Message

From: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [stephen.brearey@I&S]
Sent: 20/08/2018 9:31:54 AM
To: DALLOW, Helen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [h.dallow@I&S]; DANGERFIELD, Joanne (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [joanne.dangerfield@I&S]; GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [johngibbs@I&S]; HOLT, Susie (ALDER HEY CHILDREN'S NHS FOUNDATION TRUST) [susieholt@I&S]; Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) Doctor V @I&S; JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [ravi.jayaram@I&S]; MCGUIGAN, Michael (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [michaelmcguigan@I&S]; SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [murthy.saladi@I&S]; Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) Doctor ZA @I&S
Subject: FW: RCPCH review
Attachments: TORs.docx

Dear all,
Just replying to Doctor ZA's email and document she has drafted. I agree with all of it other than the para regarding the RCPCH report. I don't think we can argue that we were misled about the remit of the college review.
I've forwarded John's email from Aug 16 in which we agreed that the TOR for the review was their standard service review plus: "Are there any identifiable common factors or failings that might in part, or in whole, explain the apparent increase in mortality in 2015 and 2016?" This is in the report TOR.

The college reviewers didn't really fulfil this TOR but I don't think we can blame the Trust. We can blame the Trust for not doing what the reviewers suggested: "Conduct a thorough external independent review of each neonatal death to determine factors which could have changed outcomes. Include obstetric and pathology/PM indicators, nursing care and pharmacy input."

Even after IH fed back to Ravi after the college review, Ravi was promised:
"They did acknowledge the concerns we raised over foul play and recommended a forensic detailed independent review of all the cases. This would be far more detailed then the thematic review and would be conducted by 2 teams independently of each other including neonatologist and a pathologist who would have access to all records and pathology specimens and reports (with air embolus specifically being considered in the pathology). Sue Eardley gave 4 names to Ian; he has contacted them all and 2 have already replied indicating that they would be willing to do this. Pending this there will be no change to our redesignation. The board are still fully aware that this may end up with the police being involved but will now await the more detailed case reviews (which is what we wanted back in June)"

Fundamentally, the execs treated the service review as a review of mortality and treated the Hawdon report as a robust review which it wasn't at her own admission, then used the Grievance procedure as evidence to suggest it all "triangulated" in IH's words. This was all very incompetent and misleading.

Other than this issue, I think John and Doctor ZA have covered all the important issues. Thanks!

Steve

From: Gibbs John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 09 August 2016 16:02
To: Jayaram Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Brearey Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Saladi Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Holt Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Murphy Anne (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Powell Eirian Lloyd (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: FW: RCPCH review