Exhibit SGO/080319/2 – Chronology of Events – revision 101

Event Date/ Time	Event	Supplementary Information	Evidence/ Questions
23/06/2016 – day shift 13:00	Allocated to care for two of the triplets Child O&P check if this is right, one was in N1) and another infant. Child O deteriorated from 13:00 and later died approx. 18:00	Reg asked to review Child O after 12:00 feed – distended abdomen, recession, vomiting. Septic screen. Antibiotics given. Further IV access gained (?check If right and if already on fluids and ? if on optiflow. Dependency of the other infants) Child O deteriorated. Transferred to Nursery 1. Doctor U ?SB . Jess Burke.	First shift back after seven days off. Allocation is done by Shift leader of the night shift without any input from day staff. As soon as concerns regarding Child O were noted, a reg review was asked for immediately Once transferred to N1 Consultant, Registrar, SHO & other nursing staff present throughout Child O was not left unattended.
24/06/2016 – day shift Approx 09:00 Time transport arrived Approx 16:00 19:00	Allocated to care for the remaining triplets Child P&R & ? another infant) Child P had increasing apnoeas and required intervention with neopuff during Drs ward round. Child P cared for in Nursery 2. Transport team came to assist. Rapid deterioration. Child P later died approx. 16:30 When dressing Child P needlestick injury from IO needle obtained.	Child P&R had been electively screened for infection overnight in view of Child P Difficulty obtaining IV access – Consultant JG had numerous attempts. Had been placed NBM overnight due to distended abdomen. IV fluids running. Drs asked to review Child P first when they attended for the ward round - MD. Deteriorated quickly. Remained in N2. IO access x2 Doctor V put one in. Had difficulty running everything that was needed due to access/compatibilities/ line full. Transport team arrived shortly after insertion of chest drain and were present for resuscitation and subsequent death. Doctor U Doctor V JG. Chris Access had to remain in situ. It had dislodged and gone through the limb.	Nursing handover finished approx. 08:15. Self-correcting apnoeas noted. Drs present for ward round from 09:00 and in the Nursery when Child P became apnoeic requiring intervention. Consultant, Registrars and SHO's along with several nursing staff were present throughout once this had occurred. The nursery was never left unattended. A discussion took place within the team and it was decided that Child P was too unstable to transfer to N1 and that he could be adequately cared for in N2 and remain with Child P to support parents. N1 was also busy and would have required other infants to be moved. Positive feedback from OR – transport team(supporting evidence) I was unaware it had become displaced until I handled Child P and it pierced my skin. Another staff nurse was present. Reg informed who removed the IO. The needle stick pathway was followed.
27/06/2016 17:34	Phonecall from Unit manager (EP) – due to start four nights that evening. Informed to swap to day shifts.		I asked the reasons for this and if there was a problem with it being such short notice (confused as Child P usually goes home at 4 so ?why phoning so late). I was told there was no problem but there are more staff on days and therefore more support for me. Did EP know what was pending? Why did she leave it until so late in the day to phone me?
28/06/2016	During the day shift EP spoke to me informally.	Days would be more supportive for me and as advised by Occupational Health she was going to make a referral and they had advised to have a period off nights	Did EP know what was pending and why wasn't I told? Is this usual protocol for OH to suggest that?
30/06/2016	Last working day on NNU		