to obtain further information, which may have explained these findings; therefore, I think it is likely that I would have continued trying to contact someone by phone. However, as I always like to ensure that results are available to the clinical team as soon as possible, my usual practice would be to verify the results before making further attempts to telephone the clinical team. As I verified the results at 09:40, these would have been in Child L's electronic case record, and thus visible to the clinical team involved in the care of Child L, only a few minutes after the call from Liverpool.

53. Had I spoken to anyone in the clinical team about Child L's results, the fact of any such conversation would have been detailed in my daily logbook, alongside the record of the results made at the time of the phone call. At that time, the only means I had of documenting information within a patient's electronic records was to insert a comment alongside the test results themselves; once the results had been verified, entering comments alongside the test results was not a straightforward process, so my practice was to document such discussions in my logbook.

54. Within my logbook I recorded summaries of any conversations I had with clinical teams, amongst other information, such as tasks and other daily activities. Unfortunately, due to the significant lapse in time between the event in question, and my being asked to review Child L's case, I no longer have the relevant logbook to refer to. Therefore, although my usual practice would have been to make further efforts to contact the clinical team in order to highlight these results, unfortunately, I have no record of having done so.

55. It is important to reiterate that staff in the Pathology laboratories would not have had access to patients' full clinical records at this time. The information available to us was largely confined to electronic entries made by the nursing team about each patient. The limitations of our access to information about the wider clinical context, combined with the sheer number of tests (at least 200 - 300) that are reviewed each day by the Duty Biochemist, constrained our ability to interpret results and understand their significance. However, as stated previously, the fact of a phone call from the referral laboratory would almost always be a prompt for contacting the clinical team.

56. Although I have no conclusive evidence of any direct communication with the clinical team in relation to Child L's Insulin, C-peptide and C-peptide: Insulin ratio results, I am aware that, as well as the verified results being made available to the clinical team on the electronic case record from the point of verification, it was standard practice for a paper copy of the results to be sent to the Neonatal Unit via the internal mail. From subsequent review of Child

L's records, I also note that these results were reviewed on a ward round on the Neonatal Unit on 15 April 2016 at 09:30. They are recorded in the clinical notes at that time, and the fact that the C-peptide: Insulin ratio was low was also documented; these paper notes were scanned on to the electronic case note system (Evolve) shortly after Child L's discharge from the Neonatal Unit.

57. In general, the clinical team who are providing the direct care for a patient, are in the best position to interpret test results, and to understand their significance; they know the question they were asking at the time of the request and the prevailing circumstances. In the case of Child L, it would have been reasonable to expect the clinical team to understand the meaning of an abnormal C-peptide: Insulin ratio, or at least for them to appreciate that the results were unusual. If they were not certain as to how these results should be interpreted, I would have expected them to seek advice: all staff are encouraged to contact the Duty Biochemist / another member of the Blood Sciences clinical team, if they are faced with laboratory results, for which there is no obvious explanation, or which are proving difficult to interpret.

Process for the communication of results in 2024

58. As stated previously, laboratory practice in the Blood Sciences department at the Countess of Chester Hospital NHS Foundation Trust has not changed fundamentally since 2016, but there are some important differences in the process of handling and communicating results, not least the fact that the Trust now has a new whole hospital computer system, which is used by all staff; this encompasses the patient electronic case record.

59. Since 2016, we have made changes to the processing of reports received from referral laboratories. Although we have been keen to implement a system which would allow the electronic transmission of requests and results between the Hospital Blood Sciences laboratory and referral laboratories, we have not yet achieved this, and still receive large numbers of paper reports daily from external sites; however, the procedure for handling them has changed. Now, the Duty Biochemist collects these reports almost immediately after they are received in the department and reviews them before they are entered onto the patients' laboratory records. They are then initialled, and any comments on the report, which need to be transcribed, are highlighted. This provides an earlier opportunity to detect any significant results, which can be communicated to the clinical team without delay.

60. Another important change is the expansion of the team of Duty Biochemists since 2016, from two to potentially four or five individuals involved in the rota. There has been an increase