(In the presence of the jury)

[DR B] (recalled)

Examination-in-chief by MR ASTBURY

MR ASTBURY: Good afternoon. Could we start with your full name, please, again for the record?

A. I'm [Dr B].

Q. You'll remember, [Dr B], I'm going to ask you to keep your voice up and generally in the direction of the microphone, which of course doesn't amplify, it only records.

You came along last week to assist us with your treatment of a little boy called [Baby O] and you've come along today, as you know, to assist with his triplet brother, [Baby P] --

A. Yes.

Q. -- known as [redacted] on the medical records.

You, I think, first met [Baby P] during the course of

a ward round on 22 June 2016; is that right?

A. That's right.

Q. Thank you. I think that took place at about 11.45 am?

A. Yes.

Q. And you were paediatrician of the week?

A. Yes, that's right.

Q. I'm going to ask, please, it's not on our carousel, but

if Mr Murphy can put up J23840, please.

(2.11 pm)

(No video feed from court)

(2.12 pm)

MR ASTBURY: Hopefully you recognise the writing?

A. Yes, that's right, that's my handwriting.

Q. Thank you. That's your note of the ward round on that

particular occasion?

A. Yes.

Q. You have noted there triplet 1, as we know [Baby P] to be.

A. Yes.

Q. And you have noted the problems as they were considered
to be at the time?

A. Yes.

Q. And then you've made a note of the various categories
that we're becoming familiar with.

A. Yes.

Q. We can see there that [Baby P] had been screened and was
receiving antibiotics. If we can scroll up and look at
your examination, please. I don't think we need to go
into too much detail on this, simply to identify it.
We can see that abdo was considered soft

at that point.

A. Yes.

Q. You have made other notes. Was he on breathing support
at that stage?

A. No, he had been taken off. Had been on -- so he was on
CPAP at the time, at this point in time when I saw him.
What I'd asked for -- so you know where it says "U&E
plus gas and trial of Optiflow"? So I had asked if we
could step -- as a step-down approach in weaning
ventilation, change him to Optiflow from CPAP. So
at the time when I saw him, he was on CPAP, and I'd
asked for that to be changed to Optiflow.

Q. Is that a positive step for a baby in [Baby P]'s position?

A. Yes, that's a positive step. So basically, CPAP is
a form of non-invasive ventilation,

which gives pressure
and aids ventilation. Optiflow is just some flow with
humidity. And as a method of non-invasive ventilation,
it's a step down towards -- the next thing that would
happen is you would wean the Optiflow and then take them
off, which is what happened with him.

Q. Thank you. We saw yesterday, indeed I should tell you
this, we've already heard in this case from [Dr A] and a
number of other doctors who treated [Baby P] on the day
we're about to deal with, so we won't need to go through
those notes. In fact, we also heard as a matter of fact
Optiflow came to an end around about 6 am on 23 June.

A. That's right.

Q. The jury, I'm sure, will remember. Just looking at
those notes, and bearing in mind the stepping down of
the ventilatory support, what's your assessment, please,

of [Baby P] or what was your assessment of [Baby P]
during the course of that ward round?

A. So from looking at the notes, it looks like I am fairly satisfied with his progress. He is one of the triplets and he is progressing as we would expect him to. He is on CPAP, we are planning to change his fluid, we're giving him antibiotics which we plan to stop, his examination is unremarkable. I've asked for some blood tests to check his kidney function, a blood gas, and wean down his ventilation and I am predicting that things will go to plan and there wouldn't be any problems with moving him on to -- out of the ventilation, introducing feeds and spending a period of time on the neonatal unit, what we call feeding and growing and establishing feeds --

Q. Right.

A. -- before being discharged.

Q. You mentioned blood gases. I wonder if I can ask
Mr Murphy to go to tile 178, please. I'm going to look
at blood gas record, please, because you -- part of your
plan was, I think, to take another blood gas record;
is that right?

A. Yes. So one of the things, if I could just clarify at
the beginning, is in my statement I have mentioned that
I have reviewed his gases, which I have not documented
here, but as part of the review I would have looked at
his observations, his temperature charts, whether he'd
opened his bowels, passed urine, what his temperature
stability had been, whether he'd had any periods of
dropping his oxygen levels or heart rate. I would have
looked at the blood gases that had been done before,
which, although I have not documented, forms part of

seeing the patient.

Q. Okay. So as of the 22nd, having completed your examination and made your plan, all that information would have been in the mix and under consideration when you decided on the progress?

A. That's correct.

Q. Thank you. If we can look at those blood gases because there's one -- if we look at 22 June, just below -- the first of the hole punches on the page, we can see there's one at 12.17, not long after your examination of him.

A. Yes.

Q. Is there anything, and again I don't think we need to go into detail, you may be asked if it is necessary, is there anything that stands out on that particular blood

gas reading at 12.17?

A. No, this is what I would call an excellent gas.

Q. We can see there's a note suggesting progress on to
Optiflow; is that right?

A. That's right.

Q. And as it happens, we have another blood gas in the
afternoon, which the entry suggests is once [Baby P] is
already on Optiflow. Again, bearing in mind the change
in ventilation, is there anything we need to have our
attention drawn to in that particular blood gas reading
record?

A. No. Again, this is an excellent gas, very similar to
the one done at 12.17, and does not raise any concerns
and looks like everything is going in the right
direction. His ventilation has been weaned to Optiflow

and he seems to be managing very well with that change.

Q. Thank you. You next considered, certainly for the purposes of your statement, and I don't think we need to go to it, as it happens we've just seen it, you then considered the examination undertaken by Dr Cooke, is that correct, on 23 June?

A. Yes.

Q. Did anything concern you from that particular examination on reviewing the notes?

A. No.

Q. Next, please, could I ask Mr Murphy to go to tile 63.

No, that wasn't in fact what I was hoping to go to.

It'll be 64, please, Mr Murphy, my error.

If we scroll halfway down, I hope. Scroll down, please. We can see there at -- just keep going, please.

It's not a note that you completed, doctor, but we can see after Dr Cooke's examination, it would appear that you've looked at what's called a CRUS, a cranial ultrasound scan.

A. Yes.

Q. And can you tell us, please, what you have noted as a result of the scan?

A. That says:

"Normal appearance, no [something] haemorrhage or dilatation."

Q. Is that "evidence of"?

A. So that's evidence of -- that the cranial ultrasound was normal, showing no features of concern.

Q. Thank you. So you're able to satisfy yourself that all was normal in that regard?

A. Yes.

Q. Thank you. We've heard already from you about events during the course of that afternoon and early evening on 23 June. We've also heard this morning, and you comment on it in your statement, Dr Gibbs reviewed both [Baby P] and [Baby R] after the death of [Baby O] that particular evening and you have seen those notes. Was there anything -- we're not going to go to them -- that stood out to you having seen those particular notes?

