review all of the cases focusing on nursing observations in the 4 hours before the arrests and identify any medical or nursing staff association with the cases. Some general suggestions for improving practice are included.

108. Appended to the report is a list of the 10 deaths, what reviews had been carried out, the cause of death, the staff allocated and the staff on duty.

109. Having reviewed this appendix in detail since, Letby was the allocated nurse for 3 of the 10 deaths and on duty (but not the allocated nurse) for a further 6. However, this is a dense report and in the absence of anyone specifically drawing this to my attention, I do not think I would have noticed this.

110. I think I have since seen a number of versions of this appendix or a similar table. Without access to all of the original emails I cannot say which versions of the report I received and when.

111. The tone and content of Dr Brearey's email attaching the thematic review did not cause me any concern. I was reassured that the events were being appropriately examined. Indeed the cases appear to have been reviewed in great detail.

112. I would have reviewed the report in overview but in the absence of any concerns being highlighted by Dr Brearey, I would not have taken any immediate action. If there were any matters specifically causing him concern, I would expect him to have drawn my attention to them in the body of the email or at least in the report. As there is nothing in the body of the email that suggests a concern regarding the correlation of staff, I think I would have inferred that the Neonatal Team were not worried about it. I think if Letby had been identified as being directly responsible for the care of the babies that might have caused me more concern, but she was not; the table simply indicates that she was on duty but not the allocated nurse for 6 of the 10 babies.

113. I am aware that Dr Brearey has stated that when he sent me the Thematic Review on 15 February 2016, he asked for an "urgent meeting to discuss [the findings]". The email in which Dr Brearey attached the Thematic Review [INQ0003140/0001] makes no reference to seek a meeting. The information was provided to me at my request, and

patient safety concerns at this time, and I would have been reassured that CQC had not identified any during the inspection.

Executive Team Meeting (6 April 2016)

134. On 6 April 2016 I attended the usual Executive Team meeting [INQ0003966]. I do not have a specific recollection of this meeting but the notes suggest that the NNU was not discussed. On reflection, I think by this stage myself or Alison Kelly probably should have alerted the other Executives to the fact that we had been alerted to an increase in neonatal mortality, that Dr Brearey and others had reviewed this, that we were in the process of arranging a meeting to discuss it and would update them if there were any issues arising from that meeting.

Letby moving to day shifts

135. I am aware that around April 2016 Letby was moved onto day shifts. I wasn't aware of this at the time, but it was later discussed at a meeting in May which I will return to. I would not expect to have been made aware of this shift change. This is because I was later advised that the decision to move Letby was primarily to support her, which I will return to later.

Sudden and unexpected deteriorations of Child L and Child M (April 2016)

136. I understand that in April 2016 Child L and Child M had sudden and unexpected deteriorations. I was not aware of these events and would not expect to have been made aware for the reasons I have set out in respect of other deteriorations. However, I believe it subsequently came to light through the criminal trial that Child L had had persistent hypoglycaemia requiring specialist blood investigations to be carried out at the Royal Liverpool Hospital. As with Child F the results were reported in the case notes and were consistent with the administration of pharmaceutical insulin, this is a baby who was not supposed to receiving this drug. At the trial Dr John Gibbs was reported as stating that the junior doctor(s) had not appreciated the significance of the result. I regard this as a failure of governance, training, and supervision. As with Child F I would

have expected the result to have either been seen by a Consultant or reported to them, a Datix report to have been submitted and the case should have been escalated. There should have been cross reference with Child F. I think if this had been identified and reported, it would have influenced our decision to go to the police.

Email from Alison Kelly (14 April 2016)

137. On 14 April 2016 Eirian Powell emailed Alison Kelly [INQ0003089] asking what her thoughts were about the thematic review. She appears to provide an updated version. I appear to have been removed from the email chain.

Email from Alison Kelly (18 April 2016)

138. On 18 April 2016 Alison Kelly emailed me about a number of matters. In relation to the NNU, she explained:

a) That Dr Brearey had not provided an initial review on a Datix incident relating to a death on the NNU and that this had been highlighted at the SI Panel the previous week. Without the Datix report I cannot say which child this relates to. The email suggests that the incident occurred on 10 February 2016.

b) That she had realised that the NNU review document that was sent to us was the review with the Consultant from Liverpool Women's Hospital. She also advised that Eirian Powell had also sent through a separate document with the clinical details and the teams involved. I believe this was INQ0003189. This version of the table sets out the cause of death, allocated staff, staff on duty and clinical details of deterioration. Letby's name is highlighted in red, as is the name of a clinician (Dr Harkness). Alison also attached the thematic review of neonatal mortality, which includes a table prepared by Eirian Powell [INQ0004538]. This table is similar to INQ0003189, but with less clinical detail and with the names all in black.

c) That the above was not going to QSPEC that day but that she thought it would need to go into the QSPEC meeting in May. Alison suggested that before

145. On 3 May 2016 Dr Brearey emailed Alison seeking an alternative time for the meeting on 4 May 2015 [INQ0005724]. Alison replied that she could not offer any alternative times and that the meeting would need to be rearranged. I cannot recall why Dr Brearey was unavailable, why we could not accommodate another time on 4 May 2015, or whether I was consulted.

146. On 4 May 2016 Dr Brearey replied to Alison, copying Eirian: "*Thanks Alison, there is a nurse on the unit who has been present for quite a few of the deaths and other arrests. Eirian has sensibly put her on day shifts only at the moment, but can't do this indefinitely. It would be very helpful to meet before she is due to go back on night shifts. There is some pressure regarding staffing numbers with this at the moment. Best wishes, Steve*".

147. On 6 May 2016 Alison forwarded the email chain to me, which I will address later in this statement.

148. I cannot recall my reaction to reading this email chain at the time, but my impression of it now is that Dr Brearey was not raising concerns about the current arrangements on the NNU but simply that they could not continue indefinitely due to staffing issues. There is no suggestion that a meeting is required urgently, save for the fact that he would like to discuss before the nurse returned to night shifts. Although it was highlighted that the nurse had been present for "quite a few" of the deaths and collapses, it was not clear what the concern about her was. I cannot recall what, if anything, I did on receipt of this chain, but Alison's email suggests that we discuss it at her 121 the following Monday.

149. On 4 May 2016 Alison Kelly emailed Karen Rees forwarding Dr Brearey's email of the same date [INQ0003138]. In the email, she asks Karen to look into this with Anne Martyn/Eirian. She highlights that if the nurse's shift patterns have been changed because of this, then this is potentially very serious. She also says that she will check the report previously sent as she had not noticed there was a staff trend. Prior to this I had also not appreciated the staff trend.