Date of Meeting: 24 August 2016 at 09:00 – 11:00

Attendees:

- Sue Ward
- Nerina Barnes
- Frances Cottle
- David Porter
- Tony Newman
- Jaina Patel – Nathwani
- Gurleen Virk (minutes)

Apologies:

- Amanda Halliwell
- Michele Harrison
- Kristian Garsed

12/07/2016	**ELS - Call Out (DoN/CN)**	ELS - Potential referral (advised to investigate locally first)	**COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**	12/07/2016	Alison Kelly Director of Nursing & Quality Countess of Chester Hospital NHS Foundation Trust Tel: (01 I&S Email: alison.kelly9@ I&S Registrant: Lucy Letby PIN: I&S Issue: • The trust has seen a rise in mortality of babies in the (maternity ward) neonatal unit. • Each death has been the subject of a clinical team case review. • The reviews have produced no evidence as to a lack of competence by individuals or the team. • Further analysis has identified one registrant that has been present at nearly all these incidents. • The trust Some clinicians are concerned that the registrant may present a serious risk to public safety although no evidence is available at this time. • The registrant concerned, Lucy Letby, has received occupational support following these deaths and is currently on leave. • The trust board executive team are due to meet today (6/7/16) to decide if this registrant will be reported to the Police to investigate. Considering the above circumstances, the NMC would need to be advised of both the trust board decision to report to the Police and any subsequent action taken by the Police in relation to this matter. I would also recommend another advise call to take place following confirmation of any Police action.	**Agreed**	**NB: stated looking into the actions of the midwife, cannot find action or conduct that the midwife is accountable. This is a matter for police investigation.** **FC: we do not have a plausible allegation** **TN: the matter is serious and concerning.** **FC: unless there is medical negligence – this is a matter for the police.** **FC: the clinical governance risk manager should be assessing the risks in relation to this.** **SW: feels like the Trust has this matter in their hands.** **FC: did not find clinical failing therefore need to look into the chain of causation – mothers in labour expect a certain amount / type of care.** **TN: will follow-up.**	