

From: [Kristian Garsed](#)
To: [Employer Link Service](#); [Claire Davidson](#); [Matthew McClelland](#); [Peter Pinto De Sa](#)
Cc: [Caitriona Rafter](#); [Tony Newman](#); [Sue Ward](#); [Frances Cottle](#)
Subject: RE: Action required please: Police investigation at Countess Chester hospital
Date: 18 May 2017 15:12:25
Attachments: [TRIM Countess Neonatal Update \(591 KB\).msg](#)
Importance: High

Dear Claire / Matthew / Peter,

Further to my conversation with Claire this morning, and further to the email I received and forwarded this morning from Alison Kelly, DoN at Countess of Chester Hospital NHS Foundation Trust (attached), I can confirm that ELS has previously been in contact with the Trust about the heightened neonatal mortality rate previously and have provided support and advice to the Trust about this.

However, there are no open fitness to practise cases relating to this issue, and we have advised previously and have further advised today that it is not necessary to make any referral / referrals at this time. The police investigation has just been initiated and its first purpose is to identify if there has in fact been any form of deliberate harm to, or endangerment of these children, so as to have caused their deaths. At present there is **“no definitive explanation”** for the increase in neonatal mortality as concluded by the service review by the Royal College of Paediatrics and Child Health in 2016 (see link below).

There have been no arrests, and although an individual registrant has been suggested as a possible ‘common denominator’ there is no evidence available at the moment which suggests she has done anything wrong. We are in continuing contact with the Trust about this and I will be meeting Alison Kelly on 15 June 2017, at which meeting I anticipate being provided with some further update.

The ‘Regulators and stakeholders brief 18 May’ which is attached to the email attached to this message explains that:

“While we anticipate media interest due to this now being a police led investigation, we will be limited in what we can say and comment on further publically.

- Media enquiries about the investigation will be handled by Cheshire Police press desk on 01606 365 942.*
- Media enquiries specific to the impact of this on operational hospital services and patient care will be handled by The Countess of Chester on 01244 362 116 or by emailing countess.feedback@nhs.net “*

As there are no fitness to practise cases, and there is unlikely to be any NMC involvement until the police investigation has progressed considerably there is little for the NMC to do at this stage, other than follow the advice in the Trust briefing to refer enquiries to either the police or the Trust.

In terms of the prior involvement of ELS, and the information we can provide internally in relation to this:

- The first contact about this was on 12 July 2017, when Alison Kelly the Director of

Nursing spoke to Tony Newman (RA) on the ELS advice line. The call note is reproduced here:

*"Alison Kelly
Director of Nursing & Quality
Countess of Chester Hospital NHS Foundation Trust
Tel: (01 [REDACTED] I&S
Email: alison.kelly9@[REDACTED] I&S*

*Registrant: Lucy Letby
PIN: [REDACTED] I&S*

Issue:

- o The trust has seen a rise in mortality of babies in the (maternity ward) neonatal unit.*
- o Each death has been the subject of a clinical team case review.*
- o The reviews have produced no evidence as to a lack of competence by individuals or the team.*
- o Further analysis has identified one registrant that has been present at nearly all these incidents.*
- o 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.*
- o The registrant concerned, Lucy Letby, has received occupational support following these deaths and is currently on leave.*
- o 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."

- The next contact was the Trust's introductory meeting on 29 November 2016, attended by Tony Newman. The relevant extract from the introductory meeting note is reproduced here:

"We discussed, in detail, the issues from the advice line call conversation in July which resulted in the downgrading of the neonatal unit following an increase in mortality there. The Trust commissioned a review by the Royal College of Paediatrics and Child Health and the Royal College of Nursing. The initial feedback is that there are no immediate risks to patient safety which have been identified, and therefore no referrals will be made, however, the reviewers have recommended a more detailed review into a number of identified incidents, which the trust has challenged, to be undertaken by an independent external consultant and this is currently being arranged. We also discussed the individual involved who has been removed from the unit for her own protection, there are no grounds for a referral and the trust is appropriately managing this person with a view to a phased approach to return to the neonatal unit. Unfortunately, the individual concerned has initiated a grievance against the trust which

is due to be heard soon."

