(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.
= a
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)