Extraordinary Medical Staff Committee Meeting 19th September 2018 (Countess of Chester)

Pre-meeting 11th September 2018:

Present: Sir Duncan Nichol, Dr S Gilby, Dr Jameson, Mr Butcher.

Agreement that the police statement will be read out at the introduction and that minutes will not be circulated by e-mail to ensure confidentiality.

Meeting 19th September. 6pm, Lecture Theatre, Education and Training Centre.

Present

J Mathew	R Temple	I London	A Dawar
S Holt	E Forrest	E Young	D Cliff
W Lin Yap	Doctor ZA	M Johnson	N Eardley
I Harrod	S Hill	D Vimalachandran	D Semple
F Cuthbertson	J Gibbs	D Gaur	K Pulupula
G Abbott	A Hilles	S Moore	C Francis
S Nair	Doctor V	S Murray	F Joseph
J Dangerfield	R Fowler	D Ewins	M Sedgwick
T Crockford	J Martin	E Davies	U Rao
J Davies	M Webb	V Finney	S Brigham
S Wood	J Hawe	J Grainger	J Somarou
R Etherington	A Logan	R Jayaram	A Solt
Z Munshi	D Lokho	P Karunahasan	E Fantom
S Dubois	R Mittal (paeds)	V Chhabra	E Wood
R Thonse	P Kenyon	S Sawalha	A Troy
T Webster	T Barnes	J Nixon	E Domane
R Banim	J Harrison	A Jared	E Redmond
J Causer	C Harding-Mckean	K Thomason	M Wall
N Meara	S Bowles	S Bricker	J Gardner
I Kustos	J Smith	N Laundy	A Franks
M McGuigan	L Wilson	S Ahmed	L Barker
K Tizard	D Wilson	R Mittal (ed)	D Castillo
J Van Rij	R Gale	N Spiteri	K Ali
M Nixon	I Benton	S Shandilya	N Campbell
M Saladi	R Trent	P Karunahsuan	P Jameson (chair)
J Butcher (sec)			

Apologies

Mr Evans	Dr Harris	Dr Dinardo	Dr McEwen
Miss Fleming	Dr Fanning	Mr Ibrahim	Dr Mullen
Mr Luff	Dr Jhamatt	Dr Scott	Dr Doyle
Mr Awsare	Dr Elder	Dr Naz	Dr W Kenyon
Mr McCormack			

Introduction

Dr Jameson (PJ) gave a statement on the purpose of the meeting. He emphasised the sensitivity and confidentiality and that bereaved parents were at the heart of the matter. The meeting had been called at the request of the Paediatric Dept. He read out a statement by DI Paul Hughes emphasising that it was quite proper that the MSC should discuss matters relevant to patient safety but that members should be careful not to refer to any matters that would prejudice the investigation into the deaths. PJ said that he would intervene if discussion crossed the line.

PJ said that the minutes would be kept confidentially and reviewed for accuracy by him, paediatricians and selected MSC colleagues. Minutes would then be accessible through the secretary but not disseminated.

PJ told the Committee that he had invited Sir Duncan Nichol (DN), Trust Chair, and Dr Susan Gilby (SG), Medical Director, to the meeting as they had asked to be present to listen to the views expressed.

SG said that this meeting was not the appropriate place for an in depth introduction for those that didn't know her. She stated that she respected the paediatricians and would have a focus on safety and quality. Patient safety concerns would be treated seriously. She said that she had put her career and reputation on the line elsewhere over safety and quality.

DN told the Committee that he was there to listen and had tried to stay close to the paediatricians. He had hoped that independent mediation would bring the parties together but had been advised that this would be impossible during the legal process. He told the Committee that Tony Chambers had decided to stand aside as CEO and that SG would be acting CEO.

PJ told colleagues that the meeting should not be a witch hunt or kangaroo court and he hoped that it would lead to a proper investigation.

Paediatric Presentation

Dr Gibbs (JG)

- **June 2015 – June 2016**: **13 neonatal deaths + 2 died elsewhere after transfer (expected 1 – 3 annually)**
- **June 2015** serious incident meeting held after 3 deaths (Neonatal manager and lead, DN, Head of Risk, Risk Manager)
- **12th Feb 2016**, Neonatal lead emailed MD and DN with report of 9 deaths reviewed by senior neonatal staff and Neonatal Network lead, requesting an urgent meeting: held on **11th May** with MD, DN, Ward manager, lead nurse for children's services
- **July 2016**, following 13th death the Consultant Paediatricians demanded action (Police Ix suggested – SC advised against)

