

# VERITA

IMPROVEMENT THROUGH INVESTIGATION

## **Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital**

A report for  
The University Hospitals Bristol NHS Foundation Trust

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## 1. Introduction

1.1 The University Hospitals Bristol NHS Foundation Trust (the trust) board commissioned this independent investigation on behalf of the trust.

1.2 The trust is made up of a group of hospitals in the heart of Bristol. It has more than 8,000 staff who deliver over 100 different clinical services from nine sites. With services from the neonatal intensive care unit to older people's care, it is one of the country's largest acute NHS trusts, with an annual income of £575m.

1.3 The Bristol Royal Hospital for Children (BRHC) is part of the trust and provides a service for Bristol children and a referral service for specialist care for families across the South West and the rest of the country. The hospital opened on 21 April 2001 and was the first purpose-built children's hospital in the South West. Another ward opened in April 2007 to accommodate children's services from Southmead and in May 2014 two specialist hospital services for children moved from Frenchay Hospital to create one centre of excellence in Bristol.

1.4 Ben, who had been born on 17 February 2015, sadly died on the paediatric intensive care unit (PICU) at BRHC 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*”

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

1.6 The Child Death Review feedback meeting 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 the 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 the parents to be concerned about the management response to these incidents and raised concerns about a potential cover-up by trust management.

**1.7** The chief executive became aware of the seriousness of the concerns when the parents emailed him directly on 16 September 2015. Subsequently, a number of internal investigations were commissioned to establish the facts. The chief executive 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 of Ben.

**1.8** Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations. Walter Merricks and Amber Sargent of Verita undertook this review. Barry Morris provided peer review. Team biographies are shown in appendix A.

## 2. Terms of reference

2.1 The University Hospitals Bristol NHS Foundation Trust board has commissioned this independent investigation into how trust management responded to allegations about staff actions and behaviours in relation to the death of Ben at Bristol Children's Hospital (part of the trust).

2.2 The allegations are as follows:

- clinicians provided inaccurate information to Ben's parents about the timing and result of blood tests;
- the paediatric intensive care unit matron was dismissive of the parents;
- at a child death review feedback meeting held on 22 July 2015 attended by Ben's parents and the trust - trust staff discussed and agreed to delete an incriminating recorded conversation which took place between clinicians in the recess of the meeting; and
- the trust tried to cover up conversations that took place at the meeting on 22 July 2015.

2.3 The overall purpose of the review is to assess the adequacy of the trust management response to these allegations, and specifically to:

- determine, where possible, who knew what and when about the above allegations;
- assess the quality and robustness of trust investigations undertaken in response to allegations;
- assess whether the findings of investigations were reasonable;
- assess whether trust actions in response to the investigations were appropriate and proportionate; and
- make recommendations for the trust about appropriate next steps and learning.

### **3. Executive summary and recommendations**

#### **Background**

**3.1** The trust board commissioned Verita to undertake an independent investigation into how trust management responded to allegations about staff actions and behaviours in relation to the death of Ben at Bristol Children's Hospital (part of the trust).

**3.2** The parents made the following allegations:

- 1) clinicians provided inaccurate information to Ben's parents about the timing and result of blood tests;
- 2) the paediatric intensive care unit matron was dismissive of the parents;
- 3) at a child death review feedback meeting held on 22 July 2015 attended by Ben's parents and the trust - trust staff discussed and agreed to delete an incriminating recorded conversation which took place between clinicians in the recess of the meeting; and
- 4) the trust tried to cover up conversations that took place at the meeting on 22 July 2015.

**3.3** The overall purpose of the investigation is to assess the adequacy of the trust management response to these allegations, and specifically to:

- determine, where possible, who knew what and when about the above allegations;
- assess the quality and robustness of trust investigations undertaken in response to allegations;
- assess whether the findings of investigations were reasonable;
- assess whether trust actions in response to the investigations were appropriate and proportionate; and
- make recommendations for the trust about appropriate next steps and learning.

**3.4** The independent investigation consisted of a series of interviews and an examination of documents provided by Ben's parents, the trust and interviewees.

**3.5** We conducted 13 face-to-face interviews. Verita provided the trust with a list of roles of interest to the investigation team. The trust subsequently arranged the interviews. An interview list is included in appendix B.

**3.6** The interviews were recorded with the agreement of the interviewees and a transcript was subsequently sent to them so that they could verify the accuracy of what they said and propose amendments, ensuring the transcript reflected what they intended to say. We assured interviewees that the transcript was confidential between them and Verita and that any quotes used in the report would be anonymised to job title. However, given the interest in the case, we warned interviewees that their job title might make them identifiable.

**3.7** Our terms of reference ask that we specifically look at the management's response to the parents' allegations and not investigate the allegations themselves. We consider that allegations 3 and 4 are fundamentally linked and must therefore be addressed together.

**3.8** All events detailed occurred in 2015 unless otherwise stated.

**Allegation 1) Clinicians provided inaccurate information to Ben's parents about the timing and result of blood tests.**

**3.9** Ben's parents attended a pre-child death review (CDR) meeting on 4 June. Also in attendance was Consultant 1 and another consultant colleague (Consultant 2). Consultant 1 was Ben's primary consultant during his care and Consultant 2 attended the meeting as a senior, experienced clinician.

**3.10** During the meeting, Consultant 1 gave inaccurate information about the timing of blood tests taken in the days leading up to Ben's death. Consultant 1 told the parents that blood tests were taken on 16 and 17 April and that the only one positive for pseudomonas (a secondary infection present at the time of Ben's death) was taken on 17 April (but reported after Ben died). This suggested a test taken on 16 was negative, when in fact no blood test was taken that day.

**3.11** The clinicians involved accept that they gave inaccurate information during that meeting. Why they did so is disputed.



**3.12** Ben's parents believe that incorrect information was deliberately given because of the catalogue of failings during their son's admission to the PICU. The parents believe that the clinicians wanted to cover up additional failings and they therefore told them a blood test was taken on 16 April and was negative for pseudomonas when in fact the test was not taken until the next day (the day he died) and was positive. Consultant 1 says that her mistake was in deciding to detail microbiological investigations from memory. She said to Ben's parent's during the meeting:

*"Please stop me if it's just not making sense to what you remember. This is from memory, hence my saying that."*

**3.13** The parents first raised their concerns about Consultant 1 and Consultant 2 having given them inaccurate information in July 2015. The trust initially tried to address the concern as part of a wider complaint response to the parents on 28 August. The parents were clearly dissatisfied with the explanation and raised their concerns directly with the chief executive by email on 16 September. The chief executive subsequently tasked the medical director with commissioning and overseeing a number of investigations - including one into the probity of Consultant 1 and Consultant 2 during the meeting on 4 June. However, an investigation into this issue had yet to be commissioned when the clinical director for critical care met the parents on 16 October (a month later).

**3.14** Senior trust managers agreed that the clinical director for critical care would meet the parents and explain their son's clinical notes, address their questions and then produce a report to send to the parents with a covering letter. The clinical director for critical care was keen to meet with Ben's parents to provide a fresh perspective from a senior clinician's point of view. We consider this to be good practice and acknowledge that the clinical director for critical care could see that the trust's standard response was not working and was therefore trying to engage in a different way with the family.

**3.15** The divisional director and the clinical director for critical care reported to the medical director that the investigation undertaken by the deputy divisional director had identified the need for a further investigation into the probity of Consultant 1 and Consultant 2 during the meeting on 4 June. The medical director subsequently asked the clinical chair to carry out this investigation in mid-October. She produced a report on 20

November - the date the parents were due to receive the findings of the most recent investigations.

**3.16** We recognise that the trust wanted to respond to the parents by the agreed deadline. However, the report was only delivered to the chief executive and the medical director on the day it was 'promised' to the parents. The clinical chair, deputy divisional director and the medical director met several times during the course of the day to consider the report. However, we feel that the trust's desire to respond to the family on that day left the executives with little opportunity to fully consider the report or ensure that all the issues had been appropriately investigated before sending it.

**3.17** The trust failed to acknowledge the seriousness of the allegation until the parents corresponded directly with the chief executive on 16 September. The chief executive then recognised the gravity of the situation: he wrote next day to the chief nurse, the medical director and chief operating officer stating that failing to investigate the allegations thoroughly would:

*“put the division and the trust at risk of collusion, or apparent collusion, in something inappropriate.”*

However, an investigation was not commissioned until after the clinical director for critical care met the parents in mid-October.

### *Investigations*

**3.18** The chief executive raised with his executive colleagues on 17 September the need for the probity of Consultant 1 and Consultant 2 to be investigated. The medical director was tasked with commissioning and overseeing a number of investigations - including one into Consultant 1 and Consultant 2 giving Ben's parents' inaccurate information during the pre-CDR meeting on 4 June. The medical director, divisional director and clinical director agreed during a meeting that the clinical chair would be asked to undertake the investigation. She did raise concerns about her independence but on the basis that this was a fact finding exercise she agreed to proceed and noted the potential conflict in her report.

**3.19** The fact finding exercise took place more than four months after the meeting when the inaccurate information was given and more than three months since the trust became aware of the parents' allegation via the complaints route. The trust knew about this serious allegation in July and correspondence suggests executives were aware of the complaint response sent to Ben's parents at the end of August. However, executives did not appear to appreciate the extent of the parents' concerns nor discuss a different approach to investigating them until an email from Ben's father on 16 September. The fact-finding exercise was not initiated for another month. This is a failure to act on the concerns in a timely manner.

**3.20** The clinical chair was senior enough to investigate, but she was not sufficiently independent of the case or of the clinicians involved. The medical director or his deputy would have been more appropriate to undertake the investigation, given the serious nature of the allegations and the fact that they involved the probity of consultants in the trust. The parents had clearly lost faith in the trust's ability to be open and honest, so it would have been more appropriate to instruct a member of staff further removed from the service to undertake the investigation.

**3.21** When the fact finding exercise was commissioned, it was not clear whether the report was a confidential internal document or one that Ben's parents would see. Trust staff clearly felt under pressure to provide a response to the parents the day that the report was presented to the medical director. Whilst the clinical chair, deputy divisional director and the medical director met several times that day to discuss the report we consider that the medical director might have found shortcomings if he had had more time to reflect on it.

**3.22** We acknowledge that the investigator was asked to undertake a fact finding exercise under the informal part of MHPS guidance. We consider, however, that it would have been appropriate to have taken a more formal approach to investigating the allegations. This should have included clear terms of reference, shared with the interviewees. The investigator should have asked both interviewees to provide a written statement and the report should have reflected both their views/role in the case, irrespective of their supposed role at the meeting. The investigator should have made interviewees aware about the purpose of the investigation and with whom the outcome would be shared.

**3.23** The trust were trying to carry out an internal, informal exercise while responding to a complaint about the same matter. The result was unsatisfactory both as a complaint response and as an internal investigation.

**3.24** The report contains little analysis. It consists mostly of Consultant in paediatric intensive care 1's testimony/reflective practice, with a short conclusion. The investigation does not appear to have gone far enough in order to answer the parents' questions. The parents believed that the trust wanted to give the impression they had tested for pseudomonas with a negative result, because a positive result would have suggested that antibiotics should have been started sooner. The parents believed that the inaccurate information should not be seen in isolation but considered in the context of the possible reasons why the clinicians might want to mislead the parents.

**3.25** The clinical chair told us that she had listened to the recordings as well as reviewing the transcripts and was therefore in a position to consider the conversation that had occurred. She said that she placed a reliance on the objective evidence of the recording and then questioned the individuals concerned regarding their intentions.

**3.26** The clinical chair said she reviewed the ICE (clinical information system) computer records as part of her fact finding. We therefore considered whether she could have established that the pseudomonas grown from Ben's lung (taken on 16 April) was actually reported and reviewed on 17 April, before Ben had died.

**3.27** The clinical chair provided us with a screenshot of the results, which shows that the results she viewed were reported on 18 April. She told us that at that point she was unaware that there were 'interim' findings, which had been reported and reviewed on 17 April. It was only when the IT capabilities of the ICE system were further interrogated that they discovered this. She told us that she was informed that interim reports are overwritten on the report site as further information about a test is added. This is a safety measure to avoid potentially opening a report with the interim result when a further, more detailed, report is available. A number of other sources confirmed this information.

**3.28** The clinical chair documented in the learning section of her report that there is "*much learning and reflection*" for the consultants and the children's service, which had been highlighted in the clinical director for critical care's letter to Ben's parents on 28 October and in the CDR report. She states:

*“I would recommend that the trust reflects on how we support clinical staff to ensure open disclosure and support for bereaved parents in their most difficult of times.”*

**3.29** However, we would have expected the clinical chair to make a number of more specific recommendations in her report. For example, we would have expected her to recommend the need for guidelines when giving information from memory. We would also have expected a recommendation about the pre-CDR meeting process - on managing parents’ expectations and clear guidelines to frame these meetings.

**3.30** We do not believe that the investigation went far enough to consider/investigate any potential underlying reasons for the clinicians giving inaccurate information. No one disputes - and the recording confirms - that inaccurate information was given to the parents. However, the investigation report suggests that clinicians were simply asked to explain why this happened and takes their word for it. Despite the investigator listening to the recordings and reviewing the transcripts, the report fails to demonstrate an attempt to investigate what the parents believed: that they were deliberately given inaccurate information to make Ben’s clinical care appear better than it was.

**3.31** The appropriateness or otherwise of Ben’s care is clearly a point for the coroner and the trust’s clinicians. Trust management needs to reflect on why it has taken almost a year since Ben’s death for them to tell the parents that some test results were reported and reviewed prior to his death and not previously disclosed to them, despite the parents asking this question on numerous occasions.

#### **Allegation 2) The paediatric intensive care matron was dismissive of the parents**

**3.32** The parents alleged in a complaint emailed to the trust on 15 May that the paediatric intensive care matron was dismissive of them and the severity of their son’s condition. The parents found the matron’s actions upsetting, but their greater concern was that, the matron represented the ‘complacency’ with which their son was treated during his stay in the PICU.

**3.33** The parents met with the matron on 15 April, shortly after Ben’s father emailed the matron about a number of issues. The meeting focused on the parents’ request for a room to stay overnight and the matron telling them it was not possible. The parents allege that the matron was dismissive and told them:

*“Your son is of no concern to us.”*

**3.34** We asked the matron about the comment he was alleged to have made. He told us that what he might have said to the parents to reassure them was “... [Ben] *has had a good night. He’s not caused us any concern over night*”.

**3.35** It is not within our terms of reference to make a judgement on whether the allegation is true. Our remit is to consider the management’s response to the allegation and consider whether it took appropriate action.

#### *Investigations*

**3.36** The first time the trust investigated the concern raised about the matron’s alleged attitude and comments was in the response letter dated 28 August, over three-and-a-half months after the parents raised their initial concerns in an email of 15 May.

**3.37** In order to investigate the nursing elements of the parents’ concerns, the general manager sent the concerns to the matron - including those relating to his behaviour - and asked him for his comments. He replied and the general manager coordinated a response. The divisional director took control of the complaint response when the general manager retired in mid-August.

**3.38** This practice of asking the individual concerned to respond to allegations is in line with the trust’s complaint investigation process. However, the response failed to adequately investigate or address the allegation the parents raised regarding the words used by the matron.

**3.39** The parents emailed the chief executive on 16 September raising a number of allegations, including one about the matron’s attitude. This email appears to have been the catalyst for this matter to be investigated outside the trust’s normal complaint process. It appears that before this, the trust failed to recognise the seriousness of the allegations or the need for a more robust approach to their investigation.

**3.40** Upon receipt of the email, the chief executive and colleagues agreed that a more comprehensive investigation needed to be undertaken. At the end of September 2015, the divisional director asked the head of nursing to investigate nursing elements of the parents' complaint raised in their email to the chief executive on 16 September- which included the attitude of the matron. The head of nursing told us that she had been asked to undertake the investigation in preparation for a meeting scheduled to take place between the clinical director for critical care and Ben's parents.

**3.41** The head of nursing told us that she had known the matron for "*a long time*". She also said that she would find it very surprising if the matron had used that language given his experience. The head of nursing was clearly appropriately senior to conduct the investigation but she had known the matron for some time and therefore would not have been seen to be suitably objective - particularly from the perspective of the complainant. She does not note her working relationship with the matron in her report nor justify why she felt able to remain objective. We are not questioning the integrity of the head of nursing, but believe the trust should have recognised the likely external perception of a long-standing colleague undertaking a sensitive investigation and therefore recognised the need for someone transparently more independent to undertake the investigation.

**3.42** The matron was asked about his actions in a more formal capacity only when the head of nursing interviewed him as part of her investigation in October 2015. We think too much time had passed and the opportunity had been lost to robustly investigate this matter and to reasonably expect the matron to recall his exact words.

