RESPONSE TO QUESTIONS RAISED BY THE CONSULTANT PAEDIATRICIANS ON 30TH APRIL 2018

DRAFT IN CONFIDENCE

1. Introduction

1.1. On Monday 30th April 2018, Ian Harvey Medical Director and Stephen Cross, Director of Corporate and Legal Services attended a meeting with the Consultant Paediatricians: Michael McGuigan, Doctor ZA John Gibbs, Steve Brearey, Murthy Saladi, Susie Holt, Doctor V and Ravi Jayaram . At the end of the meeting, Dr Jayaram passed to them, on behalf of all the Consultant Paediatricians, a written paper setting out 26 questions that they would like responses to.

2. Background

2.1. The Trust provided a range of paediatric and neonatal services. The neonatal unit has 20 cots and provided critical care, high dependency care, special care and transitional care for newborn babies.

2.2. The Trust provided a Local Neonatal Unit service (Level 2 care) providing short term ventilation. The Neonatal Unit provided care from 27/40 gestation; any baby born below this criterion being transferred to the nearest Level 3 unit. The critical care and high dependency care cots were interchangeable and could therefore flex according to the needs of the unit.

2.3. An internal comprehensive case review was undertaken in February 2016 following the deaths of 10 neonates (including one who died shortly following transfer). A Consultant from Liverpool Women's Hospital was present during this review.

3. Sequence of events

3.1. Concerns were raised by the paediatric clinical team to the Executive regarding a higher than usual number of neonatal deaths from January 2015 (8 in 2015 and 5 in the first 6 months of 2016 compared with an average of 2.4 per annum in the previous 5 years) which resulted in a meeting between the Medical Director, Director of Nursing and Quality, the neonatal lead, and senior neonatal nursing staff on 11th May 2016. At this meeting the results of reviews carried out on the unit and also in conjunction with the network lead were discussed. It was highlighted at this meeting that there was one member of the nursing

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staff who had been present at more of the cases than any other member of staff. However, there was no evidence, other than coincidence. The nurse was noted to work full time and have the Qualification in Speciality (QIS). She was therefore more likely to be looking after the sickest infant on the unit. She also regularly worked overtime when the acuity was high or unit was over capacity. There were no performance management issues, and there were no members of staff that had complained regarding her performance. The nurse had been moved on to days to ensure that she was supported. It was agreed at this meeting that all babies who deteriorated would be reviewed; that there would be a review of the hour of care before death of the babies who had died at night; that the nurse would remain on days for 3 months and a further meeting was to be held after 2 months.

3.2. Two of triplets born on PD June 2016 died on 23rd and 24th June 2016. This exacerbated the concerns, there being no obvious cause for the babies' collapses and it was alleged that the nurse referred to above was involved in the care of these babies and that unnatural causes had to be considered. As a consequence, following a series of meetings of the Executives and clinicians it was determined that in the best interests and welfare of babies and staff there would be a number of actions taken:

- The unit to be redesignated to Special Care Unit (SCU) caring for infants from a minimum of 32 weeks gestation with consultation with the Cheshire & Merseyside network
- A comprehensive internal review of the unit to include activity, acuity and staffing levels
- A review of babies who had collapsed unexpectedly
- An invited review from the Royal College of Paediatrics and Child Health (RCPCH).
- The Coroner (via his deputy) was appraised of the concerns that had been raised and the steps that were being taken.
- The nurse was redeployed off the unit as a neutral act.

3.3. The internal review, which was run under a "silver control" type methodology involving senior clinical, managerial and analytical staff, identified that every month from February – December 2015 had seen a greater number of care days than the long term average. This suggested that the Neo Natal Unit (NNU) had been busier and workloads had been higher. Within this the increase in high acuity care days became clearer when we combined L1 (ITU) and L2 (HDU) days per month. Between May 2015 and March 2016, only one month showed care days drop below the long term average. In addition, between March and December 2015 there was a higher than average number of babies born with a birth weight below 2000g in all but two months. This correlated with the increased demand for high level care over the same period.

