Why (and How) the Hummingbird Flew

In the first half of 2017, Cheshire Police were persuaded by Countess of Chester Hospital (The Countess) paediatricians to launch an investigation into nurse Lucy Letby (at trial, Letby's defence argued the paediatricians were seeking to cover up their own negligent care).

In the second half, they were persuaded by a long-retired paediatrician instructed as an expert that babies had been intentionally harmed (including some that Letby was not present for).

The investigation into elevated mortality at The Countess (or, rather, into Letby) was called Operation Hummingbird. It was launched in May 2017 after intense lobbying by Countess paediatricians who had pointed the finger at Letby on the basis ONLY of some correlation they had noted between babies' collapses and her presence (and it was far from a perfect correlation, just stronger that that of other nurses). In other words, there was no hard evidence. And there's always going to be a nurse who is present for the most deaths.

Lucy Letby was eventually charged in relation to 7 "on unit" deaths, leaving 10 others that were not deemed suspicious (6 other "on unit" deaths plus 4 that occurred elsewhere following transfer away from The Countess). Given the pre-2015 average of 2.4 deaths per year, this means there were two massive and supposedly unrelated spikes in mortality: one suspicious, one not suspicious. And at exactly the same time. The likelihood of one of these spikes on their own is very low. The likelihood of both at different times is extremely low. Both at the same time? Practically zero.

To some extent Cheshire Police were victims of the treating paediatricians and their baseless accusations (as were many others including, arguably, main prosecution experts Dr Evans and Dr Bohin). However:

Should Cheshire Police have been more sceptical about the paediatricians' motivations and the strength of their evidence against Letby? Yes.

Should they have been more sceptical about whether a nurse simply being present for a high proportion of deaths was in fact suspicious? Yes.

Should they have been more sceptical about the likelihood of two massive and supposedly unrelated spikes in mortality occurring at the same time? Absolutely.

What follows is a detailed account of the truth about why, and how, the Cheshire Police investigation into nurse Lucy Letby got started. It contains information (emails, letters, etc) which demonstrate definitively that Lucy Letby was scapegoated.

Contents

The five phases of the Lucy Letby case

Phase 1: pre-2015

The Countess of Chester's neonatal unit increasingly becomes a disaster zone e.g. senior nurses progressively get replaced with junior/nursery/bank nurses.

Phase 2: 2015/6

Disaster Strikes. There is a sharp rise in mortality and morbidity from June 2015 and paediatricians point the finger at Lucy Letby. Following deaths of two triplets in June 2016, Lucy Letby is taken off the ward and in September 2016 files a grievance against the paediatricians. In January 2017 she wins her grievance.

Phase 3: 2017 – Jun 2018

The paediatricians are told to apologise to Lucy Letby but then get support from the regional neonatal lead to persuade the hospital to report their concerns to Cheshire Police. Cheshire Police are then persuaded by the paediatricians to mount an investigation into Lucy Letby. Dewi Evans falls into their lap and by the end of the year declares that babies have been intentionally harmed.

Phase 4: Jul 2018 – August 2023

Cheshire Police arrest Letby in July 2018 and proceed to put together a case against her, leading to a trial at which in August 2023 she is found guilty of murdering and attempting to murder babies.

Phase 5: August 2023 onwards

Lucy Letby's appeal attempts in 2024 fail but doubts about the safety of her convictions start to emerge, with many eminent experts questioning the prosecution evidence presented at trial.

Why did paediatricians point the finger at Lucy Letby? Two conflicting views within the pro-Letby camp

With respect to Phase 2, in June 2015, three babies died (Babies A, C and D) in the space of 15 days on The Countess of Chester's neonatal unit. Although this was an unusually high number (there had been “just” 12 deaths in total over the previous 5 years i.e. 2.4 per year) all three postmortems cited natural causes. So, why, if the three babies all died of natural causes, did Drs Brearey and Jayaram start pointing the finger at nurse Lucy Letby just days after the last of the three deaths, that of Baby D?

It is over three years since the trial of a nurse accused of murdering and attempting to murder 17 babies got underway in Manchester. Even before the trial started it could be seen that a) the nurse was likely innocent, and b) the nurse would likely be found guilty.

The main evidence in the public domain before the trial began that the nurse, Lucy Letby, was likely innocent comprised:

> 1) the RCPCH report that cited numerous hospital failings and issues during the period of elevated mortality (what are the chances there being such horrific care AND a serial killer nurse?!)
>
> 2) a second overlapping, and even larger, spike in deaths, but one with which Lucy Letby was not associated (what are the chances of two huge, simultaneous, and unrelated spikes?!)

As for why she would likely be found guilty, one only needed to look at the many caregivers wrongly convicted over the previous decades (on the basis of testimony of fanatical expert doctors such as Roy Meadow) to see how easily it can happen. There was little doubt there would be fanatical expert doctors testifying against Lucy Letby at trial. And little doubt that the jurors would think they were credible (people tend to trust doctors).

There are now of course thousands (possibly a few orders more if recent polls are to be believed) who think that at the very least Lucy Letby did not get a fair trial. And yet one thing supporters cannot agree on is why doctors, specifically Brearery and Jayaram, started pointing the finger at her so early on, just days after the June 2015 deaths of Babies A, C and D.

Broadly, supporters of Lucy Letby fall into two camps. They think either that the two doctors genuinely (but incorrectly) believed that Lucy Letby was harming babies. Or they think Brearey and Jayaram were covering up their or their colleagues' clinical negligence in relation to one or more of the three babies. It should be noted that the latter is what Lucy Letby’s defence argued, in vain, at trial.

The Countess doctors' conviction that Lucy Letby was intentionally harming babies strengthened between the death of Baby D in June 2015 and the deaths of Babies O and P in June 2016, though they never, per GMC guidelines, went to the police. One may wonder why.

The causes of death of Babies A, C and D cited in the original postmortem reports

Lucy Letby was convicted of murdering 7 babies, six of whom underwent postmortems that all cited natural causes as cause of death. The causes of death cited in the postmortems of the babies who died in June 2015 were:

Baby A:

1A: UNASCERTAINED (Note: this means a natural cause but not clear which one. Had the pathologist suspected that Baby A may have been intentionally harmed he would have proceeded very differently).

Baby C:

1a: Widespread hypoxic/ischaemic damage to heart/myocardium due to

1b: Immaturity of lung (atelectasis, hyaline mebrane and fresh bleeding) due to

1c: Severe Maternal Vascular Underperfusion/MVUP

Contributory cause:

2: Severe intrauterine growth restriction

Baby D:

IA: Pneumonia with acute lung injury

When did Countess paediatricians point the finger at Lucy Letby?

The earliest indication that Lucy Letby was being put in the frame by doctors came in early July 2015, days after the third death in June 2015, that of Baby D.

It is a matter of fact that a meeting took place on 2 July 2015 to review the unusual occurrence of the three deaths in the space of two weeks. According to Dr Brearey, neonatal unit manager Erian Powell was at this meeting and reported that Lucy Letby had been present at all three deaths. Here is the exchange between Lucy Letby's barrister Ben Myers and Dr Brearey at trial on 14 March 2023:

> *Myers: All right. It's from that point, the end of June 2015, that certainly you have or had identified to you the presence of Ms Letby on three of those events?*
>
> *Brearey: That's correct. I think my comment in the meeting at the time was, "No, it can't be Lucy, not nice Lucy".*

And yet, at the Thirlwall Inquiry on 25 November 2024, director of nursing Alison Kelly had a different recollection:

> *Q: Dr Brearey in his evidence to the Inquiry, both in writing and orally, described the process of going through the children's deaths at the meeting and then at the end he said that Eirian Powell raised the observation that Lucy Letby had been on the unit on the three occasions when the three babies had collapsed and his reaction, which he described in detail to this hearing was "oh no, not nice Lucy". And you were at that meeting and he recalls you having heard that as well; do you remember that?*
>
> *Kelly: That wasn't said at that meeting, Eirian Powell wasn't at that meeting, so my notes reflect that and I have said in my witness statement that Lucy Letby's name was not mentioned at that meeting at all.*
>
> *Q: In his evidence he says that your response to that information that Letby was the connecting factor because I think Eirian Powell had in fact identified her quite early on as being the connecting factor, was that was something you needed to keep an eye on. You said that: we'll keep an eye on it. Do you remember that?*
>
> *Kelly: No, I don't because Lucy Letby's name wasn't mentioned at that meeting and Eirian Powell wasn't at that meeting.*
>
> *Q: Did she ever mention she had spotted the connection between that member of staff quite early on?*
>
> *Kelly: No.*
>
> *Q. So even after the issue came up a year or so later, did she ever say: well, in fact, I spotted this back in June 2015?*
>
> *Kelly: No, not to my knowledge.*

The exchange at trial on 14 March 2023 between Myers and Brearey continued:

> *Myers: Dr Jayaram also was party to that, wasn't he, to that knowledge at that time* [that Lucy Letby had been present at all three deaths and that Dr Brearey had suspicions about her]*?*

*Brearey: Dr Jayaram wasn't at the meeting, but obviously he was the clinical lead at the time.*

*Myers: Yes. So you'd have shared that with him soon afterwards?*

*Brearey: I shared it with all my colleagues because it was a meeting about the deaths in the neonatal unit.*

*Myers: So everybody knew that, to that extent at least, Ms Letby was an object of interest from June -- by everyone I mean your consultant colleagues knew by June 2015 that Ms Letby was a subject of interest?*

*Brearey: I certainly emailed Dr Jayaram. I can't remember emailing my other colleagues, although we might have discussed it, I can't remember.*

*Myers: You remember emailing Dr Jayaram?*

*Brearey: Yes.*

There was also reference at the trial to use of the word "nice" by Dr Brearey at another time, as below.

*Myers: All right. You have told us about early 2016 and the review you did and Eirian Powell putting together a report into the moralities of babies. She did that in advance of the review in February 2016, didn't she?*

*Brearey: Yes.*

*Myers: She identified who had been present at the time of various incidents, didn't she?*

*Brearey: Yes.*

*Myers: She documented the names of doctors in that review but you told her you didn't want it to include doctors, didn't you?*

*Brearey: I can't recall that.*

*Myers: Are you saying you didn't do that or you just can't recall?*

*Brearey: I can't recall it.*

*Myers: Do you recall whether the column which had details of doctors that were present was removed before being sent to Alison Kelly, the head of nursing?*

*Brearey: I don't recall that. I would have been more than happy for all the doctors to be included in that.*

*Myers: When Eirian Powell pointed out that Melanie Taylor was the next most commonly present nurse after Lucy Letby, was your reply, "Yes, but she's nice"?*

*Brearey: I can't recall that either. It doesn't sound like anything I would have said, to be honest.*

So, Dr Brearey at one point testifies under oath that he had said, "No, it can't be Lucy, not nice Lucy". And at another point that "Yes, but she's nice" doesn't “sound like anything I would have said”. This inconsistency should be viewed with great scepticism.

Regardless, it seems that Dr Brearey was keen to convey the message that he had started to suspect Lucy Letby shortly after the three deaths in June 2015, and had shared his concerns with colleagues, or at least Dr Jayaram.

However, given postmortem findings of natural causes, why should there have been a need to point the finger at Lucy Letby? Spikes in mortality on neonatal units in the UK are not uncommon, so surely the inevitable investigation into the cluster of three deaths would have identified an “innocent” cause such as an infection, some form of contamination, or faulty equipment.

Unless, of course, the deaths were the result of the doctors’ clinical negligence that they wanted to cover up (this was, after all, the defence argument at trial). It is also possible that Lucy Letby, who was on duty for all three deaths, had witnessed their negligence and the doctors worried she might report it. After all, if you are going to accuse someone of something, it is important to get your accusation in first. Second just looks retaliatory.

Did Babies A, C and D die as a result of negligent care?

Set out below are some of the medical aspects relating to Babies A, C and D. It would be interesting to get expert medical opinion as to whether it is possible that there had been clinical negligence that was so egregious that the doctors would have wanted it covered up. The lengths to which people will go to protect their livelihoods and reputations should not be underestimated.

Baby A

· Baby A's mother had antiphospholipid syndrome, a rare disorder that can cause blood clotting. Prosecution expert haematologist Sally Kinsey testified at trial that this condition had no bearing on the death of Baby A (or indeed the collapse of Baby A's twin, Baby B). However, Shoo Lee's panel found that "Baby A died from thrombosis" (also that "Baby B collapsed from thrombotic emboli originating from a central intravenous catheter, which was potentially aggravated by maternal anti-phospholipid syndrome"). In his third witness statement, Dr David Harkness wrote that, "I would not routinely have expected deterioration at this point , unless there was an issue with the line its self (sic) or a clot at the end it [There was! It was noted in the contemporaneous notes.], these reasons did not fit though or another reason could have been air in the line, but you would need quite a lot of air pushing through causing an air embolus." And yet, the pathologist Dr Shukla wrote in the postmortem report that, "However, at 21:20 [should be 20:20] hrs the patient went into apnoea. Bagging was started immediately. There was good chest movement seen but saturations were poor. It was thought to be related to long line, so long line was removed and help was called. Intubation was attempted. Blood-clots were noted in the tube." It is also not clear why Dr Harkness did not mention his having observed no blood clots (itself not true), in either of his first two statements.

· NNU manager Erian Powell noted that Baby A's mother had SLE (Systemic Lupus Erythematosus or Lupus for short). Nowhere else did this get mentioned, whether in clinical notes, witness statements, or at trial. It may have been mentioned in maternal notes, but these were never admitted into evidence. Indeed none of the 13 sets of maternal notes were admitted. The NCA recommended to Cheshire Police that they should engage an obstetrician (who would have requested the maternal notes) but this advice was ignored (see Phase 3 section below).

· Baby A's mother was thirty-one weeks pregnant with twins, and had planned to give birth in London, so that a specialist could monitor her and the babies, but her blood pressure had quickly risen, and she had to have an emergency C-section at the Countess.

· The timeline of events with respect to the peripheral cannula, the UVC and the long line is as follows.

· Dr Teresa MacCarrick, a paediatric registrar, was on duty during the day on 8 June, the day on which Baby A died. She noted in her witness statement that Baby A required an umbilical venous catheter (UVC), writing that, "The reason Baby A required the UVC was due to Baby A being born prematurely. His gut was not ready to absorb milk in the volumes that he required for nutrition"). She inserted a UVC in the early afternoon under supervision of Dr Sally Ogden, but an X-ray taken at 14:28 noted that it was in the liver and needed to be "removed and re-sited".

· She writes in her witness statement, "Dr Ogden and I sought advice from the responsible paediatric consultant, Dr Jayaram, who had just finished his clinic and was in the vicinity. Dr Jayaram agreed that the UVC had deviated from its intended course, and appeared to be sited in the hepatic circulation. When this happens, it is standard practice to take the UVC out and straight away replace it with a new cathater, which is what Dr Jayaram advised us to do. Dr Jayaram also advised that if, on this second attempt at insertion, the UVC was not in a satisfactory position, a peripheral longline

should be inserted as an alternative. Two attempts of inserting the UVC is standard practice, after that, it is my experience that most senior colleagues would suggest abandoning further attempts to insert the UVC but rather undertake a longline insertion instead."

· Some time before 16:30 Dr MacCarrick removed and reinserted the UVC, this time without the supervision of Dr Ogden who was reviewing a patient in the paediatric ward. An X-ray taken at 16:30 again found that the UVC was in the liver.

· In her witness statement, Dr Ogden wrote, "At 16:00 on the 8th June 2015, I handed over to the evening registrar, Dr Harkness who had returned from his other commitments. During handover, I once again reviewed the Xray of the new umbilical venous catheter that had been inserted by Dr MacCarrick. This showed that the catheter was still sited within the hepatic vein. I asked Dr Harkness to remove this umbilical venous catheter and to insert a peripheral long line instead into Baby A. It was around the same time I was informed by one of the neonatal nursing staff that Baby A's peripheral cannula had tissued, this was the line that Baby A was receiving his nutrition through and therefore it had become slightly more urgent, during the handover I informed Dr Harkness of this."

· Dr Ogden also wrote, "I made an error when documenting on the Xray sticker for the 2nd Xray, as I stated I had removed the second umbilical venous catheter. I had not removed this catheter instead I had asked Dr Harkness to do this when I handed over as my shift had ended and I had gone off duty."

· Dr MacCarrick wrote in her statement that, "On inspection of the repeat xray, the UVC again appeared to me to be situated in the hepatic circulation rather than the IVC. By this time (approximately between 16:00 and 17:00 on 08/06/15) Dr Ogden was in the handover room on the paediatric ward, handing over to Dr Harkness (paediatric registrar) who would be covering the evening on-call shift. I went to the handover room and requested Dr Ogden and Dr Harkness to review the X-ray with me. They agreed with my impression that the UVC appeared to be in the hepatic vein and that Baby A would need a longline as previously discussed with the consultant, Dr Jayaram. At this time, Baby A remained in the neonatal unit being monitored by the nurses and the inserted UVC would not have been used. It is standard procedure not to use a UVC until it has been confirmed to be in the correct position on xray. I did not return to the neonatal unit to remove the UVC after this discussion, as both Dr Ogden and Dr Harkness advised me that they would return to the Neonatal Unit to continue Baby A's care. To the best of my memory, I asked if they wanted me to remove the UVC. Dr Odgen said she needed to return to the unit to complete documentation and Dr Harkness had some jobs to do in the neonatal unit, so they both assured me that as I had already stayed beyond the end of my shift, I could go home and they would complete all remaining jobs. I left the hospital sometime after 5 pm, leaving Baby A in the care of Dr Harkness and Dr Ogden. I had no concerns regarding Baby A's clinical condition at any point during the insertion or replacement of the UVC."

· Dr Harkness did not remove the UVC as Dr Ogden had advised him he should. But he did, according to him, at 17:00 insert a long line as a substitute for the wrongly placed UVC. An X-ray taken at 19:09 noted that the UVC was in the liver and the long line was in the superior vena cava.

· In his first witness statement, Dr Harkness wrote, "It was a very busy evening on both the Neonatal unit and Children's ward. Three babies on the Neonatal Unit required peripheral long lines, which only I was able to insert. In relation to Baby A, his care was handed over from Doctor Ogden (Registrar) and Teresa McCarrick (SHO) between 1630 and 1700 hours. I noted that Baby A had an Umbilical Venous Catheter (UVC) previously inserted into his belly button which was in an inappropriate position for long term use, likely in the portal circulation as it was seen on X-Ray heading towards the liver. It was also handed over to me that the catheter had been removed as per their discussion with a Dr Jayaram."

· He went on the write, "Due to how busy the department was at that present time and there being a strong possibility of being interrupted by other medical emergencies whilst trying to insert a new venous line into Baby A, I decided to leave his UVC in situ until a satisfactory replacement IV line was available. This would mean that if I was called away the UVC could be pulled back to a low lying, safe position outside of the liver to deliver IV fluids for a short period until a further IV line could be sited."

· Then, "After the line was inserted, the metal guide wire was removed immediately. Blood was easily aspirated from the line and it was then flushed with approximately 1ml of 0.9% Saline which flushed easily with no change in Baby A's clinical condition. An X-Ray was performed after insertion at 19:08 whilst I was inserting another line in the third baby in nursery 1. I was able to review the X-Ray whilst scrubbed (still sterile) at 20:10 upon request from Nurse Letby, at that time, Nurse Letby was stood next to Baby A's incubator. I can't recall who else, if anyone, was present at that time. The tip of the long line was projected over the superior Vena cava, across the midline. It did not appear to be sitting in the heart; however I felt at the time that it would be better positioned closer to the midline to avoid migration into the right atrium. I was unable to do this at the time as I was inserting a line into the third baby in the room. As I was happy with the line's position, I decided the line was satisfactory to use and asked the nurse, I think it was nurse Lucy Letby, the designated nurse for Baby A's care, to start running a 10% Glucose infusion, a standard fluid providing hydration / energy. Looking back, my concerns were that the line may have been in too far but with experience and looking at the BAPM guidelines (British Association of Perinatal Medicine), the line was in an ideal position and didn't require re-positioning."

· A nursing note from the day shift said that the baby had had "no fluids running for a couple of hours," because his umbilical catheter, a tube that delivers fluids through the abdomen, had twice been placed in the wrong position, and "doctors busy."

· There is uncertainty as to precisely when Dr Harkness inserted the long line. In his first statement, Dr Harkness wrote, "My initial contact with Baby A was around 17:00 when I inserted a peripheral long line." However, in his second statement, he wrote, "There is an entry on the 'line insertion/removal record chart' which states that the date and time of insertion of the peripheral longline was 19:00hrs on 8/6/15 but this is not in my handwriting and is likely to have been documented by one of the SHO's." but then, "The notes were written up at 19:00hrs after I had finished everything in respect of this, so I can say that I would have inserted the peripheral longline into Baby A at some time between 17:00hrs and 19:00hrs on 8th June 2015 but from my recollection of events that day I would estimate that this was more likely around 18:00hrs." And in the clinical notes, which *were* in his handwriting, he wrote, "Long line inserted at 1900". Regardless of when the line was inserted, and whether it was in the correct position, Dr Harkness gave the go ahead, as above, for it to be used to run a 10% glucose infusion. This was done by Lucy Letby and Melanie Taylor (from whom Lucy Letby was taking over) shortly after 8pm (it was recorded in the clinical notes that Taylor was present for the resuscitation between 20:26 and 20:58 so it seems sole care was not handed to Letby at the 8pm handover time). Given that it had been noted earlier in the afternoon that Baby A's peripheral cannula had tissued, that the UVCs could not be used because they were incorrectly positioned, and that there were all sorts of delays with the long line, it seems that the baby had not been receiving fluids for several hours by this time.

· Twenty minutes later, at 20:26, Lucy Letby and another nurse (Melanie Taylor?) a few feet away, noticed that Baby A's oxygen levels were dropping and that his skin was mottled (skin discolouration was not recorded by doctors and the mottling described in nursing notes bore no similarity to what Jayaram described in his witness statements years later, a description that uncanniliy matched that in the 1989 paper). Dr Harkness, who had inserted the longline, worried that he had placed it too close to the child's heart, and he immediately took it out.

· Resuscitation that immediately followed was unsuccessful and at 20:58 Baby A was declared dead.

· Nurse Caroline Bennion, in her police statement, wrote, "I remember literally as we came on duty that Baby A deteriorated, and I remember actually saying to Dr Harkness, 'It's not the position of the line is it? Has that line been checked?' Because I know that if, a long line touches a vessel that could cause an acute deterioration."

· The pathologist observed that the baby had "crossed pulmonary arteries," a structural anomaly, and there was also a "strong temporal relationship" between the insertion of the longline and the collapse. However, it seems, given that the long line was inserted between 5 and 7pm, that the temporal relationship of the collapse was with the fluid commencement 20 minutes previously, not with the long line insertion that was at least an hour and a half earlier.

· As noted by Dr Shoo Lee's panel, "Mother had anti-phospholipid syndrome, which is a condition in which the immune system mistakenly creates antibodies that attack tissues in the body. These antibodies can trigger blood clots to form in arteries and veins. During pregnancy, antibodies can pass through the placenta to the neonate and lead to thromboembolism, particularly if there is concurrent infection. Post mortem of Baby A showed a recent non-occluding thrombus in the liver, which means there was a recent thrombotic event. On the day of collapse, Baby A had 2 central catheters that were left without infusion for up to 4 hours, which predispose to thrombosis when there is no infusion. Shortly after infusion was started in the most central line, Baby A collapsed. A thrombus from the catheter tip likely migrated to an artery supplying the brain stem, causing sudden collapse and inability to resuscitate the infant. It is also possible that Baby A had placental fetal vascular malperfusion, in which the fetal villi in the placenta present small thrombi that can travel to and occlude small blood vessels in major organs like the heart, brain and liver. If a small thrombus lands in the artery supplying a critical structure like the brain stem, it can cause sudden death and they are very hard to find on post mortem. Collapse associated with fetal vascular malperfusion can occur 1-2 days after birth."

· Mistakes that the doctors may have wanted to cover up are: 1) Failure to recognise risks to baby of mother's antiphospholipid syndrome, 2) Incorrect placement of peripheral cannula (it was noted to have tissued) 3) Incorrect placement of UVC (twice), 4) Recording that UVC had been removed when it hadn't been, 5) Leaving UVC in for several hours without infusion, predisposing baby to thrombosis and, if the end of the UVC had been left open, air embolism 6) Delays with the long line, 7) Baby not receiving fluids for several hours, predisposing baby to refeeding syndrome 8) Using long line for fluids when it was known to be incorrectly positioned.

<u>Baby C</u>

· Baby C was born by emergency caesarean section on 10th June 2015 at 15:31 for IUGR (intra-uterine growth restriction) with reverse EDF (end-diastolic flow) at 30+1 weeks gestation. Baby C weighed 800 grams at birth which confirmed that he was significantly growth restricted.

· IUGR makes babies susceptible to conditions such as necrotising enterocolitis (NEC). The absence in notes of details about further growth scans suggests that there was a lack of understanding and awareness of how long baby was failing to grow and why, which would have influenced the decisions made around feeds. This information would have been contained within the antenatal notes (maternal) and should have been actively sought and recorded by a team with the experience of looking after neonates.

· Upon admission to the neonatal unit, Baby C's temperature was 35.9°C. This was hypothermic (low) and is suggestive of poor thermoregulation care which directly impacts on survival of premature infants.

· Baby C had breathing difficulties (grunting, tracheal tug and recession of the chest wall were all noted). It is not recorded in the notes as to when the oxygen requirement started rising and as to whether baby had been placed on respiratory support such as CPAP first. In the nursing notes, the baby's admission is recorded as "ventilated".

· A blood gas test done at 16:55 showed that baby was being overventilated (pH 7.478, pC02 3.57, p02 6.09, BE -2.5, bicarb 19.4, lactate 7.7. Baby was on SIMV (a ventilation mode). Adjustments were made to the ventilator (with rate down to 20 and pressure reduced down to 16/4).

· At 18:19, an X-ray showed the umbilical venous catheter (UVC) was located in the heart, so it was withdrawn by 3 cm. The X-ray also revealed lung shadowing and the presence of a gastric tube in the stomach. The X-Ray also confirmed that the surfactant administered via the ETT that was too long went down the right lung.

· Baby's C's initial blood tests revealed a low white cell count (2.3), low neutrophil count (0.7), and low platelet count (90), while C-reactive protein (CRP) was below 1.

· The next day, 11 June, Baby C was noted to be "stable" on CPAP. However, within the nursing notes, chest wall recession (a sign of respiratory distress) and baby breathing quickly (tachypnoea – which can also be a sign of respiratory distress) were consistently noted.

· At this point there is no record in the notes of Baby C having been seen by a Consultant.

· A doctor at ST4 level attempted to insert a catheter into Baby C's radial artery. It appears that this was inserted but removed straight away due to the baby's fingers going dusky/white at insertion.

· Phototherapy was commenced at around 13:00 as baby was noted to have developed jaundice.

· On 12 June, nursing notes reported "UVC found in bed" at 07:00. This means that the central line fell out of the baby's umbilicus. In other words, it hadn't been adequately secured. Baby C had become hypoglycaemic (blood sugar of 1.7) as a consequence of the delivery of intravenous nutrition/sugar having been interrupted.

· The morning ward round was again done (at 10:15) by a relatively inexperienced doctor (at ST3 level).

· Baby C was receiving 120ml/kg/day of a combination of parenteral nutrition and 10% Dextrose and lipids. Minimal gastric aspirates were noted and urine output was recorded at 4.3ml/kg/hour. Baby C had still not passed meconium at this stage. CRP was noted to have risen to 23 from less than 1.

· On the recorded X-ray review, it was noted that the NGT was "in stomach, seems straight" and other comments were "large stomach bubble, gaseous bowel". The large amount of air in the stomach would not have been unsurprising in a baby on CPAP who did not have an aired NG tube. However, having such an enlarged (with air) stomach would have compromised Baby C's ability to expand his lungs and should thus have been addressed rather than just noted and not acted upon.

· There is a retrospective nursing note recorded on 14 June at 17:38 for the care that Baby C received during the day shift of 12 June (it was recorded in another baby's notes by mistake).

Importantly, this note commented that Baby C had had a bilious vomit, as signified by the fact that bile was noted on his blanket at 18:30. 2 ml of black-stained fluid was further aspirated from his nasogastric tube. Further to this it was noted that baby was reviewed by Dr Ogden and there was advice to “hold feeds” given.

· The medical team (Registrar called Dr Davis) examined Baby C at 21:20 on 12 June and noted the presence of bilious aspirates. It was noted that baby remained nil by mouth due to bilious aspirates. The bilious vomit from 18:30 was not noted/recorded.

· From the nursing chart, it was recorded that baby had vomited “dark bile” at midnight. This was now the second bilious vomit in spite of baby having an NG tube on free drainage. Despite this, there was no documented review by a doctor until the ward round the following day.

· Medical opinion asserts that vomiting bile should be considered highly significant (as opposed to getting small amounts of light green aspirates which is not uncommon in preterm babies). Baby C should have been treated for bowel obstruction immediately, with arrangements made for surgical review and strong consideration of a contrast study in order to exclude a malrotation with volvulus. This should have happened after the first episode of bilious vomiting, noted at circa 21.20 on 12 June 2015.

· On 13 June, Baby C was seen on the ward round at 09:30, once again by a relatively inexperienced doctor (at ST3 level). They noted “very dark bilious/black” gastric aspirates and the fact that Baby C hadn’t had a bowel movement yet.

· It was not recognised/recorded that baby had had a bilious vomit twice the previous evening. No external examination of the anus was recorded. Abdomen noted as soft and not distended on clinical examination. It was noted that baby had still not opened bowels. No consideration was given to the administration of a glycerine chip.

· Baby C was finally seen by a consultant, Dr John Gibbs, at 15:55 on 13 June (in his police witness statement, Dr Gibbs wrote, “I had seen Baby C several times during the first three days of his life, including on the afternoon of 13 June 2015 and on each occasion he had been stable”, which is not corroborated by the contemporaneous notes). His recommendations were noted by Dr Sally Ogden, an ST3 registrar, though there is no documented clinical examination of Baby C by Dr Gibbs so it is unclear on what he based his clinical recommendations. Dr Gibbs' recommendations were to commence intravenous ranitidine, to hold off feeds and to review in the afternoon and if “not getting worse start trophic feeds”. His own entry in the notes comprised only, "US head normal" (likely a reference to a cranial ultrasound being normal). It was recorded that if baby were to worsen, an abdominal X-ray would be repeated and antibiotics changed. It was not clear from the notes what “getting worse” would constitute in light of the fact that baby had had continued bilious aspirates and had not yet passed meconium, both very serious problems.

· A nursing note recorded at 16:19 on 13 June noted that Baby C’s respiratory support had been changed from CPAP to "high flow oxygen" at 13:00 using an Optiflow device. This was done as the nurses were concerned baby was “unsettled” on CPAP.

· The nursing note also recorded that Baby C had lost 84 grams since birth, now weighing 717 grams. It was recorded that Baby C “continues to have dark bile aspirates, frequently this morning but improving this afternoon” and “abdo full but soft, slight shine to abdo”. It was also once again recorded that baby still hadn’t opened bowels and that baby had been reviewed by Dr Gibbs, as noted above.

· There were no further medical reviews recorded in the notes until Baby C collapsed just before midnight.

· 0.5ml of feed was given via the NG tube at 23:00. Preceding this feed, bilious aspirates were noted at 22:00 and 23:00. In the nursing notes, it was documented that commencing feeds had been discussed with the Registrar, Dr Davis, who had “agreed”. Feeding baby would have involved administering the feed via the NG tube, which meant the NG tube was no longer on free drainage which is what baby needed.

· 15 minutes after this feed was administered, at 23:15, Baby C had an apnoea (as documented in the nursing entry from 14 June 2015 timed at 08:46). Baby C was reported to have experienced a prolonged bradycardia (low heart rate) and desaturation at 23:15. A crash call was put out by the nursing staff and they commenced resuscitation.

· The registrar was crash bleeped at 23:26 and arrived at the neonatal unit “in less than 1 minute”. She was not able to intubate the baby. Note: the nursing notes say that the registrar intubated Baby C. However, the medical notes describe all intubation attempts by her as unsuccessful due to cords being “swollen and oedematous”.

· Consultant Dr Gibbs (consultant) was documented to have received a call “to attend urgently” at 23:28 and he arrived at the Neonatal unit at 23:35.

· Active resuscitation was discontinued at 00:45 after intermittent gasps were observed, though Baby C was alive until 05:58 (time of death).

· According to expert medical opinion, there was poor medical care at multiple points throughout Baby C’s stay.

· Shoo Lee's panel concluded that Baby C died "because of a decision to discontinue respiratory support and resuscitative effort in the face of a poor response following inadequate resuscitation for at least 20 minutes after an acute episode of apnoea." Also that, "The clear prior signs of intermittent bowel obstruction that warranted urgent surgical opinion and investigation had gone unrecognized."

<u>Baby D (taken from Prof Shoo Lee panel's summary report)</u>

· It was alleged that Baby D was a stable infant, who died from injection of air into the intravenous line, causing air embolism resulting in collapse, patchy discolorations of the skin and death.

· Baby D [born on 20 June 2015] was a 37+1/7 week, 3.13 kg birth weight, female infant, who was delivered by emergency Caesarean section for failed induction of labour after prolonged premature rupture of membranes.

· The Apgars were 8 at 1 min, 9 at 5 min. At 12 minutes, she became pale and floppy and needed respiratory support with bag and mask. She was admitted to the neonatal unit 3½ hours later; she was cold, blue, dusky, and had respiratory distress, polycythemia and infection (high white cell and neutrophil counts).

· The first blood gas taken 4 hours after birth showed high CO2 and respiratory acidosis. Continuous positive airway pressure (CPAP) was started nearly 4 hours after birth. She was electively intubated after 3 attempts and ventilated. Chest x’ray showed pneumonia.

· The following day, she developed fever, deteriorating blood gases, and increasing metabolic acidosis. The next day, she was mottled, and had dark brown and black tracking lesions across the trunk, and two evolving purpuric looking patches on the abdomen. She had prolonged coagulation times, raised CRP, and repeated episodes of apnoea and desaturation, until final collapse and death.

· In Dec 2024, Zhou and Lee (Am J Perinatol 2024 Dec 27. doi: 10.1055/a-2508-2733) published new research showing that patchy skin discolorations have never been reported in infants with venous air embolism, including IV air injection. When air is injected into the veins, air bubbles must first traverse the lungs where they are filtered out by a vast bed of small blood vessels. In infants, there is a hole in the heart (foramen ovale) that normally closes shortly after birth, so it is possible for air bubbles to escape through the hole into the arterial system but Zhou and Lee reported no patchy skin discolorations in infants with IV injection of air.

· The mother should have been given antenatal antibiotics for prolonged premature rupture of membranes in a preterm infant. NICU admission, blood gas and CPAP were delayed for 3-4 hours, and Chest x'ray was delayed for 6 hours, which subjected the infant to unnecessary acidosis, high CO2 and delay of antibiotic treatment.

· The infant continued to deteriorate after admission and showed signs of worsening infection, with fever, intolerance of CPAP removal, deteriorating blood gases, increasing metabolic acidosis, raised CRP and repeated episodes of apnoea and desaturation.

· She developed prolonged coagulation times, which indicate the infection was going out of control and causing early disseminated intravascular coagulation (DIC). DIC causes coagulation in the blood vessels, coagulation defect and bleeding.

· Coagulation defects do not occur with air embolism. The patchy skin discolorations were caused by DIC causing clotting in the small blood vessels of the skin which compromised blood flow, which together with hypoxia, triggered dilation and contraction of small blood vessels in the skin, resulting in patches of skin discoloration, purpuric patches and tracking lesions.

· The panel's conclusion was that, 1. Baby D died of systemic sepsis, pneumonia and disseminated intravascular coagulation. 2. The mother should have received intrapartum antibiotics. 3. There was delay in recognizing respiratory distress after birth and starting antibiotics, and treatment. 4. There was no evidence of air embolism.

The “unusual rash”, the 1989 paper, and the birth of the air embolism thesis

The prosecution asserted that Lucy Letby had injected air into the bloodstreams of all three babies who died in June 2015 (this includes Baby C, whom Dr Evans, out of nowhere, said on the stand had been intravenously injected with air by her, his evidence for which was *only* “baby collapsed and died”). Indeed, of the 17 babies in total on the indictment, it was alleged Lucy Letby had injected air into the veins of 9 of them, 2 of whom, somehow, survived).

The prosecution’s evidence of intravenous injection of air centred on an unusual rash noted on some of the nine babies by doctors, a rash that, according to an obscure 1989 research paper, *Vascular Air Embolism in the Newborn*, was pathognomonic of air embolism (the paper described “*bright pink vessels against a generally cyanosed cutaneous background”)*.

The problem for the prosecution was that in precisely none of the cases had a single doctor, or indeed nurse, described in the contemporaneous notes an unusual rash matching the description in the 1989 paper. The unusual rash matching that in the paper was described only months and years later in doctors’ (Drs Jayaram and Dr Harkness’) written witness statements.

There is also the question of when Countess doctors happened upon the 1989 paper, as this provides insight into when and how they first started to suspect Lucy Letby, and therefore into the question of whether they were covering up poor care or genuinely believed she was harming babies. It also provides insight into the integrity of the doctors.

Jayaram's testimony is critical here, with respect to both when the unusual rash was noted and when the 1989 paper was found.

With respect to the June 2015 babies, it was alleged on the indictment that Lucy Letby murdered Babies A and D by injecting air into their bloodstreams. It was also alleged that on 9 June 2015 she had attempted to murder Baby A's twin, Baby B, using the same method. Evidence of air embolism at trial in all three cases centred on unusual rashes that matched the description in the 1989 paper. At trial, out of nowhere (it had not until then been alleged by the prosecution), Dr Evans said on the stand that Baby C may also have been injected with air intravenously.

Before looking at what was written in the contemporaneous medical notes about rashes with respect to the three babies, let's look at what was written in witness statements.

Baby A

Dr Jayaram (18 Sep 2017)

> *"He had unusual discoloration; you’d expect babies to look fairly ghastly and pale and grey but he had an odd sort of discoloration where there were flitting patches of pink areas on the background of bluey grey skin; these patches seemed to appear and disappear. It wasn’t like the rash seen with a meningococcal sepsis which is caused by blood vessels bursting. It would flit and the reappear and disappear. It didn’t fit with anything I’d ever seen before. I would describe the marks as blotches which were fairly ill-defined, about 1 centimetre to 2 centimetres, not discreetly round but blotchy patches of brighter pinkness on a background of bluey grey."*

Dr Harkness (5 July 2018)

> *"I recall that there was an unusual blotchy pattern of well perfused pink skin over the whole of Baby A's body coupled with patches of white and blue skin; it was all over his body. This*

*discolouration remained for a number of minutes. This progressed into being pale and cyanosed (blue discolouration due to lack of oxygen) along with a drop in his heart rate and oxygen levels."*

In none of the other witness statements of the many Countess medical staff, doctors and nurses, was there any mention of an unusual rash.

This is what the Lee and Tanswell had to say about skin discolouration in their paper with respect to air embolism cases in their study:

> *Blanching and migrating areas of cutaneous pallor* [abnormally pale skin colour] *were noted in several cases and, in one of our own cases we noted bright pink vessels against a generally cyanosed cutaneous background.*

It is interesting how similar the above description is with those of Jayaram and Harkness in their witness statements, respectively, 2 years and 3 years later (and after not having mentioned them in clinical notes nor to the coroner).

