225. The second attachment "NNU mortality 2015.docx" (**Exhibit SB24**) is a copy of Appendix 1 of the thematic review report which included staff names present for every baby, but with an added column entitled "Date and time of initial deterioration" but which has clinical details for each case and Dr David Harkness's name in red, whenever he was involved. I assume the implication was that he might have somehow been responsible for the collapse or death. His name appears in this column for four babies. **INQ0103142**

226. The third attachment is "NNU monitoring mortality 14 04 16.docx" (**Exhibit SB25**) – this includes three babies: one baby who died shortly after birth in February 2016 with a condition called severe foetal hydrops and was never expected to survive (Dr John Gibbs is highlighted in red for this case); another baby who died in March 2016 who was born with multiple congenital abnormalities and was not part of the indictment (Dr John Gibbs is also highlighted in red for this case); and Child M (Dr John Gibbs was Child M's consultant). I assume the implication was that Dr John Gibbs might have been in some way at least partially responsible for these deaths. **INQ0103143**

227. The fourth attachment was "Neonatal Unit review 2015 assurance.docx" (INQ0003243). I assume this was written with the intention of assuring Executives that there were no concerns that LL might be responsible for any of the neonatal deaths. 15 assurance points are listed. Some of the points were clearly irrelevant. Some points falsely attributed the deaths to other staff members (Dr John Gibbs and Dr David Harkness), the unavailability of cots in other hospitals and problems with the transport service. It states, "There is no evidence whatsoever against LL other than coincidence." The document seemed poorly written and lacked any objectivity. The arguments in the document are the same that were used the following week by Anne Murphy and Eirian Powell when we met Ian Harvey and Alison Kelly.

228. After learning of this meeting, I felt let down by Eirian Powell and very disappointed that she had not invited me to the meeting and that she did not feel able to talk to me herself about these opinions, without going to a senior manager about them. I had very little contact with Karen Rees before then and knew that she would have been relatively unfamiliar with the events on NNU since June 2015. I was uncertain whether she had any neonatal experience or expertise.

Meeting with Executives 11 May 2016

229. On 11 May 2016, Ian Harvey and Alison Kelly met Anne Murphy, Eirian Powell and I to discuss neonatal mortality, the thematic review and the association with LL. I think the written notes (INQ0003181) belonged to Alison Kelly. I can remember her taking notes during the meeting. My recollection of the meeting is that I started by talking about the thematic review report. I explained that we had found some clinical areas of practice we could learn from in some of the cases, but they were all relatively minor and none were common to all the deaths. Generally, I was happy with the NNU being an area of good practice and the previous annual mortalities had been quite low. I felt the number of deaths in 2015 and early 2016 were exceptional. I highlighted that six of the nine deaths occurred between midnight and 0400

which was unusual. I highlighted that there seemed to be a disproportionately high number of sudden unexpected collapses. We had reviewed care on multiple occasions, including with an external neonatologist, and the only common theme was the association with LL being on duty. We needed guidance and help on how to take this forward. I also made it clear these were concerns of my colleagues and were not mine in isolation.

230. Anne Murphy and Eirian Powell countered my concerns quite forcibly and with great emotion, using the arguments described above in the assurance document (INQ0003243). I can remember one part of the conversation regarding Dr John Gibbs when I explained that consultants are usually not at the cot side when a baby collapses unexpectedly as we are usually called to assist when nursing and junior medical staff have already started resuscitating a baby. As well as Dr John Gibbs being present for significantly fewer cases than LL, this made his culpability in these cases highly unlikely. Anne Murphy disagreed with a fervour that I had not seen before. The comments from the handwritten record (INQ0003181), "absolute no issues with the nurse" and "circumstantial" are quotes from Eirian Powell and Anne Murphy during that meeting.

231. In the handwritten record, one baby is described under the heading of suboptimal care – this baby died in December 2015 and was not part of the indictment. A junior pharmacist had overridden a consultant decision regarding the frequency of iv antibiotics. Regardless of who was correct, I did not think this was the cause of the sudden collapse of the baby during a subsequent night shift. I explained this at the meeting. LL's background was discussed including that she trained at Chester University, the Countess of Chester hospital and started work in 2012. It was also discussed that there had been no overnight collapses since she started day shifts.

232. Alison Kelly and Ian Harvey appeared quite passive at the meeting and I formed the impression they had not read the thematic review report beforehand. Alison Kelly suggested we meet again before LL was due to re-start night shifts at the beginning of July. There seemed to be no other actions from the meeting. I did not feel that this was an adequate response to my concerns. The fact that there had been no deaths or collapses at night, as far as we were aware, since March 2016 was not completely reassuring. With a feeling of anxiety and confusion, it was difficult to know what to do next following this meeting. I can understand that Eirian Powell and Anne Murphy were clearly close to LL, emotionally driven and seemingly in denial of the facts. However, I was surprised and still do not understand Ian Harvey and Alison Kelly's response to the concerns I raised. The same concerns were raised to the CDOP panel and to the police a year later and the responses from these non-clinical professionals could not have been more different. Similarly, my initial discussion with Susan Gilby two years later seemed to lead to her understanding the gravity and worrying nature of the incidents almost immediately. It seemed that Eirian Powell and Anne Murphy's illogical views weregiven more credibility than me and my colleagues' concerns.

233. I discussed the meeting with Dr Ravi Jayaram afterwards. I also sent an email to my INQ0103144 colleagues dated 16 May 2016 (see **Exhibit SB26**) asking them to contact me if they are aware of a baby who deteriorates suddenly or unexpectedly or needs resuscitation. When writing