HAND COPY FROM RAVI J. ON NNU. 30 APRIL 2018. TONY

In June 2016 the paediatric team escalated a serious patient safety concern to the medical director in the belief that we would receive help and support in managing this sensitive and difficult problem that members of the executive had been aware of since at least Feb 2016. Contrary to a statement by the medical director we made no ultimatums or demands to the medical director at this time.

In August, the medical director presented to the Board the findings of work that had been undertaken and suggested that increased acuity and staffing changes may have been contributory to the increased mortality rate. The paediatricians considered the methodology and conclusions of the medical director's presentation to be of a low standard. In addition, we felt that the chief executive and some members of the board treated the consultants' views with contempt.

1. **Please could you advise us as to the source of neonatal expertise the medical director consulted before presenting his conclusions?**
2. **Please would you advise us why all meetings we have had with executives have either not been minuted and why we have not received the minutes?**

Regarding the grievance procedure, for which we have been given different reasons for its purpose, members of the board commissioned it, gave evidence to it and received its report. The Head of Pharmacy, who had been involved in reviewing the care of one of the babies who died, chaired the process. The nurse involved in the grievance indicated she had been told it proved she had done nothing wrong.

3. **Please indicate if you feel the grievance procedure had been undertaken in a fair and impartial way?**
4. **Regarding our meeting with executives and non-executive directors in Jan 2017, why were we led to believe that this would be a meeting for us to discuss and see the contents of the RCPCH service review report and the case note review report?**

The board had made a decision prior to this meeting about how they would respond to these reports. There were no paediatricians involved in this decision making or even neonatologists from outside the Trust.

In the meeting, the Medical Director said that evidence triangulated and indicated poor consultant presence on NNU, poor supervision and poor relationship with nursing colleagues. Having had the chance to read both reports, we do not think this is was a fair summary of the reports and that he made many important omissions. As well as many positive observations, the RCPCH reviewers observed that even the areas of improvement were not materially different to other units. From the case note review, the medical director omitted to mention at least 4 babies' care still needed further forensic review.

Paediatricians were criticised in the meeting for unprofessional and unacceptable behaviour. We have not been told what this behaviour was nor had a chance to challenge that statement.

We only have an idea of what we are alleged to have said through rumours that appear to have been circulated by senior members of the Trust. We consider this to be a slur on our character, integrity and professional reputation.

Also in the meeting in Jan 17, the chief executive indicated that we must agree to the decisions of the board and that a line had been drawn under this affair. We were to apologise to the nurse in question who was to return to work because she had done nothing wrong. We were not to cross the line or there would be consequences. The chief executive's tone was aggressive and threatening.

5. **Why were no paediatricians or neonatologists from inside or outside the Trust involved in discussing the results of the reports prior to the meeting?**
6. **Please advise us why the medical director chose to select only some negative comments from the reports and to omit to mention that further investigation had been recommended by an external reviewer?**
7. **Do the board still believe some paediatricians behaved in an unprofessional and unacceptable way?**
8. **If so, please provide the evidence for it so that we are provided an opportunity to challenge what appear to be unsubstantiated allegations.**
9. **Please investigate how rumours of unsubstantiated allegations were allowed to be propagated and apologise to the clinicians concerned.**
10. **Do the board and chief executive consider what was said to the paediatricians in this meeting to be an error of judgement?**

Following the meeting, the paediatricians wrote 3 letters to the chief executive, signed by all, for fear that any one paediatrician might be singled out and victimised. The first letter asked for us to be able to see the reports and for the chief executive to confirm in writing the demands of the board from the meeting.

11. **Why did the chief executive not confirm in writing the decisions of the board and what was expected of us?**

The paediatricians wrote a non-specific apology to the nurse in question.

12. **Please indicate what specifically we were supposed to be apologising for.**

The medical director made a Trust press statement indicating that there were only 2 babies for whom the cause of death was not known. He was aware that Jane Hawdon recommended that 4 babies have further forensic review and that the paediatricians and an external neonatologist felt there were at least 8 in which the cause of collapse was uncertain.

