Prosecution Closing Speech Day 4

Thursday, 22 June 2023
(10.30 am)

(In the presence of the jury)

Closing Speech by MR JOHNSON (continued)

MR JOHNSON: Welcome back, ladies and gentlemen, and good morning. You'll have worked out that we have four children left to deal with, so the order in which I'll deal with them will be [Baby I] first, then [Baby J], then [Baby N] and then [Baby Q]. I will then give you a composite series of lists. You'll notice as I have been going through I've been pointing out various features which we say these children's cases have in common and I'll give you the composite lists at the end.

So starting with [Baby I]. [Baby I] died on 23 October 2015, having been born in the Liverpool Women's Hospital on Friday, 7 August.

She was well travelled for a child who never left hospital. She was moved from Liverpool to Chester on 18 August, back to Liverpool on 6 September, and then back to Chester on 13 September. Then from Chester to Arrowe Park on 15 October. And then from Arrowe Park back to Chester on 17 October. As I say, to Chester, where she died on the 23rd.

After the evidence of [Baby I]'s mum, [Mother of Baby I], was read to you on 25 January this year, the next witness was Dr Palanasami, who is a consultant neonatologist at the Liverpool Women's Hospital. He told you about [Baby I]'s progress following her birth, her transfer to Chester on day 11 of life, and her subsequent return with suspected NEC. One of the things that he told you was that medics don't worry about self-correcting desaturations.

In the weeks before she died, [Baby I]'s path crossed that of Lucy Letby on multiple occasions.

During that time, both [Baby G] and [Baby H] were still in the neonatal unit in Chester and, having failed to kill either [Baby G] or [Baby H], we say that Lucy Letby turned her attentions to [Baby I].

Of the four occasions that we allege [Baby I] was sabotaged by Lucy Letby, Lucy Letby was her designated nurse on two. On both of those two occasions we say that Lucy Letby falsified the records to make it look like [Baby I] was deteriorating before her collapses.

The three incidents before [Baby I]'s death are important, but because this is an allegation of murder, it's the fourth incident that really matters.

We do not suggest that any of the first three incidents caused [Baby I]'s death. But incidents 1 to 3 are important because they inform your interpretation of the events immediately connected to [Baby I]'s death. I'm sure you'll be invited on behalf of Lucy Letby in due course to consider events in August and early September, which were highlighted by Dr Evans in his reports but those incidents did not cause or contribute to [Baby I]'s death.

I'm just going to deal with the four occasions on which we allege Lucy Letby attacked [Baby I]. But just before I do, I want to remind you of something that Dr Marnerides told you. There was no evidence from the post-mortem examination of [Baby I] that she ever had NEC or that she ever had any other bowel disorder. If [Baby I] had had NEC then the evidence would have been found in the histology at the post-mortem. So we say you can exclude NEC in this case.

So starting with incident 1, this was 30 September at 16.30 hours when there was a large vomit and desaturation, followed by a further desaturation at handover, interestingly, at 19.30.

[Baby I]'s first collapse that day was marked with a "large vomit from mouth and nose ++ and desaturation into the 30s". You may think -- and we encourage you to consider the similarities between that as a description of what happened and what had happened to [Baby G], both on the 7th and 21 September. In other words, so far as that latter incident was concerned, only 9 days earlier.

The day before what I'm referring to as incident 1 for [Baby I] was 29 September and a Dr Lucy Beebe, who finished part of her training in Chester in December 2015 or January 2016, examined [Baby I] in preparation for the grand round the following day, the Wednesday. She remembered [Baby I], despite the fact that Dr Beebe didn't work in Chester for very long, because, as Dr Beebe described it:

"[Baby I] had been seemingly well but became unwell, was shipped out to a tertiary unit and made a rapid recovery, which seemed to happen a number of times."

This, she said, had never happened with any child she had known, although you know it's a feature of several of the cases that you are considering, several of the children who were in contact with Lucy Letby. Dr Beebe told you that she had been shocked and

frustrated at [Baby I]'s death because Dr Beebe felt that something was going on that they were not getting to the bottom of. She was absolutely right about that, wasn't she?

On 29 September, Dr Beebe found [Baby I] to be in good condition with no markers of concern. [Baby I] was anaemic, but you heard that was a long-standing problem, and according to Dr Beebe is very common in premature babies. And it wasn't a problem because there was evidence that [Baby I]'s bone marrow, her own physiology, was correcting the problem.

Dr Beebe said that the fact that [Baby I] looked "a little pale" on that examination was consistent with this issue of ongoing anaemia and that [Baby I]'s heart rate and her CRP were normal. And that so far as she, Dr Beebe, was concerned the priority was to continue feeding and growing [Baby I]. The aim was to get [Baby I] on bottles full-time.

Wednesday the 30th was a day shift for Lucy Letby and [Baby I] was in nursery 3 and if we look at the population chart, which is in the first of the [Baby I] sequences, at tile 44, we can see there [Baby I] in nursery 3. Lucy Letby had a monopoly of the children in that room at that time. And you know Lucy Letby didn't like being in nursery 3.

Wednesday, of course, was the day of the grand round, which started at 9 o'clock and it was Dr Newby, the consultant, who reviewed [Baby I]. You will find her note of that review at tile 46. There were no remarkable findings. The plan was to give [Baby I] her immunisations, to wean her off her hot cot, and to feed and grow her. Give her immunisations, just like [Baby G], another coincidence.

There was nothing wrong with [Baby I]. [Baby I]'s mum fed her with a bottle and did her cares at 10 am and you can see that in the feeding chart, which you've got in hard copy behind divider 12 of your second jury bundle at page 14780.

It's the last document in section 1 of that document and what you can see is that during that examination -- sorry, during that feed at 10 o'clock, [Baby I] produced a small stool. You can see in the BO column, it says "Small BO". And the entry, of course, is signed by Lucy Letby.

The fact that the immunisations were being planned shows, we suggest, and for the reasons you now understand without me having to explain them, that the doctors were very happy with [Baby I]. If we then go to tile 51, please, here we see Dr Beebe -- she's now known, of course, as Dr Hunt -- and we see notes of the doctor's examination at 11.40.

The important point here, ladies and gentlemen, is the reason for the review. This is after the grand round, so after Dr Newby had considered [Baby I]. A couple of hours, possibly, after the grand round. The reason for the review was recorded by Dr Beebe as [Baby I]'s "reduced temperature". You see at the top:

"Asked to review as [and then the arrow going down] temp."

At this stage, [Baby I] was taking full bottles, she was gaining weight and on examination, according to these notes and according to the evidence she gave to you, Dr Beebe told you that [Baby I] was handling well.

During the examination, she produced a "normal, yellow seedy stool". It's just at the bottom of that screen as you're looking at it now. That indicated that her gut health was normal. It is inconsistent with any suggestion of NEC according to Dr Beebe and indeed a lot of other medical practitioners from whom you've heard and, in any event, NEC has been excluded, as I've told you, by Dr Marnerides.

[Baby I]'s chest was clear, she was not in distress, her abdomen appeared similar to the previous day.

Dr Beebe's plan was to increase the temperature of the hot cot and to monitor [Baby I] closely even though she appeared to be "clinically well". The important thing to remember so far as this note is concerned, ladies and gentlemen, was Dr Beebe's evidence that in order properly to interpret her note you need to insert a comma between "monitor closely" and "if further concerns". So not "monitor closely if there are further concerns", but "monitor closely, if further concerns", et cetera. And this is critical to what happened afterwards.

Dr Beebe remembered [Mother of Baby I], who at this time was there visiting [Baby I] a lot and was friendly with the staff. So what was going on at this examination, ladies and gentlemen? [Mother of Baby I]'s evidence was read to you as agreed evidence. In that statement [Mother of Baby I] told you that Lucy Letby raised the issue with her about [Baby I]'s stomach, so on this day Lucy Letby was saying to [Mother of Baby I], "There's an issue with [Baby I]'s stomach".

And yet that was not the reason that Lucy Letby called in Dr Beebe: the reason was the reduced temperature.

So what was going on here? In the agreed evidence read to you on the morning of 26 January, Dr Ogden told you:

"If ever concern was expressed about a swollen abdomen, we would examine the baby."

No concern was being expressed by Lucy Letby to the medical staff at this stage about [Baby I]'s abdomen, despite the fact that Lucy Letby apparently, and the agreed evidence is, was expressing concern to [Mother of Baby I].

So why -- back to my favourite word -- why was Lucy Letby expressing to [Mother of Baby I] concern about [Baby I]'s abdomen? And if she was concerned, and the fact that she was communicating concern is agreed, why did Lucy Letby not raise the issue with Dr Beebe?

The reason inevitably, we say, is that Lucy Letby was managing the expectations of [Mother of Baby I]. Back to gaslighting. She was suggesting a problem, a problem that didn't exist, and, lo and behold, the problem arrived, and the reason the problem arrived is that Lucy Letby caused the problem.

If we go back to the feeding records, ladies and gentlemen, and you have them in your jury bundles behind divider 12, they are pages 14778 and 14780. We can see that by this stage -- we see the 28th here on the screen, and then followed the next day on the 29th, and then on the 30th -- [Baby I] was an enthusiastic feeder from a bottle.

But when we get to the 30th, everything was unremarkable until 13.00 hours when [Baby I] was apparently asleep and apparently, according to the records at least, had to be fed via a nasogastric tube by Lucy Letby. You'll remember [Mother of Baby I] in her agreed evidence said at lunchtime she'd meet her family in the canteen. So this coincides with lunchtime, doesn't it, and the absence of [Mother of Baby I]?

According to the record, [Baby I] was fed 35ml with fortifier, and we've heard from several witnesses that that would have taken a bit of time to do via the nasogastric tube. You will remember the evidence relating to [Baby G] in that respect. Well, let's be generous and say it took 15 minutes. It might actually have taken longer if it was done properly, but let's say it took 15 minutes and therefore would have ended, if the time is correct -- and that's always a big if with any record made by Lucy Letby, we suggest, but if it did take 15 minutes it would have ended at 13.15.

Well, what did Lucy Letby write in the notes and when did she write the notes? The one accurate time that we get in this case so far as Lucy Letby is concerned is in the nursing notes, isn't it, and the medication notes, because they are times that are stamped by the computer system?

If we go to tile 61, please, we can see that Lucy's nursing note began at 13.36 and it concluded at 13.48.

So this was, at the most, a note begun 20 minutes or so after the feed that I've just shown you on the feeding chart via the NGT was given by Lucy Letby to [Baby I]. And what Lucy Letby recorded in the nursing note is that [Baby I] had had two bottles and one NGT, that the doctors had been asked to review and advised to continue with the current plan. That's not quite right, is it? The requested -- this review can't have been the grand round, can it, because Dr Beebe, we know, had examined Lucy Letby -- had examined [Baby I] at 11.40. So this has to be a reference to Dr Beebe's examination.

At tile 62, a continuation of the nursing note is an addendum and this is a note made towards the end of the shift at 19.31. This note is interesting, we suggest, because it speaks of a "review by doctors", plural, at 15.00 hours, and you will remember that we allege this note is a complete fabrication. There was no examination of [Baby I] at 15.00. It doesn't appear in the medical records. After Dr Beebe's note at 11.40, the next medical record is made and timed by [Dr A] and it's at tile 73. You see at the top there:

"Asked to see patient due to vomit and desaturation."

Now, if [Dr A] had examined [Baby I] an hour and a half earlier he'd have made a note of that fact here, wouldn't he, even if he didn't make a note at the time? So who was this or who were these, if we take Lucy Letby's nursing note literally, doctors who examined [Baby I] at 15.00 hours?

If we go back, please, to page 62, which is the nursing note in the top left of the page, we can see that in this invented examination at 15.00 hours Lucy Letby speaks of [Baby I] appearing:

"Mottled in colour with distended abdomen and more prominent veins."

Well, you won't find any reference to [Baby I] appearing mottled in the medical notes either at 15.00 hours, because there isn't a note, or at 16.30 in [Dr A]'s note that we just looked at.

The nursing note though that we're looking at here, the one we say is invented, speaks of being advised to recommence full monitoring. You see the text is:

"Full monitoring recommenced."

If we look at tile 57, which is the vital signs chart, we can see full monitoring did recommence at 15.00 hours. But who advised it? The answer, it's back to Dr Beebe's evidence, isn't it? Dr Beebe had advised that at 11.40. So why did Lucy Letby wait until [Mother of Baby I] had gone to pick up her kids from school to recommence the full monitoring? Why did she invent a mythical medical examination at 15.00?

We know it is invented because if we go back to Dr Beebe's notes, we see the yellow seedy stool. And in Lucy Letby's note, the one we were just looking at, the one that was made at the conclusion of the shift, she refers to the fact that at this invented 15.00 hours examination, [Baby I] produced a yellow seedy stool. So what Lucy Letby is doing here is she is transposing events from 11.40, taking them and moving them on to a medical examination that she says happened at 15.00, which never actually happened.

The possibility of there being a mistake here, ladies and gentlemen, can be excluded because Lucy Letby's first note, the one I showed you first, had been made after Dr Beebe's 11.40 examination and before any events at either 15.00 or later. So this is a very calculated way of using the records to give the appearance that a child with whom there was no problem at all had a problem.

Lucy Letby planned her attack on [Baby I].

[Mother of Baby I] told you that she always stuck to a routine: she'd drop off her kids at school, she'd go and see [Baby I], and she left in time to pick the kids up from school; she had her break at lunchtime; [Baby I]'s dad would come in at 17.30. [Baby I] had been in the Countess for a long time and this was a well-established routine.

And therefore, from the moment that [Mother of Baby I] left to pick the kids up from school, and you all know what time kids leave school, from that moment Lucy Letby had the perfect opportunity to attack [Baby I], didn't she? Because as I have shown you before, she had a monopoly on the children in nursery 3.

She attacked -- she had a window of opportunity between [Mother of Baby I] leaving and [Father of Baby I] arriving. Yet another case of a child suffering a life-threatening collapse just after a parent had left, having visited.

What are the chances of these things happening at precisely that point in the context of notes that you can be certain have been manipulated by Lucy Letby? If you're in any doubt about it, ladies and gentlemen, and the calculated way this attack was

carried out, if we go to tile 93, and we look at the family contact note which Lucy Letby made at 19.32. What Lucy Letby wrote was:

"Mummy present when reviewed by doctors. Had left when [Baby I] had large vomit and transferred to nursery. Staff Nurse Taylor telephoned mum to update her and she is currently visiting."

So had left unit when this happened.

At the end of the day shift there was a further desaturation when [Baby I] was being handed over to Bernie Butterworth and you'll remember the failure by Lucy Letby to note up the gas that was taken at 17.15.

Bernie Butterworth said that she couldn't remember doing the bolus, which is noted at 19.30, on tile 162. If we could just look at that, please.

Bernie Butterworth said that when the Neopuff was used there was no chest movement and [Baby I]'s abdomen inflated. So this is a classic case of what Lucy Letby has tried to persuade you happened to a lot of these children, that it was the Neopuff that inflated their stomach. But that was not what caused the collapse, was it? It can't be what caused the collapse.

And remarkably, despite everything that had happened, [Baby I] improved over the course of the night shift when Lucy Letby was not there. The temperature was reduced on the incubator, having been increased by Lucy Letby on the day shift. Her abdomen was less distended and there were minimal aspirates at night.

Tile 200. Yet another miraculous improvement. [Baby I] was rooting for her feeds overnight, showing signs she wanted to be fed. All good, once Lucy Letby had left.

It was the opinion of Dr Evans that the lack of any gradual decline before the collapse and the relatively quick recovery meant that the reason for [Baby I]'s collapse was not infection. Dr Evans thought the only explanation consistent with the facts, including the vomiting, was a dose of air being put down the nasogastric tube.

Dr Bohin agreed and she said that the effect would have been to splint the diaphragm in a child with what she described as "not entirely normal lungs". Dr Bohin discounted the possibility of NEC.

Professor Arthurs reviewed the radiograph taken at 17.39, which is tile 78. The original radiologist's report speaks of "splinting of the diaphragm due to bowel distension" and

Professor Arthurs' view was that the stomach and "almost all of the gut", as he put it, was distended. We say [Baby I] had been given a lot of air by Lucy Letby.

By the time Ashleigh Hudson took over [Baby I]'s care on the following day shift, 1 October, [Baby I] was clearly improving. Her stomach was less distended and advice was taken from the doctors on recommencing feeds. The effect of Lucy Letby's sabotage was diminishing.

We come next to the second event, the event at 3.20 hours on 13 October. This is what I'll call "seeing in the dark" and you know what I mean. So far as this event was concerned, we heard from Ashleigh Hudson on Friday, 27 January. Nurse Hudson had looked after [Baby I] for several times before the night shift of the 12th to the 13th. She ran through the documents explaining to us that [Baby I] was prospering, the level of monitoring which had been in place had been scaled right back and you'll remember her taking us through the observation charts behind divider 12.

[Baby I] was so well that the probe that monitored her heart, her sats and respiration rates had been removed from the beginning of the morning shift on 11 October.

You'll find that behind divider 2 or behind the second part of divider 12 in your jury bundles.

On 13 October, there's a feeding chart showing that [Baby I] had 55ml via bottle or from a bottle at 01.30.

Your paper copy is numbered 14790. There it is.

Nurse Hudson took us through her nursing notes for the shift. They recorded that [Baby I] had been breathing for herself in air, was alert and, critically we say, was demanding feeds. So this is the first part of the night shift of the 12th into the 13th. And so far as [Baby I] being pale was concerned, Nurse Hudson told us that that was entirely normal for [Baby I].

[Baby I]'s collapse in the early hours, we were told, was a much more serious event than what had happened on 30 September. Ashleigh Hudson remembered that [Baby I] was still in nursery 2 and she, Ashleigh Hudson, was her designated nurse. Before [Baby I] collapsed, she'd been in good clinical condition, behaving appropriately for her age and appearing very stable.

The fact that she was waking and cueing for feeds was really encouraging and it was expected that she was coming up for discharge, for going home from the neonatal unit within a couple of weeks.

