Unsigned - awaiting final copy.

Countess of Chester Hospital NHS
NHS Foundation Trust

DIRECTORATE: URGENT CARE

GRIEVANCE INVESTIGATION INTERVIEW CONDUCTED BY DR CHRIS GREEN

ON 7th November 2016

PRIVATE AND CONFIDENTIAL

Present:	Dr Chris Green	Investigating Manager
	Ian Harvey	Medical Director
	Lucy Sementa (LS)	HR Specialist

Standard:	Introduced the members of the interview. Stated the purpose of the interview and informed of his/her right to be accompanied by a trade union representative, fellow employee. Explained that notes would be taken so that a final statement could be agreed by all parties. The statement will be used in the completion of the final report Stress that this meeting was to be treated as a highly confidential discussion and the content of the meeting was not for discussion with any other persons. Counselling support also offered and need for confidentiality stressed.

Body of Interview

IH	SB highlighted the increase in the number of deaths. There was no alarm bell on mortality rates as the numbers of deaths are so small, but there had been a significant increase over 12 months. Raised areas of concern re: numbers. As part of the areas of concern raised there was reference to LL being in attendance but that was as far as it went. We agreed to do a review at three months (May – August) but lost 2 triplets before this was due and this escalated. SB did some work and looked at rotas. One medical trainee is present in some cases, but LL was present on the unit for the vast majority and looking after main proportion, but SB presented the case that we had to consider the unthinkable, with no other cause identifiable. More meetings with consultants have taken place, and they seemed to think the same way. Executives were uncomfortable in assigning blame without every other cause being excluded. There was a threat to go to the police from the consultants. Execs considered - do we go to the Police? How do we take this forward? How do we protect LL from allegations whilst carrying out the investigation in work?? Going forwards, to protect Lucy from the

	allegations… we felt this (redeployment) was the best course of action.
CG	How did you agree the course of action?
IH	There are issues with nursing with regards to investigations compared to medical staffing. We have measures specifically supported by GMC and NCAS. If there are doubts speak to them, RC then would manage resistance from the consultants. If it were a doctor then there would be a period of supervised practice and development, but there was a block to that as the consultants were not prepared to have the nurse on the unit, and if we do, they said the police will be called.
CG	Is that why the proposed supervision didn't go ahead?
IH	There were 2 elements – the consultants didn't want that, and also the cover issue – there was sickness on the unit. We didn't call the police, as the conversations that we had showed other areas of concern but the Police were on the table if evidence suggested an issue. Tony Chambers said if there is no other possible consideration, then he would personally make that call. I believe we ensured safety – we felt by downgrading and that the over bedding of unit was addressed but the consultants felt it was as LL was not on the unit. This was by far the most difficult situation I have ever had to deal with. I have lost more sleep over this than anything else. Medical staff ~~are treated differently~~ have a different process, the trainee highlighted had been involved in less than half the cases, they had left by the time it started. Major concerns would have been highlighted. Dr Gibbs not on many either. The number of cases is less than half, so didn't call NCAS, as there was not a significant enough level. For a trainee I would go through the Lead Employer in that circumstance.
CG	In the analysis table, the column showing doctors was removed, were you aware?
IH	I wasn't aware of that. There has been a number of behaviours on the ward that do not reflect too well. I had to go and speak to RJ that some of the trainees had been making reference to 'Angel of Death', but no specific person was named. ~~This~~ There was behaviour in clinic its being heard, talking about killing babies on the unit. I had to speak to Ravi about comments about killing babies. This was not denied ~~but~~ and RJ did accept that it was inappropriate.
CG	Did you hear about Jim McCormack telling Eirian Powell she was harbouring a murderer?
IH	No, I hadn't heard that
IH	Got security to review. Lack of security re getting in / out of the unit became apparent. There are no grounds to suspend, but there are ample grounds to move her to protect her, even in hindsight, if we did the wrong thing, it was done for the right reasons. An unwritten threat to call the police, was greater threat to LL, as she would have been arrested then there would have been the impact on her and also the impact on the unit. It felt purely circumstantial - 'Gut feeling' so took Stephen Cross' advice – we wanted more if we were going

Comment [IH1]: Not sure what this means

	to call the police. They would have left a bomb site if they had come in. I am more and more sure it was right not to call the police, as things have progressed.
CG	Have you had any previous cases like this?
IH	<u>Not personally.</u> Paediatrics was happy to quote Beverley Allitt but equally there was the nurse in Stockport who was ultimately not responsible for anything.
CG	Have there been any cases involving concerns of a nurse with no evidence?
IH	No. Consultants felt an unusual pattern to a number of the collapses and hadn't responded to how would expect collapsed babies to recover. 13 deaths, 4 near misses. John Gibbs did a deep dive and then we commissioned neo natal deep dive from London. They were drafted in but need to send more info as the numbers are small. The college suggested a 2 person review and there was only a few neonatal reviewers and this has been reduced due to illness. Jane Horton told review if she had any specific concerns she would go to a second person. The maximum number will be 5 deaths with concerns I suspect, but may be less but will send further information. Suspect it will come down to 2 or 3. Given the nature of that kind of medicine, this would probably be average. Report – I don't know how LL knew. I received an email with password protection. I shared with AK, and told execs ~~to~~ <u>it had</u> come in. I controlled the number of printed copies – only the execs so I don't know where she got that from. Don't know how Steve would have known. He had asked me if it had come in, I didn't tell anyone else.
CG	Is the aim for LL to return to the unit? Is this possible?
IH	Based on everything coming in, yes. Ultimately reports seen so far, say nothing to tie her to anything untoward. But the Trust want assurances. It was a Board decision to redeploy her, so will need to be a board decision to ~~being~~ <u>bring</u> her back in. I am meeting with SB and Anne Murphy on Thursday to let them read and draft report. (EP **I&S**) RJ is not sure can come on Thursday. The report is redacted partly on colleagues advice on what should be shared with staff which relate specifically to HR aspects of LL. Need to control what goes out, and hoping that the final version goes next week. Mortality review draft in, going to have to chase PM reports, however hopefully next week will have everything. If the final reports don't differ significantly from what we have now. There may need to be a period of supervision as LL been off the unit for some time. As regards SB / RJ concerns about Lucy returning to the unit. Something that I will have to manage, both as MD and a team of Execs.
CG	The Nursing staff have been redoing their competencies, will the medical staff be doing the same?
IH	It is a different system for doctors, consultants, and trainees. This forms part of portfolio, and goes to annual review. This affects what is needed. Tick box