COCH/100/026/000007

Meeting with COCH, Operation Hummingbird - Minutes / Actions

Held at 09:00 on Friday 12th May 2017
Meeting Room 5, Cheshire Constabulary HQ

Cheshire Constabulary

Darren Martland	Assistant Chief Constable
Nigel Wenham	Chief Superintendent, Public Protection Directorate
Paul Hughes	Detective Inspector, Major Investigation Team
David Bryan	Head of Legal
Laura Fox	Secretary

Countess of Chester Hospital

Tony Chambers	Chief Executive Officer
Stephen Cross	Director of Corporate and Legal Services
Ian Harvey	Medical Director

DM opened the meeting with the purpose. The meeting was a follow up from the preliminary meeting held on 5th May 2017 following a letter sent to Chief Constable Simon Byrne on 2nd May 2017 relating to concerns about a number of child deaths that have occurred at COCH.

To Approve the Minutes from the Previous Meeting held on 05/05/2017
SC had made tracked changes to the minutes issued. The amended minutes were accepted as a true and accurate record.

Actions Update
The Action Matrix was updated accordingly.

Operation Name
SC raised sensitivities around the operation name 'Hummingbird'. There is a film called Hummingbird, which relates to sex, violence and murder. All agreed to change the operation name.

Overview – Cheshire Constabulary
DM opened the meeting with the purpose to establish the current position. It was necessary to consider the sequences and timings from the past week, including reviews, telephone communications and emails.
The preliminary meeting last week focused on the letter received from Chief Executive Tony Chambers, followed by a comprehensive update from COCH including outlining service review, a clinical review conducted by Dr J Hawdon, and a QC review which have been conducted in relation to concerns that have been raised of a number of child deaths from January 2015 to July 2016.
At the conclusion of the last meeting, Cheshire Constabulary were looking at a potential TOR for a police led investigation.

Situational Review – Cheshire Constabulary
Royal College of Pediatrics and Child Heath makes the recommendation for a forensic review of the 13 deaths.

Dr J Hawdon, Consultant Neonatologist, Royal Free London Hospital makes recommendation 6, subject to coroners post mortem report there should be a broader forensic review as described in category 2 a bove after an independent clinical review of these deaths remain unexpected and unexplained.

When referring to category 2, on page 50 there are two numbered paragraphs and it is thought Dr Hawdon is referring to point 2, where the death collapses is unexplained. Reference numbers have been given to the babies concerned:

- Ref No. I&S Child O
- Ref No I&S Child A

Hi Stephen

These are the notes from the meeting with the police - do you need to make any amendments.

Thanks,
Claire

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- Ref No. I&S Child P
- Ref No. I&S Child I

This review was submitted on 22nd October 2016 and since, there have been further updates on their coronial process.

DM emphasised that if COCH have any significant concerns in relation to any criminal act for the death of the babies then Cheshire Constabulary will investigate.

DM had concerns after reading the reviews. Several reviews have been conducted and there is nothing in the reviews, as a non-clinical expert, as to a direct allegation or suggestion of a significant negligence or act that could potentially constitute as a criminal act. If the police were to get involved, they would look at securing and preserving evidence in relation to a criminal investigation.

There have been a number of issues raised that have requested service reviews. If the police get involved, it is a criminal investigation and Cheshire Constabulary would be duty bound to speak to families of the babies concerned. This is uncomfortable as there is no specific allegation at this point to suggest a criminal act. We do not have any reasonable grounds to suspect or believe that this may have been the case.

