3.8 There were no significant factors which predicated the deaths that were not present in equivalent units within the network and beyond. However in June 2016 the deaths of two triplets provoked further concerns.

3.9 Most of the consultants hade been involved with at least one of the deaths and on reflection they noted several had collapsed unexpectedly and had been surprisingly unresponsive to resuscitation, despite ~~large amounts of adrenaline being administered~~following standard protocols in each case. One infant was mentioned as needing resuscitation over three nights but subsequently recovered. The consultants did not initially consider any links, but after some time they began to note similarities, including some of the infants displaying a sudden mottling appearing after a few minutes of resuscitation, usually starting on the limbs, but for at least one on the central abdomen and chest. The consultants had researched **I&S** insulin injection or air embolism as possible causes but there remained only a tenuous correlation

3.9 The neonatal lead,had identified that one nurse had been present on the ward for all (??) the deaths although the nurse had always been rostered to care for the index baby, ~~and s~~Subsequently the paediatric lead and all the consultant paediatricians had become convinced by the ~~there was a link with a single nurse who had been rostered on shift when each death had occurred.~~ and, although ~~t~~There was no other evidence beyond this simple correlation ~~yet~~ an allegation had been made and the nurse had been removed from the clinical area.

3.10 In response to this allegation and the high acuity and activity on the unit the Medical Director, Nursing Director and Trust Board decided on 7th July to

remove the nurse temporarily from the unit to other duties

reduce the designation of the service to a Special Care Unit (SCU) caring for infants from a minimum of 32 weeks gestation..

These actions were taken pending an external review by the RCPCH.

3.11 The staff within the unit are naturally distressed about each death and the actions that had been taken and were keen that the issues were resolved. Management requested in early July that the RCPCH conduct an independent review to consider the wider service, including network support and advice, protocols and transfer arrangements. This was intended to provide assurance that there are no common factors to the deaths and that in each case there were no missed opportunities to take action that could have prevented or mitigated the infant deaths.

3.12 Only on arriving for the visit did the RCPCH Review team discover ~~the other action taken on~~that the ~~individual~~ nurse~~who~~ had been moved to an alternative position some ten weeks previously without explanation nor any formal investigative process being established. This was apparently due to the risk of the consultants approaching the police with allegations. The individual told the Review team that no

Commented [SE8]: not on our list but might e improtant

Commented [SE9]: Too much detail?

Commented [dm10]: Yes, I rhink you could probably just say 'a number of possible causes'

Commented [SE11]: all the bits in green can be removed if we want this to go to a wider audience. – they relate directly to L.

Commented [MA12]: However, the significance of this one nurse being rostered on shift at the time of each of the deaths had not been investigated via a thorough process, and is only individual senior consultants' subjective view. There is no evidence or reports to suggest this nurse 's clinical judgement or skills were in question. We were not shown any reports to suggest that this nurse had not cared for these babies appropriately. Not sure I'm making sense, but I think it's important that we recognise that these allegations were only hearsay, and have no substance.