Neonatal Services at the Countess of Chester Hospital NHS FT

Summary

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.

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

Sequence of events

Concerns were raised by the 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 six 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 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 are 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.

Two of triplets born on PD June 2016 died on 23rd and 24th June. 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 Execs and with clinicians 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. A review of babies who had collapsed unexpectedly
4. An invited review from the Royal College of Paediatrics and Child Health (RCPCH).
5. The Coroner (via his deputy) was appraised of the concerns that had been raised and the steps that were being taken.
6. The nurse was redeployed off the unit

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 has 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. 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.

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 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 review 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."

As a result of the RCPCH review a formal HR process was instituted involving one member of the clinical staff which resulted in a subsequent "grievance" investigation and report which has also made a number of recommendations.

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

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

Dr Hawdon submitted her review in October 2016. This report highlighted areas were 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".

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".

The Trust's Director of Corporate and Legal Affairs and Medical Director met with the Coroner on 8th February 2017 following publication of the College review. They met again on 15th February; the Deputy Coroner was also in attendance. This followed the receipt of a letter from the Consultant Paediatricians in which they asked that we ask the Coroner to undertake a full investigation of all the deaths and unexpected collapses (this latter isn't within the Coroner's remit) 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 Paediatricians letter was also shared with the College reviewers and Dr Hawdon since in that letter the Paediatricians highlighted that they felt that the concerns that they had expressed were not included in the report. The College representative reported that the Paediatricians had been in contact with them and that

the College 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 College 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."

On 28th February 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.

Following the meeting on 28th February a further meeting was held between the CEO, the Medical Director, the Director of People and OD, the Neonatal and Paediatric Leads and the Network Director and Lead. 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 weren't due to natural causes.

<u>Summary</u>

In summary, we can demonstrate that we have taken the concerns raised seriously and have been open and transparent with the Coroner, our regulators, parents and the public. However, despite extensive and intensive review, the Paediatric Consultants still feel that there are questions to be answered and we feel that we need to share the details and discuss with the police.

Ian Harvey

Medical Director

3rd April 2017