(5)

Paediatrics Meeting
27th March 2017 – 5.10pm – 6.20pm

Attendees

Tony Chambers (TC)
Ravi Jayaram (RJ)
Nim Subhedar (NS)
Ian Harvey (IH)
Steve Brearey (SB)
Sue Hodkinson (SH)
Julie Maddocks (JM)

TC	Welcomed everyone to the meeting. Provide some context of the current position. We've had: 1. Royal College Review – actions and recommendations 2. Members of Staff – grievance 3. Clinical, how we get to the point the Board and Organisation has done everything to answer questions. If it's not at that point, what do we need to do to get to this point?
IH	RJ/SB/NS/John Gibbs – we had a useful meeting were we reviewed the 13 deaths. There were five everyone was comfortable with. There were eight were there were still concerns either cause of collapse, failure to respond to resus. Further in-depth review, which focused on collapses. IH completed reviews of the eight and review of rotas together with all case notes and what recorded in the notes. The next stage was to go through these It was important that we were conscious of deaths in the first instance. This would drive anything regarding babies collapsed. There are a number of questions we need help with: - Collapsed unexpectedly, fail to respond - If looking at potential causes, continuing consequences of collapses and how this is unpicked. -
SB	This was discussed on a weekly basis. Focused on 8/13 and transferred babies It is disappointing the depth that this has been gone into. A further 6 babies, arrested unexpectedly, which we identified in July. We don't feel these have been investigated in depth. Nine months on and the hospital should not investigate this any further This needs to escalate to the police. We have not had any explanation and we escalated this in July.
TC	Why are you escalating this now?
SB	We are still very worried. There is no natural cause of death.
RJ	There have been deaths….
SB	But these were explainable. Not included in mortality review.
TC	You don't believe the different admission criteria had an impact?

RJ	As a group of paediatricians, we accept the Royal College review, the case note review and Jane Howden's review identified further ones. It's a difficult thing, what level of review do we need to do. We have a collective view that this now needs to be at the level of a rota review, who, where involved, a forensic investigation. We accept that we may not find cause. We have our names on the end of the incubator, we need more assurance. The interpretation of the reports differs to the Board. We were presented with a plan and we have explored every avenue with the BMA (British Medical Association).
TC	The review identified that there was no single casual factor, you identified further cases. What do you agree and don't agree on?
SB	The College review is a service review not investigating the deaths. Jane Horden – four cases forensic review, her review was not forensic, it stimulated discussion and learning. There are four cases not reviewed yet.
TC	If this is your intention this is always going to continue, only higher authority is the police, not sure what they will say?
NS	The cluster caused concern here. The College review is a service review not case note and followed up with further detail review. In depth review for more than four cases. The standard needs to be external to be some degree.
TC	I need to know if we do an individual case note review, or phone the police.
JM	Given the information, on the balance of probability, illegal activity has caused the deaths.
IH	Or reasonable doubt?
TC	If no process, the determining factor is that there is no other answer. Mischievous activity is the only causal factor. I didn't think that was where we are. We can phone them now, everyone will be interviewed.
SB	The worries not going away. I'll share with you an email from one of our experienced consultants, who was new with us in July; he has some stronger feelings than me. Quotes e-mail (from Michael).
TC	If that is where we are, then phone the police. You can call the police.
RJ	After the case note review, we are still left with 8 cases.
NS	Left missing staffing data, if that is reassuring.
IH	Does not highlight a single individual?

SB	But we have not interviewed nurses, Junior Doctors which is really important.
RJ	Who could do that level of investigation? Does not look good on the Trust's reputation. As a group of clinicians, we do not know what to do but all of which are disturbed by this. All unusual ones where they have not responded and should. Board felt reassured, accept inefficiencies.
TC	The Board recognises that there is no single casual factor. If saying more assertive review, then we need a clinical investigation. Only confession, no evidence. Identified themes, delays in decision making, failings but this did not explain collapse so needed a deeper dive. I thought this meeting was to test what this may look like. But if we are in the position of not being satisfied you could have phoned police. Why have you not phoned the police?
RJ	Our career would be on the line if we contact police, it would be whistleblowing. Following BMA advice, if there is an alternative of a deeper dive, we should go for it. But this is a worry.
SB	We were promised a thorough investigation; we were a promised college review. We hoped no great service issue as no difference to other neonatal units, and we didn't see the report until February. There is a different direction that the Trust is going in. A different interpretation to what we feel as a group of Paediatricians.
NS	Within the College Review there were redacted elements, it feels like the report/college raising other issues.
IH	This was in relation to the HR process, incidents and gut feelings
SB	Sue Eardley said two reports
IH	You've seen the observations; it was highlighted in the green text.
SB	We had the chance to read the redacted report. Our worry is that this is showing unbalanced view. Nothing said about the paediatricians being worried. It's unbalanced and misleading.
IH	You've had access to everything including the reference to the HR processes that were redacted.
SB	But there are factual inaccuracies in the report.
TC	So what is the issue? Key messages in the report – there is no single casual factor, individual investigation. Jane Horden suggested do more.
SB	Not had chance to respond to the Board decision in late February. By the time

	both reports received, we had concerns. We've written three letters. We've done anything to exhaust all internal avenues. We have 7 paediatricians' very experienced, very serious concerns, that the causes are unnatural.
IH	We have three options 1. Contact the Police, 2. Internal with NS support 3. Other experts conduct further review (e.g. Janet Renney) if anything to be gained?
RJ	What would be the level of depth?
IH	We've had the meeting with Jane Howden, there was our meeting, there has been the subsequent work I've done. It would be a case review with staff but this is not something that can be done remotely.
RJ	We need to speak to all individually, most of time they're not on the unit, which proves nothing but there is an association at the point of the collapse. We need to understand who, where this was. However, time has passed. Genuinely do not remember everything. All we want as a group: 1. Is that we feel reassured enough that this cannot be investigated any further 2. Is that the Board understand where we are coming from and that there is the Board's interpretation. We are now more aware than you guys.
TC	I thought we'd agreed we need to do more now but if we are saying this needs to be done in a different way….
SB	Don't think we are but the Joint Review has not offered anything else.
TC	As a Board, we have been guided by everybody that we have a safe unit. You guys, the nursing team. I can't risk babies being nursed in that environment. If there is a forensic dive needed – we can do that, get in a higher authority require authority, we can get on with that.
SB	There are six others we have not reviewed yet. (SB provides further details of the babies). This means there are twelve plus six, so there are eighteen cases to go to police with as we still have no answer.
TC	Need to explain this so let me check - There are babies cared for and died on our unit - There are a group of babies who survived - There are a group of babies on another unit?
SB	The first group died at Chester. There are eight unexplained causes of death. The second group systematic review, some survived some died. John Gibbs identified six cases as unexplained. Assumptions IH made?