

*There should be a 'Children's Champion' on the Board. One of the executive directors should have a specific remit to support the neonatal nursing and medical team until the enquiry and subsequent management action plan is completed (4.3.7)*

*An annual report should be prepared for the unit which is disseminated to the Board and Network stakeholders (4.1.7)*

*Include a unit-wide debrief for neonatal deaths on the unit to include all grade of clinical staff who cared for the infant (4.3.6)*

*An agreed mechanism for data recording, management and reporting across the IT systems including noting M&M case review reports and CDOP notifications should be devised and implemented systematically (4.4.11)*

*All neonatal guidelines should be developed in conjunction with the network and tertiary service for consistency of care in emergencies (4.4.10)*

IV. Network and others

*Arrange for central monitoring and management of transport team enquiries out of hours across the network (4.5.2)*

*Ensure tertiary advice calls include an 'early warning' or conference call to the transport team to enable better planning and deployment of the crews (4.5.2)*

*The NHSE/Network to expedite the decision on the whole-network transport service and centralise the administration out of hours in the interim (4.5.4)*

*The CDOP should consider whether its processes could have detected the cluster of deaths and initiated external review more swiftly (4.4.25)*

*Clarify between network and commissioners the arrangements for multi-site investigations and timely implementation of actions (4.5.9)*

*The Network should develop a policy for temporary closure of a unit to admissions due to capacity concerns (4.5.9)*

107. I cannot see, in this version of the report (document INQ0009618), any reference to potential/threatened police involvement. I do not know why this is. I am not sure which version of the report is the final version but if this is the final version then such information was not included.

108. At paragraph 3.12 it is stated that the paediatric lead and all the consultant paediatricians had become convinced by the link between Letby and the deaths, but it is stated *"this was a subjective view with no other evidence or reports of*

*clinical concerns about the nurse beyond this simple correlation.* In section 4 it is stated: *there was no other evidence or history to link Nurse L to the deaths*". In my opinion, I cannot speak for the whole team, this was the personal view/feelings/interpretations of one person regarding Ms Letby, it was not based on fact and was uncorroborated. Even now I would not consider his view as objective or impartial as he was too involved, too close to the situation and had a conflict of interest. There had been no independent review or oversight of the allegations and information provided in support of the allegations. There were no checks and balances in place (as would have been provided by a formal investigation). As a result I considered at the time that there was a risk that Ms Letby had been scapegoated by others, and the mixed messages being sent by staff, including those in senior roles, reflected this.

109. I cannot recall what consideration had been given to the staff rotas and any analysis of them (for instance the grid in document INQ0010072) and whether we reached our own conclusion on the correlation point. It was one uncorroborated piece of evidence. We did not, I believe, even get to see all of the rotas on which the grid was based to even be able to decide it was accurate. My view, as noted above, is that correlation does not mean causation.
110. Section 4 (document INQ0009618) attributes to the consultants a comment that their allegation was based on "*gut feeling*". As noted above I can see in document INQ0014603 the comment that the consultant's concerns were described as "*gut instinct*". I do not recall this phrase being used although I can see I asked a question about moving forward and, possibly, about (re)integrating Ms Letby although that is based on the transcription as the handwritten note is not decipherable. I do not know who responded to the question. I am not aware that the phrase "*gut instinct*" was used previously by anyone.
111. I am unable to recall specific consideration by the review team to whether the deaths being unexpected/unexplained, the absence of any explanation for deterioration, the number of instances of unexpected and unexplained deaths and whether this was usual or unusual, the report of the presence of mottling and the significance, if any, of this sign gave rise to, or added to, grounds for suspicion.
112. I believe the report, on review, does address the fourth term of reference "*to consider concerns about the Neonatal Unit with specific reference to: Are there any identifiable common factors or failings that might in part, or in whole, explain the apparent increase in mortality in 2015 and 2016?*" throughout as the reasons