- Tony contact Alison Kelly on 05.01.17, to discuss receiving prior notification of the publication of the RCPCH review.
- The next contact was the provision of a link to the RCPCH review by email to Tony Newman on 06 February 2017. AK advised that the report which had been provided to the Trust in November 2016, would be made public on 8th February 2017. Tony advised the NMC media team of this. The link is here: <http://www.coch.nhs.uk/corporate-information/news/neonatal-review-and-update.aspx>
- Most recently I have spoken to Alison Kelly today. The note of my conversation with her this afternoon is below:

"Date & time of call: 18.05.17, 13.54

Call duration: 15 minutes

*Name, designation, Tel no and email of caller: Alison Kelly, DoN, 01 [redacted] I&S
alison.kelly9@[redacted] I&S*

Name of organisation: Countess of Chester Hospital NHS Foundation Trust

Name & PIN of Registrant: Lucy Letby. PIN: [redacted] I&S

Brief reason for call: On 17.05.17, AK requested a telephone discussion with Tony Newman or Kristian Garsed, in relation to the Royal College of Paediatrics and Child Health Service Review November 2016. An arrangement was made for KG to call AK on 18.05.17 at 09.30am. Called at 09.30am was advised that she had been required to deal with some urgent issues and was overrunning so I provided my mobile number and requested to be called back. Call back received at 13.54 prior to which during the morning I received an email with a press release and attached regulator and stakeholder briefings in relation to the announcement of a new police investigation into the neonatal deaths, being undertaken by Cheshire Police. (Email in docs.)

Discussion / advice: AK explained that this has been an ongoing situation since June / July 2016 and that the RCPCH full service review provided to the Trust in November 2016, had been thought to be likely to be the last stage in examining the heightened neonatal mortality rate in the period June 2015 - June 2016.

AK advised me that as she had explained to TN previously there was a view held by several medical colleagues that a registrant (Lucy Letby) may be the common denominator, and are quite strong in their view that she may be the cause. This is largely based on an identification of her as having been present on most, but not all of the occasions, when infants collapsed and or died. However, as is noted in the RCPCH review there is no certain picture of who was present on these occasions, and the most in depth analysis undertaken of the staffing situation, did not extend to non-clinical staff. In addition, the registrant has apparently a very good professional history and a high degree

of clinical credibility and was not present on all of the relevant occasions. Other staff were present on a similar number of relevant occasions.

The registrant has been moved to a different area and a non-clinical role primarily to support her, by enabling her to work in a different area outside of the pressure of that clinical environment and to protect her from the stress of being under a degree of suspicion from the medical team.

Following on from the completion of the RCPCH review, it has been decided by the Trust that the only option is to invite the police to examine the circumstances of the deaths / near deaths, to determine if there has been any deliberate harm to, or endangerment of, these children, and then only if so, to identify the person or persons responsible.

The police investigation has only just now been initiated and so it at a very early stage. The investigation will examine the circumstances of the deaths of eight babies that occurred where medical practitioners have expressed concern. In addition the investigation will also conduct a review of a further seven baby deaths and six non-fatal collapses during the same period.

The investigation is likely to be large, complex and long lasting. The registrant has not been arrested, charged or suggested to be a suspect as yet, she is a witness and she as well as numerous other colleagues will be interviewed as witnesses by the police. I advised that at this stage, as she has been advised previously, there is nothing which could amount to an identifiable or sustainable allegation of impaired fitness to practise, however the outcome of the police investigation has the potential to be very significant, and if this individual or any other registrant is identified as having been involved in the deliberate endangerment or murder of any of the infants in question, then plainly a referral / referrals would be necessary. Accordingly we will need to be updated as matters progress.

Outcome: Followed up on outcome of local investigation. Advised to wait for the police investigation to develop and to keep us regularly updated with any meaningful developments."

I hope that this assists all colleagues interested in this issue and the developments today.

Kind regards,

Kristian

Kristian Garsed
Regulation Adviser
Employer Link Service

Linking with employers across the UK

Nursing and Midwifery Council

1st Floor
1 Kemble Street

London WC2B 4AN
DX: **I&S** Kingsway
www.nmc.org.uk

04 **I&S** (ELS team and advice line)
01 **I&S** (switchboard)

From: Employer Link Service
Sent: 18 May 2017 11:58
To: Kristian Garsed
Subject: FW: Action required please: Police investigation at Countess Chester hospital
Importance: High

Dear Kristian,

Please see the below email further to our conversation.

