Examination of Lucy Letby
by Ben Myers KC

First session begins 2nd May 2023

Part A

Includes:
- Lucy's background
- How the allegations, arrests and imprisonment affected her
- Her mental health
- The post-it notes

Q. Miss Letby, would you give the court your full name, please?
A. Yes, Lucy Letby.

Q. And what's your date of birth, Miss Letby?
A. The 4th of January, 1990.

Q. So you're now 33 years old?
A. Yes.

Q. In the period that we're looking at in the most detail in this case between June 2015 through to June 2016, you were 25, 26 years old.
A. That's right, yes.

Q. Which part of the country were you born in Miss Letby?
A. Herefordshire.

Q. I want you to tell us a little bit about that and becoming a nurse first. That's the first thing I'm going to ask you about. Are your family from Herefordshire?
A. Yes, they are. Yes.

Q. Whereabouts in Herefordshire did you grow up? Not the precise address, but the area.
A. Within Hereford city centre itself.

Q. And who did you grow up with in your house?
A. It's just myself and my mum and dad.

Q. And did you go to school locally?
A. Yes.

Q. Where did you go to college?
A. I went to the local sixth form college.

Q. When was it that you first knew you wanted to be a nurse?

A. I've always wanted to work with children, but it was towards the end of secondary school that I thought I wanted to do nursing and then picked A-level subjects that would best support that career.

Q.All right. Did you have to go to university to study nursing?
A. Yes.

Q. Is that something new for someone in your family?
A. Yes, I was the first person in the family to go to university, yes.

Q. Where did you do your nursing degree?
A. At the University of Chester

Q. And can you help us, how long is the course that you take to become a nurse?
A. It's a three-year degree programme.

Q. And do you spend all of it in the university, or are bits of it spent out in hospitals?
A. It's 50/50. Part of it is theory based at the university, and then you have numerous placements throughout that time in different clinical areas to give you experience of different areas of nursing.

Q. Did you ever get any familiarity with the Countess of Chester before you went to work there?
A. Yes, the majority of my placements, clinical placements, were at the Countess of Chester.

Q. And any particular units on the Countess of Chester?
A. Yes, either the children's ward or the neonatal unit.

Q. When did you qualify as a Band 5 nurse, Miss Letby?
A. September 2011.

Q. And does that coincide with the end of your degree, or was there some further training you had to do to become a Band 5?
A. No, that was the end of my degree training.

Q. Over the period of 2015 to 2016, you know we're looking at a number of babies in this indictment, and you understand that, don't you?
A. Yes.

Q. There's 17 of them.
A. Yes.

Q. But could you put a figure on the number of babies you cared for over that 12-month period?

A. Probably hundreds.

Q. Hundreds.
A. Yes.

Q. And did you care for them?
A. Yes.

Q. Did you ever do anything that was meant to hurt any of them?
A. No, I only ever did my best to care for them.

Q. Did you ever want to hurt any baby you looked after?
A. No, that's completely against everything that being a nurse is. I'm there to help and to care, not to harm.

Q. All right. I want to ask you next about the period, in fact, after you were removed from clinical duties. So we're looking at the period in July 2016 when you were moved away from clinical duties. Why did you think you were being put in a non-clinical role that July?
A. That there'd been an increased mortality rate on the unit and as a result numerous members of staff were having to go through a competency check and redo their competencies, and that would be starting with myself.

Q. And how did you come to believe that is what was happening?
A. That's what I was told.

Q. And who were you told that by?
A. By management within the hospital and the executive team.

Q. That you were going to be undergoing training or testing in your competencies?
A. Yes.

Q. Is it something you had volunteered to do?
A. No.

Q. Is it something you were keen to do?
A. No.

Q. How did you feel when you were removed from clinical duties and were told that your competencies were going to be checked like this?
A. I was devastated.

Q. Why were you devastated?
A. Because I've always prided myself on being very competent and the fact that potentially I hadn't been competent in something, really, really affected me, and to be taken away from the job that I loved, it was very difficult.

Q. When you say it really affected you, could you convey to the ladies and gentlemen of the jury the extent of that, when you say it really affected you?
A. It was just, it was life-changing in that moment. I was taken away from the support system that I had on the unit. I was then put into a non-clinical role that I didn't enjoy. I had to pretend to a lot of people that it was a voluntary process, which it wasn't. And from a self-confidence point of view, it completely, well, it made me question everything about myself.

Q. Right. When was it, so far as you can recall, you first discovered that you were being held responsible for harm to babies on the unit, or their deaths?
A. Not until the September of 2016.

Q. What event was it in September 2016 that led you to discovering that you were being held responsible for deaths of babies?
A. I received a letter from the Royal College of Nursing in which they had been informed that actually the true reason for my redeployment was because I was being held responsible.

Q. We're thinking about— do you remember roughly what date that would have been that you received that letter? Not the precise day, but maybe which month?
A. It was September.

Q. September 2016?
A. Yes.

Q. And what was going on that meant you received that letter at about that time? What was taking place, or about to start?
A. So I was looking at putting in a grievance procedure.

Q. About what?
A. About how I'd been redeployed from the unit and the information that I'd been given in relation to that.

Q. Did you have any idea how many babies you were being held responsible for harming, or for their deaths?
A. No.

Q. How did it make you feel when you received the news that you were being held responsible?
A. Well, it was sickening. It was-- I couldn't believe it.

Q. I want you to describe how best you can-- it, it may not be easy, but describe as best you can what it felt like to have that being said about you, Miss Letby, if you can.

A. I mean, it was devastating. I don't think there's, I don't think you can be accused of anything worse than that. And yeah, I was just devastated.

Q. Well, you tell us how it affected you. That might be another way of looking at this. What was the effect of this on you? What happened?
A. I just changed as a person. My mental health deteriorated and I felt very isolated from my friends and family on the unit. And--

Q. Just pausing there, when you say isolated, of course you'd been removed from the neonatal unit. Had you had friends on the neonatal unit?
A. Yes, a lot of friends. We were a very supportive unit as well. Regardless of whether we were personal friends we were a very supportive nursing team.

Q. When you moved on to-- sorry, sorry to interrupt you.
A. It's OK.

Q. When you moved to a non-clinical role and you were being told that you'd undergo the competency testing, were you able to explain that to other people on the unit?
A. No. So at that time the hospital advised me not to communicate with anybody on the unit, and to sort of go with the pretence that it was a voluntary secondment. And it was identified at that time that there were two or three friends that I would be able to speak to, but otherwise I was not to have contact with anyone on the unit.

Q. You say it was identified there were two or three friends you could speak to. Who were they?
A. It was Nurse E, Doctor A and Mina Lapalainen.

Q. Nurse E
A. Yes.

Q. Doctor A
A. Yes.

Q. And Mina Lapalainen.
A. Yes.

Q. You said that you'd felt isolated. You had been describing how it felt when you learned you were being blamed for a death, or deaths. You made a reference to your mental health. Did you go to and seek any assistance with how it affected you, mentally speaking?
A. I did, yes. I went to my GP. I wasn't sleeping, I wasn't eating. I just had a complete change in my whole life, and I was

starting on some antidepressants at that point which I remain on now.

Q. So did the GP put you on antidepressants?
A. Yes.

Q. If it doesn't seem too obvious a question: What's that for? What were you given them for? What state were you in?
A. They diagnosed me with depression and anxiety at that time.

Q. And you say you've remained on that medication?
A. Yes.

Q. And are you receiving that now?
A. Yes.

Q. Do you take any other medication at the moment?
A. I also take medication to help with sleep, yes. I am unable to sleep without medication.

Q. How bad did the negative feelings get so far as you're concerned, about yourself? How bad?
A. There were times when I didn't want to live.

Q. And what did you want to do? What did it make you think of doing?
A. To myself?

Q. Yes.
A. I thought of taking my own life.

Q. Had you done anything wrong?
A. No.

Q. Why did you think of taking your own life? Somebody might ask.
A. Because of what was being inferred,

Q. How hard had you worked to become a nurse?
A. Very hard.

Q. How much did it matter to you?
A. My job was my life. It was, it was everything.

Q. How did it feel to have that taken away and be held responsible for the deaths of babies you'd cared for?
A. I can't put that into words. It's just, my whole world just stopped.

