ChatGPT's review of Dewi Evans' correspondence with Peter Elston

Source: Mephitis — "My Correspondence With Dr Dewi Evans".

I reviewed the full correspondence on the page and extracted the substantive information supplied by Dewi Evans, rather than Peter Elston's questions/comments.

Because the page is copyrighted, I'm **paraphrasing Dr Evans's statements rather than reproducing the correspondence verbatim**. The source is Mephitis — "My Correspondence With Dr Dewi Evans".

1. His approach when joining Operation Hummingbird

Dr Evans says that **avoiding bias was a crucial part of his remit**.

He says that at his first meeting with Cheshire Police on **10 July 2017**, he requested clinical records for **all deaths and collapses from January 2015 through December 2016**, explicitly saying that he wanted *all* deaths and collapses, not merely those considered unexplained or suspicious. He says he selected this two-year period because there had been a "peak" in deaths during 2015–16, although he did not initially know the precise dates.

He says:

- He told police that if they had suspects, **he did not want to know their names**.
- Police did not initially tell him about Letby's handwritten notes, "handover" notes, WhatsApp/Facebook messages or Post-it notes; he says he learned about these around the time of the trial.
- He did not receive reports previously prepared by other people.
- The RCPCH report was online but redacted; he says he only discovered after the verdict that the complete report referred to Letby, and that he still had not seen the complete report.
- Police did not initially give him Letby's rota; he says he eventually received it on **5 September 2024**.
- He says he primarily examined **medical/clinical notes rather than nursing entries**, and therefore no nurse's name registered with him during his initial review of 33 cases.
- He says he never spoke to local doctors or nurses.
- He visited the neonatal unit only very briefly immediately before the trial, by which point it had moved to another site.

There is, however, an important qualification in the correspondence: when asked about the initial cases, he says **Countess of Chester clinicians selected the cases**, and that he was dependent on police and Chester clinicians identifying cases. He also says he initially requested only "a couple" of cases and received **Baby O** as his first case, to get a feel for the clinical process, documentation, senior-doctor involvement and autopsy findings. He did not ask why Baby O had been selected.

He says reviewing every admission during 2015–16 would initially have involved more than **400 admissions**, although he says such a comprehensive review was subsequently being undertaken.

2. What he says he actually identified

Dr Evans says that it was **not police who presented him with a list of suspicious events for him to explain**.

His account is that, after receiving the clinical records, **he himself identified deteriorations** and divided them into events that were:

- explainable;
- unexplained;
- concerning;
- suspicious; or
- indicative of inflicted harm.

Of the initial **17 deaths**, he says he identified **seven** where he could not explain the death through a natural event and where there was a concerning pattern of collapse. He says those seven were the babies for whose murders Letby was subsequently convicted.

He later says that he developed concerns about some of the other deaths as well and notified Cheshire Police of those additional concerns in **September 2023**. He says these babies had underlying clinical problems, making it extremely difficult to distinguish natural death from deliberate harm or poor clinical care.

3. The other deaths

He says that of the other deaths:

- **Infant K** was one of the additional cases; he says he had not identified anything concerning in his 2017 review because the consultant involved in the initial resuscitation had not recorded anything specific in the records at the time.
- Infant K was transferred to Arrowe Park and died two days later; Evans describes her as extremely premature and never stabilising.
- He agrees that the consultant should have recorded his concerns contemporaneously.

Regarding the remaining deaths, he describes:

- two babies who died elsewhere;
- one baby who had been severely asphyxiated before birth;
- four premature babies, two at 29 weeks and two at 30 weeks;
- infections present before birth in two cases and developing subsequently in two;
- four babies with complicated congenital abnormalities.

He says that with the premature/infection cases and the congenital-abnormality cases, it could be impossible to distinguish a natural death from one "assisted" by poor care or deliberate harm.

For the severely asphyxiated baby, he says the asphyxia occurred **before birth**, that the baby was virtually stillborn, had Apgar scores of 0 at one and five minutes, and that the autopsy supported this through the presence of amniotic squamous cells in the lungs.

4. Infant C

Evans's position regarding Baby C was:

- He says he did **not** change his mind several times.
- His first two reports highlighted concerns about the ventilation up to midnight on 13 June.
- Those reports, he says, did not allege anything.
- He considers it possible that the collapse could have resulted from a massive injection of air into the stomach immediately beforehand, but considers bloodstream air injection more likely, drawing an analogy with Infants A and B.
- He refused to provide his revised police report because police had asked him not to disclose it.
- He said the issues were sufficiently clinical that the report would best be discussed with a neonatologist.