A. No.

Q. Any concerns?

A. No.

Q. Moving on then, please, to 24 June, were you present at the morning handover?

A. I was.

Q. This would have been the morning after [Baby O] passed?

A. Yes.

Q. What time would that handover normally take place?

A. 8.30 in the morning.

Q. Do you remember having any conversation with
Dr Mayberry, who had been the night registrar?

A. So this is part of my statement. I don't remember it
exactly now, but as I've mentioned in my statement,
Dr Mayberry had said in the handover that he had been
asked to review [Baby P] overnight and felt that he had
some abdominal distension and had, as a result of that,
stopped his feeds and started him on intravenous fluids.

Q. Right.

A. He was already on antibiotics from the evening before
when Dr Gibbs had reviewed him after [Baby O] sadly passed
away. Both [Baby R] and [Baby P] had been screened and
started on antibiotics, more as a precaution, just to make
sure that we were covering them for infection.

Q. We've heard, I think this morning, that the consideration is the fact that they are triplets --

A. Yes.

Q. -- so there is the potential for similar features to
arise in siblings who are born in that way?

A. That's right, yes.

Q. Had [Baby P], do you recall, been changed to intravenous
feeds as opposed to bottle feeds or milk feeds?

A. So he had been changed, so his feeds -- he was only having nasogastric feeds during the course of the previous evening when Dr Mayberry was asked to review him overnight there were some concerns that he'd had short episodes of desaturations and bradycardias as well as some abdominal distension. So I think more as a precaution, given what had happened with [Baby O], Dr Mayberry rightfully decided to play it safe and stop the feeds and put him on intravenous fluids, taking into account that his -- he was already on antibiotics. He also notes that despite these episodes of brief dips in oxygen and heart rate, he remained in air, so Dr Mayberry wasn't concerned and didn't think about

putting him back on any form of assisted ventilation and
was satisfied that just stopping the feeds and managing
it that way was the right thing to do, which I agreed
with when I briefly reviewed him the next morning.

Q. So at that point you've just confirmed for us that [Baby P] remained breathing for himself in air?

A. That's right, yes.

Q. Dr Ukoh, I think you just mentioned, took a review at 9.30 that morning?

A. That's right.

Q. Did you play any part in that review?

A. My part in that was -- so that morning wouldn't have
been one of the days where we undertook morning ward
rounds. However, when Dr Ukoh was reviewing [Baby P], I
came and sort of cast an eye on [Baby

P], just to make sure
he was okay and I don't remember noting anything unusual.
I have seen Dr Ukoh's note entries, so at the time
he was still -- [Baby P] was still in air, his abdomen was
a little bit distended, he was on antibiotics. As far
as I can remember there were no major concerns as
such -- he was on caffeine as well and I suggested to
Dr Ukoh that we undertook some investigations just to
screen for a few things. Those have been listed: there
was a blood count, which is just to check his blood
cells; a CRP to check for infection; a kidney function
test to make sure his blood salt levels were okay;
a blood gas; and an ammonia, which is basically a test
that is done, a blood test, which we send on ice to
check for metabolic disorders.
I think this was from the background of [Baby O]
having passed away the day before, so this is just
thinking beyond, "Is there anything else

we should be
looking for", and as part of that I'd asked for, while
we're doing bloods, can we do this as well.

Q. Do you recall how that particular examination of [Baby P]
came to an end?

A. I did not examine [Baby P], so there is no note for me
saying that I have examined him. Dr Ukoh has and from the
note entries, I have written -- I think while I was
seeing him, I was either -- I don't remember this exactly
-- either asked by one of the nurses that there was a phone
call from the coroner about [Baby O] or I was bleeped,
I don't remember, because the previous evening I had
left my contact details on the answer machine about
[Baby O]. So at about around the same time I have been
asked to go to -- there was a resource room in the
neonatal unit where we would take phone calls, which

would be out of hearing.

Q. Just break that down then. Having been present at [Baby P]'s examination by Dr Ukoh, you then had cause to go to the resource room, was that?

A. Yes.

Q. To make a phone call?

A. Yes.

Q. And your recollection of who that phone call was to?

A. Again, this is from note entries. In my note entries, I have written that I was on to the phone to the coroner and, again, I have been asked this by the police, as to why I remember the conversation, and I have replied that

I do not remember what exact conversation I had with them. However, it would have been to do with a summary of the unexpected events from the day before with [Baby O] and my filling in the coroner -- either the coroner or the coroner's officer, because I think you can confirm that from my statement who I spoke to because this is documented in the notes. I updated them on the previous day's --

Q. Okay. Well, rather than concentrate on what exactly you were telling them, what happened while you were on that phone call?

A. Yes, so I was asked to come and quickly review [Baby P] during that.

Q. And why was that?

A. Because, again, he'd suddenly become unwell and that was literally just 10-15 minutes after I'd

seen him.

Q. Okay. We've heard that was the start of a series of
difficulties for [Baby P] throughout the day; does that
accord with your recollection?

A. Yes.

Q. Did you make a note of your involvement through the
course of that day later on that evening?

A. Yes.

Q. I'm going to ask you then to look at that note, please,
doctor, to assist you. It's tile 625.
It's quite a long note. I've gone to this tile
because it's where all the notes are. But for the
jury's help, it's spread out through the

chronological
order but I have gone straight to this so that we can
take it through.
You've written -- just identify that is your note?

A. Yes.

Q. We should do that first, thank you. You have put:
"Written retrospectively from around 9.30 am."
You were called to nursery 2 because [Baby P] was
unwell; is that right?

A. That's right.

Q. You have noted that Dr Ukoh and Nurse Lucy were present;
is that right?

A. That's right.

Q. Anyone else present when you got there?

A. As far as I remember, no.

Q. Then you have noted that [Baby P] was dropping his sats,
that's the saturation levels of oxygen in his blood, and
his heart rate had dropped as well?

A. Yes.

Q. Is that right?

A. Yes.

Q. "Just a few minutes earlier I had briefly seen [Baby P]
and discussed with registrar to do..."
And I think you have listed those tests you have
already very helpfully told us about, I'm not going to
go through those again:
"Shortly after this, [Baby P] deteriorated, Dr Ukoh
started to bag and [you have put, is that] intravenous
access x1 lost as not flushing"?

A. That's right.

Q. Can you explain that, please, to us from your recollection?

A. So basically, when I was called in to see, which was quite a shock, I saw that his saturations -- I don't remember the exact numbers, we would probably have to go back to the charts to look at that. His heart rate was dropping and his saturations were dropping. In my statement I think I have written that his sats were low and the heart rate was around 80, which is quite alarming because with any heart rate drop to 60, we start CPR, which is cardiopulmonary resuscitation. One of the first things you want in a child is you want to look at the airway. So you look at if they are dropping their oxygen levels, you start assisting them, which Dr Ukoh does, so he gets the Neopuff and starts to bag with -- assisting that, and I look for intravenous

access.

