recommendations. In addition the reviewers made some observations regarding the allegations made about the nurse: "The consultants explained that their allegation was based on the nurse being on shift on each occasion an infant died (although not necessarily caring for the infant) combined with 'gut feeling'. There was no other evidence or history to link [the nurse] to the deaths, and her colleagues had expressed no concerns about her practice."

2.6. The RCPCH review advised a further, in-depth, independent case note review of each unexpected neonatal death. This review was commissioned, on the advice of the RCPCH, from Dr J Hawdon, Consultant Neonatologist, Royal Free London Hospital. Dr Hawdon submitted her review in October 2016. This report highlighted areas where practice could have been different. There were 4 cases in which Dr Hawdon felt that the cause of death was unascertained and she advised that: "Subject to coroner's post mortem reports, there should be broader forensic review of the cases ... as after independent clinical review these deaths remain unexpected and unexplained". I've discussed your question with Ian Harvey who describes how time constraints precluded a comprehensive reading and has no recollection that he omitted to mention that further investigation of a small number of cases was recommended, it certainly was not intentional. Ian was progressing this concurrently – the next step seeking permission of the Coroner to speak to the Alder Hey pathologists, then consulting them regarding post mortem findings. Both Ian and I are sorry if the constrained summary at the meeting is perceived to be derogatory towards you or the paediatric service.

2.7. Ian Harvey subsequently had cause to meet with Dr Jayaram on two occasions, firstly to discuss reports of paediatric trainees making reference to the 'Angel of Death' and secondly following a complaint by a member of staff regarding a comment Dr Jayaram had made in the out-patients about someone on the unit.

2.8. See 2.7

2.9. See 2.7

2.10. See 2.4

2.11. On the 16th February 2017 I wrote to you in response to your letters dated 30th January 2017 and 10th February 2017, acknowledging that as stated by the Consultant Paediatricians, they agreed that it was appropriate for them to send a letter of apology to Nurse x. I asked for an understanding of how and when this letter will be sent to Nurse x. In this letter dated 16th February 2017, I also detailed the actions taken in response to the letters from the Consultant Paediatricians and that an action plan was to be developed to