A meeting was held on 08/05 at Cheshire Constabulary with Paul Hughes (Senior Investigating Officer) and Stephanie Davis (Coroners Manager). Stephanie was able to provide more details in relation to the contents of Dr J Hawdon's report surrounding the four deaths.
NW gave an update:

- Child O – A post mortem has taken place. Awaiting a decision from the coroner's whether an inquest can be held. The cause of death was given as 1a; fresh bleeding into abdominal cavity due to 1b; rupture of sub capsular hematoma of liver and 1c; to be established following full histology.
- Child A – A post mortem has taken place. Inquest was held on 10/10/2016, and at the inquest conclusion the cause of death was unascertained.
- Child P – A post mortem, has taken place. The cause of death has been withheld pending full histology. Awaiting decision from the coroner whether an inquest will be held.
- Child I – A post mortem has taken place. No inquest has been held. The post mortem result was 1a; hypoxia damage of brain and chronic lung disease of prematurity due to 1b; extreme prematurity born at 27 weeks gestation.

Of those there is two where the post mortem has given a cause of death. One has gone to inquest, two are pending inquest and there is one outstanding in terms of histology.
There has been an update since Dr J Hawdon's report on the unexpected and unexplained deaths, if the pathology is taken as being correct.

PH added that details from Senior Coroner's Officer was requested to give narratives, with the exception of Child A which is unexplained cause of death. In accordance to the pathologies of Dr Khaki and Mr McPartland at Alder Hey, the rest are all explained causes of death in the narratives.

DM stated clarity is required regarding recommendation 6 of Dr J Hawdon's review whereby she stated the deaths remain unexpected and unexplained. There is a need to be clear about the current status of the four referred to in category 2 on page 50 of the report. An update is required in terms of the terminology used, what is the accurate and correct current status agreed by Cheshire Constabulary.

PH replied 3 out 4 are explained, according to the pathologist.

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IH added there is a professional difference of opinion between Dr J Hawdon and the pathologists. The pathologists are comfortable in their explanation, whereas Dr J Hawdon from her experiences as a neonatologist feels that given the age of the babies, she was not comfortable with prematurity alone to explain the clinical picture. IH approached the pathologist for clarification and this was fed back to Dr J Hawdon, who was still uncomfortable with explanations.

COCH/005 – Paul Hughes to confirm factual accuracy and current status of the four deaths referred to in Dr J Hawdon's review, recommendation 6.

SC sent DM an email on 10/05, and held a further telephone conversation where DM outlined the concerns as articulated above. SC did not raise any significant issues about what DM said.

On 10/05 an email was sent direct to NW from COCH consultant Dr Ravi Jayaram. This document has now been shared with the COCH executive team.
NW gave an overview of the contents. Dr Jayaram is expressing the collective review of the 7 clinicians that operate in the unit and has made significant allegations of concern or suspicion in relation to the number of deaths. He has used strong language including "highly suspicious" and makes specific reference to the nurse directly relating to the deaths and the sequencing timeline. Dr Jayaram concluded that "it is highly unusual and may indicate a possible unnatural cause of death". A professional challenge around some of the pathology findings is outlined, and it is significant in terms of the content, narrative and language being used.

DM added that having received this, a number of concerns were raised. There was no personal information sent within the email and it was felt appropriate COCH executive team were made aware of this.

This led to a further telephone conversation between DM and SC on 11/05 to make him aware of email sent from Dr Jayaram.

DM summarised the current picture:

- Letter received from the Chief Executive, Tony Chambers raising concerns and requesting a forensic review.
- Two reviews which Cheshire Constabulary have had sight of: Dr J Hawdon, Royal Free London Hospital and Royal College of Pediatrics and Child Health.
- A QC review has further taken place by Simon Medland.
- An email has come in from Dr Ravi Jayaram, COCH Consultant.

COCH/005 – Stephen Cross to send the QC report to Darren Martland.

Situational Review – Countess of Chester Hospital
TC stated that there is nothing new in the email review from Dr Jayaram that has not already been shared with the Royal College of Pediatrics and Child Health and all the enquiries that have gone on. It reads in a fairly unbalanced way, and it needs to be looked at in the context of all of the information that COCH can share with Cheshire Constabulary.