On the clinical management preceding Baby C's death, he says:

- only **0.5 ml of milk** was given;
- delayed bowel action is common in premature babies;
- trying a small amount of milk can reasonably be used to stimulate intestinal movement;
- he could not say whether clinicians had examined the anus/bottom for an obstruction, but because no anal blockage was found at autopsy, he says there was no anatomical obstruction in the intestinal tract;
- he suspected surgical consultation would have been considered on Sunday or Monday;
- he says another baby with significant bowel obstruction had been transferred to Alder Hey within 12 hours and successfully operated on.

He says he considered the resuscitation of Baby C to have been standard and did **not** attribute its failure to poor resuscitation skills.

5. Infant K and later cases

Evans says that the additional 48 cases were received after Letby's arrest in July 2018, plus the second insulin case.

He says he prepared reports on these cases during **2019–2021** and, in September 2023, wrote to Cheshire Police suggesting that up to **25 cases** should receive more detailed examination. These included some episodes from the original 34 that were not used at trial and cases among the later 48.

He says:

- some cases had originally been prepared by Dr Sandie Bohin and peer-reviewed by him;
- Sandie Bohin and Dr Martin Ward Platt had peer-reviewed his initial 34 cases;
- other cases came from different sources, including parents;
- he describes the 48 as essentially a random group rather than a pattern;

- after reporting restrictions were lifted, journalists supplied him with two additional case files, one of which he considered very concerning and one not;
- he forwarded his responses to police;
- he says police were investigating approximately **4,000 cases**;
- he says 60 people were working exclusively on Operation Hummingbird when he left Manchester in April 2023;
- he understood that Liverpool as well as Chester cases were being reviewed.

He says none of those 48 later cases had, at that point, appeared on the indictment because they had been reviewed after Letby's initial arrest.

6. Letby's presence at deaths

This is one of the most substantial parts of his correspondence.

Evans says that, after obtaining the rota, he examined Letby's presence during the 17 deaths.

His breakdown was:

Category	**Evans's account**
7 prosecution deaths	Letby present for all 7
3 babies who died elsewhere	Letby present when 2 deteriorated
4 deaths involving congenital abnormalities	Letby present in 3
3 deaths associated with prematurity/infection	Letby present in all 3
Total	**Letby present at deterioration/death in 15 of 17**

He stresses that in the 15 cases she was present **at the point of deterioration**.

He also says that when he referred to Letby being "present", he sometimes meant that she was in **sole charge** of the baby. When challenged about three alleged murder victims for whom she was not the designated nurse, he said she was nevertheless physically present, and specifically referred to Baby C, where he says Letby repeatedly entered the nursery despite being responsible for another baby.

7. The rota and his statistical calculations

Evans says he received a copy of Letby's work rota, calculated by Cheshire Police, covering **1 June 2015–30 June 2016**.

His calculation was:

- 57 weeks;
- 14 shifts per week;
- 798 total nursing shifts;
- Letby worked 163;

- therefore Letby worked **20.4%** of shifts;
- 15 deaths occurred during her 163 shifts;
- 2 occurred during the remaining 635 shifts.

He initially said he had not previously considered "mortality per nurse shift" to be a relevant statistical/clinical concept. The comparison with the Liverpool breathing-tube figures prompted him to explore it.

He then calculated historical Chester mortality per nursing shift as approximately:

- 2012: **0.5%**
- 2013: **0.4%**
- 2014: **0.4%**
- Letby not on duty: **0.3%**
- Letby on duty: **9.2%**

He described the 9.2% figure as a **"massive outlier"**, but explicitly said that determining its statistical significance was outside his expertise and that its clinical significance also needed examination.

He subsequently described the comparison as **9.2% versus 0.3%** and asked for the statistical significance using the actual numbers rather than merely percentages. He said that if Peter could not perform the analysis, he would involve a friend with a DPhil in statistics.

He says this was the first time in the Letby case that he had explored the possibility of statistical analysis.

His Oxford-DPhil friend, a City financier, reportedly found the figures "astonishing" and troubling. Evans said he wanted Peter's statistical interpretation before speaking to journalists.

8. His views about statistics generally

Evans says:

- he is neither a statistical sceptic nor cynic;
- he considers himself reasonably knowledgeable about statistics as applied to clinical research;
- he believes the prosecution did not seek a statistical expert because, in his view, it presumably did not regard statistics as a significant part of the trial;
- likewise, he assumes the defence did not seek one because it presumably did not believe statistics were being misconstrued.

