Prosecution Closing Speech Day 3

Wednesday, 21 June 2023
(10.30 am)

(In the presence of the jury)

Closing SPEECH by MR JOHNSON (continued)

MR JUSTICE GOSS: Mr Johnson.

MR JOHNSON: Thank you, my Lord.

Good morning to you all, ladies and gentlemen.

Day 3. You will remember at the end of proceedings yesterday we had been dealing with the twins, [Baby A] and [Baby B]. I had reminded you of the evidence, some of the evidence, that we called in relation to those children. I'd got to the stage of taking you or reminding you about the expert evidence relating to the children and I'd dealt with all of that apart from the evidence of Dr Bohin, so I will turn to Dr Bohin.

Dr Bohin told us that, in her opinion, [Baby A] was stable and doing well until he collapsed. She referred to [Baby A]'s observations and noted that they were so stable that he'd been started on enteral feeds and that he was handling well. You will remember he'd been out for skin-to-skin with his parents and she told us that the misplaced UVC had no bearing on his collapse and that it was a very common issue. You'll remember you heard quite a lot of evidence about how once you put the tube through the umbilicus, it can go into the liver because you simply can't control what happens to it once it goes in. So that was a common problem.

Dr Bohin discussed with us the discolouration on [Baby A] and said it wasn't plausibly explicable other than by air embolus. Later on today, I'll give you another reason, in the context of one of the other children, why it is not plausibly explicable other than by air embolus.

Dr Bohin also told us about the possibility of air being introduced into an intravenous line on the patient side of the pump, and you'll remember early on you received quite a lot of evidence about how the pumps work, how they have an alarm on which notifies of the presence of air, and the way round that of course is to introduce the air on the patient side of the pump.

When Dr Bohin was cross-examined about [Baby A] it was suggested to her that she could not exclude genetic causes for his death. Her response was, we suggest, a definitive rejection of the

possibility of there being genetic causes. What she said was this:

"I do not know of any genetic condition that causes you to collapse and die within 24 hours of life."

And no genetic cause was suggested to her in any of the subsequent 17 -- yes, 17 -- appearances she made in the witness box. You might want to think about that, ladies and gentlemen. It's all very well if that had been the only time you'd seen Dr Bohin, but she reappeared on 17 further occasions and no specific suggestion was made to her.

We suggest, as you know, because I have said it to you more than once, this is typical of the way Lucy Letby is presenting her case: she floats the spectre of possibilities, there are never specifics, and that is why we went through the exercise with her in the witness box of tying her down to specifics in each individual case.

Dr Bohin accepted that going without fluids for 4 hours -- and you'll remember that detail from the fact that [Baby A]'s first line had occluded and then Dr Harkness had to insert the second line. That going without fluids for 4 hours was "not okay", as she put it, but it would not have caused [Baby A]'s sudden collapse.

You will remember other evidence that we heard about dehydration, which told us that if a child of this age gets dehydrated the heart rate increases because of the drop in the amount of fluid in the circulation, so the heart in effect has to work harder to keep sufficient fluid going round the plumbing of the intravenous system. That was never seen in [Baby A]. So dehydration is not a credible cause.

Dr Bohin also said that the lack of fluids would cause a drop in blood sugar if anything. In that respect you will remember that [Baby B] was in a similar position, but her blood sugars were measured and they were absolutely fine.

When the suggestion was put in cross-examination that an air embolism could have arisen innocently through the catheter -- remember the Datix form for JA, put in over a year later -- I remind you, she said that she had never heard of it happening in a neonate because the lumen or the bore of the tube is so small.

Dealing with the case of [Baby B], Dr Bohin thought that the fact that she'd been having skin-to-skin on 9 June, the day after [Baby A]'s death, was indicative of the fact that she was in good shape. Dr Bohin thought that [Baby B] too had been the victim of an intravenous injection of air.

She was cross-examined about the lack of fluids on the 8th. She was cross-examined about the several attempts to site a long line. She was cross-examined about the description written by [Dr B] in the medical records and conceded that she would not have said that was sufficient to diagnose air embolus by comparison to the Lee and Tanswell description, and that might well be right and in fact she conceded it, but it completely ignores Dr Lambie's description, doesn't it? It's taking one little piece of evidence and ignoring the body of evidence.

Dr Lambie's evidence does coincide with that description. And in any event, ladies and gentlemen, you may think that the fixation on Lee and Tanswell as some sort of gold standard isn't necessarily a good thing. In their paper, Lee and Tanswell, the description related to a single case and who is to say that their powers of description are any better than anybody else's?

These diagnoses, ladies and gentlemen, of air embolus by Drs Evans and Bohin are based on the overall clinical picture together with, and importantly together with, the exclusion of other innocent potential causes.

This is where you have the advantage, as I've said more than once, over the experts. You're able not only to put all the pieces of the jigsaw together, you're entitled to go beyond the expert evidence to all the other material relating to the circumstances of these collapses, both individually and putting them alongside the cases of the other children. You're entitled to take into account the fact that there was a poisoner at work in this unit. You're entitled to take account of the fact that the [Babies A & B] twins collapsed in very similar circumstances. You can take into account the fact that Lucy Letby was standing over [Baby A] when he collapsed and was the last person to have any contact with [Baby B] before she collapsed.

You can look at her texts and the fact that she was seeking to come up with innocent theories. You can look at Lucy Letby's unusual interest in the parents, at her odd behaviour following some of the deaths. These are all pieces of the evidence that you can put together to draw your conclusions. As I said earlier, it's the cumulative picture which we say is inexplicable by anything other than the fact that she murdered or tried to murder these children. [Baby B] escaped, [Baby A] perished, but both were attacked by Lucy Letby.

So ladies and gentlemen, we've now reviewed together nine of the 17 cases. We've seen the poisonings of [Baby F] and [Baby L], deliberate targeted poisonings, each of their brothers injected with air, the attack on [Baby E] interrupted by [Mother of

Babies E & F], the attack on [Baby K] interrupted by Dr Jayaram. And in both their cases Lucy Letby persisted with creating the impression that there were ongoing problems. That was something that Lucy Letby repeated with [Baby P] at the time of what I've called the tea room collapse, moving his tube when he was completely incapacitated with pancuronium. [Baby P] also had a liver injury, which, if you look at it in isolation, doesn't tell you very much, but when you look at it in the context of what happened to his brother the day before, that tells you an awful lot, doesn't it? This is the power of circumstantial evidence.

If we now factor in the [Babies A & B] twins we've got similar discolouration in both of them at the times of their collapses. We have what we suggest was a concession in the witness box from Lucy Letby that [Baby A] died from an air embolus, "If we agree" -- do you remember those words:

"If we agree he died from an air embolus. It wasn't me, it was Melanie Taylor."

You have Dr Harkness' evidence that it was the same discolouration in [Baby E] and [Baby M].

We have evidence which supports the diagnosis of air embolus from Dr Marnerides from the histology in [Baby A].

We have Dr Arthurs' evidence from the X-ray of the air bubbles relating to [Baby A], which are a very similar picture to that of [Baby O] and, as we will see, also later today, [Baby D]. And we have Lucy Letby migrating, to use the words of Kathryn Percival-Calderbank, into nursery 1, just before [Baby B] collapsed. And we've still got another eight children to go.

I'm going to move on to [Baby C]. It was during the case of [Baby C] that we first heard from Dr John Gibbs. Dr Gibbs, who you saw for the first time on Hallowe'en, he started his evidence on Hallowe'en and concluded it the following day, on 1 November.

On 1 November, he was asked the following couple of questions in cross-examination:

"Do you think he [that's a reference to [Baby C]] would have been better placed, when you look at the whole thing in hindsight now, at a tertiary unit rather than the Countess of Chester?"

Dr Gibbs' response:

"That depends what caused his sudden collapse and unexpected death."

Next question:

"Question: In any event, given his health complications, don't you think he would have been better placed at a tertiary unit?

"Answer: No."

That exchange encapsulates a theme which has run through the defence of Lucy Letby and it has been suggested, hasn't it, time and time again, that if a particular child had been in a tertiary unit then they wouldn't have had a problem? There's been no medical evidence that substantiates that as a proposition, has there? None at all. And as his Lordship directed you last Thursday, the questions or the suggestions are not the evidence; it's the answers that are the evidence.

If you conclude, ladies and gentlemen, that there is some actual evidence, some identifiable failure that caused a collapse or the death of a specific child, then no doubt you will be more than pleased to acquit Lucy Letby in that particular case. We suggest that what's been in very short supply has been specifics.

What alleged failure or alleged shortcoming caused the collapse or death of any of these children? We invite you to ask yourselves that question in every single case, just as we asked Lucy Letby.

Unfortunately, the evidence has shown in this trial that these children would have been better off anywhere else other than with Lucy Letby, and it may be that that's really what Dr Gibbs meant when he said in answer to that first question:

"That depends what caused his sudden collapse and unexpected death."

[Baby C] was born on Wednesday, 10 June. Lucy Letby murdered him, we say, on the night shift of the 13th into the 14th. [Baby C]'s mum, [Mother of Baby C]'s statement was read to you. [Mother of Baby C] said that the problems were first highlighted at 21 weeks, when she'd been pregnant for 21 weeks, when it was realised that [Baby C] was smaller than he was expected to be.

Thereafter, [Mother of Baby C] was closely monitored and at 28 weeks she gave up work. As further problems appeared, [Mother of Baby C] was admitted to the Countess of Chester, where, on Wednesday, 10 June, it was discovered that there was an issue with the blood flow to [Baby C] through the umbilical cord.

Despite that, [Baby C] was born in good condition at 30 weeks plus 1 day.

He was intubated and then extubated very quickly and he made good progress. Lucy Letby wasn't working on the Thursday or the Friday, and [Baby C] remained on CPAP until Saturday, 13 June. At that stage he had mild subcostal recession, which you'll remember is a medical term for an eventuality that indicates an increased, slightly increased, work of breathing. But he was handling well and, most importantly, because here the suggestion being made on behalf of Lucy Letby is that there was an abdominal problem, so most importantly on Saturday the 13th, on the day shift, [Baby C]'s tummy was soft and not distended. And you will find evidence of that in Melanie Taylor's note, which she made in the early hours of 13 June. It's tile 41 if you want to find it. I'm not going to go to it now, but it's there in the records.

This was day 4 of life and [Baby C] had no outward sign of abdominal problems after 4 days. You will remember, just pausing and remembering what we dealt with yesterday, [Baby E] met Lucy Letby on day 6 of his life and that's when he developed abdominal problems, apparently. Well, here we have a child on day 4, no problems, or not until at least he met Lucy Letby.

Prior to the events of 13 June into 14 June, something had happened which was noted by Yvonne Griffiths, but which was misplaced in the nursing notes, and you can find it at tile 170. She inserted it after [Baby C] had died, and this is important, so I will show it to you, please. Do you remember, this was mistakenly put into another child's notes but was found after [Baby C] had died and was therefore inserted after the event, as you can see on 14 June.

It concerned events at 18.30 on Friday, 12 June, which is more than 24 hours before [Baby C] collapsed.

Yvonne Griffiths had found some bile on the blanket, then aspirated the nasogastric tube of 2ml of what she described as "bile-stained fluid". Just under that part of the note, you'll see something else that we suggest is highly significant. [Baby C] had spent most of the day with his parents on that same afternoon, that is the 12th:

"Kangaroo care most of the afternoon."

You now know, although many of you didn't before we started this case, but you now know, but that that's a very, very good sign.

After that event, there were tiny aspirates and the position was static. [Baby C] was not getting any worse.

When she gave evidence on 31 October last year, Dr Katherine Davis was asked about this, asked about the bile specifically, and was asked this specific question:

"When you see bile like that, and taking into account the constellation of other features in this case, and all the other information to hand, would you expect a collapse as sudden and as like this in such circumstances?"

Her answer:

"Absolutely not. I have seen lots of babies with significant abdominal issues and even as far as babies who have NEC, that have perforated their bowel, so made a hole in their bowel, so the air's come out and into their abdomen, they don't behave and they don't die in the way [Baby C] died."

So that's Dr Davis.

That question and answer followed questioning on behalf of Lucy Letby, which had concentrated on the possibility that [Baby C] was developing an abdominal problem. And Dr Davis dealt with that by saying that her examination showed that [Baby C] had a soft tummy and if there'd been an abdominal issue she would have expected him to, these are her words, "be kind of really sore", and that he would have reacted, whereas he "handled well".

She referred to the fact that if babies are unwell with abdominal problems, then when they're examined they'll drop their sats and they'll drop their heart rate and yet none of that was happening with [Baby C].

That's why the fact that he was out for kangaroo care on the 12th is so important.

By the following morning, so Saturday, 13 June, the day that was to have the night shift on which [Baby C] died, on by the following morning [Baby C]'s presentation and his improvement were such that he was cleared for one half of 1ml trophic feeds on the night shift. There is a note relating to that at tile 77 if you want to find it.

You'll remember the evidence you heard from several of the doctors, I think, about the fact that these very tiny, one half of 1ml, feeds are given to prime the gut, to get things moving. Dr Ogden had noted, at 09.30 hours that morning, Dr Gibbs' advice to start the trophic feeds if the bile issue got no worse. Dr Gibbs told you about that, that if [Baby C]'s was a case in which there was an intestinal blockage, then the aspirates would have increased, and that is not what we see.

Witness after witness was asked about the aspirates and each gave more or less the same answer: they were very small, they were a potential concern, but when viewed in the light of the general presentation of [Baby C], they were not a problem. Both Dr Gibbs and Dr Bohin made it clear that the black colour of tiny aspirates and the single vomit or posset was altered blood, it wasn't bile, because bile is not black.

Dr Gibbs made it clear that the blood came from inflammation in the stomach, which is why he put [Baby C] on to the drug ranitidine.

For all the efforts made by Lucy Letby to create the impression that [Baby C] had a problem with his intestines, you know as a fact from the evidence of Dr Marnerides that there wasn't a problem with [Baby C]'s gut. Dr Marnerides told us that there was:

"No evidence of infection or of sepsis in the bowel histology."

So we say that excludes the possibility of the problem. He said that if there had been a problem it would have shown up on the slides of the samples taken from the bowel tissue, which he examined. Not only that, but there was no pathological evidence of there having been any obstruction in [Baby C]'s bowel, and whilst [Baby C] was on antibiotics, they were not the antibiotics for NEC and the aspirates never got worse, so this is not a case of NEC. I'll come back to Dr Marnerides at the end of [Baby C]'s case.

Just going back to the sequence, ladies and gentlemen, Yvonne Griffiths, who had had [Baby C] on the 12th, described him, [Baby C], as a lively little baby who was at his happiest when he was being held kangaroo-style by his parents.

Joanne Williams, who had [Baby C] on the day shift of Saturday the 13th, described him as "lovely and feisty".

She too said that on the day shift [Baby C] was really settled when he was cuddling his parents.

Sophie Ellis, who was the designated nurse on the night shift of the 13th into the 14th, the shift on which [Baby C] died, also used the same word, "feisty", to describe [Baby C]. Much was made of [Baby C]'s very small size, even for his gestation, but all the treating staff said the same thing: he was doing very well. And as I hinted at earlier, his doing well happens to coincide with the period of 3 days when Lucy Letby wasn't on the unit. But she came in for the night shift of the 13th to the

14th and, within a few hours, [Baby C] had collapsed. And after hanging on to life for several hours, he died.

As I said earlier, Dr Gibbs, giving evidence on the afternoon of 31 October, had dealt with the unusual circumstances of [Baby C]'s collapse, partial recovery and then death. And at the end of that day's evidence he said this:

"I can't imagine, I can't think of any natural disease process that would allow a heart to restart later on when you hadn't been able to get that heart to restart with full intensive care and multiple doses of adrenaline and so on. So that suggests -- and I can't say any more than that, I don't know what it was -- whatever catastrophic event led to his death was reversing or had reversed after we stopped resuscitation. I don't understand that from a natural disease process."

All his years of experience and that's Dr Gibbs' conclusion.

Looking at the overall picture, looking at the trends, the evidence leading up to that fatal night shift from the treating nurses and medical staff tells us that [Baby C] needed very little extra oxygen and his breathing support had progressively reduced from CPAP to Optiflow and then he was in air.

If we could just look at tile 182 because this is quite a useful reminder for us of precisely what the position was with [Baby C]. There you will see that [Baby C] came off CPAP at 11 o'clock that morning, the 13th. He was then on nothing at all, but went on to Optiflow from 13.00 hours.

During that day shift, [Baby C] managed two periods with no breathing support at all when he was being cuddled by his mum and dad for a total of over 4 hours.

He was not a child who was struggling, was he? His problems didn't get worse -- or at least not until Lucy Letby arrived. If anything, they got better. His temperature, his respirations, his heart rate, they were all regular and normal. And I have just reminded you a few minutes ago of what Dr Katherine Davis said about it.

