

Investigation into the death of a child and lessons learned

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William Randell gives a personal view of what he learned from an investigation into a child's death.

An investigation into the death of a child involves many people – those who cared for the child at the time, the staff affected by the investigation process and, most importantly, the family who suffered a tragic loss.

The initial meeting

When I received a call from the director of nursing asking me if I was free in 10 minutes to come to an urgent meeting, I had no idea of what I was about to be informed of or the implications on my time for the next three months. In attendance were the clinical director, general manager and matron for the paediatric directorate, the director of nursing and myself. The clinical director and matron explained what they were aware of at that time.

The incident

Child A had been unwell at home and had suffered a convulsion, after which the family had called paramedics to the house in the early hours of the morning. After an uneventful transfer to the A&E department of the Luton and Dunstable Hospital by the paramedics, A was:

- seen by the senior house officer in A&E and, as is standard practice, referred to the Paediatric Assessment Unit (PAU) at the hospital;
- seen on the PAU and admitted to the paediatric unit at 9am;
- assessed and reviewed by the admitting consultant, with a working diagnosis of gastroenteritis. A plan of care was made, in essence consisting of fluid replacement and anti-pyretics (to bring down the child's temperature).

Observations were performed and to all intents and purposes A was "doing OK" throughout the rest of that day, and overnight.

The following morning, A was found to be profoundly unwell by the oncoming morning shift. Despite full and extended resuscitation attempts, A died at 10am having been under the care of the trust for just over one day.

The context

The paediatric directorate had experienced a similar incident some two years previously, as a result of which it had begun to use a "Paediatric Early Warning Score" (PEWS). The directorate had dedicated considerable time and effort to training staff in the use of PEWS and the actions that should be taken in response to certain scores. If use of the PEWS system indicated a child's condition was deteriorating, it would be referred to more experienced members of the paediatric team.

Both the clinical director and the matron believed that this referral process may not have occurred in A's case and wanted this to be investigated by the impartial insider in the organisation, the risk manager. The director of nursing was also very sensitive to the wider

implications of this death and strongly supported its investigation as an internal serious untoward incident.

The investigation

Having been given the bare facts, I commenced my investigation. The National Patient Safety Agency (NPSA) has provided the NHS with a wide range of methodologies and training in root-cause analysis (RCA). If there is one lesson for all risk managers in this training, it is that the key to an investigation is information gathering. Further to this, I would say that timely information gathering is vital, as memories can become blurred with the passage of time.

Information gathering commenced with my obtaining A's notes and taking a full copy of them – this protects the trust and the investigation process as, regrettably, notes can disappear. With the assistance of the directorate, I identified all staff who had had contact with A and wrote to them, requesting that they provide a factual statement of their involvement (if any) with A. The letter that was sent to staff was worded in collaboration with the human resources (HR) department. The trust felt that a single investigation process carried out by the risk management department would lessen the impact on staff, while allowing a review of the patient records, which in turn might identify weaknesses in the professional performance of some staff members involved in A's care.

Staff involved completed statements and, following this, I constructed a timeline of events. This commenced with the family's call to the ambulance service and ended with the death of A. The construction of the timeline was helpful to the investigation process as it started to flesh out what had, or, more importantly, had not, occurred and when. This allowed the investigation to focus on the key times and the various actions or potential omissions that had taken place.

The statements told part of the story of what had occurred that day but there was a need to interview all staff involved. As my clinical experience is not paediatrics, I was assisted in this process by paediatric ward sisters who were not directly involved in the care of A and by the lead consultant from the neo-natal unit. The interviews, too, added more flesh to the bones of the investigation process and enabled the timeline to become ever more populated.

It was vital to this investigation that we gained a feel for the environment that the paediatric team were working in over this 28-hour period. This included the pressures they were working under, staffing levels, and competencies of the staff – in essence, trying to paint a picture of the day that was being investigated.

At this point of the investigation it was becoming clearer that some staff members had not followed trust guidance and this in turn had led to a failing in meeting professional standards. We used the NPSA's *Incident Decision Tree*, a tool that helps to identify appropriate management action and to determine whether staff need

to be suspended following an adverse incident. The actions of 11 medical and nursing staff were assessed using the decision tree. This was done as a two-person exercise, involving the risk manager and either the neo-natal consultant for the medical staff or paediatric sister for nursing staff. Involving two professionals provided further impartiality and insight in using the tree.