If we go to tile 31, please, we can see the population distribution. Ashleigh Hudson had left nursery 2 because she had been called to assist Laura Eagles with a procedure in nursery 1. You can see that Lucy Letby had a single child on this shift and that child was in nursery 1. Ashleigh Hudson said that she asked one of her colleagues to watch [Baby I]. She couldn't remember who it was she'd asked but there were two candidates who'd been by the desk at the time, she said: they were Caroline Oakley and Lucy Letby.

Well, Caroline Oakley was the shift leader and her statement was read to you. She had no recollection of being asked to monitor [Baby I]. Looking at tile 31, we suggest, knowing what you now know of how things operated in that unit, it is obvious who would have been the ideal candidate to have kept an eye on [Baby I]. In effect, Lucy Letby and Ashleigh Hudson swapped places, didn't they? It's obvious.

Although Ashleigh Hudson recalled being away helping Laura Eagles for about 15 minutes in nursery 1 and became aware there was an issue after she came back into nursery 2, she had been in the milk room, said Ashleigh Hudson, having left nursery 1. [Baby I] wasn't due a feed at the time but some milk needed defrosting in preparation for [Baby I]'s feed. When she got back to nursery 2, there was no one, or no adults at least, in the room and she started -- do you remember, there's a desk by the window that leads from the corridor to the nursery? Ashleigh Hudson started to prepare [Baby I]'s milk with her back to [Baby I], who was clearly behind her.

The next thing that Ashleigh Hudson remembered was the appearance of Lucy Letby in the doorway, and Lucy Letby pointed out that [Baby I] looked pale.

Lucy Letby apparently was about 5 or 6 feet away from the cot at the time and, do you remember, Ashleigh Hudson sat in the witness box and she pointed to the court clerk and gave that as being the approximate distance that Lucy Letby would have been away from [Baby I].

Lucy Letby said something along the lines of, "Don't you think [Baby I] looks pale?" According to Ashleigh Hudson, the lighting in the nursery was low, the main light was off, but the corridor light was on, so you could see to do things in the room. And you will remember, I'm sure, what Lucy Letby said about this in interview. If you would, please, can we go to the [Baby I] interviews? They're right at the back of file number 1 of the interviews. And it's divider 3 of the [Baby I] interviews, which is the penultimate divider in the file.

Divider 3 should take you to the interview of 11 June 2019, and if you go in that interview, it's one of the longest interviews in the case, go to page 42.

At the bottom of page 42, the issue of the lighting in the nursery was addressed by the police with Lucy Letby.

At the very bottom of page 42, this question:

"And you were stood at the doorway and the lights in the nursery were off; do you agree with that?"

And the answer over the page:

"Yeah."

And further down:

"Question: Do you therefore agree that it wouldn't be possible to see if [Baby I] was pale?"

"Answer: No, because there's still an element of light in the window coming from the doorway and [Baby I]'s cot was positioned by the window."

The police then went on to ask questions about that tent structure. Do you remember it being explained to us that would have been over [Baby I] for the very purpose of shielding her from the light, ironically?

Well, according to Ashleigh Hudson, [Baby I] had a blanket over her, this tent structure, and "nesting around her". This is to keep her secure as a premature baby. Ashleigh Hudson, who was actually in the room, couldn't see [Baby I] because of the canopy and the lighting. At this point she was closer to [Baby I] than Lucy Letby and Lucy Letby therefore did not have a better view.

Ashleigh Hudson switched on the light, pulled back the canopy and went to help [Baby I], realising immediately that she was in a very poor condition. She described her as incredibly pale in colour, almost white, had not responded to the blankets being pulled back, was hypotonic, which means floppy, and was gasping, agonal breaths, dying breaths. Ashleigh Hudson's first thought was that [Baby I] had deteriorated so rapidly that she, Ashleigh Hudson, was too late to save her and she described [Baby I]'s deterioration as "quite remarkable".

That's Ashleigh Hudson.

At the conclusion of her evidence, Nurse Hudson said that she'd been in the position in which Lucy Letby was standing when Lucy Letby said that [Baby I] looked pale and Ashleigh Hudson has told you that you cannot see a child in [Baby I]'s position from the position that Lucy Letby was in. And do you remember a photograph was produced in which an effort had been made to recreate the view and the lighting at the time?

Well, Ashleigh Hudson couldn't see, neither we say could Lucy Letby. And again, we have a head-on credibility conflict, don't we, ladies and gentlemen? It's a bit like [Mother of Babies E & F] with [Baby E]: two witnesses whose accounts don't live in the same world. And we asked Lucy Letby about this when she gave evidence, didn't we? You'll remember her reaction when she was asked whether going from an illuminated corridor into the darkened nursery 2 was something which would have improved her ability to see.

And you knew the answer, she knew the answer, but her first answer was:

"I don't know."

Then she conceded that it would have meant that she would have not been able to see as well and yet she persisted in saying that she could see [Baby I]. Then we had a break, it was an afternoon session, and when we came back, I asked Lucy Letby about what she'd said in interview at page 34.

What she said in interview was this:

"Maybe I spotted something that Ashleigh wasn't able to spot. The rooms are never that dark that you wouldn't be able to see a baby at all. There's always a level of light for that reason."

And I asked her the following questions and got the following answers:

"Question: You don't have better eyesight than Ashleigh, do you?

"Answer: No.

"Question: At page 35 [I was talking about the interview], over the page, you were putting all this down to your greater experience; is that right?

"Answer: No.

"Question: Well, the question is [I was then quoting from the interview], 'How would you be able to spot the colouring then

that Ashleigh couldn't if you were both stood at the same place?' And your answer?"

And she said:

"I had more experience so I knew what I was looking for or looking at."

You will remember the way -- I am not going to try to reproduce it because your memory is the best evidence. You will remember the way she corrected herself at that point. And I said:

"Ah, you knew what you were looking for. What did you mean by that?"

We had a very long pause, didn't we? A very long pause. I then broke the silence by saying:

"Your answer. You explain it."

And she knew what she'd done, didn't she, Lucy Letby? She said:

"Yeah, I didn't mean it like that. I'm finding it quite hard to concentrate on all the dates at the moment."

"All the dates." Dates had nothing to do with what was being asked about here, did it, ladies and gentlemen?

You saw Lucy Letby give that evidence, you heard what she said. Did she make an innocent mistake or did something else slip out? Under the pressure of the witness box, did something else just slip out?

We say that on that night the reason she knew [Baby I] was in extremis was because she had caused the problem and the reason she said what she said in the witness box was the same. Well, you have this, what I've called, credibility contest between Ashleigh Hudson and Lucy Letby. Taking that evidence into account, you can decide where the truth lies.

Because there was no other indication for what had happened. [Baby I]'s anaemia was treated with a blood transfusion and you heard that the warning signs for anaemia are dips in oxygen saturations, changes in breathing pattern, temperature stability or the child is lethargic. And during that shift, before this crisis, [Baby I] had displayed none of those symptoms at all, nor in the preceding shifts, other than a very slight variation in temperature.

Because [Baby I]'s collapse was nothing to do with anaemia. As Dr Neame and Dr Newby told you, following three doses of

adrenaline and CPR, [Baby I] recovered, became pink and vigorous, yet another miraculous recovery, shades of [Baby H] and what I was reminding you of at the end of the day yesterday.

Lucy Letby's nursing note is at tile 47 in the second sequence of the [Baby I] sequence.

Lucy Letby put a bit of thought into this one. She timed her view as having been 2 minutes before Ashleigh Hudson and she said that she'd seen events at 3.20 in this note made at 7.59.

When Lucy Letby wrote this note, she would have been able to see Ashleigh Hudson's note because the time at which Ashleigh Hudson wrote her note was earlier at 5.04 hours. So why did Lucy Letby time her view earlier than Ashleigh Hudson's? The answer is she was making the point that it was she who had been able to see [Baby I]'s decline first. She also knew by this stage that Ashleigh had named her in the records as having been the person who saw things first. Do you think Lucy Letby would have written this note in those terms if Ashleigh Hudson hadn't made a note in the records before she made her note? It would have been another plausibly deniable one, wouldn't it, otherwise if Ashleigh Hudson hadn't thought to write down Lucy Letby's name?

Professor Arthurs reviewed the radiograph taken at 4.25, so after the collapse. This is tile 80. He said that in this one, the stomach was not particularly distended but the large bowel was, and he noted that the nasogastric tube was curled up in the oesophagus rather than being in the stomach. That's an interesting coincidence, isn't it, that the NGT, which of course would drain the stomach if there was air in there after an incident like this, just happens to have ended up curled up in the oesophagus?

Dr Evans told us that in his view the only reasonable explanation for this collapse was that someone injected air into [Baby I]'s stomach. And as part of the cross-examination it was pointed out to Dr Evans that there was nothing in the records to suggest that [Baby I] had a nasogastric tube at this stage. But we also know from Dr Bohin's evidence that to an experienced nurse, getting a nasogastric tube in and out is the work of a couple of seconds, apparently. Very quick.

Dr Bohin was of the view that [Baby I] was sabotaged by air down the nasogastric tube and air into the intravenous line. Dr Bohin thought that the appearances in the X-ray taken at 4.25 were indicative of air having been put down the nasogastric tube and I've just reminded you of what Professor Arthurs said and indeed the radiologist's report that accompanies that particular image speaks of "marked gaseous distension of bowel loops".

The note goes on to say, you will see:

"Clinical information regarding the outcome of the previous episode of bowel distension would be helpful in interpretation of the current image as the appearance is similar."

That previous image is tile 78 in the same sequence -- I've given Mr Murphy the wrong reference. It's the same sequence, please, DP2.

(Pause)

It says:

"Splinting of the diaphragm due to bowel distension with moderately severe bowel distension."

So the radiologist was making a connection between this incident and that incident.

The reality is, we say, there was no innocent reason for [Baby I]'s extreme and life-threatening collapse.

There was no illness, there was no significant physical infirmity, and the circumstances in which Lucy Letby appears to have been able to see something, which you can be sure of the evidence of Ashleigh Hudson she simply would not have been able to see, coupled with the fact that she must have been the person who substituted for Ashleigh Hudson, coupled with the way she explained all this to you in evidence, all combine together to create a set of circumstances in which we suggest you can be sure that it was Lucy Letby who sabotaged [Baby I] on this occasion.

That takes us to the next night shift, the night shift of the 13th into the 14th and a desaturation at 06.00 on the 14th.

At the handover to this night shift, Dr Jayaram told you that there were no specific concerns about [Baby I].

He told you that he was in the habit of calling into the neonatal unit between 22.30 and 23.00 hours to discuss any concerns with the registrar. The registrar on this shift was Dr Neame.

By that stage Dr Neame had actually seen [Baby I] and Dr Neame told us that at 22.15 hours [Baby I] was settled and pink. Her heart rate was normal, her capillary refill time was normal and she was stable. And this was the second occasion that Lucy Letby -- the second of the two in the context of the four occasions that Lucy Letby was [Baby I]'s designated nurse and the second

time, therefore, that she had the opportunity to falsify the notes.

Dr Neame was the person who was called when [Baby I] desaturated dramatically shortly before 6 am on the 14th. If we look at tile 79, we can see his note there, shortly before 6 am at 05.55.

This is not -- one of the issues that was taken up in the evidence was the question of whether or not this was a retrospective note. All right? So is this a note being written at 05.55 relating to events that had happened some time earlier?

We say this is certainly not a retrospective note because, if we look at its terms, we can see that when he was treating [Baby I], Dr Neame ordered an increase in the sedative morphine and an urgent chest and abdominal X-ray. Those are two things which are timed with a timestamp from the system.

The prescription is tiles 80 and 81, timed, as you see there, just from the tile, we don't need to go behind it, at 05.56. The urgent X-ray, we see at tile 85, is timed at 06.05. So that shows you, doesn't it, that this is not a retrospective note at 05.55?

But if we go to tiles 74 and 76, starting with 74, you see this is a note made at the beginning of the shift. What I need is -- I think it's at the bottom.

Sorry, that's right. That's the right one.

So this is a note made at 08.43, after [Baby I] had desaturated, and you can see the middle paragraph of what we've got to the screen says:

"At 05.00 abdomen noted to be more distended and firmer in appearance with area of discolouration spreading on right-hand side."

Spreading discolouration. There you go:

"Veins more prominent. Oxygen requirement began to increase. Colour became pale. Reviewed by Registrar Neame. Ventilation increased."

So that's the impression given by Lucy Letby in the nursing note. If we go to tile 76, please. We see a continuation of that note. So what we have there is the suggestion in the nursing note by Lucy Letby that this desaturation was happening at 5 o'clock. That's why it's important -- that's why Dr Neame was being cross-examined on the basis that his note at 05.55 was retrospective, wasn't it?

We know it wasn't retrospective because of the stamped times for the morphine and the time of the urgent X-ray. The urgent X-ray, as a matter of fact, comes 10 minutes after the time in Dr Neame's notes when he ordered it, and so why, you may ask, would Lucy Letby do this? Well, one of the things we have to bear in mind is that, given what had happened with [Baby I] the previous night, if [Baby I] had really had these problems of spreading discolouration from 5 o'clock, what would any competent, responsible nurse have done?

The answer is call the doctor, isn't it? She'd had a life-threatening collapse the night before, but there was no call to the doctor. So that tells you, the fact that the -- the absence of a call to the doctor tells you that there was, in fact, no problem at 5 o'clock.

The impression that Lucy Letby is trying to create in this note, in the context of this desaturation, is that this is an evolving problem. It's not a crash, it's a baby getting progressively worse, which is entirely in keeping with many of the medical witnesses who you've heard give evidence for the prosecution, who have said to you in cases of infection or natural issues you have a gradual decline, you don't have a baby going off a cliff.

The point of it, of course, is that if anybody starts to put two and two together and thinks that perhaps there's a problem involving Lucy Letby, if they go back to the notes, they're thrown off the scent, aren't they? That's the point of it.

Just going back to Dr Neame's note, please, at tile 79, he was called by Lucy Letby to see [Baby I], she had low oxygen saturations at 77%. Her heart rate was up a bit at 180. Her capillary refill time was a little elevated. Her abdomen was distended and mottled. Do you remember what Dr Neame said about the mottling? It was unusual, according to Dr Neame. That is why he recorded it. How many times have we heard that in this case?

[Baby I] had an ET tube in. So how was it that her abdomen was distended? Because with a tube in, the air can't go into the stomach, can it? That's the whole point.

Dr Marnerides has excluded NEC, so you're left with one possibility, aren't you, ladies and gentlemen? As always in these events involving Lucy Letby, it's pushing air in down the nasogastric tube.

When Dr Neame examined [Baby I], she appeared uncomfortable, she had her eyes open and she grimaced; tile 79. Dr Neame thought that the abdominal distension was making it difficult for [Baby I] to breathe, her diaphragm was splinted. He was concerned, was

Dr Neame, about the appearance of the abdominal X-ray and discussed it with Dr Jayaram because he noticed an area of apparent collapse in the upper end of [Baby I]'s right lung. He noticed the bowel loops and the small appearance of the lungs, which are being squashed by the diaphragm, which is being pushed up by the air that Lucy Letby had injected into [Baby I].

A further radiograph was taken that morning at 06.05; it's tile 85. Professor Arthurs gave us a graphic description of this. His words were:

"Here the stomach is markedly dilated and there's lots and lots of dilation of both the small bowel and the large bowel here. No features of NEC."

In a further film taken at 08.03, which is tile 129, there's a similar picture, except the stomach had been decompressed. In another image taken the following morning there were no issues with the bowel at all. So this wasn't a natural problem at all, was it, ladies and gentlemen? This was man or woman-made.

Dr Neame also spoke to Alder Hey by landline, but as he was doing that [Baby I]'s condition was getting worse.

Dr Neame on the phone, doctor out of the room on the phone, baby gets worse; you've heard that or things like that before. Because the next event Dr Neame recalled was a further collapse of [Baby I] at 07.00 hours and he decided to remove and replace the ET tube. The pressures on the ventilator were increased and [Baby I] improved and there was then a further episode of desaturation, but by this time it was associated with a negative cold light test, so it wasn't an issue with a collapsed lung, there was good air entry, good chest wall movement, and so you know air was getting in and out, and yet, as with so many other of these children, [Baby I] was desaturating. So Dr Neame gave a muscle relaxant to counteract the pressure from the abdomen impeding the effect of the ventilator.

At handover, 7.45, [Baby I] had a cardiac arrest, and she deteriorated to the extent that she needed CPR, a muscle relaxant and adrenaline. But even then there was good air entry, a positive sign on the capnograph, which showed that CO2 was coming out of the lungs. So the issue wasn't air getting in and out of [Baby I]'s lungs.

And Dr Jayaram said, when he gave evidence to you on 1 February in the afternoon, that this is explicable as the result of an issue being caused with the blood flowing through the lungs, what he described as persistent pulmonary hypertension.

And certainly the physical manifestations of what was going on with [Baby I] are very similar, if not identical, aren't they, to so many others of these children? A picture that recurs and recurs in the presence of Lucy Letby.

Later that day, on the 14th, Dr Neame was called to see [Baby I] at 21.30. She'd desaturated but by the time Dr Neame got there, she'd recovered. Her levels were not as bad as they'd been the night before and later in the shift, in the early hours of the following morning, at about 02.00, there were further desaturations but that was because her airway was blocked with secretions, so that was all obviously explicable by a medical cause, unlike the desaturations associated with the presence of Lucy Letby.

[Baby I] was shipped out to Arrowe Park and Dr Babarao's statement was read to you, dealing with what happened there. In a nutshell, [Baby I] had a miraculous recovery once she got to Arrowe Park. She was soon off the ventilator, just like [Baby H] before her, and her improvement continued following her return to the Countess of Chester until she had the misfortune once again to come into contact with Lucy Letby.

As before, Dr Evans told us that there were no signs of [Baby I] having an infection so far as the collapses on the 14th are concerned. She was not declining and she collapsed out of the blue. Again, and in the absence of any evidence to support a benign cause, he thought, Dr Evans, that [Baby I]'s stomach had been injected with air.

