Paediatric consultant letter 30th April 2018	Reply by Mr Chambers 30th May 2018	Paediatricians' comments
In June 2016 the paediatric team escalated a serious patient safety concern to the medical director in the belief that we would receive help and support in managing this sensitive and difficult problem that members of the executive had been aware of since at least Feb 2016. Contrary to a statement by the medical director we made no ultimatums or demands to the medical director at this time. In August, the medical director presented to the Board the findings of work that had been undertaken and suggested that increased acuity and staffing changes may have been contributory to the increased mortality rate. The paediatricians considered the methodology and conclusions of the medical director's presentation to be of a low standard. In addition, we felt that the chief executive and some members of the board treated the consultants' views with contempt.	On Monday 30th April 2018, Ian Harvey, Medical Director and Stephen Cross, Director of corporate and Legal Services attended a meeting with the Consultant paediatricians : Michael McGuigan, Doctor ZA John Gibbs, Steve Brearey, Murthy Saladi, Susie Holt, Doctor V and Ravi Jayaram. At the end of the meeting, Dr Jayaram passed to them, on behalf of all the Consultant paediatricians, a written paper setting out 26 questions that they would like responses to. I know that the events over the past 18 months have been very difficult and the constant feeling of being in the spotlight has been a challenge for everyone yet **through all of this I have never lost sight of the fact that behind these mortality numbers, there have been families left bereaved by the loss of their baby**. I also recognise that these events have inevitably put a strain on the relationship between us and with hindsight there are always examples of how things could have been better. Yet even against this backdrop we have still been able to move our paediatric service forward. Not least of all in the recruitment of two new outstanding colleagues and eventually pushing the business case for the Neonatal new build over the line, thank you for your support in these endeavours. Notwithstanding this I acknowledge that communications between us could have been better and that at times the constraints of confidentiality and later, on police advice, might have given the impression of my	We have copies of correspondence (albeit redacted) which clearly make the claim that an ultimatum had been given to the board by us regarding the removal of a particular staff member as well as being told by that same staff member in a 1 to 1 meeting that she has been told this by the board. There is neither a denial of this nor an admission of this in this response, it is simply ignored This statement does not correlate with the statements and actions of the Board. Ian Harvey made a public statement in Feb 2017 saying "This means that when we speak with parents we can now share full and accurate information, on an individual basis." This took no account of the 4 sets of parents for whom there was no accurate information regarding the cause for their babies' deaths. We cannot quantify the impact on their grief of such misinformation. One of the consultant posts was withdrawn by the executive immediately after the RCPCH review for "strategic" reasons. This decision was made with no input from the paediatricians, nor was the decision communicated to the paediatricians; it was only when a question was sked of medical staffing regarding an interview date that the paediatricians knew.

	There was no other evidence or history to link [the nurse] to the deaths, and her colleagues had expressed no concerns about her practice."	
6. Please advise us why the medical director chose to select only some negative comments from the reports and to omit to mention that further investigation had been recommended by an external reviewer?	The RCPCH review advised a further, in-depth, independent case note review of each unexpected neonatal death. This review was commissioned, on the advice of the RCPCH, from Dr J Hawdon, Consultant Neonatologist, Royal Free London Hospital. Dr Hawdon submitted her review in October 2016. This report highlighted areas where practice could have been different. There were 4 cases in which Dr Hawdon felt that the cause of death was unascertained and she advised that "Subject to coroner's post mortem reports, there should be broader forensic review of the cases... As after independent clinical review these deaths remain unexpected and unexplained". I've discussed your question with Ian Harvey who describes how time constraints precluded a comprehensive reading and has no recollection that he omitted to mention that further investigation of a small number of cases was recommended, it certainly was not intentional. Ian was progressing this concurrently-the next step seeking permission of the Coroner to speak to the Alder Hey pathologists, then consulting them regarding post mortem findings. Both Ian and I are sorry if the constrained summary at the meeting is perceived to be derogatory towards you or the paediatric service.	It is extremely concerning that 'time constraints precluded a comprehensive reading' of one of the 2 reports by the sole clinician on the board. There was never an impression given in the meeting of time pressure. There was more than adequate time in the meeting to have discussed the findings of the 2 reports in more detail. The board appeared to have chosen to spend the majority of the meeting discussing the grievance process and it appeared to have been a pre-planned and choreographed strategy, as evidenced by having Karen Rees present in order to melodramatically read a letter to us. It was very clear in the meeting that the executives who spoke were trying to portray the neonatal unit as a failing and stretched service with consultants who were being unprofessional making unfounded allegations against an innocent nurse. Sections of the reports were selected to support this view. This could be interpreted as a form of selection bias.
7. Do the board still believe some paediatricians behaved in an	Ian Harvey subsequently had cause to meet with Dr Jayaram on two occasions, firstly to discuss	This question has not been answered. Dr Jayaram was been given very limited and