    - NNU activity reduced (32 weeks gestation upwards, no intensive care, 12 cots) + other safety measure
    - Internal investigation, results presented by MD but seemed inadequate (no external input)
    - RCPCH service review commissioned
- **Sept 2016** RCPCH review team spent 48 hours at COCH
- **Sept 2016** Review of neonatal deaths commissioned from experienced Neonatologist
- **Nov 2016** Draft RCPCH report received. 2 Paediatricians saw redacted report in MD's office for 1 hour, warned not to discuss
- **Jan 2017** meeting between Paediatricians and Executives – deaths explicable, NNU activity to remain reduced until staffing addressed, other safety measure to cease. Paediatricians to accept this decision (without having seen the reports)
- **Feb 2017** RCPCH + Deaths review reports seen by Paeds. Unexplained deaths = 4; Paeds and Liverpool Neonatologist = 8
- **Jan – Mar 2017** 3 letters from all Paediatricians to CEO expressing concerns over unexplained deaths and collapses
- MD and Trust Solicitor discussed with Coroner – not to re-open past inquests, await future inquests
- **Mar 2017** CEO agreed at meeting with Paediatricians, network leads and MD to request a Police Investigation
- **Apr 2017** QC appointed by Trust met Paediatricians. Initial advice not to involve Police, then suggested contacting CDOP DI
- **April 2017** CDOP Lay Chair and DI met MD with 2 Paediatricians to discuss neonatal mortality
- **May 2017** Deputy Chief Constable informed CEO that Police Investigation would take place

Concerns:

- Lack of action following serious patient safety concerns raised from Feb 2016 until July 2016; 4 further deaths and several unexpected collapses had occurred
- Only 2 Paediatricians briefly saw redacted RCPCH report and none saw the Expert Neonatologist's review of deaths report prior to meeting with Execs in Jan 2017
- Executives decided deaths and collapses were explicable – Paediatricians disagreed after seeing reports (as did the regional neonatal network lead)
- Executives proposed reversing a safety measure when Paediatricians felt the deaths had not been adequately investigated (and despite the concerns raised by the consultants)
- Repeated concerns raised by Paediatricians and Neonatal Network were not acted upon & Police became involved only after CDOP insistence
- Paediatricians made to feel they were at fault for raising serious safety concerns. Poor practices on NNU were blamed for increased mortality. Documents described Paediatricians as "unprofessional and dishonest" displaying "conduct below the standards expected by the Trust"
- Repeated misleading statements made to media. Concerns regarding what has been said to parents

Dr Saladi (MS)

MS wanted to make three comments about the way trust conducted the investigation:

If a group of senior consultants went to senior executives with increased mortality on the neonatal unit where deaths were unexpected and unexplained despite post mortems in some, they were expecting the executives to get a detailed account from each one of the paediatricians as to why they thought these deaths were unexpected and unexplained and why they were raising these concerns a few months after these deaths.

Unfortunately that never happened. They never got the paediatricians' side of the story. The only time a representative of the trust asked for their side of story was a year later when they met with trust legal representative about going to police.

However they conducted a sufficient investigation to allow them to instruct the paediatricians to write a letter of apology in the beginning of 2017. MS couldn't discuss the nature of the apology in this meeting, except to say that they had to write a letter of apology.

When MS sent an email with the subject "Should we refer ourselves to external investigation?" one of the senior executives wrote a two line reply which ended as follows.
'All emails cease forthwith. We will share with you what action we are taking.'

MS asked whether that suggested an open process of discussing concerns.

Doctor ZA

Doctor ZA told the Committee that the paediatricians raised significant patient safety concerns, were initially ignored and then bullied, threatened and victimised. They remained extremely worried that others raising patient safety concerns will be/have been treated in the same way. They only got to the point they did by sticking together and consistently repeating concerns in writing as a group. Would an individual or smaller group be silenced? This was one of the main reasons they felt that they needed to share experiences with the MSC.
The relationship with the exec board had broken down to the extent that current patient safety was jeopardised. No meaningful attempts to rebuild trust from the exec board despite involving DN.
To say "it doesn't matter how we got here, we got there in the end" ignores repeated attempts to silence the paediatricians and belittles the profound distress and adverse effect on their physical and mental health of continued undermining, threats and intimidation.
They believed they could lose their jobs by continuing to speak up. Members of the team applied for other jobs and discussed plans with their families to live without their wage.
The RCPCH review was commissioned but they were initially misled in its remit (to review the service, not investigate the deaths). The report of the review was deliberately withheld from them. Despite the overall positive tone of the review

report, only negative comments were highlighted and used out of context (eg staffing below recommended levels, but not in fact materially different to other units while being reported as low staffing). They were asked to agree with the board's recommendations without being given the detail of these recommendations or being allowed to read the review. Reports were only shared with consultants after considerable pressure.
Complex medical reports were not interpreted by anyone with neonatal expertise. The regional neonatal network lead offered an independent opinion to help the board, but this was initially declined.
Comments made in forums where they believed they could speak out safely were then used against some consultants in an HR grievance procedure. A narrative developed in which two consultants were portrayed as ring-leaders and were irrational and leading the others, despite reiterated written and oral statements that the concerns were shared by the whole consultant body. There was ongoing victimisation of these two consultants and coercion to enter mediation. Unsupported accusations were documented as fact with no right to reply or challenge.
The paediatricians had significant concerns that grieving families had been misled over the cause of their children's death.

