RCPCH Royal College of Paediatrics and Child Health	**Invited Reviews Programme**		
	Chronology		
Organisation	Countess of Chester NHSFT	**Date**	14th Feb 2018

The following chronology has been prepared in response to an approach to the RCPCH's president by Dr Steve Brearey clinical lead at Countess of Chester. He raised concerns on behalf of the paediatricians about the delay in contacting police following their raising concerns with rust management and that he felt the RCPCH review process caused further delay. He feels the duration of the investigation is damaging to parents and staff.

The CEO at RCPCH has requested a governance review of the IR process and this chronology outlines what decisions were made by whom and when.

28 June 16	First approach from Ian Harvey Medical Director	**From:** Harvey Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [mailto:i.harvey@ I&S **Sent:** 28 June 2016 10:02 **To:** Enquiries **Subject:** External reviews Good morning A number of Colleges offer an independent review service for individuals practice or for departments where there are concerns. I can find no reference to such a service on your website, do you provide this service please? Thanks Kind regards Ian Harvey Medical Director Countess of Chester Hospital NHS FT ☎ 01 I&S ✉ i.harvey@ I&S
30 June	To Ian Harvey	Proposal document prepared following telecon with Ian Harvey who was under pressure from his chair to get a proposal
4 July	To David Milligan	Seeking whether he would lead – agreed.
7 July 16	From Ian H	We are happy with the proposal and want to proceed, thanks. I have attached an amended TOR for your review, happy to discuss a final version. For your info, we are today, after lengthy network and regulator consultations downgrading our unit today, effectively closing the ITU cots pending further data collection and the review. It may be that this will feature in the press, at least locally.

		Re the parents – we made every effort to contact the parents of every baby who had died during the increased incidence period before the story was in the local paper – address and phone number changes meant we couldn't contact all. Part of the conversation was that we would share the findings of the review with them. To my knowledge none has requested seeing the review team.
13 July	Programme Board minutes	"Concerns about neonatal services at Countess of Chester has sparked an enquiry for an independent review, following discussions with their Medical Director. The LNU has been temporarily reclassified as a SCU and the Trust has managed public interest well so far. The Review team will visit in August 2016".
15-20 July	Sue E	Seeking BAPM nominee to join the team – Alan Fenton, Sanjeev Deshpande, Gopi Menon, Ben Stenson. Andy Currie. Simon Newell circulated a request to colleagues … Finally agreed a DGH neonatologist might be better so Graham Stewart agreed to participate.
21 July	Sue E	Contracts out to review team Dr David Milligan, Dr Graham Stewart, Claire McLaughlan, Alex Mancini (RCN) – 18-19th August agreed as date
27 July	Sue E	Visit date confirmed as 1-2 September as Dr Milligan had double booked 19th August.
26 August	From David M	I have had a look at most of the documentation (but not yet all the individual baby files) and we have much of the workload data I was looking for plus a more in-depth analysis of what happened with the index cases but a number of questions arise from that, not least that one individual appears to have been present for all but one of them.
1-2 Sept		**Review took place**
5 Sept	Sue E	Letter sent to Trust explaining we formally knew on 1st September about the allegation.
15 October		QA completed by Nic Wilson and Jon Dorlng Nic - I hope my contribution was useful. I felt only that you might tone down your justifiable high dudgeon about how badly the Trust had dealt with the 'exclusion' and the supine behaviour of the Union rep. Your conclusions were entirely sound, their governance is flawed, 'Green for Danger'.....before your time, of course. In Neonatal Medicine death is one of our few, clearly definable, outcome measures and should be closely monitored, not just by the doctors. As has been well said, 'if you want to drain the pond - don't ask the frogs'.
18 Oct 16	From Sue E	Draft report sent to Ian Harvey MD. Included within two green-type sections all the details of the allegations and concerns by the doctors, but an appendix with casedetails promised later. We suggested that

		Ian share the draft report with the lead paed, lead neontaologist and lead nurse.
Oct 2016	Programme Board written update	"Two recent reviews have become much more complex than initially anticipated, mainly due to the management (our clients) not being open and honest with their paediatric team and/or not responding to our requests for data. This is always a risk given that the reason we are invited may be due to dysfunctionality but we are reflecting on how to ensure our approach is appropriate and we identify and mitigate problems at an early stage".
27th October	Sue E	Appendix 4 with case details and invoice sent to the Trust
11 Nov	From Paeds	Dr Brearey copied me to an internal note – the paediatricians had seen the redacted report and made some comments which were forwarded to RCPCH on 15th November, confirming the draft report had been seen by the Execs, Steve Brearey, Ravi Jayaram and Ann Murphy (in place of Eirian Powell) and there comments have been taken in to account.
28 Nov	David S – QA of final report	Queried why the Trust did not go to the police originally. "Quite an interesting and complex review. Good to have David M leading that one. Almost felt a bit like the Grantham situation 30 years ago and my only question was why they didn't involve the police if they had those suspicions. Otherwise looks like a good report with very clear recommendations"
28 Nov 16	To Ian	Final report sent with covering letter from Dr Shortland
6 Jan 17	From Ian correspondence and reply about publishing a redacted version of the report	We are reaching the end of the forensic review, just waiting for secondary pathology reviews of 4 cases, and are now discussing the sharing of reports. We have concerns that effectively there are two reports, one described as confidential and the other for dissemination. We don't want to be seen as concealing anything given how that would be perceived post Morecombe Bay, and whilst I appreciate that the former related to HR aspects regarding one of our nurses, is there anything in the report that the College wouldn't want published or were the two reports purely to protect the nurse and the Trust? From SE – after taking advice from review team Dear Ian Thanks for your note and Happy New Year - with all the challenges that brings! The latter. From our perspective either can be published if you choose to do so; we recognised the importance of wide dissemination of the report but also the responsibility to protect individuals for the HR issues (that aspect is the only difference) which we had a duty to report formally to you as they were a concern to