Kind regards

Gurleen Virk
Employer Link Officer
Employer Link Service

Nursing and Midwifery Council
23 Portland Place
London
W1B 1PZ
www.nmc.org.uk

02 **I&S** (direct)

From: Claire Davidson
Sent: 18 May 2017 11:48
To: Caitriona Rafter; Catrin Cassidy; Frances Cottle; Employer Link Service
Cc: Paul Douglas; Matthew McClelland
Subject: Action required please: Police investigation at Countess Chester hospital
Importance: High

Dear All

I've just been alerted to the following article by Jackie's office which reports on the police launching an investigation into a number of baby deaths at the Countess Chester Hospital. It states they are looking at 8 baby deaths and seven further deaths, along with six non fatal baby collapses. The events are reported to have taken place in a 12 month period from June 2015.

I don't seem to remember us having any cases in relation to this so could I please ask colleagues as follows:

High Profile team

- Review if we have any cases relating to this matter and let me know the details of any if so?
- If we do not have any cases, to review the content of the article and decide on next steps on whether we need to open an FtP case

Employer Link Service

- Provide any detail of recent ELS engagement with the hospital/trust and whether they have brought any details of this to our attention

I would be grateful if you could let me have any information on this asap today so I can update Jackie's office. I will also alert our media team to the article if they are not already aware and let them know we are looking at this in anticipation of any press enquiries. I'm working from home today, but fully contactable on email and BB 07 [REDACTED] **I&S**

<http://www.dailymail.co.uk/news/article-4518212/Baby-deaths-Countess-Chester-Hospital-probed.html>

Thanks
Claire

Claire Davidson
Executive Manager
02 [REDACTED] **I&S**

Nursing and Midwifery Council
1st Floor
1 Kemble Street
London WC2B 4AN

From: [KELLY, Alison \(COUNTRESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST\)](#)
To: [KELLY, Alison \(COUNTRESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST\)](#)
Subject: Countess Neonatal Update
Date: 18 May 2017 10:50:41
Attachments: [Regulators and stakeholder brief 18 May.pdf](#)
[External stakeholder FAQs 18 May.pdf](#)
Importance: High



Thursday 18 May 2017

Information for regulators and stakeholders regarding neonatal services at The Countess of Chester Hospital

This briefing is to provide you with advance information regarding an updated position on our ongoing review of neonatal services and the involvement of Cheshire Police at our request. At 10.30am today (Thursday) the information outlined below will be published by each respective organisation.

While we anticipate media interest due to this now being a police led investigation, we will be limited in what we can say and comment on further publicly.

- Media enquiries about the investigation will be handled by Cheshire Police press desk on 01606 365 942.
- Media enquiries specific to the impact of this on operational hospital services and patient care will be handled by The Countess of Chester on 01244 362 116 or by emailing countess.feedback@nhs.net

Updated position on neonatal services and its ongoing review

The Countess of Chester Hospital has requested the input of Cheshire Police into its ongoing review of neonatal services.

In February this year we published the findings from an independent, clinical review into neonatal services at the Countess carried out by the Royal College of Paediatrics and Child Health. This report pointed to 24 recommendations for improvement which are now underway. It included a further detailed case note review by an independent neonatologist that has been unable to answer all of the questions regarding the cause of death for a number of babies.

The Trust and its doctors have continuing concerns about the unexplained deaths and are very keen to understand that everything possible has been done to help determine what has happened in our neonatal unit between June 2015 and June 2016.

As a hospital we have taken the clinical review as far as we can. We have now asked for the input of Cheshire Police to seek assurances that enable us to rule out unnatural causes of death.

Countess of Chester Hospital Medical Director Ian Harvey said: "We are deeply sorry for the further distress and heartache this will cause. Throughout this we have never lost sight of the families left bereaved by the loss of their baby, and they will continue to be our main concern.

At every point where the hospital has been able to share information with families and the public, we have done so. Approaching the police is not something we have undertaken lightly. This is to ensure we have been completely thorough in understanding what has happened here and to get the answers we and the families so desperately want."

Specially trained officers from Cheshire Police have been in contact with those families directly affected, and we will continue to provide our support where it is appropriate.

Our focus at this time is on supporting our staff, and those patients receiving care at the hospital.

