

### Conference call notes

27 April 2017

| Attendees                            |                                          |
|--------------------------------------|------------------------------------------|
| Margaret Kitching (MK) [NHS England] | Stephen Cross (SC) [Countess of Chester] |
| Vince Connolly (VC) [NHSI]           | Ian Harvey (IH) [Countess of Chester]    |

#### Discussion

MK gave a brief overview of the commissioner concerns around not understanding the full picture regarding the deaths, this is because they don't feel that they have had full access to the detail of the investigations, and it is the senior clinicians in Specialised Commissioning that believe the police should now be involved to seek an opinion.

VC asked if IH could provide details of the consequences of the CDOP meeting and bring us up-to-date with the current position

IH explained that he was unsure why the commissioners felt this way as he had met with MG, AB and LP and updated them accordingly

IH also explained about the sensationalist story reported in the Sunday times which caused further upset to some of the families and therefore it was important information sharing was kept to a minimum

IH explained that the unit was downgraded to a level 1 service as a result of this incident to ensure safety until this was fully resolved, there has only been 1 death since then and this was an expected death, therefore they believe the unit is safe.

IH explained that the incident occurred as a result of a Paediatrician and neonatologist alert re numbers of deaths in the unit, which resulted in the Trust commissioning the RCPCH to undertake an investigation into all the deaths. There was no single factor identified rather it was multi-factorial. It was recommended that an investigation into each of the deaths was undertaken, this was completed by an independent expert who did not identify any significant additional issues.

It was determined that a single member of the nursing staff were on duty and attended to most of the cases, but not all, and her full time status meant that this was probably not unusual

The Trust also sought an independent Legal opinion, on evidence so far, and the findings were that they could not see any evidence of criminality

The Independent reviewer identified out of all of the deaths that 4 were unexplained and

therefore recommended a broader forensic review. The Trust clarified this with the reviewer and it was determined that involving CDOP would enable a further consideration which would involve the police who is a member of CDOP

Furthermore the Trust has shared everything with the Coroner throughout this process and kept the families involved

The CDOP meeting occurred today to consider if there was any possibility that there could be unnatural causes. The police representative of CDOP, advised that there may be a need to seek their support/advice and this could be done via a scoping type meeting, he agreed to speak with his Chief Constable and get back to IH with their opinion on this.

MK thanked IH for his time and briefing and recognised that the Trust was doing all they could to resolve this. The involvement of CDOP and the police is welcomed

MK raised communications and the media risks around this. We would need to connect a NHSE/NHSI comms lead to support the Trust with this. If the police decide to investigate, some of the information will be in the public arena.

IH agreed to let us know the outcome of discussions with the police.

| Actions                                                                                                                                                                                                                                                           | Lead   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|
| It was agreed that it may be useful to have a single point of contact which could be MK and/or VC which may help to ensure that communication channels are kept to a bare minimum. MK & VC would inform senior colleagues of developments on a need to know basis | MK, VC |
| MK and VC offered support to the Trust and left them to consider this                                                                                                                                                                                             | MK, VC |
| Ian asked MK if she could expedite the action plan input from the network to be completed and returned                                                                                                                                                            | MK     |
| MK also agreed to speak with the CCG, CQC, local DCO team and Specialised Commissioning so that the Trust can just use a single point of contact for the purpose of information sharing re this incident                                                          | MK     |
| IH agreed to brief MK re the results of the police decision                                                                                                                                                                                                       | IH     |
| Identify Comms lead                                                                                                                                                                                                                                               | MK, VC |