Baby B

There is no mention in any of the witness statements, whether those of Countess medical staff or prosecution medical experts, of Baby B having an unusual rash.

Baby C

There is no mention in any of the witness statements, whether those of Countess medical staff or prosecution medical experts, of Baby C having an unusual rash. Note that the first mention of air embolus came from Dr Evans on the stand i.e. it had never been (until Evans in the witness box!) the prosecution's allegation that Baby C had received air intravenously.

Baby D

There is no mention in any of the witness statements, whether those of Countess medical staff or prosecution medical experts, of Baby D having an unusual rash.

The only mention of the word "pink" in Baby D's clinical notes was "pink and active" by Dr B. At trial, the prosecution tried to argue this was a description of a rash, notwithsatnding the fact that it bore no resemblance to the description in the 1989 paper. Below is what Myers put to Dr Evans at trial on 1 November 2022:

> *And it was said: "Question: Dr B interpreted her own handwriting for us this morning. That 'pink and active' wasn't read to you. Do you see that?" You said yes. And you were asked this: "Question: Is that consistent or inconsistent with Lee and Tanswell?" And your reply was: "Answer: It's a good point, actually."*

In other words, the only mention of a rash in written witness statements matching the description in the 1989 paper is by Drs Jayaram and Harkness. And in relation to Baby A only.

What did doctors write in the contemporaneous notes, postmortem referral forms (with respect to Babies A, C and D) and in statements to Coroner (with respect to Baby A) about unusual rashes?

Baby A

With respect to Baby A's collapse, resuscitation and death, the contributions of both Jayaram and Harkness to the medical notes are considerable and detailed. And yet, nowhere do either of them mention anything close to what they 2-3 years later wrote in their witness statements with respect to an unusual rash. In fact, there's no mention of a rash at all, let alone one matching the description in the 1989 paper.

Nor did Jayaram make any mention in his 24 July 2015 statement to the coroner of the unusual rash he later described in great detail in his police witness statement.

In his second written statement, he wrote:

> *"It is clear from the above statement to the Coroner that I did not mention within it any observations related to blotches and discolouration on Baby A's body, whereas I have done in my statement to the police. My explanation for this is that, at the time my statement to the Coroner was written, I did not believe the blotches to be relevant. The above statement was written before I had any suspicions, before any pattern had developed or been recognised, and a long time before we approached police. It was only later during conversations with colleagues who had seen similar things that I began to realise the relevance of the blotches. It is also the case that I did not describe these blotches in the medical notes. This is simply because there was so much else going on, e.g. CPR and talking to parents. I thought it was a bit odd but I really didn't see the significance at the time as compared to everything else we were doing to try and save Baby A."*

Dr Saladi was both the reporting doctor and the consultant listed in the postmortem referral form. In the "Circumstances surrounding the death" section of the form, Dr Saladi wrote:

> *Dr reported Mum is inpatient – Baby A was born at 31 weeks +2 by emergency C Section due to [I&S], [I&S], [I&S]. Male and female twin – female is ok – Baby A born in good condition but needed cpap – needed cannula inserted for nutrition, UVC the position of the line was not appropriate – so baby had long line – also abx iv fluids* [intravenous antibiotics*] – Dr told that suddenly baby alarm sounded. Information to coroner was that umbilical line was inserted but found on X-ray to have gone too far. It was left in. A percutaneous line was inserted and also went too far. Sometime later the baby suffered an apnoeic event and then went into p.e.a.* [Pulseless electrical activity] – *patient died. Paediatric PM authorised.*

It seems strange that it was Dr Saladi who completed the form as both reporting doctor and consultant, given that he was not present at resuscitation, nor indeed did he at any point during Baby A's life make any entry in the clinical notes. It should also be noted that Saladi made no mention of the rash that Jayaram and Harkness years later said was so notable and strange.

Baby B

Below are key extracts from Baby B's contemporaneous notes.

Night shift 8/9 June 2015

*02:30: "Widespread purple discolouration of skin with white patches" (Dr Lambie ST6)*

Night shift 9/10 June 2015

*00:50: "Suddenly purple blotching of body all over" (Dr V)*

*01:00: "Purple rash around skin" (Dr ?)*

Some time after the resuscitation: "Purple discolouration almost resolved ?? cause" (Dr V)

Day shift 10 June 2015

*10:30: "Updated on Baby B's progress overnight, and purpuric episode" (Dr Ogden)*

Day shift 11 June 2015

*09:20: "Purple discolouration to finger/feet/mouth improving" (Dr Ogden)*

According to the prosecution in its opening:

> *"…at about 00:30hrs on 10th June, Baby B's alarm sounded and Nurse T was called by Lucy Letby to Baby B's incubator. Baby B was not breathing (apnoeic). An emergency 'crash call' was put out at 00:33 hrs on 10th June 2015; Baby B had suffered a sudden desaturation to 50% - associated with cyanosis, apnoea and limpness. Nurse T began resuscitation and noted a rapid colour change in Baby B's skin with purple blotches and white patches all over her body. Baby B's heart rate dropped (bradycardia)."*

Below is what Nurse T actually wrote (retrospectively around 7am) in the nursing notes:

> *"00.30. Sudden desaturation to 50%. Cyanosed in appearance. Centrally shut down, limp, apnoeic. CMV via neopuff commenced and chest movement seen. Colour changed rapidly to purple blotchiness with white patches. Started to become bradycardic."*

> *"Emergency call for Drs put out. Continued with neopuff via geurdal air way till Dr Lambie arrived. Became bradycardic to 80's. Successfully intuinated [intubated?] by Dr Lambie and HR improved quickly. 0.9% saline bolus give and colour started to improvae almost as quickly as it had deteriorated. Started to breathe for self. Morphine commenced and placed on ventilator Rate 30 20/6 at 00:50. [I&S]."*

> *"0100-present….Dr Lambie has just spoken to parents as D-Dimer is raised. Has explained that this may indicate a clotting problem and will be discussed with tertiary centre today."*

> *"…[Parents] updated re D-dimer this morning by Dr Lambie and though glad to have the start of an answer are understandably upset too. Mum became very upset, blaming herself because of her own clotting disorder."*

So, Nurse T did not write in the nursing notes that she had been called to Baby B's incubator by Lucy Letby. This is something she recalled, rather remarkably, years later.

And clearly the descriptions of skin discolouration ("purple/white blotchiness", "purpuric episode") do not match that described in the 1989 paper.

Baby C

There was no mention whatsoever of unusual skin discolouration in clinical notes, particularly around the time of the fatal collapse late on 13/6/15.

As for the postmortem referral form, this was completed by Dr Gibbs, as both reporting doctor and consultant. What Dr Gibbs wrote in the "Circumstances surrounding the death" box (below) seems paltry in light of the 18 pages of doctors' notes which detailed Baby C's various medical issues over the four days that he was alive.

> *Baby was born at 30 weeks. Was suffering respiratory distress syndrome due to prematurity and was on neonatal ward. Was [PD] days old when he had sudden collapse and died.*

There may also be a parallel with Baby A (i.e. whether Dr Saladi had indeed been involved with Baby A's care as the postmortem form suggested he had been, despite no mention of him in the clinical notes). In Dr Gibb's witness statement in relation to Baby C, he wrote, "I had seen Baby C several times during the first three days of his life, including on the afternoon of 13 June 2015 and on each occasion he had been stable". Dr Gibbs did indeed record in the notes his review at 15:55 on 13 June ("US Head. Normal") but he had recorded no previous reviews and nor did other doctors. Furthermore, the nursing notes' first record of his name is in relation to him being called late on 13 June when Baby C suffered his fatal collapse.

Baby D

Night shift 21/22 June 2015

01:40: "Nurses noted that became extremely mottled +++. Also noted to have tracking lesions – dark brown/black across trunk" and "Skin -> brown. Areas of discolouration – light brown across trunk" (Dr Brunton)

> *2am: "2 "bruised" areas on abdomen – like evolving purpura. Most likely due to sepsis" (Dr Newby)*
>
> *02:35: "Areas of discolouration completely disappeared" (Dr Brunton)*
>
> *03:15: "Skin discolouration again became more prominent but not as obviously as previously" (Dr Brunton)*
>
> *04:21: RIP*

Clearly the skin discolouration referred to in Dr Brunton's 01:40 entry do not match the description in the 1989 paper.

Consultant Dr Elizabeth Newby wrote a very detailed pathologist referral form. In "Circumstances surrounding the death", she wrote:

> *Baby D was born at 4pm Saturday afternoon, 36 hour pre delivery her waters had broken* [it was in fact 60 hours not 36 and mum never received antibiotics as she should have]*, gestation was 37+1 week, 3.1kg. Mum was induced but the induction was caesarean section. Baby was born*

*in reasonable condition, but at 12 mons of age baby laid in dad's arms and had floppy episode and lost colour – PLEASE SEE FURTHER INFO. Cannot offer Cause of Death and paediatric PM required.*

The "further info" she referred to carried on as below:

*Given rescue breaths and bagged briefly, by midwife. Baby D quickly pinked up and had good respiratory effort. Baby then started to grunt, began to have respiratory distress, quietly grunting, but seemed well. Couple of hours later paediatric SHO was called as the nurse reported that the baby colour was off, baby brought to neonatal unit, baby looked dusky* [dusky skin tone is a medium-to-dark skin tone, often characterized by a warm, deep color that can have golden, bronze, or olive undertones] *with poor respiratory effort, sats 45%, so baby transferred to incubator and pinked up, Baby D was given full infection screen / iv abx. Blood gas showed respiratory acidosis, so instituted respiratory support and started on CPAP and given bolus of fluid. Around 9pm, the gas was improving, but still not good, so night registrar intubated and ventilated 9pm Sat night. Baby well over night, baby weaned very well on ventilator and extubated Sunday morning.*

*Dr Newby saw baby Sunday, and though Baby D was little bit quiet and little stiff, thought to be clinically septic, but seemed well, breathing fine, iv abx increased, planned to repeated gases and bloods soon after extubation. One hour later blood gas after extubation wasn't satisfactory so put back onto CPAP which quickly corrected and she remained in air with no real increased work in breathing. The day registrar inserted umbilical lines for better IV access, and then she remained well over the course of Sunday. Then at 1.30am the night registrar was called as she had become mottled and had tracking, dark brown discolouration – which had resolved after about ten mins. During that episode she had required an increase in oxygen but by the time Dr Newby attended she was back in air – was assumed this was septic picture, added in abx – repeated bloods, and abdo xray, line was good, bloods were reassuring, her inflammatory markers were ok and her gas was very good. She then went on to have a further episode of discolouration around 3.15am, doing very well at that* [page ends]

The next page is missing, but presumably details the period leading up to Baby D's death. As for the baby having become "mottled and had tracking, dark brown discolouration", this description bears no similarity whatsoever to the "pink on blue" in the 1989 paper. Nor does "baby colour was off/baby looked dusky" (according to one weblink, dusky skin is "a rich and radiant skin tone that is typically a shade between wheatish and deep brown, with undertones that can be warm, cool, or neutral").

The pathologist noted in the postmortem report:

*Although pneumonia can develop secondary to ventilation, the period of intubation and ventilation was short in this case, and taking into account the clinical scenario, with spontaneous rupture of membranes 36 hours before birth [*it was in fact 60 hours and the Mum never received antibiotics as she should have in this scenario, thus increasing infection risk to baby], *and then collapse of baby soon after birth, followed by continuing respiratory problems, and the histological pneumonia which is quite convincing. I think it is likely that the pneumonia was already present at birth, and is the underlying cause of Baby D's initial collapse and ultimate death. It is most unfortunate that the placenta was disposed of after delivery, as examination may have revealed an ascending genital tract infection as the cause of congenital pneumonia, which would have allowed me to be more definitive about the timing of onset of the pneumonia.*

Dr Laurence Abernethy, Consultant Paediatric Radiologist at Alder Hey, noted that:

*There is quite marked postnatal moulding of the posterior part of the skull; in the lateral projection, the parietal bones appear to override the occipital bone, with overlying soft tissue swelling. No other significant skull vault or skull base abnormality has been identified. A small amount of intracranial air is visible, but this probably represents post-mortem change. No other significant skeletal abnormality has been identified. There are no signs of injury to the spine, pelvis, thorax, or peripheral skeleton, and no evidence of systemic bone disease or skeletal dysplasia. There is almost complete opacification of both hemithoraces, with air visible only in the central portions of the lungs. A nasogastic tube is in place, with its tip in the stomach. Air is visible in multiple bowel loops within the abdomen. There are no signs of pneumoperitoneum or air within the partal venous system. An umbilical venous catheter is in place; its tip appears to lie just below the margin of the liver. There appears to be a small amount of intravascular air around the tip of the catheter. Intravascular air is also visible in the descending aorta. Intravascular catheters are present in both hands.*

It is clear that Dr Abernethy's comments with respect to air do not support the prosecution's assertions of Letby having injected air into Baby D's bloodstream. The reason that Dr Abernathy's comment about intravenous air being "visible in the descending aorta" does not support the IV air thesis is that prosecution radiologist expert Prof Owen Arthurs wrote in his expert report:

*Dr Abernathy in his report describes this air being in the aorta, but I do not think it is possible to distinguish precisely which vessel the gas lies in, from this lateral projection, nor from the other radiographs in the series.*

What the paediatric consultants told the RCPCH review panel in relation to skin discolouration

While it seems skin discolouration (though in no way similar to the 1989 paper's description) did sometimes precede or accompany collapse that necessitated resuscitation, the below paragraph from the RCPCH service review (paragraph 3.11) provided another revealing observation by the doctors:

*"Following reflection both individually and in discussions the consultants noted that several of the infants had collapsed unexpectedly and had been surprisingly unresponsive to resuscitation, despite the staff following standard protocols in each case. One surviving infant was mentioned as having needed resuscitation for similar collapses over three nights but subsequently recovered, although the review team did not see details of 'near misses' such as this. The consultants did not initially consider that there were any links between the episodes of collapse in the infants that died but subsequently they began to note similarities. For example some of the infants displayed a sudden mottling appearing after a few minutes of resuscitation, usually starting on the limbs, and on at least one occasion on the central abdomen and chest. The consultants had considered a number of possible causes for this appearance but there remained no definite explanation."*

One might wonder why the doctors did not think that the likely explanation for the mottling "appearing after a few minutes of resuscitation" was that it was the result of resuscitation. At trial, everything changed, and the mottling was the result of Letby injecting air into babies' veins, was described as "pink on blue" (per the 1989 paper) not brown/purple/dusky etc, and preceded the resuscitations rather than appeared "after a few minutes of resuscitation".

When did Dr Jayaram first find the 1989 paper?

Dr Jayaram testified on various occasions to having first found the 1989 paper at three different times, months apart: after death of Baby D, after collapse of Baby M, and after deaths of Babies O and P.

Time 1: After death of Baby D

We know that by the time Dr Jayaram wrote his Baby A statement to the Coroner on 24 July, he had already, for the first of three times (see below), found the 1989 paper, so was in a position to mention to the Coroner the relevance of the unusual rash that he said he had observed.

Here is the relevant part of the exchange between Myers and Jayaram at trial on 24 October 2022:

> *Q. So the paper, Dr Jayaram, the paper that you read at some point mentions moving patches of skin colour, doesn't it? The paper mentions bright pink against a blue background, doesn't it?*
>
> *A. It does.*
>
> *Q. Yes. What you said to the police when you went to make your statement in 2017 was made after you had read this paper, wasn't it?*
>
> *A. It was.*
>
> *Q. When you were interviewed?*
>
> *A. Yes.*
>
> *Q. And you told the police about bright pinkness on a background of blue/grey, yes?*
>
> *A. Yes.*
>
> *Q. You didn't mention bright pinkness on a background of blue/grey in your notes at the time, did you?*
>
> *A. I didn't at the time --*
>
> *Q. No.*
>
> *A. -- because I wasn't aware of the clinical significance.*
>
> *Q. And you didn't mention bright pinkness on a background of blue/grey when you made your statement to the coroner, did you?*
>
> *A. No, I didn't.*
>
> *Q. Has your description of what you said to the police and you say now been influenced by what you read in that paper, Dr Jayaram?*
>
> *A. I would say it hasn't. And the reason being, as I say, it is very easy to have confirmation bias. I remember reading this paper for the very first time and reading about this description and really feeling quite cold and worried. Now, it is a matter of regret for me that I didn't mention this to the coroner in the statements or at the time.*

Dr Jayaram's reasons for not telling the Coroner about the unusual rash are unclear. In one version of events, he says the reason is that he would not mention to the Coroner something he had not written in the medical notes. And yet this is a lie:

> *Q. So the statement to the coroner contains things that are not in your notes, doesn't it, Dr Jayaram?*
>
> *A. I beg your pardon?*
>
> *Q. Your statement to the coroner does contain --*
>
> *A. Yes.*
>
> *Q. -- things that aren't in your notes.*
>
> *A. For example, the UVC. But I remember --*
>
> *Q. So, for example, pulling back the UVC?*
>
> *A. Yes.*
>
> *Q. So when you tell the jury you don't put in a statement to the coroner anything that isn't in the notes, that's not right, is it?*
>
> *A. I accept that.*

In another version, he says he would not mention something to the coroner whose clinical significance he did not understand. This is also a lie. By the time he wrote his statement to the coroner on 24 July 2015 he had already come across the 1989 paper, so would have been able (and indeed would have wanted) to claim he understood the clinical significance of the unusual rash he later says he remembers, despite not mentioning any rash whatsoever in the medical notes:

> *Myers: All right. So I just want to be clear. When I asked, did you do some research after [Baby D]'s death into this paper, the answer to that, without wishing to be rude, is: yes, you did?*
>
> *Jayaram: Yes.*
>
> *M: Thank you. Now, everyone had been -- well, you say your colleagues as a group had been talking about these deaths, so that research is conducted. Do you recall when it was you came across that paper?*
>
> *J: I can't remember.*
>
> *M: But within days of [Baby D]'s death, as you were discussing this; is that correct?*
>
> *J: I think so, but I can't be sure.*

In Jayaram's second witness statement he writes that him having done a literature search after the death of Baby D on 22 June 2015, and finding the 1989 paper, was corroborated by Dr Brearey:

> *"I am told that Dr Stephen BREAREY has mentioned in one of his statements* that I reviewed Baby D's case and suggested that an air embolus could have caused her rash. This stems from some research I did into what we had seen in a number of babies. It had become apparent,*

*that in a number of babies on the unit, we had observed a discolouration of blotchy pink skin patterns that flitted around otherwise pale and bluish skin. None of us had seen this before so I started to think through any possible reasons for this phenomenon. I had a vague memory of reading that air embolisms could casue this pattern, so I carried out a literature search which resulted in me finding an article called Pulminary Vascular Air Embolism in the Newborn dated 1989 which I now produce into evidence as Exh Ref. RJ/5"*

Given that Jayaram found and read the 1989 paper before he wrote his statement to the Coroner, it is extraordinary that he made no mention of a pink on blue rash in his statement, particularly since he later wrote that reading the description of the rash "gave him chills".

* Below is *the section of Brearey's police witness statement that Jayaram referred to:*

*"Following her collapse Baby D became mottled and developed dark brown/black tracking regions across her trunk. Two bruises were noted on her abdomen but as the baby improved the area of discoloration completely disappeared. The rash lasted for 30 minutes. This is unusual. I am used to seeing rashes in very sick, septic babies and this rash is called purpura. This does not come and go and will stay for a longer time, well after the baby has got better. I think in this circumstance at the time, the rash was interpreted as purpura of sepsis but the fact it disappeared relatively quickly is perplexing and really unusual. I do not think the hospital paediatricians or neonatologists who reviewed this case could explain a cause for these rashes. My colleague Doctor JAYARAM came up with a suggestion of air embolus. With babies that have received air emboli rashes like this have been reported to appear."*

Time 2: After Baby M's collapse

In Jayaram's first witness statement, he writes about finding the 1989 paper after the collapse of Baby M:

*"Baby M was a twin. I attended Baby M after he had collapsed on 8th April 2016 and resuscitation was once again well underway. Baby M displayed the same type of unusual blotching as Baby A, fortunately Baby M survived. Note: This strange blotching didn't fit with anything I'd ever seen before in my 27 years as a Paediatrician but it happened on Baby A, Baby B (Baby A's sister who collapsed the next night although I was not involved in that resuscitation) and Baby M, and I began to wonder whether there was some common cause. I did some research and one of the things that I came across, was the possibility of something called an 'air embolism'. This is where air gets into the circulation. It usually happens accidentally, people have intravenous lines inserted into their veins and air can be injected into the blood stream. I knew that an air embolism was dangerous and could kill you. I found a review paper, an old academic paper, written in the 1980's which looked at a case series of air embolism in babies, I produce a copy of this paper as evidence reference RJ/2."*

Dr Jayaram's first and second witness statements were written 16 months apart. When he wrote his second statement one might have expected him to have checked what he had written 16 months earlier.

Time 3: After deaths of Babies O and P

At trial, on 22 February 2023, Jayaram testified that he found the 1989 paper after the deaths of Babies O and P:

> *"One of the things that came up in discussion was, could this be air embolus. I can't remember who suggested it, but it prompted me. That was a meeting we had on 29 June 2016. It prompted me that evening to do a literature search where I found the paper that was referred to. I then, the following morning, 30 June, emailed the link to that to colleagues because that paper described this skin discolouration that myself and colleagues had seen. And I actually remember the evening before, sitting on my sofa at home with the iPad, looking and researching that, and I remember reading that description and I remember the physical chill that went down my spine when I read that because it fitted with what we were seeing."*

Let's not forget that Dr Jayaram says he remembers having chills when he first read the 1989 paper. In other words, on three separate occasions, months apart. Which, let's face it, is absurd. It is reminiscent of him saying in an ITV interview after the trial in relation to Baby K that the events of that night, based on his memory of nurses' movements, "will be etched on my memory for ever". Until the Baby K retrial, that is, when he learned that the swipe data (and thus nurses' movements) was the wrong way round so his earlier memory could not have been etched as he had said it was. One would be forgiven for thinking he had made it all up.

Dr Evans also claimed that it was he who, independently of the clinicians, found the obscure 1989 paper. To his credit, he says he found it for the first time only once, though it is quite a coincidence that two doctors would happen upon such an obscure paper independently.

Importantly, Cheshore Police passed Dr Jayaram's September 2017 statement to Evans in 2018, before Evans really got going with the air embolism idea. This statement included:

> *"What was interesting with Baby A was that he had intubation and had cardiac massage started appropriately and they had received appropriate drugs. Adrenaline is the main drug that we give to stimulate the myocardium (the heart muscle) to try and get the heart to work better. He had unusual discoloration; you'd expect babies to look fairly ghastly and pale and grey but he had an odd sort of discoloration where there were flitting patches of pink areas on the background of bluey grey skin; these patches seemed to appear and disappear. It wasn't like the rash seen with a meningococcal sepsis which is caused by blood vessels bursting. It would flit and the reappear and disappear. It didn't fit with anything I'd ever seen before.*
>
> *"I would describe the marks as blotches which were fairly ill-defined, about 1 centimetre to 2 centimetres, not discreetly round but blotchy patches of brighter pinkness on a background of bluey grey."*

And, notably:

> *"I found a review paper, an old academic paper, written in the 1980's which looked at a case series of air embolism in babies, I produce a copy of this paper as evidence reference RJ/2."*

So, is it really credible that Dr Evans found the 1989 paper himself?

In their oral and written testimony, doctors Brearey and Jayaram clearly say that they suspected Lucy Letby in late June/early July 2015. It is also clear that the accusation that she had in June 2015 injected babies intravenously with air was enabled by the discovery of the 1989 paper about air embolism in early July 2015 by Jayaram. All that was then needed was to retrospectively concoct a skin rash that matched that described in the paper. Virtually word for word.

As for why they pointed the finger at Lucy Letby in the wake of the three deaths in June 2015, I leave you to judge.

You may think that Dr Jayaram's various statements are not in any way inconsistent. You also may think that the clinical care that Babies A, C and D received as described above was just fine. And, therefore, you're likely to think that Drs Brearey and Jayaram were right to think that the only explanation was that a nurse was attacking babies. And that that nurse was Lucy Letby.

Or, just possibly, you may think the evidence points to their care having been grossly negligent and them knowingly having scapegoated her.

Phase 3 (2017/8) and its three stages:

Stage 1 (Jan-May 2017): the Countess doctors

a) Countess doctors persuade the hospital to report their concerns about Lucy Letby to the police,
b) then, the Countess doctors persuade Cheshire Police to mount a criminal investigation into Lucy Letby.

Stage 2 (May-Jul 2017): Cheshire Police

a) communication between Cheshire Police and the NCA/NID,
b) separately, Evans sends email to NCA saying he's interested in helping; NCA introduces him to Cheshire Police,
c) Evans first meets Cheshire Police and immediately, upon looking at the case of one baby for 10 minutes, declares the baby has been murdered, despite the original pathologist finding no evidence of harm.

Stage 3 (Jul 2017-Jun 2018): Dr Dewi Evans

a) Evans agrees arrangements with Cheshire Police, who send him the cases of 28 babies to review,
b) Evans reviews the notes of the 28 babies declares in October that 16 of them have been intentionally harmed.
c) Lucy Letby was not present at 10 of the incidents of harm that Evans identified, so he revises his opinions, which he presents at a meeting in March 2018. Following this meeting, he is also given Jayaram's retroactive description of Baby A's rash which gets the air embolism theory going.

Phase 3, Stage 1: the Countess doctors

In January 2017, Lucy Letby's grievance against the paediatricians that she submitted in September 2016 was upheld. The paediatricians were told to apologise to her. It was official – they had scapegoated Lucy Letby. Plans were made to get her back on the ward.

But there was a problem. There was still a huge spike in mortality and morbity that needed investigating. However, this time it would be investigated not through the lens of a murderous nurse but one of poor care and possible clinical negligence as set out above. The paediatricians could not let this happen. They had to make sure Lucy Letby was investigated in such a way that she would be charged and found guilty.

Shortly after Lucy Letby's grievance was upheld, the Royal College of Paediatric and Child Health (RCPCH) service review of increased deaths commissioned by The Countess in July 2016 and completed in November 2016 was leaked to The Sunday Times.

The RCPCH review, which considered the general situation at the Countess during the period of elevated mortality, had recommended medical reviews of the 13 deaths (those that occurred at The Countess i.e. not including the 4 that occurred following transfer away from The Countess). These reviews were conducted by neonatologist Jane Hawdon, who concluded four of the thirteen deaths were unexplained. Following this, paediatric pathologist Jo McPartland determined that only two of these four were unexplained.

This information was conveyed to the journalist, per above, by Harvey, who was also compelled to publish the RCPCH review on the hospital website, which he did on 8 February (it has since been taken down).

It is likely the leak to The Sunday Times came from the paediatricians, as they would have wanted the fact that deaths remained unexplained to be made public, thus putting pressure on the hospital to report their concerns about Lucy Letby to the police.

The Sunday Times article, published on 5 February, noted that:

> *The royal college [RCPCH], which examined the deaths of 13 premature babies, is expected to recommend an immediate, thorough, external independent review of any unexpected neonatal deaths. The Countess of Chester Hospital NHS Foundation Trust says two deaths remain unexplained.*

Despite Dr McPartland's conclusion, the consultants it seems believed that more than two deaths were unexplained. Or perhaps they *needed* more than two deaths to be unexplained. They set about compiling their own report, which ended up citing eight deaths that they said were unexplained. These eight comprised the four in Dr Hawdon's review and four others. Interestingly, the four others included two babies who were born with "multiple congenital abnormalities" (the consultants did not think these were life threatening which is why they said the deaths were suspicious). These, however, did not end up on the indictment because Evans said the deaths were *explained by* the congenital abnormalities. This is one of many examples of material disagreement over whether events were suspicious.

The Countess executives were eventually persuaded by the paediatricians, in April, to go to the police about Lucy Letby. And, by mid-May, the police had also been persuaded. The tactics that the paediatricians employed to achieve this were questionable to say the least.

The below emails and documents set out first how the hospital was persuaded to go to Cheshire Police, and then how Cheshire Police were persuaded to launch an investigation into Lucy Letby (publicly it was framed as an investigation into increased mortality).

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 07 February 2017 08:21
To: Nim Subhedar
Cc: Maddocks Julie

Subject: RE: NNU review
Importance: High
Sensitivity: Confidential

Good morning Nim [Dr Nim Subhedar was a Consultant Neonatologist at Liverpool Women's Hospital, and also the Clinical Lead for the Cheshire & Merseyside Neonatal Network]

As you are probably aware, the review was leaked to the Sunday Times. I believe that we have forwarded embargoed copies to commissioners, regulators and the network (I was on leave last week when this "kicked off".

We have completed some of the recommendations, including the independent case review. I feel that it is important that the clinical team have the opportunity to see this review (carried out by Jane Hawdon) and, since we will be meeting with the Coroner and parents, come to a consensus taking in to account all the internal and external reviews and views. It may be that Steve has already raised this with you but would you be able to assist us with this? For a number of reasons we are running to a tight time frame so in the first instance I would forward a copy for you read and consider ahead of any meeting. I'm happy to discuss if you want more info.

Kind regards
Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

From: Nim Subhedar
Sent: 07/02/2017 10:40:11
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
CC: Maddocks Julie

Subject: RE: NNU review
Sensitivity: Company Confidential

Dear Ian,

Thanks for your email.

Yes, I'd be very happy to receive a copy of the independent case review report and contribute to the contribute to the overall consensus view.

Best wishes,
Nim

From: Nim subhedar
Sent: 10 February 2017 15:06
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: RE: NNU review
sensitivity: Confidential

Dear Ian,

Thank you for sending me the RCPCH report and Jane Hawdon's individual case note review. My comments about the latter are detailed below.

1. The terms of reference of the individual case note review wasn't clear to me: what was she asked to do and what information did she have available to her? It seems she reviewed 13 deaths and 4 survivors who suffered a sudden collapse.

2. My own interpretation of the 13 deaths included in her review suggests there were 4 cases in whom there is no clearly identified cause of collapse/death, and a further three cases where the cause of the initial collapse leading ultimately to the baby's death remain unexplained.

3. I am broadly in agreement with her recommendations. However, it should be noted that many of these recommendations are relevant to all LNUs, not just COCH. Additionally, I see no specific justification for recommendation (5) on the basis of her review.

4. The single most important and relevant recommendation is (6) which advises 'broader forensic review' of the cases in whom the death/collapse remains unexplained. I would recommend extending this to the 7 cases that I have identified:

    a. Child O
    b. Child A
    c .Child P
    d. Child D
    e. I&S
    f. I&S
    g. Child I

I would like to make one further observation in relation to the RCPCH report and recommendations.

Many of the recommendations relating to the governance arrangements around neonatal deaths are valid and sensible, but again extend beyond the neonatal unit at COCH. The unit in Chester is by no means an outlier either in terms of processes around mortality reviews or consultant presence and supervision on the neonatal unit. The COCH team's commitment to the Network's Steering Group and Clinical Effectiveness Group is exemplary and, in my view, demonstrates a commitment to improving the safety and quality of the neonatal care they provide.

I hope this is helpful. With your consent, I'd like to share my findings with Steve Brearey – please would you let me know if you're happy for me to do this?

Best wishes,
Nim

[Subhedar shares the above with Brearey two weeks later, on 27 Feb – see below]

Comment: There were so many differences in doctors' opinions as to which deaths and collapses were unexplained. Dr Hawdon said there 4 were, Dr McPartland 2, Dr Subhedar 7, and the Countess paediatricians 8, then 9. When Dr Evans came along, his list of which deaths and collapses were unexplained and thus suspicious kept changing (until it matched Letby's shift schedule). Over the last year, many highly eminent doctors have said that *none* of them were unexplained/suspicious.

From: GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 24 February 2017 00:30
To: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: Re: So....

Hi Ravi.

Been a long day - stuck in A&E most of the time apart from popping to and from the wards to check how things were getting on, then seeing the PaedOW urgents at lunchtime. Anyway, all quiet now!

Managed to get to see Ian this evening - and it was just Ian. Although he'd said this was to discuss 'my' review of nonfatal collapses, this was only covered in passing. The areas discussed were:

- The review Anne Martyn and I undertook. Ian didn't tell me how many patients had been identified but said there were quite a few (I don't think he was hiding anything, he didn't have the data with him), but he's promised to send me the info. Apparently, Lucy did not feature prominently in the staff correlation analysis of those collapses. [I'm keen to see the data because if there really were many such cases then I'm not sure that these were the specific ones that were highlighted as being unusual or unexpected - and if the staff analysis was undertaken for too many of the collapses then that might have obscured an unusual correlation between certain staff and those unusual/unexpected collapses – but let's wait until we've seen the data; Ian agreed that I could share it with all of 'us'].

- In relation to that review, I mentioned that it had been disappointing that we'd not be able to see the results of the analysis. And whilst on that theme, I said that we had all been surprised and very disappointed that the Board had come to its decision without us actually seeing the two review reports. Ian admitted that there were lessons to be learnt about communication during the whole of this 'investigation' and he also included keeping parents more closely informed and updated. Apparently, this will be considered during a major debrief to take place at some stage.

- Ian felt that he and Stephen Cross had made our concerns clear to the Coroner. As Tony Chambers had said in his letter to each of us, our letter in which we gave our view that the deaths and non-fatal collapses had not been adequately addressed through the two reviews so far, and that we felt some of these were unnatural, was given to the Coroner. Also, Ian and Stephen Cross discussed our concern that one particular nurse featured more often than any other nurse in the resuscitations/immediate care of the deaths and collapses. Also, as we already knew, the Coroner has the 'full' College review (where our concerns are again covered), and also Dr Hawdon's review.

- This discussion was held both with the soon-to-retire coroner, Nicholas Rheinberg, and the deputy Cheshire Coroner, Alan Moore, who is to take over from the current Coroner next month (like Rhienberg, Moore's background is as a lawyer). [I feel it was useful for both to be informed together because although Rheinberg will not doubt want to maintain his professional integrity, I would worry that his decision over what action, if any, to take might to an extent be influenced by his imminent retirement whereas the new coroner may have a different perspective at the start of his role as Cheshire Coroner].

- The coroner told Ian that he would not expect to have to re-open inquests that have already been held but that the forthcoming inquests, of which Ian thinks there are likely to be 3 (although 2 of these are probably! Child O and P would provide an opportunity to examine issues associated with the deaths. Ian does not know if the coroner/deputy coroner are considering any other actions.

- Ian explained that we can look at issues surrounding the deaths that Jane Hawdon/Nim have identified as unexplained when we meet next week (this is on Tues afternoon - but I don't think you'll be back then, will you, Ravi?).

- Ian asked me what I thought would be the end point of these reviews and further discussions and whether we'd be able to draw things to a close and move on with implementing the recommendations from the College review in order to enhance the neonatal service (he didn't specify what level of unit this would be). I said that we are preparing letters to both Tony Chambers and Lucy but this has been held up with holidays (which Ian says he entirely understands).

- I also explained that a problem 'we' have (and I said I thought this applied to all the consultant Paediatricians), was that we remain somewhat suspicious of Lucy's involvement but we don't know what she did (if anything), nor how she did it and, obviously, we don't know that she actually did anything untoward. Even so, I made it clear that unlike the impression given in the full version of the College review that it was only after Steve's first review (at the end of 2015) happened to highlight an association between Lucy and many of the sudden, unexpected collapses that our suspicions over Lucy then became aroused, each of us had already started to become worried about this association from our own personal involvement in various episodes. Initially, we felt Lucy was just unlucky in happening to be involved in more of these infants than other nurses but this association become steadily more worrying especially with recurrent sudden collapses at night that stopped when Lucy was moved off nights and then, on one occasion (only that I'm aware of), when Lucy covered a stable infant during a colleague's coffee break during which that infant unexpectedly collapsed. Ian again mentioned that Lucy, being a young, single nurse, undertook more sessions than other nurses on the unit and so would be expected to be associated with more 'events' but I countered that this was true but her involvement still seemed to be unexpectedly frequent. I added that in any mediation with Lucy it would be very difficult to know how to answer if Lucy (or the mediator with Lucy present), asked whether we still had 'suspicions' about her - although I suggested that like a politician we could aim to resolutely refuse to answer the question directly and instead talk about [next page missing]

From: Nim Subhedar [Nim.Subhedard, l&S
Sent: 27/02/2017 17:02:46
To: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: FW: NNU review
Sensitivity: Company Confidential
Flag: Follow up

FYI. Please don't share more widely at this stage.

Thanks,
N

From: GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 28 February 2017 20:44
To: L Doctor V 1(COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST);L Doctor ZA ;(COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Cc: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: Discussion between John Gibbs and Ian Harvey 23/02/17

Dear All,

Below is an email I sent Ravi after a discussion I had with Ian Harvey last week. Ravi had informed me before he went on leave that Ian wanted to meet with me. Understandably, Ravi was keen to know the outcome of this discussion (even though he was I&S), so the email below [ABOVE] is my feedback to Ravi (which is now being shared with you all). At the end of the email you can see that I've included my opinion that I feel we've probably pushed things as far as we can given that the Coroner knows of our concerns about unnatural deaths (and non-fatal collapses), and has a copy of our letter to Tony Chambers. However, I'm aware from the meeting we had yesterday (in Steve's office), that this may not be the majority view and I'm sure we'll be discussing this further. Anyway, for now, here's what I discussed with Ian Harvey (at his request), last week:

JOHN

P.S. I shall also circulate the summary that Ian has now sent me of the review of non-fatal collapses leading to transfers out of the Trust, undertaken by myself and Anne Martyn , that I mention below (note, this review did NOT cover patients who collapsed and survived but did not require transfer out of the unit).

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
To: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: FW: NNU Meetings
Date: 01 March 2017 13:45:09
Importance: High
Sensitivity: Confidential

Dear Steve

Further to yesterday's meeting I wanted to thank you for contributing, I believe that further progress has been made. I gather that an apology letter was forwarded to Lucy today and I would also like to

thank your part in that for that. I repeat my comments of yesterday that we must separate the concerns raised and the reviews from the grievance procedure.

On a related note, please could I counsel you to make every effort to attend the preliminary meeting with the facilitator next week, the 7th March. You may have already noted but this is an initial meeting, just with the facilitator, and will enable you to address some of the issues that were called out yesterday. I think that this gesture would also go a long way to protect you from a possible referral to the GMC from other parties which, having supported many doctors who have done no wrong through, even then isn't a comfortable process.

As previously my door is open to discuss any issues.

FYI — I have sent a similar email to Ravi

Regards
Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

INQ0004406 - Pages 1 – 2 of minutes of a Paediatrics Meeting held between Tony Chambers, Ian Harvey, Sue Hodkinson, Ravi Jayaram, Steve Brearey, Julie Maddocks, and Nim Subhedar, dated 27/03/2017

27th March 2017 — 5.10pm — 6.20pm

Attendees
Tony Chambers (TC)
Ravi Jayaram (RJ)
Nim Subhedar (NS)
Ian Harvey (IH)
Steve Brearey (SB)
Julie Maddocks (JM)
Sue Hodkinson (SH)

TC: Welcomed everyone to the meeting. Provide some context of the current position. We've had:

1. Royal College Review — actions and recommendations

2. Members of Staff — grievance

3. Clinical, how we get to the point the Board and Organisation has done everything to answer questions. If it's not at that point, what do we need to do to get to this point?

IH: RJ/SB/NS/John Gibbs — we had a useful meeting where we reviewed the 13 deaths.

There were five everyone was comfortable with.

There were eight were there were still concerns either cause of collapse, failure to respond to resus. Further in-depth review, which focused on collapses.

