THURS. 27. APRIL. 2017. IH. Susie Holt. Ravi.
12.30pm. TC's office. Hayley Frame. Rajiv Nigel W. SPR.

Outline - IH.
Hayley. Does 2nd report make any recommendation.
IH. Broader forensic review - done "Whatever you want it to be".
Now coop conversation.
Believe that we explored everything.
Ravi. done - looked
In her view & warranted broader forensic review. But we think further &
What is 'broader forensic review'.
We remain uncertainty
Fragile & poorly babies - collapse.
Group of children died.
Prem & unwell collapsed. Did not respond.
Also group who did respond.
Struggling on direct cause on all of these factors in report - general
Assoc. w/ 1 member of staff - concern
Beverley Allitt.
Uncomfortable that not enough done on that 1 person or any other
Suggested a police level review
IH. Nurse. full time - overtime -
Allocated sick & poorly babies
Susie. Niggling us & came together as Paeds
Has it bothered other staff - not for us to investigate. Cd more evidence be found by scrutinise any more staff.
We hv. not shared our concerns with others directly. Tension bet Docs & Nurses.
V. difficult. Level change. Huge connotations.

Staff know of review.
Ravi. Paed. Nurse - days & nights &
moved off night. & then no incidents on nights.
Since level change - no real incidents
I under current level wd hv. been the same.
IH. Working to higher level than we shd hv.
Increase in babies under 2000gms.
V. hot unit. Staff working under pressure.
Context of work in unit.
MW. Don't take below 32wks & don't keep
intensive care level babies. Since June last yr.
Workload change on level change
IH. About safety
Ravi. Summary. Investigations so far
not ID'd cause & never will. but sufficient
investigation.
or shd there be further investigation?
Feeling from clinicians - bit of discomfort
not investigated deeply enough
We are not trained to know the answer to this.
Shd all staff be i/v'd ? Pathology?
Hv. we lost sight of reality
Centring of Paed. experience - all uncomfortable
IH. Coroner - frank conversation.
& family - keen for end point.
full & frank conversation.
Inqs. still to be held.
Susie.
NW. PM's? All
Susie. No - early cohort. Baby well
Die'd quite suddenly. Coroner decided
quiet problem. - No PM. Isolated - ok.
BUT PM. incredibly
Dealt with difference bet PM's & forensic
Histo Pathologists

NW. Any samples retained
Susie. Another agency cd look at this
What was consented for.
NW. Report ∘ Royal College
∘ Dr. Jane Hawdon - not widely shared.
outcome. → 4 babies ref.
Susie. No-one has taken an overview of all
Hawdon's report. Coroner sd indiv. deaths.
Strength of concern lies in the collective.
Royal College referenced.
NW. 13 over 18 mths.
Susie. Yes. but also unexplained collapses.
NW. Collapses but recovered
Ravi. No recognisable pattern.
Hayley. How many collapses?
Ravi. Subjective but together 6 or 7.
Not looked further back.
But one odd in 2013. & that member
of staff was involved.
No-one in hosp. can look
Needs expertise & resources.
NW. We hv. to be police led.
Rely on with multi-agencies.
In terms of decision
Police Access to other reports.
Conversations internally
You may hv. to write in to Chief Constable.
Acceptable that more intrusive need
Ravi. Implications — Trust family.
Everyone a suspect.
to date every Dr. & Nurse not spoken to.
NW. Don't use word suspect.
All witnesses.
Hayley. Not a collective view.

HW. Wd sit with Major Incident Unit.
Need info.
to generate a line of enquiry.
Ravi. Paeds yes - junior staff thro'out
region. Looked at allocated person. BUT
As Paeds been angst bet us & Board.
Important things hv come out.
On 27 April not controllable no further
forward but ↓ possible.
Not sure night ↓ Q's hv. been asked
Susie. Best for unit families & safety
Hayley chairing CDOP & LSCB need
assurance going fward.
∴ to forensic investigation / police.
HW Are all babies post 27 wks. Prem babies
Susie. Prem yes born early very ill.
Not well enough to be in community
7 > than 32 wks.
not babies on edge of viability
Ravi. Abnormalities but not reason for collapse
Susie. Not life threatening
Did abnormalities affect death - no.
Ravi. Done H. → 4. We are not happy with others
BUT. Disproportionate number
Hayley Looked at 4 collapses but no recommendat
HW. Normal 3 per annum in last 5yrs.
Hayley. Patterns - not all Cheshire babies.
& Bcy of inquests not all renewed.
Going fward 10. location of death.
Ravi. Not previously done in Paeds
If concerns going ahead. SUDIC
for agencies.
HW. Daily Telegraph enq? Refer to COCH
HT. Yes we responded. & Sunday Times

IH

D. Telegraph. Banned from looking after babies.
Posters etc.

Hayley. Whistleblowing

NW. Records – secure. No issue.

