Leaked Countess of Chester & Operation Hummingbird documents

Source documents from the anonymous report: "Why (And How) The Hummingbird Flew."

Disclaimer: *The compiler of this document has not independently verified the authenticity of the source material. The material is therefore presented for informational purposes only and should be treated with caution.*

Note: *Initials of non-indictment babies included in the original report have been amended to a single initial + X + [2,3,4..]*

The Countess of Chester Hospital

The following 2 emails are from:
https://thirlwall.public-inquiry.uk/wp-content/uploads/thirlwall-evidence/INQ0058920_1.pdf

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7 February 2017 — Ian Harvey (Medical Director, COCH) → Nim Subhedar

Harvey tells Subhedar the NNU review has leaked to the Sunday Times and asks him to review Jane Hawdon's independent case review ahead of meeting the coroner and parents.

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) Sent: 07 February 2017 08:21
To: Nim Subhedar
Cc: Maddocks Julie

Subject: RE: NNU review
Importance: High
Sensitivity: Confidential

Good morning Nim [Dr Nim Subhedar was a Consultant Neonatologist at Liverpool Women's Hospital, and also the Clinical Lead for the Cheshire & Merseyside Neonatal Network]

As you are probably aware, the review was leaked to the Sunday Times. I believe that we have forwarded embargoed copies to commissioners, regulators and the network (I was on leave last week when this "kicked off".

We have completed some of the recommendations, including the independent case review. I feel that it is important that the clinical team have the opportunity to see this review (carried out by Jane Hawdon) and, since we will be meeting with the Coroner and parents, come to a consensus taking in to account all the internal and external reviews and views. It may be that Steve has already raised this with you but would you be able to assist us with this? For a number of reasons we are running to a tight time frame so in the first instance I would forward a copy for you read and consider ahead of any meeting. I'm happy to discuss if you want more info.

Kind regards
Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

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7 February 2017 — Nim Subhedar → Ian Harvey

Subhedar agrees to receive the independent case review and contribute to a consensus view.

From: Nim Subhedar
Sent: 07/02/2017 10:40:11
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
CC: Maddocks Julie

Subject: RE: NNU review
Sensitivity: Company Confidential

Dear Ian,

Thanks for your email.

Yes, I'd be very happy to receive a copy of the independent case review report and contribute to the contribute to the overall consensus view.

Best wishes,
Nim

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10 February 2017 — Nim Subhedar → Ian Harvey

Subhedar sets out detailed comments on the RCPCH report and Jane Hawdon's case note review, and asks to share his findings with Steve Brearey.

https://thirlwall.public-inquiry.uk/wp-content/uploads/thirlwall-evidence/INQ0103192.pdf

From: Nim Subhedar
Sent: 10 February 2017 15:06
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: RE: NNU review
sensitivity: Confidential

Dear Ian,

Thank you for sending me the RCPCH report and Jane Hawdon's individual case note review. My comments about the latter are detailed below.

1. The terms of reference of the individual case note review wasn't clear to me: what was she asked to do and what information did she have available to her? It seems she reviewed 13 deaths and 4 survivors who suffered a sudden collapse.

2. My own interpretation of the 13 deaths included in her review suggests there were 4 cases in whom there is no clearly identified cause of collapse/death, and a further three cases where the cause of the initial collapse leading ultimately to the baby's death remain unexplained.

3. I am broadly in agreement with her recommendations. However, it should be noted that many of these recommendations are relevant to all LNUs, not just COCH. Additionally, I see no specific justification for recommendation (5) on the basis of her review.

4. The single most important and relevant recommendation is (6) which advises 'broader forensic review' of the cases in whom the death/collapse remains unexplained. I would recommend extending this to the 7 cases that I have identified:

a. Child O
b. Child A
c. Child P
d. Child D
e. I&S
f. I&S
g. Child I

I would like to make one further observation in relation to the RCPCH report and recommendations.

Many of the recommendations relating to the governance arrangements around neonatal deaths are valid and sensible, but again extend beyond the neonatal unit at COCH. The unit in Chester is by no means an outlier either in terms of processes around mortality reviews or consultant presence and supervision on the neonatal unit. The COCH team's commitment to the Network's Steering Group and Clinical Effectiveness Group is exemplary and, in my view, demonstrates a commitment to improving the safety and quality of the neonatal care they provide.

I hope this is helpful. With your consent, I'd like to share my findings with Steve Brearey – please would you let me know if you're happy for me to do this?

Best wishes,
Nim

[Subhedar shares the above with Brearey two weeks later, on 27 Feb – see below]

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24 February 2017 — John Gibbs → Ravi Jayaram

Gibbs recounts a meeting with Ian Harvey about the non-fatal collapses review, the Coroner's position, and the consultants' ongoing suspicion of Lucy Letby.

https://thirlwall.public-inquiry.uk/wp-content/uploads/thirlwall-evidence/INQ0014268_01-02.pdf

From: GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) Sent: 24 February 2017 00:30
To: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: Re: So....

Hi Ravi.

Been a long day - stuck in A&E most of the time apart from popping to and from the wards to check how things were getting on, then seeing the PaedOW urgents at lunchtime. Anyway, all quiet now!

Managed to get to see Ian this evening - and it was just Ian. Although he'd said this was to discuss 'my' review of nonfatal collapses, this was only covered in passing. The areas discussed were:

- The review Anne Martyn and I undertook. Ian didn't tell me how many patients had been identified but said there were quite a few (I don't think he was hiding anything, he didn't have the data with him), but he's promised to send me the info. Apparently, Lucy did not feature prominently in the staff correlation analysis of those collapses. [I'm keen to see the data because if there really were many such cases then I'm not sure that these were the specific ones that were highlighted as being unusual or unexpected - and if the staff analysis was undertaken for too many of the collapses then that might have obscured an unusual correlation between certain staff and those unusual/unexpected collapses – but let's wait until we've seen the data; Ian agreed that I could share it with all of 'us'].

- In relation to that review, I mentioned that it had been disappointing that we'd not be able to see the results of the analysis. And whilst on that theme, I said that we had all been surprised and very disappointed that the Board had come to its decision without us actually seeing the two review reports. Ian admitted that there were lessons to be learnt about communication during the whole of this 'investigation' and he also included keeping parents more closely informed and updated. Apparently, this will be considered during a major debrief to take place at some stage.

- Ian felt that he and Stephen Cross had made our concerns clear to the Coroner. As Tony Chambers had said in his letter to each of us, our letter in which we gave our view that the deaths and non-fatal collapses had not been adequately addressed through the two reviews so far, and that we felt some of these were unnatural, was given to the Coroner. Also, Ian and Stephen Cross discussed our concern that one particular nurse featured more often than any other nurse in the resuscitations/immediate care of the deaths and collapses. Also, as we already knew, the Coroner has the 'full' College review (where our concerns are again covered), and also Dr Hawdon's review. - This discussion was held both with the soon-to-retire coroner, Nicholas Rheinberg, and the deputy Cheshire Coroner, Alan Moore, who is to take over from the current Coroner next month (like Rhienberg, Moore's background is as a lawyer). [I feel it was useful for both to be informed together because although Rheinberg will not doubt want to maintain his professional integrity, I would worry that his decision over what action, if any, to take might to an extent be influenced by his imminent retirement whereas the new coroner may have a different perspective at the start of his role as Cheshire Coroner].

- The coroner told Ian that he would not expect to have to re-open inquests that have already been held but that the forthcoming inquests, of which Ian thinks there are likely to be 3 (although 2 of these are probably! Child O and P would provide an opportunity to examine issues associated with the deaths. Ian does not know if the coroner/deputy coroner are considering any other actions.

- Ian explained that we can look at issues surrounding the deaths that Jane Hawdon/Nim have identified as unexplained when we meet next week (this is on Tues afternoon - but I don't think you'll be back then, will you, Ravi?).

- Ian asked me what I thought would be the end point of these reviews and further discussions and whether we'd be able to draw things to a close and move on with implementing the recommendations from the College review in order to enhance the neonatal service (he didn't specify what level of unit this would be). I said that we are preparing letters to both Tony Chambers and Lucy but this has been held up with holidays (which Ian says he entirely understands).

- I also explained that a problem 'we' have (and I said I thought this applied to all the consultant Paediatricians), was that we remain somewhat suspicious of Lucy's involvement but we don't know

what she did (if anything), nor how she did it and, obviously, we don't know that she actually did anything untoward. Even so, I made it clear that unlike the impression given in the full version of the College review that it was only after Steve's first review (at the end of 2015) happened to highlight an association between Lucy and many of the sudden, unexpected collapses that our suspicions over Lucy then became aroused, each of us had already started to become worried about this association from our own personal involvement in various episodes. Initially, we felt Lucy was just unlucky in happening to be involved in more of these infants than other nurses but this association become steadily more worrying especially with recurrent sudden collapses at night that stopped when Lucy was moved off nights and then, on one occasion (only that I'm aware of), when Lucy covered a stable infant during a colleague's coffee break during which that infant unexpectedly collapsed. Ian again mentioned that Lucy, being a young, single nurse, undertook more sessions than other nurses on the unit and so would be expected to be associated with more 'events' but I countered that this was true but her involvement still seemed to be unexpectedly frequent. I added that in any mediation with Lucy it would be very difficult to know how to answer if Lucy (or the mediator with Lucy present), asked whether we still had 'suspicions' about her - although I suggested that like a politician we could aim to resolutely refuse to answer the question directly and instead talk about [next page missing]

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27 February 2017 — Nim Subhedar → Stephen Brearey

Subhedar forwards his NNU review comments, asking Brearey not to share them more widely yet.

From: Nim Subhedar [Nim.Subhedard, l&S
Sent: 27/02/2017 17:02:46
To: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: FW: NNU review
Sensitivity: Company Confidential
Flag: Follow up

FYI. Please don't share more widely at this stage.

Thanks,
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28 February 2017 — John Gibbs → COCH consultants (cc Ravi Jayaram)

Gibbs circulates his account of the discussion with Ian Harvey and the summary of the non-fatal collapses review.

From: GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 28 February 2017 20:44
To: L Doctor V 1(COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST);L Doctor ZA ;(COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Cc: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: Discussion between John Gibbs and Ian Harvey 23/02/17

Dear All,

Below is an email I sent Ravi after a discussion I had with Ian Harvey last week. Ravi had informed me before he went on leave that Ian wanted to meet with me. Understandably, Ravi was keen to know the outcome of this discussion (even though he was I&S), so the email below [ABOVE] is my feedback to Ravi (which is now being shared with you all). At the end of the email you can see that I've included my opinion that I feel we've probably pushed things as far as we can given that the Coroner knows of our concerns about unnatural deaths (and non-fatal collapses), and has a copy of our letter to Tony Chambers. However, I'm aware from the meeting we had yesterday (in Steve's office), that this may not be the majority view and I'm sure we'll be discussing this further. Anyway, for now, here's what I discussed with Ian Harvey (at his request), last week:

JOHN

P.S. I shall also circulate the summary that Ian has now sent me of the review of non-fatal collapses leading to transfers out of the Trust, undertaken by myself and Anne Martyn , that I mention below (note, this review did NOT cover patients who collapsed and survived but did not require transfer out of the unit).

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1 March 2017 (email); 27 March 2017 (minutes) — Ian Harvey → Stephen Brearey

Harvey thanks Brearey for the meeting and asks him to attend the facilitator meeting on 7 March; attached are the minutes of the 27 March 2017 paediatrics meeting on the neonatal deaths.

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
To: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: FW: NNU Meetings
Date: 01 March 2017 13:45:09
Importance: High
Sensitivity: Confidential

Dear Steve

Further to yesterday's meeting I wanted to thank you for contributing, I believe that further progress has been made. I gather that an apology letter was forwarded to Lucy today and I would also like to thank your part in that for that. I repeat my comments of yesterday that we must separate the concerns raised and the reviews from the grievance procedure.

On a related note, please could I counsel you to make every effort to attend the preliminary meeting with the facilitator next week, the 7th March. You may have already noted but this is an initial meeting, just with the facilitator, and will enable you to address some of the issues that were called out yesterday. I think that this gesture would also go a long way to protect you from a possible referral to the GMC from other parties which, having supported many doctors who have done no wrong through, even then isn't a comfortable process.

As previously my door is open to discuss any issues.

FYI — I have sent a similar email to Ravi

Regards

Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

INQ0004406 - Pages 1 – 2 of minutes of a Paediatrics Meeting held between Tony Chambers, Ian Harvey, Sue Hodkinson, Ravi Jayaram, Steve Brearey, Julie Maddocks, and Nim Subhedar, dated 27/03/2017
27th March 2017 — 5.10pm — 6.20pm
Attendees
Tony Chambers (TC)
Ravi Jayaram (RJ)
Nim Subhedar (NS)
Ian Harvey (IH)
Steve Brearey (SB)
Julie Maddocks (JM)
Sue Hodkinson (SH)

TC: Welcomed everyone to the meeting. Provide some context of the current position. We've had:

1. Royal College Review — actions and recommendations

2. Members of Staff — grievance

3. Clinical, how we get to the point the Board and Organisation has done everything to answer questions. If it's not at that point, what do we need to do to get to this point?

IH: RJ/SB/NS/John Gibbs — we had a useful meeting where we reviewed the 13 deaths.

There were five everyone was comfortable with.

There were eight were there were still concerns either cause of collapse, failure to respond to resus. Further in-depth review, which focused on collapses.

IH completed reviews of the eight and review of rotas together with all case notes and what recorded in the notes.

The next stage was to go through these

It was important that we were conscious of deaths in the first instance. This would drive anything regarding babies collapsed.

There are a number of questions we need help with:

- Collapsed unexpectedly, fail to respond
- If looking at potential causes, continuing consequences of collapses and how this is unpicked.

SB: This was discussed on a weekly basis.

Focused on 8/13 and transferred babies

It is disappointing the depth that this has been gone into.

A further 6 babies, arrested unexpectedly, which we identified in July. We don't feel these have been investigated in depth.

Nine months on and the hospital should not investigate this any further

This needs to escalate to the police. We have not had any explanation and we escalated this in July.

TC: Why are you escalating this now?

SB: We are still very worried. There is no natural cause of death.

RJ: There have been deaths.. . .

SB: But these were explainable. Not included in mortality review.

TC: You don't believe the different admission criteria had an impact?

RJ: As a group of paediatricians, we accept the Royal note College review, the case review and Jane Howden's review identified further ones. It's a difficult thing, what level of review do we need to do. We have a collective view that this now needs to be at the level of a rota review, who, where involved, a forensic investigation.

We accept that we may not find cause.

We have our names on the end of the incubator, we need more assurance. The interpretation of the reports differs to the Board.

We were presented with a plan and we have explored every avenue with the BMA (British Medical Association).

The review identified that there was no single casual factor, you identified further cases.

What do you agree and don't agree on?
SB: The College review is a service review not investigating the deaths. Jane Horden — four cases forensic review, her review was not forensic, it stimulated discussion and learning. There are four cases not reviewed yet.

TC: If this is your intention this is always going to continue, only higher authority is the police, not sure what they will say?

NS: The cluster caused concern here. The College review is a service review not case note and followed up with further detail review. In depth review for more than four cases.

The standard needs to be external to be some degree.

TC: I need to know if we do an individual case note review, or phone the police.

JM: Given the information, on the balance of probability, illegal activity has caused the deaths.

IH: Or reasonable doubt?

TC: If no process, the determining factor is that there is no other answer. Mischievous activity is the only causal factor. I didn't think that was where we are. We can phone them now, everyone will be interviewed.

SB: The worries not going away. I'll share with you an email from one of our experienced consultants, who was new with us in July; he has some stronger feelings than me. Quotes e-mail (from Michael).

TC: If that is where we are, then phone the police. You can call the police.

RJ: After the case note review, we are still left with 8 cases.

NS: Left missing staffing data, if that is reassuring.

IH: Does not highlight a single individual?

[End of page 2. Further pages not released by Thirlwall Inquiry]

INQ0003236_0001 [Countess Board meeting]

EXTRA-ORDINARY BOARD OF DIRECTORS (PRIVATE)
MINUTES OF THE MEETING HELD ON THURSDAY,
13TH APRIL 2017 at 9.30AM
BOARDROOM
SPC/CER FINAL

3. TO CONSIDER THE CURRENT POSITION WITH REGARD TO THE NEONATAL UNIT

Sir Duncan outlined the starting point where all the Board have been informed at each significant stage and they all know the steps taken and the further important step was to seek Mr Medland Q.C.'s advice.

Sir Duncan noted that the Board had received a copy of the minutes from the meeting with Mr Medland and the paediatricians.

Mr Medland thanked the Board for inviting him to the meeting and noted that the minutes that had been shared with the Board which were a summary of a long and important meeting. The background is an unexpected rise in neonatal deaths which could be due to all kinds of reasons but one matter crystallised in the consultant's minds about the unexpected number and certain infants who in their professional view would not ordinarily have died and they have in their mind that this could be criminal offences by a person or persons. The Royal College report says things could be done better and that some standards were not quite met in matters of quality and delivery. Neither the Royal College review or Dr Hawden's review identified any criminal issues. Dr Hawden said that a forensic review should take place. The consultants take the view that they are not militant or agitating for the matter to go to the police but they cannot see anyone else who could investigate it but the Trust view

is if go the police this is an irrevocable step and carries potentially enormous risks for reputation and for the families, the question is, does it merit that step? All of us around the table agree that if there is clear evidence of a crime that you would want to go to the police straight away.

Mr Medland stated that in his view there is no evidence of a crime but the consultant view is to go to the police. He suggested that an alternative approach would be to approach the police member of the Child Death Overview Panel (CDOP) although it is possible he may say he is unable to help due to his position, he also suggested the Coroner, Mr Rheinberg but there would be a conflict of interest. We cannot say no to a further review of some sort as Dr Hawden's report says a broader forensic review is needed of the class 2 cases. He believed the next step is to acknowledge the aggravated sense of the consultants, put our arms around them and say that we propose to refer to Dr Hawden and ask her to tell us what she means as to a forensic review as this has many meanings and also what she feels will address this and could then speak to the police. This may satisfy their curiosity but he does not know.

Mr Medland added that you need to accept that if something is still unanswered or there are still genuine concerns in well minded people you should go to the police.

Mr Wilkie said that he had no real issue with what was being recommended but asked why doing this now and not at the point of getting a further report. Mr Harvey replied that it was not just about the forensic review but also the pathology review had taken some time as permission is needed from the Coroner to approach the pathologists at Alder Hey and also then contact them about the babies involved so this added to the delay. There was then a meeting with the paediatric consultants to discuss further work and clarify the number of cases after the pathology queries this went back to 13 and then 8 after a consultant meeting. As far as they are concerned there were still 8 cases despite what Dr Hawden said. There was another follow up meeting which has led us to where we are now and the delay is partly due to seeking permission from the Coroner to get to the pathologists.

Mr Wilkie asked if we can truthfully argue that there has not been a delay and that it had not been possible to do sooner. Mr Harvey replied there is due process and we have done everything in a reasonable and explicable order but we are beholden to other delays. M Chambers added that an enormous amount of work had been done and the clinicians will not recognise this but still hold the view that we have not taken this seriously.

Sir Duncan stated that the Board needed to decide for ourselves if we feel the work took long, did it answer Dr Hawden's report. The Board has a story to tell and follow through.
Mr Harvey said that was why he met with the consultants with the review to come to one view. Their view doubles the number of cases where there are concerns and they could not define what they felt was a forensic review.

Sir Duncan asked what did Dr Hawden mean, what would it amount to and could it be done without a police investigation. Mr Harvey said that it could mean many things and her view may not satisfy everyone. Mr Harvey is content to speak to Dr Hawden however this may not move us forward as the consultants may not agree. Mr Chambers said that this had been the purpose of the consultant meeting a couple of weeks ago. The Board view is answered up to 4 cases but consultants say 8 cases. There is a view of one or two consultants that there should be a police enquiry with interviews of individuals.

Mr Medland felt it may help to sit down with the consultants and say not ignoring their concerns and that we are going to do this with you as one team. The consultants feel split from the Executive team

and sometimes think no one is listening. They also said the hospital has listened but not heard us. There is a need to bring the consultants back to the fold, say here is the action plan and that you want to work with them. We want a sensible way to acknowledge the difficulties. Mr Medland suggested that Dr Hawden be asked what is the forensic review and why the level 2 cases. He would invite the consultants in to the process as this will help them understand that it is not secret or kept away from them. We need to get to a position that there is a bomb proof criteria and actions.

Mr Higgins stated that as a Board there is a need for something bomb proof as quickly as possible rather than this is what we are going to do. In the discussion with Dr Hawden a representative from the consultants could be asked to be involved. Mr Oliver added that this could stop the perception and we need to have a solution to address that.

Mrs Fallon asked if we can get a timeline to speak to Dr Hawden so that we are clear when we can speak to her. Mr Medland suggested that Mr Chambers and Mr Harvey invite the consultants to a meeting tomorrow and speak to Dr Hawden then.

