Countess of Chester Hospital NHS
NHS Foundation Trust

EXTRA-ORDINARY BOARD OF DIRECTORS (PRIVATE)

MINUTES OF THE MEETING HELD ON THURSDAY,
13TH APRIL 2017 at 9.30AM
BOARDROOM
SPC/CER FINAL

		Attendance	
Chairman	Sir D Nichol	☑	
Non Executive Director	Mr A Higgins	☑	
Non Executive Director	Mr J Wilkie	☑	
Non Executive Director	Mr E Oliver	☑	
Non Executive Director	Mrs R Hopwood	☑	
Non Executive Director	Ms R Fallon	☑	
Chief Executive	Mr T Chambers	☑	
Medical Director	Mr I Harvey	☑	
Interim Chief Finance Officer	Mr S Holden		☒
Director of Nursing & Quality	Mrs A Kelly	☑	
Director of People and Organisational Development	Mrs S Hodkinson	☑	
Director of Corporate & Legal Services	Mr S P Cross	☑	
Director of Operations	Ms L Burnett	☑	

In attendance:
Mrs C Raggett – Secretary to the Board
Mr S Medland, Q.C. Exchange Chambers

FORMAL BUSINESS

1. **WELCOME AND APOLOGIES**

Apologies were received from Mr Holden.

2. **DECLARATIONS OF INTEREST**

There were no declarations of interest.

3. **TO CONSIDER THE CURRENT POSITION WITH REGARD TO THE NEONATAL UNIT**

Sir Duncan outlined the starting point where all the Board have been informed at each significant stage and they all know the steps taken and the further important

step was to seek Mr Medland Q.C.'s advice.

Sir Duncan noted that the Board had received a copy of the minutes from the meeting with Mr Medland and the paediatricians.

Mr Medland thanked the Board for inviting him to the meeting and noted that the minutes that had been shared with the Board which were a summary of a long and important meeting. The background is an unexpected rise in neonatal deaths which could be due to all kinds of reasons but one matter crystallised in the consultant's minds about the unexpected number and certain infants who in their professional view would not ordinarily have died and they have in their mind that this could be criminal offences by a person or persons. The Royal College report says things could be done better and that some standards were not quite met in matters of quality and delivery. Neither the Royal College review or Dr Hawden's review identified any criminal issues. Dr Hawden said that a forensic review should take place. The consultants take the view that they are not militant or agitating for the matter to go to the police but they cannot see anyone else who could investigate it but the Trust view is if go the police this is an irrevocable step and carries potentially enormous risks for reputation and for the families, the question is, does it merit that step? All of us around the table agree that if there is clear evidence of a crime that you would want to go to the police straight away.

Mr Medland stated that in his view there is no evidence of a crime but the consultant view is to go to the police. He suggested that an alternative approach would be to approach the police member of the Child Death Overview Panel (CDOP) although it is possible he may say he is unable to help due to his position, he also suggested the Coroner, Mr Rheinberg but there would be a conflict of interest. We cannot say no to a further review of some sort as Dr Hawden's report says a broader forensic review is needed of the class 2 cases. He believed the next step is to acknowledge the aggravated sense of the consultants, put our arms around them and say that we propose to refer to Dr Hawden and ask her to tell us what she means as to a forensic review as this has many meanings and also what she feels will address this and could then speak to the police. This may satisfy their curiosity but he does not know.

Mr Medland added that you need to accept that if something is still unanswered or there are still genuine concerns in well minded people you should go to the police.

Mr Wilkie said that he had no real issue with what was being recommended but asked why doing this now and not at the point of getting a further report. Mr Harvey replied that it was not just about the forensic review but also the pathology review had taken some time as permission is needed from the Coroner to approach the pathologists at Alder Hey and also then contact them about the babies involved so this added to the delay. There was then a meeting with the paediatric consultants to discuss further work and clarify the number of cases

after the pathology queries this went back to 13 and then 8 after a consultant meeting. As far as they are concerned there were still 8 cases despite what Dr Hawden said. There was another follow up meeting which has led us to where we are now and the delay is partly due to seeking permission from the Coroner to get to the pathologists.

Mr Wilkie asked if we can truthfully argue that there has not been a delay and that it had not been possible to do sooner. Mr Harvey replied there is due process and we have done everything in a reasonable and explicable order but we are beholden to other delays. M Chambers added that an enormous amount of work had been done and the clinicians will not recognise this but still hold the view that we have not taken this seriously.

Sir Duncan stated that the Board needed to decide for ourselves if we feel the work took long, did it answer Dr Hawden's report. The Board has a story to tell and follow through.