He had one cannula in place, [Baby P], and as the further resuscitation comes and follows, that was lost fairly quickly because, shortly after this, his heart rate dropped to 60 and we started cardiopulmonary resuscitation and as part of cardiopulmonary resuscitation one of the drugs that's given is adrenaline. So the first --

Q. I'm going to ask you to pause there because, if it assists you, we've seen [Dr A]'s note and he confirms that the heart rate was down to, as you said, 80, and sats were down to 60%, which you're right, is in your statement. I think you were about to tell us that the heart rate dropped still further; is that right?

A. That's right, yes.

Q. So your recollection of how long it was before that took

place, roughly?

A. It probably wouldn't have been very long. Maybe within a couple of minutes.

Q. Okay. We've heard it before, but you tell us what happens when it drops to 60 or below?

A. Yes. If it drops to 60 or below, we commence cardiopulmonary resuscitation, which starts off by external cardiac compressions. So because the heart output is not enough to oxygenate, you assist by cardiac compressions and you give medication to improve the heart rate and the medication that's given is adrenaline.

Q. Okay. Pausing there, did adrenaline start on this occasion?

A. The first entry, as far as I can remember, is at 9.55,

the first adrenaline.

Q. How was that administered?

A. The first dose was intravenous. So normally, we would give the adrenaline and then you would flush it to make sure that it goes into the -- because it's only a small dose, it's 0.1ml per kilogram, so he would have had 0.2ml, which literally -- you need to give a bit more fluid to make sure it goes in the system. And the cannula... When I say it flushed, there's a swelling that comes up at the end of it, which tells you that you can't use it anymore because it's not going in the vein, the cannula has tissued, is the word that we use, so the IV access is lost.

Q. Having commenced the resuscitation procedure that you have told us about, access is vital?

A. Access is vital, absolutely, yes.

Q. So were you able to administer more than one dose of
adrenaline via the intravenous line that was eventually
to block?

A. No.

Q. So what did do you then?

A. We then proceeded -- at this point [Dr A] had also
come. So this now becomes more than one people (sic).
So one person is looking after the airway --

Q. I am going to interrupt you again, I am sorry. Do we
take it from what you have said [Dr A] wasn't there
to start with?

A. He wasn't there to start with but then he arrived and
took over the airway management over from Dr Ukoh. He
put the Guedel airway in and started bagging and we were

getting ready for intubation. Around this time the
adrenaline was also given, the IV access is lost, and
Dr Ukoh and I moved to this end to start --

Q. Someone is taking a note of what you say, so I'm going
to ask you to slow down. Lots going on at once.

A. Yes.

Q. [Dr A] has taken over the airway?

A. That's right.

Q. He's introduced a Guedel airway, which we've heard about
before?

A. Yes.

Q. Preparations are being made for intubation?

A. That's right.

Q. And in the meantime, drugs are being administered,
initially via an intravenous line, but then that line is
lost; is that right?

A. That's right.

Q. Okay.

A. So in the first instance, both Dr Ukoh and I attempted
to re-site an intravenous line, which is through --
which is inserting a cannula. I do not recall how many
attempts, but normally in a very sick baby or a child,
we would not spend too long before moving to an
intraosseous route, keeping in mind then when a baby
collapses circulation is very poor and obtaining
intravenous access can be very challenging. However,
it is very important to have some kind of an access and
an alternative to intravenous access is intraosseous
access.

Q. We have heard that's through the bone in the leg, into the bone marrow within.

A. Yes.

Q. And that enables intravenous drugs --

A. Intraosseous, yes.

Q. Sorry, intraosseous as it then becomes. Can we return to your note so you don't have to try to remember too much because I think you have made a note as to what unfolded with the intraosseous access. If we can go down, please.

You have then noted:

"Airway maintained with Neopuff whilst bagged whilst getting intubation ready. Few attempts at IV access unsuccessful. [Dr A] arrived and took over airway from Dr Ukoh. Dr Ukoh and I inserted an intraosseous, [is that] needle"?

A. That's right.

Q. "First in left (Dr Ukoh)..."
Is that his action?

A. Yes.

Q. "... and then the right (by myself)."
Is that right?

A. Yes.

Q. "Heart rate falling."
Then you put:
"Adrenaline was given via intraosseous access."
Is that right?

A. That's right.

Q. Then:
"Intubated successfully at first attempt by [Dr A]."

A. That's right.

Q. So scroll down a little further, please. You have then
put that:

"[Dr A] and I were present with [Baby P] through the day. For detailed notes on management and resuscitation, please refer to [Dr A]'s note entries."

A. That's right.

Q. So that presumably is for times and quantities and the like?

A. That's right.

Q. Okay. Whilst the drugs are being delivered via the intraosseous route, did resuscitation continue?

A. Yes. So again, I have not made detailed notes here, but with the -- I think he had at least four collapses. He had three or four doses of adrenaline and a sodium chloride bolus before the return of spontaneous circulation --

Q. Well, again, if it assists you, it was not too long

after 10 o'clock that [Dr A] notes that [Baby P]
stabilised.

A. Yes.

Q. Once that first collapse or the emergency had passed of
that first collapse, did you then go to contact somebody
else?

A. Yes. So as I've written here as well, after this
happened, this was now beginning to really concern me,
that it was very similar to what had happened the day
before. We had stabilised [Baby P] and I went away to
speak to the neonatal transport team consultant, Dr
Rackham, who is the same -- so it can be a different
person, but it happened to be Dr Rackham who had been
the same consultant that I'd spoken to the previous day
for [Baby O].

Q. Was intravenous access, [Baby P] now -- the emergency
having passed for now, was intravenous access regained?

A. Yes. So again there is a detailed note of that in my
notes. I'll just clarify here, basically, very shortly
after [Baby P]'s passing, [Dr A] and I sat down and
discussed the chronology of events and when -- what
happened and just to make some sense of what had
happened and I wrote my statement with times and what
had actually happened in my statement very shortly
after. So in that, I have made a note that once [Baby P]
was stable, [Dr A] managed to site an IV access. I think
one was on the right side and a short while later on the
left. So not long after the first resuscitation, he had
a -- one intravenous access and then, after that, two
intravenous accesses, plus an intraosseous access.
When babies, or even older children,

are unwell,
it is recommended that they have at least two
intravenous accesses, one, because multiple medication
can be needed, and two, you have a back-up in case one
stops working.