Hayley. Paper records.

Susie. Imaged in.

Rajiv. CDOP process not linked to Coroner
to SUDIC

Susie. Wd need advice from Police
on clarity & process – does
anything different need to be done.

NW. Ops mtg pull something together on process

Hayley. If unexpected death now –
wd there have to be forensic investigation

Ravi. Pol. Cheshire approach?

Susie. Going to discuss how we go fward.
Want to go back to level 2. That's our goal.

NW. Death now to Coroner.
Cd trigger SUDIC process.
If forensic – joint – unexplained.
Holding position for now.

Rajiv. s/ment on SUDIC. (see document)
to responsible PAED. initially & then
multi-agency.

NW. Control → 3am death.

IH. Cd. be elsewhere eg. Arrowe or Liverpool

Hayley. Don't want to open womens.
a con of wom. but death elsewhere.

Susi. Yes – Arrowe Park.

NW. T of Ref if investigation

Hayley. Rationale for COCH now

NW. Changed level since dire look yr.

Susie. Nurse taken off unit.
Concern is not her. But many changes.

IH. To protect Nurse.
Hayley. What Nurse. doing now
Susie. Does hv. attendance on unit.
IH. Grievance. the. process.
Recomm. of mediation
Behavioural issues.
No previous on Nurse skills or abilities
Init criticised for what we did
To be re-introduced
Hayley not wise. for her to return
NW. 2nd Review please
IH. Secure email address. - NW. Yes
Ravi. Paed analysis of Jane's review.
NW. hmmm
IH. Brief - needed. Cop. people at table.
Ravi. We are completing document.
In a wks time.
NW. Attendees - all us
Susi. plus Steve Brearey
SB - with body of consultants
Each Paed to give o/e.
Ravi. Paed not there at collapse.
NW. Further review
Resources
Facilitate a mtg. in nxt few wks.
Will clarify if we want a L. to
scope a forensic investigation
Hayley As chair of CDOP. - wd not
normally be directly involved. Independent
+ Rajiv. - Assurance
NW. Will to
Appoint SIO. from MIU. - Mentor
TBL Rev. Gathers info. Assess.
Holmes. - Short lines of enq. Buildup + solicito

Take Time

Strategy witnesses simult

Chronol

NW. Sheil cd need L from CoCH to scope.
Ravi. If Police - how does this affect NNU.
Confident what we are doing now.
Do we shut down
Blue & white tape everywhere
NW. To Ref wd determine investigation at particular time.
Proportionate response.
Will clearly need sharing → Families! Reputation
Need decision quite soon.
Transparent.
Ravi. Only Police who cd do this.
NW. Reading is their level of concern
No correlation
Degree of concern | sinister
Ruling out criminal act.
Ravi. Collective with concerns
Hayley More deaths than normal
NW. Do nothing
Brief ACC
Initial brief
Letter option - invitation - scope.
All reports to NW.
List of attendees today
+ anyone else
w/i 2 wks
IH. Inq. on 23. May 17.
Steering at Police
Jennifer. coop@ I&S
Hayley will inform Cnl Frome
IH. NHS I. Conf. call at 3pm.
CCG.

[redacted]

N.W. Who are the prof. organisations.
NHS1.
Network.
Close. 1.50 pm.

Thurs. 27 April 17. 3pm
Margaret Kitchen Vince → Regional Med Dir.
↓ Council. NHS1
Regional Nurse Chief.
Lot of noise in system
Commissioners not at a sufficient level.
Not seen report.
V. Nervous about hanging on
Longer going on - more nervous.
Nutshell → Vince & I had with Tony
Don't ignore Commiss. concerns.
TC. updated Margaret & Vince.
CMC & or Police.
Spec. Comm. leads are concerned.
Not giving all info to Commiss.
Vince → brief conversation with Ian some wks ago.
↳ I'm not fully appraised & understand it.
Need to help manage these other factors.
IH. → Met with Spec. Comm some weeks ago.
so shd
Circumspect → by Sunday Times / Telegraph
Mindful → porters / domestic staff.
Boards affected by S. Times story.
Families concerned - opening grief again.
Initiated by our PAEDS - increase in deaths
13 in 18 mths. failure to respond to treatment.
Commissioners Ryan Collett then Jane Hawden
↳ No single question.
Multi-factorial Re-designating for safety shift