On the morning of the 13th, at 9.30, Dr Ogden and Dr Gibbs saw [Baby C]. I think I've already told you this. Dr Ogden noted, tile 77:

"Abdomen soft, not distended. Bowel sounds heard."

And she told you in evidence, "bowel sounds heard"

is a reference to normal bowel sounds. Do you remember that Dr Bohin later told us that this is evidence that there was no obstruction in the bowel because, in a case of obstruction, either no bowel sounds are heard or, if they are, they're what medics term tinkling bowel sounds. You probably remember that. It's quite an unusual phrase.

By the time of the night shift at 20.00 hours, Dr Gibbs had taken the decision to introduce the trophic feeds and that happened at 23.00 hours, 11 pm, that's tile 170, albeit you will remember Sophie Ellis had not noted the fact that she gave that one half of 1ml to [Baby C].

On the night shift on which [Baby C] died, Lucy Letby was the designated nurse for a child with the initials JE and you will remember that JE was in nursery 3. But [Nurse B] was of the view that JE was more of a concern than [Baby C] because JE was having breathing problems, but Lucy Letby was not happy about being in nursery 3.

If we go to tile 147, please. We see here there telling her friend, the nursery nurse Jennifer Jones-Key:

"I just keep thinking about Monday."

So that's a reference back to [Baby A]:

"Feel like I need to be in 1 to overcome it but [Nurse B] said no."

Jennifer Jones-Key said that she agreed with [Nurse B] and at 149 Lucy Letby said this:

"Not the vented baby necessarily."

The vented baby in this context is the child MRE:

"I just feel I need to be in 1 to get the image out of my head. Mel said the same and [Nurse B] let her go."

She doesn't like the fact that Mel got what she wanted:

"Being in 3 is eating me up."

"Eating me up."

"All I can see is him in 1."

So you know, don't you, that -- we haven't got a population distribution chart for this shift, but the evidence proved, we suggest, that there were two children in nursery 1. One was

[Baby C] and the other was the child MRE. That text tells you, doesn't it, who it was Lucy Letby wanted? Not the vented one, not MRE, the other one. And the other one in this context is [Baby C].

This is where her jealousies start to play into what's going on. Sophie Ellis was [Baby C]'s designated nurse. Mel Taylor, as I've just said, was MRE's designated nurse. And there was no reason, therefore, for Lucy Letby to be in nursery 1 doing anybody's meds. But if we go to tile 161, please, what Lucy Letby was telling Jennifer Jones-Key at this stage was:

"Yeah, I've done couple of meds in 1. I'll be fine."

Now, this is one of those many situations where something that Lucy Letby has either said or written down, she seeks to revise or reinterpret for you. We've seen it in some of the interviews that we've dealt with over the last couple of days and we will see it in material that we've yet to review.

But those are normal English words, aren't they, ladies and gentlemen?

"I've done a couple of meds in 1."

Well, what was she doing in 1? If you look at the neonatal review, and it's lines 38 to 41, I'm not going to ask you to turn it up because it delays us, but it's on the screen. These tell you that Lucy Letby had co-signed for some meds for HM and EB between 22.08 and 22.15. That last one is 19 minutes before that text at tile 161.

But that's not doing meds in 1, is it? The idea that "I've done some meds in 1" means "I went in to fetch some medicine and then administer them to a child in a different nursery" we suggest stretches the English language way beyond any sensible interpretation.

Sophie Ellis -- or if we look at tile 253, "the new girl", as Lucy Letby dismissively referred to her -- Melanie Taylor and [Nurse B] were all questioned on behalf of Lucy Letby and it was repeatedly insinuated that Sophie Ellis wasn't sufficiently qualified to be looking after [Baby C]. Do you remember? Three witnesses, all questioned about Sophie Ellis' qualifications and whether she was up to the mark to look after [Baby C].

Each of those three nurses rejected that suggestion and no evidence was ever produced to support the suggestion, was it? It's something that we took up with Lucy Letby in cross-examination and I asked Lucy Letby this question:

"Question: Sophie Ellis, Melanie Taylor and [Nurse B] were all asked questions on your behalf on the basis that Sophie Ellis was insufficiently qualified to have been looking after [Baby C].

"Answer: Yes.

"Question: Do you remember that?

"Answer: Yes.

"Question: Is that your position?

"Answer: Yes.

"Question: So does it come to this then, you wanted to be in nursery 1?

"Answer: Yes.

"Question: Your wish was being frustrated by management?

"Answer: By the shift leader, not by management, but the shift leader, yes.

"Question: And in your view, the person who had what you wanted, in other words to be looking after the non-vented baby in nursery 1, wasn't sufficiently qualified for the job?

"Answer: No, Sophie wasn't, I don't think, in the correct position to care for [Baby C]."

Then I asked the question I always ask:

"Question: Why? Why's that?

"Answer: She was recently qualified, she didn't have the experience or the skills.

"Question: Which particular skill was she deficient in?

"Answer: She didn't have experience of premature babies, small babies like [Baby C].

"Question: But which -- you see, one of the questions I asked you several minutes ago now was whether there was some sort of deficiency in care that led to [Baby C]'s death, so I would like you to explain to us why is it Sophie was insufficiently qualified to be doing the job she was doing?"

Then this answer:

"I'm not saying Sophie caused anything with [Baby C], I'm just saying she was the least experienced member of staff on that shift. She was in nursery 1, the intensive care room, with another ventilated baby, and she had very little experience with small premature babies like [Baby C] that we needed to keep a close observation of."

Well, she wasn't looking after the vented baby, was she? It was Mel Taylor. But anyway. Next question:

"Question: So she had something you wanted?

"Answer: No.

"Question: The care of [Baby C], wasn't that what you wanted?

"Answer: No, not specifically, no."

Well, we've seen it in the text message at the time, haven't we? That is precisely what she wanted.

Ask yourselves this question, ladies and gentlemen: what did Sophie Ellis do or fail to do that the most senior consultant in that hospital would have done differently? No suggestion was ever made, either to Sophie Ellis or to anyone else, and so why, if there's no evidence to support it, was the suggestion being made to three separate nurses? It's the same line of questioning, isn't it? It's like insinuating that Drs Harkness and Jayaram were lying about seeing discolouration or their descriptions of fleeting discolouration that was noted and attested to by others whose evidence was accepted.

It's trying to create in your minds the impression that there is something seriously wrong with the hospital. It's gaslighting you, isn't it? It's doing to you what Lucy Letby was doing to her colleagues in the Countess of Chester.

And when you are considering the eyewitness evidence that puts Lucy Letby in nursery 1 at that critical point when [Baby C] collapsed, we invite you to take into account the texts she was sending at the time, which put her in there just at that moment. We also invite you to consider the subject matter of some of those texts.

Tile 152, sent at 21.59:

"The image of the one you've lost never goes."

Tile 167:

"I've seen any fair share at the Women's."

A reference to Liverpool Women's Hospital.

Tile 174:

"I lost a baby one day and a few hours later was given another dying baby."

That's sent at 23.01.

Tile 178, sent at 23.09:

"Only those who saw him know what image I have in my head."

That tells you a number of things, not least Lucy Letby wasn't exactly rushed off her feet on this shift, was she? But we say, given the context of this and the other texts that I dealt with before, she was in nursery 1 with death on her mind when she sabotaged [Baby C].

Sophie Ellis said that when she fed [Baby C] that one half of 1ml of expressed breast milk at about 23.00 hours, she left the room. Yet another "left the room". Before she fed [Baby C], please don't forget this, before she fed [Baby C] at 23.00 she had aspirated a small amount of green bile. We say that the fact that she aspirated [Baby C]'s stomach at 23.00 tells you that there was nothing in his stomach at that time apart from the bile, obviously. She had the bile. There was no air and there was nothing else. Yet having left the room, within a short period of time, according to Sophie Ellis' evidence, she heard the alarm and returned to the room to see, even if you don't remember it, you know what I'm going to say, Lucy Letby standing over [Baby C], who said, "He's just had a brady and a desat".

That was in her evidence on 28 October. Within a short time, and whilst Sophie Ellis was in the room, [Baby C] desaturated again. This was the serious desaturation that led to [Baby C]'s death.

Melanie Taylor remembered Lucy Letby being there and she was challenged repeatedly on behalf of Lucy Letby.

What she'd said to the police in an audio recorded statement was put to her, but she told you that despite the inconsistencies between what she said then and told you, she remembered Lucy Letby being at the centre of events, particularly because she was:

"Surprised how cool Lucy Letby was and very calm."

That was evidence on 28 October.

It was Dr Katherine Davis who was crash bleeped.

She told us that during CPR, when she listened, there was no heart rate, no heart sounds or respirations.

This, she told you, was very unusual. What she said exactly was this:

"I've been to a number of collapses of neonates over my career and usually, even with the very smallest, sickest babies, there is some heart rate, but it's a slow heart rate or there's some respiratory effort.

But there was nothing in [Baby C]'s case at all."

This is a replica, isn't it, of what I was reminding you of yesterday in [Baby M]'s case on 9 April, the following year? The evidence given then by Dr Jayaram.

Dr Davis went to intubate [Baby C] and when she looked down his throat, you may not remember but you know what I am going to say, his cords were swollen and oedematous, another word for swollen -- like lawyers, never use one word when two words will do -- swollen and oedematous, even before she put anything into his airway. Think [Baby N]. Think lots of other cases that we'll come to.

The swelling could not have been caused by the Guedel airway that was used. As Dr Beech told us, a Guedel airway sits far short of the vocal cords. If this finding of swollen vocal cords was just an isolated case, you might say, well, we won't read necessarily too much into that. But we have [Baby E], we have [Baby G], we have [Baby H] and we have [Baby N]. Add [Baby C] and you have five children with this type of finding. And this is the power of coincidence, the power of circumstantial evidence, isn't it? It's not a second-class category of evidence. Someone had put something down [Baby C]'s throat before Dr Davies had a look. Who do you think that was? She's sitting in the dock.

Dr Gibbs told us that the one half of 1ml of milk could not have caused [Baby C]'s respiratory arrest. And that doesn't seem to have been disputed. He, Dr Gibbs, joined the efforts to resuscitate [Baby C] and, as I said earlier, he couldn't think of any natural disease process that would have produced what was seen in [Baby C].

You'll remember he said:

"Whatever catastrophic event led to his death was reversing."

Resuscitation was stopped and when, on behalf of Lucy Letby, he was asked about abdominal obstruction, Dr Gibbs rejected that as a suggestion because he said that if that was the case there would have been repeated vomiting and this is the importance of [Baby C] being 4 days old.

You heard some poignant evidence relating to the time that [Baby C] clung to life from his parents. It was agreed evidence. [Baby C]'s father, [Father of Baby C], said:

"Once [Baby C] was baptised they stopped trying to resuscitate him. It was during this time that [Baby C] started breathing on his own. [Mother of Baby C] and I were escorted into a family room. [Baby C]'s mum, [Mother of Baby C], said we held him for hours. Shortly before he passed away, [Baby C] was given another dose of morphine by one of nurses. I can't recall which of the two nurses this was. This was at about 5.30 on Sunday the 14th."

You will remember that that rally or that survival period was, relatively speaking, a long time. Dr Gibbs had recorded handing [Baby C] back to his parents at 00.45 and Dr Davis recorded [Baby C]'s time of death at 05.58, so that's just over 5 hours, isn't it?

During that time, the privacy of that family was interrupted by a nurse who [Father of Baby C] described in his statement as "nurse 3", and he thought that nurse 3 was Lucy Letby. She wheeled in a ventilated basket to the room and said something to the effect, "You've said your goodbyes now. Do you want to put him in here?"

When asked about this in interview, Lucy Letby said that she didn't remember the conversation; you'll find that at page 23 of her interview. But you will remember, of course, that [Nurse B] told us that Lucy Letby was going in and out of that room while [Baby C] was dying. And [Nurse B] had to tell Lucy Letby to look after JE more than once.

You will, in that context, remember the excitement and odd behaviour exhibited by Lucy Letby in the aftermath of the deaths of [Baby P], described by [Dr B]. You'll remember Lucy Letby's remark about being at [Baby I]'s first bath, that her mum [Mother of Baby I] told you about.

What was the attraction of that room at that time to Lucy Letby? Again, this was an isolated occasion. You might not read too much into it, you might say, well, the parent was in a difficult position, maybe their perception -- maybe they've just got the wrong end of it. When you have similar occurrences happening at different times involving different people, who say in effect

the same sort of thing, it is the power of coincidence, isn't it? It is not an innocent coincidence. That's the point.

You need, we suggest, to look no further than the tragic aftermath of Lucy Letby's attack on [Baby C] to recognise how much she enjoyed what was going on.

And after repeated questioning in cross-examination, she could not give a plausible reason, could she, for going into that room whilst neglecting her responsibilities to JE, who had breathing difficulties?

The staff on the unit were all confused by what had happened to [Baby C] because he was stable. We know that because of the text [Nurse A] sent to Lucy Letby at tile 288. It's a series of texts, actually, 288 to 305. It starts with Lucy Letby telling [Nurse A] that [Baby B] is in 4. Then 289:

"Yay, bless her. How are [Mother of Babies A & B] and [redacted]?"

That conversation carries on.

Then at 293, talking about [Baby B]:

"There's something odd about that night and the other 3 that went so suddenly."

And within that same minute, 21.49, Lucy Letby's reply:

"What do you mean?"

This doesn't prove anything in itself, does it? But knowing what you know now, "What do you mean?", straight back.

And then followed again:

"Odd that we lost 3 and in different circumstances."

[Nurse A], 6 minutes later:

"I dunno. Were they that different?"

Then:

"Ignore me, I'm speculating."

Then 298:

"Well, [Baby C] was tiny, obviously compromised in utero."

Gaslighting:

"[Baby D], septic."

Well, we know [Baby D] wasn't septic:

"It's [Baby A] I can't get my head around." Said Lucy Letby.

[Nurse A]:

"Was she definitely septic? Did the PM confirm?"

We're going to come to [Baby D] in a moment, aren't we?

Then this one, 301, talking about the post-mortem:

"When's [Baby A]'s? They were talking of doing a joint one for all 3 as all close together and similar in being full arrests in babies that were essentially stable."

There you are. There you have it. The power of circumstantial evidence, eh? They were similar, all unexplained, all confusing, and all the responsibility of Lucy Letby.

The expert evidence. Dr Evans confirmed what Dr Gibbs said, that [Baby C]'s respiratory support had stabilised over several days before his death. He was being weaned down from CPAP to nothing and then back to Optiflow. He wasn't being given supplemental oxygen.

Dr Evans made the point that [Baby C] would not have been having skin-to-skin if he'd been unstable from a respiratory point of view.

He repeated what, in effect, Dr Gibbs had already said, that the aspirates were not of concern in the overall context and, most importantly, they were not increasing, three nurses describing [Baby C] as feisty was not consistent with [Baby C] having a bowel obstruction.

He told us about the raised CRP, but that was dealt with in the histology by Dr Marnerides, which I'll come to in a moment. And he repeated an oft-repeated mantra in this particular case, that [Baby C]'s progress was not what one would expect to see in a child who was being overwhelmed by some sort of systemic infection. And in particular, his capacity to keep his saturations high in air, in other words without any additional oxygen, was not consistent with his pneumonia getting progressively worse.

Dr Evans concluded that the reason for [Baby C]'s collapse and death was an injection of air into the nasogastric tube. Dr Evans was criticised, and we accept justifiably criticised, for not having given a cause of death in his report, but then saying it in the witness box, because experts should and must notify any alteration of their opinion in writing.

But he returned to the witness box on 14 subsequent occasions and if anyone was caught by surprise by what he said, there was plenty of opportunity to deal with it. But if you think, ladies and gentlemen, that the way that Dr Evans failed to give advance notice of his opinion in the report has or even may have had or caused any unfairness to Lucy Letby, then we encourage you to disregard what he said in this case, not least because, when we get to Dr Marnerides, we will see that he gave a much more detailed description and reasons for reaching precisely the same conclusion. So you get the evidence from a different source in any event.

Dr Bohin, who gave evidence on the 1st and 2 November, referred to [Baby C]'s raised markers for infection, which she told you was consistent with the pneumonia that can be seen on his X-rays. But she reminded you that putting the radiological evidence into context, into the clinical context, [Baby C] had been taken off CPAP and put on to Optiflow well before the time that he collapsed, and if you want an easy ready reckoner, I think I've already shown you -- actually this is a different one, I think. It's in tile 121, which is the gas chart. That tells you when [Baby C] was on various forms of breathing support. Dr Bohin said that the typical path of decline with pneumonia was a slow one, with ever-increasing ventilation requirements.

