e. Meeting with Simon Medland QC on 12 April 2017.
f. Meeting with representatives from Child Death Overview Panel ("CDOP") in April 2017 that I attended with Dr Jayaram.
g. Meeting with Detective Chief Superintendent Nigel Wenham on 15 May 2017.

Speaking up and whether the police and other external bodies should have been informed sooner about suspicions about Letby

7. Lessons learned about adverse incidents or deaths of neonatal patients were considered at Perinatal Mortality Review Tool ('PMRT') discussions. These were joint meetings with the obstetricians and held as part of rolling education sessions. I attended meetings when I could, depending on annual leave and clinical commitments.

8. I cannot remember being involved in any specific debriefs or discussions.

9. I was never involved in discussions with any local network of hospitals about adverse incidents and/or deaths of babies.

10. I recall that in 2016 I had read the NHS whistleblowing policy and had the paper copy on my desk as I referred to it frequently during this period. I think we, as a group of consultant paediatricians, spoke to the Freedom to Speak Up Guardian but I cannot now remember the details.

11. Many discussions were held with my consultant paediatrician colleagues over many months. We frequently met in one of the consultant offices in the hour before the normal seniors meeting on a Monday to discuss where matters relating to the higher frequency of neonatal deaths were up to and what next steps would be.

12. In my Facere Melius interview, at page 4 of **[INQ0012987],** I have been referred to the entry where I and my colleague's sought advice and guidance about whistleblowing:

> *"We first wondered about calling the police. In an email sent some months before that, if I could change one thing in my life and all of this stuff, things I've done, I could change one thing in my life. I would have called the police that day. Because it's so easy to say with hindsight is. We knew that, you know, we were always very clear, we are not forensically trained. We didn't, it felt so much*

bigger than a group of consultant paediatricians. But it was it was so unusual. But every time you read, you know, I mean, we all read ferociously. We read the GMC guidance on whistleblowing. We talked to our defence unions. We read all of the case reports about Beverley Allitt's. You lived in this sort of slightly dark world of just what did others do and how did they do it? And I think we were just really, I think we were wrong to put faith in the management system to make the right decisions. Because I think, you know, reputation of course, it would cause damage. So it's going to do so much when it comes out. So it was always going to cause damage. But actually, I think if we had called the police sooner than they may have, you know, make the changes to the unit that were made anyway, later on, they may have moved her sooner off the ward. You know, that would have I suspect that would have been life saved if different actions had happened. And I don't entirely pass blame onto other people. You know, we didn't we didn't call the police. We talked about it, but we didn't do it.'

13. I recall that we, as a group of consultant paediatricians, spoke to the Local Negotiating Committee representative at that time, Dr Sean Tighe. I cannot recall the date. I remember feeling that he was supportive. With hindsight, I feel that he gave advice in line with the whistle-blowing guidance as he consistently advised us to escalate our concerns within the Trust management structure. This we had already tried to do. I also spoke to my medical defence union. I did not find them helpful. Their advice was similarly to keep raising it with the Trust's management. Again, this we had already done. I am aware that my colleagues sought advice from other organisations and this was fed back to us all as a group.

14. I did have training from the Trust on the processes used to review deaths retrospectively in adults. I cannot remember the date of this training. It did not cover child deaths or processes and organisations relevant to child death, such as Child Death Overview Panel (CDOP) or Sudden Death in Infancy/Childhood (SUDI/C). It did not cover when and how to raise concerns or suspicions regarding possible criminal actions. I do not think our paediatric training covered in sufficient detail the CDOP process but would also note that the training programme was revamped in 2018 and I feel this is now more comprehensive.