IH completed reviews of the eight and review of rotas together with all case notes and what recorded in the notes.

The next stage was to go through these

It was important that we were conscious of deaths in the first instance. This would drive anything regarding babies collapsed.

There are a number of questions we need help with:

- Collapsed unexpectedly, fail to respond
- If looking at potential causes, continuing consequences of collapses and how this is unpicked.

SB: This was discussed on a weekly basis.

Focused on 8/13 and transferred babies

It is disappointing the depth that this has been gone into.

A further 6 babies, arrested unexpectedly, which we identified in July. We don't feel these have been investigated in depth.

Nine months on and the hospital should not investigate this any further

This needs to escalate to the police. We have not had any explanation and we escalated this in July.

TC: Why are you escalating this now?

SB: We are still very worried. There is no natural cause of death.

RJ: There have been deaths.. . .

SB: But these were explainable. Not included in mortality review.

TC: You don't believe the different admission criteria had an impact?

RJ: As a group of paediatricians, we accept the Royal note College review, the case review and Jane Howden's review identified further ones. It's a difficult thing, what level of review do we need to do. We have a collective view that this now needs to be at the level of a rota review, who, where involved, a forensic investigation.

We accept that we may not find cause.

We have our names on the end of the incubator, we need more assurance. The interpretation of the reports differs to the Board.

We were presented with a plan and we have explored every avenue with the BMA (British Medical Association).

The review identified that there was no single casual factor, you identified further cases.

What do you agree and don't agree on?

SB: The College review is a service review not investigating the deaths. Jane Horden — four cases forensic review, her review was not forensic, it stimulated discussion and learning. There are four cases not reviewed yet.

TC: If this is your intention this is always going to continue, only higher authority is the police, not sure what they will say?

NS: The cluster caused concern here. The College review is a service review not case note and followed up with further detail review. In depth review for more than four cases.

The standard needs to be external to be some degree.

TC: I need to know if we do an individual case note review, or phone the police.

JM: Given the information, on the balance of probability, illegal activity has caused the deaths.

IH: Or reasonable doubt?

TC: If no process, the determining factor is that there is no other answer. Mischievous activity is the only causal factor. I didn't think that was where we are. We can phone them now, everyone will be interviewed.

SB: The worries not going away. I'll share with you an email from one of our experienced consultants, who was new with us in July; he has some stronger feelings than me. Quotes e-mail (from Michael).

TC: If that is where we are, then phone the police. You can call the police.

RJ: After the case note review, we are still left with 8 cases.

NS: Left missing staffing data, if that is reassuring.

IH: Does not highlight a single individual?

[End of page 2. Further pages not released by Thirlwall Inquiry]

INQ0003236_0001 [Countess Board meeting]

EXTRA-ORDINARY BOARD OF DIRECTORS (PRIVATE)
MINUTES OF THE MEETING HELD ON THURSDAY,
13TH APRIL 2017 at 9.30AM
BOARDROOM
SPC/CER FINAL

3. TO CONSIDER THE CURRENT POSITION WITH REGARD TO THE NEONATAL UNIT

Sir Duncan outlined the starting point where all the Board have been informed at each significant stage and they all know the steps taken and the further important step was to seek Mr Medland Q.C.'s advice.

Sir Duncan noted that the Board had received a copy of the minutes from the meeting with Mr Medland and the paediatricians.

Mr Medland thanked the Board for inviting him to the meeting and noted that the minutes that had been shared with the Board which were a summary of a long and important meeting. The background is an unexpected rise in neonatal deaths which could be due to all kinds of reasons but one matter crystallised in the consultant's minds about the unexpected number and certain infants who in their professional view would not ordinarily have died and they have in their mind that this could be criminal offences by a person or persons. The Royal College report says things could be done better and that some standards were not quite met in matters of quality and delivery. Neither the Royal College review or Dr Hawden's review identified any criminal issues. Dr Hawden said that a forensic review should take place. The consultants take the view that they are not militant or agitating for the matter to go to the police but they cannot see anyone else who could investigate it but the Trust view is if go the police this is an irrevocable step and carries potentially enormous risks for reputation and for the families, the question is, does it merit that step? All of us around the table agree that if there is clear evidence of a crime that you would want to go to the police straight away.

Mr Medland stated that in his view there is no evidence of a crime but the consultant view is to go to the police. He suggested that an alternative approach would be to approach the police member of the Child Death Overview Panel (CDOP) although it is possible he may say he is unable to help due to his position, he also suggested the Coroner, Mr Rheinberg but there would be a conflict of interest. We cannot say no to a further review of some sort as Dr Hawden's report says a broader forensic review is needed of the class 2 cases. He believed the next step is to acknowledge the aggravated sense of the consultants, put our arms around them and say that we propose to refer to Dr Hawden and ask her to tell us what she means as to a forensic review as this has many meanings and also what she feels will address this and could then speak to the police. This may satisfy their curiosity but he does not know.

Mr Medland added that you need to accept that if something is still unanswered or there are still genuine concerns in well minded people you should go to the police.

Mr Wilkie said that he had no real issue with what was being recommended but asked why doing this now and not at the point of getting a further report. Mr Harvey replied that it was not just about the forensic review but also the pathology review had taken some time as permission is needed from the Coroner to approach the pathologists at Alder Hey and also then contact them about the babies involved so this added to the delay. There was then a meeting with the paediatric consultants to discuss further work and clarify the number of cases after the pathology queries this went back to 13 and then 8 after a consultant meeting. As far as they are concerned there were still 8 cases despite what Dr Hawden said. There was another follow up meeting which has led us to where we are now and the delay is partly due to seeking permission from the Coroner to get to the pathologists.

Mr Wilkie asked if we can truthfully argue that there has not been a delay and that it had not been possible to do sooner. Mr Harvey replied there is due process and we have done everything in a reasonable and explicable order but we are beholden to other delays. M Chambers added that an enormous amount of work had been done and the clinicians will not recognise this but still hold the view that we have not taken this seriously.

Sir Duncan stated that the Board needed to decide for ourselves if we feel the work took long, did it answer Dr Hawden's report. The Board has a story to tell and follow through.

Mr Harvey said that was why he met with the consultants with the review to come to one view. Their view doubles the number of cases where there are concerns and they could not define what they felt was a forensic review.

Sir Duncan asked what did Dr Hawden mean, what would it amount to and could it be done without a police investigation. Mr Harvey said that it could mean many things and her view may not satisfy everyone. Mr Harvey is content to speak to Dr Hawden however this may not move us forward as the consultants may not agree. Mr Chambers said that this had been the purpose of the consultant meeting a couple of weeks ago. The Board view is answered up to 4 cases but consultants say 8 cases. There is a view of one or two consultants that there should be a police enquiry with interviews of individuals.

Mr Medland felt it may help to sit down with the consultants and say not ignoring their concerns and that we are going to do this with you as one team. The consultants feel split from the Executive team and sometimes think no one is listening. They also said the hospital has listened but not heard us. There is a need to bring the consultants back to the fold, say here is the action plan and that you want to work with them. We want a sensible way to acknowledge the difficulties. Mr Medland suggested that Dr Hawden be asked what is the forensic review and why the level 2 cases. He would invite the consultants in to the process as this will help them understand that it is not secret or kept away from them. We need to get to a position that there is a bomb proof criteria and actions.

Mr Higgins stated that as a Board there is a need for something bomb proof as quickly as possible rather than this is what we are going to do. In the discussion with Dr Hawden a representative from the consultants could be asked to be involved. Mr Oliver added that this could stop the perception and we need to have a solution to address that.

Mrs Fallon asked if we can get a timeline to speak to Dr Hawden so that we are clear when we can speak to her. Mr Medland suggested that Mr Chambers and Mr Harvey invite the consultants to a meeting tomorrow and speak to Dr Hawden then.

Mr Harvey suggested that Dr Hawden be invited to the Trust to discuss and agree a common line. Mrs Kelly and Mr Harvey have spoken with the Chair of CDOP and they have offered their assistance and Mr Harvey has agreed that he will discuss with them how they could assist in the process. Mr Medland felt that saying to the consultants that these are the steps we are taking would show that you are not trying to be secretive and this is a collegiate move forward.

Sir Duncan stated that the co-creation of the forensic review was a good idea and that would help to understand what forensic means to us all. It is hard to think that there should be another step after that. They may say we are handicapping ourselves by excluding the police at the moment but let's see where the next step recommended by Dr Hawden takes us.

Mrs Hopwood asked if the consultants would accept one representative being involved. Mr Medland replied that this was difficult to know as the sense if they all say should be a further enquiry but not pressing to go to the police but could not see an alternative. Some are more militant than others but there is potential with the proposed actions with Dr Hawden and CDOP. The consultants will understand that is difficult to get them together, could email them all and say get together before Easter and then set a date after Easter with Dr Hawden and CDOP and let hem decide who can attend. It is about not shutting them out and looking for the best way forward to get activated.

In response to a question from Mr Higgins, Mrs Kelly gave details of the role of the CDOP in such matters,

Mr Chambers asked Mr Medland about paragraph 14 in the minutes. Mr Medland said that consultants have swirling ideas about the potential crime so I said it would be helpful for them to think about what crime they thought had happened, i.e. did it always happen at tam, it is about designing a process to shed light on any issues as you cannot just go to the police without some detail.

Sir Duncan referred to the Beverley case and asked what are the common threads i.e. mottling or anything else they can think of. They are bothered by a spike but is there a common thread. We are not them and it is hard to believe but that does not matter, we need to understand what they are thinking.

Sir Duncan stated that the co-creation of the process will not satisfy anyone if it is a desk top exercise however as soon as it goes to an interview process, we may as well have called the police.

Mrs Hopwood asked if there was a plan to communicate this to the families. Mr Chambers replied that the Trust has written to the families advising them this is what we know in an open and transparent way.

Mrs Hopwood stated that there is a need to have some pre-emptive lines for the families. Mr Chambers said that there are the families, the nurse and The Telegraph and it may be easiest to phone the police, given all the potentials for an unmanaged grenade. To take forward the recommendations so far we will need to meet again next week. We have been trying to manage this and it may get away from us. Mrs Hopwood replied that she felt it had got away from us.

Mr Wilkie asked about the confidentiality of the CDOP. Mr Chambers replied that it would be shared with the Chair of CDOP and added that all the members of CDOP have received a copy of the Royal College report.

Mrs Hopwood asked if the report had been shared with the families. Mr Chambers confirmed it had and that the report was available on the Trust's website.

Mr Harvey stated that he had met with one of the sets of parents and their concern was that we will turn their world on its head and that they would start grieving all over again. They are very angry with the Solicitor that leaked the report to the Times. The Trust has endeavoured to keep the families up to date. The parents have given some useful feedback and there are things to be learned especially from the early days. We do need to be careful when approaching the parents.

Sir Duncan stated that there is a need to have a plan in place when approaching the parents.

Sir Duncan asked if everyone was comfortable that the Trust explores with Dr Hawden to take the forensic review forward. Everyone confirmed that they were content with this approach.

Mrs Hopwood asked would it be 4 or 8 cases. Mr Medland replied that it states class 2 cases. Sir Duncan added that it would not be limited as it is not yet known what the foremsic review means. We will sit down with the consultants and discuss what to do about following up the recommendations. It may mean that we cannot satisfy everyone short of saying go to the police now but maybe able to satisfy the right leader however they may still come back and say they want to go to the police in any event.

Mrs Hopwood asked what if the consultants after the forensic review still want to go to the police. Mr Chambers replied that we would have a discussion with the consultants.

Mr Cross reported that an inquest into one of the babies involved in the review was due to be held on 25th May 2017.

Mr Wilkie said that it would be good to have the forensic review completed before them.

Sir Duncan said that there was one other consequence as LL is expecting to come back to work and what do we say to her about the delay. It is not for the whole Board to discuss but it is important to get it right when explaining the further delay.

Sir Duncan added that we are still searching for explanations, not saying she is still in the frame but it is a legitimate point that the forensic review be conducted.

Mrs Kelly stated that the nurse asks every time we meet when can she go back on the unit. Sir Duncan replied that it was about getting the truth about why babies died and that we need more time for the forensic review.

Mr Chambers stated that we will find a way and there will be consequences, there are lots of moving parts to try and control and also the rest of the NHS structure such as NHS England who are part of this and they will also want to express an opinion, especially having regard to matters currently on-going Shrewsbury.

Sir Duncan added that the biggest risk is losing control of the situation and again noted the need to communicate with the parents.

Sir Duncan thanked Mr Medland for his help and support.

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) Sent: 13 April 2017 11:29
To: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V I (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: Mr Medland - In confidence
Sensitivity: Confidential

Dear All

Firstly, thank you for meeting with Mr Medland yesterday; I hope that you found it useful. Please could you confirm that you have all received copies of his notes and are happy with them?

[No response from consultants until 24 April, a week and a half later, see below]

From: GREGORY, Michael (NHS ENGLAND)

Sent: 19 April 2017 10:20
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: Update please

Hello Ian

Are you able to update me please as to the decision after your Board meeting?
I have to report back to colleagues today

Dr Michael Gregory
Regional Clinical Director for Specialised Commissioning (North)
NHS England

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 19 April 2017 12:26
To: GREGORY, Michael (NHS ENGLAND)

Subject: RE: Update please
Sensitivity: Confidential

Good afternoon Michael

Following our Board meeting — having completed the College review and the further case review - we have consulted further with the external, independent case reviewer and since we have 4 cases in which, in the reviewer's opinion, the death is unexplained we are following the process that would be the case in the event of an unexplained death out of hospital and are consulting with the CDOP. I have a phone call scheduled with the Chair of the CDOP tomorrow and will feed back further after this.

Regards
Ian Harvey

From: GREGORY, Michael (NHS ENGLAND) [Irrelevant & Sensitive]
Sent: 19/04/2017 11:56:16
To: PATEL, Lesley (NHS ENGLAND), KITCHING, Margaret (NHS ENGLAND), CORNALL, Robert (NHS ENGLAND)

Subject: Update on Chester
Sensitivity: Company Confidential

Hello

Here is an update from Ian Harvey.

I am concerned that they are avoiding the issue that we wish to see (contacting the police) but I suppose we should allow this call to occur then if they don't call the police after speaking to CDOP then perhaps consider we insist?

Michael
Dr Michael Gregory
Regional Clinical Director for Specialised Commissioning (North)
NHS England

INQ0102758
From: DODD, Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 20 April 2017 16:02
To: 'hayley frame'
Subject: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL NEXT WEEK - NNU REVIEW
Importance: High

Dear Hayley

Mr Harvey asked that a meeting be held as soon as possible at Countess of Chester Hospital NHS Foundation Trust and has invited you to attend as Chair of CDOP.

The meeting will be for approx. 1.5 hrs and will include himself, Tony Chambers(Chief Exec), Stephen Cross (Director of Legal & Corporate Affairs), Dr Raj Mittal (Consultant Paediatrician) and our Chairman, Sir Duncan Nichol.

The provisional dates I have held in our diaries are Monday, 24th April 1.30— 3.00pm and Tuesday, 25th April 12.30 — 2.00pm.

Mr Harvey asked if you can also invite anybody else from CDOP who you fee is appropriate.

Please can you let me know if you would be available on the above dates as a starting point.

I look forward to hearing from you.

Personal Assistant to
Mr Ian Harvey, Medical Director & Deputy CEO
Mr Simon Holden, Interim Finance Director

INQ0102758
From: hayley frame
Sent: 21 April 2017 10:20
To: DODD, Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: RE: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL NEXT WEEK - NNU REVIEW

Hi, I am delivering a serious case review practitioner event that morning in Nottingham so won't be available. Next week is full unfortunately apart from Thursday?

Thanks
Hayley

INQ0102758
From: DODD, Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 21/04/2017 12:00
To: hayley frame
Cc: anne.mckenzie
Subject: RE: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL K – NNU REVIEW - THURSDAY, 27th April 2017

Hi Hayley

Thursday is fine for everyone here. It would be good to hold the meeting at 12.30 — 2.00pm? Is this okay with you?

Are you inviting anybody else from CDOP?

Kind regards

Personal Assistant to
Mr Ian Harvey, Medical Director & Deputy CEO
Mr Simop_Holderii Interim Finance Director

INQ0102758
From: hayley frame
Sent: 21 April 2017 12:18
To: DODD, Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Gill Frame
Cc: anne.mckenzie

Subject: RE: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL K - NNU REVIEW - THURSDAY, 27th April 2017

That's fine, thank you.

I wonder whether we should invite Nigel from Cheshire Police and Gill Frame, Independent Chair of Chester LSCB? Please can you canvas Mr Harvey's views?

Thanks
Hayley

INQ0102758
From: DODD, Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 21 April 2017
To: hayley frame
Cc: MCKENZIE, Anne
Subject: RE: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL K - NNU REVIEW - THURSDAY, 27th April 2017
Importance: High

Hi Hayley

Mr Harvey agrees that they should be invited. Would you be able to arrange this with them as I don't presently have their contact details.

I confirm the meeting will take place at 12.30pm — 2.00pm on Thursday, 27" April 2017 in the Executive Office, Countess of Chester Hospital NHS Foundation Trust.

If you come to the main reception of the hospital and ask for me and I will show you to the meeting room.

We look forward to seeing you on the 27th.

Kind regards
Personal Assistant to
Mr Ian Harvey, Medical Director & Deputy CEO
Mr Simon Holden, Interim Finance Director

INQ0102758
From: MCKENZIE, Anne
Sent: 21 April 2017 16:05
To: Nigel Wenham
Cc: DODD, De COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); PD

Subject: FW: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL K – NNU REVIEW - THURSDAY, 27th April 2017
Importance: High

Hi Nigel

Please see below an e-mail trail for an invitation to a meeting to discuss the NNU at COSH, could you let Debbie Dodd know if you are able to attend.

Many thanks

Anne MacKenzie

Business Administrator, Cheshire East Council

INQ0102758
From: Nigel Wenham
Sent: 21 April 2017 21:00
To: MCKENZIE, Anne
Cc: DODD, Debbia.I.C_OLMTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST);
PD PD

Subject: RE: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL K – NNU REVIEW - THURSDAY, 27th April 2017 ,.[NOT PROTECTIVELY MARKED]

All, I have tweaked my diary, I can attend

INQ0102758
From: DODD, Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Date: 24 April 2017 at 12:01:07
Subject: RE: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL K – NNU REVIEW - THURSDAY, 27th April 2017

Many thanks for confirming Nigel.

Please come to the main reception on Thursday and I will show you to the meeting room.

Kind regards.

Personal Assistant to
Mr Ian Harvey, Medical Director & Deputy CEO
Mr Simon Holden, Interim Finance Director

From: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 24 April 2017
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST),
Cc: GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: RE: Mr Medland - In confidence
Sensitivity: Confidential

Thank you Ian, I am replying on behalf of the team after discussions.

We are happy with the minutes. However, at the start, we had a discussion about our respective understandings of the purpose of the meeting which highlighted a discrepancy. We had been led to believe that the purpose of the meeting was to help the Trust to frame what needed to be said to the police whereas Mr Medland told us that his brief was to discuss whether there was enough in our articulated concerns to make reporting to the police worthwhile.

We feel that his suggestion of speaking informally with Detective Superintendent Wenham from CDOP would be very helpful and would like this to be facilitated as soon as is practicably possible.

We would also be interested in the outcome of your discussion with Dr Hawdon about what in her view constituted "broader forensic review".

Thanks
Ravi

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 25 April 2017 16:43
To: GREGORY, Michael (NHS ENGLAND)

Subject: Meeting re NNU

Dear Michael

Further to you contacting the Trust, Tony has asked me to email to confirm that we will be happy to meet once we have completed our process.

Kind regards
Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

From: GREGORY, Michael (NHS ENGLAND)
Sent: 26 April 2017 09:18
To: CORNALL, Robert (NHS ENGLAND); PATEL, Lesley (NHS ENGLAND); BIBBY, Andrew (NHS ENGLAND)

Subject: Response from Ian Harvey

Hello

Please see the response from Ian about the meeting we had requested.

At RMT yesterday Margaret said she was prepared to give them a bit more time to respond.

I was going to respond to Ian with the following points:

- That we were planning to see them after they have the CDOP meeting
- We would like to know the outcome of that meeting
- We would like to understand the concerns of the clinicians and if they have been addressed?
- What was the discussion during the meeting with the legal advisor and the clinicians — what did he mean by "They (the clinicians) still don't feel that we have completed what the external reviewer described as a "broad forensic review"?
- What is the issue with the four unexplained deaths?
- We would like to agree that we have access to the redacted external review
- Which part of the process has to be completed before they agree to meet with us?

What are your views?

I was going to escalate to Margaret but she was initially prepared to give them time without knowing we had decided to meet them but I wonder if her view may change.

Dr Michael Gregory
Regional Clinical Director for Specialised Commissioning (North)
NHS England

From: PATEL, Lesley (NHS ENGLAND)
Sent: 26 April 2017 09:29
To: GREGORY, Michael (NHS ENGLAND); CORNALL, Robert (NHS ENGLAND); BIBBY, Andrew (NHS ENGLAND)

Subject: RE: Response from Ian Harvey

Hi Michael

Teresa and James are discussing this with Robert today, so I would await this conversation. The CDOP could take weeks so not sure awaiting 'their process' will be timely enough considering the level of concern.

Lesley
Lesley Patel
Director of Nursing Specialised Commissioning (North)
NHS England

On 26 Apr 2017, at 15:22, CORNALL, Robert (NHS ENGLAND) wrote:

Spoke with Teresa at lunchtime —we both think (as does James P) we should just refer to the Police now. They are happy to make the call if it helps with Trust relations. If all ok with this — Michael do you want to progress?

Robert Cornell
Regional Director of Specialised Commissioning North
NHS England
North East Office I Waterfront 4 I Newburn Riverside I Newcastle upon Tyne I NE15 8NY

From: KITCHING, Margaret (NHS ENGLAND)
Sent: 26 April 2017 17:44
To: CORNALL, Robert (NHS ENGLAND); BARKER, Richard (NHS ENGLAND)
Cc: PATEL, Lesley (NHS ENGLAND); GREGORY, Michael (NHS ENGLAND); BIBBY, Andrew (NHS ENGLAND)

Subject: Re: Response from Ian Harvey

Dear all

I have copied Richard in as it is important that he is connected and I suspect he would want a call with Lyn Simpson before taking such a decision outside of the Trust. I believe a call with their CE should happen tomorrow to clarify our position and if we are still concerned we should give them the opportunity to seek advice from the police first.

In my experience CDOP processes are not lengthy and I suggested at the RMT that we would give them to the end of this week if we have not received any further assurance.

Richard, it would help if you can advice from your perspective.

Kind regards
Margaret

From: KITCHING, Margaret (NHS ENGLAND) Irrelevant & Sensitive
Sent: 26/04/2017 17:47:34
To: CORNALL, Robert (NHS ENGLAND)
CC: PATEL, Lesley (NHS ENGLAND), GREGORY, Michael (NHS ENGLAND), BIBBY, Andrew (NHS ENGLAND)

Subject: RE: Response from Ian Harvey

Hi Robert
I have now briefed Richard so await his response
Thanks
Mx

From: CORNALL, Robert (NHS ENGLAND)

Sent: 26 April 2017 17:52
To: KITCHING, Margaret (NHS ENGLAND)
Cc: PATEL, Lesley (NHS ENGLAND); GREGORY, Michael (NHS ENGLAND); BIBBY, Andrew (NHS ENGLAND)

Subject: RE: Response from Ian Harvey

Who should make the call tomorrow?

Robert Cornall
Regional Director of Specialised Commissioning North
NHS England
North East Office I Waterfront 4 I Newburn Riverside I Newcastle upon Tyne I NE15 8NY

Comment: it is not clear if minutes of the CDOP meeting on 27 Apr were taken and, if they were, whether they have since been released publicly. Nevertheless, former DCS Nigel Wenham's statement to Thirlwall (below) provides a useful account of this meeting, even if it cannot be confirmed to be accurate.

INQ0102367 – Pages 6, 13 – 14 and 17 of Witness Statement of Nigel Wenham, Former Detective Chief Superintendent, Cheshire Police, dated 21/06/2024 (relevant excerpt about 27 April CDOP meeting):

Meeting on 27th April 2017 at COCH.

50. I attended this meeting representing Cheshire Constabulary and also present at the meeting were the following persons: Ian Harvey (Medical Director COCH) Stephen Cross (Director Corporate Legal Service COCH) Dr Ravi Jayaram (Paediatrician COCH NNU) Dr Susie Holt (Paediatrician COCH NNU) Dr Rajiv Mittall (Paediatrician COCH NNU / CDOP Panel member) Hayley Frame (Chair CDOP).

51. I recall I would have been involved in the planning of this meeting 27th April 2017. I cannot now recall, nor do I have access to precisely how this was done, but it was, either via telephone, email or through the constabulary business support team.

52. I cannot recall if there was any formal minutes shared regarding this meeting. It is likely others present made their own notes. I made some notes of this meeting in my day book and have previously exhibited these [INQ0102291] as Exhibit NW/6 [this document has not been posted on the Thirlwall website]. My original notes do not mention Hayley Frame and Dr Rajiv Mittall being present, however, I know they were present and information recorded in other attendees' notes, specifically notes made by Stephen Cross, confirm this. The notes from the meeting made my Stephen Cross are exhibited as Exhibit NW/7 [INQ0102292] [note that this document has not been posted on the Thirlwall website]. I have outlined a brief overview of the key points of discussion from this meeting as recorded in my day book:

- An overview of the COCH NNU operations was provided
- Outlined the number of neonatal deaths during the relevant period
- Previous 5 yrs. 2/3 year which is consistent with other areas

• During 18 month period 13 deaths in the NNU
• Reviews had been conducted including one by Royal College Nursing
• Recommendations from that review, that independent review is carried out relating to 13 cases, 4 cause death could not be explained, 8 not explained
• Highlighted that one member of staff was disproportionately present during these events
• This staff member would have had access to the babies, was working nights and day shifts
• Since had been moved from nights to day shifts, been no further events
• These were fragile sick babies
• Investigations so far have been thin, not identified cause for these deaths
• Feelings from clinicians, have lot of discomfort not investigated enough
• They have extensive range of experience and all are uncomfortable
• They are not comfortable with the findings and level of investigation
• Not all deaths subject of Post Mortem (PM)
• Assumptions had been made regarding early cases ad cause of death

53. It was during this meeting that I first heard the term 'angel of death' as a term used to refer to the Nurse Lucy Letby. I think one of the clinicians used the term. At the time I recall the significance of this comment and this was concerning to me. I recognised the risks if this term was used wider outside of this meeting and in particular in the public domain. I was therefore careful to not use this term any wider, although I would have briefed this into the Constabulary to those who needed to know.

54. I am aware that a request had been made to Ian Harvey to write to the Chief Constable (CC), requesting the Constabulary conduct a formal investigation into the events at the COCH NNU. I cannot recall if I made this request of him on behalf of ACC Martland, or if this request had come direct to him from ACC Martland. The letter to the CC is exhibited at point 100 of my statement as exhibit NW/29f [INQ0102319].

55. Following this meeting 27th April, I sent email to Ian Harvey. My memory of this email has been refreshed as I have seen the email contained in the bundle of material sent to me to assist with my statement. I have exhibited this email as Exhibit NW/8 [INQ0102293]. I sent this email to Ian Harvey on 27th April 8.14pm. The email was sent via Karen Dodd, Personal Assistant to Ian Harvey. I briefly outlined in this email that I had briefed to Chief Officer Level (ACC Martland) and a further meeting was planned for me to brief senior command within the Constabulary. I made it clear a decision as to progressing of criminal investigation would be taken once further information had been obtained and this included a request to hold a meeting with Ian Harvey and other representatives from the COCH at Constabulary Headquarters. I would have briefed ACC Martland following this meeting via telephone call as was my customary practice.

56. During this meeting on 27th April, I was mindful of its intended purpose and my responsibilities. I had to remain measured and not express opinion or speculate. Even though at this early stage, I felt this was progressing towards a criminal investigation, there was a critical need to remain cautious for the reasons I have previously outlined. Following this meeting, I had gained further information regarding the events that had taken place at the COCH NNU. My own personal concerns regarding these events remained and if anything, further increased. The content of the email I sent following this meeting clearly indicate my own personal mindset regarding these events and the potential direction of travel in terms of any investigation.

67. I have been asked by the Public Inquiry to comment if the report by Ian Harvey to the COCH Board accurately reflects my recollection of the meeting between us. I did make notes of the meeting that Ian Harvey refers to on 27th April 2017 and these have previously been summarised in my statement and my notes exhibited. The comments outlined above do generally correlate with my notes and

recollection of the events of this meeting. I was measured during the meeting and I may have said it would be an investigation and that staff would then be interviewed. Clearly his description and comments will reflect his interpretation of this meeting and what was discussed.

From: GREGORY, Michael (NHS ENGLAND)
Sent: 27/04/2017
To: FENECH, Teresa (N31 LIMITED), PALMER, James (UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST); BIBBY, Andrew (NHS ENGLAND); PATEL, Lesley (NHS ENGLAND); CORNALL, Robert (NHS ENGLAND)

Subject: Update on Countess of Chester

Hello

Margaret Kitching has updated me on the call she had with the Countess. She was on the call with Vince Connolly from NHSI. Margaret will send a briefing email out. I will keep things at a high level as this is an email. In summary the CDOP team met with the representatives from CoCH. There was a police officer on the panel. They are aware of the issues that we were concerned about and the police are going to discuss it with the Chief Constable and scope the work that needs to be done. They will decide on that next week. Even if they conclude they need to investigate the CDOP panel will still review the cases causing concern. There are some other processes that have been agreed about information sharing and points of contact. Margaret and Vince were satisfied with what was agreed. Margaret feels that as commissioners we need to step back and allow the police and CDOP to proceed.

Michael
Michael Gregory
Regional Clinical Director North Specialised Commissioning NHS England.

From: KITCHING, Margaret (NHS ENGLAND)
Sent: 28 April 2017 14:20
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Cc: CONNOLLY, Vincent (NHS IMPROVEMENT - T1520)

Subject: Fwd: Conference call notes (with logos)

Dear Ian

I have taken a few notes from yesterday's teleconference which I hope you find useful. It is to ensure I have interpreted the conversation correctly but more importantly details our action. Let me know if you are ok with these and can you pass to your colleague Stephen.

Kind Regards
MARGARET KITCHING
Chief Nurse North , NHS England

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 28 April 2017 16:10
To: KITCHING, Margaret (NHS ENGLAND)
Cc: CONNOLLY, Vincent (NHS IMPROVEMENT - T1520)

Subject: RE: Conference call notes (with logos)

Many thanks Margaret — I think that is a reasonable summation. Re the Comms lead — NHSE Spec Com have recently pinched our comms lead, she will be starting shortly, she wouldn't need briefing!

Regards
Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

INQ0004221 [Countess Board meeting]

EXTRA-ORDINARY BOARD OF DIRECTORS (PRIVATE)
MINUTES OF THE MEETING HELD ON THURSDAY,
2ND MAY 2017 at 12 NOON
TRAINING ROOM 3 & 4

UPDATE ON THE NEONATAL SERVICE

Mr Harvey reported that following completion of the Royal College review, we had met with clinicians about what else could be done. In respect of meeting with the parents it became clear that we were unlikely to get to that point. Dr Hawden had been asked what she meant by a forensic review and she said it was whatever we wanted it to be. Mr Harvey had met with the Chair of the Child Death Overview Panel (CDOP), a small number of CDOP members, including Superintendent Nigel Wenham of Cheshire Police, Dr Holt and Dr Jayaram to discuss the circumstances that led to the reviews, where we had got to and to discuss from a CDOP point of view where to get a degree of closure. The feeling was that we had done everything and that the next step was to consider a police investigation. It was agreed that Superintendent Nigel Wenham would discuss this with the Assistant Chief Constable (ACC) and guide the Trust to a letter to invite a police investigation to the Chief Constable. Mr Chambers, Mr Harvey and Mr Cross are meeting the ACC and wider police team on 15th May 2017 to report on the reviews and actions taken to date. Superintendent Wenham has been very measured at the meeting and made it clear it would be an investigation and that the staff interviewed would be interviewed as witnesses not suspects. The scope of the investigation will be restricted to an 18 month time period.

Mrs Hopwood asked if there was a future process agreed for any unexplained deaths. Mr Harvey replied that he had already had the conversations and any unexplained deaths would now be reported to CDOP. Sir Duncan asked who determines if a death is unexplained. Mr Cross replied that if a death occurred the Executive Team would be aware as the process for the paediatricians to raise this is

already in place. In any exceptional circumstances these would be discussed with the Chair of CDOP and the police.

Mr Higgins referred to the meeting on 15th May 2017 where there will be a discussion of what has been done to date and asked how the investigation would go forward. Mr Harvey stated that there was an earlier meeting on 5th May 2017 with the police to discuss the terms of reference for the investigation.

In response to a question from Mr Wilkie about informing parents and staff, Mr Chambers advised that the police at this stage are keen that the process be managed jointly by the police and the Trust. The next steps will be agreed at the meeting with the police on 5th May 2017.

In response to a question from Mrs Hopwood about communications, Mr Harvey gave details of the agreed single point of contact for wider NHS stakeholders such as NHSI, NHS E and the CCG. Ms Margaret Kitchen, Chief Nurse North, NHS England will be the single point of contact as she has had previous similar experience. Mr Harvey has updated Ms Kitchen on the process to date and she has feedback that we have done everything in the way and order that it should be.

Mrs Hopwood asked in terms of the relationship with the Board and clinical leaders of the unit, was there an action plan to address this, Mr Harvey replied that there is an action plan as part of the Royal College review and this is in draft at the moment due to the network being slow to respond. Mr Harvey has asked Ms Kitchen to speak to the network about this. Mr Harvey had also met with Dr Jayaram to update him as to where we are up to.

Mrs Fallon asked about the position of the staff member that had been due to go back to the unit. Mrs Kelly and Mrs Hodkinson continue to meet with the staff member on a weekly basis with support from the Head of Nursing, Urgent Care, Occupational Health and RCN support. She is still keen to get back on the unit and due to on-going clinical concerns raised by the consultants we have told her that we did not feel it was appropriate. She is continuing to support the complaints function and she is obviously finding it difficult to manage her parents. Mrs Kelly and Mrs Hodkinson have agreed to have a conference call with her and her parents.

Sir Duncan asked if the staff on the unit know there has been a CDOP referral. Mr Harvey replied that the staff on the unit did not know. Mrs Kelly added that as further concerns were raised this was told to the member of staff in a high level way and we were open with her but we do not know what she has fed back.

Mr Harvey stated that it was not a formal CDOP referral as he had telephoned the Chair of CDOP to explore as to how to take this forward given the actions we have taken to date.

Mrs Hodkinson reported that he RCN full time officer was the union representative for the staff member and he had asked about a secondment in a clinical basis but we advised that we would not do that.

Sir Duncan stated that after the meeting on 15th May 2017, there may be a need for the Board to meet up again.

From: KITCHING, Margaret (NHS ENGLAND)
Sent: 04 May 2017 14:29

To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: RE: Conference call notes (with logos)

Hi Ian
Have you had any updates from the police
I know you were hoping they would come back to you last week
regards

MARGARET KITCHING
Chief Nurse North , NHS England

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 04 May 2017 15:26
To: KITCHING, Margaret (NHS ENGLAND)
Subject: RE: Conference call notes (with logos)

Hi Margaret

We have a meeting scheduled for 15th May, 10.30-12.30 to meet together with some of our neonatologists for the scoping meeting. However, I have had a conversation with Nigel Wenham, the DCS on CDOP, and he, the ACC and the DCI who would be Senior Investigating Officer want to meet with Tony, Stephen Cross and I before this. We are going to Winsford on Friday afternoon. I shall email you on Friday after this first meeting.

Regards
Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

On 4 May 2017, at 15:26, KITCHING, Margaret (NHS ENGLAND) <margaret.kitching@[I&S]:

Thank you Ian

Much appreciated
MARGARET KITCHING
Chief Nurse North , NHS England

On 5 May 2017, at 18:58, HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST):

Hi Margaret

Further to previous correspondence Tony, Stephen and I met with the ACC, Det Supt and DCS Wenham (who is on the CDOP). In short:

There will be an investigation but it will be described as an invited police investigation to investigate unexplained deaths, not a criminal process. They are drawing up TORs to share with us and agree next week. We are forwarding details of the 13 babies and parents and the nurse. They will be advising the Coroner(s) and then jointly with us discussing with all the parents before it gets out by other routes i.e. the Coroner adjourning a forthcoming inquest. They will then liaise re the investigation and analysis- they already have an SIO, analyst and Liaison Officer identified. They have advised us to discuss the nurse with the LADO [Local Authority Designated Officer]. They have you as the point of contact for NHSE. Think that's the major points- I will keep you updated. Let me know if there are any queries.

Regards
Ian

From: KITCHING, Margaret (NHS ENGLAND)
Sent: 05 May 2017 19:46
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: Re: Conference call notes (with logos)

Thank you Ian

If you need any support let me know

Kind regards
Margaret

INQ0102298 – Notes of a meeting between Cheshire Police, including Nigel Wenham, Tony Chambers, Stephen Cross and Ian Harvey, 05/05/2017.pdf
Operation Hummingbird — Summary / Actions
Held at 15:30 on Friday 5th May 2017
ACPO Meeting Room, Headquarters Cheshire Constabulary

Cheshire Constabulary:
Darren Martland, Assistant Chief Constable
Nigel Wenham, Chief Superintendent, Public Protection Directorate
Aaron Duggan, Superintendent, Head of Crime
Claire Miles, Staff Officer
Laura Fox, Secretary

Countess of Chester Hospital:
Tony Chambers, Chief Executive Officer
Stephen Cross, Director of Corporate and Legal Services

Ian Harvey, Medical Director

DM opened the meeting with the purpose to discuss the content of the letter sent by Tony.

Chambers to Chief Constable Simon Byrne on 2nd May 2017. Concerns have been raised regarding a higher than usual number of neonatal deaths from January 2015 to June 2016. There were 8 in 2015 and 5 in first six months of 2016, in comparison to an average of 2.4 per annum in the previous 5 years.

Ch. Supt Wenham attended a meeting on 27th April 2017 with COCH to discuss concerns.

Supt. Duggan has informed the HM Senior Coroner Alan Moore and HM Senior Coroner John Gittins.

There are four outstanding cases one of which is listed for inquest on 25th May 2017, Child D. This case may need to be adjourned if an investigation is to take place. COCH have also spoken to both Mr Rheinberg and Mr Moore.

Overview - COCH

TC stated that the board has been managing the process, with the priority being the safety of babies and the welfare of both families and staff.

IH gave an overview. Met with Director, Alison Kelly in May 2016 as it had been recognised there were more neonatal deaths than what COCH is used to. An in house review was conducted, and no common cause of death has been identified. It was agreed there was more work to be done with regards to the review; the concern was the number of deaths and pattern.

There have been 13 deaths, 3 of which are yet to go through the coronial _process: Child D, Child O and Child P. These 3 babies and Child A (inquest already held) have unexplained circumstances of death, the post mortems did not assist further, even following conversation between the Medical Director and pathologist, with the permission of the Coroner. An external case review (Dr J Hawdon) has recommended a broader forensic review.

AP — IH to provide personal details of all 13 families. (red from original document)

There are three levels of neo natal units. COCH was operating at Level 2 during the period of the deaths, this provides short term ventilation. Since July 2016 COCH has been operating at Level 1, which cares for older babies that do not require life support systems. There have been 0 deaths on the unit since July 2016 (one baby transferred out subsequently died), the expected death rate at this level is between 1-2 per year.