As for the build-up of gas on 12 June 2015, in other words the day before, and you'll remember she was and other witnesses were asked about this, because Lucy Letby was not there on that occasion, or at least there's no record of her being there, I should say, in the light of some of the other evidence you've heard in this case. Dr Bohin said that the records were very unclear as to (1) whether [Baby C]'s stomach was being aspirated at that point and, (2) whether the nasogastric tube had actually been left on free drainage. Dr Bohin thought that if that hadn't been left on free drainage then the CPAP that [Baby C] was receiving at that stage, the previous day, could account for the gas.

The other thing that Dr Bohin pointed out, something I think I've already mentioned, was what Dr Ogden had said about hearing normal bowel sounds on the morning of the 13th, and that in effect excluded the possibility of there being a bowel obstruction.

Dr Marnerides made a substantial contribution to the evidence in this case. He said there was nothing abnormal about [Baby C]'s bowel. He said [Baby C] did not have a volvulus. The fact that at the post-mortem meconium was seen proves that there was no volvulus.

Madam, on the back row there, you'll remember being asked to hold up your water bottle because he said that's the colour of what you see if there is a volvulus. I'm paraphrasing him now, but, "I'd sack my apprentice if he missed or she missed something like that".

Following a meeting with the clinicians, including experts from the defence, Dr Marnerides concluded that [Baby C] died with pneumonia rather than from pneumonia because there was nothing to suggest that there was any cellular response to a systemic infection. So putting that into language I can understand, what he was saying was that if a particular infection in a location spreads then you get a cellular response in other parts of the body, which is identifiable at a post-mortem, and that was absent, and therefore it shows you, tells you, that it was not the pneumonia that killed [Baby C].

He said that the gas in [Baby C]'s bowel could not be explained either by an infection, because that was excluded by the histology, or an abnormality of the bowel or, importantly, by post-mortem decomposition. He "confidently excluded", those were his words, post-mortem decomposition. And therefore Dr Marnerides concluded that air must have been injected into the nasogastric tube, causing a splinting of the diaphragm, which in a baby with pneumonia was enough to compromise his breathing and kill him.

When it was suggested to Dr Marnerides that an explanation for the air in [Baby C]'s bowel was the fact that he was on CPAP, and I've already told you he'd not been on CPAP for hours before this, what Dr Marnerides said was this:

"I have never in the past 10 years that I have been doing this type of examination come across even a suggestion that CPAP belly would result to the deterioration of a baby, let alone this gastric distension that would be associated with a baby's death."

He continued:

"I could not see that if this was a likely mechanism this would not have been reported in any pathology paper or review or post-mortem examination or congress that I have been to or a case

that I have discussed. That is why I regard the proposed mechanism as unlikely."

And that line of questioning on behalf of Lucy Letby, we suggest, also overlooked a number of important facts. First, [Baby C] came off CPAP at 11.30 -- sorry, 11 o'clock that morning. In other words, a full 12-plus hours before he collapsed. In the interim, he survived without any intrusive breathing support, being cuddled by his parents.

Second, he did so well that when the kangaroo care ended, he was put on to Optiflow at 13.00 hours, which, as you know, is a much less invasive form of breathing support.

Thirdly, and finally, his nasogastric tube, this is the point I made to you before about Sophie Ellis, his nasogastric tube had been aspirated shortly before his collapse and yet no air was obtained.

Dr Marnerides referred to "massive gastric dilation" and "ballooning of the stomach"; they're his words, not mine. He excluded NEC on pathological grounds. When he was asked why the air didn't just pass into the bowel rather than splinting the diaphragm, he gave us a little lesson in physiology and told us that the opening of the stomach into the bowel was called the pylorus and when overfilled the pylorus goes into spasm, which prevents the passage of the air through the pylorus.

So just to summarise our position, ladies and gentlemen, before the break. This is a case in which we suggest that Lucy Letby's interviews are very important, and I invite you to look at them with me now, please.

You'll find them in the interview bundle number 1, they're about the sixth or seventh tab, the [document redacted] tab. I'm going to start at the beginning with this one. So page 1, please. Lucy Letby said that her only involvement with [Baby C] was with his resuscitation.

Pages 2 to 3. She told the police that she remembered that [Baby C] had not long had his first feed when he had deteriorated. You remember I asked her about how she remembered that and she said it was in the notes she was given before the interview.

She said at page 4 that she was not or she did not remember being the person who fed him, although she did, if you go back to page 2, remember that Sophie Ellis had been the designated nurse.

She claimed at page 3 that she was not the person who discovered [Baby C] collapsing.

Well, you know what the evidence is on that.

Interestingly, at page 5, almost exactly halfway down the page, she said that rough notes of a resuscitation would be transposed into the medical notes and then disposed of. In that context, you might just want to write "[Baby M]?"

Lucy Letby confirmed at page 8 that she had had contact in the family room with the [Baby C] family when [Baby C] was dying.

In the second interview at page 11, she would not accept Sophie Ellis' account of having gone in when [Baby C] collapsed and seeing Lucy Letby standing over [Baby C]. This is an interesting interview, this one.

Page 12. When asked why she would have been in there, she said that perhaps she was checking the resus trolley or getting drugs for her baby or using the computer. Well, we know from the neonatal review that that isn't the explanation, at least getting drugs for her baby isn't the explanation. Query, why would you want to use a computer in a darkened room when there's other computers in the light? And why would you be checking the resus trolley?

Page 12, of the remark attributed to her by Sophie Ellis, "He's just dropped his heart rate or sats", she said:

"She must have said that because that was what she had seen on the monitor."

At page 13 she was asked about the text conversation about seeing a dead baby in a cot space, the conversation she'd had with Jennifer Jones-Key on the night. She claimed, unbelievably, that she didn't know what that conversation was about or where she had been when she had sent the messages. We say that is incredible, it is not believable, the idea that she didn't know what that was about.

When the police suggested it, though, she admitted of the possibility, to use her word, that it was a reference to [Baby A]. She also said that she was frustrated as this emerged, she was frustrated when she was texting Jennifer Jones-Key and was looking for a more compassionate response. That's why we suggest she was angry when she murdered [Baby C].

Of the text, "Being in 3 is eating me up", that's the one at tile 149, it's page 15 of the interview, she accepted that she was frustrated that she was not in nursery 1.

Page 16. She said the fact she was texting up to 6 minutes before the collapse did not give her any thoughts.

And then, 16 to 17, she accepted that she was in nursery 1 at the time of the collapse, that she was the only staff member there at the time and she was feeling frustrated and upset.

In the final interview on 10 November 2020, she was asked about the blood that I reminded you was seen by Dr Katherine Davis. It's page 18, [document redacted]. She denied that she had inflicted any trauma.

At pages 19 to 20, she said that she did not remember getting involved with the [Surname of Baby C] family after [Baby C]'s death when she had her own baby to look after in nursery 3 and when [Nurse B] was telling her to care for her own patient, pages 19 to 20. "I don't remember it." Shades of what's to come with [Baby D].

With regard to Facebook searches, pages 20 to 21, she said she wasn't sure why she'd done it. Then back to the phone messages, 21 to 22, being asked about the conversation or the text conversation she'd had about Jennifer Jones-Key, she said she didn't -- so she repeated what she was saying earlier in effect in a different interview. She said she didn't remember where she was and what she had asked Mel to do. She said she did remember the messages. As for not being allowed in nursery 1, she didn't specifically remember what she was thinking.

So ladies and gentlemen, what does that all give us?

What does it all give you? It gives you a case of a baby who did not have an abdominal issue that could have caused his sudden collapse and death; that's Dr Marnerides and the paediatricians. It gives you a collapse and death that is inconsistent with any naturally occurring issue; that's all the medical evidence. It gives you Lucy Letby alone in the nursery when [Baby C] collapsed, having just been texting her friend about how angry and frustrated she was; that's her own words in interview. It gives you Lucy Letby making references in her texts to a child who, for reasons we have already explained, she had murdered a few days earlier.

Lucy Letby started the interview process by lying about where she was and lying about her reasons for being in nursery 1. [Baby C] had massive gastric dilation and ballooning of the stomach, which he'd not had when he was fed by Sophie Ellis. In the absence of natural causes, it's obvious what happened, isn't it? Even if you don't take into account any of the other cases.

When you put [Baby C]'s case alongside the others, it's as plain as the nose on your face that Lucy Letby must have injected air down the nasogastric tube into [Baby C]'s stomach.

It was, after all, one of her favourite ways of killing and trying to kill the children in this case.

And when you add to that the fact that [Baby C]'s vocal cords were swollen and that his designated nurse was absent from the room at the time, we say you have a constellation of coincidences, which together and in combination with other children's collapses and deaths, can make you sure that [Baby C] did not die from natural causes and it was Lucy Letby that murdered him.

My Lord, that may be a good point for the break.

MR JUSTICE GOSS: Certainly. We'll have a ten-minute break then, please, members of the jury.

(11.49 am)

(A short break)

(12.00 pm)

MR JOHNSON: When she gave evidence, Lucy Letby claimed to you that she doesn't really remember [Baby D]. She said that to you because that's what she told the police in interview. And she said that in interview because she thought that the absence of her name from the paperwork for [Baby D] gave her the opportunity for plausible deniability.

What she didn't realise, though, and what she has now not taken account of is the fact that through the hard work of the police, they can put her in the room.

That is tile 168. What Lucy Letby said to the police in interview is completely undermined not only by that image on your screen but also by her Facebook activity.

She searched for [Mother of Baby D] on 25 June 2015 and more than 3 months later, when, in October, she did two searches for [Father of Baby D]. Either she has a very good memory for names or she was using the handover sheets, although the handover sheets don't have the parents' name on, do they? And if she has a good memory then her claim to have forgotten [Baby D] to you was a lie.

Why tell that lie? In this context, and when you're thinking about that question, if you do, you'll remember her Facebook

search for [Surname of Baby K] on 28 April 2018, 26 months after [Baby K] had left the neonatal unit, having been there for less than 12 hours on 17 February 2016. When I asked her about that, she said she could not explain. We say that is a lie. We say she will not explain. You might ask yourselves, why won't she tell you the truth? Because the truth is bad for her, isn't it? It's bad.

When [Baby D] was born, she was 37 weeks' gestation.

She was over 3 kilograms in weight. She had good Apgar scores and yet she survived just over 36 hours. Her mum, [Mother of Baby D], had a difficult time before giving birth on 20 June at 16.01 hours. You will remember her telling -- [Mother of Baby D] telling you all about that on 3 November last year.

There's no doubt, is there, ladies and gentlemen, that [Baby D] suffered sub-optimal care in the immediate aftermath of her birth? But once Lisa Walker had intervened and called for help, when [Baby D] arrived at the neonatal unit at 19.30, you find that at tile 8, her progress was upward. She was heading in the right direction.

Because she had breathing difficulties, she was intubated at 22.10; that's tile 40. And Dr Brunton, the Scotsman, told us about this and he referred to his notes of the intubation, which you'll find at tiles 34 and 35.

By the following morning, 21 June 2015, exactly 7 years (sic) ago today, [Baby D] was intubated at 09.00 hours. You'll find that in Kate Bissell's note at tile 105 and Dr Newby's note at tile 107.

By the end of the day shift on 21 June, Dr Sarah Rylance, tile 158, the witness who gave evidence from Switzerland through the video link -- you'll remember we had a French judge taking part in our case -- Dr Rylance told you this -- a Swiss judge, I should say, not a French judge, speaking French.

Dr Rylance told you this:

"At 19.00, on 21 June, from what I've documented, she [in other words [Baby D]] was stable with a minimal level of respiratory support in no additional oxygen.

She was responsive and she was making good progress and had responded well to the treatment given since entering the neonatal unit."

And we can see from Dr Rylance's note that [Baby D] was on CPAP. She was responsive when she was handled. Her chest was clear.

This is a child with pneumonia. Her chest was clear and she had regular respiratory effort.

Her abdomen was soft and not distended. You know why I'm telling you that? She was kept on CPAP because when she was taken off, [Baby D]'s breathing became irregular.

[Baby D] died 9 hours and 25 minutes after that examination.

So I'm going to go straight to the night shift on which she died. It was Father's Day 2015, Sunday, 21 June. Nurse Caroline Oakley became [Baby D]'s designated nurse at handover. She gave evidence to you on Friday, 11 November last year. If we look, we will see her notes at tile 168 -- sorry, I don't think it's her notes, I think it's the population distribution.

So Caroline Oakley, designated nurse for [Baby D], and importantly, we say, she also had a child in nursery 2, the child OC. The other two children in nursery 1 were MRE and JE. Their designated nurse was Lucy Letby. JE is the same JE who was in nursery 3 on the night [Baby C] died. So it looks like [Nurse B] was right about him, doesn't it?

So why, thinking back to [Baby C] just for a second, was Lucy Letby ignoring him to go into the family room?

But more importantly in the context of [Baby D]'s case, the fact that Caroline Oakley had a child in nursery 2 meant, as you know, that she, Caroline Oakley, would have to leave the room from time to time, leaving Lucy Letby alone with [Baby D].

On the night shift, until things started to go wrong, Caroline Oakley was happy with [Baby D]. She told you that [Baby D] was breathing for herself and was stable, and if you look at tile 169, it's your J2291 in your hard copy bundle, you will see that [Baby D]'s observations were all completely normal. Those are Caroline Oakley's words, not mine.

To quote again from Caroline Oakley, this is how she described it in the witness box, looking at that chart:

"She's breathing beautifully in air and she's saturating. Her oxygen blood saturations of oxygen are 100% and that's the highest they can be."

In a child with pneumonia, what could be better, ladies and gentlemen?

At 21.10 that evening, Dr Brunton examined [Baby D].

His notes are tile 174. [Baby D] was still 100% saturated on CPAP in air. No additional oxygen. He said things were clinically improving, there was no sign of increased work of breathing or respiratory distress.

[Baby D]'s abdomen was soft and her bowel sounds were normal. Dr Brunton said he'd expect bowel sounds to be present and they listen for them in case there are any signs of obstruction. This was a standard clinical examination. And Dr Brunton's plan was to institute enteral feeds, 1ml every hour. [Baby D] was well enough to start taking milk. And as Dr Brunton put it:

"We should be trying to improve her status by giving milk."

There were no problems with [Baby D] until Caroline Oakley went on her break at 01.00 hours. Just like in the case of [Baby C], [Baby G], [Baby I], [Baby J], [Baby K] and [Baby N], all of whom collapsed when their designated nurse either left the room or went on a break. Caroline Oakley asked Kathryn Percival-Calderbank to keep an ear out for [Baby D]. After all, Lucy Letby was in the room. But being an experienced nurse, Nurse Percival-Calderbank checked on [Baby D] and the first time she checked her, when Caroline Oakley had gone on her break, she said [Baby D] was "nice and stable and settled". She checked the equipment and she left the room.

She checked [Baby D] again 10 minutes later and [Baby D] was still settled. She then heard the alarms and went back into nursery 1. And there in nursery 1 was Lucy Letby. It maybe, it probably will be, that you will be reminded in due course that in her evidence Kathryn Percival-Calderbank said she couldn't be certain it was Lucy Letby who was in nursery 1. But we say who else could it have been? Who was it who should have been in the room at that time in nursery 1? Who else had children to care for in that room? Who else didn't have children to care for in any other room? And if we go back to the population distribution at tile 168, if it wasn't Lucy Letby in nursery 1 when Kathryn Percival-Calderbank walked in, the only other people who it could have been, given that Caroline Oakley was on a break, and it wasn't Kathryn Percival-Calderbank, were [Nurse C] -- well, she was in nursery 2 and she said she was alerted to [Baby D]'s collapse and then went to nursery 1 -- or Elizabeth Marshall, who was a nursery nurse and wouldn't have been working in nursery 1, whose agreed statement was read to you on 8 November 2022, in which she made it clear that she wasn't working in nursery 1 and heard about [Baby D]'s collapse from somebody else. And when she looked into nursery 1, said Elizabeth Marshall, she saw Lucy Letby doing chest compressions on [Baby D], the child she doesn't remember.

What Kathryn Percival-Calderbank saw was a

"reddy/blue, reddy/brown rash" on [Baby D]. She said that in her 27 years' experience at that time it was a type of rash that she had -- you know the rest of the sentence -- never seen before.

In cross-examination she was taken to task about her statement and it was suggested that she had added detail, added detail that didn't appear in the statement. What she had said was not in the written statement that had been transposed by the police from the audio recording of her evidence. But it was in the original recording and she confirmed that when she was shown the transcript of the original recording. What she'd said there was that [Baby D] had discolouration that was "a mosaic, a mottley colour, blotchiness".

Caroline Oakley, the designated nurse who was on the break, recorded in the nursing notes that she was called back by Lucy Letby and Kate Percival-Calderbank, and this is one of those cases, ladies and gentlemen, where the paper records are not straightforward.