Q. Have you ever been able to recover your kind of mental ease after all this started?

A. No, I think it's just progressively got worse.

Q. How hard is it to cope with what you're being accused of?
A. It's very difficult.

Q. If you think back to the young woman you were when you were 25 or 26 before you were taken off the unit, before you were being blamed for what happened, are you the same person in yourself now as you were then?
A. No, I think it's completely changed everything. A lot about me and my life, about the hopes that I had for the future. Everything is just gone.

Q. Where have you been living since November 2020? What type of place?
A. So I've been remanded in prison since that time.

Q. That's since your third arrest in November 2020?
A. Yes, I've been in four different prisons since then.

Q. I'm not going to ask you the locations of any prison, Miss Letby, I don't invite you to do that, but before that first arrest in July 2018 had you ever been in trouble with the police before for anything?
A. No.

Q. I'm going to ask you a little bit about the experience of arrest and prison. When I do that I make it absolutely clear that we are grateful to the officers at court, and those who bring you to and from court, and the cell staff, for the care you have received. And that's the same for you, isn't it Miss Letby?
A. It is, yes.

Q. So we're just looking at the effect of events on you. There is nothing at all critical about the people caring for you.
A. No.

Q. And we are grateful for that. You were arrested for the first time on July the 3rd, 2018?
A. Yes.

Q. Had you ever experienced anything like that before?
A. No.

Q. Are you able to just describe in simple terms the impact of your arrest and that process on you? Let me start with this: How did you know the police were coming that day? What's the first you knew?
A. When there was a loud knocking at the door at 6 o'clock in the morning by the police.

Q. You were at home in 41 Westbourne Road, Chester. Is that right?
A. I was, yes.

Q. Were you on your own there, as it happens?
A. No, my father was staying with me at that point so he was there as well.

Q. Had you any idea the police were coming that day?
A. No, none at all.

Q. So when they came, what happened with you?
A. They told me that I was being arrested for multiple counts of murder and attempted murder. And then they quickly handcuffed me and took me away.

Q. All right. And you were taken to a police station. Is that right?
A. In my pyjamas, yes.

Q. And over the next three days you were interviewed at various times.
A. Yes.

Q. And we've asked DS Stonier about that. Again, the way that was done is just the way the police deal with it and that's not critical of them for the process they followed. When that process had ended after the three days of interviews, were you released from police custody?
A. Yes, I was, yes.

Q. On bail?
A. Yes.

Q. And did you have to live anywhere in particular after that?
A. Yes. As a part of my bail conditions I wasn't allowed to return to my house in Chester. So from that point on- uh, I then lived with my parents back in Hereford.

Q. Is that where you were living when we come to the time of your second arrest on 10th of June 2019?
A. It is, yes.

Q. And on that occasion did you know the police were coming that day?
A. No, it was a mirror image of the time before. It was just loud banging and knocking at the door, and we opened it to find the police there.

Q. It may be difficult taking your mind back to these things, Miss Letby, but so that the jury understand: What was the impact on you, the banging and being arrested again? If you're able to say.
A. It was just the most, the scariest thing I've ever been through. It not only happened once, it happened twice and then a third time. And it's just, it's just traumatised me. I just..

Q. The third time was on 10th of November 2020?
A. Yes.

Q. And that's the time after which you weren't actually released, you were kept in prison.
A. Yes.

Q. And you've been in prison since then?
A. I have, yes.

Q. When you say it traumatised you, we've heard that you're on medication, so we can understand: Has it left you sensitive to particular things? So the jury understands, certain things that affect you, in certain ways?
A. Yes, the biggest way it's affected me is just, I'm very sensitive to any noise, any unexpected change or new people. I'm easily startled, easily frightened of things.

Q. Were you like that before the arrests began?
A. No, not at all.

Q. And have you received psychological support in prison and the court, as we've been going forwards?
A. I have, yes. I've been diagnosed with PTSD in direct relation to the arrests, yes.

Q. Right. And so far as being at court is concerned, again we're grateful to all those who care for you and bring you to and from court. But without going into the business of locations, how long is the trip to court each morning for you?
A. It's usually around an hour and a half each way.

Q. And the same time in the evening?
A. It is, yes.

Q. What time do you normally get up before you come to court?
A. About half past five.

Q. Where do you have your breakfast?
A. I have my breakfast when I arrive here at court. We leave about 6.30 in the morning and I eat when I arrive here. I also get quite bad travel sickness so I wait and eat my breakfast when I've arrived here.

Q. What time do you get back to the prison in the evenings, as a general rule?
A. Usually around 7:00 PM.

Q. We've all seen various notes that were taken by the police that you had written. You know the notes I'm referring to, don't you?
A. Yes.

Q. We're going to look at a number of them as we're going through your evidence, Miss Letby, not all in one go but at various points. But just to help the jury with this in general: Are you the sort of person who writes things down in notes-- on notes?
A. Yes, it's something I've done my whole life. That is my way of dealing with things just day-to-day. That is what I've always done. I've always written things down.

Q. And do you throw them away? Do you always throw them away when you've written things down?
A. No, I never throw anything away. I have difficulties throwing things away. Everything is just kept.

Q. Right. Let's look at the note which we've got in the images the prosecution gave us. It's the prosecution images, page 18. We'll see if Mr Murphy can help us with that. We'll look at a close-up in a moment, but I'm going to ask you some questions about the note that's on the right hand side of this page, Miss Letby. What are notes like this in your house? Or is it just how they've been arranged for the purposes of photographing it?
A. No, that's how it's been arranged.

Q. So the police have set it out so we can see it for the photograph.
A. Yes.

Q. Do you know when it was? Can we go to page 19, in fact, Mr Murphy, so we can see the note more clearly, thank you. We'll have a look at this in a moment, Miss Letby. But do you recall when it was you would have written this? What period of time?
A. After my removal from the unit in 2016 and prior to my arrest, this time,

Q. Do you know any precise date when you wrote it?
A. No.

Q. We're going to have a look at what's written here. Look at the top if you would, it says "Not good enough", yes? Why have you written "Not good enough" and underlined it?

A. I think that's the overwhelming thought and feelings that I had about myself at that point, that I wasn't good enough.

Q. And why did you think you weren't good enough?
A. Because of the way people had made me feel.

Q. Had you actually done anything wrong to hurt any babies?
A. No.

Q. How were you feeling because of the things that people were saying about you?
A. I felt an immense responsibility. I thought that I'd been incompetent or done something wrong that'd harmed children.

Q. When we're looking at the notes, do you-- is it the case you've always written everything we see on them on one occasion, or are they sometimes-- are they sometimes written at different times, bits of the notes.
A. It can be both.

Q. Right. We're going to track across this. It says on the left "There are no words". That seems to carry on the left hand side. "I can't breathe", "I can't focus". Perhaps you could read it, Miss Letby.

Nick Johnson KC: The objection isn't to my learned friend reading the words, it's to him interpreting that one bit that follows the other. I'd rather the witness said which bit was written by--

Q. That's fine. "There are no words". What would come after "There are no words" when you look at that, Miss Letby?
A. The text to the left hand side: "I can't breathe", "I can't focus".

Q. Right.
A. "Overwhelming fear and panic".

Q. And what's that describing when it says "There are no words", "I can't breathe", "I can't focus", "Overwhelming fear and panic"?
A. That's how I felt about my life at that moment in time.

Q. Under that it says "I haven't done anything wrong". Why does it say "I haven't done anything wrong" ?
A. Because I haven't done anything wrong.

Q. Who are you writing this note for, or to?
A. It wasn't to anyone. It was just me processing my thoughts. It was never meant to be read by anyone.

Q. Can you just help us with why it says "Police investigation" on the left hand side, under that?
A. Because I knew that ultimately the worst case scenario would be that the police would be involved, and that was something that had been threatened by the hospital.

Q. Why under that does it say, if you can help us, "Slander", "Discrimination"?
A. That's how I felt about the Trust and the hospital. That's how I felt they were towards me, that it was slander and discrimination.

Q. And what was slander and discrimination?
A. The allegations.

Q. Under that it says "All getting too much". What follows on from "All getting too much"? When we look at the note, if anything follows on.
A. Um, "Everything's taken over my life". Um, I think it's "Everyone", and "I feel very alone and scared".