**3.43** The head of nursing gave a verbal report to the clinical director for critical care before he met the parents on 16 October. She told us that after the meeting she asked the clinical director for critical care whether the family were satisfied with her response and if they raised any further nursing concerns during the meeting. She told us that they family were satisfied and she therefore did not consider that a written report was required until the divisional director asked her to produce a written report in December 2015. She told us that it was a summary of actions and not a formal report of her investigation.

**3.44** The email from the parents to the matron on 15 April 2015 raises concerns about accommodation. The head of nursing's summary report does not acknowledge that the meeting with the matron came about as the direct result of that email or the difficulties

the parents experienced. The report implies that they had a conversation that focused on where the parents originated from in the UK rather than their concerns for their son or their ability to stay with him while he was in PICU.

**3.45** The 'findings' consist of two paragraphs - one of which explains why the matron was not on the ward for most of Ben's stay in PICU. The finding about why the matron did not speak to the parents for the first part of his stay is reasonable, but it is written in a way that makes it look as though the parents are simply wrong in their recollection of events. The fact that the parents met the matron on only one occasion was never in dispute.

**3.46** The head of nursing's report does not detail conclusions or offer a judgement on the allegation about the matron's attitude. She offered no learning points for the trust. We would have expected a more thorough investigation. She told us that the report was just a summary of actions taken which is why it does not contain the level of detail we would expect. However, given the serious nature of the allegation we would have expected the investigator to produce a formal report.

**3.47** It appears that neither the trust nor the matron investigated the allegations as thoroughly as they should have. The matron's version of events changes from his not being able to remember, to stating he had several meetings with the parents, to offering a form of words that he 'may have used' that the parents 'could' have taken out of context.

**Allegations 3 and 4) At a child death review meeting held on 22 July 2015 attended by Ben's parents and the trust - trust staff discussed and agreed to delete an incriminating recorded conversation, which took place between clinicians in the recess of the meeting. The trust tried to cover up conversations that took place at the meeting on 22 July 2015.**

**3.48** At the CDR feedback meeting held on 22 July 2015 - trust staff discussed and agreed to delete an incriminating recorded conversation that took place between clinicians in the recess of the meeting. The parents allege that the trust subsequently tried to cover up conversations.

**3.49** The CDR-feedback meeting held on 22 July was attended by:



- Consultant 3 (consultant in paediatric intensive care and chair of the CDR);
- Consultant 4 (consultant in neonatal intensive care at another trust);
- General manager (now retired); and
- Ben's parents.

**3.50** Both Ben's parents and the trust agreed to audio-record the meeting.

**3.51** Before a recess in the meeting, the attendees were discussing the timing of antibiotics given to Ben and whether clinicians should have prescribed and administered them sooner. The consensus reached at the CDR meeting was that Ben:

*“did not show clear signs of sepsis syndrome until 1440 on 17/4/15, and if antibiotics had been started at this point, he would have received only one additional dose of antibiotics and it is unknown if this would have been able to change the outcome in severe pseudomonas sepsis.”*

**3.52** The parents left the room during the recess and the discussion continued. Shortly after, trust staff realised that the recording was still going and switched off the trust recorder. The rest of the discussion was captured on the parents' recording device.

**3.53** The parents say that Consultant 4 informed them when they returned from the recess that there was “*something extra*” for them on their recording. The general manager told us that she also explained to the parents that a further discussion had taken place, they were sorry it happened and that it had been left on the recording for them to hear.

**3.54** The parents said they listened to the ‘extra’ recording in the car on the way home and were shocked. They believed the recess discussion was an admission that Ben should have been prescribed and administered antibiotics sooner.

**3.55** The staff involved did not dispute that the discussion about deleting the recording took place. However, their reason for requesting and agreeing to delete the recording differs from the parents' interpretation.

**3.56** The parents believed that the staff wanted to delete the recording because it was incriminating. During the recess discussion the clinicians admitted that the parents had “*a point*”. Consultant 4 said during the recess discussion:

*“I struggle to see why he wasn’t given antibiotics if on the Tuesday they’ve said if he gets worse give him antibiotics.”*

**3.57** Consultant 3 said she asked the general manager if the recording could be deleted because she just forgot that it was still recording and that it could get them into difficulty because the clinical team were not there to speak from experience about the case. She said she was just representing a consensus view from the CDR meeting and felt very uncomfortable about these statements without the clinical team being able to respond.

**3.58** The general manager told us that she initially agreed to delete the recording. However, she reflected while she was making coffee for the parents and believed that nothing had been said that was detrimental. In fact, she felt it would be positive for the parents to hear that they were recognising that they were asking the right questions.

**3.59** Staff involved in the CDR feedback meeting with the parents on 22 July told us they informed others (Consultant in paediatric intensive care 1, Consultant 2 and the clinical chair) about the recess discussion. However, it appears that no one sought to proactively engage with the parents about the recording. Instead, they waited to see if anything further would materialise.

**3.60** There appears to have been confusion about the exact nature of the parents’ concerns - there was the belief that some of the recording had been deleted from the trust’s recording. However, it was established that the trust recorder was switched off while the parents’ recording device continued to capture the conversation.

**3.61** After the parents’ email to the chief executive on 16 September and subsequent correspondence with the divisional director, senior managers believed that the parents had concerns about the consistency of what staff said during the recess and the second half of the meeting. This interpretation of the parents’ concerns resulted in the divisional director commissioning his deputy to undertake an investigation into the consistency of what was discussed.

**3.62** The parents had clearly raised concerns about deletion in September but the trust failed to address this point. The parents shared their version of the audio recording with the trust on 7 October, however even at that point senior managers failed to realise the

significance of the allegation. An investigation into this allegation was not commissioned until December 2015, after the transcript and audio recording featured in the Daily Mail.

### *Investigations*

**3.63** Two investigations were commissioned in relation to these allegations:

1. The divisional director asked his deputy on 13 October to assess whether anything said during the recess of the CDR-feedback meeting on 22 July contradicted what was said in the second part of the meeting.
2. The medical director commissioned his deputy in late December 2015 in line with MHPS guidance to investigate the suggestion of deletion of part of the recording made during a break at the CDR-feedback meeting on 22 July.

#### First investigation

**3.64** The deputy director sought clarification to ensure she was investigating under the appropriate trust guidelines and was clear about the scope of her investigation. She reviewed transcripts of the meetings with the parents and interviewed Consultant 3 and Consultant 4.

**3.65** The deputy director concluded that she was satisfied that nothing the clinicians said in the second part of the CDR feedback meeting directly contradicted what they said during the recess. However, she found they had proceeded with caution and had perhaps been not as open and transparent with Ben's parents as they might have been at such a meeting.

**3.66** Given the scope of her investigation, her approach, findings and conclusions were reasonable. However, the scope was too limited to address the parents' main concern: why a clinician would suggest part of a discussion be deleted and a manager would agree to it.

**3.67** The divisional director told us he believed at the time that the parents' concern related to the clinicians contradicting themselves during the second part of the meeting. However, the trust should have recognised the seriousness of the suggestion that any

element of the meeting should be deleted - and the reason for such a suggestion - and ensured that any investigation covered these points.

## Second investigation

**3.68** The medical director commissioned the deputy medical director in December 2015 to undertake a preliminary investigation under Maintaining High Professional Standards (MHPS) guidance to formally investigate allegations made by Ben's parents - that deliberate attempts were made by trust staff to falsify recordings of a meeting they attended on July 22 July 2015.

**3.69** The investigation had clear terms of reference, which included reviewing both the parents' and the trust's recordings of the CDR-feedback meeting on 22 July and interviewing all staff who had been present.

**3.70** The investigation report set out a clear methodology for the investigation and a background to the concerns. The investigator interviewed all staff present at the CDR-feedback meeting and asked about the suggestion to delete the recess recording.

**3.71** The investigator set out her findings and conclusions in a report and presented it to the medical director. The medical director then included the key findings in a letter to Ben's parents dated 1 April 2016. The letter states that there is clear evidence that Consultant 3 asked for the section recorded during the recess to be deleted. It goes on to say that this comment was made in haste and was not followed up or actioned, supporting a view that there was no real intent to delete the recording.

**3.72** The medical director's letter to the parents containing the findings of the investigation did not answer the parents' fundamental question: why Consultant 3 wanted part of the recess discussion deleted and why that recording would have got them into difficulty.

**3.73** The investigator did put this question directly to Consultant 3 and the general manager as part of her investigation. The interviewees offered their opinion on Consultant 3's motive and what she meant. Consultant 4 acknowledged what had happened but said

that they had been honest with the parents about the recess discussion and felt that duty of candour had been met.

**3.74** The medical director's letter to the parents of 1 April failed to address the parents' concerns, despite their concerns being investigated as part of the deputy director's investigation. A separate complaint response needs to be drafted if the trust deem the investigation is not appropriate to be shared with the parents because it was conducted under MHPS guidance and is therefore an internal HR document. The separate response should either draw on the MHPS findings or a further investigation needs to be undertaken. Either way, the trust must ensure that all concerns raised by the parents are addressed in the complaint response - which includes answering why Consultant 3 suggested part of the recess discussion should be deleted.

**3.75** Trust management knew about the parents' concerns about the recess discussion but failed to recognise the point they were making or the seriousness of the suggestion of deleting a discussion - whether or not any deletion actually took place. This lack of grip on the issue resulted in a delay of four months before the deputy medical director's investigation.

**3.76** The trust failed to recognise the substantive issues in a timely way and therefore the first investigation was inadequate, even though the investigator fulfilled her brief.

**3.77** The second investigation was not commissioned until December and concluded at the end of March. This delay was allowed to occur despite the parents having raised their concerns about the transcript in the email to the chief executive on 16 September. Everything took too long and the parents had lost confidence in the trust by the time of the second investigation.

### **Overall conclusions**

**3.78** The trust missed a number of significant opportunities to engage pro-actively with Ben's parents after the death of their son. For example, the trust failed to share important findings about the presence of a secondary infection at the time of Ben's death. While there has been some debate about when the results were reported and reviewed - the fact is the parents were not informed of the finding until seven weeks after their son's death.

**3.79** 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. For example, at the second pre-CDR meeting held on 11 June, staff appeared very reluctant to share information with the parents and give definitive answers to the parents' questions. This may have been appropriate given the CDR was taking place less than a week later and the clinicians involved would be able to have a more informed discussion. However, the way in which the meeting on 11 June was conducted made staff appear guarded and reluctant to engage with the parents.

**3.80** 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. For example, when management were informed about the discussion which took place in the recess of the CDR feedback meeting (including the suggestion of making a deletion), the response was to wait to see whether anything further came of it rather than tackling the issue head on.

**3.81** 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.

**3.82** There was a long delay in senior management getting a 'grip' of the complaint and recognising the serious nature of the parents' concerns.

**3.83** 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.

**3.84** 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.

**3.85** 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.

**3.86** 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.

**3.87** The purpose of the meeting on 22 July appears to have been two fold - to provide the parents with feedback from the CDR 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 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, in particular in relation to the prescribing of antibiotics.

**3.88** 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.

**3.89** 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.

**3.90** 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.

**3.91** 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.

**3.92** 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.

## **Recommendations**

**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.

**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.

**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 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.

**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.

**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.

**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.

**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.

**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.

## 4. Approach

4.1 This independent investigation consisted of a series of interviews and an examination of documents provided by the parents of Ben, the trust directly and individual interviewees.

4.2 We conducted 13 face-to-face interviews. Verita provided a list of roles of interest to the investigation team and the trust subsequently arranged the interviews. An interview list is included in appendix B. All staff were emailed to invite them to be interviewed.

4.3 We told interviewees in advance that a colleague, friend or member of a professional body or trade union could accompany them. The interviews were recorded with the agreement of the interviewees and a transcript was subsequently sent to them so that they could verify the accuracy of what they said and propose amendments, ensuring the transcript reflected what they intended to say. We assured interviewees that the transcript was confidential between them and Verita and that any quotes used in the report would be anonymised to job title. However, given the interest in the case, we warned interviewees that their job title might make them identifiable.

4.4 We reviewed documents provided by the parents of Ben, the trust and individual interviewees. A list of documents reviewed is included in appendix C.

4.5 Our findings from interviews and documents are in ordinary text and our comments and opinions are in *bold italics*.

4.6 Section 5 sets out a chronology of events and action taken after the death of Ben. Sections 6 - 8 set out our findings relating to the management response to the four allegations:

1. Clinicians provided inaccurate information to Ben's parents about the timing and result of blood tests.
2. The paediatric intensive care matron was dismissive of the parents.
3. At a child death review meeting held on 22 July 2015 attended by Ben's parents and the trust - trust staff discussed and agreed to delete an incriminating recorded conversation which took place between clinicians in the recess of the meeting; and
4. The trust tried to cover up conversations that took place at the meeting on 22 July 2015.

**4.7** Section 9 contains our overall conclusions.

**4.8** The terms of reference for our investigation ask that we specifically look at the management response to the allegations, the action taken and whether it was appropriate. We are not asked to comment specifically on the truth of the allegations but to assess whether the trust appropriately investigated them.

## 5. Chronology of events following the death of Ben

5.1 The chronology contains factual information about the events that followed Ben's death. Individuals' opinions and our judgements are reserved for the specific points contained in sections 6 - 8.

5.2 Ben, who had been born on 17 February 2015, sadly died on 17 April 2015 on the PICU at Bristol Children's Hospital. Whenever a child dies on the PICU, standard practice is for the palliative care nurse to contact the parents within three days to offer support. We were told that in this case, the nurse tried several times without success to phone the parents. The parents said they did not receive any missed calls from the trust after their son's death.

5.3 It is normal practice to conduct a Child Death Review (CDR) following the death of a person under 18 years old<sup>1</sup>. Consultant 1, Ben's primary consultant during his care, wrote to Ben's parents in May (letter received 15 May) inviting them to a meeting to discuss questions they might have ahead of the CDR meeting. The parents accepted the invitation by email and the meeting was scheduled for 4 June 2015.

5.4 The parents' acceptance email said they would like the opportunity to discuss some of their concerns about their son's care:

*"Whilst at the time we were relatively happy with the overall care shown during...[Ben's] time in Bristol Children's Hospital there are areas of concern that we would like to follow up on."*

5.5 The email goes on:

*"Another area we would like reviewed is relating to a conversation with the ward Matron...regarding us staying close to...[Ben] in the hospital. The Matron informed us that we were in his words 'not a priority for staying there as...[Ben] was not a concern for the doctors as there were children on the ward who could possibly die unlike...[Ben].' We would like to pursue with a formal complaint against the ward matron."*

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<sup>1</sup> Every death of a child (expected or not) is subject to a Child Death Review where professionals investigate and discuss the death.

*Whilst very angry and disappointed at the words spoken by the matron and his lack of personable skills, I feel now looking back that his complacency towards...[Ben's] condition was in our eyes similar to that of the consultants on the ward with exception of the final day. We would like to establish were the complacency towards...[his] condition stemmed from as clearly the eventual outcome for...[Ben] was far worse than 'not a priority' would suggest."*

**5.6** Ben's parents attended the pre-child death review (CDR) meeting on 4 June. Also in attendance was Consultant 1 and another consultant colleague (Consultant 2). Consultant 2 attended the meeting as a senior, experienced clinician. A member of LIAISE<sup>1</sup> also attended the meeting in an administrative capacity. The clinicians told the parents that their son had a secondary infection (pseudomonas) when he died, which was identified only when the blood results were reviewed on 20 April, three days after his death. However, the results were not shared with the parents until this meeting, seven weeks after his death.

**5.7** Consultant 1 gave inaccurate information about the timing of blood tests taken in the days leading up to Ben's death. Consultant 1 told the parents that blood tests were taken on 16 and 17 April and that the only one positive for pseudomonas was taken on 17 April (but reported after Ben died). This suggested a test taken on 16 April was negative, when in fact no blood test was taken that day.

**5.8** The parents requested a further meeting in light of the new information relating to the presence of a secondary infection at the time of their son's death. This second meeting took place on 11 June.

**5.9** The day after the pre-CDR meeting on 4 June Ben's father emailed the member of the LIAISE team who had attended. In this email he reattached his email of 15 May to Consultant 1 (in which he confirms he wants to meet and raises concerns about Ben's care and treatment). He says in the follow-up email to the LIAISE support worker:

*"I have attached below the original email for which I wish to proceed with a formal complaint against the ward Matron...I do have other areas of concern based on the*

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<sup>1</sup> LIAISE is a dedicated patient and parents support service for Bristol Children's Hospital and for women and children's services which includes maternity, gynaecology, neonatal care and children's audiology. LIAISE stands for - Listening, Information, Advice, Involving, Support, Experiences.

*previous meeting but I would like to keep these completely separate from the above and discuss with the PICU team as planned.”*

**5.10** The LIAISE support worker forwarded the parents’ email to the patient and liaison (PALs) team on 8 June. She explained in the email that the clinical team were meeting with the parents but that they had specifically requested that the issue of the matron’s attitude be addressed as a formal complaint. She asked the PALs team to contact the parents to tell them about the timescales and process.