He says that the issue of deaths is not simply the number of deaths: what matters clinically is **the cause**—whether deaths were unexplained, unexpected, suspicious, etc. He therefore argued that statisticians would not necessarily have resolved the underlying clinical question.

He nevertheless ultimately produced his own shift-based mortality analysis and sought statistical assistance interpreting it.

9. The breathing-tube figures at Liverpool

Evans says that at the Thirlwall Inquiry he heard a barrister disclose figures indicating that breathing tubes were displaced during approximately **40% of Letby's shifts at Liverpool in 2012 and 2015**, compared with **less than 1%** of shifts when she was not on duty.

He cautioned that the figures required scrutiny because "<1%" seemed extraordinarily low. He speculated that it might refer only to **unexplained** tube displacements. If so, he said the 40% figure would be very concerning.

He says that this comparison was what prompted him to start considering "mortality per nurse shift."

10. Why he believed Letby's presence mattered

Evans repeatedly says the combination of:

- the timing of deterioration,
- the clinical presentation,
- Letby's presence,
- and the apparent clustering of events

was significant.

He says he did not initially use statistics because he approached the matter clinically. His stated position is essentially that the statistical pattern is supplementary rather than the foundation of his clinical conclusions.

He also says the seven babies he identified in 2017 were the babies for whose murders Letby was convicted.

11. Genetics

When asked why he did not request whole-genome sequencing using Guthrie cards, Evans said he had **not requested genome sequencing** and questioned what genetic disorder or inborn metabolic error would present in the same way as the seven babies.

He pointed out that two deceased babies had surviving twins who had not shown unusual disorders, and that the surviving member of the triplets was well.

When Peter pressed the point, Evans dismissed the proposal as essentially cherry-picking and said it would fuel conspiracy theories.

However, the page's author notes that Evans had previously told Cheshire Police in March 2018 to **consider gene sequencing for Babies O and P and their surviving sibling**, following a suggestion by Dr Kokai. That historical statement is Elston's comment rather than Evans's statement in this correspondence.

12. Air embolism

Evans provides a fairly extensive account of his views about air embolism.

He says:

- It is impossible to quantify precisely how much air or air-plus-fluid is required to destabilise a baby.

- There is very little published research because accidental air embolism is rare and hospitals generally do not publish reports of accidents occurring in their own departments.
- As far as he knows, **deliberate/inflicted harm by air embolism had not previously been described**.
- Piglet experiments are relevant because they demonstrate how rapidly air can compromise a subject.
- He says Shoo Lee's frequently cited experience was based on only three of 50 Toronto cases published in 1989, and neonatal intensive care has advanced considerably since then.

Speed of collapse

His explanation is that:

- a **large volume injected rapidly** can cause immediate collapse and death;
- by "immediate", he means **seconds**;
- when air is introduced through an IV line, it can take minutes for bubbles to travel from the tubing into the bloodstream, with the delivery rate being slower;
- he had sent the prosecution calculations concerning line/cannula volumes but says neither prosecution nor defence questioned him about them;
- in newborns, air can travel from the venous to arterial circulation through the **patent foramen ovale (PFO)**;
- he believes this can account for unusual skin discoloration in some babies;
- he says the volumes may have been small in some survivors;
- consequently, the safest general conclusion is that deterioration would occur "quickly", but the exact timing depends on volume and delivery rate.

He says the catastrophic collapses at Chester involved oxygen saturation falling to **50% or less**, accompanied by a corresponding fall in heart rate. He says a 2024 update by Lee described air-embolism features that were broadly similar to those observed in several Chester babies.

13. His estimate for Baby G

When asked how much air/fluid he thought might have been introduced in Baby G, Evans gave an approximate calculation:

- Baby G had been fed **45 ml**;
- she vomited three times;
- nevertheless, 45 ml plus another 100 ml remained in the stomach;
- Evans therefore estimated at least **145 ml** of surplus milk/milk-and-air, plus perhaps at least another 50 ml represented by the vomited material;
- he therefore estimated a **minimum of roughly 200 ml in a 2 kg baby**.

He compared 100 ml/kg in a 2 kg infant with approximately 8 litres in an 80 kg adult, illustrating the scale of the volume. He said Baby Q probably involved a similar amount, although involving clear fluid rather than simply milk or air.

