The Local Safeguarding Children Board
Working to Keep West Cheshire's Children and Young People Safe

FRONT SHEET FOR SUBMISSION OF REPORTS / AGENDA ITEMS FOR BOARD & SUB GROUP MEETINGS

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LSCB Board/Sub Group Meeting Date:	**5th June 2017**
Attachments for circulation: *(if appropriate)*	

1	**Subject**
	Neonatal Review & Police Investigation into the increase in Neonatal Mortality at the Countess of Chester Hospital NHS Foundation Trust
2	**Summary**
	This briefing paper provides an overview of the reason for the review of neonatal services, the steps taken to investigate the concerns raised. It also articulates the up to date position in respect of police involvement.
3	**Recommendation (s) please indicate whether: For decision/ For action/ For information**
	For Information
4	**Any other considerations/ Information**
	N/A
5	**Is a Child Impact Assessment needed? (see guidance at the LSCB web pages) www.cheshirewestandchester.gov.uk/lscb** **NO**

Please forward this form and any attachments electronically to Noreen Gallagher @ Noreen.gallagher@ I&S no later than 10 working days prior to the meeting.
Please note that all items submitted will need approval by the Chair before inclusion on the agenda

Neonatal Review & Police Investigation into the increase in Neonatal Mortality at the Countess of Chester Hospital NHS Foundation Trust

1. Background

The Trust provides 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. 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. Sequence of Events

A higher than usual number of neonatal deaths were identified from January 2015, 8 in 2015 and 5 in the first six months of 2016 (compared with an average of 2.4 per annum in the previous 5 years), 5 of these babies were Welsh. During early June, two babies died (as part of a set of triplets). Concerns were raised, there being no obvious cause for the babies' collapses at that time. As a consequence, following a series of meetings within the Trust, it was determined that in the best interests and welfare of babies and staff there would be a number of actions:

1. The unit to be redesignated to Special Care Unit (SCU) caring for infants from a minimum of 32 weeks gestation with consultation with the C&M network
2. A comprehensive review of the unit to include activity, acuity and staffing levels
3. An invited review from the Royal College of Paediatrics and Child Health (RCPCH).
4. The Coroner (via his deputy) was appraised of the concerns that had been raised and the steps that were being taken.

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 suggests that the NNU had been busier and workloads had been higher.

As part of the external review, 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) 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 review in November 2016 with 24 recommendations. There was no one factor identified,

recommendations included reference to culture, risk management, team work, communication and staffing as well as external factors such as the neonatal transfer service. An action plan is in place to address the recommendations.

The review team advised a further, in-depth, independent case note review of each unexpected neonatal death be undertaken. This detailed review was commissioned, on the advice of the RCPCH, from a Consultant Neonatologist, Royal Free Hospital, London.

Following further discussion within the Trust regarding continued clinical concerns, advice was sought from key members of the CDOP (Child Death Overview Panel). The Trust felt they had taken the clinically-led review as far as they were able. Following this discussion, the Trust formally requested proactive support from Cheshire Police.

Given the distressing situation, the Trust has not lost sight of the parents of the babies involved. Parents have been communicated with throughout, some with additional support from the Coroner; some have had face to face meetings at the Trust. Cheshire Police have spoken to all the families involved and specially trained family support officers are supporting them.

The Neonatal unit at the Countess continues to operate at a Level 1 status, all staff on the unit are requiring significant support during this time and a number of support mechanisms are in place. Cheshire Police have commenced their enquiry and initial information gathering is underway.

3. Summary

In summary, the Trust can demonstrate that the concerns raised have been taken seriously and it has been open and transparent with the Coroner, regulators, parents, wider stakeholders and the public. At every point where the hospital has been able to share information with families and the public, it has done so. Approaching the police is not something that has been undertaken lightly. However, despite extensive and intensive review, the Trust has formally requested support from Cheshire Police to enable the Trust to rule out unnatural causes of death.

4. Recommendation

Members of the Local Safeguarding Children's Board are asked to note the contents of this briefing paper. A further update can be provided at an appropriate time in the future.