Mr Harvey suggested that Dr Hawden be invited to the Trust to discuss and agree a common line. Mrs Kelly and Mr Harvey have spoken with the Chair of CDOP and they have offered their assistance and Mr Harvey has agreed that he will discuss with them how they could assist in the process. Mr Medland felt that saying to the consultants that these are the steps we are taking would show that you are not trying to be secretive and this is a collegiate move forward.

Sir Duncan stated that the co-creation of the forensic review was a good idea and that would help to understand what forensic means to us all. It is hard to think that there should be another step after that. They may say we are handicapping ourselves by excluding the police at the moment but let's see where the next step recommended by Dr Hawden takes us.

Mrs Hopwood asked if the consultants would accept one representative being involved. Mr Medland replied that this was difficult to know as the sense if they all say should be a further enquiry but not pressing to go to the police but could not see an alternative. Some are more militant than others but there is potential with the proposed actions with Dr Hawden and CDOP. The consultants will understand that is difficult to get them together, could email them all and say get together before Easter and then set a date after Easter with Dr Hawden and CDOP and let hem decide who can attend. It is about not shutting them out and looking for the best way forward to get activated.

In response to a question from Mr Higgins, Mrs Kelly gave details of the role of the CDOP in such matters,
Mr Chambers asked Mr Medland about paragraph 14 in the minutes. Mr Medland said that consultants have swirling ideas about the potential crime so I said it would be helpful for them to think about what crime they thought had happened, i.e. did it always happen at tam, it is about designing a process to shed light on any issues as you cannot just go to the police without some detail.

Sir Duncan referred to the Beverley case and asked what are the common threads i.e. mottling or anything else they can think of. They are bothered by a spike but is there a common thread. We are not them and it is hard to believe but that does not matter, we need to understand what they are thinking.

Sir Duncan stated that the co-creation of the process will not satisfy anyone if it is a desk top exercise however as soon as it goes to an interview process, we may as well have called the police.

Mrs Hopwood asked if there was a plan to communicate this to the families. Mr Chambers replied that the Trust has written to the families advising them this is what we know in an open and transparent way.

Mrs Hopwood stated that there is a need to have some pre-emptive lines for the families. Mr Chambers said that there are the families, the nurse and The Telegraph and it may be easiest to phone the police, given all the potentials for an unmanaged grenade. To take forward the recommendations so far we will need to meet again next week. We have been trying to manage this and it may get away from us. Mrs Hopwood replied that she felt it had got away from us.

Mr Wilkie asked about the confidentiality of the CDOP. Mr Chambers replied that it would be shared with the Chair of CDOP and added that all the members of CDOP have received a copy of the Royal College report.

Mrs Hopwood asked if the report had been shared with the families. Mr Chambers confirmed it had and that the report was available on the Trust's website.

Mr Harvey stated that he had met with one of the sets of parents and their concern was that we will turn their world on its head and that they would start grieving all over again. They are very angry with the Solicitor that leaked the report to the Times. The Trust has endeavoured to keep the families up to date. The parents have given some useful feedback and there are things to be learned especially from the early days. We do need to be careful when approaching the parents.

Sir Duncan stated that there is a need to have a plan in place when approaching the parents.

Sir Duncan asked if everyone was comfortable that the Trust explores with Dr Hawden to take the forensic review forward. Everyone confirmed that they were content with this approach.

Mrs Hopwood asked would it be 4 or 8 cases. Mr Medland replied that it states class 2 cases. Sir Duncan added that it would not be limited as it is not yet known what the foremsic review means. We will sit down with the consultants and discuss what to do about following up the recommendations. It may mean that we cannot satisfy everyone short of saying go to the police now but maybe able to satisfy the right leader however they may still come back and say they want to go to the police in any event.

Mrs Hopwood asked what if the consultants after the forensic review still want to go to the police. Mr Chambers replied that we would have a discussion with the consultants.
Mr Cross reported that an inquest into one of the babies involved in the review was due to be held on 25th May 2017.

Mr Wilkie said that it would be good to have the forensic review completed before them.

Sir Duncan said that there was one other consequence as LL is expecting to come back to work and what do we say to her about the delay. It is not for the whole Board to discuss but it is important to get it right when explaining the further delay.

Sir Duncan added that we are still searching for explanations, not saying she is still in the frame but it is a legitimate point that the forensic review be conducted.

Mrs Kelly stated that the nurse asks every time we meet when can she go back on the unit. Sir Duncan replied that it was about getting the truth about why babies died and that we need more time for the forensic review.

Mr Chambers stated that we will find a way and there will be consequences, there are lots of moving parts to try and control and also the rest of the NHS structure such as NHS England who are part of this and they will also want to express an opinion, especially having regard to matters currently ongoing Shrewsbury.

Sir Duncan added that the biggest risk is losing control of the situation and again noted the need to communicate with the parents.

Sir Duncan thanked Mr Medland for his help and support.

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13 April 2017 — Ian Harvey → Consultant paediatricians

Harvey thanks the consultants for meeting external reviewer Mr Medland and asks them to confirm they are happy with his notes.

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) Sent: 13 April 2017 11:29
To: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V I (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: Mr Medland - In confidence
Sensitivity: Confidential

Dear All

Firstly, thank you for meeting with Mr Medland yesterday; I hope that you found it useful. Please could you confirm that you have all received copies of his notes and are happy with them?

[No response from consultants until 24 April, a week and a half later, see below]

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19 April 2017 — Michael Gregory (NHS England) → Ian Harvey

Gregory asks for an update following the Trust's Board meeting.

From: GREGORY, Michael (NHS ENGLAND)
Sent: 19 April 2017 10:20
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: Update please

Hello Ian

Are you able to update me please as to the decision after your Board meeting?

I have to report back to colleagues today

Dr Michael Gregory
Regional Clinical Director for Specialised Commissioning (North)
NHS England

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19 April 2017 — Ian Harvey → Michael Gregory

Harvey reports that, following the Board meeting and further case reviews, four cases remain unexplained.

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 19 April 2017 12:26
To: GREGORY, Michael (NHS ENGLAND)

Subject: RE: Update please
Sensitivity: Confidential

Good afternoon Michael

Following our Board meeting — having completed the College review and the further case review - we have consulted further with the external, independent case reviewer and since we have 4 cases in which, in the reviewer's opinion, the death is unexplained we are following the process that would be the case in the event of an unexplained death out of hospital and are consulting with the CDOP. I have a phone call scheduled with the Chair of the CDOP tomorrow and will feed back further after this.

Regards
Ian Harvey

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19 April 2017 — Michael Gregory → Lesley Patel, Margaret Kitching, Robert Cornall (NHS England)

Gregory shares Harvey's update and says he is concerned the Trust is avoiding contacting the police.

From: GREGORY, Michael (NHS ENGLAND) [Irrelevant & Sensitive]
Sent: 19/04/2017 11:56:16
To: PATEL, Lesley (NHS ENGLAND), KITCHING, Margaret (NHS ENGLAND), CORNALL, Robert (NHS ENGLAND)

Subject: Update on Chester
Sensitivity: Company Confidential

Hello

Here is an update from Ian Harvey.

I am concerned that they are avoiding the issue that we wish to see (contacting the police) but I suppose we should allow this call to occur then if they don't call the police after speaking to CDOP then perhaps consider we insist?

Michael
Dr Michael Gregory
Regional Clinical Director for Specialised Commissioning (North)
NHS England

INQ0102758

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20 April 2017 — Debbie Dodd (PA to Ian Harvey) → Hayley Frame (Chair, CDOP)

Dodd asks Frame to attend an urgent meeting at the Trust about the NNU review.

From: DODD, Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 20 April 2017 16:02 To:
'hayley frame'
Subject: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL NEXT WEEK - NNU REVIEW
Importance: High

Dear Hayley

Mr Harvey asked that a meeting be held as soon as possible at Countess of Chester Hospital NHS Foundation Trust and has invited you to attend as Chair of CDOP.

The meeting will be for approx. 1.5 hrs and will include himself, Tony Chambers(Chief Exec), Stephen Cross (Director of Legal & Corporate Affairs), Dr Raj Mittal (Consultant Paediatrician) and our Chairman, Sir Duncan Nichol.

The provisional dates I have held in our diaries are Monday, 24th April 1.30— 3.00pm and Tuesday, 25th April 12.30 — 2.00pm.

Mr Harvey asked if you can also invite anybody else from CDOP who you fee is appropriate.

Please can you let me know if you would be available on the above dates as a starting point.

I look forward to hearing from you.

Personal Assistant to
Mr Ian Harvey, Medical Director & Deputy CEO
Mr Simon Holden, Interim Finance Director

INQ0102758

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21 April 2017 — Hayley Frame → Debbie Dodd

Frame says she is unavailable on the proposed dates but could manage Thursday.

From: hayley frame
Sent: 21 April 2017 10:20
To: DODD, Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: RE: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL NEXT WEEK - NNU REVIEW

Hi, I am delivering a serious case review practitioner event that morning in Nottingham so won't be available. Next week is full unfortunately apart from Thursday?

Thanks
Hayley

INQ0102758

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21 April 2017 — Debbie Dodd → Hayley Frame

Dodd confirms Thursday 27 April and asks who else from CDOP will attend.

From: DODD, Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) Sent: 21/04/2017 12:00
To: hayley frame
Cc: anne.mckenzie
Subject: RE: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL K – NNU REVIEW - THURSDAY, 27th April 2017

Hi Hayley

Thursday is fine for everyone here. It would be good to hold the meeting at 12.30 — 2.00pm? Is this okay with you?

Are you inviting anybody else from CDOP?

Kind regards

Personal Assistant to
Mr Ian Harvey, Medical Director & Deputy CEO
Mr Simop_Holderii Interim Finance Director

INQ0102758

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21 April 2017 — Hayley Frame → Debbie Dodd; Gill Frame

Frame agrees to Thursday and suggests also inviting Cheshire Police and the LSCB Independent Chair.

From: hayley frame
Sent: 21 April 2017 12:18
To: DODD, Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Gill Frame
Cc: anne.mckenzie

Subject: RE: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL K - NNU REVIEW - THURSDAY, 27th April 2017

That's fine, thank you.

I wonder whether we should invite Nigel from Cheshire Police and Gill Frame, Independent Chair of Chester LSCB? Please can you canvas Mr Harvey's views?

Thanks
Hayley

INQ0102758

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21 April 2017 — Debbie Dodd → Hayley Frame

Dodd confirms Harvey agrees to invite them and sets out arrangements for the 27 April meeting.

From: DODD, Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 21 April 2017
To: hayley frame
Cc: MCKENZIE, Anne
Subject: RE: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL K - NNU REVIEW - THURSDAY, 27th April 2017
Importance: High

Hi Hayley

Mr Harvey agrees that they should be invited. Would you be able to arrange this with them as I don't presently have their contact details.

I confirm the meeting will take place at 12.30pm — 2.00pm on Thursday, 27" April 2017 in the Executive Office, Countess of Chester Hospital NHS Foundation Trust.

If you come to the main reception of the hospital and ask for me and I will show you to the meeting room.

We look forward to seeing you on the 27th.

Kind regards
Personal Assistant to
Mr Ian Harvey, Medical Director & Deputy CEO
Mr Simon Holden, Interim Finance Director

INQ0102758

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21 April 2017 — Anne McKenzie → Nigel Wenham

McKenzie forwards the meeting invitation to Wenham on behalf of Cheshire East Council.

From: MCKENZIE, Anne
Sent: 21 April 2017 16:05
To: Nigel Wenham
Cc: DODD, De COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); PD

Subject: FW: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL K – NNU REVIEW - THURSDAY, 27th April 2017
Importance: High

Hi Nigel

Please see below an e-mail trail for an invitation to a meeting to discuss the NNU at COSH, could you let Debbie Dodd know if you are able to attend.

Many thanks

Anne MacKenzie
Business Administrator, Cheshire East Council

INQ0102758

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21 April 2017 — Nigel Wenham → Anne McKenzie

Wenham confirms he can attend.

From: Nigel Wenham
Sent: 21 April 2017 21:00
To: MCKENZIE, Anne
Cc: DODD, Debbia.I.C_OLMTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST);
PD PD

Subject: RE: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL K – NNU REVIEW - THURSDAY, 27th April 2017 ,.[NOT PROTECTIVELY MARKED]

All, I have tweaked my diary, I can attend

INQ0102758

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24 April 2017 — Debbie Dodd → Nigel Wenham

Dodd thanks Wenham for confirming and gives arrival instructions.

From: DODD, Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Date: 24 April 2017 at 12:01:07
Subject: RE: URGENT PLEASE REPOND - MEETING AT COUNTESS OF CHESTER HOSPITAL K – NNU REVIEW - THURSDAY, 27th April 2017

Many thanks for confirming Nigel.

Please come to the main reception on Thursday and I will show you to the meeting room.

Kind regards.

Personal Assistant to
Mr Ian Harvey, Medical Director & Deputy CEO
Mr Simon Holden, Interim Finance Director

24 April 2017 — Ravi Jayaram → Ian Harvey (cc consultant colleagues)

Jayaram, replying for the consultants, raises a discrepancy over the meeting's purpose and asks to speak informally with DS Wenham and to learn Dr Hawdon's view on "broader forensic review".

From: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) Sent: 24 April 2017
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST),
Cc: GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: RE: Mr Medland - In confidence
Sensitivity: Confidential

Thank you Ian, I am replying on behalf of the team after discussions.

We are happy with the minutes. However, at the start, we had a discussion about our respective understandings of the purpose of the meeting which highlighted a discrepancy. We had been led to believe that the purpose of the meeting was to help the Trust to frame what needed to be said to the police whereas Mr Medland told us that his brief was to discuss whether there was enough in our articulated concerns to make reporting to the police worthwhile.

We feel that his suggestion of speaking informally with Detective Superintendent Wenham from CDOP would be very helpful and would like this to be facilitated as soon as is practicably possible.

We would also be interested in the outcome of your discussion with Dr Hawdon about what in her view constituted "broader forensic review".

Thanks
Ravi

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25 April 2017 — Ian Harvey → Michael Gregory

Harvey confirms the Trust will meet with NHS England once its internal process is complete.

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 25 April 2017 16:43
To: GREGORY, Michael (NHS ENGLAND)

Subject: Meeting re NNU

Dear Michael

Further to you contacting the Trust, Tony has asked me to email to confirm that we will be happy to meet once we have completed our process.

Kind regards

Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

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26 April 2017 — Michael Gregory → Robert Cornall, Lesley Patel, Andrew Bibby

Gregory shares Harvey's response and lists the questions he intends to put to the Trust.

From: GREGORY, Michael (NHS ENGLAND)
Sent: 26 April 2017 09:18
To: CORNALL, Robert (NHS ENGLAND); PATEL, Lesley (NHS ENGLAND); BIBBY, Andrew (NHS ENGLAND)

Subject: Response from Ian Harvey

Hello

Please see the response from Ian about the meeting we had requested.

At RMT yesterday Margaret said she was prepared to give them a bit more time to respond.

I was going to respond to Ian with the following points:

- That we were planning to see them after they have the CDOP meeting
- We would like to know the outcome of that meeting
- We would like to understand the concerns of the clinicians and if they have been addressed?
- What was the discussion during the meeting with the legal advisor and the clinicians — what did he mean by "They (the clinicians) still don't feel that we have completed what the external reviewer described as a "broad forensic review"?
- What is the issue with the four unexplained deaths?
- We would like to agree that we have access to the redacted external review
- Which part of the process has to be completed before they agree to meet with us?

What are your views?

I was going to escalate to Margaret but she was initially prepared to give them time without knowing we had decided to meet them but I wonder if her view may change.

Dr Michael Gregory
Regional Clinical Director for Specialised Commissioning (North)
NHS England

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26 April 2017 — Lesley Patel → Michael Gregory, Robert Cornall, Andrew Bibby

Patel says colleagues are discussing the situation; includes a forwarded note from Robert Cornall suggesting the police be contacted directly.

From: PATEL, Lesley (NHS ENGLAND) Sent:
26 April 2017 09:29
To: GREGORY, Michael (NHS ENGLAND); CORNALL, Robert (NHS ENGLAND); BIBBY, Andrew (NHS ENGLAND)

Subject: RE: Response from Ian Harvey

Hi Michael

Teresa and James are discussing this with Robert today, so I would await this conversation. The CDOP could take weeks so not sure awaiting 'their process' will be timely enough considering the level of concern.

Lesley
Lesley Patel
Director of Nursing Specialised Commissioning (North)
NHS England

On 26 Apr 2017, at 15:22, CORNALL, Robert (NHS ENGLAND) wrote:

Spoke with Teresa at lunchtime —we both think (as does James P) we should just refer to the Police now. They are happy to make the call if it helps with Trust relations. If all ok with this — Michael do you want to progress?

Robert Cornell
Regional Director of Specialised Commissioning North
NHS England
North East Office I Waterfront 4 I Newburn Riverside I Newcastle upon Tyne I NE15 8NY

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26 April 2017 — Margaret Kitching → Robert Cornall, Richard Barker

Kitching says she is looping Barker in given the seriousness of escalating outside the Trust.

From: KITCHING, Margaret (NHS ENGLAND)
Sent: 26 April 2017 17:44
To: CORNALL, Robert (NHS ENGLAND); BARKER, Richard (NHS ENGLAND)
Cc: PATEL, Lesley (NHS ENGLAND); GREGORY, Michael (NHS ENGLAND); BIBBY, Andrew (NHS ENGLAND)

Subject: Re: Response from Ian Harvey

Dear all

I have copied Richard in as it is important that he is connected and I suspect he would want a call with Lyn Simpson before taking such a decision outside of the Trust. I believe a call with their CE should happen tomorrow to clarify our position and if we are still concerned we should give them the opportunity to seek advice from the police first.

In my experience CDOP processes are not lengthy and I suggested at the RMT that we would give them to the end of this week if we have not received any further assurance.

Richard, it would help if you can advice from your perspective.

Kind regards
Margaret

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26 April 2017 — Margaret Kitching → Robert Cornall

Kitching confirms she has briefed Richard Barker.

From: KITCHING, Margaret (NHS ENGLAND) Irrelevant & Sensitive
Sent: 26/04/2017 17:47:34
To: CORNALL, Robert (NHS ENGLAND)
CC: PATEL, Lesley (NHS ENGLAND), GREGORY, Michael (NHS ENGLAND), BIBBY, Andrew (NHS ENGLAND)

Subject: RE: Response from Ian Harvey

Hi Robert
I have now briefed Richard so await his response
Thanks
Mx

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26 April 2017 (email); 21 June 2024 (witness statement) — Robert Cornall → Margaret Kitching

Cornall asks who will make a call the next day; followed by an extract from Nigel Wenham's Inquiry witness statement describing the 27 April 2017 CDOP meeting at the Trust.

From: CORNALL, Robert (NHS ENGLAND)
Sent: 26 April 2017 17:52
To: KITCHING, Margaret (NHS ENGLAND)
Cc: PATEL, Lesley (NHS ENGLAND); GREGORY, Michael (NHS ENGLAND); BIBBY, Andrew (NHS ENGLAND)

Subject: RE: Response from Ian Harvey

Who should make the call tomorrow?

Robert Cornall
Regional Director of Specialised Commissioning North
NHS England
North East Office I Waterfront 4 I Newburn Riverside I Newcastle upon Tyne I NE15 8NY

INQ0102367 – Pages 6, 13 – 14 and 17 of Witness Statement of Nigel Wenham, Former Detective Chief Superintendent, Cheshire Police, dated 21/06/2024 (relevant excerpt about 27 April CDOP meeting):

Meeting on 27th April 2017 at COCH.

50. I attended this meeting representing Cheshire Constabulary and also present at the meeting were the following persons: Ian Harvey (Medical Director COCH) Stephen Cross (Director Corporate Legal Service COCH) Dr Ravi Jayaram (Paediatrician COCH NNU) Dr Susie Holt (Paediatrician COCH NNU) Dr Rajiv Mittall (Paediatrician COCH NNU / CDOP Panel member) Hayley Frame (Chair CDOP).

51. I recall I would have been involved in the planning of this meeting 27th April 2017. I cannot now recall, nor do I have access to precisely how this was done, but it was, either via telephone, email or through the constabulary business support team.