It is disappointing that it does feel that as a group of clinicians they have not moved on despite all of the reviews and enquiries that have been completed. The concerns appear to be less the details of their allegations, but more the feeling that they have not been listened to and not had the opportunity to have an enquiry and assertive interview with an independent body.

The motivation held for writing to the Chief Constable, was to state these are all the enquiries that have been conducted, and there are still some unanswered questions. It has been looked at from a

clinical and service review, but not from a criminal view. COCH have seen no leads from their perspective.

TC shared the same concerns as DM regarding putting the families through a process that feels unnecessary. TC would be comfortable to pause at this point, but equally would be comfortable to see what level of enquiry could be done that would not necessitate an open transparent conversation with the families.

IH added that the content and tone of Dr Jayaram's email with the assertion that they have not been listened to hints a lack of trust with COCH executive team. The two leads for both paediatrics and neonatologists are aware met with Cheshire Constabulary, and that there is going to be potential for an investigation. At no point have the COCH uncovered anything that would indicated a significant chance that there was an underlying criminal act, but the clinicians still feel it is unexplained.

DM replied that Cheshire Constabulary have similar concerns. If an objective third party view is taken, we have clinicians who are experts in their field and other reviews conducted and at this stage, there is no direct allegation of any wrong doing on the part of an individual(s) or significant negligence, which could potentially constitute to a criminal offence. There is nothing to suggest this is the case.

DM will be guided by COCH on where we go next. Cheshire Constabulary can do nothing if COCH are satisfied with everything that has been done so far, or if COCH not comfortable and would like a criminal investigation as there are reasonable grounds for a potentially criminal offence has been committed. DM added that resourcing or media reputation is not the issue for conducting an investigation; it is more how it will affect the families.

IH agreed with DM regarding the families, most of which have come to terms with what has happened to their babies.

DM outlined the primary concerns:

1. Establishing the facts
2. Welfare of the families of deceased babies

Cheshire Constabulary are not clinical experts, any reports or information that is presented that may potentially constitute as evidence of a criminal offence then as soon as threshold is met it will be picked up as a criminal investigation. It does not feel like this stage is being met, at present.

DM questioned if there is any scope for an external review, is there a body that would sit independently and would take all of the reviews to look at from a 3rd party perspective with the requisite clinical expertise. Dependent on these findings it would dictate whether it is an issue for the hospital in terms of management, potential issues for learning points or potential evidence of a criminal wrong doing.

TC replied in the first instance the body would be the Royal College of Pediatrics and Child Health. They would identify the TOR of the review, which was structured in a way that all concerns would have been in scope and any environment / behaviour concerns. RCPCH would constitute a review panel consisting of 2 experienced neonatologists, 1 senior nurse and a barrister.

TC added that through all of this, COCH have tried to explore what higher authority there may be to give an oversight or review the work to date. The first step was the neonatal network, they do not operate in isolation of each other as they are a network of units. There is a governance that supports this.

- 1st – Neonatal Network

- 2nd – RCPCH
- 3rd – Dr J Hawdon
- 4th – QC – Purpose to involve was to help clinicians understand the difference between what they thought was criminal evidence and something that may not constitute as criminal evidence.

COCH doctors would state that the other route that has not been taken is a criminal investigation. COCH have been transparent and kept the HM Senior Coroners, Mr Rheinberg and Mr Moore, fully informed.

It is evident that based on the email from Dr Jayaram, the clinicians do not think that the enquiry is complete. As a board and organisation, now the broader forensic review has been explored with Cheshire Constabulary and ascertain based on evidence and trails, now would be the time to focus on the future than continually look back.

The RCPCH review did not express any single causal factors, it expressed a range of things that collectively could be argued that this is an explanation. It would be an unsatisfactory outcome for the clinical team.
TC was unsure of where COCH could go, but also comfortable if explanations were clear to take back to board to state all reviews have been satisfied and just because clinicians state differently it does not make this right.

SC added that it is worth bearing in mind the report from Dr Jayaram has been sent 11 months on. If the clinicians had such a concern they have been advised from the beginning to contact the police.