Q. Okay. Shall we return to your note, then, if we may?
I think you've made a note that you spoke to Dr Rackham
at about 10.30 and updated him about [Baby P], you were
advised that they would enquire whether a bed was
available and also to try to take [Baby R] to the same
unit was the plan. That was the parents' request so
that they could be together; is that right?

A. That's right.

Q. You then go on to talk about speaking to Dr Rackham at
1 pm, but picking up about what you were saying about
the times and sitting down with [Dr A], [Dr A] has

recorded another desaturation and bradycardia at 11.30,
involving [Baby P].

A. That's right.

Q. And a serious one; is that right?

A. That's right.

Q. Do you have a recollection of that second collapse?

A. Yes, I do. The second collapse, again, the oxygen
saturation dropped and the heart rate dropped and he
needed full resuscitation with adrenaline, bicarbonate
and sodium chloride boluses.

Q. Okay. Which we've heard are the standard resuscitation
drugs in these circumstances?

A. That's right.

Q. And we've also had the explanation as to what each is
designed to do. Having collapsed at

11.30, is it right
that spontaneous circulation returned as soon as 11.36
with [Baby P]?

A. Yes. So I think -- was this the time that he only
needed one dose of adrenaline?

Q. Yes, I think.

A. Yes. One of the things which was -- again, I don't have
my statement in front of me, but I recall -- was it at
this time that it says he was very vigorous and
breathing against the ventilator, so he was given some
morphine --

Q. Right.

A. -- which again is -- so when you have a baby who is
sick, who has sort of gone downhill and gradually become
unwell to the point that you have intubated and
ventilated them, they don't bounce back that quickly

that in 5 minutes they'll be wanting to get this tube
out, "I don't want this anymore". So that's basically
the baby complaining that they don't like the tube down
their throat, which is why we've gone and given him some
morphine to sedate him.

Q. Okay. Can we break that down? 11.30, collapse
requiring -- again, was there --

A. Cardiopulmonary resuscitation.

Q. Thank you for saying that. To such an extent that he
required the full resuscitation programme, if we put it
that way?

A. Yes.

Q. Those drugs that you have told us about, the first dose
is being administered?

A. Yes.

Q. Six minutes later, you have spontaneous circulation again?

A. Yes.

Q. And how soon after is the baby effectively complaining about the intubation?

A. Around the same time. So what I have noted in my statement is that [Baby P] fighting the ventilator and breathing against the ventilator. When babies are being ventilated artificially with an endotracheal tube and we are giving them artificial ventilation, it's not ideal that they should be breathing against the ventilator, so we then have to take measures to try and stop them breathing or synchronise with the ventilator somehow.

Q. I think you were, and I'm sorry for interrupting, telling us that it came as a surprise

that he displayed
that behaviour --

A. Yes.

Q. -- so quickly afterwards?

A. Absolutely, yes.

Q. Just explain to us why that was such a surprise, please.

A. Because basically, if a baby -- the first collapse was
unusual. There was no reason for him to have suddenly
dropped his oxygen levels and his heart rate. There had
been nothing to suggest that. We had taken the
necessary measures and resuscitated him and were still
trying to work out what had actually happened, which
was -- when you're thinking, "I don't get what is going
on here, I need to discuss this with someone", and that
someone at that moment in time is a tertiary specialist,
which is why I'd gone and spoken to Dr

Rackham, you're
asking yourself, okay, I've done ABC, the baby is now
stable, I don't understand what's going on, I need to
speak to someone else and use their expertise, to
include their advice in this.
So that's all going on and then while -- there's no
reason again for him to collapse a second time, but it
happens, and then he comes back very quickly and not
only does he start breathing again, he's very vigorous,
he's breathing against, he's kicking and he's
complaining, which means that whatever event happened
was a short period and then his circulation was back and
he was --

Q. It's a very rapid recovery from a very low point?

A. Yes.

Q. How did [Baby P] appear in that period then when he was

resisting the ventilator?

A. So he was -- what babies then do is you see them moving
their arms and legs and they're trying to breathe and
gag. And they open their mouths and you can see that
they are appearing distressed from the intervention
that...

Q. How would you have described -- it's a snapshot,
I suppose, but how would you have described generally
[Baby P]'s condition at that moment in time?

A. At that moment in time I would have thought, well, okay,
he's come back quite quickly -- and I think one of the
things is you -- what you do is very mechanical in that
time, you deal with each situation as it's happening and
you're trying to count -- because the only thing in your
mind at that point is, how do I make this baby better,
what do I do, and what do I have to do?

So when a baby collapses, you give them adrenaline, you do CPR, you do the intubation, you've done that. Then if it happens again, you do the same thing again. So you're countering or trying to deal with every problem as it happens.

So at this point in time I see a baby who's come back very quickly, who's vigorous, but he's not -- I'm not in a place to say, well, okay, you're vigorous, you don't like your tube, I'm going to take the tube out.

I can't do that, I have to leave that tube in because this baby is having these collapses that I don't understand. So I then have to find a way to try and sedate him so he doesn't fight the ventilator.

Q. Okay. I think the medication that was given to [Baby P] at that stage was pancuronium; is that right?

A. Did he not have morphine before that? Because I think
at one point he had 100 micrograms per kilogram of
morphine first and then he had the pancuronium.

Q. Did that have the desired effect?

A. Yes. With the pancuronium, what the pancuronium does is
it just stops them moving, it paralyses you. Basically
it's a drug that paralyses you. That means that you can
control the baby's breathing completely. They do not
move, you breathe for them, you basically have to make
sure that the ventilation settings are optimal and you
can anticipate that the baby is not putting in any
effort, but that also means that you have control over
their breathing and by ventilation you can't cause any
harm.

Q. Right. What I would like you to look at next, please,
if we can go back to tile 178, you

comment on a blood
gas record that was taken not too long after this
episode at 12.08.

A. Yes.

Q. If we can scroll down, please, I'm going to ask you to
look at the penultimate entry on that particular line.

A. The 12.03 gas, this -- I remember being very pleased
with this gas when I saw it because this had come after
a few very poor gases. There's one that's not here
which was a 6-point-something as well which is in my
statement and it's in another gas record but that's not
been entered here.
So the 12.03 gas, the pH of 7.32, which is very
good. A CO2 of 3.33, which is low normal, which means
we are ventilating him well. A PO2 of 5.72 is the
capillary gas; that doesn't worry me. Base excess is
minus 11.4, which is quite high, and

this was a problem
that we, as you can see from the previous gases as well,
that's been progressively rising so this is metabolic
acidosis, which means that the tissues are being
deprived of oxygen, and that is producing the lactate
which -- despite us having given him quite a few doses
of bicarbonate and he went onto a bicarbonate infusion
as well later on. That is minus 11.4, but to me that
was -- I remember breathing a sigh of relief, phew,
because by this time I'd spoken to Dr Rackham a few
times, they were on their way and I am thinking, okay,
we've paralysed him, we've got control of his
ventilation, we've done a gas, the gas is good, so yes,
we are dealing with the metabolic acidosis and, fine,
the transport team are going to be here soon, we're
going to be okay. I just remember that sort of sigh of
relief at that point.

