From: GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 28 February 2017 20:44
To: Doctor V (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); 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 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).

-----Original Message-----
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 non-fatal 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