It was clear to me that Eirian Powell did not have the same level of concern about LL as I did. It was also clear that some of her arguments to defend LL did not seem rational or reassuring. Comments such as LL being with us since 2012; that some doctors were present for some of the deaths too and that the causes of deaths were different were not reassuring to me but seemed to be the foundation of Eirian Powell's defence of her colleague. I hoped that discussing these issues with her might allow us to take the right actions together.

210. I cannot recall a meeting taking place that I requested after Eirian Powell returned from leave, but we may have had one or more informal discussions. Eirian Powell's email to me on 15 March 2016 (INQ0005697) probably followed one of these discussions. The email summarised the annual deaths on the NNU 2010 to 2016 and a statement that LL had worked on the NNU since 2012. I interpreted this email as Eirian Powell telling me that if LL was linked to the deaths in some way, we would have seen a rise in mortality from 2012 rather than from 2015.

211. On 17 March 2016, Eirian Powell emailed Alison Kelly (INQ0003089_0002) to request a meeting. The commonality with LL was included in this email. I hoped that meeting Alison Kelly and Ian Harvey would allow us to escalate the problem appropriately and help protect my working relationship with Eirian Powell. From our discussions, Eirian Powell was already aware that I had emailed Ian Harvey and we were still waiting for a reply in terms of a meeting date, so she agreed to send the email on 17 March to try to expedite the meeting with Alison Kelly and Ian Harvey. The meeting eventually took place on 11 May 2016.

212. On 7 April 2016, Eirian Powell moved LL to day shifts. I was not informed of this decision at the time and was only informed by Eirian Powell in May 2016. Eirian Powell told me she had done this for pastoral reasons due to the stresses LL must have experienced from being present at so many deaths. She explained that it was intended to be for a period of three months up to the end of June 2016. In a minor way this decision was reassuring because I was aware of the high proportion of deaths that had occurred after midnight. I was not aware of any sudden collapses or deaths at night between 7 March and 11 May 2016, which was both a relief and a worry to me. I later found out from the police that LL did in fact undertake some night shifts in June and that one of these shifts involved a baby suddenly and inexplicably deteriorating with an unusual rash.

**CQC visit to the hospital 16-19 February 2016**

213. There was a great deal of preparation before the CQC visit so that the Trust could present itself during the inspection in the best light. I attach an email from the Trust's CQC compliance lead, Sally Goode, responding to what seems to have been my request to attend an interview and to talk about neonatal care (**Exhibit SB23** is an email from Sally Goode to me dated 10 February 2016). **INQ0103141**

214. I can remember sitting in a room in the education centre of the hospital with my paediatric consultant colleagues and the CQC inspectors, who included a neonatal consultant. Early in the meeting, Dr ZA said something like "we have some serious patient safety concerns