Can we start with tile 221, please? I asked Lucy Letby about this chart in cross-examination and the questions and answers went as follows:

"Question: Can we go to tile 221, please? There's an entry at 01.30. Do you see that?

"Answer: Yes.

"Question: Whose handwriting is 'oral secretions ++'?

"Answer: I can't say definitively.

"Question: Whose does it look like?"

You know the routine now, ladies and gentlemen?

"Answer: It could be mine.

"Question: Yes. Why were you writing in [Baby D]'s chart, if it was you at 01.30, if you were not the person looking after her?

"Answer: It may have been something that I documented alongside Caroline Oakley, who's filled in the other columns.

"Question: Yes, but if she's on her break she can't have filled them in at the time, can she, if she's on her break?

"Answer: So you mean she's filled them in at 1.30 when she was on her break retrospectively?

"Question: Well, it all depends, doesn't it?

If we move across, please, in the chart towards the right of it, do you see where it says suction 'pp LL'?

"Answer: Yes.

"Question: Whose writing is that?

"Answer: It's not mine, I'd assume it's Caroline Oakley.

"Question: Well, who is LL in this context?

"Answer: It would be me.

"Question: Because I'm suggesting you were, to use Dr Jayaram's phrase, babysitting [Baby D]. You had, as a matter of fact, been in nursery 1 throughout, hadn't you?

"Answer: I can't comment on that. I don't know for certain."

Do you believe that, ladies and gentlemen?

We then went to the neonatal review and we established that at line 122 Lucy Letby had made an entry on JE's chart at 01.30 in the same room, at the same time that [Baby D] was collapsing. In the chronology, as we were going through the cases, of course you'll remember this was the fourth case that we dealt with.

This was the first time the issue or potential issues, depending on your findings, of falsifying paperwork came up, and you know what happened after that.

The observation chart is at tile 193. If we can go to that, please. What we can see is a record that's timed there at 01.15, signed by Caroline Oakley. You can see that the previous record is 24.30 and the subsequent one is 02.30. Something you might have forgotten, I'm sure at least one of you will remember, is that Caroline Oakley told you that she filled in those details at 01.15 with details that had been told to her "by the girls". And which of the girls do you think that was? Who was the only one who was in the room?

We suggest that what happened here was that Lucy Letby took the readings whilst Caroline Oakley was on her break, but passed them on to Caroline Oakley to fill them in. It's the only credible explanation for the timings recorded in the paperwork if, and only if, you accept the evidence you heard that Caroline Oakley was on her break, as she and others said she was and

which was not disputed in cross-examination on behalf of Lucy Letby.

It would follow, wouldn't it, if that's right, if we're right about this, that Lucy Letby deliberately did not note the data for [Baby D], who we now know was about to collapse? Why? Plausible deniability. The only explanation can be, we suggest, that she didn't want the paperwork to suggest that she'd had anything to do with [Baby D] and that explains the tack she took in interview "I don't remember [Baby D]". It explains what she's told you.

If we go to tile 201 and we look at the entry timed at 01.14, so this is a minute before what we've just seen on the observations chart, we can see that it's unsigned. And so now that you know very well where I was going with this, I asked Lucy Letby about it in cross-examination. The questions and answers went as follows.

"Question: The blood gas for [Baby D] taken at 01.14 was done by you, wasn't it?

"Answer: I don't know.

"Question: That's your writing, isn't it?

"Answer: It could be my writing, yes.

"Question: Yes, it is. You see where it says 01 and then the 14 in slightly elevated --

"Answer: Yes.

"Question: -- numbers. That's the way you write these numbers?

"Answer: Yes.

"Question: You're not the only person, of course, but that's the way you do it?

"Answer: Yes.

"Question: And that's your writing, isn't it?

"Answer: It looks like my writing, yes.

"Question: Yes. Why didn't you sign it?

"Answer: That's just an oversight, the same as the gas on the next line down hasn't been signed. It's just an error that happens from time to time."

Well, it may be. People do forget to do things, don't they, ladies and gentlemen? Of course they do.

On a busy neonatal unit you would be wholly exceptional if you didn't make mistakes. We all make mistakes. But it's the timing of the errors, isn't it? It's the patterns of the errors. It's the power of circumstantial evidence.

Between that blood gas at 01.14 and [Baby D]'s collapse there's also an entry in the neonatal infusion prescription chart at 01.25, which is at tile 203.

You will see that that's signed by Lucy Letby and Caroline Oakley. Caroline Oakley who wasn't actually there at the time. Caroline Oakley who couldn't explain it but we know she was out of the room on her break at the time.

This is clear evidence, isn't it, that Lucy Letby, in the absence of Caroline Oakley, gave an intravenous infusion to [Baby D] 5 minutes before she collapsed and whilst the designated nurse was on a break? Access to the intravenous line in a case where the experts say death came about as a result of air embolus.

Caroline Oakley gave similar evidence of what she saw on [Baby D] to what Kathryn Percival-Calderbank said and she made a record in the nursing notes. If we go to tile 207 we will see it. She saw a rash on [Baby D] that she had "never seen before in her 20 years of experience". And what she described in evidence was this:

"I hadn't seen that rash before on a baby I've looked after in my years of neonates, over 20 years.

I remember it as like a deep red/brown, different than mottling, different to what I have seen before."

Evidence given to you on 4 November.

Dr Emily Thomas was a very junior doctor at the time, an ST1, so starting out on her specialist career.

Her statement was read to you on 8 November last year.

From the sequence of events we know exactly when Dr Thomas went into the NNU because at tiles 204 -- we know when she was in there, sorry, because at tiles 204 and 205 we have timed pathology samples which she ordered. They're timed at 01.29.

What Dr Thomas, in her agreed evidence, said was this:

"I remember [Baby D] had an unusual episode where she came out in a rash. This occurred about 1.30 in the morning. I remember taking a look. I'd describe the rash as almost having the appearance of a meningococcal-type rash. It was purple in colour and mainly over the abdomen. Andrew [which is Dr Brunton] called the consultant Dr Newby for advice. She came into the unit and reviewed the care and added an extra antibiotic into [Baby D]'s treatment. [Baby D] seemed to settle down and the rash appeared to fade."

And you can see Dr Thomas' contemporaneous note made at tiles 204 and -- sorry, that's the pathology samples, they're at 204 and 205. But Dr Thomas wasn't being influenced by anybody else, was she, and yet she there gives you a remarkably similar description to the descriptions you've heard from many other people.

Dr Brunton gave evidence on 7 November. Tile 214 is his note. Dr Brunton remembered attending on [Baby D] at 01.40. He said that [Baby D]'s oxygen level or oxygen requirement had gone up and she had developed a rash.

If we could just look at his note, please, I think it's 214:

"Nurses noted that became extremely mottled +++.

Also noted to have tracking lesions (dark brown/black)

across trunk."

What he, Dr Brunton, said to you was the way he'd written that note suggested that the description given in the note was what the nurses told him. It's obvious, isn't it, from his use of language there that that's exactly what this is?

Now, this is the key or one of the keys to this particular case because this explains "I don't remember". If Lucy Letby admitted to you and to the police that she remembered [Baby D], she would also have to admit that it was either her or somebody who was in the room with her at the time that gave this description to Dr Brunton, wouldn't she?

Do you remember an answer she gave me from time to time when I was asking her questions about what other people had noted at the time of these collapses and the mottling or the colour or however you want to describe it? "I don't remember that being discussed at the time"

was one of her refrains, wasn't it? Dr Brunton has actually recorded it here. This is what Lucy Letby saw and this is why

she doesn't want to engage in having to give answers or explanations for what she saw. This is why Lucy Letby says, "I don't remember".

At that stage [Baby D]'s oxygen had to be increased to 60%. There was slight subcostal recession, but Dr Brunton had no concern when he actually listened to [Baby D]'s lungs, and this is significant, we say, in a child whose issue had been pneumonia. Dr Brunton said he had no concerns about [Baby D]'s lungs. Her heart was normal, as was the abdominal examination. You can see there in that tile what Dr Brunton noted about the discolouration. He planned to do a blood gas, then a fluid bolus, and Dr Newby agreed that she would come in to review.

What Dr Brunton said at this stage of the collapse was this:

"This was a completely unusual situation that I had never seen before. The changes in the skin, I could not explain it."

Yet another doctor. At 02.00 Dr Newby, who gave evidence to you on 9 November, was called in because [Baby D] had been so stable and yet had had such a profound desaturation. And when Dr Newby arrived [Baby D] was actually saturating well, but there were what Dr Newby described as:

"Two bruised areas on her abdomen, like evolving purpura..."

And that's in her note at tile 218. Actually, it's here already. Mr Murphy, as always, is ahead of me:

"... as if they were secondary to sepsis."

We're hearing the same thing so often, ladies and gentlemen, aren't we? If you take a step back and try and remember one's which, it becomes quite difficult.

That's the best example, we suggest, you could have of the power of circumstantial evidence, these things, which these independent doctors are all saying separately, "I've never seen this before, it completely foxed me what was going on".

Do you remember what we reviewed yesterday, what Dr Brearey saw on the chest of [Baby O], a year and 1 day later? "An unusual small rash on [Baby O]'s chest" was how he described it in evidence. Just keeping this on the screen, looking at Dr Newby's description there, I'll read to you Dr Brearey's description of [Baby O]. If you want to find it, it's in the [Baby O] sequence at tile 206. He wrote this:

"Small discoloured [query] purpuric rash on right chest wall."

And he said in evidence:

"It looked like something normally associated with meningitis. A purpuric rash, which is very, very rare in a neonate."

Like meningitis. Exactly what Dr Thomas says in her statement about [Baby D]: meningococcal rash, meningitis.

So here, a year and a day apart, we have very similar descriptions being given by different consultants and a senior house officer relating to different children, both of whom were suffering unexpected and perplexing collapses at the hand of Lucy Letby.

The reason the descriptions are so similar, ladies and gentlemen, is that the causes of the collapses were the same. You'll remember [Baby O] also had that liver injury, which was the result of the application of deliberate force.

So after the first crash, [Baby D] had a good blood gas at 02.22; that's tile 219. Dr Newby told us that she didn't expect [Baby D] to have a further problem or at least not in the way that she, as it happened, did.

By 02.35, the areas of discolouration had completely disappeared, that's in Dr Brunton's note at tile 222, but Lucy Letby remained involved in [Baby D]'s treatment.

You'll remember we went through these in cross-examination because I was suggesting that when Lucy Letby was saying to you that she couldn't remember all this she wasn't telling the truth about it.

We've got the bolus at tile 227; that's at 02.40.

We've got other medications at tiles 230 and 231. And at 3 o'clock, [Baby D] was crying and desaturated again; that's tile 234. And again, Lucy Letby on the chart of MRE -- and this is the neonatal review at line 166 -- has herself doing something for MRE in the same room at the time of the second desaturation. So twice now.

Can you imagine, a child having a life-threatening event and you're a nurse in the room and you just -- "I'll just do the observations for this child over here".

Is that genuine? Are those records genuine? Or, as we suggest, is this all part of her attempt to create plausible deniability?

Dr Brunton was called again and made a note at 03.15, which is tile 236, and the unusual skin discolouration reappeared. What are the chances, eh?

Dr Brunton said that [Baby D] was "quite agitated and upset", which had been unusual for her. But other than the discolouration and the agitation, she then became normal and returned back to air.

The third and fatal collapse of [Baby D] came an hour later at 03.45. At the time Dr Emily Thomas, whose statement was read on 8 November, was in room 2 or 3 attending a child who needed a septic screen and she heard a member of staff shout for help in room 1. You know who Dr Thomas thought that member of staff was, don't you? It was Lucy Letby. Because Dr Thomas is the doctor who said that a later time in the shift, she found Lucy Letby very upset. This is Dr Thomas' words from her statement:

"At about 4.30 in the morning I was on the neonatal ward..."

So this is after [Baby D] had died. Sorry, I'm getting slightly confused. This is at the time of the collapse.

What Dr Thomas says is this:

"At about 4.30 in the morning I was on the neonatal unit. I was in either room 2 or 3. I was with another baby that I think needed a septic screen. I was in the middle of trying to insert a cannula or reviewing the baby when I heard a member of staff shouting for help in room number 1. I'm not sure, but I think the member of staff was a nurse called Lucy. I recall that she had brown hair and was the designated nurse for [Baby D]."

What could have given her the impression that Lucy Letby was the designated nurse for [Baby D]?

"This nurse later became very upset in front of me.

I believe she had been the designated nurse for [Baby A], who had died on the unit only a couple of weeks previously. I think she said something like 'This is my second baby that this has happened to'."

That tells you a lot in this case, doesn't it, ladies and gentlemen? It tells you that at the time, even Lucy Letby was associating what had happened to [Baby D] with what had happened to [Baby A], because she recognised, didn't she, that other people were associating these events, but yet she claims to you she can't remember.

This can't be a mistaken reference by Dr Thomas to Caroline Oakley because Caroline Oakley wasn't working on the shift that [Baby A] died. So you think about that if you were worried that that might be an explanation.

That is not the explanation.

And other than Lucy Letby, on this shift, the shift that [Baby D] died, the only other member of the staff who was working when [Baby A] had died was Elizabeth Marshall, the nursery nurse. Her statement was read to you and what she did was act as a scribe during the resuscitation because she wasn't sufficiently qualified to do anything else.

On this final occasion, [Baby D] was in cardiac arrest, she wasn't breathing, she had lots of secretions.

Dr Brunton intubated her. He got a positive capnograph result, good chest movement again. There then followed six doses of adrenaline, all to no avail.

According to Dr Brunton, he had "never seen a baby behave in this manner prior to this or after this".

He's now a consultant in the biggest hospital in Glasgow.

In cross-examination, he was asked about [Baby D]'s sodium levels and blood gases and he told you something that many of the medics have said:

"Everything must be looked at in clinical context."

He was struck, was Dr Brunton, by [Baby D]'s precipitous collapses, followed by remarkable recoveries, followed by periods of stability, and again something which is wholly unusual generally, but tragically not uncommon in the cases that you are considering.

What Dr Brunton didn't say, because Dr Brunton didn't know, was that the circumstances of [Baby D]'s collapse were so similar to the circumstances of the collapses of many of the other children in this case.

A similarity, as I've already said, which Dr Thomas, if you accept what she says, records being spoken about, even by Lucy Letby at the time.

We say that that similarity makes this all the more remarkable and all the more likely to be the result of sabotage. It also tells you that Lucy Letby is lying when she says she doesn't remember [Baby D].

At first blush, the interviews in [Baby D]'s case are unremarkable, but they do, we suggest, contain one or two interesting remarks. Lucy Letby began by saying that she didn't remember [Baby D]. If you want the references for that, they are pages 2 and 4.

We say you should contrast that with evidence that she gave in answer to questions from her own counsel on the morning of 2 May, the first day she gave evidence.

Then, when she was being asked about the effect of deaths on the unit on the staff, she said without any hint of irony:

"You don't forget things like that. They stay with you."

This is the same person whose case is "I don't remember this child who collapsed three times and died in front of me". What was she trying to get you to think, ladies and gentlemen, by, "We don't forget things like that, they stay with you"? Is she trying to get a bit of sympathy from you, give the impression that she was a good nurse, doing the right thing for the right reasons?

In the 10 November interviews, she was asked about the Facebook searches. She accepted she'd done them but couldn't explain why she'd done them or what she was looking for. She was asked about messages she'd sent to [Nurse A]. It's in the [Baby D] interviews at page 9. These are the messages where she said she came out in a rash looking like overwhelming sepsis, messed about a bit:

"Messed about a couple of times and came out in this weird rash. Looking like overwhelming sepsis."

A child she doesn't remember.

She was asked about tile 325. You'll find it at page 10 of the interviews:

"I think there's an element of fate involved.

There's a reason for everything."

You know what the reason is in this case, don't you?

Tile 349, trying to persuade her colleagues that there's an innocent cause, gaslighting. 349.

I'll make sure I get this quotation right. It's at page 12 of the Lucy Letby interviews, so it's the third of the Lucy Letby

interviews. The very last thing, the very last thing she said that we have given you. It may not have been the last thing she said because these are, obviously, edited:

"Question: Do you remember at the time about 26 June 15, after [Baby D]'s death, were you particularly upset and disturbed by what had happened?

"Answer: I honestly can't remember."

How does that tie in with the evidence that she was giving to you on 2 May in answer to questions from her own counsel?

This is a case, we say, where the text messages tell you an awful lot. 286, please:

"We had such a rubbish night. Our job is just far too sad sometimes."

287:

"No. What happened?"

288:

"We lost [Baby D]."

289:

"What? But she was improving. What happened?