Mr Harvey said that was why he met with the consultants with the review to come to one view. Their view doubles the number of cases where there are concerns and they could not define what they felt was a forensic review.

Sir Duncan asked what did Dr Hawden mean, what would it amount to and could it be done without a police investigation. Mr Harvey said that it could mean many things and her view may not satisfy everyone. Mr Harvey is content to speak to Dr Hawden however this may not move us forward as the consultants may not agree. Mr Chambers said that this had been the purpose of the consultant meeting a couple of weeks ago. The Board view is answered up to 4 cases but consultants say 8 cases. There is a view of one or two consultants that there should be a police enquiry with interviews of individuals.

Mr Medland felt it may help to sit down with the consultants and say not ignoring their concerns and that we are going to do this with you as one team. The consultants feel split from the Executive team and sometimes think no one is listening. They also said the hospital has listened but not heard us. There is a need to bring the consultants back to the fold, say here is the action plan and that you want to work with them. We want a sensible way to acknowledge the difficulties. Mr Medland suggested that Dr Hawden be asked what is the forensic review and why the level 2 cases. He would invite the consultants in to the process as this will help them understand that it is not secret or kept away from them. We need to get to a position that there is a bomb proof criteria and actions.

Mr Higgins stated that as a Board there is a need for something bomb proof as quickly as possible rather than this is what we are going to do. In the discussion with Dr Hawden a representative from the consultants could be asked to be involved. Mr Oliver added that this could stop the perception and we need to have a solution to address that.

Mrs Hopwood asked if there was a plan to communicate this to the families. Mr Chambers replied that the Trust has written to the families advising them this is what we know in an open and transparent way.

Mrs Hopwood stated that there is a need to have some pre-emptive lines for the families. Mr Chambers said that there are the families, the nurse and The Telegraph and it may be easiest to phone the police, given all the potentials for an unmanaged grenade. To take forward the recommendations so far we will need to meet again next week. We have been trying to manage this and it may get away from us. Mrs Hopwood replied that she felt it had got away from us.

Mr Wilkie asked about the confidentiality of the CDOP. Mr Chambers replied that it would be shared with the Chair of CDOP and added that all the members of CDOP have received a copy of the Royal College report.

Mrs Hopwood asked if the report had been shared with the families. Mr Chambers confirmed it had and that the report was available on the Trust's website.

Mr Harvey stated that he had met with one of the sets of parents and their concern was that we will turn their world on its head and that they would start grieving all over again. They are very angry with the Solicitor that leaked the report to the Times. The Trust has endeavoured to keep the families up to date. The parents have given some useful feedback and there are things to be learned especially from the early days. We do need to be careful when approaching the parents.

Sir Duncan stated that there is a need to have a plan in place when approaching the parents.

Sir Duncan asked if everyone was comfortable that the Trust explores with Dr Hawden to take the forensic review forward. Everyone confirmed that they were content with this approach.

Mrs Hopwood asked would it be 4 or 8 cases. Mr Medland replied that it states class 2 cases. Sir Duncan added that it would not be limited as it is not yet known what the foremsic review means. We will sit down with the consultants and discuss what to do about following up the recommendations. It may mean that we cannot satisfy everyone short of saying go to the police now but maybe able to satisfy the right leader however they may still come back and say they want to go to the police in any event.

Mrs Hopwood asked what if the consultants after the forensic review still want to go to the police. Mr Chambers replied that we would have a discussion with the consultants.

Mr Cross reported that an inquest into one of the babies involved in the review

was due to be held on 25th May 2017.

Mr Wilkie said that it would be good to have the forensic review completed before them.

Sir Duncan said that there was one other consequence as LL is expecting to come back to work and what do we say to her about the delay. It is not for the whole Board to discuss but it is important to get it right when explaining the further delay.

Sir Duncan added that we are still searching for explanations, not saying she is still in the frame but it is a legitimate point that the forensic review be conducted.

Mrs Kelly stated that the nurse asks every time we meet when can she go back on the unit. Sir Duncan replied that it was about getting the truth about why babies died and that we need more time for the forensic review.

Mr Chambers stated that we will find a way and there will be consequences, there are lots of moving parts to try and control and also the rest of the NHS structure such as NHS England who are part of this and they will also want to express an opinion, especially having regard to matters currently on-going Shrewsbury.

Sir Duncan added that the biggest risk is losing control of the situation and again noted the need to communicate with the parents.

Sir Duncan thanked Mr Medland for his help and support.