. But things deteriorated for [Baby O] on 23 June, which was the first day back from Lucy Letby's holiday in Ibiza. And that, ladies and gentlemen, is no innocent coincidence, is it?

Overnight on the 21st to 22 June, Amy Davies, in agreed evidence, told you there were no concerns for [Baby O] or [Baby P]. On the day shift of the 22nd, Samantha O'Brien, again in an agreed statement, said that [Baby O] was fine. Yvonne Farmer looked after [Baby P] in nursery 2, and during the day [Baby O] was moved into nursery 2 with his brother.

Overnight on the 22nd to 23 June, just to remind you, when we asked Lucy Letby about her alleged shortcomings in the case of [Baby O]'s case, she suggested that there had been an issue with the adequacy of dealing with the concerns raised by Sophie Ellis overnight. So that was the allegation by or the suggestion by Lucy Letby.

Well, what's the evidence of that? The shift leader, Caroline Oakley, told us that [Baby O] had done well during the day shift and was clinically well overnight. Both he and [Baby P] went from CPAP down to Optiflow. You'll remember that Chris Booth put it very nicely. He said he thought that [Baby O] would "sail through", do you remember him saying that, "with no problems".

Sophie Ellis looked after [Baby P] and [Baby O] and she's now a very experienced nurse and was looking back at events with the benefit of her experienced eye. She told us that overnight [Baby O] was:

"Very stable and there was nothing concerning."

"Very stable and nothing concerning." Put that against the alleged inadequacy of dealing with the concerns raised by Sophie Ellis.

Lucy Letby is trying to persuade you, she's doing to you what she was doing on the ward, ladies and gentlemen, trying to persuade you that a problem existed where none existed.

You will find, I'm not asking you to look at them, his observations at J23658. They are all very good.

He'd had his ECG leads removed because he didn't need them and his antibiotics had been stopped. And the fact that [Baby O] had had no infection is demonstrated by the results that were pending at that stage. If you want confirmation of that, all you

need do is look at tile 175 in the [Baby O] sequence. You remember, as always, they take 5 days to come back. After he died, it was confirmed that there was no problem. There you see it:

"No bacterial growth after 5 days' intubation."

Sophie Ellis told us that she was getting back under half of the feed as a partially digested aspirate, which, according to her, showed he was tolerating the feed. That's tile 52, J23958. His blood gases were good.

Sophie Ellis said that the increase in the donor-expressed breast milk was standard and there were no signs that [Baby O] was not tolerating it. And at the end of the shift, she had [Baby O] reviewed by Dr Mayberry because he had quite a full abdomen.

Dr Mayberry remembered [Baby O]. Do you remember him being challenged about that in cross-examination? How could you possibly -- the gist of the cross-examination was: given that you didn't make a note, how could you possibly remember this child? And you will remember his answer, won't you, ladies and gentlemen, that came out in re-examination? He'd never come across naturally conceived triplets before. It's not quite in the category of a medical marvel perhaps, but something highly unusual that you would remember, and he did remember.

Dr Mayberry told us that [Baby O] was very well, those were his words, and that his abdomen was:

"Mildly distended with no other concerning features. His observations were within normal limits."

So what are these concerns? You remember the very short list, won't you, of the alleged shortcomings that was actually given by Lucy Letby when she was put on the spot in each case? This one isn't actually an issue at all. Maybe that's why she was so reticent in actually giving you anything to suggest that there was a motive for any of the Gang of Four to be conspiring to cover up their shortcomings.

You will remember, I'm sure, that Dr Mayberry didn't actually make a note himself about this examination because he was emergency beeped for another child and asked Sophie Ellis to note the fact that [Baby O]'s abdomen was soft. And you will remember that when I was asking her questions, Lucy Letby pointed out the fact that Dr Mayberry had not made a note himself, and she took the opportunity to remind me that when there had been no doctor's note corresponding to a nursing note for which she had been responsible, I had suggested that she,

Lucy Letby, had made up the nursing note. You'll remember Dr Beebe with [Baby I] on 30 September.

Well, ladies and gentlemen, so that there's no doubt about this, we absolutely stick to the suggestion we made to Lucy Letby.

There are two occasions in particular where we say she invented things relating to doctors. The first was the supposed contact with the SHO or Dr Wood in [Baby E]'s case and the second, as I've just said, the imaginary examination by Dr Beebe of [Baby I] on 30 September.

In Lucy Letby's notes for those two occasions you will find no doctor's name in her notes. But if you look at Sophie Ellis' note at tile 105, what do you think we're going to see? We'll look at it. There is a mention somewhere in the nursing notes of Dr Mayberry.

The second box down:

"Reg Mayberry informed."

And that's the difference, isn't it, ladies and gentlemen? It's a very important difference:

"Reg Mayberry reviewed: abdo soft, does not appear in any discomfort on examination. Has had bowels opened. To continue to feed but to monitor."

That is the difference between Lucy Letby's notes, "Doctors examined", "SHO", whatever it is, non-specific.

Here, when there's a genuine note, it's attributed to a genuine doctor.

Dr Mayberry said that had he found anything concerning, first of all, he would have acted on it and, secondly, he would have returned later to have made a note. When he was asked about blood in [Baby O]'s peritoneum, this is the blood found later in the abdominal cavity at the post-mortem, he told us that if that had existed when he examined [Baby O] at the end of the night shift, it would not have been consistent with [Baby O]'s presentation. In other words, he gave him a physical examination and the way [Baby O] reacted to the examination was not consistent with him having the bleed at that stage.

And by that means we say that you can safely exclude as a reasonable possibility that [Baby O] had the subcapsular haematoma in his liver at that stage.

Dr Mayberry said [Baby O] would clearly have been in discomfort and that was a very rare finding in a child of this age. And you can see Sophie Ellis' note is consistent with that being the position: no real problem with [Baby O].

The following day, when Sophie Ellis arrived for her shift, do you remember who met her in the corridor to tell her the news about [Baby O] having died?

The day shift of 23 June. This was student Rebecca Morgan's first shift. She was attached to Lucy Letby and Student Nurse Morgan fed [Baby O] at 08.30; that's tile 94. She got a trace aspirate. The shift leader for the shift was Melanie Taylor. She said there were no concerns as to [Baby O]'s stability at the start of the shift and she also confirmed that the staff were generally twitchy about getting babies' tummies reviewed. That's important, isn't it? If there's a problem with the tummies, they would get the doctors to review.

She also told us that shift handover sheets go in the confidential waste. She did not expect [Baby O] to collapse.

On the morning ward round Dr Katarzyna Cooke, at 09.30, examined [Baby O] and [Baby P] having taken the handover from Dr Mayberry. She said that if any concerns had been raised by Dr Mayberry, she would have noted them at the time before doing the ward round. She did make a note and Lucy Letby, or the designated nurse, as Dr Cooke described her, told Dr Cooke there were no concerns. So much for failing to deal with concerns raised by Sophie Ellis. Direct evidence from Dr Cooke: Lucy Letby told her there were no concerns.

Part of Dr Cooke's notes were:

"Trace of aspirates, none bilious."

That's what she wrote in the medical notes.

Dr Cooke upped [Baby O]'s feeds in accordance with the protocol, which is what Dr Brearey confirmed for you, and Dr Cooke said that this was a normal examination, which included [Baby O]'s abdomen. There was absolutely nothing abnormal and she had no concerns. She described his clinical course as "uncomplicated" and said he was making good progress. She excluded the possibility of there having been liver haematomas at that time.

If one had been present, she said, and had been an acute concern, [Baby O]'s observations would have suggested a deterioration and she would have had concerns expressed from the nursing team. In other words, from Lucy Letby.

But when I was questioning her, I asked Lucy Letby about this examination and the questions and answers went as follows:

"Question: Do you accept that at 09.30 Dr Cooke examined [Baby O] and actually felt the liver area and excluded there being an injury at that point?

"Answer: Yes.

"Question: So does it therefore follow that the liver injury [Baby O] did sustain happened in effect on your watch?

"Answer: Yes.

"Question: Yes. Do you accept, therefore, that somebody must have inflicted that liver injury on [Baby O] during the day shift?

"Answer: I agree that it's happened during that shift. I don't know how it's happened.

"Question: Well, we heard expert evidence from Dr Marnerides about how these things happen, haven't we?

"Answer: Yes.

"Question: Your case is you don't know how it's happened and I assume you will say that you deny that it happened at your hand?

"Answer: That's right.

"Question: Do you accept the evidence of Dr Marnerides?

"Answer: Yes."

So ladies and gentlemen, that is why we suggest you can be sure that [Baby O] sustained his liver injury while Lucy Letby was looking after him.

It's notable, we say, that that morning she was clearly missing [Dr A]. She'd been in a text conversation with him until just before midnight the previous day and if we go to tile 123, we can see that she was upset that he was in a clinic.

At tile 127 she was asking whether he would be on the neonatal unit this afternoon.

At tile 137 she said:

"Bit rubbish that you couldn't stay on the NNU."

And he replied that he was in clinic.

At tile 158 at 10.36, he told her that he'd be finished in an hour, and [Dr A] appeared on the NNU to see [Baby Q], ironically, at 12.10 hours.

You will see that in the neonatal review at lines 35 and 36.

We can see, going back, that at tile 165 he saw [Baby O] and when Lucy Letby fed [Baby O] at 12.30, at tile 167, so this is 12.30, Lucy Letby recorded no problems. He was given 13ml of donor-expressed breast milk or at least that's what she recorded. You'll understand why I say that.

We say that it's obvious from what followed that Lucy Letby deliberately overfed [Baby O], and when you put this event into the context of what had gone before in the chronology with other children, like [Baby G], we suggest you can be sure that is what she did.

There was an issue at 13.15. Tile 168, please.

[Dr A] arrived to deal with a problem with [Baby O], this child who had been fed supposedly only 13ml of milk, just 45 minutes earlier. By this stage he had vomited and his abdomen was distended. We say frankly, ladies and gentlemen, Lucy Letby was fulfilling two objectives here: first, she was sabotaging [Baby O], but second, she was also attracting the attention of [Dr A].

At tile 169 Lucy Letby recorded in the nursing note that [Baby O] was tachycardic, and that was an exaggeration. She also recorded in the note that he had vomited undigested milk. But he'd not been fed, according to the records, since 12.30, and previous to that there had been no real problems, had there?

In this context, ladies and gentlemen, it's interesting to remember what Samantha O'Brien said in her agreed statement. She said that although Lucy Letby had been asked -- had asked for [Dr A] to review [Baby O], she said this:

"Other than his stomach appearing slightly distended, there was nothing else visibly apparent to me."

And yet Lucy Letby was telling [Nurse E] -- if we go to the text message at 334, please. This is a message sent much later in the day at 21.15, that [Baby O] had:

"... blew up abdomen."

You'll remember the similar message she sent to Sophie Ellis in [Baby P]'s case the following evening, which is tile 654 of the [Baby P] sequence of events.

At this 13.15 event -- that's the Sophie Ellis one.

Ironically, drawing the parallel, Lucy Letby there, between what happened to [Baby O] and what happened to [Baby P], and we agree on that at least.

[Dr A], just going back to the 13.15 examination, examined [Baby O] because he was asked to by Lucy Letby.

He told you he'd been in nursery 3 and was told that [Baby O] had vomited, which he said was unusual. Perhaps unusual generally, but as you know from the cases of [Baby C], [Baby E], vomited blood, [Baby F], [Baby G], [Baby I] and [Baby L], perhaps not so uncommon in the context of this case.

[Dr A] said that he was not told when it was that [Baby O] had vomited and his medical notes that we were looking at before at tile 168, at the same time, record that his heart rate was elevated. It's 160 to 170. His sats in air were "perfect" and his temperature was perfect at 36.8.

If you go, ladies and gentlemen, to J23658, which you'll find in jury bundle 2 behind divider 20, or it's on the screen now, you'll see, oddly perhaps, that Lucy Letby didn't even bother plotting the normal temperature on [Baby O]'s vital signs chart. Why do you think that is? A normal temperature. Why wouldn't you plot that? The answer: because you're trying to create the impression that here we have a child who has a problem. So anything that's normal doesn't fit the narrative, does it, ladies and gentlemen?

More to the point, when do you think -- sorry, where do you think that she got the information from when Lucy Letby made her nursing note at the end of the shift, long after [Baby O] had died? She enters into the nursing note details about what was going on at this time, so where has that information come from if she's not recorded it on the chart?

What was Lucy Letby actually doing between the 12.30 feed and the 13.15 vomit? If you look in the neonatal review, you'll find no record of her having done anything.

Now, Lucy Letby made another false record on another document at about this time. She timed it at 13.20, so that would be 5 minutes after [Dr A]'s examination, and you'll find it in the blood gas chart. It's tile 170 or J23667. I'm sure you'll all

remember this one. Even by the standards of her misrecording information, this one is right up there.

There she records that [Baby O] was moved from Optiflow on to CPAP. That is a lie. Completely untrue.

It's the one that was spotted by Dr Bohin, do you remember? But as an explanation for why a child is full of air or a child's stomach and guts are full of air, it's a very good explanation, isn't it, and it's one that's been advanced to you on many occasions or advanced to the witnesses on many occasions during cross-examination? If anyone ever reviewed this paperwork, they'd look at that and they'd think: well, perhaps that is an innocent explanation for why this particular child, who died, had been pumped up with air.

You will recall that we asked her about this when she was in the witness box and Lucy Letby began by saying that she didn't know why she'd written it and then she said this:

"He wasn't on the full CPAP machine. I can't say whether he was having CPAP via the Neopuff, I don't know."

That was her answer. Well, what did [Dr A] find?

He found that [Baby O]'s abdomen was distended because Lucy Letby pumped him full of air. That's why she tells the lie in the document. The area around his umbilicus was normal, the liver, the kidneys and the spleen felt normal, and [Baby O]'s bowel sounds were normal.

The blood gas suggested he was more acidotic than [Dr A] was expecting to find, but he could divine no cause. He prescribed second line antibiotics -- his full note is at T169 -- and included the prescription of a saline bolus of 10ml per kilo. Because [Baby O] weighed 2 kilos that makes 20ml of saline. And Lucy Letby recorded the giving of that in the nursing notes at tile 196 and it was signed for by Melanie Taylor and Samantha O'Brien within a couple of minutes, and within a couple of minutes [Baby O] collapsed.

Before [Baby O] collapsed, Melanie Taylor had looked at him and thought that he didn't look as well as he had, and you remember this bit of evidence, don't you, ladies and gentlemen? What she didn't know, what you know from all the circumstances, is that [Baby O] by this stage had an internal bleed. We know that Melanie Taylor was in nursery 2 because that information appears at line 57 of the neonatal review. And Melanie Taylor was the shift leader and she said to Lucy Letby:

"I don't think he looks as well as he did before."