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There was not an increase in admissions in the most severely premature categories (below 26 weeks and between 26 and 30 weeks) but there was an eight month run of higher than average admissions at 31-36 weeks gestation.

3.4. An extra-ordinary Board of Directors meeting was held on 14th July 2016 with Dr Brearey and Dr Jayaram in attendance. During this meeting Dr Jayaram stated that the data presented by the Medical Director was helpful and backed what the Consultant Paediatricians had said. Dr Jayaram also stated that the Paediatricians thought that the actions were proportionate and felt that the holding measure (changing of unit status) to reduce risk as far as possible pending the investigation into the data and the external review.

3.5. The Board of Directors' meetings have been minuted.

3.6. The internal review was not undertaken in isolation as Dr Gibbs, one of the Consultant Paediatrician team members and a senior nurse were reviewing all unexplained collapses. The Medical Director suggested that the increased acuity and staffing changes ***may*** have been contributory to the increased mortality rate but he was certainly not saying that they were only causes nor did he regard that he was commenting on things that needed neonatal expertise.

3.7. The RCPCH sent a team consisting of two paediatricians with a special interest in neonatology, plus a senior neonatal nurse manager and a lay reviewer (a barrister who was working with NCAS who had previously been on the fitness to practice panel of the Nursing & Midwifery Council NMC) on 1st and 2nd September 2016. They had access to all policies, procedures and activity data and conducted interviews with all relevant staff groups and the network. This led to the issuing of a final report in November 2016 with recommendations. In addition the reviewers made some observations regarding the allegations made about the nurse: "The consultants explained that their allegation was based on the nurse being on shift on each occasion an infant died (although not necessarily caring for the infant) combined with `gut feeling`. There was no other evidence or history to link [the nurse] to the deaths, and her colleagues had expressed no concerns about her practice."

3.8. The RCPCH review team recommended that a formal HR process was instituted involving a member of the nursing staff which resulted in a subsequent "grievance" investigation and report which has also made a number of recommendations.

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3.9. The Trust's Grievance Procedure complies with the ACAS Code of Practice on Disciplinary and Grievance Procedures and ensures that all meetings are held in a manner consistent with the Trust values and behaviours. The Trust endeavoured to ensure that an independent internal investigator was commissioned and to maintain further independence, impartiality and fairness, the Trust commissioned an external Hearing manager. However, the Trust recognises that there are learnings from the arrangements we put in place with this case, as with many cases, and will consider these learnings for future hearings.

3.10. The Medical Director subsequently had cause to meet with Dr Jayaram on two occasions, firstly to discuss reports of paediatric trainees making reference to the 'Angel of Death' and secondly following a complaint by a member of staff regarding Dr Jayaram had made In the out-patients to someone on the unit "killing babies".

3.11. The RCPCH review advised a further, in-depth, independent case note review of each unexpected neonatal death.

3.12. This review was commissioned, on the advice of the RCPCH, from Dr J Hawdon, Consultant Neonatologist, Royal Free London Hospital.

3.13. Dr Hawdon submitted her review in October 2016. This report highlighted areas where practice could have been different. There were 4 cases in which Dr Hawdon felt that the cause of death was unascertained and she advised that: "Subject to coroner's post mortem reports, there should be broader forensic review of the cases … as after independent clinical review these deaths remain unexpected and unexplained".

3.14. The Medical Director felt that time constraints precluded a comprehensive reading and has no recollection that he omitted to mention that further investigation of a small number of cases was recommended, it certainly was not intentional. The Medical Director was progressing this concurrently – the next step seeking permission of the Coroner to speak to the Alder Hey pathologists, then consulting them regarding post mortem findings.

3.15. On 26th January 2017 a meeting with the executive team, a non executive director, Karen Rees, Sean Tighe and the Consultant Paediatricians was held for the Medical Director to outline the findings of the RCPCH

report. Karen Rees also read out the statement from Nurse L to the meeting and it was highlighted that the Trust encourages staff to speak out safely. The statement from Nurse L was to form the basis of the letter of apology from the consultant paediatricians to Nurse L, which the consultant paediatricians had agreed to send, as detailed in their letter to the Chief Executive dated 30th January 2017.