TC stated that there have been 13 babies die, but at what point did the only reasonable explanation link to a single nurse. When there is a death, there is an M&M review within the organisation, some of this will be recorded accurately. COCH spoke to the general managers, asking if it felt uncomfortable. They went back to the clinical team asking if there is anything to be worried about, any problems with the environment / staffing levels etc. The feedback that the general managers received was that everything was fine.

IH has repeatedly challenged the clinicians asking if there has been any act(s) which COCH need to be aware of which would effectively give a case but repeatedly they have said no.

IH met with the seniors and the network lead in February / March with all the reviews. Each case was gone through with a hope to come to a consensus for each of the families (all of which the COCH have had contact with). Although there was a cause of death and the coroner had been comfortable either with or without inquest, they were still uncomfortable with the collapses. As far as they were concerned there was no other way COCH could complete an investigation or commission an investigation from another NHS body that would satisfy the clinicians.

DM clarified that there was nothing new that has come out of the email that COCH were not already aware of, and nothing contained in email that makes specific allegation, which would cause COCH to believe that potential criminal offences have been committed. TC and IH both agreed there was nothing to suggest this and nothing new within email.

IH noted that the clinicians had their own separate session with the RCPCH reviewers and in that they raised concerns about the individual. This was not in the RCPCH TOR as they considered this a HR issue, but the RCPCH did produce separate observations outside of the report in which they called out the pediatricians concerns. RCPCH stated that their allegations were based on nothing more than coincidence and 'good feeling'. There was nothing definitive.

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At this stage, COCH have exhausted all lines possible and there is nothing that could potentially be evidence of a criminal investigation. The concerns raised by the consultants have been raised previously and there is nothing they are aware of that they would consider or believe that potential criminal offences may have been committed.

TC stated a meeting had been held on 11/05 with COCH executives, and it was felt that the explanations of what has happened do not lie in a single place or cause, and certainly not criminal. Concerns from the consultants were also expressed to RCPCH as it is referenced in their review.

IH added COCH are mindful they do not want to use Cheshire Constabulary as a HR process for staff. If you place yourself in the mindset of paediatricians to see what the motivation is, there is a strong sense of personal accountability that a clinician feels and when there is no clinical explanation they feel uncomfortable. It is unusual that they have a collective mindset. This is a problem which COCH need to manage as it is not a criminal issue.

TC satisfied that Cheshire Constabulary would determine whether or not there has been any criminal intent. COCH have maintained an open mind and would welcome an enquiry, if necessary but this has never felt the issue. It was felt amongst the executives that it needed to be checked.

DM was clear to TC that all Cheshire Constabulary have done to date is look through reviews and reports they have not investigated. There is a need to clarify points made in Dr J Hawdon's review in relation to the coronial position of the 4 babies in category 2.
If there is no direct allegation or suggestion from COCH of any potential criminal wrongdoing then DM would be comfortable to put into writing, based on meetings and documentation so far in response to TC letter that Cheshire Constabulary will not conduct a criminal investigation at this stage with caveat if further information comes to light.

DM asked what COCH intentions are in relation to the email sent from Dr Jayaram.

COCH have not spoken to Dr Jayaram yet, it would be dependant on the outcome of this meeting. It cannot be left as they have made the same allegations again, but with more focus than previous. A conversation would be required around the discussions COCH and Cheshire Constabulary have had in light of their email. There is a need to discuss what COCH can do to reach an end point, which they are comfortable with. IH would look at how COCH can manage the end point prospectively.

TC stated it would become a wider GMC issue as there becomes a point where a group of clinicians who are not prepared to take the recommendations of RCPCH are blocking the ability to move forward which creates a more difficult and dangerous environment for sick babies.