Q. All right. Is that how you were feeling?
A. Yes.

Q. I want to look across to the right hand side if we could for the time being, reading down the right, "I'm an awful person. I pay every day for that right now". You tell me if I read anything incorrectly, by the way.
A. Yes.

Q. Why are you saying "I'm an awful person. I pay every day for that right now"?
A. Because at that time I did feel that I must be an awful person to have made any mistakes that had harmed anyone, and that I was paying the price for that by what had happened to me.

Q. And what had happened to you at this point, as best you can remember?
A. That I'd been taken away from the job that I loved and accused of things that I just hadn't done.

Q. Underneath, it says "I'll never have children or marry" . Can you read the next bit? "I'll never"..
A. "Never know what it's like to have a family".

Q. Right. Why were you saying that?
A. Because at that time I couldn't see any future for myself. I couldn't imagine what my life was going to be, or that I'd ever have a future.

Q. This is all your handwriting, do you agree?

A. It is, yes.

Q. Why have you written "No hope" at an angle towards the side of the note, on the right hand side?
A. Because there were times when I didn't have any hope. My whole situation felt hopeless at times.

Q. And at that same kind of angle, a bit below that it says "Despair". Can you see that?
A. Yes.

Q. What is that describing?
A. Again, one of the emotions that I was feeling at that time.

Q. Just to the left of "Despair", it says-- what does it say, "I hate myself so much for what this has". And then it's hard to read, we can perhaps scroll down a bit there. Let's see if that follows through with anything. Thank you Mr Murphy. Does it follow with anything, or does it just run out at "what this has"?
A. I believe it just runs out there, I think.

Q. It says "I hate myself so much for what this has". And then we can see a circle heavily in ink and the word "Hate" in it.
A. Yes.

Q. Why did you say "Hate myself so much for what this has"? Why did you say that in the note?
A. Because at that time I did hate myself.

Q. You said in the note, "I haven't done anything wrong". So people might think, well, how do you hate yourself if you haven't done anything wrong?
A. Because I was made to feel that I had done something wrong. So potentially, I thought I had been incompetent in some way.

Q. What kind of mental state were you in at the time you were writing this note?
A. Not good at all.

Q. Had you been to see the doctor by this time, or do you not know?
A. I couldn't say, but throughout that period my mental health was poor.

Q. How well were you coping with the situation you were in?
A. I did my best but it was difficult in the circumstances, with the isolation that I felt. And yeah, it was difficult.

Q. We know you were arrested in July 2018. How long a period was this kind of thing going on for, and these sort of thoughts going on for?
A. Two years.

Q. Carry on looking across to the left hand side again now, following from where it says, can you see, "How can I get through it" Do you see that Miss Letby?
A. Yes.

Q. "How can I get through it". What's directly under that please? Could you read the next--
A. "How will things ever be like they were".

Q. Then if we carry on, on the left hand side it says "I don't deserve to live". Is that what it says?
A. Yes.

Q. Then does it say "I killed them on purpose because I'm not good enough"?
A. Yes.

Q. Was there anything that follows on from that, "because I'm not good enough"? Does it stop or does it carry on?
A. "I'm not good enough to care for them and I'm a horrible, evil person"

Q. Right. When you say "killed them on purpose", does that mean you've gone and done something intentionally to harm them and kill them?
A. No.

Q. What are you meaning when you say "I killed them on purpose because I'm not good enough to care for them"?
A. That I hadn't been good enough, and I'd in some way failed in my duties and my competencies

Q. Why did you think you hadn't, or you might not have been good enough?
A. Because that was the suggestion throughout, that I had to redo my competencies, that I'd been removed from the unit. I felt that I'd done something wrong. That was what was insinuated to me, that my competencies had to be re-checked.

Q. It says: "I don't deserve Mum and Dad"?
A. Yes.

Q. And then, "World is better off", is that "without me"?
A. Yes.

Q. What's the bit that follows that, "without me"?

A. That says-- it mentions my cousins.

Q. Is that one sentence or is that different things?
A. No, I've written there "I don't deserve Mum and Dad and my cousins", and I think "World is better off without me" is separate to that.

Q. So you say you don't deserve your Mum or your Dad or your cousins, and you have also said the world is better off without you?
A. Yes.

Q. And it says at the bottom, "I am evil I did this". Why did you say that?
A. Because I felt at the time that if I'd done something wrong and I didn't know that I had done that, I must be such an awful, evil person if I'd made mistakes and not known.

Q. But we've seen at the top of the note, the actual heading of it underlined is "Not good enough". So what did you believe had happened, or you'd done or might have done?
A. That somehow I'd been incompetent, and that I'd done something wrong which had led to affecting those babies.

Q. Just looking on the right hand side, at an angle, it says: "Panic", "Fear", Lost". Do you see that?
A. Yes.

Q. What's that describing?
A. That was how I was feeling

Q. Under "Hate", it says "I did this". Can you see "I did this"?
A. Yes.

Q. What do you mean when the note says, "I did this"?
A. That I felt I must be responsible in some way.

Q. You've also written "Why me". If you're able to, can you help us with why it says "Why me", if you can?
A. Because I didn't understand why it was happening to me. I thought I'd always been competent, I'd always done my best. I couldn't understand why it was happening to me.

Q. Looking back on this now, as much as you can, how were you coping with the situation you were in at the time you wrote this note?
A. I think looking back on it now, I was really struggling. This is a way of me expressing everything that I felt at that time, that I wasn't able to say to anyone else.

Part B

Includes:
- Lucy's training & qualifications
- Her nursing experience
- NNU procedures and clinical notes

This covers Lucy's training, qualifications and nursing experience as well as NNU procedures in relation to the recording of clinical notes.

Q. You told us earlier that writing things down is a way that you deal with them. Is that right?
A. Yes.

Q. Writing them down in words on bits of paper like this, is that something that you've done in the past?
A. Yes, it's what I do regularly. It just can be on any piece of paper just randomly, yes.

Q. Well, as I've said, there's other notes and papers and we'll return to them as we go along so we can have a look at what you've said, and you help us with bits of them as best you can.

Just to assist you and also to assist the court and the ladies and gentlemen of the jury, just so we know how we're going to deal with your evidence, if we can, with your assistance we're going to go through all the kind of general background and pieces of information to do with things the police found, or how the unit worked, general type of material.

That might take a little while. Then when we've done that, we'll turn to looking at the babies on the indictment to which the allegations relate. All right?
A. Yes.

Q. How does it feel inside yourself when, for instance, I ask you questions about the arrest process and you're talking about the banging on the door and things?
A. It's uncomfortable for me.

Q. Looking at the notes and things, how does that feel?
A. The same. I'm a very private person and those weren't ever meant to be read.

Q. I'm going to ask you next a little bit more about the Countess of Chester neonatal unit and some aspects of the work that goes on there. All right?
A. Yes.

Q. Can you remember when it was that you first experienced working at the Countess of Chester Neonatal unit?
A. Yes, I had a placement there during my nurse training, I think it was in 2010. That was the first time I'd ever been on a neonatal unit.

Q. Do you remember when it was that you started there full time as a qualified nurse?
A. Yes, January 2012.

Q. And you'd have been a band 5 nurse at that point?
A. That's right, yes.

Q. And when you started in January 2012, what levels of babies would you be qualified to care for?
A. So at that time when you first qualify, you're only able to look after special care and high dependency babies.

Q. We're familiar with the unit and the nurseries, which are the nurseries, the special care and the high dependency babies would be in?
A. Predominantly nurseries 3 and 4.

Q. Right. During the time that you worked on the neonatal unit, was there a system where you continued training and attended courses?
A. Yes, you continued training throughout your career, really.

Q. How much did you value being a nurse?
A. Oh massively. It was everything.

Q. And caring for babies?
A. Yes, and I always strive to go on every course possible to try to be the best that I could.

Q. Did you ever play a part in training or helping to guide other people who wanted to be nurses?
A. Yes, I did, yes. Part of my role would be to support further junior band fives coming into the unit, and I was also a mentor for student nurses at the university as well.

Q. Just so we understand a little bit more, what does being a mentor for student nurses involve?
A. You undergo a mentorship qualification, so I went to the university and completed a mentorship module, which means that when student nurses come to the unit, you are then their sole mentor. They work with you, you're responsible for their paperwork and their competency assessments.

