35. I do not recall anyone raising concerns about the number of neonatal deaths on the unit during the Neonatal Mortality Meeting referenced in the document at **[INQ0003288]**.

36. I do not recall how often mortality meetings were held on the Neonatal Unit or how many of them I may have attended during my placement.

37. I do not know how many deaths occurred on the Neonatal Unit in 2015-2016, although I understand that this information may now be publicly available.

38. I do not believe that I had access to data prepared by MBRRACE-UK, the National Neonatal Research Database (NNRD), NHS England or any other organisations regarding the mortality rate and number of serious adverse incidents on the Neonatal Unit when I worked there in 2015-2016.

39. I do not recall many details of the hospital's processes for identifying lessons learned about adverse incidents or deaths in the hospital during my time there in 2015-2016. I believe that the hospital used an online incident reporting system at this time. I believe that the department conducted regular joint Neonatal Morbidity and Mortality meetings with the Obstetric Department, but I do not recall the frequency of these meetings or the format that was used to record findings or to disseminate lessons learned. I do not recall being involved in discussions with any local network of hospitals about adverse incidents and/or deaths of babies that occurred on the neonatal unit.

40. I recall developing a subjective sense of concern about the number of deaths and unexpected deteriorations on the Neonatal Unit during my placement there in 2015-2016. I recall discussing these concerns informally with colleagues, for example, highlighting that shifts had been unexpectedly busy at Consultant handover meetings, but I did not raise these concerns formally. In part, I believe that this is because I was confident that these observations had already been noted by the more senior cohort of medical and nursing colleagues, and in part this was because I held the assumption that the episodes were related to unexplained or unexpected medical factors rather than being caused by factors related to deliberate harm or incompetence.

41. I do not recall any details of formal processes for investigating the deaths of babies on the Neonatal Unit beyond being invited to participate in relatively informal "debrief" discussions. I do not recall how post-mortem arrangements were coordinated on the Neonatal Unit or whether there was a formal process for determining whether post-mortems would be requested.