Harper-Lea Sarah (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)

From: Harper-Lea Sarah (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 04 March 2016 19:02
To: Millward Ruth (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Kelly Alison (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Harvey Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Bennett Dean (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Jones Geraint (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Williams Sian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Cc: Crocombe Mary (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Dodd Debbie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Cross Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: Legal Services SUI Report
Attachments: PERINATAL MORBIDITY AND MORTALITY MEETING RECORD 150624.doc; NNU mortality thematic review 2015 - Action plan Feb 16.docx; Jan-Jun 2015 NNU; SUI Meeting 7 March 2016.docx

Dear All

Please find attached the SUI Report for Monday's Panel which I have sent through today as I am on leave on Monday. The main item to consider is the forthcoming Inquest for Child A

Baby Child A **(deceased)**
The Inquest for the above had been set by the Coroner to be held on 23 March 2016, this date has now been withdrawn and will be set at a later date. This is due to the fact that the Coroner requested an additional 8 reports be obtained from the Junior doctors that were involved in Child A's care and that the Thematic Neonatal Unit Mortality Review needed to be completed, reviewed and shared as appropriate.

I have received an update from Steve Brearey this week in relation to the thematic neonatal review that has been undertaken, a copy of which is attached. You will see from the review that it is concluded in Child A's case that line related complications (peripheral longline and UVC) were very unlikely to have caused arrest. Steve advised that this case had been discussed at a special care meeting with Alison, Ruth, Debbie and Eirian Powell on 2 July 2015 and that the general consensus at that time was that a SUI was not necessary and the findings of the review are in line with this.

A review in to the care also took place at the perinatal morbidity and mortality meeting, which are attached.

Action Required
In order to prepare for the Inquest we need to consider Duty of Candour which Steve Brearey has advised Dr Saladi would be best placed to do.
Steve also stated that from the questions that the family have asked there still appears to be some confusion around their understanding of the circumstances and that the offer of a family meeting may be helpful to them.

Can SUI consider communication with the family now that the review is complete and also what we will disclose to the Coroner in terms of the reviews that have taken place as the Coroner had suggested that a 'SUI be undertaken due to complications in longline and catheter insertion'.

Letter of Claim - CC I&S
A complaint investigation is ongoing and we are now in receipt of a formal Letter of Claim.