had been transferred out of the NNU to other NNUs from late 2013 until June 2016. I was informed that the previous day a list had been drawn up of all babies transferred out of the NNU over the stated time period. Babies whose transfers to a more specialised centre was deemed inevitable due to problems identified before or soon after birth (such as a congenital malformation requiring surgery or urgent investigation), had been removed from the list. This seemed reasonable because the need to transfer those babies was not primarily the result of a deterioration in their condition that had occurred on the NNU either due to deficiencies in the care provided or possible deliberate harm caused to them.

369. I did not receive a written request for this review but I was told that my task was to highlight any of the babies transferred out from the NNU in whom I considered that there had been something unusual or unexpected that had contributed to the need to transfer the baby. In this way it was hoped to identify babies who had collapsed for unexpected or unusual reasons. A staff analysis would then be performed, I did not know by whom, to determine which members of staff had been involved in the care of the babies at the time they had experienced an unexpected or unusual collapse.

370. Non-fatal collapses were not well defined and were not monitored and reviewed on our NNU. Concentrating on the cohort of babies who required transfer from the NNU would identify some of the babies who had suffered non-fatal collapses. It had been my impression, and that of my consultant Paediatric colleagues, that Letby had been involved in many of the non-fatal collapses but I did not have, nor was I aware of anyone else having, data against which to assess staff involvement in non-fatal collapses. It was important to check whether the impression was correct that Letby had also been closely associated with non-fatal collapses whilst accepting that the analysis of staff involved in these episodes might reveal that no staff member was over-represented or even that a member of staff other than Letby might have been involved in an unusually high number of these events.

371. A limitation of this exercise was that it would only identify unusual non-fatal collapses from amongst NNU patients that then required transfer out to another hospital following that collapse. It would not identify any non-fatal collapses where the baby remained on the NNU in Chester. Even so, this offered a way to analyse the staff on duty during at least some of the non-fatal collapses so that this analysis could then