WED. 29. JUNE 2016 EXECS. CONF/.

QUALITY. None.
SUI this pm.

BOARD. Agenda agreed.
Childbirth Trust.

PEOPLE. 360° to share.

NHS. GAMES, → Soon.

WALKABOUT. → 1 JULY. 2016. AK & TC.

COMMS. to comms out following walkabout

MERSEY. AUDIT. update → Governance.

WED. 29. June. 16. NNU. mtg. IH. AK. TC + SPC

Low reporting area. NNU → small unit.
Steadily low reporting from NNU.

150. 14/15 }
180. 15/16. } Incidents. No partic themes.
21. 16 to date }

'Shifting' is a trend but not near what you would expect.
Lid learning = incidents

Cases for further review + SBARS. are highlighted '2015 Review'.
Staff can talk around areas or not complying with guidelines.
Language issue PD - open bed CCG waiting for PM report

Child A → Inquest } cases low
Child C Record keeping. drag } difficult to establish more detail.

Dr. Brierey does not like talking to me (RM)
Review June 2015. (4 deaths) unexpected but not necessarily suspicious.
No causation
(Review) FEB. 2016. (10 deaths) Includes EXTERNAL
(Jan '15 - Jan '16)

AK. Nothing highlighted by Coroner. Recent deaths *
Not all went to PM. TRIPLETS - have they gone to P.M?

Following Feb review - still uncomfortable!
Any commonalities - further review
This ID'd a staff member - 'deterioration' = death.
Nurse → ID'd in no. of cases.
Further case not SBAR'd ← 'Cooling' - take off vent!
(not hit radar yet)

Dept. closed off → maybe more CONCERN!
Anne-Marie has ID'd this nurse.

NNU. mtg cont/   LB. joined mtg.

In papers — shared learning.
Near miss incidents – 4 cases. Not previously known
Ruth has only seen them today. Anne-Marie reviewing.
Maybe another 4! ie 10 to 14.
Thematic review was a clinical review.
End is around environment issues. Need to grid this further 4.
Some babies graded – deterioration. – no cause! Not unheard of.
· Theme – stable, unexpected incident, crash. death (deterioration).

Eirean has made point. Some babies did not respond to resusc as she wd hv. expected.
Potential things that cd hv. caused this? Brearey has sd Don't know
Dept. keep us out! Dept does not communicate.
Baby I&S for cooling – incident – POTENTIAL CLAIM!
Was in APRIL. & looking at it now.

- Comparison with national data paper.
- PM's reports. more about Mum. Do not appear relevant.
- No formal complaints from 2014 to date.
- CLAIMS – Mother D & Child A (Inquest)
  + potential in 2011 – obstetrics.
- 2015 causes of death in thematic review.
- Assurance – audit activity – no real concerns.
- Risk register – W & C's structure (governance) before escalation elsewhere. (see risks)
- Culture seems to be not to talk o/s W&C's (Speciality)
- KIRKHAM response – sep. obstetrics & neo-natals.
- ROTA's. confusing. Pulled Badger data for comparison.
  → need to ID. closure of unit.
- Sickness & AL. data being supplied by HR (ESR staff)
- Discipline – warnings to staff
- Review of staffing competencies AK has asked Eirean)
- Appraisals, mandatory trng – usually highly competent.
- No performance concerns

- On call rota's. – Dean.
- Dr. performance issues? – Jan Ellis checking
- Schedule 'highlighted yellow' for staff still to come.
- HR. re: Nurse: she has reported 'incidents'!

SUMMARY. (RUTH)

- Concerned witchhunt for Nurse.
  BUT F/time + additional hrs. means she is on duty more.
- Will get unknown outcomes
- Closed culture in Dept
- Concerned re: learning
- Do not know why this is happening.

LB. Do have concerns about safety in Dept.
Not infection control
Don't know why?
Safety issue – YES.

RM Is there stuff we do not know?
Something somewhere is WRONG.
Each case needs independent deep dive.

SPC. Emails from consultants.
SB → targeting one individual

LB. David Semple sd: "If SB. has a concern I believe him"
AK Nothing personal bet. SB. & Nurse.
IH. Do they keep record of every resusc?

TC. Why shut unit? Press.
IH Consultants concern – series of deaths – investigated.
No indiv. concerns but collectively CONCERN.
Cannot explain sufficiently why our deaths higher than normal.
AK Hv. done review of obstetrics.
We shd not hv. received complaints – Steve Brierley did this.

Are there micro-biology issues? Review! Look back.
Significant evidence of sepsis but not infection control!
TC. Clearly something not right. But
culture maybe future of maternity in Q,
taking too much on in unit, some kind
of Dept's way of dealing:-
poor incident reporting
closed culture.
potential harm
ABSOLUTE is police. But what other options:-

Managing comms with Consultants & need to meet.

LB. High risk pregnancies in future - check.

Do we inform Police?
Do we shut unit?
Do we exclude nurse?
Complicity bet. obstets & NNU?
Response re. new model of care - not interested?

Summary
- Increase in mortalities.
- Arguably don't know why → Unexpected but are they suspicious?
- All clinical issues examined. NO OBVIOUS CAUSATION.
- Q. of Nurse involvement - only evidence 'on shift'.
- Review or Police? DAVID S. RAVI. STEVE B. Murthy Saladi
  ↳ Police. Unit closed.
  Forensic examination.
  I/V of all staff
  Arrest of Nurse.

ALL SAY YES TO POLICE.

- REPUTATIONAL ISSUES FOR TRUST - LINK TO CQC REPORT

WED. 29. JUNE. 2016. TC. AK. IH. Dave S. Steve B.
5.10pm. TC. office. Ravi Saladi. LB. SPe
AK outline
Martin Sedgewick aware (Ravi)
Steve B. Some PMs reports but not all. Inconclusive.
Some not satisfactory giving answers
Inconsistent DATIX reports.
'Near misses' not a term used by Steve B.
Difficult in Neo-nates.
Unexplained collapses - perhaps shd DATIX.
Lot of complexity around reporting - tricky to get oversight.
Ruth sd. - look at data in a grid fashion to look
at all, not just clinical. No kit/beds issues
Microbiology? nature of neo-natals.
Steve B. outlined one particular incident/birth.
Pseudomonas growing from taps but not
evident in incidents.
Looked at clinical factors & more (environmental)
Inconclusive.
Emails → staffing
Steve B. Met July 2015. 3 cases common theme
was nurse. Discussed at thematic with
Liverpool & May 2016.
Ravi. entirely subjective
Staff member - almost always Nurse in charge
Babies were stable & then deteriorated.
Why always this nurse?
Babies were unwell but getting better
Babies not getting oxygen - then crash.
Babies did not respond as they should.
Steve B. Disturbing thing - twin survived
& got better in Arrowe Park.
Babies coming back to COCH Babies deteriorate
Nurse 7 out of 9 bet. 12noon & 4am
& since change none