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Email Mother C @ I&S  
07/02/2017

Mr Ian Harvey  
Medial Director  
Countess of Chester Hospital

Dear Mr Harvey,

I am writing as a bereaved parent, following the recent Royal College review of the neonatal services at The Countess of Chester Hospital.

I suffered a complicated pregnancy in 2015 and was under the care of Mr McCormack in Fetal Medicine. Due to problems with my son's growth I had a caesarean section at 30 weeks gestation on PD June 2015 and our son, Child C was transferred to the NICU for support. He was born in good condition (all things considered), although very small, having suffered severe IUGR due to placental insufficiency. It was felt by the paediatric team that he was high risk but had a very good chance of survival. On 13<sup>th</sup> June whilst on the postnatal ward I was called down to the Neonatal Unit urgently as Child C had suffered a very sudden and unexpected cardiac arrest. Although an output was regained after what I understand to be around 50 minutes of resuscitation it was clear to us that Child C was not going to survive. With our families we spent several hours holding him as he died in the early hours of 14<sup>th</sup> June 2015.

Due to the unexpected nature of his death he was referred for a post-mortem, the results of which took five and a half months to come to us. I am aware that this was a delay at the coroner's office. It was a very difficult wait for us. It was concluded that Child C died of severe myocardial ischaemia despite normal coronary arteries – a rare cause of death in a neonate for which there was no explanation.

It is very hard to explain what this tragedy has done to us and our family. The effect it had at the time was devastating and the impact it will have forever is impossible to put into words. Losing Child C changed our perspectives on almost every part of life.

Six months later, in December 2015, I&S

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In amongst the things that went wrong I feel it is important to acknowledge those things that went right. Mr McCormack, Jill Ellis and Jo Gwinn deserve high praise and we will be forever grateful to them for what they did for us.

Although [redacted] I&S, we were truly horrified when, in July 2016, we read an article in the Chester Chronicle detailing that an investigation was taking place into deaths on the Neonatal Unit covering the period during which we lost our son. This article stated that support was being offered to the families involved. At NO POINT had anyone contacted myself or my husband to inform us of this investigation into our son's death- the only way we knew about it was to read it in the newspaper. I am sure you would agree that this is a significant failure of the Trust and, quite frankly, a disgrace. I met with Sian Williams and Alison Kelly when I turned up at the Bereavement Office really quite distressed following this publication. It was explained to me that an attempt had been made to contact us on our landline number on [redacted] Child C's records (which was our previous landline number). It was known that I was a patient under Fetal Medicine but no other attempts to contact us were made. E.g by mobile or letter. In an already stressful situation, coping with our loss and dealing with a new pregnancy, we were put in a position where we felt that the Trust did not respect our grief enough to go to every possible length to inform us about this investigation. More effort should have been made. This caused a significant setback for us when we were trying to focus on remaining positive about [redacted] I&S and our future.

Sian Williams and Alison Kelly were very pleasant during this meeting and I was told I would be kept informed from there on.

I was surprised following this that I did not hear anything from the Trust until Friday 3<sup>rd</sup> February 2017 (7 months later) when I was called by Sian Williams whilst on holiday in Lanzarote. She informed me that there had been a leak of the Royal College report and that an article would be going in the Sunday Times. I understand that this leak was not internal. She offered me the option to collect a copy of the report, which I did, on Monday 6<sup>th</sup> February. When I met Sian to pick up the report she advised me that there was a plan to meet families individually to go through the case reviews as these did not feature in the report.

The report from the Royal College opened up questions that I had already asked myself. [redacted] I&S I am fully aware of the fact that sometimes there are questions that do not have answers. I have asked myself over time whether it would be helpful to us to know what, if anything, went wrong, or whether that would just cause us further distress. I have asked myself whether someone may have acted negligently, whether the respiratory support [redacted] Child C was given was sufficient, were his blood gases, electrolytes and blood glucose monitored closely enough and, indeed, was he in the right unit in the first place or should he have been transferred to a more specialised centre? The report does strike me as having some suspicion that there were some unusual features of the deaths of