Countess of Chester Hospital NHS
NHS Foundation Trust
The Countess of Chester Health Park
Liverpool Road
Chester CH2 1UL
Personal Assistant: Debbie Dodd
Tel: 01 I&S Fax: I&S
Email: debbie.dodd1@ I&S

Mr Ian Harvey, MChOrth FRCS Ed(Orth) MB ChB
Medical Director and Consultant Upper Limb & Hand Surgeon

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5th October 2016

Dr J Hawdon
Consultant Neonatologist
Personal Data

Dear Dr Hawdon

Thank you for accepting our instructions to carry out a review of case notes and associated records relating to 13 neonatal deaths and four ' near misses' from the Countess of Chester Hospital NHS FT.

These instructions follow from an invited review by the Royal College of Paediatrics and Child Health. The review team agreed that the pattern of recent deaths and the mode of deterioration prior to death in some of them appeared unusual and needed further enquiry to try to explain the cluster of deaths. They did not feel that this was possible within the terms of reference for the review. They recommended that a detailed forensic case note review of each of the deaths from July 2015 be undertaken. They also recommended that the investigation should include as a minimum the following elements:

a) a full systematic chronology for each case including all interventions, and details of nursing and medical observations and activity

b) a view on whether escalation of each case at an earlier stage to involve more senior opinion locally or more expert opinion from a regional centre would have potentially made a difference to the outcome

c) examination (with the relevant paediatric pathologist) of the post mortem findings and any additional information available on their files which might identify cause of death, including rare conditions such as air embolism and severe metabolic derangement

d) details of all staff with access to the unit from 4 hours before the death of each infant. Ancillary and facilities staff should be included