Within the neonatal unit you would expect to see on shift at any one time, 3 trained nursing staff assisted by 1 nursery nurse. They would look after approximately 5-10 babies. During the index period, the neonatal unit had been busier, staff had increased workloads and staff could have been looking after anything up to 20 babies within the same staffing compliment.

The Consultant Paediatricians collectively felt that of the 13 deaths, 5 could be explained but 8 could not as the doctors felt that both the collapses and / or deaths could not be explained.

Reviews

The families are all aware that two reviews have been conducted:

1. Dr 3 Hawdon, Consultant Neonatologist, Royal Free London Hospital — October 2016
2. Royal College of Pediatrics and Child Heath (RCPCH) — November 2016 (Following visit September 2016)

An earlier Trust review led to a number of actions including:

- Redesignated neonatal unit
- The transferring babies below certain age / weight to be out treated

It was also noted the unit was 'running hot' and there was an increase in the number of lower birth weight babies, based on previous trends. The College review identified there were issues with communications between medical and nursing staff, incident review processes and delays in clinical escalation. Whilst the staffing was in line with surrounding units, it did not comply with the national standards.

On the back of the College review conducted came a recommendation for an independent external case review. Since the redesignation of the unit, there has only been 1 baby death which was explicable.

The independent review (Dr J Hawdon) took a clinical perspective, looking from birth to death. As such the families each received an in depth, independent case note review that was pertinent to their baby.

A criminal QC was instructed by the Trust, who after consideration of the relevant papers advised that there was no evidence to suggest criminal activity. At a later meeting with the QC, consultants expressed their views that they were not satisfied. The clinicians felt that there was no further work or investigation short of a police investigation that could be conducted to satisfy them that some of the deaths were not due to natural causes.

DM stated that there are two critical issues drawn from the overview and reviews:

- Potential of malpractice
- Practice issue involving COCH

There are at present no other reviews / investigations ongoing at the COCH.

Nurse

As part of the review staffing was looked at, there was a notable high statistical relationship between a member of the nursing staff and babies deteriorating in the unit. There is no evidence, other than coincidence.

Correspondence between Countess paediatricians from 3/5/17 to 10/5/17:

In many respects these emails make it clear that the paediatricians' aim was not to provide Cheshire Police with their objective appraisal of events but to present them in such a way that would "pique Cheshire Police's interest", given what Susie Holt reported Nigel Wenham had said (see below) at the CDOP meeting on 27/4/17 ("there are clearly resource implications and so the 'scoping' exercise

initially would be focused to determine whether there is sufficient level of concern to proceed to further investigation and potentially a major crime investigation").

From: HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 03 May 2017 23:44
To: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: Neonatal deaths & collapses

Dear all,

Following on from the meeting with CDOP representatives last week, the next meeting is to be held on Monday 15/05/17 @10:30 at Winsford. The CDOP police officer (Detective Chief Superintendent Nigel Wenham) was honest & transparent in admitting that there are clearly resource implications and so the 'scoping' exercise initially would be focused to determine whether there is sufficient level of concern to proceed to further investigation and potentially a major crime investigation. Therefore they will need to identify lines of enquiry in some of the more 'concerning' cases.

I am currently preparing a 'timeline' of events which was another thing that DI Wenham felt would be useful. Rest assured in the first instance this will be anonymised (with the use of a key) until there is clarity regarding patient confidentiality issues.

Please find attached the summary report started by Steve with comments from John and myself. Do people feel it is the appropriate time/forum to document clear suspicion of criminal activity? If so, please add this information to the individual cases. If not, perhaps we can discuss further on Monday. I agree with Steve's earlier Whatsapp. It is probably useful to meet on Monday at 11:00 & discuss where we are up to. What do others think?

See you tomorrow

Susie

Comment: One wonders how Drs Brearey and Jayaram reacted to Holt's comment: "The CDOP police officer (Detective Chief Superintendent Nigel Wenham) was honest & transparent in admitting that there are clearly resource implications and so the 'scoping' exercise initially would be focused to determine whether there is sufficient level of concern to proceed to further investigation and potentially a major crime investigation". It is clear from Dr Jayaram's response (below) that he felt there was a need to "pique the interest of the police", and made a number of amendments as below.

From: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 04 May 2017 13:23
To: HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); BREAREY,

Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: RE: Neonatal deaths & collapses

Thanks Susie

Suggestion for discussion

Should we highlight explicitly for these cases that LL was in attendance and in close proximity to the incubators (in those situations we know for a fact she was)? This is after all the basis of our concerns and I think for the police to have their interest piqued we need to have that with all of the cases (it's not going to be in the info Ian H/Stephen C have given to the police). I have attempted to do this as below for the ones I was involved with but hopefully more In a stating the facts way than a subjective finger pointing way. If everyone is in agreement we should all do something similar for the ones we know about. Time is of the essence, I would like to get this to Superintendent Wenham by the middle of next week at the latest.

Ravi

Page 2 – after "This is highly unusual and may indicate a possible unnatural cause of death" should we say "for example air embolism". The review paper attached describes such rashes in air embolism.

Page 2 – Baby A - Maybe add in "peripherally inserted central venous catheter inserted 90 minutes previously, in an appropriate position on x-ray. Initially became apnoeic, dropped oxygen saturations and then became bradycardic with no warning. Staff nurse Letby in attendance and with baby at the time of deterioriation. Resuscitation commenced immediately but did not respond to timely and appropriate interventions. No heart sounds heard but evidence of low voltage electrical activity on ECG trace. Decision taken to stop resuscitation after 30 minutes."

Page 6 – baby no 3 of the unexpected collapses 33 week gestation twin born in good condition. Day 2 sudden cardiorespiratory arrest, 6 doses of adrenaline and CPR. No cause identified.

? add " stable and breathing spontaneously on no respiratory support. Slightly distended abdomen during afternoon but observations steady. Sudden unexplained apnoeic episode followed by drop in oxygen sats, bradycardia and arrest. CPR started immediately. Heart rate present after adrenaline but slow at 60bpm. Resus continued for 30 minutes with no improvement (6 doses of adrenaline, 2 doses of sodium bicarbonate, 2 boluses of normal saline). Noted to have unusual patches of pinkish discoloration on skin on background of pale/blue discoloration. Patches seemed to come and go. Discussion with parents on withdrawing care but at 27 minutes heart rate above 100 and respiratory effort noted. Staff nurse Letby in attendance during resuscitation, unclear if present at moment of collapse from notes.

Page 6 25 week gestation infant. Ventilated. Sudden deterioration at 0350 with misplaced ETT. Transferred and died in APH.

?add " Born at 0212 after mum went into spontaneous labour, needed bag and mask

resuscitation at delivery, breathed spontaneously. Electively intubated and given surfactant, connected to ventilator, IV line placed for IV glucose and IV antibiotics. Plan for transfer to Arrowe Park hospital due to gestation. Stable observations and ventilator requirements. Sudden deterioration at 0350, oxygen saturations dropped to 40%. Connected to bag and mask and chest not moving. Carbon dioxide monitor attached to endotracheal tube – not changing colour suggesting tube had dislodged from trachea. New tube placed and baby recovered. Baby looked after by Staff nurse Williams. At time of deterioration, nurse Williams off ward talking to parents on labour suite, Staff nurse Letby at incubator and called Dr Jayaram to inform of low saturations. Endotracheal tube had been secured properly and baby not over-active. No obvious reason for tube to have dislodged. Baby subsequently deteriorated and eventually died but events around this would fit with explainable events associated with extreme prematurity"

Those are my ones, over to you!

From: GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 04 May 2017 14:17
To: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: RE: Neonatal deaths & collapses

From my perspective, for the babies that I was involved with who died unexpectedly, I can only say that LL was involved when they collapsed but I was not aware of what she had been doing prior to the collapse, or even if she had been the main nurse carer for the baby on that shift (since by the time I arrived, on each occasion, resuscitation was in progress and LL was involved). This applies to babies B, F, K. Baby F is the one where I joined Murthy around 08:30 at handover time on a Sat morning when the resus was in progress. Murthy (and I think Matt Neame) had been involved with the baby earlier during the night so I don't know if you have any other relevant observations to make, Murthy, concerning LL prior to the resus?
JOHN

From: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 04 May 2017 19:32
To: GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: RE: Neonatal deaths & collapses

I've revised the document and hopefully made it better.

It now has a table of contents. I've added a paragraph saying acuity and staffing is irrelevant. I've changed the cases who survived to letters, following on alphabetically and added more detail to those cases. I have mentioned nurse L was present for all of them. The code is:

Baby N ----I&S---- [PW - not on indictment]
Baby O ----I&S---- [AS - not on indictment]
Baby P ----I&S---- [Baby M on indictment]
Baby Q ----I&S---- [Baby K on indictment]
Baby R ----I&S---- [Baby G on indictment]
Baby S ----I&S---- [KC - not on indictment]

Would someone be able to add the other [Family A/B] twin (mentioned in the mortality section), Baby Q, SH and anyone else not mentioned we are worried about? I have attached a document regarding acuity and staffing that maybe doesn't need to be in the main document but we can take with us and refer to if needed. I'm sorry - Tracked changes and comments drive me crazy! I've tried to remove them once incorporated – hope that's OK?

Steve

**From:** GIBBS, John (COUNTESS OF CHESTER HOSPITALNHS FOUNDATION TRUST) <johngibbs@I&S>
**Sent:** Friday, May 5, 2017 8:42 AM
**To:** BREAREY, Stephen (COUNTESS OF CHESTER HOSPITALNHS FOUNDATIONTRUST) <stephen.brearey@I&S>; JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITALNHS FOUNDATIONTRUST) <ravi.jayaram@I&S>; HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATIONTRUST) <susieholt@I&S>; Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATIONTRUST) <I&S>; MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITALNHS FOUNDATION TRUST) <michaelmcguigan@I&S>; SALAD!, Murthy (COUNTESSOF CHESTER HOSPITAL NHS FOUNDATIONTRUST) <murthy.saladi@I&S>; Doctor V (COUNTESS OF CHESTER HOSPITALNHS FOUNDATIONTRUST) <I&S>

**Subject:** Re: Neonatal deaths & collapses

This is very helpful Steve. Well done.

The mortality document:
could there be a glossary for the non-medics (e.g. Police), who may not even know what NNU stands for, let alone LNU, BAPM, IC, HD, SC, NC?

would be useful at the beginning to point out that previously our mortality data was very similar to other DGH NNUs in the region otherwise some of those reading this document with little prior knowledge of neonatal services in this area might wonder if we've always had a much higher mortality rate than our regional peers (although it may be felt this is unnecessary since it is mentioned in the other document).

I was a bit confused about the two final graphs. Presumably this shows activity in our unit (do you think we need to make it clear it's our unit, since the preceding tables show activity across a range of units?). I presume these graphs are 'pulled off' Badger in the format shown but it's a little strange having two overlapping graphs one showing activity Jan 13 - Dec 15 and the other Jan 14 - Dec 16. Would it be possible just to show a single graph with activity Jan 13 - Dec 16?

The summary document:

Just one suggested change - at the top of page 2, the phrase:..... cannot therefore be considered to be a significant the sole reason why there have been no deaths..... should be re-phrased either as - cannot therefore be considered to be the sole reason why there have been no deaths - or - cannot therefore be considered to be a significant reason why there have been no deaths - or perhaps even - does not adequately explain why there have been no deaths. (I rather like this 3rd option!).

JOHN

From: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: Wednesday, May 10, 2017 6:31 PM
To: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) <ravi.jayaram@I&S>
Subject: FW: Neonatal deaths & collapses

1st attachment is the one
Steve

**From:** BREAREY, Stephen (COUNTESSOF CHESTER HOSPITAL NHS FOUNDATION TRUST}
**Sent:** Wednesday, May 10, 2017 6:35 PM
**To:** HOLT, Susie (COUNTESSOF CHESTER HOSPITAL NHS FOUNDATION TRUST} <susieholt@I&S>; JAYARAM, Ravi (COUNTESSOF CHESTERHOSPITAL NHS FOUNDATION TRUST} <ravi.jayaram@I&S>

**Subject:** FW: Neonatal deaths & collapses

Just for our own records as well Baby T ----I&S---- (SH)
Baby U ----I&S---- (FB)

Steve

10 May 2017: X5010 - NW.16 - Summary Report on Neonatal Deaths and Collapses, Final Version 10.05.2017.pdf

*Reasons for concerns regarding a possible criminal cause for increased neonatal mortality at the Countess of Chester Hospital NHS Foundation Trust, June 2015 – July 2016*

*Summary*
*The historical annual number of deaths on the neonatal unit at the hospital has been between 1 and 3. From June 2015 there were 13 deaths in the 13 months. The probability of this increase in mortality occurring by chance alone is very low. Many of the babies who died were born at gestations where death is statistically very unlikely (Appendix 1). Of the babies who died, most deteriorated unexpectedly without explanation at the time or subsequently. It is very unusual not to see any clinical evidence of a baby becoming unwell e.g. you might expect to see their heart beating faster or the level of oxygen in their blood changing. In some of these cases there was no recovery to adequate resuscitation measures. For this to occur in such a large number of babies is highly unusual and could be considered as suspicious.*

*There is an association with a member of staff who was present during the majority of instances when the babies unexpectedly deteriorated. When this member of staff was put onto day shifts for 3 months, no sudden collapses occurred during the night. Previous to this change in her work pattern, in 6 out of 9 deaths, the arrests occurred between 0000 and 0400. When this member of staff was no longer working on the unit (July 2016-present), there have been no neonatal deaths on the unit and no unexpected or unexplained sudden deteriorations. This member of staff was present on the unit during the deterioration of the babies who died A, B, C, D, E, F, G, H, I, L and M.*

*The gestation at birth of the babies who died was between 27 weeks and 40 weeks. 6 babies were >32 weeks gestation. The redesignation of the unit from July 2016 (only permitted to care for babies >32 weeks gestation) cannot therefore be the only reason why there have been no deaths or sudden unexplained deteriorations of babies on the unit since July 2016.*

*An external neonatologist from London [JANE HAWDON] has identified 4 babies [A, G, L and M = A, I, O and P on indictment] who require further forensic review. Further to her report, a consensus between 3 CoCH paediatricians and an external neonatologist from the Liverpool Women's Hospital (LWH) [NIM SUBHEDAR] have identified a further 4 babies [B, C, F and K = C, D on indictment and LO and KV not on indictment ] for whom the cause of death is still unexplained.*

*An unexplained rash was observed for at least 3 babies. This was initially thought to be due to infection by the clinical teams. However, the rashes resolved spontaneously despite the babies being very ill. This is highly unusual and may indicate a possible unnatural cause of death.* [RCPCH: RASHES APPEARED AFTER A FEW MINUTES OF RESUSCITATION]

*The increase in neonatal mortality did not coincide with any significant changes in acuity* [NOT TRUE] *or staffing levels in 2015 and 2016. Nursing staffing in Chester NNU was above the national average* [NOT TRUE]. *The percentage of shifts staffed to BAPM standards was higher than other LNUs in the network and higher than the national average. High dependency and intensive care days did not change appreciably in 2015 and 2016 compared to previous years.*

*In addition to the babies who died, there were also a significant number of babies who suffered an unexpected collapse or deterioration. The cause for the deteriorations is unknown and the member of staff mentioned above was present on the Neonatal Unit (NNU) for the majority of these cases.*

*The investigations undertaken by the Trust to date do not appear to have included a comprehensive analysis of staffing at the time of all the collapses and deaths. Senior medical staff, trainee doctors and nursing staff involved with the cases listed below have not been interviewed in relation to the care given around the time of the events listedbelow.*

*The babies who were transferred from the unit and subsequently died and the babies who collapsed unexpectedly and survived do not seem to have been adequately investigated by the Trust to date. In addition to the concerns listed below, some clinical staff (consultants and trainee doctors) had specific concerns regarding aspects of care of some of these babies but have not had an opportunity to share these concerns with an investigative team.*

*In summary:*

- *The number of neonatal deaths in this time period is highlyunusual.*
- *The number of unexpected and unexplained collapses is highlyunusual.*
- *Cause of death is still uncertain for 8 babies.*
- *Many of the babies who died did not respond to adequate resuscitation aswould normally be expected.*
- *One member of staff has been present during the collapse and/or deaths of an unusually high proportion of the babies involved. The likelihood of this occurring by chance alone is very low.*
- *Investigations and reviews to date have not identified any other potential cause for the increased mortality or been able to exclude an unnatural cause of the deaths and collapses.*

*<u>Mortality cases</u>*

Baby A [Baby A on indictment]
*31 week gestation twin born in good condition. Sudden unexpected arrest on day 1. PM and inquest failed to identify cause of death.*
*External London neonatologist has recommended further forensic review, yet to be undertaken.*
*Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.*

Baby B [Baby C on indictment]
*30 week gestation baby, birth weight 800g. Died on day 5 of life despite stable observations 24 hours prior to deterioration – clinically this death would not have been anticipated.*
*Primary cause of death given on PM as widespread hypoxic damage to heart. However, this was likely to have been caused following the decision to withdraw intensive care. As part of the dying process this baby had several hours of very slow heart rate and occasional respiratory gasps. During this time the heart would not have received adequate oxygen and therefore caused the changes seen at PM. The PM finding of hypoxic heart damage does not explain his sudden deterioration following normal observations beforehand.*
*Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.*

Baby C [Baby D on indictment]
*37 week gestation baby admitted to NNU at 3 hours of age with congenital pneumonia. Subsequently*

*she improved clinically. On Day 3 of life she became mottled and developed dark brown/black tracking lesions across her trunk. 2 "bruises" noted on abdomen thought at the time to represent infection but as the baby improved the areas of discolouration completely disappeared. Areas of discolouration then reappeared prior to sudden deterioration. No response to resuscitation efforts. Awaiting an inquest. PM states primary cause of death is pneumonia with acute lung injury. However, the baby was on CPAP and had no oxygen requirement immediately prior to deterioration. Clinically therefore this makes acute lung injury as a cause of the deterioration and subsequent death very unlikely.*
*The transient rash is also unexplained. Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.*

Baby D [Baby E on indictment]
*29 week gestation twin, 1327g. Died on day 7. Blood stained and bile stained aspirates prior to cardiorespiratory arrest. No PM agreed with coroner and cause of death given as necrotising enterocolitis (NEC) and prematurity. However, abdominal X ray taken less than 1 hour before death showed no signs of NEC, therefore clinically it would not be anticipated that this baby would have deteriorated and died in such a short time frame.*

COMMENT: Why did the Countess paediatricians not say they thought death of Baby D (Baby E on indictment) was unexplained?

Baby E [MM - NOT on indictment]
*Term baby admitted as poor condition at birth and meconium at delivery. Had neonatal SVT (Supraventricular tachycardia - abnormally fast heart rate) which resolved spontaneously at 3 hours of age. Occasional brief self-resolving SVTs thereafter. Otherwise, she normalised and took some bottle feeds. Possible seizure on day 3 of uncertain cause.*
*Bradycardic cardiac arrest (loss of circulation due to a sudden, very slow heart rate). PM identified Ebstein's anomaly (a type of structural congenital heart disease), and blood culture grew alpha haemolytic streptococcus. Babies with Ebstein's anomaly would not usually be expected to arrest in this way in the first days of life. Infection can cause neonatal death but you would expect to see progressive clinical compromise (i.e. change in the heart rate, other observations) prior to cardiac arrest rather than a sudden event.*

Baby F [LO - NOT on indictment]
*Term baby with multiple congenital abnormalities and diagnosed with Varadi Papp Syndrome on PM in which there are various abnormalities of the face and limbs. These abnormalities were not life threatening, therefore there is no explanation as to why the infant stopped breathing and subsequently died. Clinically, this was not anticipated.*
*Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.*

Baby G [Baby I on indictment]
*27 week gestation infant born at LWH and transferred to CoCH on day 11. Transferred back to LWH 3 weeks later due to distended abdomen, desaturations and bradycardia.Improved at LWH and returned to CoCH 1 week later. 1 month later, found blue and apno eic in cot at 0336, responded to resuscitation. Treated for suspected NEC and/or infection. Following day at 0500, further arrest and distended abdomen. Responded to resuscitation and improved. Following day at 0400, further arrest and resuscitation. Presumed abdominal pathology. Transferred to Arrowe Park Hospital (APH) – improved and no further deteriorations so transferred back to CoCH 3 days later. 6 days later, further arrests overnight and resuscitation discontinued at 0230. No evidence of abdominal pathology on PM. PM cause of death given as hypoxic ischaemic damage of brain and chronic lung disease*

*of prematurity. There is no clinical explanation for the repeated sudden deteriorations at CoCH and periods of stability and improvement elsewhere and it is highly suspicious.*
*External London neonatologist has recommended further forensic review, yet to be undertaken.*
*Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.*

Baby H [EW - NOT on indictment]
*28 week gestation baby born after un-booked pregnancy (mother had not had any medical care associated with pregnancy) with neonatal infection. Deteriorated and arrested on day 4 after an initial period of stabilisation. Cause of death was neonatal infection and extreme prematurity.*

Baby I [MegB - NOT on indictment]
*30 week gestation twin (Other twin also deteriorated and required transfer to APH).*
*Sudden deterioration on day 3 and unsuccessful resuscitation. PM cause for death given as congenital pneumonia with foetal inflammatory response syndrome.*

Baby J [WC - NOT on indictment]
*Preterm neonate born with antenatally diagnosed severe fetal hydrops, large ascites and pleural effusion (massive over production of fluid in most body compartments including in the chest – pleural effusion – and in the abdomen - ascites). Extremely poor prognosis given to parents prior to birth. Baby responded temporarily to initial resuscitation (including drainage of excess fluid), after birth but then deteriorated and died.*
*Clinically, this was an expected death.*

Baby K [KV - NOT on indictment]
*Term baby with multiple congenital abnormalities (cleft lip and palate, abnormal eyes, ears, nose, genitalia). Developed abdominal distension and cardiac arrest on day 2. PM was consistent with Fronto-Facial-Nasal Dysplasia. However, the abnormalities were not life threatening and neither PM findings nor blood tests are able to explain why she deteriorated and arrested. Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.*

Baby L [Baby O on indictment]
*Triplet born at 33 weeks gestation. Generally well and stable - clinically evident as on optiflow and NGT feeds. On day 3 he suddenly deteriorated with inadequate breathing, a very slow heart rate and abdominal distension. Did not respond to resuscitation.*
*Subsequent PM showed a ruptured sub-capsular haematoma of liver which may have occurred during attempts to resuscitate the baby and is unlikely to be the cause of his sudden deterioration. Had a discoloured abdomen at one stage which resolved later. Awaiting inquest. External London neonatologist has recommended further forensic review, yet to be undertaken. Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.*

Baby M [Baby P on indictment]
*Triplet born at 33 weeks gestation. Generally well and stable - clinically evident as on optiflow and NGT feeds. On day 4 he suddenly deteriorated with inadequate breathing, a very slow heart and abdominal distension. Did not respond to resuscitation. Had been started on antibiotics and had a thorough consultant review after sibling's death and no concerns raised. Clinically very surprising that subsequently arrested. No cause for death identified on PM. External London neonatologist has recommended further forensic review, yet to be undertaken. Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.*

*Babies who had an unexplained deterioration and survived or died outside CoCH*

*Baby N [MasB - not on indictment]*
*29 week gestation twin. Initially ventilated for 15 hours. Stable until an unexplained deterioration requiring ventilation on day 7. Nurse L present at time of deterioration. Mottled appearance to abdomen noted. Improved at APH and transferred back to CoCH 3 days later.*

*Baby O [AS - not on indictment]*
*30 week IUGR. Ventilated for 48 hrs. Abdominal distension and bile stained aspirates for a number of days. Collapsed and required ventilation overnight on day 11. Died in LWH shortly after transfer. Nurse L cared for baby on night shifts on days of life 9, 10 and 11.*

*Baby P [Baby M on indictment]*
*33 week gestation twin born in good condition and stable on day 1. Day 2 sudden cardiorespiratory arrest, requiring 6 doses of adrenaline and CPR. No cause identified. Nurse L present at resuscitation.*

*Baby Q [Baby K on indictment]*
*25 week gestation infant. Ventilated. Sudden deterioration at 0350 with misplaced ETT. Consultant could not explain how the ETT became misplaced. Transferred and died in APH. Nurse L present on unit.*

Comment: Dr Brearey above (email of 4 May) says that this baby's initials are FF (not MF per indictment) but the first 'F' likely stands for 'female'. That said, Brearey also notes that this baby's hospital number was ----I&S---- whereas elsewhere her number was cited as ----I&S---- (the numbers are almost identical so it is assumed that there was a mix up with the last digit).

*Baby R [Baby G on indictment]*
*23 week infant born in APH and transferred to CoCH at equivalent of 34 weeks gestation (i.e. about 11 weeks old). At 3 months of age had a large vomit and collapsed at 0315 requiring intubation and ventilation. Nurse L took over care of baby overnight. No cause for deterioration identified and she rapidly improved at APH and was transferred back 8 days later.*

*Baby S [KC - not on indictment]*
*34 week twin with persistent hypoglycaemia or low blood sugar. Collapsed on day 6 – cause unknown. Required treatment for severe hypoglycaemia. Unusual clinical findings of stable blood sugar during the day and then unexplained low blood sugars during the night. Nurse L on shift and recording blood sugar readings during those night shifts.*

*Baby T [SH - not on indictment]*
*37 week gestation baby who developed symptoms of abdominal distension and so was admitted to the neonatal unit for investigations and close observation. An xray suggested likely perforation (hole) of his bowel on 07/04/16 @ 02:42 & this was confirmed (using slightly different xray technique) @ 05:30 but clinically he was not requiring any additional respiratory support. Nursing nurses document some evidence of fast breathing & occasional desaturations. Care of the baby was handed over to LL for day shift. A decision was made in conjunction with transport team to electively intubate for transfer (this would be considered normal practice). The baby was clinically stable immediately prior to intubation, but the baby unexpectedly arrested during intubation. Despite emergency equipment check' documented in LL notes, the neopuff (equipment to support baby's breathing) would not administer high pressures & so incubator had to be moved to allow access to emergency equipment in adjacent bed space. Pt did not respond to resuscitation measures initially but did after some time and survived. He was transferred to AHCH for surgery.*

*Baby U [Baby B on indictment]*
*31 week gestation twin (sister of Baby A, who arrested on Day 2 of life). Day 3 at 0030 suddenly became cyanosed, limp, apnoeic and bradycardic with purple blotches on skin. Successfully resuscitated and intubated. Nurse L present. No cause for respiratory arrest identified.*

*Compiled by:*
Dr Stephen Brearey
Dr John Gibbs
Dr Susie Holt
Dr V
Dr Ravi Jayaram
Dr Murthy Saladi
Dr ZA

*Glossary of terms*
*APH – Arrowe Park Hospital, also known as Wirral University NHS Foundation Trust Apnoeic – pauses in breathing which are a sign of illness in neonates.*
*Arrest/collapse - Respiratory arrest is defined by the absence of spontaneous respiration (breathing) or a severe respiratory insufficiency (not breathing effectively to sustain life) that require respiratory assistance. Cardiac arrest is defined as the absence of central arterial pulse or signs of circulation (movement, cough or normal breathing) or the presence of a central pulse less than 60 beat per minute in a child who does not respond, not breath and with poor perfusion (i.e. the heart has stopped beating or is beating so weakly/slowly as to be ineffective). The two are closely linked (i.e. heart is dependent on lungs and vice versa) but in children (including neonates) the most likely cause of an arrest is due to oxygen insufficiency leading to a respiratory arrest.*
*Aspirate – babies have a naso gastric tube (NGT) that allows them to be fed as they have not yet developed the suck reflex and/or are unable to feed normally due to illness. Prior to feeding, the nurses will connect a syringe and suck the contents of the stomach to ensure the NGT is in the correct position. This is the aspirate.*
*BAPM – British Association of Perinatal Medicine is an organisation that aims to improve the standard of care delivered to unwell, newborn infants by improving standards of hospital care, clinical guidance and supporting ongoing education. The BAPM standards is an aspirational document outlining how hospitals should aim to deliver neonatal care including physical factors e.g. the environment, space around beds and human factors e.g. ratios of nurses to infants etc.*
*Bilious – bile from the intestines is seen in the secretions taken from the stomach. This is a concerning feature in neonates. See NEC*
*Bradycardia – pathologically slow heart rate*
*CoCH - Countess of Chester Hospital NHS Foundation Trust Congenital – present from time of birth*
*Desaturations – a fall in the oxygen level detected in the blood (routinely measured on neonatal unit)*
*Gestation – period from conception to birth which is typically 40 weeks. Newborn infants are categorized according to when they were born. A baby born 8 weeks early is born at 32 weeks gestation. The World Health Organisation gives the following definitions for the different stages of preterm birth:*
*extremely preterm: before 28 weeks*
*very preterm: from 28 to 32 weeks*
*moderate to late preterm: from 32 to 37 weeks.*
*Hypoglycaemia – low blood sugar level Hypoxic – due to insufficient oxygenation.*
*Ischaemic – insufficient oxygen to living tissue causing it to die LNU – local neonatal unit*
*LWH – Liverpool Womens' Hospital*

*Meconium – this is first stool passed by infants. There is controversy around the clinical implication if meconium is present at the time of delivery and it may be linked to foetal compromise (meaning that the foetus may have not got sufficient oxygen via umbilical cord) during the labour & delivery but must be interpreted alongside other clinical signs & symptoms.*
*Mortality – number of deaths*
*Neonatologist - on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on a neonatal unit alone i.e. paediatricians who have undertaken specialist training in neonatal medicine*
*Necrotizing enterocolitis (NEC) - is the most common gastrointestinal emergency occurring in neonates. Prematurity and low birth weight are the most important risk factors. The disease is not well understood but affected infants will not tolerate their feeds, and have progressive symptoms including aspirates (milk from the stomach after a feed as not being digested), abdominal distension, pain and other evidence of compromise.*
*NNU – neonatal unit, ward in hospital where newborn infants are cared for if they become unwell.*
*Pathology/pathological – linked to disease*
*PM – post mortem. Some infants had post-mortem examinations but none of them were home office post mortems.*
*Pneumonia – medical term for chest infection.*
*Resuscitation – this is a skill learnt by all doctors and some nurses. It follows set guidance from the resuscitation council which promotes team work and improves outcomes. There are logarithms that are learnt and followed if a child is recognised to have arrested (for whatever reason).*
*Term – babies born at or around expected due date (37-42 weeks gestation).*
*Ventilatory support – if unable to breathe adequately, ventilatory support may be required. This is a complex area.*
*Invasive ventilatory support is when a breathing tube is placed in big airways of the lung and 'breaths' are given by a ventilator.*
*CPAP or BiPAP is non-invasive ventilatory support. A tight fitting mask is applied to the nose &/or mouth and a ventilator produces intermittent pressure so the effort of breathing is less (but patient is spontaneously breathing). It is less intensive than above.*
*Optiflow is a way of delivery warm and humidified oxygen at different flow rates. It is less intensive than either of the above.*

*Appendix 1: Survival graph below taken from Office for National Statistics: Pregnancy and ethnic factors influencing births and infant mortality: 2013*

[Chart]

COMMENT: IT IS NOTABLE THAT TWO OF THE FOUR ADDITIONAL DEATHS THAT THE PAEDIATRICIANS THOUGHT WERE UNEXPLAINED PERTAINED TO BABIES WHO HAD CONGENITAL ABNORMALITIES, THE REASON BEING THAT THEY DID NOT THINK THE ABNORMALITIES WERE LIFE THREATENING. DR EVANS LATER SAID THE DEATHS WERE EXPLAINED (BECAUSE OF THE CONGENITAL ABNORMALITIES!) AND THEY DID NOT END UP ON THE INDICTMENT.

INQ0102300 – Pages 3 – 4 of Emails between Dr Ravi Jayaram and Nigel Wenham, dated 10/05/2017.pdf:

From: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 10 May 2017 18:36
To: Nigel Wenham

Subject: Countess neonatal issue
Importance: High
Sensitivity: Confidential
CONFIDENTIAL

Hello Superintendent Wenham

I met you a couple of weeks ago at the Countess during our discussions about the unexplained neonatal deaths and collapses. I am aware that the Trust have sent you copies of the RCPCH report and the independent case note review from Jane Hawdon as well as the results of internal reviews of staffing, intensity etc.

Attached are two documents that attempt to articulate the clinical concerns of the 7 consultant hospital paediatricians here at the Countess as to why we are uncomfortable about not only the increased number of deaths and collapses but also the nature of the deaths and collapses. One is a brief summary of each case (both deaths and unexplained/unexpected collapses) and the concerns, if present, for each of them, the second is a timeline of events referencing the babies in the 1st document.

The 3rd document is data from the regional neonatal network report looking at intensity, staffing and mortality in the period January 2015 to July 2016 in our unit and other units. The data comes from BadgerNet which is the database used across the Cheshire and Mersey neonatal network.

I am sending these in my role as lead for the department but this is a document that represents the collective view of us all. The document has no patient identifiers but if you require this information please do not hesitate to contact me and I can get this to you.

I hope that this is of use to you.

Ravi Jayaram
Consultant Paediatrican/ Clinical Lead for Children's Services
Dept of Paediatrics

From: Nigel Wenham
Sent: 12 May 2017 12:58
To: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: Countess neonatal issue —[NOT PROTECTIVELY MARKED]—
Sensitivity: Confidential

Dr Jayaram

Would you be available on Monday morning for a meeting to review the contents of your report? I think you have a meeting already booked with the Police following the meeting we had several weeks. If in agreement, can we meet you at 1030 as planned, or a little earlier if available? I can attend the COCH if you can secure a room, or you can pop over to Blacon Police Station. The purpose of this meeting is to clarify some of the issues you have highlighted. At this point we not conducting a formal police investigation, we are gathering information to inform future decision making. If you could please let

me know. I will be attending with Det Inspector Paul Hughes. We are not looking to meet with anyone else at this time, just yourself.

Regards
Nigel

INQ0102309 – Pages 2 – 7 of Notes of a meeting between Nigel Wenham and senior clinicians, dated 15 May 2017.pdf

Original notes made by T/Chief Supt Nigel Wenham, recorded in ONE Note at the time and amended spelling and grammatical errors following the meeting.

Notes from meeting Paediatricians
15 May 2017, 10:21

Dr Stephen Brearey - SB
Dr Susie Holt - SH
Dr Ravi JAYARAM - RJ
Paul Hughes - PH
Nigel Wenham – PH

NW welcome and outline purpose of the meeting: To review the contents of the report that was sent to NW last week, titled 'Reasons for concerns regarding a possible criminal cause for increased neonatal mortality at the Countess of Chester Hospital NHS Foundation Trust, June 2015 — July 2016

**Understand more about current operation of the ward**

7 Paediatric & neonatal (combined posts) Consultants employed by Countess of Chester NHS Foundation trust during time period. Business case approved in 01/2016 for 2 new consultants in keeping with national NHS recommendations. 8th consultant (Dr McGuigan) employed 01/2017 and interviews for 9th consultant took place on day of meeting. Dr Liz Newby in one of the Consultant posts until 03/2016 when left to work in Stepping Hill, succeeded by Dr Susie Holt

Funding of neonatal unit is split: Specialised commissioning through NHS England pay for care on the neonatal unit

Some care of newborn infants is funded by CCG,

NHS Improvement not involved

SB very keen from the start to involve the neonatal network
Part of network care across Cheshire/Mersey, there is some degree of accountability in the network, for example, mortality reviews

RJ — if you have concerns about Dr you would report to GMC; concerns about a Nurse to Nurse and midwifery council, if wider issue like this, escalate through the trust. Regarded as whistleblowing if you go outside. We have taken advice from our medical defence unions to do everything within the trust and deal that route

SH - guidance is available on line from the BMA & GMC

SB - there are invited college reviews, like the one from Sept, that was service review. They did recommend multi service review

SB - the case notes review by Dr Hawden did assess some cases, this was not what the Royal College of Paediatrics & Child health (RCPCH) review asked for. What happened was ONE neonatologist looked at cases notes, this was not multi discipline review that was suggested

Trust can have root cause analysis to invite professionals in to do review of whole case, these tend to be single case, not cohort reviews.

CQC have a responsibility for all NHS organisations and private, as clinicians very unusual for us to go direct, this would be more whistleblowing. We have not directly contacted the CQC, advice from legal reps exhaust all possibilities first

RJ - the JH review specifically mentioned forensic review, we can not conduct that level of review. The fact is these babies would not be the ones you would have expected, at the point they collapsed and they did not respond physiologically to the treatment as expected

**Understand more detail of their concerns**

SB - of those 9 we reviewed initially, 6/9 collapsed between 000-0400, which was highly unusual. One of the action was to review the period prior and nothing was found (will share these reviewed) that review also noticed a significant number of collapses.

SB - following on from that thematic we discussed the nurse (Lucy) but no action taken.
I shared the report with IH prior to the COC inspection (Feb) at this time the nurse had been put on day shifts for mentoring reasons

Q: Confirm how many that Nurse has been present?

SB - the nurse was present in all but one of the deaths

RJ - the staffing review has looked at the notes, this has not necessarily been picked up. What has not been looked at, this baby collapsed, who was where, what were you doing at the time. As consultants, it is very rare that consultants were present at time of collapse. At the point of the collapse, the nurse was present at that time in close proximity. This has not happened to other staff.

I can speak about one that did collapse, but survived, 27 weeks, was stable had breathing tube down, good ventilation, named nurse (ie nurse assigned to care for baby during that particular shift) had gone out of nursery. I went back in, the baby's oxygen levels had dropped, first thing to do disconnect baby from ventilator and bag. I noticed the breathing tube had been dislodged. The nurse (L) was present at the time.

RJ - there is perception that we are on campaign, this is not the case. Other (consultants & junior doctors) had come to the same view. It got to the point that when Nurse was on duty we feared something would happen.

RJ - we are not on a witch hunt, we have concerns that this nurse was present in far too many occasion

Provided example of baby that was being treated for low blood sugars, very erratic pattern of sugar level which changed with shift pattern no clinical explanation, consulted with Alder Hey, who agreed was unable to explain.

SB - we have looked hard, we cant find any explanation

- **Identify any specific evidence of any criminal or suspected criminal activity**
- **Clarify some aspects regarding the pathology and causes of death**

Q: 3 cases were certified by Dr's on wards, why?

SB - one baby 29 wks, felt that baby displaying typical signs of NEC, felt at time this was not suspicious. The baby had abdominal x ray an hour before death, there was no signs of NEC. The fact xray was normal is odd. As an isolated case, he would not have been considered suspicious, but assessed on the timeline, there are concerns

Q: questioned on the cause of deaths and pathology?

SB - this is what PM diagnosis is Neo is so hard. JH review identified those 4 cases, we also reviewed these and another 4, we felt there was unexpected or unexplained cause of death.

SB - there are several babies with clear genetic diagnosis, in some cases the PM does not explain why the babies suddenly collapsed and died.

Q: do you consult with the Pathologist regarding PM findings?

Outlined that this was not normal practice, communication would take place between the pathologist and coroner

Q: if third party involvement would you expect to see the same indicator?

SB - it is relatively easy to manipulate fluid, to administer drugs and or too block an airway

SB - there seems to be a theme with multiple births (triplets & twins) and the more stable infant being the one to collapse

SH - case of Babyliqtwins, 1 twin was on CPAP — but babr.si(not needing any respiratory support) was the one that collapsed, from clinical perspective neither were anticipated to collapse but clinically the one on respiratory support was more vulnerable

RJ - concern we have is could something be done deliberately to harm them. We don't know, I don't know if this is something we just have to live with, we would rather there was some explanation, our concern is have enough questions been asked, can we be satisfied that we have done all we can to confirm if there is something more going on.

