

Advice call- Countess of Chester Hospital NHS Foundation Trust - 18 May 2017

Date & time of call: 18.05.17, 13.54

Call duration: 15 minutes

Name, designation, Tel no and email of caller: Alison Kelly, DoN, 01 Irrelevant & Sensitive  
alison.kelly9@ I&S

Name of organisation: Countess of Chester Hospital NHS Foundation Trust

Name & PIN of Registrant: Lucy Letby. PIN: I&S

Brief reason for call: On 17.05.17, AK requested a telephone discussion with Tony Newman or Kristian Garsed, in relation to the Royal College of Paediatrics and Child Health Service Review November 2016. An arrangement was made for KG to call AK on 18.05.17 at 09.30am. Called at 09.30am was advised that she had been required to deal with some urgent issues and was overrunning so I provided my mobile number and requested to be called back. Call back received at 13.54 prior to which during the morning I received an email with a press release and attached regulator and stakeholder briefings in relation to the announcement of a new police investigation into the neonatal deaths, being undertaken by Cheshire Police. (Email in docs.)

Discussion / advice: AK explained that this has been an ongoing situation since June / July 2016 and that the RCPCH full service review provided to the Trust in November 2016, had been thought to be likely to be the last stage in examining the heightened neonatal mortality rate in the period June 2015 - June 2016.

AK advised me that as she had explained to TN previously there was a view held by several medical colleagues that a registrant (Lucy Letby) may be the common denominator, and are quite strong in their view that she may be the cause. This is largely based on an identification of her as having been present on most, but not all of the occasions, when infants collapsed and or died. However, as is noted in the RCPCH review there is no certain picture of who was present on these occasions, and the most in depth analysis undertaken of the staffing situation, did not extend to non-clinical staff. In addition, the registrant has apparently a very good professional history and a high degree of clinical credibility and was not present on all of the relevant occasions. Other staff were present on a similar number of relevant occasions.

The registrant has been moved to a different area and a non-clinical role primarily to support her, by enabling her to work in a different area outside of the pressure of that clinical environment and to protect her from the stress of being under a degree of suspicion from the medical team.

Following on from the completion of the RCPCH review, it has been decided by the Trust that the only option is to invite the police to examine the circumstances of the deaths / near deaths, to determine if there has been any deliberate harm to, or endangerment of, these children, and then only if so, to identify the person or persons responsible.

The police investigation has only just now been initiated and so it at a very early stage. The investigation will examine the circumstances of the deaths of eight babies that