Additional information about neonatal services and what this means

- Up until the point a baby is born it is looked after under the care of a maternity and obstetrics team. If a baby is poorly when it is born and needs to go to a neonatal unit, their care will transfer to doctors and nurses on a neonatal team. A neonatal unit specialises in the care of babies born early with low weight or a medical condition that requires specialised treatment. The Countess is now equivalent to a Level 1 Special Care Baby Unit. To understand the different levels of care visit www.bliss.org.uk/different-levels-of-care
- The Countess neonatal unit will remain open to women over 32 weeks in their pregnancy. We are confident the unit is safe to continue in its current form.
- We will be working with staff to ensure that expectant Mums and those individuals currently on the unit are provided with the necessary assurances to allow us to continue to care for them here at The Countess.
- Any Mums-to-be who have any queries about their pregnancy and what this means for them, can request an antenatal appointment via their community midwife.

Information from Cheshire Police regarding their investigation

In May 2017, The Countess of Chester Hospital Foundation Trust contacted Cheshire Constabulary regarding neonatal services at the

hospital. This was in relation to a greater number of baby deaths and collapses than expected during the period June 2015 and June 2016. The hospital also made the Constabulary aware of a number of independent reviews that they had commissioned into these deaths. As a result, Cheshire Constabulary has launched an investigation, which will focus on the deaths of eight babies that occurred between that period where medical practitioners have expressed concern. In addition the investigation will also conduct a review of a further seven baby deaths and six non-fatal collapses during the same period. "We recognise that this investigation will have a significant impact on all of the families involved, staff and patients at the hospital and the public. Parents of the babies are being updated on the investigation and will be supported throughout the process by specially trained officers. We are committed to carrying out the investigation as quickly as possible. The investigation is in its very early stages. We are unable to provide any further details at this time."

Additional information:

- Please note that the term 'collapse' relates to: A medical collapse is when the patient's breathing and/or heart rate suddenly deteriorates to the point where they are at risk of dying unless doctors or other health professionals take action.
- Of the 15 baby deaths, 13 of these were at the Countess of Chester Hospital. The other 2 babies collapsed at the Countess of Chester Hospital and were transferred to other hospitals where they subsequently died.

Alison Kelly
Director of Nursing & Quality
Countess of Chester Hospital NHS Foundation Trust
Tel: 01244 373111
Email: alison.kelly9@nhs.net

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FAQS FOR EXTERNAL STAKEHOLDERS

Background information regarding use of these potential questions

This document sets out a series of proposed handling lines in the event of questions that may be asked by patients or concerned members of the public following the publication of the neonatal review. Please note:

- Cheshire Police will be handling all media enquiries relating to the investigation. The press desk is 01 [redacted] I&S
- The Countess will be handling all media enquiries relating to what neonatal care is, and assurances that the unit is safe on 01244 362 116 or by emailing [countess.feedback@\[redacted\] I&S](mailto:countess.feedback@[redacted] I&S). Outside of office hours this is via the usual on call manager arrangements.

What has happened?

- As part of our ongoing review of neonatal services it is clear that some but not all questions have been answered about the unexplained deaths seen in neonatal services between June 2015 and June 2016 at The Countess of Chester.
- The hospital has taken its clinical review of neonatal care as far as it is able to. This is why we have now asked for the help of Cheshire Police to seek assurances that enable us to exclude and rule out unnatural causes of death.

What was this clinical review? I haven't heard about it?

- In July 2016 we took the decision to change admission arrangements for neonatal facilities. The unit stopped providing intensive care. Any women expected to deliver earlier than 32 weeks were transferred to a neighbouring facility. This step was taken because we wanted to better understand why there had been a greater number of deaths than we would normally expect on our neonatal unit in 2015 and 2016.
- In addition we requested a review of the unit from The Royal College of Paediatrics and Child Health and the Royal College of Nursing. We asked for this external assessment, it was not imposed on us or mandated.
- This report was published in February 2017. It was circulated widely, published on our website and covered in regional and national media. In the report, there is no single cause or factor identified to explain the increase we have seen in our mortality numbers. The review makes a total of 24 recommendations across a range of areas including compliance with standards, staffing, competencies, leadership, team working and culture. We are already working to implement these recommendations.
- One of the recommendations included conducting a further thorough independent review of each neonatal death in 2015 and 2016 to determine any factors which could have changed the outcomes.
- You can see the report here: <http://www.coch.nhs.uk/corporate-information/news/neonatal-review-and-update.aspx>

What is neonatal care – I don't understand the difference between maternity care and neonatal care...