TC added that the consultants have made their points, and they have been seen and not judged as sufficient to warrant a police led investigation, looking at how close it constitutes as a criminal act. There was a need to explore to ensure COCH have not missed anything, but there is also a need to move on. It will become a GMC issue, likewise if the media are involved. This is for COCH to manage appropriately.

DM replied that if COCH's position is that they are satisfied where they are, and there is nothing of anything that would cause to believe potentially criminal offences have been committed which may warrant a police investigation then this needs to be placed in writing to DM.
DM would respond that based on meetings and discussions at this stage the police position could be summarised that police investigation will not be led due to these reasons listed.

DM asked that COCH need to be clear what their expectations are of Cheshire Constabulary if a criminal investigation is required, and equally DM needs to document back to COCH what Cheshire Constabulary's position is. This is to ensure a clear audit trail of what the information was, the decision making and the grounds for those decisions, should anything arise in the future.

TC questioned if the email from Dr Jayaram had been sent to Cheshire Constabulary without the conversations held previously, it is of the assumption that a conversation would have been held with Dr Jayaram. It appears that until the clinicians have had the opportunity to sit opposite a police officer, they will remain motivated and there is an apparent lack of trust with the COCH executive team. The clinicians view is that COCH have not listened, but they have just not agreed. If this is to be the sufficient point to draw the line, dependant upon the rationale for not conducting a police enquiry or a criminal investigation, it cannot be on the basis that COCH does not feel that it is warranted. It has to be based on Cheshire Constabulary not investigating based on the reviews / reports.

DM stated that the question is whether or not there is a police criminal investigation. Cheshire Constabulary will be guided by COCH. If there is evidence that could potentially constitute as a criminal offence then it would be investigated, but the impact of which the families.

TC stated that COCH will have a conversation with clinicians following this meeting to agree those points, and state that based on what has been provided as a clinical team and what is known from the reviews it does not appear there are any grounds for a criminal investigation. A request will be made for any other information that is being withheld that would help meet the 'threshold' requirements. COCH can hold this conversation, but why cannot Cheshire Constabulary have this conversation, TC queried what the difference is.

DM replied that Cheshire Constabulary are guided by COCH as the clinical expertise, and that the email sent from Dr Jayaram has not highlighted anything new that COCH are not already aware of. COCH need to clarify that they are happy based on the email from Dr Jayaram that there were no concerns prior to email that would potentially warrant a criminal investigation and has this position changed since the email.

NW added an observation that Dr Jayaram has sent the email directly to the police and bypassed the COCH executive team. Cheshire Constabulary are duty bound to respond to Dr Jayaram on behalf of the clinician team. It might be appropriate to have a conversation with Dr Jayaram around the content of the letter and gain a feel of anything else that they may wish to disclose, which would add some value to the contents of the letter.

PH added that it needs to be clear what format NW is speaking to Dr Jayaram in, is it an evidential format or just a conversation.

DM clarified what NW was articulating, that there could potentially be allegations of bullying, intimidation on the part of COCH. It seems reasonable as they have written to have a conversation with Dr Jayaram to clarify there is nothing else sat behind the letter which has not been disclosed.

NW agreed with DM that Cheshire Constabulary should speak to Dr Jayaram to give the clinicians an independent 'voice'.

TC clarified whether it is possible to have a conversation with clinicians without involving the families as the clinicians would value the conversation with a police officer. DM wished to make clear that Cheshire Constabulary are not opening up an investigation, this is about dissecting an email submitted by Dr Jayaram and confirming that there is nothing else that ought to be aware of that is not in email.

COCH would need to convey in writing to Cheshire Constabulary that nothing new has been disclosed to them since Dr Jayaram's email, and DM can close off. All agreed as an appropriate action.