He says other babies were also compromised by air in the bloodstream, making those cases more complicated.

14. Oxygen saturation

Evans's position on oxygen saturation is nuanced.

He says the **usual target** for oxygen saturation is **96–100%**, but premature babies are vulnerable to retinopathy from excessive oxygen, so values in the low 90s can be accepted/tolerated. He says interpretation requires consideration of the relationship between oxygen saturation and partial pressure of oxygen.

Later, when challenged over a 94% figure, he says he believed that the 94% figure in question related to a **leak rather than oxygen saturation**; if it referred to oxygen saturation, he said 94% was fine.

He subsequently says that optimal oxygen saturation is influenced by prematurity and that excessive oxygen should be avoided in premature babies because of retinopathy risk. Ideally, he says, clinicians would also measure arterial partial pressure of oxygen, although doing so requires an arterial sample and can be difficult and painful.

15. His comments about the study day attended by Letby

Evans says he learned during the trial that Letby had attended a study day concerning the administration of intravenous drugs and fluids approximately **one week before the first fatality**.

His view is that such a study day would strongly emphasise the danger of introducing air/oxygen into the bloodstream, a danger he says has been known for a very long time.

He says he was unsure whether the study day was used as evidence at trial.

He also says—while explicitly indicating that he was willing to be corrected—that he understood Letby had told police that she did not know about the danger of air embolism in babies, although she knew about it in adults. He considered that an unusual claim for someone whose training and practice concerned babies.

16. Baby O / liver injury

In discussing Baby O, Evans says he understood the evidence concerning the timing of the alleged physical attack on the liver differently at different stages.

The correspondence records Peter challenging this, rather than Evans responding directly to each allegation. Evans's broader position elsewhere is that his clinical interpretation of the case remained that Letby had inflicted harm.

The page also records Evans's willingness to discuss the case with neonatologists, but his refusal to disclose certain reports at police/parental request.

17. His response concerning pathologists and other clinicians

When Peter pointed out that previous postmortems and reviews had reached natural/non-criminal explanations, Evans said he had read some of Jane Hawdon's reports but considered them not very comprehensible.

He declined to comment on disagreements between different pathology opinions, saying that such disagreements were matters for pathologists.

He also says anonymous reports he received from an unnamed neonatologist were "dreadful" and, in his opinion, would be demolished by a competent barrister. He says he had been asked not to share those reports.

18. His views on the Thirlwall Inquiry

Evans says he was frustrated by the demand from 24 experts that the Thirlwall Inquiry be postponed, characterising it as disrespectful to Lady Thirlwall and to the families.

Later, he says that because of the volume of new evidence emerging from the Inquiry, he believed it was appropriate to wait for **all the evidence and Lady Thirlwall's report** before expressing further views.

19. The February 2017 "Independent Medical Review"

When asked whether he was a member of an Independent Medical Review allegedly commissioned by the Countess of Chester Hospital in February 2017, Evans says:

He was not involved and does not believe he knew about it before Peter raised it.

This is significant because the correspondence distinguishes this purported February 2017 review from Evans's own involvement beginning in July 2017.

20. His explanation of his role for the CPS

Evans strongly rejects the suggestion that he had effectively "overridden" other clinicians in order to obtain lucrative CPS work.

His position is:

- expert opinions do not "override" one another;
- where experts disagree, each can give evidence under oath and be cross-examined;
- the jury decides which evidence is more persuasive, after the judge's directions and the advocates' submissions;
- he does not give pathology opinions; he reports/quotes pathology findings;
- he had previously prepared prosecution reports without being called as a witness;
- he cites the cases of **Finlay Biden, Alfie Steele and Jacob Crouch** as examples;
- he says that although those cases resulted in convictions, he personally received **£0 from the CPS** because he was not called; he says police authorities pay for his reports.

He therefore rejects the suggestion that he knew in December 2017 that he would subsequently become the CPS's principal medical expert and that this influenced his conclusions.

21. His position on the conviction

Evans says that the deaths and injuries were not ultimately matters decided by him but by a **court of law**, and that the convictions were subsequently confirmed by three Court of Appeal judges.

He also refers to evidence from Dr Stephen Brearey suggesting that Letby may have harmed or killed additional babies. Evans says he was no longer involved in the investigation and was waiting for developments.

