respiratory collapse. Most of the time, the Registrar and the house officer would be adequate but at times a Senior Clinician such as the Consultant is needed. Some Registrars were not happy at the consultant being called in, as they felt it a sign of failure and that they should be able to deal with it. Nursing staff felt that having the Consultants knowledge and experience a relief.

37. As a nurse, I felt that I could speak up and raise my concerns with medical colleagues both on NNU and Labour ward. I would put my views and concerns to the Consultant on the Central Labour suite if needed, and escalate it to the NNU Consultant if I felt my concerns had not been acknowledged, such as NNU being full and Obstetrician wanting to deliver Preterm baby, when Mum should have ideally been sent out as an inter transfer earlier that day.

Child D

38. I confirm my police statements dated 9 January 2018 (INQ0000804), 25 February 2020 (INQ0001410) and 5 June 2020 (INQ0000633), are correct and exhibit these to the statement as Exhibit KPC1, 2 and 3. As stated in my police statement dated 9 January 2020 (INQ0000804) (Exhibit KPC1), I was not the designated nurse caring for Child D on the Night shift 21-22 June 2015. I was caring for others in outside Nurseries. Caroline Oakley was the designated Nurse. I had been asked to look after the baby when she went on her break. I cannot recall when I first became aware when Child D had died.

39. I do not know if Child D death was discussed at handover, as I was not at handover for that shift, but it is usual to discuss a death of a baby at a handover as it has a profound effect on the whole of the team, it always saddens and upsets me when a baby dies. The baby's death would have probably been discussed as members of the day staff would have been assigned to support the parents and if the baby had not been taken to the mortuary or all the relevant paperwork and mementoes did not complete the day staff member would take over this task.

40. From day staff to night staff, it is common to discuss a child's death especially if it is the same staff returning as they would want to check if everything was completed or anything outstanding and ensuring parents had been supported or need continuing support depending on where the baby is, for example If the child has been taken on a cold cot to be with parents on the postnatal ward or at the mortuary. Most staff are upset and would have a brief discussion.

41. I do not know what was said at the handover after Child D's death as I was with the babies I was caring for and had them to handover to the day staff member. I know we would have been upset, but due to the time lapse I am afraid I do not know what was said.