?

Tues 31st May
1st June 04

Sperrin Lakeland Trust.

Death → reporting coroner. ⟨ ?Royal / ?Erne.
→ Why review / case notes / how select ad. / ?ask another T. / ?paid for services /
→ What nature of litigation. Bolam.
→ Why settle - what were pressing issues.
→ When did record keeping capture + how
→ What training issues followed. →
→ Now what status litigation - what forecast.
→ What changed - clinical management.
→ What current status Dr O'Donohue - Trust ? Working ?Capacity.
PM - ?Consented.

Log of meetings etc { Communication with family. / Communication after death - / Communication after PM re explanation.

• When was int review give to family.
B Slann

Referred to coroner ✓ Curtis - No.
Hosp. PM. Dr. O'Hara 14.4.00.
• Med director informed crit. event early hrs of morning - Clerk contacted - inc. rev. arranged - relatively new at that time.
Mr. Lee / Mr Dr. Anderson
Hugh - spoke to Dr Quinn
Spoke to Bill McConnell. - 14/4/00.
Mark Bradley informed

M. Quinn provided report
met c Dr Quinn
Get TOR.
Wrote Dr. Quinn 21/4/00 ⟨ Type / vol fluid / cause of oedema / change electrolytes

006 - 016 - 316

DHSSPS

? Any other observation

Communicⁿ:

- Met Dr O'Donohoe 5/5/00. Didn't know issues.
- Family met c̄ Dr O'Hara + Stanley Millar. (Council acting at request of family).
- 22nd Sept. Formal complaint through council. - unhappy c̄ level of care.
- Oct. ~~Nov~~ - family advised that int review conducted - copy requested. Trust wanted to meet c̄ family rather than issue report - ongoing comm Oct 00 - Jan 01
- 16th March. Family wrote no formal response to complaint - ∴ Final response from C Exec - wr letter from H. Mills 30 March.
- 27th April 01 - letter from solicitor Family - care substandard - negligent
- letter acknowledged - legal advisers instructed
- Apr 01 - Dec 03 - Indirect + direct approach from Crawford - re distress. Pt / Client advocate contacted GP to assure family receiving support. Advised against mediation by legal advisor
- Dec 03 Settlement

June 01 - Med Directors meeting

Rec Action

offered to meet Sr Sec session

June 2001 Trust aware that dealt with be relevant to hyponatraemia death.

Roberts

March 2002 John Jenkins report hyponatraemia meeting Head.

March 01 - BMJ article

letter Trust June 2001

006-016-317

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* → CMO Now are June 2001 of Lucy's death → Check was
* this discussed @ Med Directors meeting?
? Contact c̄ M.Quinn's report – how independent
is an independent review?
"VR fluids within normal parameters"
Unlikely Comp due to fluid admin
– Fluid regime while not properly recorded
was not the cause of death

20 ml per hr.
Recs: Prescription orders clearly doc + signed
- Standard protocols should be made avail
- Team involved informed of findings.
- Meeting of family – to appraise them.

Governance committee up + running since
Sept 2001 –
Critical incident reporting system 2002. – Daytex
system to capture information.

Following inquest. Trust reviewing processes
& procedures. Engaged c̄ Ann O'Brien
– support team clinical governance.
About to launch work c̄ (CCAT) working
→ mediator of family to encourage their
involvement. Review to address revised
procedures
Root Cause analysis

Int. Review / Informed Board. 006-016-318
May 2000 → Bill McConnell formally
informed int case review
Belfast Med / Belfast Path / Belfast Coroner

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Post LC other concerns re Dr O' → for staff grades
→ Looked at by Trust, sought ass. for RCPaed.
engaged Dr Moira Stewart – Report.
FORMAL in May/June 01. *.
Recommendations: - Raised issue changing
^ guidelines. ? Poss. that Lucy had additional
abnormality ? Fluid potentially part of
problem – Royal had changed guidelines.
? GMC consider only if. ? Overall performance issue for GMC.
Other incidents – 'bullying' harassment,
personal conduct.
Health, sickness, fitness to practice.
FORMAL 2002. RCPaed. Dr Andrew Boon/Dr M. Stewart (sup)
– interviews ++ c staff, GPs etc.
Recommendations but GMC referral not needed
Wrote to CMO
2003 Dr O. Senior Paediatrician – Many
strengths in teaching/training.
After inquest 2004 – formal apology. – for H. Mills →
Paed asked if any risk – No
Senior nurses asked – No.
M. Quinn asked grounds susp/referral No
RCPaed " " No.
Last yr. 3 new consultant paed.
of high quality – all.

Dr S/L since inquest. Dr occupational
health. advice subject to OH.
report return to work ? 28 June 04

006-016-319

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No. guidance →
Communication →
How independent was ind. review →

- Why was fluid changed
-
- What links c Report
- When s/h receive PM report.

• Report
• invest
• action

Board →

⇒ ? Short submission - - Reporting -
Communication - Supporting
- Dr. O'Donoghue - inform
Apology - - too little too late more personal

⇒ ? Addition Q+A

⇒ ? Board action re report.
⇒ Med Directors June 2001 - ? Sept 2001.
+ 2002

Get reports - Int. review/case notes
correspondence to CMO etc

Procedures in place at time followed.
* Failed = terms of communication -

Get Sharon's copy - papers ✓

Everyone applying 2004 standards to 2001 case

failure talk to family

No guidance - how to investigate
how to appt ext person -

Root/Cause analysis

006-016-320

No specific req. for Boards or Trusts to inform Dept.
Matter of judgement for Board. →
no specific guidelines in place.
will still be a matter of judgement →

* Trust

006-016-321

Scope:
The root cause analysis will examine:
- adverse incident investigation process
- complaints handling process
- litigation process (including preparation for Inquest)
- media/public relations processes and
- related cpd/cme processes regarding updating of professional standards

- Key staff involved in the processes set out above will be invited to participate and contribute to the RCA exercise
- Currently the Trust is approaching the family to assess their preparedness to engage with this process
- Findings for the RCA will be presented to the Steering group along with any recommended remedial actions.
- A final report will be provided to the Trust Chair and Chief Executive and the CSCG committee for adoption.

Membership of Steering Group:
The group will be chaired by a Non Executive Director of the Trust. The following additional members have been identified to secure independent views, a consumer perspective and professional overview:
- Trust Medical Director
- Chief Nurse, WHSSB
- Chief Officer, WHSSC
- Representative of the CSCG Support team

Process & Resources:
- External expertise on RCA methodology will be sourced via the NI CSCG support team. The Trust will meet costs in this respect.
- Guidance and support will be provided by the CSCG support team representative – costs for this will be met by the Director of the NI CSCG support team.
- Limited administrative support will be provided by the Corporate Affairs directorate through the CSCG Project Officer.
- A workplan will be agreed with the RCA Consultant(s) at an early stage. This will include:
  - Core groups for engagement/participation
  - Timescales/key timelines
  - Reporting arrangements

Timescales:
- The exercise should be completed within 4-6 months of initiation.

bor/mmcg/0702

→ the chair.