And Melanie Taylor queried whether [Baby O] should be moved into nursery 1. Do you remember what Lucy Letby said, don't you? She said no. She wanted to keep him with his brother. Lucy Letby was so insistent that Melanie Taylor felt quite put out, as if, according to Melanie Taylor, Lucy Letby was undermining her.

Well, Melanie Taylor deferred to Lucy Letby because Lucy Letby had been looking after [Baby O] all day. But you will know, and you can take into account, that if [Baby O] had been moved to nursery 1 there were senior nurses in there and Lucy Letby's other two babies were in nursery 2 and there would therefore have been a real risk, wouldn't there, that if [Baby O] had been moved Lucy Letby wouldn't have got the opportunity to carry through her plans for [Baby O]? So that's the reason why she was against Melanie Taylor's suggestion that [Baby O] should be moved to nursery 1.

In the time between the desaturation of [Baby O] at 13.15 and the beginning of his terminal collapse, we know that [Dr A] had left the neonatal unit because he and Lucy Letby were exchanging Facebook messages, first at 2.08, tile 178, and tiles 183 to 185, 14.20 to 14.29, and finally at tile 190, which is 14.37.

Three minutes later, at tile 199, [Dr A]'s note records that [Baby O] desaturated, he was mottled, he was transferred to nursery 1, Lucy Letby and Samantha O'Brien then set up an infusion, which is tile 200. Just go to 200, please. This was a time when Lucy Letby recorded that [Baby O] was not only "mottled ++" but also had a "red and distended abdomen". And there appear to have been no doctors around, therefore when [Baby O] collapsed -- sorry, there appear therefore to be no doctors around when [Baby O] collapsed at 14.40, so Lucy Letby therefore had her opportunity to sabotage him. So that's the point about the absence as denoted by or as revealed by the text messages of [Dr A] from the unit at that stage.

Melanie Taylor arrived soon after [Baby O]'s collapse at 14.40. She then moved [Baby O] with [Dr A].

[Dr A] told us that when he'd arrived, the student and Lucy Letby were there. [Baby O] had a low heart rate, he'd desaturated, he was mottled, he needed continued breathing support in 100% oxygen as he was being transferred with sats of only 50 to 60%. And [Dr A] said that this was a prelude to a full cardiac arrest if it had been left untreated. That's what he described as a peri-arrest event.

[Dr A] drugged and successfully intubated [Baby O] and he recorded that as having happened between 15.03 and 15.08. He then left the unit to speak to [Baby O]'s parents on the post-

natal ward. This is a recurring pattern, isn't it, ladies and gentlemen? Doctor leaves, and you know what will happen.

The X-ray that was taken just before the intubation, if we can go to tile 197, please. Professor Arthurs told us about this. He said it showed a level of gas in the bowel:

"... which was more than would be expected in a normal baby."

And as an explanation for how that could have got there, Professor Arthurs said either it was NEC -- well, we know from the evidence of Dr Marnerides that it was not NEC -- or someone had injected air down the nasogastric tube.

Looking at the time of that, ladies and gentlemen, it's just before the intubation, I think. You'll take into account that at 13.15, so before this, [Baby O] had vomited, so that would have decompressed quite significantly, wouldn't it, the stomach? So this is even after a vomit.

Dr Brearey had been in a meeting in the unit that morning. He spoke to [Dr A], who'd just moved [Baby O] from room 2 to room 1. Dr Brearey confirmed that there was good IV access because dopamine, one of the inotropes, was given at a later stage, and he offered to help [Dr A] intubate [Baby O].

The mild metabolic acidosis, as it was described, indicated a non-respiratory problem, so this wasn't a breathing problem, apparently. One cause or one potential cause that Dr Brearey gave for a mild metabolic acidosis was blood loss. So in other words, the blood gas at this stage, at this stage of the intubation, is consistent with blood loss, and given what you know, that they didn't know, you can put those pieces of information together and we suggest this all tells you, doesn't it, that that injury to [Baby O]'s liver had been inflicted by about this stage?

This was long before any chest compressions, and [Baby O] was then successfully intubated. During the intubation, Dr Brearey noticed an unusual small rash on [Baby O]'s chest. He said he looked like something normally associated with meningitis, a purpuric rash, which is "very, very rare in a neonate". And it perplexed him because it was associated with good perfusion, he was pink. Dr Brearey thought therefore perhaps it was sepsis that was causing the problem, and you'll remember that text I showed you earlier that Lucy Letby sent later in the evening.

But we can exclude sepsis, ladies and gentlemen, from the blood test results at tile 175. So that wasn't the problem. They didn't know all this at the time, but you know that wasn't the problem.

We heard about a meeting between [Dr B] and [Dr A] on the stairway. Do you remember that? This is when [Dr A] had left to go and speak to the parents. They were together, were [Dr B] and [Dr A], on the stairs at 15.49 when the bleep went off; that's tile 214. So this must have been after [Dr A] had spoken to [Baby O]'s parents, following the intubation.

Tile 217 shows that [Dr A] entered the NNU, we say with -- [Dr B] and [Dr A] together entered the NNU at 15.53. What they saw, according to [Dr B], was:

"[Baby O] being bagged by the nurse."

His sats were very low, he looked very unwell, [Dr B] couldn't remember who the nurse was but said that she would have taken the history from the nurse.

[Dr B] was shocked by what she saw. [Baby O]'s collapse was "completely unexpected". The day before, he'd been fine. You will find that in notes at 218.

Both [Dr B] and [Dr A] confirmed that there was good air entry on auscultation. Do you remember that medical word for listening, literally listening to the chest? But [Baby O]'s sats were not improving, and this is a thing we see time and time again, isn't it, with these children? Air going in and coming out, but the sats not improving. [Baby O] was re-intubated but his heart rate continued to be low. He was desaturating, he was given a second cannulation by [Dr B] via a vein in his leg, which you'll find at tile 217, and [Dr B] -- do you remember her explaining to us why that was? So they had two points of access just in case one of them failed. And you'll bear this in mind in the light of the false Datix, which we'll come to.

While that was unfolding, Dr Brearey was recalled at 16.30 to help [Dr B] and [Dr A]. [Baby O] had been resuscitated. He'd received by that stage two boluses of adrenaline and CPR, and by the time Dr Brearey appeared [Baby O]'s heart rate was back up to 140 and his saturations were in the 90s and spontaneous circulation had been re-established. Another miraculous recovery, ladies and gentlemen, a fingerprint of some of these attacks. But the ventilatory support had to be increased and [Baby O]'s perfusion was not as good as it had been earlier.

The rash that Dr Brearey had seen earlier had disappeared, something he, Dr Brearey, had never seen before or since, and which he described in his understated way as "perplexing". Well, you know what the reason is, don't you, given everything you know, everything you've heard about all these children?

[Dr B] said that this series of collapses was something she had never seen before. An experienced consultant:

"I've never seen this sort of thing before. It seemed like whatever we gave him was having no effect."

[Mother of Babies O, P & R] described her son arresting and one of the significant elements of her harrowing account was the way [Baby O] was "changing colour" with "discolouration and prominent veins", which she said she saw the next day on [Baby P].

[Baby O]'s dad, [Father of Babies O, P & R], gave that video-recorded interview, part of which you saw. And we suggest it was very important evidence in this case, not only in [Baby O]'s case but in the case in general. What he said was this:

"[He] could see all his veins, bright, bright blue, going different colours. It looked like he had prickly heat. You could see something oozing through his veins."

Oozing. That's movement, isn't it, ladies and gentlemen? It's agreed evidence: different colours and movement.

As with many other cases, [parents of Babies O, P & R] had just visited their son at the time of the fatal collapse. They were called back as a matter of urgency.

You'll remember what I reminded you of about [Babies L & M] yesterday, what we will see again with the [parents of Baby H] and [Baby H], and what was to happen with them the very next day with [Baby P].

These are the circumstances, ladies and gentlemen.

This isn't second-class evidence, is it? It's really compelling evidence of what was going on.

[Father of Babies O, P & R] described [Baby O]'s stomach as being "like ET's". Some of the younger ones amongst you may have to ask the older ones exactly what that is. Most, if not all of you, know exactly what that means.

[Baby O] deteriorated and he was baptised. He required further CPR. He was one of the babies who had good gas going in and out but failed to recover. Part of the resuscitation involved Dr Brearey seeking to decompress the abdomen by using a cannula at McBurney's point. You'll remember how he described that by reference to the iliac crest and I won't try and replicate his very clear description.

It was obvious where the cross-examination was going, wasn't it? Because it was being suggested that that in some way had caused the liver injury. Do you remember? But you will remember also, I am sure, first of all, the fact that Dr Brearey rejected that as a possibility. Well, the defence might say, well, he would say that, wouldn't he? If he caused the injury, he would deny it. But it's not just Dr Brearey, it's Dr Marnerides and his very compelling evidence that a perforation from a needle would not, could not, cause the liver injuries that were photographed at the post-mortem.

There was no response to a resus that lasted for more than half an hour. The blood gas proved that there was not a respiratory cause, it was not a breathing issue that caused the collapse. The haemoglobin was down, but not so low that it would have been expected to have caused the collapse that was witnessed. And so far as Dr Marnerides -- I may be getting confused between my doctors here.

Anyway, [Baby O] died at 17.47. At 20.09 that same evening, an X-ray was taken of [Baby P], and it's tile 173 of the sequence. Dr Arthurs took us to that image on Friday, 17 March, and he said this -- you'll remember this is 2 hours or 2 hours and 20 minutes or so after [Baby O]'s death, so this is [Baby P]. Professor Arthurs said this:

"The stomach is dilated. These [and he pointed out for you the small bowel] are loops of small bowel and then this [and again he pointed out] is the large bowel, so going all the way down. So this is gas throughout the gut. Very similar to the appearances of [Baby O]. This degree of gas is quite unusual in a baby like this. It doesn't show obstruction, it doesn't show necrotising enterocolitis, and there is a nasogastric tube in situ."

And I asked him:

"What are the potential causes?"

And he said this:

"I think they're the same causes that we described in [Baby O]. So infection, necrotising enterocolitis, those sorts of things can cause this."

Well, you know he didn't have that:

"There are obstructions to the bowel that you can be born with."

We know that -- and this is him talking still:

"We know neither [Baby O] nor [Baby P] suffered from those. So you are left with other causes such as administering air via a nasogastric tube."

It wasn't CPAP, was it? But that's the explanation for why CPAP was written on the chart in that false entry.

The deaths of [Baby P] and [Baby O] caused real concern for Dr Brearey. He said of the triplets that:

"All were born in such good condition and had been following a path, a healthy path, to growing and hopefully going home."

He described these events as "exceptionally unusual". The rash he saw was something he had not seen before and he has not seen since. All natural causes were excluded so far as Dr Brearey was concerned, even with the benefit of all the years that have intervened.

[Dr A] said this:

"This was incredibly unusual and it was unexpected. The ward round that took place at 9.30 in the morning recorded a well baby and, as the afternoon progressed, [Baby O]'s clinical condition deteriorated in a way that's indicative of sepsis."

But we know it wasn't sepsis. And that is why Lucy Letby was saying what she was saying to her mate [Nurse E] later that evening. And it started with a lie at tile 339. I'll just check my reference, I'm sorry. Sorry, at 339, [Nurse E] says:

"Assume they all seem stable if had all 3."

Then Lucy Letby responded:

"Yeah, we're all fine. This one still on Optiflow..."

True.

"... but weaning and all fully fed."

Then at 342:

"Had big tummy overnight."

There's the lie. For this read, "I inherited a problem":

"Just ballooned after lunch and went from there."

Well, [Baby O] went from there, ladies and gentlemen, because Lucy Letby took him there, took him to his death.

21.33, tile 403, please. She was sowing the seeds.

Do you remember me saying gaslighting yesterday? Here she is sowing the seeds for what she has planned for [Baby P] and you will bear in mind that this text at 21.33 comes about an hour and a half after that X-ray I just showed you of [Baby P], the one described by Professor Arthurs as showing, if you exclude all the other eventualities, which can be excluded, air down the NGT.

There's another interesting text later that evening, ladies and gentlemen, which tells you what Lucy Letby means, and this will become relevant, when she writes a plus after something. I'm sure you've got the point, but this is "air +++" or whatever in the context of [Baby G]. We're going to come to this, albeit the events relating to [Baby G] happen before this, but this is one of the reasons that I have taken things in this order.

From tile 411 onwards, so that's from 21.38 hours, Lucy Letby was having a conversation with [Dr A] in which they were thanking each other for the support that they'd given each other.

At 416 [Dr A] wrote:

"I'm glad you could talk to me and I hope I helped?"

And she responded:

"Didn't want you collapsing mid-resus!"

If we can carry on, please:

"Yes, you did ++."

So two pluses for [Dr A] for all his help. It gives you an idea, doesn't it, when we're looking at some of her other notes, this is somebody who we suggest, you'll decide, that she was very keen on, not just as a friend and two pluses was the best he was going to get.

Ironically, a week later, on 30 June, if we go to tile 498, please, Lucy Letby submitted a Datix form, which is what I was talking about earlier. This Datix form did not accurately reflect what really happened.

You can see the description there at the bottom:

"Infant had a sudden acute collapse requiring resuscitation. Peripheral access lost. Intraosseous access required."

Peripheral access was not lost. Do you remember [Dr B] had inserted a second -- when things started to turn for the worse for [Baby O], [Dr B] had put in a second line in the -- I think it was in the saphenous vein, if my memory serves me correctly, in [Baby O]'s leg.

Dr Brearey told you that this is a lie, this is untrue -- he didn't say it's a lie, he said it's not correct; we say it's a lie. You can find it's a lie if you think that's the right finding. But it's important, ladies and gentlemen, because here Lucy Letby is trying to create the impression through the use of the Datix form that the intravenous access was lost, and if there was no intravenous access what can't you do? You can't inject a child's circulation with air if there's no intravenous access, can you? So if people accept what she's written here, it would tend to support her case that this was not a case of air embolus.

Now, that's something that the experts just can't factor into their considerations. It's not a matter for expert evidence, is it? It's a matter for you as a jury to look at this, decide whether it's important, and decide where it takes you. This is where you have the advantage over everybody else. You are entitled to say: this is a lie, she knew it was a lie, why is she lying?

And if the only sensible conclusion is to cover up something she's done, what does it cover up? If it covers up air embolus, you are entitled to say, "We are sure this is air embolus".

Dr Evans identified three areas of concern. First, the vomiting at 13.15, then the subsequent distension of the gut and, finally, the death in association with the rash that he had seen identified in Dr Brearey's notes.

Do you remember, he was criticised, he was taken to task for changing his opinion over a period of writing several reports? That period, as it happened, coincided with him being fed more information about what had happened as the inquiry progressed.

Well, imagine the opposite, ladies and gentlemen.