Wanna chat? I can't believe you were on again, you're having such a tough time."

Then we come to the ones I've already quoted to you:

"Messed about a couple of times."

Then at 292:

"Then collapsed and had full resus. So upsetting for everyone. Parents absolutely distraught, dad screaming."

Father's Day 2015, "I don't remember [Baby D]".

Her approach in interview, ladies and gentlemen, as I said to you at the beginning, was: because my name isn't really on the medical records, I'll get away with simply saying I don't remember.

Well, she did remember. She's not prepared to admit it to you and you will ask yourselves why.

This is a case to which Professor Arthurs made an important contribution, we suggest. On Friday, 11 November, when asked about the series of X-rays from the evening of 20 June into the afternoon of the 21st, he said they showed that the:

"Minor infection [Baby D] had in her lung was improving."

He then said this:

"If you were to tell me that this is a baby -- this baby was in air for all that time or didn't need any treatment for their infection, that would be consistent."

And that is the clinical picture, isn't it? Of the post-mortem pictures Professor Arthurs said that the line of gas in one of the main vessels was "highly unusual". And he'd also seen it in the cases of [Baby A] and [Baby O]. He told you that he had never seen this quantity of air in the great vessels of a baby when no reason for it could be found, and in the absence of sepsis, which you know can be excluded, he thought that intravenous injection of air was an explanation that needed to be considered.

Well, you have much more evidence than he had, ladies and gentlemen. For all that he is clearly a pre-eminent radiologist, he is limited to what he can see on a screen with his specialised equipment in the hospital.

Dr Marnerides said:

"Infection would not explain [Baby D]'s death."

In his experience, babies with congenital pneumonia would settle unless they were overtaken by sepsis, and he excluded sepsis in this case. As to the gas in the great vessels, he said that the delay between death and the X-ray was not long enough for there to have been any significant decomposition of [Baby D]'s body and therefore that does not explain the gas.

His view was that, on the balance of the evidence that he was considering, [Baby D] was killed by an air embolus. Dr Marnerides doesn't consider lies to the police, doesn't consider lies from the witness box, doesn't consider the similarity with other cases, doesn't consider the alteration of medical records, doesn't consider the position of somebody who gives the appearance of recording observations for another child in the same nursery at the time that this child is suffering fatal

collapses. They are all features which you can take into account. It is the power of circumstantial evidence.

Dr Bohin reviewed all the evidence in the notes relating to [Baby D]'s short life. She made the point that [Baby D] was born in good condition, her pneumonia had stabilised and she was recovering at the time of her fatal collapse. She thought, this is Dr Bohin, that the speed of [Baby D]'s collapses and recoveries were very unusual and not indicative of infection. She described them as perplexing and having no clear cause. And having excluded the alternatives, she attributed the collapses and death of [Baby D] to an air embolus.

She said that the requirement for such extreme intervention in the absence of some disease process at play, [Baby D]'s distress, the rash, the disappearance of the rash, and the air in the great vessels were all features which tended to support her opinion. And she rejected the idea that taking [Baby D] off CPAP had contributed to her death.

Dr Evans reviewed the notes and the medical evidence. He agreed with the view expressed by the treating physicians that [Baby D] was recovering from pneumonia at the time she died; you'll remember Professor Arthurs' view. Dr Evans' view was that this was a case of air embolism and he said that, having excluded pneumonia, air embolism was the only viable cause of death. The reasons he gave were: first, there was intravenous access in place; second, the discolouration attested to by the witnesses; third, the failure of resuscitation; and fourth, the presence of air in the great vessels shown in the radiographs.

One of the things that Dr Evans was challenged about was the blood gas recorded at 01.40, the one that was unsigned and the one that you may think Lucy Letby admitted having made in the witness box. Well, we say that if you think about that, that blood gas can never help Lucy Letby and, in any event, it was dealt with by Dr Bohin in her report and she had told you that the blood gas was satisfactory.

My Lord, that takes me to the end of [Baby D]'s case and that may be a good point to have the break, please.

MR JUSTICE GOSS: Certainly, yes. Thank you.

Right, ladies and gentlemen, we'll break off and resume at 2.05, please. Thank you very much.

(12.59 pm)

(The short adjournment)

(2.05 pm)

MR JOHNSON: We're on to [Baby G] next, please, ladies and gentlemen. Three counts of attempted murder, as you know: the first on 7 September, the second and third on 21 September 2015.

[Baby G] was the first born of all the children about whom you've heard in the evidence. She was also significantly the most premature and was also the lowest birth weight. She was born at Arrowe Park Hospital on the Wirral on Sunday, 31 May 2015 at 23.57.

Her mum is [Mother of Baby G] and that name is not straightforward to spell, and you understand the relevance of that. You'll remember that her parents, [Baby G]'s parents were told that because of her extreme prematurity, [Baby G] had a low chance of survival, yet survive she did and she was clearly a fighter.

By the time that she was transferred from Arrowe Park to the Countess of Chester on 13 August, and had what we suggest was the gross misfortune to meet Lucy Letby, she weighed a few grams under 2 kilograms.

Before arriving at Chester, [Baby G] outperformed all reasonable expectations. In Chester, in the 3 weeks following her transfer, the only health issue had been her breathing problems but that was not what caused her life-threatening collapses.

As you know, the allegations relating to [Baby G] are in counts 7, 8 and 9, and I will deal with count 7 first, which is the alleged overfeeding of milk on [Baby G]'s 100th day of life, which you have heard, in the context of things in a neonatal unit, is a very significant milestone.

The banner was up and a cake had been baked. As a result of the incident that morning, 7 September, [Baby G] incurred a severe brain injury, which has left her severely disabled and wholly dependent on her parents, and you will remember, I'm sure, the evidence of both Dr Pek Wan Lee from Arrowe Park and Professor Stavros Stivaros from the Royal Manchester Children's Hospital.

Up to the point that [Baby G] collapsed, everybody -- doctors, nurses and experts -- agreed that she was in a very satisfactory position.

The other two counts on 21 September, counts 8 and 9, happen to have been [Baby G]'s due date. So we have two milestones in this child's life, the second two, the second two her due date, in other words the date where, if she had remained in utero and the pregnancy had run the full course of 40 weeks, she would have

been delivered. Well, odd coincidences do happen in life, of course, but in the context of all the other evidence in this case do you believe in coincidences like that?

And these coincidences always seem to happen when Lucy Letby was about. We also know that Lucy Letby knew of these dates. The due date, for example, you will find in a text message at tile 106 in the second [Baby G] sequence.

So starting -- yes, there you are. Thank you, Mr Murphy. A message sent to her friend [Nurse A].

So dealing with count 7 first. At about 2.30 that morning, [Baby G] was full of air and milk. She projectile vomited. As her father [Father of Baby G] told you in a statement, which was agreed evidence, she had never done that before.

As Dr Bohin told you, having reviewed all the medical evidence, she had never done that before. There was no history of this before 7 September or of large aspirates, and that was despite the fact that [Baby G] had accidentally been overfed to the extent that she'd been given 45ml rather than 36 on 24 August, so about 2 weeks before this incident.

The vomiting on the morning in the early hours of 7 September, its type and its force and its spread was something that Dr Brearey, the consultant on night call that night, said that he had never seen before, except in cases of pyloric stenosis. You'll remember Dr Marnerides gave you an explanation of what that means. And that was evidence, in effect, repeated by both Drs Evans and Bohin, with Dr Bohin describing this event as "extraordinary".

You'll remember that pyloric stenosis can be excluded as a cause of this vomit, though, because if that had been the problem it could only have been resolved through surgery. That's not a self-resolving problem.

So we say that in effect you have two choices: the first is that [Baby G] was sabotaged by being overfed or, the second, having had a long-standing history of ever-escalating quantities of milk without a problem, did she all of a sudden vomit with unprecedented force because she had an infection, an infection which none of the treating doctors or prosecution experts have ever seen present in that way, either before or since?

Some people say that there is a first time for everything, but [Baby G]'s extreme collapse was not the first time that a child in this case had a life-threatening event when her nurse had just gone on a break. She's one of the names in a long list: [Baby C], [Baby D], [Baby I] number 2 and number 4, [Baby J],

[Baby K] and [Baby N] number 1. This was no naturally occurring event, ladies and gentlemen. It is the handiwork of Lucy Letby.

If we remind ourselves of the feeding charts on the 5th and 6 September, they are behind divider 7 in your jury bundle should you want to look at them, they're pages 7012 and 7013. You can see just how [Baby G] was doing, just how well she was doing, right up to that point at 2 o'clock on 7 September, which is at tile 75.

There was some disagreement as to whether the evidence of [Nurse E] proved that [Baby G] had digested her previous feed before she, [Nurse E], fed [Baby G] at about 2 o'clock, and we suggest that there are two reasons why you can be sure that [Baby G] had digested the feed she'd been given at 23.00 hours the previous night.

I'll come to them in a moment.

[Baby G] had been under the care of Nurse Vicky Blamire, the nursery nurse, on the day shift of the 6th, and Vicky Blamire had taken over [Baby G] from another nursery nurse, Valerie Thomas. [Baby G] was at that stage taking 45ml of milk and the feeding charts in the couple of days before her collapse in the early hours on the 7th show a normal baby, feeding properly. And you will see reference in the charts to the fact that she was feeding on demand, she was "give me milk" as we all know babies do.

Amongst the evidence that you heard about [Baby G] before the midnight -- sorry, before the night shift of the 6th into 7 September was the evidence of [Baby G]'s father, of [Nurse E], who was the designated nurse, and of Dr Ventress. [Nurse E] and Dr Ventress both friends of Lucy Letby.

They all told you that at about 8 o'clock/20.00 hours on the 6th, in other words the beginning of the night shift, [Baby G] was doing well, was not a concern, and others said the same. So moving then, with that problem-free background, as it was in the lead-up to the night shift of the 6th to the 7th, I come to the night shift and start with tile 47, please, in the first [Baby G] sequence.

This is the handover. It shows you the distribution of the babies and the nursing staff on the shift.

If we scroll down a little bit more, please. You can see it was a quiet night or it should have been a quiet night. [Baby G] was the only child in nursery 2.

[Baby G] took a full feed from a bottle -- not an NGT feed, from a bottle -- at 23.00 hours. It was 45ml.

She was thriving and yet some time after 02.15 she had begun a precipitous decline.

As I said earlier, the issue here is whether that decline is the result of an infection or being overfed.

We suggest that you can infer from the fact that [Baby G] took her full feed at 23.00 hours from a bottle that she had no problems at that point. You don't need to be medically qualified to work that one out. Anyone who has fed a small baby knows that. Little babies don't take full feeds from bottles unless they're happy little babies, do they?

One of the issues you may want to consider is the time when [Baby G] vomited because we suggest that Lucy Letby has massaged the times here, as she did in the cases of [Baby D], [Baby E], [Baby H], [Baby I], [Baby K], [Baby N] and [Baby O]. We suggest that the vomit was at about 02.30, not 02.15.

When Ailsa Simpson, the shift leader, was cross-examined on behalf of Lucy Letby, her written police statement was put to her. She had told the police that she, Ailsa Simpson, had been sitting at the nursing station with Lucy Letby from about 01.15, so for an hour before the time that Lucy Letby says this happened and that she, Ailsa Simpson, and Lucy Letby, were together at the time [Baby G] projectile vomited at 2.15, so a full hour, according to the statement of Ailsa Simpson, sitting at the nursing station.

Therefore if that was true -- this is the defence's position, isn't it? -- Lucy Letby cannot have interfered with [Baby G] by overfeeding her because she has an alibi.

And that must be right, mustn't it? It must be right.

However, we then heard that when Ailsa Simpson was interviewed by the police 7 months before she signed the statement, she'd told them that she didn't know where the other nurses were when [Baby G] vomited, but that she had run into nursery 2 with Lucy Letby.

For reasons I'll come to in a moment, Ailsa Simpson's account to the police of the timings is wide of the mark to say the least. But before we get to her timings we just need to take a careful look at the time that [Baby G] actually projectile vomited. Can we start with the nursing note at tile 79, please?

You can see it on the screen. This is a note made by Lucy Letby at between 08.57 and 09.11. It says:

"Written in retrospect for care given from 02.00 to present. [Baby G] had large projectile milky vomit at 02.15."

That's an interesting line, isn't it, not just for the time of the vomit but "care given from 2 o'clock to present". So what Lucy Letby is saying there is, this incident happened at 02.15 but I was giving care from 02.00, isn't it? So when you're asking yourselves when [Nurse E] went on her break who she left [Baby G] with, you might want to take that into consideration.

We know, of course, that this is a note made 6.5 hours later and we invite you to take any -- to approach any timing with care, but particularly a timing that's recorded by Lucy Letby because we've already demonstrated, we suggest, not least in the case of [Baby E], but in other cases, that Lucy Letby habitually misrecords important information at important times.

At tile 78 we've got [Nurse E]'s record and I'd like to look at that, please. This is also made at the end of shift, as you can see at the top of the data there.

What [Nurse E] recorded is:

"Nurse L Letby taken over care following vomit/apnoeic episode after 02.00 feed."

Well, we know, don't we, that [Nurse E] wasn't there? No one has suggested that [Nurse E] was there when this happened. And you will remember, not least because I have just reminded you, that, relatively speaking to the other children that you've heard about in this case, [Baby G] was taking relatively large feeds, 45ml, and they were thickened with fortifier. And according to [Nurse E]'s evidence, a feed like that could take anything up to 20 minutes to administer via the nasogastric tube.

I'll come now to the reasons why we say you can be sure that [Baby G] had digested her previous feed at 23.00 hours. First of all, because before [Nurse E] gave the feed at 2 o'clock, she got an acidic aspirate from the nasogastric tube, a pH of 4. As Dr Bohin told you, the natural pH of an empty stomach of a baby of this age is between 3.5 and 5. So that's right -- it's bullseye, isn't it, absolute bullseye?

The second reason we suggest is that [Baby G]'s stomach simply wouldn't have accommodated a 45ml feed administered under gravity if the stomach was already full with undigested milk. It just wouldn't go in. The force of gravity wouldn't be sufficient

to overcome the force of the full stomach. That's a point I'm going to return to.

Ailsa Simpson saw the aftermath of the projectile vomit and we have that photograph, which is J26510.

What you can see in the photograph accords also with Lisa Walker's statement, the agreed statement, which was read on 6 December. So a photograph from Ailsa Simpson, statement from Lisa Walker.

What Lisa Walker said was that Ailsa Simpson and Lucy Letby were clearing up the vomit around [Baby G]'s cot.

And Lucy Letby told her, Lisa Walker, that vomit was everywhere around the cot. So going back to the timing of this, Ailsa Simpson initially said that when [Baby G] vomited she, Ailsa Simpson, was sitting at the nurses' station with Lucy Letby. But we know that that doesn't correspond with the records in the neonatal review.

If we look at page 3 of 7 of the first neonatal review for [Baby G], please, it's line 41. What we can see there is that Ailsa Simpson, line 41, fed the child AC in nursery 1 at 02.20.

You saw the child AC's feeding chart during the evidence. If you want to make a note of it, it's J29015. AC was demanding food and you know you don't keep little babies waiting.

The milk -- so the feed was given at 2.20. The milk would have taken time to warm before being given.

Seven minutes was the estimate put on that by Ailsa Simpson when she gave evidence.

At tile 66 of the sequence you can see that Ailsa Simpson was co-signing for administering medication to [Baby G] at 01.42, put into the computer at 01.46.

Ailsa Simpson also assisted with medication for another child, DB, at 02.13, and that's in the neonatal review at J29020. We don't, unfortunately, know which room DB was in. But all that material shows that around this time Ailsa Simpson was busy. She wasn't just sitting at the nursing station with Lucy Letby. So that proves that she simply cannot be accurate with her alibi for Lucy Letby. And the most important point is she was feeding AC in a different nursery at 02.20 and, given the time she had to warm up the bottle for, that excludes it, we suggest, so you can be sure that Ailsa Simpson is wrong about the times.

But the best bit of evidence as to when this really happened comes from Dr Ventress' note, which is at tile 80:

"Called to review [Baby G] urgently at 02.35. Had very large projectile vomit (reaching chair next to cot and canopy)..."

I'm not going to read all that out. You have seen it before and you can read it at your leisure.

This was an urgent call. Doctors don't wait 20 minutes to answer an urgent call, do they? We know it was urgent because [Baby G] suffered a catastrophic brain injury. Dr Ventress was there within a very short period of time and that coincides with the agreed statement of Lisa Walker, which was read to you on 6 December. Lisa Walker said Dr Ventress arrived within minutes.