Dr Jayaram (RJ)

RJ explained that he had become aware that the RCPCH and independent neonatologist reports had come back to the board as he had been told by Mr McCormack who in turn had heard form a senior midwifery manager. The board had not made any effort to inform the paediatric consultants that the reports had in fact come back to the Trust

He also had become aware of the fact that comments had been made at senior level questioning the professionalism of himself and his colleagues. With advice from the BMA, he put in subject access requests to see minutes of board meetings, minutes of meetings which he and his colleagues had attended and other board documents that could not be specified in this forum. He received some heavily redacted documents but was told that many of the documents were not being released under the data protection act as third parties might be identifiable, even though he had been present at these meetings. He was also told that some minutes were not yet ready from meetings that had taken place months before and that he would get those in due course. These have never arrived to date

He quoted some of the documents that he had received in which he and colleagues were described as "unprofessional and dishonest" and which suggested that he and colleagues had behaved in manner "below expected standards" However the same document, when discussing the evidence behind these alleged behaviours, stated that there was "no evidence to say these things did not happen". Further to this, another board document suggested that many "executives and senior managers had witnessed these behaviours" The only contact "executives and senior managers" had had with RJ and colleagues was in

fora where patient safety concerns should have been able to be discussed openly and honestly. He suggested that things said in "Speak Out Safely" fora had been used against the paediatricians to fit with the narrative the Board wanted of the neonatal deaths being due to poor practice and a dysfunctional consultant group

Dr Brearey (SB)

SB told the Committee that, in July 2016, he spent some time with Gill Galt, head of communications and engagement, to help ensure the press statement relating to the redesignation of the neonatal unit was factually accurate.
Subsequent to this, no paediatricians had any input into the content of any of the Trust's press releases. All press statements and verbal statements from executives since then had, in some part, been inaccurate or misleading. Examples include:
In Feb 2017 after release of the college service review report:
The media statement led with "there is no single cause or factor identified to explain the increase we have seen in our mortality numbers." SB said that reviewing mortality was never in the terms of reference of the service review team.
"The review makes a total of 24 recommendations…" SB said that there were in fact 21.
"…recommendations across a range of areas including … leadership, team working and culture" – SB said that issues with leadership in the redacted report explicitly referenced communication between the board and clinical staff and recommended a children's champion at board level.
SB said that, still in Feb 2017, in reference to the Hawdon report, Mr Harvey stated that "when we speak with parents we can now share full and accurate information, on an individual basis."
SB said that Mr Harvey stated that there were only two infants for whom the cause of death was uncertain. SB said that these statements were inaccurate.
In May 2017 when the police investigation started (and a year after the unit was redesignated):
"As a hospital we have taken the clinical review as far as we can. We have now asked for the input of Cheshire Police to seek assurances that enable us to rule out unnatural causes of death."
SB said that this statement did not accurately represent the events prior to the police investigation.
In a May 2018 Interview with the Chester Chronicle:
Tony Chambers is reported to have said: "…there were just a few niggles that our clinicians said, look, we think we have got 90% of the answers but there are still bits that we need to in a sense be clear that we have not missed anything."
SB told the Committee that this statement did not accurately reflect the paediatricians' clinical concerns and that finally:
"Throughout this we have never lost sight of the families left bereaved by the loss of their baby, and they have always been our primary concern."
SB said that this statement did not match executives' actions in response to our clinical concerns.
SB said that:

'I'm sorry I am not able to discuss the detail of these cases with you today but will let you make your own judgements as to why the executives made repeated misleading statements to the public and what effect this will have for affected parents'.

Dr Holt (SH)

SH thanked the members of the MSC for their supportive remarks and acknowledged the strength of their department in working together effectively.

She highlighted that the purpose of the meeting had changed in light of events that day. Their remit had been to highlight that the consultant paediatricians had raised very serious patient safety concerns with the Executive repeatedly in 2016 and 2017 and that their clinical concerns were not dealt with appropriately. Therefore they as a department had no confidence in the Executive board at the Countess of Chester and specifically in Mr. Tony Chambers (former Chief Executive Officer), Mr. Stephen Cross (Director of Corporate & Legal Affairs) and Mr. Ian Harvey (retired Medical Director).

When asked from the floor what could be done going forward to remedy the situation:
The paediatric department had been informed of the process to follow if they wished to formalise concerns regarding Stephen Cross which they would consider and action if deemed appropriate.
SH told the Committee that they would support an independent investigation into the way patient safety concerns are handled within the trust but were mindful of the ongoing police investigation. Their primary concern was for the past, current and future families on the neonatal unit including those involved in the investigation and they did not want to compromise this in anyway. She highlighted the importance, for future safety concerns, of acting within one's sphere of knowledge or seeking independent expert advice where necessary (example cited: an orthopaedic surgeon offered expert advice on neonatal medicine).
The paediatricians would like any/all formal documents in which any/all are named, including the grievance procedure, to be independently reviewed in a fair and transparent process, and if errors have been made or due process not followed then documents should be formally retracted/amended and appropriate apologies issued

Discussion from the floor

Dr Trent (RT) Thanked the paediatricians for sticking together

PJ asked whether any other departments had been treated the same way

Dr Meara (NM) told the Committee that pathology colleagues had raised concerns with the Medical Director and had resigned.

Dr Ridler (SR) said that there was consultant cohesion in the anaesthetic dept and asked whether there could be any meaningful enquiry in the absence of a prosecution.