is how I left it with her; I had also written it in a letter which was sent to her. She was upset at the news and I found the process quite hard, my daughter is also a nurse and of a similar age and I would say that it was one of the hardest things I have ever had to do. I would say that Nurse Letby was visibly holding back tears, although she didn't outwardly cry. She didn't say very much, she knew there had been an ongoing review around the mortality rate. The meeting with Letby took place in my office at the Hospital and Erianne Powell was also present.

When Nurse Letby came into work on the Monday, things did not go to plan, something had happened and she was told that she couldn't come back to work at all on the unit and was going to be moved to a clerical role in my team, which consisted of complaints, PALS and patient safety. I believe Letby was told that there was insufficient staffing on the unit for her to be supervised, to be honest I wouldn't have agreed to the idea if I had known that this was the case, I believe that the clinicians on the unit had also objected to her returning. Due to the nature of what was being investigated I made the decision that it was not appropriate for her to work within patient safety so assigned her to work on complaints, where she remained until I left. I did not have a great deal of contact with Letby when she worked for me due the way in which the department was set up, she did not actually work in the same building as me, my office was in the main part of the hospital and the rest of the team worked in Mostyn Lodge. I would go and see her occasionally, I bumped into her in the corridor a couple of times, I recall one occasion when she was a bit upset, however she did not want to speak to me about it. I think she came on a couple of nights out with the team, possibly a Christmas drink; however I remember her as a quiet person. I made it my business to speak to team members to get feedback on how she had settled in; she was clearly stressed by the whole situation so I wanted to make sure she was okay. The feedback was generally positive. In terms of her actual work, as a hospital, we receive numerous complaints and there was a bit of a backlog. Letby's job was to look at the responses from the various staff involved in the complaints and pull them together into a letter, which would then be proof read and finalised by the patien experience lead sent out to the complainants once signed at executive level.

I recall working on a couple of mortality reviews around the same time, I can't remember the names of the babies, however I think it was two of a set of triplets. Steven Brearey was involved and it was clear

that the clinicians were becoming 'twitchy' about the situation; nurse Letby's name came up again during the review. It was clear that they were concerned, the mortality review was about 10 days after the event, but the clinicians had kept a bag of fluids that one of the babies had been fed with at the time of death. This was highlighted to me during the meeting and I was unsure what to do with them so I phoned the trust secretary, Steven Cross who has a legal background, he informed me that given there was a suspicion of foul play I should ensure they were kept. After the discussion he advised me to speak to Chris Green, the head pharmacist, it was early evening when I did this as the mortality meeting ended late, I understand the bag was collected and I presume placed in a fridge. I am unsure of what happened to the bag, however when the enquiry came out into the open I emailed Steven Cross about the bag of fluids to remind him that we had them, his secretary assured me that he had read the email and that the fluids were being dealt with.

I remember being at another meeting after the review I had done, with the Consultants and the Medical Director, the clinician staff were clearly 'twitchy' about the whole situation, I recall one of the female consultants, possibly Doctor ZA suggesting that the deaths might have been caused by the injecting of air. The meeting was very upsetting, Ian Harvey went through the mortality reviews and one of the Dr's had recently Irrelevant & Sensitive I would describe the meeting as very tense.

As part of my role, I did visit the NNU, I am not trained in neo natal nursing, but I remember the first time I visited I was shocked at how poor the conditions were for space and storage, I couldn't believe that it hadn't been updated with the rest of the children's ward. I knew Erianne Powell and the head nurse quite well as they had been there a long time, but it was not a unit I had ever worked on.

Many years ago I was involved in a slightly similar situation where foul play was suspected, at that time I discussed it with the then Chief Executive who agreed that the police should be informed and brought in. Right from the beginning of the situation in 2015 I said the same, that the police should be involved, I was basically told that 'we can't be doing that' and that we need to do our own investigation, I reiterated that they should re-consider, because ultimately the trust were taking a long and winding route to the