**5.11** The clinicians told the parents at the start of the second meeting (on 11 June) that they had only an hour available. This upset the parents. The inaccurate information about the timing of blood results was not repeated during the meeting, neither was it corrected.

**5.12** The parents ended the meeting early because they did not feel the clinicians were being open and honest with them. However, the clinicians felt that many of the parents’ questions would have been better taken to the child death review meeting for discussion by specialists.

**5.13** The parents emailed the child death review coordinator next day, copying in the LIAISE support worker and saying they would like their concerns to pursue a more formal route. The email says:

*“I have attached all the questions and points that we were due to raise in the second meeting which were never discussed and we would appreciate answers to each and every one. I have also attached all the previous questions from the 1st meeting, all of which we would like to be discussed and considered with person attending the death review.”*

**5.14** The child death review coordinator responded the same day, saying she had spoken with Consultant 2 and he assured her that he would take all the key issues raised to the CDR meeting on 17 June. The email also confirms that a member of the complaints team will be in contact regarding the formal complaint process.

**5.15** Clinicians met on 17 June 2015 to hold the CDR into Ben’s death. The clinicians addressed the question of whether antibiotics should have been started earlier and concluded in their report:

*“It was discussed if earlier commencement of antibiotics could possibly have altered the outcome. However...[Ben] did not show clear signs of sepsis syndrome until 1440 on 17/4/15, and if antibiotics had been started at this point, he would have only received one additional dose of antibiotics and it is unknown if this would have been able to change the outcome in severe pseudomonas sepsis.”*

5.16 The meeting ended by agreeing that the chair of the CDR (Consultant 3) and Consultant 4 (who was not present at the CDR but knew the parents from the neonatal intensive-care unit) would meet with the parents once the minutes had been circulated to attendees/invitees and finalised. It is usual practice for clinicians who treated a child to be involved in the post-CDR feedback meeting. However, the relationship between the parents and Ben’s clinicians (Consultant 1 and Consultant 2) had broken down and the parents wanted no further meetings with them.

5.17 After the meeting Consultant 2 and Consultant 1 had with the parents on 11 June, Consultant 2 alerted the general manager that Ben’s parents remained unhappy and likely to pursue the complaint. The general manager therefore began liaising with the parents.

5.18 The chief executive wrote to the parents on 14 July, thanking them for their email of 6 July 2015 and saying that he was concerned about the difficulties the parents were experiencing after their phone conversations with the patient support and complaints team. The chief executive confirmed that an investigation into the issues they raised was underway and would be completed by 25 August 2015.

#### Comment

*The trust clearly failed to communicate internally about the issues raised by Ben’s parents in May 2015. This resulted in the issues not being investigated for a significant time.*

5.19 The post-CDR feedback meeting with Ben’s parents took place on 22 July 2015. Consultant 3 (CDR chair and PICU consultant) and Consultant 4 (consultant neonatologist) were present. The general manager also attended to go through the parents’ list of

complaints. The first half of the meeting focused on the complaint and the second on the CDR feedback/chronology of Ben's care. Both the parents and the trust recorded the meeting. During a recess in the meeting, the parents left the room and the two consultants continued to discuss elements of Ben's care and treatment. They then realised that both audio recorders were still running and the trust recorder was turned off. The parents' recorder continued to run and captured further debate about the timing of antibiotic administration:

*"Consultant 4: But... [Consultant 3] they are absolutely right.*

*Consultant 3: They've got a point."*

**5.20** The general manager sent a consolidated list of the parents' concerns to Ben's father on 28 July. He replied with a number of amendments and additions. A finalised list of issues for investigation under the complaints process was subsequently agreed and the general manager told the parents they would receive a response *"as soon as is practically possible"*. We understand that the parents were subsequently told they would receive a response by 20 August.

**5.21** The general manager gave Ben's parents a memory stick on 5 August 2015 containing the audio recording of the post-CDR meeting on 22 July.

**5.22** Between 9 and 11 August Ben's father exchanged emails with the general manager and a member from the trust's Patient Support and Complaints Team regarding possible editing of the recording. Everyone concluded (including Ben's parents) that no changes were made. The trust's recording had simply been stopped while the parents' continued to record.

**5.23** The chief executive responded to the parents' complaint on 28 August, a week later than initially agreed.

**5.24** Ben's father emailed the chief executive on 16 September saying he was not satisfied with the trust's complaint response. For the first time the family's complaint mentions:

*"Attempts to cover up information including suggestions to delete recordings after accepting responsibility."*



**5.25** This allegation relates to the clinicians' discussion during a recess in the post-CDR feedback meeting. At this point, the trust did not have a copy of the parents' audio recording, which contains a discussion about deleting the recess conversation.

**5.26** The email from the parents also alleges that the trust failed to investigate issues relating to:

- Consultant 1 and Consultant 2 giving them inaccurate information during a meeting on 4 June; and
- the dismissive attitude of the matron during their son's admission on PICU.

**5.27** The chief executive emailed the chief nurse (the executive responsible for the complaints function) on 17 September, copying in the medical director and the chief operating officer. The email asked the chief nurse and medical director to meet with the clinical chair for children's services to:

*“Consider a wholesale review of complaint handling and clinical review processes in the event of a child death, because this isn't the first time that we've had issues arising out of child death reviews connected to complaints.”*

#### **Comment**

*The chief executive told us during interview that this comment related to the commissioning of the independent review of concerns about children's congenital heart services in Bristol commissioned in 2014 - which included complaints about misleading and incomplete information.*

**5.28** The chief nurse responded suggesting that the medical director look into the issue around the consultant behaviour.

**5.29** The chief executive reported in an email on 21 September to the chief nurse (copied to the medical director and the chief operating officer) that the clinical chair was going to review the transcript of the meeting on 4 June between the parents and Consultant 1 and Consultant 2. However, the clinical chair told us that the first time she was asked to review

what was said during the meeting was in late October after a meeting between the medical director, divisional director and clinical director for critical care.

**5.30** In the chief executive's email on 21 September, he repeated that the medics concerned would still need to be asked what they had said and suggested that the division and the trust would "*put themselves at risk of collusion or apparent collusion in something inappropriate*" if this did not happen. He thought the trust's normal processes were not sufficient to deal with such serious allegations and asked for a different approach, starting with this case. The trust then introduced a formal escalation process, which assigns an executive officer to oversee any such serious complaint.

**5.31** The chief executive assigned the medical director to the executive oversight role for this case. A discussion took place at the end of a routine fortnightly Paediatric Cardiac Steering Group meeting. The discussion was not minuted but interviewees agreed it probably took place after the meeting on 24 September. In attendance were:

- chief executive;
- chief nurse;
- clinical chair;
- divisional director; and
- deputy divisional director.

**5.32** The meeting agreed it was necessary to depart from the normal complaints procedure and that the following actions would be taken:

- the clinical director for critical care would offer to meet the parents to provide a fresh clinical perspective on Ben's care and treatment;
- the head of nursing would investigate the nursing elements of the complaint, including the concerns raised about the attitude of the matron; and
- the divisional director would contact Ben's father to discuss the possibility of a meeting with the chief executive.

**Comment**

*The above actions address one of the four areas of concern included in the terms of reference for this investigation. The agreed actions fail to address three allegations:*

- 1) Consultant 1 and Consultant 2 gave the family inaccurate information during the pre-CDR meeting on 4 June 2015.*
- 2) Consultant 3 asked the general manager to delete a conversation that took place during a recess of the CDR feedback meeting on 22 July. The general manager agreed to do this.*
- 3) The trust tried to cover up conversations that took place at the meeting on 22 July.*

5.33 The chief executive wrote to the parents on 5 October saying he was “*extremely sorry*” to receive their letter of 16 September and that he and his clinical team “*deeply regret*” that the trust had failed to fully respond to their concerns. He committed to providing a further response by 21 October. He also offered them the opportunity to meet him and the clinical director for critical care.

5.34 The divisional director phoned the parents on 7 October and suggested they meet the clinical director for critical care. The parents agreed to do so on 16 October. The clinical director for critical care was keen to meet with Ben’s parents to provide a fresh perspective from a senior clinician’s point of view.

#### **Comment**

*We consider this to be good practice and acknowledge that the clinical director for critical care could see that the trust’s standard response was not working and was therefore trying to engage in a different way with the family.*

5.35 The divisional director told us that it was during the phone call with Ben’s father on 7 October that he became aware of the parents recording of the discussion that took place in the recess of the CDR feedback meeting on 22 July 2015. He told us that the trust received

a copy of the parent's transcript the following day and from there instigated an investigation (which was subsequently undertaken by the deputy divisional director).

**5.36** The head of nursing concluded her investigation into the actions of the matron. She verbally reported her findings to the clinical director for critical care on 15 October - a day before his meeting with Ben's parents.

**5.37** The clinical director for critical care went through Ben's clinical notes, his blood results and his x-rays at the meeting with Ben's parents on 16 October. He assured them that their concerns regarding the probity of Consultant 1 and Consultant 2 and the suggestion that clinicians had privately agreed that antibiotics should have been given sooner were being taken seriously, and that the trust was initiating an investigation but had not yet done so.

**5.38** The chief nurse emailed the executive directors on 22 October to update them on a "*planned development*" related to the process for escalating complaints to executives. The email mentions the:

*"...need for complex complaints to have executive oversight of one designated executive lead, so that all parties, executive colleagues and divisional colleagues are clear who is liaising and supporting responses."*

#### **Comment**

*This complaint was the first to follow this new process so it developed as the case progressed rather than following existing guidance.*

**5.39** The deputy divisional director completed her investigation into the recess transcript on 22 October 2015. The terms of reference required her to investigate whether anything clinicians said during the recess contradicted what they said in the second half of the meeting. She was not asked to investigate the allegation that one consultant had asked the general manager to delete the recess discussion.

**5.40** The deputy divisional director told the divisional director that she thought a further investigation was needed into the inaccurate information Consultant 1 and Consultant 2 gave at the meeting on 4 June.

**5.41** The clinical director for critical care wrote to Consultant 1 and Consultant 2 on 27 October explaining that the parents remained unhappy about “lies”. He told Consultant 1 that he and the divisional director had met with the medical director the day before and had requested that the medical director’s office carry out an investigation into the probity of Consultant 1 and Consultant 2. After discussion, it was agreed that the clinical chair would be asked to undertake the investigation.

**5.42** The clinical director for critical care wrote to Ben’s parents on 29 October summarising the key points from their meeting on 16 October.

**5.43** The clinical chair concluded her investigation into the probity of Consultant 1 and Consultant 2 and provided the medical director with the report on 20 November - the day the parents had been informed they would receive a copy of the report on the outcome of the most recent investigations. The investigation reports from the deputy divisional director and from the clinical chair were sent to the parents that day with a covering letter from the medical director.

**5.44** The head of nursing produced a report in December 2015, formalising the investigation findings about the matron’s attitude. She had verbally reported to the clinical director for critical care before his meeting with the parents (on 16 October).

**5.45** The divisional director told us that the trust’s head of communications called him at home on Saturday 5 December. She told him that the *Mail on Sunday* planned to publish an article the next day about the discussion during the recess of the CDR meeting on 22 July. The divisional director told us he went into work and contacted staff who would be named in the article.

**5.46** A meeting took place on 7 December to discuss the case. It was attended by the:

- chief executive;
- medical director;
- chief operating officer;

- divisional director; and
- director of HR and organisational development.

**5.47** The meeting agreed that the divisional director would compile a timeline of what had happened. He would also develop an action plan of all the outstanding actions.

**5.48** The chief executive contacted Verita on 9 December to discuss the need for an independent investigation.

**5.49** The chief executive called a meeting on 16 December between the:

- clinical chair;
- medical director;
- divisional director;
- director of HR; and
- chief operating officer.

**5.50** Its purpose was to establish what had been investigated, the status of those investigations and why the trust found itself on the front page of the *Mail on Sunday*.

**5.51** The meeting discussed a timeline of the actions taken and the investigations commissioned. The chief executive identified that no investigation had been undertaken into the allegation about the deletion of the recess discussion at the post-CDR feedback meeting on 22 July. He therefore requested that allegation be investigated.

**5.52** The deputy medical director was subsequently commissioned to undertake this investigation - with HR support - under Maintaining High Professional Standards guidance.

**5.53** On 17 December Ben's parents emailed the chief executive and copied in a number of clinical staff. Some staff found the email upsetting and management asked if they would like subsequent messages to be blocked from reaching them. Individuals' wishes were then followed.

**5.54** Verita was formally commissioned to undertake this independent investigation into the management response to allegations about staff behaviours related to the death of Ben on 17 December 2015.

## **6. Clinicians provided inaccurate information to Ben's parents about the timing and result of blood tests**

### **Background and allegation**

**6.1** Standard national process is to hold a Child Death Review (CDR) after the unexpected death of a person under 18 years. In this trust, it has become the practice to the parents of the child to meet the clinician(s) involved in their child's care to ask any questions which can then be taken to the CDR to be discussed by a multi-disciplinary team.

**6.2** In Ben's case, the pre-CDR meeting took place on 4 June 2015 - seven weeks after his death. The parents state that this was the first proper contact they had with the trust after their son's death. They reported that the palliative care nurse left a voicemail on their phone but this was several weeks after their son's death. The pre-CDR meeting was attended by Ben's parents, Consultant 1 and another consultant colleague (Consultant 2). A member of LIAISE also attended in an administrative capacity - primarily because Ben's parents had asked that the meeting be recorded.

**6.3** Consultant 1 told us she had discovered a few days before, while preparing for the meeting on 4 June, that Ben's medical notes recorded a positive blood culture for pseudomonas. The parents had not been informed of the finding. The timing of the exact discovery of pseudomonas infection is in debate, although the trust has now confirmed to the parents that the result was grown (from the lung) and reported/reviewed on 17 April, the day Ben died.

**6.4** Consultant 1 told Ben's parents about an hour into the pre-CDR meeting that test results that came back after he died showed he had a pseudomonas infection. She subsequently explained the series of tests undertaken that week - although she did not have with her the blood culture information (including dates and results of tests). This information is generally not kept in the clinical notes. She therefore recalled this information from memory.

**6.5** Consultant 1 gave inaccurate information about the timing of a blood test taken in the days before Ben's death.

6.6 Consultant 1 told the parents:

*“When we took that fluid from the lungs that subsequently grew that, that bug, we did blood cultures at the same time, and they didn’t grow anything. He had more cultures taken on the day he died, when he was sicker. And that they did.”*

6.7 Consultant 2 confirms the misinformation given by Consultant 1 during the meeting:

*“I think in the latter half of that week, he developed pseudomonal septicaemia, i.e. blood culture infection. And I say in that following week, because I think we had to go back and check this. But I think the cultures maybe on the 16<sup>th</sup> were negative. On the 17<sup>th</sup>, maybe, it was just on the cusp. I think that caused him to be very ill on that 17<sup>th</sup>...”*

6.8 The clinicians involved now accept that they gave inaccurate information during that meeting. Why they did so is disputed.

6.9 Ben’s parents believe that incorrect information was deliberately given because of the catalogue of failings during their son’s care on the PICU. The parents believe that the clinicians wanted to cover up additional failings and they therefore told them a blood test was taken on 16 April and was negative for pseudomonas when in fact the test was not taken until the next day (the day he died) and was positive. The parents believe that if a blood test had been undertaken on 16 April it would have found pseudomonas and the infection could have been treated sooner.

*Comment*

***We acknowledge the significance of this point for Ben’s parents but this is a clinical matter. Our terms of reference ask that we specifically look at the management’s response to the parents’ allegations; it has not been our role to investigate the allegations themselves. The coroner will consider the cause of death; however, the parents continue to have a number of concerns regarding their son’s clinical care that need further investigation.***



**6.10** Consultant 1 told us she informed the parents during the meeting on 4 June about the pseudomonas infection. She then talked - from memory - through the microbiological investigations undertaken and the timing of antibiotics. This was when she wrongly told the parents that a blood test had been taken on 16 April.

**6.11** After the meeting, Consultant 1 emailed the microbiology team explaining that a CDR was due to take place for Ben and that his parents had specific questions regarding the part that the secondary infection (pseudomonas) played in his death, the timing of getting results etc. She thought it would be helpful for a microbiologist to attend a second pre-CDR meeting with the family on 17 June. In the email exchange, Consultant 1 says:

*“BAL positive for pseudomonas on 16 April (day before death) - cultures on this day negative but became positive just before death on 17<sup>th</sup>”.*

**6.12** At face value, this appears to directly contradict what the consultants told the family during their meeting earlier that day:

*“It was something unfortunate we didn’t find out until after he had died was that he did grow a bacteria from his lungs that day”.*

**6.22** A trust microbiologist has explained that:

*“When referring to a positive culture we use the date the specimen was taken NOT the date or time that the culture is noted to be positive. We do this because the time to positivity depends on the number of bacteria in the blood sample and the type of blood culture and prior exposure to antibiotics.”*

**6.32** In this instance, the BAL was taken on 16 April and the blood cultures were taken on the afternoon that Ben died, on 17 April. This explains the terminology used by the clinicians discussing Ben’s results. The consultant was referring to the time/date of the test, not when the positive result became apparent.