So we suggest that Dr Ventress' note is the reliable evidence on which you can and should act. It was made at the time, not later, like the nursing notes, and the vomit therefore occurred at the time Ailsa Simpson was feeding the child AC in nursery 1. The clouds are clearing, aren't they? So the alibi is given by a person who at the time of the vomit was in nursery 1 feeding a different child. Ailsa Simpson distracted in nursery 1. Best mate [Nurse E] gone on a break.

Perfect time to sabotage [Baby G].

And it follows, doesn't it, if we're right about that, Lucy Letby has deliberately misrepresented the time of the vomit in the nursing notes? You'll remember the case of [Baby E], deliberate misrepresentation of the time that [Mother of Babies E & F] arrived. We'll come to more examples. Why? Why as a nurse do you deliberately misrepresent the time that a child suffered a catastrophic brain injury? Well, I shall give you the answer. The earlier it was, the closer it was to the time that [Nurse E] fed [Baby G], therefore the more likely it was that people would mistakenly think that the planned feed was the reason for the vomit.

Associated with that point, ladies and gentlemen, the longer the gap between the feed and the vomit, in other words the later the vomit, the less likely it would be that the feed could be the reason for the vomit.

And third, if the vomit was when Lucy Letby recorded it, it was more likely that Lucy Letby would be covered by the notes in the records for other patients, something we've seen her manufacturing in other cases.

As an example, HS on the final time [Baby I] collapsed. It would also take the vomit back from the time that other people were engaged with their children.

In other words, it would look in the records as if the vomit had happened at a time when other people were around to see what was going on rather than being distracted.

So this is highly manipulative, isn't it? When Dr Ventress returned to [Baby G] after the projectile vomit, [Baby G]'s abdomen was "discoloured, purple and distended". And that was after the vomit. If we look at Dr Ventress' notes again at tile 80, please. What we see is, amongst other things, once the full feed had been aspirated:

"Large watery stool passed, after which abdo appeared slightly better."

So this is literally the physical aftermath of pumping a child with liquid, isn't it? It comes out the other end and the abdomen looks a bit better. That wasn't the state [Baby G] was in when she was fed by [Nurse E], was it? [Baby G] had been fine when [Nurse E] had fed her over a period of anything up to 20 minutes about 30 minutes earlier.

What could have happened? If [Baby G] was so ill, do you think she would have taken that full 45ml feed in her sleep? The truth is that after the feed someone inflated [Baby G] with milk and air. The evidence of that is the projectile vomit and, having projectile vomited, the fact that [Baby G], despite the projectile vomit, was still distended. This is not a case of an accidental overfeed, is it, ladies and gentlemen? And other than for a short time in cross-examination before she retracted the suggestion, even Lucy Letby agrees this isn't an accidental overfeed.

We say that the only reasonable conclusion to draw is that somebody forcefully injected [Baby G] with milk, using the plunger in the syringe. Who did it? Or who pushed it in, to use the phrase that I think was first used by Lucy Letby in cross-examination?

Well, having sabotaged [Baby G], Lucy Letby took over her care and we say she took advantage of that access.

Dr Ventress' note at tile 84 relates to the doctors' attendance on [Baby G] when she desaturated a short time later at 03.15. So poorly was [Baby G] at that stage that Dr Ventress was actually called out of theatre and she decided to intubate [Baby G] and because of perceived problems with [Baby G]'s abdomen, CPAP was

not the preferred option. And as she intubated [Baby G], Dr Ventress noted, even if you don't remember, you know, don't you?

"Bloodstained fluid coming up from the trachea between the vocal cords."

What had Lucy Letby done to [Baby G]? Later that morning, shortly after 6, [Baby G] was inflated with air again. At this stage she'd been on a ventilator since her earlier catastrophic collapse and we know that if the air is going into the lungs from a ventilator, then the ET tube is at a point where the air cannot inflate the stomach because it's gone beyond the entrance point to the stomach. So that was not the cause.

In this respect, Dr Brearey gave some interesting evidence on 12 December. When he was being asked about [Baby G]'s desaturation whilst on the ventilator, Dr Brearey said this:

"I can't explain that, actually. It's unusual for babies to desaturate on a ventilator, particularly in view of the normal gas that they'd had or [Baby G] had had prior to that. It doesn't. And the fact that Dr Ventress was getting chest movement when she was Neopuffing the baby off the ventilator, it's perplexing and I cannot think of a natural cause why that would happen."

It was suggested in cross-examination to Dr Ventress that the air in the stomach after 6 o'clock might have been the result of 5 minutes of using the mask to oxygenate her. But the mask was what had to be used because she'd desaturated, wasn't it? What had caused her to desaturate was the air in the stomach. When you consider this, ladies and gentlemen, we suggest you should bear in mind Dr Ventress' evidence that she was getting good chest movement with the Neopuff. That shows the air is going into the lungs, not the stomach, doesn't it? So that cannot be the explanation for [Baby G]'s stomach being inflated later in the shift.

Dr Brearey couldn't think of any natural process which would account for what happened. That is because the truth is, it was an unnatural process, an unnatural process administered by the hand of Lucy Letby.

Later in the morning there was a blood clot on the ET tube. We know that the blood was there before [Baby G] had been intubated because Dr Ventress told us so. It was suggested to Dr Ventress that it wasn't unusual for some injury to be caused by intubation and she agreed.

But she also said that it wasn't there before because she saw it before she started the intubation process and also the blood was

coming up from below the cords, which is an area that is not reached or touched by the laryngoscope.

So again, it can't be the explanation. A baby bleeding from somewhere in the oesophagus or below.

[Baby E], [Baby N], [Baby P], [Baby C]'s swollen oedematous vocal cords, [Baby H]. It's the power of circumstantial evidence, isn't it?

What caused the throat of an otherwise well baby to bleed in conjunction with unprecedented projectile vomiting? Well, there is only one sensible answer to that, isn't there? Lucy Letby. And it's a signature of many of her attacks on these babies.

It wasn't the clot on the tube that caused the later collapse that morning because the ventilator didn't alarm and it would have done if it had been blocked by a clot. The capnograph was showing CO2 coming out, so there wasn't a blockage. So how did this problem originate? The only sensible explanation, even looking at this case on its own, is that it has to be the product of sabotage.

When you're considering how [Baby K]'s tube kept moving, you might like to bear these events in mind. All innocent coincidence or the hand of Lucy Letby?

So we say somebody did something which caused bleeding below [Baby G]'s (inaudible), just as somebody did something which caused her to vomit in a way not seen before or since, and it was not [Nurse E].

When [Baby G] desaturated just after 6 am on the 7th, a further 100ml -- 100ml -- of air, or either air, which is what Dr Ventress, or milk/fluid said Dr Brearey, was aspirated from her stomach. Whether it was air or fluid, where could it have come from? The only possible source is Lucy Letby. And it indicates her determination, doesn't it, to kill [Baby G], a child who by that stage had already suffered a devastating brain injury?

It's interesting, you may think, that Dr Evans' statement was that [Baby G] had been injected with at least two times 45ml before she vomited at about 2.30, almost exactly the same amount as was aspirated before she was re-intubated at about 6.10. So the two events have a parallel as well. And the splinting of the diaphragm can be the only sensible explanation for the fact that [Baby G]'s sats were falling, despite the fact she'd been on a ventilator following her initial collapse. That was Dr Brearey's view.

When [Baby G]'s stomach was aspirated of all that air or fluid, whichever it was, and she was re-intubated, her sats improved, so again that shows you the cause. As the day progressed, her CRP level rose, but she didn't have any further issues with her stomach. Why not if her infection was progressing?

The answer, of course, is that what was vomited and aspirated had nothing to do with any infection. A good deal was made of the rising CRP because on behalf of Lucy Letby it was suggested that [Baby G] had vomited because of an infection and the CRP was evidence of the infection.

As Dr Bohin told us on 13 December, the CRP level peaked in Arrowe Park at 7.23 hours on 9 September.

That is 53 hours after [Baby G] vomited. It was suggested repeatedly on behalf of Lucy Letby to the prosecution experts that CRP peaks between 24 and 48 hours after infection. Well, if that's right that proves that [Baby G] didn't have an infection at the time she vomited, doesn't it, because the CRP level peaked at 53 hours after the vomit? And that's ignoring all the other features that I have just explained.

[Baby G]'s infection started after she was compromised by Lucy Letby. That made her more vulnerable to infection, didn't it? That's the chronology here.

Now, as I have gone through this incident, I have reminded you of many of the things Dr Evans said. As happened on several occasions, Dr Evans was accused of making things up in the witness box to help the prosecution. In particular, it was suggested that he'd introduced the idea that milk had been put in under pressure and we say that was a completely unfair accusation for the reasons we've already explained.

You can't get excess milk into a stomach under the force of gravity. It won't -- gravity -- because they don't take the syringe up to the third floor of the hospital to get an extra drop, do they? This is a tube, as we've heard explained many times, that's next to the baby, just above the level of the baby, so it goes in gently. And so if an expert is saying extra milk was put in, of necessity it involves pushing it in, doesn't it?

What Dr Evans had said in terms in his report was that it had been "put down the NGT". And as he said, that can only be done, excessive milk, by use of a syringe. It's common sense.

Dr Sandie Bohin told you that just prior to the collapse on the 7th, [Baby G] had been very stable. She made the point I've just reminded you of, namely that in her opinion, because of pH

reading obtained by [Nurse E], it follows that [Baby G]'s stomach was empty.

And she said in terms that she discounted the possibility that there was undigested milk when [Baby G] was fed by [Nurse E].

Dr Bohin said that if infection was an issue with [Baby G] at the time of the projectile volume, there would have been subtle and increasing markers leading up to the vomiting. There were none, therefore infection was not the issue.

She disagreed with Lucy Letby's assertion in interview that [Baby G] must have swallowed air when she vomited. Do you remember that repeated several times, I think, by Lucy Letby in interview? Because that was her explanation for why [Baby G] was full of air.

Dr Bohin described the photograph marked by Ailsa Simpson and Dr Ventress as extraordinary, she also, as I have told you, had been through [Baby G]'s record and said there was no pre-existing history of vomiting.

In cross-examination Dr Bohin was taken through some of the life-threatening events that had befallen [Baby G] in the first few days of her life at Arrowe Park and she made the point that [Baby G] was extraordinarily premature, under 24 weeks, and what happened at Arrowe Park was virtually par for the course for a child of that gestation.

Concerning bloodstained secretions on 14 June 2015 at Arrowe Park, Dr Bohin said that that was attributable to the use of a suction catheter and that's a wholly different situation to what had happened on 7 September where the blood had been seen coming up from beneath the cords in the absence of an ETT.

Lucy Letby's interviews in relation to [Baby G] support our case, we suggest, that it was Lucy Letby who sabotaged her. She remembered that [Nurse E] was on a break, that [Baby G] was in nursery 2; you'll find that at page 4. She said that [Nurse E] would not have left [Baby G] if there'd been an issue with her, but, at page 6, you will find that Lucy Letby suggested the vomit had not left the cot. We say this was an attempt to minimise what happened and is at odds not only with the evidence of Ailsa Simpson and the agreed evidence of Lisa Walker, but also the note made at the time by Dr Ventress.

Lucy Letby confirmed that there was a large amount of air aspirated with the milk; you'll find that at page 8. It was suggested to her by the police that she must have received a bolus of air from the feeding syringe. The police were saying

[Baby G] must have received a bolus of air from the feeding syringe. And the reply? You may have forgotten. Page 20:

"Well, air has got in there somehow, yes."

That's an important admission, ladies and gentlemen, because that is exactly how it got in.

She said, if you go to page 9, she had seen [Baby G] vomiting. Not sitting at the nursing station:

"I saw [Baby G] vomiting."

I'll come back to that nursing note:

"Care taken over at 02.00. 02.15, [Baby G] vomited."

Incident 2, counts 8 and 9. [Baby G] was transferred out to Arrowe Park at 3.50 on 8 September, returned to Chester on 16 September, and once again had the misfortune to have Lucy Letby as her designated nurse on the 21st. This was her full term date.

The full extent of the brain injury [Baby G] had suffered as a result of the earlier events wasn't yet apparent to the medics, although I'm sure you will remember that [Baby G]'s dad said in his agreed statement that after the incident of 7 September she was not the same baby.

But [Baby G] was stable when she returned from Arrowe Park and remained so until the day shift when Lucy Letby was her designated nurse. She was in nursery 4.

Overnight on the 20th to 21 September, before Lucy Letby came on at 8 am, the designated nurse for [Baby G] was Valerie Thomas, the nursery nurse. And her statement was read to you and she recounted how [Baby G] was taking her feeds by bottle and had only one via nasogastric tube at 3 am to let her rest. Val Thomas' summary you will find at tile 44 of the second [Baby G] sequence.

I'm going to come straight to the day shift. The population distribution chart is at tile 45, please.

This is [Baby G] 2, tile 45.

(2.53 pm)

(No audio or video feed from court)

(2.54 pm)

MR JOHNSON: You can see from that, ladies and gentlemen, that Lucy Letby had all three babies in nursery 4 and you know that she disliked being in nursery 4. [Baby G] was due to have her immunisations, she was fed 40ml of expressed breast milk at 9.15, according to the note made by Lucy Letby at tile 47, though at tile 48 the nursing note suggests this happened at 9 o'clock, not 9.15.

At about 10.15, according to the nursing note made by Lucy Letby later in that shift -- and this is tile 50, please, and I'd like to look at that if we can -- [Baby G] produced two large projectile vomits and desaturated to 35%, a life-threatening level.

Thirty millilitres of milk was aspirated from the nasogastric tube. [Baby G]'s bowels opened +++ and there was a loose green watery stool. This is almost a carbon copy, isn't it, of what happened on 7 September when, after being brought back from the brink of death, [Baby G] had passed a large watery stool, according to the note of Dr Ventress?

[Baby G] had been sabotaged again by Lucy Letby. But if you look at [Baby G]'s observations just before this at tile 46, J7831, you will see that her observations were entirely normal. You'll remember this one, ladies and gentlemen, the 9 o'clock one, as being the occasion where somebody put in two temperature readings. Who could have done that? Why would somebody do that?

When I asked Lucy Letby about it in cross-examination, I suggested she'd been making it look like [Baby G] was declining before she vomited again. Well, you will decide. Is it just a mistake, an error or, in the context of all the other inaccurate records made by Lucy Letby at important times, can you be sure that yet again this is an effort by her to misrepresent what was going on, to give the impression to the outsider that there was a benign, natural reason for [Baby G]'s collapse?

Context is everything, isn't it?

Dr Fielding arrived and was told by the nursing staff that [Baby G]'s abdomen was more distended than usual; that's tile 51. He recorded two projectile vomits, which, as Dr Gibbs said, is very unusual. We've heard all that before, haven't we, on 7 September? We say this: as in many other instances, it is a coincidence too far. It's yet another example of Lucy Letby trying to kill one of the children in the neonatal unit.

Later that evening, Lucy Letby was misrepresenting what had happened when she texted her friend [Nurse A]. If we go to tile 111 at 21.20, she wrote:

"Looked rubbish when I took over this morning, then she vomited at 9 and I got her screened."

Put that against what was to happen further down the line, ladies and gentlemen. It shows you the power of circumstantial evidence, doesn't it? Lucy Letby was trying to give her senior colleague the impression that she had inherited a problem, which was untrue. When you think about what happened to the [Babies O & P] boys, who we dealt with yesterday, and what I'm yet to remind you about [Baby N], it becomes very clear what's going on, doesn't it?

Lucy Letby didn't mention having fed [Baby G] to her friend [Nurse A], did she? Why do you think that was? You may think it would make no sense for her to have fed [Baby G] without referring her to a doctor first if what she was saying in the text is true. This is the mirror image of [Baby N], isn't it, where she's saying, do you remember, I didn't feed him because I was waiting for the doctors because he didn't look very well, or, as [Nurse E] had said in one of the notes,

"[Baby N] looked shit"? You'll remember that. It's a lie to divert suspicion.

If we look at tiles 100 to 114, there's an interesting conversation about [Baby G]. It starts with Lucy Letby saying:

"Sounds like Wednesday night might not be on now."

Sorry, let me just get my reference. Yes:

"Not enough interest."

And that provokes a response from [Nurse A]:

"Yeah, I heard about Wednesday. What's up with [Baby G]? I was a bit unsure about her being put in 4 so fast. Seemed too good to be true and trust her."

Then:

"You on tonight?"

And Lucy Letby responded:

"Been on today."

"Ah [says [Nurse A]], thought you weren't nights. [Baby G] septic again?"

Then this:

"Nights Friday, Sat, Sunday. [Baby G] vomiting, pale, apnoeas/desats. On Optiflow in 1. CRP 18, been cold last 24 hours."

And you'll remember, take note of that in the context of the double-entry in the temperature chart:

"Due date today!"

That's what I was pointing out to you before, the fact that she well knew, did Lucy Letby.

