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Countess of Chester Hospital NHS
NHS Foundation Trust

INVESTIGATION INTERVIEW WITH RAVI JAYARAM CONDUCTED BY CHRIS GREEN

DATE 11.11.16

PRIVATE AND CONFIDENTIAL

Present:	Chris Green Lucy Sementa Ravi Jayaram Tom Carter Karen Beard-Jones	Investigating Officer HR advisor Interviewee Union Representative Note Taker
Standard:	CG went through introductions and process. It was explained that notes would be taken and then a copy would be sent to RJ for checking and signing. Any amendments are to be made in red. This meeting is treated as a highly confidential discussion and the content of the meeting is not for discussion with any other persons.	

Body of interview

TC – asked for clarification that they are here today as a witness which was confirmed.

CG – about a year ago there were concerns raised about the mortality rates n Neonatal.

RJ – There was a rise in Neonate death rate and near misses. Premature babies are at a high risk – our rate was comparable to neighbouring units. There was a rise in mortality and they were not the babies you would have predicted – none of these babies responded to timely resuscitation manoeuvres. As a group of consultants we were very concerned that the babies were deteriorating and needed to looked at why. It was raised to Executive Board about increase in death rates – also reviewed individual cases internally. Stephen Brearey organised a thematic review with external reviewers. There didn't appear to be anything in terms of clinical practise, equipment or the environment that was relevant. There did appear to be an association with Lucy Letby either looking after or being present at the time of the deaths. Discussed with the Obstetricians – we were all concerned that we were potentially putting babies at risk when there was something there that might have been a factor. Concerns were raised to the Executives who took further decisions. One outcome was to downgrade the status of the unit. We only look after babies at 32 weeks and above. RCPCH was commissioned to review the service – this has been done and we are awaiting publication of the formal report.

CG – I believe earlier this year there was a meeting with Ian Harvey - agreement made to have a 3 month review as to progress. In the interim there was the incident with the triplets.

RJ – SB had raised concerns earlier in the year– then there was the incident with the triplets in June (*RJ was not on duty or on call at anytime*) these were babies who were getting better and were stable who suddenly collapsed. This led to a review sooner than the 3 months.

CG – In terms of the consultants response to that there was a meeting on a Monday either the week after or the week after that (*RJ to confirm date*). The meeting was to discuss the triplet babies who had died on the Thursday and the Friday and the decision was taken to go to the Executive Board. What were the concerns that were raised?

RJ – Only concerns raised were that we had a statistically significant rise in unexplained deaths and near misses and we didn't know why. We were concerned because as clinicians we were unable to explain why this was happening. We had safety concerns and were worried that if we carry on doing what we are doing, whatever it is we are doing, this might continue. We escalated to the Execs and asked for guidance on what we should do next.

CG – Was there a push to move Lucy?

RJ – All that was said was that we had concerns. We noted the association with Lucy being present. Decisions made were entirely those made by Senior Management – no Clinicians were involved in the decision to remove Lucy from the unit. It was a Board decision.

CG – Was there a suggestion that if Lucy was not moved then the police would be called?

RJ – No. A discussion took place that if no explanation found, then the police may have to be involved. Don't recall any discussion as explicit as that. Concern was raised about Lucy as she had been exposed to so many deaths. Both the consultants and nursing colleagues felt that it could have been traumatic for her.

CG – Was deliberate intent by Lucy suggested? That she might have been doing something to the babies - air embolism was mentioned.

RJ – I'm not here to speculate on things. Can only say that the consultants had concerns and they escalated these to the Executive Board.

TC – I agree that we should avoid speculation. RJ is here as a witness whilst there are ongoing investigations outside as well unfair to speculate.

CG – So to avoid speculation did you hear any suggestion that Lucy had been deliberately harming babies?

RJ – No objective evidence to suggest this at all. The only association was Lucy's presence on the unit at the time. Anything else is speculation.

CG – So to clarify, was there any suggestion from any of the consultant team that Lucy had been deliberately harming babies?

RJ – We discussed a lot of possibilities in private.

CG – So that's not a yes or no?

RJ – We discussed a lot of possibilities in private and took our concerns to the Executive Board.

CG – So Lucy's removal was not instigated by Consultants?

RJ – The decision was taken at a much higher level than Paediatric Consultants – don't know what the decision making process was and who made the decision.

CG – If Lucy was to return to the unit would you have any concerns?

RJ – That decision should be made by those who removed her after completion and outcome of the report

CG – If the report shows no foul play, would you have a problem with her returning?

RJ – If the Executive Board felt it was appropriate for her to return then she would be back working on the unit. If subsequently there were further associations we would raise concerns but that would be speculation.

CG –The nursing staff have said that Lucy is a good nurse, very experienced and well-trained in looking after the sicker babies. It is likely that Lucy as a nurse will be looking after a baby that dies therefore she will be associated.

RJ – In a small unit with high intensity babies every nurse will be associated with babies that deteriorate.

LS – I assume there is a percentage or a threshold of the number of deaths for a unit this size?

RJ – On average 2 or 3 in a year - number has increased to 9 in a year. Concern was not just the deaths but also the way in which the babies collapsed.

LS – Is it looked at in terms of every Trust or unit as individual or is there a percentage threshold at which point it would become a concern?

