(6)

Paediatrics Meeting
27th March 2017 – 5pm 10pm – 6.20pm.

Attendees

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

Welcomed everyone to the meeting. Provide some context of the current process we've had.

TC	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/Nim/JG – had had a useful meeting and reviewed 13 deaths. There were five everyone was comfortable with. There were eight still to conceive either cause of collapse, failure ~~helped~~ to respond to resus and further in depth review, collapses review. 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. ~~Various deaths in first instance~~. Drive anything regarding babies collapsed. Questions need help with: - Collapsed unexpectedly, fail to respond. - If looking at potential causes, continuing consequences of collapses and how this is unpicked.
SB	Discussed weekly reviews 8/13 and transferred babies Disappointed at the depth gone into. A further 6 babies, arrested unexpectedly, which we identified in July. Don't feel investigated in depth. Nine months on and should not be investigated any further Need to escalate to police. Not had any explanation and escalated in July.
TC (SB)	Why escalating now? Still very worried. No natural cause of death.
RJ	Been deaths.
SB	But explainable. Not included in mortality review.
TC	Don't believe different admission criteria had an impact?
RJ	As a group of paediatricians, Royal College review accept case note. June Hordens review identified further ones. Difficult thing, what level do we need to do. Collective view is it needs to be lead, rota, who, where, forensic investigation. Accept may not find cause. Names on end of the incubator, need more assurance. Interpretation of reports

important that we are conscious of the deaths in the first instance.

	differs to Board. We were presented with a plan and explored every avenue with BMA.
TC	Review no single casual factor, you identified further cases. What agree and don't?
SB	College review – service review not investigation deaths Jane Horden – four cases forensic review, her review not forensic, stimulated discussion learning, four cases not reviewed yet.
TC	Intention always going to continue, only higher autonomy. Police, not sure what to say?
NS	Cluster caused concern here. College review service review not case notes. followed up further detail review. In depth review for more than four cases. Standard needs to be external to be same degree.
TC	Need to know individual case note review, or phone police.
JM	Given information, balance of probability, illegal activity caused deaths.
IH	Reasonable doubt.
TC	If no process, determining factor no other answer, only casual factor, didn't think that where we are. Phone them now, be interviewed.
SB	The worries not going away. Email experienced consultant, new in July, some stronger feelings than me. Quotes e-mail (Michael).
TC	If that is where we are, phone the police you can call the police.
RJ	Case note, still left with 8 cases.
NS	Left missing staffing data, if that reassuring.
IH	Does not highlight single individual?
SB	Not interviewed, nurses, Junior Doctors which is really important.
RJ	Who could do that level of investigation? Does not look good on teh Trusts reputation. Group of clinicians, do not know. All of which are disturbed by this. All unusual ones. Board felt reassured, accept inefficiencies.
TC	Board recognises that no single casual factor. If saying more assertive review, clinical investigation. Only confession, no evidence. Identified names, delays in decision making, failings did not explain collapse, deeper dive. This meeting test what may look like. But if in position not satisfied phone