52. I cannot recall if there was any formal minutes shared regarding this meeting. It is likely others present made their own notes. I made some notes of this meeting in my day book and have previously exhibited these [INQ0102291] as Exhibit NW/6 [this document has not been posted on the Thirlwall website]. My original notes do not mention Hayley Frame and Dr Rajiv Mittall being present, however, I know they were present and information recorded in other attendees' notes, specifically notes made by Stephen Cross, confirm this. The notes from the meeting made my Stephen Cross are exhibited as Exhibit NW/7 [INQ0102292] [note that this document has not been posted on the Thirlwall website]. I have outlined a brief overview of the key points of discussion from this meeting as recorded in my day book:

- An overview of the COCH NNU operations was provided
- Outlined the number of neonatal deaths during the relevant period
- Previous 5 yrs. 2/3 year which is consistent with other areas
- During 18 month period 13 deaths in the NNU
- Reviews had been conducted including one by Royal College Nursing
- Recommendations from that review, that independent review is carried out relating to 13 cases, 4 cause death could not be explained, 8 not explained
- Highlighted that one member of staff was disproportionately present during these events
- This staff member would have had access to the babies, was working nights and day shifts
- Since had been moved from nights to day shifts, been no further events
- These were fragile sick babies
- Investigations so far have been thin, not identified cause for these deaths
- Feelings from clinicians, have lot of discomfort not investigated enough
- They have extensive range of experience and all are uncomfortable
- They are not comfortable with the findings and level of investigation
- Not all deaths subject of Post Mortem (PM)
- Assumptions had been made regarding early cases ad cause of death

53. It was during this meeting that I first heard the term 'angel of death' as a term used to refer to the Nurse Lucy Letby. I think one of the clinicians used the term. At the time I recall the significance of this comment and this was concerning to me. I recognised the risks if this term was used wider outside of this meeting and in particular in the public domain. I was therefore careful to not use this term any wider, although I would have briefed this into the Constabulary to those who needed to know.

54. I am aware that a request had been made to Ian Harvey to write to the Chief Constable (CC), requesting the Constabulary conduct a formal investigation into the events at the COCH NNU. I cannot recall if I made this request of him on behalf of ACC Martland, or if this request had come

direct to him from ACC Martland. The letter to the CC is exhibited at point 100 of my statement as exhibit NW/29f [INQ0102319].

55. Following this meeting 27th April, I sent email to Ian Harvey. My memory of this email has been refreshed as I have seen the email contained in the bundle of material sent to me to assist with my statement. I have exhibited this email as Exhibit NW/8 [INQ0102293]. I sent this email to Ian Harvey on 27th April 8.14pm. The email was sent via Karen Dodd, Personal Assistant to Ian Harvey. I briefly outlined in this email that I had briefed to Chief Officer Level (ACC Martland) and a further meeting was planned for me to brief senior command within the Constabulary. I made it clear a decision as to progressing of criminal investigation would be taken once further information had been obtained and this included a request to hold a meeting with Ian Harvey and other representatives from the COCH at Constabulary Headquarters. I would have briefed ACC Martland following this meeting via telephone call as was my customary practice.

56. During this meeting on 27th April, I was mindful of its intended purpose and my responsibilities. I had to remain measured and not express opinion or speculate. Even though at this early stage, I felt this was progressing towards a criminal investigation, there was a critical need to remain cautious for the reasons I have previously outlined. Following this meeting, I had gained further information regarding the events that had taken place at the COCH NNU. My own personal concerns regarding these events remained and if anything, further increased. The content of the email I sent following this meeting clearly indicate my own personal mindset regarding these events and the potential direction of travel in terms of any investigation.

67. I have been asked by the Public Inquiry to comment if the report by Ian Harvey to the COCH Board accurately reflects my recollection of the meeting between us. I did make notes of the meeting that Ian Harvey refers to on 27th April 2017 and these have previously been summarised in my statement and my notes exhibited. The comments outlined above do generally correlate with my notes and recollection of the events of this meeting. I was measured during the meeting and I may have said it would be an investigation and that staff would then be interviewed. Clearly his description and comments will reflect his interpretation of this meeting and what was discussed.

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27 April 2017 — Michael Gregory → Teresa Fenech, James Palmer, Andrew Bibby, Lesley Patel, Robert Cornall

Gregory reports that Margaret Kitching has updated him after a call with the Trust and NHS Improvement.

From: GREGORY, Michael (NHS ENGLAND)
Sent: 27/04/2017
To: FENECH, Teresa (N31 LIMITED), PALMER, James (UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST); BIBBY, Andrew (NHS ENGLAND); PATEL, Lesley (NHS ENGLAND); CORNALL, Robert (NHS ENGLAND)

Subject: Update on Countess of Chester

Hello

Margaret Kitching has updated me on the call she had with the Countess. She was on the call with Vince Connolly from NHSI. Margaret will send a briefing email out. I will keep things at a high level as this is an email. In summary the CDOP team met with the representatives from CoCH. There was a

police officer on the panel. They are aware of the issues that we were concerned about and the police are going to discuss it with the Chief Constable and scope the work that needs to be done. They will decide on that next week. Even if they conclude they need to investigate the CDOP panel will still review the cases causing concern. There are some other processes that have been agreed about information sharing and points of contact. Margaret and Vince were satisfied with what was agreed. Margaret feels that as commissioners we need to step back and allow the police and CDOP to proceed.

Michael
Michael Gregory
Regional Clinical Director North Specialised Commissioning NHS England.

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28 April 2017 — Margaret Kitching → Ian Harvey (cc Vincent Connolly)

Kitching shares her notes of the previous day's conference call.

From: KITCHING, Margaret (NHS ENGLAND)
Sent: 28 April 2017 14:20
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Cc: CONNOLLY, Vincent (NHS IMPROVEMENT - T1520)

Subject: Fwd: Conference call notes (with logos)

Dear Ian

I have taken a few notes from yesterday's teleconference which I hope you find useful. It is to ensure I have interpreted the conversation correctly but more importantly details our action. Let me know if you are ok with these and can you pass to your colleague Stephen.

Kind Regards
MARGARET KITCHING
Chief Nurse North , NHS England

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28 April 2017 (email); 2 May 2017 (Board minutes) — Ian Harvey → Margaret Kitching

Harvey thanks Kitching for the notes; followed by the extraordinary Board minutes of 2 May 2017 recording the decision to seek a police investigation.

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 28 April 2017 16:10
To: KITCHING, Margaret (NHS ENGLAND)
Cc: CONNOLLY, Vincent (NHS IMPROVEMENT - T1520)

Subject: RE: Conference call notes (with logos)

Many thanks Margaret — I think that is a reasonable summation. Re the Comms lead — NHSE Spec Com have recently pinched our comms lead, she will be starting shortly, she wouldn't need briefing!

Regards

Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

INQ0004221 [Countess Board meeting]

EXTRA-ORDINARY BOARD OF DIRECTORS (PRIVATE)
MINUTES OF THE MEETING HELD ON THURSDAY,
2ND MAY 2017 at 12 NOON
TRAINING ROOM 3 & 4

UPDATE ON THE NEONATAL SERVICE

Mr Harvey reported that following completion of the Royal College review, we had met with clinicians about what else could be done. In respect of meeting with the parents it became clear that we were unlikely to get to that point. Dr Hawden had been asked what she meant by a forensic review and she said it was whatever we wanted it to be. Mr Harvey had met with the Chair of the Child Death Overview Panel (CDOP), a small number of CDOP members, including Superintendent Nigel Wenham of Cheshire Police, Dr Holt and Dr Jayaram to discuss the circumstances that led to the reviews, where we had got to and to discuss from a CDOP point of view where to get a degree of closure. The feeling was that we had done everything and that the next step was to consider a police investigation. It was agreed that Superintendent Nigel Wenham would discuss this with the Assistant Chief Constable (ACC) and guide the Trust to a letter to invite a police investigation to the Chief Constable. Mr Chambers, Mr Harvey and Mr Cross are meeting the ACC and wider police team on 15th May 2017 to report on the reviews and actions taken to date. Superintendent Wenham has been very measured at the meeting and made it clear it would be an investigation and that the staff interviewed would be interviewed as witnesses not suspects. The scope of the investigation will be restricted to an 18 month time period.

Mrs Hopwood asked if there was a future process agreed for any unexplained deaths. Mr Harvey replied that he had already had the conversations and any unexplained deaths would now be reported to CDOP. Sir Duncan asked who determines if a death is unexplained. Mr Cross replied that if a death occurred the Executive Team would be aware as the process for the paediatricians to raise this is already in place. In any exceptional circumstances these would be discussed with the Chair of CDOP and the police.

Mr Higgins referred to the meeting on 15th May 2017 where there will be a discussion of what has been done to date and asked how the investigation would go forward. Mr Harvey stated that there was an earlier meeting on 5th May 2017 with the police to discuss the terms of reference for the investigation.

In response to a question from Mr Wilkie about informing parents and staff, Mr Chambers advised that the police at this stage are keen that the process be managed jointly by the police and the Trust. The next steps will be agreed at the meeting with the police on 5th May 2017.

In response to a question from Mrs Hopwood about communications, Mr Harvey gave details of the agreed single point of contact for wider NHS stakeholders such as NHSI, NHS E and the CCG. Ms Margaret Kitchen, Chief Nurse North, NHS England will be the single point of contact as she has had

previous similar experience. Mr Harvey has updated Ms Kitchen on the process to date and she has feedback that we have done everything in the way and order that it should be.

Mrs Hopwood asked in terms of the relationship with the Board and clinical leaders of the unit, was there an action plan to address this, Mr Harvey replied that there is an action plan as part of the Royal College review and this is in draft at the moment due to the network being slow to respond. Mr Harvey has asked Ms Kitchen to speak to the network about this. Mr Harvey had also met with Dr Jayaram to update him as to where we are up to.

Mrs Fallon asked about the position of the staff member that had been due to go back to the unit. Mrs Kelly and Mrs Hodkinson continue to meet with the staff member on a weekly basis with support from the Head of Nursing, Urgent Care, Occupational Health and RCN support. She is still keen to get back on the unit and due to on-going clinical concerns raised by the consultants we have told her that we did not feel it was appropriate. She is continuing to support the complaints function and she is obviously finding it difficult to manage her parents. Mrs Kelly and Mrs Hodkinson have agreed to have a conference call with her and her parents.

Sir Duncan asked if the staff on the unit know there has been a CDOP referral. Mr Harvey replied that the staff on the unit did not know. Mrs Kelly added that as further concerns were raised this was told to the member of staff in a high level way and we were open with her but we do not know what she has fed back.

Mr Harvey stated that it was not a formal CDOP referral as he had telephoned the Chair of CDOP to explore as to how to take this forward given the actions we have taken to date.

Mrs Hodkinson reported that he RCN full time officer was the union representative for the staff member and he had asked about a secondment in a clinical basis but we advised that we would not do that.

Sir Duncan stated that after the meeting on 15th May 2017, there may be a need for the Board to meet up again.

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4 May 2017 — Margaret Kitching → Ian Harvey

Kitching asks whether there has been any update from the police.

From: KITCHING, Margaret (NHS ENGLAND)
Sent: 04 May 2017 14:29
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: RE: Conference call notes (with logos)

Hi Ian
Have you had any updates from the police
I know you were hoping they would come back to you last week regards

MARGARET KITCHING
Chief Nurse North , NHS England

4-5 May 2017 — Ian Harvey → Margaret Kitching

Harvey reports meeting the Assistant Chief Constable; an "invited police investigation" into unexplained deaths, not described as criminal, will follow.

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 04 May 2017 15:26
To: KITCHING, Margaret (NHS ENGLAND)
Subject: RE: Conference call notes (with logos)

Hi Margaret

We have a meeting scheduled for 15th May, 10.30-12.30 to meet together with some of our neonatologists for the scoping meeting. However, I have had a conversation with Nigel Wenham, the DCS on CDOP, and he, the ACC and the DCI who would be Senior Investigating Officer want to meet with Tony, Stephen Cross and I before this. We are going to Winsford on Friday afternoon. I shall email you on Friday after this first meeting.

Regards
Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

On 4 May 2017, at 15:26, KITCHING, Margaret (NHS ENGLAND) <margaret.kitching@[I&S]:

Thank you Ian

Much appreciated
MARGARET KITCHING
Chief Nurse North , NHS England

On 5 May 2017, at 18:58, HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST):

Hi Margaret

Further to previous correspondence Tony, Stephen and I met with the ACC, Det Supt and DCS Wenham (who is on the CDOP). In short:

There will be an investigation but it will be described as an invited police investigation to investigate unexplained deaths, not a criminal process. They are drawing up TORs to share with us and agree next week. We are forwarding details of the 13 babies and parents and the nurse. They will be advising the Coroner(s) and then jointly with us discussing with all the parents before it gets out by other routes i.e. the Coroner adjourning a forthcoming inquest. They will then liaise re the investigation and analysis- they already have an SIO, analyst and Liaison Officer identified. They have advised us to discuss the nurse with the LADO [Local Authority Designated Officer]. They have you as the point of contact for NHSE. Think that's the major points- I will keep you updated. Let me know if there are any queries.

Regards
Ian

5 May 2017 (email); 5 May 2017 (meeting notes) — Margaret Kitching → Ian Harvey

Kitching offers support; followed by notes of the 5 May 2017 meeting between Cheshire Police and Trust executives launching "Operation Hummingbird".

From: KITCHING, Margaret (NHS ENGLAND)
Sent: 05 May 2017 19:46
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: Re: Conference call notes (with logos)

Thank you Ian

If you need any support let me know

Kind regards
Margaret

INQ0102298 – Notes of a meeting between Cheshire Police, including Nigel Wenham, Tony Chambers, Stephen Cross and Ian Harvey, 05/05/2017.pdf
Operation Hummingbird — Summary / Actions
Held at 15:30 on Friday 5th May 2017
ACPO Meeting Room, Headquarters Cheshire Constabulary

Cheshire Constabulary:
Darren Martland, Assistant Chief Constable
Nigel Wenham, Chief Superintendent, Public Protection Directorate
Aaron Duggan, Superintendent, Head of Crime
Claire Miles, Staff Officer
Laura Fox, Secretary

Countess of Chester Hospital:
Tony Chambers, Chief Executive Officer
Stephen Cross, Director of Corporate and Legal Services
Ian Harvey, Medical Director

DM opened the meeting with the purpose to discuss the content of the letter sent by Tony.

Chambers to Chief Constable Simon Byrne on 2nd May 2017. Concerns have been raised regarding a higher than usual number of neonatal deaths from January 2015 to June 2016. There were 8 in 2015 and 5 in first six months of 2016, in comparison to an average of 2.4 per annum in the previous 5 years.

Ch. Supt Wenham attended a meeting on 27th April 2017 with COCH to discuss concerns.

Supt. Duggan has informed the HM Senior Coroner Alan Moore and HM Senior Coroner John Gittins.

There are four outstanding cases one of which is listed for inquest on 25th May 2017, Child D. This case may need to be adjourned if an investigation is to take place. COCH have also spoken to both Mr Rheinberg and Mr Moore.

Overview - COCH

TC stated that the board has been managing the process, with the priority being the safety of babies and the welfare of both families and staff.

IH gave an overview. Met with Director, Alison Kelly in May 2016 as it had been recognised there were more neonatal deaths than what COCH is used to. An in house review was conducted, and no common cause of death has been identified. It was agreed there was more work to be done with regards to the review; the concern was the number of deaths and pattern.

There have been 13 deaths, 3 of which are yet to go through the coronial _process: Child D, Child O and Child P. These 3 babies and Child A (inquest already held) have unexplained circumstances of death, the post mortems did not assist further, even following conversation between the Medical Director and pathologist, with the permission of the Coroner. An external case review (Dr J Hawdon) has recommended a broader forensic review.

AP — IH to provide personal details of all 13 families. (red from original document)

There are three levels of neo natal units. COCH was operating at Level 2 during the period of the deaths, this provides short term ventilation. Since July 2016 COCH has been operating at Level 1, which cares for older babies that do not require life support systems. There have been 0 deaths on the unit since July 2016 (one baby transferred out subsequently died), the expected death rate at this level is between 1-2 per year.

Within the neonatal unit you would expect to see on shift at any one time, 3 trained nursing staff assisted by 1 nursery nurse. They would look after approximately 5-10 babies. During the index period, the neonatal unit had been busier, staff had increased workloads and staff could have been looking after anything up to 20 babies within the same staffing compliment.

The Consultant Paediatricians collectively felt that of the 13 deaths, 5 could be explained but 8 could not as the doctors felt that both the collapses and / or deaths could not be explained.

Reviews

The families are all aware that two reviews have been conducted:

1. Dr 3 Hawdon, Consultant Neonatologist, Royal Free London Hospital — October 2016
2. Royal College of Pediatrics and Child Heath (RCPCH) — November 2016 (Following visit September 2016)

An earlier Trust review led to a number of actions including:

- Redesignated neonatal unit
- The transferring babies below certain age / weight to be out treated

It was also noted the unit was 'running hot' and there was an increase in the number of lower birth weight babies, based on previous trends. The College review identified there were issues with communications between medical and nursing staff, incident review processes and delays in clinical

escalation. Whilst the staffing was in line with surrounding units, it did not comply with the national standards.

On the back of the College review conducted came a recommendation for an independent external case review. Since the redesignation of the unit, there has only been 1 baby death which was explicable.

The independent review (Dr J Hawdon) took a clinical perspective, looking from birth to death. As such the families each received an in depth, independent case note review that was pertinent to their baby.

A criminal QC was instructed by the Trust, who after consideration of the relevant papers advised that there was no evidence to suggest criminal activity. At a later meeting with the QC, consultants expressed their views that they were not satisfied. The clinicians felt that there was no further work or investigation short of a police investigation that could be conducted to satisfy them that some of the deaths were not due to natural causes.

DM stated that there are two critical issues drawn from the overview and reviews:

- Potential of malpractice
- Practice issue involving COCH

There are at present no other reviews / investigations ongoing at the COCH.

Nurse

As part of the review staffing was looked at, there was a notable high statistical relationship between a member of the nursing staff and babies deteriorating in the unit. There is no evidence, other than coincidence.

Correspondence between Countess paediatricians from 3/5/17 to 10/5/17:

In many respects these emails make it clear that the paediatricians' aim was not to provide Cheshire Police with their objective appraisal of events but to present them in such a way that would "pique Cheshire Police's interest", given what Susie Holt reported Nigel Wenham had said (see below) at the CDOP meeting on 27/4/17 ("there are clearly resource implications and so the 'scoping' exercise initially would be focused to determine whether there is sufficient level of concern to proceed to further investigation and potentially a major crime investigation").

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3 May 2017 — Susie Holt → Fellow consultant paediatricians

Holt updates colleagues on the forthcoming CDOP meeting and circulates the draft summary report for comment.

From: HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 03 May 2017 23:44
To: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION

TRUST); Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: Neonatal deaths & collapses

Dear all,

Following on from the meeting with CDOP representatives last week, the next meeting is to be held on Monday 15/05/17 @10:30 at Winsford. The CDOP police officer (Detective Chief Superintendent Nigel Wenham) was honest & transparent in admitting that there are clearly resource implications and so the 'scoping' exercise initially would be focused to determine whether there is sufficient level of concern to proceed to further investigation and potentially a major crime investigation. Therefore they will need to identify lines of enquiry in some of the more 'concerning' cases.

I am currently preparing a 'timeline' of events which was another thing that DI Wenham felt would be useful. Rest assured in the first instance this will be anonymised (with the use of a key) until there is clarity regarding patient confidentiality issues.

Please find attached the summary report started by Steve with comments from John and myself. Do people feel it is the appropriate time/forum to document clear suspicion of criminal activity? If so, please add this information to the individual cases. If not, perhaps we can discuss further on Monday. I agree with Steve's earlier Whatsapp. It is probably useful to meet on Monday at 11:00 & discuss where we are up to. What do others think?

See you tomorrow

Susie

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4 May 2017 — Ravi Jayaram → Fellow consultants

Jayaram proposes highlighting Lucy Letby's presence at collapses and suggests wording changes to the draft report.

From: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 04 May 2017 13:23
To: HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: RE: Neonatal deaths & collapses

Thanks Susie

Suggestion for discussion

Should we highlight explicitly for these cases that LL was in attendance and in close proximity to the incubators (in those situations we know for a fact she was)? This is after all the basis of our concerns and I think for the police to have their interest piqued we need to have that with all of the cases (it's

not going to be in the info Ian H/Stephen C have given to the police). I have attempted to do this as below for the ones I was involved with but hopefully more In a stating the facts way than a subjective finger pointing way. If everyone is in agreement we should all do something similar for the ones we know about. Time is of the essence, I would like to get this to Superintendent Wenham by the middle of next week at the latest.

Ravi

Page 2 – after "This is highly unusual and may indicate a possible unnatural cause of death" should we say "for example air embolism". The review paper attached describes such rashes in air embolism.

Page 2 – Baby A - Maybe add in "peripherally inserted central venous catheter inserted 90 minutes previously, in an appropriate position on x-ray. Initially became apnoeic, dropped oxygen saturations and then became bradycardic with no warning. Staff nurse Letby in attendance and with baby at the time of deterioration. Resuscitation commenced immediately but did not respond to timely and appropriate interventions. No heart sounds heard but evidence of low voltage electrical activity on ECG trace. Decision taken to stop resuscitation after 30 minutes."

Page 6 – baby no 3 of the unexpected collapses 33 week gestation twin born in good condition. Day 2 sudden cardiorespiratory arrest, 6 doses of adrenaline and CPR. No cause identified.