IH wished to raise two items:

1. When the issues were first raised by Stephen Brewery (Neonatal Lead) it was held under the 'speak out safely' policy so that he had protection as a whistleblower.
2. There is a meeting scheduled with COCH and the parents of Child D and their solicitor on 16/05/2017 prior to the inquest scheduled for 25/05/2017. The question that whether this should be deferred pending, as we may not be in a position on Tuesday to have a conversation that we are comfortable is not going to change within a matter of days. The purpose of this meeting on16/05/2017 is to feedback to the family the reviews, which they have had the opportunity to read and give them a chance to ask any questions / raise any concerns they have. This is a normal pre-meeting prior to the inquest.

DM reiterated what has been agreed:

- On part of Cheshire Constabulary, a meeting will be held with Dr Jayaram on 15/05/2017.
- The meeting will be held with Dr Jayaram only to discuss the contents of the email sent to Cheshire Constabulary, to ensure it has been interpretated correctly, it is factually accurate and is there anything of significance that has not been disclosed which is not in the email.
- If Dr Jayaram does disclose anything which potentially could be evidence of a criminal wrong doing then Cheshire Constabulary would have to consider a criminal investigation.
- Equally if there was nothing new raised in the email or conversation, then would look to COCH to write to Cheshire Constabulary to confirm their position stating we are / are not requesting a criminal investigation.
- Once Cheshire Constabulary has held this meeting with Dr Jayaram, they will then formally report back to COCH with the outcome, and Cheshire Constabulary will put this in writing to COCH.
- An exchange of letters would need to be agreed pending the outcome.

NW agreed, and added that effectively Cheshire Constabulary are just trying to gather further facts and information to inform the decision.

TC agreed that as Dr Jayaram has bypassed COCH executive team, it is appropriate he has the opportunity to speak and when the decision is made to either proceed or not to a full enquiry it will be based on the whole picture and it will be a stronger position for COCH. At this point, TC would feel more comfortable that the clinicians should be able to move on.

SC raised that it could potentially 'leak' that Dr Jayaram is meeting with Cheshire Constabulary, and although there is no police enquiry at present COCH need to be mindful of this.

COCH/006 – Nigel Wenham to arrange a 1-1 meeting with Dr R Jayaram on 15/05/2017 to discuss concerns raised within email sent.

DM stated that at present there does not appear to be any evidence of a criminal wrongdoing from the reports and reviews, which would warrant a police led criminal investigation. However, Dr Jayaram has raised some concerns in an email, which is believed to have been covered in previous correspondence with COCH and we do not believe there is anything new. However, we will agree to give him the opportunity to raise those concerns with the police as he has sent it directly.

TC raised he was uncomfortable writing to Cheshire Constabulary suggesting that the threshold has not been met, and felt that this should come from Cheshire Constabulary to COCH.

DB replied that it is about COCH stating that they have shared everything with Cheshire Constabulary and they do not believe that within those reports / reviews and to the rest of the knowledge that there has not been any potential criminal wrongdoing by any of their staff.
NW added the letter also ought to cover COCH asking for Cheshire Constabulary's position / decision as to future activity.

Safeguarding
DM stated that safeguarding related specifically to the nurse as thought she was a single parent. However, this is not the case, she is a single person not a single mother therefore there is no immediate requirement for any safeguarding referrals.

Coronial Update
This has already been covered, and an action raised for PH to confirm factual accuracy and current status of the four deaths referred to in Dr J Hawdon's review, recommendation 6.

NW raised timescales with the pending inquest due on 25/05/2017. The HM Senior Coroner, Mr Moore has said if the inquest needs to be adjourned, then it would be left for Cheshire Constabulary to speak to the family. The tipping point for the adjournment would be if there is going to be an investigation.

TC stated that once Nigel Wenham has met with Dr Jayaram on 15/05/2017 this will be the start of knowing whether or not there will be an investigation, which will assist COCH with any adjournments of their meeting with the family of [Child D] on 16/05/2017 at 13:00hrs.

COCH/007 – Nigel Wenham to update the HM Senior Coroner Mr Moore today (12/05/2017) on what has been agreed at the meeting to ensure he is fully updated. NW to provide Mr Moore with a further update on 15/05/2017 following meeting with Dr R Jayaram.