He also thought that she'd received a dose of air into her intravenous system. As before, [Baby I]'s response to resus was not what would have been expected if she'd had an infection and there was also what he described as a "astonishing amount of air in [Baby I]'s bowel". That repeats, in slightly different language, what Professor Arthurs told you, doesn't it?

Dr Bohin agreed. She thought that the discolouration noted at the time, together with the X-ray appearance of the bowel, all in conjunction with the extreme nature of [Baby I]'s collapse, in the absence of any underlying illness or issue, was evidence to support her view.

I'm going to move on to now to the death of [Baby I] on the 22nd into the 23rd. It's slightly early, but it will even out, my Lord. That's probably a good point.

MR JUSTICE GOSS: Yes, if that's an appropriate moment, we'll have the break. A 10-minute break, please, members of the jury, and then we will continue.

(In the absence of the jury)

MR JOHNSON: My best estimate, my Lord, is I should finish today, but it's going to be very tight.

MR MYERS: I was going to raise a matter relating to that in fact unless Mr Johnson has anything to add to what he just said.

MR JUSTICE GOSS: I think that's fairly clear. We can see it'll go until the normal end of the court day.

MR MYERS: Yes. Fairly tight, he said. Can I raise this, because it's something that's in my mind? What happens if we run into tomorrow for whatever reason. If that happens, we would be grateful, if that happens, if we could address the jury on Monday so that we can start afresh, as indeed the prosecution did this week, having had time to consider the way the prosecution close their case. There's a lot of material we've been handling as this has proceeded, and with the jury, importantly, fresh and ready to hear what we have to say on behalf of Ms Letby rather than following on at whatever time after the prosecution have just finished when we have just heard that, and at the very end of a long week when there are matters we wish to raise with them when we commence or that we anticipate raising with them when we commence that we need their attention for as well as the time required to accommodate whatever it is the prosecution say in closing.

When we considered the position, were the prosecution to run into Thursday in part, your Lordship kindly took the view that we could be afforded the rest of Thursday to deal with it before we moved to Friday, and in many ways we are looking ahead to that position if we find ourselves running into tomorrow --

MR JUSTICE GOSS: Mr Myers, let's just see whether he does finish today or not. I don't really want to lose a whole day when your speech is no doubt going to encompass many days and you'll be able to come back to points that are raised perhaps late in Mr Johnson's speech, but it's just another day that goes by when there have been days -- so if Mr Johnson doesn't finish until well into tomorrow then certainly I wouldn't expect you to start.

MR JOHNSON: What I was about to ask was if, I need an extra -- and I think it might be this tight, an extra 10 minutes at the end of the day, can I have it so that we finish?

MR JUSTICE GOSS: You will do, yes. I am not going to clock-watch between 4 and 4.15. I have been watching the defendant and she is able to follow it very closely.

I've been watching the jury, they're following it all very closely. They don't have any concentration difficulties that are apparent.

I'm not trying to be awkward.

MR MYERS: My Lord, no.

MR JUSTICE GOSS: But we are now significantly overrunning for various reasons and I don't want to just lose another day for the sake of it.

MR MYERS: Very well, my Lord.

MR JUSTICE GOSS: I'll say at 10 to, if that's long enough.

(11.41 am)

(A short break)

(11.50 am)

MR JOHNSON: So to the events immediately concerning [Baby I]'s death on 23 October, ladies and gentlemen. Just to give you a bit of context, the previous night shift, the 21st into 22 October, Ashleigh Hudson again was [Baby I]'s designated nurse and she told us that [Baby I] was a baby who was very easy to settle.

She told us that [Baby I]'s observations were stable, with the slight exception of a single raised temperature reading at 22.00 hours on the 21st. There were no aspirates from the nasogastric tube, which was on free drainage, and although [Baby I] was in nursery 1, that was an entirely precautionary measure given the history rather than being militated by specific requirements.

And she was an incubator for ease just in case the level of her care was escalated.

[Baby I] was self-ventilating in air and her sats level was optimal, according to Ashleigh Hudson. What Ashleigh Hudson said was this:

"She looked very well. She was pink and well perfused and she had a soft and non-distended abdomen."

So A1. During the day shift of the 22nd, Caroline Oakley told us in a statement that was read that [Baby I] was alert, her abdomen was fine, it was soft and not distended and they were getting minimal clear aspirates from the NG tube. So if in due course effort is made to persuade you that [Baby I] had

abdominal problems, ladies and gentlemen, that is the background to the position when Lucy Letby came on shift.

The night shift of the 22nd to 23 October. Could we go to tile 47, please? Ashleigh Hudson had the care of [Baby I] again on this shift. The handover was quick because Ashleigh Hudson had had [Baby I] the night before.

She said again, Ashleigh Hudson, that [Baby I]'s observations were "optimal". [Baby I] had no respiratory or ventilatory support at the time. There was an issue over her line occluding, blocking, so Dr Chang inserted a cannula into [Baby I]'s right foot.

Dr Gibbs told us that [Baby I]'s breathing was "fine" at this time and the only concern was a forthcoming test at Alder Hey. But despite that virtually perfect scenario, [Baby I] suffered a series of collapses.

Tile 91, please. Here we see in Ashleigh Hudson's nursing note, relating to the blocked line, that, as usual, Lucy Letby was getting herself involved. That must have been, we say from its context, at about 23.00 hours. [Baby I]'s first collapse came at midnight.

She was very unsettled with "a quite relentless cry".

She couldn't be settled. Ashleigh Hudson, who was familiar with [Baby I] and the way she would cry, said that on this occasion her cry was not typical. It was the type of cry that she had not heard from [Baby I] before:

"Loud, relentless, almost constant and with no fluctuation."

All Ashleigh Hudson's words.

In cross-examination, Ashleigh Hudson stressed the volume of the cry, the fact that it was relentless, and she interpreted it as distress and said it was markedly very different to [Baby I]'s cry when she was hungry.

When [Baby I] was repositioned on her tummy, she stopped breathing. Ashleigh Hudson called for help and Lucy Letby appeared. [Baby I]'s sats dropped and her heart rate dropped. But at this stage her abdomen was soft and it was not distended. You will find that in Ashleigh Hudson's nursing notes that I just showed you.

Dr Chang was called. She was told that [Baby I] was crying and had had a significant deterioration associated with the crying

and Dr Chang intubated [Baby I] and [Baby I] recovered quite quickly.

Dr Gibbs confirmed what happened and told us that he remembered [Baby I] being resuscitated. He said that the two nurses who were involved with [Baby I] were Lucy Letby and Ashleigh Hudson. He was told that [Baby I] had had an abnormal cry and then her sats and heart rate had dropped.

After resuscitation, [Baby I] started to fight the ventilator, which is a very good sign. She was awake, alert and cueing for a feed according to Ashleigh Hudson. Dr Gibbs told us that [Baby I]'s recovery was perplexing because he "could not understand what natural disease process would have caused her deterioration and yet she's recovered so rapidly". That was evidence he gave on 9 February.

He said that whilst prem babies can deteriorate quickly, usually there's some warning, and if a child had deteriorated as a result of some natural disease, then she would not have been expected to recover as quickly.

We say the midnight collapse is yet another example of Lucy Letby making misleading entries in the paperwork. This time it wasn't in the paperwork of her victim, it was in the paperwork of the child HS, who you will remember as the child who was being shipped out to Stoke.

You will remember, I'm sure, because we dealt with it in cross-examination, that Dr Chang had reviewed HS and had ordered or had mandated that the TPN which was feeding HS needed to be changed for dextrose so that HS could be taken by the transport team.

So starting with the documents that you were shown in cross-examination, J34535, please. These are Dr Chang's notes from HS's medical records, an examination at 22.00 hours, and this is the discharge examination.

At 34537 we have Lucy Letby's nursing note for HS.

You can see the time of the note is 22.50 to 22.53.

Lucy Letby recorded that HS's TPN was to be changed to glucose for transfer and that is what she did immediately because, if we go to 34542, we have the prescription and we have the chart, but of course -- and we see it's co-signed with Chris Booth. But you can see that 23.00 hours has been changed to 24.00 hours. The reason for that is it is an alibi for [Baby I]'s collapse at midnight, pure and simple.

In cross-examination, we went to [Baby I]'s records, and at tile 117 more altered times on Lucy Letby's records. We see the second row down and the fourth row down. The fourth one is actually out of sync then once it's been changed, isn't it? No explanation in evidence.

Following [Baby I]'s collapse, Ashleigh Hudson went to report the incident to [Baby I]'s parents, and the incident itself, the collapse, had taken about 30 minutes before Ashleigh Hudson could do that. In that context you'll note that there was an X-ray at tile 116, which is timed at 00.23. Ashleigh Hudson told you that she tried many times to call the parents and eventually she got through.

After that event, and before [Baby I] collapsed for the second time, Ashleigh Hudson said she did not remain with [Baby I] throughout and she remembered either being at the nursing desk or at the computer and she certainly said that she had come out of nursery 1 to maintain quietness in the room. What she heard was either the monitor or [Baby I] cry, she went straight into the nursery and Lucy Letby was already there with her hands in the incubator.

At that stage [Baby I]'s observations were normal and it all begs the question, you may think, of what was it that took Lucy Letby into there? She had a child in nursery 3 and she had a child in nursery 2. She had no responsibilities in nursery 1.

We say Lucy Letby was there because when [Baby I] started crying, she had sabotaged [Baby I]. She caused her to cry the same cry that she'd had when [Baby I] collapsed for the first time at midnight, the loud, relentless and unlike any cry that Ashleigh Hudson had previously heard from her. Her words, Ashleigh Hudson's words.

Ashleigh Hudson thought that [Baby I] was about to have a similar episode to what had happened before and she said as much to Lucy Letby. What she said was:

"She's going to do it again. It's the same cry."

And even if you don't remember precisely, you know what's coming next, don't you, ladies and gentlemen? Lucy Letby putting her off, saying, "She just needs to settle".

Events of earlier in the shift repeating themselves: [Baby I] became quiet, her breathing slowed, her heart rate dropped, and she started to drift. Once Chris Booth came to help, Ashleigh Hudson ran to get Dr Chang, and Ashleigh Hudson told us that an NG tube was in place to prevent the diaphragm splinting, but air

++ was aspirated. How on earth could that have got there other than from having been pushed in by Lucy Letby?

At tile 116 there is an X-ray which shows a massive stomach bubble. You can't miss that stomach on that X-ray, can you, ladies and gentlemen? It's also referred to in Dr Chang's note, I think, at tile 118.

Dr Chang told us about the resuscitation, that [Baby I] did not pre-oxygenate well. Having intubated [Baby I], her heart rate did not pick up, and Dr Chang had to resort to adrenaline to the extent that they actually had to access some reserve supplies of adrenaline.

Dr Chang could hear air going in and out of [Baby I], could see her chest rising and falling, but there was no improvement. Dr Chang told us that as far as she was concerned, [Baby I]'s death was inexplicable. Perhaps inexplicable by natural means, but we suggest you know very well what the explanation is.

Dr Gibbs told us about this too. [Baby I] was receiving chest compressions again, which were in progress when he arrived. Lucy Letby and Ashleigh Hudson were there again. [Baby I] had mottling all over her body. He recorded that the Neopuff was changed to a bag and then he observed good chest movement and air entry, but again [Baby I]'s pulse was slowing, her sats were falling and she had an abnormal heart rhythm.

The resuscitation for [Baby I] went on for an hour but to no avail. Dr Gibbs told us that he could not understand why [Baby I] had died and so he referred the case to the coroner. In the immediate aftermath of [Baby I]'s death her grieving parents agreed to bathe her body and, as they did so, Lucy Letby came into the room.

She came into their moment. She wasn't the designated nurse. She had two other children to look after. To quote [Mother of Baby I], this is a direct quotation from her statement:

"Lucy came back in. She was smiling and kept going on about how she was present at [Baby I]'s first bath and how much [Baby I] had loved it. I wish she had just stopped talking. Eventually, I think she realised and stopped. It wasn't something we wanted to hear right then."

Shades of the evidence from [Dr B] in the aftermath of the evidence of [Baby P] and of Lucy Letby's behaviour whilst [Baby C] was dying.

We then have evidence of the card, don't we? That card she was writing out at home, a short distance away, but brought into the

unit to take the photograph. Why would you do that? We never got an adequate explanation for that, did we?

Well, the expert evidence. Because this is a murder case and not an attempt, it's the final incident that counts. We suggest that you have to look at the events immediately prior to [Baby I]'s death in the context of what had happened in the other incidents and what you can be sure Lucy Letby had done. Dr Evans' view was that this was another episode of air injected into the intravenous circulation -- sorry, injected intravenously into the circulation.

He pointed to the fact that [Baby I] had been stable for the preceding week or so, she'd been breathing spontaneously in air, her saturations were 96% plus; you'll find that at J15034-5. He thought that the nature of the collapse, [Baby I]'s relentless crying, the futility of a prolonged resuscitation, all demonstrated that this was a case of air embolus. He relied in part on the description given by Dr Gibbs as to the unusual discolouration of [Baby I] during her final collapse and Dr Gibbs, you will recall, spoke of purple/white discolouration of the skin.

There was no evidence of any natural disease to account for what happened to [Baby I]. Dr Bohin's opinion was that [Baby I]'s death was a result of air embolus. So far as she was concerned, the notable features in support of that diagnosis were: first, the sudden and unexpected catastrophic collapse; second, [Baby I] being unsettled, agitated and crying in an uncharacteristic way; third, the inconsolable crying in a baby of [Baby I]'s age was "extremely unusual" and she thought that [Baby I] must have been in severe pain; fourth, she could think of nothing "innocent" that would have caused [Baby I] to have a pink face but a mottled trunk and limbs in association with being very unsettled.

In cross-examination, on behalf of Lucy Letby, Dr Bohin was asked whether she had "a coherent theory" of exactly how an air embolus presents. And almost without pausing for breath, Dr Bohin then gave an answer which lasted for about 10 minutes.

She made the point that in [Baby I]'s case there was no plausible pathological reason for [Baby I]'s collapse and that she was driven to conclude that air embolus was the cause. Dr Bohin was cross-examined, you may remember, about [Baby I]'s poor weight gain and she replied that that didn't make her more prone to cardiac arrest.

Dr Arthurs. Dr Arthurs gave evidence about [Baby I]'s case on 3 February. Taking an overview of the radiology and having reviewed the imaging that I have reminded you of, he said this:

"There aren't many conditions that cause intermittent dilation of all the bowel and occasionally of the stomach as well. That's not a feature of NEC. In fact, there weren't many other features of NEC on her case either, so one of the explanations for this would be giving air down the NGT."

He then deferred to Dr Marnerides on the ultimate question of whether [Baby I] had NEC and continued by saying:

"It's quite unusual to see this degree of stomach dilation in particular."

He excluded Professor Arthurs, he excluded CPAP as a cause, as he said:

"Were CPAP belly to be such a common phenomenon I don't think we'd be looking at these radiographs and thinking, 'Gosh, that's quite striking given the baby's on CPAP'."

And having excluded other possibilities, he agreed that it is reasonable to infer that [Baby I] had been injected with air.

Professor Arthurs' evidence is important in the case of [Baby I] because, in effect, we say he has excluded natural causes for the episodes of distension that we focused on.

We come finally to Dr Marnerides. He told us, first, the histology revealed that at the time she died [Baby I] had no acute illness.

Second, she had abnormalities in the bowel, the photographs showed that some segments were very dilated because of the presence of air, but there were no other abnormalities. In other words, there was no disease which was causing the presence of gas, it was the presence of gas which was abnormal, gas with no pathological cause.

He said [Baby I] had excessive air in her stomach. He said that the brain showed some old evidence of damage caused by a lack of oxygen that was not related to [Baby I]'s birth, so attributable to some of the other incidents or an incident at least we say.

He said that the collapses of 30 September and 13 October were reasonably attributable to an injection of air down the NGT rather than some innocent process, and finally he said that, from a pathological point of view, what killed [Baby I] was an injection of air down the NGT.

Under cross-examination on behalf of Lucy Letby, Dr Marnerides dismissed the possibility that the excessive air seen at the

post-mortem could have been caused by decomposition, so it was not a post-mortem artefact.

So what we say is [Baby I]'s case is a stark one. She had life-threatening collapses when Lucy Letby was there. The two other collapses, which were explored in cross-examination, didn't come into the same category as the ones we have examined. Lucy Letby made repeated and determined efforts to kill [Baby I]. She falsified the nursing notes to create the impression that problems were brewing when they were not. She altered the notes of another patient to make it look like she wasn't present on the occasion [Baby I] collapsed for the first time on the occasion she died. She involved herself with [Baby I] when she had no cause to. She gave herself away in nursery 2 with Ashleigh Hudson on the night of 13 October. And that incident in itself tells you about her agenda towards [Baby I].

Lucy Letby's gave of behaviour in the aftermath of [Baby I]'s death was bizarre and inappropriate. She was excited because she'd killed yet another child. She revelled in what she'd done and she enjoyed the distress and anguish that it caused to others. Her voyeuristic tendencies drove her to look for [Baby I]'s mum on the internet. She inflicted pain on [Baby I] on more than one occasion and ultimately succeeded in killing her.

Having killed her, she wrote and condolence card and you will remember her answer to the question about where she was when she wrote the card and why it was that she felt the need to be photographing it in the place where [Baby I] had died. It was still on her phone when it was seized by the police.

[Baby J]. [Baby J] was born on 31 October 2015.

The incident about which I am going to speak happened on 27 November. [Baby J]'s mum is [Mother of Baby J] and [Mother of Baby J] gave evidence to you on 10 February 2023.

She told you about having lost [Baby J]'s twin whilst having a surgical operation in London.

[Mother of Baby J]' waters broke early, [Baby J] was born at the Countess by emergency C-section at 32 weeks and 2 days. [Baby J] produced some bile through her mouth shortly after being admitted to the NNU and was therefore taken to Alder Hey in Liverpool, where she was found to have a perforated bowel and had an operation.

You'll recall that she had two stomas as a result of that operation and she returned to Chester with those stomas and a Broviac line on 10 November 2015.

