FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: Review of neonatal collapses requiring transfer out of unit (June 15 - July 16).
Sensitivity: Confidential

Dear All,

(Please see my other email concerning my discussion with Ian Harvey last week).

Attached is the health record review that Anne Martyn and I undertook of infants who collapsed/deteriorated in our NNU and needed transfer elsewhere from June 15 - July 16. Anne and I initially looked at a larger group of patients who required transfer out during that time period (can't remember exactly how many – perhaps 30 or more). Any who had a problem that would automatically require transfer (e.g. significant bowel malformation, severe congenital heart disease), were excluded – and some of these sorts of patients had already been excluded by various senior nurses and risk managers before Anne and I started working through the list of remaining transfer patients. Admittedly, this was a very subjective review but if I felt the deterioration leading to transfer was reasonably explained (I was not looking for certainty), then these infants were excluded. This left a relatively small group of inadequately explained deteriorations/collapses needing transfer out.

I looked through the health records and Anne Martyn took notes (which included recording the ID of each infant). I deliberately did not want to know which staff had been looking after the infant. I only looked at the paper health record so I could not avoid seeing which doctors had made entries in the notes and they sometimes mentioned other doctors involved at various points in a patient's care and occasionally mentioned a nurse who had been involved. But for most of the cases, during most of their care, I was intentionally ignorant of which nurses were involved. Anne did look up the nursing notes on Meditech and reported what these said to supplement the health records that I was reading but whilst she could see which nurse had made each entry she did not tell me. Nor did Anne include and info about named nurses in the notes she made on each patient.

When we finished the review, Anne gave the notes she had made to one of the senior nurses (I think it was Sian Williams), and we had understood that, with the help of colleagues in HR, there would be an analysis of all the nurses and doctors on duty when each patient deteriorated/collapsed (not just the nurses assigned to the patient for that shift, although that info would clearly also be included). Unfortunately, we have not received any feedback on our review, and had no idea what the staffing analysis revealed, until Ian sent the attachment to me at the end of last week (after I asked for this info at our meeting). Since Anne and I didn't keep a photocopy of the notes taken during our review, I can't remember exactly why I was concerned about the patients we highlighted, nor even the IDs of these patients. I had thought that Anne and I only highlighted about 6 patients (can't remember the exact number – but Anne feels likewise), as being inadequately explained – and I admit that I set a high threshold so I'm not claiming that there couldn't be anything unusual about some of the other infants transferred out of the unit (it's just that I thought there was a reasonable explanation for their deterioration/collapse).

Although I thought we had highlighted about 6 inadequately explained patients, the attachments contains 17! Perhaps these were all the patients that Anne and I reviewed (before we selected out those that were inadequately explained), but I thought the number was closer to 30 (or even more). Ian has told me that this attachment is a transcription of the notes we made. Apparently, the comments shown in red are those that Anne and I highlighted as showing unusual, unexpected or inadequately explained events. Only 6 of the patients in the attachment have such red comments so perhaps these are indeed 'the' patients with inadequately explained collapses/deteriorations that Anne and I highlighted (this is certainly similar to the number we both thought we'd identified). However, looking at this info now, I'm not sure why some of the red comments were thought to indicate unexplained events and also there are one or two patients in the list without red comments in whom unusual events seemed to have occurred (but perhaps when I was looking through the notes, these didn't raise concerns). Ian has added comments (in blue), from his review of each case and this includes comments about some of the staff involved (which is not the sort of comprehensive staffing analysis

that Anne and I had thought was going to be performed – but perhaps this has actually been undertaken and someone has this info somewhere?).

JOHN

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 24 February 2017 08:16
To: GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: Notes review
Sensitivity: Confidential

Good morning John

Thanks for meeting yesterday – I found it very helpful.

Please find attached the transcript of your case note review. The text in blue is bits that I have added cross-referencing with Meditech. Please let me know if there are any queries.

Thanks

Ian

Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

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