? add " stable and breathing spontaneously on no respiratory support. Slightly distended abdomen during afternoon but observations steady. Sudden unexplained apnoeic episode followed by drop in oxygen sats, bradycardia and arrest. CPR started immediately. Heart rate present after adrenaline but slow at 60bpm. Resus continued for 30 minutes with no improvement (6 doses of adrenaline, 2 doses of sodium bicarbonate, 2 boluses of normal saline). Noted to have unusual patches of pinkish discoloration on skin on background of pale/blue discoloration. Patches seemed to come and go. Discussion with parents on withdrawing care but at 27 minutes heart rate above 100 and respiratory effort noted. Staff nurse Letby in attendance during resuscitation, unclear if present at moment of collapse from notes.

Page 6 25 week gestation infant. Ventilated. Sudden deterioration at 0350 with misplaced ETT. Transferred and died in APH.

?add " Born at 0212 after mum went into spontaneous labour, needed bag and mask resuscitation at delivery, breathed spontaneously. Electively intubated and given surfactant, connected to ventilator, IV line placed for IV glucose and IV antibiotics. Plan for transfer to Arrowe Park hospital due to gestation. Stable observations and ventilator requirements. Sudden deterioration at 0350, oxygen saturations dropped to 40%. Connected to bag and mask and chest not moving. Carbon dioxide monitor attached to endotracheal tube – not changing colour suggesting tube had dislodged from trachea. New tube placed and baby recovered. Baby looked after by Staff nurse Williams. At time of deterioration, nurse Williams off ward talking to parents on labour suite, Staff nurse Letby at incubator and called Dr Jayaram to inform of low saturations. Endotracheal tube had been secured properly and baby not over-active. No obvious reason for tube to have dislodged. Baby subsequently deteriorated and eventually died but events around this would fit with explainable events associated with extreme prematurity"

Those are my ones, over to you!

4 May 2017 — John Gibbs → Fellow consultants

Gibbs says he can only confirm Letby's presence at the collapses he was personally involved with.

From: GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 04 May 2017 14:17
To: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: RE: Neonatal deaths & collapses

From my perspective, for the babies that I was involved with who died unexpectedly, I can only say that LL was involved when they collapsed but I was not aware of what she had been doing prior to the collapse, or even if she had been the main nurse carer for the baby on that shift (since by the time I arrived, on each occasion, resuscitation was in progress and LL was involved). This applies to babies B, F, K. Baby F is the one where I joined Murthy around 08:30 at handover time on a Sat morning when the resus was in progress. Murthy (and I think Matt Neame) had been involved with the baby earlier during the night so I don't know if you have any other relevant observations to make, Murthy, concerning LL prior to the resus?
JOHN

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4 May 2017 — Stephen Brearey → Fellow consultants

Brearey circulates a revised version of the report with a table of contents and additional case detail.

From: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) Sent: 04 May 2017 19:32
To: GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: RE: Neonatal deaths & collapses

I've revised the document and hopefully made it better.

It now has a table of contents. I've added a paragraph saying acuity and staffing is irrelevant. I've changed the cases who survived to letters, following on alphabetically and added more detail to those cases. I have mentioned nurse L was present for all of them. The code is:

Baby N <*patient id redacted*> [PX - not on indictment]
Baby O <*patient id redacted*> [AX - not on indictment]

Baby P <*patient id redacted*> [Baby M on indictment]
Baby Q <*patient id redacted*> [Baby K on indictment]
Baby R <*patient id redacted*> [Baby G on indictment]
Baby S <*patient id redacted*> [KX - not on indictment]

Would someone be able to add the other [Family A/B] twin (mentioned in the mortality section), Baby Q, SX and anyone else not mentioned we are worried about? I have attached a document regarding acuity and staffing that maybe doesn't need to be in the main document but we can take with us and refer to if needed. I'm sorry - Tracked changes and comments drive me crazy! I've tried to remove them once incorporated – hope that's OK?

Steve

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5 May 2017 — John Gibbs → Fellow consultants

Gibbs praises the revised report and suggests further edits, including a glossary and clarified graphs.

From: GIBBS, John (COUNTESS OF CHESTER HOSPITALNHS FOUNDATION TRUST) <johngibbs@I&S>
Sent: Friday, May 5, 2017 8:42 AM
To: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITALNHS FOUNDATIONTRUST) <stephen.brearey@I&S>; JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITALNHS FOUNDATIONTRUST) <ravi.jayaram@I&S>; HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATIONTRUST) <susieholt@I&S>; Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATIONTRUST) <I&S>; MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITALNHS FOUNDATION TRUST) <michaelmcguigan@I&S>; SALAD!, Murthy (COUNTESSOF CHESTER HOSPITAL NHS FOUNDATIONTRUST) <murthy.saladi@I&S>; Doctor V (COUNTESS OF CHESTER HOSPITALNHS FOUNDATIONTRUST) <I&S>

Subject: Re: Neonatal deaths & collapses

This is very helpful Steve. Well done.

The mortality document:
could there be a glossary for the non-medics (e.g. Police), who may not even know what NNU stands for, let alone LNU, BAPM, IC, HD, SC, NC?
would be useful at the beginning to point out that previously our mortality data was very similar to other DGH NNUs in the region otherwise some of those reading this document with little prior knowledge of neonatal services in this area might wonder if we've always had a much higher mortality rate than our regional peers (although it may be felt this is unnecessary since it is mentioned in the other document).

I was a bit confused about the two final graphs. Presumably this shows activity in our unit (do you think we need to make it clear it's our unit, since the preceding tables show activity across a range of units?). I presume these graphs are 'pulled off' Badger in the format shown but it's a little strange having two overlapping graphs

one showing activity Jan 13 - Dec 15 and the other Jan 14 - Dec 16. Would it be possible just to show a single graph with activity Jan 13 - Dec 16?

The summary document:

Just one suggested change - at the top of page 2, the phrase:..... cannot therefore be considered to be a significant the sole reason why there have been no deaths..... should be rephrased either as - cannot therefore be considered to be the sole reason why there have been no deaths - or - cannot therefore be considered to be a significant reason why there have been no deaths - or perhaps even - does not adequately explain why there have been no deaths.
(I rather like this 3rd option!).

JOHN

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10 May 2017 — Stephen Brearey → Ravi Jayaram

Brearey forwards the correct attachment.

From: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: Wednesday, May 10, 2017 6:31 PM
To: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) <ravi.jayaram@I&S>
Subject: FW: Neonatal deaths & collapses

1st attachment is the one
Steve

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10 May 2017 (email); 10 May 2017 (final report) — Stephen Brearey → Susie Holt, Ravi Jayaram

Brearey circulates the case list for the team's records; followed by the final "Summary Report on Neonatal Deaths and Collapses" setting out the consultants' concerns.

From: BREAREY, Stephen (COUNTESSOF CHESTER HOSPITAL NHS FOUNDATION TRUST}
Sent: Wednesday, May 10, 2017 6:35 PM
To: HOLT, Susie (COUNTESSOF CHESTER HOSPITAL NHS FOUNDATION TRUST} <susieholt@I&S>; JAYARAM, Ravi (COUNTESSOF CHESTERHOSPITAL NHS FOUNDATION TRUST} <ravi.jayaram@I&S>

Subject: FW: Neonatal deaths & collapses

Just for our own records as well Baby T <*patient id redacted*> (SX)
Baby U <*patient id redacted*> (FX2)

Steve

10 May 2017: X5010 - NW.16 - Summary Report on Neonatal Deaths and Collapses, Final Version 10.05.2017.pdf

Reasons for concerns regarding a possible criminal cause for increased neonatal mortality at the

Countess of Chester Hospital NHS Foundation Trust, June 2015 – July 2016

Summary

The historical annual number of deaths on the neonatal unit at the hospital has been between 1 and 3. From June 2015 there were 13 deaths in the 13 months. The probability of this increase in mortality occurring by chance alone is very low. Many of the babies who died were born at gestations where death is statistically very unlikely (Appendix 1). Of the babies who died, most deteriorated unexpectedly without explanation at the time or subsequently. It is very unusual not to see any clinical evidence of a baby becoming unwell e.g. you might expect to see their heart beating faster or the level of oxygen in their blood changing. In some of these cases there was no recovery to adequate resuscitation measures. For this to occur in such a large number of babies is highly unusual and could be considered as suspicious.

There is an association with a member of staff who was present during the majority of instances when the babies unexpectedly deteriorated. When this member of staff was put onto day shifts for 3 months, no sudden collapses occurred during the night. Previous to this change in her work pattern, in 6 out of 9 deaths, the arrests occurred between 0000 and 0400. When this member of staff was no longer working on the unit (July 2016-present), there have been no neonatal deaths on the unit and no unexpected or unexplained sudden deteriorations. This member of staff was present on the unit during the deterioration of the babies who died A, B, C, D, E, F, G, H, I, L and M.

The gestation at birth of the babies who died was between 27 weeks and 40 weeks. 6 babies were >32 weeks gestation. The redesignation of the unit from July 2016 (only permitted to care for babies >32 weeks gestation) cannot therefore be the only reason why there have been no deaths or sudden unexplained deteriorations of babies on the unit since July 2016.

An external neonatologist from London [JANE HAWDON] has identified 4 babies [A, G, L and M = A, I, O and P on indictment] who require further forensic review. Further to her report, a consensus between 3 CoCH paediatricians and an external neonatologist from the Liverpool Women's Hospital (LWH) [NIM SUBHEDAR] have identified a further 4 babies [B, C, F and K = C, D on indictment and LX and KX2 not on indictment] for whom the cause of death is still unexplained.

An unexplained rash was observed for at least 3 babies. This was initially thought to be due to infection by the clinical teams. However, the rashes resolved spontaneously despite the babies being very ill. This is highly unusual and may indicate a possible unnatural cause of death. [RCPCH: RASHES APPEARED AFTER A FEW MINUTES OF RESUSCITATION]

The increase in neonatal mortality did not coincide with any significant changes in acuity [NOT TRUE] *or staffing levels in 2015 and 2016. Nursing staffing in Chester NNU was above the national average* [NOT TRUE]. *The percentage of shifts staffed to BAPM standards was higher than other LNUs in the network and higher than the national average. High dependency and intensive care days did not change appreciably in 2015 and 2016 compared to previous years.*

In addition to the babies who died, there were also a significant number of babies who

suffered an unexpected collapse or deterioration. The cause for the deteriorations is unknown and the member of staff mentioned above was present on the Neonatal Unit (NNU) for the majority of these cases.

The investigations undertaken by the Trust to date do not appear to have included a comprehensive analysis of staffing at the time of all the collapses and deaths. Senior medical staff, trainee doctors and nursing staff involved with the cases listed below have not been interviewed in relation to the care given around the time of the events listed below.

The babies who were transferred from the unit and subsequently died and the babies who collapsed unexpectedly and survived do not seem to have been adequately investigated by the Trust to date. In addition to the concerns listed below, some clinical staff (consultants and trainee doctors) had specific concerns regarding aspects of care of some of these babies but have not had an opportunity to share these concerns with an investigative team.

In summary:

- *The number of neonatal deaths in this time period is highly unusual.*
- *The number of unexpected and unexplained collapses is highly unusual.*
- *Cause of death is still uncertain for 8 babies.*
- *Many of the babies who died did not respond to adequate resuscitation as would normally be expected.*
- *One member of staff has been present during the collapse and/or deaths of an unusually high proportion of the babies involved. The likelihood of this occurring by chance alone is very low.*
- *Investigations and reviews to date have not identified any other potential cause for the increased mortality or been able to exclude an unnatural cause of the deaths and collapses.*

<u>Mortality cases</u>

Baby A [Baby A on indictment]
31 week gestation twin born in good condition. Sudden unexpected arrest on day 1. PM and inquest failed to identify cause of death.
External London neonatologist has recommended further forensic review, yet to be undertaken.
Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.

Baby B [Baby C on indictment]
30 week gestation baby, birth weight 800g. Died on day 5 of life despite stable observations 24 hours prior to deterioration – clinically this death would not have been anticipated.
Primary cause of death given on PM as widespread hypoxic damage to heart. However, this was likely to have been caused following the decision to withdraw intensive care. As part of the dying process this baby had several hours of very slow heart rate and occasional respiratory gasps. During this time the heart would not have received adequate oxygen and therefore caused the changes seen at PM. The PM finding of hypoxic heart damage does not explain his sudden deterioration following normal observations beforehand. Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.

Baby C [Baby D on indictment]

37 week gestation baby admitted to NNU at 3 hours of age with congenital pneumonia. Subsequently she improved clinically. On Day 3 of life she became mottled and developed dark brown/black tracking lesions across her trunk. 2 "bruises" noted on abdomen thought at the time to represent infection but as the baby improved the areas of discolouration completely disappeared. Areas of discolouration then reappeared prior to sudden deterioration. No response to resuscitation efforts. Awaiting an inquest. PM states primary cause of death is pneumonia with acute lung injury. However, the baby was on CPAP and had no oxygen requirement immediately prior to deterioration. Clinically therefore this makes acute lung injury as a cause of the deterioration and subsequent death very unlikely.
The transient rash is also unexplained. Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.

Baby D [Baby E on indictment]
29 week gestation twin, 1327g. Died on day 7. Blood stained and bile stained aspirates prior to cardiorespiratory arrest. No PM agreed with coroner and cause of death given as necrotising enterocolitis (NEC) and prematurity. However, abdominal X ray taken less than 1 hour before death showed no signs of NEC, therefore clinically it would not be anticipated that this baby would have deteriorated and died in such a short time frame.

Baby E [MX - NOT on indictment]
Term baby admitted as poor condition at birth and meconium at delivery. Had neonatal SVT (Supraventricular tachycardia - abnormally fast heart rate) which resolved spontaneously at 3 hours of age. Occasional brief self-resolving SVTs thereafter. Otherwise, she normalised and took some bottle feeds. Possible seizure on day 3 of uncertain cause.
Bradycardic cardiac arrest (loss of circulation due to a sudden, very slow heart rate). PM identified Ebstein's anomaly (a type of structural congenital heart disease), and blood culture grew alpha haemolytic streptococcus. Babies with Ebstein's anomaly would not usually be expected to arrest in this way in the first days of life. Infection can cause neonatal death but you would expect to see progressive clinical compromise (i.e. change in the heart rate, other observations) prior to cardiac arrest rather than a sudden event.

Baby F [LX - NOT on indictment]
Term baby with multiple congenital abnormalities and diagnosed with Varadi Papp Syndrome on PM in which there are various abnormalities of the face and limbs. These abnormalities were not life threatening, therefore there is no explanation as to why the infant stopped breathing and subsequently died. Clinically, this was not anticipated.
Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.

Baby G [Baby I on indictment]
27 week gestation infant born at LWH and transferred to CoCH on day 11. Transferred back to LWH 3 weeks later due to distended abdomen, desaturations and bradycardia. Improved at LWH and returned to CoCH 1 week later. 1 month later, found blue and apnoeic in cot at 0336, responded to resuscitation. Treated for suspected NEC and/or infection. Following day at 0500, further arrest and distended abdomen. Responded to resuscitation and improved. Following day at 0400, further arrest and resuscitation. Presumed abdominal pathology. Transferred to Arrowe Park Hospital (APH) – improved and no further deteriorations so transferred back to CoCH 3 days later. 6 days later, further arrests

overnight and resuscitation discontinued at 0230. No evidence of abdominal pathology on PM. PM cause of death given as hypoxic ischaemic damage of brain and chronic lung disease of prematurity. There is no clinical explanation for the repeated sudden deteriorations at CoCH and periods of stability and improvement elsewhere and it is highly suspicious.
External London neonatologist has recommended further forensic review, yet to be undertaken. Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.

Baby H [EX - NOT on indictment]
28 week gestation baby born after un-booked pregnancy (mother had not had any medical care associated with pregnancy) with neonatal infection. Deteriorated and arrested on day 4 after an initial period of stabilisation. Cause of death was neonatal infection and extreme prematurity.

Baby I [MX2 - NOT on indictment]
30 week gestation twin (Other twin also deteriorated and required transfer to APH).
Sudden deterioration on day 3 and unsuccessful resuscitation. PM cause for death given as congenital pneumonia with foetal inflammatory response syndrome.

Baby J [WX - NOT on indictment]
Preterm neonate born with antenatally diagnosed severe fetal hydrops, large ascites and pleural effusion (massive over production of fluid in most body compartments including in the chest – pleural effusion – and in the abdomen - ascites). Extremely poor prognosis given to parents prior to birth. Baby responded temporarily to initial resuscitation (including drainage of excess fluid), after birth but then deteriorated and died.
Clinically, this was an expected death.

Baby K [KX2 - NOT on indictment]
Term baby with multiple congenital abnormalities (cleft lip and palate, abnormal eyes, ears, nose, genitalia). Developed abdominal distension and cardiac arrest on day 2. PM was consistent with Fronto-Facial-Nasal Dysplasia. However, the abnormalities were not life threatening and neither PM findings nor blood tests are able to explain why she deteriorated and arrested. Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.

Baby L [Baby O on indictment]
Triplet born at 33 weeks gestation. Generally well and stable - clinically evident as on optiflow and NGT feeds. On day 3 he suddenly deteriorated with inadequate breathing, a very slow heart rate and abdominal distension. Did not respond to resuscitation.
Subsequent PM showed a ruptured sub-capsular haematoma of liver which may have occurred during attempts to resuscitate the baby and is unlikely to be the cause of his sudden deterioration. Had a discoloured abdomen at one stage which resolved later. Awaiting inquest. External London neonatologist has recommended further forensic review, yet to be undertaken. Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.

Baby M [Baby P on indictment]
Triplet born at 33 weeks gestation. Generally well and stable - clinically evident as on optiflow and NGT feeds. On day 4 he suddenly deteriorated with inadequate breathing, a

very slow heart and abdominal distension. Did not respond to resuscitation. Had been started on antibiotics and had a thorough consultant review after sibling's death and no concerns raised. Clinically very surprising that subsequently arrested. No cause for death identified on PM. External London neonatologist has recommended further forensic review, yet to be undertaken. Consensus of CoCH paediatricians and external Liverpool neonatologist that the cause of sudden deterioration and the cause of death are still unexplained.

Babies who had an unexplained deterioration and survived or died outside CoCH

Baby N [MX3 - not on indictment]
29 week gestation twin. Initially ventilated for 15 hours. Stable until an unexplained deterioration requiring ventilation on day 7. Nurse L present at time of deterioration. Mottled appearance to abdomen noted. Improved at APH and transferred back to CoCH 3 days later.

Baby O [AX - not on indictment]
30 week IUGR. Ventilated for 48 hrs. Abdominal distension and bile stained aspirates for a number of days. Collapsed and required ventilation overnight on day 11. Died in LWH shortly after transfer. Nurse L cared for baby on night shifts on days of life 9, 10 and 11.

Baby P [Baby M on indictment]
33 week gestation twin born in good condition and stable on day 1. Day 2 sudden cardiorespiratory arrest, requiring 6 doses of adrenaline and CPR. No cause identified. Nurse L present at resuscitation.

Baby Q [Baby K on indictment]
25 week gestation infant. Ventilated. Sudden deterioration at 0350 with misplaced ETT. Consultant could not explain how the ETT became misplaced. Transferred and died in APH. Nurse L present on unit.

are almost identical so it is assumed that there was a mix up with the last digit).

Baby R [Baby G on indictment]
23 week infant born in APH and transferred to CoCH at equivalent of 34 weeks gestation (i.e. about 11 weeks old). At 3 months of age had a large vomit and collapsed at 0315 requiring intubation and ventilation. Nurse L took over care of baby overnight. No cause for deterioration identified and she rapidly improved at APH and was transferred back 8 days later.

Baby S [KX - not on indictment]
34 week twin with persistent hypoglycaemia or low blood sugar. Collapsed on day 6 – cause unknown. Required treatment for severe hypoglycaemia. Unusual clinical findings of stable blood sugar during the day and then unexplained low blood sugars during the night. Nurse L on shift and recording blood sugar readings during those night shifts.

Baby T [SX - not on indictment]
37 week gestation baby who developed symptoms of abdominal distension and so was admitted to the neonatal unit for investigations and close observation. An xray suggested likely perforation (hole) of his bowel on 07/04/16 @ 02:42 & this was confirmed (using slightly different xray technique) @ 05:30 but clinically he was not requiring any additional respiratory support. Nursing nurses document some evidence of fast breathing & occasional desaturations. Care of the baby was handed over to LL for day shift. A decision was made in conjunction with transport team to electively

intubate for transfer (this would be considered normal practice). The baby was clinically stable immediately prior to intubation, but the baby unexpectedly arrested during intubation. Despite emergency equipment check' documented in LL notes, the neopuff (equipment to support baby's breathing) would not administer high pressures & so incubator had to be moved to allow access to emergency equipment in adjacent bed space. Pt did not respond to resuscitation measures initially but did after some time and survived. He was transferred to AHCH for surgery.

Baby U [Baby B on indictment]

31 week gestation twin (sister of Baby A, who arrested on Day 2 of life). Day 3 at 0030 suddenly became cyanosed, limp, apnoeic and bradycardic with purple blotches on skin. Successfully resuscitated and intubated. Nurse L present. No cause for respiratory arrest identified.

