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Countess of Chester Hospital NHS

NHS Foundation Trust

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Thursday 16th February 2017

Dear Dr Ravi Jayaram

Thank you for your letter of 10th February 2017 and I note that you have now had the opportunity to read the RCPCH Report released to you on the 3rd and 7th February 2017.

The Trust first advised the Coroner of Cheshire of this matter on Friday 8th July 2016 and has subsequently kept him informed of developments.

I can confirm that a copy of the report was shared with the Coroner on the 20th January 2017 following which a meeting with Mr Reinberg, the Trust Medical Director and Director of Corporate and Legal Services was held at the Countess on Wednesday 8th February 2017 to ensure that the Coroner was fully briefed on all matters.

Further to your letter of the 10th February 2017 I can also confirm that the Trust Medical Director and Director of Corporate and Legal Services again met with the Coroner yesterday (15th February 2017) when a copy of your letter was passed to him. For sake of clarity the Coroner is aware of the details and concerns you expressed to the Reviewers.

It is now clearly a matter for the Coroner to decide what action he may or may not take.

I also confirm that your letter of the 10th February 2017 has been shared with the RCPCH college review team and Dr Hawdon for comment in view of the fact that you are not satisfied with the findings, despite all this information and data collated by the Trust being shared with them.

Whilst your specific allegations are not included in the published report, they were referenced in additional comments and observations made by the Reviewers, which are now attached.

The re-designation of the neonatal unit was an important step taken by the Board because patient safety is the Trust's absolute priority.

Finally, further to your letter of 30th January 2017, you agreed that it was appropriate for you to send a letter of apology to Nurse Letby. It would therefore be most helpful for me to understand how and when you are doing this as action is now being taken to return her to the unit at the earliest possible time.

In summary, there has been a thorough internal and external review in to the unexpected increase in mortality levels for new born babies on our neonatal unit for 2015 and 2016 compared to previous years. Including;

- independent external RCPH review
- independent external review of each of the 13 deaths by an experienced independent clinician
- thorough review of activity, acuity levels and staffing profiles of the unit during the past 3 years

All this data has been shared fully with these review teams and at all times the allegations made by the consultant team were shared openly too. All conclude that there is no single causal factor to explain the change in mortality rates nor to substantiate the allegations you have made.

We now need to look to the future. And I look forward to us working together to develop and implement an action plan that concludes all 24 recommendations identified in the report. Please can you confirm your intention to support the Board in these endeavours.

Yours Sincerely

PD

Tony Chambers
Chief Executive