**6.12** The consultants involved in the meeting on 4 June have reflected on the giving of inaccurate information. Consultant 1 says on reflection that her mistake was in deciding to detail microbiological investigations from memory. She said to Ben’s parent’s during the meeting:

*“Please stop me if it’s just not making sense to what you remember. This is from memory, hence my saying that.”*

**6.13** Reflecting on giving Ben’s parents inaccurate information, Consultant 2 told us:

*“We conducted ourselves with the best of intentions throughout and hindsight is a wonderful thing. An error was made and, yes, we find ourselves here.”*

*Comment*

*The terms of reference for our investigation ask that we specifically look at the management response to the sharing of inaccurate information, the action taken and whether it was appropriate. We are not asked to comment on the truth of the allegation but assess whether the trust appropriately investigated it.*

**6.14** Below we detail the timeline of the management response to the allegation and outline the action that was taken and by whom.

**6.15** After the pre-CDR meeting on 4 June the parents requested a second meeting with Consultant 1 and Consultant 2, which was arranged for 11 June. The consultants knew the parents were likely to want to discuss further questions - particularly in light of new information about the presence of a pseudomonas infection at the time of their son’s death.

**6.16** The second meeting was attended by Ben’s parents, Consultant 1 and Consultant 2 and the same member of LIAISE who attended the first meeting. During this meeting, the parents were given copies of the microbiology and virology results. The consultants then explained the tests and results sequentially. Consultant 2 said:

*“So I think on that day [16 April]...[Consultant 1] will fill in the gaps, that they were concerned that...[Ben’s] x-ray wasn’t progressing in a way that they might have hoped, so they did a lung lavage. Is that right?”*

6.17 Consultant 1:

*“Yeah.”*

6.18 Consultant 2:

*“And that was - so that’s the date it was collected. The date it was reported is on the 18<sup>th</sup>.”*

*Comment*

*The trust has now confirmed that the lung results were reported and reviewed on 17 April. We were therefore surprised that Consultant 2 told Ben’s parents that the results were reported on 18 April when they were in fact reported and reviewed the previous day - while Ben was alive.*

*However, the trust reports that the results reported on 17 April were interim findings and the report was overwritten when further information was reported on 18 April. This was not identified until attempts to further interrogate the ICE (clinical information) system were made earlier this year.*

*The fact still remains that initial findings were reported and reviewed when Ben was still alive. We have not reviewed the ICE (clinical information) system and therefore do not know who reviewed the reported results on 17 April. However, the safeguard system in place to override interim reports with up-to-date information explains why Consultant 2 would have believed results were reported and reviewed on 18 April.*

6.19 Consultant 2 went on:

*“And then this is then a blood culture done on 17<sup>th</sup> - this is on the day...[Ben] died. It was received in the laboratory at 25 past two. It was reported on the 20<sup>th</sup> and that’s the blood culture which grew pseudomonas.”*

6.20 During the second meeting, neither clinician mentioned a blood test being undertaken on 16 April (the misinformation provided during the meeting on 4 June). None

of the meeting attendees recognised that the tests being described during the second meeting did not correlate with those discussed at the first.

**6.21** Consultant 1 and Consultant 2 told us that at the time of the second meeting with the parents on 11 June they did not know they had given inaccurate information about the timing of a blood test. The transcript from the 4 June meeting had not yet been finalised so the attendees had not seen it by the time of the second meeting.

**6.22** Both the parents and the consultants thought the second meeting did not go well. Consultant 1 and Consultant 2 told us they felt it was important to take many of the questions to the CDR where they could be discussed with a specialist in the particular field. Consultant 2 told us:

*“That second meeting didn’t go well because they felt that I wasn’t answering their questions honestly, but it was only because I wasn’t in a position of expertise to give them the answer, and we had the multi-professional meeting the week later.”*

**6.23** Consultant 1 told us:

*“I think in part they were finding it frustrating because I think they wanted us to be quite exact and specific about how relevant this new finding was, and, unfortunately, we still don’t know how relevant that was... A lot of questions you can just put to bed immediately, and that is by far the best thing for everyone, but for the ones you can’t, the whole point of the CDR is to get a consensus from the wider group. I think they were frustrated that we were deferring some of those questions around infection to that meeting.”*

**6.24** The parents felt the consultants were defensive and reluctant to answer their questions:

*“They were very prepared to not answer anything...We were sitting in a room with two people who cared for him who weren’t willing to answer any question, who deflected every question on to somebody else, ‘We will discuss this at the Child Death Review, because everybody will be at the Child Death Review.’”*

**6.25** The parents brought the meeting to an end because they felt they were not getting answers.

#### *Comment*

*The second meeting between the parents and Consultant 1 and Consultant 2 was not helpful according to all involved. We question why consultants went to a meeting when they were reluctant to answer questions. We understand the parents were keen to have this second meeting but it did not meet their needs and served only to cause a further breakdown in relations, with the parents growing increasingly suspicious about what they saw as the trust's apparent lack of openness and candour.*

#### **Timeline of management response**

##### *Who knew what and when?*

**6.26** The transcripts of the two meetings with the parents on 4 June and 11 June were made available to Consultant 1 sometime after the second meeting. She told us her focus was on checking the medical terminology of the transcripts and not looking at dates given to the parents about various tests. She said she did not know at this point that she had given the parents inaccurate information at the meeting on 4 June.

**6.27** Ben's parents discovered the inaccuracy of the information when they compared transcripts of the two meetings. They noticed that clinicians had said nothing at the second meeting about a blood test being undertaken on 16 April when they talked through a hard copy of test results.

**6.28** The general manager became aware of the parents' concerns - through their correspondence with the trust and through a discussion with Consultant 2 - who advised her after the second meeting with the parents on 11 June that there would likely be additional concerns raised by the parents. The general manager contacted the parents to discuss the approach to addressing their concerns. They agreed that the post-CDR feedback meeting on 22 July would be used to go through the chronology of Ben's care, share the CDR findings and capture any additional points of complaint for investigation.

**6.29** The general manager told us her understanding of the purpose of the meeting:

*“It was two-pronged; one was to go through the entire week with the timelines and why things were done, why decisions were made, why, in this particular case, antibiotics weren’t given. The second part was to work through the CDR and where the parents felt it was inappropriately documented or mis-documented and could these areas be reviewed if possible. There was to be a discussion about that and then, from my perspective, I felt I needed to come away with anything that was still outstanding that we then needed to either investigate further or new to investigate from the beginning, and to then put that into what would be the final written complaint response.”*

**6.30** Ben’s parents wrote another letter of complaint to the trust. This is the first correspondence we saw that highlights the issues of miscommunication of information by Consultant 1 and Consultant 2 during the meeting on 4 June. The letter asks:

*“Can we confirm that this specimen [from 16 April] was taken and cultured as no record found in medical records? Has this been investigated?”*

**6.31** The general manager wrote to the parents with her understanding of outstanding issues for investigation and asked that they confirm she had appropriately captured all the points. The parents responded with a few additions - one of which was detailed in an email on 26 July:

*“I have been reading through the notes from the first meeting [4 June] and there was a comment made that suggests that...[Consultant 1 and Consultant 2] had previously spoken about the blood cultures done on the 16<sup>th</sup> (or not done) prior to our meeting. It is therefore even more surprising that a mistake of such a scale would be made by two senior consultants. Can you see where we are coming from?”*

**6.32** The general manager responded on 28 July confirming that she had noted the parent’s changes and that she would work with the staff, who were to provide a response by 3 August. She would then compile a response to Ben’s parents through the trust’s complaint process. The parents were initially told by the general manager they would receive a response by 20 August.

**6.33** The general manager provided the parents with a number of updates. She compiled a first draft of the complaint response. However, she retired on 14 August and the coordination of the response was passed to the divisional director. He considered the draft needed more work, both in clinical input and in the language it used. He therefore met with some key clinicians involved, including Consultant 1 and Consultant 2, in order to finalise the report. The clinical director for clinical care also objectively reviewed Ben's care to try to provide answers to the parents questions.

**6.34** Consultant 1 told us this was when she realised she had given inaccurate information during the meeting on 4 June. She said:

*“Essentially that’s the first time I realised. In...[the chief executive’s] response to that...that’s the first time we apologised for the error and accept that it happened because that’s the first time it had been flagged to me, that it had happened. It was somewhere between that 22 July meeting and the letter going out...[on 28 August], that I became aware of it.”*

**6.35** Although the trust had originally undertaken to respond to the parents by 25 August, the divisional director thought it was better to provide them with a slightly delayed response that was complete rather one delivered on time that was incomplete. The final letter was sent to the parents on 28 August.

**6.36** In relation to the points raised by the parents regarding the inaccurate information they were given during the meeting on 4 June. It says Ben:

*“...had a full septic screen including blood cultures and lumbar puncture on admission. He had a bronchoalveolar lavage and repeat viral testing on the 16<sup>th</sup> April. He did not have repeat blood cultures until 17<sup>th</sup> April. I apologise that incorrect information regarding the blood culture data was given to you at your first meeting with... [Consultant 1 and Consultant 2]; this was a genuine error on their part.”*

**6.37** The parents' next question addressed in the response was:

*“If confirmation as suspected that no blood cultures were taken on the 16<sup>th</sup> as... [Consultant 1 and Consultant 2] said, can you please have (sic)an explanation as to why this was said?”*

**6.38** The trust complaint response says:

*“... [Consultant 1] has stated that this was an error on her part for which she apologises. She has explained during discussions at the first meeting with you, it had been her recollection that blood cultures had been taken although on subsequent close scrutiny of the notes this was not the case. At the second meeting with you... [Consultant 2] was able to give you copies of all... [Ben’s] microbiological results confirming that cultures were not taken on 16<sup>th</sup> as had previously suggested. I am sorry for this confusion and would offer every assurance that this was a genuine error on... [Consultant 1’s] part.”*

**6.39** The parents responded to the chief executive on 16 September expressing dissatisfaction with the response and level of investigation. For the first time the family’s complaint mentions:

*“Attempts to cover up information including suggestions to delete recordings after accepting responsibility.”*

**6.40** The chief executive told us during our investigation that he received the parents’ email the next day and started correspondence with his clinical executive leads about the points they raised. The chief executive told us he was concerned there were:

*“...dissatisfied bereaved parents...there were allegations of lies and attempt to cover up by consultant staff.”*

**6.41** The chief executive emailed the chief nurse (the executive responsible for the complaints function) on 17 September, copying in the medical director and the chief operating officer. The email asked the chief nurse and medical director to meet the clinical chair for children’s services to:

*“...consider a wholesale review of complaint handling and clinical review processes in the event of a child death.”*



**6.42** The chief nurse responded suggesting that the medical director investigate the consultants' behaviour.

**6.43** The chief executive acknowledged in emails that the clinical chair would review the transcript of the 4 June meeting between the parents and Consultant 1 and Consultant 2. He repeated that the medics concerned would still need to be asked what they said and suggested that the division and the trust would "*put themselves at risk of collusion or apparent collusion in something inappropriate*" if this did not happen.

**6.44** He did not think the trust's normal processes were sufficient to deal with complaints containing such serious allegations and he asked for a different approach, starting with this case. The trust at once introduced a formal escalation process that assigned an executive officer to oversee the complaint.

**6.45** The chief executive told us the correspondence did not establish when or how he assigned the executive oversight role to the medical director but that he had done so. He said he discussed complaints escalation with the chief nurse on 17 September. He told us he took the opportunity at the end of a fortnightly Paediatric Cardiac Steering Group meeting to discuss the complaint because of the staff present - the chief nurse, the clinical chair, the divisional director and the deputy divisional director. The chief executive told us:

*"There was one on 24 September, I assume that's when I clarified to... [the medical director] that I expected him to run this one. It is possible that it was two weeks later, on 8 October, and I don't have a record of that."*

**6.46** The divisional director confirmed the discussion that took place after the steering group meeting. He said that the attendees discussed the need to depart from the normal complaints procedure. They agreed that the clinical director for critical care would meet the parents and explain their son's clinical notes, address their questions and then produce a report to send to the parents with a covering letter. This would be instead of a formal complaint response. The clinical director for critical care told us:

*"Rather than writing more letters, if they are willing to meet me, I think it would be much better if I could sit down, go through everything."*

**6.47** The chief executive wrote to the parents on 5 October saying he was “*extremely sorry*” to receive their letter of 16 September and that he and his clinical team “*deeply regret*” that the trust had failed to fully respond to their concerns. He committed to giving the parents a further response by 21 October. He also offered the parents the opportunity to meet him and the clinical director for critical care.

**6.48** The divisional director phoned the parents on 7 October and suggested a meeting with the clinical director for critical care. The parents agreed to meet him on 16 October. During the meeting the parents discussed their concerns about the inaccurate information Consultant 1 and Consultant 2 gave them on 4 June. The clinical director for critical care explained Ben’s clinical notes, blood results and x-rays and tried to help the parents understand the details of the care given to their son. He told us that in doing so he identified:

*“There were areas I thought we could have done better.”*

**6.49** The clinical director for critical care followed up with a letter to the parents dated 29 October summarising the key points. It says:

*“I very much regret the fact you had been given misleading information and that this has now caused you considerable extra upset on top of your bereavement. We are taking the allegation that this was a deliberate attempt to mislead you, rather than an ill-informed error, very seriously...I have spoken to the...medical director and an investigation into this is underway.”*

**6.50** Consultant 1 told us she first became aware that Ben’s parents had not accepted her apology issued in the complaints response from the chief executive (dated 28 August) when the clinical lead for critical care emailed her on 27 October explaining that the parents remained unhappy about “*lies*”. He told Consultant 1 he and the divisional manager had met with the medical director the day before and had requested that the medical director’s office carry out an investigation into the probity of Consultant 1 and Consultant 2. After discussion, it was agreed that the clinical chair would be asked to undertake the investigation.

**6.51** The chief executive told us the clinical chair sent two reports to him and the medical director on 20 November. He said that was the first he had seen of what was being done to

investigate specific concerns but he had gone home sick that day. He said he was looking at emails later that afternoon to see what was happening generally. He found the email from the clinical chair to the medical director and “skim-read” the reports. He said he tried to write back but his home email failed. He finally got through to the office on the phone after 5pm. His assistant had gone home, leaving one secretary in the main office. He asked whether the medical director was there and what was happening with the reports sent by the clinical chair earlier that day. He was told that the medical director was in discussion with the clinical chair and the deputy divisional director. The intention was to send the reports to the parents along with a letter from the medical director. The chief executive told us:

*“What I didn’t do, and now regret, is to say don’t send these, whatever you have promised... [the parents], until some of us can sit down on Monday and review the content.”*

**6.52** He reflected in our interview:

*“Is the decision to work to a deadline for sending to the parents rather than a deadline that allowed proper internal scrutiny and oversight of investigation?”*

#### *Summary and analysis of management response*

**6.53** The parents first established that Consultant 1 and Consultant 2 had given them inaccurate information when they compared transcripts of the two June meetings in July 2015. They raised this concern with the trust in July and it was included in allegations to be investigated/coordinated by the general manager.

**6.54** The trust sent its response to the parents’ complaint on 28 August. It failed to address appropriately their concerns in relation to this point (discussed later in this section).

**6.55** Although the chief executive reviewed the complaint response letter sent to the parents on 28 August, he told us that first became concerned about the allegations following the parents’ response to the complaint letter, which they emailed directly to him on 16 September. He subsequently asked the medical director to commission an investigation into the probity of Consultant 1 and Consultant 2.

**6.56** The deputy divisional director concluded her investigation into the recess conversation at the CDR feedback meeting and alerted the divisional director (on 22 October) of the need for an investigation into the probity of Consultant 1 and Consultant 2 at the 4 June meeting.

**6.57** The parents' meeting with the clinical director for critical care also proved to be a catalyst for action. He emailed Consultant 1 on 27 October to tell her that an investigation into her (and Consultant 2's) probity was to be undertaken. That investigation was conducted by the clinical chair and she produced a report on 20 November - the date on which the trust had agreed the findings would be shared with the parents. The chief executive was not in the trust that afternoon. The medical director and the deputy divisional director decided to send the report to the parents with a covering letter, together with the report about the recess discussion at the CDR feedback meeting.

**6.58** We recognise that the trust wanted to respond to the parents by the agreed deadline. However, the report was delivered to the chief executive and the medical director on the day it was 'promised' to the parents. The clinical chair, deputy divisional director and the medical director met several times during the course of the day to consider the report. However, we feel that the trust's desire to respond to the family on that day left the executives with little opportunity to fully consider the report or ensure that all the issues had been appropriately investigated before sending it to Ben's parents.

