had not yet started enteral feeds (feeding with milk via a feeding tube) and was being treated for suspected infection with antibiotics. He was receiving parenteral nutrition (IV nutrition) via a peripheral intravenous cannula. This is a temporary route for providing IV nutrition and more secure central IV access is required for longer term nutrition. Due to this, I made the decision that a more secure central line (which is safer for delivering parenteral nutrition through) was required. This was via an umbilical venous catheter (UVC) where the line is inserted into the vein in the umbilical cord and thread into a central position inside the body. I performed the insertion of this line jointly with Dr MacCarrick (ST1 Paediatric Trainee) as I was teaching her how to perform the procedure. It is a sterile procedure, so we were both wearing sterile gowns and gloves to perform this procedure inside the incubator. The difficulty when inserting a UVC is that the length of the line is calculated but the line may not follow the veins directly into the inferior vena cava via the ductus venosus as intended but instead pass into the portal veins and be malpositioned. This can be identified by the position of the line on a x-ray. On reviewing the x-ray of Child A after we had inserted the UVC, we identified that the line was likely in the portal vein due to the shape the of the path the line had taken. Rather than being straight and finishing just below the diaphragm it curved towards the liver. I discussed this with Dr Jayaram (Paediatric Consultant on-call for the neonatal unit that day) and he agreed we should remove the line and try again to pass a new line via the umbilical vein, hoping it would be positioned in the inferior vena cava as intended. As Dr MacCarrick had watched and jointly put the previous line in, I asked her if she was happy to do this repeat procedure independently, which she was. She informed me and has documented in the clinical notes at **[INQ0000017]** that the line had been inserted without any difficulties and she was waiting for a repeat x-ray to review the position on the tip again. I have documented in these clinical notes that on review of the repeat x-ray, the UVC tip was again malpositioned towards the liver and needed removing.

12. We were informed in the handover the next day by Dr Lambie (Paediatric Registrar) about Child A's death. As noted in my statement at **[INQ000054],** I was surprised. I do not recall the details of exactly what we were told in that handover other than that he had died. I do not recall specifically who else was in the handover that morning or whether there was any further discussion about the death, but the morning handovers were normally attended by the day and night medical teams.

13. I have stated in my statement at **[INQ000054]** that Child A's death *"came completely out of the blue"* because I was surprised by his death. When I had left the neonatal unit on the evening of 8th June, I did not expect him to die that same day. He had been stable for a preterm baby with stable blood results and requiring relatively moderate support for a preterm baby with cpap in air.

14. There had been no complications with the UVC insertion that would have made me suspect him to deteriorate. The malposition of a UVC into the portal vein would not lead to the death of a baby, it would just mean the line cannot be used as intended and needs replacing and this is a known complication of UVC insertion. Based on his clinical condition when I had left the neonatal unit the previous evening, I did not expect him to die and was therefore surprised by his death and felt it *"came out of the blue"*.