articulate the possibility of Letby causing inadvertent or deliberate harm but when expressed openly, it became clear that I was not the only consultant with these concerns.

Question 88b

296. In November 2015 Dr Brearey also told me that mortality table compiled by Eirian Lloyd-Powell **(INQ0003189)** that identified the presence of Letby at each death.

297. However, I was also aware that I had no definitive evidence of how Letby's association could have been causative and was unsure how to escalate this further based on just "gut feeling" nor what specific actions to take to explore these concerns.

October 2015 mortality table

Question 89

298. I do not recall seeing the document **(INQ0003189)** that Eirian Lloyd-Powell (ELP) emailed to Dr Brearey on 23/10/15 **(INQ0005609)** and I was at the start of a period of leave at the time it was shared by email.

299. On my return in early November, I do not recall specifically seeing the document but Dr Brearey about the association with Letby's presence. However he told me that he had flagged up and discussed his concern about the association with Letby that had been highlighted by the document to ELP, which added to the suspicions that had already begun to form in my mind.

300. As discussed previously, I was at a loss as to how to sensitively and diplomatically the need to investigate this association further.

301. I recall Dr Brearey discussing whether arranging an external review by a tertiary neonatal consultant might be the most appropriate next step.

302. I also understood from Dr Brearey that he understood that the association with Letby that had been highlighted in the Mortality Table was being escalated by ELP to Sian Williams (Divisional Nursing Director) and Alison Kelly (Director of Nursing)

Question 90

303. I was aware that Dr Brearey had asked Dr Subhedar in his role of C&M neonatal network lead clinician if he would undertake a review of the deaths. I agreed with this approach because I felt that, in spite of internal reviews, we could not identify any obvious cause in terms of clinical care, processes and procedures, equipment and environment that could explain any natural causes for these deaths. External review would help to ensure that local reviews had not failed to identify the cause of death in each case.