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02
07 **I&S**

Mr Ian Harvey
Medical Director
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5th September 2016

IN CONFIDENCE

Dear Ian

Re: Invited Review of the Neonatal service and COCH

Thank you for inviting the RCPCH to review your neonatal services last week. It was a pleasure for us to meet you and your colleagues.

I explained that we would write to confirm the short term advice which the team shared with you, Alison and then Tony on Friday. This is to enable you to move forward swiftly towards resolving the concerns and issues which have been raised, being just and fair to all involved and restoring confidence in the service as a whole. Our full report will be ready in draft form for checking in 4-6 weeks, sooner if we can.

We were aware that on 7th July the LNU facility was revised to operate as a Special Care Unit for infants over 32 weeks gestation, and that one of our terms of reference were to explore whether there were any common factors that might explain the apparent increase in mortality in 2015 and 2016.

The Review team was not aware until we met you on 1st September that action had also been taken in early July to move one of your nurses from the unit to other duties, with a requirement that she did not contact colleagues from the neonatal unit. We understand that this took place without a formal process nor clear notification to her of the reasons for so doing. These steps appear to have been taken on the basis of an allegation made by one member of medical staff, supported by his medical colleagues. Some staff were aware of this and the reasons, others were not.

As you know members of the Review team met with the nurse who has been moved, supported by her preferred union representative. She was under the impression that

the RCPCH review would resolve the situation and enable her to resume duties on the unit. She appeared to be distressed that there was very little information as to the reasons for her move, and appeared isolated and vulnerable.

Action required - HR Investigation

It is important that the Trust takes immediate steps to formalize the actions you are taking with the nurse. Our understanding is that an allegation has been made and therefore a process of investigation needs to be put in place which sets out the nature of the allegation and the process you will follow to investigate it. No doubt you have your own policies for this but the MHPS process used for doctors provides a helpful framework. This should include providing appropriate support to the nurse in question and an effective communication strategy for the unit.

Action required – Case review

The Review team agrees, from the information received, that the pattern of recent deaths and the mode of deterioration prior to death in some of them appears unusual and needs further enquiry to try to explain the cluster of deaths. This was not possible within the terms of reference for the review or from the information received. To this end we recommend that, alongside the HR investigation, a detailed forensic casenote review of each of the deaths since July 2015 should be undertaken, ideally using at least two senior doctors with expertise in neonatology / pathology in order to determine all the factors around the deaths. The casenotes and electronic records should ideally be paginated to facilitate reference and triangulation. This investigation should include as a minimum the following elements

a) a full systematic chronology for each case including all interventions, and details of nursing and medical observations and activity

b) a view on whether escalation of each case at an earlier stage to involve more senior opinion locally or more expert opinion from a regional centre would have potentially made a difference to the outcome

c) examination (with the relevant paediatric pathologist) of the post mortem findings and any additional information available on their files which might identify cause of death, including rare conditions such as air embolism and severe metabolic derangement

d) details of all staff with access to the unit from 4 hours before the death of each infant. Ancillary and facilities staff should be included

e) Consideration of any other `near miss` cases with similar chronology /presentation where the child survived.