13. **Why did the medical director make a public statement that was clearly inaccurate?**

The RCPCH service review report was shared with us and the public. It was clear to us that large sections of the report had been removed without any statement indicating this. The medical director had promised to share the full report with the parents of affected babies.

The Medical Director has repeatedly said there is only one report. The Chairman of the Trust and the RCPCH review lead have both said there are 2 reports. The report was treated by the medical director in our discussions with the Board as a review of the mortality, which was outside the scope

of the service review. Deleting sections of the report skewed the observations of the review toward clinical practice rather than our specific patient safety concerns.

14. **Do you consider that the heavily redacted report shared with the public adequately reflected the discussions and contribution made by the paediatricians during the review?**
15. **Do you now consider it was an error of judgement and misleading to the public to share the report and not indicate that large sections had been redacted?**

The paediatricians continued to write to the chief executive expressing their concerns that the neonatal deaths had not been adequately investigated.

16. **Why did the chief executive not meet or talk to the paediatricians at this time?**

Some paediatricians were coerced to enter mediation with the nurse in question with an inherent threat of GMC referral if they refused. In the meantime, the medical director and head of HR ignored all pleas from the consultants that this was wholly inappropriate when the cause of deaths was still uncertain and further investigation was still required.

17. **Why did the Head of HR and the Medical Director ignore the paediatricians at this time and continue to exert pressure on them to engage in the mediation process?**

In March 2017, the chief executive and medical director met with 2 paediatricians and neonatal network representatives. The paediatricians explained that we felt the deaths had not been adequately investigated and were concerned that parents had been misled. We asked the chief executive to refer the Trust for a police investigation. The chief executive agreed to this request. He said that he had always expected this to go to a police investigation and he would take action that week.

18. **Why did the Trust not discuss neonatal mortality with the police until May, 2 months later?**
19. **If the chief executive had expected a police investigation from the start why did it take a year from our escalation and why did he make the statements contrary to this in our meeting with him in Jan 2017?**

The paediatricians met Simon Medland QC in April 2017 at the request of the medical director. The medical director advised us that the purpose of the meeting was for Mr Medland to understand our concerns before the Trust approached the police. Mr Medland advised us that he had been asked to discuss with us whether the Trust had enough evidence to request a police investigation.

20. **Why did the medical director mislead the paediatricians regarding the purpose of the meeting?**

21. **Why was Simon Medland commissioned by the Trust, when the chief executive had already agreed to request a police investigation a month earlier?**

The chief executive made a statement after the start of the police inquiry stating the RCPCH review and case note review had gone so far and that the police inquiry was a continuation of this so that he had asked for it. The statement seemed contrary to our experience and impression that the Trust did everything possible to avoid a police inquiry.

22. **Why did the chief executive give the impression that we wanted a police investigation when it was quite clear to us that he had tried to avoid it?**

The chief executive has not spoken to the paediatric team since the police investigation started.

23. **Why has the chief executive and medical director not made any meaningful communication with the paediatric team from May 17 to April 18?**

In Sep 2017 the Children's Champion non-executive director was introduced to the paediatiric team by the Medical Director. It was stated to them that the biggest problem facing the department was the paediatric team's trust in the executive.

24. **Why was no action taken after making this comment?**

In March 2018 the chief executive made a statement to the local media saying he thought the issues around neonatal mortality had generally been handled well, that the paediatricians had a few niggles and that the police investigation would be completed at the earliest in the Spring. The paediatricians wrote to the chief executive after this was published expressing concern that his statement was misleading especially to parents of affected babies. The chief executive's response in writing was dismissive.

25. **Does the chief executive consider his words and actions in this case to be an error of judgement?**

Some paediatricians have felt bullied and victimised by members of the board and chief executive. This has affected the physical and mental health of those concerned. This puts at risk our ability to provide safe and effective care and continue to provide the excellent service we have consistently provided.

26. **How will the Trust investigate why members of the Board have not demonstrated the compassionate supportive behaviour they advocate to all other employees in the Trust?**