3.16. The Chief Executive recognises that this was a difficult meeting and that some very difficult messages were shared directly and firmly; and acknowledges that was uncomfortable for the Paediatricians as it was for him. The perception that he was aggressive and threatening is regrettable and was definitely not intended and nobody has ever been threatened, either at the meeting or at any time subsequently.

3.17. With the Coroner's permission the advice of the Pathologists at Alder Hey Childrens Hospital (where the post mortems had been carried out) was sought. They reviewed the findings of the post mortems and felt that there were two deaths which were "unascertained".

3.18. The Trust's Director of Corporate and Legal Services and Medical Director met with the HM Coroner, Mr Rheinberg on 8th February 2017 following publication of the RCPCH review. They met again on 15th February 2017; the Deputy Coroner, Mr Moore was also in attendance. This followed the receipt of a letter from the Consultant Paediatricians in which they asked that the Trust ask the Coroner to undertake a full investigation of all the deaths and unexpected collapses between June 2015 and July 2016 because they were not reassured that all the deaths were due to natural causes . This letter, together with Dr Hawdon's report, was shared with the Coroner and Deputy and a detailed conversation was had regarding the Paediatricians' specific concerns. The Coroner stated that at this stage that he could only review deaths that fell within his jurisdiction. In the event that he had any concerns, he would contact the Trust. The Coroner did not have cause to do so.

3.19. On the 16th February 2017 the Chief Executive wrote to all the Consultant Paediatricians in response to their letters dated 30th January 2017 and 10th February 2017, acknowledging that as stated by the Consultant Paediatricians, they agreed that it was appropriate for them to send a letter of apology to Nurse L. The Chief Executive asked for an understanding of how and when this letter will be sent to Nurse L. In this letter dated 16th February 2017, the Chief Executive also detailed the actions taken in response to the letters from the Consultant Paediatricians and that an action plan was to be developed to address the 24

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recommendations from the RCPCH report and sought confirmation of the Consultant Paediatricians' intention to support the Board in doing so.

3.20. The Paediatricians letter was also shared with the RCPCH reviewers and Dr Hawdon and in that letter the Paediatricians highlighted that they felt that the concerns that they had expressed were not included in the report. The RCPCH representative reported that the Paediatricians had been in contact with them directly and that the RCPCH had explained that the first two recommendations in the report related specifically to these issues whilst other sections in the published report recognised their concerns about the collapses and mention an allegation and the Trust's response. The RCPCH also referenced confirmation bias, also called confirmatory bias or myside bias, the tendency to search for, interpret, favor, and recall information in a way that confirms one's preexisting beliefs or hypotheses. Dr Hawdon's view was: "I perceive a combination of understandable professional pride regarding standards of care on the unit along with concern over unexpected and unexplained events, both of which are entirely reasonable reactions, but both of these should not prevent accepting and learning what could have been improved."

3.21. The Redactions to the report were requested by the RCPCH and were purely because they related HR concerns. The Medical Director is of the opinion that the redactions made no material difference to the content of the report given the terms of reference. The report is as presented by the RCPCH, and as such, reflects the views of the 4 person review team. The Medical Director does not consider this to be an error of judgement or misleading. The Medical Director has confirmed that the RCPCH are content to share the un-redacted report directly to the Consultant Paediatricians.

3.22. On 3rd February 2017 The Medical Director made a public statement following publication of the RCPCH service review report which was accurate.

3.23. On 28th February 2017 the Medical Director met with the Neonatal and Paediatric Leads, the senior Consultant and the Network lead to review the case reviews to determine if there was consensus regarding the care, clinical course and cause of death for the babies. Of the 13, it was agreed that 5 could be explained but in 8 the paediatric doctors did not feel that either the collapse(s) and/or the death could be explained and it was agreed that further detail was required.

