05
06.04.04 Prep for meeting

Discuss with Spmin Lakeland Trust regarding the death of Lucy Crawford 14/4/2000.

Present ~~WHSSC~~ SLT — Dr Kelly, Hugh, Eugene

WHSSC 9HQ | HQ | SM.

SLT —

Areas WHSSC wants to cover

Why a hosp PM not coroners — who decided that?

1 When did SLT/Cons become aware that LC had died because of her treatment

2. What action was taken
Who was involved
Who was this communicated to

BoR 3. Complaint process
Did a senior manager (eg Dir of A Care/C Exec offer to meet i family
Written response to complaint — did not happen → why?

4
What new protocols for treatment and observation are in place (med/nursing) eg 12:15 - 3am — level of obs — Has this changed.

5. Reporting (1) onward critical incident
- When by whom to whom → outcomes
-

(2) near-misses
as above.

6. Learning within Trust + medical + across Trusts

how does this happen
who ensues this happens.

Accountability.

✓ Issue of Consultant not (his right) giving evidence

Would the family want to speak with Dr O'D.

- Suspension during investigation - how does this work - was it a consideration
Exp asked specifically if suspension shd be an option -
✓ - GMC. involvement Y/N.

Cons responsibility re evidence based practice
- keeping up with latest research etc.

- What role does CMO have
How is this being taken forward.

Compl.
- Any new learning re policy/proc
- Personal contact esp - death.
- Need to go to ster for post for answers
- Support to bereaved family/Parents.

CMO seemed to suggest that this was a rare reaction to Rx is this still med opinion or is it regarded as the wrong Rx for babies/sm chd (body weight)

Sequence of events. → change in protocols

LC adm to hospital	13/4/2000	Erne
died	14/4/2000	Royal
P. Morem.		

next March 2002

New IV fluid protocol	2001	SLT
" " "	2002	CMO

What prompted change ahead of Coroners findings in Feb 2004