Baby (born [redacted] January 2016)

194. One of twins, this baby died on 8 January 2016. Reviews were undertaken as previously. The consultants raised concerns to executives in 2016 and to the police in 2017.

Cheshire and Merseyside Neonatal Network Clinical Effectiveness Group Meeting on 21 January 2016

195. I attended this meeting and the minutes (INQ0005559) seem an accurate reflection of the meeting. As with all the CEG meetings, a large number of neonatal mortalities were discussed as the mortality rate in the intensive care units (NICUs) was usually much greater than in local neonatal units (LNUs) such as the Countess of Chester. Incidents were also discussed at the meeting. This meant that the discussion of each mortality was brief. The main purpose of the meeting was to share learning from these events across the network. I did not think it appropriate to discuss the increased neonatal mortality in association with LL at this meeting with professionals from every hospital in the network for reasons given earlier in my statement.

196. I emailed Dr Ravi Jayaram, Eirian Powell, Anne Murphy, Yvonne Griffiths, Dr Joanne Davies and Debbie Peacock to update them regarding my discussion with Dr Nim Subhedar after the CEG meeting (INQ0005643). He was willing to attend the thematic review meeting. In addition to Dr Nim Subhedar, I also invited senior members of the team who I felt had enough expertise and experience to usefully contribute to the review. This included Dr V (Consultant paediatrician), Eirian Powell (NNU manager), Ann Murphy (Lead nurse for Children's services), Laura Eagles (senior NNU nurse) and Debbie Peacock (Quality improvement facilitator). Chris Green (Director of Pharmacy) was also invited but did not attend. Dr Ravi Jayaram and Yvonne Griffiths were unable to attend that day. Laura Eagles was attending on behalf of Yvonne Griffiths.

Thematic Review of Neonatal Mortality 2015 – Jan 2016 – 8 February 2016

197. Eirian Powell emailed me with a further staffing analysis with LL's name highlighted in red (INQ0005643_0001-0002) on 19 January 2016. I can remember asking Eirian Powell to update the previous staffing analysis she had completed in preparation for the thematic review meeting. I asked her to do this because I was aware of a further two neonatal deaths in December 2015 and January 2016 and hoped these could be included in the meeting. Attendees were:

S Brearey	Neonatal lead
Dr V	Consultant
N Subhedar	LWH consultant
E Powell	NNU manager