Then responses from [Nurse A]:

"Oh, she likes to celebrate the big ones in style.

When was she screened if been cold for 24 hours?"

Then:

"Due immunisations today too. I got her screened this morning after she vomited."

"Was she still in 4 then?"

Then this:

"Yup. And had nursery nurse all weekend. Looked rubbish when I took over this morning, then she vomited at 9 and I got her screened."

[Nurse A]:

"See, it really worries me. I wasn't on when she was moved, but I wouldn't have done it myself."

Then 113:

"I personally felt it was a big jump considering how sick she was just a week ago. Being in 4 is bad enough and then having a nursery nurse that just don't always know what to look for/act on. Mum said she hasn't been herself for a couple of days."

So nursery nurses bad, they don't know what to look for, or is this just all lies to create the impression with her colleagues? It's obvious what is going on, isn't it? It ties in, though,

doesn't it, with [Baby J]? "Nursery nurses shouldn't be doing stomas", until we see the BAPM guidelines, which say, yeah, nursery nurses can do stomas.

Lucy Letby didn't write her note until 12.47. It's tile 48. Just look at the top of the page, please. She wrote that [Baby G] was pale. She also wrote:

"Temperature 36.4. Hat in situ and well wrapped."

Holding that temperature in your head, if you go back to tile 46, she'd made a mistake because in the temperature section of the observation chart Lucy Letby had entered a normal temperature of 36.8. This all ties in with the "being cold in the last 24 hours" sent as a text to [Nurse A] later that evening. It's all part of the false narrative, isn't it? It couldn't be clearer, we suggest. Could not be clearer.

Following the first -- perhaps that's a good time for a break, actually, my Lord, because I'm going to come on to the second incident on that day.

MR JUSTICE GOSS: Yes, that would seem sensible. We'll have a ten-minute break, please, members of the jury.

(3.06 pm)

(A short break)

(3.16 pm)

MR JOHNSON: So going back to 21 September then, ladies and gentlemen. The first incident that day is count 8.

Moving on to count 9, following the first incident, [Nurse B] took over as [Baby G]'s designated nurse, but you will remember, I'm sure, that [Nurse B] had another baby in room 1.

Lucy Letby remained in nursery 4 with [Baby G] and count 9 relates to the incident where [Baby G] was behind a screen having a cannula inserted into her and what happened thereafter, I'm sure you remember this.

You'll remember it was at about 15.30, so mid-afternoon, and you will remember, I'm sure, that the medical staff were having problems getting a cannula into [Baby G] because she'd been in hospital for so long and had so many cannulas put in different parts of her that it was proving difficult. And Dr Chang, who I'm sure you'll remember from the [Babies O & P] cases, had failed to put in the cannula and so the senior consultant, Dr Gibbs, was called in.

Dr Gibbs and Dr Harkness set up a screen in room 4, put [Baby G] on to a trolley to carry out the procedure, and whilst that was going on, from time to time [Nurse B] would come into the room from looking after her other baby in room number 1. And each time she did so and went behind the screen and saw what was going on, she saw that the monitor was switched on and [Baby G] was attached to it while the procedure was being carried out.

[Nurse B] told us that about a month before she gave evidence, so she gave evidence to you about this on 13 December, she had contacted the police in this case to tell them that she believed that Lucy Letby had not switched off the monitor because, on 21 September 2015, after the event, both Dr Gibbs and Dr Harkness were outside nursery 4 when one of them, and she couldn't remember who it was, had apologised to her for not having put the monitor back on and for having left [Baby G] behind the screen.

When this was suggested on behalf of Lucy Letby to Dr Gibbs, he replied that he had no recollection of that incident, but what he did say was that if [Nurse B] said it was true, he accepted it was true.

Dr Harkness, it was suggested to him as well. He was not quite as accommodating to the suggestion. He said to the police and to you that he had told a nurse that they had completed the cannulation and that one reason was that they were so keen to get fluids going again for [Baby G] because [Baby G] hadn't had any fluids for 6 hours. So what Dr Harkness is saying is she wasn't just left there and the message not passed on, because the whole point of this exercise was that it had been 6 hours since [Baby G] had had any fluids and therefore it was important and therefore we needed to tell the nursing staff that the procedure had been completed.

Dr Harkness gave you that evidence back on 12 December last year.

When he was cross-examined, Dr Harkness was reminded of a statement in which he'd said that the sudden collapse of babies of [Baby G]'s age was quite common and he said:

"Well, when I worked at Chester, that was my view, because that was my experience but my more recent and more extensive experience elsewhere leads me to review that as a suggestion."

And he did not accept. Well, we say, ladies and gentlemen, that that exchange about what Dr Harkness had put in a statement really highlights the point that the behaviour of a single rogue nurse in a neonatal unit -- it highlights that the behaviour

had, in effect, gaslighted all the other staff into believing what was wholly exceptional was in fact normal. Dr Harkness now, with his more extensive experience since leaving Chester, recognised in the evidence he gave to you on 12 December that [Baby G]'s collapse was not normal by any standards.

Whatever conclusion you draw about the evidence surrounding this final event, you will, we suggest, want to look at all the circumstances with a critical eye, particularly as [Nurse B] was out of the room in nursery 1 and Lucy Letby, the only children for whom she was responsible were in nursery 4 with [Baby G].

What [Nurse B] said was that [Baby G] was back in her cot when she came back into the room having heard Lucy Letby shouting for help. Is it as Lucy Letby suggested that she moved her from the trolley, having found her in extremis, put her back in the cot and then Neopuffed her? Is that a realistic suggestion? We suggest not in her case. Is it credible, do you think, that two doctors would have carried out a cannulation on a child with a history like [Baby G] and yet would not have put the monitor on and attached it, the monitor that Dr Harkness said was definitely not turned off?

Whatever [Nurse B] says that Dr Gibbs and Dr Harkness said to her, it's clear that neither of them can remember it and no one made a note in either the nursing or the medical notes. And Dr Gibbs made it very clear, having made his concession, that whatever the position was with regard to the monitor, he would made sure that [Baby G] was stable once he'd cannulated her and before he left, and he also said he would have told someone that he had finished. And if [Nurse B] wasn't in the room then we suggest there is only one person he could have told, and that is, of course, Lucy Letby.

So is it an innocent coincidence that [Baby G] desaturated just after Dr Gibbs and Dr Harkness left the room, having left her in a stable condition? And why was Lucy Letby behind the screen at all? Why did she simply not pass on the message to [Nurse B]?

Why didn't Lucy Letby move the screen?

We say that you can be sure from a combination of all these circumstances, and taking them in the light of all the other evidence in the case, that this was another occasion when Lucy Letby tried to kill [Baby G], having failed on her previous two attempts.

It was put to [Nurse B] on behalf of Lucy Letby that Lucy Letby had spoken to her and had been cross that the doctors had left [Baby G] behind the screens with the monitor off. Well, [Nurse B] didn't remember that, did she? Neither did she remember the

conversation that was being suggested to her about putting in a proposed Datix report or dealing with things her own way. She didn't remember, ladies and gentlemen, because what was being suggested to her by Lucy Letby was not true. And this is an example, isn't it, of her opportunistic character? She saw a baby behind a screen and thought she would attack it.

It was not until after Christmas that we heard from Drs Evans and Bohin about count 8. We didn't deal with any expert evidence in relation to count 9 because that's just a factual issue, that's for you to determine on the facts.

So just dealing with the incident in the morning then of the 21st, Dr Evans said that the degree of desaturation at 10.15, together with the two projectile vomits and the aspiration of 30ml of milk in a baby who had only been fed 40ml was all indicative of the fact that once again [Baby G] had been overfed, with potentially catastrophic consequences. Dr Evans thought that the fact that [Baby G]'s stomach had to be aspirated supported his view and he disagreed with the suggestion put to him in cross-examination that this was some sort of self-resolving issue.

The point that Dr Bohin stressed was one that we suggest is very much common sense. It was what she called basic arithmetic:

"2x large projectile milky vomits."

You'll see that in Lucy Letby's note at tile 50, plus the 30ml that was aspirated, meant that [Baby G] was fed much more than she should have been. It's as simple as that. We suggest that you should look at the 10.15 incident in the context of what happened 3 weeks earlier. On both occasions, clear evidence that Lucy Letby was involved. When are looking at the event of 7 September please bear in mind who it was that overfed [Baby G] on the 21st.

These two events, we say, are very similar, albeit the consequences of the first were very much more severe and they are lifelong as far as [Baby G] is concerned. You heard that she will be forever fed through a PEG because of the brain damage she suffered on 7 September. The fact that Lucy Letby in those circumstances attacked her again during the morning and then yet again during the afternoon, we say, self-evidently proves her intention to kill.

I'm going to move on to [Baby H] next, please. Sometimes, starting at the end rather than the beginning can be illuminating. I'm going to do that with [Baby H] and I'm going to start at tile 499, please. It's not quite the end but it's

almost the end. This is the discharge written by Dr Matthew Neame to Arrowe Park on 27 September.

If we scroll down, please. There we see:

"Diagnosis: pneumothorax. Ventilated for 2 days.

CPAP for 2 days. Initiated on CPAP after birth due to grunting and poor capillary gases."

We see mention of the chest drains, the further deterioration on 25 September associated with a re-accumulation of the left-sided pneumothorax, the needle thoracentesis, the re-insertion of another drain, the non-pigtail drain, that's Dr Jayaram's drain, the further deterioration on the 26th at 2.15. The third pigtail drain.

Further down, please. It says:

"[Baby H] currently ventilated. Chest X-ray shows well expanded lungs with no pneumothorax."

Then again, please. And again:

"Thank you for accepting this 34-week gestation baby who has had two significant episodes of bradycardia, requiring resuscitation with adrenaline and CPR in the last 24 hours with no clear precipitating factors."

Then just down to check there's nothing else, please:

"[Baby H]'s course has been complicated by the development of RDS and pneumothoraces, as outlined above, but the acute episodes with desaturations and bradycardias do not seem to be directly related to the respiratory problems."

So that, you know, was the view when [Baby H] left, and it is a familiar refrain in this case, isn't it?

As with others who were removed from the orbit of Lucy Letby, once [Baby H] left the hospital her management quickly de-intensified. The chest drains and the ET tube were removed, she did well, her heart was normal, as was her blood pressure, and as [Baby H]'s mum and dad said in a statement -- [Baby H]'s mum, I beg your pardon, said in a statement:

"She was like a completely different baby at Arrowe Park."

[Baby H] was in the neonatal unit with both [Baby G] and [Baby I]. [Baby H] was a large baby by the standards of this case, 2.33 kilograms, and she was not particularly premature. She

undoubtedly had RDS, respiratory distress syndrome, but that's something which is not unusual and something that in a neonatal unit should not have caused serious problems.

Between her birth on 22 September and her transfer to Arrowe Park early on the morning of the 27th, she desaturated several times and had associated bradycardias and she had the two cardiac arrests mentioned in that discharge letter. And as the letter says, and as the evidence you heard established, those two events were of a very different character to what happened otherwise.

A significant period of time in the evidence during the prosecution case involved questioning about the delay in giving [Baby H] surfactant and the staffing levels. But as the cross-examination of Lucy Letby revealed, at least as far as the staffing levels were concerned, they didn't contribute to the collapses of [Baby H].

At the time [Baby H] had her most serious collapses she was the only child in nursery 1. At the time she always had one-to-one nursing care. And incidentally, the delay in giving surfactant had nothing to do with the two collapses, which required adrenaline. So we say please don't get distracted by that.

Many of the apnoeas and bradycardias that [Baby H] had were caused by obvious issues. Primarily, it was the accumulation of air in her chest outside her left lung.

On some occasions, the tube was blocked, but on two occasions, the occasions specified in counts 10 and 11, when she had the most extreme collapses, the tube was not blocked. There was no pressing problem with the pneumothoraces and the treating medics could hear air going in and out of her lungs. So that proves, doesn't it, that that wasn't the problem?

[Baby H]'s mum is [Mother of Baby H], and [Mother of Baby H]'s statement was read to you on 18 January.

You will remember that [Mother of Baby H] has diabetes and because of blood sugar issues was admitted to Chester, to the Countess, and [Baby H] was delivered by C-section, as I said, on 22 September. [Baby H] was in good condition, but she developed breathing problems and was put on to CPAP, and that night she was put on to a ventilator.

Overnight on the 23rd to the 24th, Lucy Letby was [Baby H]'s designated nurse. Dr Ventress told us that [Baby H] had been weaned down to CPAP and was in air by 6 am on 24 September.

On the day shift of the 24th, [Nurse B] came on and took over [Baby H]'s care. [Baby H] was deteriorating at handover from Lucy Letby, she had a poor blood gas and desaturated to the 50s and needed bagging, though her heart rate remained at over 100.

She then had to be intubated, having previously been on CPAP.

As the day shift progressed, it became clear that [Baby H] had a pneumothorax and a first chest drain was inserted at 10 o'clock by Dr Harkness. So far as the acute problem was concerned, the immediate problem, that was sorted.

On the night shift of the 24th into the 25th, by the time it got into the 25th, Lucy Letby -- on that shift Lucy Letby was the designated nurse again. Dr Ventress was urgently bleeped at 01.14. When Dr Ventress arrived, [Baby H] was being Neopuffed and there was then a rapid increase in saturations. But chest movement remained poor and the capnograph was slow to change and [Baby H] desaturated again at 01.25 with poor chest movement and so Dr Ventress used a needle to aspirate 70ml of air from [Baby H]'s pneumothorax and called for Dr Jayaram. Dr Jayaram arrived at 01.50, which is tile 50, and he put in the second drain. This was the old-fashioned drain, if you remember, not the pigtail drain.

Dr Jayaram was cross-examined about the possibility of chest drains coming into contact with the vagal nerve or heart, presumably as a prelude to a suggestion that that must have been the reason for [Baby H]'s two unexplained collapses. And Dr Jayaram said in no uncertain terms he had never seen either eventuality happen. He made the point that if the drain was in the pleural space then the lung was between it and the pericardium, which is the sac containing the heart. And the pericardium in any event would block the route of the drain to the heart.

Dr Jayaram was asked to look at the radiographs and he made the point, did Dr Jayaram, that they're two dimensional images, so they can be very misleading. He said that because the drain was at the front of the chest it wouldn't come into contact with either the heart or the vagal nerve. He also made the point that the internal point of the drain would only move, that's internal to the chest, as the pneumothorax resolved, as the air was evacuated. He said it could not wiggle about as was being suggested to him.

Now, we had a lot of evidence about this, you'll remember, I'm sure. It wasn't until some time later, on 3 February, when Professor Arthurs made an appearance and made what we suggest is a very significant contribution to the debate. If we'd had

Professor Arthurs' evidence at the time, it may well have reduced the amount of time that we spent on the issue.

Professor Arthurs said several things, important things. First, I'm quoting him:

"Chest drains aren't known necessarily to cause bradycardia and desaturations, otherwise we'd have been seeing it in almost every baby who had a chest drain in.

Second, we don't examine where chest drain positions are in detail because they tend not to cause any problems.

Their precise position is not really that relevant to a radiologist."

Third, he said the interpretation of the position of a chest drain was his field of expertise, not that of neonatologists or paediatricians. And he said that in his opinion, looking at these images, the chest drains were in the pleural space. In other words, they were where they were supposed to be and they were not a concern.

So that's the evidence, ladies and gentlemen. The professor of radiology from Great Ormond Street told you there isn't an issue with the position of the chest drains as shown in the imaging in this case.

You don't have to accept what he says, of course.

That's a matter for you. But you don't actually have any evidence that contradicts him, do you?

So with that in mind can we go to the evidence of the two collapses, starting with count 10, the collapse on 26 September at 03.22, the timing coming from Lucy Letby's note at tile 241. We start with 177.

Thank you very much. That's where we get the time from.

If we go to 177, please. We can see on this the first night shift on which one of these incidents happened. Lucy Letby was [Baby H]'s designated nurse and she had [Baby H] to herself in room number 1. We say therefore she could pick her moment.

[Baby H]'s dad is [Father of Baby H]. [Father of Baby H]'s statement was read to you and it covered the time before [Baby H] collapsed. [Father of Baby H] recounted to you how he and his wife spent time in the neonatal unit from [Baby H]'s birth through to Friday, 25 September.

When he got to his description of what happened on the Friday, he said this -- and I'm quoting directly from the statement:

"I'd been there with [Mother of Baby H]'s mum on Friday until about midnight..."

It's the time that's important, "until about midnight":

"... and we'd come back to the house. I was awoken by her in the early hours. She'd had a call from [Mother of Baby H] that we needed to go back to the hospital."

Remember [Mother of Baby H] was in hospital as an inpatient.