**6.59** The trust failed to acknowledge the seriousness of the allegation until the parents corresponded directly with the chief executive on 16 September. The chief executive then recognised the gravity of the situation: he wrote next day to the chief nurse, the medical director and chief operating officer stating that failing to investigate the allegations thoroughly would put the division and the trust at risk of collusion or apparent collusion in something inappropriate.

**6.60** The chief executive recognised the seriousness of the allegations in September and told his senior staff about them but an investigation was not commissioned until after the clinical director for critical care met the parents in mid-October.

**6.61** The parents first raised their concerns about Consultant 1 and Consultant 2 having given them inaccurate information in July 2015. The trust initially tried to address the

concern as part of a wider complaint response to the parents on 28 August. The parents were clearly dissatisfied with the explanation and raised their concerns directly with the chief executive by email on 16 September. The chief executive subsequently tasked the medical director with commissioning and overseeing a number of investigations - including one into the probity of Consultant 1 and Consultant 2 during the meeting on 4 June. However, an investigation into this issue had yet to be commissioned when the clinical director for critical care met the parents on 16 October (a month later). The clinical director for critical care and the divisional director raised this issue with the medical director and the clinical chair was asked to carry out an investigation. She produced a report and presented it to the medical director on 20 November. He reviewed it and sent it to Ben's parents on the same day.

### **Commissioning of the 'probity' investigation**

**6.62** In this section, we review the investigation trust management commissioned in response to allegations.

**6.63** The chief executive raised with his executive colleagues on 17 September the need for the probity of Consultant 1 and Consultant 2 to be investigated. The medical director was tasked with commissioning and overseeing a number of investigations - including one into Consultant 1 and Consultant 2's probity (giving Ben's parents inaccurate information during the pre-CDR meeting on 4 June).

**6.64** We asked the chief executive whether he was directly involved in commissioning the investigations into the allegations raised by the parents in the email of 17 September. He responded:

*"I didn't directly...I believed that I had set my expectations out, I didn't involve myself in the details of how those investigations were being done. I didn't ask for terms of reference, I didn't look at terms of reference. The first I knew of the scope of what had been done was seeing the reports that came out on 20 November. I think reports were sent by... [the medical director]."*

**6.65** The chief executive asked the medical director to commission/oversee investigations towards the end of September. However, an investigation was not commissioned until the

end of October. This was after the parents met with the clinical director for critical care and continued to raise concerns about the inaccurate information given to them. The divisional director told us his deputy reported to him when she completed her investigation into the CDR feedback meeting recess discussion:

*“I’ve done my investigation and I’ve done my report as you have requested, but there’s one thing that I am concerned about, which is the probity issue. Not of the deletion but of... [Consultant 1 and Consultant 2] giving information to the parents in the first meeting about a blood culture test being taken on 16 April, which wasn’t taken...I don’t feel that I’m equipped to look at that and that is an outstanding issue that is a matter of concern.”*

**6.66** The divisional director went on:

*“That was outstanding, so I talked with... [the clinical director for critical care] about how we might deal with that. I went down with...[him] and saw... [the medical director], I can’t remember when the meeting was, towards the end of October...[we] said to...[him] ‘this is where we are with this complaint response. There’s this issue that... [the deputy divisional director] doesn’t feel she can deal with, it’s an issue of probity, we’d like the medical director’s office to take this on and investigate it, and I suggested that... [the deputy medical director], would do that’. We spent quite a long time talking it through... [The deputy medical director] apparently wasn’t able to do it and there were no other thoughts about who could do it, so it was passed back to the division for... [the clinical chair] to take that part of the investigation on.”*

**6.67** The medical director, divisional director and clinical director agreed during a meeting that the clinical chair for the division would be asked to carry out a ‘fact finding’ exercise into the probity of Consultant 1 and Consultant 2, based on the allegation that they provided the parents with inaccurate information at a meeting on 4 June.

**6.68** The medical director asked that that the investigation be conducted under the informal part of the MHPS guidance. The clinical chair did raise concerns about her independence but on the basis that this was a fact finding exercise she agreed to proceed and documented the potential conflict in her report.

**6.69** The medical director initially asked his deputy to undertake the investigation but she was not available.

**6.70** *Maintaining High Professional Standards (MHPS) in the Modern NHS* issued by the Department of Health in 2005 offers guidance about conducting both formal and informal investigations into clinicians practice or behaviour.

**6.71** In relation to formal investigations the MHPS guidance states:

*“The case investigator has wide discretion on how the investigation is carried out but in all cases the purpose of the investigation is to ascertain the facts in an unbiased manner. Investigations are not intended to secure evidence against the practitioner as information gathered in the course of an investigation may clearly exonerate the practitioner or provide a sound basis for effective resolution of the matter.”*

**6.72** Regarding the informal approach to MHPS, the guidance states:

*“As a first step, preliminary enquiries are essential to verify or refute the substance and accuracy of any concerns or complaints. In addition, it is necessary to decide whether an informal approach can address the problem, or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from the NCAS or Occupational Health Service (OHS) where necessary.”*

**6.73** The clinical chair told us she was not formally investigating the allegations but was conducting a more informal exercise. Its outcome would inform the medical director whether a more formal investigation needed to be undertaken in line with MHPS guidance.

*Comment*

*This exercise took place more than four months after the meeting when the inaccurate information was given and more than three months since the trust became aware of the parents’ allegation via the complaints route. The trust knew about this serious*

*allegation in July and correspondence suggests executives were aware of the complaint response sent to Ben's parents at the end of August. However, executives did not appear to appreciate the extent of the parents' concerns nor discuss a different approach to investigating them until an email from Ben's father on 16 September. The fact-finding exercise was not initiated for another month. This is a failure to act on the concerns in a timely manner.*

*MHPS guidance says 'informal investigations' should be undertaken in four weeks, and the investigator met this requirement. However, the concerns took too long to be identified and investigated.*

6.74 The clinical chair for the division told us during interview that when she was asked to review the allegations she had “*quite a lot on her plate*”, having just been involved with a high-profile inquest. She also told us that she wanted assurance from the medical director that she was the right person to undertake the investigation. She said she told the medical director in an email that she had already been involved with the parents' complaint response: she had seen some of the transcripts and had answered several queries. She also felt she was not completely independent because of her previous involvement in the complaint response. However, the medical director commissioned her to, as she put it:

*“Do the preliminary informal part of the MHPS process”.*

6.75 With this brief - to establish whether there was a case to answer - the clinical chair was happy to proceed. She went on:

*“Basically this has been an allegation made, this was an opportunity for my clinicians to give their side of the story, for me to look... at the transcript of actually what was said...”*

6.76 The medical director told us that he considered the clinical chair for the division to be appropriately independent because she was the divisional chair of the largest division in the trust - with approximately 150 consultant medical staff. She was based in a different hospital to Consultant 1 and Consultant 2, she was from a different medical specialty and was a trusted member of the medical management team.



Comment

*The medical director or his deputy would have been more appropriate to undertake the investigation, given the serious nature of the allegations and the fact that they involved the probity of consultants in the trust. The clinical chair was senior enough to do it but we do not consider that she would have been viewed as sufficiently independent of the case or of the clinicians involved. The parents had clearly lost faith in the trust's ability to be open and honest, so it would have been more appropriate to instruct a member of staff further removed from the service to undertake the investigation.*

6.77 The clinical chair told us she reviewed the parents' allegations primarily by reviewing the correspondence between them and the clinical director for critical care, which summarised the allegations. The allegations were that Consultant 1 and Consultant 2 had misled Ben's parents about taking samples on 16 April, the day before Ben died.

6.78 The clinical chair looked at the records to review the information. She reviewed the computer records herself to establish what tests had been requested when and where and when they were reported.

Comment

*The trust informed Ben's parents in a letter dated 24 March 2016, that the results of the lung test were reported and reviewed on 17 April - before Ben died. This is the first time the trust has acknowledged this finding to the parents - despite them asking on numerous occasions.*

*The clinical chair said she reviewed the ICE (clinical information system) computer records as part of her fact finding. We therefore considered whether she could have established that the pseudomonas grown from Ben's lung (taken on 16 April) was actually reported and reviewed on 17 April, before Ben had died.*

*The clinical chair provided us with a screenshot of the results, which shows that the results she viewed were reported on 18 April. She told us that at that point she was unaware that there were 'interim' findings, which had been reported and reviewed on 17 April. It was only when the IT capabilities of the ICE system were further interrogated that they discovered this. She told us that she was informed that interim reports are overwritten on the report site as further information about a test is added. This is a safety measure to avoid potentially opening a report with the interim result when a further, more detailed, report is available. A number of other sources confirmed this information.*

**6.79** The clinical chair told us she reviewed the computer records before she met separately with Consultant 1 and Consultant 2. She made “short notes” and she followed up with a summary email. She told us that for Consultant 1:

*“The interview was actually more supportive, she was quite devastated during the time, for... [Consultant 1] to read what... [the parents] was accusing her of, goes to the core of where you are as a caring clinician. She felt that she had done her best and that she had given as much care and compassion as she could, she was devastated by it.”*

*Comment*

*The clinicians involved were undoubtedly 'devastated' by the events and the allegations but this should have had no effect on the process. We find it inappropriate that the investigator/fact-finder approached the meeting as supportive meeting, when she had been charged with investigating whether there was a case to answer. A person charged with investigating serious allegations can be respectful and compassionate while not compromising the required level of professional independence.*

*In response to this comment, the clinical chair reported that she considered she conducted her investigation in a professional manner whilst acknowledging the impact*

*this investigation had on the clinicians involved. She also reiterated that this was an informal process as opposed to a formal investigation.*

**6.80** The clinical chair wrote to Consultant 1 after the meeting to put to her questions about the allegations. She reframed them to moderate the emotion the parents had expressed. She asked Consultant 1 to respond. Consultant 1 did so adding a reflective practice piece - parts of which were included in the clinical chair's written report to the medical director.

**6.81** We asked the clinical chair why her report did not refer to Consultant 2's practice or views beyond saying he agreed with Consultant 1's version of events. She told us that Consultant 2 attended the meeting on 4 June only to support Consultant 1. She said Consultant 2 had explained during their meeting he believed they had met the parents for three hours and had tried to give answers and be as helpful as possible. Consultant 2 felt strongly that he and Consultant 1 had simply made a mistake and were very sorry.

**6.82** The clinical chair did not ask Consultant 2 to provide a written statement. She asked him to complete a reflective practice piece, which his appraiser had confirmed he did. We asked the clinical chair why her report focused on Consultant 1's version of events. She said:

*"I would prefer to have received a reflective piece from... [Consultant 2] from the timescale, but we were working to a timescale to get something back as well."*

**6.83** She also told us that Consultant 1 made the error in the meeting and Consultant 2 simply repeated it, believing her to have given accurate information.

**6.84** The clinical chair did not meet or speak to the parents to seek clarity on their allegations or gather their view or test their evidence. She told us she was clear about the allegations and her brief was to provide the medical director with a report indicating if there was a case to answer.

**6.85** In line with the 'informal'/fact finding part of the MHPS guidance, the 'fact finder' must consult with others (e.g. medical director or director of HR) regarding what further action is required. The options are:

1. no action
2. remedial action (i.e. local action plans)
3. consider immediate exclusion
4. instigate formal part of the MHPS progress

**6.86** The clinical chair's report does not say if there was a case to answer or what action should be taken as a result of her investigation. She concludes:

*"It is my judgement that they did not deliberately intend to mislead... [Ben's parents] during their meeting."*

**6.87** No further action was taken.

#### *Comment*

*Both the medical director and the clinical chair said the exercise was 'fact-finding' to establish if there was any case to answer before deciding whether a more formal investigation was required. Both were clear about the brief but it would have been appropriate to have taken a more formal approach to investigating the allegations. This should have included clear terms of reference, shared with the interviewees. The investigator should have made interviewees aware about the purpose of the investigation and with whom the results would be shared.*

*The clinical chair told us that her 'fact-finding' exercise was in line with the informal/preliminary stages of a MHPS investigation. However, there seems to be some cross-over and confusion about what was being investigated as a complaint and therefore governed by the trust's complaint policy and what was just 'fact finding' as a preliminary to a possible MHPS investigation. This clearly affected what the trust understood to be appropriate to share with the parents at the conclusion of the exercise.*

*We believe interviewees should have been interviewed formally, with minutes or a transcript of the meeting taken and shared with them. The investigator should have asked both interviewees to provide a written statement and the report should have*

*reflected both their views/role in the case, irrespective of their supposed role at the meeting.*

*The report should have made clear conclusions and reported what was to happen next, in line with the informal phase of MHPS guidance.*

*These steps would have helped to ensure that the trust took appropriate action to investigate a serious allegation. They would have also demonstrated to the parents that the investigation was robust.*

**6.88** The clinical chair took her report to the medical director on 20 November. She told us she had drafted a covering letter saying she would like him to read the report and assess whether it should be sent to Ben's parents or whether the findings should be incorporated into a comprehensive covering letter. She thought the report would be kept as an internal document, with the key findings shared in a letter.

**6.89** The parents had been told they would receive a response to the latest investigations by 20 November - the date the clinical chair presented her report to the medical director. There was therefore little time for executives to consider the findings of the report and assess whether it addressed the issues raised by the parents.

*Comment*

*When the 'fact finding' exercise was commissioned it was not clear whether the report was a confidential internal document or one that Ben's parents would see. Trust staff clearly felt under pressure to provide a response to the parents on the promised date. The medical director might have found shortcomings if he had had time to reflect on the report.*

*The trust were trying to carry out an internal exercise while responding to a complaint about the same matter. The result was unsatisfactory both as a complaint response and as an internal investigation.*

## The quality and robustness of trust investigations

**6.90** Having established which investigations had been commissioned, this section considers the quality and robustness of the investigations undertaken.

**6.91** The medical director had commissioned the clinical chair to investigate the allegation that Consultant 1 and Consultant 2 gave inaccurate information to Ben's parents during a pre-CDR meeting on 4 June.

**6.92** The clinical chair investigated the concerns by reading the full transcripts of the three meetings, interviewing the two clinicians concerned and reviewing the ICE computer record of laboratory investigations.

**6.93** The medical director's letter to the parents (20 November) which accompanied the report of the investigation said:

*"In summary, the findings suggest that our clinicians should have been more open and transparent with you and they should have ensured that the information they gave you was factually correct. However, after meeting with... [the clinical chair], and a full review of...[her] report, I do not consider that dishonesty was intended on the part of any of the clinicians involved. I realise that this was not your view and I include the investigation report for you to see the detail behind my conclusion."*

**6.94** The clinical chair told us her investigation was to establish the facts but her report begins:

*"I have been asked to investigate the serious concerns..."*

**6.95** The letter from the clinical director for critical care (29 October) to the parents after their meeting says:

*"We are taking the allegation that this was a deliberate attempt to mislead you, rather than an ill-informed error, very seriously... [the divisional director] and I have spoken to the hospital trust's medical director and an investigation into this has now been launched."*

## Comment

*The allegations should have been more formally investigated. The clinical chair's "fact-finding" report contains little reference to Consultant 2's version of events - other than saying he agreed with Consultant 1. The clinical chair did not ask him to provide a written statement. He completed a reflective practice piece but this was not shared with the investigator. The complaint calls into question the probity of both doctors and this allegation should have been investigated in light of that, irrespective of the role Consultant 2 was due to play in the meeting.*

*The report contains little analysis. It consists mostly of Consultant 1's testimony/reflective practice, with a short conclusion.*

## Whether the findings of investigations were reasonable

**6.96** The clinical chair's report concluded that although Consultant 1 and Consultant 2:

*"...did give the wrong information that blood cultures and infection markers were taken on the 16 April 2015; but it is my judgement that they did not deliberately intend to mislead... [Ben's parents] during their meeting".*

## Comment

*The investigation/fact-finding exercise would have benefited from clear terms of reference.*

*In light of reviewing the transcript and meeting with the two clinicians, it reached a reasonable conclusion. However, the investigation does not appear to have gone far enough in order to answer the parents' questions. The parents believed that the trust wanted to give the impression they had tested for pseudomonas with a negative result because a positive result would have suggested that antibiotics should have been started sooner. The parents believed that the inaccurate information should not be*

*seen in isolation but considered in the context of possible reasons why the clinicians might want to mislead the parents.*

*The clinical chair said she reviewed the ICE (clinical information system) computer records as part of her fact finding. We therefore considered whether she could have established that the pseudomonas grown from Ben's lung (taken on 16 April) was actually reported and reviewed on 17 April, before Ben had died.*

*The clinical chair provided us with a screenshot of the results, which shows that the results she viewed were reported on 18 April. She told us that at that point she was unaware that there were 'interim' findings, which had been reported and reviewed on 17 April. It was only when the IT capabilities of the ICE system were further interrogated that they discovered this. She told us that she was informed that interim reports are overwritten on the report site as further information about a test is added. This is a safety measure to avoid potentially opening a report with the interim result when a further, more detailed, report is available. A number of other sources confirmed this information.*

*We also consider that the report could have emphasised the need for a clear process for giving information to the parents. Clinicians who provide information from memory should make this clear to the parents and tell them the facts will be verified as soon as the meeting has ended. Alternatively, the meeting should be adjourned until the clinicians have the factual information to hand.*

Whether trust actions in response to the investigations were appropriate and proportionate

**6.97** In this section, we consider the trusts response to the investigation and what action was taken.

**6.98** The clinical chair states in her report:

*"There is much learning and reflection for the consultants and the children's service, which has been highlighted in... [the clinical lead for critical care's] letter 28 October 2015 and the child death review".*



**6.99** However, the only specific recommendation she makes is for the trust to:

*“Reflect on how we support clinical staff to ensure open disclosure and support for bereaved parents in their most difficult of times”.*

#### *Comment*

*We would have expected the clinical chair to make a number of recommendations in her report. For example, we would have expected her to recommend the need for guidelines when giving information from memory. We would also have expected a recommendation about the pre-CDR meeting process - on managing parents' expectations and clear guidelines to frame these meetings.*

#### **Conclusions**

**6.100** We believe the trust missed opportunities to engage better with the parents and to be more open and honest with them - to help to create a relationship where Ben's parents would have less cause to believe that clinicians were not being candid with them.

