273. On 12 July 2016 Alison Kelly forwarded to me an email from Ruth Millward with the subject line "Draft NNU Review July 2016 v2" [INQ0003125] and attaching a draft position paper entitled "Neonatal Unit Mortality 2013-2016" [INQ0001888]. This was a summary of the outcome report following the silver command data analysis. The document outlines the background to the unit, the number of deaths and the investigations which had been undertaken.

274. The report identified that the deaths or collapses of Child M, Child Q, Child N and another child between January and June 2016 had not been reported via the Datix system and therefore required case reviews.

275. It was noted that the NNU Risk Register at that time included 4 "high" risks relating to pseudomonas, the availability of transfers in the network and the availability of medical staff.

276. The report concluded on the basis of the availability of the data that there had been a step change in mortality levels on the unit since June 2015. It was noted that admissions were higher than usual, but that previous periods of high admissions had not resulted in the same rate of deaths. It was noted that activity levels could be a contributory factor, but not the sole factor. It was opined that an increased and sustained acuity level may also be a contributory factor. It was also noted that the NNU did not consistently meet the BAPM recommended nurse staffing levels.

277. The review included a review of staffing competencies and it was noted that no issues had been raised.

278. The references to "challenges to the analysis undertaken" refers to the complexities of pulling data from a number of different sources which I understand made the data more difficult to track and analyse.

279. Appended to the review was:

(1) The mortality case review for Child A, Child C and Child D undertaken by Dr Brearey dated 1 July 2015.