Report to meeting in common of the Bristol People Scrutiny Commission and the South Gloucestershire Health Scrutiny Commission, 27 February 2017

INDEPENDENT INVESTIGATION INTO THE MANAGEMENT RESPONSE TO ALLEGATIONS ABOUT STAFF BEHAVIOURS RELATED TO THE DEATH OF A BABY AT BRISTOL CHILDREN'S HOSPITAL

1. INTRODUCTION

This paper updates the Bristol People Scrutiny Commission and the South Gloucestershire Health Scrutiny Commission on progress in delivering the recommendations of an independent investigation, commissioned by the University Hospitals Bristol NHS Foundation Trust from a specialist investigations consultancy called Verita, into events following the death of a baby at the Bristol Royal Hospital for Children in April 2015.

The Trust has previously provided reports on this issue to the two Commissions in August and November 2016.

2. BACKGROUND

Ben, who was born at 29 weeks' gestation on 17 February 2015, sadly died on the paediatric intensive care unit at the Bristol Royal Hospital for Children on 17 April 2015, after one week on the unit.

Subsequent to Ben's death, his parents raised concerns about:

- a delay in informing them that Ben had had an infection (pseudomonas)
- inaccurate information from clinicians about the timing of blood tests
- suggested deletion of an audio recording of a discussion between clinicians in a recess of a Child Death Review feedback meeting
- inadequate Trust investigations into these concerns.

In December 2015, the Trust commissioned Verita to undertake an independent investigation into the management response to allegations about staff behaviours related to Ben's death.

Verita concluded that Ben's parents had, very soon after their son's death, formed the view that his care had been inadequate, that his death might have been avoided, and that there had been a conspiracy to cover this up (which the Trust disputes). Verita found that the Trust had missed a number of significant opportunities to engage proactively with Ben's family after their baby's death, to be more open and candid with the family, to understand the seriousness of their allegations and to give them clear answers to a number of their questions.

The Trust accepted Verita's findings in full and wrote to the family, giving unreserved apologies for the failings identified by the Verita investigation.

Subsequent progress in implementing Verita's recommendations has been reported publicly at meetings of the Trust Board. In line with recommendation 9, the Trust identified two senior clinicians, independent of the PICU, to work with Ben's family to ensure that their remaining questions were fully understood. Over a number of weeks these two clinicians met with Mr Condon on four occasions, for a cumulative period of about ten hours, to discuss and define these remaining questions. From this engagement, a detailed list of 80 questions was produced which, in the family's opinion, remained to be addressed.

Following this the Trust then identified another senior clinician, Professor Michael Stevens, Emeritus Professor at the University of Bristol and former Consultant Paediatric Oncologist, who accepted the task of working with the set of questions and, by reviewing existing records and consulting with staff as appropriate, producing a set of responses, documented in a report to be submitted to the family by the end of January 2017.

This task was completed within the timeframe and a 45 page document providing responses to the set of questions was produced and forwarded to the Condon family. The document concluded with a suggestion for next steps with the ongoing engagement, and described a proposal for a meeting, or series of meetings, between Professor Stevens, Senior Trust management including the Chief Executive and Medical Director, and an independent mediator with experience of mediation in a health care setting. The family subsequently indicated their wish to decline this offer.

3. INQUEST

An inquest into the death of Ben Condon took place at the Coroner's Court on 21st June 2016.

This determined that Benjamin Condon was born premature at 29 weeks on 17th February 2015. He was discharged from hospital (North Bristol Trust) following his birth on 7th April 2015. On 10th April he was unwell and was taken to his local hospital (Weston General) by his parents. Following an assessment he was transferred that day to the Bristol Royal Hospital for Children, Upper Maudlin Street, Bristol. He was diagnosed with human metapneumovirus respiratory infection. He received supportive treatment. He developed acute respiratory distress syndrome, this caused his collapse on 17th April and his death.

The conclusion of the coroner as to the death was that Benjamin Condon died due to viral bronchiolitis caused by the human metapneumovirus which was the trigger for his acute respiratory distress syndrome; it was the development of this condition that caused air to leak from his lungs causing a catastrophic deterioration of his condition on 17th April and his death.

4. ANSWERS TO THE 6 ACTIONS FROM NOV JHOSC

Responses to actions from the November JHOSC are at appendix 1.

5. RECOMMENDATIONS

Councillors are asked to:

- Note the Trust's response to the Verita recommendation to address outstanding issues with Ben's family and the steps taken to do so in an entirely open and collaborative way

Appendix 1. Actions form the meeting in common – 23rd November 2016

Minutes No.	Title of Report/ Description	Action and Deadline	Responsible officer	Action taken and date completed
57	Independent Reports related to the Bristol Royal Hospital for Children 2016 – Three month review	A7. The family suggested that Recommendation 1 had not been completed. The Trust agreed to address the concern when provided responses to the 80 questions submitted.	UHB	Addressed again in Prof Stevens report under section A.3.1
57	Same as above	A10. The Trust were asked to check what the circumstances were in this case regarding family accommodation.	UHB	Children come to Bristol from throughout the South West Region, Wales and beyond for specialist treatment. We have three internal parent rooms close to intensive care and accommodation supported by our charity providers at Ronald MacDonald and the Grand Appeal. The demand for parent accommodation does, on occasion, exceed our capacity A degree of priority is given to parents who live long distances from Bristol and would therefore not be able to commute daily to visit their child. We believe that no parent accommodation was available when the family made their request. Accommodation became available later in the admission, by which time the parents opted to remain in the accommodation they had arranged themselves.

57	Same as above	A12. The Trust we asked to check the date and outcomes of the South West audit at Verita	UHB	The action specified in Recommendation 4 was implemented immediately following receipt of the Verita report. A follow up audit completed in August 2016 showed that all new BRHC guidance documents approved since the implementation were compliant with the policy and had ratification and review dates specified.
57	Same as above	A15. The Trust were asked to provide the specific figures related to the number of senior leaders who had been trained in accordance with recommendation 6.	UHB	A total number of 58 senior Trust leaders have received formal training in investigation methodology at two training events held in August and December 2016.
As part of the Resolution	Same as above	A visit to the hospital to see some of the changes first-hand would be arranged for Councilors prior to the next update meeting on the 27th February 2017	UHB / Officers	Visits have been arranged.
As part of the Resolution	Same as above	An update on the 80 questions formulated with the Condon family would be provided as part of the six month update in February 2017	UHB	A response to the 80 questions was provided to the family in January 2017.