Q. Bearing in mind in his recent intubation, what does that
gas, if anything, tell you about the effectiveness or
otherwise of his ventilation?

A. That it is effective, that his ventilation is working.
So he has been paralysed now, we have sort of dealt with
the fact that he was fighting the ventilator. We don't
know why it's happened still. We are just, as I said,
trying to deal with the problems as we are facing them,
not quite understanding why these collapses have
happened. But where we are from his airway/breathing
point of view, I am reasonably satisfied, circulation
I'm not very happy with, with the base excess of minus
11.4, but I feel like we're getting there, things are
getting better and under control.

Q. Had you carried out any cold light tests during the
course of the two resuscitations?

A. Yes, we had, and the cold light hadn't indicated that there might be a pneumothorax or an air leak.

Q. But I think that changed with an X-ray taken at 11.57; is that right?

A. That's right, yes.

Q. Go to tile 400, please. We can see there the time and date on the X-ray. I suspect the clue is in the question. What can you see there, on that particular X-ray?

A. Particularly in that chest X-ray we can see a right-sided pneumothorax, but it's not a tension pneumothorax. So the baby is intubated, I can see an endotracheal tube, I can see that there is a rim of air on the right side, you can see the lung margins, and you

can see the air.

Q. Thank you.

A. However -- so pneumothorax is an air leak. Sometimes in babies who are otherwise not unwell, we can see small air leaks, but if the -- so a tension pneumothorax is when you get a large amount of air on one side and it pushes the heart to the other side. That is an acute emergency that you have to do something about.

Q. Is that the case here?

A. No. So this was not a tension pneumothorax, there was no mediastinal shift, which is why at the time, given with what had happened, we decided not to do anything. There was no mediastinal shift, there was an air leak, but that changed with the next collapse because when we move on, when he deteriorated again, one of the first

things we thought about was: well, yes, it wasn't a tension pneumothorax then, but has it become one now? We needed to deal with that, so we then went on to do a needle aspiration to relieve that.

Q. In [Dr A]'s note that third deterioration took place at 12.28?

A. That's right.

Q. Again, in the timeline, does that accord with your recollection?

A. Yes, it does. I do remember exactly what had happened at that time as well. So with that gas that we looked at, we were sort of -- [Dr A] and I, I think, both breathed a sigh of relief. We were in nursery 2. It's an L-shaped corridor, [Dr A] and I walked down to the kitchen -- there's a little kitchen just as you enter the neonatal unit -- to make a drink.

And I remember
putting the kettle on and [Dr A] and I were talking
through -- when you are just trying to get your head
round what's actually happened, talking out loud,
thinking out loud.
I don't think we got very far. So literally,
I don't think the kettle had even boiled, where somebody
shouted from the end of the corridor, "Can you please
come now", so both of us were out of the room when that
collapse happened.

Q. Was there anyone left in the room when you went out?

A. Yes. As far as I can remember, Staff Nurse Lucy Letby
was there with him all of that time.

Q. Anyone else there when you left him?

A. I don't remember.

Q. Do you remember who called you back?

A. No, I don't even know if I saw the person because
I think we were in the kitchen and somebody just
shouted -- because it was literally shouting distance,
so they would have gone to the end of the corridor and
shouted us because they knew where we were and we just
came running back.

Q. When you came running back, what did you find?

A. So as far as I can remember, he was desaturating and his
heart rate was dropping and his oxygen levels were
dropping as well. And it looked like this child who had
been paralysed with pancuronium had dislodged his
ET tube. And one of the problems with pancuronium is
whilst it's very good in controlling the ventilation,

the baby can't do anything for themselves, so if the tube becomes dislodged for any reason -- and it is unlikely, unless -- because the baby is not moving, they are not breathing so unless something really untoward happens, you wouldn't expect that tube to dislodge, which was why I think we had sort of walked away from it, thinking, well, you know, he's now not going to breathe or fight the vent, we have a few minutes to think about is there anything we are missing or, you know, what we need to think about.

So we came back to find him crashing, that's the term you would use, and when we checked, the tube had dislodged.

Q. Do you happen to recall who was in the room when you went back?

A. I don't have a vivid memory but I do remember Lucy was at the bedside of the baby. She would

have obviously
asked somebody to call us.

Q. Okay. Were you given any explanation as to what had
happened when you got back?

A. To be honest with you, I don't remember asking for one.
That wasn't my priority at the time.

Q. What was it that caused you to believe that the problem
was the tube?

A. So the baby's connected to the ventilator, you are
giving them breathing through the ventilator. If their
oxygen levels start to drop, then the first thing you
think about is, is the ventilator and the tube doing
what they're meant to be doing? Because

in a paralysed
baby, it's the tube and the ventilator doing everything,
the baby can't do anything. So you're basically --
literally one of the things -- first things you think
about -- and if you're not supplied with oxygen through
the ventilator for long enough, it's only a matter of
time before your heart gets deprived of oxygen as well
and starts dropping as well.
So the first thing you go to in a baby who's
paralysed and starts to drop their saturations is, "Is
there a problem with the tube?"

Q. Okay. Did you examine the tube?

A. I must have had a listen, tried to bag and checked if
either there was no air entry or the chest wasn't
inflating, but that decision was probably made quite
quickly that the tube wasn't in anymore. Yes, I think
I've written the capnograph wasn't changing colour.

That's one way of finding out.

Q. What happened then to the tube?

A. We removed that tube and [Dr A] re-intubated him.

Q. For a third time, was cardiopulmonary resuscitation recommenced?

A. Yes.

Q. What happened this time? Can you recall?

A. This time, as well, he received multiple doses of adrenaline, sodium chloride, sodium bicarbonate. We also commenced him on adrenaline infusion. I think this was -- around this time, 12.20, was around the time to, give him a constant supply of -- either at this time or

maybe a bit later on he went on two more infusions of dopamine and dobutamine to, again, improve his circulation and his cardiac contractility.