Nobody has talked to junior Dr's who have been involved. We appreciate that a lot of time has passed since these. We at end of the day are responsible for patient safety on the ward, the buck stops with us.

SB- to put in perspective consultant who joined us from Crewe, he has never experienced anything like this in 5 years as consultant

RJ - we all have concerns, nothing significant changed over the years to explain the deaths e.g. the changes in patient numbers, staffing, do not explain the number of deaths or collapses.

RJ — We do not dispute the findings from the RCPCH report and it has made useful suggestions for our service, but feel these are background factors

RJ - the pathology report may attribute a likely cause of death, but this does not explain timing nor what caused the collapse that ultimately led to death

Agreed not challenging the pathology findings, but the fact is the cause of collapse leading to death has not been identified

SB - survival rate for babies over 32 is nearly 100%, for 6 of our babies to have died who were over 32 weeks, to die is not right.

**Review the key statements outlined in the report**

***The historical annual number of deaths on the neonatal unit at the hospital has been between 1 and 3. From June 2015 there were 13 deaths in the 13 months. The probability of this increase in mortality occurring by chance alone is very low. Many of the babies who died were born at gestations where death is statistically very unlikely (Appendix 1).***

***Of the babies who died, most deteriorated unexpectedly without explanation at the time or subsequently. It is very unusual not to see any clinical evidence of a baby becoming unwell e.g. you might expect to see their heart beating faster or the level of oxygen in their blood changing. In some of these cases there was no recovery to adequate resuscitation measures. For this to occur in such a large number of babies is highly unusual and could be considered as suspicious.***

SB - did thematic review in Jan 2016, looking at the 9. senior nursing staff from Liverpool Woman's Hospital, looking at themes trends. Staffing was included in that report, staffing on shift, designated nurse, consultant on duty, name of junior Dr;s present. Could not find link with consultant or Dr's.

RJ - all collapses and deaths would involved wide range of professionals

NW - at what point was concerns raised?

SB - from December, I raises some concerns. The first discussion took place in June 2015, when we had 3 deaths within few weeks, this was highly unusual, we met with IH and head of risk at that time, we reviewed all three cases. Could not identify any issues regarding clinical practice. At that time the unit manager noticed that Lucy Letby (The nurse) was present at all three. That was first conversation.

All three reported to coroner and had PM's

RAVI was clinician for XXX, he attended inquest, cause of death unascertained [BABY A]

SB – XXX [BABY A] collapsed unexpectedly and died. His twin [BABY B] collapsed but recovered. This was unexpected and unusual, now looking back we think this was suspicious. She had unusual rash.

SB – [Baby ?] improved after intervention being brought into the unit & started on treatment,. collapsed and died on day!. All blood markers did not indicate worsening infection. PM still spots inflammation in the lungs, but this does not explain the improvement in the baby health and then collapse.

Explain collapse?

SB - baby do not have cardiac arrest like adults do, collapse on unit would be inadequate breathing, babies stop to breathe, may stop breathing, dropped oxygen levels, breathing stops and oxygen level for period, heart slows down, this requires cardiac massage. These babies had apnoea, stopped breathing. Increased number result in desaturation. These babies just stopped out of the blue.

How do we know that?

RJ - they are on monitors, however monitors don't keep digital record of numbers. Nurses document observations from monitors hourly on observation charts.

SB - most babies were at gestation would not expect these sort of things happening.

RJ - these babies simply did not respond as expected, interventions did not result in expected results. The baby XXX interventions were put in place, there was evidenced electrical activity of the heart, but he did not have output (no pulse). Not many things can cause this, he had adrenalin, he did not respond, half hour without output (Child A).

SH - there is big difference adult and neonatal practice, with intervention we would expect to see some response and statistics support this.

What was thought process with no response?

RJ - in one off, there could be explanation.

SB - we would expect the PM to find evidence to support cause of death. The pick up rate from pathology has not informed us as to why the babies have collapsed.

RJ - we accept in medicine some uncertainty, we accept cognitive bias, but we cant see explanation. Is it people, practice, building, accommodation, it is big leap of faith to suggest these all lined up and led to the deaths. All of these factors (acuity of unit, medical & nursing staff levels) are there and common to other neonatal units in the country.

SB - PM for XXX [Baby A?] was done urgently

RJ - if any concerns we would escalate to the coroner, would discuss and agree process

SB - all neonatal deaths are discussed with the coroner

There is an association with a member of staff who was present during the majority of instances when the babies unexpectedly deteriorated. When this member of staff was put onto day shifts for 3 months, no sudden collapses occurred during the night. Previous to this change in her work pattern, in 6 out of 9 deaths, the arrests occurred between 0000 and 0400. When this member of staff was no longer working on the unit (July 2016- present), there have been no neonatal deaths on the unit and no unexpected or unexplained sudden deteriorations. This member of staff was_present on the unit during the deterioration of the [X] Children who died (Child A, C, D, E,I&S, I&S, Child I, I&S, I&S, Child O and Child P).

The gestation at birth of the babies who died was between 27 weeks and 40 weeks. 6 babies were >32 weeks gestation. The redesignation of the unit from July 2016 (only permitted to care for babies >32

weeks gestation) cannot therefore be the only reason why there have been no deaths or sudden unexplained deteriorations of babies on the unit since July 2016.

An external neonatologist from London has identified 4 [Child A, I, O and P] who require further forensic review. Further to her report, a consensus between 3 CoCH paediatricians [comment: not all seven] and an external neonatologist from the Liverpool Women's Hospital (LWH) have identified a further 4 Child C, D, I&S and I&S for whom the cause of death is still unexplained.

**An unexplained rash was observed for at least 3 babies. This was initially thought to be due to infection by the clinical teams. However, the rashes resolved spontaneously despite the babies being very ill [comment: at trial the babies were well/stable]. This is highly unusual and may indicate a possible unnatural cause of death.**

RJ - did some reading and found that situation called air embolism, small amounts of free air in circulation can obstruct flow of blood into the lungs, free oxygen can be picked up. There is a rash associated with these diagnosis

SH - explained that we associated infection with rashes, this was not the case here, not a recognisable rash outside these collection of babies.

RJ - air embolism can happen deliberately or accidently, for example, cannula administering drugs, what could happen, there could be error in how the cannula is managed

Babies i&s, Child D and one survived (Child B)

RJ - my understanding is that unless the PM is done very soon, there will not be any evidence on the PM

**Closing comments:**

RJ - we are used to dealing with uncertainty, this is what we do. We have said we want enough done to rule out foul p ay. IH has suggested getting another neonatal review. JH refers to forensic, but what this means

SB - we were very worried, the triplets (twins who died) there was no explanation, she was named nurse, other nurses have gone off work with stress, she didn't' Duty exec was happy for nurse to remain on duty at that time. When expressed our concerns, we don't think the executives have understood our concerns.

In Jan, we met with Chief exec, all seven of us, we were told we have spoken to family, don't cross the line, we are dealing with it.

Every Paediatrician were worried about her going back to work and none of us were happy with her returning back to work, we don't feel this is acceptable. This has not been investigated properly.

RJ - I don't want the obvious fractious relationship between us and the executive, this is not why we want you here. We are not sure the process, reports have asked the right questions, we want to exclude is there anyone who is deliberately harming these babies.

At a meeting in Jan executive read out letter from the nurse that stated she was exonerated by reviews to date.

RJ - we fully understand the impact of investigation, damaging to the trust, the neonatal unit and staff and the impact on the families of the babies. At the end of it you may ask what was the point. Speaking for myself, we are not comfortable as worried about safety of our patients.

Stage 1 ends with Cheshire Police, on 18 May, announcing *publicly* that they have launched an investigation into increased mortality on The Countess' NNU (see article in The Guardian below). *Privately*, however, their sights are firmly *and only* on Lucy Letby, as evidenced by the 5 May email from Ian Harvey that stated, "There will be an investigation *but it will be described as* an invited police investigation to investigate unexplained deaths, not a criminal process".

If it really was an investigation into unexplained deaths there would have been no need to write, "…but it will be described as…"

**Police investigating baby deaths at Countess of Chester hospital**
https://www.theguardian.com/uk-news/2017/may/18/police-investigating-baby-deaths-at-countess-of-chester-hospital

*Cheshire police will look at deaths of 15 babies and six non-fatal incidents between 2015 and 2016 after trust contacted them*

**Frances Perraudin** *North of England reporter*
Thu 18 May 2017 14.41 BST

Cheshire police have launched an investigation into an unusually high rate of baby deaths and collapses at the Countess of Chester hospital over a 12-month period.

The hospital said it had contacted the police this month to help them rule out unnatural causes of death in its neonatal unit between June 2015 and June 2016. The force said it would examine the deaths of 15 babies and the collapses of six.

"Cheshire constabulary has launched an investigation, which will focus on the deaths of eight babies that occurred between that period where medical practitioners have expressed concern," DCS Nigel Wenham said.

"In addition, the investigation will also conduct a review of a further seven baby deaths and six non-fatal collapses during the same period."

Last November a report by the Royal College of Paediatrics and Child Health (RCPCH) found that staffing at the hospital's neonatal unit, which reported a "higher than usual" number of baby deaths, was inadequate. Two babies died in the unit in 2013 and three died in 2014. In comparison, there were eight deaths in 2015 and five in 2016.

The review found no definitive explanation for an increase in mortality rates, but identified significant gaps in medical and nursing rotas, poor decision-making and insufficient senior cover. Last July the Countess of Chester hospital stopped providing care for babies born earlier than 32 weeks.

In a statement, the trust said it was confident its neonatal unit was safe to continue in its current form. "We will be working with staff to ensure that expectant mums and those individuals currently on

the unit are provided with the necessary assurances to allow us to continue to care for them here at the Countess," it read.

Wenham said that the investigation was in its very early stages, so police would not be able to provide any further details. "We recognise that this investigation will have a significant impact on all of the families involved, staff and patients at the hospital and the public," he said.

"Parents of the babies are being updated on the investigation and will be supported throughout the process by specially trained officers. We are committed to carrying out the investigation as quickly as possible."

The trust said it had sought the input of Cheshire police after the findings of the report from the RCPCH. The review made 24 recommendations for improvement, which the hospital said it had now undertaken.

A statement said the trust had "continuing concerns about the unexplained deaths" and were "very keen to understand that everything possible has been done to help determine the causes".

Ian Harvey, the hospital's medical director, said: "We are deeply sorry for the further distress and heartache this will cause. Throughout this we have never lost sight of the families left bereaved by the loss of their baby, and they will continue to be our main concern.

"At every point where the hospital has been able to share information with families and the public, we have done so. Approaching the police is not something we have undertaken lightly. This is to ensure we have been completely thorough in understanding what has happened here and to get the answers we and the families so desperately want."

A solicitor for one of the affected families told the BBC: "Clearly the death of any child is a tragedy, but this is exacerbated in circumstances where questions remain unanswered.

"However, we are reassured that all steps are now being taken to investigate these deaths in their entirety, and we are hopeful that the investigation can provide some answers for the families of these children."

Phase 3, Stage 2: Cheshire Police

Stage 2 begins with Dr Evans, on 21 May, sending an email to his contact at the National Crime Agency (NCA), Nick Casey, in which he offers his services with respect to the investigation:

> *Incidentally I've read about the high rate of babies in Chester and that the police are investigating. Do they have a paediatric/neonatal contact? I was involved in neonatal medicine for 30 years including leading the intensive care set-up in Swansea. I've also prepared numerous neonatal cases where clinical negligence was alleged. If the Chester police had no-one in mind I'd be interested to help. Sounds like my kind of case. I understand that the Royal College (of Paediatrics and Child Health) has been involved but from my experience the police are far better at investigating this sort of problem.*

It is instructive that Dr Evans in this first email rubbishes the RCPCH and by implication its findings in relation to poor care, etc.

There has been speculation that The Countess paediatricians tipped off Evans about the investigation and their suspicions, on the basis they knew each other and Evans was known to always provide the opinion required of him. However, there is no evidence of this.

Nick Casey immediately passes Evans' 21 May email to his NCA colleague Jim Shingler.

The next day, 22 May, Shingler emails Janet Moore at Cheshire Police to say that he understands that Cheshire Police requires experts and tells her he has referred her enquiry to the NID (National Injuries database, part of the NCA). He also writes that he understands she is meeting with national SIO adviser Ken Donnelly and NID manager Sonya Baylis on 26 May.

Comments:

1. Shingler does not mention Evans to Moore. It seems he does not want it to be known that the NCA/NID was alerted to the investigation by Evans. Also, why tell JM he has referred case to NID if he knows she is meeting NID (and NCA) in four day's time. Who told him about this 26 May meeting?

2. In Part 1 of this interview (https://www.youtube.com/watch?v=TdczC3MvSCc&t=4s) with DS Paul Hughes who had been appointed Operation Hummingbird's SIO, he says "We sought advice from the National Crime Agency about how we go ahead and we appoint the relevant expert, the best expert we can have." It is disingenuous of Hughes to say that Cheshire Police "sought advice" from the NCA about getting a relevant expert, when it was the NCA who contacted Cheshire Police and presented Evans to them. It is disingenuous of Hughes to suggest he wanted advice about "how we go ahead and we appoint the relevant expert, the best expert we can have" when a) Cheshire Police accepted Evans from the NCA, unvetted, b) there was no discussion about what qualifications the "relevant expert" should have, c) Evans was as far from "the best expert we can have" as it was possible to be.

On 23 May, Casey wries back to Evans,

> *"Thanks for your emails and your offer of support for the Chester child death investigation. The NID is being deployed on Friday for a briefing in Cheshire and your support is much appreciated. We will keep you updated on the progress."*

Comment: should Casey have shared with Dr Evans the information about the NID being deployed? Surely a simple “Thank you for your emails” would have sufficed. And does the plural (emails) suggest that Evans sent more than one?

On 24 May, Moore tells Shingler that her DI, Paul Hughes, has provided documents to Baylis ahead of the meeting two days later. The next day, Baylis is told that the documents had been "stuck in the system".

Following meetings on 26 May in Cheshire and in early June in Birmingham between Cheshire Police and the NCA/NID, Baylis emails Hughes to tell him that she has left a message with Evans to call her.

Comment: is this when NCA/NID tells CP about Evans? In other words, it would have reflected badly to have mentioned Evans and his 21 May email before this meeting, per previous comment.

Baylis also sends him [PH] her write up of the 26 May meeting setting out the NID's recommendations to Cheshire Police:

Baylis records that,

> *"A potential nominal has been highlighted who is a nurse at the hospital who was on duty when all the babies died"*

and that Cheshire Police's request is for,

> *"a number of expert medical opinions in a number of key areas providing opinions on whether the babies who died or collapsed had pre-existing issues to cause their conditions or neglect was involved due to processes, staffing levels and working practices in place within the hospital or whether there was third party intervention."*

Comments:

1. Lucy Letby was not “on duty when all the baies died” Where did Baylis get this information from?

2. Cheshire Police did not request, “a number of expert medical opinions in a number of key areas providing opinions on whether the babies who died or collapsed had pre-existing issues to cause their conditions or neglect was involved due to processes, staffing levels and working practices in place within the hospital or whether there was third party intervention." This is what the NID offered/suggested to Cheshire Police. Furthermore, Cheshire Police ignored the NID’s offer/suggestion. They engaged only Evans, who then never considered whether “neglect was involved due to processes, staffing levels and working practices in place within the hospital”.

Baylis offers assistance with respect to

> *"What samples have been retained by the hospital and what tests have been conducted so far as well as reports produced, which will be required by the medical experts, if required, as well as any pre-existing medical conditions and medication used" as well as to "the potential exhumations of 5 of the buried babies".*

The write up goes on to set out "Additional Material and Questions required by the Suggested Experts". In relation the the babies, this includes:

*o All the images of the babies' including those of the injuries, with scale if available, would be required;*
*o Has any photography using alternative lighting been undertaken?*
*o Full documentation of the babies injuries/medical conditions would be required including medical notes, medical statements and scans, post mortem reports (including routine post mortem examinations), hospital admission notes, GP medical history, hospital tests and reports, medication given, whether bloods/urine/samples have been taken and retained including blocks/slides for potential further testing, etc. The red book, health visitor and midwife notes as well as the birthing notes. Also, the review conducted by the two pathologists at the Alder Hey Children's Hospital and the joint report by the paediatricians.*
*o What clothing were the babies wearing at the time which may assist with any interpretation of external injuries?*
*o Are there any previous incidents to the baby and/or mother that the medical expert will need to know including the health of the mother?*
*o Copy of any relevant witness statements.*

Comments:

1. As far as photos of injuries are concerned, the only ones that came close to such were the postmortem photos of Baby O showing liver damage. These were shown to Dr Evans at his first meeting in Chester and prompted him to declare immediately that the injury had been intentionally inflicted. He later in his first witness statement correlated the injury to the liver with a) an external bruise over the liver area noted by Dr Brearey, and b) the increasing heart rate at 1am on 23 June 2016. But the bruise was not a bruise because Dr Brearey declared in a witness statement years later (and after Evans' first statement) that it had disappeared (it was a transient rash). And Letby was not on the night shift of 22/23 June but on the following day shift. In Evans' later statement, the bruise that was a transient rash became evidence of air embolism and the heart rate increase that was evidence of the attack took place at 8-10am not 1am.

2. As for the question of whether there were any "previous incidents to the baby and/or mother that the medical expert will need to know including the health of the mother", answering this would have required an obstetrician to look at the maternal notes but one was never instructed.

Regarding "the suspect", Baylis writes that,

> *"Once the nominal has been interviewed or provided a prepared statement, a copy of this will be required by the medical experts."*

As for the NID's suggested services, the first is:

> *To instruct a neonatal paediatrician (Dr Dewi Evans) to review the babies medical history, any test results, hospital notes/reports/scans, medication, etc, i.e. the full case file, and provide opinion on whether the medical history would support the cause of death for the deceased babies and for the collapsed babies. To also comment on whether it is in keeping with the version of events provided by the nominal or witnesses or due to an underlying natural cause. This expert would also be willing to assist with the interview process.*

Comments:

1. It seems the NID recommended Evans only on the basis that he had written to Nick Casey, was on the NID's expert list, and was a paediatrician. Should there have been a better process? Clearly there has been a quick decision made within the NCA that there is no need for a formal “neonatal paediatrician” selection process. Nor even an informal one. They've got one. And he's been given the nod by the NCA’s Jim Shingler to whom Nick Casey forwarded Evans’ 21 May email.

2. Evans’ offer to assist with the interview process also seems inappropriate. Would it not be a conflict of interest for him to be involved in interviews that he would later assess in relation to his own opinions.

Baylis then suggests to Cheshire Police that the NID helps them with respect to instructing the following experts:

> *Forensic and neonatal pathologists to review, jointly, the medical histories, etc*

Comment: Cheshire Police engaged just one pathologist, Dr Marnerides, and it is not clear that he was either a “forensic pathologist” or a “neonatal pathologist”.

> *A forensic toxicologist and/or clinical pharmacologist to review the test results for all sampling conducted on all the babies, etc*

Comment: neither a forensic toxicologist nor a clinical pharmacologist was instructed. One may ask why. Did Cheshire Police find it difficult to identify a forensic toxicologist expert who would not have said that the insulin immunoassay should not be used for forensic purposes? This may explain why it was Anna Milan who testified at trail as a witness of fact rather than an expert witness, saying that the only explanation for the high insulin/low c-peptide was exogenous insulin.

> *A nurse with experience of working in a special baby unit for neonatal births, etc*

Comment: The nurse expert who was instructed was an adult nurse.

> *A medical expert with experience of the working practices involved in a special baby unit for neonatal births, etc*

Comment: none was instructed.

> *An obstetrician to review the medical histories, tests results, hospital notes/reports/scans, medication, etc*

Comment: no obstetrician was instructed.

Other help offered by Baylis relates to:

> *"discussing with a medical expert or lead in the CDOP process whether there were any failings by the local CDOP team with regards to not flagging early the peak in mortality numbers at the hospital including reviewing both reports provided by an independent paediatrician instructed by the hospital and the RCPCH. In addition, to provide national/regional statistics on neonatal deaths in a medical setting to support the investigation team as well as non-fatal collapses."*

> *"conducting a scope search of the National Injuries Database for similar cases"*

Comment: Cheshire Police did not accept either offer

Baylis then writes (her red) that,

> *"These are suggestions only and it is ultimately your's (sic) and CPS's decision who you wish to use and instruct to provide expert opinion for your investigation considering the key issues involved. This process can be phased according to your priorities. Please let me know those that are required first and are more urgent."*

At the end of her notes, Baylis writes,

> *"We strongly advise you to provide a courtesy e-mail informing any experts who have already worked on this case, in particular Dr Nick Hunt of our involvement and forward on any relevant information that we provide to you, as this may assist the expert (s) with their final opinion. I can make contact with Dr Hunt regarding the experts suggested above, if required."*

Is this (https://www.dailymail.co.uk/news/article-1308509/David-Kelly-doctor-Nicholas-Hunt-cautioned-breaking-GMC-rules.html) the "Nick Hunt" that Baylis mentions? If so, is it appropriate that the NID was collaborating with a doctor who was "under a five-year warning for breaking General Medical Council guidelines"?

On 28 June, Moore writes to NID:

> *"Sonya [NID] has recommended various experts (as per below). We were hoping to meet with Dr Dewi Evans in advance of deciding on the other experts. Is this possible and should we go through yourselves to organise this? I can attach a summary of the enquiry so far if he is agreeable?"*

Comments:

1. It seems that Cheshire Police wants Evans to do things on his own (he later advises Cheshire Police there is no need to instruct other experts). Why is this? Smells fishy.

2. Why is there no consideration given to whether the summary includes information that should not be shown to Evans? For example, that a nominal has been identified.

Sonya (Baylis) writes back,

> *"Dear Janet, In relation to your e-mail below and confirmation of one of our services i.e. instruction of Dr Dewi Evans, I will now formalise his services and e-mail him as well as try and call him (though I have left several messages including to Paul). Once I have made contact I will get his availability to meet and discuss the case further with yourselves and what his costings will be. In the meantime, a copy of the current situation report would be useful please and confirmation that a copy of the case summary can be provided to Dr Evans."*

Comment: The NID seems to be aware that the report might include info that Evans should not see so is double checking with CP that it can send to him.

She then also writes to Evans,

> *"Dear Dr Evans, I am supporting an investigation on behalf of Cheshire Police in relation to a number of neonatal deaths in a special baby unit within a hospital (15) and significant*

*collapses (6) between June 2015 – June 2016. You kindly approached one of my team Nick Casey to offer your services, which I'm grateful for and since offered this to the investigation team. The force have now confirmed your services are required and would like a meeting soon to discuss the case further and the current situation as well as your costings for your services as this will be a lengthy process involving reviewing the working practices and processes in the unit, the initial complaint by a group of paediatricians within the hospital and the subsequent reviews as well as the actual conditions of the babies and their eventual deaths as well as collapses. In the meantime, I have suggested that they need to collate all the relevant paperwork including medical histories of all the babies, interviews of the staff involved, medical reports produced, tests conducted and medication given, etc. But further guidance from yourself with regards to all the essential material that is required would be useful. Please can you let me know your availability to meet with the Senior Officer in the Case and myself as facilitator at a location suitable to you and whether any costs would be involved for this initial meeting. Look forward to hearing from you. In the meantime, I have left several messages but to date have not received a response from yourself. Kind regards, Sonya"*

Comments:

1. There is no evidence that there was any serious consideration of whether Evans was the right "neonatal paediatrician".

2. The only one of these ("reviewing the working practices and processes in the unit, the initial complaint by a group of paediatricians within the hospital and the subsequent reviews as well as the actual conditions of the babies and their eventual deaths as well as collapses") that Evans did was the last i.e. condition of babies etc.

This is followed by an email from Sonya to Cheshire Police:

*"Dear All, I have since e-mailed Dr Evans having had confirmation from Janet that his services are required and asked for all his costings for each phase as well as availability for a meeting amongst ourselves. Also, can you confirm who the original pathologists were please as I seemed to have included Dr Hunt in my assessment below who I believe was not involved my apologies."*

Janet Moore writes back,

*"I will start getting a summary of the case together and forward it to you. The pathologists involved were Dr McPartland, Dr Kokai and Dr Shuklar."*

On 30 June, Janet Moore writes to Sonya Baylis,

*"Hello Sonya, I attach a summary of Op Hummingbird if you can please pass onto Dr Evans? Many thanks, Janet"*

Comment: there was information in the summary document that Evans should not have been given.

And on the same day, Sonya Baylis finally hears back from Evans,

*"Dear Sonya, Thanks for this. I've been away in court in N Ireland most of this week so would have missed any phone message. I'm in mid Wales today - recreational:) Variable signal. Can I suggest we discuss everything on Monday. We can discuss everything with the SIO and sort out*

*the logistics. It would be easier for me to go to the cases I suspect than for the cases to come to me. Should be able to sort things during July. I'm sure we can arrange an initial meeting without any costings. We could meet in Cardiff, or anywhere that's convenient for Chester Wyboston and Cardiff. I'll phone Monday if that's okay. Best wishes, Dewi"*

Comments:

1. Why would being in Northern Ireland mean missing phone messages?

2. The comment "recreational☺" seems highly inappropriate/unprofessional.

A few days later, Baylis writes,

*"Hayley confirmed that she has sent the current situation report to Dewi securely by email"*

Below is the *summary of Op Hummingbird* aka *current situation report* produced by Cheshire Police at the start of the investigation and which Moore asked Baylis to send to Evans.

*Operation Hummingbird Summary - Countess of Chester Hospital Enquiry*

*Background of the Hospital and Investigation*

*The Countess of Chester Hospital Trust provides a range of paediatric and neonatal services. The Neonatal Unit has 20 cots and provided critical care, high dependency care, special care and transitional care for newborn babies.*

*The Trust provided a Local Neonatal Unit service (Level 2 care) providing short term ventilation. The Neonatal Unit provided care from 27/40 gestation; any baby born below this criterion being transferred to the nearest Level 3 unit. The critical care and high dependency care cots were interchangeable and could therefore flex according to the needs of the unit.*

Comments: in reality, babies born at The Countess who should have been transferred to a tertiary unit were not, exposing them to significantly higher mortality risk. Why is this not mentioned in this report?

*An internal comprehensive case review was undertaken in February 2016 following the deaths of 10 neonates (including one who died shortly following transfer).*

Comments:

1. Two external investigations were carried out, one by the RCPCH, which was published in November 2016 and one by Dr Jane Hawdon which was published in Oct 2016. The RCPCH report focused mainly on the procedures in the Unit. The report by Dr Hawdon focused on the actual infants and includes summaries of 17 infants (some of whom had died and some who had collapsed and survived). One of the recommendations was for a further forensic review to be carried out.

2. One may wonder why "into just 4 of the 17 cases" was not appended to the end of the last sentence above.

*Sequence of events*

*Concerns were raised by the clinical team of the hospital to the Executive regarding a higher than usual number of neonatal deaths from January 2015 (8 in 2015 and 5 in the first six months of 2016 compared with an average of 2.4 per annum in the previous 5 years). This resulted in a meeting between various staff members in May 2016. It was highlighted at this meeting that there was one member of the nursing staff who had been present at more of the cases than any other member of staff. However, there was no evidence, other than coincidence. The nurse was noted to work full time and have the Qualification in Speciality (QIS). She was therefore more likely to be looking after the sickest infant on the unit. She also regularly worked overtime when the acuity was high or unit was over capacity. There were no performance management issues, and there are no members of staff that had complained regarding her performance. The nurse had been moved on to days to ensure that she was supported. It was agreed at this meeting that all babies who deteriorated would be reviewed; that there would be a review of the hour of care before death of the babies who had died at night; that the nurse would remain on days for 3 months and a further meeting was to be held after 2 months.*

Comments:

1. How can concerns that refer to the five deaths in the first six months of 2016, which included the deaths of Babies O and P in June 2016, result in a "meeting between various staff members in May 2016"? Was there some sort of time travel involved?

2. That concerns were "raised by the clinical team of the hospital to the Executive" only after the deaths of Babies O and P contradicts the paediatricians assertions that they had raised concerns much earlier.

3. Dr Evans was sent this report so he was alerted to the fact that a nurse was under suspicion. Should he therefore have been sent the report? Might this explain why he never considered other explanations for the deaths and collapses as he was requested to do?

4. If Lucy Letby "regularly worked overtime when the acuity was high or unit was over capacity", this contradicts the prosecution's assertion that "deaths followed her around". In other words, she was called for duty when acuity was high, rather than babies' acuity being high because she attacked them.

*Two of triplets born on 21st June 2016 died on 23rd and 24th June. This exacerbated the concerns, there being no obvious cause for the babies' collapses and it was alleged that the nurse referred to above was involved in the care of these babies and that unnatural causes had to be considered. As a consequence, following a series of meetings of the Executives and with clinicians it was determined that in the best interests and welfare of babies and staff there would be a number of actions:*

*1. The unit to be redesignated to Special Care Unit (SCU) caring for infants from a minimum of 32 weeks gestation with consultation with the C&M network*
*2. A comprehensive review of the unit to include activity, acuity and staffing levels*
*3. A review of babies who had collapsed unexpectedly*
*4. An invited review from the Royal College of Paediatrics and Child Health (RCPCH).*
*5. The Coroner (via his deputy) was appraised of the concerns that had been raised and the steps that were being taken.*
*6. The nurse was redeployed off the unit*

Comment: Regarding the “comprehensive review of the unit to include activity, acuity and staffing levels” this was done by Dr Brearey, who concluded that the elevated mortality and morbidity had nothing to do with acuity, activity and staffing. As one of Letby's main accusers, him conducting the review represented a significant conflict of interest. Indeed, his finding that the elevated mortality and morbidity had nothing to do with acuity, activity and staffing was simply not true. It had *everything* to do with them.

> *The internal review identified that every month from February – December 2015 had seen a greater number of care days than the long term average. This suggests that the NNU has been busier and workloads had been higher. Within this the increase in high acuity care days became clearer when we combined L1 (ITU) and L2 (HDU) days per month. Between May 2015 and March 2016, only one month showed care days drop below the long term average. In addition, between March and December 2015 there was a higher than average number of babies born with a birth weight below 2000g in all but two months. This correlated with the increased demand for high level care over the same period. There was not an increase in admissions in the most severely premature categories (below 26 weeks and between 26 and 30 weeks) but there was an eight month run of higher than average admissions at 31-36 weeks gestation.*

Comment: The below is from Google AI about the findings of the February 2016 review. One may wonder why a number of these points were not included in this Cheshire Police report.

> *The February 2016 internal review at the Countess of Chester neonatal unit examined 10 infant deaths from January 2015 to January 2016 but concluded that no single common theme or explanation could be found for the unexpected deteriorations and deaths. The hospital's senior management was also not fully briefed on all of the clinicians' concerns at the time.*
>
> *Summary of the review's findings*
>
> *No evidence of foul play: The review, which included a consultant from Liverpool Women's Hospital, did not find any evidence of "foul play". This was a key factor in the hospital management's delay in involving the police.*
>
> *Identified clinical issues:*
>
> *The review did identify some clinical issues in the cases examined, including:*
>
> - *Care issues involving umbilical venous catheters (UVCs).*
> - *Two infants were given ranitidine, a medication later advised against for preterm babies due to increased risk of death.*
> - *Delayed umbilical cord clamping in some preterm deliveries, which goes against national recommendations.*
> - *A higher-than-average number of cardiac arrests occurred between midnight and 4 a.m.*
>
> *High-acuity cases:*
>
> *The review found a higher-than-average number of babies with low birth weight and gestational periods between 31 and 36 weeks were admitted from March to December 2015. This was noted as a potential factor for the increased mortality rate.*

*Inadequate management oversight:*

*In their report, the review team noted that leadership at the senior hospital trust level seemed "somewhat remote" from the day-to-day issues occurring on the neonatal unit.*

The document continues:

*The RCPCH sent a team who had access to all policies, procedures and activity data and conducted interviews with all relevant staff groups and the network. This led to the issuing of a final review in November 2016 with recommendations. The review advised a further, in-depth, independent case note review of each unexpected neonatal death.*

Comment: Why were not at least some of the RCPCH's findings included in this report? They could have chosen just one or two from the below list.

- Inadequate staffing (in an email to Countess chief executive Tony Chambers in December 2015, paediatric consultant Alison Timmis wrote that staff are "stretched thinner and thinner and are at breaking point. When things snap, the casualties will either be children's lives or the mental and physical health of our staff").
- There was a need to employ two Advanced Neonatal Nurse Practitioners (ANNPs), though review panel members may not have known that CoCH had got rid of 8 highly qualified senior nurses, including two ANNPs, in the years leading up to 2015 and replaced them with poorly qualified agency and nursery nurses.
- gaps in both medical and nursing rotas.
- poor decision making; delays in seeking advice.
- delayed retrieval of infants to tertiary units.
- indecision around integration of the three network transport services.
- non-compliance on nurse and medical staffing levels, environment and accommodation for parents, support from the community neonatal team and postnatal follow-up.
- the 'hot week' system being insufficient to safely cover both the paediatric and neonatal wards.
- Insufficient storage space resulting in many pieces of equipment being stored in corridors.
- poor direct visibility from one area to another.
- infants being moved regularly to accommodate acuity, an extra risk in the system.
- the locum recruitment process not being sufficiently robust, and there having been no documented learning/action in relation to one particular locum.
- nurses reporting that external escalation was not always as timely as it could have been, and them not feeling empowered to participate.
- non reporting of deaths and it not being clear who was responsible for DATIX entry.
- while other areas in the hospital reported well, the neonatal unit had for some time apparently been less systematic in reporting.
- the higher activity not having been raised as a risk since data had not been formally reviewed and in response the neonatal team had just worked harder.
- concern at whether there were sufficient staff for the unit to care for triplets.
- concern that the Child Death Overview Panel (CDOP) did not appear to have been alerted to the elevated mortality.

- significant capacity pressures on the Cheshire and Merseyside Neonatal Transfer service, which contributed to delays in transferring infants out promptly.
- reports of doctors waiting too long before escalating concerns about an infant, both from junior to consultant and also to the network and when they do seek tertiary level advice, the transport team is not informed sufficiently early to be on 'standby'.
- there being no use of a ‘conference call’ system employed at other hospitals to inform transport team of status of infants which may require transfer; inadequate liaison between COCH clinicians and the transport team.
- there being no mechanism to trigger closure of a unit when it has reached capacity; in cases requiring surgery, there was confusion among clinicians regarding protocols.
- consultants not exploring possible factors behind the elevated mortality in a systematic way, nor following sound governance and root cause analysis processes.
- staffing levels being inadequate when mapped to the actual activity and acuity of a level 2 unit under the British Association of Perinatal Medicine (BAPM) standards, both from a nursing and a medical perspective.
- the need for a lower threshold for escalation of concerns to tertiary units for advice or transport; issues with umbilical venous catheter (UVC) insertion that required new protocols to be introduced in February 2016.
- the proportion of late gestation admissions falling in 2015-6 to 7.8% from 10.7% previously (by implication, the proportion of higher risk early gestation admissions had risen).
- there had been “higher activity and lower admission birthweight than average during the period corresponding to the increase in mortality” but “this was not however considered to have been significant enough to explain the increase in mortality.” Even if it were true that it wasn’t significant enough, which it wasn’t (see above about Brearey conducting the review), just because these may not have *solely* explained the increase in mortality does not mean they were not part of an array of potentially unfavourable prognostic factors. A contributory factor is just as important as one that explains all variation. Indeed, rarely is variation in empirical data explained by a single factor.

The document continues:

> *This review was commissioned, on the advice of the RCPCH, from Dr J Hawdon, Consultant Neonatologist, Royal Free London Hospital. Dr Hawdon submitted her review in October 2016. This report highlighted areas were practice could have been different. There were 4 cases in which Dr Hawdon felt that the cause of death was unascertained and she advised that: “Subject to coroner’s post mortem reports, there should be broader forensic review of the cases … as after independent clinical review these deaths remain unexpected and unexplained”.*
>
> *Views from the Pathologists at Alder Hey Childrens Hospital (where the post mortems had been carried out) was sought. They reviewed the findings of the post mortems and felt that there were two deaths which were “unascertained”.*
>
> *The Trust met with the Coroner twice in February 2017. The second time was following the receipt of a letter from the Consultant Paediatricians. The Paediatricians asked that the Trust ask the Coroner to undertake a full investigation of all the deaths and unexpected collapses between June 2015 and July 2016 because they were not reassured that all the deaths were*

*due to natural causes. This letter, together with Dr Hawdon's report, was shared with the Coroner. The Paediatricians letter was also shared with the College reviewers and Dr Hawdon.*

*On 28th February the Medical Director met with the Neonatal and Paediatric Leads, the senior Consultant and the Network lead to review the case reviews to determine if there was consensus regarding the care, clinical course and cause of death for the babies. Of the 13, it was agreed that 5 could be explained but in 8 the paediatric doctors did not feel that either the collapse(s) and/or the death could be explained and it was agreed that further detail was required.*

Comment: the 8 deaths included two that did not end up on the indictment (the treating paediatricians felt the congenital abnormalities were not like-threatening, Dr Evans felt they were). So, 6 of these 8 were on the indictment, meaning that there was one of the 5 that the paediatricians originally said was explained but at trial they said was unexplained (there were 7 deaths on the indictment).

*The Police were later asked to carry out an investigation.*

Comment: should this not have been "The police decided to…" rather than "The police were asked to…"?

*In May 2017, Cheshire Major Investigation Team began work on the enquiry. They have begun to obtain records relating to the identified infants from the Countess of Chester Hospital along with other hospitals that the infants visited.*

*The MIT were initially told about 13 infants deaths. The figure quickly increased to 15 infant deaths, once two additional infants who had died elsewhere having collapsed at the Countess were identified. There were also 6 infants identified to us by the Countess who would also be part of the enquiry who had collapsed and survived.*

*Once the enquiry had commenced, other hospital documents were viewed and the media interest had begun it became clear that there were other deaths and collapses that should feature in the enquiry. The current figures being investigated are 17 deaths in 2015/2016 and 11 collapses and survived infants.*

*The investigation is currently focusing on the 8 deaths identified by the paediatricians (which incorporate Dr Hawdons 4 identified deaths) which appear to be unnatural. The additional deaths and collapses will be reviewed after this initial focus.*

Comment: Who was doing "this initial focus" into the 8 deaths? It wasn't Dr Evans, as he was given 17 deaths (and 11 non fatal collapses) to appraise when he joined the investigation.

On 3 July, Sonya Baylis gets an email from DS Adam Bolger at Cheshire Police,

*"Hi Sonya, I am another one of the Cheshire MIT DS's working on this enquiry. I know DS Janet MOORE has already updated you with the list of pathologists. Has Dr Dewi EVANS come back to as yet with his costings and availability? We could do with speaking with him sooner rather than later – even if we can just get a telephone appointment with him initially? Cheers, Adam (DS3889 Adam Bolger MIT, Warrington Police Station)"*

Comment: It is notable how poor Dr Evans' communication is. One may wonder why this is.