Q. Did you become a mentor?
A. I did, yes.

Q. When did you qualify as a mentor?
A. I think it was fairly early on in my career, perhaps 2012 it would have been.

Q. Just remember the dates as best you can, no one is expecting every detail to come to mind. Fairly early on is when you recall. How did you feel about working with students when they came on?
A. I really enjoyed that aspect.

Q. Do you know how many you acted for as a mentor?
A. Across the whole time frame?

Q. Yes, over the years you worked there.
A. Probably 5 or 6.

Q. We saw when we were dealing with the cases of child O and P, there was a student nurse called Rebecca Morgan who was with you.
A. Yes.

Q. Was that part of the mentorship scheme?
A. Yes.

Q. What sort of things would she be doing whilst she's with you?
A. So she would be undergoing a lot of the care for the baby under my supervision and with my guidance.

Q. And where is she when she's doing that in relation to you, Miss Letby? Where would she be?
A. It would depend on the sort of stage of their training that the student was at, but usually they're directly with me. They would be under direct supervision.

Q. That's training of other people and being a mentor with them. I asked you about training that you could undertake. I'm going to ask you about something we've heard of now and we're familiar with and that's QIS qualification specialty.
A. Yes.

Q. What does that mean once you get your QIS?
A. That means then, that you are qualified to look after the intensive care babies.

Q. Right. Does that mean it covers all levels of care for babies?
A. At that point you can then care for any level of care that's needed, yes.

Q. And you got your QIS, did you?

A. Yes.

Q. Which meant that you could look after intensive care babies.
A. Yes.

Q. What did you have to do to become QIS authorised or qualified, whatever the terminology is?
A. It's a university module that involves lectures, various assessments, both written assignments and practical assignments. And then I did a placement at Liverpool Women's Hospital, which is the Level 3 unit and that's where you get the hands on clinical experience and intensive care.

Q. When did you start the training for this QIS?
A. I think it was towards the end of 2014.

Q. Right. How much time does it take to do the training and then be Qualified In Specialty?
A. Around, I think it's around six months.

Q. Do you recall when it was that you would have been qualified to then start looking after intensive care babies?
A. I think it was around the March, April time of 2015.

Q. And the period we're looking at in this case is from June 2015 approximately, around that period?
A. Yes.

Q. So you were QIS by March, April 2015?
A. Yes.

Q. And that meant that you could care for the sickest babies on the unit, is that correct?
A. Yes.

Q. Or those requiring the most intensive care?
A. Yes.

Q. Had all the nurses on the neonatal unit got their QIS?
A. No.

Q. Do you recall who did have it at your level in terms of band fives?
A. At that time there was myself and one other Band 5 nurse that had the QIS training.

Q. Who was that one other Band 5 nurse?
A. Bernie Butterworth.

Q. Whilst we go forwards in the period we're looking at, did any other band 5 nurse get QIS whilst you were still on the unit?

A. Shelley Tomlins.

Q. And the band 6 nurses, they will be QIS?
A. They are, yes.

Q. So at the time we're looking at we've got the band sixes who are QIS. Who are the shift leaders, what band of nurse?
A. That's always a band 6.

Q. Of the band fives you and Bernadette Butterworth were QIS?
A. Yes

Q. And Shelley Tomlins became QIS?
A. Yes.

Q. QIS, if you are QIS, what does that mean about the type of work you're given on the unit?
A. Predominantly you're allocated to the high dependency or intensive care babies. Because of the skill mix on the unit it tends to be that you have two band sixes, a high grade band 5 and a lower band 5 who doesn't have the intensive care course.

Q. If we pause there for a moment, you said quote "because of the skill mix". What are you talking about, the skill mix? You say you have two band 6?
A. Usually, generally on a shift you would have two band sixes, one of which would be supernumerary and in charge. Then you'd usually have a QIS band 5 like myself and then a non-QIS trained band 5 member of staff, with nursery nurses.

Q. Over this June 2015 to June 2016, how much of your work, if you can just describe this, would have been intensive care work? Intensive care babies or maybe..?
A. That's predominantly what I did for that period of time.

Q. And why would you predominantly-- all your time predominantly be allocated to that? Why would you be selected for that?
A. So partly it would be that that's how the skill mix on the unit would work. We did have a lot of intensive care babies at that time.

Q. Right. Let's just go through this. A lot of intensive care babies?
A. Yes.

Q. So there's a need for intensive care trained nurses?
A. Yes.

Q. Right. What about the fact that you just qualified in specialty? What did that mean about you?

A. So when you complete training, the unit is quite proactive in putting that training to use. You are the most up-to-date member of staff at that point. Obviously you've brought clinical skills back from a tertiary centre, so predominantly you do tend to look after those babies to develop your skills and to bring those skills to the unit as well for other people to learn from.

Q. When you talk about the skill mix and who's doing what, did you always have enough QIS band fives to cover everything that needed to be covered in terms of the babies?
A. No. Not to meet the correct guidelines, no.

Q. Which guidelines are those?
A. The BAPM guidelines.

Q. How flexible were you able to be with requests to work when called upon?
A. I was very flexible. At that time I was living in hospital accommodation on the site. I didn't have a family or any commitments myself, so I was very amenable and flexible to changing shifts last minute or doing overtime and extras as needed.

Q. We'll have a look at where you were living in due course, but even when you had a house of your own, did you cease being as flexible as that, or did you remain flexible?
A. No, it was the same.

Q. How much did you enjoy the intensive care work?
A. I did enjoy it. That was my-- that was kind of my passion for that area. I enjoyed all aspects, but I did enjoy the intensive care side.

Q. Did you make it clear to the nurses who were allocating nurses to babies that that was where your interest or enjoyment lay?
A. Yes, and I think all nurses on the unit have an area in some way that they prefer or excel at than other areas. So yeah, the staff knew that I enjoyed that area and that that was where I was most happy.

Q. Did you ever say that other areas of work were boring?
A. No, because no aspect of my work was ever boring.

Q. We heard evidence from a nurse called Kathryn Percival-Calderbank, who said that on one occasion at least, there had been a debate with you or an argument as to where you should be working, and you made it plain you wanted to work in intensive care, although you did go where she asked you to go, as it happens. Did you get involved in an argument with Kathryn Percival-Calderbank, as far as you can remember about that?

A. I have no recollection of that, no.

Q. Do you recall getting in arguments with anyone about where it was you should be working?
A. No.

Q. Did you make your feelings clear about where you preferred to work?
A. Yes. As I say, I think everybody on the unit would know who preferred working in different areas. So yeah, staff knew that I'd recently done my QIS training and therefore enjoyed being in Nursery 1 to develop those skills, yes.

Q. I'm going to ask you next a little bit about the paperwork and some of the tasks you deal with on the unit. For the nursing staff, what's the principal-- or what was the principal system for recording an account of what had taken place when looking after a baby at the time we're looking at?
A. So it would be the electronic nursing notes.

Q. Right. Is there a name for that system?
A. It's called the Meditech system.

Q. Is that the system which generates the notes that we've looked at where you see a date and a time?
A. It is, yes.

Q. And usually initials.
A. Yes.

Q. All right. So to go onto that system, where are the terminals in the nursery or where do you go to get onto that system?
A. There's a computer based in nursery 1 and then the rest of the computers are outside, around the area of the nurses station. There's several computers around that area.

Q. Can a nurse who wants to put an entry on the system use any one of those terminals?
A. Yes they can.

Q. So if you're going to use a terminal to put a note, what do you do? You walk up to it and then what?
A. So every member of staff has specific login details. That enables you to log onto the system and that then produces, as we've seen, the initials for any medication or any note that you might put onto that system.

Q. And are you able to make notes as events happen as they go along or is that not always possible?
A. No, so usually the notes are sort of the last thing that we would do after the patient care. So they're usually written

retrospectively and cover a large period of the shift in one note.

Q. If they are written retrospectively, we've seen a lot of them with varying amounts of detail, but sometimes quite a lot of detail. How do you or other nurses, how do you keep in mind the detail that's going to go on that note?
A. Part of it would come from the paper documentation that's filled in throughout the shift, and it would also be notes that I would make myself on the back of my handover sheet of things that have happened throughout the day that I knew I needed to document.