Compiled by:

Dr Stephen Brearey
Dr John Gibbs
Dr Susie Holt
Dr V
Dr Ravi Jayaram
Dr Murthy Saladi
Dr ZA

Glossary of terms

APH – Arrowe Park Hospital, also known as Wirral University NHS Foundation Trust Apnoeic – pauses in breathing which are a sign of illness in neonates.

Arrest/collapse - Respiratory arrest is defined by the absence of spontaneous respiration (breathing) or a severe respiratory insufficiency (not breathing effectively to sustain life) that require respiratory assistance. Cardiac arrest is defined as the absence of central arterial pulse or signs of circulation (movement, cough or normal breathing) or the presence of a central pulse less than 60 beat per minute in a child who does not respond, not breath and with poor perfusion (i.e. the heart has stopped beating or is beating so weakly/slowly as to be ineffective). The two are closely linked (i.e. heart is dependent on lungs and vice versa) but in children (including neonates) the most likely cause of an arrest is due to oxygen insufficiency leading to a respiratory arrest.

Aspirate – babies have a nasogastric tube (NGT) that allows them to be fed as they have not yet developed the suck reflex and/or are unable to feed normally due to illness. Prior to feeding, the nurses will connect a syringe and suck the contents of the stomach to ensure the NGT is in the correct position. This is the aspirate.

BAPM – British Association of Perinatal Medicine is an organisation that aims to improve the standard of care delivered to unwell, newborn infants by improving standards of hospital care, clinical guidance and supporting ongoing education. The BAPM standards is an aspirational document outlining how hospitals should aim to deliver neonatal care including physical factors e.g. the environment, space around beds and human factors e.g. ratios of nurses to infants etc.

Bilious – bile from the intestines is seen in the secretions taken from the stomach. This is a concerning feature in neonates. See NEC Bradycardia – pathologically slow heart rate

CoCH - Countess of Chester Hospital NHS Foundation Trust Congenital – present from time of birth Desaturations – a fall in the oxygen level detected in the blood (routinely measured on neonatal unit) Gestation – period from conception to birth which is typically 40 weeks. Newborn infants are categorized according to when they were born. A baby born 8 weeks early is born at 32 weeks gestation. The World Health Organisation gives the following definitions for the different stages of

preterm birth: extremely preterm: before 28 weeks very preterm: from 28 to 32 weeks moderate to late preterm: from 32 to 37 weeks.
Hypoglycaemia – low blood sugar level Hypoxic – due to insufficient oxygenation.
Ischaemic – insufficient oxygen to living tissue causing it to die LNU – local neonatal unit LWH – Liverpool Womens Hospital
Meconium – this is first stool passed by infants. There is controversy around the clinical implication if meconium is present at the time of delivery and it may be linked to foetal compromise (meaning that the foetus may have not got sufficient oxygen via umbilical cord) during the labour & delivery but must be interpreted alongside other clinical signs & symptoms.
Mortality – number of deaths
Neonatologist - on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on a neonatal unit alone i.e. paediatricians who have undertaken specialist training in neonatal medicine
Necrotizing enterocolitis (NEC) - is the most common gastrointestinal emergency occurring in neonates. Prematurity and low birth weight are the most important risk factors. The disease is not well understood but affected infants will not tolerate their feeds, and have progressive symptoms including aspirates (milk from the stomach after a feed as not being digested), abdominal distension, pain and other evidence of compromise.
NNU – neonatal unit, ward in hospital where newborn infants are cared for if they become unwell.
Pathology/pathological – linked to disease
PM – post mortem. Some infants had post-mortem examinations but none of them were home office post mortems.
Pneumonia – medical term for chest infection.
Resuscitation – this is a skill learnt by all doctors and some nurses. It follows set guidance from the resuscitation council which promotes team work and improves outcomes. There are logarithms that are learnt and followed if a child is recognised to have arrested (for whatever reason).
Term – babies born at or around expected due date (37-42 weeks gestation).
Ventilatory support – if unable to breathe adequately, ventilatory support may be required. This is a complex area.
Invasive ventilatory support is when a breathing tube is placed in big airways of the lung and 'breaths' are given by a ventilator.
CPAP or BiPAP is non-invasive ventilatory support. A tight fitting mask is applied to the nose &/or mouth and a ventilator produces intermittent pressure so the effort of breathing is less (but patient is spontaneously breathing). It is less intensive than above.
Optiflow is a way of delivery warm and humidified oxygen at different flow rates. It is less intensive than either of the above.

Appendix 1: Survival graph below taken from Office for National Statistics: Pregnancy and ethnic factors influencing births and infant mortality: 2013

[Chart]

THOUGHT WERE UNEXPLAINED PERTAINED TO BABIES WHO HAD CONGENITAL ABNORMALITIES, THE REASON BEING THAT THEY DID NOT THINK THE ABNORMALITIES WERE LIFE THREATENING. DR EVANS LATER SAID THE DEATHS WERE EXPLAINED (BECAUSE OF THE CONGENITAL ABNORMALITIES!) AND THEY DID NOT END UP ON THE INDICTMENT.

INQ0102300 – Pages 3 – 4 of Emails between Dr Ravi Jayaram and Nigel Wenham, dated 10/05/2017.pdf:

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10 May 2017 — Ravi Jayaram → DCS Nigel Wenham

Jayaram sends the consultants' reports articulating their clinical concerns, describing them as the collective view of the department.

From: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) Sent: 10 May 2017 18:36
To: Nigel Wenham
Subject: Countess neonatal issue
Importance: High
Sensitivity: Confidential
CONFIDENTIAL

Hello Superintendent Wenham

I met you a couple of weeks ago at the Countess during our discussions about the unexplained neonatal deaths and collapses. I am aware that the Trust have sent you copies of the RCPCH report and the independent case note review from Jane Hawdon as well as the results of internal reviews of staffing, intensity etc.

Attached are two documents that attempt to articulate the clinical concerns of the 7 consultant hospital paediatricians here at the Countess as to why we are uncomfortable about not only the increased number of deaths and collapses but also the nature of the deaths and collapses. One is a brief summary of each case (both deaths and unexplained/unexpected collapses) and the concerns, if present, for each of them, the second is a timeline of events referencing the babies in the 1st document.

The 3rd document is data from the regional neonatal network report looking at intensity, staffing and mortality in the period January 2015 to July 2016 in our unit and other units. The data comes from BadgerNet which is the database used across the Cheshire and Mersey neonatal network.

I am sending these in my role as lead for the department but this is a document that represents the collective view of us all. The document has no patient identifiers but if you require this information please do not hesitate to contact me and I can get this to you.

I hope that this is of use to you.

Ravi Jayaram
Consultant Paediatrican/ Clinical Lead for Children's Services
Dept of Paediatrics

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12 May 2017 (email); 15 May 2017 (meeting notes) — Nigel Wenham → Ravi Jayaram

Wenham asks to meet to review the consultants' report; followed by DCS Wenham's notes of the 15 May 2017 meeting with the paediatric consultants about their concerns over Lucy Letby.

From: Nigel Wenham

Sent: 12 May 2017 12:58
To: JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

Subject: Countess neonatal issue —[NOT PROTECTIVELY MARKED]—
Sensitivity: Confidential

Dr Jayaram

Would you be available on Monday morning for a meeting to review the contents of your report? I think you have a meeting already booked with the Police following the meeting we had several weeks. If in agreement, can we meet you at 1030 as planned, or a little earlier if available? I can attend the COCH if you can secure a room, or you can pop over to Blacon Police Station. The purpose of this meeting is to clarify some of the issues you have highlighted. At this point we not conducting a formal police investigation, we are gathering information to inform future decision making. If you could please let me know. I will be attending with Det Inspector Paul Hughes. We are not looking to meet with anyone else at this time, just yourself.

Regards
Nigel

INQ0102309 – Pages 2 – 7 of Notes of a meeting between Nigel Wenham and senior clinicians, dated 15 May 2017.pdf

Original notes made by T/Chief Supt Nigel Wenham, recorded in ONE Note at the time and amended spelling and grammatical errors following the meeting.

Notes from meeting Paediatricians
15 May 2017, 10:21

Dr Stephen Brearey - SB
Dr Susie Holt - SH
Dr Ravi JAYARAM - RJ
Paul Hughes - PH
Nigel Wenham – PH

NW welcome and outline purpose of the meeting: To review the contents of the report that was sent to NW last week, titled 'Reasons for concerns regarding a possible criminal cause for increased neonatal mortality at the Countess of Chester Hospital NHS Foundation Trust, June 2015 — July 2016

Understand more about current operation of the ward

7 Paediatric & neonatal (combined posts) Consultants employed by Countess of Chester NHS Foundation trust during time period. Business case approved in 01/2016 for 2 new consultants in keeping with national NHS recommendations. 8th consultant (Dr McGuigan) employed 01/2017 and interviews for 9th consultant took place on day of meeting. Dr Liz Newby in one of the Consultant posts until 03/2016 when left to work in Stepping Hill, succeeded by Dr Susie Holt

Funding of neonatal unit is split: Specialised commissioning through NHS England pay for care on the neonatal unit

Some care of newborn infants is funded by CCG,

NHS Improvement not involved

SB very keen from the start to involve the neonatal network
Part of network care across Cheshire/Mersey, there is some degree of accountability in the network, for example, mortality reviews

RJ — if you have concerns about Dr you would report to GMC; concerns about a Nurse to Nurse and midwifery council, if wider issue like this, escalate through the trust. Regarded as whistleblowing if you go outside. We have taken advice from our medical defence unions to do everything within the trust and deal that route
SH - guidance is available on line from the BMA & GMC

SB - there are invited college reviews, like the one from Sept, that was service review. They did recommend multi service review

SB - the case notes review by Dr Hawden did assess some cases, this was not what the Royal College of Paediatrics & Child health (RCPCH) review asked for. What happened was ONE neonatologist looked at cases notes, this was not multi discipline review that was suggested

Trust can have root cause analysis to invite professionals in to do review of whole case, these tend to be single case, not cohort reviews.

CQC have a responsibility for all NHS organisations and private, as clinicians very unusual for us to go direct, this would be more whistleblowing. We have not directly contacted the CQC, advice from legal reps exhaust all possibilities first

RJ - the JH review specifically mentioned forensic review, we can not conduct that level of review. The fact is these babies would not be the ones you would have expected, at the point they collapsed and they did not respond physiologically to the treatment as expected

Understand more detail of their concerns

SB - of those 9 we reviewed initially, 6/9 collapsed between 000-0400, which was highly unusual. One of the action was to review the period prior and nothing was found (will share these reviewed) that review also noticed a significant number of collapses.

SB - following on from that thematic we discussed the nurse (Lucy) but no action taken.
I shared the report with IH prior to the COC inspection (Feb) at this time the nurse had been put on day shifts for mentoring reasons

Q: Confirm how many that Nurse has been present?

SB - the nurse was present in all but one of the deaths

RJ - the staffing review has looked at the notes, this has not necessarily been picked up. What has not been looked at, this baby collapsed, who was where, what were you doing at the time. As consultants, it is very rare that consultants were present at time of collapse. At the point of the collapse, the nurse was present at that time in close proximity. This has not happened to other staff.

I can speak about one that did collapse, but survived, 27 weeks, was stable had breathing tube down, good ventilation, named nurse (ie nurse assigned to care for baby during that particular shift) had gone out of nursery. I went back in, the baby's oxygen levels had dropped, first thing to do disconnect baby from ventilator and bag. I noticed the breathing tube had been dislodged. The nurse (L) was present at the time.

RJ - there is perception that we are on campaign, this is not the case. Other (consultants & junior doctors) had come to the same view. It got to the point that when Nurse was on duty we feared something would happen.

RJ - we are not on a witch hunt, we have concerns that this nurse was present in far too many occasion
Provided example of baby that was being treated for low blood sugars, very erratic pattern of sugar level which changed with shift pattern no clinical explanation, consulted with Alder Hey, who agreed was unable to explain.

SB - we have looked hard, we can't find any explanation

- **Identify any specific evidence of any criminal or suspected criminal activity**
- **Clarify some aspects regarding the pathology and causes of death**

Q: 3 cases were certified by Dr's on wards, why?

SB - one baby 29 wks, felt that baby displaying typical signs of NEC, felt at time this was not suspicious. The baby had abdominal x ray an hour before death, there was no signs of NEC. The fact xray was normal is odd. As an isolated case, he would not have been considered suspicious, but assessed on the timeline, there are concerns

Q: questioned on the cause of deaths and pathology?

SB - this is what PM diagnosis is Neo is so hard. JH review identified those 4 cases, we also reviewed these and another 4, we felt there was unexpected or unexplained cause of death.

SB - there are several babies with clear genetic diagnosis, in some cases the PM does not explain why the babies suddenly collapsed and died.

Q: do you consult with the Pathologist regarding PM findings?

Outlined that this was not normal practice, communication would take place between the pathologist and coroner

Q: if third party involvement would you expect to see the same indicator?

SB - it is relatively easy to manipulate fluid, to administer drugs and or too block an airway

SB - there seems to be a theme with multiple births (triplets & twins) and the more stable infant being the one to collapse

SH - case of Baby [I&S] twins, 1 twin was on CPAP — but baby [I&S] (not needing any respiratory support) was the one that collapsed, from clinical perspective neither were anticipated to collapse but clinically the one on respiratory support was more vulnerable

RJ - concern we have is could something be done deliberately to harm them. We don't know, I don't know if this is something we just have to live with, we would rather there was some explanation, our concern is have enough questions been asked, can we be satisfied that we have done all we can to confirm if there is something more going on.

Nobody has talked to junior Dr's who have been involved. We appreciate that a lot of time has passed since these. We at end of the day are responsible for patient safety on the ward, the buck stops with us.

SB- to put in perspective consultant who joined us from Crewe, he has never experienced anything like this in 5 years as consultant

RJ - we all have concerns, nothing significant changed over the years to explain the deaths e.g. the changes in patient numbers, staffing, do not explain the number of deaths or collapses.

RJ — We do not dispute the findings from the RCPCH report and it has made useful suggestions for our service, but feel these are background factors

RJ - the pathology report may attribute a likely cause of death, but this does not explain timing nor what caused the collapse that ultimately led to death

Agreed not challenging the pathology findings, but the fact is the cause of collapse leading to death has not been identified

SB - survival rate for babies over 32 is nearly 100%, for 6 of our babies to have died who were over 32 weeks, to die is not right.

Review the key statements outlined in the report

The historical annual number of deaths on the neonatal unit at the hospital has been between 1 and 3. From June 2015 there were 13 deaths in the 13 months. The probability of this increase in mortality occurring by chance alone is very low. Many of the babies who died were born at gestations where death is statistically very unlikely (Appendix 1).

Of the babies who died, most deteriorated unexpectedly without explanation at the time or subsequently. It is very unusual not to see any clinical evidence of a baby becoming unwell e.g. you might expect to see their heart beating faster or the level of oxygen in their blood changing. In some of these cases there was no recovery to adequate resuscitation measures. For this to occur in such a large number of babies is highly unusual and could be considered as suspicious.

SB - did thematic review in Jan 2016, looking at the 9. senior nursing staff from Liverpool Woman's Hospital, looking at themes trends. Staffing was included in that report, staffing on shift, designated nurse, consultant on duty, name of junior Dr's present. Could not find link with consultant or Dr's.

RJ - all collapses and deaths would involved wide range of professionals

NW - at what point was concerns raised?

SB - from December, I raises some concerns. The first discussion took place in June 2015, when we had 3 deaths within few weeks, this was highly unusual, we met with IH and head of risk at that time, we reviewed all three cases. Could not identify any issues regarding clinical practice. At that time the unit manager noticed that Lucy Letby (The nurse) was present at all three. That was first conversation.

All three reported to coroner and had PM's

RAVI was clinician for XXX, he attended inquest, cause of death unascertained [BABY A]

SB – XXX [BABY A] collapsed unexpectedly and died. His twin [BABY B] collapsed but recovered. This was unexpected and unusual, now looking back we think this was suspicious. She had unusual rash.

SB – [Baby ?] improved after intervention being brought into the unit & started on treatment,. collapsed and died on day!. All blood markers did not indicate worsening infection. PM still spots inflammation in the lungs, but this does not explain the improvement in the baby health and then collapse.

Explain collapse?

SB - baby do not have cardiac arrest like adults do, collapse on unit would be inadequate breathing, babies stop to breathe, may stop breathing, dropped oxygen levels, breathing stops and oxygen level for period, heart slows down, this requires cardiac massage. These babies had apnoea, stopped breathing. Increased number result in desaturation. These babies just stopped out of the blue.

How do we know that?

RJ - they are on monitors, however monitors don't keep digital record of numbers. Nurses document observations from monitors hourly on observation charts.

SB - most babies were at gestation would not expect these sort of things happening.

RJ - these babies simply did not respond as expected, interventions did not result in expected results. The baby XXX interventions were put in place, there was evidenced electrical activity of the heart, but he did not have output (no pulse). Not many things can cause this, he had adrenalin, he did not respond, half hour without output (Child A).

SH - there is big difference adult and neonatal practice, with intervention we would expect to see some response and statistics support this.

What was thought process with no response?

RJ - in one off, there could be explanation.

SB - we would expect the PM to find evidence to support cause of death. The pick up rate from pathology has not informed us as to why the babies have collapsed.

RJ - we accept in medicine some uncertainty, we accept cognitive bias, but we cant see explanation. Is it people, practice, building, accommodation, it is big leap of faith to suggest these all lined up and led to the deaths. All of these factors (acuity of unit, medical & nursing staff levels) are there and common to other neonatal units in the country.

SB - PM for XXX [Baby A?] was done urgently

RJ - if any concerns we would escalate to the coroner, would discuss and agree process

SB - all neonatal deaths are discussed with the coroner

There is an association with a member of staff who was present during the majority of instances when the babies unexpectedly deteriorated. When this member of staff was put onto day shifts for 3 months, no sudden collapses occurred during the night. Previous to this change in her work pattern, in 6 out of 9 deaths, the arrests occurred between 0000 and 0400. When this member of staff was no longer working on the unit (July 2016- present), there have been no neonatal deaths on the unit and no unexpected or unexplained sudden deteriorations. This member of staff was present on the unit during the deterioration of the [X] Children who died (Child A, C, D, E, I&S, I&S, Child I, I&S, I&S, Child O and Child P).

The gestation at birth of the babies who died was between 27 weeks and 40 weeks. 6 babies were >32 weeks gestation. The redesignation of the unit from July 2016 (only permitted to care for babies >32 weeks gestation) cannot therefore be the only reason why there have been no deaths or sudden unexplained deteriorations of babies on the unit since July 2016.

An external neonatologist from London has identified 4 [Child A, I, O and P] who require further forensic review. Further to her report, a consensus between 3 CoCH paediatricians [comment: not all seven] and an external neonatologist from the Liverpool Women's Hospital (LWH) have identified a further 4 Child C, D, I&S and I&S for whom the cause of death is still unexplained.

An unexplained rash was observed for at least 3 babies. This was initially thought to be due to infection by the clinical teams. However, the rashes resolved spontaneously despite the babies being very ill. This is highly unusual and may indicate a possible unnatural cause of death.

RJ - did some reading and found that situation called air embolism, small amounts of free air in circulation can obstruct flow of blood into the lungs, free oxygen can be picked up. There is a rash associated with these diagnosis

SH - explained that we associated infection with rashes, this was not the case here, not a recognisable rash outside these collection of babies.

RJ - air embolism can happen deliberately or accidently, for example, cannula administering drugs, what could happen, there could be error in how the cannula is managed

Babies I&S, Child D and one survived (Child B)

RJ - my understanding is that unless the PM is done very soon, there will not be any evidence on the PM

Closing comments:

RJ - we are used to dealing with uncertainty, this is what we do. We have said we want enough done to rule out foul play. IH has suggested getting another neonatal review. JH refers to forensic, but what this means

SB - we were very worried, the triplets (twins who died) there was no explanation, she was named nurse, other nurses have gone off work with stress, she didn't. Duty exec was happy for nurse to remain on duty at that time. When expressed our concerns, we don't think the executives have understood our concerns.

In Jan, we met with Chief exec, all seven of us, we were told we have spoken to family, don't cross the line, we are dealing with it.

Every Paediatrician were worried about her going back to work and none of us were happy with her returning back to work, we don't feel this is acceptable. This has not been investigated properly.

RJ - I don't want the obvious fractious relationship between us and the executive, this is not why we want you here. We are not sure the process, reports have asked the right questions, we want to exclude is there anyone who is deliberately harming these babies.

At a meeting in Jan executive read out letter from the nurse that stated she was exonerated by reviews to date.

RJ - we fully understand the impact of investigation, damaging to the trust, the neonatal unit and staff and the impact on the families of the babies. At the end of it you may ask what was the point. Speaking for myself, we are not comfortable as worried about safety of our patients.

The Cheshire Police

On 18 May Cheshire Police announced publicly that they had launched an investigation into the increased mortality at The Countess of Chester's NNU.

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21 May 2017 — Dr Dewi Evans → Nick Casey (National Crime Agency)

Evans offers his services as an expert to the police investigation, having read press coverage of the case.

