Operation Hummingbird – Summary / Actions

Held at 15:30 on Friday 5th May 2017
ACPO Meeting Room, Headquarters

Cheshire Constabulary

Darren Martland	Assistant Chief Constable
Nigel Wenham	Chief Superintendent, Public Protection Directorate
Aaron Duggan	Superintendent, Head of Crime
Claire Miles	Staff Officer
Laura Fox	Secretary

Countess of Chester Hospital

Tony Chambers	Chief Executive Officer
Stephen Cross	Director of Corporate and Legal Services
Ian Harvey	Medical Director

DM opened the meeting with the purpose to discuss the content of the letter sent by Tony Chambers to Chief Constable Simon Byrne on 2nd May 2017. Concerns have been raised regarding a higher than usual number of neonatal deaths from January 2015 to June 2016. There were 8 in 2015 and 5 in first six months of 2016, in comparison to an average of 2.4 per annum in the previous 5 years.

Ch. Supt Wenham attended a meeting on 27th April 2017 with COCH to discuss concerns.

Supt. Duggan has informed the HM Senior Coroner Alan Moore and HM Senior Coroner John Gittins. There are four outstanding cases one of which is listed for inquest on 25th May 2017, Child D Child D. This case may need to be adjourned if an investigation is to take place.
COCH have also spoken to both Mr Rheinberg and Mr Moore.

Overview - COCH

TC stated that the board has been managing the process, with the priority being the safety of babies and the welfare of both families and staff.

IH gave an overview. Met with Director, Alison Kelly in May 2016 as it had been recognised there were more neonatal deaths than what COCH is used to. An in house review was conducted, and no common cause of death has been identified. It was agreed there was more work to be done with regards to the review; the concern was the number of deaths and pattern.

There have been 13 deaths, 3 of which are yet to go through the coronial process: Child D Child D, Child O and Child P. These 3 babies and Child A (inquest already held) have unexplained circumstances of death, the post mortems did not assist further, even following conversation between the Medical Director and pathologist, with the permission of the Coroner. An external case review (Dr J Hawdon) has recommended a broader forensic review.

AP – IH to provide personal details of all 13 families.

There are three levels of neo natal units. COCH was operating at Level 2 during the period of the deaths, this provides short term ventilation. Since July 2016 COCH has been operating at Level 1, which cares for older babies that do not require life support systems. There have been 0 deaths on the unit since July 2016 (one baby transferred out subsequently died), the expected death rate at this level is between 1-2 per year.

Within the neonatal unit you would expect to see on shift at any one time, 3 trained nursing staff assisted by 1 nursery nurse. They would look after approximately 5-10 babies. During the index period, the neonatal unit had been busier, staff had increased workloads and staff could have been looking after anything up to 20 babies within the same staffing compliment.

The Consultant Paediatricians collectively felt that of the 13 deaths, 5 could be explained but 8 could not as the doctors felt that both the collapses and / or deaths could not be explained.

Reviews
The families are all aware that two reviews have been conducted:

1. Dr J Hawdon, Consultant Neonatologist, Royal Free London Hospital – October 2016
2. Royal College of Pediatrics and Child Heath (RCPCH) – November 2016 (Following visit September 2016)

An earlier Trust review led to a number of actions including:

- Redesignated neonatal unit
- The transferring babies below certain age / weight to be out treated

It was also noted the unit was 'running hot' [1] and there was an increase in the number of lower birth weight babies, based on previous trends. The College review identified there were issues with communications between medical and nursing staff, incident review processes and delays in clinical escalation. Whilst the staffing was in line with surrounding units, it did not comply with the national standards.
On the back of the College review conducted came a recommendation for an independent external case review. Since the redesignation of the unit, there has only been 1 baby death which was explicable.

The independent review (Dr J Hawdon) took a clinical perspective, looking from birth to death. As such the families each received an in depth, independent case note review that was pertinent to their baby.

A criminal QC was instructed by the Trust, who after consideration of the relevant papers advised that there was no evidence to suggest criminal activity. At a later meeting with the QC, consultants expressed their views that they were not satisfied. The clinicians felt that there was no further work or investigation short of a police investigation that could be conducted to satisfy them that some of the deaths were not due to natural causes.

DM stated that there are two critical issues drawn from the overview and reviews:

- Potential of malpractice
- Practice issue involving COCH

There are at present no other reviews / investigations ongoing at the COCH.

Nurse
As part of the review staffing was looked at, there was a notable high statistical relationship between a member of the nursing staff and babies deteriorating in the unit. There is no evidence, other than coincidence.