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3.24. On 1st March 2017 the Chief Executive received a letter from the Consultant Paediatricians who continued to express their concerns over the nature of the reviews taken so far.

3.25. During March 2017 and as part of the outcome from the grievance process, a recommendation from the external hearing manager was that mediation was undertaken. This was considered a reasonable request as mediation could support any potential future working arrangements for all parties concerned. Several meetings took place with Dr Jayaram and the Director of People and Organisational to discuss how to take this forward. It is important to recognise that mediation is a voluntary process and may not proceed if all involved are not in agreement with proceeding. If there was a perception that pressure was exerted unnecessarily to proceed with the mediation process by the Director of People & Organisational Development, then this was not intended and please accept her apologies for this.

3.26. The Medical Director did not threaten the consultant paediatricians with the GMC but did say that the other member of staff's parents had threatened to do this.

3.27. The Medial Director accepts that communications could have been better and there have been long and difficult conversations with Dr Jayaram and Dr Brearey with regards to both the police investigation and the grievance. However, the Consultant Paediatricians have to be mindful that whilst there can be service based conversations all else is limited by concerns regarding potential press leaks and subsequently because of police involvement there was limited information that could be shared as the Trust could not assume that any one staff group would be more likely to breach trust.

3.28. On the 16th March 2017, the Chief Executive and the Director of People and Organisation Development visited the consultant paediatrician leads to further discuss their concerns.

3.29. On 27th March 2017, the Chief Executive and the Medical Director met with 2 Paediatricians and neonatal network representatives. The end point of this meeting was that the clinicians felt that there was no further work or investigation short of a police investigation that could be done that could satisfy them that some of the deaths were not due to natural causes. The Chief Executive agreed to take this forward.

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3.30. On the 12th April 2017 a meeting between Simon Medland QC and the Consultant Paediatricians was facilitated by the Trust to support and further understand the nature of a police investigation and to bring an independent objective view to the situation.

3.31. On 27th April 2017 the Medical Director, Director of Corporate and Legal Services, Dr Mittal, Dr Holt and Dr Jayaram met with the Chair of the Child Death Overview Panel (CDOP) including Chief Superintendent Nigel Wenham the police representative on the panel, to discuss the Consultant Paediatricians' continuing concerns.

3.32. This subsequently resulted in a meeting of the Chief Executive, Medical Director, Director of Corporate and Legal Services, Assistant Chief Constable and Head of the CID at Cheshire Police Headquarters on 5th May 2017 to discuss the matter. The Trust has always had under consideration a potential police investigation however, did consider that there were a series of reviews to be undertaken before getting to that point, which was duly acknowledged and supported by the police. The police were subsequently provided with all relevant documentation and the required time to assess the basis of any proposed investigation they would undertake.

4. Summary

4.1. In summary, the Trust can demonstrate that it has taken the concerns raised seriously and has been open and transparent with the Coroner, our regulators, and as far as the police investigation allows with staff, parents and the public.

4.2. The Chief Executive in his covering letter to accompany the publication of the RCPCH report took the opportunity to thank the 52 healthcare professionals and patient representatives from Neonatal services and paediatric care for the time they spent with the review team providing information and contributing towards the recommendations. He acknowledges that it has been a difficult time for everyone. However, in all of this the Trust has never lost sight of the fact that behind these mortality numbers, there have been families left bereaved by the loss of their baby. At the same time there is a dedicated team of doctors and nurses who have felt the devastation of not being able to do enough to save a life and left questioning if there is anything they could have done differently.

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4.3. The Chief Executive recognises that the events described in this report have inevitably put a strain on relationships and with hindsight there are always examples of things that could have been better managed – recent press reporting being an example. He acknowledges that at times the desire to balance the 'rock and hard place' context for communications might have given the impression of being dismissive and genuinely and sincerely wants the neonatal team to know that they have his full support and respect and that of the entire board and colleagues throughout the Trust and this has never changed.

24th May 2018

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