On 21 May Dewi Evans sent an email to his contact at the National Crime Agency (NCA), Nick Casey, in which he offers his services with respect to the investigation:

> *Incidentally I've read about the high rate of babies in Chester and that the police are investigating. Do they have a paediatric/neonatal contact? I was involved in neonatal medicine for 30 years including leading the intensive care set-up in Swansea. I've also prepared numerous neonatal cases where clinical negligence was alleged. If the Chester police had*

> *noone in mind I'd be interested to help. Sounds like my kind of case. I understand that the Royal College (of Paediatrics and Child Health) has been involved but from my experience the police are far better at investigating this sort of problem.*

It is instructive that Dr Evans in this first email rubbishes the RCPCH and by implication its findings in relation to poor care, etc.

There has been speculation that The Countess paediatricians tipped off Evans about the investigation and their suspicions, on the basis they knew each other and Evans was known to always provide the opinion required of him. However, there is no evidence of this.

Nick Casey immediately passes Evans' 21 May email to his NCA colleague Jim Shingler.

The next day, 22 May, Shingler emails Janet Moore at Cheshire Police to say that he understands that Cheshire Police requires experts and tells her he has referred her enquiry to the NID (National Injuries database, part of the NCA). He also writes that he understands she is meeting with national SIO adviser Ken Donnelly and NID manager Sonya Baylis on 26 May.

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23 May 2017 — Nick Casey → Dr Dewi Evans

Casey thanks Evans for his offer and says the NID is being deployed to Cheshire.

On 23 May, Casey writes back to Evans,

> *"Thanks for your emails and your offer of support for the Chester child death investigation. The NID is being deployed on Friday for a briefing in Cheshire and your support is much appreciated. We will keep you updated on the progress."*

On 24 May, Moore tells Shingler that her DI, Paul Hughes, has provided documents to Baylis ahead of the meeting two days later. The next day, Baylis is told that the documents had been "stuck in the system".

Following meetings on 26 May in Cheshire and in early June in Birmingham between Cheshire Police and the NCA/NID, Baylis emails Hughes to tell him that she has left a message with Evans to call her.

Baylis also sends him [PH] her write up of the 26 May meeting setting out the NID's recommendations to Cheshire Police:

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26 May 2017 (write-up) — Sonya Baylis (NCA National Injuries Database) → Cheshire Police / DI Paul Hughes

Baylis's write-up naming a nurse "nominal", listing the medical evidence needed, and setting out the experts — including Dr Dewi Evans — the NID suggests instructing.

Baylis records that,

> *"A potential nominal has been highlighted who is a nurse at the hospital who was on duty when all the babies died"*

and that Cheshire Police's request is for,

"a number of expert medical opinions in a number of key areas providing opinions on whether the babies who died or collapsed had pre-existing issues to cause their conditions or neglect was involved due to processes, staffing levels and working practices in place within the hospital or whether there was third party intervention."

Baylis offers assistance with respect to

"What samples have been retained by the hospital and what tests have been conducted so far as well as reports produced, which will be required by the medical experts, if required, as well as any pre-existing medical conditions and medication used" as well as to "the potential exhumations of 5 of the buried babies".

The write up goes on to set out "Additional Material and Questions required by the Suggested Experts". In relation the the babies, this includes:

o All the images of the babies' including those of the injuries, with scale if available, would be required; o Has any photography using alternative lighting been undertaken? o Full documentation of the babies injuries/medical conditions would be required including medical notes, medical statements and scans, post mortem reports (including routine post mortem examinations), hospital admission notes, GP medical history, hospital tests and reports, medication given, whether bloods/urine/samples have been taken and retained including blocks/slides for potential further testing, etc. The red book, health visitor and midwife notes as well as the birthing notes. Also, the review conducted by the two pathologists at the Alder Hey Children's Hospital and the joint report by the paediatricians.

o What clothing were the babies wearing at the time which may assist with any interpretation of external injuries? o Are there any previous incidents to the baby and/or mother that the medical expert will need to know including the health of the mother?

o Copy of any relevant witness statements.

Regarding "the suspect", Baylis writes that,

"Once the nominal has been interviewed or provided a prepared statement, a copy of this will be required by the medical experts."

As for the NID's suggested services, the first is:

To instruct a neonatal paediatrician (Dr Dewi Evans) to review the babies medical history, any test results, hospital notes/reports/scans, medication, etc, i.e. the full case file, and provide opinion on whether the medical history would support the cause of death for the deceased babies and for the collapsed babies. To also comment on whether it is in keeping with the version of events provided by the nominal or witnesses or due to an underlying natural cause. This expert would also be willing to assist with the interview process.

Baylis then suggests to Cheshire Police that the NID helps them with respect to instructing the following experts:

Forensic and neonatal pathologists to review, jointly, the medical histories, etc

A forensic toxicologist and/or clinical pharmacologist to review the test results for all sampling conducted on all the babies, etc

A nurse with experience of working in a special baby unit for neonatal births, etc

A medical expert with experience of the working practices involved in a special baby unit for neonatal births, etc

An obstetrician to review the medical histories, tests results, hospital notes/reports/scans, medication, etc

Other help offered by Baylis relates to:

"discussing with a medical expert or lead in the CDOP process whether there were any failings by the local CDOP team with regards to not flagging early the peak in mortality numbers at the hospital including reviewing both reports provided by an independent paediatrician instructed by the hospital and the RCPCH. In addition, to provide national/regional statistics on neonatal deaths in a medical setting to support the investigation team as well as non-fatal collapses."

"conducting a scope search of the National Injuries Database for similar cases"

Baylis then writes (her red) that,

"These are suggestions only and it is ultimately your's (sic) *and CPS's decision who you wish to use and instruct to provide expert opinion for your investigation considering the key issues involved. This process can be phased according to your priorities. Please let me know those that are required first and are more urgent."*

At the end of her notes, Baylis writes,

"We strongly advise you to provide a courtesy e-mail informing any experts who have already worked on this case, in particular Dr Nick Hunt of our involvement and forward on any relevant information that we provide to you, as this may assist the expert (s) with their final opinion. I can make contact with Dr Hunt regarding the experts suggested above, if required."

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28 June 2017 — DS Janet Moore → NID / Sonya Baylis

Moore asks about arranging a meeting with Dr Evans before deciding on other experts.

On 28 June, Moore writes to NID:

"Sonya [NID] has recommended various experts (as per below). We were hoping to meet with Dr Dewi Evans in advance of deciding on the other experts. Is this possible and should we go through yourselves to organise this? I can attach a summary of the enquiry so far if he is agreeable?"

c. 28-29 June 2017 — Sonya Baylis → DS Janet Moore

Baylis says she will formalise Evans's instruction and asks for the current situation report.

Sonya (Baylis) writes back,

> *"Dear Janet, In relation to your e-mail below and confirmation of one of our services i.e. instruction of Dr Dewi Evans, I will now formalise his services and e-mail him as well as try and call him (though I have left several messages including to Paul). Once I have made contact I will get his availability to meet and discuss the case further with yourselves and what his costings will be. In the meantime, a copy of the current situation report would be useful please and confirmation that a copy of the case summary can be provided to Dr Evans."*

---

c. 29 June 2017 — Sonya Baylis → Dr Dewi Evans

Baylis formally asks Evans to confirm his availability and costs to discuss the case.

She then also writes to Evans,

> *"Dear Dr Evans, I am supporting an investigation on behalf of Cheshire Police in relation to a number of neonatal deaths in a special baby unit within a hospital (15) and significant collapses (6) between June 2015 – June 2016. You kindly approached one of my team Nick Casey to offer your services, which I'm grateful for and since offered this to the investigation team. The force have now confirmed your services are required and would like a meeting soon to discuss the case further and the current situation as well as your costings for your services as this will be a lengthy process involving reviewing the working practices and processes in the unit, the initial complaint by a group of paediatricians within the hospital and the subsequent reviews as well as the actual conditions of the babies and their eventual deaths as well as collapses. In the meantime, I have suggested that they need to collate all the relevant paperwork including medical histories of all the babies, interviews of the staff involved, medical reports produced, tests conducted and medication given, etc. But further guidance from yourself with regards to all the essential material that is required would be useful. Please can you let me know your availability to meet with the Senior Officer in the Case and myself as facilitator at a location suitable to you and whether any costs would be involved for this initial meeting. Look forward to hearing from you. In the meantime, I have left several messages but to date have not received a response from yourself. Kind regards, Sonya"*

---

c. 29 June 2017 — Sonya Baylis → Cheshire Police

Baylis confirms she has emailed Evans and asks the police to confirm which pathologists were originally involved.

This is followed by an email from Sonya to Cheshire Police:

> *"Dear All, I have since e-mailed Dr Evans having had confirmation from Janet that his services are required and asked for all his costings for each phase as well as availability for a meeting amongst ourselves. Also, can you confirm who the original pathologists were please as I seemed to have included Dr Hunt in my assessment below who I believe was not involved my apologies."*

c. 29-30 June 2017 — DS Janet Moore → Sonya Baylis

Moore names the original pathologists and says she will prepare a case summary.

Janet Moore writes back,

> *"I will start getting a summary of the case together and forward it to you. The pathologists involved were Dr McPartland, Dr Kokai and Dr Shuklar."*

---

30 June 2017 — DS Janet Moore → Sonya Baylis

Moore sends the Operation Hummingbird summary for forwarding to Dr Evans.

On 30 June, Janet Moore writes to Sonya Baylis,

> *"Hello Sonya, I attach a summary of Op Hummingbird if you can please pass onto Dr Evans? Many thanks, Janet"*

---

30 June 2017 — Dr Dewi Evans → Sonya Baylis

Evans finally replies, apologising for the delay and proposing to discuss arrangements the following Monday.

And on the same day, Sonya Baylis finally hears back from Evans,

> *"Dear Sonya, Thanks for this. I've been away in court in N Ireland most of this week so would have missed any phone message. I'm in mid Wales today - recreational:) Variable signal. Can I suggest we discuss everything on Monday. We can discuss everything with the SIO and sort out the logistics. It would be easier for me to go to the cases I suspect than for the cases to come to me. Should be able to sort things during July. I'm sure we can arrange an initial meeting without any costings. We could meet in Cardiff, or anywhere that's convenient for Chester Wyboston and Cardiff. I'll phone Monday if that's okay. Best wishes, Dewi"*

---

c. early July 2017 — Cheshire Police (Janet Moore, via Sonya Baylis) → Dr Dewi Evans

The "Operation Hummingbird Summary" briefing document: hospital background, the chronology of internal concerns, the RCPCH and Hawdon reviews, and the scope of the police investigation.

A few days later, Baylis writes,

> *"Hayley confirmed that she has sent the current situation report to Dewi securely by email"*

Below is the *summary of Op Hummingbird* aka *current situation report* produced by Cheshire Police at the start of the investigation and which Moore asked Baylis to send to Evans.

> *Operation Hummingbird Summary - Countess of Chester Hospital Enquiry*
>
> *Background of the Hospital and Investigation*
>
> *The Countess of Chester Hospital Trust provides a range of paediatric and neonatal services. The Neonatal Unit has 20 cots and provided critical care, high dependency care, special care and transitional care for newborn babies.*

The Trust provided a Local Neonatal Unit service (Level 2 care) providing short term ventilation. The Neonatal Unit provided care from 27/40 gestation; any baby born below this criterion being transferred to the nearest Level 3 unit. The critical care and high dependency care cots were interchangeable and could therefore flex according to the needs of the unit.

An internal comprehensive case review was undertaken in February 2016 following the deaths of 10 neonates (including one who died shortly following transfer).

Sequence of events

Concerns were raised by the clinical team of the hospital to the Executive regarding a higher than usual number of neonatal deaths from January 2015 (8 in 2015 and 5 in the first six months of 2016 compared with an average of 2.4 per annum in the previous 5 years). This resulted in a meeting between various staff members in May 2016. It was highlighted at this meeting that there was one member of the nursing staff who had been present at more of the cases than any other member of staff. However, there was no evidence, other than coincidence. The nurse was noted to work full time and have the Qualification in Speciality (QIS). She was therefore more likely to be looking after the sickest infant on the unit. She also regularly worked overtime when the acuity was high or unit was over capacity. There were no performance management issues, and there are no members of staff that had complained regarding her performance. The nurse had been moved on to days to ensure that she was supported. It was agreed at this meeting that all babies who deteriorated would be reviewed; that there would be a review of the hour of care before death of the babies who had died at night; that the nurse would remain on days for 3 months and a further meeting was to be held after 2 months.

Two of triplets born on 21st June 2016 died on 23rd and 24th June. This exacerbated the concerns, there being no obvious cause for the babies' collapses and it was alleged that the nurse referred to above was involved in the care of these babies and that unnatural causes had to be considered. As a consequence, following a series of meetings of the Executives and with clinicians it was determined that in the best interests and welfare of babies and staff there would be a number of actions:

1. *The unit to be redesignated to Special Care Unit (SCU) caring for infants from a minimum of*

32 weeks gestation with consultation with the C&M network

2. *A comprehensive review of the unit to include activity, acuity and staffing levels*
3. *A review of babies who had collapsed unexpectedly*
4. *An invited review from the Royal College of Paediatrics and Child Health (RCPCH).*
5. *The Coroner (via his deputy) was appraised of the concerns that had been raised and the steps that were being taken.*
6. *The nurse was redeployed off the unit*

The internal review identified that every month from February – December 2015 had seen a greater number of care days than the long term average. This suggests that the NNU has been busier and workloads had been higher. Within this the increase in high acuity care days became clearer when we combined L1 (ITU) and L2 (HDU) days per month. Between May 2015 and March 2016, only one month showed care days drop below the long term average. In

addition, between March and December 2015 there was a higher than average number of babies born with a birth weight below 2000g in all but two months. This correlated with the increased demand for high level care over the same period. There was not an increase in admissions in the most severely premature categories (below 26 weeks and between 26 and 30 weeks) but there was an eight month run of higher than average admissions at 31-36 weeks gestation.

> *The February 2016 internal review at the Countess of Chester neonatal unit examined 10 infant deaths from January 2015 to January 2016 but concluded that no single common theme or explanation could be found for the unexpected deteriorations and deaths. The hospital's senior management was also not fully briefed on all of the clinicians' concerns at the time.*
>
> *Summary of the review's findings*
>
> *No evidence of foul play: The review, which included a consultant from Liverpool Women's Hospital, did not find any evidence of "foul play". This was a key factor in the hospital management's delay in involving the police.*
>
> *Identified clinical issues:*
>
> *The review did identify some clinical issues in the cases examined, including:*
>
> - *Care issues involving umbilical venous catheters (UVCs).*
> - *Two infants were given ranitidine, a medication later advised against for preterm babies due to increased risk of death.*
> - *Delayed umbilical cord clamping in some preterm deliveries, which goes against national recommendations.*
> - *A higher-than-average number of cardiac arrests occurred between midnight and 4 a.m.*
>
> *High-acuity cases:*
>
> *The review found a higher-than-average number of babies with low birth weight and gestational periods between 31 and 36 weeks were admitted from March to December 2015. This was noted as a potential factor for the increased mortality rate.*
>
> *Inadequate management oversight:*
>
> *In their report, the review team noted that leadership at the senior hospital trust level seemed "somewhat remote" from the day-to-day issues occurring on the neonatal unit.*

The document continues:

> *The RCPCH sent a team who had access to all policies, procedures and activity data and conducted interviews with all relevant staff groups and the network. This led to the issuing of a*

final review in November 2016 with recommendations. The review advised a further, in-depth, independent case note review of each unexpected neonatal death.

- Inadequate staffing (in an email to Countess chief executive Tony Chambers in December 2015, paediatric consultant Alison Timmis wrote that staff are "stretched thinner and thinner and are at breaking point. When things snap, the casualties will either be children's lives or the mental and physical health of our staff").
- There was a need to employ two Advanced Neonatal Nurse Practitioners (ANNPs), though review panel members may not have known that CoCH had got rid of 8 highly qualified senior nurses, including two ANNPs, in the years leading up to 2015 and replaced them with poorly qualified agency and nursery nurses.
- gaps in both medical and nursing rotas.
- poor decision making; delays in seeking advice.
- delayed retrieval of infants to tertiary units.
- indecision around integration of the three network transport services.
- non-compliance on nurse and medical staffing levels, environment and accommodation for parents, support from the community neonatal team and postnatal follow-up.
- the 'hot week' system being insufficient to safely cover both the paediatric and neonatal wards.
- Insufficient storage space resulting in many pieces of equipment being stored in corridors.
- poor direct visibility from one area to another.
- infants being moved regularly to accommodate acuity, an extra risk in the system.
- the locum recruitment process not being sufficiently robust, and there having been no documented learning/action in relation to one particular locum.
- nurses reporting that external escalation was not always as timely as it could have been, and them not feeling empowered to participate.
- non reporting of deaths and it not being clear who was responsible for DATIX entry.
- while other areas in the hospital reported well, the neonatal unit had for some time apparently been less systematic in reporting.
- the higher activity not having been raised as a risk since data had not been formally reviewed and in response the neonatal team had just worked harder.
- concern at whether there were sufficient staff for the unit to care for triplets.
- concern that the Child Death Overview Panel (CDOP) did not appear to have been alerted to the elevated mortality.
- significant capacity pressures on the Cheshire and Merseyside Neonatal Transfer service, which contributed to delays in transferring infants out promptly.
- reports of doctors waiting too long before escalating concerns about an infant, both from junior to consultant and also to the network and when they do seek tertiary level advice, the transport team is not informed sufficiently early to be on 'standby'.
- there being no use of a 'conference call' system employed at other hospitals to inform transport team of status of infants which may require transfer; inadequate liaison between COCH clinicians and the transport team.

- there being no mechanism to trigger closure of a unit when it has reached capacity; in cases requiring surgery, there was confusion among clinicians regarding protocols.
- consultants not exploring possible factors behind the elevated mortality in a systematic way, nor following sound governance and root cause analysis processes.
- staffing levels being inadequate when mapped to the actual activity and acuity of a level 2 unit under the British Association of Perinatal Medicine (BAPM) standards, both from a nursing and a medical perspective.
- the need for a lower threshold for escalation of concerns to tertiary units for advice or transport; issues with umbilical venous catheter (UVC) insertion that required new protocols to be introduced in February 2016.
- the proportion of late gestation admissions falling in 2015-6 to 7.8% from 10.7% previously (by implication, the proportion of higher risk early gestation admissions had risen).
- there had been "higher activity and lower admission birthweight than average during the period corresponding to the increase in mortality" but "this was not however considered to have been significant enough to explain the increase in mortality." Even if it were true that it wasn't significant enough, which it wasn't (see above about Brearey conducting the review), just because these may not have *solely* explained the increase in mortality does not mean they were not part of an array of potentially unfavourable prognostic factors. A contributory factor is just as important as one that explains all variation. Indeed, rarely is variation in empirical data explained by a single factor.

The document continues:

> *This review was commissioned, on the advice of the RCPCH, from Dr J Hawdon, Consultant Neonatologist, Royal Free London Hospital. Dr Hawdon submitted her review in October 2016. This report highlighted areas were practice could have been different. There were 4 cases in which Dr Hawdon felt that the cause of death was unascertained and she advised that: "Subject to coroner's post mortem reports, there should be broader forensic review of the cases … as after independent clinical review these deaths remain unexpected and unexplained".*
>
> *Views from the Pathologists at Alder Hey Childrens Hospital (where the post mortems had been carried out) was sought. They reviewed the findings of the post mortems and felt that there were two deaths which were "unascertained".*
>
> *The Trust met with the Coroner twice in February 2017. The second time was following the receipt of a letter from the Consultant Paediatricians. The Paediatricians asked that the Trust ask the Coroner to undertake a full investigation of all the deaths and unexpected collapses between June 2015 and July 2016 because they were not reassured that all the deaths were due to natural causes. This letter, together with Dr Hawdon's report, was shared with the Coroner. The Paediatricians letter was also shared with the College reviewers and Dr Hawdon.*
>
> *On 28th February the Medical Director met with the Neonatal and Paediatric Leads, the senior Consultant and the Network lead to review the case reviews to determine if there was consensus regarding the care, clinical course and cause of death for the babies. Of the 13, it was agreed that 5 could be explained but in 8 the paediatric doctors did not feel that either the*

collapse(s) and/or the death could be explained and it was agreed that further detail was required.

paediatricians felt the congenital abnormalities were not like-threatening, Dr Evans felt they were). So, 6 of these 8 were on the indictment, meaning that there was one of the 5 that the paediatricians originally said was explained but at trial they said was unexplained (there were 7 deaths on the indictment).

The Police were later asked to carry out an investigation.

In May 2017, Cheshire Major Investigation Team began work on the enquiry. They have begun to obtain records relating to the identified infants from the Countess of Chester Hospital along with other hospitals that the infants visited.

The MIT were initially told about 13 infants deaths. The figure quickly increased to 15 infant deaths, once two additional infants who had died elsewhere having collapsed at the Countess were identified. There were also 6 infants identified to us by the Countess who would also be part of the enquiry who had collapsed and survived.

