43. The above mentioned meeting went ahead on 11 May 2016 despite my attempts to convene the meeting as early as February 2016. The meeting was attended by me, Eirian Powell, Mr Harvey, Alison Kelly and Ann Murphy.

44. At the meeting we discussed the mortality on the Unit and concerns were raised to Mr Harvey and Alison Kelly about Nurse A's presence on the Unit for each baby's death. I raised concerns about the number of deaths occurring on the night shift between the hours of 00.00am and 06.00am and also that there had been no overnight collapses since Nurse A had been moved onto day shifts.

45. Eirian Powell was very defensive of Nurse A at the meeting and raised concerns about some doctors on the Unit. However, no doctors were associated with as many deaths and collapses as was the case for Nurse A. Eirian Powell also stated that each baby had been diagnosed with a different cause of death and that no concerns had previously been raised about Nurse A. Concerns that I shared with my consultant colleagues regarding babies who had not died, but had unexplained and unexpected collapses, were also discussed at this meeting.

46. There were no clear actions coming out of the meeting and it was not minuted. The only outcome was that we would convene another meeting just before Nurse A was to start working night shifts again. I was still concerned and on 16 May 2016 I emailed my consultant colleagues and the senior neonatal nurses to ask them to let me know if any babies deteriorated suddenly on the Unit. A copy of my email is produced as exhibit **"SPB8"**.

47. On 23 and 24 June 2016 two more babies died on the Unit. Child O and Child P were triplets of 34 week gestation. They were both stable in the first few days of life. Child O deteriorated quite quickly and was treated for suspected sepsis with antibiotics. He also had an unusual rash on his torso which looked like a septic rash. He was started on IV