When Lucy Letby was giving evidence and answering questions from her own counsel about [Baby J] on 16 May, there was the following exchange:

"Question: Is there a particular band that nursery nurses are at?

"Answer: They're a band 4.

"Question: Can they do intensive care?

"Answer: No, they can't, nor high dependency.

"Question: Not high dependency, not intensive care?

"Answer: No.

"Question: So far as you understand, should they be involved in handling and recycling stomach bags if that is required?

"Answer: No, and particularly as nursing staff there were unfamiliar, nursery nurses would have been even more so unfamiliar than nursing staff.

"Question: Is there any reason why you had a band 4 dealing with something that presented the problems that stoma bags did?

"Answer: I think the unit was very busy and we had to use staff where we could."

Ladies and gentlemen, we submit that the implication of that exchange, the impression that was sought to be created with you was, first, that [Baby J] received incompetent care and, second, that staffing levels were not up to the mark and therefore there was some sort of compromise by giving [Baby J] to a band 4. And that theme continued with a review of the text messages.

Can we go to tile 56, please:

"Question: 'Okay, that makes sense', you say to [Nurse E], 'but Jenny was actually doing it'.

"'Hmm, don't know when to stop, do they?'

"Then tile 57, from [Nurse E] to you, 17.19 on the 19th, we are now I should say:

"'Nope, Laurie and [Nurse B] thought it was terrible."

"Then this at tile 58, 17.21, you to [Nurse E]:

"'It's shocking really that they were willing to take the responsibility for things that they have no training or experience, et cetera, on. Don't think they appreciate the potential difficulties.'"

And then this:

"Question: Pausing there, Ms Letby, should nurses take on tasks for which they have no training or experience in the care of babies like this?

"Answer: No."

And she continued, Lucy Letby, by saying this was "potentially dangerous."

And at that point his Lordship intervened and said this:

"So you're saying it's shocking that the band 4s are prepared to do this?"

That's a question directed to Lucy Letby.

Lucy Letby's answer:

"Yes."

The questioning from Lucy Letby's counsel then continued with this.

"Question: In an ideal world would anyone think of getting a band 4, in your experience, to look after babies who require stoma recycling?

"Answer: No."

You will remember over the months, the time that you have listened to various witnesses being cross-examined about the BAPM guidelines. Lucy Letby apparently is very keen on the BAPM guidelines and they were quoted from time to time.

Part of the BAPM guidelines that was never quoted by Lucy Letby was the bit that deals with stomas. You'll remember that we showed that to Lucy Letby in cross-examination. It is very clear: band 4 nurses are well equipped to deal with babies with stomas. So that whole series of evidence from Lucy Letby was designed to mislead you, to create the impression that a problem existed where none really did exist. It's the same type of behaviour that Lucy Letby engaged in with her colleagues at the Countess of Chester. She fooled them, she thinks she can fool you.

When [Baby J] was in Alder Hey, Dr Gibbs told us that she had no respiratory problems. On her return from Liverpool, [Baby J] was being fed increasing amounts of milk and managed ultimately to take bottles. She was taking 165ml per kilogram per day, and by the time of these events, importantly, [Baby J] had no respiratory complications and she was fully bottle fed.

Prior to these events, [Baby J] was breathing normally for herself in air. She didn't have any lung disease and she didn't need any respiratory support.

[Mother of Baby J] told us that [Baby J] had moved from room 1 right down through to room 4. [Mother of Baby J] told you that she planned to stay overnight at the Countess as an induction to giving [Baby J] 24 hours per day care in person in preparation for taking her home. And [Mother of Baby J]' first night with [Baby J] was 25 November or into 25 November.

On the night shift of the 25th into the 26th, Nicola Dennison was initially [Baby J]'s designated nurse.

She described [Baby J] as "lively, alert and engaging".

She told us that [Baby J] was almost ready to go home and was going home with the stoma, the stoma that apparently nursery nurses aren't sufficiently qualified to look after.

The notes that Nicola Dennison wrote at the end of the shift, tile 68, confirm that [Baby J] was stable, there had been no desaturations, no problems, and she handled well. [Baby J] had passed urine and her bowels had opened.

The day shift of the 26th. Nothing untoward happened on the day shift. [Mother of Baby J] went home at the end of that shift, intending to return at 8 o'clock the following morning, but she was to receive an emergency call before she left to return.

At tile 140 we have the staff and population distribution chart. Lucy Letby was in nursery 3 with two children. [Baby J] was with the nursery nurse Nicola Dennison, again in nursery 4, with another child and Nicola Dennison confirmed that because the children in nursery 4 are about to go home, the approach is to leave them alone so far as possible, particularly at night. And she also said that the nursery nurses, like her, spend a lot of their time "doing the washing, the stocking up and various things" as she put it. She said that many of those items are off the unit, so often they would not always be immediately available. In other words, they're not there in the nursery at night with the children.

The unusual thing that she remembered of [Baby J] on this shift was that early on there wasn't much material coming out of the proximal stoma, so that's the stoma nearest the stomach. The material comes out of there, goes into the distal (inaudible: no audio) and comes out the other end.

But later on in the shift, at about midnight, Nicola Dennison said that things normalised and [Baby J] was producing a healthy volume. Forty minutes after a feed at about 04.00 hours, [Baby J] desaturated, she said, and if you look at tile 160 you'll find the note that was made at the time that times this at 04.40.

Mary Griffith was working that shift as well in room 2. Mary Griffith told us that [Baby J] was a very nice baby, "a joy to look after", as she put it, and she was the nurse to whom [Baby J] was handed over once she became unwell. Mary Griffith told us about the first desaturation, as did Nicola Dennison. Mary Griffith went to intervene, but she said there were enough staff to deal with the issue, and as we see, this chart suggests it was at 04.40.

[Baby J]'s saturations at this stage were alarmingly low and you will remember what Dr Verghese said about handling potentially interfering with the signal from the monitor.

Although this was an apparently significant desaturation, Nicola Dennison told us that [Baby J] completed her partially consumed feed, but if you look at J16347, the feeding chart, that doesn't tend, we suggest, to support Nicola Dennison's recollection.

When she was cross-examined, when Nicola Dennison was cross-examined, she said that the desaturation was after the feed, and that we would accept is entirely consistent with what is recorded.

However, [Baby J] desaturated again when Nicola Dennison wasn't there. She'd left [Baby J]. She asked someone to keep an eye out, but she couldn't remember who it was, and when she returned Nicola Dennison said that [Baby J] had collapsed and was being helped by Mary Griffith.

Dr Verghese was called. He told us that the shift was busy because, as he remembered it, there were two premature twins admitted, who'd been born at home, who were actually admitted during the shift, and actually, as things panned out, you'll remember the admission of those twins is probably the key to what really happened on this shift.

One of the twins had a cleft lip, Dr Verghese remembered, and suggested that both twins went into nursery 1, and you can see

them named at least by their initials in the neonatal review towards the end, admitted at 06.10 and 06.30 hours respectively.

Dr Verghese was asked to see [Baby J]. He implied that he saw her once, not twice, as suggested by Nicola Dennison, because there was a single entry in the notes. He told us that everything he wrote before his examination was information given to him by the nursing staff. That's a reference to his notes at tile 165.

You'll remember that the information he has in his notes also contradicts what Nicola Dennison told us. If we could just have a quick look at 165, please. You can see it says:

"Asked to see patient. Two profound desats."

And that, we would suggest, is entirely consistent with his first and only examination at this stage being after both of the desaturations.

As a matter of fact, that suggestion being made by me ties in with the door swipe data at tile 164, which times his arrival at 5.03, which of course is after the second desaturation.

Dr Verghese took the decision to omit the next feed and he moved [Baby J] into nursery 2 where she was handed over to Mary Griffith. Thereafter, though, ladies and gentlemen, we see from the neonatal review that Lucy Letby was spending time in nursery 2 with FB and KB, Lucy Letby, whose children were in nursery 3; you can see that in lines 119 to 120 and 122 to 123.

So let's deal with the emergency and the twins.

Dr Gibbs, it's tile 182, arrived that morning at 06.34, but that was because of the emergency arrival of the twins, who had been born at home. This arrival was just after Lucy Letby had sent a text to [Nurse E] at tile 177, telling her that [Baby J] had had two profound desats and the twins had just arrived.

At tile 186 at 06.43, Lucy Letby sent [Nurse E] another text saying the unit was closed and:

"Cleft baby being tubed I think."

But then if we go to 192, there was some doubt about the tubing of the cleft baby, as he or she had been described by Lucy Letby, and at 193, Lucy Letby sent a message:

"It's all a bit tits up."

So this is, as we see, 06.49, and you can imagine the scene, can't you, ladies and gentlemen? A full neonatal unit, two extra babies had arrived, one with a cleft palate, who potentially needed to be tubed, resources inevitably being diverted to the most needy, in other words the new arrivals. This was the perfect opportunity for Lucy Letby to attack [Baby J].

And you will note that the texting stopped at that point of 06.49.

At 06.56, [Baby J] collapsed, 7 minutes after that last text. She was in nursery 2. It's J15454 if we can find that, please. You'll remember, this is one of the maps that was marked. Okay, there's a problem. It doesn't matter. I'm sure you remember, there was a map that was marked with the relative position of where [Baby J] was and where another child was, who was the responsibility of Mary Griffith.

This time, not only did [Baby J]'s saturations drop but so too did her heart rate. So this was a more serious event. In evidence, Mary Griffith remembered Lucy Letby and Caroline Oakley coming to help. But what she noted at the time is in tile 198, midway down the right-hand side of that image, please.

She noted:

"[Baby J]'s monitor went off at 06.56. Myself and L Letby attended. Found baby with pale hands and baby very [it says 'ridged', I think it means rigid]. Sats went to 7 and heart rate down to 68."

Maybe 70 and 68:

"[Baby J] Neopuffed with little improvement. Dr Gibbs on unit and called to help."

Mary Griffith told you that she recalled that [Baby J] had desaturated, she was pale, and one of her arms was rigid, which she took as denoting some sort of fit or a brain problem. [Baby J] was Neopuffed, she was given saline. That stabilised [Baby J]. Mary Griffith was not concerned, she said, but the notes suggest that this went on for 16 minutes before [Baby J]'s sats were restored. And we suggest that when you are assessing how serious this incident was, you will bear in mind the fact that it was bad enough to divert Dr Gibbs, the senior consultant, away from the emergency admissions.

That wouldn't have happened if this was just some trivial incident, would it? Not for a full 16 minutes.

Tile 200 shows that [Baby J] was given an infusion.

You will see Lucy Letby's signature with Mary Griffith, and Mary Griffith told us that because she wasn't intensive care trained, she wouldn't have been the person that administered the bolus. The glucose bolus was started at 07.20. The signatures in the right-hand column are the nurses and timed at the time they gave it, and the saline prescription was struck through to prevent the re-administration of it because it was a bolus and it had been given at 07.09.

At 07.40, there followed a second incident. It's tile 210. This was very similar to the first. [Baby J]'s fists were white and clenched, her eyes rolled to the left, her sats dropped to the 70s, she had to be Neopuffed again, and Lucy Letby again got involved, this time with Caroline Oakley. Dr Gibbs' notes are at tile 197 and they give us a more reliable time than the nursing notes. The notes are made at 07.35. He recorded two seizures, one on each occasion. He told you that the deviation of [Baby J]'s eyes was an indication of there having been a seizure.

So far as the first one was concerned, he remembered that Mary Griffith and Lucy Letby were there when he arrived. He said [Baby J] was fisting her hands, having a seizure, which began to resolve after about 10 minutes, what he described as "a reasonably long seizure". He said there was not too much time before the second event happened.

Dr Gibbs thought there was a time when he moved away from [Baby J] to look at the computers for her blood tests, to see her blood tests and on the second occasion Dr Gibbs was either close at hand with [Baby J] when the event started -- sorry, he was either close at hand or with [Baby J] at the time the event started.

He said on that occasion, the second occasion, [Baby J] required a shorter period of ventilation and that Dr Gibbs checked the sodium, calcium and potassium levels of [Baby J].

Prior to these events, there was no history of seizures with [Baby J] and she has never had a convulsive seizure since these events. Whatever happened never recurred and she recovered and was in air very quickly afterwards.

[Baby J]'s blood sugars weren't low, her electrolytes were normal, she had no bacterial infection that could be found, the blood test was normal insofar as potential causes of seizure were concerned, and all that information is at tile 170.

A brain scan was conducted, which revealed no abnormality. An abdominal X-ray and an ultrasound scan revealed no abnormality that could have caused the seizures. He couldn't find a reason

for the oxygen drop. Dr Gibbs also told us that he would have expected a rise in CRP and the white cell blood count if there'd been an infection, even if the antibiotics he selected as an educated guess, as he put it, were correct.

Dr Brearey told us about events later on, on the day shift of the 27th, and he confirmed the view expressed by Dr Gibbs that there was no explanation for [Baby J]'s deteriorations earlier that day. His investigations included a cranial and abdominal ultrasound scan. He, that is Dr Brearey, characterised [Baby J]'s recovery as:

"... remarkable given what had happened overnight, particularly in the light of the fact there was no explanation for why [Baby J] had had these seizures."

He thought that the most likely cause for the seizures was hypoxia, a medical term for a lack of oxygen, but there was no explanation for what caused the hypoxia.

So far as the experts were concerned, both Dr Evans and Dr Bohin said similar things on 14 February. They said them, as always, in rather different ways.

Dr Evans told us that all the tests for infection at the time were normal, all the markers for infection indicated no infection, in particular a blood sample taken between the two later and more serious collapses returned normal results. He also made the point made in many of the cases that if such an extreme collapse was caused by infection then [Baby J]'s recovery would not have been so rapid.

He agreed with Dr Brearey that there was plainly a hypoxic event which caused [Baby J] to exhibit physical signs which are characteristic of a fit. He was inclined to the view that because she'd had no seizure related behaviour before or since, it was not due to what he termed "an epileptic focus".

Dr Bohin put it all in very straightforward language. I quote her directly:

"Babies who are ready to go home do not have major desaturations which lead to prolonged resuscitation with Neopuff. These were completely unexpected and she required Neopuff ventilations for a long time before she came round and was well again. I just thought that seemed extremely unusual, just the speed of collapse, the longevity of the resuscitation, and then the fact that she seemed to recover really quite quickly."

Well, ladies and gentlemen, we suggest that the collapses of [Baby J] bear all the hallmarks of an attack by Lucy Letby.

[Baby J] was a child who was on the cusp of going home. She had triumphed over an unpromising and dangerous start to life and was prospering until she met Lucy Letby.

She was in nursery 4 when she collapsed whilst her designated nurse was away. The subsequent and more serious collapses at around 7 o'clock were at a time when the resources of the unit were distracted by the arrival of two emergencies, and it's clear that it was all hands to the pump, and yet Lucy Letby's hands were on her phone and so you can infer that Lucy Letby was not in the room with the emergency twins.

Perhaps she felt left out. After all, we know that she liked to be in nursery 1. She stopped texting her friend [Nurse E] 7 minutes before [Baby J] had her first serious desaturation and fit and we know from the fact that she wasn't helping with the twins that she had the opportunity and at a time when everyone else was distracted.

With everything else that you know about Lucy Letby and what she was up to on that unit, the real cause for [Baby J]'s collapses, we suggest, is obvious.

Lucy Letby's suggestion in interview that she had little memory of that shift is, we submit, not realistic, particularly because of the arrival of the twins. Knowing what you know about Lucy Letby, her desire to be where the action was, do you really think she's forgotten what happened on that shift? We suggest that she was running with the "I don't remember" line to avoid getting drawn into answering questions about what she was up to.

Whether or not she searched for many people on Facebook, her search for [Parents of Baby J] on Thursday, 17 December 2015 at 22.46 and 22.48 is, we suggest, inexplicable other than by an unnatural interest in them. She couldn't explain it. Well, that's what she said. We say she would not explain it because she is not prepared to admit the real reason she did it.

[Baby N]. There are three incidents involving [Baby N], three counts: count 17 on 3 June 2016, counts 18 and 19, both on 15 June 2016. What I propose to do is to deal with the first one before the break if I may.

[Baby N] was born on 2 June at 13.42. He was 34 weeks plus 4. We heard about his birth from his mum, [Mother of Baby N].

The concerns relating to [Baby N] centred around haemophilia. There were no bleeding issues associated with [Baby N]' birth. We allege that, like [Baby J], [Baby N] was sabotaged by Lucy Letby as he was about to go home.

I will return to [Mother of Baby N]'s evidence when we get to counts 18 and 19.

The first incident, count 17, 3 June, a desaturation when [Baby N]' designated nurse had gone on a break. We say that this incident was characteristic of Lucy Letby's handiwork. [Baby N] desaturated and collapsed just after his designated nurse, Chris Booth, went on a break. So to that extent, we're dealing with a similar situation to the collapses of [Baby C], [Baby D], [Baby G], [Baby I], [Baby J] and [Baby K].

[Baby N] collapsed on the night shift of the 2nd into the 3rd. In the first of the sequences at tiles 52 and 53, we have the staff list and population distribution.

We suggest that Lucy Letby was in her least favourite nursery, 4, with only -- I say "only", I mean relatively -- two feeders and growers to care for.

We suggest she had time on her hands and we know from the evidence, don't we, that she had time on her hands because she spent an age exchanging text messages with [Nurse E], talking about Melanie Taylor's shortcomings and about [Dr A].

In amongst the conversation with [Nurse E] is the "go commando" comment, which Lucy Letby claimed in interview she didn't understand. Well, if she is not even prepared to tell you the truth about something as trivial -- and it is trivial, isn't it -- something as trivial as that, what do you think she is prepared to tell you the truth about? There can be no doubt, we say, that Lucy Letby was interested in [Baby N]. We say she was excited.

If we look at tile 68, please.

"We've got a baby with haemophilia", she was sending to [Nurse E] at 20.00 hours, at the beginning of the shift.

