then, she and I meet with Dr Brearey and Eirian to check on actions "as a few were due to be completed in April". This, in combination with the fact that the earlier email chain had not indicated any degree of urgency, was why I formed the view that a meeting was not required urgently.

139. In the email Alison also refers to a number of other issues and projects which are not relevant to the NNU.

140. I cannot say why the meeting with Dr Brearey and Eirian was proposed for May. It is possible that this was due to diary commitments. Alternatively, it could have been that it had been flagged that further actions were due to take place in April and Alison wanted to wait until that had been completed to discuss.

141. There had been no suggestion to me that a meeting was required urgently and I did not try to schedule it faster.

Notes of Alison Kelly (18 April 2016)

142. I have seen a handwritten note made by Alison dated 18 April 2016 with the heading "IAN" **INQ0003385**. Looking at the content of this document I cannot say whether it is Alison's preparation for a meeting between us or a record of a meeting between us. A number of issues are raised which largely reflect the email she sent to me the same day.

Email from Alison Kelly (28 April 2016)

143. On 28 April 2016 Alison Kelly sent out a meeting invite to me, Dr Brearey and Eirian Powell "re Thematic review" for 4 May 2016 [INQ0003592]. Later the same day, Eirian forwarded the invite to Anne Murphy, the Lead for Paediatric Services as she was "aware of the current status".

144. I have been asked why it took until 28 April to arrange the meeting. I cannot remember whose responsibility it was and the meeting could have been delayed for a number of reasons. I don't recall anyone suggesting that a meeting was required urgently.

Emails from Stephen Brearey (3 and 4 May 2016)

demonstrates that Letby was on duty, but not the allocated nurse, for two of the three incidents. Her name is not highlighted in red, but the name of a clinician who was present for two of the three incidents is highlighted in red. Another nurse is also present for two of the three incidents.

159. I do not think I have seen this document in this format, but at some stage I was made aware of three additional incidents.

Emails with Alison Kelly on 6 May 2016

160. On 6 May 2016 Alison Kelly forwarded to me the email she had received from Dr Brearey [INQ0005724]. In the body of the email, Alison stated that Dr Brearey's comments had alarmed her, and that she had asked Karen Rees to liaise with Eirian about Letby. She said that she was currently reassured there were no issues but that it would be worth of a wider review which had been arranged the following week. The following documents were attached to the email:

a) A document containing some of Letby's shifts **INQ0004529**

b) "NNU mortality 2015" **INQ0007060**

c) "NNU monitoring mortality 14 04 16" **INQ0006951**

d) "Neonatal Unit review 2015 assurance" **INQ0004508**

161. I replied to Alison the same day **INQ0107818** and said: "I see what you mean, although perhaps he just meant that he was concerned for her?" and confirmed that I was available for the meeting.

Meeting with Alison Kelly, Eirian Powell, Dr Brearey and Anne Murphy (11 May 2016)

162. On 11 May 2016 I had a meeting with Alison Kelly, Eirian Powell, Dr Brearey and Anne Murphy. My recollection of this meeting is that it took place relatively late that day, in my office. I do not recall being made aware that Letby was being associated with every death, although she was over-represented. I recall that Eirian Powell explained that Letby was a Specialist Practitioner and tended to care for the sickest babies. She was also single and tended to do extra shifts on the NNU. I do remember some

discussion about Letby being moved on to days, but that this was in order to support her given that she had been present for a number of deaths. The tone of the meeting was calm and I don't recall anyone being aggravated or forthright about a concern about Letby. It was very much a statement of facts; a run through of the incidents, what reviews and actions had been undertaken. My impression was that the information was being provided to Alison and I for our information, partly for reassurance that we agreed with the actions that the neonatal team were taking. I did not feel that anything further was being sought from us. It seemed to me that the cases had been reviewed in detail, further investigation was being undertaken, and in the meantime they would continue to monitor the situation for a further two months whilst Letby worked on day shifts. This action struck me as proportionate and appropriate. My understanding at the end of the meeting was that we were dealing with a spike in deaths on the NNU which were unexplained despite thorough review and that we were reassuring Dr Brearey we, the Executives, were aware and supported the actions being undertaken by the clinical team. At no stage during this meeting did I feel that it was being reported because there was worry that Letby was responsible for the deaths.

