

Child A

A meet on morning
of hearing

Pre-Inquest Meeting

- adjustment of the line, but as P.M. suggesting it had an impact
 - was nurse involved in Child A's case? Re: video review
 - where Child A's death fits into the sequence.

POLICIES
PROTOCOLS...

Q. Sequence

Nurse

- ↳ if yes, Disclosure to family
- + spike in deaths, not just nurse = DISCLOSURE.

Dr Sally Ogden:

-: short period of time from the birth until the patient died

→ Louis explaining Inquest -: thoroughly cover pre-inquest pack

- half-a-day = suggests coroner thinks issues are relatively discreet.

• P.M. → page 9. Re: long line

and: "In summary, P.M. has found..."

very important. ↳ final page - CVL related to death -
cannot say - uncertain.

- as long as we as team don't contradict those findings, there
shouldn't be a problem.

+ No evidence of correlation.

Dr. Ogden:

→ on first check, nothing to suggest that Child A had any
problems. Needed a central line for nutrition - necessary.

→ page 15/16 medical notes.

- V (ventilation) → CPAP of 5
- N-neurology • F (fluids) → 60mL/kg = standard amounts
- S (sepsis) M (Metabolic) CV (cardio-vascular)

• copies of protocols in place to Louis that are mentioned in staff reports.

→ page 3 - Dr. Boech - mention of Trust Guidelines.

→ then PLAN - est. (establishing).

next involvement with TERESA MACCARICK.

why afternoon? 12:30-1:00 - staffing, Sally only paediatrician in the neonatal unit at the time.

→ Sally explained UVC insertion.

↳ all sterile - gloves, scrubs etc.

→ goes off weight - $1.5 \times \text{weight} + 4.5$, add on length of chord. Usually 6/7 cm in these cases. X-Ray after ~~insertion~~ to see if it is in place. No fluids through line unless X ray shows its in place.

Dangers of UVC in Child A?

• Bleeding / vascular → pushing plastic into walls (veins)

↳ any distress / major problems during insertion would be apparent from monitors.

1608: - both scrubbed up, Dr Ogden showing Dr MacCarick, but quite who pushed the line cannot remember.

+ took about 20 minutes, which is what is usual length of time for UVC insertion.

• 1428 - X Ray of first UVC, so 1st UVC would be done at 1400 or so.

1700:

handing over - plan to remove long line, in retrospect notes suggest it had already been removed

Stopping levels:

- on that day, being only registrar on wasn't particularly busy, as children's ward was relatively quiet.

- stopping levels, and nursing and care given, no impact on his care.

→ Potential impact on Dr. Harkness, would have to ask him, Re: knock on effect of handing over 3 long lines.

DR WOOD

- GP training, 2nd year.

→ Pg 187 -: Dr. Harkness' notes

21:20: scrubbed, inserting long line in another patient

→ when was long line pulled back?

- Dr. Wood didn't believe it happened until after resuscitation attempt.

Pg 22 - Dr. Wood's note, re sequence of events.

→ never had situation where apnoea has occurred so quickly after intubation.

Actions:

→ Set up over next week or so, telephone conferences. Email out to say, "We helped to have a telephone conference".

+ Lunchtime / Tea time more likely (send to (law)).

+ Dr. Harkness: availability over next couple of weeks. ✓ sent email

→ Got Policies - email Ruth Milward, Re Child A would you be kind enough to identify relevant policies for neonate. ✓ sent email

yes - nursing notes

09 JUNE 15 17:56

09 JUNE 15 18:23

+ And are you able to send me a copy.

→ check through medical notes Re:

was nurse involved in care? LUCY LETBY.

+ SPC to leadface Re: review. from notes.

Child A

INQUEST

• Telephone Conference: Thursday 6th October 2016 @ 1300 hrs

Attending:

- Stephen Cross
- Louis Browne
- Dr Ravi Jayaram
- Dr Martha Saladi
- Dr David Harkness
- Dr Teresa MacLarick

C O

I&S

(CHAMBERS)

Issues To Raise:

- Give Dr Harkness & Dr MacLarick their witness summons letters.
- Discuss travel arrangements. Taxi from main reception if we meet at 0715 hrs, gives us time to meet with counsel before the inquest.
- OR Can make own way there, meet where and when - Louis Browne.
- + usually take original records - but away being examined?

