the RCPCH review would resolve the situation and enable her to resume duties on the unit. She appeared to be distressed that there was very little information as to the reasons for her move, and appeared isolated and vulnerable.

Action required - HR Investigation

It is important that the Trust takes immediate steps to formalize the actions you are taking with the nurse. Our understanding is that an allegation has been made and therefore a process of investigation needs to be put in place which sets out the nature of the allegation and the process you will follow to investigate it. No doubt you have your own policies for this but the MHPS process used for doctors provides a helpful framework. This should include providing appropriate support to the nurse in question and an effective communication strategy for the unit.

Action required – Case review

The Review team agrees, from the information received, that the pattern of recent deaths and the mode of deterioration prior to death in some of them appears unusual and needs further enquiry to try to explain the cluster of deaths. This was not possible within the terms of reference for the review or from the information received. To this end we recommend that, alongside the HR investigation, a detailed forensic casenote review of each of the deaths since July 2015 should be undertaken, ideally using at least two senior doctors with expertise in neonatology / pathology in order to determine all the factors around the deaths. The casenotes and electronic records should ideally be paginated to facilitate reference and triangulation. This investigation should include as a minimum the following elements

a) a full systematic chronology for each case including all interventions, and details of nursing and medical observations and activity

b) a view on whether escalation of each case at an earlier stage to involve more senior opinion locally or more expert opinion from a regional centre would have potentially made a difference to the outcome

c) examination (with the relevant paediatric pathologist) of the post mortem findings and any additional information available on their files which might identify cause of death, including rare conditions such as air embolism and severe metabolic derangement

d) details of all staff with access to the unit from 4 hours before the death of each infant. Ancillary and facilities staff should be included

e) Consideration of any other `near miss` cases with similar chronology /presentation where the child survived.