Sonya calls Adam and writes to self,

> *"Spoke to Adam and confirmed the arrangements with Dewi Evans".*

Adam Bolger writes to Sonya Baylis,

> *"Hi Sonya, Thanks for the call today, I have checked with the SIO and Monday 10th July around 1130 is great for us. DI HUGHES, DS MOORE, DS JOHNSON and myself will all be present. We are based out of Chester Police Station for this Operation - adddress = Blacon Ave, Blacon, Chester, CH1 SBD. There is a visitor car park and if you just ask for one of us at the front desk (we'll let them know you and Dr EVANS are coming). If you can confirm for me that the time is ok With yourself and Dr EVANS, I'll get usa room booked etc at the Police Station. So we are fully prepared for the meeting, can you let me know exactly what yourself and Dr EVANS would ideally like from us at the initial meeting (med records etc) - I can then make sure this is all in place Thanks a lot, Adam"*

Comment: Dr Evans was engaged by Cheshire Police to consider all possible explanations for the elevated mortality and morbidity. He did not request documents that would have been necessary for him to determine whether the failings and issues set out in the RCPCH report were to blame. Who at Cheshire Police was responsible for checking that Dr Evans was fulfilling his obligations in relation to considering all possibilites? It seems that he was allowed to conduct his investigation in any way he liked.

Sonya Baylis responds,

> *"Thanks for the confirmation Adam, I will e-mail Dr Evans separately and let you know but we had provisionally booked Monday 10th July at 11.30am. I have also copied in my MCIS colleagues Aaron Day and Ken Donnelly who may wish to attend the meeting too. Is the venue the headquarters where the initial meeting was previously held? I will aim to travel by train to Winsford and Dr Evans may do so too or drive, I will confirm. If Dr Evans is driving I will advise him of the car parking arrangements. Dr Evans has proposed for the meeting that we start with a briefing on the current situation and background to the case even though he has been given a copy of the current situation report provided by Janet. Thank you. He then wishes to stop for lunch (after an hour and a half) followed by a final meeting to discuss his terms of reference and hls proposed way of working. In the past for similar cases, he has stayed for a number of days locally to the Police Station/Hos pitaI to enable access to all the documentation whilst there, if any was missing, to review each case and record his findings. He would then return to his office and get his final report typed up. This may or may not work for your Operation depending on how many days he needs to do all the cases and his fees. He has agreed for this preliminary meeting to be free apart from his travel expenses, which I hope you are willing to pay for. During this meeting we will also discuss additional experts that may be required, which can be facilitated by the NID team using either our experts or those suggested by Dr Evans that require checking before instruction including an infectious diseases expert, obstetrician and forensic paediatric pathologist (already suggested by myself and will come with names from the NID list to the meeting). Hayley can you provide me with a list of the experts we have for the disciplines I have highlighted please for my meeting on Monday. I will need these for Thursday. Thank you. Finally, he did say to make his trip worthwhile if any full case files are ready for him to take back he would be willing to do this. However, I know that we did discuss what actual material is required, which I highlighted in my assessment. But at the meeting we can formalise*

*all the material that is required as Dr Evans has worked in this environment before and would know which specialists and staff were involved, tests undertaken and medication given as well as notes and assessments performed. Any work proposed and undertaken by Dr Evans I will record and make sure you have a copy for your reference and records. Any other research and questions please let me know and look forward to seeing you all next week. Kind regards, Sonya"*

Comments:

1. Re, "Dr Evans has proposed for the meeting that we start with a briefing on the current situation and background to the case", this is not how the meeting proceded. He later asks to see medical records pertaining to one or two cases to "give him an idea of what Cheshire Police were looking at". And in fact he was just given records of Baby O, and declared within ten minutes, having gone straight to the PM photos, that the baby had been physically attacked (despite the pathologist asserting that the cause of death was natural)

2. Re, "he [Evans] has been given a copy of the current situation report provided by Janet", this confirms that he was told a nurse was under suspicion, which he shouldn't have been (and he said he hadn't been).

3. Re, "During this meeting we will also discuss additional experts that may be required, which can be facilitated by the NID team using either our experts or those suggested by Dr Evans that require checking before instruction including an infectious diseases expert, obstetrician and forensic paediatric pathologist (already suggested by myself and will come with names from the NID list to the meeting)", Dr Evans told Cheshire Police that it was not necessary to instruct other experts at that time. Furthermore, Evans did not later say that an infectious diseases expert and obstetrician were required, per the NID's recommendations. One may wonder why.

4. Re, "a list of the experts we have for the disciplines", most discipline recommendations by the NID were ignored by Cheshire Police/Evans but it would be useful to see this list.

5. Re, "he did say to make his trip worthwhile if any full case files are ready for him to take back he would be willing to do this", not only did the meeting not involve, as Dr Evans requested, "a briefing on the current situation and background to the case" but instead of him being given full case files "to take back", he reviewed one set (Baby O) at the meeting itself.

And on the same day, she writes to Evans,

*"Dear Dr Evans, I have had confirmation from the force that Monday 10th July for an 11.30m start for the meeting will be fine. The venue is Chester Police Station not the Headquarters and the address is - Blacon Ave, Blacon, Chester, CH1 5BD. Parking is available at the station if you intend to drive, you just need to ask for either Adam Bolger, Janet Moore or Paul Hughes for authorisation. If you intend to travel by train the nearest station to the venue is Chester. Just let me know what time you intend to arrive so I can tally my arrival and my colleagues can pick us both up and take us to the venue. I've checked and my train gets into Chester at 11:21am. The force are also keen to know how much your ticket will cost so that they can reimburse you. I have explained to them your proposal for the setup of the meeting i.e. that we start with a briefing on the current situation and background to the case even though a copy of the current situation report has been provided to you. Then you wish to stop for lunch (after an hour and a half) followed by a final meeting to discuss your terms of reference and proposed way of*

*working. I also explained how you worked in the past on a similar case i.e. stayed for a number of days locally to the Police Station/Hospital to enable you to access all the documentation whilst there, if any was missing, to review each case and record your findings. Then you would return to your office and get your final report typed up. This may or may not work for this Operation depending on how many days you require to do all the cases and your fees. I also confirmed that you agreed for this preliminary meeting to be free apart from your travel expenses, which they are willing to pay just need costings. I then said that during the meeting that we would also discuss additional experts that may be required, which can be facilitated by the NID team using either our experts or those suggested by yourself that require checking before instruction including an infectious diseases expert, obstetrician and forensic paediatric pathologist (which I had already suggested and will come to the meeting with names from the NID list). Finally, I said to make your trip worthwhile that if any full case files are ready for you to take back that you would be willing to do this. However, I know that they were having issues highlighting what was actually required though I did provide a preliminary list. So I thought at the meeting it would be useful to formalise all the material that is required by yourself as you have worked in this environment before and would know which specialists and staff were involved, tests undertaken and medication given as well as notes and assessments performed. I then offered to record all work proposed and undertaken by yourself and to make sure that a copy was provided to the SIO for his reference and records. I hope that is all the information that you require. All I need from you now is confirmation of travel arrangements i.e. car or train. Date of arrival at Chester train station and travel costs involved. Look forward to hearing from you. Kind regards, Sonya"*

Comments:

1. Re, "you agreed for this preliminary meeting to be free", he was shown Baby O's case notes at this meeting. Should he have been it if he had not at that point been instructed?

2. Re, "*we would also discuss additional experts that may be required, which can be facilitated by the NID team using either our experts or those suggested by yourself that require checking before instruction including an infectious diseases expert, obstetrician and forensic paediatric pathologist (which I had already suggested and will come to the meeting with names from the NID list), Evans' response to this below ("I do not think it's necessary to consider additional expert opinion al this stage") is important*.

The following day, 4 July, Hayley writes to Sonya,

*"Hi Sonya, I have collated the potential experts for Op Hummingbird into this document (Potential Expert List.doc). Let me know if you need anything else. Thanks, Hayley"*.

Comment: it would be useful to see the document Potential Expert List.doc. Did it include the names of the other prosecution experts who were later instructed?

Sonya:

*"Great thanks Hayley. Just noticed you put Dr Klein down twice, is there anyone else or just a duplication? Thanks, Sonya"*

Comment: in the later March 2018 meeting, Dr Evans recommends Dr Klein, but they are not instructed. Why is this?

Hayley:

> *"Sorry! I was using the layout as a template but neglected to change the details. Have changed it to Dr Vas Novelli at GOSH."*

Comment: Dr Vas Novelli is Consultant in Paediatric Infectious Diseases. Evans clearly didn't want him involved (an infectious disease expert may well have said that infection was to blame) nor any other experts. He was clearly laying the ground for finding criminality, and other experts appointed thereafter rubber stamping his conclusions.

On the same day, Sonya receives a long email from Evans,

> *"Thanks for the message and for the Summary, which I have read. It's all rather unusual. I think that the best, possibly the only way to look at the issues is to start from scratch and look at the clinical notes. I mean no disrespect to previous reviews. It's just better this way. One needs to avoid 'groupthink'. Before looking for suspicious matters one needs to see if the clinical trends in the hours and days prior to death followed a recognised clinical pattern. I suspect not, which is why the paediatricians have flagged it up. Premature babies, even tiny premature babies, tend not to "just die". They may stop breathing, but this is well known, is picked up by monitors, and usually remedied. Also, one can identify evidence of infection, which is common, and haemorrhage, via the usual tests, all easily available in baby units in 2015, and for the past couple of decades. If the police have copies of the clinical notes of the cases ready for Monday it would be great. If they don't have all of them that can be sorted later. Copying the information electronically is more and more common, and works very well. It provides an instant paginating system. We can discuss how to approach the investigation at Monday's meeting. One needs to apply a different logistical approach I suspect, given the numbers of cases involved, and the common factor (same hospital). One option, which I discussed with you yesterday, would be for me to park myself in Chester for a few days, trawl through the notes, put it all on tape, and move on to the next case. I have a very good secretarial service. All reports return within 1 working day. It's a very effective way of working. If the Cheshire Police thought that this may be useful we could agree on a 'flat rate' probably, equivalent to a consultant salary. Top increment, with "seniority"points, but without "higher" awards, works out at about £XXX per day, plus travel, sustenance and hotel costs. [I don't have the exact salary scales on me, but there has been little change in income during the Austerity Years.] Finally I hope that I can assure you that I'm not under any kind of investigation as a result of my clinical or legal practice, and managed 30 years in consultant paediatric practice without having my clinical skills queried by the GMC or any other body. I have prepared about 180 safeguarding cases since 2008 including 43 cases for police authorities, mainly via the NCA, since 2014. [My only contact with the GMC during the whole of my career related to 2 separate safeguarding cases of mine, where the perpetrators complained. This was a common phenomenon. I was also a GMC representative in a Fitness to Practise tribunal involving another paediatrician]. I enclose a CV, just to get up to date. My kind regards, and hoping that we meet up Monday around 11.30 am. Dewi"*

Comments:

1. Re, “Before looking for suspicious matters one needs to see if the clinical trends in the hours and days prior to death followed a recognised clinical pattern. I suspect not, which is why the paediatricians have flagged it up”, this is clear and early evidence that Evans was not keeping an open mind. If he had been he would not have included the second sentence.

2. Re, “Premature babies, even tiny premature babies, tend not to "just die", again, why is this necessary before seeing the notes?

3. Re, “Also, one can identify evidence of infection, which is common, and haemorrhage, via the usual tests, all easily available in baby units in 2015, and for the past couple of decades”, Dr Evans appears to be saying that because infection can be easily identified, there is no need for an infectious diseases expert.

4. Re, “One needs to apply a different logistical approach I suspect, given the numbers of cases involved, and the common factor (same hospital).”, why does Evans feel the need to make it explicit that the common factor is the hospital? Is it because he already knows that the common factor that Cheshire Police are looking at is in fact a nurse but has to pretend he doesn’t know about that?

5. The terms “park myself in Chester” and “trawl through the notes” are thoroughly unprofessional/inappropriate.

6. Re, “Finally I hope that I can assure you that I'm not under any kind of investigation as a result of my clinical or legal practice, and managed 30 years in consultant paediatric practice without having my clinical skills queried by the GMC or any other body”, he is careful not to divulge whether his testimony in previous trials had been questioned by presiding judges (it had been). Why did Cheshire Police not ask?

To which, the next day, 5 July, Sonya responds,

> *"Dear Dewi. Thanks for the response. Okay no problem. You will have a parking space waiting for you no issue but I will let those concerned know that a space will be required by yourself and provide your car details. I totally understand and will make sure some clinical paperwork for some of the cases is available for you on Monday. I will ask for these to be provided electronically for you. Yes I agree and we can confirm your terms of reference on Monday and the agreed approach. Thanks too for the reassurance with regards to your clinical practice and status. I will forward your current CV to the SIO. If I get any further information Dewi I will let you know but for your reference my contact details are: (work) / (personal). My colleague Aaron Day Look forward to seeing you on Monday. Kind regards, Sonya"*

Comment: Re, “…will make sure some clinical paperwork for some of the cases is available for you on Monday”, this is contrary to what Evans previously asked for and anyway is inappropriate as it conveys that things are being done in a very haphazard and piecemeal way.

Sonya the same day writes to Adam Bolger,

> *"Hi Adam, One thing more for Monday’s meeting, Dr Evans asked if some clinical paperwork for some of the cases could be made available for him to take away on Monday and provided electronically possibly please. Thank you and see you Monday. I’m not in the office tomorrow but if you require me urgently please send an e-mail either to the group inbox below or contact the group number below, and someone will get in touch with me. Kind regards, Sonya"*

The meeting takes place on 10 July, and Sonya writes,

*"Meeting held at Chester Police Station at 11:30 on 10/7/17 attended by NCA – Aaron Day, Sonya Baylis and Dr Dewi Evans. Also in attendance was SIO Paul Hughes, Janet Moore, Adam Bolger and DS Johnson. Current situation brief provided to Dr Evans and the rest of the team then discussed two cases in detail. Finally draft Terms of Reference was drawn up between the investigation team and Dr Evans. Potential to instruct a forensic paediatric pathologist at a later stage with regards to some of the CODs. NCA colleagues signed a confidentiality agreement. Next stage to get all further cases to Dr Evans electronically to his agreed location securely i.e. 28 cases in total including collapses for his review by the beginning of August. Envisage he needs two weeks to do all the cases and make notes which in turn will be typed and provided the following 24hrs for proof reading. A follow up meeting will be held at the beginning of September."*

Comments:

1. Re, "discussed two cases in detail", this had not been the original plan, and suggests a disorganised, nonsystematic approach. While Dr Evans in his various post-trial podcast interviews says that one of the two babies was Baby O ("I knew within ten minutes…") who was the other baby?

2. Re, "Potential to instruct a forensic paediatric pathologist at a later stage" what happened to the obstetrician and the infectious diseases expert? And why "at a later stage"? Why not straight away? Or even before Evans looks at the notes?

3. Re, "at the beginning of September", why was this meeting 6 weeks late (it was eventually held on 11/12 October)?

Sonya Baylis' notes of 10 July 2017 meeting between Cheshire Police, NCA/NID, and Dewi Evans:

*Monday 10 July 17*

*10.15 meeting*
*DI Hughes, DS Moore, DC Bolger*
*DC Woods/DC Thomas joining*
*Discussion re meeting with Dewi Evans*
*Priorities –Baby I/Babies O and P/Babies A and B/Baby K*

Comment: Baby K was not one of the 8 that paediatricians had concerns about. So why is it a priority? Perhaps it is because of what Dr Jayaram told police about Baby K which may have helped convince them to launch an investigation. Indeed, David David MP has asked Cheshire Police to investigate Dr Jayaram for perjury in relation to what he told police and said on the stand in relation to Baby K.

*11.30 meeting*
*Dr Dewi Evans, DI Hughes, Sonya Baylis, Aaron Day, DS Janet Moore, DS Adam Bolger, DS Martin Johnson*

*Introductions*

*Aaron*
- *north of England contact NCA*

*Dewi*

- *doesn't want to see other reports*
- *Clinician*

*Thresholds*

1) *Why child died?*
2) *Anything surprising about why child died?*
3) *If unexpected is anything suspicious?*
4) *If suspicious was there breach of duty?*
5) *If suspicious has someone inflicted anything?*

*Are paediatricians covering their backs due to high number of deaths?*

- *Premature babies – stress stop breathing + HR goes down*
- *Oxygen sat falls then HR falls*
- *If on life support machine essentially carry on breathing*
- *They are intubated to keep airway open*
- *If something gets into lung will collapse lung*

*Causes:*

1. *Blockage*
2. *Infection*
3. *Complications – DIC (bleeding) from an infection can kill. Happens over hours*
4. *Brain haemorrhage – IVH*

*To accelerate death*

- *Miss alarm sounding or turn off*
- *Tube becomes dislodged or in wrong position*
- *Kink in a tube – accidental or on purpose*

*On tubes/lines*

- *Can get air in intravenous line – accident or on purpose*
- *Can never pick up on it as disperses*
- *Too much potassium. If don't shake tube can give too much*
- *Calcium – too much*

Comment: Dr Evans says here that one can never pick up on air embolism because the air disperses. He later changes his mind and asserts not only that one can but also that there is evidence of Chester babies having been injected intravenously with air.

*No tubes/lines/no ventilation*

- *Still being monitored*
- *They don't die*
- *All babies have ultrasound scan soon after birth + then more afterwards*

*Can you plan collapses*

- *If baby paralysed and kink in tube will take minutes*
- *If child can breathe on own although still attached to O machine if kink in tube may take longer*
- *If sedated with morphine etc*

*Heart rate not monitored on machine*

- *If general drop of CO2, HR + RR then would drop slowly*
- *If air taken away baby would fight + all would go up not down*

[Discussion moves to specific cases?]

- *Rare for Drs to be alone with babies. Usually nurse present. Nurse usually alone.*
- *Usually very competent nurses due to experience needed*
- *Nurse likely to cause more harm than Dr*
- *Collapses quick except with infection building up or brain bleed or if lose tube*
- *Triplet surviving 24 hours should survive*
- *What caused collapse*
- *[Baby O] – liver – ruptured subcapsular haemotoma – could be injury. Pathologist says birth or resuscitation*
- *Handwritten notes awaiting. Nurses – within Drs notes*
- *Notes for [Baby O] show decreases in HR/RR but didn't die until late afternoon*
- *Was liver damage caused then?*
- *Enlarged abdomen late morning/early afternoon.*
- *Abdominal xray [Baby O] – notes say taken of [Baby P]. Pacs – ultrasound/xrays/CT scans – ok on head scan*
- *Check have PM photos as may show bruising to area of liver*
- *Collapse of [Baby O] detailed as 14.40 although injury poss caused earlier in the day*

Comment: "Check have PM photos as may show bruising to area of liver" is strange as Dr Evans in podcast interviews says that he saw these photos at this meeting.

*Advice*

- *Go through 28 cases*
- *<u>No maternity needed</u>*
- *After [?] dictation will type for him*

Comment: it seems extraordinary that Dr Evans advised that maternity notes were not needed given the role they play in understanding babies' in utero development and thus their health both pre and post birth.

*Confidentiality agreement*

*DoB – order of babies*
*Name of child + birthweight, gestation, DoB, DoD*
*Number file pages Index inc nos of pages i.e. 326*

- *No other hospital notes*
- *Coroners reports for those who died elsewhere*
- *All coroners reports*
- *Need paediatric pathologist*
- *May need Consultant paediologist [sic] currently practicing*

Comments:

1. Re "No other hospital notes", is Dr Evans saying there is no need for other medical records such as maternal notes, or other hospital notes relating to failings and issues set out in the RCPCH report?

2. Re, “May need Consultant paediologist [sic] currently practicing”, it is instructive that Cheshire Police appear to be acknowledging here the limitations of Dr Evans given he had been out of clinical practice for nearly ten years.

*Ultrasound scan 3rd triplet to see if congenital abnormality of liver*

*1st Aug to Dewi*
*? ? – Reports*

*Head of ne natal unit ) future need MGII [some sort of mgmt. acronym?] re practice*
*Head of nurses )*

*A216 Establish what drugs the pharmacy issued to neonatal unit Jan 2015 to June 2016 and if possible which staff requested. Produce into evidence.*

*A217 Obtain MGII [?] apt person in neonatal unit who can provide overview of dept and usual practices of Doctors*

*A218 “ “ “ who can provide overview of nurses role in NNU and usual practices*

*A219 Obtain all photos (xrays taken during post mortems of I, P, A, O, D, C, LF, EMW, MgB, MM*

Comment: “LF” was on consultants' list but so too was “KV” so why is only one of them here and not the other? And where did EMW, MgB, MM come from? And where is Baby E?

*A220 Obtain medical records – neonatal/scans/photographs/xrays for [Baby R] (brother of [Babies O and P]) from COCH*

The day after the meeting, 11 July, Adam Bolger writes to Sonya,

*"Hi Sonya, Thanks for attending yesterday. We were certainly impressed with Dr EVANS and he’s clearly very interested in assisting us! Do you have some details of SIO’s that he has provided statements for in the past? Cheers, Adam"*

Comment: “…clearly very interested in assisting us!” is very revealing. Not only is it an inappropriate comment but Dr Evans should not have been “very interested in assisting”. The latter smacks of bias that Cheshire Police should have been wary of rather than enthusiastic about. Also, it is not clear whether Sonya ever supplied Adam with details of SIOs that Evans had previously supplied statements for. This is the only indication of any sort of vetting of Evans but there is no evidence any was in fact done.

It is not clear how or whether Sonya responds to Bolger, but on 18 July, Evans writes a long letter to Moore:

*Dear DS Moore*

*Re: Operation Hummingbird. OP 106859*

*I was pleased to meet up with you and the team last Monday I10 July] and write to suggest how we can make progress in what is going to be a complex and challenging operation.*

*I would suggest that you forward to me a copy of all the case files and copies of all post mortem reports. I think that reviewing the Chester records is sufficient for now. If it looks as if we need the records of babies who were transferred elsewhere and I or who died elsewhere, one can do that later. I would prefer NOT to receive the findings of any previous revlews or investigations as I want to minimise the risk of 'groupthink contamination'.*

Comments:

1. Re, "all post mortem reports", is this not why a paediatric pathologist should have been instructed at this point?

2. Re, "I think that reviewing the Chester records is sufficient for now" this refers only to babies' notes, per previous messages and meeting minutes. Again, why did he not want to see documents related the RCPCH report on hospital failings and issues?

3. Re not receiving findings from any previous revlews or investigations in order to minimise 'groupthink contamination', not only does Evans receive reviews such as Dr McPartland's, but his entire investigation is clearly the result of the Texas Sharpshooter Fallacy bias.

*I understand that there are files for 28 babies, who between them sustained 40 'collapses' [or ALTEs - Acute Life Threatening Events]. I propose to review all 28 files, doing so in date of birth order. This should correlate reasonably accurately with the date of the ALTE. Some infants sustafned more than one event. Conducting the investigation in date order may show useful information regarding trends_ One needs to accept at all times that babies who are unwell and in need of neonatal intensive care facilities are frequently clinically unstable. ALTEs are common, with some babies surviving having experienced several 'collapses'.*

Comments:

1. Re "who between them sustained 40 'collapses' [or ALTEs - Acute Life Threatening Events]", surely it was for Evans to opine what the babies sustained.

2. Re, "One needs to accept at all times that babies who are unwell and in need of neonatal intensive care facilities are frequently clinically unstable", he uses the words "unwell" and "unstable" at this point but later he and the other prosecution experts throughout their statements and the trial speak of the babies being "well" and "stable".

3. Re, "ALTEs are common, with some babies surviving having experienced several 'collapses'", does this contradict later statements about ALTEs being rare?

*With regard to the clinical issues I propose to look at each ALTE (and death) by applying the following thresholds.*

*• Is there a clear explanation regarding the cause of the collapse? Common causes include infection, intracranial bleed, or blocked endotracheal tube. If there is an identifiable clinical*

*cause it's unlikely that one would be able to distinguish this clinical event from a potentially suspicious one. If not;*
*• Is the cause of the collapse unexpected or unusual? If it is;*
*• Is there any indication of unacceptable care, such as a delay in identifying subtle symptoms and signs? If there is, it this takes us down the road of alleged breach of duty. Or;*
*• Is there any indication that a collapse occurred as a result of a deliberate act on the part of one (or more) member of staff? This of course means "thinking the unthinkable" and exploring potential criminal acts. The evidence (or proof) required to identify any such situation will need to be compelling, to satisfy due process. Any ALTE that reaches this level of suspicion would need a careful review looking at matters such as opportunity, unusual but known clinical events, and FIi (Fabricated or Induced Illness].*

Comments:

1. Re, "If there is an identifiable clinical cause it's unlikely that one would be able to distinguish this clinical event from a potentially suspicious one", there were many identifiable clinical causes. And pathologist McPartland said only two deaths were unexplained. So, why was Evans so easily able to say that events were suspicious when he says that it is unlikely that one would be able to?

2. Re, "Is there any indication of unacceptable care, such as a delay in identifying subtle symptoms and signs? If there is, it this takes us down the road of alleged breach of duty", there were many many such indications. Why did Evans ignore them?

3. Re, "The evidence (or proof) required to identify any such situation will need to be compelling", the only evidence that came remotely close to being compelling was the two blood test results, and even that has been thoroughly debunked by new experts. Surely if the evidence of intentional harm was compelling it would have been picked up by the original pathologists, Countess doctors, etc.

4. Regarding Evans mention of "FIi (Fabricated or Induced Illness]", this, interestingly, is another term for Munchausen Syndrome. This is a syndrome invoked in many previous wrongful convictions of caregivers by fanatical expert doctors. Perhaps this is why there was no mention of it again.

*I have liaised with the NCA and feel that the most practical way of arranging fees is via a 'flat rate', and that a fee of XXXXX is reasonable. As with all my cases, my invoice will include a schedule of the time taken. I would estimate that preparing my initial report will take the equivalent of two working weeks.*

*I do not think it's necessary to consider additional expert opinion al this stage. If there is evidence indicating that one (or more) of the ALTEs is suspicious of an inflicted act the whole investigation will need to address the issue(s) very thoroughly.*

Comment: It is extraordinary that Dr Evans is allowed by Cheshire Police to override the NID's recommendations to instruct a number of experts. Why does he not think it is necessary to consider additional experts at this stage? Clearly because he wants it to be his show and thinks other experts might disagree with the inflicted harm he is eager to invoke. Much better to get them on board later, simply to peer review his work rather than investigate alongside him, as indeed happened.

*I would be pleased to receive copies of all necessary documents electronically. I would ask that each case file Is labelled in sequence, noting the individual infant's file number [File Number 001 to 028) in date of birth order followed by a Surname, e.g, 021.Jones.*

*You are welcome to prepare your own Letter of Instruction, as it's going to be important to look at the case from a police investigation paint of view, as well as from the clinical perspective.*

*Given the recent cyber attack I have decided to close down my nhs.net account permanently. I am currently in the process of creating a new secure e-mail, and have completed all the forms required to get approval from the Ministry of Justice's own system; cjsm [Criminal Justice Secure eMail). This should facilitate prompt and secure communication and I hope it will be up and ready asap.*

Comment: did Dr Evans actually set up a CJCM email account or use an unsecure personal one? To which address were the 28 case notes he was furnished with sent? Dr Evans suggests that had there not been a cyber attack, his nhs.net account would have been fine to use, suggesting this was as secure as a CJSM address (if it is true that he had an nhs.net account that is).

*If you could forward all the files to me before the end of the month I would hope to have completed the review of the Chester notes before the end of August. At the moment I'm due in court in North Wales with another case during the week beginning 4 September. That week may be a good time to organise another meeting of the whole team.*

Comment: the next meeting took place on 11/12 October, not during the week beginning 4 September. Why was this delay not foreseeable?

*My kind regards*
*Yours sincerely*
*[signature]*
*Dewi Evans*

*Consultant Paediatrician*

Baylis' handwritten notes on 26 July are fully redacted.

Comment: why wre these notes redacted? Was it because they pertained to another case or because the police did not want Letby's defence to see them.

Phase 3, Stage 3: Dr Dewi Evans

We are now into Stage 3: Evans has been instructed and goes about appraising the cases of 28 babies (17 deaths and 11 non-fatal collapses) with a view to determining whether or not there is anything suspicious about them.

There has been a gap in correspondence involving Evans between late July and mid-September, presumably during which Cheshire Police compiles documents, sends them to Evans, and he appraises them.

In October 2017 Evans meets with Cheshire Police to present his opinions on the 28 cases he had been given to appraise. He cites 10 clinical events as being suspicious but where Lucy Letby was not on duty. These are quickly and quietly removed, and Evans' November 2017 written reports (as well as the meeting in March 2018) reflect much more closely the (eventual) indictment events. Is it possible that these changes were facilitated by Evans being given Lucy Letby's shift data? The other explanation is that Evans reappraises his opinions, realises many of them are wrong, and comes up with new ones that just happen to now be consistent with Lucy Letby's shift data.

Stage 3/Phase 3 ends with the March 2018 meeting between Evans and Cheshire Police. It is at this meeting that Evans is given Jayaram's description of Baby A's rash, and the air embolism thesis goes "full throttle".

Email from Evans to Moore on 15 Sep:

> *"Very pleased to have our chat this morning. The last of the 17 who died are [Babies P and O]. I'd check staffing for the night shift of 23/24 June 2016. Could I also suggest that you ask the management for a copy of the design of the neonatal unit. They will have one somewhere. It's useful to know how the various rooms of a Neonatal Unit function. Babies will have a designated nurse usually but there is reasonable flow between staff, especially if there is an acute emergency. I should complete the review of the 11 surviving babies and the 2 siblings. It may take me until the week after next as I have other targets to hit next week."*

Comments:

1. Evans writes that Cheshire Police should "check staffing for night shift of 23/24 June 2016". At what point was he told that Lucy Letby had not been on duty on that night shift, thus bringing into question his clinical competence?

2. Re, "Could I also suggest that you ask the management for a copy of the design of the neonatal unit. They will have one somewhere. It's useful to know how the various rooms of a Neonatal Unit function. Babies will have a designated nurse usually but there is reasonable flow between staff, especially if there is an acute emergency", why does Dr Evans want this? The information is not clinical. It suggests he wants to get involved in the process of associating the nurse he has been told about with his clinical opinions, which is not his job.

3. Re, "the 2 siblings" it seems likely these were Babies F and L?

Email from Moore to Evans on 18 Sep:

*"I assume that you have a copy of the change over of shifts in the NNU. If not here are the details.*

*Long Day (LD) - 07.30hrs -20.00hrs*
*Early (E) not undertaken often - 07.30hrs -15.30hrs*
*Night (N) - 19.30hrs - 8.00hrs*

*I seem to remember when talking about [Baby O], when you visited us, it was around the cross over period of the night/morning shift that we were talking about. Re the 23/24th June as per below – Baby O died at 17:47 on the 23/06/16 and Baby P died 16:00 24/06/16. Is it the night shift for both the 22/23 June and 23/24th that are of interest?*

Comment: It seems that Moore knows that Lucy Letby was not on duty on the shift that Evans said Cheshire Police should look at. When she mentions the cross over period, she appears to be nudging him in the direction of the day shift rather than the night shift. Thus, when she asks him if it is the night shift(s) he is interested in, she is essentially saying that he shouldn't be.

*We were given an old plan of the unit which wasn't up to date therefore we had our plan drawer draw up another one. This is attached to this email. When you discuss those babies that you think were of no concern can we also have some explanation surrounding your thoughts on these?*

*We have realised that for 6 of the babies that went to The Liverpool Womens Hospital we have not provided you with the full notes. We have only just been told about this by the hospital. Do you want these extra notes paginating separately or do you want each baby to be redone?"*

Email from Evans to Moore on 20 Sep:

*"Thanks for all this. First some irritating news. I need to get back to court tomorrow. Yesterday's attendance was postponed as the barrister was ill. Whole day enjoying the beauty of Croydon. West Wales it is not :)*

*So it's back to Croydon tomorrow (Thursday). Joy. This has got in the way of my completing the remaining 11 cases, (as I was in Cardiff in meetings on Monday). But I've a whole week without appointments next week, so should have a good run at it and aim to complete.*

Comment: His need to be chummy with the police is inappropriate and nauseating.

*The plan of the unit is interesting. I note three (smallish) 'Nurseries'. Were the sick babies managed in one or more of the three nurseries, or in the bigger one in the middle? The staff will tell you in which part the various babies were managed.*

*Thanks for the shift arrangements. Very useful. Night shift starts at 19.30. Handover completed by 20.00.*

*Re the notes from the other hospitals, I would copy them separately and send them to me either via e-mail or via another PenDrive. The arrangements so far are pretty good. PenDrive works with no need for a CD. There are several duplications, which is not a problem. With the extras, e-mail attachment will probably be fine. Whatever is easier for your IT people.*

Comment: Which email address is he referring to? A secure CJSM one or a personal and thus unsecure one?

*I've received most of the reports back re the 17 deaths. They include my views on the 'no-concern' ones, so that's sorted. I've gone through several of the reports already, checking for typos, duplications etc. Would have completed them before Friday but for my Croydon odyssey.*

Comments:

1. Who typed up Dr Evans' reports for him? Had they signed NDAs?

2. Some of Evans' "no concerns" cases ended up on the indictment and some "concerns" cases didn't. One may wonder why.

*The common theme I have noted so far is that several babies seem to collapse wholly unexpectedly. Some go on to develop additional complications. We'll need to discuss independent neonatal pathology opinion, but that can wait until I've sorted all 28 cases, and you have clarified who was there [doctors and nurses] at the time, and also in which nursery. [If the baby was in one of the small nurseries it's likely that there would be just the one nurse in charge]. Another thought. Can you arrange photos of the various parts of the nursery, i.e, how visible was each individual nursery from the other parts of the unit. [I helped design the NICU in Swansea in 1999, and visibility is a key issue].*

*All in all, making progress. [I've no trips to North Wales / North West arranged at present. My recent N Wales case settled - changed plea to guilty].*

Comments:

1. Re, "The common theme I have noted so far is that several babies seem to collapse wholly unexpectedly", new medical experts have found that none of the babies' collapses should have been unexpected.

2. The section, "We'll need to discuss independent neonatal pathology opinion, but that can wait until I've sorted all 28 cases, and you have clarified who was there [doctors and nurses] at the time, and also in which nursery. [If the baby was in one of the small nurseries it's likely that there would be just the one nurse in charge]", raises all sorts of questions. Why does Dr Evans need to know the locations of each doctor and nurse before seeking independent neonatal pathology opinion? In fact why does he need to know that at all? Surely correlating presence is not his job, and knowing this information simply allows him to remove events that he said were suspicious but where Lucy Letby is not on duty (this is exactly what happened between his first and second set of opinions that he presented in October 2017 and March 2018 respectively.

3. Re, "Can you arrange photos of the various parts of the nursery, i.e, how visible was each individual nursery from the other parts of the unit. [I helped design the NICU in Swansea in 1999, and visibility is a key issue]", did Dr Evans ever say that visibility was poor on the basis of these photos, assuming he received them that is?

Email [date unclear] from Moore to Op Hummingbird following Evans' email:

*"R and I doc*
*Reg to Dr Evans*
*Take photos of the neonatal unit at the COCH to include the view from room to room."*

Comment: what do "R and I doc" and "Reg to Dr Evans" mean?

Baylis notes on 20 Sep are redacted.

Comment: per previously, why are these redacted?

DS Moore's handwritten notes of 11-12 Oct meeting with Evans

Comment: these have not been transcribed for this document but it would be useful to compare them with the typed up notes below.

DS Moore's typed up notes of 11-12 Oct meeting with Evans:

Comment: it looks like these notes were what David Rose's 1 Feb 2025 article, "Why the Letby case isn't closed", was based on.

Summary Meeting Dr Evans, Sonya Bayliss, Ken Donnelly 11/12 17 [this should be 11/12 Oct 17] (continued 12/10/17)

Comment: the 40 ALTEs mentioned earlier that the 28 babies suffered are not that easily identifiable from the below. A reconciliation would be useful.