22. His personal/administrative comments

A few non-clinical points are also supplied by Evans:

- He says he had stopped taking on new cases in **2022**.
- He says he removed himself from the GMC licence to practise in **June 2024** and was trying to retire.
- He says he was not involved in reviewing the Liverpool cases and regarded those developments as new information to him.
- He says he wanted to reduce his media involvement and was no longer doing additional TV interviews, preferring to answer objective questions from named people.
- He said he was willing to let Peter forward his observations to other medics.

23. Dr Dimitrova

Evans says his interest in communicating with Dr Dimitrova was specifically prompted by a David Rose/UnHerd article listing incidents involving babies **when Letby was not on duty**.

He says he wanted to discuss those cases with her because he considered the matters best discussed between clinicians rather than journalists, lawyers or statisticians.

He says he was happy to contact her and later asked Peter to have her get in touch.

Later he says he had heard—explicitly identifying this as **hearsay**—that Dimitrova was no longer part of Mark McDonald's team and no longer part of the Ockenden investigation, and wondered whether she had prepared medicolegal reports.

24. His exchanges over Richard Gill / criticism

Evans expresses strong hostility toward statistician Richard Gill, saying that journalists had forwarded him what he regarded as abusive material from Gill.

He says he found the language following the lifting of reporting restrictions extremely unpleasant and hoped that professional discussion between himself and statisticians could reduce the heat and increase the light.

He also complains that Peter had made insulting social-media comments about his involvement in the case and asks, essentially, for greater professional courtesy.

25. Freemasonry

Evans asked Peter whether he was or had ever been a member of the **Brotherhood of Freemasons**, saying that the question arose from evidence given by Dr Stephen Brearey.

Peter replied that he was not and had never been a Freemason and asked whether Evans was suggesting collusion with former hospital managers.

Evans did not subsequently elaborate on the allegation in the correspondence reproduced on the page.

26. His final position in the correspondence

The correspondence ends with Evans still willing to answer clinical questions but increasingly unwilling to engage in the statistical dispute.

He says that:

- he had answered Peter's queries;
- he could not disclose Baby C's report because the parents, via police, had requested that it not be shared;
- he wanted a statistical expert to address his **9.2% vs 0.3%** calculation;
- his DPhil statistician friend had found the numbers significant/astonishing;
- he thought further correspondence should await developments in the Thirlwall Inquiry.

The most important factual propositions supplied by Evans

If your objective is to isolate **what Dr Evans himself asserted**, rather than the surrounding argument, I would reduce the entire correspondence to these central propositions:

1. **He says he sought to avoid bias**, including initially asking for all deaths and collapses over 2015–16.
2. **He says he did not initially know Letby's identity**, although his later BBC account, reproduced/commented upon by Elston, creates an apparent tension on this point.
3. **He says the initial clinical cases were selected by Chester clinicians/police**, and that he personally identified the suspicious clinical events after reviewing records.
4. He says he identified **seven deaths as unexplained/suspicious in 2017**, corresponding to the seven murder convictions.
5. He later developed concerns about **additional deaths**.
6. He says Letby was present at the point of deterioration/death in **15 of 17 deaths** he reviewed.
7. He calculated **9.2% mortality per Letby shift versus 0.3% when she was not on duty**, calling it a massive outlier but acknowledging that its statistical and clinical significance required further analysis.
8. He says breathing-tube displacement at Liverpool appeared to be **40% on Letby's shifts versus <1% on other shifts**, subject to checking exactly what those figures represented.
9. He believes the **clinical evidence of air embolism** is compatible with several Chester cases.
10. He says rapid injection of a large amount of air can cause collapse within **seconds**, while IV-line delivery can take longer.
11. For Baby G, he estimated **at least ~200 ml** of residual/injected milk/air/fluid in a 2-kg baby.

12. He says the normal oxygen-saturation target is generally **96–100%**, while lower values may be tolerated in premature infants because of retinopathy risk.
13. He says he did **not** request whole-genome sequencing in the cases he reviewed, although the page records an earlier instance in which he had suggested considering sequencing for Babies O and P and a surviving sibling.
14. He says he was **not involved in the February 2017 Independent Medical Review** referred to by Peter.
15. He rejects the idea that his conclusions were driven by an expectation of future CPS employment or financial gain.
16. He says he had stopped taking new cases and had removed himself from the GMC register/licence to practise, and was attempting to retire.
17. He believes the evidence of Letby's involvement was much stronger clinically than critics acknowledge, while also accepting that the statistical component requires proper statistical analysis.

These points are all drawn from Evans's own responses in the correspondence, with the important caveat that **some are his recollections, estimates, interpretations or opinions rather than independently established facts**.