Once the enquiry had commenced, other hospital documents were viewed and the media interest had begun it became clear that there were other deaths and collapses that should feature in the enquiry. The current figures being investigated are 17 deaths in 2015/2016 and 11 collapses and survived infants.

The investigation is currently focusing on the 8 deaths identified by the paediatricians (which incorporate Dr Hawdons 4 identified deaths) which appear to be unnatural. The additional deaths and collapses will be reviewed after this initial focus.

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3 July 2017 — DS Adam Bolger → Sonya Baylis

Bolger asks whether Dr Evans has confirmed his costs and availability.

On 3 July, Sonya Baylis gets an email from DS Adam Bolger at Cheshire Police,

"Hi Sonya, I am another one of the Cheshire MIT DS's working on this enquiry. I know DS Janet MOORE has already updated you with the list of pathologists. Has Dr Dewi EVANS come back to as yet with his costings and availability? We could do with speaking with him sooner rather than later – even if we can just get a telephone appointment with him initially? Cheers, Adam (DS3889 Adam Bolger MIT, Warrington Police Station)"

---

3 July 2017 — Sonya Baylis (note to self) → —

Baylis records that she has spoken to Bolger and confirmed arrangements with Evans.

Sonya calls Adam and writes to self,

"Spoke to Adam and confirmed the arrangements with Dewi Evans".

c. 3-4 July 2017 — DS Adam Bolger → Sonya Baylis

Bolger confirms Monday 10 July at 11.30am for the meeting and asks what the team should prepare.

Adam Bolger writes to Sonya Baylis,

> *"Hi Sonya, Thanks for the call today, I have checked with the SIO and Monday 10th July around 1130 is great for us. DI HUGHES, DS MOORE, DS JOHNSON and myself will all be present. We are based out of Chester Police Station for this Operation - address = Blacon Ave, Blacon, Chester, CH1 SBD. There is a visitor car park and if you just ask for one of us at the front desk (we'll let them know you and Dr EVANS are coming). If you can confirm for me that the time is ok With yourself and Dr EVANS, I'll get us a room booked etc at the Police Station. So we are fully prepared for the meeting, can you let me know exactly what yourself and Dr EVANS would ideally like from us at the initial meeting (med records etc) - I can then make sure this is all in place Thanks a lot, Adam"*

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c. 4 July 2017 — Sonya Baylis → DS Adam Bolger

Baylis confirms the meeting details and Dr Evans's proposed format for the day.

Sonya Baylis responds,

> *"Thanks for the confirmation Adam, I will e-mail Dr Evans separately and let you know but we had provisionally booked Monday 10th July at 11.30am. I have also copied in my MCIS colleagues Aaron Day and Ken Donnelly who may wish to attend the meeting too. Is the venue the headquarters where the initial meeting was previously held? I will aim to travel by train to Winsford and Dr Evans may do so too or drive, I will confirm. If Dr Evans is driving I will advise him of the car parking arrangements. Dr Evans has proposed for the meeting that we start with a briefing on the current situation and background to the case even though he has been given a copy of the current situation report provided by Janet. Thank you. He then wishes to stop for lunch (after an hour and a half) followed by a final meeting to discuss his terms of reference and hls proposed way of working. In the past for similar cases, he has stayed for a number of days locally to the Police Station/Hospital to enable access to all the documentation whilst there, if any was missing, to review each case and record his findings. He would then return to his office and get his final report typed up. This may or may not work for your Operation depending on how many days he needs to do all the cases and his fees. He has agreed for this preliminary meeting to be free apart from his travel expenses, which I hope you are willing to pay for. During this meeting we will also discuss additional experts that may be required, which can be facilitated by the NID team using either our experts or those suggested by Dr Evans that require checking before instruction including an infectious diseases expert, obstetrician and forensic paediatric pathologist (already suggested by myself and will come with names from the NID list to the meeting). Hayley can you provide me with a list of the experts we have for the disciplines I have highlighted please for my meeting on Monday. I will need these for Thursday. Thank you. Finally, he did say to make his trip worthwhile if any full case files are ready for him to take back he would be willing to do this. However, I know that we did discuss what actual material is required, which I highlighted in my assessment. But at the meeting we can formalise all the material that is required as Dr Evans has worked in this environment before and would know which specialists and staff were involved, tests undertaken and medication given as well as notes and assessments performed. Any work proposed and undertaken by Dr Evans I will record and make sure you have a copy for your reference and records. Any other research and*

questions please let me know and look forward to seeing you all next week. Kind regards, Sonya"

---

4 July 2017 — Sonya Baylis → Dr Dewi Evans

Baylis confirms the venue, timings, and proposed structure for Monday's meeting.

And on the same day, she writes to Evans,

> *"Dear Dr Evans, I have had confirmation from the force that Monday 10th July for an 11.30m start for the meeting will be fine. The venue is Chester Police Station not the Headquarters and the address is - Blacon Ave, Blacon, Chester, CH1 5BD. Parking is available at the station if you intend to drive, you just need to ask for either Adam Bolger, Janet Moore or Paul Hughes for authorisation. If you intend to travel by train the nearest station to the venue is Chester. Just let me know what time you intend to arrive so I can tally my arrival and my colleagues can pick us both up and take us to the venue. I've checked and my train gets into Chester at 11:21am. The force are also keen to know how much your ticket will cost so that they can reimburse you. I have explained to them your proposal for the setup of the meeting i.e. that we start with a briefing on the current situation and background to the case even though a copy of the current situation report has been provided to you. Then you wish to stop for lunch (after an hour and a half) followed by a final meeting to discuss your terms of reference and proposed way of working. I also explained how you worked in the past on a similar case i.e. stayed for a number of days locally to the Police Station/Hospital to enable you to access all the documentation whilst there, if any was missing, to review each case and record your findings. Then you would return to your office and get your final report typed up. This may or may not work for this Operation depending on how many days you require to do all the cases and your fees. I also confirmed that you agreed for this preliminary meeting to be free apart from your travel expenses, which they are willing to pay just need costings. I then said that during the meeting that we would also discuss additional experts that may be required, which can be facilitated by the NID team using either our experts or those suggested by yourself that require checking before instruction including an infectious diseases expert, obstetrician and forensic paediatric pathologist (which I had already suggested and will come to the meeting with names from the NID list). Finally, I said to make your trip worthwhile that if any full case files are ready for you to take back that you would be willing to do this. However, I know that they were having issues highlighting what was actually required though I did provide a preliminary list. So I thought at the meeting it would be useful to formalise all the material that is required by yourself as you have worked in this environment before and would know which specialists and staff were involved, tests undertaken and medication given as well as notes and assessments performed. I then offered to record all work proposed and undertaken by yourself and to make sure that a copy was provided to the SIO for his reference and records. I hope that is all the information that you require. All I need from you now is confirmation of travel arrangements i.e. car or train. Date of arrival at Chester train station and travel costs involved. Look forward to hearing from you. Kind regards, Sonya"*

---

4 July 2017 — Hayley (Frame) → Sonya Baylis

Hayley sends the collated list of potential experts for Operation Hummingbird.

The following day, 4 July, Hayley writes to Sonya,

"Hi Sonya, I have collated the potential experts for Op Hummingbird into this document (Potential Expert List.doc). Let me know if you need anything else. Thanks, Hayley".

---

c. 4 July 2017 — Sonya Baylis → Hayley

Baylis queries a duplicated name on the expert list.

Sonya:

"Great thanks Hayley. Just noticed you put Dr Klein down twice, is there anyone else or just a duplication? Thanks, Sonya"

---

c. 4 July 2017 — Hayley → Sonya Baylis

Hayley corrects the duplicate, substituting Dr Vas Novelli.

Hayley:

"Sorry! I was using the layout as a template but neglected to change the details. Have changed it to Dr Vas Novelli at GOSH."

---

c. 4 July 2017 — Dr Dewi Evans → Sonya Baylis

Evans sets out his proposed approach — reviewing the clinical notes from scratch — and his fee arrangements.

On the same day, Sonya receives a long email from Evans,

"Thanks for the message and for the Summary, which I have read. It's all rather unusual. I think that the best, possibly the only way to look at the issues is to start from scratch and look at the clinical notes. I mean no disrespect to previous reviews. It's just better this way. One needs to avoid 'groupthink'. Before looking for suspicious matters one needs to see if the clinical trends in the hours and days prior to death followed a recognised clinical pattern. I suspect not, which is why the paediatricians have flagged it up. Premature babies, even tiny premature babies, tend not to "just die". They may stop breathing, but this is well known, is picked up by monitors, and usually remedied. Also, one can identify evidence of infection, which is common, and haemorrhage, via the usual tests, all easily available in baby units in 2015, and for the past couple of decades. If the police have copies of the clinical notes of the cases ready for Monday it would be great. If they don't have all of them that can be sorted later. Copying the information electronically is more and more common, and works very well. It provides an instant paginating system. We can discuss how to approach the investigation at Monday's meeting. One needs to apply a different logistical approach I suspect, given the numbers of cases involved, and the common factor (same hospital). One option, which I discussed with you yesterday, would be for me to park myself in Chester for a few days, trawl through the notes, put it all on tape, and move on to the next case. I have a very good secretarial service. All reports return within 1 working day. It's a very effective way of working. If the Cheshire Police thought that this may be useful we could agree on a 'flat rate' probably, equivalent to a consultant salary. Top increment, with "seniority" points, but without "higher" awards, works out at about £XXX per day, plus travel, sustenance and hotel costs. [I don't have the exact salary scales on me, but there has been little change in income during the Austerity Years.] Finally I hope that I can assure you that

I'm not under any kind of investigation as a result of my clinical or legal practice, and managed 30 years in consultant paediatric practice without having my clinical skills queried by the GMC or any other body. I have prepared about 180 safeguarding cases since 2008 including 43 cases for police authorities, mainly via the NCA, since 2014. [My only contact with the GMC during the whole of my career related to 2 separate safeguarding cases of mine, where the perpetrators complained. This was a common phenomenon. I was also a GMC representative in a Fitness to Practise tribunal involving another paediatrician]. I enclose a CV, just to get up to date. My kind regards, and hoping that we meet up Monday around 11.30 am. Dewi"

---

5 July 2017 — Sonya Baylis → Dr Dewi Evans

Baylis confirms parking and paperwork arrangements for Monday's meeting.

To which, the next day, 5 July, Sonya responds,

"Dear Dewi. Thanks for the response. Okay no problem. You will have a parking space waiting for you no issue but I will let those concerned know that a space will be required by yourself and provide your car details. I totally understand and will make sure some clinical paperwork for some of the cases is available for you on Monday. I will ask for these to be provided electronically for you. Yes I agree and we can confirm your terms of reference on Monday and the agreed approach. Thanks too for the reassurance with regards to your clinical practice and status. I will forward your current CV to the SIO. If I get any further information Dewi I will let you know but for your reference my contact details are: (work) / (personal). My colleague Aaron Day Look forward to seeing you on Monday. Kind regards, Sonya"

---

5 July 2017 — Sonya Baylis → DS Adam Bolger

Baylis asks that clinical paperwork for some cases be made available for Evans to take away.

Sonya the same day writes to Adam Bolger,

"Hi Adam, One thing more for Monday's meeting, Dr Evans asked if some clinical paperwork for some of the cases could be made available for him to take away on Monday and provided electronically possibly please. Thank you and see you Monday. I'm not in the office tomorrow but if you require me urgently please send an e-mail either to the group inbox below or contact the group number below, and someone will get in touch with me. Kind regards, Sonya"

---

10 July 2017 — Sonya Baylis → —

Baylis's account of the 10 July meeting between Cheshire Police, the NCA/NID and Dr Evans, at which draft Terms of Reference were agreed.

The meeting takes place on 10 July, and Sonya writes,

"Meeting held at Chester Police Station at 11:30 on 10/7/17 attended by NCA – Aaron Day, Sonya Baylis and Dr Dewi Evans. Also in attendance was SIO Paul Hughes, Janet Moore, Adam Bolger and DS Johnson. Current situation brief provided to Dr Evans and the rest of the team then discussed two cases in detail. Finally draft Terms of Reference was drawn up between the investigation team and Dr Evans. Potential to instruct a forensic paediatric pathologist at a later stage with regards to some of the CODs. NCA colleagues signed a confidentiality agreement.

Next stage to get all further cases to Dr Evans electronically to his agreed location securely i.e. 28 cases in total including collapses for his review by the beginning of August. Envisage he needs two weeks to do all the cases and make notes which in turn will be typed and provided the following 24hrs for proof reading. A follow up meeting will be held at the beginning of September."

---

10 July 2017 — Sonya Baylis (handwritten notes) → —

Detailed notes of the 10 July meeting, including Dr Evans's framework for assessing whether each collapse was suspicious, and case-by-case discussion including Baby O.

Sonya Baylis' notes of 10 July 2017 meeting between Cheshire Police, NCA/NID, and Dewi Evans:

Monday 10 July 17

10.15 meeting
DI Hughes, DS Moore, DC Bolger
DC Woods/DC Thomas joining
Discussion re meeting with Dewi Evans
Priorities –Baby I/Babies O and P/Babies A and B/Baby K

11.30 meeting
Dr Dewi Evans, DI Hughes, Sonya Baylis, Aaron Day, DS Janet Moore, DS Adam Bolger, DS Martin Johnson

Introductions

Aaron
- *north of England contact NCA*

Dewi
- *doesn't want to see other reports*
- *Clinician*

Thresholds
1) *Why child died?*
2) *Anything surprising about why child died?*
3) *If unexpected is anything suspicious?*
4) *If suspicious was there breach of duty?*
5) *If suspicious has someone inflicted anything?*

Are paediatricians covering their backs due to high number of deaths?

- *Premature babies – stress stop breathing + HR goes down*
- *Oxygen sat falls then HR falls*
- *If on life support machine essentially carry on breathing*
- *They are intubated to keep airway open*
- *If something gets into lung will collapse lung*

Causes:

1. *Blockage*
2. *Infection*
3. *Complications – DIC (bleeding) from an infection can kill. Happens over hours*
4. *Brain haemorrhage – IVH*

To accelerate death

- *Miss alarm sounding or turn off*
- *Tube becomes dislodged or in wrong position*
- *Kink in a tube – accidental or on purpose*

On tubes/lines

- *Can get air in intravenous line – accident or on purpose*
- *Can never pick up on it as disperses*
- *Too much potassium. If don't shake tube can give too much - Calcium – too much*

No tubes/lines/no ventilation

- *Still being monitored*
- *They don't die*
- *All babies have ultrasound scan soon after birth + then more afterwards*

Can you plan collapses

- *If baby paralysed and kink in tube will take minutes*
- *If child can breathe on own although still attached to O machine if kink in tube may take longer*
- *If sedated with morphine etc*

Heart rate not monitored on machine

- *If general drop of CO2, HR + RR then would drop slowly*
- *If air taken away baby would fight + all would go up not down*

[Discussion moves to specific cases?]

- *Rare for Drs to be alone with babies. Usually nurse present. Nurse usually alone.*
- *Usually very competent nurses due to experience needed*
- *Nurse likely to cause more harm than Dr*
- *Collapses quick except with infection building up or brain bleed or if lose tube*
- *Triplet surviving 24 hours should survive*
- *What caused collapse*
- *[Baby O] – liver – ruptured subcapsular haematoma – could be injury. Pathologist says birth or resuscitation*
- *Handwritten notes awaiting. Nurses – within Drs notes*
- *Notes for [Baby O] show decreases in HR/RR but didn't die until late afternoon - Was liver damage caused then?*
- *Enlarged abdomen late morning/early afternoon.*
- *Abdominal xray [Baby O] – notes say taken of [Baby P]. Pacs – ultrasound/xrays/CT scans – ok on head scan*
- *Check have PM photos as may show bruising to area of liver*

- *Collapse of [Baby O] detailed as 14.40 although injury poss caused earlier in the day*

Advice

- *Go through 28 cases*
- *No maternity needed*
- *After [?] dictation will type for him*

Confidentiality agreement

DoB – order of babies
Name of child + birthweight, gestation, DoB, DoD
Number file pages Index inc nos of pages i.e. 326

- *No other hospital notes*
- *Coroners reports for those who died elsewhere*
- *All coroners reports*
- *Need paediatric pathologist*
- *May need Consultant paediologist [sic] currently practicing*

Ultrasound scan 3rd triplet to see if congenital abnormality of liver

1st Aug to Dewi
? ? – Reports

Head of neonatal unit) future need MG11 [witness statement] re practice
Head of nurses)

A216 Establish what drugs the pharmacy issued to neonatal unit Jan 2015 to June 2016 and if possible which staff requested. Produce into evidence.

A217 Obtain MG11 apt person in neonatal unit who can provide overview of dept and usual practices of Doctors

A218 " " " who can provide overview of nurses role in NNU and usual practices

A219 Obtain all photos (xrays taken during post mortems of I, P, A, O, D, C, LX, EX2, MX4, MX

A220 Obtain medical records – neonatal/scans/photographs/xrays for [Baby R] (brother of [Babies O and P]) from COCH

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11 July 2017 — DS Adam Bolger → Sonya Baylis

Bolger says the team was impressed with Dr Evans and asks for details of past cases in which he gave evidence.

The day after the meeting, 11 July, Adam Bolger writes to Sonya,

"Hi Sonya, Thanks for attending yesterday. We were certainly impressed with Dr EVANS and he's clearly very interested in assisting us! Do you have some details of SIO's that he has provided statements for in the past? Cheers, Adam"

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18 July 2017 — Dr Dewi Evans → DS Janet Moore

Evans sets out his proposed methodology for reviewing the 28 case files, his fee, and practical arrangements, including closing his NHS email account.

It is not clear how or whether Sonya responds to Bolger, but on 18 July, Evans writes a long letter to Moore:

Dear DS Moore

Re: Operation Hummingbird. OP 106859

I was pleased to meet up with you and the team last Monday I10 July] and write to suggest how we can make progress in what is going to be a complex and challenging operation.

I would suggest that you forward to me a copy of all the case files and copies of all post mortem reports. I think that reviewing the Chester records is sufficient for now. If it looks as if we need the records of babies who were transferred elsewhere and I or who died elsewhere, one can do that later. I would prefer NOT to receive the findings of any previous reviews or investigations as I want to minimise the risk of 'groupthink contamination'.

I understand that there are files for 28 babies, who between them sustained 40 'collapses' [or ALTEs - Acute Life Threatening Events]. I propose to review all 28 files, doing so in date of birth order. This should correlate reasonably accurately with the date of the ALTE. Some infants sustained more than one event. Conducting the investigation in date order may show useful information regarding trends_ One needs to accept at all times that babies who are unwell and in need of neonatal intensive care facilities are frequently clinically unstable. ALTEs are common, with some babies surviving having experienced several 'collapses'.

With regard to the clinical issues I propose to look at each ALTE (and death) by applying the following thresholds.

- *Is there a clear explanation regarding the cause of the collapse? Common causes include infection, intracranial bleed, or blocked endotracheal tube. If there is an identifiable clinical cause it's unlikely that one would be able to distinguish this clinical event from a potentially suspicious one. If not;*
- *Is the cause of the collapse unexpected or unusual? If it is;*
- *Is there any indication of unacceptable care, such as a delay in identifying subtle symptoms and signs? If there is, it this takes us down the road of alleged breach of duty. Or;*
- *Is there any indication that a collapse occurred as a result of a deliberate act on the part of one (or more) member of staff? This of course means "thinking the unthinkable" and exploring potential criminal acts. The evidence (or proof) required to identify any such situation will need to be compelling, to satisfy due process. Any ALTE that reaches this level of suspicion would need a careful review looking at matters such as opportunity, unusual but known clinical events, and FIi (Fabricated or Induced Illness].*

I have liaised with the NCA and feel that the most practical way of arranging fees is via a 'flat rate', and that a fee of XXXXX is reasonable. As with all my cases, my invoice will include a schedule of the time taken. I would estimate that preparing my initial report will take the equivalent of two working weeks.

I do not think it's necessary to consider additional expert opinion al this stage. If there is evidence indicating that one (or more) of the ALTEs is suspicious of an inflicted act the whole investigation will need to address the issue(s) very thoroughly.

I would be pleased to receive copies of all necessary documents electronically. I would ask that each case file Is labelled in sequence, noting the individual infant's file number [File Number 001 to 028) in date of birth order followed by a Surname, e.g, 021.Jones.

You are welcome to prepare your own Letter of Instruction, as it's going to be important to look at the case from a police investigation paint of view, as well as from the clinical perspective.

Given the recent cyber attack I have decided to close down my nhs.net account permanently. I am currently in the process of creating a new secure e-mail, and have completed all the forms required to get approval from the Ministry of Justice's own system; cjsm [Criminal Justice Secure eMail). This should facilitate prompt and secure communication and I hope it will be up and ready asap.

If you could forward all the files to me before the end of the month I would hope to have completed the review of the Chester notes before the end of August. At the moment I'm due in court in North Wales with another case during the week beginning 4 September. That week may be a good time to organise another meeting of the whole team.