1 [RT]
Ambulance *to hospital, intubation, resuscitation. Nothing suspicious*

*2 [KBD] Apgar 0 at 5 minutes Brain damage – HIE*
*Placental haemorrhage could have caused asphyxia Nothing suspicious*

*3 [Baby G] -Suspicious COCH / Arrow Park*
*07/09/15 02:35 Projectile Vomit – very unusual Abdomen purple / distended*
*Stabilised and then dropped Further Desat*
*Signs of infection*
*Could be air into stomach? – Syringe? Mechanism to do this would be discreet How was [Baby G] being fed?*
*If put air in would be instant reaction*
*Intravenous air – wouldn't cause swollen abdomen but extension of stomach would*
*Ilias could cause sickness but Nurse would know beforehand and would syringe*
*excess liquid out*

*4 [Baby B] – suspicious*
*No respiratory issues even though premature 02:40 10th June relevant*
*00:50 onwards Antibiotics Recovery*
*22:50 19th June relevant 21:30 onwards*
*Ask sample CPAP prongs used and take photo of baby with prongs now*
*Intravenous air? Or hand over face?*
*No vomit so no syringe Need photo resus bag used*

*5 [Baby A] – suspicious*
*8th June from 5pm relevant*
*Who looking after at 20:26 collapse? Where?*
*Should have been able to resus Poss air into stomach*
*Long line wouldn't have caused collapse*

*6 [Baby C] – suspicious ?*
*His UV line was seen to have come out at 07:00 12/06/15. Can this be explained?*
*Shouldn't have come out*
*Infection*
*13th June 23:26 crash beeped Died of infection*
*If the UV line being out is suspicious then death suspicious*

*7 [Baby D] – suspicious*
*Poor care 21/22 June*
*21st June 01:50 gas normal*
*01:40 22nd June mottled – lesions across abdomen No oxygen needed*
*Bruising in abdomen Antibiotics*
*02:35 improved – discolouring disappeared 03:00 discolouration, crashed, died Infection*
*PM – Intercranial air present PM says PM could cause it*
*Dr Evans thinks born with infection*
*Could be air in which transported to brain*
*Shouldn't die from pneumonia*

*8 [Baby E] – suspicious?*
*09:25 2nd August – Inc risk NEC 3rd Aug 22:10 bile stained aspirate Haemorrhage*
*01:40 died*
*No abdominal distension*
*Fresh blood from haemorrhage in stomach? No explanation*

*9 [Baby I] – suspicious*
*Born LWH*
*COCH 3rd Sept oxygen – breathing support 5th Sept 09:35 no concerns*
*21:00 5th Sept inc desats Suspected sepsis*
*Chronic lung disease – shouldn't have collapsed 6th Sept from 23:15hrs deteriorating / crashes*
*3 episodes but recovered*
*21:00*
*22:30*
*23:15 big drop*
*00:30 normal blood gases To Liverpool womens 13th Sept back to Chester*
*30th Sept required bagging Abdomen distended*
*22:00 respiratory arrest – pale/distressed – blood gases normal Query NEC*
*Abdomen went down quickly so air Air into stomach can use milk line Was sick prior*
*8th Oct CLP 71 High to 21 Low 13th Oct 03:36 blue apneic in cot Doesn't look like NEC*
*4pm NEC*
*14th Oct 08:10 not improving To arrow park*
*18:15 15th Oct getting better 17th oct 10am back to COCH*
*If septicemia /NEC wouldn't go back to COCH so quickly*
*22nd Oct midnight crashed Intravenous air*
*If air into abdomen will be unwell but will not die and would not cause a crash*
*Could be a nasal gastric tube*
*Intravenous would kill Hand over mouth would kill*

*Need senior sister procedures for feeding babies using naso gastric tubes*

*10 [FE] No concerns*
*Growth retardation / down syndrome Intubation – abdominal surgery*
*Right leg dusky / leg mottled*
*Septicemia – died LWH – complications neonatal IT care Unwell for whole of the time*

*11 [MM] No concerns*
*Cardio problem*
*Epsteins anomaly – won't always kill you*
*Fluid outside lung*

*12 [Baby H] Suspicious?*
*18:45 sub costa recession Respiratory problems*
*7am 24th Sept – intubation Aair entry reduced*
*Pneumo thorax – lung collapsing*
*Did she deteriorate because of pneumothorax? Or other way around? Pneumothorax because of intubation?*
*Grunting*
*CPAP Treatment – tubes into nose*
*More like pneumothroax caused collapse If increased pressure via machine*
*Side effect of CPAP would have air into stomach Baby had air in stomach*
*Baby getting better so unusual to collapse at this point*
*Air infusion / septicemia would cause mottling*

*13 [LO/LF]*
*Multiple organ failure No suspicion*
[LO/LF was one of the 8 that the paediatricians were suspicious about]

*14 [Baby J] - suspicious*
*Other twin died before birth Premature*
*Initially stable*
*Distended bowel – operation to remove piece of bowel 27th Nov 5.15 two profound saturations*
*Negative blood test for infection 17th Dec 09:35 crying / went blue Cardiac massage*
*Resus*
*Back to normal*
*Whilst in Manchester hospital high CPP marker and did have infection*
*Belief that infection caused by collapse and not other way around*
*HR goes up – infection can cause*
*But shouldn't crash*
*Hand over mouth would cause it*

*15 [EMW] – suspicious* [comment: not on indictment]
*CRP 245*
*Antibiotics CPAP*
*Floppy , collapsed, resus Further arrests*
*20:30 10th Dec*
*01:00 11th Dec normal*
*22:30 11 Dec intubated / monitor*
*Need photo of baby on ventilation to show how tube held in place Tube 02:23 properly situated*
*Put in firstly in correct position Baby well and further x ray 05:54hrs Tube had moved lower down*

*Someone could have pushed the tube down Lungs collapsed*
*Need sample of ET Tubes – one of each (normally 2.5 and 3)*

*16 [MgB] Not suspicious Twin*
*Natural cause*
*Needed resus just after birth Bagging needed*
*ET tube in*
*7th Jan reintubated 02:00 8th Jan poor colour Pulled tube back a little Poss infection*
*08:55 profound desat*
*10:39 x ray*
*Cardiac arrest 14:35 8th Jan Pneumonia*

*17 [AS] – suspicious?* [comment: not on indictment]
*Died DIC – bleeding from asphyxia Intubated*
*29th Jan off ventilator – stable until 5th Feb Query sepsis*
*05:30 6th Feb vomit Tinged yellow/green bile Long line in*
*Abdomen slightly distended 08:00 deterioration – resus 7th Feb 09:15 CO2 -10*
*Take tube out LWH*
*Chest drains*
*Abnormal coagulations Due to DIC*
*What caused DIC?*
*DIC caused by babies born in poor condition or infection*
*Can't say cause*
*Smothering could cause hypoxia which could cause DIC*

*18 [KC] Twin*
*Can't ascertain cause of death*
*Hypoglycemia*
*Collapse when normal glucose values 18:15* 22nd Feb no insulin poisoning

*19 [Baby K]*
*No suspicions Intubated Deteriorated Resus*
*Arrow park Premature*
[comment: no suspicions but on indictment]

*20 [WC] No suspicions Hydrops*
*Swollen Attempt resus*

*21 [PW]*
*Natural no suspicious Tummy distended*
*NEC?*
*Bile*
*00:45 16th march 3 brachiadas On ventilator – normal Antibiotics*
*Arrow park Chester*
*Probably infection*
*Significant deterioration 15/16 March*

*22 [KV] No suspicions*
*Multiple congenital problems*
[KV was one of the 8 that the paediatricians were suspicious about]

*23 [SH]*

*Good condition*
*24 hrs later to neonatal Grunting / no feeding Distended abdomen Bile aspirate*
*Air in abdomen and perforation in intestines Possible perforation from birth or prior to birth*
*Good care*
*No suspicions*

*24 [Baby M] – suspicious*
*Crash call*
*Abdominal distention*
*14:00 and 16:00 9th April relevant CPR*
*Sudden profound apneic episode Off ventilator 10th April*
*10:15 10th April neo puff could be from previous day Had clot*
*Where from? Could cause cardiac arrest Clot could be caused from cardiac arrest*
*What caused cardiac arrest?*
*Dr Shauq was contacted re clot but no response received – we will find out*
*Doesn't think thrombosis and thinks suspicious*

*25 [Baby P] – suspicious*
*CPAP in air*
*Abdomen full*
*SNT – what does it mean (hospital to be asked) 10:06 23rd June bagged intubated*
*24th June 15:14 cardiac arrest Pneumo thorax – slight*
*Drain in and worked Moderately distended abdomen*
*Pulmonary hypertension can be caused by pneumo thorax but shouldn't be a problem with this case Shifts to look at 23rd day, 23/24th night and 24th day*

*26 [Baby O] – suspicious*
*13:15 vomiting – abdominal distention 16:15 collapse*
*22nd June all normal Xrays 23rd June 16:00 Air in intestines*
*Discoloured purple rash in chest wall 18:00 23rd June Was he seen before collapse?*
*Shouldn't be vomiting as NSG feeding Think problems before collapse (liver)*
*5am 23rd HR climbing*
*Overnight 22/23 relevant*

*27 [Baby Q] – suspicious*
*Evening /night 24/25th June from 20:00 relevant*

*28 [JA]*
*Good care not suspicious*

*<u>General Questions for each baby</u>*
*Which Room was the baby in for the time the nurse was on shift?*
*What other babies were in that room?*
*What medical staff were in that room for the duration of the shift?*
*After the baby had collapsed did anyone stay with him/her?*
*What did he/she after each crash?*
*What did other staff do after each crash? Are the cots numbered?*
*Are the rooms given names / numbers?*
*Medical staff should be given chance to view files before statement taken*

Comment: If Evans is asking, "Which Room was the baby in for the time the nurse was on shift?" this surely confirms that Evans had been told about "the nurse". Knowing "Which Room was the baby in

for the time the nurse was on shift" would allow him to revise his list of suspicions, one that was consistent with "the nurse's" shift data.

DS Moore's handwritten note on 16 Oct (redacted)

Comment: per above, what was in this note?

6 Nov:

> *A48 Redacted - Action re Dr Brearey - death rate*
> *Text:*
> *TI key witness Paediatrician Dr Stephen BREAREY re involvement on Unit and concerns expressed.*
> *Produce emails between Paediatricians into evidence*
> *DS Southcott producing strategy*
> *UPDATED BA9147MB 24/05/2017 14:25*
> *UPDATED 07BA3178JM 03/04/2019 13:58*
> *Dr Brearey should provide a statement to detail that there have been no deaths in the neonatal unit since June 2016. If it is possible can he also comment on unexpected collapses. Can he say if there have been any unexpected collapses since then?*

Comments:

1. Re, "Produce emails between Paediatricians into evidence", were these the ones that were NOT produced into evidence but ended up being sent to Thirlwall, whereupon Cheshire Police realised they should have been disclosed in 2017 so quickly sent them to Lucy Letby's defence?

2. Re, "Dr Brearey should provide a statement to detail that there have been no deaths in the neonatal unit since June 2016. If it is possible can he also comment on unexpected collapses. Can he say if there have been any unexpected collapses since then?", was it appropriate to tell Dr Brearey what was required of him?

Notes of meeting on 27-28 Mar 2018 with Evans:

Comment: the suspicions set out below by Dr Evans are very different to those he set out in the October 2017 meeting. Events that he had deemed suspicious but where it turned out Lucy Letby was not on duty have mysteriously disappeared.

> *[Baby G] Re Tampering with equipment – Could be by holding and squeezing tube*

Comment: a far cry from the eventual "deliberately overfed and had air injected into her stomach through the nasogastric tube, causing the vomiting and clinical deterioration".

> *[Baby B] Specialist needed Haemotology to query whether APS syndrome could be link to collapse/death. Use Alder hey Dr. Photos to be given to Dr of CPAP attached to [Baby B].*

Comment: the haemotology expert that Cheshire Police instructed, Sally Kinsey, was not at Alder Hey. Is it possible an Alder Hey doctor said APS syndrome could be linked to death/collapse?

*[Baby A] Specialist as above. Explanation of potassium chloride – used as a supplement for potassium. Dr Jayaram description of rash given to Dr Evans.*

Comment: the description of the rash given to Dr Evans appears to be the one from Jayaram's 18 September 2017 statement:

> *"He had unusual discoloration; you'd expect babies to look fairly ghastly and pale and grey but he had an odd sort of discoloration where there were flitting patches of pink areas on the background of bluey grey skin; these patches seemed to appear and disappear. It wasn't like the rash seen with a meningococcal sepsis which is caused by blood vessels bursting. It would flit and the reappear and disappear. It didn't fit with anything I'd ever seen before. I would describe the marks as blotches which were fairly ill-defined, about 1 centimetre to 2 centimetres, not discreetly round but blotchy patches of brighter pinkness on a background of bluey grey."*

Comment: Perhaps Cheshire Police were frustrated that Dr Evans was still, after several months, not invoking the air embolism thesis that the paediatricians had been, so felt the need to give him a nudge by passing him Dr Jayaram's description. Presumably this is when he was also nudged towards the 1989 paper that Jayaram had found.

*[Baby C] Need pathologist opinion. Didn't die of hypoxia – kept alive for baptisms.*

Comment: it seems Dr Evans didn't like the original pathologist's opinion that Baby C died of hypoxia so wanted another one.

*[Baby D] Will rewrite conclusion to make it stronger due to Dr McPartland comments.*

Comment: Dr Evans had said he did not want to see other reviews. And what does "make it stronger" mean?

*[Baby E] Can NEC cause an acute bleed – unusual*

*[Baby I] Consider Radiology opinion – but in hindsight don't need. Change of times from 22:00 and 03:00 to 16:30 and 19:30. Change due to either Dr notes being incorrect or genuine mistake – How do we cover this in statement? 30th Sept Now need to add long day shift to clarification sheet. Will consider collapses on 14 Oct and 15 Oct overnight.*

Comment: the above all stinks!

*[Baby J] Need microbiologist opinion (but not yet as may be for other babies too) – recommends Nigel Klein Gt Ormand St – Paediatrician expert in viral and bacterial infection in young children. Ref er para 18/19/20 Dr Evans statement and pages 454 and 474 in compilation medical records exhibit to Dr Evans.*
*27 Nov – timings changed from 05:00 to 07:11 to from 05:00 to include collapse at 07:24 or 07:40 (times different on nurses/Dr's notes). Will need to include day shift on clarification docs.*
*17th Dec – no longer thinks relevant as believes down to infection.*

Comments:

1. Opinion of Nigel Klein or any other microbiologist was never sought, whether with respect to Baby J or any other baby. It seems that all sorts of things changed once Dr Evans had been nudged in the direction of air embolism.

2. Why had Dr Evans not noted the 07:24/07:40 collapse when he first looked at the notes months earlier?

3. What are "clarification docs"?

> *[Baby O] Made mistake re increase in HR. Initially says 1am but chart shows 7am (handwriting not great). Now agreed 7am. PH levels dropping between 05:32 and 13:20 so needs to look at night and day shift. Need Paediatric radiologist – Gives two names – action raised. Will give other babies who need too. Pathologist will need to make comment on relevance on clotted blood. Need radiology opinion. Consider doing gene sequencing for [O, P and R surname] as per Dr Kokai suggestion.*

Comments:

1. Dr Evans has also said that he did not suggest gene sequencing on the bais it was not necessary.

2. Evans admitting to a mistake re increase in HR appears disingenuous. Firstly, there was an increase from 1am. Secondly, he refers explicitly to the increase in HR rate in the early hours in his November 2017 statement. Thirdly, he cites in the statement three different times that the increase began: 1am, 1.30am, and 2am, as below:

> *From 02.00 hr there is a significant increase in heart rate*
>
> *There is a key clinical change from around 01.00 hr on 23 June, where there is a significant increase in both his trend of heart rate and respiratory rate*
>
> *This suggests that Baby O sustained some form of trauma which initially led to his increased heart rate and increased respiratory rate from around 01.30hr on 23 June, and which eventually led to a "tipping point" where the effects of the bleeding led to his collapse and subsequent death.*

3. It should also be noted that the trauma that Evans said Baby O sustained from 1.30am on 23 June could not have been inflicted by Lucy Letby as she was not on the night shift but the day shift several hours later. And that Evans' revised time, 7am, didn't work either as she was still not on duty.

4. Re, "Need Paediatric radiologist – Gives two names", Evans has said he did not recommend specific experts.

5. Re, "Pathologist will need to make comment on relevance on clotted blood", there WAS no clotted blood. The original PM noted unclotted blood:

> *Along with unclotted blood (@20 ml) which spontaneously empties after initial incision, there was a blood clot identified underneath the liver approximately 2.5 cm x 1 cm which is fragile irregular. The free margin of the convexity of the liver contains several sac like*

*extension of the capsule underneath which there was dark unclotted blood collection identified (=subcapsular haematoma).*

*[Baby P] Doesn't think first or second collapse on 24/06/16 due to pneumothorax due to cold light checks. Need radiologist. Will say night and day shift of 24th until 09:40 when collapse took place.*

Comment: Dr Evans had previously referred to night shift of 23/24 June. He now refers to collapse occurring at 09:40 on 24 June and so includes the 24 June day shift too. Lucy Letby was not on duty for the former but was for the latter.

*General*

*Dr Evans wants a nurse to explain optiflow system – doc for Nurse updated.*

Comment: Is this Dr Evans admitting he has no idea what optiflow is?

*He wants a selection of syringes obtaining from COCH – Stuart updated via D5 and COCH. He has seen the other equipment items he previously requested.*

*Wants photos of babies on IPPV Ventilation, CPAP and Optiflow. Stuart to sort via internet with an apt nurse.*

*Should be finished end of April with new reports re corrections, extra 3 babies and [Baby N]. [Baby N] will be in top category of inflicted injury.*

Comments:

1. What promted corrections to be required?

2. It appears that the extra three babies were F, L and N. Why does Dr Evans say that Baby N will be in the top category of inflicted injury? Why does Dr Evans not spot F and L's blood test results (this is left for Dr Brearey)?

*Charges for experts should be [redacted].*

*Would like copies of correspondence and reports from RCPCH – around charging time?*

*Wants file for [Baby R] to compare with other [siblings Babies O and P] – Martin has done.*

*He will explain things further in relation to Claires queries.*

Comment: the reference to "around charging time" suggest there is a presumption, even at this early stage, that Lucy Letby will be charged (she is, but over two and a half years later).

On 4 Jun 2018, Evans sends email to Moore:

*I'm pleased to forward my invoice re my fees and expenses regarding the following items of work. My fees and expenses: -*

*My fees: 28 March (9 hr), 29 March (5 hr)*
*Consultation, Cheshire Police, Blacon Rd, Chester, Review of 14 Witness Statements {references below)*

*Note:*
*1. My fees re based on the agreed rate of-per hr.*
*2. The review of the 14 Witness Statements took place during 30 May and 1 - 3 June 2018. Time taken was approx. 4 to 6 hr per day. My estimate of a total of 14 hr is a conservative one, and Is acceptable to me.*
*3. Train travel and other expenses is limited to the single (29 March) journey. I was in the North of England with other business during 27 March 2018.*
*4. I have not included 'travel time'.*
*5. * indicates receipt enclosed. (Please note that the rail fare relates to 'Booking 3" only, and relates to the fare from Chester to Cardiff.]*
*6. The 14 Statement reviews relate to 03 [Baby G], 04 [Baby B], 05 [Baby A], 06 [Baby C], 07 [Baby D], 08 [Baby E], 09 [Baby I], 12 [Baby H], 14 [Baby J], 24 [Baby M], 25 [Baby P], 26 [Baby O], 27 [Baby Q] and 28 [Baby N].*

Comments:

1. Whose were the "14 witness statements"? Were they Ward Platt's peer reviews of Evans' statements?

2. The list of 14 babies excludes F, K, and L. Perhaps Dr Brearey had not by this point uncovered the two blood tests. As for Baby K, this earier had been a priority so it is unclear why there was no statement for Evan to review in relation to this baby.

3. At the March 2018 meeting, Evans referred to "*extra 3 babies and [Baby N]".* Baby N was not one of the 28 babies Evans appraised in October 2017, and yet in his 4 June email, Evans says Baby N was #28 in his Oct 2017 list (#28 was in fact JA). At trial Evans refers to Baby N as #29 so it seems he was mistaken in his email above and that he should have written "29 [Baby N]" not "28 [Baby N]".

4. The questions still remains as to why Baby N was not one of the original 28 babies, given that at the March 2018 meeting, Evans said "[Baby N] will be in top category of inflicted injury".

5. As for the "three extra babies", these must have been F, K, and L, as these were the only three indictment babies not mentioned in Evans' 4 June email to Moore.

Cheshire Police action records on 5 December 2018 state:

*Dr Brearey re those additional babies he has referred to Dr Evans as suspicious and which Dr Evans believes to have inflicted injuries. Details of babies as yet unknown.*

*Dr Jayaram re those additional babies he has referred to Dr Evans has suspicious and which Dr Evans believes to have inflicted injuries. Details of babies as yet unknown.*

Comments:

1. It is known that Brearey uncovered the blood test results for Babies F and L, and that Jayaram's testimony was pivotal with respect to Baby K, so this all ties together.

2. Who wrote the first witness statements for F, K and L? Brearey and Jayaram? Were they completed before LL's first arrest in July 2018? Did Evans write a witness statement on each before LL's first arrest? Presumably not given above 5 December 2018 action records.

3. By when did CP have the final list of 17 indictment babies?

4. Why did it take so long to sort out the Baby K allegation? This is particularly pertinent given that initially Lucy Letby was charged with murdering her, a charge that the prosecution did not present evidence for so a 'not guilty' was recorded in June/July 2022, a few months before the trial started.

2018-2023 (Phase 4): Putting together and presenting the case that would convince jurors that Letby was guilty of attacking babies

The three stages of Phase 4:

Stage 1 (June 2018 – November 2020): The police first arrest Letby in July 2018, instruct other experts to peer review Dr Evans reports, the go about putting a case together against her. In November 2020 they arrest Letby for the third and last time, following which she is formally charged and the case handed to the CPS.

Stage 2 (November 2020 – October 2022): The CPS puts the prosecution case together that will be presented at trial.

Stage 3 (October 2022 – August 2023): The trial, culminating in the jury's 14 guilty verdicts (also 2 not guilty and 6 'no verdict') that were announced to the public on 18 August 2023.

Phase 4, Stage 1

Other experts are instructed to rubber stamp Evans' reports. They were only instructed once Evans had refined (based on LL's presence) his suspicions. It is not clear how these other experts were selected but paragraphs 22-24 of the main trial court of appeal judgment shed some light on the process with respect to both Evans and the other experts:

> *22. During the police investigation which followed, Dr Evans, a retired consultant paediatrician was instructed to review clinical records of the babies in the unit who had died or collapsed suddenly. Initially he reviewed 33 sets of clinical records where an infant had died or deteriorated and where the event was unexpected and/or unexplained. He was later sent a further 28 sets of records for review. The purpose of the review was to consider, in each case, the cause of the collapse of the baby. He produced a very large number of reports including a general statement dated 17 April 2019 setting out his background and experience and a glossary of terms; a review of published literature regarding air embolus in newborn infants dated 3 July 2019 and a series of reports considering the events surrounding the deaths or collapses of babies who were on the subject of charges.*
>
> *23. Dr Evans remained the lead expert throughout the investigation and trial. His conclusions were peer reviewed by Dr Bohin, a currently practising consultant neonatologist from Guernsey. Her specific instructions (as set out in her report on Baby A of 29 November 2020) were:*
>
> *i) to peer review the work and statements submitted by Dr Evans using his statements, additional material and access to the same medical files he used in forming his opinion;*
> *ii) to provide section 9 statements of those reviews conducted in a thorough and transparent manner, to continue to assist the investigation in answering the question of "what happened to each baby" and provide detailed explanations of areas of inconsistency in respect of the views of other experts; and so*
> *iii) to provide a robust clinical review of Dr Evans' opinions, setting out whether she agreed or disagreed with him and, as appropriate, to provide an alternative causation for the collapse.*

*24. Dr Evans advised the police on the instruction of experts from specific specialisations and further experts were instructed and provided reports as set out below:*

*i) Dr Andreas Marnerides, forensic pathologist and histopathologist;*
*ii) Professor Owen Arthurs, consultant paediatric radiologist;*
*iii) Professor Sally Kinsey, consultant paediatric haematologist;*
*iv) Professor Peter Hindmarsh, consultant paediatric endocrinologist;*
*v) Professor Stavros Stivaros, consultant paediatric neuroradiologist;*
*vi) Dr Simon Kenney, consultant paediatric surgeon.*

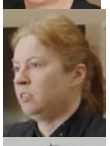
The Operation Hummingbird video

Shortly after the verdicts were announced on 18 August 2023, Cheshire Police posted a video about its “Operation Hummingbird” (https://www.youtube.com/watch?v=Ng7Cs6XPSqU&t=28s). Below is a transcript of the video, together with a list of those involved in the investigation who appeared in the video. Comments have also been appended to the transcript.

It is notable that some police officers who were involved in the investigation (e.g. Nigel Wenham and Janet Moore) did not participate in the video.

DCI Nicola Evans

DI Andrea Price, Central Reception Team



DI Rob Woods, Disclosure

DS Simon Blackwell

DS Ben Hilton, File Preparation

DSupt Paul Hughes

DS Lucy Kennedy (Medical Expert Manager & Family Liaison Officer)

DS Ian Smith, Witness Care Team

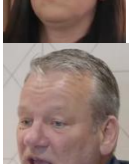
DS Danielle Stonier, Family Liaison Officer

DC Michelle Burkett, Family Liaison Officer

DC Collin Johnson, Exhibits

Claire Hocknell, Analyst

Civilian Investigator and Retired DC Darren Riley



Dr Claire Foster, Consultant Clinical Psychologist

*Voice over (DCI Nicola Evans)*

*I can't begin to imagine how the families feel today. I just hope that today's verdicts bring all of them some peace of mind for the future. And that we have answered some of the questions that they were looking for. Cheshire Constabulary will continue to support all of the families in this case in the coming days and weeks ahead. There will be a period of reflection as everybody comes to terms with what they've experienced here today.*

*DSupt Paul Hughes*

*When we got this - it's not a secret because it's been in the in the media, now that Lucy Letby had been moved off the ward, the deaths and collapses had stopped - the immediate question for me, once I've said yeah we'll investigate that, was well why don't you go and arrest her right now which is a good question, quite difficult not to answer. But ultimately, we've seen many times in investigations like this where we've gone the wrong way, police nationally have gone the wrong way, jumped into a suspect. Now, my view of that was by investigating that it could be any one means we're not focused on one person. Investigating that it could be any thing means we're not focused on any one event. Which means that when you come later on and the defence want to attack your investigation for being 'you chose, it was Lucy Letby', 'you chose it was this event', no we didn't choose that, and we didn't choose that. I actually had a choice. I wanted one of the experts to come back and say 'we found it'. It was a bad bug in the water that happened, and I could tell parents it was tragic, but this is not murder.*

Comments:

1. Why was the announcement made at this point? There would be no reason for them to be proactive so it may be that the press were making enquiries and police felt the need for a holding statement. Significantly, this was the day after DChSupt Wenham had met with Jayaram et al on 17 May 2017. It would be interesting to investigate how and why the announcement was made.

2. Why does Hughes imply that the deaths and collapses had stopped because Lucy Letby had been moved off the ward when he knew that the reason was instead that the unit had been downgraded and other issues such as staffing addressed?

3. "Going the wrong way in investigations like this <u>many times"</u> seems like quite an admission. And how many other investigations "like this" where police had "gone the wrong way" had there been? There have not been that many nurse cases. Did police go the wrong way with all of them?

4. Re "bad bug in the water", that is exactly what might have caused the elevated mortality and morbidity, given the reports of sewage and infection outbreaks. Why was Hughes happy to suggest that the experts were right *not* to come back with that as an explanation? Also, it is clear that Dr

Evans never even considered other possibilities such as poor care, infection, or clinical negligence.

5. Also, when Hughes joined the investigation as SIO he was a DI. So between May 2017 and mid 2023 when the video was made he was promoted first to DCI then to DSupt. Is this normal?

*I'm Detective Superintendent Paul Hughes, senior investigating officer with Operation Hummingbird. What I was presented with was effectively a number of reports written in medical jargon that tried to explain why babies had collapsed and why there was effectively a spike in numbers at the Countess of Chester Hospital. For me, there was more questions than answers, so I determined that we should investigate.*

Comment: the decision to investigate was made in May 2017. This was before Dr Evans was even engaged, so whose reports were these? Or is he saying that the decision to investigate was not in fact made until after Dr Evans had produced his first reports in November 2017?

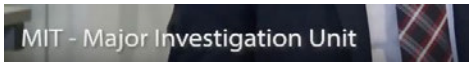
*DS Simon Blackwell*

*You don't often hear of multiple child, baby, infant deaths. They are extremely rare. One is rare enough as it is and tragic enough, but if you have a number of potential babies who have died or been harmed it is absolutely, hugely important.*

*I'm Detective Superintendent Simon Blackwell and the Strategic lead or 'pit four' for the investigation. These things are far from routine. They're extreme, even nationally, internationally, very rare. So, to hear that there may be allegations of such or concern at a hospital in our area, was a huge thing.*

*DS Paul Hughes*

*The way we work on MIT (Major Investigation Unit) is as a team we go and take actions and come back and deliver them actions. But this was different, it was a different investigation. So, we had to go back, scrap that, so I made the decision to give each detective their own investigation.*




Comments:

1. The decision to separate out the key lines of enquiry and to allocate each line to an individual or team of investigators is reasonable. It would be interesting to see what lines of enquiry were

identified and whether officers were allocated to each line. It seems from the narrative that Hughes means that investigation teams were allocated to each questioned baby. Again, sight of the decision log is crucial here.

2. What did it mean that each detective was given their own investigation? Was it that each detective was given a set of babies? This seems odd, given that the investigations into each baby were medical investigations that detective could not conduct.

3. Perhaps Cheshire Police should consider changing the acronym for Major Investigations Unit from MIT to MIU.

*Civilian Investigator and Retired DC Darren Riley*

*I remember going into the office when I first joined and speaking to Paul at length. I knew that there was going to be a case to answer because otherwise he wouldn't be gathering people in. I was given a couple of babies to investigate, one of them, the twins, one of which is an insulin case, and it was very quickly obvious that someone, whether it be Letby or not, someone had administered insulin to this particular baby.*

Comments:

1. How can Riley say that it was "very quickly obvious" that the baby in question had received exogenous insulin when he was not a toxicologist? Clearly he was told that there had been a blood test showing high insulin and low c-peptide and that the only explanation was exogenous insulin. Had he not simply accepted this, he might have searched for and found the laboratory guidance that said there were TWO explanations for such a result, one unnatural, one natural (many others did).

2. If the decision to conduct a major investigation was made on 17 May 2017, it would be expected that a team was being built from the date. As evidence came into the investigation, others may be drawn in. In the early stages of a major investigation resourcing can be very dynamic as the workload changes.

*DS Lucy Kennedy (Medical Expert Manager & Family Liaison Officer)*

*The investigation team realised that they needed expert witnesses to help them with the investigation. They got in touch with the National Crime Agency and so they have a list or database of expert witnesses, they provide the vital key evidence for the investigation. They also advise us as police officers on medical terminology or in medical practises because we are police officers, we didn't have any idea, or I certainly didn't have any idea, about any kind of medical terms or even what to look for within these medical records.*

Comment: It is simply not true that the investigation team contacted the NCA to find an expert to help them. Dr Evans contacted the NCA, and the NCA forwarded his details to Cheshire Police.

*[On screen: Medical Experts]*

*Not many investigations have so many expert witnesses, and not many investigations rely on so many opinions of these expert witnesses. So, it's a totally unique role to policing.*

*I'm Detective Sergeant Lucy Kennedy and part of Operation Hummingbird. When I joined the investigation and started looking through every bit of evidence that we've got, I think it then becomes apparent of just the severity of the investigation. In total there are 8 main expert witnesses and we also have an independent nurse advisor.*

*In July 2017 there was a meeting held with the expert witness. From there we had then the massive task of putting together the medical bundles for him to look through for all the different cases that we wanted him to review. It was quite a challenging task that because it's been described as the medical files have just been thrown up in the air and put back together. It is just the way they were brought to us and we aren't medical experts, we're not even medically minded so it was hard for us to fathom how to put this medical bundle together, which also was a challenge for the expert who then received it to go through. But some of these medical records were a thousand pages long because some of the babies have been in the unit for weeks or months. We then took it to him for him to review and he would decide whether there was a suspicious case or a non-suspicious case.*

Comments:

1. Again, it seems that Dr Evans went straight to the babies and never considered the other possible explanations mentioned.

2. In relation to, "We then took [the medical records] to [Dr Evans] for him to review and he would decide whether there was a suspicious case or a non-suspicious case", it is important to understand why he was given the 33 that he was given. This should be evident in the SIO's Decision Log which should make it clear what criteria has been used to select them. Sight of the Decision Log is key.

*DSupt Paul Hughes*

*What we found out was in neonatal infants it's very clear that they know when a baby is going to collapse and die and parents are already prepared for that and that neonatal units which my expectation was that it's full of sick babies that could die at any moment, it's actually not. So, they explained that these babies do not die, so if a baby collapses, it's usually expected. And even on the outside chance of it being unexpected, it's always explainable. What separated this*

*collection of events away from everything else was that they were unexpected and unexplained, and that was then serving as the key significant factor for me deciding this is not necessarily suspicious at that time, but the events surrounding it needed to be investigated (inaudible).*

Comment: If Hughes learned that it is very clear that doctors know when a baby is going to collapse and die, why did he not consider the possibility that the reason the events were unexpected and unexplained was that the doctors were asleep at the wheel? And anyway, is it true that doctors always know when a baby is going to collapse and die? What about SIDS?

*We eventually received signed statements from Dr Evans, who was our primary lead witness, and Dr Evans had defined in his statements that he thought the children have been harmed by infliction. And a variety of different methods for that. And then at the same time the analytical product had been coming together and the investigative products have been coming together, so reconstructed.*

*[On screen: roster table of Xs showing LL on duty at all the events with which she was charged]*

Comment: why did the roster chart need to "come together"? This comment suggests that it evolved until there was a neat, uniterrupted line of 25 X's, as per David Rose's Feb 2025 article in UnHerd Magazine.

*So, at that point I knew that, in most cases we've been able to prove already that Lucy Letby was present there was more work to be done, and I could prove that it was inflicted harm.*

Comment: "in most cases"? Is he conceding that Evans had identified suspicious incidents that she was not on duty for?

*Civilian Investigator and Retired DC Darren Riley*

*My opinion was very quickly that yes, there was something not right, and yes, the only obvious person was Lucy Letby.*

*DSupt Paul Hughes*

*So, the three things we wanted to try and draw together was:*

- *Medically, what happened? Do we have a murder? Do we have a natural occurring death?*
- *Secondly, what did that shift look like? That was the timely bit because you're taking statements of nurses and doctors.*
- *And then the analytical part which is phenomenal work done by Claire and Kate on building that factual evidence which is: we know Lucy Letby was present. We know, more importantly, other people weren't.*

*Claire Hocknell, Analyst*

*I'm Claire Hocknell, one of the intelligence analysts on Operation Hummingbird. As an analyst, I would have in the past been expected to take part in strategic work in terms of establishing threat areas across the force but also deployed to operational responsibilities. So, if it was burglaries or drugs conspiracy, I'd be involved in looking at the data behind which supported that investigation and trying to really interrogate that data, see what it tells us, what evidence it gives us, and put that into a product to help the investigation team. If it's a proactive job or if it was reactive, putting together a product so that the investigation team, CPS in the court process and understand that information, the parents, sequence of events, call logs. It might be maps of locations or might include CCTV.*

*But this job hasn't been like that. Primarily it was a case of looking at what data was available at that time. Mainly it was, still is, as medical records soon found out that a lot of that medical data was scanned in PDF format and it was just going to be a manual extraction of data so we just had to, I just had to apply the methodology of just reading through and picking it out manually. With this investigation, your mind, your subconscious is constantly searching for the reason for it not to be her even you go months just methodically working through overlaying (inaudible) sequences and then you read something and it just like winds you a bit, and you think, gosh, she really has done this, and then you kind of have to separate yourself out from how you feel about it, you've just like, you got to do the work, you've got to give it justice as to what's happened. You have got to remain impartial and that's how we've managed to, well, how I've managed to continue for nearly six years that I've been working on it.*

Comment: The comment, "With this investigation, your mind, your subconscious is constantly searching for the reason for it not to be her even you go months just methodically working through overlaying (inaudible) sequences and then you read something and it just like winds you a bit, and you think, gosh, she really has done this, and then you kind of have to separate yourself out from how you feel about it, you've just like, you got to do the work, you've got to give it justice as to what's happened", betrays bias in the investigation. Where is the evidence that all explanations for the elevated mortality and morbidity were being considered, rather what appears to have been the case, namely Lucy Letby having been the starting point? There is also no evidence that records had been redacted, something that would have been necessary in order to eliminate or at least reduce confirmation bias. There is no explanation of a methodology that was designed to avoid inappropriate bias. Again, access to Decision Logs is key. There should be explicit instructions from the SIO as to how the intelligence analysis should be conducted.

*DSupt Paul Hughes*

*[On screen: June 2018]*

*I'm going to declare now it's criminality. Tell parents. We're going to bring parents in and tell him for the first time we think their baby's been murdered and attempted to be murdered. Many, many with twins, triplets, siblings, all affected.*

Comment: It is not clear whether the analysis allowed for non-independence. In fact, the appeal case looks as if it did not.

*DC Michelle Burkett, Family Liaison Officer*

*We initially went out to speak to, I think about 28 families then and we were all given a formal words to explain to the families that there will be an investigation: from this period of time your child was born there or sadly some of them passed away there and we would be looking into the circumstances around that.*

Comment: Evans was given cases of 28 babies to appraise in July 2017, pertaining to around 25 families (there were several multiples). So, where did the "28 families" come from?

*I'm Michelle Birkett, I'm a family liaison officer and also (inaudible) coordinator. So, they were told very little at the beginning because we didn't know anything at the beginning.*

*DSupt Paul Hughes*

*It's horrific for the parents to have to deal with, because in my view, in a case that's gone like this so long, they've dealt with the loss of their child. And then again, and again and again. More trauma each time we do something, each time we arrest, each time we make a decision, each time we charge, parents are reliving.*

*At that point I had difficult decisions to make. In fact, the hardest decisions to make of my career. I think it's fair to say at that time, and probably still so. Do I arrest Lucy Letby for multiple murders and attempted murders.*

*DS Simon Blackwell*

*So it comes to 2018, we're at the point in the summer there that we were in a decision where we had a suspect, we believed there was criminality that had happened against a number of babies, some of which had died. And the next stage then, balancing risks and reward, was to arrest and effect an arrest. And against, you know, potential ramifications of saying, publicly, because the arrest would become public that we have a child serial killer. So that is not something that you want to get wrong.*

Comment: If that is something Hughes did not want to get wrong, why put Lucy Letby in handcuffs when that was clearly unnecessary? Why were journalists camped outside her home the day before? Why refer to "child serial killer" not "suspected child serial killer"? And why use the emotive term "serial killer" and not something more formal?

*[Audio from video released on 3rd July 2018]*

*[on screen: July 2018] We have today arrested a healthcare professional. She was arrested this morning on suspicion of the murder of eight babies and the attempted murder of a further six, and currently remains in custody.*

Comment: The “eight babies” suspected of having been murdered included Baby K. A few months before the trial started, the prosecution offered no evidence in relation to this murder charge so a “not guilty” verdict was recorded (at the same time, four other babies were added in relation to attempted murder charges). To have charged Letby with murder of a baby who died at another hospital is a major error and suggests very poor record keeping.

*DC Michelle Burkett, Family Liaison Officer*

*Families were all told of the first arrest. You're knocking on the door and you’re turning their life back upside down again. They've already gone through the bereavement of saying goodbye to their last child, and then you're knocking on the door and telling them, well, somebody is responsible for your baby not being here anymore or somebody is responsible for what's happened to your daughter or son, and the condition that they are in now. The reactions vary. Disbelief, some of them because some of the families had gone on and raised money for charity for the unit and just couldn't believe that somebody could be, you know, responsible for what what's happened to them. And then some of the families, ‘I knew something was wrong. I knew something wasn't right, I knew my child was not right’.*

*Family liaison officers were brought in as a point of contact between the family and the investigation. Rather than a family member having twelve different detectives phoning them with twelve different bits of information, they have a single point of contact.*

*DS Danielle Stonier, Family Liaison Officer*

*You are the link at between the investigation and the families involved, so the victim's side of the family.*

*I’m Detective Sergeant Danielle Stonier. I’ve got 18 years of service and I currently work on Operation Hummingbird. It's a really difficult and challenging role but also really rewarding as well. You're there to kind of keep them updated about the investigation, speak to them and gain any evidence that they've got to offer, if you need to get statements. A lot these families haven't had any involvement with the police in general, let alone an investigation. So, it's about making sure they understand every step of the process and feel supported and that they feel informed.*

*DC Michelle Burkett, Family Liaison Officer*

*It's not all done on day one. It's done in little steps. First initial contact is made and sometimes you can be the one that's actually breaking the news that you're knocking on the door of somebody you’re very aware that you're going to change their life forever. You are there giving*

*them bad news that their daughter or son has been killed and you take them through the whole process, to visiting them in the mortuary, explain circumstances of how they have died. In this particular incident under investigation, a lot of the family liaison officers didn't have to do that. It was more about explaining to the families what's happening, when it's happening, and why the period of time is sometimes lengthy.*

*DS Danielle Stonier, Family Liaison Officer*

*I've been a family liaison officer for a number of years and no job has been the same, no family has been the same that's supported. And it can look very differently. People's needs are very different. So, it's really important to kind of set out an understanding at the start so they are aware of what they can expect from me. But also what I will be looking at from them. So it can be something simple as, how often do you want me to phone you to check in? Do you want to be contacted every week? Even if I've got no information, do you still want a call? Or do you just want me to call you any pertinent points?*

*DSupt Paul Hughes*

*The arrest was planned for the purpose of obtaining evidence by questioning. Obviously, our evidence and statistical analysis showed Lucy Letby being present at everything so there is, in effect, she's a suspect, but she's also the key source of information. She knows more about this case than anyone else because our evidence would suggest that she's been there. Because of the very size of the investigation, it took that time, it took that first year, fourteen months to build enough evidence to be able to put us in a position where we could ask her realistic questions and have some pretty robust knowledge about what we know is going on.*

Comment: As there was no statistical expert, who did the statistical analysis?

*DCI Nicola Evans, Deputy Senior Investigating Officer*

*It's really difficult to explain the depth in which the investigation has gone through in such a short period of time. To put that into some context, when the interviews took place, it was really important that every single baby was covered in as much detail as possible because that's what they deserve. They deserve for us to have completely covered their case and it is about them, and it is about their parents.*

*I am Nicola Evans and Detective Chief Inspector, Cheshire Constabulary, and I am the deputy senior investigating officer on Operation Hummingbird. I was employed onto the operation in March 2018, which is a little while after the investigation commenced and my role initially it was as a specialist interview advisor in relation to how we obtained evidence from witnesses and also how we interviewed the suspect.*

Comments:

1. As the Specialist Interview Advisor Evans should have prepared the Interview Strategy for approval by the SIO. Access to those documents would be useful.

