Countess of Chester Hospital NHS
NHS Foundation Trust

Our Ref: CER/SPC

The Countess of Chester Health Park
Liverpool Road
Chester CH2 1UL

Direct Dial: 01 I&S
Exec office Fax: 01 I&S

Private & Confidential

Mr N L Rheinberg
HM Coroner for Cheshire
West Annexe
Town Hall
Sankey Street
Warrington
Cheshire
WA1 1UH

15th February 2017

Dear Mr Rheinberg,

Re: Royal College Review

Thank you for letter your letter dated 13th February 2017, following your meeting at the Countess on the 8th February 2017 with the Medical Director and myself.

Please find enclosed the following documents:

- In depth review into baby deaths, advisory medical report from Dr J M Hawdon, dated October 2016
- Letter from the Countess Paediatric Consultant body to Mr T Chambers, Chief Executive dated 10th February 2017
- Observations additional to the RCPCH Review of Neonatal Services at the Countess of Chester Hospital NHS FT

I confirm that the Medical Director and myself will discuss this matter with you at our meeting at 2pm today, 15th February 2017.

Yours sincerely,

PD

Stephen Cross PD
Director of Corporate and Legal Services

Summary of cases.
The cases may be divided into 2 groups and I have assigned each case to a likely group.

1. The death/collapse is explained but may have been prevented with different care, and learning may improve outcome for other babies (date of first collapse is noted).

I&S		11.12.15
Child H	(?outcome)	21.9.15
Child Q	(survived)	25.6.16
Child E		3.8.15
I&S		27.1.15
Child C		PD 6.15
I&S		18.2.16
I&S		8.1.16
I&S	(survived)	6.4.16
I&S		6.3.16
I&S	survived)	9.14
I&S		3.9.15
Child D		22.6.15 (changed following PM review)

2. The death/collapse is unexplained. It is the investigation of these cases which would potentially benefit from local forensic review as to circumstances, personnel etc (date of first collapse is noted).

Child O	23.6.16
Child A	PD 6.15
Child P	24.6.16
Child I	22.10.15

*Cause of death as given in post mortem report should be reviewed given baby stable in air in days preceding collapse

Observations additional to the RCPCH Review of Neonatal Services

Countess of Chester Hospital NHS FT

November 2016

The neonatal lead, in an effort to be thorough and explore all possibilities had identified that one nurse had been rostered on shift for all the deaths although the nurse had not always been assigned to care for that specific infant. Subsequently the paediatric lead and all the consultant paediatricians had become convinced by the link. Although this was a subjective view with no other evidence or reports of clinical concerns about the nurse beyond this simple correlation an allegation was made to the Medical Director and Director of Nursing

On arriving for the visit the RCPCH Review team was told that the nurse had been moved to an alternative position around ten weeks previously without explanation nor any formal investigative process having been established. The Review team was told that the individual was an enthusiastic, capable and committed nurse who had worked on the unit for four years. She herself explained to the Review team that she was passionate about her career and keen to progress. She regularly volunteered to work extra shifts when available or change her shifts when asked to do so and was happy to work with her friends on the unit. The Directors understood there was nothing about her background that was suspicious; her nursing colleagues on the unit were reported to think highly of her and how she responded to emergencies and other difficult situations, especially when the transport team were involved. There were apparently no issues of competency or training, she was very professional and asked relevant questions, demonstrating an enthusiasm to learn along with a high level of professionalism.

When the Neonatal Lead made allegations to management, the Director of Nursing considered supervised practice for the nurse but the consultants would not accept this and required the nurse be removed from the unit. Senior operational staff on the unit reported being very upset at the situation and the neonatal nurse manager in particular explained the difficulty of wanting to support the nurse and managing morale and anxiety amongst the other nursing staff who were not aware of the allegation. The consultants explained that their allegation was based on the nurse being on shift on each occasion an infant died