Dr J M Hawdon

MA PhD MBBS MRCP FRCPCH

Tel Personal Data ***(home)***
(mob)

PD

Email: jane@ I&S

29/10/2016

Dear Mr Harvey,

Thank you for your letter of 5th October and enclosures.

Having worked through box 1 and reporting on the files therein, I was a little taken aback to find loose records for these cases bundled together in envelopes in box 2, rather than inserted into each file.

In total there were 16 cases for whom there were files including medical records. There were also loose print outs for 1 patient who did not have a file and for whom medical records were not supplied. Therefore the total number of cases was 17 (13 deaths and 4 "near misses").

The contents of each box were not as indexed.

Within the set of print outs for I&S there was a copy email regarding printing records for this cohort of patients, and a copy email regarding staff signing their own letters which appears unrelated to this investigation.

With regards to your instructions:

a) Were I to carry this out for each case, each case would take 10-12 hours and I would not have the capacity to do this alongside my other reporting commitments, it would be extremely costly for the Trust, and I do not consider would yield on investment. Rather, I have prepared a synopsis of key events and issues, focussing particularly on events preceding and during episodes of collapse or demise. I have applied MBRRACE-UK methodology to standards of care.

b) I agree this is an important aspect and I have commented on this where relevant.

c) Given that many cases had coroner's post mortem and these results were not available to me, I am not in a position to consult with a perinatal pathologist. Neither woud I be in a position to contract with a pathologist. I suggest that once you are in receipt of my report and the coroner's PM reports, you instruct an independent perinatal pathologist.

d) I am not in a position to perform this. This should be commissioned locally and for relevant cases the review should include the period before a collapse, or series of collapses, rather than the period before death.

e) I can only consider the cases that you have supplied. I note that the twin of I&S I&S had a similar course but I was not supplied with his records.

I suspect you have copied the suggested terms of reference for an overall investigation suggested by RCPCH, one element of which was independent case review by a neonatologist.

It would be useful to review copies of SI reviews and reports for these cases, and findings of the CDOP panel and triangulate findings with my independent review. Was this cluster noted and investigated at the time by the Trust or coroner? Has the pattern persisted?

Finally I fully appreciate the personal tragedy for each family, whether or not death was explained or not explained, and the burden on staff who supported families and each other around these tragedies.

Please do not hesitate to contact me if you would like to discuss my review.

Yours sincerely,

Dr J M Hawdon
Consultant neonatologist
Associate chief medical officer
Executive director, women's and children's health

Dr J M Hawdon

MA PhD MBBS MRCP FRCPCH

Tel Personal Data *(home)*
(mob)

PD

Email: jane@ I&S

Ian Harvey
Medical Director
Countess of Chester Hospital
Liverpool Road
Chester
CH2 1UL

Invoice no. I&S

For professional services.

Countess of Chester Hospital

To review cases and prepare report:

24 hours @ I&S hour	
VAT @20%	I&S
Total	

Dr J M Hawdon
Consultant neonatologist
28/10/2016

VAT registration numbe I&S