Notes of a meeting held on 22 December 2016 at 2.00pm in Chief Executive Office, Countess of Chester Hospital

Present:	Sue Letby (SL)	
	John Letby (JL)	
	Lucy Letby (LL)	
	Hayley Cooper (HC)	RCN Representative
	Karen Rees (KR)	Head of Nursing, Urgent Care
	Tony Chambers (TC)	Chief Executive
	Ian Harvey (IH)	Medical Director/Deputy Chief Executive
	Alison Kelly (AK)	Director of Nursing & Quality
	Sue Hodkinson (SH)	Director of People & Organisational Development

TC welcomed everyone and introductions were made.

SL and JL asked if they could read a statement, a reflection on how they feel. They have been advised what they want to say and will provide a copy of the statement.

SL then read out the statement. SL advised that they recognised that AK/SH supported with KR/HC. SL added about the importance of this meeting; what we discuss in the meeting and how we manage the next steps. We have waited a long time for this.

AK and SH went through the letter related to the grievance.

TC explained that there had been an increase in mortality rates in NNU. We had been alerted to an increase, lots of investigation into the cause, we couldn't ignore the change in pattern and mortality rates. The second point is the explanation that the only reasonable cause was mischievous behaviour, but we never accepted this. In the spirit of protecting our staff, babies and the service, we downgraded the unit, undertook a robust internal investigation and announced the Royal College review. Unsubstantiated claims were made that the only common link was that Lucy was on duty.

We had a decision to make, and we could have contacted the police. However, we acted in the best interests of LL, staff and babies on unit. There is nothing fair about this but we acknowledge that the actions we've made were genuinely with the best interests of you, the babies and the unit. We never once believed that the only plausible action was action within the team, but we had to take reasonable actions.

SL Dr Steve Brearey (SB) held you to ransom, if Lucy didn't go off the unit.

TC If we had kept Lucy on the unit and something happened, then it could have been a self-fulfilling prophecy. We ensured the unit and Lucy were safe and that we could

TC Our judgement was that this was not a criminal investigation.

LL Annette Weatherly suggested we could seek police advice, but felt it had never been that extreme.

TC But then the unit would have been closed down, you and others could have been arrested, this would have been harmful for the unit and reputationally, very damaging for everybody. If we believed it was a criminal issue, we would have phoned the police, it would not then be about reputational issues, it would have been about the babies harmed. The unit was downgraded, the criteria for access changed, a whole range of things to manage this. Equally right was the support for you so that you were protected from all of that. The spirit was right for you and the unit.

SL But Steve Brearey was making comments. Why was Lucy in charge of the sickest babies?

AK We had a meeting with SB in May 2016, and during internal paeds meetings. Nothing was flagged to the professional lead, there were no issues with Lucy's practice. We were content nothing needed to be done, no concerns raised. No action to be taken.

SL SB wouldn't have LL on ward.

AK Not sure why said as clinically …

SL SB seems to be above everybody.

JL Look at the highlighted section of the grievance. At the summing up of the hearing, Dr Chris Green (CG) advised everyone that they showed everyone empathy, only RJ/SB lacking. The behaviour of those two people, they should be instantly dismissed.

IH I need to advise on the lead up to this. Concerns were raised to AK and myself. We undertook a couple of reviews and then subsequently came together in May after two further baby deaths. We support any member of staff in raising a concern. We accept the behaviours were not appropriate. We set actions to undertake an external review and close to a conclusion. There was a panel of 4 of them, who spent 3 days here. They compiled their report quicker than normal. They then came out for a secondary review, taken to a further level. A small component needs to be completed early in the New Year. That is why we have not shared the completed review.

SL Have you investigated LL?

LL No.

IH It is a comprehensive review; it's not aimed at any one person. The only people who have seen it at this stage are the Executives, the Chairman, 2 consultants and senior nurse, who have seen a draft and any comments were sent back to the College. We are planning who/how we share it. LL is at the top of the list, staff, parents of the babies, and the coroner and then a wider conversation with people.

LL Do you know when it will be? I was promised several weeks ago.

IH The final part is with Alder Hey, but we will be sharing in the next few weeks, in the New Year. Part of this sharing is us as an organisation drawing a line; anyone steps over that full disciplinary policy may be used.

SL Not what SB/RJ say about LL? That is why she was redeployed and no other reasons, she was removed from NNU by instructions from the unit. SB collaborated with others. LL was not on the ward for several of the deaths, so collaboration has gone on. Speaking honestly and from your recommendations, this all happened - you allowed it to happen. Cannot see 6 months down the line all this still going on. Someone, possibly you, taps you on your shoulder; you're the chief man, you could have stopped it. Given the opportunity, no heads on poles, nobody being realistic and saying we're doing wrong thing here. That's all I've got to say.

TC Our ambition was to keep LL and the unit safe. It has taken longer to resolve than we hoped for. We had unexpected deaths, we have received an explanation by expert reviews.

LL But SB doesn't want Lucy back on the unit.

TC He doesn't run the organisation. We will be meeting in the New Year. We have learnt a lot, we are not an outlier, we have a safe unit. We will be meeting with the consultants early in the New Year. What I was thinking we would do is to share with them your statement Lucy?

LL Will Karen be allowed to attend?

AK/SH Yes, we've already agreed that in our meetings.

TC It will be a tough meeting. We will discuss the recommendations of the Royal College review, behaviours we expect to see will be clearly described, and then

disciplinary action may follow if not followed. IH and I categorically support this.

SH This would be a reasonable management instruction, and if necessary we would follow the disciplinary policy.

SL/LL In the grievance, it was agreed to receive 4 apologies.

TC We will be meeting with them all in the New Year. Then when you are ready, you come back to the unit. We don't underestimate how difficult that will be. You have my categoric assurance that we will support you.

SL What if something happens; they will point finger at LL again.

TC That itself will instigate a different process.

JL Have you read the interviews? I can't believe the comments.

SL Called Lucy an "Angel of Death".

LL In public areas.

SL Mr McCormack said the Trust is "harbouring a murderer", "you're harbouring a murderer".

Doctor V said she is "cold and calculated".

Eirian Powell said "what if LL goes home and kills herself". SB: "don't care".

RJ: "knowingly deliberate action by LL". Heard in Outpatients by a nurse, someone deliberately killing babies, in statements and people named said it.

TC It's not acceptable.

LL It's personal. It's not acceptable.

SL They have a personal grudge.

JL Have you spoken to Ravi?

IH It is not appropriate behaviour. Not had it reported to me subsequently. SH and I met with SB, will be followed up with documentation to all of them.

JL What severity of action?

SH It depends on the issue; if it's helpful, we can share the disciplinary policy with you so you are aware. Hayley will also be able to advise you from her understandings.