2. Was Evans senior to Paul Hughes in March 2018 (DCI v DI) but junior to him in 2023 (DCI v DSupt)?

*[Video of LL being interviewed.]*

*LL: They told me that there had been a lot more deaths and that I'd been linked as somebody that was there for a lot of them.*

*Officer: Did you have any concerns that there was a rise in the mortality rate?*

*LL: Yes*

*Officer: Okay, so tell me about that, what concerns did you have?*

*LL: I think we'd all just noticed as a team in general, the nursing staff, that this was a rise compared to previous years.*

*DCI Nicola Evans*

*Those interviews took a great deal of time to ensure that they were meaningful, they were direct, but also that all of the evidence had been put to the suspect in the correct way so that it could be used later on during the trial.*

Comments:

1. The decision of whether or not to use the interviews at trial would have been a tactical one by CPS & Counsel. Their decision will have been based upon a Record of Taped Interview (ROTI) prepared by the police, this is a document summarising what the police consider are the key relevant passages. The defence will have been given copies of all interviews on CD/ Digital as well as the ROTI, so both Prosecution and Defence Counsel could have compared the interviews with the ROTI documents to identify whether the records were fulsome and relevant.

2. It is notable that during the many hours that Lucy Letby was questioned, she never incriminated herself. Prosecution counsel had to resort to telling jurors in closing argument that they could interpret Letby's handwritten notes as a confession, rather than referring to anything incriminating in the police interviews.

*DS Danielle Stonier, Family Liaison Officer*

*Those first interviews are really, really important because it's when they first become aware of a police investigation and potentially that they're being classed as a suspect.*

*Claire Hocknell, Analyst*

*When Lucy Letby was first arrested and the material that came back into the investigation room at that time. We just, our minds blew, it was like, wow. This this is her. This is her life.*

*[On screen: the post-it notes]*

*DSupt Paul Hughes*

*The amount of evidence we recovered from her home address was just not expected. So, thousands and thousands of documents, many devices that led to downloads of half a million pages of information that we didn't expect to find. We didn't expect her to have kept a catalogue year on year on year.*

Comment: Why not? Many people keep stuff. Hughes wants to convey not only that finding thousands and thousands of documents is unusual (it isn't) but that they incriminated her (they didn't – if they had, she would have had plenty of time to destroy/delete them). It is important that there is no comment upon whether the material related only to babies who were subject of charges or whether it included many others where there was no evidence of harm. It is clearly more significant if Letby kept documents relating to - or searched the parents on the internet in respect of - the babies subject of the charges, than if she just generally kept stuff and searched. Furthermore, was there any comparison with any other nurse or doctor? As police expectations 'evidence'? Many other nurses report keeping stuff and taking an interest in families etc.

*Claire Hocknell, Analyst*

*Going through her phone, and I can't remember the name of the article, but it resonated with me when I read it: as human beings, we all are more alike than we are different. So, reading through her phone, it was remarkably normal. For a lot of it, and it's not until you overlay times and dates of some of the things that she's saying, in text messages or whatever, WhatsApp messages. Is that the timing of it? As well as what she's saying, that really, you can pick up those patterns and as an analyst that's what you're trying to find it's these patterns to things.*

Comments:

1. Remarkably normal? Wasn't it also said that it was abnormal to find so much?

2. As for finding patterns, how statistically valid were they? There appears to be projection of a narrative onto material which leads to unconsciously fitting the pre formed schema into non existent patterns. It is what humans are programmed to do by adaptive drives but which should be guarded against in a professional investigation. Patterns require explicit definitions of what is expected, and why - the assumptions made. Then one requires a comparator dataset or two. That's was is required for patterns such as fingerprints or DNA i.e. do you agree with the interpretation?

*DSupt Paul Hughes*

*[On screen: August 2018]*

*Between '18 and '19 particularly that was the key focus, all the evidence that we recovered from the address. There's more medical evidence, pathology, more peer review work. But the*

*review of the exhibits found at the address took a long time. And then what came from that is a load of inquiries, external inquiries across the country, different parts of the country tracking people down who'd known Lucy. As we started building up a suspect-ology if you like of history of her trying to look for, in any way, shape or form, answers to maybe 'why?'*

Comments:

1. More peer review work? Why was a full independent review not conducted?

2. The sentence, "As we started building up a suspect-ology if you like of history of her trying to look for, in any way, shape or form, answers to maybe 'why?'" is gobbledygook.

3. As for "answers to maybe 'why'", the police never put forward a motivation. One may wonder why this was though, to be fair, they don't have to. An extant motive is not required in murder cases. The key issue here is a complete lack of evidence inappropriately bolstered by unsustainable inferences as to material interpreted within a skewed lens.

4. Hughes' remarks do make it clear that the focus was only on Letby. Was anything equivalent done for any others? Sight of SIO Decision logs would shed light on this, but it appears that no investigation of any other potential suspect was conducted. Or indeed into other explanations such as infection, etc.

*[On screen: June 2019]*

*We need to stress we needed to ask her more questions, but subsequently three further cases of attempted murder by this time have been identified. So we wanted to ask her about them. And also, we knew that she would write a lot and she did we've seen it during the first arrest, so we wanted to arrest her and see what she'd been writing about. Maybe in the year that we've been investigating.*

Comment: It is clear that Hughes was delighted the handwritten notes that were found, given that among the many scribblings of clearly traumatised and innocent individual, there were one or two that appeared incriminating. The prosecution told jurors they should consider the notes to constitute a confession. Hughes must have too. They clearly weren't and he knew that.

*DI Rob Woods, Disclosure*

*When Miss Letby was arrested for the second time, I was tasked with planning and coordinating the search of her home address in Chester.*

*My name is Rob Woods. I'm a Detective Inspector on Operation Hummingbird. My primary and sole role now is lead for disclosure in the investigation. The amount of material we found at her home address was I think a massive surprise to us when she was first arrested, but it gave us a really good steer on the second occasion as to what sort of things we were looking for. So, as*

*an example, something that's proved very useful to the inquiry has been Miss Letby's diaries. There appeared to be, and it became clear later that it was, almost a code of coloured asterisks and various other things put in a diary that marked significant events in our investigation. So, when we went to search the address for the second occasion that was something that we knew we were looking for because we didn't have the complete chronology, there were a couple of years missing, so that was a very clear item. We also knew that she was a copious writer of notes. Now we saw that perhaps having been arrested, you might stop doing that. It turned out when we searched that second address, she had continued to write her thoughts and all sorts of processes about the investigation, about the events that she was being investigated for. So yeah, we seized quite a large amount material in that second search.*

Comments:

1. 'A code of coloured asterisks' sounds sinister. Did police ask Lucy Letby about them? And what were the 'other things that marked significant events' in the investigation. Did they mark all the events? Were there similar things that did not mark events? Were patterns being seen where they were none? Many people asterisk things in diaries - there has been no attempt to adduce evidence that the markings were on key dates, or indeed what they inferred that they meant. Even if the markings were in some way related to events at the hospital, Letby was aware that deaths were high on the unit and was presumably worried about it even before she knew she was under investigation.

2. Re, "Now we saw that perhaps having been arrested, you might stop doing that", did police not consider that it was possible that the reason she did not stop was because she was innocent?
3. There is an implicit assumption of guilt in expecting her to stop writing. So one could interpret not stopping as a demonstration of innocence.

4. Re, "she had continued to write her thoughts and all sorts of processes about the investigation, about the events that she was being investigated for", why on earth is this suspicious? Surely it is reasonable that if you are under investigation for murder, you keep track of what was happening? And a good nurse would be used to careful observation.

*[On screen: Exhibits]*

*DC Collin Johnson, Exhibits*

*During the course of the investigation, Operation Hummingbird generated over 4,500 exhibits, their spread over 130 scenes. Our day-to-day business is to ensure that the exhibits recovered are stored safely, are processed and that the information that they may contain are disseminated to the investigators. During the trial there have been a number of instants where prosecution counsel have requested and exhibited short notice to be shown to the court. You can imagine trying to find something, one item within 4,500 can be quite daunting, so we have a*

*process where we're able to identify where the exhibit's been placed, where it's been stored to ensure that we can recover it quickly and efficiently.*

*During the course of the operation, the police searched Lucy Letby's property on four occasions, during which items of significance were recovered. Some were medical notes, medical records relating to patients of the hospital. Obviously searching officers, we're aware that this sensitive information shouldn't have been in a domestic setting so that was recovered. I think in total we recovered 257 individual A4 pieces of paper that list patients' names and their conditions.*

Comments:

1. Johnson is referring to handover notes that were found at Lucy Letby's homes, implying that was suspicious. It wasn't. 1) handover notes are not part of patients' medical records, 2) nurses often take handover notes home by mistake, 3) they cannot have been trophies as suggested because many of them did not pertain to babies on the indictment, 4) if she was guilty, and had been smart enough to not be seen harming a single baby, she would surely have been smart enough to throw away the handover notes.

2. 'Unused material' includes all material generated during the investigation and would include documents, digital material and physical exhibits. Material relevant to the prosecution will be included in the prosecution file and presented to the court. All other 'unused material' including physical exhibits must be retained and assessed for its potential to undermine the prosecution case or to support a defence case, if either case pertains then they should have been disclosed to the defence. It should be assessed whether this was properly done but this would require a review in detail of the disclosure schedules, something that would happen in a full independent review of the investigation.

*[On screen: June 2019]*

*DC Michelle Burkett, Family Liaison Officer*

*Then she was released. The frustrations came on the release. They wanted to know why, and it was all about getting the evidence together.*

*DS Danielle Stonier, Family Liaison Officer*

*You could see why at the time, and it was all because we needed to get the evidence as strong as possible for the charges. And you can see why the CPS lawyer involved made that decision to keep on re-baling her and for me those were low points in my role as a Family Liaison Officer. Because we needed to make those phone calls and try and explain why her bail was being extended for another six months on top and it's going to be six months until we reach that next milestone of the investigation of potentially Lucy Letby being charged.*

*[On screen: November 2020]*

*DSupt Paul Hughes*

*The third arrest in November 2020 was because we had exhausted sufficient lines of inquiry and that's where we were really, you know, because if we got any further, we'd have probably lost the opportunity to interview her a final time and we wanted to ask some questions and the Crown Prosecution Service wanted us to ask some questions. But if you get too far and you're already in a position where you know you will charge, then PACE only allows you to clarify some things it doesn't allow you to investigately question. So it was that balance where we're almost satisfied, but not quite and we had conversations with CPS. It just seemed the time was right, the stars that aligned in evidential process and we arrested her and at that third point we had every intention of arresting her and seeking charge advice and being successful with getting charge advise.*

Comments:

1. The comment "…we'd have probably lost the opportunity to interview her a final time" is nonsense. The only time that police are restricted in their ability to question is post charge when only clarification questions can be posed.

2. Hughes is suggesting that if police and CPS are close to being satisfied that they have sufficient evidence then they would be restricted. This is not the case. Police can continue to question (within the PACE time limits) up until he point of charge, the timing of which is a matter for Police & CPS.

3. If they knew they were going to charge, why mention, in almost the same breath, 'if you get too far and you're already in a position where you know you will charge, then PACE only allows you to clarify some things it doesn't allow you to investigately question'?

*DI Rob Woods, Disclosure*

*I coordinated plans and executed if you like the final, third and final arrest of Miss Letby at her home address in Hereford. Again it's something I remember very clearly. There was a lot of planning that went into it, because the worst thing would have been to turn up in Hereford and not be there or us not being able to arrest her so there was a massive amount of planning. But ultimately the whole of the team, all of the interview team here, all of the search teams, all of the investigative team were all waiting for me to make that call and say yes, she's under arrest and we're our way back so I don't think I slept a lot the night before.*

Comments:

1. Why was there a massive amount of planning? On the police video that was released to the media it all seemed very straightforward. They must have known that Lucy Letby's arrest would be extremely easy. As for the handcuffs…

2. It seems strange that 'risk' was a consideration. Letby had been cooperative in the past and was likely to be so in the future.

3. As for the first arrest, a standard approach would have been to contact her solicitor and invite Letby in for interview in the first instance. If the approach was declined then arrest.

4. This nature if the arrests appears disproportionate and may give further insight into the mind set of the investigation.

> *I remember getting up very early, 3:00 in the morning. We met at Blacon and we drove down. It's an hour and a half, two hours even at that time in the morning gave me a lot of time to ruminate and think about what could go wrong. I do remember having a great relief when we knocked on the door. Mr Letby opened the door and it was all very low key. Obviously despite the severity of this investigation, not a suspect posed a great deal of risk to us as police officers so it was a very low key arrest. A gentle knock on the door, went in, we explained why we were there. They knew because they'd been through it twice before. Miss Letby's mum was very distressed but Miss Letby herself, she complied, was very subdued.*

Comments:

1. A low key arrest? Didn't it require a "massive amount of planning"?

2. Miss Letby was subdued? Having thought about doing a runner, she must have realised that it was pointless to resist....

> *Did I know that we were going to be getting charges? No, I didn't. Did I know that we were going to be asking for charging advice. Yes, I did. And again, I think that added a little bit of extra weight to 'we must get this right'. So, everything must be done absolutely by the book. The procedure must be perfect. Because this will be scrutinised at court and will be scrutinised by the defence and do not let the team down because as I say if we'd messed up that initial bit of arresting all the other planning and all the other bits, the team that were waiting, would have been for nothing if we'd not secured it. So yeah, I do remember the door closing on the BMW that she was going to be driven back up to Chester in. And her pulling away, me phoning Detective Inspector Hughes as he was at the time and saying 'yep job done'. She's in the car. She's on the way. That was definitely a moment of, I can relax a little bit.*

> *DS Danielle Stonier, Family Liaison Officer*

> *After we'd finished the last lot of interviews with Lucy Letby there was a team I was working upstairs in the custody unit, 7 or 8 of us in there. It was intense. It was intense. Because we were going to the CPS and we were going to seek charging authority at that point. And also we're all just praying that that we did have enough at that point. We were confident we did. We'd already had early indications that she would be looking to charge.*

> *DCI Nicola Evans*

> *A key moment for me really was the charge, at the charge stage of the case. Until that point, we were working really hard as a really small team on this case and also not talking about it elsewhere and to anybody else because it was really important that we kept the integrity of the investigation, of the exhibits, of everything that we've found and to ensure that when the trial did come around, that it was a fair trial. And so once we got to the point of charge it felt like a really momentous occasion that actually now we told the Crown Prosecution Service and we've gone through the evidence with them and that they'd authorised those charges and that was really a big day for the police team and clearly for the families in the case, it was huge.*

Comment: A really small team? Wasn't it a really big team?

*DI Rob Woods, Disclosure*

*And I remember the phone ringing, Nicola herself, she picked up the phone, you could tell from the conversation she was having that the CPS were telling her that the e-mail was on our way to her with the charging advice. CPS didn't say which way that charging advice had gone and I remember her putting the phone down, just looking at Paul saying it's here. There was then maybe a minute of silence while she read it, and I remember her just looking at Paul and saying all of them, she's charging all of them.*

*There was no celebration. We did shake hands and there was kind of almost a relief. I don't know whether they'll thank me for telling you this or not, but Paul and Nicola felt that they simply wouldn't be able to give the team that news. I said that I thought I would be able to do it. I wasn't sure if I'm honest, but I said I would be able to do it and about 5 minutes later we called the whole team into the office and we told them that we had the charging advice in and I stood, and I read out charges relating to the 17 cases individually.*

*DSupt Paul Hughes*

*The charges were read out and I didn't know what people would do, would people clap, cheer, celebrate, cry. And it was, it was nothing. Not in it was nothing. It was nothing as in it was absolute silence. You could have heard a pin drop. Nobody said anything. Some people became emotional, took themselves out the room. People left the room to spend some time on their own. And it was probably about 10-15 minutes before anybody said anything. It was almost like, you know, everybody's, instead of being something celebrate, I think there was, it felt like a profound loss. I think it was that realisation when you heard it in that context. All these babies have been murdered. They, you know, I think there was a realisation of actually people who have children of their own or seeing their own children grow up, what that actually means now, we're saying that these children who all had their lives, had they not been murdered or damaged of affected or inflicted by an attempted murder by Lucy Letby.*

Comment: "All these babies have been murdered"? How did he know? Wasn't that for the trial to determine? What about the presumption of innocence? The children might well not have lived, even if LL had not been a nurse at CoC.

*DCI Nicola Evans*

*There was actually just an overwhelming feeling of sadness. Everybody had worked to that point and almost look forward to getting to a point where we could tell the families this is what was happening. But it actually was an overwhelming feeling of just real sadness really to kind of a watershed as to what had happened and that we were going to take this case to trial and everything that that meant for the people involved.*

*DS Danielle Stonier, Family Liaison Officer*

*And I remember it really well. There was myself and my colleagues who carefully I've interviewed with. We were stood in the in the custody area at the back and Lucy Letby was brought out of the cell and it was another colleague who read out those charges to it in custody*

*because the number of charges it took it took a while. And hearing those names and hearing each individual charge was a bizarre feeling if I'm honest as I say it was a feeling of reality that this is happening, of getting a case and investigation trial ready as such is on a totally different scale, totally different scale. So as much as everybody was grateful to get to that point, the reality hit that this is when the hard work really does start now.*

*DC Michelle Burkett, Family Liaison Officer*

*Looking back at what we've all been through, I've been a family liaison officer for a very long time. There was one point where we had to go out and inform all the families that she'd been charged. And we also want to go out and inform those families prior to the charge of her arrest and what we were looking at, the fact that she may well be responsible, or is responsible, for the death of their children and you do that on a murder, you'll drive along to the family, you'll knock on their door and you'll introduce yourself and you'll explain to them what you're there for and the circumstances around it. And then you'll spend time with them explaining what's happening and the process that's going to come after. Then we get back in the car. We normally go home. We had to do that five times. We had to go once, gather your thoughts, and go another time. And I explained this to a colleague, I said, how did you feel that night? And he said it was one of the most draining, emotionally draining things he's ever had to do. That was a difficult challenge for us as individuals.*

*From memory, as some of the families, the reactions, you can't say joy. They've been waiting a long time for it. But there was tears. There's no happiness, they just want somebody to be held responsible for whatever happened. So, either their child, the collapse, or their child not being here.*

Comment: Regarding the comment, "*That was a difficult challenge for us as individuals",* it will also be very difficult for the families and the officers if the conviction is demonstrated not only not to be safe, but if the whole analysis is invalid.

*[On screen: November 2020]*

*DSupt Paul Hughes*

*It's that overwatch aspect to the families at the heart of what we do. It was so important for us as a team that they got their time in court, and it wasn't affected by clerical or administration errors or errors in evidence and where is everything we've done so far going to get its most stringent test. And it's right there in the courtroom. (Inaudible) 10% excited it was getting started and a 90% nervousness that it runs well. Work starts now again. In preparation for what's going to be a massive trial, make sure that the disclosure machine swings into action and the amount of challenges we believed we had really became a reality at charge, but because we'd allocated a number of events to individual officers there was real team ethic and a real team bond that I don't believe I've worked with before. I've worked with some terrific teams in my career. But this team, on this job, people were doing it because they had such a best interest. I genuinely believe if you'd said to people 'we're not paying you' they'd come in.*

*[On screen: Disclosure]*

*DI Rob Woods, Disclosure*

*When you charge someone with a crime and you're going to go to court, you have evidence, so you have statements, you have exhibits, you have documents, you have officers' reports, all of those are joined together to form your case. They're your evidence that you say proves that the person on trial is guilty of the offence. However, when you investigate any crime, whether it be a shoplifting or multiple murders as we have here, you also collect a lot of material that isn't evidence, but you still have that material, and disclosure is, in very simple terms, the process of how you deal with all the other material that isn't your evidence.*

*In terms of unused material, which is all that material that isn't evidence, we're currently standing at 16,571 items. But what has to be remembered, of course, is that some of those items themselves are thousands of pages long. Disclosure is absolutely vital to a fair trial because when you hear of jobs being thrown out of court, the vast majority of those will be because of mistakes or failings in disclosure, often not deliberate, but mistakes of failings of disclosure is what causes big investigations to fall down.*

Comments:

1. Not all of the 'Unused Material' is required to be disclosed to the defence. The Disclosure Officer/ Team must record and retain all material obtained or generated by the investigation, then review each item to decide whether the material may tend to undermine the prosecution or support the defence (which they will be aware of since the defence are required to submit a 'Defence Statement' of their key issues, this will guide the disclosure team in understanding whether any item of unused material may tend to support the defence case.)

2. This duty to review the relevance of unused material is ongoing, and as the case progressed including during the trial the disclosure team must be aware of the progress of the case in order to assess whether there is anything not yet disclosed that in the current context needs to be.

3. With regard to "*material that isn't evidence"* how did they decide what was evidence and what wasn't evidence. How were these defined. Were the deaths of babies that were not in the roster chart presented in court not considered evidence? The decision is that of the Police & CPS. Not all material can be out to the court, it would be too much and confusing. Sufficient relevant evidence is put into the prosecution file by the police and reviewed by CPS. All other items of 'Unused Material' are dealt with as above.

4. How much of the unused material was not disclosed to the defence? If there were 16,571 items, some of which were thousands of pages long, how was Woods single handedly able to determine what should be disclosed? The figure of 16,571 items relates to all "Unused Material'. Each item should have been subject to review as described above and if material may tend to undermine the prosecution or support the defence then it must be disclosed to the defence. It will only be known whether everything was properly disclosed if there is a full independent review.

*DS Simon Blackwell*

*Post charge, late 2020 I was able to have discussion with colleagues at the Home Office and submit an appropriate financing, bid, if you like, which ultimately means that it's such a huge case of clarity and importance that necessitates extra funding. It's out of mainstream business. The force needs support. And that's enabled the team plus the support the force has put in in the PCC to grow from sort of single figures to you know, 60 or 70 staff across lots of disciplines*

*whether it's analytical, administrative, finance, civilian investigators, detectives to actually be an investigatory body and team. A department in itself, out of mainstream business, give justice and deliver the best investigation we possibly can.*

*It required an approach as how we would manage the witnesses, how we manage public contact, the information that was coming on, understanding, I suppose, what was happening in the media. And the social media. So we did a lot of sort of assessment of what had been done before nationally on large operations and got some good learning or insight, but then tailored an approach that would work (inaudible). So, we set up a dedicated witness care team. The force and other forces have a good support usually. The witness care as the run up to trial, which was good, but it needed bolstering and it needed a real coordinated approach because we had scores and scores and scores of witnesses. So that was a unique thing and I would certainly advocate similar for future cases of scale, definitely.*

Comment: Extra funding was indeed granted. As an aside, there is a huge imbalance between resourses, financial or otherwise, available to each side. Given the presumption of innocence, this seems wrong.

*DS Ian Smith, Witness Care Team*

*[On screen: Witness Care Team]*

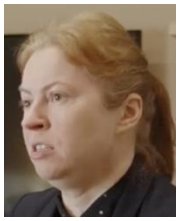
*On Operation Hummingbird I've have managed over 100 witnesses, which for me is unprecedented. I've never known this happen in Cheshire Police previously and in fact I've never known it happen in anywhere across the country. There's no other investigation like this, so it's a privilege to apply for a job and be successful to get on the investigation. I think it was very important to pick the right staff for this role due to dealing with anxieties of all the witnesses and the staff have been excellent. My role was to engage with the witnesses and speak to the staff at the NNU [neonatal unit] and explain what we could do for them in the months of the trial. The first struggle we had was the anxiety levels of the staff. All of the staff would work alongside the defendant for a period of time, and some of them were actually friends with her. So we had to get an engagement, build rapport with them. I went in a number of times just that my staff to introduce ourselves and to tell them what we could expect from us, what standard of service they could expect. Some of that was initially met with negativity insomuch as we said, we'd run every witness to and from court. If they wanted to come independently, we would facilitate that for them. And the initial response is you won't be able to do that. But I assured them that we would and we did. We've driven over 15,000 miles transporting witnesses to and from court. The reason for that is the worry. Going to court and driving home from court, we take that away from them by making sure they get home safe and get to court safe in the morning. They need to give best evidence, achieving best evidence at court and but by us reassuring them, transporting them to and from and bear in mind some of these witnesses have come seven or eight times. It's not like a normal case where you go and give your evidence once and then you're released.*

*DS Simon Blackwell*

*We envisaged a lot of media interest coming into the investigation. We knew it anyway, but certainly at trail. So we looked at options and decided to create a mini hub, if you like, within the team called the Central Reception Team and ultimately that was some digital media investigators, some intelligence staff and some detectives and basically we'd take the ownership of public contact, contact in the force by emails, potential phones, questions, letters, whatever, into our team so that we could assess real time.*

*[On screen: Central Reception Team]*

*DI Andrea Price, Central Reception Team*



*I'm Detective Inspector Andrea Price. I've been working on Operational Hummingbird for a number of years now, I'm a detective, you want to turn every stone and make sure you're giving absolute best to families. And I know that's what's happened from day one. We obviously gathered information from other large-scale investigations before the trial to see, you know, how they set up their processes, what could we take from them and any learning that we could implement. And one of those things was visiting the Hillsborough Inquiry, an investigation that was run for that. They implemented what's called a Central Reception Team, the reason being because of the volume of both families that were involved in that investigation and also the level of content they're expecting, they set that up separate to the major investigation room because they didn't feel like that were able to cope. So, we decided to bring in this Central Reception Team a couple of months before the trial so we had the systems in place that we could test and make sure were working before the trial began and that has been very much used throughout the trial effectively.*

*Rather than going to the control room, any member of the public that contacts Operation Hummingbird goes through to our Central Reception Team and they monitor and deal with all public inquiries. They monitor and assess any threat risk or harm related to social media or wider additional environment. I mean obviously the scale and national interest of this investigation has generated a large amount of both national and international media attention and again that was one of the reasons we set up the Central Reception Teams to both monitor and manage anything to do with the media.*

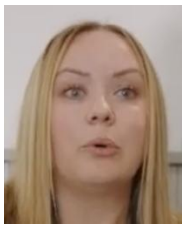
*DS Simon Blackwell*

*Another really good and innovative area of the business that we've put in place was the embedded consultant support. So we have within the team, led by a local company consultant psychologist support, an appropriate nursing and mental health awareness support. This has been available for all our staff who are dealing with obviously really emotive and upsetting area of business, childbirth, and so all the team have the ability to drop in or have structured support, debriefs, interviews and referrals for extra help and that's been widened to our families*

*and that's been really beneficial and enabled us to retain staff and ensure that everybody can work to their maximum potential.*

*[On screen: Psychological Support]*

*Dr Claire Foster, Consultant Clinical Psychologist*



*I'm asked to be part of this, it's a huge privilege because it hasn't ever been done before. We've learned a lot really within the last, say, 10 years, The Hillsborough Inquest, the Manchester Arena inquiry and within both of those I am really pleased to know that there was psychological support available for the families. However, nothing like this to my knowledge has ever been done with a criminal trial before. Cheshire Police have definitely invested in the principles of psychological safety, but that being across the board for their staff, but also for families who have been involved in this process and what we've been able to put in place is a provision of a therapist support who is at court every single day that this trial has been ongoing. That means that they are there on a very informal basis. They are there every morning when the families come in. They are there to be able to provide informal support, listen to how they are experiencing things and be part of a very informal conversation. That is, help them to build a rapport with those family members and importantly then to be able to do one-to-one work with the family members. If they have decided that is also what they would want to have. And I think as a psychologist it's the ripples. This is about thinking that an incident, multiple incidents in this case have happened. But the way that that mushrooms out and the way that that affects individuals, families, extended families, communities, organisations, every part of this investigation and people who've been part of it, that will resonate with them. So, we set up a strategy where I'm here every single week and on a rotational basis, generally every couple of months, I will see each member of staff. And I provide that one-to-one support.*

Comment: there is a concern here that a psychologist supporting investigators re potential trauma should also be supporting family members who were also witnesses. The psychologist is likely to be biased towards the mindset of the investigation, and this may influence the witnesses. Psychological support for the families should have been provided by Witness Support agencies not police.

*DCI Nicola Evans*

*Part of the preparation for the trial was around how the investigation would continue during trials, so even when trials are unfolding and underway, the investigation doesn't stop and we continue to follow lines of inquiry, we continue to follow up evidence that the witnesses have given and also that when and if the defendant gives evidence then we continue to work closely with the CPS and counsel to ensure that we're following every line of inquiry correctly. So very early on it became really apparent that we needed a police team within Manchester because the trial was being held at Manchester Crown Court and so it was really important that we had the correct officers there to be able to support the families who wished to watch the court from*

*that location and also to support councel and the CPS with any further actions that they wished to continue as the investigation continues to move on during the trial.*

Comment: Did Lucy Letby mention the sewage during police interview? If she did, was it followed up? It appears not.

*[On screen: File Preparation]*

*DS Ben Hilton, File Preparation*

*So I'm Ben Hilton, I'm a Detective Sergeant and I'm the file team and case management supervisor for Operation Hummingbird. The file team is essentially made up of three detectives who act as officers in the case for the seventeen individual cases that form the indictment and they're responsible essentially for the evidence and the file preparation that's involved with each of the 17 cases. So once Lucy Letby had been charged, there was still a huge amount of work that needed to be done to prepare the case for trial. There were still multiple lines of inquiries that were being followed. Experts were still reviewing cases. There was lots of analytical work ongoing to prepare the sequence of events, and so the file team would periodically prepare large submissions of evidence that we'd send to the CPS. So we'd essentially act as the liaison between the inquiry team and the CPS and that work carried on all the way up to and during trial those submissions of evidence. I think that the challenge of it has been because of the size and scale of the inquiry we're essentially dealing with 17 cases of murder and attempt murder in one trial. So everything that we did, all the evidence we prepared was essentially multiplied by 17.*

Comment: There was indeed "lots of analytical work ongoing to prepare the sequence of events", including how 28 families became only 13 families?

*Civilian Investigator and Retired DC Darren Riley*

*The case building for Hummingbird was unlike anything that we'd done before, there's a set procedure using Holmes [computer system used to manage serious and complex crime investigations] and the files are built within Holmes. Everything is done in a in a specific way and that's the way we've always done it, murder after murder. It was different for Hummingbird. So we liaised with CPS and they didn't particularly want it like about, they wanted more of an electronic version in folders, more like the way we did files when we used to handwrite them when I first joined the job we used to hand write files and send them off.*

*DS Ben Hilton, File Preparation*

*A large part of the work that was ongoing in child preparation was the analytical work so that was led by our two analysts as they prepared sequence of events in each of the 17 cases. And one of the other challenges was how do we present the information that's been gathered at trial. You know, in most cases, you have something that's visual for a jury, you know, you might have CCTV of an interaction or photographs of a crime scene or of injuries or of weapons, but with the Hummingbird inquiry there wasn't much in that way, there wasn't much that was visual. It was that real challenge to present the information that we gathered to the jury in a way that they would understand and that was easier for them to follow because the vast majority of our evidence was medical records and it's difficult to put that into a format that's easy to understand and that engages the jury. So we instructed an external digital forensics company who had the task of converting the sequence of events that the analysts had produced into a digital product that prosecution counsel could use to follow the case during trial and present the evidence to the jury.*

Comments:

1. It is extraordinary that there was no visual evidence of Lucy Letby attacking a single baby.

2. Re, "…in most cases, you have something that's visual for a jury", the Letby case had the roster chart and other visuals such as the handwritten notes. With respect to the chart, some babies appear two or three times. Twins and triplets are not distinguished. And only 'suspicious events'. And only nursing staff, despite the serious criticisms of medical staff by RCPCH. Probably not possible to count how often this was shown to the jury.

*Claire Hocknell, Analyst*

*Having this interactive electronic presentation allows them to look at not only the sequence of events that Kate and I produced or by interactive so that they can click into a record and not only see what we've transcribed, but then go and have a look at the original record by clicking a button to be able to see that original exhibit.*

Comment: So one should be able to ascertain quite quickly whether the documents were properly redacted. And why the other 15 families were excluded.

*[On screen: October 2022]*

*DCI Nicola Evans*

*So the trial started on 4th October 2022 a much anticipated date that we counted down to in the office and actually never thought we'd get to when we had hundreds of days written on the board. It felt like a relief that the trial had actually started, but also there was just a lot of anticipation as to how it would unfold and also nervousness around ensuring that we could properly support the families who were going to listen to some really upsetting and devastating evidence. And so it was a really strange time for the investigation team because there was so many emotions running alongside was knowing what we had to do in the job we were there to do and it is kind of trying to keep those emotions separate because actually our role is to support the families and to support the investigation and keep our own feelings separate.*

*DC Michelle Burkett, Family Liaison Officer*

*So for a long, long period of time the families didn't actually know what had happened to their children, their babies and what the case was about, all they knew was that their child had had a collapse and died, some of them with a collapse and survived and they didn't realise the enormity of it all. And it's when they've been here in Manchester and listened to the evidence in court and they've found that it's all overlapped and it's all, you know, the jigsaw puzzle is put together. They realised how in-depth the investigation has been and now understand the reasons why we couldn't tell them a lot of things.*

Comment: there is so much evidence that the investigation did not consider other explanations for the elevated mortality and morbidity as it should have done (there were indeed more far more viable explanations). Also that it honed in on the nurse suspected by the paediatricians, without questioning their motivations. This is a classic example of the Texas Sharpshooter Fallacy, in which arrows are not fired at a target but a target is drawn around the arrows.

*DCI Nicola Evans*

*It was really important that each of the cases were explains in detail methodically and in full and that every single one of the victims has their case presented as a case within itself and so if you think about the scale of that in that we've got 17 victims, so 17 separate murder and attempted murder cases to present to one jury. It was really important that that was done at a really slow speed so that people could understand, but also that each of those victims has the time that was needed to explain their case and that the parents felt that that case was explained correctly and methodically and so the trial has gone on longer than we expected it to.*

*Claire Hocknell, Analyst*

*Because Kate and I take, took responsibility for the different cases, once you got in there, and started giving evidence it was fine, but the anticipation of giving evidence is much worse than actually being in there and doing it. I think both of us would concede that going through the sequence of events of one of the deaths was more difficult because you knew what was coming and the families are sat behind you when you're giving evidence, particularly reading the text messages that Lucy Letby had either sent or received and the connotations that come out of that, how upsetting it is to say those words out loud as I read them. So no matter how many times we say them out loud, it brings what's black and white into full technicolour and at times perhaps kind of like being like taking deep breath just get to the end. But knowing that that's the first time that the families had heard that evidence was quite tough.*

Comment: none of Lucy Letby's text messages were incriminating (if any text messages were incriminating, it was the many sent by Dr A to Lucy Letby). There should have been defence evidence to refute the interpretations placed upon this and other items. Also, was the context in which she sent text messages clarified? Were some of them written when she was already under suspicion?

*DCI Nicola Evans*

*There is an attachment from the investigation team to each of the cases and so the anticipation throughout the prosecution case particularly of each of those cases and how tense I think everybody felt to make sure that that case came out in the best possible way and that we had*

*done everything that we possibly could to make sure the jury could understand and give each of those babies the justice that they deserved. It was a really intense time, so when we did get to the end of the prosecution case, it did feel like a key moment within the trial, although there's been many ups and downs during that. And it was an anticipated date that we kind of worked towards and when we actually got to it, actually the feeling was we've got to carry on, we've got to keep going and that the work didn't stop there. Although it's been a really long, protracted trial for everybody involved it's been really important that everybody remains focused on the job in hand that they're doing and the whole team have. The trial has been challenging for everybody involved, not least the families who I just can't begin to imagine how they feel. The way in which they've sat through the case, and they've listened in such a dignified, compassionate way, it is really humbling to be around them and the way in which they've conducted themselves has just really been overwhelming.*

Comment: is Evans' remark, "give each of those babies the justice that they deserved" appropriate? Surely it is for juries to administer justice, not the police.

*DS Lucy Kennedy (Medical Expert Manager & Family Liaison Officer)*

*When Letby first got in the box and started giving her evidence, there was a real mix of emotions. And some families were relieved that she was actually in the box giving the evidence, hearing the answers to the questions. And I think some were angry with the answers and I think some were upset as well for various different reasons, so why they were upset.*

*DCI Nicola Evans*

*Many of the people over at the trial have worked on this investigation since birth, the very early days and I think although we have a job to do and it is our job, I also don't think that anybody will be the same person they were when this trial is finished because there's been such an emotional attachment also to ensuring that we do everything correctly and that we have put this case in the best possible position for it to go to trial and I think that will be a part of that that stays with everybody that's works on it throughout.*

Comment: in relation to Evans' comment, "there's been such an emotional attachment also to ensuring that we do everything correctly", logically, the Cheshire Constabulary, the CPS, the barrister and the judges are emotionally primed to reject criticism. From the meeting of Wenham and Hughes with Jayaram and Brearey on 17 May 2017, the investigation was biased and increasingly emotionally affected.

Concluding remarks

- Even neurotypical people, if their careers, reputations, and livelihoods are materially under threat, will go to extreme lengths to protect them. Sociopaths, who have no empathy towards others, will find it easier, and may harm vulnerable and innocent people for lesser reasons.
- In medicine, where diagnosis and opinion is often subjective, it is easy to frame a nurse. A highly unlikely cause of death or collapse can be made, convincingly, to sound like the most likely, perhaps even the *only* cause.
- Police are not qualified to judge whether doctors' allegations are sound from a medical perspective. However, they are in a position to question and investigate their motives.
- The bar is set very low for so-called experts to get on the NCA's National Injuries Database, so it is easy for police to find doctors who will endorse, as "experts", the opinions of treating physicians who allege inflicted harm. Indeed, there are many unscrupulous firms who will revalidate doctors for a few hundred pounds and a cursory interview.
- In prosecuctions, these same doctors can act as the expert witnesses – a horrific conflict of interest.
- Police can also be susceptible to confirmation bias. They probably do not understand that a roster chart that seemingly incriminates a particular individual is a statistical abomination.
- Judges have a lot of discretion to exclude evidence that should be included (e.g. in the Letby case, the RCPCH report, Alison Timmis' "chaos" email, etc) and include evidence that should be excluded (Dr Evans' testimony, the roster chart, handwritten notes that jurors were told constituted a confession, etc).
- Police can fail to disclose documents to the defence that they should (e.g. in the Letby case, documents pertaining to instruction by police of medical statistician Jane Hutton, etc). In the Cheshire Police's Operation Hummingbird video, disclosure officer DI Rob Woods said there were 16,571 items of unused evidence, some thousands of pages long. How much of this material was not disclosed to the defence is not known, however, on the basis of exculpatory unused material that is known to have not been disclosed (see above) and the mammoth task Woods faced in deciding what should and should not be disclosed, it is almost certain that other important items were not disclosed.
- Jurors trust doctors. Furthermore, if they only hear from doctors instructed by the prosecution, because it has been made impossible for various reasons for the defence to put its own expert doctors on the stand, it is even easier for jurors to return guilty verdicts.
- It is impossible for jurors to understand complex medical and scientific arguments. They may instead rely on other prosecutionevidence that they think is compelling such as a roster chart or a "confession note". They may also wish to give the impression, through their verdicts, that they have understood and carefully considered complex medical and scientific arguments.
- There is a massive imbalance in time and financial resources between prosecution and defence. This means that in cases where the prosecution evidence is both complex and copious, a defence team may miss things (e.g. in the Letby case, laboratory guidelines saying that blood test results can have both natural and unnatural explanations, rather than just the latter).

END