Imagine an expert who, when he's given more information that is inconsistent with an opinion he's expressed, doesn't change his mind. That would be astonishing, wouldn't it? Yet here he's being criticised because he's given further information and he says, "Actually, that does change my mind".

His first report had been in 2017, but it wasn't until 2019 that he was told that the rash that had been noted by Dr Brearey at

15.03, the one in his notes at tile 206, had disappeared. And the questioning was extended. We then established that in the medical notes there's no mention of the rash disappearing and it was only in 2019 that Dr Evans had been told about Dr Brearey's witness statement where he'd said the rash disappeared.

Well, these are all matters for you to decide. Is the defence criticism of Dr Evans for changing his mind in the light of that information a justified criticism or not? If it's not you might ask yourself why is the criticism being made? Is it just to create the impression with you that Dr Evans doesn't know what he's talking about? We suggest that it would have been astonishing if Dr Evans hadn't changed his mind, particularly when you look at how [Father of Babies O, P & R] described events and how Lucy Letby herself described events.

I'm not asking you to look now, but at page 6 of the [Baby O] interviews she says she went into the nursery at 14.40, the monitor was alarming. At page 7, she says nobody else was there at the time, that [Baby O] was mottled all over with a red abdomen and a blotchy purple/red rash, with a red abdomen. I'm on page 7 of the [Baby O] interviews.

At page 8 she said that you quite often see mottling but not to that extent. So even Lucy Letby in her police interviews was suggesting there was something very strange about what was going on.

Dr Evans formed his view independently of either of those descriptions, but you may think, knowing what you now know, that both descriptions actually support what Dr Evans said. And as he, Dr Evans, himself said in cross-examination:

"I did not have all the information at the beginning and therefore inevitably one amends one's opinion as a result."

And that was evidence he gave you on 16 March.

We then had cross-examination about CPR, do you remember that, because the suggestion being made was that in some way CPR was responsible for [Baby O]'s liver injury. This question or suggestion was made on behalf of Lucy Letby:

"I'm going to suggest that you well know chest compressions are performed just in the area or just below the sternum, below the sternum, almost over the area where the liver is or very close to it. That's where they're performed, isn't it, Dr Evans?"

Answer:

"I know exactly where it's performed and I don't know any baby who was resuscitated by experienced people who either died and where the post-mortem showed liver trauma as we describe here and I know of no case where babies were resuscitated successfully where cardiac compression was required but where subsequent investigation noted the liver haematoma as described here."

Then this:

"What I just asked you, it was a simple question, I apologise for having to repeat it: chest compressions on a baby are performed in the area over, just below the sternum, around the sternum or over and very close to where the liver is. That's what I asked you. Are you going to answer that?"

Well, he had just answered it, hadn't he, but he gave us another one:

"No, it's over the top of the sternum. You're pointing in the wrong direction, it's over here [and he indicated] and the liver is down here."

And he indicated.

Well, a few days later, you saw the national guidance on CPR and the national guidance on CPR supported what Dr Evans said. Not only that, but you also heard later the evidence of Dr Marnerides, which I will come to in a moment.

On 5 April 2023, in the context of the post-indictment text messages, you heard evidence from [Dr A] that CPR was performed correctly on [Baby O] and on [Baby P]. Do you remember those text messages that were being exchanged between Lucy Letby and [Dr A] after the event? And so CPR is not the cause. There's no reasonable possibility, is there, that CPR caused [Baby O]'s liver injury?

Dr Bohin -- towards the end of her cross-examination, it was suggested to Dr Bohin:

"We have no discolouration from any of the clinicians who are present that we can identify as linking it with the Lee and Tanswell description, do we?"

It's not just doctors who have eyes, ladies and gentlemen, surprisingly. Sometimes parents who are watching their children dying in front of them are quite interested in what's going on. [Father of Babies O, P & R]'s recorded account, what better description? It's not second-class evidence, is it? Dr Bohin, of

course, spotted that lying entry in the gas chart. I've already dealt with that.

It was then suggested on behalf of Lucy Letby to Dr Bohin that:

"You've just tried to use any bit of discolouration you can come across to support you with this, Dr Bohin, where you think you can, don't you?"

Well, you'll be the judges of that, ladies and gentlemen. As Dr Bohin said, by the time she was giving evidence to you, she was taking into account what she had heard [Father of Babies O, P & R] say, how he gesticulated with his hands, do you remember, on that video:

"You could see all his veins, bright, bright blue, going different colours, looked like he had prickly heat. You could see something oozing through his veins."

What Dr Bohin hadn't heard, ironically, at that point, but what Lucy Letby knew was coming when this was all being put to Dr Bohin, was Lucy Letby's own description, that one at page 7:

"Mottled all over. Red abdomen, bluey/purply red rash."

And:

"You've just tried to use any bit of discolouration you come across."

That's the assertion being put on behalf of Lucy Letby, who herself gave that description.

Is there an attempt being made to pull the wool over your eyes, ladies and gentlemen, by Lucy Letby, just as she managed with all her colleagues in the neonatal unit?

Professor Arthurs -- I'm almost at the end of this section, my Lord, so I'll continue if I may.

Professor Arthurs said that -- well, what was being put in cross-examination, or part of the attack in cross-examination on Dr Bohin, was the finding of Professor Arthurs. It was said to Dr Bohin that Professor Arthurs "does not conclude that this was a case of air embolus", as if Professor Arthurs had given you an alternative conclusion or had ruled out air embolus.

Well, nothing could be further from the truth, we suggest, because what Professor Arthurs actually said was that you need to look at the history of the child in question. Do you remember the air in [Baby O]'s great vessels? You may have a mental image

of the spine of these children lying prone and the bubbles of air above it and the mental image you have in the case of [Baby A], [Baby D] and [Baby O] may be a very similar one and the reason is because the pictures, we suggest, are very similar, at least to the untrained eye.

What Professor Arthurs was saying is you need to look at the history of the child in question, and he said that the air in [Baby O]'s great vessels could have been there because of CPR, could be trauma, could be infection or because someone had injected air into the circulation. So Professor Arthurs wasn't excluding air embolus by any means.

But let's look at the alternatives. We know that [Baby O] did not have an infection, so that leaves CPR, trauma or air embolus.

Well, we know there was trauma because of the liver injury, don't we? So that doesn't really help Lucy Letby.

That therefore leaves CPR. Well, ask yourselves: why did [Baby O] need CPR? Who inflicted the trauma? And we suggest that the answer here has to be that either this is a direct consequence of another injury inflicted by Lucy Letby or it was an air embolus, and air embolus is obviously the answer, isn't it, because of the moving rash, the moving discolouration?

Professor Arthurs wasn't taking into account the evidence of the eyewitnesses or of Lucy Letby or of the fact that Lucy Letby made a false entry on the gas chart. He was just working from his images in his darkened room. He wasn't taking into account the fact that both [Baby A] and [Baby D] had similar imaging after their deaths, both cases in which there was also evidence of discolouration.

Professor Arthurs told us that he'd looked at all the children in this case independently and did not use the findings he'd reached in one case in interpreting the images in another case. In other words, he was deliberately not doing what you can do. You are entitled to look at everything, and so with that in mind we suggest that what he said bears a good deal of consideration. And he told you, didn't he, and I've reminded you of this before, so I won't do it any great length, he told you that radiographic evidence of air embolus is very rare and that the attention of the -- because the consequences of air embolus are so serious, the attention of the treating medics is directed to saving the child's life rather than standing back and taking photographs or keeping a note of what it is they can see on the skin of a child. That's an obvious reason, isn't it, for why [Father of Babies O, P & R], the dad, saw it but the medical professionals didn't?

And so in relation to [Baby O], we've finally come to Dr Marnerides. I just want to give you, if I may, a few bullet points from Dr Marnerides.

We suggest that his evidence is both compelling and uncontroverted. You will probably never forget the presentation he gave you or the findings from [Baby O]'s liver, and of those liver injuries he said this:

"(1) They were full thickness, right through the body of the liver. (2) They were an impact injury because there were lacerations on the outer surface of the liver and therefore someone exerted significant force on the 2-kilogram [Baby O]. (3) This was certainly not an injury from CPR."

And in this connection he said that it was the position of the injuries and the force required to have caused the injuries which meant that CPR was not a viable cause. He had never seen, had never heard of, had never read of this type of an injury being caused by CPR. And given the number of children who have to be resuscitated at hospitals up and down the country, we suggest that the idea that this is the only time this sort of injury has resulted from CPR is truly fanciful.

He also said, finally, that these were not injuries caused by Dr Brearey's attempts to decompress the abdomen and the reasons he gave was that there was no corresponding puncture injury which could have caused the internal bleeding in the parenchyma, in the body of the liver, and the location of the danger to the liver would have been impossible to cause with a needle.

As for the mark on the outer surface of the liver on the photo, he told you that in all likelihood that was something that had occurred after death because there was no associated bleeding. He said that if it had been caused by Dr Brearey then by that stage [Baby O] had no active circulation so in reality, in effect, was already dead.

Otherwise he said there was profound gastric and intestinal distension. Putting it more bluntly, ladies and gentlemen, in the sort of language that I can understand, [Baby O]'s stomach and bowels had been blown up with air. And his view, Dr Marnerides' view, was that the cause of [Baby O]'s death was:

"An inflicted traumatic injury to the liver, profound gastric and intestinal distension, following acute excessive injection of air via the NGT and air embolus."

We say simply, ladies and gentlemen, that the murder of [Baby O] was cruel and it was violent. All of the offences on this

indictment were appalling examples of attempts and completed murders. Some of the earlier offences were less overtly violent, but no less devastating. We say Lucy Letby used violence and air on [Baby E]. Unfortunately, there's no evidence from a post-mortem examination of what internal injuries caused him to bleed, but no doubt the fact that she'd got away with so much by the time she returned from Ibiza gave Lucy Letby the misplaced confidence that she could pretty much do whatever she wanted.

Her objective as always was to kill. In [Baby O]'s case, she undoubtedly combined all of the three methods she had previously used to such devastating effect on the other children in this case and, in order to try to cover up what she did, she had falsified the notes. And we say, frankly, by this stage she was completely out of control and was determined to mete out the same treatment to [Baby P] the very next day.

And perhaps after the break, I'll deal, rather more swiftly, with [Baby P]'s case.

MR JUSTICE GOSS: Yes, thank you. A 10-minute break then, please, members of the jury.

(11.58 am)

(A short break)

(12.10 pm)

MR JOHNSON: [Baby P]. [Dr A] told us that [Baby P] was born in very good health. He needed no active resus, very little intervention. He was in normal room air from 6 minutes of life. Initially, he needed no respiratory support. He and his brothers were treated for presumed sepsis. The decision was made to stabilise his breathing through the use of CPAP and give him fluids, IV, for nutrition.

You will remember that it was his case which caused confusion with several witnesses as to when it was he came off breathing support and I will come back to that because it's important.

On 22 June, Yvonne Farmer looked after [Baby P] and he was doing so well that at 11.45 that day [Dr B] decided to have a trial of taking him off CPAP and trialling him on Optiflow. If you want a documentary reference for that, it's J23840. It's not in the sequence of events. His gases were excellent.

The following day, the 23rd, this is the day [Baby O] died, at 06.00 [Baby P] was taken off Optiflow. You will find that at tile 22 or in your hard copy observation chart J23956. From that

point on, in other words 6 am on the 23rd, [Baby P] needed no breathing support.

By 10 am, at 36 hours of age, [Baby P] was self-ventilating in air; you will find that in the note of Dr Cooke at tile 64. His antibiotics were stopped, he was being partially fed with expressed breast milk, and both Dr Cooke and [Dr A] referred to that examination at 10.00 hours as unremarkable. So this is the morning his brother was murdered by Lucy Letby.

At the end of the day shift and after [Baby O] had died, at 18.00 hours there was a further examination by Drs Gibbs and Cooke. When he arrived on the unit at the time of [Baby O]'s death, Dr Gibbs told you this:

"I remember feeling uncomfortable when I arrived on the unit and saw [Baby O] and I thought, 'Oh no, not another one', because I'd become increasingly concerned, and I know that my consultant colleagues shared this concern, but I'd been increasingly concerned at the accumulating number of unusual, unexpected, inexplicable deaths and collapses that had been happening on the neonatal unit and the fact that Staff Nurse Letby had been involved in all of them."

On examination, [Baby P]'s abdomen was "full, mildly distended with no tenderness", and this was at about the time that Lucy Letby recorded feeding [Baby P]. You will see that in the fluid balance chart at tile 133 or J23981.

This is the feed that in evidence Lucy Letby claimed was administered by the student nurse. You can imagine that, can't you, ladies and gentlemen, that with his brother having just died, with the consultants scratching their heads and worrying, looking at [Baby P] and wondering what was going on, that Lucy Letby would tell the student nurse to crack on with feeding his brother [Baby P]? You only need to put it that way to realise how absurd that is.

[Baby P] was active, he was tolerating his feeds.

In interview, Lucy Letby said that she gave this feed because somebody was on a break; that's in the [Baby P] interview at page 3. Perhaps she was not anticipating that the police would be able to prove she was the designated nurse. Who can say? It's a variation from "I was standing in for someone who was on a break" to "the student did it". It's just a morphing of her lies.

[Baby P] appeared very well. He was active, his CRP was normal, his breath sounds were clear and he had a normal respiratory pattern. There was a little redness around his umbilicus, which

we were told was likely the result of the rubbing of the clip on the umbilicus.

According to Dr Gibbs, he was remarkably well, very well grown for a triplet, excellent for a triplet baby.

And the plan was modified to a more cautious one because of what had happened to [Baby O]. A number of blood tests were undertaken at 18.45, which is tile 145, and those blood tests would not normally have been done. But what they show us is that there is no evidence of infection.

As a precaution, [Baby P] was put on to antibiotics.

The X-ray ordered by Dr Gibbs at 18.00 hours was taken just over 2 hours later at 20.09. It's the one I showed you earlier as I was getting towards the end of my review of the case of [Baby O].

When he gave evidence, Dr Gibbs said that the abdominal distension shown was CPAP belly from 12 hours earlier, but he, like Dr Ukoh, had misread the chart.

As I explained to you earlier, [Baby P] had not had CPAP for more than 2 days and he had been off Optiflow since 6 o'clock that morning. One thing you can be sure of, ladies and gentlemen, is that was not CPAP belly.

The abdominal gas shown on the X-ray was pumped into [Baby P] by Lucy Letby, just as she had done with his brother and with others, just as she did with [Baby N], just before she went off shift on 14 June, so about a week and a bit earlier. And she did it just as she went off her shift to destabilise [Baby P] overnight so that she could take advantage the next day and create in the minds of all the people in the unit the impression that this was a child who was deteriorating.

Professor Arthurs dealt with the radiograph. It's the one I have just been talking about, taken just after 8 pm, it's at tile 173. He said:

"This is quite unusual in a baby of this age and gestation. You cannot determine how or why the gas got there from the radiograph alone."

