APPENDIX B

University Hospitals Bristol NHS
NHS Foundation Trust

Report to meeting in common of the Bristol People Scrutiny Commission and the South Gloucestershire Health Scrutiny Commission, 12 August 2016

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 is provided to support a specially convened meeting in common of the Bristol People Scrutiny Commission and the South Gloucestershire Health Scrutiny Commission on 12 August 2016.

It sets out the context for 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. It reports the conclusions from the investigation and the Trust's progress in delivering the recommendations.

2. BACKGROUND

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

His death was described as 'unexpected' and his cause of death was documented as:

"1a. Acute Respiratory Distress Syndrome
1b. Human Metapneumovirus Respiratory Infection
1c. Sepsis
2. Prematurity"

In a meeting with consultants, his parents found out on 4 June 2015 (seven weeks after his death) that he had had an infection (pseudomonas) that was not mentioned at the time. During the meeting, clinicians gave Ben's parents inaccurate information about the timing of blood tests in the days before he died.

Every child death is subject to a statutory review, reported to the West of England Child Death Overview Panel under local safeguarding arrangements. The Trust operates a comprehensive Child Death Review process. We invite parents to contribute questions to the review and provide feedback to parents once the Review has taken place.

The Child Death Review feedback meeting for Ben's case took place on 22 July 2015. The Trust and Ben's parents both agreed to audio record the meeting. During

a recess of the meeting, clinicians continued to discuss Ben's clinical care after his parents had left the room. The clinicians suddenly realised that both audio recorders were still recording and one of them suggested that the recess discussion should be deleted. The general manager agreed to delete the recording. The Trust's recorder was paused while the family's recorder continued to capture the discussion. Whilst the Trust did not subsequently delete their recording, the suggestion that it should be deleted caused Ben's parents to be concerned about the management response to these incidents and raised concerns about a potential cover-up by Trust management.

As Chief Executive, I became aware of the seriousness of the concerns when Ben's parents emailed me directly on 16 September 2015. Subsequently, I commissioned a number of internal investigations to establish the facts. I became aware in December 2015 that at least one of the areas of investigation was inadequate and commissioned Verita to undertake an independent investigation into the management response to allegations about staff behaviours related to the death.

Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations.

Verita provided the report of their investigation to the Trust on 16 June. Our understanding is that it was provided to the family at the same time. The full report is attached as **Appendix Bi**.

3. CONCLUSIONS OF THE INVESTIGATION

Verita concluded 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. Despite our belief that as a Trust we had endeavoured to respond fully to their concerns, we failed to get an appropriate grip of the complaint and we lost the trust of the family as a result.

Verita's overall conclusions are replicated below:

- *The trust missed a number of significant opportunities to engage pro-actively with Ben's parents after the death of their son.*
- *When trust staff did engage with Ben's parents there were a number of occasions when this could have been done in a more open and candid way.*
- *There are also examples of the trust just waiting to see what happened rather than being more pro-active in their communication with Ben's parents.*
- *There was a delay in the complaint investigations getting underway. There were, subsequently, attempts to work with the parents to identify their concerns and investigate them. However, not all the issues were fully understood and investigations into some of the concerns fell short of expected standards.*
- *There was a long delay in senior management getting a 'grip' of the complaint and recognising the serious nature of the parents' concerns.*
- *The executive team – including the chief executive – became aware of the extent of the parents' concerns following an email from Ben's father directly to the chief executive on 16 September. At that point, the executives and senior managers*

decided that they needed to move outside of the normal complaint process in serious cases such as this. It was agreed that such cases would have executive oversight and in this instance, the chief executive states that he delegated responsibility to the medical director. However, the medical director considered his role was purely to oversee investigations regarding medical staff.

- *Despite the medical director having oversight of several investigations undertaken to address the parents' allegations, we conclude that there was a failure by the trust to get a real grip of the issues. While a number of investigations were commissioned at that point there was a failure to recognise one of the most serious allegations being made by the parents – why a clinician would want a conversation deleted and why a senior manager would agree to do it – irrespective of whether any deletion actually happened. At this point the trust instigated an investigation, but with a limited remit, to establish whether anything said in the second part of the meeting contradicted anything discussed as part of the meeting recess. Whilst the investigator met her terms of reference they failed to recognise or address the more serious allegation.*
- *A number of the investigations commissioned failed to get to the heart of the issues raised by the parents. They considered each concern in isolation and failed to consider the background and context in which the allegations were set. At times, investigations were conducted without clear terms of reference and the investigator was not clear from the outset whether it was an internal exercise or whether their report would be shared with Ben's parents. On one occasion, the investigator was unlikely to be perceived as sufficiently objective given she had known the person she was investigating for a considerable time.*
- *The chief executive and his executive colleagues recognised the need for a different approach to serious allegations. However, it was a new, untested process being piloted with this case.*
- *The purpose of the meeting on 22 July appears to have been two fold – to provide the parents with feedback from the CDR [Child Death Review] meeting and to clarify points for complaint investigation. Clinicians who were involved in Ben's care were not present at the meeting and the clinicians in attendance clearly felt uncomfortable stepping outside of the 'consensus' view reached at the CDR [Child Death Review] meeting. This may have made them appear reluctant to engage in any discussion with the parents, which would have required them to depart from the consensus reached at the CDR [Child Death Review], in particular in relation to the prescribing of antibiotics.*
- *Overall, we consider that there was a lack of focused responsibility for, and oversight of, the complaint. Action was not timely and senior staff failed to recognise the serious nature of the allegations made. The trust has failed to provide Ben's family with clear answers to a number of their questions.*
- *The trust appeared to lose sight of the fact that this was a grieving family who wanted straight answers to questions about their son's diagnosis, care and treatment. The 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. The trust dispute this finding – they believe they spent considerable time responding to Ben's parents to try to ensure they provided the right answers and engaged with them in an empathetic way.*

