were ongoing and that a decision would be made by the Board in respect of the actions to be taken.

15. At paragraph 51 of my first statement I said as follows regarding a meeting on 29 June "*there was a discussion in relation to the implications of what calling the Police would mean for the COCH during which I echoed my thoughts which I had expressed during the meeting at 1pm, in that the NNU would be closed, the Police would carry out an investigation, all staff would be interviewed and the nurse would likely be arrested. These were factual steps which I thought would occur based on my own experience*". I have been asked whether I said this because I thought there was a reasonable suspicion that the nurse had committed an offence.

16. At paragraph 56 of my first statement I said that during a meeting on 30 June 2016 "*I again explained my understanding of what action the Police would take which would include a full investigation, the interview of staff, examination of any potential crime scene and if appropriate arrest any suspects*". I confirm that this statement is an accurate reflection of my understanding at the time. To the best of my recollection I was explaining the steps that I thought the police would take if they had reasonable suspicion that the nurse had committed an offence. I did not have any evidence that, nor did I have a reasonable suspicion that, the nurse had committed an offence.

17. I have been asked to consider and comment on what Ian Harvey, Alison Kelly and Tony Chambers say about my advice about going to the police generally. My solicitors have read the relevant evidence to me. I cannot add anything further than stated within my first statement, but I would like to add again that my recollection is based upon contemporaneous notes that I made of the discussions at the time.

Dealings with the Coroner

18. I have been asked about document INQ0008638, which is a document entitled "Guidance on Writing Statements". I did not draft this document as this was not within my role. It is more likely in my experience that solicitors instructed by the Trust would prepare documents like this. I knew that such documents existed and that they were not uncommon, but I am unable to provide detail as to when such documents would be provided to witnesses. I recall that if a doctor or nurse within COCH requested help in relation to a legal matter arising out of their role at COCH then guidance documents would be available to them.

19. I have been asked to consider and comment on what the Coroner and Assistant Coroner said about the communication I had with the Coroner's office on 8 July 2016. To the best of my recollection, the purpose of my call was to fully brief the Coroner,

or the Assistant Coroner in the Coroner's absence, and I did so and told him everything available to me. I liaised with the Coroner on a regular basis and it is my strong recollection that on 8 July 2016 I called him and updated the Assistant Coroner in respect of everything I was aware of about the current position, including the suspicions relating to Lucy Letby.

20. I have been asked what the basis was for my comment to the Coroner in an email of 6 October 2016 (INQ0107964) that RCPCH was "entirely satisfied with the care within the neonatal unit and raised no concerns". I cannot recall the specific reasoning as to why I made this comment at the time. However, throughout my career as a police officer and as a solicitor, all of my communications with the Coroner's Court were honest and well intentioned. The intention was to share the RCPCH Review Report in full with the Coroner in any event. In addition, I can see that within the same email I stated "Dr Ravi Jayaram as the lead Consultant is also fully aware of this matter. He is called to give evidence at this inquest and will be able to answer any questions regarding the review". This demonstrates that I was alerting the Coroner to the opportunity to ask questions about the review to the relevant witness, Dr Jayaram.

Inquests into the deaths of Child A and Child D

21. I have been asked a number of questions about the Inquest of Child A. Specifically, I have been asked whether I attended a meeting on 8 September 2016 in advance of the Inquest of Child A. I have referred back to the notes in my notebooks dated 8 September 2016 and whilst my notes confirm that I attended an EDG meeting at 11am on that date (as referred to at paragraph 93 of my witness statement dated 12 August 2024), I have no further notes of any meetings from that date and as such am unable to provide any detail in relation a meeting on 8 September 2016.

22. I have been asked to confirm the name of the "external legal adviser" present at the meeting on 6 October 2016. Counsel, Louis Browne, of Exchange Chambers was present at the meeting on 6 October 2016. It was not unusual for external legal Counsel to be instructed in relation to Inquests in which COCH had involvement, due to the specialist nature of the process and the legal assistance required both in respect of COCH and any employees required to give live evidence to the Coroner during the Inquest. The Trust worked with Hill Dickinson as part of the NHS Litigation Authority ("NHSLA") process. As I was a qualified Solicitor, I was able to instruct Counsel directly which saved money in external solicitors' fees for the Trust, and so I did that from time to time if I considered appropriate.