Observations additional to the RCPCH Review of Neonatal Services

Countess of Chester Hospital NHS FT

November 2016

The neonatal lead, in an effort to be thorough and explore all possibilities had identified that one nurse had been rostered on shift for all the deaths although the nurse had not always been assigned to care for that specific infant. Subsequently the paediatric lead and all the consultant paediatricians had become convinced by the link. Although this was a subjective view with no other evidence or reports of clinical concerns about the nurse beyond this simple correlation an allegation was made to the Medical Director and Director of Nursing

On arriving for the visit the RCPCH Review team was told that the nurse had been moved to an alternative position around ten weeks previously without explanation nor any formal investigative process having been established. The Review team was told that the individual was an enthusiastic, capable and committed nurse who had worked on the unit for four years. She herself explained to the Review team that she was passionate about her career and keen to progress. She regularly volunteered to work extra shifts when available or change her shifts when asked to do so and was happy to work with her friends on the unit. The Directors understood there was nothing about her background that was suspicious; her nursing colleagues on the unit were reported to think highly of her and how she responded to emergencies and other difficult situations, especially when the transport team were involved. There were apparently no issues of competency or training, she was very professional and asked relevant questions, demonstrating an enthusiasm to learn along with a high level of professionalism.

When the Neonatal Lead made allegations to management, the Director of Nursing considered supervised practice for the nurse but the consultants would not accept this and required the nurse be removed from the unit. Senior operational staff on the unit reported being very upset at the situation and the neonatal nurse manager in particular explained the difficulty of wanting to support the nurse and managing morale and anxiety amongst the other nursing staff who were not aware of the allegation. The consultants explained that their allegation was based on the nurse being on shift on each occasion an infant died