The results

The results of using the decision tree were communicated to the paediatric general manager, clinical director and matron as there were issues of underperformance that had to be taken forward using HR procedures.

The investigation concluded with a full report that was made available to all members of the paediatric team involved in A's care and to A's family. The report contained a number of recommendations that focused on both the paediatric directorate and the organisation as a whole with what were believed to be meaningful and achievable timescales. A summary of the report was also shared with the board. The period of time between the incident and this final summary was four months.

Root causes

The post-mortem had shown that A died of multi-organ failure as a result of a group A streptococcal infection. The investigation found that A had had regular observations, but results of these were not communicated within the hierarchy of nursing and medical staff and, therefore, a medical review was not undertaken. Furthermore, observations were not performed overnight and A's deteriorating condition was not recognised by the named nurse and communicated to more senior staff.

Being open

This incident occurred just as the NPSA's *Being Open* guidance was launched. It was agreed that the organisation should be as open and helpful as possible with A's family. I was in regular communication with A's mother. It is fair to say that these conversations were difficult, as she obviously needed to know what had happened, and why and how her child had died. Simultaneously, as the risk manager undertaking an investigation, I needed to compile evidence for a final report, which would document my interpretation of events during the incident. I told A's mother that I would be as fair and as impartial as possible, but that my conclusions might not be what the family wished to read and this might be challenging to them.

Lessons from this investigation

The key lessons for me from this investigation concern time, sharing learning, supporting other processes and a different approach to managing medical staff.

Time

This type of investigation just eats up time. I reviewed my diary and found that at least 29 days of my time were taken up by this investigation. I utilised senior staff to assist me in the investigation process and I have not attempted to calculate the time that they set aside to assist me. However, if I had not had this assistance the investigation would have taken even longer to complete.

There are suggestions from the Department of Health that more investigations of this type should be undertaken. While I fully support this concept, in this case it was recognised at a very early stage that this was a serious untoward incident with associated HR issues, and the investigation process was commenced in a timely manner.

Many deaths are not recognised as an untoward occurrence until a mortality-type review is undertaken and this can be some months after an event. There are also the inevitable resource issues and I doubt this type of investigation would be sustainable with the present resources that risk managers have at their disposal. There is a suggestion that a truncated RCA investigation might be undertaken; but if a job is worth doing it is worth doing it well, and short cuts in an investigation will not support an organisation in the long term.

Sharing learning

This incident is well known within our organisation, but the question has to be asked: "Will this prevent the death of another child?" This is very difficult to answer. We believe that we have shared all the lessons from this incident as widely as possible using paediatric training days. However, with a rapidly changing workforce and increasing patient throughput, there will inevitably be another incident of this type. What we cannot count are all the patients who have had a positive outcome as a result of the clinical lessons learned from this incident.

Clinical changes

The organisation has recognised that the night-time cover for the registrar staff was lacking and the cover for nights has been increased from one to two registrars at night, one for the neo-natal unit and one for the paediatric wards. The use of the PEWS has been re-enforced throughout the paediatric directorate as a tool to help assess the condition of children and to stress the need for timely referral to more senior staff to assess a potentially deteriorating child.

Supporting other processes

The investigation has been used to support other processes within the organisation. The day that the report was made available to the family, we received a complaint about the care that their child received. The family have used the trust's report to aid their complaint process by enabling them to ask insightful questions. However, the investigation process has also supported the trust in answering the complaint. The family have now taken their complaint to the Healthcare Commission and the report has been forwarded to the commission.

Following the HR processes arising from the trust's risk management investigation, the Nursing and Midwifery Council was informed of professional concerns and it in turn is in the process of conducting its own investigation into this aspect of the incident. The timeliness of the trust's investigation process has aided staff in this process.

Medical staff

One of the lessons for me was the different approach that is now taken to managing medical staff who have been involved in this type of incident (for example, with greater involvement of the medical deanery). One of the key phrases that stuck in my mind was from a consultant, who said: "This is very different, but better than how we used to do things."

Conclusion

This incident, from an investigation point of view, is long finished. However, because of complaints, the potential for litigation and the involvement of professional bodies, this incident continues to have the ability to affect all those involved in the short time that A was at the hospital.

The report concluded that we owed it to both the child and the organisation to learn from this event. I believe that the organisation has indeed learned from this incident and that we will provide high-quality care for all those that pass through our doors. 