From:	Nim Subhedar
To:	BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject:	FW: [secure] NNU review
Date:	27 February 2017 17:02:48
Attachments:	0.gif
Sensitivity:	Confidential

FYI. Please don't share more widely at this stage.

Thanks,
N

-----Original Message-----
From: Nim Subhedar
Sent: 10 February 2017 15:06
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: RE: [secure] NNU review
Sensitivity: Confidential

Dear Ian,

Thank you for sending me the RCPCH report and Jane Hawdon's individual case note review. My comments about the latter are detailed below.

1. The terms of reference of the individual case note review wasn't clear to me: what was she asked to do and what information did she have available to her? It seems she reviewed 13 deaths and 4 survivors who suffered a sudden collapse.

2. My own interpretation of the 13 deaths included in her review suggests there were 4 cases in whom there is no clearly identified cause of collapse/death, and a further three cases where the cause of the initial collapse leading ultimately to the baby's death remain unexplained.

3. I am broadly in agreement with her recommendations. However, it should be noted that many of these recommendations are relevant to all LNUs, not just COCH. Additionally, I see no specific justification for recommendation (5) on the basis of her review.

4. The single most important and relevant recommendation is (6) which advises 'broader forensic review' of the cases in whom the death/collapse remains unexplained. I would recommend extending this to the 7 cases that I have identified:

a. Child O
b. Child A
c. Child P
d. Child D
e.
f. I&S
g. Child I

I would like to make one further observation in relation to the RCPCH report and recommendations. Many of the recommendations relating to the governance arrangements around neonatal deaths are valid and sensible, but again extend beyond the neonatal unit at COCH. The unit in Chester is by no means an outlier either in terms of processes around mortality reviews or consultant presence and supervision on the neonatal unit. The COCH team's commitment to the Network's Steering Group and Clinical Effectiveness Group is exemplary and, in my view, demonstrates a commitment to improving the safety and quality of the neonatal care they provide.

I hope this is helpful. With your consent, I'd like to share my findings with Steve Brearey - please would you let me know if you're happy for me to do this?

Best wishes,
Nim

From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)