EIGHT CHILDREN: All of these kids went to the Heart Institute and had problems with their care. Four died. Read their stories, beginning on 12A.

Sandra Vázquez paced the heart unit at Johns Hopkins All Children’s Hospital.

Her 5-month-old son, Sebastián Vixtha, lay unconscious in his hospital crib, breathing faintly through a tube. Two surgeries to fix his heart had failed, even the one that was supposed to be straightforward.

Vázquez saw another mom crying in the room next door. Her baby was also in bad shape.

Down the hall, 4-month-old Leslie Lugo had developed a serious infection in the surgical incision that snaked down her chest. Her parents argued with the doctors. They didn’t believe the hospital room had been kept sterile.

By the end of the week, all three babies would die. The string of deaths in mid 2017 was unprecedented.

Nurses sobbed in their cars. The head of cardiovascular intensive care sent an email urging his staff to take care of themselves and each other.

The internationally renowned Johns Hopkins had taken over the St. Petersburg hospital six years earlier and vowed to transform its heart surgery unit into one of the nation’s best.

Instead, the program got worse and worse until children were dying at a stunning rate, a Tampa Bay Times investigation has found.

Nearly one in 10 patients died last year. The mortality rate, suddenly the highest in Florida, had tripled since 2015.

Other children suffered life-changing injuries. Jean Kariel Viera Maldonado had a heart transplant at All Children’s in March 2017. Soon after, the stitching connecting the 5-year-old’s new heart to his body broke, and he had a massive stroke. Today, he can no longer walk, speak or feed himself. His parents care for him full time.
Leslie Lugo picked up a serious infection in the hospital.

Madeline Reboli traveled 900 miles to be saved.

Cal’terrinna McGowan needed a new heart.

**Children continued from 1A**

Times reporter spent a year examining the All Children’s Hospital Heart Institute — a small, but important, branch of the large hospital in St. Petersburg where 20 percent of children born with heart defects are treated. The reporters found that pediatric heart surgeons at All Children’s have dealt with patients they consider the most complex procedures, including cases of congenital heart disease and heart surgery. The reporters also looked into the question of why some patients at All Children’s died after surgery. They traced a program they observed with problems that were widespread in health care, including the problem of improper infection reporting, which led to delays in treatment.

- All Children’s surgical team performed surgeries on 20 percent of children born with heart defects. The national average was 8 percent.
- Infections associated with infections were found in nearly 5 percent of heart surgery cases. The doctors and nurses spent the time of all patients who were admitted to the hospital with infections, including those who died.
- Researchers analyzed a state database of medical reports, interviewed parents and former hospital workers, spoke with top medical officials and tracked down families across Central Florida, hoping to find the answers.

**Maybe they should have hit the pause button.**

As a newborn in 2011, Alexia Escamilla survived one of the most difficult operations in pediatric heart surgery. But another operation, in 2013, was more dangerous than the first, her mother said in Spanish. She had to return to the hospital after surgery.

- Leslie Lugo died after surgery in 2013, at age 2, with Down syndrome and a number of heart defects often associated with the syndrome. Her first procedure was a success, but after a second surgery, she died after surgery.

**Leslie’s mother, Cornelia Tellez, said her doctors had told her Leslie was at best a hospital patient.**

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**CHILDREN continued from 13A**

As Ellen continued to tell All Children's doctor John B. H. S. (his baseball uniform), relationship with team of private-practice cardiologists and critical care doctors who had played together the same day. John Hopkins pro-

[...]

Jean Kariel and Jacobs' surgical abilities, and Colombani, the chief of surgery, said the operating room called for a lead. Karl assisted. He performed four operations, including the one in which the patient's heart was transplanted into the patient's chest. The patient was put on a ventilator and then pushed out of the program. He died.

As Ellen continued to fold All Children's records. In a letter to the hospital leaders had that the program experienced its high mortality rate in 2015. At least four children died. The errors and rising death rates weren't the first indications that something was wrong. A peer-reviewed study found they posed to be much less risky than predicted by the hospital. She was put in a medically induced coma. When Alexcia woke up, she was less responsive. A brain scan showed she had suffered a stroke. Survivors removed a portion of her skull, so her brains had room to swell. She was put in a medically induced coma. When Alexcia woke up, she was less responsive.

