arranged. This underlines the point I made above about the lack of spare capacity within mine and Ian's diaries to accommodate meetings.

249. On 4 May 2016, as part of the email chain which included the emails above, Dr Brearey replied to my email stating "*There is a nurse on the unit who has been present for quite a few 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*" (emphasis added).

250. The email from Dr Brearey indicated to me that the reason he felt there was some time pressure for the meeting was because Letby had been moved off night shifts and this was impacting on nurse night-shift staffing numbers. The inference was that Letby was going to be moved back onto night shifts at some point and Dr Brearey felt it would be helpful to have a meeting before then. I was unaware of Letby having her shifts changed prior to Dr Brearey mentioning it in his email and had I known this it is certainly a factor that would have influenced how urgent I considered the meeting to be. The 4 May 2016 email is the first time anyone had specifically drawn to my attention the name "Letby".

251. There is nothing mentioned within his email which expressly or impliedly suggests that Dr Brearey had concerns about the deaths being from unnatural causes. I also note that he said the nurse had been present for "*quite a few deaths and other arrests*" he was not saying that she had been present for all of them or the vast majority. Dr Brearey's email did not convey any sense of material concern about Letby, he did not question her competence or make any suggestion that she should not be allowed to work on the unit. His email appeared to be about the impact moving Letby was having on the nursing rota.

252. On 4 May 2016, I emailed Karen Rees in relation to Stephen Brearey's email [INQ0003138]. In the email, I stated: "*if there is a staff trend here and we have already changed her shift patterns because of this, then this is potentially very*

serious!! I will check the report they sent through – I did not notice there was a staff trend!!". With this new information being provided to me, I immediately asked Karen Rees to speak with Letby's manager, Eirian Powell, to gather more information about the nurse and the change in her shift patterns. I also sent Karen Rees a copy of the Thematic Review saying "*Letby is highlighted in red!! I have not noticed this when I first reviewed*." I am not sure when I first received the Thematic Review with Appendix 1 showing names in red. I was quite alarmed when I typed this email as I assumed that the shift patterns had been changed as a direct result of the staffing trend identified.

253. As mentioned above, I would receive hundreds of emails each day (including receiving all Datix reports with moderate or above level of harm) and I would receive reports about all manner of things associated with Trust related matters. To provide some further context, I have reviewed my notebooks for this time period to provide an idea of how much time I spent in meetings each working day (unfortunately I do not have access to my Outlook calendar). On average, I was in meetings for six hours each day and a significant number of these meetings would have taken place off-site (for example, regular meetings of the regional Director of Nursing forum and the Local Workforce and Education Group). In between scheduled meetings, I would also often (like other Executive colleagues) have to deal with urgent or impromptu issues that would crop up during the course of a day.

254. In addition to my usual day to day activities as the Director of Nursing there were also a number of large projects I was heavily involved in during this period of time this included: establishing the Model Hospital programme of transformation (supported nationally), developing a plan for a nurse staffing establishment review, developing a procurement plan and business case for the purchase of Electronic Rostering (linked to an acuity-based workforce model), developing and implementing a Trust financial savings strategy, management of operational

275. In Eirian's note she summarised the escalation and actions already taken and the fact that they needed "*advice and support as to what (if any) do we do next?*". Advice had been sought already from risk facilitators within the Trust (Debbie Peacock); Dr Subhedar; the Neonatal Network and higher management. As noted above, the meeting on 11th May was more to seek reassurance about the actions taken to date and to make myself and Ian aware of the current thoughts around a particular staff members' connection with the deaths. I was very open to hearing Eirian, Anne and Dr Brearey's thoughts on the Thematic Review and whether they thought it was likely that there was a direct link between the increase in deaths and Letby. I can recall feeling reassured that there was nothing to be concerned about and no performance issues which needed to be addressed. I would not say that Eirian was "*defensive*" about Letby but I seem to recall that she did point out that it wasn't just Letby's name which appeared many times in Appendix 1 there were clinicians' names repeated too.

276. I left that meeting feeling that we had a better understanding of the Thematic Review and the steps that were being taken by those directly responsible for the management of the unit. It seemed to me that a lot of careful consideration had been given to reviewing the cases of the babies involved and debating all the potential factors which may have contributed in some way. We had agreed the actions going forward (which included completing the action plan contained within the Thematic Review itself) and we agreed to meet again in two months. By which time we would be able to assess how Letby had been whilst on day shifts, progress would have been made with the Thematic Review action plan and we would have more information from the further monitoring of any collapses.

277. Based on the information provided at the meeting, there was nothing at all to justify an immediate suspension of Letby. Had I been told that she had been seen doing anything that compromised the safety of any patient or that there was evidence of potential intentional harm being caused to any of the babies I would

have immediately moved to have her suspended from the unit. I believe that both Ian and myself acted in a way which was proportionate to the information presented to us at the time.

278. I cannot recall it being mentioned that there was any specific mention of babies who had collapsed unexpectedly but not died. However, that said, it was an agreed action to "*review all babies who [suddenly] deteriorate*". This would have been a reference to Dr Brearey and his colleagues conducting a review of any babies over the coming two months who suddenly deteriorated. This would therefore suggest that it was raised as something that the clinical team needed to keep a close eye on. Any sudden and unexpected deteriorations should, in any event, have been recorded via the Datix system, which all staff are trained to use.

279. On 16 May 2016, Dr Brearey wrote to the other Paediatric Consultants about "neonatal mortality" [INQ0005721]. I was not copied into this email but I have reviewed a copy and I note that Dr Brearey said "*Eirian and Anne and myself met Ian Harvey and Alison Kelly last week to discuss the rise in neonatal mortality last year. It was a helpful meeting and they were grateful for the work we have done in the various reviews and involving an external clinician. Naturally we will be keeping a close eye on things in the immediate future. If you do come across a baby who deteriorates suddenly or unexpectedly or needs resuscitation on NNU, please could you let me and Eirian know…*". This is in line with my recollection of this being a helpful and informative meeting with everyone on board about the way forward and the need for an increased level of monitoring.

May 2016 – other events

280. On 16 May 2016 QSPEC met [INQ0004304]. I attended this meeting and I have seen the minutes where a range of safety matters were discussed but not in relation to the NNU. I am not sure why this was as I had raised previously that I wanted it to be discussed at the next QSPEC meeting. In hindsight, I think it could