From: HODKINSON, Sue (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 04 April 2017 08:54
To: CROSS, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: FW: Strictly confidential - legal privilege applies

Importance: High

Hi Stephen,

This may be of interest to you as we discussed last week.

Sue Hodkinson MCIPD
Executive Director of People & Organisational Development
Countess of Chester Hospital NHS Foundation Trust, Countess of Chester Health Park, Liverpool Road, Chester, CH2 1UL
Email: sue.hodkinson@ I&S
Tel: 01 I&S / **Internal Extension:** I&S
Twitter: @ I&S
My PA's contact Details: Claire Jones, claire.jones28@ I&S Telephone Number 01 I&S (extension I&S

From: Slingo, Corinne [mailto:cslingo@ I&S
Sent: 04 April 2017 08:44
To: HODKINSON, Sue (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Cc: Hely, Deborah
Subject: Strictly confidential - legal privilege applies
Importance: High

Dear Sue

Further to our recent call, I write to summarise some suggested next steps in this matter, based on your helpful precis of what has happened over the last few months. I appreciate you were due to catch up with your colleague on Friday to discuss whether our advice would be required, as he may have already engaged lawyers to support the Trust. I look forward to hearing further on that.

I note that the neonatal unit mortality concern has now been investigated in a number of ways:

1. Royal College review - which identified no single root cause nor expressly confirmed avoidable deaths, but was critical of communication, team dynamics and other factors. I understand this may be perceived as more of a service review than serious incident investigation, but recommendations made have been actioned. The report has been shared with the CQC and the Coroner.

2. Forensic pathology review - also shared with key stakeholders.

3. A review of each case by the medical director. I am not sure what form the output from this may have taken, and this will be relevant for next steps in terms of any further disclosure outside the Trust, and also the use that may be made of that material by the police, should an investigation ensue. This review and material will also be relevant to any any

decision making by the Board.

4. An HR investigation following a grievance brought by the nurse redeployed in response to the concerns. I understand there has been no investigation of the potential allegations re the nurse, simply an investigation of her grievance around how the matter was dealt with.

5. Close liaison has continued with HM Coroner, including meetings to share the outcome of investigations in order to give the Coroner the opportunity to reopen inquests or take any other steps. As discussed, the Coroner has a statutory power to refer matters within his jurisdiction to the police if he is concerned a crime may have been commissioned, and thus far this has not happened.

The question the Trust is now considering is whether, and if so how, to liaise with the police in this matter, with particular pressure being brought by a consultant and others, about the desire to continue to investigate the issue in the neonatal unit. The motivation for this concern is unclear, but may spring from the personal accountability and involvement of the consultant in the care of the neonates on the unit, and the absence of any clear explanation for 5 of the deaths in particular, which I understand remain unexplained, despite review.

I advised the following:

- If the matter is to be referred to the police, it is more helpful on balance for this to be the Trust's decision than for the Trust to await a potential whistleblower situation. That said, any decision by the Board needs to be taken with an eye to the whole picture, not as a reactive step to the events of last week;

- There are existing arrangements between the CQC, the Coroner and the police, such that if the CQC or the Coroner considered the current material presented a criminal concern, they would have shared the material already;

- Any decision by the Trust Board ought to have the benefit of a short briefing paper looking at the key evidence and issues, and factoring in the broader governance and assurance issues, to deliver a decision that is robust. This is particularly relevant here given the potential impact on the families, the Trust and on individuals at the Trust, of a decision to refer the matter for further investigation by the police;

- The minutes of prior decisions on this incident should be considered externally, to assess the extent to which the Board approach thus far is sustainable if scrutinised, and the minutes arising from this week's Board discussion also need careful consideration given that they may become disclosable (either through FOIA or a police or CQC investigation at a later stage).

- The decisions in the neonatal matter are also relevant to compliance with Reg 17 Governance, and again would benefit from a 'critical friend' pair of eyes to check how robust they are.

- As discussed, a police investigation may need to consider corporate manslaughter issues (although the causation issues appear a challenge currently if there is an absence of root cause for the deaths or obvious connection between them), as well as exploring gross negligence manslaughter by individuals, and also the new offence of wilful neglect (albeit that remains testing ground currently). Any police investigation would also be prone to sharing information with the CQC who will need to explore any potential regulatory breaches in parallel (however they should be doing this already).

- If a decision is made to actively engage the police, I discussed how you may seek to do so in a way which is more constructive. This adopts some principles of the approach within the Memorandum of Understanding between the police and the NHS, albeit usually reserved for an immediate reaction to a serious incident. I found your meeting with the Coroner very reassuring and feel this could be extended to holding a further meeting with the Coroner, but inviting a local police CID lead to that meeting, so there is a 3 way discussion about where the Trust's processes have got to, what the options are now, and to engage the police in whether this is a matter they would wish to become involved in (which is a rather different approach to simply referring the concern to them). The police are obviously aware of the neonatal unit issues given the media coverage, so meeting suggestion can be positioned as a step that the Trust would welcome to bring matters to a close in terms of investigations, but wanting to challenge itself before closure, by running the situation past the coroner and the police in full.

- The above step would enable confirmation to be given to the concerned consultant that as a final step in good governance and transparency, the Trust plans to meet with the Coroner and the police to ensure all that ought to be done, has been, and that if the police consider they should pick up the baton in light of that meeting, the Trust will of course be cooperating fully with that investigation. This also leaves the Trust less exposed on the issue of parents and any individuals impacted by a decision by the police to actively investigate further.

- I should add that a full police investigation will be highly disruptive, will require additional resources at the Trust to manage information requests and interview support etc – we would be pleased to offer support if needed for that step, as we have significant experience in this area over many years, from Stepping Hill through to Maidstone and Tunbridge Wells NHS Trust. Similarly if a CQC investigation ensues.

As discussed, we would be very pleased to support the Trust through the next stage of decision making, if needed. I would request access to the 2 external reports and the internal review materials, and notes of any meetigns with the Coroner, to assess the robustness of what has been completed to date, and the strength of the Trust's position if scrutinised by others at a later date, as well as the decision currently faced regarding police referral. There is clearly an employment component in this too, with the nurse and the consultant in terms of whistleblowing potential and protected actions and we would work closely with Deborah to bring you support which anticipates the various pressures and issues faced.

Kind regards

Corinne

Corinne Slingo,
Partner – Head of Healthcare Regulatory
DAC Beachcroft LLP
Portwall Place, Portwall Lane, Bristol BS99 7UD

T. +44 (
M.+44 (
F. +44 (
E. cslingo@

I&S

I&S

Think of the environment. Do you need to print this email?

comply with any instructions contained within it. Instead, please telephone your DAC Beachcroft contact to verify the email. DAC Beachcroft cannot take responsibility for any losses arising from your transfer of funds or disclosure of confidential information.