- *We have not seen conclusive evidence to prove or disprove the charge of a conspiracy to cover up what happened to Ben. Nor is it within our remit to say whether his death could have been avoided.*
- *What we can conclude is that if there had been a conspiracy it was poorly executed, and little that the trust did was well directed to disproving its existence. Few of those charged with carrying out investigations on behalf of the trust grasped the seriousness of what was being alleged. The one proactive attempt to engage with the family at the level necessary was the intervention by the clinical director for critical care.*
- *If there had been no conspiracy, what the trust actually did, far from allaying suspicion, served to bolster the family's belief that there had been one.*

4. TRUST RESPONSE

The Trust accepts Verita's findings in full.

As Chief Executive, I wrote to the family on 17 June, giving our unreserved apologies for the failings identified by the Verita investigation and advising them that in the interests of supporting openness and transparency the report would be published on our Trust website the same day.

We have taken action to address Verita's findings in a number of ways:

- the formal recommendations from the investigation are being addressed as described in the next section;
- our Medical Director will share wider learning across the Trust from related internal investigations, in order to guide staff who are meeting with parents after a serious incident so that parental expectations concerning how information and explanation will be received may be met consistently. A new guidance note has been approved for incorporation into our Trust's Staff Support and Being Open Policy (Duty of Candour), with a dissemination plan;
- the Trust Board has reviewed the detailed findings to establish whether other action beyond that described in this report was required. The Board took assurance that all appropriate steps were in hand but intends to seek further assurance in September.

5. PROGRESS IN IMPLEMENTING THE VERITA RECOMMENDATIONS

Appendix Bii sets out the Trust's analysis of progress to date against the recommendations in the Verita report.

We shared this report with Ben's family prior to its consideration at our Trust Board meeting in public on 28 July 2016. To note, the family queried the status of a number of the Verita recommendations as reported by the Trust. The family's concerns were shared with Board members prior to the meeting, and, as described below, we are continuing our engagement with Ben's parents to try and resolve these outstanding differences.

In our July meeting, the Trust Board noted Verita's finding that there was no conclusive evidence to prove or disprove the charge of a conspiracy to cover up

what happened in Ben's care and that internal investigations had identified no intention to deceive and no cover-up on the part of Trust staff involved.

However, the Board formally noted Verita's conclusion that the Trust had failed to provide Ben's family with clear answers to a number of their questions. The Board noted Verita's recommendation that we identify a senior individual to work with Ben's family to ensure that their remaining questions are fully understood and a plan developed, with the family, to address the issues raised.

The Board agreed that the concerns of the family about the status of all the recommendations should be addressed through this route.

We have offered the services of Mr Alan Bryan, Consultant Adult Cardiac Surgeon and Clinical Chair of the Division of Specialised Services, to act as an intermediary who is independent of children's services, supported by Ms Sue Dolby, Consultant Clinical Psychologist. Ben's family have agreed to be contacted by Mr Bryan to discuss this process further.

Terms of reference for this work have been shared with Ben's family, as follows:

- To constitute a Trust team, this will be led by a Senior Trust Clinician and will comprise of a nominated Trust assistant and secretarial support, who will take the minutes of the meeting.
- To engage with Ben's family so that a meeting can take place at an agreed time and location.
- To meet with Ben's family and identify those questions they consider as remaining to be addressed, given all previous Trust responses. To confirm the outstanding questions, agree the approach for dealing with each question and clarify the desired outcome with Ben's family.
- To seek responses from the representatives of the Trust and the Division of Women's and Children's Services and to present these responses to the Trust and the family within an agreed time frame
- To agree this plan with Ben's family.

6. RECOMMENDATIONS

Councillors are asked to:

- Note the context/circumstances and reasons for initiating the independent Verita investigation, and the recommendations made
- Note the Trust response to Verita's report and recommendations – including addressing outstanding issues with Ben's family
- Seek further information and assurance about the progress of the action plan to deliver Verita's recommendations over the coming months.

Robert Woolley
Chief Executive
3 August 2016