Q. Okay. Were any measures taken regarding, at this stage, the pneumothorax that you'd seen about --

A. Yes. Again, with the -- you'll have to go back to the statement to consult with the time. So one of first things we then also thought about with this collapse once the ventilation had happened was to needle the pneumothorax, the right side. The needling of the pneumothorax is that you insert a cannula and allow the air to come out. So that's an emergency procedure, which always should be followed by inserting a chest drain. However, a chest drain insertion is an aseptic and a fairly sort of lengthy procedure. It's not a --

in an emergency, it's a procedure we call needle thoracocentesis. So you put a needle in and you allow the air to escape. So if there is a tension pneumothorax that's causing a massive compromise, it will release the air and allow the lung to expand and then you go back and insert a chest drain properly, which is what was done.

Q. In the context of what was happening around this time, we've mentioned 12.28, do you remember at what stage that needle was introduced to, as it were, first aid the pneumothorax --

A. Um...

Q. -- or would you be reliant on [Dr A]'s note for that?

A. I would be reliant on my statement and his notes because we both did them in conjunction -- at the time when this

was happening everything was happening in quick succession so thinking --

Q. Who inserted the needle?

A. [Dr A]. So basically, the first thing to do would have been to secure the airway. Needle thoracocentesis wouldn't have been a primary procedure. So you intubate the baby again, a baby who's paralysed is not breathing, you -- you tube them again and then the first thing you do is a needle thoracocentesis to release the air and then go from there.

Q. I'm going to ask Mr Murphy, please, to go, I think, I hope I'm right, to tile 435, please. This is [Dr A]'s note on this point. I'm going to ask you to have a look at this, please. You can see at the top the reference to the re-intubation that you told us about.

A. Yes.

Q. It's just that second paragraph down, please, beginning
"Chest X-ray".

A. Yes.

Q. Does that suggest a chest X-ray was taken -- is that at
around 12.30?

A. That's right.

Q. Do you recall that taking place?

A. Yes. That would have all been happening in that time,
yes.

Q. I'm sorry, it's not your writing, but are you able to
read what --

A. Yes.

Q. Is that "right-sided lateral" --

A. "Right-sided lateral pneumothorax decompressed with
24-gauge Jelco at second to third intercostal
space/mid-clavicular line at 12.40."
I think it says "2 to 3", but you might have to ask.

Q. Just dealing then with that paragraph, doctor, we've
looked at the X-ray that was taken at 11.57.

A. Mm.

Q. You tell us that you recall that chest X-ray being taken
around 12.30?

A. No, I don't. The timeline, I am not going to be precise
about. The timeline of the X-ray machine is the most
accurate one because it records the time when the chest
X-ray is taken. Yes?

Q. Or should do?

A. Which... It should do, yes. Whatever time we have

here, I have or [Dr A] has approximate times because these are -- we have gone back and thought about, okay, we would have done this around this time.

Q. Okay. Well, I'm going to go back to your note now, please, at 625. We can scroll to the point that we'd reached in your note.

We had got, I think, to the bottom of the page, certainly on to the next page. You'd spoken to Dr Rackham, you told us, around 10.30, but on a number of occasions; is that right?

A. Yes, I did. I haven't documented them all but I spoke to him a few times.

Q. Do you recall the resolution of the resuscitation that began at around 12.28 that we've been discussing?

A. Do I recall the resolution as in return of spontaneous

circulation?

Q. Yes.

A. Yes.

Q. Okay. How long, from recollection, do you recall that
taking?

A. I think it lasted several minutes and he probably needed
a good few doses of adrenaline from what I can remember.

Q. So that's a third resuscitation during the course of
about 4 hours?

A. Yes.

Q. Okay. Moving on then in the timeline, if we may, and
returning to your note:
"Spoke to Dr Rackham."
Is that about 1 pm?

A. Yes.

Q. "Updated about frequent collapses with desats and bradys
on ventilation and possibly pulmonary hypertensive
episodes."
Is that right?

A. That's right, yes.

Q. Just explain to us a pulmonary hypertensive episode,
please.

A. I was discussing with Dr Rackham -- so when I spoke to
him at 1, this would have been -- did you say the fourth
or the third?

Q. The third was at 12.28.

A. Yes. He must have recovered from this and by this time
I was obviously becoming extremely worried and again
revisiting, are we missing something here, is there
something else we can do, and I spoke to Dr Rackham
again. Pulmonary hypertension is a

condition where --
which babies can develop in which you can intermittently
have periods where lung pressures go very high and
oxygenation is compromised. So we are thinking here of
every box that we can that might explain why these
collapses are happening. And one of the possibilities
Dr Rackham suggested was -- "Is he going into pulmonary
hypertensive crisis?" was one differential. And he
suggested to try and get an echocardiogram to see if
that's the case.

Q. Okay. That will be the way, would it, to determine
whether that was the problem or not?

A. Yes.

Q. Did you succeed in getting an echocardiogram?

A. Yes. I spoke to Dr Brearey, he is one of our colleagues
who has a specialist interest in

cardiology, to come and
do an echocardiogram. Dr Brearey did and excluded
pulmonary hypertension and, basically, I think I have
written he had mild tricuspid regurgitation, which is
nothing to be concerned about.

Q. All right. Let's pause there. You're quite right to
say that's the rest of your note and I just wanted to
deal with that first. You've then put:
"Already on dopamine and adrenaline infusions"?

A. Sorry, where are we now?

Q. After you have said --

A. Yes, "Already on dopamine and adrenaline infusions".

Q. "Due to frequent deterioration..."
Is that dobutamine?

A. Yes, "dobutamine prepared". So all these drugs augment
each other and do slightly different things. So

dopamine is good for children who have poor peripheral
circulation. So he had already been on that.
Adrenaline, because it improves cardiac contractility
and again maintains blood pressure and improves
perfusion. So he was already on that. And then again,
he obviously went on and had another collapse despite
being on this. So one of the things Dr Rackham
suggested was to add in dobutamine, which again has
a special effect in improving heart contractility
because we were having frequent episodes of his heart
rate going down as well.
So he was -- yes, he said, start him on dobutamine
as well and get an echo done to see what is going on.

Q. And you put here:
"Dr Brearey performed an echo that showed mild
tricuspid regurgitation."

A. Yes.

Q. Anything to worry about with that?

A. No.

Q. And, "Good cardiac contractility", is that?

A. Yes, the heart -- he could see that the heart was contracting well, so obviously at the time when Dr Brearey did the echo his heart rate was good and, from what he could see, there was no reason for a pulmonary hypertensive crisis to be causing this problem.

Q. You have then put -- is that, "Continue on dobutamine"?

A. Yes.

Q. HCO3, that's bicarbonate, is it?

A. Yes.

Q. "Infusion..."

A. "... commenced over 6 hours. Full correction as per advice from Dr Rackham."

So looking at his blood gas pattern one of the things that we could see was that we gave him multiple doses of -- so normally, there is a formula we calculate of how much bicarbonate a baby needs so when you get the full -- from the formula when you get the full dose, you halve it and give it over half an hour and that's it.