163. I did not make notes of this meeting, as Alison was making notes and I wanted to pay attention to what was being said. I have reviewed Alison's notes [INQ0001381] and they broadly accord with my memory of this meeting.

164. I have been asked to confirm whether I agree or disagree with the following comments Dr Brearey made about this meeting in a witness statement [INQ0006890]:

- [Para 43] That the meeting "*went ahead on 11 May 2016 despite my attempts to convene the meeting as early as February 2016*". To the best of my knowledge and recollection, the meeting was suggested by Alison Kelly in an email dated 21 March 2016. I accept that efforts could have been made to convene a meeting earlier. However, as previously referenced in my statement, there was no sense of urgency in the email trail prior to this meeting, nor did anyone approach me to express concern regarding any delay.

- [Para 44] "*I raised concerns about the number of deaths occurring on the night shift between the hours of 00:00am and 06:00am and also that there had been no overnight collapses since Nurse A had been moved onto day shifts*". This was part of the discussion, however, I felt that the short period that "Nurse A" had been moved from nights rendered this of limited, if any, relevance. Also, I believe that there was limited evidence, given the short period of time Letby had been off the unit, to be able to comment on the frequency of deaths in any period. As a general proposition, clinical risks within a hospital are greater at night and at weekends. In the case of NNUs, this had been recently been reinforced by the Imperial College report for weekends.
- [Para 45] "*Eirian Powell was very defensive of Nurse A at the meeting and raised concerns about the doctors on the Unit".* I agree that Eirian was supportive of Letby in this meeting. At this stage I believe that it was right to review all factors, including all staff.
- [Para 46] "*There were no clear actions coming out of the meeting and it was not minuted. The only outcome was that we would convene another meeting just before Nurse A was to start working night shifts again*." I have not seen any formal minutes of this meeting, but handwritten notes were prepared by Alison Kelly [INQ0003181]. Alison's notes indicate that the following actions were agreed: "*- Review all babies who deteriorate, stay on days x 3 months - 2 further months to go, Review of deaths on nights – looked at pre 1 hour before arrest. Meet in 2 months' time*". I do not recall anyone raising any concerns about the actions agreed, or that any further action was required at that time.

165. I have been asked to confirm whether, during this meeting, I asked for a formal recording or notification system to be instituted in relation to any sudden and/or unexpected deteriorations. I did not, because there already was a formal clinical incident reporting system – the Datix system. In addition to this, following this meeting, I

would have expected to have been made aware of any concerning issues on the NNU by the neonatal team.

QSPEC Meeting (16 May 2016)

166. On 16 May 2016 the monthly QSPEC meeting took place, which I attended. The minutes [INQ0004304] indicate that neonatal mortality was not discussed. I cannot think of any particular reason why it was not discussed, other than the fact that I had received a degree of assurance from Dr Brearey and Eirian Powell and that actions were being undertaken. On reflection, it probably ought to have been raised to the Committee, or at least the Chairman. If it had been raised, it would have simply been for the awareness and information of the Committee pending any further update from the neonatal team.

Women and Children's Care Governance Board Meeting (19 May 2016)

167. I understand that on 19 May 2016 there was a meeting of the Women and Children's Care Governance Board [INQ0003214]. I was not a regular member of this Board. The minutes suggest that a neonatal update about recent incidents was provided, but it does not appear that the concerns raised in respect of neonatal mortality were discussed. I cannot say why this is. I would have expected this Board to have been made aware of any concerns. I do note that page 6 of the notes indicate that this Board had received a Mortality Review for 2016 from "SB" but I am not sure which report this refers to.