RJ – It's a concern as we compare our own levels with other units in the area and we have always been comparable. There isn't a percentage threshold where you need to take action. We felt as a consultant body that there was a significant enough increase to escalate to the Board.

LS – Originally it was suggested that Lucy would undertake a period of supervision and redo clinical competencies on the unit?

RJ – I am aware that it was one suggestion that Lucy would work under direct supervision – don't know why this was not taken up.

CG – It was felt at the time there weren't enough staff to both supervise and complete routine work.

RJ – It is a very difficult situation. There is still no explanation for the increase in the death rate nor why the individual patients deteriorated didn't respond. It is hoped that the report will elucidate this

(it was agreed that a copy of the minutes would be forwarded to TC)

Meeting Closed

I declare that this is a true and accurate record.

Interviewee:-

Signed_____

Date:_____

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Countess of Chester Hospital NHS
NHS Foundation Trust

INVESTIGATION INTERVIEW WITH STEPHEN BREAREY CONDUCTED BY CHRIS GREEN

DATE 11.11.16

PRIVATE AND CONFIDENTIAL

Present:	Chris Green Lucy Sementa Stephen Brearey Jenny Bremner Karen Beard-Jones	Investigating Officer HR advisor Interviewee Union Representative Note Taker
Standard:	CG went through introductions and process. It was explained that notes would be taken and then a copy would be sent to SB for checking and signing. Any amendments are to be made in red. This meeting is treated as a highly confidential discussion and the content of the meeting is not for discussion with any other persons.	

Body of Interview

CG – About a year ago there were concerns raised about the mortality rates on the Neonatal unit - what was behind them?

SB – Attended a meeting with Ian Harvey, Alison Kelly, Ruth Millward and Eirian Powell in June/July 2015 regarding 3 Neonatal mortalities that were close together.

CG – During the meeting were any concerns aired about why that might have happened?

JB –Asked SB for clarification of whether this was a formal meeting he had attended and whether notes were taken?

SB – Replied yes and that there was a note taker however he had not seen any notes/minutes. The cases were discussed individually. Alison Kelly asked Eirian Powell whether there were any nurses on duty on all 3 cases – Eirian replied only Lucy Letby.

CG – What prompted Alison to ask that?

SB – Believe that they were looking at all possible avenues - that he wasn't involved and was a spectator to the discussion between Alison and Eirian.

CG – You met with Ian Harvey earlier in year and agreed a 3 month review. Before the 3 month review could take place 2 of the triplets died. From your perspective what happened?

SB – Are you talking about the meeting with Eirian? In what terms...

CG - In terms of what led to Lucy being redeployed from the unit?

JB – How would you know that? What led to it?

SB – It wasn't my decision. We had undertaken a thematic review of the deaths in 2015 and one that occurred in January 2016. We wanted to identify common themes linking the deaths. (*SB offered to send CG a copy of the report*) From memory there were no issues in terms of clinical care – 6 of 9 died between midnight and 4am. Eirian Powell looked at staff present looking after the babies involved in the review and this is part of the review. SB looked at both junior and senior medical staff involved in looking after the babies – no common cause. Eirian Powell identified that Lucy Letby was on shift around the time of the deaths but was not necessarily the named nurse. The purpose of the meeting with Ian Harvey & Alison Kelly following that was to discuss the thematic review.

CG – Moving forward to when the 2 of the triplets died - what happened around then?

SB – In 3 month period following the meeting with Ian Harvey and Alison Kelly starting to arrange the review meeting prior to Lucy going back on nights. There had been no episodes of sudden collapse or deaths at night. SB not on call, it was Doctor V SB was on the unit for other reasons on the Thursday that the first triplet died. For acuity and because of workload the registrar asked for him to assist and supervise with the incubation. SB was there as an additional consultant and as another pair of hands for Doctor V and was asked to perform an echo cardiogram. On the Friday, similar situation occurred. SB was not as involved – left the unit on a couple of occasions but was present at debrief held by the Neonatal Transport Consultant who was there at the time. On this occasion Lucy was the nurse present looking after the baby. She had been identified as being on shift for the previous deaths during the thematic review and now triplets. Alerted the Duty Nurse Manager Karen Rees with concerns about the association of her being on shift and the deaths and that she was due to work on the Saturday as well. Karen felt that no action to take. SB agreed to raise with the management team on Monday.

CG - What happened on the Monday?

SB – Ian Harvey and Alison Kelly visited Neonatal in the morning with Eirian Powell and Ravi Jaram. Ravi wasn't completely up to speed with what had gone on the previous week. Ian Harvey mentioned that they were asking for an external review. Ravi updated the senior paediatric team at the Monday weekly 12pm meeting. It was agreed at that meeting as a body of consultants and senior nurses that this should be escalated because of the association between shift pattern and deaths. SB spoke to Ian Harvey after that meeting about what the consensus was from us as a group of clinicians

CG – Asked whether the nurses were in agreement? Eirian Powell said that she didn't feel need to be concerned?

SB – Consensus and agreement between all seven consultants. Eirian Powell works more closely with Lucy on the unit. It was agreed to escalate at that meeting. Nobody at that meeting including Eirian said anything to the contrary that included Ann Murphy and Martin.

CG – There was talk about calling the police at that time.

SB – Don't recall that.

LS – Do you recall it ever being discussed about calling the police?

SB – Ever as in?