Note of meeting with Susie Holt and Steve Brearey with Jo Revill and Emily Arkell
12/7/2019

List of acronyms:

- Steve Brearey – SB
- Susie Holt – SH
- Sue Eardley – SE
- Medical Director (Ian Harvey) - MD

Status of police investigation

- New peer reviewer needs to be appointed
- There is a large volume of evidence – each case has 50 statements attached to it
- There are links to Liverpool Women's hospital – the nurse who is under investigation used to work at the neonatology unit in Liverpool.

Reflections by Steve Brearey and Susie Holt

Prior to 2015, there was a strong paediatric and neonatology unit department at the Countess of Chester hospital which had good results despite usual NHS pressures.

The doctors on the neonatology unit became concerned after there had been three deaths in one week – though they noted this could have been a statistical blip. SB stated that his concerns were confirmed after there had been eight deaths by December 2015.

These were reviewed externally by a neonatologist in Liverpool and the commonality with all cases was the presence of the nurse who was present on the ward when the deaths happened.

In June 2016, two triplets died.

SB raised this with Ian Harvey, Medical Director (MD) and felt that the MD didn't see this as a priority. He was told firmly that a police investigation would be damaging to the Trusts.

SB added that the MD was an orthopaedic surgeon and he felt that his work on acuity was inadequate.

The MD organised an invited review of the service. SB stated that he was happy and felt confident to accept scrutiny though the review was mainly a service review rather than looking into the unexplained higher than average mortality rate in the neonatology unit. SH added that the invited review was an opportunity to share her level of concern about the deaths of babies on the unit.

SB stated that the MD had added an extra clause to the terms of reference of the review to look into the common identifiable factors or failings that might in part, or in whole, explain the apparent increase in mortality in 2015 & 2016.

SB stated that staffing issues had not been reviewed.

Jane Hawdon was commissioned to look at the case notes but she didn't review all of them. SB felt that the work by Jane Hawdon was less comprehensive that the work the doctors had already done. SB felt that the reviewers wanted to focus on BAPM standards.

SB stated that the information that the doctors shared with the Invited Review team was the same information which was shared with the Child Death Overview Panel, and this is was led to the police investigation starting 2 weeks later.

The nurse was placed in a non-clinical role (in the Risk Dept). but returned to clinical duties following mediation.

SB stated that there had been a dialogue with SE where he was seeking clarifications.

A draft copy of the review report was sent to the MD.

In December 2017, SB saw a draft copy of the review report which he checked for accuracy. The report SB saw was a redacted copy and he provided feedback on inaccuracies that he identified. However, he is not sure these were incorporated. SB added that he feels that the report doesn't go into the level and depths that are set out in the terms of reference.

SH stated she contacted SE directly to see a copy of the report as agreed by the MD. SE stated that she couldn't share a copy of the report as it needed to be shared with doctors via the MD.

Both SB and SH stated that they are still not sure if they have seen the final report.

SB stated that he had spoken to SE who confirmed there are two reports – a redacted and a final report.

SH stated that she felt bullied by the Trust. SB stated that he felt completely "hung out to dry" when the nurse returned to clinical duties. Both SH and SB feel that the MD was misrepresenting what they and their medical colleagues were saying.

SB spoke to Neena Modi in January 2018 and she suggested that he speak to the CQC about his concerns.

SB added that he spoke to SE after the nurse had been arrested for the first time in 2018. SB stated that he felt that SE couldn't seem to take any criticism of the approach.

SB also raised the issue of coverage of the invited review in RCPCH press cuttings which implied that the RCPCH's review had led to the police investigation. Both SB and SH were annoyed about this and strongly felt this misrepresented what had happened.

<u>Current status</u>

NHSE/I had placed the neonatology unit on its previous designation.

The CEO at the Countess of Chester is cognisant that there could be corporate manslaughter charges and has shored up the risk management processes.