He can't, he's just a professor from Great Ormond Street. You can because you are the jury and you can take into account all the other evidence. You can take into account the circumstances in which this picture was taken, the fact that there had been no CPAP belly for more than 36 hours, no Optiflow for 14 hours, take into account the fact that the issue arose just as Lucy

Letby was going off shift. The timing is no innocent coincidence because what happened here, as we will see, mirrors what happened to [Baby N] the night before Lucy Letby tried to kill him on 15 June.

The night shift of the 23rd into the 24th. A detail which will not have been lost on you is that Lucy Letby did not leave the unit that night until about 9 pm. We know that because she sent a message to [Dr A] at 20.59, tile 190, saying she was just finishing her notes. This is a reference to her notes for [Baby O], which you'll also find at tile 323 in [Baby O]'s sequence of events. I'm not asking to go there now. When Lucy Letby left, [Baby P] did not have an infection, and we know that from the lab results that came back several days later on 29 June.

In the cross-examination of [Dr B], Dr Evans and Dr Bohin, some emphasis was put on the good blood gas at 20.27, no doubt in an effort to make the point that when Lucy handed over [Baby P] to Sophie Ellis he was in good condition. But Sophie Ellis gave evidence on 20 March.

She had [Baby P] that night. T169 has her note and I would like to look at it to remind you:

"[Baby P] desaturated and had a self-correcting bradycardia early on in the shift."

As I said earlier, no innocent coincidence.

Having had no problems with his feeds all day, [Baby P] had an issue with a 14ml part-digested milk aspirate at 20.00 hours; that's tile 171. If you want to look at the hard copy that you've got, it's J23981. So Lucy Letby's still on the unit at this point, remember.

Thank you, Mr Murphy. So that's the 20.00 entry.

We say, quite simply, you can infer, given that it's a 14ml part-digested milk aspirate, that Lucy Letby had overfed him just before that was taken. What other possible explanation is there for that picture that day?

No problems and then, just as she's going off, a part-digested milk aspirate. That, of course, is why she's so keen, Lucy Letby is so keen to persuade you that the 18.00 hours feed was done by the student. A large-volume aspirate.

At 00.00, midnight, a 20ml aspirate was obtained, which was discarded, and the feeds were stopped on the advice of Dr Mayberry. Dr Mayberry said that at the start of the shift the decision had been taken that if there were any concerns

overnight then milk feeds were to be stopped and intravenous fluids started. And in a phone call he was told that there'd been a milky aspirate and he advised the nurses to put [Baby P] on to IV fluids.

It was in the light of the unexplained death of [Baby O] there was a very low threshold for doing that.

He thought that this happened at the start of the shift, somewhere at about 21.30, and thought that he had spoken to Belinda Williamson. You'll remember that he was diverted by an emergency in A&E.

You will also remember, I'm sure, that in cross-examination on behalf of Lucy Letby the times were clarified by reference to the feeding chart.

Dr Mayberry said that given [Baby P]'s gut was clearly moving, from which -- bowels opened and passed urine, the figures of aspirate were not all the story. And finally he told us that he gave the instruction to leave the nasogastric tube on free drainage.

At the invitation of Sophie Ellis, Kathryn Percival-Calderbank said that she had gone into the room and looked at [Baby P], who was awaiting a medical review.

Again, initially she thought that this was early in the shift and she said that:

"He was a well baby, but his abdomen was quite distended so I aspirated his NGT."

And she made the observation in evidence that at the time she was looking for milk. She was then shown the feeding chart, which you've got there, I think actually it's -- yes, it's that morning's feeding chart. So she was shown that feeding chart and she confirmed that this actually was done at 04.00 hours, as you can see the entry there.

At 07.00 hours, Sophie Ellis aspirated a further 5ml of air and 2ml of milk. She, when she was being questioned, wasn't sure whether the air had been there all along or not, but we suggest that, if you think about it, the fact that she got milk at 7 o'clock shows that [Baby P]'s stomach had not been fully emptied at 4 o'clock. That must be the case, mustn't it, because nobody was feeding him overnight? So that gives you an idea of what was going on.

Kathryn Percival-Ward confirmed that by the end of the shift [Baby P] was:

"... comfortable, settled and seemed like a well baby."

So the problem that Lucy Letby had created at the end of the shift on which she had murdered [Baby O] had been resolved by proper nursing care from Sophie Ellis and Kathryn Percival-Calderbank.

So we come to the day shift on which Lucy Letby murdered [Baby P]. Tile 258 shows you where people were.

Kathryn Percival-Calderbank said that Lucy Letby needed support for the day shift and that was why Chris Booth was with her in nursery 2. Kathryn Percival-Calderbank remembered having allocated Lucy Letby on a previous occasion to one of the less intensive nurseries and Lucy Letby had said that being in nurseries 3 and 4 was boring.

On those occasions she said Lucy Letby would migrate, that's her word, migrate back to nursery 1 when things happened. That is something you have seen happening, isn't it, in the evidence? There was an occasion before June 2016 when Kathryn Percival-Calderbank argued with Lucy Letby about this and Lucy Letby was unhappy with her decision.

Now you know what was going on on shifts when Kathryn Percival-Calderbank wasn't actually there, you have a much fuller picture of what was going on, don't you?

At the shift handover, Sophie Ellis told [Mother of Babies O, P & R] that [Baby P] had been "a little angel" overnight. That was agreed evidence.

We'll come to Sophie Ellis' note in a moment, but later that morning [Mother of Babies O, P & R] was called back to the neonatal unit. Lucy Letby had come on duty and [Baby P] had collapsed, just like his brother. As [Mother of Babies O, P & R] said, it was like déjà vu.

We suggest that [Baby P]'s case shows the malevolence of Lucy Letby at its height. Lucy Letby had handed over [Baby P] to Sophie Ellis in the aftermath of the death of his brother, [Baby O]. Just before she did so she did something to destabilise him and on her way home she sent that text, which I showed you from [Baby O]'s sequence at tile 403:

"Worry as identical."

This is gaslighting at its very best or very worst, isn't it? She was laying the ground for her attack on [Baby P].

What had happened overnight with [Baby P], as I say, mirrored what happened with [Baby N]. Tile 249, please, from [Baby P]'s sequence. Sophie Ellis' note made at 06.39:

"Abdo has been soft and non-distended."

Twenty-five millilitres of air aspirated by Kate Ward, NGT placed on free drainage. There was nothing wrong with [Baby P] by the end of that night shift.

The NGT was on free drainage, which means that if there was any naturally occurring gas in the stomach, it would ventilate through the NGT. Sophie Ellis had fixed the problem. But because Lucy Letby had decided that [Baby P] was going to die, and because she wanted people to believe that there was some sort of issue that the brothers had in common, she decided to use the template that had been established the day before.

If we look at Lucy Letby's nursing note for [Baby P] at 8 o'clock on 24 June. We can see what she wrote.

I don't have the tile reference for Mr Murphy, I'm afraid. I haven't got my paper copy.

MR JUSTICE GOSS: I think it may be 263.

MR JOHNSON: Thank you.

MR JUSTICE GOSS: But please check.

MR JOHNSON: 8 am on the 24th, please. It is -- actually, my note is further down, I've just written it in the wrong place. 263. Thank you, my Lord.

It's the bottom right-hand corner, I think. Yes, just above where the cursor is:

"Abdomen full. Loops visible. Soft to touch."

That, of course, wasn't written until quite some time later that day, 13 hours later as a matter of fact that was written. It was a fabricated note to create the illusion of the ongoing problem, the problem that hadn't existed at 06.40 that morning.

When you're looking at that note, ladies and gentlemen, do you remember what Sophie Ellis had written the day before as she signed off [Baby O] at 7.32? What she had written was:

"Abdo looks full, slightly loopy."

So it's the nursing equivalent of copying somebody else's handwriting.

So the problem that had disappeared overnight had apparently reappeared immediately at the handover, out of nowhere, in a child whose nasogastric tube was on free drainage.

If [Baby P] really did have an issue at 8 o'clock that morning, we suggest that Lucy Letby would have escalated it immediately, given what had happened to [Baby O] the previous day. But she didn't escalate it because there wasn't a problem. There was nothing to escalate. She was texting [Dr A] at tile 267, please, at 8.19:

"Watching them both like a hawk."

This is after the time that she is putting into the nursing notes as [Baby P] having loopy -- slightly loopy bowels.

If you look at the text she sent just before that at 264, she'd written to [Dr A] -- sorry, she was telling [Dr A]:

"I've got [initials of Babies P & R]."

So [Babies P & R]. No mention to her friend that there's a problem with [Baby P]. If there really had been an abdominal issue, given what had happened to [Baby O] the day before, she would have told him, wouldn't she? You know from the other evidence she was desperate to get him into the unit. There was no problem. And this plays in in due course to [Baby Q], doesn't it, right at the end? Do you remember?

"The reason I didn't feed [Baby Q] at 9 o'clock is because I was going to escalate it to the doctors."

The same thing is happening time and time again.

[Dr B] spoke to Dr Mayberry about [Baby P]'s overnight abdominal distension at the handover and there was no suggestion of the fact that it was an ongoing concern, and yet in interview -- and you'll find it at pages 6 and 7 of the [Baby P] interview -- Lucy Letby said that the bowel issue was obvious at handover and she was told by the nurse in charge to wait for the ward round.

A lie. Cover for her lying nursing note entry and lies to the police about it.

Chris Booth, who was looking after [Baby R], who was incredibly stable, fully monitored and in the far end of the nursery, in a position where Chris Booth -- where an eye could be kept on [Baby R]. [Baby P] was on no sort of respiratory support. How

does that fit with what Lucy Letby was saying in the note? How does it fit with what she was saying in interview?

At 9.35, and this is tile 289, Dr Ukoh did a ward round and examined [Baby P]. He found a moderately distended abdomen with bloating, and you will remember that in cross-examination Lucy Letby said that the loopy bowel had been visible at this examination and she claimed initially that Dr Ukoh saw the loops as well. But then we checked the note, do you remember, and there it wasn't: no mention at all from Dr Ukoh.

Dr Ukoh said that [Baby P]'s abdomen was soft on examination and that his skin was "slightly mottled".

Dr Ukoh ordered a series of blood tests, including ammonia, which was to deal with the possibilities of a metabolic condition and Dr Ukoh's impression was that he needed to keep an eye on [Baby P], although he wasn't particularly unwell. Dr Ukoh's principal concern seems to have been the possibility of an infection or NEC, but there were no other concerns.

[Dr B] said there was nothing of concern, although the abdomen was "a little bit distended", and although he didn't examine [Baby P] -- she didn't examine [Baby P], [Dr B] suggested screening him to include a test for metabolic disorders, which ties in with what Dr Ukoh was telling you. [Dr B] then went to speak to the coroner about [Baby O].

Here we have yet another example of Lucy Letby falsifying the notes to make the situation of a baby look worse than it was. In the nursing note recorded after [Baby P]'s death -- and it's tile 286, please -- Lucy Letby recorded that [Baby P] had been Neopuffed for a minute before he was examined by Dr Ukoh. It's right at the bottom, I think. We suggest this is a deliberate misrecording, timing a minor collapse 10 minutes before the major collapse at about 9.40 or so.

The record "abdomen becoming distended" is Lucy Letby's way of covering what she did. It was becoming distended because she was pumping [Baby P] with air. [Dr B] said in terms that what Dr Ukoh had seen at 9.35 did not explain why, 10 minutes later, [Baby P] crashed, his heart stopped and so did his breathing. And this is deterioration number 1 for [Baby P].

Chris Booth recalled the monitors going off for [Baby P] and said that Dr Ukoh and [Dr A] were around with himself, Lucy Letby, and Becky Morgan, the student in the room, and he described [Baby P] as "dusky and mottled", but we suggest for reasons that will become apparent that he was wrong about who was there when this happened.

Tile 295, please, is [Dr A]'s note. This shows that he was called to the neonatal unit and arrived at 9.50. Apparently, it wasn't an emergency, it was just "come quickly" as he put it. [Baby P] was in nursery 2 with a heart rate of 80 beats per minute, oxygen sats of about 60%, he was being bagged in air. Dr Ukoh and [Dr B] were already there when he arrived.

According to Rebecca Morgan, when [Baby P] collapsed he was at [Baby R]'s incubator -- sorry, she was at [Baby R]'s incubator in nursery 2, and Lucy Letby was not in the room according to Rebecca Morgan. Well, if that's right, you might wonder why not.

Lucy Letby had no other child to care for. [Baby P] had only just been desaturating and might be thought to have been at risk given what had happened to [Baby O], and Lucy Letby, after all, had been telling her friend the previous night that she was worried as they were identical and had told [Dr A] that she was watching [Baby P] like a hawk. So if Rebecca Morgan is right about that then we have shades of what was going to happen with [Baby Q] the next day, don't we, being out of the room at the time of the collapse?

When she arrived, [Dr B] said that only Dr Ukoh and Lucy Letby were there. She made a note at your J23848. [Dr A] said that the heart rate was lower than he would have expected, as was the oxygen saturation level. [Baby P] was intubated at the first attempt by [Dr A] and there was good colour change on the capnograph. The blood gases at 9.51 were poor and suggested that over the previous 15 or 20 minutes [Baby P] had been working hard with his respiration.

Dr Ukoh thought he was called back at about this time as well. He said [Baby P] appeared very different to earlier and his oxygen levels were down to 60% with a low heart rate. He said, Dr Ukoh:

"Whoever was doing the Neopuff was very keen on getting [Dr A]."

Well, we know who that was, don't we?

We say that, knowing what you know, the person doing the Neopuff has to have been the designated nurse, Lucy Letby, and Lucy Letby wanted [Dr A] and she wanted [Dr A] because for some reason she enjoyed these situations when he was there.

According to [Dr B], adrenaline was started at 9.55, and it was realised that intravenous access had been lost so [Dr B] and Dr Ukoh tried to re-site a cannula. That was unsuccessful so the intraosseous access was established.

The gases at 10.06 were even worse even though the airway was satisfactorily managed. [Baby P] was given a sequence of doses of adrenaline at 9.55, 10.02, 10.08, 10.15, followed at 11.10 by a loading dose of morphine.

The gas at 10.46 showed a slight improvement.

Dr Evans was at a loss to explain any natural cause for this collapse. Dr Bohin concluded that this was a case of air being put down the NGT, which had had splinted [Baby P]'s diaphragm, and you will not have missed the fact that Lucy Letby's own note records "abdomen becoming distended", tile 286. That's why it's important he was not on CPAP. This was her covering what she had done. These are all inferences you as a jury can draw. Experts can't get involved in determining the facts, you can.

The second deterioration at 11.30. There was then an episode of bradycardia and desaturation, which required CPR from [Dr A] and [Dr B]. [Baby P] was given adrenaline once more. [Dr B] said at this time, following the collapse, [Baby P] was "very vigorous and breathing against the ventilator". This was not a child who was ill, ladies and gentlemen, this was a child who was being sabotaged.