**6.101** Ben's parents undoubtedly believed that communication could and should have been better on the ward but for the purpose of the terms of reference, we are considering actions in the time following Ben's death.

**6.102** The missed opportunities began immediately after his death with the trust's failure to establish contact until sending a letter inviting the parents to a pre-CDR meeting. The trust also missed the opportunity to share the positive pseudomonas result with the parents - which we now know was reported on and viewed before his death. This matter is outside of the scope of our investigation but will no doubt be an issue for the coroner to explore further. The parents should not have had to wait seven weeks after their son's death to learn of a second infection.

**6.103** Consultant 1 told us that she learnt of the positive pseudomonas result when she reviewed Ben's clinical notes and pathology results two days before the pre-CDR meeting

with the parents. Even at this stage, the parents may have wanted to know the findings before the meeting to enable them to read about the infection and ask questions.

**6.104** We are surprised that such information ‘slipped through the net’. Clearly, safeguards need to be put into place to prevent results being missed in such circumstances.

**6.105** The clinicians shared the new finding with the parents almost an hour into the pre-CDR meeting. This raised the parents’ suspicions and the clinicians did not seem prepared to answer their questions about pseudomonas. The parents wanted to focus on this new information and had many questions. It might have been sensible to break at that point to ensure all culture results were available - or at least make clear that nothing was certain without the notes and the clinicians would follow up with the parents to confirm the facts.

**6.106** Both Consultant 1 and Consultant 2 were on call during the second meeting. This information was likely to upset the parents and make them feel as though the clinicians did not see the meeting as important enough to clear their diaries.

**6.107** We do not believe that the investigation went far enough to consider/investigate any potential underlying reasons for the clinicians giving inaccurate information. No one disputes - and the recording confirms - that inaccurate information was given to the parents. However, the investigation report suggests that clinicians were simply asked to explain why this happened and takes their word for it. Despite listening to the recordings and reviewing the transcripts, the report fails to demonstrate an attempt to investigate what the parents believed: that they were deliberately given inaccurate information to make Ben’s clinical care appear better than it was.

**6.108** The appropriateness or otherwise of Ben’s care is clearly a point for the coroner and the trust’s clinicians. Trust management needs to reflect on why it has taken almost a year since Ben’s death for them to tell the parents that some test results were reported and reviewed prior to his death and not previously disclosed to them, despite the parents asking this question on numerous occasions.

## 7. The paediatric intensive care matron was dismissive of the parents

### Background and allegation

7.1 The parents alleged in a complaint emailed to the trust on 15 May 2015 that the paediatric intensive care matron was dismissive of them and the severity of their son's condition. The parents found the matron's actions upsetting but their greater concern was that, the matron represented the 'complacency' with which their son was treated during his stay in the PICU.

7.2 The parents told us they contacted the matron only once - on 15 April 2015. We reviewed a copy of their email that was sent:

*"I am dropping you a quick email to see if you can assist in anyway. We are one of the families on PICU after our son was admitted last Friday. We have enquired several times about any possible accommodation and each time have been refused for a number of different reasons and told we are not priority. What sort of thing is that to say to a distressed parent...Apologies for emailing and I know you are busy but every time we ask we are just shot down immediately without us being able to explain our case. I would like to discuss it face to face but thought it would be better to get my point across on email first as I currently cannot think straight."*

7.3 Ben's parents told us that 10/15 minutes after they sent the email the matron came out of his office and invited them in to talk to him. The conversation focused on the parents' request for a room to stay overnight and the matron telling them it was not possible. The parents allege that the matron was dismissive and told them:

*"Your son is of no concern to us".*

7.4 The parents said they had no further meetings or exchanges with the matron. They said that they were so distressed by the matron's comments that as their son became increasingly sick they told a consultant about the remark and he responded:

*"Just forget about it, just don't worry about it, just concentrate on what is going on now."*

7.5 The parents decided after their son's death to make a formal complaint about the attitude of the matron.

#### *Matron's version of events*

7.6 We asked the matron about the comment he was alleged to have made. He responded:

*"Initially...[Ben] was responding to treatment, we assumed he had bronchiolitis, so what I might have said to the parents to reassure them is, '[Ben] has had a good night. He's not caused us any concern over night'.*

7.7 He went on:

*"The only thing I am adamant about is that I would never have followed that on with, 'And there are other children who are sicker on the Unit and may die'. That's just not a phrase I would ever use."*

#### Comment

***It is not within our terms of reference to make a judgement on whether the allegation is true. Our remit is to consider the management's response to the allegation and consider whether it took appropriate action. In the next section we consider who knew what and when about the allegation.***

#### Management response

7.8 The trust found out about the parents' concerns regarding the matron's attitude in their first complaint correspondence to the trust dated 15 May - less than a month after Ben's death.

7.9 The trust first responded to this complaint in a letter to the parents on 28 August 2015. The general manager had coordinated this response with questions put directly to the matron. His reply was included as part of the complaint response. The trust's letter says:

*"The matron...would like to apologise that he was not able to speak to you on a regular basis. He does make every effort to catch up with parents on a daily basis as he sees this as a critical element of the matron's role but acknowledges that this is not always achievable".*

7.10 The letter also addresses the issue raised about lack of accommodation/supporting families who live further away but is silent on the issue about the use of language by the matron.

7.11 The parents responded to the complaint response in an email to the chief executive on 16 September. It asks:

*"Why did... [the matron] say '[Ben] is of no concern to us, we have children on the ward who are seriously ill and could die'"*.

7.12 The chief executive discussed the email with his senior colleagues [see point 6.43]. The divisional director subsequently asked the head of nursing to investigate the nursing concerns (which included concerns about the matron's attitude). The plan was for her to give the clinical lead for critical care a summary of her findings in preparation for his meeting with the parents on 16 October.

7.13 The head of nursing carried out her investigation and reported her findings verbally to the clinical lead for critical care, who discussed the allegation with the parents as part of their meeting. His summary letter of the meeting - dated 29 October - says the matron:

*"Could not remember using those words, but you were clear that he had used them. I could throw no further light on this when I met you, I'm afraid. I can pass onto you that he was quite shocked to hear what he had said you heard in this way and he apologises if he had expressed himself poorly. You also said that you had to email him to ask to see him. It appears he was away from the hospital on the weekend of...[Ben's] admission and then the Monday and Tuesday on NHS business elsewhere*

*in the UK. He thinks it was for this reason that you would not have seen him till the Wednesday.”*

**7.14** The head of nursing produced a summary report in December 2015 after her investigation into the nursing concerns the parents raised in their email to the chief executive on 16 September.

### *Summary*

**7.15** The trust first knew about the parents’ concerns about the alleged attitude of the matron in May 2015. They tried to address the concern through the trust’s complaint process, which entailed giving the matron opportunity to respond to the allegations. The complaint response letter was sent to the parents on 28 August - over three months after the parents first raised their concerns. They expressed their dissatisfaction with it in an email to the chief executive on 16 September. The chief executive delegated executive oversight of a number of investigations to the medical director and in turn the head of nursing was asked to investigate this concern. She gave a verbal report to the clinical director for critical care before he met the parents on 16 October and before the divisional director asked her to produce a summary report in December 2015.

### **The quality and robustness of trust investigations undertaken in response to the allegation**

**7.16** In this section we consider what action was undertaken to investigate the allegations about the matron and whether the action taken was appropriate and robust.

**7.17** The first time the trust replied to the concern raised about the matron’s alleged attitude and comments was in the response letter dated 28 August, over three-and-a-half months since the parents raised their initial concerns in an email of 15 May.

**7.18** In order to investigate the nursing elements of the parents’ concerns the general manager sent the concerns to the matron - including those relating to his behaviour - and asked him to comment. He replied and the general manager coordinated a response. The

divisional director took control of the complaint response when the general manager retired in mid-August.

*Comment*

*This practice of asking the individual concerned to respond to allegations is in line with the trust's complaint investigation process. However, the response failed to adequately investigate or address the allegation the parents raised regarding the words used by the matron.*

**7.19** The standard process for complaint management in the trust is for the general managers - with the direct involvement of the clinical teams - to investigate. Once the response is collated and the clinical teams and the general manager have signed it off, it goes to the head of nursing to review it from a clinical point of view and ensure it is accurate. It then goes to the divisional director for the final response before it goes back to the trust complaints team then on to the executive for final sign-off.

**7.20** The head of nursing told us that on this occasion she was not directly involved with the complaint response because she was on annual leave. However, she was aware that a draft response had been collated which was with the divisional director for review. We asked her if she thought it was robust and adequately addressed the parents' concerns. She responded:

*"I spoke to... [the divisional director] about it and said that I felt it needed further investigation and perhaps an independent review in terms of some of the responses, and I believe that is what he then asked... [the clinical director for critical care] to undertake to do."*

**7.21** The parents emailed the chief executive on 16 September raising a number of allegations, including one about the matron's attitude. The chief executive and colleagues agreed that a more comprehensive investigation needed to be undertaken. At the end of September 2015, the divisional director asked the head of nursing to investigate nursing elements of the parents' complaint raised in their email to the chief executive on 16 September- which included the attitude of the matron. The head of nursing told us that the

chief executive and chief nurse at a meeting on 24 September 2015 had agreed this approach. She told us that she had been asked to undertake the investigation in preparation for a meeting scheduled to take place between the clinical director for critical care and Ben's parents.

**7.22** As part of her investigation, the head of nursing:

- reviewed Ben's medical and nursing records;
- met with the matron on 30 September and 3 October; and
- met with the matron and the clinical director for critical care on 15 October to report her findings prior to his meeting with the parents on 16 October.

**7.23** The head of nursing told us that she had known with the matron for "a long time". We asked what she first thought when she heard of the allegation:

*"I would find it very surprising had... [the matron] used that language. He is an extremely experienced paediatric nurse, extremely experienced in looking after and supporting families with critically ill, very sick children, and he has a number of years of experience. Therefore, I would be very surprised if... [the matron] had used that language or would have dismissed the parents' concerns around their child's illness in that manner."*

*Comment*

*The head of nursing was sufficiently senior to conduct the investigation but she had known the matron for some time and therefore would not have been seen to be suitably objective - particularly from the perspective of a complainant. She does not note her working relationship with the matron in her report nor justify why she felt able to remain objective.*

*We are not questioning the integrity of the head of nursing but believe the trust should have recognised the likely external perception of a long-standing colleague undertaking a sensitive investigation and therefore recognised the need for someone transparently more independent to undertake the investigation.*



**7.24** The head of nursing says in her written summary of her investigation dated December 2015 that the matron:

*“Distinctly remembers talking with ...[Ben’s] parents because they were from Liverpool and Manchester and he picked up their accents as he spent time in Manchester...and they engaged in conversation about the area....[the matron] recalls that they did not raise any concerns at this time...[he] was devastated that the parents recall that he said...[Ben] is of no concern to the unit and that the unit have children on the ward who are seriously ill and could die...[the matron] has no recollection of saying this and has apologised to the parents if his actions misled them in any way.”*

*Comment*

*The email from the parents to the matron on 15 April raises concerns about accommodation. The statement above does not acknowledge that the meeting with the matron came about as the direct result of that email or the difficulties the parents experienced. The report implies that they had a conversation that focused on where the parents originated from in the UK rather than their concerns for their son or their ability to stay with him while he was in PICU.*

**Whether the findings of investigations were reasonable**

**7.25** The head of nursing told us that her brief was to provide a verbal report for the meeting between the clinical director for critical care and Ben’s parents. She therefore did not produce a written report until the divisional director asked her to compile a summary in December 2015.

**7.26** The ‘findings’ of the summary report consist of two paragraphs - one of which appears verbatim above at 7.24 and the other explains why the matron was not on the ward for most of Ben’s stay in PICU. The finding about why the matron did not speak to the parents for the first part of his stay is reasonable, but is written in a way that makes it look

as though the parents are simply wrong in their recollection of events. The fact that the parents met the matron on the one occasion was never in dispute.

**7.27** The head of nursing's report does not detail conclusions or offer a judgement on the allegation about the matron's attitude. However, she told us that this is because it is not a formal report of her investigation but a summary of the actions taken. It does not appear that she produced a formal investigation report at the time of her investigation.

### **Whether trust actions in response to the investigations were appropriate and proportionate**

**7.28** The head of nursing told the clinical director for critical care her findings before meeting with the parents on 16 October. She told us that after the meeting she asked the clinical director for critical care whether the family were satisfied with her response and if they raised any further nursing concerns during the meeting. She told us that they family were satisfied and she therefore did not consider that a written report was required until the divisional director asked her to produce a written report in December 2015. She told us that it was a summary of actions and not a formal report of her investigation.

**7.29** The head of nursing concluded that the matron:

*“...has no recollection of saying this and has apologised to the parents if his actions misled them in any way”.*

**7.30** The summary report does not contain any learning points or action.

### **Conclusions**

**7.31** The parents' email to the chief executive on 16 September was the catalyst for this matter to be investigated outside the trust's normal complaint process. It appears that before this the trust failed to recognise the seriousness of the allegations or the need for a more robust approach to their investigation.

**7.32** The trust found out about allegations regarding the matron's attitude in the parents' email sent on 15 May 2015. The trust asked the matron to comment on the allegation as part of its response to the parents' complaint. The response was sent to the parents on 28 August.

**7.33** The matron was asked about his actions in a more formal capacity only when the head of nursing interviewed him as part of her investigation in October 2015. By that time, six months had passed since the events under dispute, and the opportunity had been lost for the matron reasonably to be expected to recall his words and for the head of nursing - or indeed anyone - to robustly to investigate this issue.

**7.34** It appears that neither the trust nor the matron investigated the allegations as thoroughly as they should have. The version of events changes from his not being able to remember, to stating he had several meetings with the parents, to offering a form of words that he 'may have used' that the parents 'could' have taken out of context. The real charge against the matron was that he was dismissive of the family and exhibited an inappropriate level of complacency given the parents' worries, while the investigation narrowly focused on the words spoken on the day.

**7.35** The head of nursing was senior enough to investigate the allegations but she had known the matron for some time. The trust should have recognised the need for someone unquestionably independent to undertake the investigation.

**7.36** The head of nursing told the clinical director for critical care her findings in October 2015. A one-page summary report followed in December 2015. The findings were short, she drew no conclusions about whether the allegations were substantiated and she offered no learning points for the trust. A more thorough investigation was needed.

**8. At the child death review meeting held on 22 July 2015 attended by Ben’s parents and the trust - trust staff discussed and agreed to delete an incriminating recorded conversation that took place between clinicians in the recess of the meeting. The trust then tried to cover up conversations that took place at that meeting**

#### **Background and allegation**

**8.1** We consider that the following two allegations are fundamentally linked and must therefore be addressed together.

1. Trust staff at the child death review feedback meeting held on 22 July 2015 discussed an incriminating recorded conversation between clinicians during a recess of the meeting and agreed to delete it.
2. The trust tried to cover up conversations that took place at the meeting on 22 July 2015.

**8.2** The CDR-feedback meeting on 22 July was attended by:

- Consultant 3 (consultant in paediatric intensive care and chair of the CDR);
- Consultant 4 (consultant in neonatal intensive care at another trust);
- General manager (now retired); and
- Ben’s parents.

