From: Hodkinson Sue (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 18 July 2016 18:25
To: 'Slingo, Corinne'; Pace, Ian
Cc: Rowbotham, Cheryl
Subject: RE: Legally privileged - confidential advice re neonatal unit

Dear Corinne,

Many thanks for your email detailing our discussion and for taking the time to speak with me this evening. Should we need further support in relation to this issue, I will of course liaise with yourselves.

Best wishes,

Personal Data

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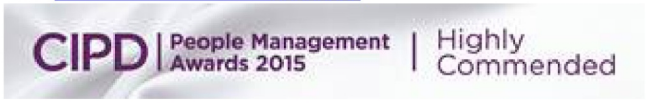

From: Slingo, Corinne [mailto:cslingo@ I&S]
Sent: 18 July 2016 18:15
To: Hodkinson Sue (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Cleverley Debra (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Pace, Ian
Cc: Rowbotham, Cheryl
Subject: Legally privileged - confidential advice re neonatal unit
Importance: High

Dear Sue

Many thanks indeed for the call this evening, it was really useful to hear where you have got to so far on this really tricky issue for the Countess. Just to summarise a few key elements of our conversation, particularly re the police, given the daily pressure of that decision:

1. Based on the fact that:
   - the only current evidence of any clinical concern is the (potentially circumstantial) fact that one particular nurse was on shift on more occasions than others at the point when neonatal deaths arose, and
   - there are also deaths/deteriorations that occurred when she was not on shift, and
   - No incidents have been linked to her practice, and
   - No previous concerns or whistleblowing has arisen in respect of the individual or the unit, and
   - There is currently no cause of death or thematic clinical basis to suggest the deaths are connected to each other, or connected by a common intervention (deliberate or not), and
   - Approximately 75% of the deaths have also been through the coronial system, with no common feature or issue arising from the individual's care;

   There does not currently appear to be any reason to formally alert the police to these issues, as there is nothing upon which one might reasonably base a suspicion of a criminal offence having been committed. We advised that this fine balance of decision making be kept under very close review, with a very low threshold for moving this to a decision to notify the police, in the event any clinical evidence comes to light in the ongoing investigations that tips the balance in favour of alerting them. We discussed the useful parallel consideration of thinking about whether you reach the point where you have enough evidence to exclude her under your usual policy, as that would certainly be a key moment to consider the level of evidence to report her to the police too.

2. From a patient safety perspective, the decision to move the individual to a non clinical role is absolutely right. Irrespective of the right or wrongs of the suspicions cast upon her involvement in the heightened mortality issue, the individual will now be under enormous pressure, and that of itself creates additional patient safety risk that needed to be managed, and taking her offline from clinical duties does this. It will be important to ensure she would not have access to any medical records for the unit, in case there is any risk of her accessing them to investigate matters herself, or (worst case) to tamper with them. Ian may have a view on this from the constructive dismissal risk, depending what the non clinical role entails.

3. There is a likelihood that, having changed the admissions criteria to remove the highest risk of sub 32 week neonates (which I agree is the right step), that the mortality rate will drop significantly in any event, and that could easily be interpreted as being due to the removal of the individual, as the timescales coincide. That may make life much more difficult for her, and also for the Trust in trying to identify the true cause of the spike in mortality for this group of babies.

4. Finally, we explored the need to ensure the clinical team and those still internally investigating any themes around the deaths, still keep open minds to a range of potential causes, rather than take any false assurance from the issue of the individual, as that may risk missing a systemic cause, or indeed any other individual cause.

Please do not hesitate to get in touch as this situation continues to evolve. It would be helpful context to see the TORs for the 2 royal college reviews, but I appreciate you are checking the level of comfort around sharing those with us.

Kind regards
Corinne

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From: Hodkinson Sue (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [mailto:sue.hodkinson@ I&S]
Sent: 18 July 2016 12:42
To: Slingo, Corinne; Cleverley Debra (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Pace, Ian
Subject: RE: Call