119. I would have spoken with the CQC at some point during the visit but have no specific recollection now of what was discussed.

120. I am told that it was reported in the media that "*senior doctors told inspectors from the Care Quality Commission (CQC) in early February 2016 that they had raised patient safety concerns with senior management but felt they had been ignored. The CQC said it alerted [Ian] Harvey to these concerns the same day.*" I have not seen a copy of this article. I have no recollection of the CQC raising any such concerns. This concern is not reflected in any of the documents I have seen relating to the CQC visit. I find it extremely unlikely that the CQC would not have included this in their report or their brief to the Board had they had any such concerns.

121. It is unclear who is referred to by "senior management", but I would like to clarify that at this time, I was not aware of any patient safety concerns. I was aware of the neonatal deaths in 2015 but was of the view that these were being investigated and that any concerns revealed by those reviews would be escalated.

Deterioration of Child K (17 February 2016)

122. Child K deteriorated unexpectedly on two occasions on 17 February 2016. I was not informed of either of these events.

Thematic Review of Neonatal Mortality Report (2 March 2016)

123. A further version of the Thematic Review of Neonatal Mortality Report is dated 2 March 2016 **INQ0006817** This version includes an additional entry which reads: "*Sudden deterioration. Some of the babies suddenly and unexpectedly deteriorated and there was no clear cause for the deterioration/death identified at PM.*" I had received an earlier version of this report in an email from Dr Brearey on 15 February 2016. This report could be the attachment in the email sent by Eirian Powell to Alison Kelly and I on 21 March 2016 [INQ0003089/01], but without access to the original email I cannot be certain.

Email from Dr Stephen Brearey (2 March 2016)