That perplexed [Dr B] because, as she said, if this was a case of infection, [Baby P] wouldn't have rebounded so quickly. What she did not know, but what you do know, is that the blood tests exclude infection.

Because he was fighting the ventilator, [Baby P] was given pancuronium, the drug that paralyses, and you will find that at tile 389. It's in [Dr A]'s note, it's also in the scribe's note at tile 391, and it's timed at 11.30 in Lucy Letby's nursing note; see for example tile 292. This is really important, this timing, ladies and gentlemen: pancuronium at 11.30.

At 11.57 there was a radiograph, an X-ray, taken which showed both a pneumothorax and air in the bowel; that's tile 400. [Dr B] said this was not a tension pneumothorax and the gas at 11.03 was good, although with a base excess that was quite high.

Just after midday, noon, after that gas, [Dr B] remembered going to nursery 2 and seeing several nurses, including Lucy Letby. You'll remember she explained to you how she saw the clock going just past noon and she told the people there that the transport team were going to be there soon. She said:

"I was thinking out loud and Lucy Letby replied to [her], 'He's not leaving here alive, is he?'"

"He's not leaving here alive." It wasn't disputed in cross-examination, was it? It was suggested in cross-examination that this was an expression of concern. Concern? But that's not what Lucy Letby said in interview. In interview, she said that she couldn't remember saying it to [Dr B]. She claimed, Lucy Letby, that she wouldn't have said that unless [Baby P] had been really sick at the time. She then said that when he started to deteriorate, she did think that he wouldn't leave alive. So in other words, Lucy Letby was saying that what [Dr B] said she said at midday was something she didn't remember saying but was thinking later on. Work that one out.

In cross-examination on 8 June, Lucy Letby agreed when I suggested that to say such a thing was not the done thing in the medical world and she repeated then on 8 June that she didn't remember saying it. So where did the suggestion made to [Dr B] that this was an expression of concern come from? We will never know.

Well, ladies and gentlemen, she did say it. She didn't dispute it. But going back to my favourite question: why did she say it? The answer -- there is only one answer, isn't there? Because by this stage she knew the endgame. She knew what was going to happen.

She was controlling things, she was enjoying what was going on and she was happily predicting something that she knew was going to happen. She in effect was playing God. And [Dr B]'s response?

"Don't say that, he's just had a good gas."

As [Dr B] said:

"I thought we were winning. There was no reason for this comment."

[Dr B] said the comment was:

"... highly unusual and that making such comments was not something that we do."

[Dr B] said that the remark was shocking and, importantly, we say you need to put this comment alongside Lucy Letby's later excitement after [Baby P] had died. We will get to that.

Before we get to that, most importantly in terms of working out who was responsible for what was going on, we get to the circumstances of [Baby P]'s collapse at 12.28.

[Dr B] told us that the adrenaline infusion started at 12.20.

I just want to deal with the 12.28 collapse before the break, if I may. This is the one that ties in with the pancuronium at 11.30. [Redacted].

[Dr B] and [Dr A] took a quick timeout and went to make a cup of tea when somebody shouted for help.

They, that is [Dr A] and [Dr B], were both out of the room when this collapse happened, and Lucy Letby of course was in the room with [Baby P]. [Dr B] said:

"It looked like this child, who'd been paralysed with pancuronium, had dislodged his ET tube."

In cross-examination [Dr B] admitted of the possibility that the tube was blocked. Well, if it was, it had blocked within a very short period of time, hadn't it, because it had been put in by [Dr A] at 09.50?

And when you're considering this piece of evidence, ladies and gentlemen, you're entitled to look at all the surrounding circumstances, something which the experts are not entitled to do. You can take into account the apparent coincidence of this happening at the precise moment that the two doctors had left the room. You can take account of the fact that it happened when only Lucy Letby was in the room, no one else in the room.

[Redacted.] You can take into account the fact that, a short time before this event, Lucy Letby had said, "He's not getting out of here alive, is he?" And you can take account of the fact that that remark was made within 13 to 28 minutes of this incident.

Significantly, [Dr A] wrote that there was "poor colour change to the capnograph". He didn't write that the tube was blocked because we suggest it was not blocked; Lucy Letby had moved it. As the nurse, Lucy Letby made no record of it being blocked because it wasn't blocked and so [Dr A] re-intubated.

CPR was recommenced, [Baby P] was given a number of adrenaline boluses through a peripheral cannula, the desaturation and bradycardia were accompanied by a profound colour change indicative of a circulatory problem.

A chest X-ray at 12.30, and you'll find [Dr A]'s note at tile 435, showed a right-sided pneumothorax, which I think we saw just before, which was decompressed with a cannula, what you now know as a needle thoracentesis.

[Dr A] thought that a pneumothorax was a possible consequence of [Baby P] fighting the ventilator at an earlier stage of

treatment and he was then given fluids and dobutamine to maintain his blood pressure and his cardiac output. And Dr Bohin thought that although the pneumothorax may have contributed to [Baby P]'s collapse at this point, the collapse was not caused by the pneumothorax. We say, frankly, ladies and gentlemen, it was Lucy Letby moving the tube, [redacted].

I'll deal with a bit of evidence before the -- I can either deal with 2 minutes now or tack it on at the beginning after lunch.

MR JUSTICE GOSS: Entirely up to you, Mr Johnson. Just carry on if you want to.

MR JOHNSON: Thank you.

Well, Dr Brearey finished his cardiac clinic at 13.00 hours. You'll remember he was the cardiac specialist at Chester. He conducted an echocardiogram at 13.30. [Baby P] had a normal heart and normal great vessels leading from the heart, with no evidence of any congenital heart disease or pulmonary hypertension. And in effect, he eliminated any heart problem as the reason for what was going on with [Baby P].

The following week, Dr Brearey reviewed the circumstances of [Baby P]'s death. He could find no reason for what had happened to [Baby P] and he said that he regarded the events of that day as being very exceptional. Treatment for [Baby P] continued with drugs to combat presumed infection, which we know didn't exist, and also to support blood pressure and cardiac output.

[Baby P] was given surfactant. The work and inefficiency of his breathing with no identifiable cause was a concern and [Dr A] said he couldn't identify any cause for what was going on.

You will remember that it was at about 3 pm, 15.00 hours, that a pigtail chest drain was inserted and [Dr A] thought it highly unlikely that [Baby P] died as a result of complications with a pneumothorax.

It was at about 15.00 hours that Dr Rackham arrived with the transport team, and after the break if I may I will continue with the rest of the case involving [Baby P].

MR JUSTICE GOSS: Yes, certainly.

You'll recall I said 1 hour and 5 minutes for our lunch break from now on, please, so 2.07, we'll continue.

(1.03 pm)

(The short adjournment)

(2.08 pm)

MR JUSTICE GOSS: We have to finish earlier this afternoon than our normal time, so if it's all right with you, we're just going to have one session this afternoon, but it'll be slightly longer than normal, and we'll finish some time between 3.30 and no later than 3.40 if that's all right.

I have told Mr Johnson to choose a moment from 3.30 onwards to break off.

MR JOHNSON: Dangerous! On more serious matters, ladies and gentlemen, the terminal collapse of [Baby P]. It was at 15.14 that [Baby P] went into cardiorespiratory arrest as [Dr B] was standing in the room talking to Dr Rackham from the transport team.

This time, [Baby P] was given high doses of adrenaline.

The X-ray at 15.36 shows the pigtail drain in place, put in at 15.00 hours by [Dr A]. At 15.54 [Baby P] had no pulse at all. He had no spontaneous circulation and he was gasping occasionally. But despite all that, there was good air entry into his chest, so the tube, the ET tube, was in a good position and that continued throughout the resuscitation process.

Dr Rackham said that there was no breathing effort from [Baby P] and, as he said:

"We had no explanation for why [Baby P]'s condition had changed."

Another thing he said was:

"It didn't fit with any obvious reason for [Baby P] to have deteriorated from the condition he was in before."

So that's Dr Rackham. It's the same thing. If I said to you "name the doctor who said that", you'd all possibly come up with different people and you might all be right.

At 16.00 it was determined that the resuscitation attempts were futile. [Father of Babies O, P & R], [Baby P]'s dad, said that the circumstances of [Baby P]'s death were very similar to [Baby O]'s, although he said specifically he could not remember his veins going different colours like [Baby O].

Again, as you have heard in many other cases, [Father of Babies O, P & R] said they'd seen the boys, spent a bit of time there, and then things happened with [Baby P], so a similar pattern.

[Father of Babies O, P & R] said that [Baby R], the boy who we suggest escaped Lucy Letby, had nothing wrong with him and was discharged from hospital after 11 days. And we say that's what would have happened with [Baby P] and [Baby O], had Lucy Letby not murdered them.

After [Baby P] died, [Dr B] went to [Baby P]'s parents to tell them that there would have to be a post-mortem and [Dr B] said that at that point Lucy Letby was "almost very animated, asking about a memory box, she seemed so excited", said [Dr B], and her behaviour seemed very inappropriate.

In cross-examination it was suggested to [Dr B] that an explanation for that could be something she's doing just to try and sound better than it actually is.

So again, Lucy Letby appears to be -- if you take that question as being evidence of what she is saying, Lucy Letby appears to be accepting that she was acting that way. And the suggestion made in cross-examination seems to have been that talking enthusiastically about a memory box was going to soften the blow for these parents who had lost two children in 2 days. We suggest that that is absurd: Lucy Letby was enjoying the drama, she was enjoying the control and she was enjoying the extremity of the grief that she was causing to other people.

[Dr B] said that, in the aftermath of [Baby P]'s death,[Father of Babies O, P & R] was sobbing and begging Dr Rackham to take [Baby R], and [Dr B] too asked that [Baby R] be removed from Chester because:

"I thought that was the only way he was going to live."

[Dr B] was worried and she did not understand what had been happening. What she had seen defied her experience as a consultant and it was not normal from a medical point of view to explain what had happened.

She was challenged about that in cross-examination and about her belief that Lucy Letby had sabotaged [Babies O, P & R]. It was suggested to her that if she really thought that Lucy Letby was responsible, she would have called the police.

Well, in answer to that, we make the same point we made in relation to Dr Gibbs: if she'd been asked by the police, "What did you see her do?", what would have been the answer?

Was [Dr B] being dramatic for your benefit, as was suggested on Lucy Letby's behalf? You saw [Dr B].

You heard what she said. Was she deliberately trying to mislead you or was her evidence an exceptionally powerful account of a murder committed by Lucy Letby in plain sight where everybody, or some people at least, realised something awful had happened, something was seriously wrong, but they just couldn't put their finger on it?

You will remember [Dr B]'s answer to that accusation:

"I have no intention of dramatising anything. It's tragic enough as it is."

Dr Gibbs told us that he was extremely concerned to hear of [Baby P]'s death and that he wouldn't have expected it at all. Dr Rackham decided that moving [Baby R] to Liverpool was a very good idea in the light of what had happened to his brothers. [Baby R], of course, was on high flow, he was pink and active.

There was a debrief led by Dr Rackham after [Baby P]'s death. This was to identify anything that had been missed and to look out for the well-being of the staff, and nothing was identified clinically to explain what had happened.

The deaths of [Baby P] and [Baby O] caused real concern for Dr Brearey. He said of the triplets:

"All were born in such good condition and had been following a path, a healthy path, to growing and hopefully going home."

The rash was something he'd not seen before or since, all natural causes were excluded, and as I said before, even with the benefit of all his experience in the years that have intervened, no explanation so far as Dr Brearey was concerned.

At the debrief, Dr Brearey asked Lucy Letby how she was feeling and suggested that she perhaps needed some time off. But she didn't appear to be upset, according to what Dr Brearey said, and told him that she was due to work the next day. And that caused Dr Brearey real concern, given her connection to these unexplained events.

The expert evidence. Dr Marnerides gave evidence on 30 March relating to the post-mortem of [Baby P] and you will remember the liver injury that he had, not as severe, but a liver injury nonetheless like [Baby O].

Dr Marnerides told you that when he gave his opinion, he did not look at one child's case in the context of another, and this is the important difference between you and him. It was suggested on behalf of Lucy Letby to Dr Marnerides that the liver injury could have been caused by CPR. Dr Marnerides was prepared to

accept that as a possibility, looking at the case in isolation. We say, however, that not only is the coincidence too much for [Baby P] to have suffered that injury accidentally, but it's also clear that at the time those who were involved in his resuscitation were very careful in what they did and the text messages sent by [Dr A] to Lucy Letby, we suggest, exclude the possibility of [Baby P]'s liver injury having been caused accidentally.

More importantly, perhaps, Dr Marnerides said there was no evidence at the post-mortem of any naturally occurring disease or condition that would account for [Baby P]'s collapse and death. He said that when he had the benefit of hearing what experts for both the prosecution and the defence said in a joint meeting, it was his view that [Baby P] died as a result of gastric and intestinal distension as a result of having excessive air injected into the nasogastric tube.

As he put it, there was no clinical or pathological pathway to explain a natural cause of death, and in that context you will remember that his discipline, pathology, enables him to exclude natural causes for the air being in the stomach and the bowel.

Right at the end of his evidence he said that had an alternative mechanism been put to him on behalf of Lucy Letby in cross-examination, he would have considered it and either would have accepted it as a possibility or explained his reason for rejecting it, and it will not have escaped your notice that, other than the CPR in the case of [Babies O, P & R], he was never asked to consider any alternatives. That, we suggest, speaks volumes: there are no alternatives.

Dr Evans took us through a summary of the chronology of [Baby P]'s progress from birth to the collapses and his death and his view was that there were no natural causes and that the reason for what happened was that he was injected with air down the nasogastric tube.

When he was cross-examined on behalf of Lucy Letby, it was suggested to Dr Evans that he had "invented an extra dollop of air just before the initial collapse".

I think to be fair, the word dollop originated from Dr Evans.

This, we suggest, is where the false entry in the nursing note made by Lucy Letby is so important and this is something that we suggest that you as a jury can take into account, which expert witnesses cannot take into account.

If you accept Sophie Ellis' uncontroverted evidence that there was no air in [Baby P] when she left at the end of that night

shift, then you can go on to consider, first, that Lucy Letby made the loopy bowels note falsely suggesting there was. Second, that she was texting [Dr A] claiming to be "watching like a hawk" at the time her later-made note suggests there was air in the loopy bowel but she didn't mention the air. Third, if there was no air then her suggestion in interview that she had a conversation with the lead nurse about it must be a fabrication. Fourth, in her nursing note she falsely recorded having used the Neopuff either before or during Dr Ukoh's first examination at 9.30.

Can we just go to tile 286, please? That's it.

It's been highlighted for you there.

