Thematic Review **[INQ0003251]**, therefore going any further was not considered until July 2016 when the NMC were contacted by Alison Kelly.

54. I did not provide any information to the coroner about any of the babies named in the indictment, nor do I know what information had been given to the coroner regarding individual babies. I was not involved on a personal basis with any of the infants and only reviewed the information given to me once reviews or investigations were in progress.

The responses to concerns raised about Letby from those with management responsibilities within the Trust

55. As I have discussed before I cannot recall when any issues were highlighted to senior management, I have a vague recollection that increased deaths in NNU were discussed originally with Jane Evans who I believe was Head of Nursing, Urgent Care prior to Karen Rees. Karen Rees was then updated during the monthly meetings she had with Eirian, Anne Martyn. Sarah Jackson and myself prior to the Consultants raising their concerns and Alison Kelly was informed. As nurses, Eirian and I did not think that Lucy Letby could have been deliberately harming babies similarly the Consultants did not believe any doctor could be involved. I personally feel that rather than Ian Harvey and Tony Chambers being confrontational and threatening towards the Consultants, the Consultants should have been listened to earlier. External agencies could have been involved earlier and had the Executive agreed to involve the police earlier, such as in March, when the Consultants first voiced their concerns about Lucy Letby, the outcome could have been a little different in the fact that several of the babies may not have died, but I think this with hindsight.

Reflections

56. I have been asked whether if the babies had been monitored by CCTV, the crimes of Letby could have been prevented. I believe CCTV in NNU may have made a difference, it may have shown, when and how any wrongdoing was carried out, who was present prior to and at the time of deterioration and who was drawing up and giving drugs to those babies. It may have been difficult to elicit whether correct resuscitation practices were being performed but experts could perhaps have made recommendations if video evidence had been available. To my knowledge, this element of the July 2016 Action Plan exhibited **[INQ0002850, p2]** was not implemented at that time, I do not know if it is used in the new NNU. I believe when the original discussion was taking place, privacy of the mums was raised as an issue, but I also believed that costings were thought out.