Tile 91. This is Lucy Letby telling [Nurse E] what she had just googled; do you remember? When we asked her questions about that she said, oh no, that wasn't information I got off Google, it was something I knew. She wasn't even prepared to say she didn't know about haemophilia.

Given Lucy Letby's level of excitement in the texts, we say that her interviews are very revealing. Could you go to the second bundle of interviews, please, and go to the [Baby N] ones, which are about two-thirds of the way down the dividers? And could you go to the very final [Baby N] interview, which is TG3, just before JG.

Could you go to page TG31, please? Bear in mind, please, ladies and gentlemen, that this is an interview on 10 November 2020. The first [Baby N] interview had been on 10 June 2019 and the second on 12 June 2019, so this was the third occasion on which Lucy Letby had been interviewed.

You can see a question right at the bottom of page 31:

"Question: Were you aware that [Baby N] had this condition?

"Answer: I'm not sure without looking at the notes."

She was then -- we say that that was a lie, not least because in that Morrisons bag under her bed was the [Baby N] handover sheet, which clearly showed that [Baby N] had haemophilia.

You can see the level of her excitement, can't you?

We're going to come -- when we get to [Baby Q] later this afternoon, I'll remind you that without any documentation at all, Lucy Letby was able to remember a name of another child in nursery 1 at the time she was looking after [Baby Q] in a different nursery. It's an astonishing memory. I wish my memory was that good.

If we look at the neonatal review at lines 2 to 7, please. Put the interviews away now, if you would, please. Lines 2 to 7 of the neonatal review. What we see between 2 to 7 is that Lucy Letby was feeding AF and doing meds for JBR. You can see the times there.

J30921 is the feeding chart for AF if it's possible to get that. Thank you.

What we see is that this feed at 20.30 was a 50ml feed and it was given via NGT because, apparently, this child was asleep. It would have taken, according to estimates we've had from various people, anything between 15 to 20 minutes, but throughout this time, 15 minutes either side, you can go either 15 minutes early and come up to 20.30, or you can count from 20.30 and go 15 minutes to 20.45 on your sequences. What you will find is that Lucy Letby was literally -- the keypad on her phone must have been hot because she was texting [Nurse E] pretty much every single minute in that period.

Now, we are not suggesting -- I hope we're not being unrealistic here, ladies and gentlemen. People are told, "Don't use your phone at work", people do use their phones at work, we recognise that, we absolutely recognise that. And we're not suggesting that if they do, they're doing anything necessarily seriously wrong.

But we know from the evidence, from Lucy Letby's own evidence, that giving an NGT feed is a two-handed process, and we know from the evidence that you can't do that if you're texting at the same time. It can't be done.

If you look at the text messages over this period from tile 90 to tile 130, so you've got 41 text messages in that short period of time. That cannot be done if you are giving, in the proper way, an NGT feed. And you will remember that I asked Lucy Letby about this.

I said:

"Question: This is all while you're feeding AF, isn't it? How do you do that? How do you text when you're doing a two-handed job of feeding a child?

"Answer: You can't.

"Question: No. Well, you can. There is a way of doing it, isn't there, to feed a child very quickly, isn't there?"

The answer you will remember:

"Answer: You think I pushed it in."

I said:

"Question: You tell the jury.

"Answer: I didn't.

"Question: How do you push it in? How would you push it in if that's what you wanted to do?

"Answer: Put the plunger on the end.

"Question: That's what you were doing, wasn't it?

"Answer: No."

At that point, ladies and gentlemen, we got to -- that was the point at which we got to tile 111, which was the introduction into the conversation of the subject of [Dr A] at 20.38. That was how we got to the "go commando" message.

Well, ladies and gentlemen, we say that this part of the evidence really tells you quite a lot about Lucy Letby and her approach to her job and her approach to giving evidence and her unwillingness to be frank with you.

Chris Booth remembered, and the fact that -- sorry, Chris Booth remembered [Baby N]. He remembered the fact that he cared for him on the night in issue and he told you that he went for an hour's break at 01.00; that's tile 170.

[Baby N] didn't require feeding. He was stable.

Nurse Booth had no concerns. As always, Nurse Booth asked somebody else to keep an eye out. He thought it would have been somebody else in nursery 1 who took over, but if we go back to the population chart at tile 53 we can see there wasn't another nurse in nursery 1. But we can see, if we go to the neonatal review, sorry to jump around, it's line 30 of the neonatal review, that at 1 o'clock Mel Taylor was making an entry on a chart for TM, who was the other baby in nursery 1.

You know from the text messages with [Nurse E] at the beginning of the shift that Lucy Letby wasn't getting on very well with Mel that night and you know who wanted to be in nursery 1, don't you, from all the evidence in the case? And you heard evidence from Nurse Booth of [Baby N] suffering "a profound desaturation" by the time he came back.

The other nurses on the shift were Melanie Taylor, the shift leader. She had no memory of taking over for [Baby N]. Sophie Ellis had a vague memory of [Baby N] but none of the shift and she had three other babies to look after in rooms 2 and 3. Valerie Thomas was a nursery nurse on transitional care. She wouldn't have been standing in in nursery 1. And therefore we suggest that a combination of all these circumstances leads to the conclusion that it must have been Lucy Letby standing in in nursery 1.

If you look at the neonatal review, you will find she wasn't doing anything else at or about 1 o'clock.

Dr Loughnane is now a consultant paediatrician at Chester and she had carried out a routine review of [Baby N] at 22.55; that's tile 161. She told us that a grunting baby is given 4 hours to settle, to see if it has fluid to the lungs. His sats were 96% in air with the respiratory rate at the upper end of normal. There was no grunting and his lungs were clear. He had no increased work of breathing, he had been screened but he was not grunting.

Dr Loughnane saw [Baby N] later that night after he desaturated at 1 o'clock. The door swipe data at tile 173 shows her entering the unit at 01.07. [Baby N] was unsettled, his oxygen levels had dropped to 40%, which she viewed as a significant desaturation.

He was mottled, he was dusky, and Dr Loughnane couldn't remember who it was who had asked her to see [Baby N].

When she arrived, he was in 40% oxygen and was screaming. Screaming.

Do you remember Dr Loughnane sitting in the witness box? I don't know if you can all -- we never get round your side of the courtroom, I don't know what your view is, all of you, of the witness box. Do you remember she sat back as she saw the word she had written, didn't she? "Screaming." And even -- well, when I asked her questions in cross-examination, do you remember I asked Lucy Letby about Dr Loughnane's response to the word "screaming" and Lucy Letby confirmed that she remembered seeing Dr Loughnane do that when Dr Loughnane read the word that she'd written, her own word.

That speaks volumes, ladies and gentlemen. By the time Dr Loughnane got there, [Baby N] was on the road to recovery and Dr Loughnane was crash bleeped away to the maternity ward. You'll see that in the swipe data at 176.

Just before we finish, if I may just trespass about 2 minutes or so into the break, thank you, Dr Evans regarded the use of the verb "screaming" as being very unusual and, so we know, did Dr Loughnane.

Dr Evans regarded the 30-minute duration of crying as being very unusual and he said that the speed of [Baby N]' decline and recovery were also unusual features of this event and he could think of no naturally occurring or innocent cause for this collapse.

Dr Bohin reminded us all that the infection markers in [Baby N] were negative. [Baby N]' observations prior to the collapse were all normal and Dr Bohin described this event as a "life-threatening desaturation". There's nothing in the records to suggest that there was an innocent event which might have caused [Baby N] pain. So Dr Bohin concluded that there must have been some inflicted painful stimulus to cause a life-threatening desaturation. An inflicted painful stimulus.

We know, you know, that that is precisely what was inflicted on [Baby O] 20 days later on 23 June when he sustained that dreadful liver injury. That was inflicted by Lucy Letby.

So, ladies and gentlemen, we say simply this event cannot be explained as some naturally occurring event.

The unusual characteristic of screaming, the coincidence with the cases so far as the crying or screaming is concerned with

[Baby I] and [Baby D] and [Baby E]. And that in itself marks out this event as being an attack by Lucy Letby.

But it doesn't end there, does it? What are the chances of a baby, who was perfectly well, having a life-threatening collapse just after the nurse who was looking after him went on a break? You can put this alongside all the other cases, can't you? That's what you can do that the experts cannot do.

My Lord, I'm going to move on to the --

MR JUSTICE GOSS: Certainly. We'll break off there, members of the jury. 2.10, please, an hour and 5 minutes.

(In the absence of the jury)

MR JOHNSON: I'm on course.

MR JUSTICE GOSS: Thank you very much.

(1.06 pm)

(The short adjournment)

(2.10 pm)

(In the presence of the jury)

MR JOHNSON: We're moving now, ladies and gentlemen, to the day shift of 14 June 2016. If we could put up tile 17 from the second of the [Baby N] sequences, please.

Tile 7, sorry. No, not that either.

(Pause)

Lucy Letby was working the day shift on 14 June.

She was [Baby N]'s designated nurse. Dr Henton examined [Baby N] at the end of the night shift and confirmed that he was due to go home that week. He was therefore in a similar position to that in which [Baby J] had been when she was attacked.

At tile 10 we should have a feeding chart, which is J19357. That shows us that [Baby N] was feeding well, he had a 45ml feed of expressed breast milk in a bottle.

He passed urine. His bowels opened. That's the 07.40 entry on that particular chart there.

At tile 16 we can see that Lucy Letby was there complaining to [Nurse E] that she had had to feed [Baby N], something that she was suggesting should have been done by Abigail Jeffels, who had had him overnight.

We get an idea of how long the feed took because this is a text message sent at 08.17 relating to a feed which was given at 07.40. Tile 13, I think, give us that information. Yes:

"Just finished doing Abi's work."

A 07.40 feed of 45ml took until about quarter past 8, "Just finished".

At tile 25, Lucy Letby noted that [Baby N] was due to go home, the only contraindication at that point being a declining serum bilirubin level.

Going back to the feeding chart at tile 23, please.

We can see that [Mother of Baby N], [Baby N]' mum, fed [Baby N] at 11.50. We can see, even though the right-hand part of the chart is cut off, you can see it says, "Cares plus feed, mummy".

We know, going back to tile 26, a slightly convoluted route through the documents here, but back to tile 26, please, that [Mother of Baby N] had left by 14.20 because that's the time this note is made and it says:

"Carried out cares and feed. Put infant to breast. Discussed feeding at home."

Et cetera, et cetera.

We say that the evidence suggests that something happened at the end of this day shift by which Lucy Letby destabilised [Baby N] for overnight. You'll remember what happened with the [Surname of Babies O, P & R] lads, won't you, on both the shifts preceding the night shift which then preceded the days on which they died? This is where Lucy Letby hit on this as a pattern, we suggest, as a way of carrying out some of these offences.

The night shift of the 14th to the 15th, Jennifer Jones-Key was the nursery nurse in nursery 3, who looked after [Baby N] that night. She told us that she had no concerns when she took over [Baby N]' care.

She said that he had been "unsettled" after handover, that's the way she put it, and that was something that was repeated by Nurse Kathryn Percival-Calderbank:

"Unsettled after handover through to midnight."

But what she actually wrote down is quite illuminating if we go to tile 78, please. It says:

"At start of shift [that's the top of that page] baby nursed in incubator with eye protection in situ. SBR repeated at 21.00. Result 150. Lights and will repeat in morning."

Then this:

"Baby demand bottle feeding on EBM, taking good amounts on own bottles. Baby very unsettled in early part of night."

And what was it that had happened that had made [Baby N] so unsettled at the beginning of this shift just after he'd been with Lucy Letby all day? This is where you are entitled, we suggest, to look at the circumstances of what happened with [Baby P] just at the handover before that night shift, just a week later.

[Baby N] started to desaturate at 01.00 when he became a little bit mottled and so Jennifer Jones-Key, as a band 4, escalated it to Belinda Williamson and to Kathryn Percival-Calderbank. [Baby N] was put on to monitoring.

Later, he was made nil by mouth and given a little supplemental ambient oxygen, and at 01.45 he was seen by [Dr A], who recorded mottling and that [Baby N] was "settled" and he'd been fed at 01.00 hours. All other signs were normal, except for a slightly raised lactate and glucose, and we were told that the raised lactate can be the result of what they call a squeezed sample.

In other words, literally the heel prick and then squeezing the heel to get the blood to come out. And the raised blood sugar was -- a potential explanation for that was because he'd just been fed.

At 03.45 there were five desaturations reported to [Dr A] as having occurred over the preceding couple of hours, but the mottling had resolved, and [Dr A] at that stage suspected infection. But [Baby N] was examining normally and [Dr A] thought, well, maybe it's the beginnings of an infection and so he took a blood for a septic screen and he gave a first-line antibiotic.

Tile 85 tells us what the outcome of that investigation was. It tells us that in effect there was no infection. [Dr A] ordered that monitoring was to take place with a repeat gas and the repeat gas was reassuring. [Dr A] described those blood results as reassuring.

At 05.15 there was an extended capillary refill time, which suggested to [Dr A] that blood flow was being diverted, which he described as "slightly more serious but non-specific". At this stage [Baby N] was still nil by mouth and, according to [Dr A], there was no nasogastric tube in place.

At tile 104 we can see [Nurse E] telling Lucy Letby:

"[Baby N] screened. Looks like shit."

And Lucy Letby responded almost straightaway at tile 106:

"Really?!"

We say that is the reason why Lucy Letby went straight to [Baby N] when she went into work early. She saw an opportunity. Nurse Percival-Calderbank confirmed in evidence that Lucy Letby went in to see [Baby N] and had been told at that stage that she was to be his designated nurse. And aside from his requirements for phototherapy at this stage, [Baby N] had no specific needs.

Now, as I said, if we go to tile 137, we can see that Lucy Letby came in extra early and if we look at tile 138, we see that the first thing she did as she came in was text [Dr A]:

"I've escaped being in 1, back in 3."

So she certainly knew, didn't she, that she was [Baby N]' nurse? The very next thing, [Baby N] collapsed.

According to Jennifer Jones-Key, from 7 o'clock [Baby N] had been having fleeting desaturations, although she, Jennifer Jones-Key, didn't make a note of it.

If we look at [Baby N]' vital signs we will see what she did actually note. Could I ask if we could have up -- for some reason I haven't written the tile number down for this one. It's behind divider 18 in bundle 2.

I'll just find the reference. It's the very first page behind divider 18 and it's page J19314.

What we can see there is that there were no worrying signs at all for [Baby N]. There is a 5 o'clock and a 7 o'clock -- it looks like a 9 but it's a continental 7, so if you're looking at the times at the top of the chart, reading in from the right-hand side of the page, it goes 10, 9, 7, 5, 1.

So you can see that the vital signs at 5 o'clock and at 9 o'clock were absolutely not concerning, and in particular, if we

look at the sats, which is towards the bottom of the page, you can see that [Baby N] was saturating at 100%. So the written evidence, the records, doesn't support, we would say, what Jennifer Jones-Key told you.

[Baby N] then had a big desaturation at 7.15.

Lucy Letby knew that she'd get a chance to sabotage [Baby N] because she knew that things were going to be very busy and she knew that because that's what she had been told by her friend, [Nurse E], at tiles 101 and 102. Actually, 100 is the best one, actually. I've given another incorrect reference there:

"5 admissions, 1 vent."

So Lucy Letby knew she was going into a busy unit and she headed straight for [Baby N].

Jennifer Jones-Key didn't remember the detail, but she did remember that Lucy Letby looked over and noticed [Baby N] was a bit pale and his monitor had gone off.

That sounds familiar, doesn't it? 13 October 2015, Ashleigh Hudson, [Baby I].

Jennifer Jones-Key was feeding another baby. Her note, "Seen by Lucy", which is what she put in the nursing records, according to Jennifer Jones-Key meant that she, that is Lucy, would have seen the monitor and the drop in sats. And Jennifer Jones-Key said that Lucy Letby had just come in to say hello because they were friends. Maybe that's what Jennifer Jones-Key thought, but we know what Lucy Letby's opinion of band 4 nurses was, don't we?

You might want to think about what Jennifer Jones-Key said about this. Who was it that Lucy Letby had been texting since she'd left work the previous day from 21.16 through to 22.29? She was texting [Nurse E] and [Dr A]. You'll find all that between tiles 44 and 75. She wasn't texting Jennifer Jones-Key. The first thing she'd done when she woke was to text [Nurse E], tile 92, at 05.10. That conversation continued right up until 07.08 at tile 135.

[Nurse E] had been working the night shift and Lucy Letby knew at 07.12 that she, Lucy Letby, was going to be with [Baby N] in nursery 3; that's tile 138 that we just looked at. That is why she sabotaged him.

Given that background, and Lucy Letby knowing that her mate, her best mate, [Nurse E], was in the unit, if she was going to talk

to her friend she'd have gone and talked to [Nurse E], wouldn't she?

[Dr A] characterised this collapse as "concerning" because [Baby N]'s heart rate had dropped and his sats dropped to 48%. But [Baby N] was due to go home, the big day in both his and his parents' lives, but after his contact with Lucy Letby he was transferred from nursery 3 to nursery 1, which just happens to be the place that you know Lucy Letby liked to be.

In interview, Lucy Letby said at page 7 that she had taken over from Jennifer Jones-Key and she said this:

"I am assuming [she was being asked to look at the chart and these are the words from the interview at page 7, TG7] that something must have happened for [Baby N] to be moved because he's gone from just temperature obs to full observations."

Do you really think that's all she remembered of this event? Because according to what she also said in the interview at page 17, she claimed that she had no memory of [Baby N] independently of the notes.

Tile 151 is Lucy Letby's nursing note covering the start of the shift. It suggests that [Baby N] was desaturating on handover. Well, that wasn't the whole truth, was it? She had come in early and she had sabotaged him. The impression you'd get from reading this is that Lucy Letby came in and was handed a child that was desaturating. That is just not the truth. It makes no mention of the fact that she was the person who discovered [Baby N], which we say is an interesting omission. Why would she leave that out?

We suggest what I've just said, really. She was trying to give the impression that she was inheriting a problem rather than creating one. What she was saying in interview was really a continuation of that effort.

