Countess of Chester Hospital NHS
NHS Foundation Trust

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

1st March 2017

Private & Confidential

Mr Tony Chambers
Countess of Chester NHS Foundation Trust
Liverpool Road
Chester
CH2 1UL

Dear Mr Chambers

Thank you for your letter dated 16th February 2017 in response to our letter of 10th February 2017. We are grateful that you have escalated our concerns about the unexpected and unexplained collapses and deaths on the neonatal unit to the coroner. We would like to reiterate that we are still concerned that these events have not been fully investigated as recommended by the RCPCH review team and by Dr Hawdon. As the coroner is aware of our concerns, we will await his response.

Regarding the RCPCH service review, we agree with the areas for improvement highlighted by the report and acknowledge that there are issues that need to be addressed both within the Trust and outside the organisation. We are keen to work together with the board to draw together an action plan to help implement their recommendations.

Please be aware that we have not made any allegations as stated in your letter. As a group of clinicians, we had noticed an apparent temporal association with the unexpected and unexplained collapses and the presence of a particular member of staff at the times of these events. Our concerns also include the unusual nature of some collapses and the responses to resuscitation efforts in a large proportion of the babies who died and in some who survived. We are very grateful to the Medical Director for allowing some of us to discuss the individual mortality cases him along with the Neonatal Network lead neonatologist on 28th February and hope that he found this meeting constructive.

It is our professional obligation to highlight why we feel that the unexpected collapses have not yet been adequately investigated:

- The RCPCH review was a service review and did not specifically investigate the cause of the deaths and unexpected collapses.
- The independent external case note review was not the multidisciplinary review recommended by the RCPCH review team but still identified 4 cases that require further broad forensic review which has so far not been undertaken. It was agreed at our meeting with the Medical Director and Network Lead on 28th February that there are a further 4 cases of unexplained clinical deterioration that may also require further review.
- The review of activity, acuity levels and staffing profiles of the unit during the past 3 years did not identify a reason for the increased mortality and was not independent or external.

Thank you for sharing the additional comments and observations made by the RCPCH reviewers in the original report. Some of the comments contain factual inaccuracies which we would be happy to discuss with you at any time. We have written and sent a letter of apology to Lucy Letby.

Thank you again for your support.

Yours sincerely,

Dr John Gibbs Dr Ravi Jayaram **Doctor V**

Dr Steve Brearey Dr Murthy Saladi **Doctor ZA** Dr Susie Holt