Q. When you go onto a shift, for instance, start working on a shift, would you pay any attention to notes that other nurses have written for that baby as an earlier shift, or other shifts?
A. Yes.

Q. What would you do with regards to that, if you're able to?
A. At some point, it would always be advisable that you would go through the previous notes, certainly for the preceding couple of days anyway. Paper notes and nursing notes.

Q. Going to go to the various notes or charts as we're looking at this section of your evidence, just by way of example. We'll go to the particular children when we go through the allegations. But just to illustrate something, I'd be grateful if we could put up tile 40 from the Child I sequence 3. If we go behind that, I just want to identify something here and actually look at the note itself. Thank you.

It's a matter for you, ladies and gentlemen, whether you track what we're doing on the iPads, but you'll see with this bit we will be moving around a number of them by way of illustration. It may be when we come to the allegations it's easier to follow through on the particular sequence of events, but it'll come on the screens anyway. If we just look at the lower entry where it begins Addendum 14, about the centre of the page on the righthand side. Thank you. So we can see the way this is set out, I'm not going to read all of it. This has got the 14th of October at 08:43 and this relates to Child I for that day.
A. Yes.

Q. It says quote "written in retrospect". So for example, where would the information have come from at 08:43 to write this in retrospect?
A. That would have come from any medical notes that had been written and then the paper charts that had been completed throughout the day, such as like the Obs charts, fluids charts, and then any notes that I may have made myself on paper.

Q. As far as you know, is the making of notes on paper so you can add things retrospectively unique to you, or is it something other nurses do as well?
A. No, it's something we all do.

Q. So this is the note 08:43. And then if we go to tile 41, please, and just pop it into this one and go into the actual note. Scroll down, thank you. Just on the left hand side, if we enlarge that, we've got the 13th of October 21:53. It says "family communication" above it. Can you see that?
A. Yes

Q. There's another note, the 14th of October 08:45?
A. Yes.

Q. What does the section with family communication relate to when we're dealing with the notes of the babies?
A. So we have two sections of notes. We have nursing notes, which are clinical care based. And then the family communication notes are specifically related to any interactions that you've had with the parents, so they're separate. They're clinical notes and then these are more family notes.

Q. So there are two separate sections in the notes that are used for that?
A. Yes, yes there are.

Q. Thank you. Mr Murphy, if we can take that down, please. With regard to taking down notes as events happen, writing them down to write them up later, if you do write them down on a piece of paper, what would you do with that piece of paper once you've written up your formal notes?
A. So ideally the paper should be discarded.

Q. And where should it go?
A. There's a confidential waste bin on the unit.

Q. If you've had paper with you to note up as you're going around during the course of a shift, where would you keep it during the shift?
A. So it would be in our pockets, in our uniform.

Q. Where does your uniform go at the end of the shift?
A. It goes home with me.

Q. Right. We know in your case, Miss Letby, there's a number of handover notes that the police recovered from your property when they came, isn't there?
A. Yes.

Q. We'll come to that in a bit, but do you agree that there was a substantial number of handover notes you had that didn't end up in the confidential waste?
A. Yes.

Q. We'll come to that in a bit. Still following through with the notes. When we're looking at the timing on nursing notes, let's say for instance notes within the body of the Meditech notes. So you're describing what's happened at various times?
A. Yeah.

Q. How accurate, how accurate is that going to be? Or is it impossible to say?
A. How accurate would the notes be? They would be as accurate as possible at that time.

Q. When it comes to prescriptions, the electronic printouts of prescriptions, how accurate are the timings on those?
A. Prescriptions and medications they would be exact. They would be to the minute, whereas the nursing notes would be a more generalised timing.

Q. We're going to have a look at some of the notes because I have some questions for you. Again, I'm identifying notes by the way of example at the minute. When they're relevant to the particular babies we'll look at that as we go along. The first one I'd like to look at is one of Child O's. It's the observation chart and it's at tile 18.

Ladies and gentlemen, most of these are in paper if you want to follow them, and I will tell you where they are in the paper bundles, but they will also be on the screens. Some of them may not be on the system, so we may have to go to the paper anyway. If we just open this up, thank you. For those of you wanting to look at the paper, it's behind Child O section, which is Tab 20, page 23658. Whilst we're looking at this, can we pull out, Mr Murphy, so we can just see the sheet in general to start with, please. Tile 18 on the screen to page 23658 behind tab 20.

I'd like you to tell us, Miss Letby, where observations are being recorded relating to heart rate, respirations and temperature. What do you actually do as part of this check and filling in this chart? Literally what happens?
A. OK, so the observations will be taken at the baby's cot side. The heart rate and respiratory rate will be taken off the monitors and then the temperature is done manually. We don't do that every hour, but if we're doing a temperature that is done by manually putting a probe under the baby's arm. Then the rest of the observations like saturation levels are taken off the monitor.

Q. Right.
A. The same as there, we've got the humidity and temperature of the incubator.

Q. Let's be clear what you have when you say the humidity and temperature of the incubator. Can we look at the lower half of the chart please, Mr Murphy? So we've seen at the top, heart rate. Is that on the monitor?
A. Yes.

Q. And respirations, is that on the monitor?
A. Yes.

Q. Temperature, that's recorded, is it?
A. Temperature is done manually, so that's not on the monitor.

Q. Right, temperature is manual. Then you were talking about humidity and something else?
A. Yes, so where we've got there, "cot incubator temp".

Q. That's the top line.
A. Yes, that's where we would document the temperature of the incubator and if there was any humidity within the incubator and that's a reading that's taken from the incubator itself.

Q. Right. We know if we look at the top of the chart, and we look at the top and then the signature at the bottom. If we look at the top of it for the entry at 13:30, please. If we look at that and look at the signature at the bottom. At 13:30 with the various entries between it, it has got a signature at the bottom. Can you help us with whose signature that is?
A. That's mine.

Q. That's yours. All right. So "LL" like that is you, is that right?
A. Yes.

Q. Are you meant to sign off when you've done readings or tests or taken observations?
A. Yes. So ideally, anything that you document should have a signature next to it, yes.

Q. Does it ever happen that you end up not signing something that has been documented by you, sorry, that's been observed or checked by you?
A. Yes. So in the reality of a busy day shift or night shift then a signature may get missed, yes.

Q. Is that something that, from your knowledge of these charts, happens sometimes with other nurses as well?

A. Yes, I would say it happens to everybody. It's just due to busyness.

Q. So for example, if we look at the entry to the left hand side of the 13:30, the 12:30 entry on the chart itself, there are various readings marked, but there's no signature there. So what's happened there? Are you able to tell us?
A. So the observations have been carried out and just unfortunately somebody hasn't gone as far as signing the chart.

Q. In fact, going left, what's RMSN for on this particular day?
A. RM of the initials of Rebecca Morgan, the student nurse, and SN reflects that, student nurse.

Q. All right. Anyway, in so far as there isn't a signature under the 12:30, is that something which is sinister?
A. No, no, not at all.

Q. If we look, please, at the page on the paper bundle before this, it's page 23657. And on the sequence of events, Mr Murphy, it's tile 15. If we pull out, first of all, just to look at the chart in general, for those of us who aren't looking at it on paper, those are the observation charts for Child O on 21st June. We can see if we look at the bottom, even from this size, signatures in the boxes, can't we?
A. Yes.

Q. If we look, please, at the timing for 04:00 top and bottom, that's 04:00. There's a gap.
A. Yes.

Q. Any of the signatures here your signature?
A. They're not, no.

Q. Is there anything sinister or strange about the fact that whichever nurse took those readings, he or she didn't sign off at the bottom of the column?
A. No, not at all. So all the information is there, they just haven't initialled, which is something that's quite often done through clinical care.

Q. All right, if we move 2 pages forwards in the paper file to 23659. I'm afraid there doesn't appear to be a file for this 23659. We might have to look in the bundles, ladies and gentlemen.
A. Do I have that?

Q. Yes, if you look in the bundles, Miss Letby, this type of chart, intensive care chart, if we look at the right hand side for 19:00 hours on 21st of June, again there's a signature that appears to be missing?

A. Yes.

Q. Is your signature any of those signatures on the right hand side?
A. No.

Q. Is there anything odd or strange about the fact that the nurse designated for caring for Child O didn't sign off on those observations?
A. No, not at all.

