(5)

Paediatrics Meeting
27th March 2017 – 5.10pm – 6.20pm

Attendees

Tony Chambers (TC)
Ravi Jayaram (RJ)
Nim Subhedar (NS)
Ian Harvey (IH)
Steve Brearey (SB)
Sue Hodkinson (SH)
Julie Maddocks (JM)

TC	Welcomed everyone to the meeting. Provide some context of the current position. We've had: 1. Royal College Review – actions and recommendations 2. Members of Staff – grievance 3. Clinical, how we get to the point the Board and Organisation has done everything to answer questions. If it's not at that point, what do we need to do to get to this point?
IH	RJ/SB/NS/John Gibbs – we had a useful meeting were we reviewed the 13 deaths. There were five everyone was comfortable with. There were eight were there were still concerns either cause of collapse, failure to respond to resus. Further in-depth review, which focused on collapses. IH completed reviews of the eight and review of rotas together with all case notes and what recorded in the notes. The next stage was to go through these It was important that we were conscious of deaths in the first instance. This would drive anything regarding babies collapsed. There are a number of questions we need help with: - Collapsed unexpectedly, fail to respond - If looking at potential causes, continuing consequences of collapses and how this is unpicked. -
SB	This was discussed on a weekly basis. Focused on 8/13 and transferred babies It is disappointing the depth that this has been gone into. A further 6 babies, arrested unexpectedly, which we identified in July. We don't feel these have been investigated in depth. Nine months on and the hospital should not investigate this any further This needs to escalate to the police. We have not had any explanation and we escalated this in July.
TC	Why are you escalating this now?
SB	We are still very worried. There is no natural cause of death.
RJ	There have been deaths….
SB	But these were explainable. Not included in mortality review.
TC	You don't believe the different admission criteria had an impact?

RJ	As a group of paediatricians, we accept the Royal College review, the case note review and Jane Howden's review identified further ones. It's a difficult thing, what level of review do we need to do. We have a collective view that this now needs to be at the level of a rota review, who, where involved, a forensic investigation. We accept that we may not find cause. We have our names on the end of the incubator, we need more assurance. The interpretation of the reports differs to the Board. We were presented with a plan and we have explored every avenue with the BMA (British Medical Association).
TC	The review identified that there was no single casual factor, you identified further cases. What do you agree and don't agree on?
SB	The College review is a service review not investigating the deaths. Jane Horden – four cases forensic review, her review was not forensic, it stimulated discussion and learning. There are four cases not reviewed yet.
TC	If this is your intention this is always going to continue, only higher authority is the police, not sure what they will say?
NS	The cluster caused concern here. The College review is a service review not case note and followed up with further detail review. In depth review for more than four cases. The standard needs to be external to be some degree.
TC	I need to know if we do an individual case note review, or phone the police.
JM	Given the information, on the balance of probability, illegal activity has caused the deaths.
IH	Or reasonable doubt?
TC	If no process, the determining factor is that there is no other answer. Mischievous activity is the only causal factor. I didn't think that was where we are. We can phone them now, everyone will be interviewed.
SB	The worries not going away. I'll share with you an email from one of our experienced consultants, who was new with us in July; he has some stronger feelings than me. Quotes e-mail (from Michael).
TC	If that is where we are, then phone the police. You can call the police.
RJ	After the case note review, we are still left with 8 cases.
NS	Left missing staffing data, if that is reassuring.
IH	Does not highlight a single individual?

IH	Absolutely why we meet with him. At some point, we need to meet with the parents. We covered the background in the last meeting. There were things to look at and I've done as much as can. If not then we need to phone police, they will revisit everything but this may not be sufficient.
TC	We have shared everything with various stakeholders; we need to do the same with the police.
RJ	I agree with NM. The focus needs to be on the babies who have died. We have discussed a lot of implications to the unit, the Trust and parents and colleagues. But this is for the greater good, the future. It's a big issue, it's huge.
IH	I know meeting with **Mother C** this blew her apart. She had just come to terms with it.
SB	There's a consensus. Morally speaking, we cannot live with ourselves. Keeping from them is difficult for of any of the clinicians.
TC	You absolutely believe we have a criminal behaviour.
RJ	We need to clarify it, beyond reasonable doubt.
SB	On the balance of probability, words used from a child protection perspective.
RJ	Honest answer is that we don't know, it's not been sufficiently explored or reassured. There is a subtle distinction.
TC	To get the distinction, the only thing to do is a police investigation.
RJ	Not sure anyone can do an investigation like that.
TC	Not effectively answer the cause of death. It is the only way to satisfy, that's where we are?
RJ	For me personally. I have a vague media profile, recognise the impact but so be it. It's for the greater good.
SB	No one accepts the trajectory and live with it. But if we are actioning the recommendations, we could never live with it
TC	Until such time as the unit is safe, nothing has changed. More risks need to be explored, that's fine. We hope this is quick and fast and we can move forward. We will see. Are you going to both be around the Trust over the next few days?