APPENDIX Bii

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

Recommendation	Owner	Status
R1 The trust must, as a matter of urgency, establish who reviewed Ben's pseudomonas results on 17 April and establish what action they took as a result.	Medical Director	**COMPLETE.** This has been followed up with the trainee doctor concerned. Action was not taken or required because appropriate antibiotics had already been prescribed. This finding was formally communicated to the family by letter on 3 June 2016.
R2 The trust must review its Child Death Review (CDR) process to ensure families are supported appropriately throughout. There needs to be clear guidance for families regarding what to expect from pre-CDR meetings and clinicians should be supported to be open and honest with the family, while acknowledging that the CDR meeting is the forum where diagnosis, care and treatment will be explored in greater detail. This review should take place within the next three months.	Chief Nurse	**IN PROGRESS.** The Division of Women's and Children's Services have reviewed the CDR process and established: • revised processes – standard operating procedure for CDR process went through Divisional Quality and Assurance Committee in April and is now in 6 month trial (complete) • use of the Patient Administration System for recording CDR documentation (complete for all PICU patients and to be implemented in oncology and NICU by October 2016) • formal responsibility for monitoring and management to be assigned to the divisional Quality and Assurance Committee (complete) • Speciality Governance meetings to have all Root Cause Analysis and CDR actions as a standard agenda item (complete) • support to families to be significantly enhanced following introduction of new bereavement team posts (complete) • written guidance for families regarding what to expect from CDR process (complete) • working group, 'Support to families following the death of a child', to write guidance to ensure all families know what support is available and to ensure staff deliver this in standardised way across the hospital no matter where a child may die. Completion date: September.
R3 The trust should share with Ben's family further findings from the investigation undertaken by the deputy medical director into the allegation that deliberate attempts were made by trust staff to falsify records of the CDR feedback meeting on 22 July 2015. The trust should do this to demonstrate that a robust investigation has been undertaken. The trust should take great care to ensure that any further information provided to the family adequately	Director of Workforce	**NOT YET ACTIONED.** The Trust's duty of confidentiality to its staff means the report itself cannot be released. Advice received is that as much as can be appropriately extracted for release was given to the family by the Medical Director in his letter of 1 April. It is proposed that further consideration of ways to address this recommendation be undertaken as part of the programme of work in response to R9. Completion date: to be determined.

addresses their concerns.		
R4 The trust must ensure that any newly developed guidance (for example the new process for managing formal complaints and the checklist following the death of a child) includes a ratification and review date. This should be implemented immediately.	Chief Nurse	**COMPLETE.** Instruction issued that all BRHC documentation to conform to corporate Procedural Document Framework standards for ratification and review. Follow-up audit is planned for completion by 31 August 2016.
R5 Before undertaking internal investigations (formal or informal), the trust must ensure that all staff involved are clear about the purpose of the investigation and the intended audience. The trust may need to review its investigation guidance in order to support staff conducting investigations.	Director of Workforce/ Chief Nurse	**COMPLETE.** Relevant policies revised to reinforce need for consideration of investigation purpose and intended audience. Separate guidance note for managers conducting investigations has been drawn up.
R6 The trust must ensure that staff are suitably trained in order to carry out investigations which are evidence-based, robust, proportionate and suitably independent.	Director of Workforce/ Chief Nurse	**COMPLETE.** Relevant policies have been reviewed to reinforce learning from this review. Revised training for senior leaders has been developed (and senior leader training scheduled for August 2016).
R7 Staff charged with conducting investigations should ensure they are clear what guidance governs their investigation and what process should be followed. They should ensure their approach is sufficiently independent and proportionate. This will include considering whether, for example, it is necessary to draft terms of reference, conduct formal interviews etc.	Director of Workforce	**COMPLETE.** Over-arching guidance note for managers conducting investigations is in place and will inform training under R6.
R8 The trust needs to ensure that it has a robust safeguarding system to ensure that results taken are still reported and flagged to the clinical team in the event that the patient has died.	Chief Operating Officer	**IN PROGRESS.** New standard operating procedure (SOP) is in development to clarify existing practice regarding the reporting and communication of laboratory results for all patients. This includes the appropriate process for dissemination of information within departments when results are received. The SOP will be presented at the Trust's Service Delivery Group in August 2016 and communicated via Divisional Boards in September 2016. A retrospective audit utilising incident forms will be completed in October 2017.
R9 Senior managers need to take steps to ensure that Ben's parents' outstanding questions are appropriately addressed. A senior individual should be appointed to work with the family to ensure that their remaining questions are fully understood and a plan developed with the family to address the issues raised.	Medical Director	**IN PROGRESS.** A senior clinician, independent of children's services, has been appointed to work with the family to understand the family's remaining questions and develop a plan with them to address the issues.

Recommendations from independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital: status report July 2016 (updated 3 August 2016).