* NOT RELATED TO THIS INQUEST *

→ I&S response - take phantom

→ I&S Inquest - speak to Dr Jenny Smith? Reasons for Kate Holloway being called. I&S Dr Smith on leave this week → Helen Thomas.

→ Inquest set for I&S, I&S October. Pre-inquest meeting, Dr Van Den Bergh has been called, is available from 1000 - 1200 hours for meeting on Monday 17th October. - liaise with Claire

+ Reva in London → mention to Louis

• Taxi from main reception @ 7.15. Give us an opportunity to meet beforehand in Costa Lopez.

+ I&S, Bundle to Stephen tomorrow.

4 mortuary: Kenon in London
SPC to mortuary to Louis.

TRAVEL ARRANGEMENTS:

- TAXI FROM MAIN RECEPTION @ 07.15 A.M.

LOUIS: explaining inquest / objective of inquest.

- who, where, when & medical cause of death.

- not anticipating any difficulties.

- + TRUST & FAMILY.

- listed for $\frac{1}{2}$ a day, Coroner believes issues are relatively discreet.

- + mention of line, and replacement - did it have any impact.

P.M. - unascertained.

- crossed pulmonary arteries - no suggestion it played a part in the death.

- long line and VVC complications - no evidence of those in this case.

- Dr. Markness: unascertained cause of death, so why inquest.

- no obvious explanation - sudden, so Coroner has to hold an inquest.

- enable family to hear evidence from clinicians and question / scrutinise.

→ Dr. MacLairick, lies.

- Afternoon of PD 1st day of life. Inserting VVC with assistance of Dr. Sally Ogden. Needed for medications / nutrients. Not first time inserting a line, but hadn't done many, hence Dr. Ogden.

- common complication for VVC line to enter hepatic vein.

↳ reviewed with Dr. Jayaram - advised remove line & replace with new line. If deviated again, place a long line

Dr. Ogden asked Dr. MacLairick if she would be comfortable doing the VVC as Dr. Ogden was only Registrar on busy ward.

- Again, VVC deviated into hepatic vein. Reviewed with Dr. Ogden and Markness. Advice, remove. Dr. MacLairick then went home.

If on inserting line, if you caused serious damage, how would you know. Ravi - rupture a vessel - heart rate up, baby would

FW email onto

& Ravi driving up.

Rachel @ Exchange.

unstable very quickly. No signs of any of that in this case.

Dr. Markness:

Only shift @ 5 o'clock. Under assumption VVC had been removed, but it hadn't. Very busy ward, didn't want to risk leaving no line; so left in place, as long line went in. Went in fine, no problems. Removed guidewire - not needed.

- Crossed midline, in hindsight in a pretty much ideal position. Pulled back slightly possibly to avoid going into heart - no evidence 10 minutes after 10%. Dextrose, apnoeic. Nothing unusual on monitor.
- Removed / Pulled back long line as that was last change in case - didn't make any difference.

Dr. Jagaram:

↳ came across, CPR going on. Told sudden deterioration, intubated correctly. In spite of appropriate intervention, no output established after 30 minutes = Prognosis poor, withdrew treatment after discussion with family. I think I thought about =

- Had there been auto haemorrhage?
 - Could line have gone into heart? X-Ray showed it didn't.
 - Lack of response to CPR etc.
- Still to this day Ravi doesn't know why this happened.

In 27 years in paediatrics, never seen this kind of situation.

Dr. Markness -

I&S

of Mother. Did this

have an impact? No mention in P.M.

Louise: If you don't know the answer, say - no speculation

↳ we can't say.

FAMILY QUESTIONS: Doni Jagaram

↳ very clear.

Dr. SALADI - involved earlier on - around birth. left at 1 o'clock on the day Child A died in the evening.

+ Dr. Northness: Alder Hey kids
↳ TAMI

DR SALADI - Coroner asks how did it inform future practice?

• REVIEW - Royal College of Paediatrics: pattern of deaths appear unusual. Further enquiry required.

Forensic Review.

• Is aware we have had a review, but not that we are having further reviews.

- If review is outside of the limit of your knowledge, then say so.

↳ And say anything unless you know. REVIEW IS Ongoing.

Q to Dr. MacLennan - why was it not possible to get line in correctly. Is that common etc.

Copies of policies on Monday - for RAVI

↳ him to deal with any questions.

• send to Rheinberg - latest part of the review.

ACTIONS:

• send to Coroner - bring to attention

MacL

↳

I&S