237 - mins.

COCH/100/024/000017

RAGGETT, Claire (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

From: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 06 March 2017 09:03
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Cc: Nim Subhedar; JAYARAM, Ravi (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); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: Meeting summary from 28th Feb 2017

Importance: High

Dear Ian,
Many thanks for with us on Tuesday. I thought it best that we should have a summary of the meeting. Ravi, John and Nim have seen this summary and agreed it is an accurate account of what was discussed.

It was made clear at the beginning of the meeting that there is general dissatisfaction from the consultant body with the way the Trust had handled this difficult situation since it was escalated. All the paediatricians voiced concerns at the time and all now feel that their professional opinions have not been given due regard and that we have been excluded from discussions which we would have expected our views to have been required and indeed welcomed. It was agreed that small changes in acuity and staffing could not explain the increase in mortality seen and actually medical and nursing staffing levels at the Countess were better than most other LNUs in the region.

Mediation was discussed and Ravi, John and Steve voiced our concern that this is occurring far too early in view of the fact that there is still a great deal of uncertainty as to the cause of the rise in neonatal mortality and unexpected collapses.

Regarding the case note review Jane Hawdon undertook, the group reviewed her findings of the 13 babies who died with some access to Evolve and Meditech. There was uncertainty as to what criteria had been used to select the 4 morbidity cases that Jane Hawdon reviewed and there are babies we are aware of who unexpectedly collapsed and were transferred from the hospital and who unexpectedly collapsed and were not transferred from the hospital for whom no external review has taken place.

There was agreement with Jane Hawdon that for 4 cases the cause of death cannot be explained and further broad forensic review is required (Recommendation 6). In addition to these cases, we agreed after review of the case notes that there are a further 4 cases in which, although there is a PM or death certificate diagnosis, there is no explanation as to why the babies deteriorated and did not respond to resuscitation.

Therefore the 8 babies that in our view require further broad forensic review are:

Child O
Child P
Child A
Child I
I&S
Child C

In addition, further external review is required for:

- The 6 babies who were transferred from Chester that were identified by John and
- Other babies that we discussed who unexpectedly collapsed, survived and were not transferred from Chester.

There was agreement that some observations Jane Hawdon made regarding the clinical care could easily be explained. For example, no telephone discussion with transport consultant when the transport consultant was in fact in the NNU room with another baby. In addition, there were some elements of sub-optimal care that Jane Hawdon had not commented on. For example, incorrectly withholding and delaying a dose of gentamicin which should have been given earlier. Recommendations 3 and 4 (decision to needle time for antibiotics and difficult airway pack) were in place during the time period of the review. The group agreed that recommendation 5 regarding excluding pneumothorax and cyanotic congenital heart disease in babies who collapse was likely to have been considered by the clinical teams and was not a cause for death for any of the babies reviewed.

Nim Subhedar stated at our meeting that he too was concerned that the cause of death and/or deterioration remained unexplained in several cases. He supported Dr Hawdon's recommendation that these cases should undergo further detailed review. Nim also emphasised the Network's position that the observed excess in neonatal mortality at COCH could not be explained merely as a consequence of medical or nursing workforce deficits or increased activity and occupancy levels. Other network local neonatal units are working at similar levels of occupancy and staffing and COCH is not an outlier in this regard. Since these units are not reporting an excess in neonatal mortality, it suggests that there is a different explanation for our increased number of unexplained deaths.

I have copied this email to the other paediatricians for their information.

Many thanks for your time and help.

Steve

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