Operation Hummingbird – Summary / Actions
Held at 15:30 on Friday 5th May 2017
ACPO Meeting Room, Headquarters

Cheshire Constabulary

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 J 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' [1] 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.

She had been moved from nights to days, and redeployed off the unit whilst the review was taking place for her protection. The nurse has a Qualification in Specialty (QIS) so was therefore more likely to be caring after the sickest babies on the unit. She regularly worked overtime when the unit was over capacity. She is still working at COCH but has no direct access to clinical care. Since looked at reintroducing her to the neonatal unit, but felt it was not appropriate.

The nurse has been working at COCH for approximately 8 years full time, she is a Cheshire resident, and a single parent. The staff member has since placed a grievance against COCH. There has been no formal investigation of misconduct and no motive identified. There are no mental health issues known and nothing has been highlighted by occupational health. There are no management issues.

AP – IH to provide personal details of the nurse, and to look at safeguarding referral as single parent.

Media
There has been an article published in *The Sunday Times*, February 2017 with reference to COCH and deaths in the neonatal unit. A media strategy would need to be adopted to manage / coordinate all activity.

Summary
If Cheshire Constabulary are involved, then it would be deemed an 'investigation'. COCH would need to assist with clinical expertise / guidance. An investigation would be to identify / gather facts to evidence and establish cause of death. Also if applicable, identify any criminal activity.

There are no significant concerns to suggest any unlawful acts, it appears a series of anomalies that needs to be investigated further.

It was agreed the coroner needs to be kept fully informed throughout the process as there are pending inquests.

AP – DM / NW to draft investigative TOR and a broader strategic TOR encompassing the investigation.

AP – AD to make contact with the Coroner Department to establish views and update issues discussed at meeting.

Gold Commander – ACC Darren Martland
Senior Investigating Officer – Paul Hughes
Family Liaison Officer – DS Janet Moore

Date of Next Meeting
Friday 12th May, 09:00 at Cheshire Constabulary HQ