Legal
DM stated from a legal perspective in terms of the threshold tipping whether it would be an issue for COCH in terms of practice, procedure etc or whether the tipping point is met for a police led investigation.

DB had no issues with what DM had said. DB had read Dr Jayaram's report and in his opinion, it does not get close to point of meeting the threshold to make further enquiries.

Investigation / TOR
DM stated at this stage this is not something that needs to be considered, as there is no police investigation. If there is an investigation, then would agree a clear TOR with COCH.

Communications
DM stated that at this stage, it is an internal management issue only. In the event of Cheshire Constabulary's communications and marketing department being contacted by any individual, the position at present would be there is no criminal investigation in relation to COCH.

There are at present no other reviews / recommendations ongoing at COCH.

Resourcing / Governance
DM stated that at this stage, resourcing / governance does not need to be considered.

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Summary
DM summarised the current position. There have been a number of reviews which have been considered by Cheshire Constabulary, a copy of the QC report will be sent through and providing there is nothing within that document of significant concern, the position at present is there is no specific criminal allegation or evidence of potential of criminal wrongdoing that we are aware of that would necessitate a police led criminal investigation.
The concerns are:

1. If there is anything in relation to anything untoward the babies it would be investigated.
2. The families of the babies who have been through the ordeal

As it stands the reports do not indicate anything that would necessitate or warrant a criminal investigation. However, Cheshire Constabulary have received a report from a consultant, Dr R Jayaram, and it has been agreed it is appropriate he is met by a police officer which will be facilitated on 15/05/2017. Depending on the outcome of this meeting, if nothing new is raised, and everything he states is contained within the document he sent then a decision will be made at the conclusion of that meeting whether an investigation should take place, or whether comfortable that nothing significant has been raised outside of the letter that could potentially give cause for concern that a criminal offence has been committed.

At the conclusion of this meeting, Cheshire Constabulary will contact COCH to give an overview of what the position is. An urgent matter then would be the meeting with the family of Child D Child D on 16/05/2017 and whether this would go ahead or not.

Finally, the other issue to consider is to contact, HM Senior Coroner Mr Moore in relation to the inquest that is due to be taking place on 25/05/2017. As a matter of courtesy, it is appropriate that Cheshire Constabulary contact the Coroners today (12/05/2017) to keep informed and providing no concerns are raised by the Coroner further contact will be made on 15/05/2017.

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Action Matrix

Action No.	*Owner*	*Action*	*Update*
COCH/001	Ian Harvey	To provide personal details of all 13 families.	12/05 – Personal details of the families have been sent through from COCH.
COCH/002	Ian Harvey	To provide personal details of the nurse, and to look at safeguarding referral as a single parent.	12/05 – Personal details of the nurse have been sent through from COCH. The nurse is not a single parent as first thought, so no safeguarding referral is required.
COCH/003	Darren Martland Nigel Wenham	To draft an investigative TOR and a broader strategic TOR encompassing the investigation.	12/05 – A draft outline TOR has been completed.
COCH/004	Aaron Duggan	To make contact with HM Senior Coroner, Mr Moore, to establish their views and update on issues discussed at meeting.	12/05 – AD spoke to Mr Moore on 05/05 following meeting held at HQ, all of which is recorded on email. Mr Moore raised an issue in relation to the timing of a pending inquest on 25/05/2017, and whether or not this needs to be adjourned.
COCH/005	Stephen Cross	To send the QC report to ACC Darren Martland.	
COCH/006	Nigel Wenham	To arrange a 1-1 meeting with Dr R Jayaram on 15/05/2017 to discuss concerns raised within email sent.	
COCH/007	Nigel Wenham	To update the HM Senior Coroner Mr Moore today on what has been agreed at the meeting to ensure he is fully updated. NW to provide Mr Moore with a further update on 15/05/2017 following meeting with Dr R Jayaram.	

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