My kind regards
Yours sincerely
[signature]
Dewi Evans

Consultant Paediatrician

Baylis' handwritten notes on 26 July are fully redacted.

Dr Dewi Evans is instructed

He is given the cases of 28 babies (17 deaths and 11 non-fatal collapses) to review.

There is a gap in correspondence involving Evans between late July and mid-September.

In October 2017 Evans meets with Cheshire Police to present his opinions on the 28 cases he had been given.

In March 2018 there is a meeting between Evans and Cheshire Police. It is at this meeting that Evans is given Jayaram's description of Baby A's rash.

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15 September 2017 — Dr Dewi Evans → DS Janet Moore

Evans reports on his progress and asks for the neonatal unit's layout plan and shift patterns.

Email from Evans to Moore on 15 Sep:

> *"Very pleased to have our chat this morning. The last of the 17 who died are [Babies P and O]. I'd check staffing for the night shift of 23/24 June 2016. Could I also suggest that you ask the management for a copy of the design of the neonatal unit. They will have one somewhere. It's useful to know how the various rooms of a Neonatal Unit function. Babies will have a designated nurse usually but there is reasonable flow between staff, especially if there is an acute emergency. I should complete the review of the 11 surviving babies and the 2 siblings. It may take me until the week after next as I have other targets to hit next week."*

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18 September 2017 — DS Janet Moore → Dr Dewi Evans

Moore sends the shift-pattern details and unit plan and asks which shifts around Babies O and P's deaths are of interest.

Email from Moore to Evans on 18 Sep:

> *"I assume that you have a copy of the change over of shifts in the NNU. If not here are the details.*
>
> *Long Day (LD) - 07.30hrs -20.00hrs*
> *Early (E) not undertaken often - 07.30hrs -15.30hrs*
> *Night (N) - 19.30hrs - 8.00hrs*
>
> *I seem to remember when talking about [Baby O], when you visited us, it was around the cross over period of the night/morning shift that we were talking about. Re the 23/24th June as per below – Baby O died at 17:47 on the 23/06/16 and Baby P died 16:00 24/06/16. Is it the night shift for both the 22/23 June and 23/24th that are of interest?*
>
> *We were given an old plan of the unit which wasn't up to date therefore we had our plan drawer draw up another one. This is attached to this email. When you discuss those babies that you think were of no concern can we also have some explanation surrounding your thoughts on these?*
>
> *We have realised that for 6 of the babies that went to The Liverpool Womens Hospital we have not provided you with the full notes. We have only just been told about this by the hospital. Do you want these extra notes paginating separately or do you want each baby to be redone?"*

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20 September 2017 — Dr Dewi Evans → DS Janet Moore

Evans reports on his progress through the case notes and asks further questions about the nursery layout and staff visibility.

Email from Evans to Moore on 20 Sep:

“Thanks for all this. First some irritating news. I need to get back to court tomorrow. Yesterday's attendance was postponed as the barrister was ill. Whole day enjoying the beauty of Croydon. West Wales it is not :)

So it's back to Croydon tomorrow (Thursday). Joy. This has got in the way of my completing the remaining 11 cases, (as I was in Cardiff in meetings on Monday). But I've a whole week without appointments next week, so should have a good run at it and aim to complete.

The plan of the unit is interesting. I note three (smallish) 'Nurseries'. Were the sick babies managed in one or more of the three nurseries, or in the bigger one in the middle? The staff will tell you in which part the various babies were managed.

Thanks for the shift arrangements. Very useful. Night shift starts at 19.30. Handover completed by 20.00.

Re the notes from the other hospitals, I would copy them separately and send them to me either via e-mail or via another PenDrive. The arrangements so far are pretty good. PenDrive works with no need for a CD. There are several duplications, which is not a problem. With the extras, e-mail attachment will probably be fine. Whatever is easier for your IT people.

I've received most of the reports back re the 17 deaths. They include my views on the 'no concern' ones, so that's sorted. I've gone through several of the reports already, checking for typos, duplications etc. Would have completed them before Friday but for my Croydon odyssey.

The common theme I have noted so far is that several babies seem to collapse wholly unexpectedly. Some go on to develop additional complications. We'll need to discuss independent neonatal pathology opinion, but that can wait until I've sorted all 28 cases, and you have clarified who was there [doctors and nurses] at the time, and also in which nursery. [If the baby was in one of the small nurseries it's likely that there would be just the one nurse in charge]. Another thought. Can you arrange photos of the various parts of the nursery, i.e, how visible was each individual nursery from the other parts of the unit. [I helped design the NICU in Swansea in 1999, and visibility is a key issue].

All in all, making progress. [I've no trips to North Wales / North West arranged at present. My recent N Wales case settled - changed plea to guilty].

September 2017 (date unclear) — DS Janet Moore → Operation Hummingbird team

Note recording an action to photograph the neonatal unit for Dr Evans.

Email [date unclear] from Moore to Op Hummingbird following Evans' email:

"R and I doc
Reg to Dr Evans
Take photos of the neonatal unit at the COCH to include the view from room to room."

Baylis notes on 20 Sep are redacted.

11-12 October 2017 — DS Janet Moore (handwritten notes) → —

Moore's handwritten notes of the meeting with Dr Evans (not transcribed in this document).

DS Moore's handwritten notes of 11-12 Oct meeting with Evans

11-12 October 2017 — DS Janet Moore / Sonya Baylis (typed notes) → —

Typed notes of the two-day meeting with Dr Evans, Sonya Baylis and Ken Donnelly, setting out Evans's suspicions case-by-case for each of the 28 babies.

DS Moore's typed up notes of 11-12 Oct meeting with Evans:

Summary Meeting Dr Evans, Sonya Bayliss, Ken Donnelly 11/12 17 [this should be 11/12 Oct 17] (continued 12/10/17)

1 [RX]
Ambulance *to hospital, intubation, resuscitation. Nothing suspicious*

2 *[KX3] Apgar 0 at 5 minutes Brain damage – HIE*
Placental haemorrhage could have caused asphyxia Nothing suspicious

3 *[Baby G] -Suspicious COCH / Arrow Park*
07/09/15 02:35 Projectile Vomit – very unusual Abdomen purple / distended
Stabilised and then dropped Further Desat
Signs of infection
Could be air into stomach? – Syringe? Mechanism to do this would be discreet How was [Baby G] being fed?
If put air in would be instant reaction
Intravenous air – wouldn't cause swollen abdomen but extension of stomach would
Ilias could cause sickness but Nurse would know beforehand and would syringe excess liquid out

4 *[Baby B] – suspicious*
No respiratory issues even though premature 02:40 10th June relevant
00:50 onwards Antibiotics Recovery
22:50 19th June relevant 21:30 onwards
Ask sample CPAP prongs used and take photo of baby with prongs now Intravenous air? Or hand over face?
No vomit so no syringe Need photo resus bag used

5 *[Baby A] – suspicious*
8th June from 5pm relevant
Who looking after at 20:26 collapse? Where?
Should have been able to resus Poss air into stomach
Long line wouldn't have caused collapse

6 *[Baby C] – suspicious ?*
His UV line was seen to have come out at 07:00 12/06/15. Can this be explained? Shouldn't have come out

Infection
13th June 23:26 crash beeped Died of infection
If the UV line being out is suspicious then death suspicious

7 *[Baby D] – suspicious*
Poor care 21/22 June
21st June 01:50 gas normal
01:40 22nd June mottled – lesions across abdomen No oxygen needed
Bruising in abdomen Antibiotics
02:35 improved – discolouring disappeared 03:00 discolouration, crashed, died Infection
PM – Intercranial air present PM says PM could cause it
Dr Evans thinks born with infection
Could be air in which transported to brain
Shouldn't die from pneumonia

8 *[Baby E] – suspicious?*
09:25 2nd August – Inc risk NEC 3rd Aug 22:10 bile stained aspirate Haemorrhage 01:40 died
No abdominal distension
Fresh blood from haemorrhage in stomach? No explanation

9 *[Baby I] – suspicious*
Born LWH
COCH 3rd Sept oxygen – breathing support 5th Sept 09:35 no concerns
21:00 5th Sept inc desats Suspected sepsis
Chronic lung disease – shouldn't have collapsed 6th Sept from 23:15hrs deteriorating / crashes 3 episodes but recovered
21:00
22:30
23:15 big drop
00:30 normal blood gases To Liverpool Womens 13th Sept back to Chester
30th Sept required bagging Abdomen distended
22:00 respiratory arrest – pale/distressed – blood gases normal Query NEC
Abdomen went down quickly so air Air into stomach can use milk line Was sick prior
8th Oct CLP 71 High to 21 Low 13th Oct 03:36 blue apneic in cot Doesn't look like NEC
4pm NEC
14th Oct 08:10 not improving To arrow park
18:15 15th Oct getting better 17th oct 10am back to COCH
If septicemia /NEC wouldn't go back to COCH so quickly
22nd Oct midnight crashed Intravenous air
If air into abdomen will be unwell but will not die and would not cause a crash
Could be a nasal gastric tube
Intravenous would kill Hand over mouth would kill
Need senior sister procedures for feeding babies using naso gastric tubes

10 *[FX] No concerns*
Growth retardation / down syndrome Intubation – abdominal surgery
Right leg dusky / leg mottled

Septicemia – died LWH – complications neonatal IT care Unwell for whole of the time

11 [MX] No concerns
Cardio problem
Epsteins anomaly – won't always kill you
Fluid outside lung

12 [Baby H] Suspicious?
18:45 sub costa recession Respiratory problems
7am 24th Sept – intubation Air entry reduced
Pneumothorax – lung collapsing
Did she deteriorate because of pneumothorax? Or other way around? Pneumothorax because of intubation?
Grunting
CPAP Treatment – tubes into nose
More like pneumothorax caused collapse If increased pressure via machine
Side effect of CPAP would have air into stomach Baby had air in stomach
Baby getting better so unusual to collapse at this point
Air infusion / septicemia would cause mottling

13 [LX]
Multiple organ failure No suspicion
[LX was one of the 8 that the paediatricians were suspicious about]

14 [Baby J] - suspicious
Other twin died before birth Premature Initially
stable
Distended bowel – operation to remove piece of bowel 27th Nov 5.15 two profound saturations
Negative blood test for infection 17th Dec 09:35 crying / went blue Cardiac massage Resus
Back to normal
Whilst in Manchester hospital high CPP marker and did have infection
Belief that infection caused by collapse and not other way around
HR goes up – infection can cause
But shouldn't crash
Hand over mouth would cause it

15 [EX2] – suspicious [comment: not on indictment]
CRP 245
Antibiotics CPAP
Floppy , collapsed, resus Further arrests
20:30 10th Dec
01:00 11th Dec normal
22:30 11 Dec intubated / monitor
Need photo of baby on ventilation to show how tube held in place Tube 02:23 properly situated
Put in firstly in correct position Baby well and further x ray 05:54hrs Tube had moved lower down
Someone could have pushed the tube down Lungs collapsed
Need sample of ET Tubes – one of each (normally 2.5 and 3)

16 [MX4] Not suspicious Twin
Natural cause
Needed resus just after birth Bagging needed
ET tube in
7th Jan reintubated 02:00 8th Jan poor colour Pulled tube back a little Poss infection
08:55 profound desat
10:39 x ray
Cardiac arrest 14:35 8th Jan Pneumonia

17 [AX] – suspicious? [comment: not on indictment]
Died DIC – bleeding from asphyxia Intubated
29th Jan off ventilator – stable until 5th Feb Query sepsis
05:30 6th Feb vomit Tinged yellow/green bile Long line in
Abdomen slightly distended 08:00 deterioration – resus 7th Feb 09:15 CO2 -10
Take tube out LWH
Chest drains
Abnormal coagulations Due to DIC What
caused DIC?
DIC caused by babies born in poor condition or infection Can't
say cause
Smothering could cause hypoxia which could cause DIC

18 [KX] Twin
Can't ascertain cause of death
Hypoglycaemia
Collapse when normal glucose values 18:15 22nd Feb no insulin poisoning

19 [Baby K]
No suspicions Intubated Deteriorated Resus
Arrow park Premature
[comment: no suspicions but on indictment]

20 [WX] No suspicions Hydrops
Swollen Attempt resus

21 [PX]
Natural no suspicious Tummy distended NEC?
Bile
00:45 16th march 3 bradycardias On ventilator – normal Antibiotics
Arrow park Chester
Probably infection
Significant deterioration 15/16 March

22 [KX2] No suspicions
Multiple congenital problems
[KX2 was one of the 8 that the paediatricians were suspicious about]

23 [SX]
Good condition
24 hrs later to neonatal Grunting / no feeding Distended abdomen Bile aspirate
Air in abdomen and perforation in intestines Possible perforation from birth or prior to birth
Good care
No suspicions

24 [Baby M] – suspicious
Crash call
Abdominal distention
14:00 and 16:00 9th April relevant CPR
Sudden profound apneic episode Off ventilator 10th April
10:15 10th April neo puff could be from previous day Had clot
Where from? Could cause cardiac arrest Clot could be caused from cardiac arrest What caused cardiac arrest?
Dr Shauq was contacted re clot but no response received – we will find out
Doesn't think thrombosis and thinks suspicious

25 [Baby P] – suspicious
CPAP in air
Abdomen full
SNT – what does it mean (hospital to be asked) 10:06 23rd June bagged intubated
24th June 15:14 cardiac arrest Pneumo thorax – slight
Drain in and worked Moderately distended abdomen
Pulmonary hypertension can be caused by pneumothorax but shouldn't be a problem with this case Shifts to look at 23rd day, 23/24th night and 24th day

26 [Baby O] – suspicious
13:15 vomiting – abdominal distention 16:15 collapse
22nd June all normal Xrays 23rd June 16:00 Air in intestines
Discoloured purple rash in chest wall 18:00 23rd June Was he seen before collapse?
Shouldn't be vomiting as NSG feeding Think problems before collapse (liver)
5am 23rd HR climbing
Overnight 22/23 relevant

27 [Baby Q] – suspicious
Evening /night 24/25th June from 20:00 relevant

28 [JX2]
Good care not suspicious

<u>General Questions for each baby</u>
Which Room was the baby in for the time the nurse was on shift? What other babies were in that room?
What medical staff were in that room for the duration of the shift?
After the baby had collapsed did anyone stay with him/her?
What did he/she after each crash?
What did other staff do after each crash? Are the cots numbered?

Are the rooms given names / numbers?
Medical staff should be given chance to view files before statement taken

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16 October 2017 — DS Janet Moore (handwritten note — redacted) → —

Note of a further discussion; redacted in this document.

DS Moore's handwritten note on 16 Oct (redacted)

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6 November 2017 — Cheshire Police (action record) → —

Action recording that Dr Brearey should provide a statement on deaths/collapses since June 2016, and that emails between the paediatricians should be produced into evidence.

6 Nov:

> *A48 Redacted - Action re Dr Brearey - death rate Text:*
> *TI key witness Paediatrician Dr Stephen BREAREY re involvement on Unit and concerns expressed.*
> *Produce emails between Paediatricians into evidence*
> *DS Southcott producing strategy*
> *UPDATED BA9147MB 24/05/2017 14:25*
> *UPDATED 07BA3178JM 03/04/2019 13:58*
> *Dr Brearey should provide a statement to detail that there have been no deaths in the neonatal unit since June 2016. If it is possible can he also comment on unexpected collapses. Can he say if there have been any unexpected collapses since then?*

27-28 March 2018 — Cheshire Police / Sonya Baylis (notes) → —

Notes of a further meeting with Dr Evans reviewing his suspicions case-by-case, including Dr Jayaram's description of Baby A's rash and consideration of gene sequencing for Baby O.

Notes of meeting on 27-28 Mar 2018 with Evans:

> *[Baby G] Re Tampering with equipment – Could be by holding and squeezing tube*
>
> *[Baby B] Specialist needed Haemotology to query whether APS syndrome could be link to collapse/death. Use Alder hey Dr. Photos to be given to Dr of CPAP attached to [Baby B].*
>
> *[Baby A] Specialist as above. Explanation of potassium chloride – used as a supplement for potassium. Dr Jayaram's description of rash given to Dr Evans.*
>
> > *"He had unusual discoloration; you'd expect babies to look fairly ghastly and pale and grey but he had an odd sort of discoloration where there were flitting patches of pink areas on the background of bluey grey skin; these patches seemed to appear and disappear. It wasn't like the rash seen with a meningococcal sepsis which is caused by blood vessels bursting. It would flit and the reappear and disappear. It didn't fit with anything I'd ever seen before. I would describe the marks as blotches which were fairly ill-defined, about 1 centimetre to 2 centimetres, not discreetly round but blotchy patches of brighter pinkness on a background of bluey grey."*

[Baby C] Need pathologist opinion. Didn't die of hypoxia – kept alive for baptisms.

[Baby D] Will rewrite conclusion to make it stronger due to Dr McPartland comments.

[Baby E] Can NEC cause an acute bleed – unusual

[Baby I] Consider Radiology opinion – but in hindsight don't need. Change of times from 22:00 and 03:00 to 16:30 and 19:30. Change due to either Dr notes being incorrect or genuine mistake – How do we cover this in statement? 30th Sept Now need to add long day shift to clarification sheet. Will consider collapses on 14 Oct and 15 Oct overnight.

[Baby J] Need microbiologist opinion (but not yet as may be for other babies too) – recommends Nigel Klein Gt Ormand St – Paediatrician expert in viral and bacterial infection in young children. Ref er para 18/19/20 Dr Evans statement and pages 454 and 474 in compilation medical records exhibit to Dr Evans.
27 Nov – timings changed from 05:00 to 07:11 to from 05:00 to include collapse at 07:24 or 07:40 (times different on nurses/Dr's notes). Will need to include day shift on clarification docs.
17th Dec – no longer thinks relevant as believes down to infection.

[Baby O] Made mistake re increase in HR. Initially says 1am but chart shows 7am (handwriting not great). Now agreed 7am. PH levels dropping between 05:32 and 13:20 so needs to look at night and day shift. Need Paediatric radiologist – Gives two names – action raised. Will give other babies who need too. Pathologist will need to make comment on relevance on clotted blood. Need radiology opinion. Consider doing gene sequencing for [O, P and R surname] as per Dr Kokai suggestion.

[Baby P] Doesn't think first or second collapse on 24/06/16 due to pneumothorax due to cold light checks. Need radiologist. Will say night and day shift of 24th until 09:40 when collapse took place.

General

Dr Evans wants a nurse to explain optiflow system – doc for Nurse updated.

He wants a selection of syringes obtaining from COCH – Stuart updated via D5 and COCH. He has seen the other equipment items he previously requested.

Wants photos of babies on IPPV Ventilation [Intermittent Positive Pressure Ventilation], CPAP and Optiflow. Stuart to sort via internet with an apt nurse.

Should be finished end of April with new reports re corrections, extra 3 babies and [Baby N]. [Baby N] will be in top category of inflicted injury.

Charges for experts should be [redacted].

Would like copies of correspondence and reports from RCPCH – around charging time?

Wants file for [Baby R] to compare with other [siblings Babies O and P] – Martin has done.

He will explain things further in relation to Claires queries.

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4 June 2018 — Dr Dewi Evans → DS Janet Moore

Evans submits his invoice for reviewing 14 witness statements.

On 4 Jun 2018, Evans sends email to Moore:

> *I'm pleased to forward my invoice re my fees and expenses regarding the following items of work. My fees and expenses: -*
>
> *My fees: 28 March (9 hr), 29 March (5 hr)*
> *Consultation, Cheshire Police, Blacon Rd, Chester, Review of 14 Witness Statements {references below)*
>
> *Note:*
> 1. *My fees re based on the agreed rate of-per hr.*
> 2. *The review of the 14 Witness Statements took place during 30 May and 1 - 3 June 2018. Time taken was approx. 4 to 6 hr per day. My estimate of a total of 14 hr is a conservative one, and Is acceptable to me.*
> 3. *Train travel and other expenses is limited to the single (29 March) journey. I was in the North of England with other business during 27 March 2018.*
> 4. *I have not included 'travel time'.*
> 5. ** indicates receipt enclosed. (Please note that the rail fare relates to 'Booking 3" only, and relates to the fare from Chester to Cardiff.]*
> 6. *The 14 Statement reviews relate to 03 [Baby G], 04 [Baby B], 05 [Baby A], 06 [Baby C], 07 [Baby D], 08 [Baby E], 09 [Baby I], 12 [Baby H], 14 [Baby J], 24 [Baby M], 25 [Baby P], 26 [Baby O], 27 [Baby Q] and 28 [Baby N].*

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5 December 2018 — Cheshire Police (action records) → —

Action records noting that Dr Brearey and Dr Jayaram should be asked about additional babies referred to Dr Evans as suspicious.

Cheshire Police action records on 5 December 2018 state:

> *Dr Brearey re those additional babies he has referred to Dr Evans as suspicious and which Dr Evans believes to have inflicted injuries. Details of babies as yet unknown.*
>
> *Dr Jayaram re those additional babies he has referred to Dr Evans has suspicious and which Dr Evans believes to have inflicted injuries. Details of babies as yet unknown.*