there were no other concerns with Child I's abdomen that shift. I was not still working in the Countess of Chester on 30th September 2015 when the alleged first attack occurred.

HM Coroner – Child A

30. In my statement for the Coroner on 23rd February 2016 at [INQ0008476], I have not made reference to the statement I made in my police interview on 6th February 2018 that Child A's death was unexpected and *"came out of the blue"*. This is true, I did not state this in my statement for the Coroner. The reason this was not included was because I understood my statement to the Coroner was a factual statement of my involvement in relation to Child A's care and the events that occurred, rather than including opinion or speculation. At that time, I was not aware that there was a concern about any individual staff member on the unit and I had not worked on the unit since September 2015, so I was not aware of any other discussions taking place in the hospital. I was not asked directly to include whether I was surprised by the death in the statement for the Coroner, I was asked this question directly by the police. With the knowledge now of what occurred on the unit, my opinion that the death was unexpected may have been relevant, but at the time I provided a factual account of my involvement of the events and was aware that the death was being reviewed by the Coroner. I was aware at the time that by virtue of an inquest being held, this meant that the death was unusual and was being considered as such as otherwise a death certificate would have been offered without the need for an inquest.

31. I gave oral evidence at the inquest. My recollection of what this entailed was answering questions around the insertion of the UVC, how and why this procedure is done and the known complication of the line position being in the portal vein. I do not recall the specific date when I gave my evidence to the Coroner. I do not recall when I found out the conclusions to the Coroner's inquest, and I was not involved in any subsequent discussions regarding this finding.

Response to Neonatal Deaths

32. I do recall finding the number of collapses or deaths on the unit at that time as unusual and concerning. I am unsure specifically when this appeared to me as unusual, but it is likely to be around the time of several of these collapses/ deaths that occurred within a few weeks of each other in June 2015. Whilst I do not recall that I specifically approached any Consultant in particular to raise specific concerns. I believe the whole department was discussing this informally as being unusual and that the senior Consultant team were raising this and investigating what could have caused this. However, at my level I would not have been involved in these specific discussions. I felt confident that the Paediatric Consultants were taking the rise in deaths seriously. I do not think I had specific access to the mortality data from MBRACE-UK, NNRD or NHS England at this time.

Reviews of Deaths and Adverse Events

33. I do not recall specifically the process for reviewing neonatal deaths on the unit at that time or what discussions occurred at network level. I was an ST3 trainee at this time so would not expect to be involved in these specific reviews or how mortality reviews were organised in the department at this time. I do not recall the specific process for reviewing neonatal deaths on the unit at that time and which doctors were involved in