From: HAWDON, Jane (ROYAL FREE LONDON NHS FOUNDATION TRUST) <jane.hawdon@ I&S >
Sent: 14 February 2017 13:53
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: RE: In confidence, please do not share

Sensitivity: Confidential

Some human factors training if not already?
With my move to RO role at this trust I have moved from working on NICU and local neonatal units to local and special care. Very few NICU consultants have had consultant experience of working outside of NICU, and believe me much more senior vigilance is required, NICU consultants have so many layers of security and if babies are poorly they are usually predictably poorly. There is then the issue of DGH consultants who find neonates boring or scary.
I don't know the current COCH team
I was in Liverpool 1992-1994 and would often come over for retrievals or teaching and knew Noel Murphy quite well.
And of course the shopping.
Jane

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 14 February 2017 13:24
To: HAWDON, Jane (ROYAL FREE LONDON NHS FOUNDATION TRUST)
Subject: RE: In confidence, please do not share
Sensitivity: Confidential

Thanks Jane – that is helpful.

We have never questioned their raising of concerns and I have assured them that I would always back them with this – it is just some of the behaviour that came with and after it – and an apparent failure to accept that things could have been improved.

Our next steps are to have a further discussion with Coroner - we have met him twice already - we need him to be assured we are doing the right things and to collate the up to date activity data and compare with 2015-16; I am concerned that they seem to think that nothing has changed. I am also concerned that there has been a death during this period albeit not on our unit but again nursing staff are raising concerns about delays in escalation and transfer out. With all that in place it is then a meeting with the paediatricians and the network lead to try to come to a consensus before we meet the parents.

Also, thanks – hint taken although we haven't talked about down-grading in comms, it has been re-designation, I need to be careful.

Thanks for the offer of a phone call, this may be necessary depending on the further response of our team.

Kind regards

PD

Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

☎ I&S / Ext I&S
✉ i.harvey@ I&S

From: HAWDON, Jane (ROYAL FREE LONDON NHS FOUNDATION TRUST)
Sent: 14 February 2017 13:06
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: In confidence, please do not share
Sensitivity: Confidential

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.

Unexpected collapse in an otherwise stable baby is rare and I agree that there have been more cases than would be expected, especially those for whom there is no explanation of the PM cause of death is in question. The paediatricians infer more cases that I did not study.

There were insufficient details in records, and unlikely to have been possible to record in anything but real time to determine for each whether collapse and impossible resuscitation:

a) purely out of the blue and unexplained
b) a slowly deteriorating baby eg infection, shallow breathing, but signs missed until baby collapsed and resuscitation too late or not optimal, even in a busy unit competent nursing and medical staff and systems should be in place to prevent the majority of such cases. In some I did have concerns regarding escalation and timing. If subtle signs are missed or not escalated or responded too, in some cases alarms going off is too late. Sadly even alarms are missed or ignored on occasions, which is below an acceptable standard of care. If units are "running hot" there should be situational awareness that risk of these is greater and workforce and workload managed appropriately. So there may have been an inherent system or leadership problem before change in designation
c) sinister cause, which seems to be the concern of paediatricians, this could range from a member of staff who for some reason was not spotting or escalating the babies in b to active harm

Hint – avoid use of term down-grade

Please let me know if you would like to talk on phone
How will you proceed?

Jane

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 14 February 2017 12:11
To: HAWDON, Jane (ROYAL FREE LONDON NHS FOUNDATION TRUST)
Subject: FW: Paediatricians response
Sensitivity: Confidential

Dear Jane

I thought that it was important to share this letter from our Paediatricians having shared both the College review and your review with them. I would make a number of comments:

We have had discussions with the Coroner, initially a briefing at the outset when all the issues were raised and again last week having shared the College review with him. We will be having a follow up conversation with him to ensure he remains happy with our plans and actions.

There is a bit of a dig at the College review in their reason 1. The Paediatricians made allegations against one member of staff which we made the review team aware of, as did the Paediatricians when they met the reviewers. These didn't feature in the final report but were covered in observations by the reviewers that were shared with the neonatal and paediatric leads – namely that this was based on coincidence and "gut-feeling". We intend to now share those comments with all the paediatricians since we are unsure that the leads have.

Our Paediatricians repeatedly raise the issue that they still feel hasn't been resolved i.e. the unexpected collapse and failure to respond to resuscitation in a way that is expected. At one point they even went so far as to suggest that, given they had observed unusual mottling, air embolism was responsible. The pathologists at Alder Hey have assured me that a significant air embolus would be detected at PM. Therefore, how common is it for a neonate to collapse unexpectedly? I appreciate that noting a failure to respond to resus is always going to be very subjective, however, given that our data indicates a unit running "very hot" i.e. regularly with significantly more cots and higher intensity than it has the space or staff for, (and this is probably rhetorical) but how time critical is responding to a collapse or impending collapse, and how often, in your experience, is this sparked by clinical observations and how often by alarms going off?

Re reason 5 – I believe that they are being selective and disingenuous in that there is no comparison between the intensity of the workload before and after we down-graded the unit and we believe that they are trying to suggest that the only significant change has been reassigning the member of staff (which we did to protect that member). This, I believe links in to the paragraph above regarding work intensity and the risks that that carries.

I would be grateful for any other observatiosn or comments you might have and thank you, as always for your help.

Kind regards

PD

Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

☎ I&S / Ext I&S
✉ i.harvey@ I&S