Fifth, if you accept Dr Ukoh's evidence about his 9.30 examination, [Baby P] was fine and yet by 9.35 [Baby P] had collapsed. [Baby P] had no naturally occurring problem that could have caused that sudden collapse and so Dr Evans was correct.

Dr Bohin reinforced Dr Evans' opinion by comparing the contents of Sophie Ellis' note at 6.39 with what Lucy Letby said was the position in the note you have on screen. Dr Bohin also pointed out that in the interim, the nasogastric tube had been on free drainage, which would have decompressed the stomach if there was any naturally occurring problem. It's a point I think I made earlier.

Dr Bohin also pointed out the apparent discrepancy between Lucy Letby's notes, which suggest having had to Neopuff [Baby P] just before Dr Ukoh's ward round, and the fact that this does not appear to have been mentioned to Dr Ukoh. After all, given what had happened to [Baby O], if you had just Neopuffed a child that you'd just called a doctor to see, as the designated nurse you would tell the doctor, wouldn't you? So the fact that that didn't happen speaks volumes.

Given that, in interview, Lucy Letby suggested that she was waiting for the doctor to do the ward round to raise the possibility of there being an abdominal issue, this is, we suggest, inexplicable other than by it being yet another example of a false record in Lucy Letby's nursing notes, designed to make [Baby P] appear to have some naturally evolving problem which covered her criminality.

Dr Bohin described the pattern of extreme collapses necessitating the use of adrenaline followed by a rapid recovery as being very abnormal; it's a pattern of what was happening to Lucy Letby's babies. Dr Bohin had decoded the adrenaline prescriptions, you will remember, and concluded that the

adrenaline infusion was double that which had been intended. But despite that, [Baby P]'s heart still failed. And because there was no plausible explanation either for the distension, the gas or the nature of the extreme collapses, followed a couple of times by good recoveries, Dr Bohin concluded that someone must have injected [Baby P] with air. She did not take into account the liver injuries, which you can, or Lucy Letby's bizarre behaviour, which you can, or the fact that his brother had died in similar circumstances the day before, which you can, or the false records, which you can.

So ladies and gentlemen, the prosecution position.

If you conclude that [Baby O] is the victim of someone inflicting force on him to cause that terrible liver injury, then the very idea that his brother [Baby P] died the next day with a liver injury is damning evidence against Lucy Letby and it's the classic example of the power of circumstantial evidence: something which when viewed in isolation may not be very significant, which may be explicable in isolation, but when taken with another piece of evidence becomes powerful proof of criminal behaviour.

[Dr B] realised there was something seriously wrong going on in that neonatal unit; that is why she pleaded with Dr Rackham. Lucy Letby predicted [Baby P]'s death at a time when the consultant [Dr B] thought it was under control. How could she have done that? Why would she have done that? We say, ladies and gentlemen, that the number of coincidences here, both with what happened to [Baby O] and with what happened to many of the other babies, [redacted], is all too much to have been the product of simple bad luck. [Baby P] and his brother [Baby O] were murdered by Lucy Letby.

As I have indicated previously, we want to focus primarily on the evidence that relates directly to each of the infants named on this indictment. However, whilst we recognise that this is a case about babies and not about paper, we suggest that a brief consideration of Lucy Letby's explanation for some of the paperwork seized on her arrest may help you to assess her honesty and credibility as a witness generally and better enable you to consider her explanation of the events surrounding the collapses of these babies.

I want to start -- I'm not going to deal in great detail with these jottings. I'll start with exhibit 15, which is the handover sheet of [Baby P] and [Baby O].

Image 24.

Lucy Letby suggested that she took this home deliberately to rely on it as an aide-memoire when writing up the drugs on her following shift. But when you look at page 2, which shows the back of this document, the only drug you will see recorded on that sheet is caffeine. So Lucy Letby's explanation is not true.

Why is she not prepared to tell you the true reason?

It can't be because it helps her, can it? We suggest that the handover sheets are capable of informing you of her unhealthy interest in some of these children.

Whether directly, as in the case of [Baby M] for example, or indirectly, as in the case of [Baby G], for example, whose handover sheet would have been a very useful reminder of how to spell her mother's French name when conducting a covert Facebook search.

And when determining or considering Lucy Letby's credibility, her believability generally, we encourage you to think about these things. First, her claim that her collection of handover sheets, acquired over years and retained through multiple house moves, was simply a consequence of her tendency to collect paper.

Second, her assertion that they were stored confidentially, her inconsistent assertions about owning a shredder and whether or not students receive handover sheets.

Third, her assertion that the word "keep" written on the side of the shredder box at her parents' house referred to the shredder rather than the handover sheets that were in the box.

And fourthly, her assertion that documents containing sensitive information about dead babies were, to use her word, insignificant.

None of that stands up to any sensible analysis.

And as I say, if she's not telling the truth about that, is the true explanation one that's going to help her in the context of the allegations being made in this case? You can safely conclude the answer to that question is no.

A second category of paper exhibits seized on her arrest are the various notes that she wrote after her removal from the neonatal unit. Here I'd like to start with image 19, please, which is the Post-it note. This was inside her 2016 diary. We suggest that the words "I am evil, I did this" should be read literally and taken as a confession.

In the defence's opening address to you back in October, it was suggested to you that, and I quote:

"Anyone who reads this fully with an ounce of human understanding will appreciate that this is the anguished outpouring of a young woman in fear and despair."

Well, the evidence that Lucy Letby gave about her anguish related significantly to the circumstances in which she was removed from the neonatal unit and, according to her, being forbidden from having any contact with her friends and colleagues other than [Dr A], Minna Lappalainen and [Nurse E].

Therefore, ladies and gentlemen, it was she, it was Lucy Letby who introduced the suggestion that she was isolated, not the prosecution. It was the defence that introduced the suggestion that she was isolated. And its purpose or part of its purpose was to explain the notes and her behaviour.

That impression may have remained until she was cross-examined, and on the final day of cross-examination a spreadsheet was given to her, setting out the contents of her phone and her diary together with some photographs. And as she so appropriately summarised it, the spreadsheet in effect set out her social life in the period July 2016 to July 2018, which includes the time that this and other notes were written.

Lucy Letby accepted, didn't she, that in reality she had a "very, very active social life", her words, which included socialising with many of her former colleagues, including the people that she, up to that stage, was telling you that she had been forbidden from having contact with and she was suggesting she hadn't had contact with.

When she was re-examined on all this by her own counsel, she was asked whether she was "at least allowed a social life", the implication being that we had produced the schedule to suggest that in having a social life, she was behaving inappropriately. That was never our suggestion. Our point is much more relevant: we say that she up to that point had been deliberately trying to mislead you about her situation at the time of writing this note with the intention of invoking some pity on your part and to deflect you from the obvious and literal meaning of some of those words. We say she is a liar, she lied to you, and that the fact she lied to you is proved by an analysis of her social life.

That's the point. We're not suggesting she wasn't entitled to a social life.

So taking stock then, ladies and gentlemen. So far, we've reviewed seven cases. We've seen that [Baby F] and [Baby L] were poisoned with insulin, each of them, for reasons I explained, was deliberately targeted, each of their brothers was injected with air. The attack on [Baby E] was interrupted by his mother, [Mother of Babies E & F], and so Lucy Letby persuaded her to leave and pressed home the attack to make it look like there was an ongoing problem.

[Redacted].

That was something that Lucy Letby repeated with [Baby P] on 24 June at about 12.30 in what I have termed from time to time "the tea room attack". [Baby P] was paralysed and cannot have dislodged his own tube. [Baby P] had a liver injury, which was found after his death, which in itself, and viewed in a vacuum, might have been explicable by CPR but when you factor in what happened to his brother the day before and the injuries he suffered, which included more serious liver injuries, the possibilities of innocent coincidence are eliminated.

And if you accept Dr Marnerides' uncontroverted evidence about what was found at [Baby O]'s post-mortem, there can be no doubt that he was murdered.

If you put that finding with the deliberate poisonings of [Baby F] and [Baby L], put that with what happened to their brothers [redacted], and factor in the false and misleading entries in Lucy Letby's notes, we say the picture is crystal clear, and therefore, so far, we have three murders and four attempted murders and we still have to look at a further ten children.

So I'm going to go back to the chronology now, ladies and gentlemen, otherwise it gets a bit complicated for me. So I'm going to go back to the beginning. I'm not going to deal with any of the children that we've dealt with so far, you'll be glad to know, so I'm going to now review [Baby A] and [Baby B].

[Baby A] and [Baby B] were born at 31 weeks plus 2 days on 7 June 2015. [Baby A] died the following day and [Baby B] had a serious collapse the day after that.

[Baby A] died almost exactly 24 hours after he had been born. Not only were the cases of [Babies A & B] the first that you heard but they were the first time you became aware of the fact that the defence were suggesting that Dr Jayaram and Dr Harkness are liars.

You will remember that his Lordship directed you last Thursday that the questions from counsel are not the evidence, it's the

answers and the way that the answers are given which is the evidence.

We dealt time and time again in cross-examination with what witnesses had said they saw and we invited Lucy Letby to contradict them. Almost without variation, she simply said that she did not see what they say they saw and so, ladies and gentlemen, you are going to have to decide where the truth lies. Did Dr Jayaram and Dr Harkness make up what they saw with [Baby A] and [Baby B] to implicate Lucy Letby in the most serious crimes and to distract from a few relatively minor imperfections in treatment?

We know now that a couple of weeks before the death of [Baby A], Lucy Letby had completed a course relating, amongst other things, to intravenous lines. On the course, the dangers of air embolus were mentioned.

Is that just a coincidence or was that what gave her the idea? Well, we will never know. We say that Lucy Letby killed [Baby A] with an injection of air into his bloodstream. When he collapsed, she was standing over him. She tried the same thing with his sister [Baby B], the following night, but [Baby B] mercifully survived.

The evidence relating to the twins started with the statements of their mum, [Mother of Babies A & B], and their dad, [Father of Babies A & B], and you will remember [Mother of Babies A & B]'s account of her antiphospholipid syndrome and the fact that she was receiving specialist treatment in London. And it had been intended to deliver the twins in London but they arrived early because [Mother of Babies A & B] had pre-eclampsia.

The primary concern at the Countess of Chester appears to have centred around the antiphospholipid syndrome, but you heard from Professor Sally Kinsey that that had absolutely no bearing on their difficulties, and Lucy Letby accepted it had no bearing on their difficulties, and thus we suggest the idea that that was the cause of what happened is a complete non-starter.

The staff at Chester knew that [Baby A] and [Baby B] were much-wanted babies; that's in Lucy Letby's [Baby B] interview at page 14.

[Baby A]. [Baby A] had been doing well after his birth. From 4 minutes of age, he was breathing for himself. He was described as "crying and vigorous on stimulation" by Dr Beech; you'll find that at tile 8 at 21.00 hours.

By 10 minutes of age he was breathing for himself in air. He was put on CPAP and, from a couple of hours of age, he was essentially on hourly observations.

At 09.45 on 8 June, he was handling well on examination by Dr Ogden, but on the afternoon of the 8th there were problems getting a UVC into a satisfactory position. If you want to find the notes relating to that, they're tiles 134 and 143 to 146. And you will remember that the cannula that was being used to give him fluids tissued or blocked at 16.00 hours, and that's tile 141.

This is one of the points that was explored in the evidence, isn't it? Dr Harkness was the registrar at the time. He was asked to intervene. He'd come on duty at 17.00 hours and his task was to insert the lines into both [Baby A] and [Baby B]. He achieved that in [Baby A]'s case at 19.00 hours, and that's at tile 154, and it was that delay, in cross-examination, that Lucy Letby suggested may have contributed to [Baby A]'s death. Well, for reasons that we'll come to we suggest that is nonsense.

[Baby A] crashed minutes after Lucy Letby came on duty and he died shortly afterwards and there's no doubt, is there, that Lucy Letby was involved in [Baby A]'s treatment and that she and Mel Taylor, who'd been the nurse or his nurse on the day shift, started an infusion through the recently inserted long line some time after 20.00 hours on 8 June? That information is in tiles 173 and 174.

The evidence shows that at the time [Baby A] crashed, Lucy Letby was literally standing over him. In the room at the time were Mel Taylor, who was at the computer behind that half wall, do you remember, in nursery 1, the wall that's between the two doors, Caroline Oakley, who was looking after [Baby B], and Dr Harkness, who was inserting a line into a third child, and we know how much concentration putting one of these very thin lines into the vein of a child of this age takes.

Dr Harkness' note records that [Baby A] went into cardiac arrest within a minute or two of him starting to insert the line into that other child.

In terms of what was going on and the number of people in and close to the room, this is a very similar set of circumstances to what happened with [Babies L & M] in the afternoon, I think, was it, of 9 April.

Lucy Letby was operating in plain sight, wasn't she?

Dr Harkness said that when [Baby A] intervened (sic), he bagged [Baby A] and saw that his chest was rising and falling. So yet

another case where that's the clinical presentation. So the issue wasn't with his breathing, but despite the fact that air was going in and out, [Baby A]'s sats were falling, as was his heart rate.

Dr Harkness intubated [Baby A], but that didn't help, and CPR began at 28 minutes past 8, 20.28; that's tile 195.

What Dr Harkness saw at that point -- it's a long time ago now, but I'm sure you all remember the gist of it at least, was this. What he described, his words:

"Very unusual patchiness of his skin. Unusual skin colour and skin change."

Which he'd never seen before and he only saw later at the Countess of Chester in the case of [Baby E].

Later in his evidence he described what he saw as:

"Patches of a kind blue/purple colour, there were patches of red colour, there were white patches and they didn't fit with something that you'd find in a baby that's not pumping any blood around the body."

Dr Harkness made the point that he was too busy trying to save [Baby A]'s life to get a definitive considered description. He said he saw:

"Bright red patches, which doesn't fit with someone dying [I'm adding the words 'with someone dying' because that was the context] because bright red patches means you've got blood going round your body."

In cross-examination, Dr Harkness was criticised for not writing down the details of the discolouration or what he saw in the medical notes. It was suggested to Dr Harkness:

"You have been influenced in that recollection by conversations that have taken place about skin colouring and that has led you to apply that to what you describe with [Baby A]."

So that was the suggestion being put to Dr Harkness on 20 October last year. Quite what the terms of those alleged "conversations" were plainly were never suggested by the defence, when they happened wasn't suggested, who they were with was not suggested. But if the conversations were about patches of blue, purple and red colour flitting around, why did you think that would have been? It would have been because that's what people were seeing.

Dr Harkness was criticised for not putting the description in a statement he wrote some time later and you might ask yourselves: what's the implication there?

What's being suggested by saying: well, you didn't put that in a statement? That Dr Harkness didn't see anything, is that the suggestion? That he didn't see what he said he saw? It was suggested to him that:

"Discussions had set in your mind the impression of this colour when it may not have been there at all."

That's Lucy Letby's case back on 20 October last year.