So he'd had quite a few doses of that.

He was collapsing repeatedly and every time we did a gas, the acidosis was worse. So it wasn't something we were getting on top of.

Persistent acidosis is not good for the heart because it has a negative effect on cardiac contractility. So we were trying to counter all these things and when I would have been speaking to Dr Rackham, I would have been giving him

the gases and
the metabolic acidosis worsening.
So another thing that he suggested was put him up on
a continuous infusion of full correction over 6 hours,
which is what he is on now.

Q. And that's to correct that acidosis that was proving
tough to shift; is that right?

A. Yes.

Q. All right. Let's go on in your note, please.

A. Sorry, say that...

Q. If we can go on with the note, please. Mr Murphy is
just going to scroll down for us again in a moment,
thank you.
Your next note is about Dr Rackham, but between that
phone call and 3 o'clock, I'd just likes to discuss that
period with you, please.

A. Yes.

Q. After those measures suggested by Dr Rackham, how was
[Baby P] up until about 3 o'clock?

A. So between this time I think there is one gas at least.
So he was relatively -- I think we also gave him in this
time some metronidazole to cover for necrotising
enterocolitis.
Dr Rackham also asked to give him a start dose of
hydrocortisone just in case there might be an element of
what we call adrenal crisis. So we took a cortisol
level and gave him that and again these are all the
differentials going through everybody's mind.
So very sick babies, the adrenal gland produces
a very important hormone, cortisol, which helps us fight
stress and sickness. If a baby is not producing that
in the right amount then that can be the cause of
collapse, so we did that blood level and

gave him some
hydrocortisone. We also give him some metronidazole.
Both of these were given through the intraosseous route.
He had a gas -- I'll have to ask you to check the
time -- of 7.25, which is not great, but still --

Q. Just pause there. We'll put it up for you if that
helps. Everyone will have seen it, it's the last one on
the sheet, sadly. It's at 13.38.

A. Yes.

Q. It's the last venous sample entered on the record.
That's the one you were trying to remember?

A. Yes. This is a pH of 7.25, which is borderline
normal/okay/acceptable. His carbon dioxide levels are
fine, which means that his ventilation is not an issue.
His oxygen PO2 is fine, but his acidosis is worse. So

his base excess is minus 13.8 and his lactate is 18.5,
which is extremely high and worrying.
So this is all metabolic now. Breathing-wise, we've
got control, it's just his circulation is that poor and
there is that much acidosis around that it's causing
him -- his body to produce a large amount of lactate and
his acidosis.

Q. You mentioned a numbered of things. Is it also right
that [Baby P] received a dose of Curosurf, surfactant --

A. Yes.

Q. -- during the course of the afternoon as well?

A. Yes, yes.

Q. And do you recall [Dr A], once it was considered
appropriate, you told us you couldn't do it in an
unstable baby, but did there come a

point when [Dr A]
felt able to do something with that temporary needle
that you told us about to drain the pneumothorax?

A. Yes, so between the time of -- after the collapse at
12.30 and re-intubation, in the period of stabilisation
that followed [Dr A] successfully sited a chest drain
and there was an X-ray confirming that that pneumothorax
has resolved.

Q. Okay. [Dr A]'s note was that that was at 3 o'clock.
Does that accord with your recollection as best you can
remember?

A. I don't recollect the exact times, but...

Q. Let's have a look at -- I would like you to look at two
X-rays, please. If we go first to tile 434.
If we actually look at the X-ray, please.
Unfortunately, not timed or dated, this

one, doctor,
hence my reservation earlier --

A. Yes.

Q. -- but we saw [Dr A]'s note. Is this before the
drain was fitted?

A. The drain is in situ now. So this tube that's coming in
(indicating) is the drain and you can see that the
pneumothorax has resolved. The endotracheal tube is in
and the lungs are inflated.

Q. Okay. I'd like you to look at another X-ray, please,
which is tile 574, which is timed.

A. Yes, that's a pigtail.

Q. Just comparing the two, I'm not going to go back to it,
the difference there is the pigtail, is it?

A. Yes. So that's the one that takes longer to insert and
you need a field of aseptic area and it takes a good
half an hour to insert. So this would have happened --

Q. That's 3.36 and would be consistent with [Dr A]'s
note that it was put in at or around 3 o'clock --

A. Around that time, yes.

Q. All right. With apologies to Mr Murphy for skipping
around, can we go back to 625, please.
I want to pick your note up at 3 o'clock, please,
which I think is on the third page, if I remember
rightly:
"Dr Rackham arrived with..."
Is that the transport nurse, in effect?

A. Staff nurse, SN is staff nurse.

Q. "... with transfer team at 3 pm as chest drain was being
inserted and fixed."

So again, consistent with [Dr A]'s note. And
then sadly:
"Shortly thereafter, [Baby P] deteriorated again."

A. Yes.

Q. Do you recall where you were when that happened?

A. I was in that room, speaking to Dr Rackham, giving
him -- I had spoken to him on a good few occasions
during the day and I remember he was just standing
opposite me and there were quite a lot of people in the
room, but I don't recall who else was there. I was
speaking to him and giving him handover on the events
through the day --

Q. Okay.

A. -- and [Baby P] started to deteriorate again, oxygen levels
dropping, heart rate dropping, and full cardiac

resuscitation was started again.

Q. I hope this doesn't sound a daft question, I appreciate
you were in the room, but how were you alerted to [Baby
P]'s sudden deterioration?

A. It would have been either the alarms going off or --
because we were in the room, so it would have been
pretty much in front of us.

Q. Right, okay. You mentioned that the resuscitation
procedure began again.

A. Yes.

Q. This time we've heard it went on for some considerable
time.

A. Yes.

Q. But sadly, on this occasion, it was not successful?

A. No.

Q. We heard this morning that, having arrived during the course of this, Dr Rackham took control of the situation; is that your recollection?

A. Yes.

Q. And beyond assisting him, did you have any other interaction with [Baby P]?

A. No. I think one of the things he added was -- we doubled the dose of adrenaline, so he had instead of 0.1ml per kilogram, 0.2ml per kilogram. Another thing Dr Rackham added was: is there a possibility that he could be having seizures, so let's give him a loading dose of phenobarbitone. So we gave him that. Another thing, because of the persistent bradycardia, adrenaline wasn't touching him, his adrenaline infusion had been doubled. We -- sorry, just one second.

Yes, atropine is another drug that we don't use very commonly for resuscitations, but he just said to give him a dose of that, so we tried that as well but it didn't do anything.

Q. It wasn't successful?

A. No.

Q. All right. Okay. Before we move on to the remainder of your note, can I ask you this: you told us -- you've given us an idea of who was there throughout the afternoon and at particular times. Any conversations with any of those people that stick in your mind?