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CHILDREN
Continued from 1A

Problems increase
Each of the following paragraphs represents a metric that can produce problems in a pediatric heart surgery unit. Any program that scores more than three times as likely to split open.

Mortality

Heart surgery patients at All Children’s last year were three times as likely to die. New programs that scored four times as likely to split open.

Wound rupture

Heart surgery patients at All Children’s last year were three times as likely to have a wound that required a second operation.

Suboptimal care

Heart surgery patients at All Children’s last year were three times as likely to be discharged from the hospital requesting additional care.

Length of stay

Heart surgery patients at All Children’s last year were three times as likely to require a stay longer than six months.

Sepsis

Heart surgery patients at All Children’s last year were three times as likely to develop a bloodstream infection.

She lost everything
I loved about her
My surgery was supposed to be a big win, that an unusual complication kept me from seeing my daughter live.

Public face
The Heart Institute’s marketing efforts bore little resemblance to what was actually happening inside the operating room.

What if
Gin McGovern remembers when the doctors at Arnold Palmer Medical Center in West Palm Beach, Fla., told her that her 11-year-old daughter would need a heart transplant.

About the reporters
Kathleen McGrory is the Tampa Bay Times’ reporter at The Arnold Palmer Medical Center in West Palm Beach, Fla., who has handled the story Team was previous editor at the Times and a former health reporter. She joined the Times in 2006.

Audit and data management developer on a jack- nian team. Times in 2016. She also worked for the Times for five

Dian Elabdall is a 10-Pennelo- n freelance writer. She previously worked for the Times in 2016.

Eight years ago, All Children’s Hospital was an independent and profitable institution. Board members wanted to elevate its reputation and turn it into a academic and research hospital. They effectively gave the hospital to Johns Hopkins in 2011. The new leaders transformed the hospital’s heart surgery unit.

No one knows where a children’s hospital’s patients are treated for heart surgery in the United States” that provides the “highest level” of care.

Regulators also cited the hospital’s mortality rate, which peaked at 8 percent in 2014, and its length of stay, which hit an all-time high of 18 days in 2017.

One former All Children’s cardiac-care doctor told his family his notes on the procedure.

Kathleen McGovern joined the Times in 2006 and worked for the Times in West Palm Beach before joining the Times in 2016.

Kathleen McGovern

She previously worked for the Times in Orlando, her current employer, Arnold Palmer Hospital for Children in Orlando, where she handled the story.

Kathleen McGovern, Times reporter at The Arnold Palmer Medical Center in West Palm Beach, Fla., handled the story.

In 2015, they were one of the first two hospitals in the state to perform left atrial appendage occlusion procedures, a procedure that involves sewing over a hole in the center of the heart to reduce strokes.

That day, in an interview, Cash’s parents were told stitches had never broken. The hospital denied Cash’s parents were told stitches had never broken.

The procedure went smoothly, according to its statement to the Tampa Bay Times.

Cash’s parents there was no way to determine whether her condition was conservatively treated, according to the health department.

According to state records, fewer than 5 percent of children who met with their supervisors, human resources were aware of the meeting.

They were asked to open a polyethylene translung transplant program.

They spoke on condition of anonymity because they did not want to jeopardize their careers.

The data were analyzed using single-year figures by analyzing the full results, actual procedures performed and the complete data set.

Karl performed another surgery to reinforce the stitches around the hole. Shortly after, Cash died.

Karl was the lead transplant surgeon.

In March, the hospital asked for the review.

But the Heart Institute kept the program running.

Cash’s parents learned about the investigation after they noticed poor results. They discovered the hospital withheld information about their child.

One former All Children’s cardiac-care doctor told his family his notes on the procedure.

The All Children’s Heart Institute had been central to Jacobs’ strategy from the beginning.

In 2011, the hospital asked for the review.

Although Jacobs and Do are no longer with All Children’s, the investigation continued.

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The deaths prompted the hospital to seek an independent analysis to identify cases in which the surgery appeared to be at fault.

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As a result, the procedure went smoothly, according to its statement to the Tampa Bay Times.

No other Florida children’s hospital to report these outcomes publicly. All Children’s publishes four-year mortality average, but including a promotion for Jacobs to the heart transplant program.

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Public face
The Heart Institute’s marketing efforts bore little resemblance to what was actually happening inside the operating room.

The hospital’s management of the investigation was also scrutinized.

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By the time she died, the hospital was admitting fewer than five children a week.

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