Q. If we just pull out, please, Mr Murphy, just look at this chart, if we may. We've seen a variety of these charts, some with greater or lesser detail on them. What type of checks would the nurse be doing for the items that might be put into this table? For instance, dextrose or aspirations?
A. So this chart is the reading of any drips that are going through. So any fluids or medications that are running, those values are all taken off the pump itself and then to the right hand side, the other columns are if we've done a nappy change or if their NG tube has been aspirated.

Q. So, depending on what the baby needs, how quickly might a nurse deal with the type of tasks that appear in this chart? If it's a very quick one without much being done.
A. If it was purely just reading the values then it would be minutes.

Q. And if it involves the other end of the scale, feeding or nappy changes, how much longer would that be, if it's possible to say?
A. It's hard to put a time frame on, but that would be considerably longer.

Q. Right. If you go to divider 22, it's on the screen as well, you'll find page 3B at the top, 24311 at the bottom. If we just enlarge please, the lower part of the right hand side of the chart. This relates to the care by a nurse called Tanya Downs who looked after Child Q on 23rd June 2016. If we look down the bottom 24:00 hours, there's various readings there. If we move across, there's no signature at that point?
A. No.

Q. But in terms of readings, the type of things we've got here, are you able to say, for instance, how long it would take a nurse to deal with taking these readings and looking at the baby in this situation?
A. So that would be minutes because you're purely reading from the pumps and the monitors around you.

Q. And again, in terms of the signature being missed, anything strange or striking about that?
A. No.

Q. Right. That's something that happens from time to time?
A. It is, yes.

Q. Remaining still with the various tasks of nursing staff when dealing with cares and observations. With regard to feeding babies, feeding them milk, if a baby is receiving milk via the NGT, the nasogastric tube, may be no more than a millilitre or a couple of millilitres. What does that process consist of, from getting ready, to doing it, to actually delivering the milk to the baby?
A. So your first step would be to get the milk prepared. So the milk would come out of the fridge, be measured out and warmed.

Q. Where does that take place, the measuring out and the warming?
A. The milk is kept in the milk room, which is a room on the unit, and then the milk is drawn up at the sort of cot side in that nursery.

Q. Right. And where is it warmed?
A. In the nursery.

Q. OK, so it's been drawn up, it's been measured, warmed. What happens next?
A. So when the milk is ready then you would be able to go and start the tube feed. So you would aspirate the NG tube first by attaching a syringe and drawing back a small amount to test the acidity of the contents.

Q. Pause there for a moment. The first thing is to aspirate it. We've heard about testing the acidity of the contents because of course the tip of the tube should be in the stomach.
A. Yes.

Q. Are the whole stomach contents aspirated every time that process is carried out?
A. No.

Q. Once that's been done, once the pH has been tested, what happens next?
A. The syringe is connected to the nasogastric tube and the milk is poured into that and fed by gravity. So you would then just hold the syringe and wait for the milk to go in.

Q. If it's just a couple of millilitres that are being fed that way, how long would that part of it take, the feeding?
A. That may only take a few minutes.

Q. We know with some of the bigger babies they may be up to things like 40 mil via the NGT?
A. Or more than that.

Q. The same process is gone through in terms of preparing that milk for feeding, is it?
A. It's exactly the same process, but the actual time it would take would be longer, because obviously you're gravity feeding a lot larger volume. So the larger the volume, the longer the feed would take.

Q. Are you able to help us with how long it might take for 40 mil to be fed via the NGT?
A. Um, about 10 to 15 minutes. Again, it would be dependent on the baby, but..

Q. Right. Is it done in little amounts or does it all go in at once?
A. No, you have a 10 mil syringe attached to the tube so it would be given 10 mils at a time.

Q. Right. If it's a baby who can be bottle fed -- people may have different experiences in their own lives of this -- if it's about 40 mil by bottle, how long would you expect that to be for a baby to receive that?
A. Again, it would be dependent on the baby, but a bottle feed would take considerably longer than a tube feed, particularly as a lot of the babies are premature so they're slow to feed and have difficulties feeding orally.

Q. So, do you say maybe 10 minutes plus to get 40 mil down the NGT?
A. Yes.

Q. Longer for a bottle?
A. I would say up to half an hour for a bottle feed.

Q. For a 40 mil bottle feed?
A. Yes.

Q. I want to ask about blood gas next. Just looking at these various tasks, Child Q is behind divider 22. Again, this is just by way of examples. I'm going to look straight at the top actually, to the top two entries for child Q for 22nd June so we can follow what's happening. The entry for 06:00 has a C. We know that means capillary.
A. That's right.

Q. What's the process for a capillary blood gas test? Talk the jury through, if you would, who does what and how long that takes?
A. OK, a nurse would gather the equipment that's needed to take a blood sample. We'd then wash our hands, go over to that baby and then a member of staff would then physically carry out the blood gas, so causing a prick onto the heel and putting the blood into the gas tube.

Q. What is that? Is that a little test tube?
A. It's like a small, yeah, a very small tube.

Q. The blood goes in there.
A. It does.

Q. And where does it go then?
A. Usually a second member of staff then would what we call run the gas. So they take the gas to the gas machine, which is outside of the nurseries and usually that's another member of staff that would do that and bring back the print-out result and fill in the chart.

Q. Pause there. We'll go back over that. You said another member of staff would go and run the gas.
A. Usually, yes.

Q. Could that be the same person that took the heel prick or would it always be a different one?
A. It's usually a different nurse because the person that has taken the heel prick would stay with the baby and obviously stop the bleeding, and we'd put a plaster on and things like that, and settle the baby because it's a painful procedure.

Q. So there would be-- there should be two nurses involved in this.
A. Usually, yes.

Q. Usually, all right. One of them remains with the baby after the sample's been taken?
A. That's correct.

Q. The other one goes and takes the blood gas to where precisely? Where do they go?
A. The Blood Gas room is a small room that's just in front of the neonatal entrance doors.

Q. I wonder if we can just put up the plan.
A. It's away from the clinical area.

Q. Let's see if we can find the plan for this so we can see exactly where the blood gas room is. If you explain to us where

the blood gas machine is, please Miss Letby, then we can go back to the readings.
A. Can I use the mouse?

Q. If it's connected and will work, yes, please do.
A. The blood gas room is just here.

Q. So not through any locked doors for that?
A. No.

Q. Straight down there?
A. Yes.

Q. Any other blood gas machines that are used elsewhere by nurses from the neonatal unit?
A. The only other blood gas machine is on the labour ward, so occasionally if our machine was broken then we'd potentially use the one on the labour ward.

Q. The blood gas having been run through the machine, we've seen little print-outs like receipts that you get.
A. Yes.

Q. And the nurse will go back with that receipt.
A. They would, yes.

Q. Thank you for showing us the map, Mr Murphy. I'll go back now if I could, to the blood gas chart that we were looking at, at tile 79 for child Q. So the nurse comes back and then who would enter this into the chart?
A. It potentially could be either person.

Q. Right. If we look at the one below, it looks like it might be a "V". It's a little hard to tell because there's a "V" and it looks like it's over the "C" Do you see that the second line down?
A. Yes.

Q. But if it is a venous sample, can you help us with what's the difference between the process there and the capillary sample?
A. So a venous sample is done by a doctor, so that's not something the nursing staff can do. That is done through the doctors taking blood from an actual vein. So therefore it will be the doctors that take that sample, and then a nursing staff member would then take that to the machine.

Q. Right. Thank you. We've finished looking at those.

Part C

Includes:
- Clinical note recording
- Shift allocation
- How babies are assigned
- Procedures followed when a baby dies.

Q. The next item I'd like us to look at, just to get an idea of how long things take and how the activities work on the unit, is an example from the Neonatal Reviews. So I'm going to ask if you could have a look, please, Miss Letby, at the neonatal review for Child B. If we look at lines 1 and 5, for example let's start with line 1, 9th June 2015 at 20:45, a baby with the name HM and it says quote "weaning change Lucy Letby". So, HM, isn't one of the babies on the indictment. First of all, where it says 20:45, a time like that, is that going to be a precise time?
A. No. So that would be to sort of the nearest.

Q. The nearest?
A. Quarter of, yes, quarter to or quarter past, or on the hour, yes.

Q. If we go to line 5 we've got for EB, the baby you're looking after there, at 21:30 the observation chart. And we know the intensive care observations, we've just been looking at it. 21:30 it says, do you see that?
A. Yes.

