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Invited Reviews Programme

Interview plan and notes

Please complete where relevant and retain as a record – hand written is fine. Please post or e-mail a copy to the team at invited.reviews@rcpch.ac.uk tel 02 I&S 07 I&S

Trust: COCH

Visit Date: 1/9/16

Time: 9a

Reviewer(s): All

Scribe: SE

Interviewee Name & Role: Ian + Alison

Key Areas to probe / take forward: ~~talk to lucy~~ ?

Parents

Opening[?]. DM said we may not be able to explore the detail of the deaths. Ia – correlation of one nurse – paediatricians see as elephant in the room, Lucy Letby. Pattern of babies collapse don't seem to follow normal pattern & respond to resuscitation in normal way

Multifactorial. Want to think the worst – but nothing else is pointing[?] to it. Director of corporate affairs was DCI before he

I&S Huge nettle to grasp. Need to unpick things around

Rely on him the unit – cultural issues? What is the tipping point?

Not police[?]

Need to pull together before we press the nuclear button.

DM – need to be open with us about it all

IH – Been through all evidence. Nothing about the nurse's background all think highly of her & how she works & responds when the transport team are involved. Senior

AK – alarmed that paediatricians had pointed to the senior nurse. Now out

of unit and doing paperwork. Tension[?] of [review?] of the [ward?] by the paediatricians thinking she is the common denominator.
Nurses are anxious about the review – have tried to reassure people. No issues with competency of the nurse. No issues with training. Highly thought of by the unit. Marge very upset that they have had to take the nurse out.

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Difficult conversations/connection[?] with clinical team and board
Lucy has full OH support + weekly catchups with [to?] her manager. Friends on the unit. Rest of the team – OH team are going to the unit & having regular visits
Alex – can we see PM reports – yes to send through
DM – we have seen themes about escalation & advice
AK – yes tends to be see how it goes – leave it too long then too late to escalate. Now put measures in place that any [?] to be transferred out has to come to Ian or Alison
Same time as downgrade, Lucy taken off
Date way over capacity Not able to ensure[?] safety. In conversation with team[?] & network the only course was to down grade. Thought about supervised practice for Lucy.
Clinicians threatened[?] to go to the police.
DM relationships?
AK used to being silent – now lifted lid all comes out. Historic difficulties with clinical decision making – nurses feel disempowered. Think they used to work well as a team. Good relationships with the network. Now got tension on the unit. Morale is ok, better now plateaued out. Sickness had gone up. now back ok. Choice to downgrade – better – people

less stressed.

Alex nursing – should be 2x6 2x5 2x4 – what were the nursing stats

at the time of the cases.

Only a few of the services/review[?] know about Lucy. But can talk to B5

in the general[?] term of the review.

Geography of the unit is poor – for nursing & obs. Need to send[?]

the [?] & [?] the clinical team to be reconfigured

Moving babies to accommodate acutes[?] – extra risk is

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Time: 9.15

Reviewer(s): All

Scribe: SE

Interviewee Name & Role: Ian + Alison

Key Areas to probe / take forward:

the system

Need details of the nurses who looked after the babies at the time.

Given them their (Ian + Alison) cards etc

CMs Process - Though HR director, union support, frank conversation in a

supportive way. Already had been stressed as looking after

the sickest babies. Now reviewed[?] to take her off nights

and support from union (RCN) Not excluded or suspended

Just taken out of duties How to get her back in again?

Need executives to get round the stem of the nettle.

IH had to intervene with the neonatal lead as junior doctors had been referring to her as 'nurse death!' Ripples through the team & trying to function. Can't see how is concluded without calling the police.

Unless there is something to satisfy the medical staff they can call the police.

DM – no completely independent external look @ all the deaths.

Regional review with Nic[?] not completely independent

Steve did own review + pulled out the nurse correlation

Analysts did data & checking[?] of the [reasons?] – only when they

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had the data they realised how busy[?] it was.

