25. Another colleague would be rostered to cover between 0830 on Saturday to 0830 on Sunday, allowing 24 hours of rest for the POW consultant. POW weeks would be swapped with colleagues to allow for annual leave requests. The number of consultants and this type of rota was very similar to most other district general hospitals with local neonatal units at the time.

26. Trainee doctors are qualified doctors who are not yet consultants. The most junior trainee doctors are at Tier 1, traditionally called senior house officers (SHOs) or more recently paediatric specialist trainees (ST1 and ST2). There were also Tier 1 doctors working on NNU who were training to be GPs (GPSTs). Tier 2 doctors were more senior paediatric trainee doctors, traditionally called registrars or "middle grade" doctors but more recently called paediatric ST3 to ST8. An ST8 will be in their 8th year of paediatric training prior to becoming a consultant.

27. In 2015 and 2016, the minimum medical cover on the NNU was a tier 1 and tier 2 doctor working every weekday between 0830 and 1630. There was also another tier 1 doctor working on the post-natal ward, allocated to undertake newborn examinations, who could be called upon to help on the NNU, if needed. There might have been more tier 1 doctors on NNU than this, depending on annual leave and training days.

28. There was also a number of nurse practitioners who could undertake advanced tasks on NNU such as blood tests and intravenous (IV) cannulation.

29. After 1630 on weekdays there would be a "long day" tier 1 doctor working on the NNU until 2100 and a tier 2 doctor covering both NNU and the Children's Ward. From 2100 to 0830, the night team would consist of one tier 1 doctor and one tier 2 doctor, covering both the Children's Ward and NNU with the "on call" consultant available for advice and to come in, if required. This rota system was common to most similar sized district general hospitals at the time.

Safeguarding

30. All doctors receive safeguarding training, and all paediatric doctors receive paediatric safeguarding training which is updated annually. Part of my role as an acute general paediatrician is to undertake safeguarding assessments when a child or infant is suspected to have been harmed.

31. Training is focused on scenarios in which a baby or child might have been harmed by a family or household member. I cannot remember at any time in my career discussing or being trained in respect of what to do where abuse on the part of a member of staff towards babies or children in hospital is suspected. However, for example, investigation of an unexplained bruise on a baby that is thought to be non-accidental would be the same for a baby who has been in hospital as for a baby who has been at home.

32. I am aware of British Association of Perinatal Medicine (BAPM) guidance regarding the sudden post-natal collapse of term babies born in good condition in hospital. This focuses on rare