case. One surviving infant was mentioned as having needed resuscitation for similar collapses over three nights but subsequently recovered, although the Review team did not see details of `near misses` such as this. The consultants did not initially consider that there were any links between the episodes of collapse in the infants that died but subsequently they began to note similarities. For example some of the infants displayed a sudden mottling appearing after a few minutes of resuscitation, usually starting on the limbs, and on at least one occasion on the central abdomen and chest. The consultants had considered a number of possible causes for this appearance but there remained no definite explanation.

3.12 The neonatal lead, in an effort to be thorough and explore all possibilities had identified that one nurse (Nurse L) had been rostered on shift for all the deaths although the nurse had not always been assigned to care for that specific infant. Subsequently the paediatric lead and all the consultant paediatricians had become convinced by the link. Although this was a subjective view with no other evidence or reports of clinical concerns about the nurse beyond this simple correlation an allegation was made to the Medical Director and Director of Nursing.

3.13 In response to this allegation and the high acuity and activity on the unit the Medical Director, Nursing Director and Trust Board decided on 7th July to

remove the nurse temporarily from the unit to other duties

reduce the designation of the service to a Special Care Unit (SCU) caring for infants from a minimum of 32 weeks gestation..

These actions were taken pending an external review by the RCPCH, and the change appeared to have been handled sensitively and effectively by management with good network and public engagement.

3.14 The staff within the unit had been naturally very distressed by each of the neonatal deaths and were also affected by the actions that had been taken in response to the concerns subsequently identified. The RCPCH was invited to review the investigations of each death and the wider service, including network support and advice, protocols and transfer arrangements, to provide a view on whether there were any contributory factors in the deaths or missed opportunities to take action that could have prevented or mitigated them.

Strategic Future

3.15 In terms of the strategic future of the unit, a Vanguard[4] project is being implemented for Cheshire and Mersey, and the STP[5] process is considering a footprint with links between Wirral and Cheshire, i.e. a longer term link for COCH with APH rather than LWH. This may have implications on the current strong fetal medicine service and obstetrics in general which cares for a relatively high proportion of women

[4] The Vanguard scheme was announced in the NHS Five Year Forward View and launched in January 2015. The West Cheshire Way `starting well` scheme is looking at better integrated care for babies for babies

[5] Sustainability and Transformation Plan – developed across organisations and launched in October 2014 to set a blueprint for more integrated working.

with high-risk pregnancies. However the obstetricians remarked that since the temporary reconfiguration there had been minimal impact from their perspective, since women were travelling to other units antenatally when a premature delivery was anticipated.

4 Findings

The individual nurse

On arriving for the visit the RCPCH Review team was told that Nurse L had been moved to an alternative position around ten weeks previously without explanation nor any formal investigative process having been established. The Review team was told that the individual was an enthusiastic, capable and committed nurse who had worked on the unit for four years. She herself explained to the Review team that she was passionate about her career and keen to progress. She regularly volunteered to work extra shifts when available or change her shifts when asked to do so and was happy to work with her friends on the unit. The Directors understood there was nothing about her background that was suspicious; her nursing colleagues on the unit were reported to think highly of her and how she responded to emergencies and other difficult situations, especially when the transport team were involved. There were apparently no issues of competency or training, she was very professional and asked relevant questions, demonstrating an enthusiasm to learn along with a high level of professionalism.

When the Neonatal Lead made allegations to management, the Director of Nursing considered supervised practice for the Nurse L but the consultants would not accept this and required the nurse be removed from the unit. Senior operational staff on the unit reported being very upset at the situation and the neonatal nurse manager in particular explained the difficulty of wanting to support Nurse L and managing morale and anxiety amongst the other nursing staff who were not aware of the allegation. The consultants explained that their allegation was based on Nurse L 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 Nurse L to the deaths, and her colleagues had expressed no concerns about her practice.

The decision was taken to redesignate the unit to an SCU from 7th July. Nurse L was on leave for two weeks from 30th June. On her return she was told that she would be supervised for a period and that others were also being supervised. She was not told of the specific allegation but she was made aware that there were concerns that she was on duty for each of the deaths. At a subsequent meeting, accompanied by her Union representative she was advised that supervision was not possible (due apparently to 'staffing levels') and she would be temporarily redeployed. She was apparently advised again that this would also happen to other members of staff. She was told not to make contact with staff on the unit. Nurse L had incorrectly been told that the RCPCH had suggested that she be redeployed, and that the review would resolve the issue within 2 weeks of the visit. No formal HR process had been put in place for the ten weeks between the redeployment and the RCPCH visit. The RCN support to the nurse had,

up to the RCPCH visit, not been very active but it was expected that the nurse would raise a grievance.

In the light of information shared with the Review team, the RCPCH advised the Trust to follow corporate processes in responding to allegations of misconduct by opening an investigation; it was also recommended that a full and detailed independent casenote review was required on the deaths, prioritising those that were unexpected.

Recommendation: Conduct a thorough external, independent review of each neonatal death between January 2015 and July 2016 to determine any factors which could have changed the outcomes. Include obstetric and pathology / postmortem indicators, nursing care and pharmacy input

Recommendation: Ensure there are clear, swift and equitable Trust processes for investigating allegations or concerns which are followed by everyone

4.1 Is the service provision compliant with current professional standards?

No. The team has self-assessed against service standards for a Local Neonatal Unit and is non-compliant on nurse and medical staffing levels, environment and accommodation for parents, support from the community neonatal team and postnatal follow up.

4.1.1 Neonatal care in the UK benefits from a range of clear and consistent service standards developed by the British Association of Perinatal Medicine (BAPM) and adopted by government through NICE Quality Standards, the Neonatal Toolkit and NHS England`s Specialised Commissioning specifications for neonatal care (E06) and neonatal transport (E07). These standards guidelines and specifications set out expectations for staffing (numbers and experience), activity, transfer arrangements, environment, governance and patient/parent/carer experience.

4.1.2 The designation as an LNU requires medical cover as follows:

- ∞ At least seven on-call consultants including at least one neonatal specialist (compliant)
- ∞ A Tier 2 rota shared with paediatrics with at least 8 staff (not compliant)
- ∞ A Tier 1 rota separate from paediatrics with at least 8 staff (not compliant)

Units with a high proportion of intensive care should have enhanced staffing.

4.1.3 The consultants appeared confident about carrying out neonatal care but they are concerned that they would lose skills if the status of the unit remains at SCU. They are able to actively cool infants for transfer, reaching the target 6 hours and the unit is performing well against peers for the standards measured through the NNAP programme.

4.1.4 Nurse staffing levels are consensus based and calculated as follows

- ∞ one nurse to one infant on intensive care