He then said that when he got back to the hospital:

"I definitely remember Lucy being there. She was doing the chest massaging. We got into the area and it was explained to us that [Baby H] had had a collapse.

Dr Ravi came in and put some chest drains in her, but prior to that time I remember she was getting massaged by Lucy and that she was a very strange colour, very mottled. As [Baby H] was coming back round, I remember the mottling was running out of her skin towards her fingers."

And that was when Dr Gibbs explained that the pressurised air in her lungs had caused a tear:

"I remember the mottling was running out of her skin towards her fingers."

Well, that's an interesting observation by [Father of Baby H], isn't it, in this case, particularly when you know what happened with other children?

But the reference to "mottling running out of her skin" at the time of this profound and serious collapse isn't the only interesting feature of what [Father of Baby H] said. As I said a moment ago, the other important point is that he left at "about midnight".

If we go to Lucy Letby's nursing note at tile 208, please, ladies and gentlemen, we see this that she wrote at 04.14:

"Written for care given from 20.00 to present.

Emergency equipment checked, fluids calculated. [Baby H] nursed in an incubator. Ventilated with size 3.5 ET tube, 8 centimetres at lips. Ventilator settings gradually increased during shift in line with blood gas and clinical picture. Currently 24/4. Two

chest drains in situ at start of shift: intermittently swinging, serous fluid accumulating."

Then this:

"23.30. Bradycardia and desaturation requiring Neopuff in 100% to recover. 10ml AI aspirated from chain by Registrar Ventress. Following poor blood gas and 100% oxygen requirement, Consultant Gibbs attended the unit and inserted a third chest drain. All 3 drains swinging and serous fluid present."

This shows, ladies and gentlemen, this shift, according to the note, was uneventful for [Baby H] until 23.30 -- at least that's the time put in the note by Lucy Letby.

She times the desaturation in the note as 23.30 and says it had the consequence not only that the Neopuff had to be used but also that Dr Ventress had to intervene by using the needle by which it means she aspirated -- sorry, no, let me get it right. No needle.

It just says:

"10ml [I think that probably is 'air', I think that was the evidence] [air] aspirated from chest drain by Registrar Ventress."

If we go to Dr Ventress' notes, which were made at the time, this is tile 210, we see a number of interesting features. First, Dr Ventress wasn't called at 23.30, she was called at 23.50. You remember what time [Father of Baby H] said he left? Just before midnight.

Second, Lucy Letby was telling her friend, Dr Ventress, that there had been "several episodes of desaturation in the past 2 hours". Where's that come from?

Third, the first desaturation reported to Dr Ventress was:

"After gas taken (good gas) became agitated."

Well, we know the time of the gas. We have to jump about a bit here, I'm afraid. It's at tile 198. It's 22.02. If we go to tile 196, Lucy Letby wrote in at 22.10, so before the good gas, a desaturation down to 52%. That doesn't appear at all in the typed nursing notes.

Going back to Dr Ventress' notes, please, tile 210.

Lucy Letby was telling Dr Ventress that there had been:

"[A] desaturation associated with poor chest movement and bradycardia. Thick mucus suctioned from ETT and then chest movement and sats improved. 10ml air aspirated."

She also told Dr Ventress that there had been other further episodes with no change in heart rate. There's nothing else in the observation charts -- if we go to tile 195, nothing in the observation charts, I should say, tile 195, to suggest that there was anything wrong during this period.

So [Father of Baby H] is there with his daughter, an apparently uneventful night, leaves just before midnight, Dr Ventress is called at 23.50, just before midnight, we've heard that before, just after the parents leave. Dr Ventress is given a long litany of problems that have been occurring over the night or over the evening. Where's the evidence in the nursing records that accords with what Lucy Letby was telling Dr Ventress? Or is this part of Lucy Letby's effort to get other people to record things in their notes that make it look like [Baby H] had a problem but in fact there was no problem? Just harking back to yesterday, [Baby E], getting Belinda Williamson to make those notes at 22.00, to which Lucy Letby then added after the event, all to make it look like other people are there when things are going wrong. But in fact it's all coming from Lucy Letby. [Baby H] hadn't had a problem until Lucy Letby caused the problem.

Another thing, going back to tile 210, please, because according to a note made by Dr Ventress, this second chest drain had managed to almost remove itself.

It's right at the bottom there:

"Second chest drain advanced back to 4 centimetres as was almost out."

Moving ET tubes, moving chest drains. A very effective way to sabotage the care of these children, isn't it? When you're considering whether or not that chest drain almost came out for an innocent reason, you might want to bear in mind that at 16.21 that afternoon, this is tile 149, [Nurse D] had made a note that:

"Following a desaturation by [Baby H], the second chest drain noted to be in a different position and holes close to chest wall. Further Tegaderm applied and chest drain tubing position altered."

This is the second drain, this is Dr Jayaram's drain. It's the same one that was noted as having come out by Dr Ventress. But it was securely fixed at that point.

Do you remember what Lucy Letby said about reading other people's notes? She made it her business to read back to get context. So she sees a problem in the afternoon and copies it in the evening. We know that's right because of the discrepancy between [Father of Baby H]'s statement, which is agreed evidence, and the contents of what Lucy Letby is telling the doctor and the fact that what Lucy Letby was telling the doctor she hadn't noted herself on the charts.

There can be, we suggest, no other possible -- this is just looking at this one event in isolation. Ignore everything else in the case. What other conceivable explanation is there?

Now, as the issues mounted for [Baby H], Dr Gibbs was called in by Dr Ventress. He came to review [Baby H], he inserted the third drain at 02.15 to help [Baby H] saturate properly and it had the desired effect and the position was confirmed by an X-ray at 02.30. Dr Gibbs then left, but he was called back at 03.30 when [Baby H] desaturated even more severely. This is the event we allege in count 10.

When Dr Gibbs returned at 03.36 he saw [Baby H] being given CPR and adrenaline. The position of the ET tube wasn't the issue because it was being used to ventilate [Baby H], and when compressions were stopped, no pulse could be felt. [Baby H] was in very, very poor shape. But after three doses of adrenaline, her spontaneous pulse returned. She'd been in arrest for 22 minutes.

22 minutes. And this is the point at which [Baby H]'s dad said:

"I remember the mottling was running out of her skin towards her fingers."

Dr Gibbs took us through all the possibilities that might have caused such an extreme collapse and he excluded them all.

In cross-examination, it was suggested to him that:

"Cumulative stress could have been the reason for [Baby H]'s near-death experience."

He rejected that suggestion and there is no evidence to support it as a proposition. Dr Gibbs was asked about whether it could have been the drains being in contact with the heart which caused the collapse. He said not. And when pressed about that -- sorry, when pressed about what he'd been advised by Dr Rath at Arrowe Park, he said it was a reference to the possibility of the drain touching the heart, causing bradycardia, not the collapses. You will remember the evidence of Dr Arthurs which, we suggest, puts this to bed completely in any event. And Dr

Gibbs also made the point that when the third chest drain was removed, [Baby H] continued to have problems, and so that was clearly not what was causing the problems. You may think, and we suggest you should conclude, that that must be right.

The second collapse, which is count 11. Shelley Tomlins, who you will remember is now in Australia, was the designated nurse for [Baby H]. Dr Soni removed a chest drain from [Baby H] and we can see that recorded in the medical notes at tile 393.

A crash call went out at 20.49, tile 396, and on this occasion the doctor called to rescue [Baby H] was Dr Neame. He gave evidence on 23 January. When he arrived, he found Lucy Letby doing the breathing support. He didn't recall anyone else being there at the time and he said that ordinarily it would be the designated nurse who briefed him on what happened and he confirmed that he told the police that he had assumed from all the circumstances that Lucy Letby was the designated nurse.

She wasn't of course, but the situation that presented itself to Dr Neame gave him the clear impression that she was. And you know why. Because, as normal, we suggest she elbowed one of her colleagues out of the way.

He remembered, did Dr Neame, seeing the ET tube blocked with secretions and so this was an innocent cause for the desaturation. But the fact that Lucy Letby was the person who was hands-on, we suggest, informs you about what was to happen later in the shift.

She was taking a very keen interest in [Baby H], having failed to kill her the night before.

The fact that Shelley Tomlins was the designated nurse for [Baby H] hadn't prevented Lucy Letby getting involved, despite the fact that [Baby H] was being ventilated. We see further evidence of this from the text messages that were passing between Lucy Letby and [Nurse A]. Can we go to tile 406, please?

So this is an hour and a half or so into the shift:

"I've been helping Shelley so least still involved but haven't got the responsibility."

Plausible deniability again, we say. This supports Dr Neame, doesn't it? He hadn't read these text messages. He got the impression that Lucy Letby was the designated nurse. This is why I say she's elbowing out her colleagues to get involved with children she has an interest in.

We know that Lucy Letby was supposed to be in nursery 2. We know from other evidence that she always wanted to be in nursery 1. And that text to [Nurse A], we suggest, confirms that she wanted to be in nursery 1. It also shows her state of mind at the time, doesn't it? Like her state of mind on the night she killed -- sorry, yes, the state of mind on the night when she killed [Baby C]. She saw this, as revealed by that text message, as an opportunity to sabotage [Baby H] without being connected to what she'd done.

If we go to tiles 414 and 415, please. There she was co-signing for medication for [Baby H] at 22.12, administering it to [Baby H] at 416 and 417. That's 22.13.

At 00.55, [Baby H] had a profound desaturation to 40%, despite equal bilateral air entry and positive capnography. ET suction yielded nil secretions. And you will find that in Shelley Tomlins' note at tile 236 -- I've obviously got the wrong reference there. Sorry, it's 436.

Equal bilateral air entry, positive capnography, it's a signature, isn't it? I keep saying it in different cases because there are so many similarities.

Air going in, carbon dioxide coming out, another child desaturating to life-threatening levels for no apparent reason. It wasn't the pneumothorax that was the problem, was it, because air entry both sides? If the pneumothorax was preventing the air going in, you wouldn't get air entry on both sides. And Shelley Tomlins confirmed in evidence that she had checked the ET tube on this occasion and there was no blockage.

The medical staff were all bleeped. Dr Neame re-intubated [Baby H], CPR was started, adrenaline administered, and mercifully [Baby H] was revived.

An X-ray taken just after this at tile 451 confirms that there wasn't an issue with the pneumothorax.

Again, the circumstances immediately prior to this collapse were dealt with in the witness statement of [Father of Baby H]. He said this, referring to his daughter:

"She was okay during the Saturday day and then quite late on, I remember going to the parents' bedroom on the ward to get some sleep. It was only shortly afterwards we got a knock on the door to say that she'd deteriorated and needed medical attention and for us to go and be with her at her bedside."

The timing of this collapse says it all, doesn't it?

The parents who now, no doubt, were besotted with their newly arrived daughter, paying her close attention, disappeared and the opportunity presented itself to Lucy Letby to sabotage yet another child. Just like [Baby M], [Baby O] and [Baby P], the departure of the parents is a signal for Lucy Letby to seek to kill.

There's another list when the nurses go, isn't there? We've dealt with that many times and I'll wrap all these up at the end for you and give you the final lists. Dr Neame attended again. Again, his memory was that it was Lucy Letby who briefed him as to what had happened. As he said:

"I remember a sense of being more concerned on this occasion because it wasn't completely clear why she had collapsed: air moving in, air moving out, [Baby H]'s chest rising and falling, but her heart rate and saturations were dangerously low. She was re-intubated, the problem persisted, and therefore CPR and adrenaline were required."

Fortunately, mercifully, again [Baby H] recovered.

There was a further desaturation at 3.30 when [Baby H] required Neopuffing. No cause was identified on that occasion, although air entry or lack of air entry was excluded because Shelley Tomlins confirmed to you that there was good air entry on both sides.

At 5.25 [Baby H] was handed over to the Arrowe Park transport team with the letter I showed you at the beginning and you know that she quickly recovered once she left Chester.

Expert evidence was called on 24 January. I've already dealt with Professor Arthurs' short but important contribution, which was a bit later. Dr Evans said -- what he said can be summarised very shortly. In his opinion, the pneumothoraces were not the cause of the two cardiac arrests. He said that if it was the insertion of the chest drains that caused the arrests then that would have happened when the drains were put in.

He addressed the possibility that perhaps infection had a part to play. He said no for three reasons.

First, the pattern of decline was not what one sees in cases of infection. [Baby H] in this case had suffered rapid and catastrophic collapses, which is not what one sees with infection.

Second, she was on antibiotics and once she got to Arrowe Park her lumbar puncture proves that she didn't have an infection.

Third, if the collapses were due to infection there would have been no need to use adrenaline and atropine to revive her.

Dr Evans was at a loss to explain what it was but told you this was not a collapse from natural causes.

Dr Bohin told us that the cause of [Baby H]'s pneumothoraces was the fact that she had RDS, she'd received surfactant relatively late. Dr Bohin said that the reason for the delay was that an X-ray was needed to confirm the position of the ET tube before surfactant was administered and it's well-known in the medical profession that if you put surfactant down a tube in the wrong place that can cause significant complications.

Having said that, Dr Bohin was still of the view that things were delayed too long with surfactant.

Dr Bohin said that the difference between the two important collapses that we allege are markers of Lucy Letby's attempt to kill [Baby H] and what had gone before was that there was a profound desaturation in conjunction with good air entry in and out of the lungs and good chest movement. The fact that the medics could hear air going in and out meant that there was no significant pneumothorax at that time and that the ET tube was not blocked.

[Baby H] then went into cardiac arrest. It took a long time to get her back and Dr Bohin said:

"I can find no obvious clinical or mechanical cause to account for this collapse or to account for why [Baby H] did not recover as she had done with what was routine intervention."

Dr Bohin also dealt with the issue of movement of the drains. She made the point that following the refixing of Dr Jayaram's drain by Dr Gibbs at 16.21 on 25th, well before the X-ray, it didn't move and was not near to the heart, and therefore cannot have been responsible for either collapse.

She added that in any event she had never known a chest drain to cause this sort of problem on two occasions and she rejected out of hand the suggestion that stress was cumulative and that in any event it could cause a cardiac arrest.

There was quite a lot of questioning about the position of the chest drain and whether or not it could have caused issues with the vagal nerve or the heart.

And as I said, unfortunately that was before we had the benefit of Professor Arthurs' opinion.

So just wrapping up our position, ladies and gentlemen. Professor Arthurs saw no problem with the position of the drains. We suggest you can dismiss that as an idea, the idea that any of them were in a position that would have caused two almost fatal collapses.

Second, even if a chest drain was in a position to interfere with the heart or the vagal nerve, the idea that that just happened to coincide with the presence of Lucy Letby and didn't manifest itself at any other time is so unlikely that it can be discounted.

Third, there was no disease or mechanically related reason for [Baby H] to suffer such extreme collapses when on both occasions air was going in and out of her lungs.

This was undoubtedly a case of sabotage that bears striking similarities to other cases you have heard about.

Fourth, the fact that both collapses occurred just after [Baby H]'s parents had left is another striking coincidence by comparison of each collapse to the other and by comparison with other cases. And we suggest it is a signature of Lucy Letby at work. And the idea that there could be some innocent reason causing the collapse just at that moment can be dismissed as fanciful.

What about what was seen by [Baby H]'s dad? Just because the medics didn't see it doesn't mean you can't take it into account. It's an astonishing coincidence, isn't it?

My Lord, that, I think, is --

MR JUSTICE GOSS: Yes, certainly. 10.30, tomorrow morning, please, members of the jury. Remember your responsibilities. I think Mr Johnson, you're likely to complete your address tomorrow?

MR JOHNSON: I'm really hoping that I will.

MR JUSTICE GOSS: Thank you.

(In the absence of the jury)

MR JUSTICE GOSS: You did in your address give the date when Professor Arthurs came back. He came back on two further occasions, didn't he? Can you remind me which one it was?

MR JOHNSON: It was the February one.

MR MYERS: 3 February.

MR JUSTICE GOSS: Thank you very much.

I did cause to be sent to you both the -- I know that will be very low on your mind, but I'm really more interested in Mr Myers' observations if any.

MR MYERS: We received it, my Lord, and I'm grateful for that. We're still considering it. We have looked at it. In fact, there was one issue with regard to delay that we were just considering further, just by way of assistance, but there was no fundamental issue raised with any of it.

MR JUSTICE GOSS: There's no rush. The point is, even if you don't know the precise words that are going to be used, there may be some slight adjustments. You know the basic directions that will be given.

MR MYERS: We do.

MR JUSTICE GOSS: We can finalise the final version when you've finished.

MR MYERS: Thank you, my Lord. Could we see Ms Letby at the conclusion of the hearing, please?

MR JUSTICE GOSS: Yes. That's acknowledged, thank you very much.

(4.16 pm)

(The court adjourned until 10.30 am on Thursday, 22 June 2023)