Deterioration of Child N (3 and 15 June 2016)

168. I understand that Child N experienced sudden and unexpected deteriorations on 3 and 15 June 2016. I do not recall being made aware of this at the time. Given that one of the actions arising from the meeting on 11 May 2016 was to consider deteriorations, I would have expected to have been informed about this.

QSPEC Meeting 20 June 2016

169. On 20 June 2016 I attended the regular meeting of the QSPEC [INQ0004309]. The minutes do not suggest that neonatal mortality was discussed. As explained above, I

205. At 10:01 Dr John Gibbs continued the chain of email conversation. I was not copied into that email. In that email Dr Gibbs stated: "…*we are entitled to discuss our concerns with one another*…". I agree entirely; my previous email was not intended to stop appropriate discussions taking place.

206. In the email Dr Gibbs asks whether Letby was on duty for all of the unexpected deaths and collapses. He also asked in how many of the cases air had been identified in the skull of the baby at post-mortem, and whether this would be unusual. He suggested that if there was an unusual and unexpected incidence of air inside the skulls of the series of neonates it would be mandatory to go to the police. I do not remember this being raised with me at the time. To the best of my recollection the possibility of air embolus was first raised with me by Dr Jayaram much later. I think this was around the time that I first approached Dr McPartland, which I will address later in this statement.

207. At 10:24 Dr Jayaram replied to Dr Gibbs as follows:

> "*The Trust are contacting the police soon, once some information gathering has taken place, which is why Ian asked for the chit chat to stop for now. The air in the skull is interesting and worrying though given the discussions we have had*".

208. I cannot explain why Dr Jayaram had said this as I cannot recall having discussed approaching the police at this stage.

209. In a separate thread, Karen Townsend forwarded to Alison Kelly and me the emails she had received from Dr Brearey [INQ0005744]. I replied to say that there was now email silence on this, that I had spoken to Dr Jayaram and that we were taking action. The "action" I was referring to were probably the actions outlined in the emails I have detailed above, or the fact that meetings with Executives had been arranged to discuss further.

210. A number of meetings took place on 29 June 2016 and it is difficult now to remember what was discussed at each. I have seen the following notes of meetings on this date:

- **INQ0003364** and [INQ0003371] – Stephen Cross
- [INQ0015537/5-7] – Alison Kelly

explained that Dr Hawdon had advised a review of the cause of death given that the baby was stable in air in the days preceding collapse.

509. I went on to say "*it may be of relevance that our clinicians have reported that one clinical feature that they had noted was that in some cases babies did not seem to respond to resuscitation as they would have expected".*

510. My understanding of Dr Hawdon's recommendation was that only the cases which were not adequately explained required review. By this stage, Dr Hawdon had proposed a natural cause of death for all of the other cases/collapses she had reviewed.

511. I received the updated comments from Dr Hawdon on 25 November 2016. I spoke with Dr McPartland on 6 December 2016. The email of 21 December 2016 indicates I had spoken with the Coroner to agree a review could be undertaken by Dr McPartland. As such I believe I was progressing this as expeditiously as I could.

512. I think I had discussed with Dr McPartland, verbally, that clinicians had raised concerns over a member of staff and her presence on the ward at relevant times.

513. I did not send a formal letter of instruction to Dr McPartland. The only instructions were contained in this email, or in telephone conversations we had. I am not certain, but I don't think Dr McPartland was provided with additional documents as Alder Hey was in receipt of the relevant documents from when the post-mortem examinations were conducted.

514. The instruction was quite informal, but I didn't have any concerns about this at the time. I had understood that what I was asking Dr McPartland to do satisfied what Dr Hawdon had suggested. In hindsight I do think I should have formally instructed someone independent, as the deaths had originally been investigated by a pathologist at Alder Hey, but I was mindful of the time constraints. To have them reviewed elsewhere I would have had to find someone with the relevant expertise and capacity, get permission from the Coroner, and then arrange for the files to be transferred from Alder Hey. Dr McPartland did not raise any concerns about her impartiality.

Executive Team meeting (21 December 2016)