Q. With you taking those observations?
A. Yes.

Q. Is 21:30 going to be a precise time?
A. No. So 21:30 would be the time that that would be started usually. So obviously there's a feed there and observations taken...

Q. Right.
A. ..all around sort of that time.

Q. So when you say there's a feed there, are you now pointing to what's in line 6 under line 5?
A. Yes.

Q. Because we can see at the same time, 21:30 on the neonatal feeding chart, quote "feed given" and you.
A. Yes.

Q. "Feed given" and "observations taken". Are those two different things that have happened?
A. They are, yes.

Q. Have they both happened at precisely 21:30?
A. No.

Q. So when you put in 21:30 there, what sort of period is that covering?
A. It's usually done to sort of the nearest either on the hour, the quarter past or half past the hour, and that's usually the time around when something has started.

Q. So is that precision timing for those?
A. No, it's not, no.

Q. If we look at lines 1 and 5, we can see that at 20:45 you are engaged with something with the baby, HM. And it says quote "weaning change" and 45 minutes later on the timings at line 5, there's observations for EB and also a feed for EB. Do you see that?
A. Yes.

Q. 45 minutes have elapsed between lines 1 and 5. What might be happening in that time when we look in these charts and there's a time lapse on the record for what nurses or you have been doing?
A. So there are lots of things that we will be doing. We would still be attending to alarms for the babies, speaking to parents. There's a lot of equipment checks and things that we need to do, medication checks. There's lots of jobs to do other than just being at the baby's cot side writing things.

Q. Because the focus in the trial to this point has obviously been on what is happening with the babies.
A. Yes.

Q. But in the units as a whole, are there other tasks during the course of a shift that have to be dealt with?
A. There are, yes.

Q. And who decides on who's doing what when it comes to those more general tasks?
A. So usually that will be the shift leader. There are set tasks that we have to do on each shift.

Q. If we look at the two lines 7 and 8, as it happens, we can see Cheryl Cuthbertson-Taylor at 21:30 involved in a feed being given and observations with two different babies.
A. Yes.

Q. LG and LT.
A. Yes.

Q. Is there anything odd or strange or suspicious in a nurse having two different activities with two different babies at the same time?
A. No. Again, the idea of these charts is that they are sort of an estimated time. They are not to an exact figure.

Q. These are two different babies with Cheryl Cuthbertson-Taylor, aren't they?
A. Yes.

Q. Anything odd about that?
A. No.

Q. If we perhaps look lower down the chart, I'd like to see if we can go to line 24, please, on the lower half of the chart. Thank you, Mr Murphy. When we come to Child B, we'll look at it in more detail, but Nurse A was the designated nurse for Child B on this evening.
A. Yes.

Q. As it happens, the first we see on Nurse A on this chart is at line 24. Can you see line 24?
A. Yes.

Q. That is at 22:00, quote "Baby JE intensive care chart Nurse A". Do you see that Miss Letby?
A. Yes.

Q. The shift starts at what time?
A. 7:30.

Q. 7:30. In your experience, is there anything odd or strange in the fact that we see no recorded activity for Nurse A before 22:00?
A. No.

Q. If we look at lines 36 and 37, do you see 23:00 hours, Miss Letby? It's Nurse A doing observations and cares for Child B.
A. Yes.

Q. Both at 23:00?
A. Yes.

Q. Then in the period after that, there are medications given, lines 38 and 39. Do you see those two lines?
A. Yes.

Q. At 23:02 for HM, we can see "Lucy Letby" and the cosigner is Nurse A. What was the situation in terms of nurses assisting one another on the unit? How important was that?

A. So you have to. Medications are always given by two people, so inevitably you will always be working with another person when doing anything to do with medication or fluids.

Q. Was there any fixed rule as to who would assist when assistance was required?
A. No, it would be any member of staff that's free or potentially anybody that's working in the same nursery as you.

Q. We'll probably come back to look at other entries as we go along, but that's just dealing with the way those entries appear on the charts. We can put those to one side now, ladies and gentlemen. If you cast your mind back to that period June 2015 to June 2016, Miss Letby, how busy did the unit seem to be?
A. Oh, it was noticeably busier than it had ever been in the previous years that I'd worked there.

Q. And was there anything about the babies coming onto the unit that, you said it was busier, but was there anything about the babies or type of babies coming onto the unit that struck you?
A. Yes, we seemed to have babies with a lot more complex needs than maybe we hadn't cared for on the unit.

Q. Is this over that period, June 2015 to June 2016?
A. Yes.

Q. Was there any change in the staffing levels to take account of that?
A. No, there wasn't.

Q. A change in the way the BAPM guidelines were provided?
A. No.

Q. Or the number of doctors available?
A. No.

Q. If you think about babies like Child H with 3 chest drains, is that something which had been encountered before in your experience at the Countess of Chester?
A. No.

Q. Or Child J who had the stomas, the surgery for the two stomas. Is that something which was regularly encountered at the Countess of Chester in your experience?
A. No. And the same with the Broviac line with child J.

Q. And child N, who we know had factor 8 haemophilia, was that something that you'd encountered in your experience at the Countess of Chester before?
A. No, it wasn't, no.

Q. In terms of the shifts that you attended, how many shifts a month did you do? Was there a set number?
A. Yes, so a full time worker would do 13 shifts a month and that could be in any combination.

Q. By shift, do you mean a 12 hour period?
A. Yes, either a day shift or a night shift.

Q. Right. Is there a limit on the most shifts you can do in a row? A maximum?
A. It's usually 4.

Q. Would you ever be asked to do more than that?
A. Quite often.

Q. More than 13?
A. Yes.

Q. Were you asked to do more than 13-- did it add up that you'd been asked to do more than 13 on some months?
A. Yes.

Q. How long in advance did you know when you'd be required on the shifts?
A. So the shifts are usually allocated about a month in advance, but realistically they change on a day-to-day basis to reflect staff sickness or the volume of babies on the unit, anything like that. So it's something that changes regularly.

Q. What's the shortest notice you'd sometimes get in terms of being asked to come onto the unit and do a shift?
A. I've been called at a lunchtime and asked if I can work that night. Sometimes it can be very short notice.

Q. And would that be in addition to the 13 shifts in the month that you were already slated to do?
A. It would be yes, or sometimes they would just move shifts around so you might end up doing a shift.

Q. Would you know which baby you are going to be designated to care for in advance of the shift?
A. No, not at all.

Q. So you'd turn up and then find out.
A. Yes.

Q. Could you ask for a particular baby?
A. You could potentially if you were doing a run of shifts, so we might try and keep the same baby for continuity of care, but otherwise no, it's just dependent on the shift leader.

Q. Is continuity of care-- what do you mean by continuity of care, if it isn't obvious?
A. So continuity of care, we try to look after the same babies as much as possible to provide the parents with some continuity in terms of familiar staff, and also that the staff get to know the babies and their conditions.

Q. And therefore, would the shifts ever be arranged, insofar as they could be, to try and maintain continuity of care, or is that something which didn't really feature?
A. No, it's something that we strive to do when possible, but obviously it's not always possible to do that.

Q. So sometimes then, you might know who you're going to be looking after before you went on. Is that right?
A. You might potentially, yes.

Q. You might potentially?
A. Particularly perhaps if you'd been in the day before or the night before, you might know.

Q. But generally?
A. No, it would be dependent on what's happened that shift and what staffing you have and what the shift leader allocates.

Q. We started with your evidence, looking at the effect of how things went for you once we got past July 2016. Can I just ask you to deal with this: in terms of your health over that period that we're looking at, the actual indictment period, were you generally well?
A. Yes.

Q. Did you have any particular issues or health problems?
A. No, I didn't, and I hadn't had any time off sick at all.

Q. How was your eyesight, generally speaking?
A. My eyesight was fine.

Q. And did you ever have to have any assistance with anything in relation to your vision?
A. I did, yes. I did have a condition called optic neuritis at one point.

Q. Pause there. Optic neuritis. What do you understand optic neuritis to be?
A. It's an inflammation of the optic nerve.

Q. What does it cause to happen?
A. It causes pain and discomfort and can cause a bit of blurred vision.

Q. And when did you have that?
A. That was in 2015.

Q. And did you receive any treatment for it?
A. I did, yes. I was under the ophthalmology team at the Countess of Chester and also the Wharton Centre in Liverpool, which is a neurology hospital.