Well, Dr Harkness said, no, because. It's what -- it was the same thing that happened with [Baby E] that made him realise how significant this was. You'll remember, won't you, the animated conversation spoken of by [Dr C] that I was reminding you of yesterday in [Baby E]'s case? And again, ladies and gentlemen, we have, don't we, the power of circumstantial evidence?

The same witness seeing the same thing in two apparently unconnected cases. I say apparently unconnected. You know what the connection was, of course: she's sitting in the dock.

What was going on? Dr Jayaram, he also told you about [Baby A]'s collapse. He gave evidence on 24 October last year. He told us about [Baby A]'s heart trace on the Philips monitor and the effect of what he was saying was that there was no problem with [Baby A]'s heart. You might remember his references to P waves, the QRS complex, and a T wave. What he was saying in medical language was what he could see. The heart trace on the monitor was normal, wasn't it?

[Baby A] was in a reduced level of consciousness.

You'll remember what Dr Jayaram said about inserting the ETT without anaesthetic and how babies usually protest when that is done. But there was no protest here because of the desperate condition in which [Baby A] was.

And to Dr Jayaram's mind there was a disconnect or a contradiction between [Baby A]'s heart activity, which on the monitor appeared to be fine, and yet his reduced perfusion, the fact that he was grey rather than pink.

Although the heart was pumping normally, there was no arrhythmia, in other words no irregular heartbeat, and although the heart was pumping normally, something was stopping the blood circulating properly. [Baby A]'s sats were crashing and there

were the pink/purple flitting patches. Dr Jayaram described them as:

"Pink patches that appeared mainly on the torso, on the abdomen, which seemed to sort of appear and disappear and flit around and I've never seen anything like this before."

[Baby A]'s collapse did not fit with him having been so well immediately before the collapse. [Baby A]'s breathing was being supported, air going in and out of his lungs, but his sats not improving.

What Dr Jayaram was seeing as [Baby A] declined was something he had never seen before. He said to you:

"It still doesn't fit. To me, with any disease process that I have ever seen, learned about, read about in my career, why didn't he respond as he should have done?"

And Dr Jayaram excluded the idea that [Baby A]'s collapse was in some way due to arrhythmia. Do you remember he was asked questions about the position of the line and you saw the position of the line on the X-ray? He gave several reasons why this was not arrhythmia. First, the line wasn't actually in the right place to have caused an arrhythmia because it was not on the sinus, which is the medical term for the natural pacemaker in the heart, the thing that controls the heart rhythm.

Second, he made what, when you say it, is an obvious point: what he could see on the Philips monitor was a regular heartbeat, not an irregular heartbeat.

And third, the ECG, where you put the stickers on to -- the monitor on to [Baby A], that was normal as well.

And he said that if the long line had been the problem they would have seen the abnormal rhythm and withdrawn the line.

Of course, all that ignores the discolouration, doesn't it, because that's got nothing to do with arrhythmia or indeed the similarity with the events with [Baby B] the following night.

And Dr Jayaram was vigorously taken to task on behalf of Lucy Letby because in his notes at the time and in his communication with the coroner, he'd not mentioned the discolouration. He said that the reason for that was because he hadn't realised the significance of what he'd seen. He said that the significance only became apparent when the same signs appeared in later children.

It was suggested on behalf of Lucy Letby that Dr Jayaram was making things up to fit his theory. It was put in terms that he had not seen the discolouration he described, although that was not quite how Lucy Letby put it when she gave evidence. He said that he did see what he said he did and it was then suggested to Dr Jayaram that he had an expectation that people would just accept what he had to say because he's a doctor.

Well, you'll be the judges of that, ladies and gentlemen.

When Dr Jayaram was cross-examined on 22 February this year about the case of [Baby M], he was referred back to the case of [Baby A] and it was suggested again in blunt terms that the discolouration "is not what you saw". And ladies and gentlemen, we suggest again this is all smoke and mirrors, it's all distraction. The attack on Drs Jayaram and Harkness was done in an effort to distract you from the truth.

If the evidence of those doctors stood alone we would suggest it is reliable and trustworthy. But fortunately, we suggest that your task in determining where the truth really lies is very straightforward on this issue because there is other evidence to help you and, importantly, evidence that is not disputed.

Can we start, please, by looking at this, ladies and gentlemen, as it's so important? It's in the [Baby A] interviews, so interview bundle 1, an interview on 4 July 2018. It’s page [redacted]. It’s behind that very first divider. I think I just said page 11, it’s pages 8 and 9, I’m sorry, and then page 11.

So at the top of page 8 Lucy Letby is saying: “Babies are usually quite pink and he’d become more pale as in almost white.” Then further down the page, she says: “So mottled is a bit more -- almost like a rash appearance, like a blotchy red marks on the skin.” At the bottom: “So when the baby’s quite pale and white they can have sort of red areas on them, like reddy-purple.” Then at page 11 in the bottom third of the page: “Question: When you talk about this mottled rash, can you give us any further description/shape?

“Answer: I think from memory it was more on the side that had his line in. It was his left.

“Question: And you describe a red/purple colour.

Can you help us with any comparisons with anything colour-wise?

“Answer: I think he was more pale than mottling -- than the little areas of the mottling.” So that’s the starter. How did Lucy Letby remember that? Because it wasn’t actually in her notes, but there we are, just like Drs Jayaram and Harkness.

The way Lucy Letby sought to explain this in cross-examination when I was asking her questions was that what she was explaining here was just normal blotchiness. To quote her directly what she said was: "I was referring to mottling. That's how I would describe mottling and I also felt that he was more pale than mottled." We say that's a lie. That's her trying to -- as she did at several stages during the interview process, what appear to be apparently incriminating admissions are explained away by Lucy Letby as being something else.

And the most startling or one of the most startling examples of that we'll come to in due course with [Baby N] and the time at which she saw blood and when the intubation happened. You'll remember all that.

But we suggest that when you read that interview, as you can if you wish, it's clear that what Lucy Letby was describing in the interview was something wholly unusual. But of course if she accepts that now she knows it causes real problems for her defence and you won't have forgotten, ladies and gentlemen, that at paragraph 39 of her defence statement she did not use the word "mottling" to describe what she saw in [Baby A], she used the word "blotchiness", a very different word, although in cross-examination she suggested to you that those words are interchangeable. Well, you will be the judges of that.

A further significant piece of evidence from Lucy Letby was in cross-examination on 18 May this year.

There was the following exchange between us, between me and Lucy Letby: "Question: Was [Baby A]'s death anything to do with Mel Taylor?

"Answer: I don't know why [Baby A] died.

"Question: But I'm asking you whether it's your case that it had anything to do with Mel Taylor?

"Answer: [And listen to this] If we agree that the cause of death was an air embolus, then I believe she attached fluid to those lines, yes.

"Question: So that's Mel Taylor's fault?

"Answer: Yes, if that's what we agree, that [Baby A] died from that, then yes.

"Question: Because you weren't standing over him at the time he collapsed?

“Answer: No, I didn’t have access to his lines, so therefore if an air embolism came, it must have come from the person connecting the fluids, which isn’t me.” Well, it’s something you might want to consider, ladies and gentlemen, but we suggest that there, Lucy Letby was as good as accepting that [Baby A] died from an air embolus. An interesting concession, we say, but it doesn’t end there.

[Nurse A] was Lucy Letby’s friend and mentored her when she was a student. Although it’s a long time ago, I’m sure you will remember that when [Baby A] crashed, [Nurse A] was just coming back into the unit and she stepped straight into nursery 1 and did the CPR for [Baby A]. She noticed a strange discolouration pattern on [Baby A] that she had -- you know what I’m going to say -- never seen before.

[Nurse A], her friend. Never seen before.

All [Nurse A]’s years of experience and she too was seeing something she had never seen before. And she described it in several ways: “He looked very ill, but he had a discolouration pattern that I’ve never seen before. It was this purply blotchiness with white that I’d not seen before.” Blotchiness, the same word that appears in the defence statement, paragraph 39.

She said that what stuck in her memory was that: “It had come on very suddenly, just how unusual it was.” And she said it was all over his chest.

Later in her evidence, [Nurse A] said that what she saw on [Baby A] had the same appearance. Those were her words.

"The same appearance as his sister the following night."

And [Nurse A] was then referred to the note she'd made in [Baby B]'s case at tile 218 and the note says:

"Colour changed rapidly to purple blotchiness with white patches."

And it was then suggested to [Nurse A] on behalf of Lucy Letby that she may have imposed her description of what she saw on [Baby B] on to her memory of what happened to [Baby A]. And the basis for that was what she'd said to the police in an audio-recorded statement and she said in no uncertain terms she had not been influenced by what anyone else had said.

She wasn't accused of being a liar, was she? Do you remember me saying to you yesterday, part of the strategy here of Lucy Letby is doctors bad, bad people doctors, they make stuff up. She

can't quite bring herself to say it about her friends though, sometimes, can she?

Dr Rachel Lambie. Do you remember her? She was involved in both the resuscitations of [Baby A] and [Baby B], but she didn't make any notes in [Baby A]'s case. The relevance of what Dr Lambie says to the case of [Baby A] depends on whether or not you accept that what was seen in his case was the same as what was seen in [Baby B]'s case, so we rely on [Nurse A] to make that connection.

I'll deal with it in a moment when I get to [Baby B], but what Dr Lambie told you was that when she got to [Baby B], who was in a state of collapse, she was:

"... very dusky, pale grey in colour, and as we were helping her she was developing widespread blotches."

That word from the defence statement again:

"Patches of purply/red colour. They would flush up, last about a few seconds, 10 seconds, and then disappear, and then reappear elsewhere."

What she wrote in the medical records, and it's in the [Baby B] sequence at tile 243, was this:

"Widespread purple discolouration of skin with white patches."

And Dr Lambie too said she had never seen anything like it before. She said:

"It was very grey and pale-looking, flashes of what looked like bruising or reddening under the skin."

Do you remember the meningococcal rashes spoken of by other people:

"It looks like bruising under the skin [we've been told], which would appear for maybe 10 seconds and then go, but appear somewhere else."

And when cross-examined on behalf of Lucy Letby, Dr Lambie confirmed that in her witness statement she said this:

"It was very grey and pale-looking, flashes of what looked like bruising or reddening under the skin and they would appear for maybe 10 seconds and then go but appear somewhere else."

Ladies and gentlemen, you will remember that Dr Harkness, "a bad doctor", made the point that his primary focus was trying to

save [Baby A]'s life, not to record the perfect description of something he'd never seen before. Have he and Dr Jayaram made up what they saw? Or do the descriptions given by Lucy Letby herself in interview, of [Nurse A], her friend, and Dr Lambie prove that what Drs Jayaram and Harkness said is true?

Remembering all the time that the flitting discolouration is only one of the signs of an air embolus. Ladies and gentlemen, if you conclude that Drs Jayaram and Harkness were telling the truth, because we say they are telling the truth, then what do you make of the attacks on their integrity? What was the purpose of attacking them for saying something that we suggest Lucy Letby herself was saying in interview, something that was not seriously challenged when it was said by her friend [Nurse A]?

We suggest the attack had a number of aims. First, it was designed to deflect you from the evidence, designed to make the case about personalities rather than about the evidence. Second, it was part of an overall strategy to try to destabilise Dr Jayaram, who's been an important witness in several of the individual children's cases, [redacted].

And finally, ladies and gentlemen, it was part of Lucy Letby's general approach to the case that essentially the nurses are good and overworked and the doctors are bad. The defence suggestion is that the doctors are seeking to cover up their own shortcomings by blaming Lucy Letby for the deaths and collapses. The defence are suggesting that there is a medical conspiracy going on, the Gang of Four, just as they are suggesting that an unidentified police officer tipped off Dr Evans that there was a suspicion of air embolus, and there's no evidence for that either.

The timing of this is clear because [Nurse A] told us that she was coming back through the doors when she saw what was going on, and you can time that precisely by looking at the door entry data in tile 180.

It was at 20.20 in [Baby A]'s case. We know that Melanie Taylor was busy on the computer at that time because the system recorded that at 20.14 she was entering her notes and we know that Dr Harkness was putting a long line into the child JE.

So ladies and gentlemen, although the unit was just post-handover, everyone else was engaged in something else. You know that that is a characteristic of the circumstances in which Lucy Letby attacked many of the children on this indictment.

Lucy Letby went home in the morning at the end of the shift and at about the time she got home she sent a message to Mel Taylor, asking her to update a chart.

You'll find that in the [Baby B] sequence at tile 55.

The next thing she did was search for [Mother of Babies A & B].

[Baby B]. [Father of Babies A & B], dad, said that in the immediate aftermath of [Baby A]'s death he and his father stood guard by [Baby B] all night, so this is the night of 8 June 2015. [Mother of Babies A & B]'s statement told us that the day after [Baby A]'s death the family was so upset that they decided that somebody would constantly remain with [Baby B]. She said:

"I didn't want her out of my sight or to be left alone. My whole focus was on her then."

And [Mother of Babies A & B] recruited her mum and dad to help and that guard was maintained, ironically, until about 8 pm, until about 20.00 hours when [parents of Babies A & B] went up to the ward for some rest.

During the day shift on the 9th, [Baby B] had done well. She was tolerating time off CPAP and she was having skin-to-skin with mum; you'll find that on tiles 76 and 78. [Baby B] was not only tolerating milk feeds, she was rooting and looking for milk, and you know now, if you didn't know before, that that's a very positive sign. You'll find that information at tile 84 in the [Baby B] sequence.

In the hours before her shift, Lucy Letby was sending texts to the effect that she didn't want to see [parents of Babies A & B] and she was telling Melanie Taylor that [Father of Babies A & B] had been:

"... on the floor crying, saying, 'Please don't take our baby away'."

That's tile 132. And she went on, Lucy Letby, to say:

"It was the hardest thing I've ever had to do."

But a few hours later she was trying her best to kill [Baby B].

At handover, Lucy Letby was put into nursery 3; that's tile 146 of the [Baby B] sequence. We know, don't we, that she didn't like being there? And it appears that she was bored. I say that because there are many text messages between her and Minna Lappalainen, Jennifer Jones-Key, Yvonne Griffiths and Charlotte James between 21.00 hours and 23.00 hours. I'm not going to go through them now, they are there if you want to see them, but 2 hours of texting to and fro between Lucy Letby and four other people.

[Baby B] desaturated in a minor way at about midnight.

You may remember this because it was an occasion when her nasal prongs for the CPAP displaced. Five minutes later, 5 minutes after that desaturation, Lucy Letby turned up in nursery 1 and we know that because she co-signed for a new bag of total parenteral nutrition and a syringe driver of lipid. You'll find that at tile 213.