**8.3** Both Ben’s parents and the trust agreed to audio-record the meeting.

**8.4** Before the recess, the attendees were discussing the timing of antibiotics given to Ben and whether clinicians should have prescribed and administered them sooner. The parents left the room during the recess and the following discussion took place:

*Consultant 4: “But... [Consultant 3] they are absolutely right.*

*Consultant 3: They’ve got a point*

*Consultant 4: They are not bolshy...*

*Consultant 3: I just don’t know what to say*

*Consultant 4: These are not misinformed parents are they?*

*Consultant 3: But..erm..."*

**8.5** At this point they realise the recording is still going and switch off the trust recorder. The rest of the discussion is captured on the parents' recording device.

*General manager: "It is whether you want to go through the CDR, you say you've got time constraints*

*Consultant 3: Well I think to go through the CDR it's going to take another 2 hours isn't it?*

*General manager: It's whether, is what we've taken away from what they've already said. I mean I've got 8 significant issues here.*

*Consultant 4: I mean you*

*Consultant 3: Is there any possibility of taking off that last bit*

*General manager: I'll do that, I'll go back when we finish and take that out*

*Consultant 3: I just forgot that it was still recording and cause that could get us in to difficulty*

*Consultant 4: This is recording (whispers) (referring to the parents' phone)*

*General manager: I don't know how to do it without deleting*

*(Further muffled conversation)*

*Consultant 3: The difficulty is though you know with infants and infection is that even if we had treated it earlier it's not to guarantee that the outcome would have been different. People still can die from infections even with antibiotics. I guess we've just got to concede that they have a point and we did talk about antibiotics before and it wasn't given and so we just don't know whether it would or wouldn't have made a difference, I think it's just we don't know.*

*General manager: erm listen I better go and make that coffee, can I offer you a cup of coffee*

*Consultant 3: no I am alright*

*General manager: oh ok, I won't be a minute ([General manager] leaves the room)*

*Consultant 4: I struggle to see why he wasn't given antibiotics if on the Tuesday they've said if he gets worse give him antibiotics, you know yes his gases haven't got worse but he is still not very well*

*Consultant 3: mmm hmmm*

*Consultant 4: and you know that's, you know they have got a point and for...[Consultant 2] to have said he had a blood culture done and they were negative, that's just*

*Consultant 3: incorrect*

*Consultant 4: its incorrect information, I mean so, you see what I was saying at the beginning, this sense of conspiracy, I mean everything that PICU, all the information they've given them supports their own inaction in terms for not treating the bacterial infection and I think that's (inaudible)*

*Consultant 4: At the Coroner's inquest they will pick up on every single point made, the coroner will pick up on these questions and there isn't going to be any you and I being quiet trying to just answer some of these things. I think that's because we found it uncomfortable sitting and listening to it, maybe more so for you cause they are your colleagues. Erm I mean we've all had cases were we have looked at could we have done more*

*Consultant 3: hmm yes*

*Consultant 4: so I don't feel that the system has bathed itself in glory with this one and done itself any favours*

*Consultant 3: No but I thought regarding the antibiotics"*

*(The parents come back in the room and the conversation stops).*

**8.6** The parents say that Consultant 4 informed them when they returned from the recess that there was "something extra" for them on their recording. The general manager told us that she also explained to the parents that a further discussion had taken place, they were sorry it happened and that it had been left on the recording for them to hear.

**8.7** The meeting reconvened and no more was said about the recess discussion. Consultant 3 was on clinical duty at the time of the meeting and had to leave before the meeting concluded.

**8.8** The parents told us they listened to the 'extra' recording in the car on the way home and were shocked. They believed the recess discussion reveals both an admission that Ben should have been prescribed and administered antibiotics sooner, and also an attempt to cover-up that admission.

**8.9** The staff involved do not - and cannot- dispute that the discussion about deleting the recording took place. However, their reason for requesting and agreeing to delete the recording differs from the parents' interpretation.

**8.10** The parents believed that the staff wanted to delete the recording because it was incriminating. The clinicians involved admitted that the parents had “a point” and that antibiotics should have been started earlier. Consultant 4 said during the recess discussion:

*“I struggle to see why he wasn’t given antibiotics if on the Tuesday they’ve said if he gets worse give him antibiotics.”*

**8.11** Consultant 3 said she asked the general manager if the recording could be deleted because she:

*“...just forgot that it was still recording and that could get us into difficulty and what I meant by that was that I didn’t have the clinical team there, I am just representing a consensus view from the [CDR] meeting and I felt very uncomfortable about these statements without the Clinical Team being able to respond.”*

**8.12** Consultant 3 told us she did not completely agree with Consultant 4 so she continued:

*“... this is paraphrasing... we had agreed at the [CDR] meeting that there were clinical signs that antibiotics could have been started earlier that day. But even if they had been started earlier that day that it would have only been one or maximum two extra doses of antibiotics and that may not have been long enough to actually change the clinical outcome, and that the baby may still have died, even if those antibiotics had been given that morning. I still believe that to be a true statement.”*

**8.13** Consultant 3 told us that the parents came back and staff explained to them that this conversation had taken place and had been recorded. She then:

*“...said the same thing that I believe that even if the antibiotics had been given that morning that it may not necessarily have changed the outcome and that the baby may still have died...We then continued to go through the questions and things that... [Ben’s father] had highlighted.”*

**8.14** We asked Consultant 3 about her remark that the comments could “get us into difficulty”. She said:

*“As I say, the normal practice is that the Clinical Team are present and they were the ones that were actually treating the baby. They saw, they were looking at the numbers, so they would be the right people to make comment on that and give their view. I was not involved with the child clinically, so I felt very uncomfortable making any comment there, when I had not treated the child, been involved clinically in the child’s care.”*

**8.15** We asked whether she also meant it could get them into difficulties with the parents:

*“No, I think I was more concerned that it was implying things about the Clinical Team which had not been agreed at the Child Death Review meeting and I didn’t have the right people there to make sure that I have got the right information. Also if you are saying that maybe the practice was not optimal in some way, I would have discussed it with our Management Team, but it is not just an individual, it has to be an organisational response...”*

**8.16** Consultant 3 went on:

*“In retrospect, what I should have said to the parents is ‘Look, I haven’t got the right people here, I haven’t got the right information, we need to just halt things here, we can re-meet when I have the right information and the right people there,’...”*

**Comment**

*Consultant 3’s role in the CDR feedback meeting was to explain the consensus view reached by the clinicians at the CDR meeting regarding Ben’s diagnosis, care and treatment. The meeting reached a difficult point when Ben’s parents presented a strong case for earlier prescribing and administering of antibiotics. Consultant 3 was not involved in the clinical care of Ben and, therefore, felt uncomfortable talking outside of the consensus formed at the CDR. This resulted in her appearing guarded*



*during the discussion with the parents. Consultant 4 had not been present at the CDR meeting, but gave his own opinion about the prescription of antibiotics for Ben.*

*It is unusual for a CDR feedback meeting to take place without the clinicians involved in a child's care. The trust needs to have a clear process for managing such meetings. Parents need to be informed that the role of the clinicians at the meeting is to feedback the consensus reached at the CDR. Questions which need to be put directly to the clinical team who cared for their child may need to be taken away from the meeting and responded to at a later date.*

*It is evident that the model used in this case did not work, and caused the family additional distress and suspicion about the readiness of trust staff to be open and honest with them.*

**8.17** The general manager told us about agreeing to delete the recording:

*"... [Consultant 4] says they're right to raise this, or something similar, and... [Consultant 3] says 'yes, but I don't know if things would have been any different'. Then she says, 'can we edit that, or delete that bit', and I say 'yes", I said this as it was not part of the meeting."*

**8.18** She said she had thought her remarks while she was making coffee for the parents and:

*"... reflected that actually we hadn't said anything that was detrimental; in point of fact, it's probably positive that they hear that we are recognising that they are raising the right questions. Before I turned on our recorder, I said what had happened and that we had continued to talk and record. That we had a further discussion after they left the room and I'm so sorry that had happened, but that I would leave that recording on and that they would hear that."*

**8.19** The general manager told us that she emailed Consultant 3 after the meeting to thank her. She thought she had shared every possible detail and been as open as she could have been. Consultant 3 responded that it was the most awful meeting and she had felt under a "good deal of pressure".

**8.20** Consultant 3 told us she went to speak with Consultant 2 (her line manager) after the meeting to explain what had happened. She said she told him about the recess discussion:

*“Then I didn’t hear anything for a long time, I was expecting to get a copy of the transcript and I didn’t receive a copy of that... I explained to Dr...[F] and I also spoke with Dr...[D], it may not have been that day, it might have been the next morning, about what had happened, so that both of the members of the Clinical Team knew. I think Dr...[F] said something ‘Oh well, we will just have to wait and see what happens now.’”*

*Comment*

*Our remit is not to consider whether the allegations are true but to review how the trust responded to the allegations. In the next section, we consider the management response, establishing who knew what and when and what they did.*

**Management response**

**8.21** Consultant 3 told us she informed Consultant 2 and Consultant 1 (clinicians involved in Ben’s care) about the meeting and the recess discussion shortly after the meeting with the parents.

**8.22** The divisional director told us that he heard about a “mix-up” with the recording “third or fourth hand”. He understood that the general manager spoke to the clinical chair about the meeting with the parents on 22 July. He said:

*“Once the recording of the meeting had gone to the parents, they came back and said this doesn’t tally... [the general manager] said I don’t understand that, it should, there’s no reason why it didn’t. There was an email exchange involving the PALS office and... [the general manager], which I observed, the culmination of which was the father recognised that there wasn’t a discrepancy in the two transcripts and apologised.”*

## Comment

*The allegation related to the suggestion that the trust deleted part of the recording from the recess discussion. However, it was subsequently established that the trust's recording had been paused while the parents' recording continued. Ben's parents have confirmed this.*

*Trust managers believed the concern about the recording was that the parents' recording contained information not on the trust's and this information had been deleted. The divisional director and others did not appear to know that a conversation had taken place in the recess which Consultant 3 had asked be deleted and to which the general manager agreed.*

**8.23** The divisional director told us that after the cardiac steering group meeting - where senior management discussed the best approach to the father's email of 16 September - attendees agreed that he would call the parents to discuss the possibility of meeting with the clinical director for critical care to get a fresh, senior perspective on Ben's care and treatment. He said during the conversation he learnt that the parents had evidence that clinicians in the CDR feedback meeting:

*"...said something in the recess that they then contradicted in the second part of the meeting."*

**8.24** The divisional director went on:

*"This was the part of the recess that he'd had recorded that we hadn't recorded, so that we hadn't ever seen it before. I said 'if you send that to me I will make sure we investigate that as well as part of the complaint process', which he duly did."*

**8.25** The divisional director told us that he was then in email correspondence with Ben's parents. He told them he had asked his deputy - who manages intensive care services - to look at the specific allegation about the consistency of the recess discussion with the rest of the meeting. The divisional director told us he thought at that point that the doctors in the meeting had said something in the recess that they had then contradicted in the second

part of the meeting. The divisional director informed Ben's father that his deputy would be undertaking the investigation and then informed the medical director and the chief executive of the proposed approach.

**8.26** We asked the divisional director why the allegation about Consultant 3 asking the general manager to delete the recess discussion was not included in the deputy director's investigation. He told us:

*"When you look back and you look at what was sent to us on the... [16 September], when it talks about deletion, everyone in the trust read that and no one picked up on that particular point. From my point of view, my mind went back to the email exchange around 10/11 August where dad was saying there's a discrepancy and things aren't there, you deleted stuff, and it was sorted out that it wasn't deleted. I saw that as a whole."*

#### *Comment*

*The parents raised concerns in their email to the chief executive on 16 September but the trust failed to identify the need for and commission an investigation into Consultant 3's suggestion that the recess discussion be deleted and the general manager's agreeing to delete it.*

**8.27** On 8 October Ben's parents shared with the trust their audio recording of the discussion that took place in the recess of the CDR feedback meeting.

**8.28** The divisional director asked his deputy on 13 October specifically to look at whether what was said during the recess contradicted what was said during the rest of the meeting. This investigation was commissioned over three weeks after the parents' email to the chief executive. However, the trust report that they did not have a copy of the recess section of the transcript until early October - five days before the investigation was commissioned.

## Comment

*At this point, the trust had considered, investigated or set up investigations into whether:*

- 1) The clinicians in the CDR feedback meeting on 22 July said anything in the recess which they contradicted in the second part of the meeting (investigated by deputy divisional director in October 2015).*
- 2) Some of the recording of the recess discussion was deleted from the trust tape recorder. Discussion between the parents and the general manager established that the trust's recording was simply stopped while the parents' continued.*
- 3) Consultant 3 requested that part of the recess discussion be deleted and whether the general manager agreed to do so (investigated by the deputy medical director in January 2016).*

**8.29** Before starting her investigation, the deputy divisional director confirmed with HR and the divisional director the approach required and whether the investigation should be governed by any specific policy. The divisional director informed her that the investigation should be undertaken in line with the complaints policy.

**8.30** The deputy divisional director undertook investigative interviews on 20 and 21 October, concluded her report next day and presented it to the divisional director and the clinical lead for critical care. The deputy divisional director reported that she believed that a separate investigation was needed into Consultant 1's and Consultant 2's giving the parents inaccurate information during the pre-CDR meeting on 4 June. This resulted in a discussion with the medical director - triggering a further separate investigation to be conducted by the clinical chair.

**8.31** The head of communications phoned the divisional manager on 5 December to tell him the Daily Mail were going to publish an article next day about the recess discussion. He then phoned staff involved (including Consultant 3) to say that they were going to be named in the Daily Mail and the parents were going to the media with the recess transcript.

**8.32** A meeting took place on or around 7 December to discuss the case. It was attended by the:

- chief executive;
- medical director;
- chief operating officer;
- divisional director; and
- director of HR and organisational development.

**8.33** The meeting agreed that the divisional director would put together a timeline of what had happened. He would also develop an action plan. The chief executive told us he asked his colleagues for a progress report on the investigation into the allegation of deleting the recess recording. At this point, the chief executive identified a gap in the investigations that had been undertaken. The chief executive then asked that a further investigation be undertaken under *Maintaining High Professional Standards in Modern NHS Policy Framework* to look at the question of probity, centred on the request for deleting the recess discussion. The medical director commissioned the deputy medical director Dr L to formally investigate these allegations.

**8.34** On 17 December Ben's parents sent a series of emails to the clinical and managerial team.

**8.35** Consultant 3 told us she was interviewed on 27 January as part of the MHPS investigation. The deputy medical director produced a report in March 2016 and a letter containing the key findings was sent to Ben's parents on 1 April 2016.

### *Summary*

*Staff involved in the CDR feedback meeting with the parents on 22 July told us they informed others (Consultant 1, Consultant 2 and the clinical chair) about the recess discussion. However, no one sought to proactively engage with the parents about the recording. Instead, they waited to see if anything further would materialise.*

*There appears to have been confusion about the exact nature of the parents' concerns - there was the belief that some of the recording had been deleted from the trust's*

*recording. However, it was established that the trust recorder was switched off while the parents' recording device continued to capture the conversation.*

*After the parents' email to the chief executive and subsequent correspondence with the divisional director, senior managers believed that the parents concerns were about the consistency of what staff said during the recess and the second half of the meeting. This interpretation of the parents' concerns resulted in the divisional director commissioning his deputy to undertake an investigation into the consistency of what was discussed.*

*The parents had clearly raised concerns about the apparent deletion in September but the trust failed to address this point. The parents shared their version of the audio recording with the trust on 7 October. Even at that point senior managers failed to realise the significance of the allegation. An investigation into this allegation was not commissioned until December 2015, after the transcript and audio recording featured in the Daily Mail.*

The quality and robustness of trust investigations undertaken in response to the allegation

**8.36** In this section, we consider the investigations that were commissioned into the allegations raised - considering their quality and effectiveness in addressing the concerns raised.

**8.37** Two investigations were commissioned in relation to these allegations:

1. The divisional director asked his deputy on 13 October to assess whether anything said during the recess of the CDR-feedback meeting on 22 July contradicted what was said in the second part of the meeting.
2. The medical director commissioned his deputy in late December 2015 in line with MHPS guidance to see if there was a case to answer in response to the suggestion that part of the recording made during a break at the CDR-feedback meeting on 22 July had been deleted.

### *First investigation*

**8.38** The divisional director commissioned his deputy to undertake an investigation on 13 October. On the same day the deputy divisional director emailed an HR manager ask for her view on her approach. She also wanted to establish whether the investigation was to be undertaken in line with any specific trust or national policy. The deputy divisional director told us she and the HR manager were unclear whether they were operating under the complaints policy or under an HR policy. They therefore asked the divisional director for confirmation. He told them they were working under the complaints policy. However, he said she should remember that HR polices might “*kick in*” if she found anything serious.

