Countess of Chester Hospital NHS
NHS Foundation Trust

The Countess of Chester Health Park
Liverpool Road
Chester
CH2 1UL

10th February 2017

Private & Confidential
Mr T Chambers
Chief Executive
Countess of Chester NHS Foundation Trust
Liverpool Road
Chester
CH2 1UL

Dear Mr Chambers,

Thank you for sharing with us a summary of the board's findings and recommendations following the completion of the reports of the RCPCH review and external case note review at our meeting on 26th Jan 2017. We had hoped to be able to see the reports and discuss their findings with the board prior to any decisions being made. We have now been able to read the reports which were released to us on 3rd Feb 2017 and 7th Feb 2017.

We are respectfully requesting you to urgently ask the Coroner to undertake a full investigation of all the deaths and unexpected collapses that occurred on the neonatal unit between June 2015 and July 2016. The reports have not reassured us that all these deaths and collapses are explicable by natural causes. The reasons for our request are listed below:

1. The RCPCH college review undertaken in September 2016 was a service review. Although its recommendations will help us provide a better service, it did not identify a cause for the sudden increase in neonatal mortality. The findings of the report identified some areas of clinical care that could be improved but which we know to be no worse than on any other local neonatal unit in the region. The report correctly identified that over a number of years the neonatal unit has had outcomes as good as or better than other local neonatal units based on most national audit standards. The concerns we expressed to the reviewers are not included in the report.

2. We agree with the conclusion of Dr Hawdon's case note review that 4 babies who died require a broader forensic review. Having had close involvement in their care, we are concerned that the cause of death or sudden collapse is also uncertain and cannot be fully explained by post-mortem findings in an additional 4 babies. As you are aware, the Cheshire and Merseyside neonatal network lead clinician has read the case note review and also considers there to be uncertainty regarding the cause of death in more babies than was identified by Dr Hawdon. We are concerned that the cause of collapse is still uncertain for 2 babies who survived and whose care was reviewed by Dr Hawdon. In addition to those babies whose care was reviewed by Dr Hawdon, we aware of a number of other babies, over the same time period, whose collapses are inadequately explained (one of whom died after being transferred to another hospital). We are very keen to learn and improve care from all

serious incidents and accept the conclusions of Dr Hawdon. However, we do not consider that the episodes of care that she considered sub-optimal could explain the rise in neonatal mortality and the sudden collapses in this time period.

3. Although a post mortem diagnosis has been made in a number of cases, there is still considerable doubt as to why certain babies collapsed unexpectedly and subsequently did not respond to appropriate resuscitation measures.

4. The internal investigation in July 2016 by paediatric staff of babies, who were transferred from Chester to a neonatal intensive care unit, identified a number of cases in which the babies' deterioration was unexplained or unusual. The paediatric team have not received any notification of how this information was used by the Trust or whether all of the data obtained by this investigation was made available to Dr Hawdon when she reviewed the cases.

5. There have been no deaths or unexpected collapses on the neonatal unit since July 2016. Unwell babies have been cared for, received intensive care and in some cases transferred to other hospitals, but their clinical courses have been far more predictable and responsive to treatment than previous cases. This change cannot be solely attributed to the re-designation of the neonatal unit or any other changes in practice that have occurred since then. Some of the babies who collapsed in the 2015 and 2016 were born at greater than 32 weeks gestation and many were not receiving intensive care at the time of their collapses.

It has been eight months since we escalated our concerns to you and we do not consider any further discussion within the Trust is in the best interests of affected families or neonatal staff. Please be assured that we, as a paediatric consultant body, are making this request because patient safety is our absolute priority. We hope that a comprehensive external investigation will be in the best interests of the bereaved families and those affected by these sad events.

Yours sincerely,

PD

Dr John Gibbs

PD

Dr Ravi Jayaram

PD

Doctor V

PD

Dr Steve Brearey

PD

Dr Murthy Saladi

PD

Doctor ZA

PD

Dr Susie Holt

cc Mr Ian Harvey, Medical Director