168. I was aware of Child I before she died, as she had been transferred back from LWH on 18 August 2015 and I was responsible for her care on 6 September 2015, after she had deteriorated overnight. Child I was transferred back to LWH that day for suspected NEC. The impression of the team at the time was that her deterioration was typical of NEC.

169. I cannot remember the exact time I was informed of Child I's death but I am sure that I either spoke to Eirian Powell or emailed her on the day Child I died (Friday, 23 October 2015) and discussed the association with LL. I was concerned regarding the repeated nature of Child I's collapses and the apparent rapid improvement after short admissions to LWH and Arrowe Park NNUs.

170. I was emailed by Eirian Powell on 23 October 2015 (INQ0005609). In this email she gave her views about Child I's care, her views about the association with LL, and attached a staffing analysis (INQ0003189) of the deaths in 2015 including Child I. I was keen to talk about LL with Eirian Powell because I felt we both needed to acknowledge the association between LL's presence on the NNU when these deaths occurred. I did not feel completely reassured by her assertions that all the cases were different, that some had NEC, gastric bleeding or congenital abnormalities and that some were ill on arrival.

171. Dr John Gibbs held a debrief for staff on the NNU on 3 November 2015. I recorded the mortality review (INQ0003286) that was undertaken on 31 October which summarises Child I's care and multiple transfers between hospitals. The impression of the clinicians looking after her at the Countess of Chester (and presumably Arrowe Park Hospital and LWH), was that she had some abdominal pathology causing her sudden deteriorations. Nursing staff and some medical staff involved were also concerned regarding a number of operational issues: delays in the transfers with the neonatal transport service, delays in discussions between medical and surgical staff in different centres, decisions made regarding where Child I was transferred to (surgical patients would normally be transferred to Liverpool) and concerns regarding their opinion that Child I was transferred back from Arrowe Park Hospital before she was sufficiently clinically stable. There was concern that important abdominal pathology had somehow been missed. The actions taken after Child I's death should be viewed in the context of these concerns and that there was no postmortem result available, which most staff assumed would show pathology, probably abdominal, that caused her death.

172. I discussed Child I with the surgical team at Alder Hey (Professor Simon Kenny). My
INQ0103119 follow up email dated 10 December 2015 appears at **Exhibit SB15** and I also emailed the
INQ0103121 neonatal network team on 26 November 2015 (**Exhibit SB16**). It was agreed to undertake a cross hospital tabletop meeting to review Child I's care. Although my concerns regarding LL had grown, I felt it was important to wait for the results of this review of Child I's care and the postmortem result. If the postmortem result had shown evidence of NEC, then there would have been an explicable reason for Child I's collapse.

173. Debbie Peacock was reporting every death on an "SBAR" form to the SI panel and Eirian Powell had mentioned discussion with Alison Kelly in her email, so I was quite confident Executives were aware of all the deaths, although I received no communication from them at

this time. It was around this time and after a discussion with Dr Jo Davies, Consultant Obstetrician, that I started to consider a further review of all the deaths with some external expert support. The increased death rate was a considerable worry for me, but it felt striking that, other than some of my consultant colleagues, no-one else within or outside the Trust seemed concerned or were requesting urgent meetings or reviews.

174. In relation to Yvonne Griffiths' police statement (INQ0000531) in which she recalls a conversation with me around 14 October 2015, I do not remember this conversation. Dr Murthy Saladi, Dr John Gibbs and Dr V were involved with Child I's care that week and I cannot remember anyone raising any concerns with me at that time. I cannot remember discussing my concerns regarding LL with any nurses, other than Eirian Powell, on the NNU in 2015. Yvonne Griffiths was the deputy NNU manager at the time and Yvonne Farmer was the practice development nurse. Both shared an office with Eirian Powell, so it is possible they might have overheard my discussions with Eirian Powell. I might have had a conversation with Yvonne Griffiths about LL later in 2016, but I think it is very unlikely any conversation between us on this subject took place in 2015.

175. In relation to paragraph 90 of my Rule 9 letter, I do not recall any meeting with Ian Harvey in October 2015. INQ0003614 appears to be an email from Ruth Millward to various senior managers, including Ian Harvey and Alison Kelly, with attachments of all the "SBAR" forms that risk facilitators had sent for review at the SI panel. The first SBAR, "I&S – NNU review by Stephen Brearey" would have been for one of the babies who had died. However, the code used is from the Datix system and I am unsure which baby it is referring to.

176. My police statement dated 4 July 2017 (INQ0007661) p234 has a mistake in the spelling of Dr Nim Subhedar (mis-spelt SUBADAL), who was the clinical lead for the Cheshire and Merseyside Neonatal Network. As stated above, I first mentioned the increased mortality rate in the Countess of Chester informally after the CEG meeting on 16 September 2015. I then emailed him following the death of Child I (**Exhibit SB16**). I then asked him to take part in a review of all the deaths in the Countess of Chester later in 2015. I cannot recall the exact time or how I asked. I did not mention to him the association of the deaths with LL because I wanted him to be objective in reviewing all the cases first, without any bias. I thought it would be a more robust process if he did not know until the end of the thematic review meeting. Dr Nim Subhedar agreed to attend the meeting, but it took much longer to organise than I was hoping for.

INQ0103121

177. In reference to the review of Child I's care that was undertaken on 31October 2015, there was no reference to "staffing factors (whether incompetence or deliberate harm)" because the purpose of these reviews was the exact opposite. Clearly, if we identified significant clinical errors then these would be recorded, and the appropriate measures would be taken in terms of staff reflection and training. However, a healthy risk conscious clinical team was expected to have a "no blame" culture, so that any sub-optimal care that was picked up in the reviews could be shared and the whole team could learn from them, without individuals feeling they had been punished. During the review there did not seem to be any significant issues with competency or numbers of staff available. It would not have been