**8.39** The deputy director told us that she read the three transcripts (two pre-CDR meetings with Consultant 1 and Consultant 2 and the CDR-feedback meeting with Consultant 3 and Consultant 4) in preparation for her investigation. She then wrote to Consultant 4 and Consultant 3 (the clinicians involved in the post-CDR feedback meeting) outlining the purpose of her investigation and asked to meet them individually. They both responded quickly and meetings were arranged for 20 and 21 October. The deputy divisional director conducted a face-to-face interview with Consultant 3 and interviewed Consultant 4 over the phone. Neither Consultant 4 nor Consultant 3 had seen the parents’ transcript of what they had said during the recess before their interview with the deputy director.

**8.40** The deputy director compiled her report the next day (22 October). She told us:

*“Recognising the weight of what I was being asked to look at and the importance of it and, equally, it being part of a complaint response where there is a parents [sic] at the end who want to know that we are getting on with things and have that feedback. I wanted it done really swiftly, so that is what I did.”*

**8.41** The deputy director concluded that she was satisfied that nothing the clinicians said in the second part of the CDR feedback meeting directly contradicted what they said during the recess. However, she found they had proceeded with caution and had perhaps been not as open and transparent with Ben’s parents as they might have been at such a meeting. The deputy director therefore used her investigation interview to seek to understand this better. She told us:



*“I have to be honest, had I come across behaviours in those meetings that led me to have further concerns about the probity or respect for the Duty of Candour, I would have written it up in a very different fashion.”*

**8.42** The deputy divisional director sent Consultant 3 and Consultant 4 a draft summary of their discussion. Consultant 3 told us that she corrected errors of fact in a draft report before being sent a final version.

**8.43** The deputy divisional director then met with the divisional director and the clinical director for critical care because she believed that they needed to commission a separate investigation into Consultant 1’s and Consultant 2’s having given the parents inaccurate information during the pre-CDR meeting on 4 June. This discussion resulted in a meeting with the medical director - triggering a further separate investigation, which the clinical chair was then asked to undertake.)

**8.44** The deputy director’s report into whether Consultant 3 and Consultant 4 said anything in the second part of the CDR feedback meeting that contradicted anything said during the meeting recess concluded that the parents’ question of probity was unsubstantiated.

Comment

*The deputy director sought clarification to ensure she was investigating under the appropriate trust guidelines and was clear about the scope of her investigation.*

*Given the scope of her investigation, her approach, findings and conclusions were reasonable. However, the scope was too limited to address the parents’ main concern: why a clinician would suggest part of a discussion be deleted and a manager would agree to it.*

*The divisional director told us he believed at the time that the parents’ concern related to the clinicians contradicting themselves during the second part of the meeting. However, the trust should have recognised the seriousness of the suggestion that any element of the meeting should be deleted - and the reasons for such a suggestion - and ensured that any investigation covered these points.*

## *Second investigation*

**8.45** The medical director commissioned the deputy medical director in December 2015 to undertake a preliminary investigation under Maintaining High Professional Standards (MHPS) guidance to formally investigate allegations made by Ben's parents:

*"That deliberate attempts were made by trust staff, including Dr...[S], to falsify recordings of a meeting they attended on July 22<sup>nd</sup> July 2015".*

**8.46** The associate director of HR supported the deputy medical director in her investigation. The investigation had clear terms of reference, which included reviewing both the parents' and the trust's recordings of the CDR-feedback meeting on 22 July and interviewing all staff who had been present. The terms of reference say the findings of the investigation will be benchmarked against GMC standards and trust policy and reported to the MHPS case manager (the medical director).

**8.47** The investigation report set out a clear methodology for the investigation and a background to the concerns. The investigator interviewed all staff present at the CDR-feedback meeting and asked about the suggestion to delete the recess recording.

**8.48** The investigator set out her findings and conclusions in a report and presented it to the medical director. The medical director then included the key findings in a letter to Ben's parents dated 1 April. The letter quotes directly from the investigation report:

*"There is clear evidence that [Consultant 3] did ask for the section recorded during the break to be deleted. This comment was made in haste and was not followed up or actioned, supporting a view that there was no real intent to delete the recording."*

## *Comment*

*This is a reasonable conclusion to draw on the evidence. However, the medical director's letter to the parents containing the findings of the investigation did not answer the parents' fundamental question: why Consultant 3 wanted part of the recess discussion deleted and why that recording would have got them into difficulty.*

*The investigator puts this question directly to Consultant 3 and the general manager, who offered their opinion on Consultant 3's motive and what she meant. Consultant 4 acknowledged what had happened but said that they had been honest with the parents about the recess discussion and felt that duty of candour had been met.*

*It is insufficient and inadequate for the trust simply to inform the parents that:*

*"This comment was made in haste and was not followed up or actioned, supporting a view that there was no real intent to delete the recording."*

*The deputy medical director's investigation is more thorough than the letter from the medical director suggests. The trust has done itself a disservice by sharing so little from the investigation report with Ben's parents.*

*A separate complaint response needs to be drafted if the trust deem the investigation is not appropriate to be shared with the parents because it was conducted under MHPS guidance. The separate response should either draw on the MHPS findings or further investigation needs to be undertaken.*

*Trust management knew about the parents' concerns about the recess discussion but failed to recognise the point they were making or the seriousness of the suggestion of deletion of a discussion - whether or not any deletion actually took place. This lack of grip on the issue resulted in a delay of four months before the deputy medical director's investigation*

Whether the findings of investigations were reasonable

### *First investigation*

**8.49** Given the terms of reference of the deputy divisional director's her findings were reasonable. However, the scope was too limited to address the parents' main concern: why a clinician would suggest part of a discussion be deleted and a manager would agree to do it.

**8.50** Trust senior management believed that the parents' main concern related to the clinicians contradicting themselves during the second part of the meeting. However, the trust should have recognised the seriousness of the suggestion that any element of the meeting should be deleted.

### *Second investigation*

**8.51** The findings of the deputy medical director's investigation were also reasonable and answered the terms of reference. The main concern for the parents was why Consultant 3 would want part of the discussion deleted. The deputy medical director put this question to her in interview. The difficulty remained that the clinician said she meant one thing but the parents thought she meant something else. This is not reconcilable through an investigation looking specifically at what was said. The parents believed the comment needed to be considered in a wider context of their son's care and treatment.

**8.52** The deputy medical director benchmarked practice against national policy (MHPS and MC). However, at the time of writing, the report remains an internal, confidential document and the parents have not seen the full report or even what Consultant 3 said about her request to delete part of the discussion and the general manager's interpretation of what she was being asked to do.

**Whether trust actions in response to the investigations were appropriate and proportionate**

## *First investigation*

**8.53** The deputy divisional director's investigation identified the following learning points:

- *“The CDR process is required to deliver an objective view on why a child has died. In this case this was hindered by the relationship between medical colleagues.*
  - *Learning 1 - the first part of a CDR meeting should ask all present whether there is anything that will prevent them from operating with full objectivity during the discussion.*
  - *Learning 2 - A ‘decision tree’ is required to identify when an external chair for the CDR meeting should be elected for any given case.*
- *[Consultant 3] was the attending consultant for HDU at the Children’s Hospital whilst at the meeting.*
  - *Learning 3 - bereavement or complaint meetings, such as this, should only proceed if all clinicians are free of clinical commitments.*
- *[Consultant 3] had not discussed the case with her colleague... [Consultant 1]. Poor preparation is a theme throughout the interview transcripts in this case.*
  - *Learning 4 - all parties representing the care delivery should be fully appraised of the facts in advance of a meeting with the parents. Where something might be controversial, or at odds with another colleagues’ opinion, opportunity must be found to discuss this in advance of meeting the parents. Openness and honesty are of paramount importance and all meetings should be conducted in this fashion.”*

**8.54** The deputy divisional director presented her report to the divisional director and the clinical director for critical care. She raised the need for a further investigation into the probity of Consultant 1 and Consultant 2 about their having given inaccurate information at a meeting with the parents on 4 June.

**8.55** The trust produced an action plan that brought together all the concerns raised by Ben’s parents. The action plan is dated 9 January 2016 and includes the learning points the deputy divisional director identified in her investigation. The action plan sets out the items to be included in the standard operating procedure (SOP) for the CDR process and/or the SOP for the management of formal complaints. The actions had a proposed completion date of 29 February 2016.

## Comment

*The trust shared with us a number of documents as evidence of progress against the recommendation in the action plan.*

*In April 2016, the division revised its 'checklist to be completed following the death of a child'. However, it does not contain a future review date. The trust has stated that they will add a date to the checklist.*

*The document entitled 'Clinical Standard Operating Procedure (SOP) - Management of formal complaints, W&C' is dated 10 October 2014 and does not have a date for next formal review. The trust reports that the SOP was reviewed in April 2016 and a review date has now added to the revised document.*

*The trust has also provided a copy of their 'clinical procedure, child death pack contents'. However, the document states that it was produced in July 2014, it is therefore unclear what information has been amended as a direct result of the action plan. The trust has agreed to review this.*

*This is the same with the following two documents:*

- 1) 'Clinical guideline, child death review process - information for professionals'.*
- 2) 'Clinical Guideline child death - unexpected child death in Bristol and wider area: checklist following the unexpected death of a child.'*

## Second investigation

**8.56** The deputy medical director investigation identified the following "Potential Learning Points":

*“The trust should consider developing guidance for staff meeting with parents and/or relatives where serious incidents/deaths have occurred in order to ensure that the meeting is as responsive as possible to the issues and concerns those families may wish to discuss.*

*Careful consideration should be given to:*

- the time allowed for the meeting*
- the staff who attend and ensuring that staff are available for the whole meeting.*
- the clinical records should be available.*
- preparation time for the meeting to ensure any questions raised by families prior to the meeting can be answered as fully as possible in the meeting and ensuring that questions that cannot be answered in the meeting are answered subsequently in a timely way, in a format agreed with the parents.*
- clarity about recording and who is responsible for recording devices.”*

**8.57** The deputy medical director submitted her report to the medical director (as case manager) to review and consider any further steps in line with MHPS guidance.

**8.58** The medical director reviewed the report and accepted its findings and conclusions. The medical director’s letter to Ben’s parents on 1 April includes the findings and says:

*“It is clear that all those involved have reflected and understand that they failed to meet your expectations... [Consultant 3] deeply regrets the distress the comment has caused and will take the learning from this into account in future practice. She has formally recorded the incident and reflective learning in her appraisal documentation, which forms part of the revalidation process for medical practitioners.*

*In addition, I will be sharing wider learning from Dr...[L’s] investigation with clinical colleagues across the trust, in particular the need to establish clear guidelines for 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.”*

**8.59** The report was finalised at the end of March/beginning of April and we have not yet seen the trust's action plan to address the recommendations.

#### *Comment*

*The medical director states in his letter to Ben's parents that those involved "failed to meet your expectations". This is another example of the trust not acknowledging the concerns they needed to address. We would argue it is not about meeting the parents 'expectations' but about ensuring that the trust answers the parents questions about their son's care in a full, open and honest way.*

#### **Conclusions**

**8.60** The trust failed to recognise the substantive issues in a timely way and therefore the first investigation was inadequate, even though the investigator fulfilled her brief.

**8.61** The second investigation was not commissioned until December and concluded at the end of March. This delay was allowed to occur despite the parents having raised their concerns about the transcript in the email to the chief executive on 16 September. Everything took too long and the parents had lost confidence in the trust by the time of the second investigation.

**8.62** The trust chose to investigate the issue of Consultant 3's probity under the MHPS guidance. This was appropriate but it meant that the report was an internal HR document and therefore the full findings could not be shared with the parents. The trust must ensure that all concerns raised by the parents are addressed in the complaint response - which includes answering why Consultant 3 suggested part of the recess discussion should be deleted.



## **9. Overall conclusions**

**9.1** The trust missed a number of significant opportunities to engage pro-actively with Ben's parents after the death of their son. For example, the trust failed to share important findings about the presence of a secondary infection at the time of Ben's death. While there has been some debate about when the results were reported and reviewed - the fact is the parents were not informed of the finding until seven weeks after their son's death.

**9.2** 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. For example, at the second pre-CDR meeting held on 11 June, staff appeared very reluctant to share information with the parents and give definitive answers to the parents' questions. This may have been appropriate given the CDR was taking place less than a week later and the clinicians involved would be able to have a more informed discussion. However, the way in which the meeting on 11 June was conducted made staff appear guarded and reluctant to engage with the parents.

**9.3** 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. For example, when management were informed about the discussion which took place in the recess of the CDR meeting (including the suggestion of making a deletion), the response was to wait to see whether anything further came of it - rather than tackling the issue head on.

**9.4** 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.

**9.5** There was a long delay in senior management getting a 'grip' of the complaint and recognising the serious nature of the parents' concerns.

**9.6** The executive team - including the chief executive - became aware 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 serious cases would have executive oversight and in this instance that was the medical director.

**9.7** Despite the medical director having oversight of the various 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.

**9.8** 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.

**9.9** 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.

**9.10** The purpose of the meeting on 22 July appears to have been two fold - to provide the parents with feedback from the CDR 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 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, in particular in relation to, the prescribing of antibiotics.

**9.11** 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.

**9.12** 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.

**9.13** 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.

**9.14** 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.

**9.15** 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.

## **Recommendations**

**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.

**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.

**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 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.

**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.

**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.

**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.

**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.

**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.

## Team biographies

### **Walter Merricks CBE - Verita associate**

Walter was the UK's chief Financial Ombudsman for 10 years until 2009, leading one of the UK's most impactful and high profile public redress institutions. Since then he has pursued a portfolio of interests. He now chairs the boards of the new press regulator IMPRESS and is a board member of the Gambling Commission and of the legal think-tank JUSTICE; he acts as service complaint reviewer for the Royal Institution of Chartered Surveyors. He recently completed five years as inaugural chair of the trustees of the Academy of Medical Royal Colleges.

In his earlier career he followed a varied path in public legal institutions that has given him extensive experience in law, healthcare, regulation, consumer protection, complaints adjudication and public policy fields. After qualifying as a solicitor he ran the UK's first publicly funded law centre, became a university law lecturer, a legal journalist, then headed the Law Society's public affairs division. He served on two important law reform bodies: the Royal Commission on Criminal Procedure, and the Fraud Trials Committee. In the health sector he was a member of the Human Fertilisation and Embryology Authority and worked with the Health Department as inaugural board chair to set up the Office of the Health Professions Adjudicator until coalition ministers closed down the project.

### **Amber Sargent - Verita director**

Amber joined Verita as a senior investigator in 2009. Previously she worked at the Care Quality Commission (CQC) where she led on several major investigations into patient safety, governance and concerns around performance. At Verita Amber has worked on a wide range of investigations and reviews - including governance and patient safety reviews. She specialises in managing complex complaints and serious incidents.

#### *Specialist areas:*

- Patient safety and governance systems

- Handling and learning from complaints
- Benchmarking services against best practice

### **Barry Morris - Verita partner**

Barry joined Verita soon after it started in 2002. He has a wide range of experience in investigations and reviews. He has recently worked on an investigation into governance arrangements in the paediatric haematology and oncology service at Cambridge University Hospitals NHS Foundation Trust following the Myles Bradbury case. Other work includes quality assurance of the Department for Education Savile investigations, leading the sampling team supporting Kate Lampard in her oversight of the NHS investigations into matters relating to Jimmy Savile and a high-profile investigation into paediatric cardiac surgery in Leeds Teaching Hospitals NHS Trust.

## List of interviewees

### Interviews:

- chief executive
- medical director
- head of nursing, women and children's division
- clinical director, critical care and cardiac services
- deputy divisional director for women and children's division
- LIAISE support officer
- general manager, cardiac services (retired)
- Consultant 1, consultant in paediatric intensive care
- Consultant 2, consultant in paediatric intensive care
- Consultant 3, consultant in paediatric intensive care
- matron and lead nurse for children's critical care and cardiac services
- divisional director for women's and children's services
- clinical chair for women's and children's services

### Meetings with:

- Ben's father

## Documents reviewed

### Documents provided by the trust

#### *Policies and procedures*

- Staff conduct policy, June 2014
- Disciplinary policy and procedure, April 2015
- Performance management policy and procedure, February 2014
- Grievance policy and procedure, November 2015
- Complaints and concerns policy, August 2014
- Staff support and being open policy, March 2013
- Policy for the management of incidents, June 2013
- Management of the interface between complaints, rapid response meetings, root cause analysis/SUI investigations and child death reviews

#### *Meeting minutes*

- Executive directors' meeting minutes - November 2015 - January 2016
- Quality and outcomes committee minutes - December 2015
- Children's governing executive committee minutes - December 2015
- Minutes of meetings with Ben's parents
- Investigation meeting minutes

#### *Other*

- Correspondence between the trust and Ben's parents
- Complaint action plan
- Trust internal investigation into the recess transcript, October 2015
- Trust internal report into concerns raised by Ben's parents, November 2015
- Timeline associated with the proposed deletion of the recess transcript
- Child death review, June 2015



### Other information reviewed

- Supporting information from interviewees
- Supporting information from the family