What she didn't want, what she was trying to prevent, was an audit trail that led back to her, back to what I was saying to you yesterday about plausible deniability in the context of the case of [Baby D].

[Baby N]' parents were called in urgently. They arrived at about 9 am to find [Baby N] in intensive care.

He was given CPR. As his mum said:

"Lucy was tending to [Baby N] in between the consultants being with him."

The aftermath of the first of the incidents that day saw Lucy Letby making more misleading notes in the record. If we go to -- let's just check. It's the same note that -- I think it's tile -- it may be further down the page or it's tile 169, please, Mr Murphy.

It's a note that's made between 14.10 and 14.12. In other words, it's made immediately after that first note. That's not the right one. It's 14.10 to 14.12, please. It's the one that mentions Bernie Butterworth if that helps.

(Pause)

It's the family contact part:

"Parents were contacted by Staff Nurse Butterworth during intubation."

Park those words in your mind, please, "during intubation". You'll remember we had quite a long sequence in evidence, didn't we, about what she meant by intubation and it was the I-Gel at 4 o'clock in the afternoon. So just park that idea for now:

"Parents contacted by Staff Nurse Butterworth during intubation. Both phones switched off and no answer on landline. Message left. Call returned shortly after and parents were asked to attend. Have been present since."

That note must, given its timing, refer to the elective intubation that was attempted by [Dr A] at 8 o'clock, 08.00 hours, because you will have noticed, and it's tile 157 if you want to find it, the drugs that were being given to [Baby N] at about that time, and there is reference in [Dr A]'s notes, it says:

"Attempted intubation x3."

You can see there about two-thirds of the way down the page.

Until Lucy Letby gave evidence, we thought that the statements of [Baby N]' parents were agreed. As his Lordship has directed you, they are not agreed, and so you will have to decide whether you are sure that what the parents say is true and accurate or whether what Lucy Letby said in the witness box is the truth.

In the statement of [Father of Baby N], he said this:

"I was at work. I then received a phone call from [Baby N]'s nurse, Lucy."

Well, he's right that [Baby N]'s nurse was Lucy:

"Lucy said that [Baby N] had been a bit unwell in the night but she said he's okay now. I told Lucy that [Mother of Baby N] would be in in a bit to see him as usual and that was that. She didn't give me any other information. I didn't get the impression that he was still unwell or that we needed to be concerned. About 10 minutes later, [Mother of Baby N] rang me. We needed to go to the hospital. It was about 9 am. When we arrived at the neonatal unit [Baby N] was in the ITU room and Lucy was in the room with him."

In her statement [Mother of Baby N] said this:

"On the 12th day [which as it happens is 14 June] we were told by a consultant that he was able to go home the next day. [Baby N] was in nursery 4 by that point. I was due to go and collect him on the 15th. Around 8 am on that day, I had a phone call from [Baby N]'s dad [Father of Baby N] to say there had been an issue at the hospital and that [Baby N] had had a bleed and was unwell but it was nothing to worry about."

So they're saying the same thing, aren't they?

"I rang the hospital to clarify whether I needed to take a car seat in with me and was told by a lady called Grace to go into the neonatal unit as soon as possible."

So [Baby N]'s parents' accounts match. Either they are truthful and accurate or somebody told [Father of Baby N] two lies.

The first lie, whether or not [Baby N] had been "a bit unwell in the night", he was much more unwell when Lucy Letby arrived. That detail was missed from the phone call completely. And secondly, the second lie, "He's okay now". That certainly wasn't true. And you might think, ladies and gentlemen, that given the drama of these events, if you were the parent of a child that you thought you were taking home and you got a phone call from the hospital and you then went through what [Baby N] and the family went through that day, you might just remember the call that you received to tell you that there might be an issue.

Can we go back to tile 169, please? That's Lucy Letby's version of events. None of this was dealt with when Lucy Letby gave evidence in answer to questions from her own counsel on 17 May, was it? Not a word about any of this.

When I asked Lucy Letby about it on Wednesday, 7 June, she said:

"I think there's a written note by Bernadette Butterworth to say that she spoke with the parents."

Do you really believe that's what she thought or was she trying it on with you, hoping that no one would notice the detail in the notes?

I took her up on it and she said:

"It's my note referring to Bernadette Butterworth and I wouldn't have put her name in there if that hadn't happened."

Knowing what else she's done, do you think that's true? We suggest, ladies and gentlemen, that this chapter of the evidence is littered with irreconcilable contradictions, but if you accept the accuracy of the read evidence of [Baby N]'s parents, and indeed of Bernadette Butterworth, whether or not it was agreed by oversight, then you will conclude that the parents were misled about the severity of [Baby N]' profound desaturation and Lucy Letby's note contains misleading information as to who it was that misled the parents.

You might ask yourselves why Bernadette Butterworth would have any interest in misleading the parents and, more to the point, why Lucy Letby would further that by making what she must have known was a misleading note about what had happened. After all, she'd been at the desaturation, hadn't she? No doubt you'll decide whether you can be sure that [Baby N]' parents are honest and accurate about this important and unwelcome setback on the morning that they were expecting to bring their son home, and, if so, go on to consider why Lucy Letby played down the urgency of the moment and misattributed the communication to her colleague, Bernadette Butterworth.

There's another point here, though, ladies and gentlemen, and it's that Jennifer Jones-Key's note recording the fact that it had been Lucy Letby who had "found [Baby N] desaturating" was not recorded by Jennifer Jones-Key until 08.19; that's tile 141.

When we say that Lucy Letby made the call to [Father of Baby N], Lucy Letby wouldn't have known that Jennifer Jones-Key had already recorded for posterity that she, Lucy Letby, was hands-on with [Baby N] at the time he collapsed.

Lucy Letby was asked about this in her third interview. It's TG29 and 30 if you want to look it up.

I'm not suggesting you do now. But when she was asked about the conversation, Lucy Letby feigned ignorance and just said that she couldn't remember, like she'd told the police that she couldn't remember why she was searching for the parents of many of these children.

But whatever Lucy Letby's motives may have been for the lies, we say that the nursing note was completely misleading. She palmed the communication off on to Bernie Butterworth and she also suggested that Bernie Butterworth hadn't been able to get through to [Father of Baby N]. The lie Lucy Letby told to [Father of Baby N] about [Baby N] being a bit unwell in the night we say was part of her attempt to distance herself from what had happened because, after all, she was the person that had come in early to sabotage him.

As for the entry in the records, that's an extension of what we've seen before in the cases of [Baby E], [Baby I] and [Baby M]. If anyone reviewed the official records at a later date, it would simply look like she had played a peripheral role at best, wouldn't it, and it mirrors what happened when [Baby N] had his collapse on 3 June.

This is, we suggest, an indication of how cunningly determined Lucy Letby was to carry on her campaign of violence against these children. And her cunning extended to working in the fact that [Mother of Baby N] had rung in, which was actually true but just didn't happen in the circumstances that she was suggesting.

If it hadn't been for the note of Jennifer Jones-Key, made as she went off shift, at tile 141, we suggest that Lucy Letby would have got away with it.

As Dr Brearey told us, there was a subsequent examination of [Baby N] at Alder Hey and [Baby N] has no significant abnormalities of his airway and that was confirmed by Dr Potter, do you remember, the anaesthetist from Alder Hey? This is important, ladies and gentlemen, the fact that there are no physical abnormalities, because [Dr A] started the intubation process of [Baby N] at 8 o'clock and here we see further parallels with other cases.

[Baby N] was given the necessary drugs. [Dr A] said Lucy Letby was there. He, [Dr A], couldn't remember Bernie Butterworth being there. Interestingly, he told us, did [Dr A], that he remembered the appearance of [Baby N]' oropharynx as he was trying to intubate him. He was standing to the left of [Baby N] who was in the incubator with his head, neck and part of his chest coming out of the incubator and when he first looked down [Baby N]' throat, he saw blood. And it was the blood that prevented him seeing where the entry to his airway was. He said he couldn't see the source of the blood, he couldn't see where he was aiming to position the tube, and he said:

"The back of [Baby N]' throat looked unusual with a degree of swelling."

He described the blood as:

"Such an unusual thing to see."

And that the suction couldn't clear it.

Under cross-examination on behalf of Lucy Letby, he repeated that the blood was there on the first attempt, he couldn't see where the blood was coming from, nor what had caused the swelling. As he said:

"It must have been unusual for me to have remembered it."

Later in cross-examination he said perhaps it was possible that blood was there as a result of his use of the laryngoscope. But if that was the case he would have expected to have seen the blood "along the route of where the blade is", in other words if this implement was the thing that caused the bleeding, that's where he'd expect to see the blood.

And this was the first time he had seen [Baby N]' throat, he abandoned after three attempts because of his anxiety (inaudible: no audio) haemophilia.

Unexplained blood or swelling of the throat of a child is another common feature of many of these cases, isn't it, ladies and gentlemen? You'll want to bear that in mind when you're considering the submission, no doubt, that will be made on behalf of Lucy Letby that it was [Dr A] that caused the bleeding. You will remember [Baby C], [Baby E], [Baby G] and [Baby H]. These are not innocent coincidences.

Dr Saladi's agreed examination at 10 am excluded an abdominal cause for the collapse. Dr Brearey told us that under normal circumstances the raft of highly experienced professionals would have been able to intubate [Baby N] and the impediment was the presence of blood and the swelling, and the haemophilia does not explain that. It would explain bleeding in the brain, we are told, but this was not a case of bleeding in the brain and Dr Brearey said he could not think of a natural cause for why [Baby N] collapsed when he did.

At 8 minutes past 9, 09.08, there was an X-ray taken. It's tile 176. The view was taken at the time that there might have been a pulmonary haemorrhage, something which has since later been excluded by the evidence of Professor Kinsey and other experts.

But the important thing here, ladies and gentlemen, is that Lucy Letby thought that this suspicion in the Countess at the time would give her a further opportunity and cover to attack [Baby N] again. So she has identified what she perceives as a weakness

in a specific child and she takes advantage of that to press home her attack.

At tile 199, 11.29, she sent a text to [Dr A]:

"Small amounts of blood from mouth and 1ml from NG. Looks like pulmonary bleed on X-ray. Given factor VIII, wait and see."

So we know the narrative that she was forwarding or impressing on others at this time.

If you could go, please, back to jury bundle 2, the page I'd like you to go to, please, is 19316. Lucy Letby was asked about this in interview and if you want to find the part of the interview it is page TG8. I'm not suggesting you should necessarily go there now. In interpreting what's on this page, what she said was when she had taken over at 9 o'clock the line was occluding. Well, of course, she'd been there since 7.15, but there we are.

She then said that at 10 o'clock, the VIP score was zero -- and you can see that to the left of "occluding" in the row below -- and that she had aspirated the NG tube and there was 1ml of fresh blood. You see that written towards the right-hand side of the 10 o'clock line.

You might want to ask yourselves, ladies and gentlemen, why was Lucy Letby aspirating the nasogastric tube at all? [Baby N] was not being fed via the NGT.

When she was asked about the 1ml fresh blood which has been noted there at page 9 of the interview, she said:

"I do not remember the 1ml of fresh blood. That would have been a concern. I don't remember what I did. Fresh blood and bile would be a concern."

It would, wouldn't it, ladies and gentlemen, in a child that had collapsed a couple of hours earlier, who had haemophilia and who the staff thought was at risk because of the haemophilia? The truth, ladies and gentlemen, if what she has noted on here -- this is a double-headed coin for the prosecution, we say, for this reason: if what she's written here is true, she would have escalated it to a doctor. In a child with haemophilia, this would have been escalated to a doctor.

So the fact that she hasn't escalated it to a doctor suggests that, we would say, if it's true -- well, that it's not true. You can look at it from the other way as well, can't you? You can reverse it completely and it still is a point against Lucy

Letby. "If it didn't happen, why did she make the note", in other words, is the opposite point of view, isn't it?

That fits with our consistent allegation that she is writing things in the notes to create the impression that a child is having problems, going down a more gradual path towards a collapse. So either way, whether it happened and she didn't escalate it, or it didn't happen and she wrote it in falsely, it's a point against Lucy Letby.

Lucy Letby had been there when [Baby E] had died, bleeding in a way that Dr Harkness had never seen before. That was her lived experience at this time and here she has another baby bleeding and yet doesn't escalate it. And you know it wasn't escalated because there's no note in either Dr Ukoh or Dr Saladi's notes at tile 184 or 185.

To explain it away in interview as she did by saying that the blood may have been a result of trauma to the airway from the nasogastric tube is, we suggest, a complete nonsense and it was something that she was very keen to move on from in the interview. If you go to page 10 of the interview you'll see she didn't want to get too involved in that question-and-answer session.

Now, in agreed evidence, which you may have forgotten, the expert nurse, Elizabeth Morgan, told you that any unusual occurrence would be escalated verbally to attending medical and nursing staff, particularly in a case where a child like [Baby N] had a particular issue to which the problem was relevant. We say that this is yet another example either of her having caused an injury, not wanting a doctor to look at it closely in the immediate aftermath or, alternatively, making a false note about something that didn't really happen, designed to give the impression of a declining child.

A detail that you may have forgotten from the statement of [Baby N]' parents, though, is that having been called in, they sat with him until they needed a break to get something to eat. And having left his side, even if you've forgotten the statement, you know what they say, don't you? He collapsed again. Yet another coincidence. The power of circumstantial evidence.

This is something that Lucy Letby was asked about in the November interview in 2020. You'll find that at page 30. She wrote it off as an innocent coincidence.

Well, it was her opportunity to sabotage [Baby N] when there were no witnesses, wasn't it, like in so many other cases?

The next major event was at 14.59. Dr Mayberry, on his link from Australia, was crash called along with others. He told us of a 3ml aspirate of blood from [Baby N]'s NGT, but that was something somebody else told him about and he couldn't remember who it was. That's what he said.

Well, we know that [Baby N]' designated nurse was Lucy Letby and therefore we suggest that you can be sure that it must have been her who told Dr Mayberry about the blood aspirate. It's a repeat of [Baby E].

Dr Mayberry did remember actually having seen blood, although he didn't say it was -- sorry, he didn't remember having seen any blood himself, not even in a pot, as was suggested to him in cross-examination.

But because of the recent history, he was worried and he bleeped Dr Saladi. Dr Mayberry made a single attempt to intubate [Baby N]. He could visualise the vocal cords.

What he saw was "a substantial swelling within the airway". So having seen that, he didn't proceed with the intubation. He said the swelling was:

"Unlike anything I had encountered previously".

He said that the epiglottis was large and swollen and more red than the surrounding mucosal tissue and reminded him of a case of epiglottitis that he'd seen in a textbook, something that he had never seen in a neonate and was even unaware that a neonate could have.

And you will remember that this swelling perplexed Dr Gibbs as well.

[Dr D] got the crash call when she was on the paediatric ward with Dr Saladi and both she and Dr Saladi came to help [Baby N]. [Dr D] visualised [Baby N]' cords, but they were very anterior and she too saw swelling below the epiglottis. She knew to be careful because of [Baby N]' haemophilia and told us that events from that point on were in effect continuous and that Lucy Letby was there throughout.

Dr Brearey was called in by Dr Saladi to help and he was the one who used the laryngeal mask, the I-Gel airway. He said that they were worried about pulmonary haemorrhage and decided that full intubation was still required. He said it was the blood in the oropharynx at the first intubation and subsequently that gave rise to the fear of pulmonary haemorrhage, though he also said that the facts didn't really fit with pulmonary haemorrhage and we know now that it wasn't a pulmonary haemorrhage.

As I said, this is when the I-Gel mask was used to help [Baby N]'s breathing. It is this event that has been seized upon in evidence by Lucy Letby as the "intubation" she was talking about in interview when she admitted that she had seen blood.

The way Lucy Letby explained that and explained that she first saw blood at this point was, we suggest, completely unconvincing. The truth -- I'm not going to go into the convoluted way in which she sought to explain away what she'd said in interview because the truth is very easily established.

If we start, please, first, with tile 199. This is what she was writing down on the day:

"Small amounts of blood from mouth plus 1ml from NG. Looks like pulmonary bleed. Given factor VIII. Wait and see."

That's the first thing.

Second, there is her own note made that afternoon in an effort to palm the phone call to [Father of Baby N] off on to Bernie Butterworth. I asked you to hold in your mind:

"Parents were contacted by staff Nurse Butterworth during intubation."

So that's the answer, isn't it? What she's writing -- however much she may try in the witness box to try and explain away what's very clear, a very clear admission that she saw blood right at the beginning, she admitted that in interview, the truth appears in what she was actually writing down at the time in the notes and to her friend, [Dr A].

The truth of it, I'm afraid, ladies and gentlemen, is that she made a very damaging admission in that interview, which completely undermines her own case on this count. At the time of the interview, of course, she didn't know how important this point would be and it all proves that she sabotaged [Baby N] before the arrival of [Dr A].

Tile 200, please:

"Sorry if I was off during intubation. Bernie winds me up faffing, et cetera. I like things to be tidy and calm (well, as much as possible)."

When you're thinking about whether it really was Bernie Butterworth who rang [Father of Baby N], just remember this text, ladies and gentlemen. Bernie Butterworth was getting on

Lucy Letby's nerves that day; who better to palm off responsibility on to than someone who's getting on your nerves?

Dr Gibbs came on duty at just before 18.00 hours that evening. He told us about the contacts he'd had with ENT specialists at the Countess of Chester and the team from Alder Hey. Various contingencies were put in place, a plan was made to take [Baby N] to surgery, and the next thing we have in the chronology is the note made by Lucy Letby at tile 294: another millilitre of blood noted by Lucy Letby at 18.00 hours this time. You can see it towards the right of that document.

[Dr D] told us that when the Alder Hey team arrived, Lucy Letby was agitated. It's an interesting word to use of a nurse, isn't it? When the cavalry arrives, when the specialist team from Alder Hey arrives to save this child who nobody in Chester could intubate, Lucy Letby got agitated. Lucy Letby approached [Dr D] a few times saying, "Who are these people? Who are these people?"