If we could just look at 214, please. This is just after the desaturation of [Baby B], the nasal prongs point. What we can see is that there were observations just after midnight. We see the 24 -- my eyesight is going now. You can work out for yourselves what that says. If we go down to the bottom -- 24.10, probably. By coincidence -- or is it a coincidence? -- nobody has signed those observations in nursery 1. We know Lucy Letby was there in nursery 1 because she signed for putting up the total parenteral nutrition at about this time, at about midnight. So she's there.

And surprise, surprise, on the obs chart, whoever completed the data didn't sign. It's the power of circumstantial evidence, isn't it, ladies and gentlemen?

We know who did the blood gas if we look at tile 215 at 00.16, though, don't we? Writing that you all recognise with a signature you all recognise. [Baby B] collapsed at 00.30 that day. Her parents were woken by one of the nursery nurses and when they got down to the ward, [Mother of Babies A & B] in her agreed evidence said this:

"It was a very similar situation to [Baby A].

[Baby B]'s heart and oxygen saturations had fallen rapidly. The female consultant went on to describe seeing blotches or mottling across her skin and feet.

She asked our permission to take pictures of the mottling and she stated she had never seen this before.

I remember being surprised that this was something she'd never witnessed before. I imagined a consultant of neonatal care would have seen everything. By the time the staff had organised a camera, it had disappeared."

Well, the female consultant was [Dr B] and the talk at the time being recalled by [Mother of Babies A & B] was that what had been witnessed was something that she, [Dr B], had never seen before. You'll find [Dr B]'s note at tile 231 in the [Baby B] sequence.

When I asked Lucy Letby about this in cross-examination, she said that she had no memory of this conversation. Given her capacity to remember the things that helped her case, we suggest that she did remember, really, but realised that admitting it happened and admitting that [Dr B] was saying, "This was something I'd never seen before", was unlikely to help her case. It also, of course, would undermine the explanation she gave about that part of the interview I showed you before, wouldn't it?

I've already reminded you that Dr Lambie described [Baby B] as:

"... very dusky grey with patches of purply/red, which would flare up for 10 seconds, disappear, then reappear."

And Dr Lambie wasn't accused of making it up. After all, she'd made a note of it at the time. You'll find that at tile 225.

When she dealt with the collapse of [Baby B], [Nurse A] said this -- it's a direct quotation:

"She suddenly looked very ill. She looked very like her brother had done the night before, with the pale white, with this purply blotchy discolouration."

And she indicated what she meant, pointing all over her chest:

"I just remember thinking, 'No, not again'. I'd never seen anything like that before and then to see his sister with the same appearance."

And [Nurse A] made a note of it and it's at tile 218, please, of the [Baby B] sequence. There it is where the cursor is.

[Nurse A] reminded us that the declines of [Baby A] and [Baby B] were both very sudden. She stressed how unusual it was. And of [Baby B]'s collapse she said:

"To see her deteriorate so quickly and look so similar, I was -- it was -- yeah, that's why I said, 'No, not again'."

And Lucy Letby again made a contribution to the discolouration issue in interview. I'm not going to ask you to look, but it's at page 7 of the [Baby B] interviews. She said there was:

"Some mottling that looked a little bit similar to [Baby A] the day before."

She described [Baby B] as being more mottled, which was darker and extended over more of her body than [Baby A]; that's page 8. She said that it was before the resuscitation; page 9.

And in cross-examination, I asked her why in interview she'd used the description "rash appearance".

Her answer? She couldn't remember.

Well, I'm going to offer you an explanation for why she used the word "rash appearance", because it looked like a rash. It's not rocket science, is it? It's not mottling, this is something wholly unusual, as the other witnesses have said.

Lucy Letby said that she'd been alerted to the rash/mottling appearance by [Nurse A] -- you'll find that at pages 9 and 10 of her interview -- either when she was in the room or at the nurses' station she was suggesting in interview, page 10.

Lucy Letby, we suggest, could not keep out of nursery 1. If we go back to [Baby B]'s charts, we suggest, as I did to her in cross-examination, that in effect she elbowed her mate [Nurse A] out of the way. Tile 226, please. It's an entry -- it's at the bottom left if you look at it in the right orientation, but Mr Murphy very helpfully has done it so we can read it. It's in the 01.00 hours column. "Intubated 23.36"

at the top there.

Tile 232, a blood gas record at 00.51 while [Baby B] was being resuscitated.

Tile 237, please. The observations at 01.00 hours.

If we just scroll down, we'll see, next to the one I pointed out before that doesn't have any initials to attribute it, there is Lucy Letby's initials.

At tile 238 and tile 239, the intensive care chart and the equipment settings.

Tile 241, morphine given at 01.10.

Tiles 250 to 251 and 253 to 256, various medications between 02.07 and 02.25.

She was relentless, ladies and gentlemen. We know that she thought she had the cover of antiphospholipid syndrome, because that was what was being offered as an explanation to the parents at the time, and therefore this was a perfect cover for her

attack, Lucy Letby's attack, in the same way, producing similar symptoms.

And if you want some reassurance that that was what was being discussed at the time, if we look at [Nurse A]'s notes at tile 287, please, there's reference in there somewhere to a clotting problem, I believe. Yes, it's the:

"Most results normal but Dr Lambie's just spoken to parents. D-dimer is raised. Has explained this may indicate a clotting problem. Will be discussed with tertiary centre today."

Lucy Letby fastened on to that as an explanation, we know, from the [Baby A] sequence at tile 337, please.

So we're going to have to change sequences, I'm afraid.

337, please, Mr Murphy:

"They are querying a clotting problem."

That same evening, she was searching for [Mother of Babies A & B] again and there is a further search at tile 393 on 2 September.

Ladies and gentlemen, the first time you heard from Professor Arthurs was on 21 October last year. He dealt with [Baby A]'s case and made the following points.

First, one I have said already, it's rare to identify an air embolus from X-ray imaging.

Second, the line of gas that can be seen on the post-mortem X-ray from Alder Hey is unusual. You will recall it, I've referred to it already, it's very similar, at least to the untrained eye, to what was seen in the comparable images from [Baby D] and [Baby O].

Professor Arthurs said that this finding was the sort of thing that would not normally be seen in a case where there'd been a natural death. It was something that was seen in road traffic accidents or the like, in cases of sepsis -- this isn't a case of sepsis -- and in cases of sudden unexplained death in infancy, which is a diagnosis of exclusion in babies aged from 3 to 9 months, so that doesn't apply here. The only other eventuality in which it was sometimes seen was cases involving extensive resuscitation, and plainly that does apply here.

But we say that the air in this case was the cause or the need for the resuscitation, not the result of it, and again we say that this is classically a situation where you are entitled to

look at the other cases in context, something that the experts are not entitled to do.

Professor Arthurs said that while this gas was not diagnostic of air embolus, in other words just because it's there it follows that it has to be a case of air embolus, he said this:

"It was the most pragmatic conclusion."

"The most pragmatic conclusion." The only time he'd ever seen this much gas in the great vessel of a child was in the case of [Baby D]. This again is classically putting cases with cases, isn't it?

Dr Marnerides gave evidence on 29 and 30 March this year and he told you about two sets of unusual findings in the histological samples taken from [Baby A]'s lungs and his brain. I'm sure you remember this. In the lungs there were two sections taken, which showed what he described as:

"Very occasional, relatively large spherical empty spaces or globules."

Which he described as "resembling a grape that has been cut through" and they were within the lumens, in other words the pipework, of medium-sized veins in the lungs. And he concluded that these empty spaces in the slides represent air bubbles, so air bubbles in the blood vessels in the lungs. And he saw a similar thing in a histological section from [Baby A]'s brain. That air bubble was surrounded by blood, which told him, Dr Marnerides, that that air was in [Baby A]'s brain while [Baby A] was alive because the blood around the bubble is an inlife reaction to the air, though he qualified that by saying it cannot be taken as "absolute proof". He concluded that these findings were "highly suggestive of air embolus".

When he was asked about the possibility of the air being a post-mortem result of decomposition, he said that was highly unlikely. Dr Marnerides found no evidence of tamponade, this interference with the heart, do you remember, which was being floated for the suggestion of the collapse of [Baby A].

And finally and importantly, he found no evidence of any natural disease that could have caused [Baby A]'s death, and he "took the view that the death of [Baby A] would be explicable on the basis of air embolism".

So putting together the evidence of Professor Arthurs and the evidence of Dr Marnerides, which you are entitled to do, they are not, we have very unusual findings in the imaging and the X-

rays, we have histological findings of air bubbles in the lung, and an inlife reaction to an air bubble in the brain.

Putting that alongside the descriptions given by four eyewitnesses, including Lucy Letby, of what happened to [Baby A], we say the picture is clear: he was killed by someone injecting his circulation with air.

And that's why, if we agree that this is a case of air embolism, the words from the witness box, that is why Lucy Letby used that phrase, because she realises, doesn't she, the evidence in [Baby A]'s case proves that his death was the result of air embolism and her only way out is to throw Mel Taylor under the bus?

We then move on to Professor Kinsey. Having excluded antiphospholipid syndrome as the reason for [Baby A]'s death and [Baby B]'s collapse, Professor Kinsey went on to mention in her report the possibility of air embolus being the reason for the odd flitting patches in the skin and she was taken to task about that in cross-examination and it was pointed out to her that she is not an expert in air embolus and she agreed. But she said that she was shocked by the descriptions given in the medical notes and the first thing that had occurred to her was that this was a case of air embolus.

We've already dealt with the fact that Dr Jayaram and Dr Harkness' descriptions are supported by Lucy Letby, [Nurse A] and Dr Lambie. Have the two doctors made all this up to settle a score against Lucy Letby, a score that has no sensible motive or origin, except perhaps in the mind of Lucy Letby as a defence, or are these clear cases of air embolus?

That then leads us, finally so far as [Babies A & B] are concerned, to the evidence of Drs Evans and Bohin. Dr Evans was of the view that prior to his terminal collapse, [Baby A] was perfectly stable, breathing unassisted in air, sats in the high 90s, heart rate within normal limits, the insertion of the UVC caused no adverse reaction or deterioration and Dr Evans believes that, given the absence of other credible potential causes of collapse, the graphic description of a flitting rash in conjunction with the precipitous and unheralded collapse was sufficient to diagnose air embolus as a cause of death.

He did that initially before he knew about the evidence of Dr Jayaram because that description, as was pointed out to Dr Jayaram in cross-examination, wasn't in the notes.

Dr Evans discounted dehydration. You'll remember that was a failure to give 4ml per hour, so in total about 16ml of fluid, and the reason he excluded dehydration was that a dehydrated

baby's heart rate would be expected to rise, which didn't happen.

It was suggested in cross-examination that collapses of neonates can happen for any number of reasons, but nevertheless Dr Evans remained of the view that what happened to [Baby A] was extraordinary and not explicable by some naturally occurring event. And you may think that that's precisely the same position that was taken by [Nurse A], who was there at the time with all her years of experience.

Dr Evans reached his conclusion without referring to the findings of Dr Marnerides as to the air bubbles in [Baby A]'s lung and brain or the evidence of what was to happen the next night shift to [Baby B] or the others, the other babies you've heard about who exhibited odd flitting skin discolouration such as [Baby D], [Baby E], [Baby I], [Baby M], [Baby N] and [Baby O].

Insofar as the case of [Baby B] was concerned, Dr Evans said there was nothing in [Baby B]'s history that would account for the nature and speed of her collapse.

He said that the fact she had skin-to-skin with no adverse effects was indicative of her doing well and he was of the opinion that [Baby B] had been either smothered or injected with air. In favour of air embolus he said that the sudden appearance and equally sudden disappearance of the skin discolouration was significant.

I see the time, my Lord. I'm quite near the end, but I can pick this up tomorrow without any problem.

MR JUSTICE GOSS: Well, unless you can finish in the next couple of minutes.

MR JOHNSON: I don't think it's fair to expect --

MR JUSTICE GOSS: All right. We will break off there then.

All right, members of the jury, 10.30 tomorrow morning, please. And of course remember your responsibilities as jurors in relation to non-communication and research.

Thank you very much.

(In the absence of the jury)

MR JUSTICE GOSS: Mr Johnson, you'll have a better idea now as to how much longer you're likely to be.

MR JOHNSON: About halfway, I think.

MR JUSTICE GOSS: I was going to say, you will certainly be going into Thursday?

MR JOHNSON: Oh yes.

MR JUSTICE GOSS: I had worked that much out. Right. Can I just mention one other thing, a matter for you and Mr Myers? You'll recall that in my second set of legal directions, I gave you a version and I've been revisiting the direction in relation to the defence statement.

In our discussions it had been agreed that there was to be no suggestion of any inference being drawn in relation to the failure to mention something now relied on. But it's just the question of what significance, if any, they can attach, the jury, to a discrepancy between what is in the defence statement and what she said in evidence.

MR JOHNSON: Yes.

MR JUSTICE GOSS: In the way that I've put it, I've put it in the sort of adverse inference mode rather than in the inconsistent statement mode. And I've given the jury -- the jury will have a direction in relation to a witness giving inconsistent accounts and the evidential status of those accounts, both being evidence, and the jury to decide whether to attach any credence to either of them or not. I'm just wondering whether it's appropriate that that would not be the more appropriate form of direction for the defence statement rather than going through the current format.

MR JOHNSON: It's a matter for my learned friend as to what he feels more comfortable with, but my instinct, without having given it a great deal of thought or having seen your Lordship's proposal in writing, and thinking about it, is that the latter is the preferable route.

MR JUSTICE GOSS: Mr Myers, do you have any immediate reaction?

MR MYERS: The same as that, my Lord. It's more a matter of inconsistency in this case than adverse inference type situation.

MR JUSTICE GOSS: Absolutely. I'm going to redraft that direction and I will have it emailed to you before we sit tomorrow morning. It's going to be a long time -- not a long time, but quite a long time before you're going to have to address that particular issue, but it may be more important for Mr Johnson, I

don't know whether he's going to make any further reference to it --

MR MYERS: Maybe, my Lord.

MR JUSTICE GOSS: -- but there we are, I just thought I ought to clear that up and this seemed to be a good opportunity given that we're finishing earlier with the jury today.

MR MYERS: Thank you.

MR JUSTICE GOSS: May I say this as well: if it comes to Thursday and Mr Johnson finishes mid-afternoon or something like that, unless you wanted to start mid-afternoon, I would not require you to start mid-afternoon.

MR MYERS: That's very kind. We're grateful, my Lord.

Having spoken with Mr Johnson, he's fairly confident he may take up most of Thursday in any event, but I'm certainly grateful to have that latitude.

MR JUSTICE GOSS: You have the options.

MR MYERS: Thank you.

MR JUSTICE GOSS: As I say, I'll leave it with you.

MR MYERS: May I just confirm, my Lord, that Ms Letby remain at the conclusion of the day downstairs so she can be visited?

MR JUSTICE GOSS: Yes, that's been noted. Thank you very much.

(3.43 pm)

(The court adjourned until 10.30 am on Wednesday, 21 June 2023)