The crisis that we hoped would never happen

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Please respect the confidentiality of the patients, families and staff discussed in this presentation

Winchester, England.
Christmas 2007……

- Mrs AK
- Aged 39
- Schoolteacher
- 3rd pregnancy

AK

- Admitted in labor, Thurs. 20th Dec.
- Normal delivery of baby girl at 01.10am Friday.
- Home Friday am, apparently well.
- Readmitted Saturday am with abdominal pain

AK

- Deteriorated 4pm with signs of septicaemia
- Transferred to ICU
- Died Sunday 23rd December from multi-organ failure secondary to Group A Streptoccus (GAS) septicaemia.

Mrs JP

- Aged 29
- Schoolteacher
- First pregnancy

JP

- Admitted in labor, Thursday 20th Dec.
- Delivery of baby boy by C/section at 01.17am Friday
- Discharged home 6pm Sunday
- Developed cough and exacerbation of asthma overnight Sunday/Monday

JP

- Called PCP Monday am
  - Prescribed inhalers, antibiotics
- Hemoptysis, then collapse at home 1pm
- Died in ED at 4pm Monday 24th December
- (Initial suspicion of PE, but autopsy confirmed GAS pneumonia)

Context

- 2,500 deliveries per year
  - Well regarded unit, above average ratings
  - Previous maternal death1996
- Recent increase in GAS infections in the local community
- (In the UK, from 2006 to 2008 there were 13 maternal deaths linked to GAS)

Context

- An organization in transition
  - New CEO, first post
  - New Chairman
  - Several Trustee and C-suite vacancies, interims etc
- Holiday time

Immediate concerns

- Could this really be as bad as it seems?
  - How could they be linked?
  - Are staff implicated?
  - Could there be more cases?
  - What do we do now?

Other questions

- Is there a mechanism for dealing with this sort of thing?
- Do we recall people from leave?
- Do we close the unit?
- …the hospital?
- Who decides?

For me

- It feels like I should take charge of this myself, but..
- ..how do I manage the CEO, Chairman, Board, other leaders?
- Who are the key people I need around me?

Chronology

- Dec 24th;
  - Inform regulators, Board, Public Health, Coroner
  - Identify family support
- Dec. 26th;
  - Autopsy
  - Ad hoc "crisis team" convened twice daily

Chronology

- Dec 26th;
  - Public Health advise against closing
  - GAS screening of staff, families etc
  - Began working on plans for;
    - Legal
    - Press
    - Regulator(s), DH, local politicians
    - Family support
    - Staff

Dec 26th – Jan 4th

- Information for patients and families
- 5 staff screened positive
- Another patient developed GAS pharyngitis

Dec 26th – Jan 4th

- No more cases
- Mothers kept coming to the unit
- Sub-typing of GAS strains found only 2 staff with the same strain (likely transmitted from patients)
- RCAs well under way

Jan 4th

- National press;
  - "Superbug kills 2 new mums" etc..
  - Media "experts" implied problems with hospital cleanliness, infection control etc
  - Press strategy worked well until the word "coincidence" was used on local TV
  - Abusive blogs, e mails etc…

Jan 2008 – May 2009

- Intermittent peaks in publicity
- RCAs
- Independent external investigations
- Reports given to families, coroner etc
- Coroner’s investigation
- Inquests May 2009

Inquests

- ***The circumstances were so tragic that it's hard to feel satisfied, but…***
  - No definite route of transmission was established
  - The hospital was found to have made mistakes and have deficiencies in systems, but to have done everything which could reasonably be expected
  - We were commended for our approach by the Coroner and the families' legal teams

Outcome

- The media gave us reasonable reports
- We are regarded locally as having done a good job in difficult circumstances
- We published the investigation report on the internet

Outcome

- Numerous internal changes in systems
- New national guidance on managing GAS clusters published May 2010
- Atypical presentation of GAS highlighted by the national body responsible for investigating maternal deaths

Personal reflections

- What went well?
- What could have been better?
- What did I learn?

What went well

- Assuming the worst
- Taking and keeping control
- Being seen
- Managing other senior leaders
  - *(give them jobs to do)*
- The “crisis team”
- Off line support and advice

What went well

- Being open
- A proactive media strategy
- Media training
- The independent review
- Patient and family support
- Tight management of out team at inquest
- Some instinctive judgement calls

What could have been better

- Having a plan
- Staff support
  - Recognising second victims
  - …and third victims??
  - (I underestimated the effects that the crisis and its management would have on me and on other leaders)

What could have been better

- There were signals in advance about culture which I should have seen
- I’m not sure that we have resolved all of the cultural and leadership issues

What could have been better

- I’m not sure we got the balance right between legal, quality and media advisors
- Our ability to respond was stretched because it was holiday time and the leadership was in transition

Questions & discussion

Take home messages

- Be prepared;
  - An organizational plan
  - A personal plan (media training, support networks, know what your role would be)
- Be proactive
  - Investigate “cultural” warning signs
  - Ensure that a robust infrastructure exists

Acknowledgements

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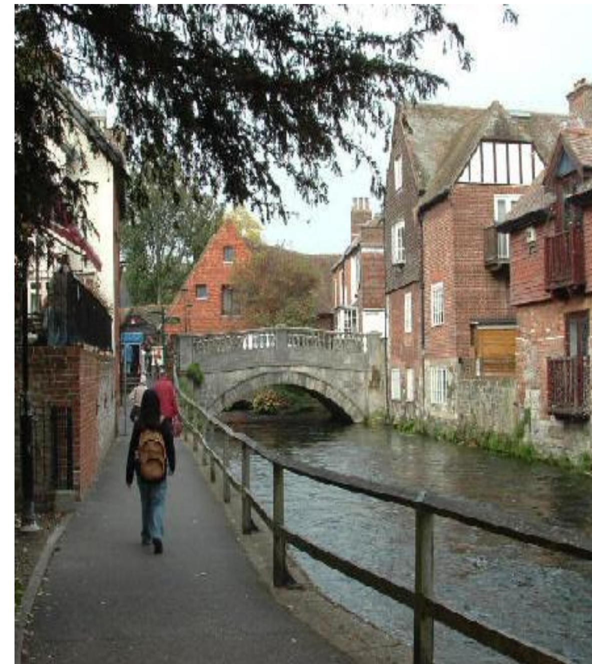

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