Child E

67. I have been asked to consider extracts of Child E's medical records at **[INQ0000187_0017 to INQ0000187_0025 and INQ0000187_0050 to INQ0000187_0059].** I do not recall how and by whom informed me of Child E's death. I also do not recall when I was informed of Child E's death, I presume I would have been alerted to the incident on my return to work on the 5th August when I was on a management day. Yvonne Farmer was on duty 4th August so would have dealt with any managerial needs in the absence of the Manager, Eirian who I&S All babies admitted to the Neonatal Unit do so due to ongoing needs and observations. Individual care and journey are individualised, and the progress of infants cannot be generalised.

68. I cannot comment whether I thought Child E's deterioration was expected or unexpected. I cannot recall being part of any debrief.

69. I had only a few management days immediately following Child E's death, as I was scheduled to clinical shifts - when the off duty was previously done, Eirian would have had the management days, and I was only allocated time for the off duty and the rest of the time was clinical. As I was not personally involved, I was not part of the debrief and any Mortality Review would have been undertaken when I was on annual leave at the end of August 2015. I am, therefore, unaware as to whether any discussions (formal or informal) between nursing staff regarding concerns and/or suspicions regarding the death of Child E.

Child I

70. I have been asked to reflect on statement to the police dated 11th June 2019 in which it states that **[INQ0000531]:** *"I think that during 14th October 2015 Doctor Brearey may have commented to me not to give Lucy [Child I] again for a third night. I cannot remember any specific conversation or decision in relation to this, I am just speculating regarding anything Dr Brearey said. I think he was suspicious of her as she had been present when several babies had collapsed. I think I agreed that I would tell the team leader not to allocate [Child I] to Lucy for the third night. I did not personally suspect that Lucy had caused any baby to collapse or come to harm, but I thought at least she could not be blamed if [Child I] had another collapse if she was not her allocated Nurse or present at the time. I think I then told [Nurse T] to allocate [Child I] to someone else".*

71. With respect to my discussions with Dr Brearey on 14th October 2015, I do recall having to reallocate the nurse allocation as the babies' collapses were causing a few concerns with the medical and nursing staff. Despite all the cases being reviewed, there wasn't anything that seemed to connect the deaths or collapses to anything specific and all the care and interventions seemed untoward and obviously the medical team were very confused. Dr Brearey did speak to me about his concern that Letby seemed to be the common denominator to all the incidents which all seemed to happen on nights. This had not been mentioned to me before the conversation, but I listened to his concerns and thought it was easier to reallocate care for Letby's protection. This was a very easy solution and one which seemed to appease Dr Brearey. We often try to protect nursing staff if they are involved in very stressful situations and working in the ITU room every shift is not healthy for nursing staff and difficult to endure.

72. I did not change allocation because I had doubts in Letby's practice but more to stop finger pointing. I was not aware of anyone else having these concerns about Letby as she was always an exemplary nurse. I did mention my conversation and action as a result to Eirian the next time I saw her on shift which would have been the following week, however, neither of us had any concerns at the time to believe she was causing any harm. There were no complaints from nursing staff or parents about unsafe practice or suspicions with regard practice, in fact nobody had reported any unsafe practice. It was Letby's last shift until the end of the following week which was after Eirian had returned to the unit following her annual leave. I was reassured that she wouldn't be back in work until Eirian had spoken to Dr Brearey.

73. Following my discussion with Dr Brearey, I did mention my conversation and action as a result to Eirian the next time I saw her on shift which would have been the following week. But neither of us had any concerns at the time to believe she was causing any harm. There were no complaints from nursing staff or parents about unsafe practice or suspicions with regard practice. No one reported any unsafe practice. I did not discuss mine and Dr Brearey's conversation with anybody else.

74. I have been asked to consider Nurse T's WhatsApp messages with Letby about Child I, dated 14 October 2015 **[INQ0000424_0059_ INQ0000424_0061].** In respect of the WhatsApp messages between Nurse T and Letby, I remember looking at the allocation that Nurse T had completed, and I just suggested that she reallocated so that Letby wasn't allocated to Child I. This was due to it being her last night and I recall she had

busy shifts in in the previous nights and it was to give her a lighter load. Nurse T listened to my suggestion; however, I did not mention Dr Brearey's concerns and the allocation was changed following our conversation.

75. In relation to the death of Child I, I would have been on my return to work on Monday, 16th October 2015.

76. Following Dr Brearey's request not to allocate Letby to Child I, I do not recall making specific enquiries in respect of Letby's presence, however, I presume that this would have been in the context of who was looking after Child I so I could offer some support.

77. In respect of Child I's passing, apart from the conversation held on the 14th October 2015 with Dr Brearey who raised his concerns around Letby, no other doctor or nurse spoke to me regarding any suspicions or concerns they held. I would have discussed any concerns with Eirian following the death of Child I, especially when Dr Brearey asked to speak to Eirian about his concerns. Both of us discussed the claims but we didn't have any hard evidence to justify the accusations.

78. **I have been asked to consider** Dr Brearey's statement to the GMC **[INQ006890, para. 23**] in which he says: *"Following [Child I's] death [23 October 2015] I emailed Eirian Powell saying that we needed to talk about [Letby] as she had been present on the unit when [Child I] died and during some of the night shifts when she suddenly deteriorated."*

79. Regarding Dr Brearey's e-mail to Eirian Powell, I do not recall it specifically, but I know Eirian would have discussed these concerns with me to see if I had heard or seen anything untoward to support these claims whilst working clinically. We are a very close team and encourage staff to speak up with an open-door policy.

80. I have been asked to reflect on the document produced by Eirian Powell **[INQ0003189]** which was a table that listed seven babies who had died in the five-month period from June to October 2015 and showed that Letby was on duty on each occasion. In respect of the same, I'm not sure when I had sight of this report, however, I did not assist with creating it.