AS Does the network function to the benefit of the unit

IH Easy to get advice transfer difficult – see cot occupancy. Sometimes[?] to [significant?] distances e.g. to Leeds

Generally team thinks it is good. Independently the LWT shut their cots independently. Don't get support they need with the way they were working takes too long

Get used to working to overcapacity and swallow their own smoke

GS Local arrangement for long term IC care - arrangements for 3rd care

* support – protocols

AK – key issue is timelines of response. Advice is ok – but do we escalate to get the advice. Transfer out is the problem. NW has had recent changes. Now if a team is doing a transfer elsewhere they don't take calls – have to go back to base first. Not good enough

AS level 2 has range[?] of skills. Do nurses adapt to who is

on duty & available?

AK New consultant v supportive of team – LWT trying to get a baby transferred in for safeguarding reasons. New consultant said no – nurses really liked that + [up arrow to indicate increase] team work

AM Need nurses to identify whether to escalate + depends who is on

AK Karen is looking after her (senior nurse)

~~We will know~~ to ask if Lucy wants to meet in [?]

AM - Do they do debriefs?

AK - Yes but not sure of detail

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Visit Date: 1/9/16

Time: 9.25

Reviewer(s): All

Scribe: SE

Interviewee Name & Role: Ian + Alison

Key Areas to probe / take forward:

Visible OH team is [?] across the organisation – Spend time

Clinically[?] with the teams

Catherine Leade – to talk to her

CMc Parents – complaints? Contacted as many parents as possible before it went to the paper[?]. No extra complaints. Accepted we are doing

the right thing. Nobody had raised concerns. No [triangle symbol] before that in terms of complaints. Family of triplets. Had candour conversation. Third triplet gone home doing well.

~~Asking Asked~~ asked question about triplets + obstetricians

---

Steve + Ravi 9.40

Ravi – consultant Doc 2004. Steve 2008.

|_> CD April 2009. Restructure to lead clinicians.

2004 was 4 consultants now 7 – or [T...] 8 pA but fully on call

don't meet FTF[?] BC approved & 2 more posts => by 2017

nine consultants on rota. Since 2008-9 hot weekly system. Cons[?] for general + neonatal to supervise admissions + emergencies. Of 2 new posts 2x hot weeks so one on general 1 on neonatal during the week. Can be harder at the moment to get over to the neonatal unit especially in winter. by early 2017 will have it in place. 7 x WTE middle grade tier. Rota OWJD[?] compliant. Generally full rotas few gaps. 18 months relied on

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LT locum to plug gaps – registrar or consultant act down

All T2 are North West trainees. can be hard to plug gaps. SHO 9 WTE - separate neonatal & ped SHO to 9pm evening 5pm Sat + Sun. One overnight

3 x paed 5GPT 1 x F2. Specialty[?] FY1 on call in the medical rota. General 4 x APNPs for assessment[?] unit = <3 WTE. No ANNPs. Used to have two but cost - [?] out of the system[?] before 2009 – weren't on the medical rota. Geography – all very compact even ED quite close. ~~N~~

Steve New posts – one diabetes cover – want someone else to take

the clinical lead. Need another to be neonatal lead so Steve can step up. Contract[?] is DGH neonatal lead in high – [grade?] + ensure all squeezed into SPA time. New job plan has space for the work. [A...] & [S...] – listed 6 for the posts.

DM What to come out

Steve - Things all ok till last June – were comparable to other units etc. Didn't feel they were much of an outlier. 3x NN deaths in June. Reviewed in detail, met Alison & SI panel to discuss them. Learning from every case but no overarching deficiency in practice. Identified one nurse present @ all collapses[?]. Didn't think it was significant. Agreed to keep an eye on things. As the year progressed each subsequent mortality not huge concern but by end 2015 numbers stacked up a little. Nothing til August - then small IUG[?] bloodstains aspirate persistently

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Time: 9.50

Reviewer(s): All

Scribe: SE

Interviewee Name & Role:

Key Areas to probe / take forward:

Ravi - It's how the babies collapsed – no indicator. Didn't respond physiologically how they should have done. Seven of them so not always the same one Talked to each other

Steve December when invited[?] Nin for half day here. Done mortality meetings + [?]

Went through all the news with Nin, NNurse, n/u team + discussed [le..ing] point with him. Included deaths for January. I&S happened in January. V helpful Feb 2016. Report. Looked @ actions & themes. Even after PM. unexplained

Steve & Nurse W looked again 12 hours prior to collapses + didn't find anything further in these cases. Now got all PMs except 2x triplets for June.