This runs completely contrary to what Lucy Letby said in interview at page 22, TG22. What she told the police was that she was relieved when the Alder Hey team arrived. Well, relief is what you would expect, isn't it? Unless you had sabotaged the baby. Outside eyes.

It's all part of the gaslighting, isn't it? You can gaslight the people you're with all the time if you're good at it, but independent people who come in from the outside sniff it out, don't they? That's why she was agitated.

The Alder Hey team was Drs Potter, Lakin and the surgeon Ms Day, and the ENT doctor, Dr Umesh, all of whom arrived at 19.15. [Dr D] told us this was an emergency. From working alongside the doctors and nurses, [Dr D] felt that Lucy Letby's behaviour was out of character from what she had previously experienced. But what [Dr D] didn't know, of course, was that Lucy Letby knew very well who these other people were.

Look at tile 281, please. This is a couple of hours before:

"Awaiting NWTS with an ENT..."

Two minutes later, tile 286, please:

"Had anaesthetics and x4 consultants... Waiting for NWTS with ENT specialist."

It mentions the I-Gel, interestingly, doesn't it? It doesn't say he's been intubated there, does it? It says I-Gel.

Tile 297, please. Talking about the anaesthetic team.

Lucy Letby knew very well who was on the way, didn't she? But she panicked when she saw them. [Dr D] remembered Lucy Letby saying, "You seem quiet tonight", and [Dr D] didn't understand why she was saying that.

At 19.40, Dr Gibbs was discussing the position with his colleagues from Alder Hey, his three colleagues from Alder Hey, plus other operating department technical staff near the entrance of nursery 1 and someone in the nursery called for help for [Baby N]. His sats and his heart rate dropped.

Doctors in a huddle talking about what to do. Baby collapsing. Yet another innocent coincidence? [Nurse B] said the doctors had all gone to the operating theatre to prepare. Whichever version you think is right, they were all distracted when [Baby N] collapsed.

Dr Potter, the anaesthetist, knew Dr Brearey and, knowing Dr Brearey, he thought that because he'd been called, Dr Potter had been called, it would be a real problem and he came with his specialist equipment. He said he was in a room nearby with Dr Lakin preparing when [Baby N] arrested. This is the arrest at the point that the other doctors are all being distracted.

He used a laryngoscope, expecting to see a lot of blood, didn't see it, and I think he said -- his phrase was "hit the hole" or something like that, he got the tube in straightaway. [Baby N]' saturations improved.

And when Dr Potter was cross-examined, he confirmed there was nothing to impede his efforts. But as you heard, [Baby N] by that stage had had drugs to reduce the swelling and also Dr Potter was facing an arrest situation in which the one thing he was interested in was hitting the hole.

So as he said, even if there was a swelling he might easily have missed it in the emergency. Various forms of resuscitation were given. Six doses of adrenaline between 19.47 and 20.09. And initially, [Baby N] wasn't responding to the resuscitation. But thanks to the skill of the medical team, they brought him back.

At the time Dr Gibbs' best guess, as he put it, was that this was a case of bleeding into the lungs, but as I've said before, we know that wasn't the case.

So [Baby N] is yet another baby who recovered dramatically once he got to Alder Hey. Dr Potter described his journey in Alder Hey as "fairly uneventful" and he'd left the ITU within 3 days once he got there.

You will remember Professor Kinsey giving evidence about this case. She excluded pulmonary haemorrhage and it seemed to be conceded in the questioning of Professor Kinsey by the defence that this is not or was not a case of pulmonary haemorrhage. Professor Kinsey said [Baby N] was in the moderate category of haemophilia, which made him more likely to bleed and trauma more likely to cause a bleed. But the bottom line, so far as Professor Kinsey's evidence, we suggest, was concerned was that the blood seen by [Dr A] at 8 o'clock could not have been spontaneous. So if there was blood at that time, somebody caused the bleeding, and that's why the issue of when Lucy Letby admitted that she first saw blood is so important. That's why we've gone to such convoluted lengths, in an explanation from Lucy Letby in the witness box, for her to try and explain this out as being something to do with the I-Gel airway at 4 o'clock in the afternoon in a situation where the documents are littered with her writing down she's seen blood, texts that she's seen blood. It is, we suggest, complete nonsense.

Dr Evans. So going back to -- I think I dealt with Dr Evans so far as the incident of 3 June was concerned.

One of the issues that was taken up with Dr Bohin about the suggestion that there was some sort of violence inflicted on [Baby N] was the suggestion -- the querying of the absence of any external sign on [Baby N]. Well, what we say about that is, all very interesting, but when you take into account the evidence of Dr Marnerides in the context of what happened to the [Surname of Babies O, P & R] boys, you will remember he told you that it is frequent that small babies with internal injuries have no outward sign of force having been inflicted on them. So we suggest that that is a red herring.

In relation to the events of 15 June, it won't have escaped your notice that both Dr Evans and Dr Bohin were asked questions on behalf of Lucy Letby on the basis that things started to deteriorate with [Baby N] in the early hours of 15 June. We say that if you look at events of the 15th on the basis that things deteriorated in the early hours of that day, it is to completely ignore the evidence of Nurse Percival-Calderbank and the nursing note of Jennifer Jones-Key, which I've already dealt with, and this is why the point about Lucy Letby having destabilised [Baby N] before she went off the night before is so important.

So it comes to this, we suggest, that really one of the keys to the events of the 15th is whether or not [Dr A] saw blood in [Baby N]' airway before he tried to intubate him at 8 o'clock that morning. He says he did, we say he did, and if he did, it follows that somebody inevitably did something to [Baby N] to cause that bleeding. When you put it in the context of all the

throat injuries to all the other children who I have repeatedly listed for you and in relation to whom I will give you a list at the end, we suggest there's only one reasonable conclusion to draw here, and that is that the person who injured [Baby N] was undoubtedly Lucy Letby.

I'm going to move on to [Baby Q] now, my Lord. That's probably the best time for a break.

MR JUSTICE GOSS: Yes, certainly. We'll have our 10-minute break now then, please, and then the final session today.

(In the absence of the jury)

MR JOHNSON: My Lord, just so that you know what's coming, relatively speaking, [Baby Q] will be quite quick. After that, I just want to give the jury some lists, and obviously I'm not allowed to give them physically the lists so I'll have to run through them at a pace that they can absorb the material. So that may take us slightly beyond 4.30, but I hope not very long.

MR JUSTICE GOSS: Well, we'll reconvene in 9 minutes now.

Thank you very much.

(3.14 pm)

(A short break)

(3.24 pm)

MR JOHNSON: [Baby Q], born at 04.09 hours on 22 June 2016 and was doing just fine until he came into contact with Lucy Letby.

He collapsed on day 4 of his life, which was 25 June, under her care, was transferred the following day to Alder Hey in Liverpool, then returned to Chester, within a couple of days having made a remarkable recovery.

[Mother of Baby Q] is [Baby Q]'s mum. Her statement was read to you on Friday, 31 March. She had a difficult pregnancy. On day 2 of life, Chris Booth told us that [Baby Q] soon came off CPAP, but was not given enteral feeds due to bile-stained aspirates.

Chris Booth described [Baby Q]'s progress as "good" and the shift as "unremarkable".

Dr Gibbs reinforced this when he told us that even when he was on CPAP, [Baby Q] didn't need supplemental oxygen. And you will find, if you want it, an easy ready reckoner for when [Baby Q] was on CPAP on the gas chart behind divider 2 at J24326.

Overnight, the 23rd to 24 June, Tanya Downes told you that at 21.30 she got a 2ml bile and blood-flecked aspirate. She checked [Baby Q]'s stomach and stopped his feeds. Before she had come on at 18.00 hours, [Baby Q] had had a "full nappy, mec ++", so we know that his bowels were working and you understand the importance of that in his case.

The day shift of Friday, 24 June, the day [Baby P] died. [Nurse D] looked after [Baby Q]. He had a few suspected bradycardias, which in fact appear to have been false readings from a loose ECG lead, otherwise nothing unusual. On the night shift of the 24th to 25 June, Samantha O'Brien, who was a witness you saw for the very first time on Monday, 3 April this year, she was working the night shift on the 24th to the 25th, she was a band 5 and was [Baby Q]'s designated nurse. She told us [Baby Q]'s respiratory condition was stable, he was self-ventilating in air, had no increased work of breathing or respiratory distress. He was tolerating very small feeds, one half of 1ml every 2 hours. His aspirates were "possibly more than would expect", but having taken her through her notes and readings, she described [Baby Q] as stable and said there was nothing that would alarm her.

[Dr D] was a registrar on that night shift. She was asked about a blood gas at 06.58 on 25 June and said that the pH was within normal limits for a preterm baby, as were the other readings, and she summed it up this way:

"I'd be happy with that blood gas."

So taking stock, ladies and gentlemen, we are now at the point 2 hours before [Baby Q]'s collapse, although I should say the defence did not like the term "collapse" being used to describe what happened to [Baby Q].

[Baby Q] was in good shape. The day shift of Saturday, 25 June. Dr Gibbs said he was unusually early at 8 o'clock. He was in unusually early at 8 o'clock.

He started on the paediatric ward. When Lucy Letby came on duty, [Baby Q]'s abdomen was "soft and non-distended".

If we can go to tile 102, please.

Lucy Letby's note for what the position was at the beginning of the shift, it's almost exactly halfway down what you can see on the screen there, so it's before the 09.10 entry:

"Abdomen soft and non-distended."

If we go to tile 87, please. This is the population distribution. You see there that Lucy Letby and Mary Griffith were the only nurses in nursery 2 and there were only two children in nursery 2.

Lucy Letby also had the child BM in nursery 1 and Mary Griffith had other babies in both nurseries 3 and 4. If we go to the neonatal review, please, lines 45 and 46, we can see there at 08.30 Lucy Letby was taking readings for the observation chart and intensive care equipment chart for BM nursery 1.

At lines 50 and 51, Lucy Letby and Mary Griffith signed for MB, so the other way round, MB's medications at 08.32 to 08.34. MB was in nursery 3.

At some stage not long after that, Mary Griffith left the neonatal unit. We know that [Baby Q] collapsed just after Lucy Letby had been in physical contact with him. If we go to tiles 97 and 98, there we see the observations conducted at 09.00 hours. So in the third column in from the right, you will see there are gaps in the data, almost as if she was interrupted by something.

I said a moment ago that Mary Griffith left the neonatal unit because, if we look at tile 99 -- actually, could we just do 98 first? I'm sorry, it's my fault. Just on the question of gaps in the data at 9 o'clock, this. You see the 9 o'clock column there? No signature, more gaps.

Going to 99, please. Mary Griffith came back at 09.01. So on the question of whether Lucy Letby was interrupted, as I suggest, the arrival of Mary Griffith at that precise time is, we suggest, highly significant.

We suggest that while her friend Mary Griffith was out of nursery 2, Lucy Letby took the opportunity to inject [Baby Q] with clear liquid and air down the NGT.

Just after this, Mary Griffith was doing observations/cares/changing nappy and doing a tube feed for the child YM. She told us that she had her back to Lucy Letby, just as she'd had her back to [Baby M] when he collapsed on 9 April.

You'll remember that Jennifer Jones-Key was feeding a baby in the same nursery when [Baby N] had collapsed on the morning of 15 July when Lucy Letby came in early. There's three coincidences that the experts can't take into account.

Returning to [Baby Q], Lucy Letby had been in the room when Mary Griffith started to feed YM but she left, and as I said, the

data in those tiles at 97 and 98 show that when she left, she'd done half a job.

In interview, she said repeatedly that at the time of [Baby Q]'s collapse she was in nursery 1 and she was able to give the police the full name of the child BM from memory. You'll remember I asked her about this in evidence. She had not been given any notes relating to that child and she remembered the name. So if you're wondering how good her memory is, she remembered that name from years earlier but doesn't remember [Baby D].

She remembered BM because BM was her alibi. She remembers the things that suit her. If she remembers the name of BM, you might think she would remember the reason why she had to go to see BM, leaving the job with [Baby Q] half done, wouldn't you?

We've already seen she had sorted out BM at 8.30. You've got the charts if you want them for BM, they are the -- the J number is 31674 and the lines from the neonatal review I just gave you were 45 and 46.

On 11 November 2020 in interview -- and it's MC15 if you ever want to find it -- Lucy Letby said that she needed to see BM because BM needed cares. But you will remember her friend Minna Lappalainen, when she gave evidence, told us that cares are something that is done about every 4 hours, and the reason for that is so that the baby can rest.

Lucy Letby had already disturbed BM at 8.30, and so we say that her reason given to the police in interview that she was doing cares for BM is nothing more than a hopeless excuse.

You will remember in cross-examination that when I asked her about this, Lucy Letby accepted that BM did not need a nappy change or anything like that and she was at a loss to explain what she was actually doing with BM.

So why did she lie to the police? My favourite question. Why? The answer can only be because she doesn't want to admit why she left the room and the reason for that is because she sabotaged [Baby Q].

Mary Griffith told us that Lucy Letby asked her to watch [Baby Q] because Lucy Letby intended to go and see the other child in nursery 1, so she was actually lying to her friend as well. That wasn't the reason for going.

And as Nurse Griffith was doing the tube feed, [Baby Q]'s alarm sounded. Mary Griffith noticed that Minna Lappalainen was at the desk, called for help because she had to make YM safe with the

tube feed before she left. And she obviously wasn't texting her mates as she was doing it, was she?

Minna Lappalainen intervened, Mary Griffith confirmed that would normally -- that she'd normally complete cares, et cetera, before moving on to another child. And if that's right, it's another reason why Lucy Letby didn't leave [Baby Q] at that point to do something for another child.

When asked what had happened, Mary Griffith's words were:

"I sucked him out because he had vomited."

Using a machine, she said, while Minna Lappalainen did the Neopuff. Mary Griffith then said that she withdrew when the doctors and Lucy Letby arrived to help.

The first thing Minna Lappalainen knew of an issue was when Mary Griffith called for her. She went in to [Baby Q] and you'll remember I asked Minna Lappalainen whether Lucy Letby would have told her that she was leaving [Baby Q] and she said no. That wasn't challenged in cross-examination. But you may think if Lucy Letby was really considering omitting a feed for a child who was receiving minuscule amounts of milk every 2 hours on the basis of things that had been recorded on a previous shift, which was another alternative explanation, the first thing she would have done would have been to escalate it to the shift leader, so that's not a possibility either because she clearly hadn't fed [Baby Q], had she? Well, she'd not recorded feeding him his half a millilitre, she'd given him something else.

If there was a problem with [Baby Q], why would she leave it so long to speak to anybody about it? There wasn't a problem because there was no problem at handover, and when Lucy Letby made her note, which I've just shown you in the nursing notes, [Baby Q] is perfectly fine according to the nursing note.

You'll remember the nursing note that Lucy Letby made that relates to the collapse though. She noted the fact that Minna Lappalainen had found [Baby Q] and also that she, in other words Lucy Letby, had aspirated air ++ and that [Baby Q] was "mottled" -- this is at tile 102, please, Mr Murphy.

It's the 09.10 entry that we're talking about here, ladies and gentlemen. It reads:

"[Baby Q] attended to by Staff Nurse Lappalainen. He had vomited clear fluid [vomited, remember again] nasally and from mouth. Desaturation and bradycardia. Mottled ++. Neopuff and suction applied. Registrar [Dr A] attended. Air ++ aspirated from NG tube."

Here we see what we have seen before, don't we? Air ++ being aspirated from a desaturating baby, air that wasn't there just before the desaturation, remarkably.

And do you remember also that Nurse Lappalainen told us that so concentrated was she on getting [Baby Q]'s breathing restored that she didn't even see the aspiration of all the air or the mottling? So in an emergency, people don't always notice mottling, do they?

You might want to bear that in mind when you're considering the defence criticisms of doctors about varying descriptions of flitting rashes or failing to note them at the time.

[Dr A] was called in. It's tile 103:

"Called to NNU at 09.17."

He told you that he had been on the children's ward doing a ward round at the time. Do you remember what happened with one of the [Surname of Babies O, P & R] boys? [Dr A] wasn't on the unit, he was on the paediatric ward, and a crisis emerged thanks to Lucy Letby, which resulted in the arrival of [Dr A]. [Baby P].

The next thing, ladies and gentlemen, is the discharge letter that I'd like to deal with, please.

It's tile 310. This refers to a profuse vomit with desaturation. So this is the letter that [Dr A] wrote to the hospital to which [Baby Q] was sent.

[Dr A] said that it's very important to get the information in the transfer letter accurate and because he wasn't there when this happened, it must follow, mustn't it, that [Dr A] was given this information by the nursing staff? There had been a profuse vomit.

When he was shown [Baby Q]'s blood gas, [Dr A] confirmed that at 06.58 it had been good. He said that the gas at 09.56, which is in [Dr A]'s notes and on the gas chart under Lucy Letby's initials, showed a respiratory acidosis. So far as the gas results are concerned, the one immediately before the event is fine, the one straight after the event shows a problem, a breathing problem.

[Dr A]'s examination continued for quite some time. He arrived at 09.17 and he was there until after 10.10, which is the time a saline bolus was given.

[Baby Q] was put on to CPAP and treated for presumed infection. This was not some minor desaturation, ladies and gentlemen, it was something that diverted [Dr A] from the children's ward for an hour. We'll come to the reasons why I'm stressing this in a moment.

The bolus of saline improved [Baby Q]'s perfusion, but [Dr A] queried in the notes whether the poor gas at 9.56 might have been the result of [Baby Q] having inhaled some vomit. Do you remember that? Although that eventuality apparently was excluded by a later X-ray. He told us, did [Dr A], that NEC in [Baby Q] at this stage wasn't a realistic consideration.

Dr Gibbs thought that he had been told about the incident with [Baby Q] later that morning and he told us that [Baby Q]'s collapse was not in keeping with a little baby who was getting tired.

If we go to tile 240, please, you will remember that message sent by Lucy Letby that evening:

"Do I need to be worried about what Dr Gibbs was asking?"

