MINUTES

Of the meeting between Simon Medland, QC and certain consultants in Meeting Room 4, Education and Training Centre, CoCH 1700-1845hrs 12.4.2017

1. The following were present: SM, Steve Brearey, Suzie Holt, Ravi Jayaram, Murthy Saladi, John Gibbs and Doctor V.
2. SM began by stating who he was and why he was here – been instructed by the hospital to bring an independent objective view to present situation and see if formal report to police was presently merited, in other words whether there is presently information giving rise to reasonable grounds for suspecting that a criminal offence has been committed in respect of any one of the neonatal deaths in question.
3. SM said that the minutes of this meeting would be shared with the Board and circulated to each one of the attendees.
4. SM invited comments. Each one of the consultants spoke at length and in detail about the cases which are at the heart of this matter. They each feel very strongly about this. They expressed themselves clearly as to their concerns which derived from the increase in number of deaths, that certain of the deaths

occurred in neonates who would not ordinarily be expected to die and that there were particular unusual features which could be shown to have occurred or been present, some of which were common amongst several of the incidents. Amongst these latter features were the presence of one particular nurse on duty during/around some of the deaths, presence of unusual or unidentifiable rashes on some of the neonates and other features.

5. We all agreed that if there was an identifiable common thread between some of the deaths (c.f. the Beverly Allitt) then this would be powerful *prima facie* evidence that there was potentially a crime or series of crimes which had been committed.

6. SM gave his view that the police, being strapped for resources and in any event, can only sensibly investigate cases where there is – at the very least – reasonable grounds for suspecting that a criminal offence has been committed. He emphasised that this was very different from there being mere suspicion and also very different from where there were questions about hospital procedures and processes, as distinct from criminal actions. SM remarked that officially reporting any matter to the police was a condign step which was effectively a public action and would incur adverse publicity and raise matters for the families of the neonates which might be seriously disturbing.

7. There was a commonality of concern amongst the consultants. They all felt (although these matters were expressed in differing ways) that this matter had not, in some significant respects, been dealt with happily by the hospital. They felt that they had sometimes been excluded from a frank and inclusive discussion of the deaths and had been told different things by different people. They all felt that there had been an unacceptable delay of 9 months when little seemed to have happened. They all felt that whilst the Royal College Report was a useful document, it did not involve a forensic (in the strict sense of being detailed, evidence-based) investigation of the circumstances of the deaths.
8. A number of the consultants emphasized that Dr Hawdon's Report concluded with a recommendation that "…there should be a *broader forensic review* of the cases described in category 2…"
9. SM emphasised that it was of the first order of importance that the hospital and the consultants worked together on this issue and that positions did not become entrenched or opposed. SM indicated that he felt it likely that the hospital would have felt itself pulled in several different directions at once: needing to protect its own reputation, looking after individual members of staff who might be adversely affected, respecting the position and valuable experience of the consultants, respecting the privacy and sensitivities of the

families of the neonates, needing to fulfill its undoubted public duty to assist in the investigation of serious crime *if there is the evidence to justify it*.

10. The consultants all asked what such a broader forensic review as recommended by Dr Hawdon might amount to. They were not blindly pressing for the matter to be reported to the police but wondered who else might conduct such a review. The coroner, Mr Rheinberg, had effectively declined to do so and in any event a probable conflict of interest was identified. Any such person would have to be independent and have effective powers of investigation; time was pressing.

11. All of them acknowledged SM's point about the public and irrevocable nature of a formal report to the police ('the toothpaste is out of the tube') and that this may impact adversely on the hospital in general and certain members of staff in particular. It might carry also an appreciable risk that parents of deceased babies would have to deal again with the fact of the death of their babies.

12. SM made the point that, as things stand he did not see that there was such material as might give rise to reasonable grounds for suspecting that a criminal offence had been committed. He expressed the view that it was important to remember that such a step may well have far-reaching ramifications and should not be taken lightly.

13. SM posited a situation where a member of staff who might come under very damaging suspicion was not a nurse but was a consultant. No doubt that consultant would only want the matter to be put into the hands of the police after very serious thought about the potential consequences of such a step and where the evidence justified such a step.

14. SM suggested that what was needed was that the consultants should make short notes setting out their 'best points'; i.e. those matters which they say most clearly indicate in their minds reasonable grounds for suspecting that a criminal offence has been committed. This would help to crystallise matters and push them forward to a sensible conclusion. It would also help everyone to deal with the matter head-on in an inclusive, collegiate way which included taking the views of the consultants and including them in the decision-making process.

15. SM canvassed with the consultants the potential routes of investigation which might be undertaken before a final decision as to whether the matter was formally put into the hands of the police. Having discussed – and rejected – the possibility of a further enquiry as this was likely to be more of a talking shop and would not answer Dr Hawdon's recommendation for a broader forensic review, SM suggested the possibility of a private discussion with Detective Chief Superintendent Wenham. He suggested that this might be