From: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 06 March 2017 13:33
To: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Cc: Nim Subhedar; JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: RE: Meeting summary from 28th Feb 2017

Dear Steve

Thank you for this and for the meeting which I felt was useful and productive. However, given the circulation list I felt that it was important to respond, especially since these notes – perhaps not surprisingly – have a particular slant and I am wary that if I didn't respond this might become the only version of the "truth".

Firstly I am surprised that there is no reference to the conversation about the Coroner. I am aware that you have each had a letter from Tony Chambers but I was able to give more detail and confirm that Stephen Cross and I had had a detailed conversation with both the Coroner and the Deputy (this latter point is important because the Deputy will be the Coroner with Mr Rheinberg's retirement on 10th March but also because it was the Deputy with whom Stephen first had a conversation in July last year when he specifically called out your concerns). I was able to confirm that not only had we given the Coroner a copy of the recent letter from you and your colleagues which highlighted your concerns but that Stephen and I also discussed this at length with them. The Coroner told us that we should not necessarily expect a response from him. He also informed us that his role wasn't to QA hospitals. I mention the conversation with the Coroner because John seemed to get significant assurance from the detail that Stephen and I had gone to with the Coroner when I spoke with him although I accept that Ravi and you did not feel the same way.

Contrary to the statement in the second para – it might have been stated but it was not agreed either that there were small changes in acuity (I certainly would dispute this) or that, by extrapolation, this couldn't play a part. I, for one, would not limit myself to looking for a single cause. Whilst I agree that Nim did say that other units are (were) working at similar levels of occupancy and staffing and COCH is (was) not an outlier – I have seen no evidence to confirm this nor have I seen anything to indicate that there was the same trajectories that we had in the period leading up to 2015/16. I accept, however, that this would not tell the whole story, most incidents are, by their nature, multifactorial in origin and it is relevant here to mention one thing that was agreed by all was that there no "smoking gun", no single cause, has been identified.

Finally, you have mentioned the mediation process and your concerns but have not referenced my response. There are two separate processes here that should not be conflated – the concerns and review process and the grievance process which should be separate and can run in parallel. Regarding the second I believe that I thanked you for the letter of apology that all the Consultants (excepting Michael) had signed individually but I also stressed that the mediation should go ahead and whilst Ravi voiced concerns about how this could run I have highlighted that there would be initial meetings just with the facilitator when there would be an opportunity to call these out.

I hope that between us we have come to a reasonable representation of the meeting.

Kind regards

PD

Ian Harvey
Medical Director
Countess of Chester Hospital NHS FT

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From: BREAREY, Stephen (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Sent: 06 March 2017 09:03
To: HARVEY, Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Cc: Nim Subhedar; JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); GIBBS, John (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor V (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); SALADI, Murthy (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); HOLT, Susie (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); Doctor ZA (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST); JAYARAM, Ravi (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)
Subject: Meeting summary from 28th Feb 2017
Importance: High

Dear Ian,
Many thanks for with us on Tuesday. I thought it best that we should have a summary of the meeting. Ravi, John and Nim have seen this summary and agreed it is an accurate account of what was discussed.

It was made clear at the beginning of the meeting that there is general dissatisfaction from the consultant body with the way the Trust had handled this difficult situation since it was escalated. All the paediatricians voiced concerns at the time and all now feel that their professional opinions have not been given due regard and that we have been excluded from discussions which we would have expected our views to have been required and indeed welcomed. It was agreed that small changes in acuity and staffing could not explain the increase in mortality seen and actually medical and nursing staffing levels at the Countess were better than most other LNUs in the region.

Mediation was discussed and Ravi, John and Steve voiced our concern that this is occurring far too early in view of the fact that there is still a great deal of uncertainty as to the cause of the rise in neonatal mortality and unexpected collapses.

Regarding the case note review Jane Hawdon undertook, the group reviewed her findings of the 13 babies who died with some access to Evolve and Meditech. There was uncertainty as to what criteria had been used to select the 4 morbidity cases that Jane Hawdon reviewed and there are babies we are aware of who unexpectedly collapsed and were transferred from the hospital and who unexpectedly collapsed and were not transferred from the hospital for whom no external review has taken place.

There was agreement with Jane Hawdon that for 4 cases the cause of death cannot be explained and further broad forensic review is required (Recommendation 6). In addition to these cases, we agreed after review of the case notes that there are a further 4 cases in which, although there is a PM or death certificate diagnosis, there is no explanation as to why the babies deteriorated and did not respond to resuscitation.

Therefore the 8 babies that in our view require further broad forensic review are:

Child O
Child P
Child A
Child I
I&S

Child C
Child D
I&S

In addition, further external review is required for:

- The 6 babies who were transferred from Chester that were identified by John and
- Other babies that we discussed who unexpectedly collapsed, survived and were not transferred from Chester.

There was agreement that some observations Jane Hawdon made regarding the clinical care could easily be explained. For example, no telephone discussion with transport consultant when the transport consultant was in fact in the NNU room with another baby. In addition, there were some elements of sub-optimal care that Jane Hawdon had not commented on. For example, incorrectly withholding and delaying a dose of gentamicin which should have been given earlier. Recommendations 3 and 4 (decision to needle time for antibiotics and difficult airway pack) were in place during the time period of the review. The group agreed that recommendation 5 regarding excluding pneumothorax and cyanotic congenital heart disease in babies who collapse was likely to have been considered by the clinical teams and was not a cause for death for any of the babies reviewed.

Nim Subhedar stated at our meeting that he too was concerned that the cause of death and/or deterioration remained unexplained in several cases. He supported Dr Hawdon's recommendation that these cases should undergo further detailed review. Nim also emphasised the Network's position that the observed excess in neonatal mortality at COCH could not be explained merely as a consequence of medical or nursing workforce deficits or increased activity and occupancy levels. Other network local neonatal units are working at similar levels of occupancy and staffing and COCH is not an outlier in this regard. Since these units are not reporting an excess in neonatal mortality, it suggests that there is a different explanation for our increased number of unexplained deaths.

I have copied this email to the other paediatricians for their information.

Many thanks for your time and help.

Steve

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