Dr Gibbs said to you that he remembered he had a heightened concern, as he put it, about what was going on on the neonatal unit. Lucy Letby clearly had a heightened concern that people were working out what she was up to. Dr Gibbs thought that he'd spoken to Mary Griffith and/or Minna Lappalainen at about the time he reviewed [Baby Q] and had asked who was looking after [Baby Q] at the time he deteriorated and he did that, he said, bearing in mind that word would get round amongst the nurses that he'd been asking.

Lucy Letby's text messages prove that Dr Gibbs' instinct was absolutely right. We suggest he was also right when he said that [Baby Q]'s collapse was not in keeping with a little baby who was getting tired because [Baby Q] had been sabotaged by Lucy Letby. The coincidence of her disappearance from the room for no good reason supports the inference that, we suggest, you may confidently draw.

When you're considering whether or not this was a collapse, ask yourselves why, if it wasn't, as the defence suggested to witnesses, the defence suggestion was this wasn't a collapse, you'll remember that, why was Dr Gibbs so interested in what had happened at the time? We allege that Lucy Letby had tried to kill [Baby Q] and had tried to create the impression that his collapse had happened when she wasn't there.

Afterwards, there is a bit of important evidence in the couple of shifts later, so I'll just summarise those briefly. The night

shift that follows, Amy Davies looked after [Baby Q] and said he was stable overnight.

[Dr D] reviewed [Baby Q] at 00.30 on the 26th, said his blood gas was acceptable but he was very unsettled although there was nothing that made her suspicious he was having a seizure. She said there were some respiratory issues later in the shift, whilst [Baby Q] was on a ventilator, although it was thought that the issue might be secondary to the fact he was sleeping, and that was confirmed by Dr Gibbs.

So far as the events of the Sunday were concerned, on the 26th, Nurse Kate Bissell took over from Amy Davies. She added nothing and [Dr A] was on the day shift again. He examined [Baby Q] about 24 hours after the collapse and he noted that there was some bile in the orogastric tube and no audible bowel sounds and he could feel small loops of bowel at that stage.

You'll remember that there's an X-ray that shows dilated loops of bowel and that's why [Baby Q] was then transferred to Alder Hey in Liverpool at 18.20 that day.

And it's clear that as that day shift proceeded, there was an evolving issue which justified transfer. But we say that is all irrelevant to what had happened 24 hours earlier.

Alder Hey. Dr Benjamin Lakin told us about what happened at Alder Hey when [Baby Q] was assessed. It was thought he was stable. He was on a combination of antibiotics, which are standard for NEC, but by the following day, on the 27th, his abdomen had normalised, he was taken off the ventilator and he was then sent back to Chester. So yet another child who, when they escape from the orbit of Lucy Letby, seems to have a remarkable recovery.

When you're thinking about the question of collapse and whether the defence's pooh-poohing of this being a collapse is right, you will remember, I am sure, the evidence of Dr Katherine Davis, who gave us a summary of his current condition. He has a mild right-sided hemiplegia, weakness and a developmental delay. And Dr Davis' evidence was supplemented by Dr Stavros Stivaros, who said that the imaging of [Baby Q]'s brain, the unusual findings in [Baby Q]'s brain, can be explained by a hypoxic ischaemic event on 25 June. This was a serious event.

Professor Arthurs dealt with the radiology on Thursday, 20 April. He told us that a radiograph, which was marked as having been taken at 5.05 on the 26th, although you'll remember there was some doubt about the time of this particular image, shows abnormalities which could be interpreted as possible early signs of NEC.

There's another radiograph that was taken at 20.22, which he said showed things were settling. He said it wasn't possible to make a diagnosis of NEC from a radiograph unless things were really bad. And we know, one has to look at the clinical picture and that things rapidly got better for [Baby Q] when he got away from Lucy Letby.

Dr Evans gave evidence on the afternoon of 6 April and he was taken to task for three things. First, it was suggested to Dr Evans that his suggestion of someone having injected fluid down the NGT was "a late addition to his opinion" and that Dr Evans had:

"... added fluid to it now because in fact, having gone through this trial, as we have, and heard the evidence, you know that air ++ can be explained by the Neopuffing."

So this was the suggestion being put to Dr Evans.

Second, it was suggested that he "had taken the word 'profuse' to use as a reason that there was something abnormal" and, third, he was criticised for saying that [Baby Q] had crashed. And it was suggested to Dr Evans, on behalf of Lucy Letby, that:

"That is a gross exaggeration of what we're dealing with."

Well, this is a child that suffered a brain injury, ladies and gentlemen. We suggest that all those criticisms were unfair and misguided. Dr Evans had first raised the issue of a clear fluid in his report dated 21 October. He wasn't raising it for the first time in the witness box. You'll remember that once that allegation was put to him in cross-examination, so discombobulated was Dr Evans that he had to be taken back to his report that he'd written in 2021 to remember that he had actually put it all in a report 2 years ago or 18 months ago. So much for making it up on the hoof.

The word "profuse" comes from [Dr A]'s discharge letter. It's not an invention of Dr Evans. That's the evidence. And where did it come from to [Dr A] to put into the discharge letter? From the nurses. And who was the designated nurse? So Dr Evans was getting it in the neck for repeating something that was in the evidence.

Finally, so far as the description of [Baby Q]'s event, as I will call it, let's just remind ourselves of the text conversation between Lucy Letby and [Dr A] on Wednesday, 6 July. It's tile 163 in the post-indictment texts:

"[Baby Q]'s care is going to be reviewed on Thursday as well because of acute deterioration."

And Lucy Letby's response:

"That makes sense."

A child whose brain damage can be explained by a hypoxic ischaemic event on 25 June 2016 according to the professor of neuroradiology at the Royal Manchester Children's Hospital. A crash, acute deterioration, you take your pick, ladies and gentlemen. It's the same thing, we suggest. And to criticise Dr Evans' description is, we suggest, unfair when you look at what Lucy Letby and [Dr A] were saying and doing at the time of these events.

Dr Evans also said that if there was a significant quantity of clear fluid vomited and aspirated from [Baby Q], then that is not explicable by any naturally occurring illness or condition. [Baby Q] wasn't sickening for an infection. If this had been an intestinal issue, the vomit would have contained bile, it would not have been clear, and Dr Evans said he was also suspicious of the volume of air that Lucy Letby recorded as having been aspirated from [Baby Q], although he accepted the possibility that air can be introduced by a Neopuff.

But ladies and gentlemen, we invite you to look at this logically. If the air was introduced to [Baby Q] by the resuscitation and there was no clear fluid, it was all mucous, as was being suggested by the defence, what was it that caused [Baby Q] to collapse in the first place? He had no naturally occurring problem at that time sufficient to cause that extremity of collapse.

And that's why the defence don't like the use of the word "crash" because they say there's nothing to see here, don't they?

In considering the question of the clear fluid and its presence, you're also entitled, we say, to take account of the notes that were made at the time. Tile 101. This is Minna Lappalainen's writing:

"Baby found to be very mucousy, clear mucus from oropharynx removed. Clear fluid +++."

There is a distinction, isn't there, on the face of the note, between mucous and clear fluid?

"O2 via Neopuff given post-suctioning. NGT used to aspirate stomach by Nurse LL."

The Lucy Letby note at tile 102:

"[Baby Q] attended to by..."

We've already dealt with this but I'll remind you:

"... Nurse Lappalainen. He had vomited clear fluid nasally and from mouth. Mottled ++. Air ++ aspirated from NG tube."

Do you remember me saying to you about [Dr A], when he was being very helpful to Lucy Letby after the death of the [Surname of Babies O, P & R] boys, was -- when Lucy Letby was giving her gratitude to him for his support said, "You've been supportive ++ "? He got two pluses. That gives you an idea of what she means by two pluses.

Then we come back to the discharge letter at tile 310, "Profuse vomit with desaturation", material given to [Dr A] by the nurses.

Ladies and gentlemen, we suggest that you can be confident from all that contemporaneous material, material recorded at the time, that what came out of [Baby Q] at 09.10 on 25 June was not just mucus. You can be sure that someone had pumped him with clear fluid because giving him excess milk wasn't an option, was it, because he was only on one half of 1ml every 2 hours?

So if he produced a milky vomit, everybody would be suspicious, wouldn't they?

Dr Bohin told us that the bile on 23 June was due to food intolerance rather than NEC. She told us that the septic screen carried out on [Baby Q] at the time of his collapse was negative. She reminded us that, although at a later stage it was suspected that [Baby Q] had NEC, the incident at 9.10 hours on the 25th was the only time he vomited.

Dr Bohin told us that if there was clear fluid +++, there was no innocent explanation for that and she made it clear that it is "uncommon for babies to vomit, desaturate, become mottled and need resuscitation".

Dr Bohin made it clear that the observation chart showed that whatever happened at 9.10 was an acute event, she described it. She said:

"Something happened over minutes to cause that change."

And that's why the absence of Mary Griffith in the immediate time before the incident becomes so important.

She made the point, did Dr Bohin, that the observation chart timed at 9 o'clock by Lucy Letby in which nothing untoward was recorded alongside the events of 9.10 with the record either of lots of mucus or lots of mucus with clear fluid, whichever you prefer, simply doesn't make sense. And one of the most important things that Dr Bohin said about this case was that:

"If there was clear fluid +++, that cannot have been the milk that he had earlier."

So the idea that this was something which was related either to NEC or to food intolerance simply doesn't make sense. And she also said that if [Baby Q] had NEC, he got well too quickly, he recovered too quickly, a picture that you have seen now in a lot of these cases.

So that brings me almost to the end. I've deliberately not spent a great deal of time dealing with handover sheets. You know what it is we say about them and we suggest that Lucy Letby was not prepared to be truthful about them. In a sentence, the fact that she was not prepared to tell you the truthful reason must be because the truth doesn't help her. It's a simple point.

As for the notes, her handwritten notes, you heard detailed evidence from Lucy Letby on 2 May about why they were written. Again, our point is very, very simple: those notes contain admissions. You know Lucy Letby said that part of the reason they were written was because of her isolation from her friends, and we have categorically proved that was a lie.

She has offered no alternative. Again, the fact that she's not been prepared to be truthful about her reasons for writing the notes must be because the truth doesn't help her. A simple point.

As she left the neonatal unit, Lucy Letby put in a lying Datix form. I dealt with the one in the [Surname of Babies O, P & R] case, I have not dealt yet, other than in passing, with the JA one, and it's important. It's Lucy Letby, we say, getting her defence in first. She knew the net was closing. The texts to and from [Dr A] in the post-indictment sequence, I'm not going to go through those, but they clearly show, don't they, that she knew there was going to be an investigation, so she put in a form containing a lie, which tells you what was going through her head at the time.

If I can just show you this one, please. The purpose of putting this in, ladies and gentlemen, is to create the impression that air embolus could have arisen on the neonatal unit as a result of poor practice.

That's the point of this. It's no coincidence, it's a calculated attempt by a devious woman to deflect suspicion. You know it's false, not only because of the way Lucy Letby dealt with it in cross-examination but also because, if you look at the details, you can see that the alleged problem wasn't actually spotted until 15.00 hours, 3 pm.

You know the shift system. You know this is one of her patients. You know she would have been on duty from 8 o'clock that morning. The idea that if she was doing her job, or anything approaching her job, properly she wouldn't have spotted that there was a bung missing off an intravenous line between 8 o'clock and 15.00 hours is, we suggest, completely incredible.

Before these air emboluses started, she'd just done a course in which -- you saw the paperwork and she had written down about the dangers of air embolus. At the end of this process in which she was injecting children with air, here she is doing the same thing in a different form to give herself something to rely on.

It speaks for itself, doesn't it?

Now, just before I finish, I want to give you some lists, please. I'm not allowed -- you may wonder, well, why am I not giving you these lists. I can't give you material as part of my speech. Okay? If anybody wants to write them down.

The 10 children who collapsed but had good air entry into their lungs but their saturations were dropping: [Baby A], tile 185 in his sequence; [Baby C], tile 196 in his sequence; [Baby D], tile 257 in her sequence; [Baby G] in the first sequence for [Baby G] at tile 8; [Baby H], event 2, tile 440; [Baby I], event 3 in her third sequence, tile 115; [Baby I], event 4 in her fourth sequence, tile 153; [Baby M], tile 182; [Baby O] in two collapses, the first referred to by [Dr B] in the sequence at tile 218 and [Dr A] at 219, the second by [Dr B] at tile 238; [Baby P], tile 593.

Children who had bleeding or other unusual signs in their throats when the medical staff looked down their windpipes in preparation for intubation -- you might want to put "bleeding and throat": [Baby C], the evidence of Dr Davis and Dr Beech; [Baby E], if you accept the evidence of [Mother of Babies E & F], because there was no injury in his mouth, the blood must have come up from underneath; [Baby G], seen by Dr Ventress; [Baby H], seen by Shelley Tomlins; [Baby N], seen by [Dr A] and then Dr Mayberry's evidence about the epiglottis.

One thing that's not quite the same but under this general heading, what we say is the false note in the nursing notes for

[Baby K]. Do you remember? The doctor who intubated [Baby K] didn't see any blood, but it appears in the nursing notes under the name of Joanne Williams, but we suggest information fed in by Lucy Letby.

Children who demonstrated unusual discolouration: [Baby A], seen by Dr Harkness who said it was similar to [Baby E], by [Nurse A ], who said it was similar to [Baby B], and by Dr Jayaram, who said it was similar to [Baby M]; [Baby B], Dr Lambie, [Nurse A ], who said it was similar to [Baby A], same point as before, and Lucy Letby, who said it was a little bit similar to [Baby A]'s appearance the day before; [Baby D], seen by Caroline Oakley, Kathryn Percival-Calderbank and Dr Emily Thomas, Dr Matthew Brunton (sic) and Dr Elizabeth Newby; [Baby E], seen by Dr Harkness, who said it was similar to [Baby A]; [Baby I], seen by Ashleigh Hudson and Dr Gibbs; [Baby M], seen by Dr Jayaram, similar to [Baby A]; [Baby O], seen by Dr Brearey and [Father of Babies O, P & R]; and finally, [Baby H], seen by [Father of Baby H].

Children who suffered life-threatening collapses out of nowhere and then recovered very quickly: [Baby B]; [Baby D], collapse 1 at midnight; [Baby H], both collapses; [Baby I], event 1 on 30 September and event 2 on 13 October; [Baby I], the initial collapse at midnight on the 22nd into 23 October, the one where we say Lucy Letby altered the records on HS's infusion; [Baby M] at 16.00 hours on 9 April; [Baby N], first collapse on 3 June; [Baby O], 15.55 on 23 June; [Baby P], collapses 1 and 2 on 24 June.

Children who collapsed or had serious events within a few minutes of their designated nurse going on a break or leaving the room: [Baby C], see Sophie Ellis; [Baby D], see Caroline Oakley; [Baby G] 1, see [Nurse E]; [Baby I] 2, see Ashleigh Hudson, 13 October; also see her final decline on 23 October when Ashleigh Hudson was out of the room and came back to find Lucy Letby standing over her with her hands in the incubator; [Baby K]; [Baby N] number 1 on 3 June; [Baby P] collapse 3, the tea room collapse.

This is slightly different, it's when the doctors were out of the room because of course Lucy Letby was the designated nurse.

A slight variation on the theme, of course, is [Baby Q], which I have just explained to you, where Lucy Letby herself got out of the room.

Premature babies who were heard to be screaming or crying uncharacteristically at the time of collapse: [Baby D], Dr Brunton; [Baby E], [Mother of Babies E & F]; [Baby I], Ashleigh Hudson; [Baby N], Dr Loughnane.

Children who have worried other nurses but who Lucy Letby suggested were all right just before a final fatal collapse: [Baby I], see Ashleigh Hudson; [Baby O], see Melanie Taylor.

Children who collapsed shortly after being visited by their parents: [Baby B]; [Baby H] both times; [Baby I] 1 on 30 September; [Baby M] on 9 April; [Baby N] in the afternoon of 15 June; [Baby O] on 23 June; [Baby P] on 24 June.

Children who recovered quickly when taken to other hospitals -- this is all of them, by the way: [Baby H]. This is all the children who were taken to other hospitals: [Baby H], [Baby I] after her third collapse, [Baby N], [Baby Q].

You won't forget, of course, that [Baby K]'s tube never moved again once she left Chester, will you?

Cases where we say Lucy Letby participated inappropriately in post-death bereavement procedures: [Baby C], [Baby I], [Baby O].

Two children poisoned with insulin: [Baby L] and [Baby F].

If anyone tries to tell you that there's no similarity between these cases, ladies and gentlemen, you've got a list of some of the similarities now, haven't you?

We say -- I'm not going to deal with the false medical notes and give you a list of those because that's up to your determination as to whether the notes are false, so you will make the factual findings there, okay?

I thought about giving you that list but I thought that's really for you, not for me.

We say that if Lucy Letby had not sabotaged them, [Baby A], [Baby C], [Baby D], [Baby E], [Baby I], [Baby O] and [Baby P] would all have gone home. But Lucy Letby murdered them.

She tried to murder [Baby B], [Baby F], [Baby G], [Baby H], [Baby J], [Baby K], [Baby L], [Baby M], [Baby N] and [Baby Q].

That's our case and you will let us know if we're right. Thank you.

MR JUSTICE GOSS: Right. That obviously completes Mr Johnson's address to you. Tomorrow you can start your address.

MR MYERS: Yes. A bit late now, my Lord, yes.

MR JUSTICE GOSS: No, I'm not suggesting you would start this afternoon, no. It's time to finish now. But obviously, I anticipate, and you will of course anticipate, that Mr Myers will occupy more than one day, so it'll go into next week. So he will start tomorrow and then continue next week. All right? Thank you very much. 10.30 tomorrow morning.

Please remember your obligations as jurors: no communication by any means with anyone apart from when you're all together and able to hear what anyone else says about the case and no research about anyone or anything to do with this case. Thank you very much.

(In the absence of the jury)

MR JUSTICE GOSS: Visit to the defendant, Mr Myers?

MR MYERS: Yes, we would like to, please, my Lord.

MR JUSTICE GOSS: Thank you.

(4.26 pm)

(The court adjourned until 10.30 am on Friday, 23 June 2023)