I&S + [?] HIE baby – no issues.

[Obs had made a plan for LWH but came in in labour]

Ravi - Wondered if something they were missing. Nursing ratios, consultant juniors, unit [?]. Space issues. But even with all these nothing consistent.

Nurse on shift @ all times. Spoke to Ian + Alison ~~da~~ – COCH

[bottom of line cut off] the place so delayed[?]

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Time:

Reviewer(s): All

Scribe:

Interviewee Name & Role: Ravi + Steve

Key Areas to probe / take forward: Susie Holt new consultant

At the time of talking to Ian + Alison Nurse W had decided to put the nurse on dayshifts not nights as staff member had been through all the harrowing episodes – post ud care.

6/9 mortalities @ night – midnight to 4am. Outcome of the Conversation then to keep a watch. No u/e collapses at night when she was on days but collapses happened in daytime – All never individually realised they had all thought the same thing. Is there some group cognisance failings[?]. Mainly consultants. Discussed with Anolfe – Children's services manager Nurse W was v defensive and pointed to docs with who were there for all of them etc. All happy with practice, record keeping + competences. Young no family partner children so always stepped up. There because does more shifts than other nurses. But when on shift don't sleep so [normally?] to make sure care is [?] the right way.

On since 2012 perfectly nice good in a crisis. Always there.

Thinking about it – what could she be doing? PMs gave no cause (not checked for electrolytes) – levels ok beforehand Inject[?] **Child A** . Lines were in +

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not taken out but UVC went into liver[?]

Showed Nin xrays of liver[?] – he thought all OK. UVC was low – decision to keep it in till the ? line[?] was in.

When thinking forensic. What happens with air embolism. Looked @ case studies + last [observations?] – chilling - ~~???~~ just like

ongoing & debrief as a special request. Got internal debrief people in

ED – could do it herself or ask someone. Same day or next day.

* Called a debrief service. Could tell us how often happened + when

Have left leaflets etc around for staff. Trustwide tends to be the

Nursing staff rather than doctors who use the counselling

Have found all the staff to be quite robust. Not noticed a difference

Before + since June. Staff just want to get on with their jobs.

Tom Were RMs done by perinatal[?] pathologist

I&S or I&S or milk[?] injection or air embolism

But all had different presentation

[bottom of line cut off] [?] Reisberg – [W...] [?] Cheshire office

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[P....] didn't do toxicology ~~do~~ because of being in hospital

Not coroners PMs

I&S should have been @ LWT but refused

I&S went into labour early – usually service short term

|_ accumulation of fluid in [p....] + chest. Over 50% of [?]

babies are unknown cause.

Home Isaac – ND (Dr Rajeev Mitthu [De..] Doctor)

Karen Milne – N Midwife

Alison Kelly executive lead for safeguarding. Karen – in team is Paula

Lewis lead nurse. Linked S/G in ED. I&S

paid by local authority in her team. I&S

ED maternity + [?] S/G Childrens policy, I&S

Policy – S/G strategy board meets monthly – work with LSCB

+ member of different subgroups. Clinical suspicion[?] policy.

Paula Lewis is early intervention lead + up to speed

patient then not expected to die its unexpected.

Don't look @ internal management of the deaths – that is done of the internal review. CDOP is to learn lessons broadly.

CDOP includes wider professionals – social care etc. 3 x DGIL at panel. None of these deaths raised concerns for Rajiv or the panel – accepted as NDeath even though some had PMs but nothing found. Only form A + B are sent

Panel only reports M&M details only if there are questions before accepting gen[?] medical cause.

Role of [?] histopathology is Alder Hey. May not be perinatal but * all are paediatricians. One is perinatal (to let us know)

Usually nurses who complete the form A. Now they email Rajiv. No [th...] also goes to Cheshire Well Partnership. Usually have a COP nurse too who informs people.

Have discussed deaths with Steve etc. Didn't find any pattens

Mostly death in LWT so noticed at panel the number had increased

Would like – full survey of the case. Change practice – After every death lead should do a survey of the case as a routine

Full details of what happened. Currently get a very simple Letter. Only do full letter if requested.

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