A. So one conversation that sticks in my mind is, you know that, when was it, just after the 12 o'clock gas, the 7.32 one. So we had that gas and after that -- so how we have the old neonatal unit, this was

nursery 2, and
then there's nursery 1, which is a bigger room. So
I remember going there, to nursery 1, and there were
a few nurses present there, including Staff Nurse
Lucy Letby. And I remember -- so when you face one
wall, there's a clock in front and I remember looking at
that clock and it was going just past 12. And I just
said, "Oh, the transport team are going to be here
soon", almost thinking out loud more than anything else,
and I'm literally sort of counting the minutes before
they arrive, just desperately wanting this baby to get
better and thinking, you know, there's something --
you're just totally out of your depth, can't think
what's going on, maybe somebody else can come and help.
And Staff Nurse Letby says, "He's not leaving here
alive, is he?" which I found absolutely shocking at the
time and I just turned round and I said, "Don't say

that, he's had a good gas." And I just remember that's
just -- all these years on, what, 7 years on, 6 years
on, that moment is still very much alive in my mind and
I said this and I left the room, but found that very --
because, yes, you know, we have babies -- all through
our careers we see babies who are very, very sick, who
are very, very unwell, and with some of them who have
followed a course and have become progressively unwell,
even when we know that their chances are survival are
very poor, personally, for me, that's something I would
never let myself think because it's that hope that makes
you keep trying. So I just found that very, very --
I don't even know if I was upset, I think I was just
shocked at the time, I was just shocked.

Q. Okay. Just pausing there then, you remember the time
roughly?

A. It was just between 12 and quarter past because he had just had this gas, I'd had the gas and I'd come out of that room and gone to another room.

Q. This is the gas that you have described to us as being --

A. The 7.35 or 7.321.

Q. The one that you were pleased with?

A. Yes.

Q. So how would you describe [Baby P] -- albeit relative to what had been going on, but how was he at the moment that conversation took place?

A. At that point in time, since that morning, he was the best you could call him. We'd managed -- this was a kid

that had had a good gas, he was ventilated, he was stable, the transport team were on their way, so I thought we were winning and found no reason for this comment, really.

Q. Okay. Through the course of the afternoon any other conversations with anybody that stick in your mind?

A. So after [Baby P] passed away, we -- so we have through -- when you go through to the labour ward, which is literally a connecting door from the neonatal unit, Lavender Suite, where the parents were. So myself and Staff Nurse Lucy Letby went down there and I went to speak to the parents.

I remember feeling -- you know, when you just feel, "I don't know how to face them, I don't know how to say this". So I went there and the parents were sitting there and I told them that [Baby P] too was going to need

a post-mortem.

Staff Nurse Letby was behind me against the door,

against a shelf, and again one of the things that

I found unusual was -- she was almost sort of very

animated in that she was saying to the parents, "Do you

want me to make you a memory box, a memory box for him,

you know like I did for [Baby O] yesterday?" And I just

remember thinking: this is not a new baby, this is

a dead baby, why are you so excited about this?

Q. Why do you use the word "excited"?

A. Because that's how she was. She was just, "Do you want

me to make you a memory box?" Like you make -- you

know, babies upstairs get these, what do you call them,

bounty packs or whatever, you know, newborns, they get

this from the hospital or someone where they have

different little things. And the parents were like,

"Yes, please, that would be nice, thank you", and
I found that very inappropriate, the way it was said.

Q. Not what was said?

A. No, not what was said, there was nothing wrong with the
content of it, it was just how it was said.

Q. Okay. So dealing with the period after [Baby P] had
passed away, can we just conclude your note, please? If
we can turn back to that, please. You've reiterated:
"For detailed notes on resus, please refer to
[Dr A]'s notes. At around 4.30 [is that] spoke to
Chris at the coroner's office..."

A. Mm.

Q. And then:
"... the senior coroner's officer, Christine Hurst."
Scroll down, please, Mr Murphy.

Thank you.

You have noted that it was agreed that both triplets' deaths -- and you have quoted: "... unexplained and would require a coroner's post-mortem"; is that right?

A. That's right.

Q. You then put the contact details for Christine Hurst and also her home number, which has been obviously taken out, and that she could be contacted over the weekend if needed; is that right?

A. Yes.

Q. Then you have noted that [Baby R] was transferred to Liverpool Women's Hospital. Anything you can recall about that process of [Baby R] being taken?

A. Yes. So I just remember thinking at the time I remember dad was there and he was absolutely sobbing, stood next

to [Baby P], and literally begging Dr Rackham, "Can you
please take him?" And even though I didn't beg, I said
to Dr Rackham in a more professional way, in my mind and
heart I just wanted him to leave because I thought
that's the only way he's going to live.

Q. You thought that?

A. Yes, I thought that.

Q. And Dr Rackham agreed to take [Baby R]?

A. Yes, he was very good about that, yes.

Q. And then you put that you spoke to them, the parents,
about the post-mortem, sadly a conversation that you had
already had on 23 June after [Baby O]'s death?

A. Yes.

Q. And they wished for [Baby O] and [Baby P] to be
transferred to the mortuary for the

weekend:

"I informed them, as per discussion with the coroner's office, that both triplets would be transferred to..."

Is that Arrowe --

A. Alder Hey.

Q. Sorry:

"... Alder Hey on Monday when various specimens for testing for infection, genetic and metabolic conditions would be taken and they would be returned to the parents by the end of next week for funeral arrangements."

And then you carry on with the arrangements for more time with [Baby O] and [Baby P] if they wished. Perhaps we don't need to -- if we scroll down a bit more. You gave dad your secretary's number so you could be contacted if necessary and also for the parents to call if they had any questions and you'd arranged to meet them.

That, I think, concludes your note

with your
signature, doctor; is that right?

A. Yes.

MR ASTBURY: Thank you. I have no more questions, but
I don't know whether that's...

MR JUSTICE GOSS: Yes. We'll have a break. Can we start
again at 20 to, so in about 8 minutes? Will that be
sufficient time for you? I'm anxious that this witness
completes her evidence this afternoon.
(In the absence of the jury)

MR JUSTICE GOSS: I don't know how long you'll be, Mr Myers,
but I don't think it would be appropriate to start
another witness this afternoon, Mr Driver.

MR MYERS: No, I think not, my Lord.

MR JUSTICE GOSS: [Dr B], we have a sort of eight-minute

or so break now. Do you wish to leave the court room for any purpose or are you happy to remain there?

A. Could I go to the toilet?

MR JUSTICE GOSS: Yes, I thought you might want to do that.

That can certainly be arranged. I will rise and someone will escort you from here and bring you back again.

(3.32 pm)

(A short break)

(3.41 pm)