- Up until the point your baby is born you are looked after under the care of our maternity and obstetrics team.
- If your baby is poorly when it is born and needs to go to our neonatal unit, their care will transfer to doctors and nurses on our neonatal team.
- You can find out more about neonatal care here: <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/baby-special-intensive-care.aspx>
- Bliss <https://www.bliss.org.uk>

Will the unit be closed during this investigation?

- No. We are confident the unit is safe. Services will continue on the same level as they have done since July 2016.
- This investigation relates to deaths between June 2015 and June 2016.
- There have been no further deaths on the unit since admission arrangements were changed in July 2016.

What if women want to change where they now have their baby?

- We have a fantastic and caring team of midwives and doctors here at The Countess. They have won awards for their care.
- Our maternity services are operating as usual. There is no need for women to re-book.
- We would encourage women planning to have their baby not to just take our word for it – look at reviews of the service (there is some really useful information on our maternity Facebook page), read our CQC report, speak to other mums for their experiences and talk to our staff.
- If any women booked in have concerns, they can arrange to speak with their community midwife.

Is there a helpline for patients?

- No. The police are in contact directly with those families affected.
- Any Mums-to-be who have any queries about their pregnancy and what this change means for them, can request an antenatal appointment via their community midwife.
- Alternatively people are able to contact the PALs team on 01 I&S

What will this mean for The Babygrow Appeal and the Chester Childbirth Trust?

- This investigation does not change our plans and ambitions for The Babygrow Appeal neonatal unit.
- Our review work to date recognises the challenges of the current environment and makes our case to progress our work with this all the more of a priority.
- We will be moving forward with the unit, with work expected to start this year.

- There is a great deal of goodwill and support for our charity plans and neonatal care at The Countess and for this we are extremely grateful.

What support are you offering for women who have queries about their pregnancy?

- Any Mums-to-be who have any queries about their pregnancy and what this change means for them, are advised request an antenatal appointment via their community midwife
- We will be working with our teams in maternity to lay on additional antenatal clinics if needed.

How can we help in assuring patients our services are safe?

- If you work here or deal with The Countess regularly, then you know we have a fantastic and caring team of midwives, specialist nurses and doctors here.
- The whole basis is that we identified the change in our neonatal services, we initiated the review, we acted on the recommendations and we have approached the police for their help.
- The Trust had its CQC inspection in February last year, the report was published in June. This can be found here: http://www.cqc.org.uk/sites/default/files/new_reports/AAAF5451.pdf
- This will be a really difficult time for everyone working in neonatal and maternity services and they need the support of us all in the weeks ahead.
- We would encourage you to tell people this, and to not just take our word for it – look at reviews of the service. There is some really useful information and reviews on our maternity Facebook page, people can read our CQC report, and we would encourage pregnant women to speak to other mums for their experiences.
- If any women booked in have concerns, they can arrange to speak with their community midwife.

What if I am approached by a patient who has lost a baby at The Countess, who wants to speak with someone about what this means...

- The police are speaking with the affected families about this.
- This investigation relates to the period of the review between June 2015 and June 2016.
- However, we appreciate this is a sensitive matter.
- If your baby was not cared for by the neonatal unit, it does not affect you. However we appreciate that this will have brought back a lot of emotions for you. If you would like to speak to someone who can provide support we can point you in the right direction.
- Are you aware of Sands? This is a local support service. You can find out more about this service here: <https://www.uk-sands.org>
- Another organisation providing support and information around neonatal care is Bliss <https://www.bliss.org.uk>

I don't understand the differences between maternity care and neonatal care

- Up until the point your baby is born you will be looked after under the care of our maternity and obstetrics team.

- If your baby is poorly when it is born and needs to go to our neonatal unit, their care will transfer to doctors and nurses on our neonatal team.
- You can find out more about neonatal care here: <http://www.nhs.uk/conditions/pregnancy-and-baby/pages/baby-special-intensive-care.aspx>
- Bliss <https://www.bliss.org.uk>