I appear to have become frustrated by a process of review which did not appear to progressing as fast as I would have liked. I also think that it must have been around this time that I was aware that a further review had been commissioned although I do not think that I knew the name of the individual who had been engaged to conduct the review.

95. On the third page of his summary ((INQ0002048_0100) Mr Ian Harvey writes that the Trust's Director of Corporate and Legal Affairs (presumably Mr Cross) and Medical Director (presumably Mr Harvey) met with the coroner on 8th February 2017. I have no recollection of that meeting but am satisfied that one took place because in his letter to me of 15th February 2017 (see below) Mr Cross has written "following your meeting at the Countess on 8th February 2017". I think that I must have wanted an update in respect of investigations being carried out by or on behalf of the Trust. It may well have been that at that time that an arrangement for Messrs Cross and Harvey to come to my office in Warrington a week later was made. I have some recollection of the meeting that took place on 15th February 2017. I took a contemporaneous note of that meeting which is to be found at (INQ0002048_0102). The reference to NLR in the note is a reference to me Nicholas Rheinberg and the reference to AGM is a reference to Alan Moore. I am careful in the manner in which I take notes and I am confident that this record will have been both accurate and comprehensive. Messrs Cross and Harvey were in attendance and I had asked Alan Moore to join us. With my retirement now I&S weeks away it was clearly sensible for Alan Moore, who was to succeed me as Senior Coroner, to take part in the meeting. I record that Mr Cross handed to me his letter of 15th February 2017 with enclosures. The letter is to be found at INQ0002048_0034. The enclosures are listed as consisting of Dr J.M.Hawdon's report (INQ0002048_0035 to INQ0002048_0090), a letter from the Countess of Chester paediatricians dated 10th February 2017 (INQ0002048_0091 and INQ0002048_0092) and a document headed "Observations additional to the RCPCH Review of Neonatal Services" (INQ0002048_0093 and INQ0002048_0094). The meeting on 15th February 2017 was the first time that these three documents had been produced and so there had been no opportunity to study what turns out to have been 60 odd pages of documents prior to the meeting.

96. Referring to my note of the meeting there appears to have been a discussion about Dr Hawdon's report and I have recorded that an expanded version was to be prepared, a copy of which would be provided to the coroner's office. There was then a discussion about the clinicians' letter (INQ0002048_0093 and INQ0002048_0094). It was clear from the Royal College's review that the clinicians were concerned about the number of deaths on the neonatal unit and it would have been extraordinary had they not been.

shortcomings revealed by the report could more properly be categorised as systemic failures rather than failures by individual clinicians".

98. I now realise that a third item had been included in the bundle 60 pages of documents. This was the document "Observations additional to the RCPCH Review of Neonatal Services" (INQ0002048_0093 and INQ0002048_0094). I am confident that the document which is dated November 2016 was not referred to at the meeting. If it had been the subject of any discussion, I would have made reference to this in my note. The first time that I saw this note was when I received the bundle of relevant papers in order to assist in the preparation of my statement of evidence to the inquiry. There are two possible explanations for the document not coming to my attention. The first is that it was not in fact included with the other papers accompanying the letter of 15th February 2017. The other and more likely explanation is that it was included but that I overlooked it. Although the note is less than an accusation of wrongdoing the suggestion that one nurse had been "rostered on shift for all the deaths" would have prompted me to ask for the identity of the nurse in question and I believe that I would probably have spoken to DI Mark Tasker or another police officer and have asked if the officer was aware of the fact that, coincident with all the deaths, was the presence on each occasion of one nurse.

99. My record of the meeting on 15th February includes the words "in relation to the list of deaths in question". Looking at subsequent correspondence I think that my mention of the list of deaths in question is reference to the fact that Mr Cross at the meeting handed me a list of all the neonatal deaths that had occurred between the relevant dates. On 21st February 2017 I wrote to Mr Cross (INQ0002048_0103 and INQ0002048_104). I begin the letter by saying "Further to our recent meeting, you handed me a list of seventeen deaths and I thought that it might be helpful if I gave you details of the position so far as this Office is concerned....) I then listed deaths which I stated had never been reported to the office. I am not able to fully deduce the information then provided because of the confidentiality coding that has been added to the letter in substitution for actual names but it appears that at least one death had not been reported to my office and that would have been in contravention of my practice direction (NLR/1 and NLR/2 **INQ0017839** **INQ0017840**) albeit as already made clear the direction did not have the force of law.

100. To be clear at no time during my tenure as senior coroner for Cheshire, either during the meetings of 8th and 15th February 2017 or by any communication from the Countess of Chester Hospital or by any other means was I made aware of any suspicions or concerns relating to the involvement of a nurse in relation to any deaths of babies at the hospital. The first time that I heard of the possible involvement of Lucy