Q. Pause there. I think earlier in the case there'd been a reference to the Wharton Centre and you attending it.
A. Yes.

Q. Is that what that related to?
A. It is, yes.

Q. And they have a specialist neurology unit there, do they?
A. Yes. And I had some investigations there and everything was found to be OK.

Q. So, no serious underlying condition.
A. No, and it resolved itself.

Q. You're not suggesting that in any way your vision interfered with what we're dealing with in this case, are you?
A. No, not at all. No.

Q. That's just dealing with your health generally.
A. It is, yes.

Q. The desperately sad nature of this case is that it involves babies not just who became unwell, but babies who died. And as we go through the evidence, I'll be asking you questions about them. And I repeat again what I've said before that I do so with absolute sensitivity, as anyone would have for those babies and for the parents and families who are bereaved. We have to look at various things in relation to that. So no insensitivity is intended when I refer to any babies in the case. These are just general questions at this point. We're going to come to the charges as we go along.
When there is a death of a baby on the unit, are you able to describe what impact that has on the unit, Miss Letby?
A. It affects everybody on the unit. There's a noticeable change in atmosphere. We're a very small unit, we work very closely together, so when anything like that happens it does have an impact on everyone.

Q. Does everybody on the unit react in the same way when there's been a death of a baby?
A. No, I think with any individual we all have different reactions to different things and different ways of expressing different emotions.

Q. What's the main source of support, if there is any, for the staff when there's been a death of a baby on the unit for the nursing staff?
A. So there's nothing formal, it would just be sort of nurses between ourselves supporting each other.

Q. I'm going to come to the families in a moment. I'm just asking about nursing staff. Would you or your colleagues ever talk about what had happened, outside of work?
A. Yes, we would, yes.

Q. Would you ever communicate by messages with one another about what had happened?
A. Yes.

Q. How important was that in terms of support for one another when there had been a death on the unit?
A. It was very important. Again, there was no formal sort of support, so we leant on each other.

Q. Was there any system of counselling for members of staff who were involved or present at the time of a death or a series of deaths?
A. No, there isn't, no.

Q. It's a fact in this case and something we all have to look at, that you were present on the unit on a number of deaths, on all the deaths on this indictment, weren't you?
A. Yes.

Q. What formal assistance did you get with coping with any of that as it went along? Structured formal assistance?
A. None.

Q. Did being moved to days in April 2016 make a great deal of difference to how you felt with everything that had happened?
A. No.

Q. And in fact, did you still continue to work nights after that date anyway?
A. I did, yes.

Q. Was there anything that you felt was part of how you would cope, if you'd been in a nursery and a baby had died there, was there any aspect of what would happen afterwards that you felt would help you cope?
A. So from my personal experience, I found at Liverpool Women's they have a very, how to put it, so there you're sort of encouraged that if you lose a baby or a baby dies, you go back into that nursery as soon as possible as a sort of way of

processing things, so that you don't ruminate on that one particular baby being in that space.

Q. Is that in any way to do with not caring about the baby?
A. No, not at all.

Q. What's the reason for going back and..?
A. Because you have to carry on and you have to be professional for all the other babies that you're caring for.

Q. With the parents of babies, if they suffer a bereavement, if a baby dies on the unit, what kind of support is given to them on the unit at that point?
A. So there is a bereavement sort of guideline that we have as nurses, which guides us into what we can offer to support the parents, but largely it's just done between the nursing staff based on the parents at that time.

Q. And what about the way that the nurses are towards the parents? How do they act with the parents and seek to provide any assistance?
A. Well, we're there to support them as much as we possibly can.

Q. The bereavement checklist? Is that something formal?
A. It is, yes.

Q. And what's that designed to do?
A. So that's there really to ensure that parents are supported and that memories are made really for them and their baby.

Q. Who would be the person, as a rule, who would be the most involved with the parents after there had been a death? Which nurse?
A. Generally it would be the nurse designated for that baby.

Q. I'm going to ask actually if we could put up the checklist which we saw earlier in the case, it's Exhibit 1141. This relates to, if we look at the top left, please, Child A, born on 7th June 2015, very sadly died on June 8th. We can see just looking at that, your signature is present on a lot of the entries. Can you see that Miss Letby?
A. Yes.

Q. Why was your signature present on these entries with child A?
A. Because I was the nurse allocated to look after child A at that point.

Q. We'll come to it, but we know his death happened soon after the handover on the 8th when you took over from Mel Taylor. Is that correct?
A. Yes.

Q. If we look at the type of entries here, just looking under emotional support if we may, please, it's got items such as about 6 lines down, photos taken on NNU camera, parental consent for photos.
A. Yes.

Q. Is that something which was, it seems a blunt word, but offered to parents? They were told they could have that if they wanted?
A. It is, yes.

Q. What other sorts of things were made available for parents to help with what had happened, if it could possibly?
A. So depending on the circumstances, it could be having hand and footprints made, bathing the baby, dressing the baby, taking a lock of hair, having any sort of religious support or baptism, things like that.

Q. This is you. We know because you were the designated nurse at this time. Did other nurses follow the same checklist if they were dealing with a bereavement and the death of a baby that they had been a designated nurse for?
A. Yes, it's a standardised form.

Q. And would nurses ever assist one another and the parents during this?
A. Yes, very much so.

Q. We've heard reference to something called a memory box. You're familiar with that term?
A. Yes.

Q. Could you explain to the ladies and gentlemen if this isn't clear, what is a memory box?
A. So a memory box is something that's donated by neonatal charities. They contain the things inside to enable to do these things, such as taking hand and footprints, taking looks of hair. It gives you a box to put those sorts of memories in for the parents. They also include a little teddy bear, one which stays with the baby and one which stays with the family. They're things that are all provided by a charity.

Q. It's part of a formal process, is it?
A. Yes.

Q. Part of the bereavement process?
A. It is.

Q. We can take the chart down now, please, Mr Murphy. After the immediate event, in terms of the unit, was there ever a system

of debriefing for the people who were involved? This is at clinical level.
A. Yes, there's usually a debrief of some sort, but that is sort of medical based rather than..

Q. Who would hold the debrief?
A. It would be run by the consultant in charge at that point.

Q. Would there always be a debrief after a death?
A. Not always, no.

Q. Who would decide if there was going to be a debrief?
A. The consultant.

Q. And who would be present at that?
A. So anybody who was present on that shift would be invited to attend. So it's up to that person whether they're free to go or if they want to go.

Q. How long after the death would a debrief be held? Was there a standard time?
A. There wasn't, no. It could be days, it could be weeks.

Q. And what was the purpose of the debrief?
A. Mainly to review sort of immediate medical care at the resuscitation, to see if there was anything that we needed to learn from.

Q. You said that people maintained as best they could a professional presentation throughout this?
A. Yes.

Q. Is that nurses and doctors?
A. Yes.

Q. Personally, how did the impact feel? However the presentation was externally, what was the impact personally, if you're able to describe?
A. It was very upsetting. You don't forget things like that. They stay with you.

Q. We'll of course return to the system and situation with the babies when we come to the allegations, but I want to move on to another area now. That's actually the area to do with your life at the time you were working on the unit. You described your commitment to the-- to your profession, Miss Letby, and we have heard some evidence about that. But were there other activities in your life outside work over that period we're looking at?
A. Yes, I had quite an active social life.

Q. What sort of things did you do? We may have seen some of it from the messages, but you tell us. What kind of things did you do when you could?
A. I used to regularly attend salsa classes, used to go out with friends, meet up for lunch. I've been on quite a few holidays with friends. Gym.

Q. Okay, did you meet up with colleagues from work, outside work hours?
A. Yes, I did.

Q. Were there any particular colleagues that you were, or colleagues that you were particularly friendly with?
A. Yes.

Q. Could you tell us who they were?
A. Nurse E. Mina Lapalainen. Dr A. Nurse A. Jennifer Jones-Key.

Q. You described at the start of your evidence that when you moved to the non-clinical duties you were able to have some support from some of those people.
A. Yes.

Q. How important to you was that support at that time?
A. Oh, it was very important. They were the only form of support I had really.