NOTES OF MEETING ON 5 APRIL 2004 RE RCA/TOR-LC

Present: E Fee, Director of Acute Hospital Services, Sperrin Lakeland Trust
Dr Kelly, Medical Director Sperrin Lakeland Trust
B O'Rawe, Complaints Manager, Sperrin Lakeland Trust
H Mills, Chief Executive, Sperrin Lakeland Trust

E Fee:

Tragedy - family
+ staff

Assessment included dehyd. IV + oral replacement
* No 18 Sol - later focus of review CMO/Inq.
4hrs later - 'fit' + sick/dia - side ward with mum
- stable
- T/F to RVH Chd

Under supervision of Dr O' Donohoe on-call consultant

M Reilly: Q - Was she under Dr O'Donohoe's care from the start

Sudden and unexplained death

Dr O'Donohoe contacted Dr J Kelly Med. Director

Review established:

? need for external opinion (rare event)

M Reilly: Q - Was external opinion given

Dr Murray Quinn - Cons Paed AHT

M Reilly: Q - reviewers independence - E Fee said he didn't personally know M Quinn

April – July 2000 Review

Asked for staff notes

PM Report - Cons in Royal - Dr O'Hara

Undertook Hospital PM

T of R

- opin re fluid balance regime - significance of type/vol fluids given

- Q re how did LC dev cerebral ode

- any other issues

- Notes sent to him

Review identified issues

Communication between staff

level and quality of documentation

incl events described up to 3am

and linkages with regional service

Rec.

(1) Meet with family

Share findings

(2) Changes to range of practices

Audit

revised doc to calculate IV

24hrs - weighing chd

Management of fluid balance

INQUEST March 2004

Trust id of issues

27/2 - met with Dr Campbell CMO

- WHSSB Briefing

- H Mills co-ord - lessons learnt

- J Kelly - GMC

Issues (E Fee):

Clinical level: (not unique to Paed)

Organisational level e.g. review/family etc

Regional level
- standardisation of t/f of records
- framework clinical issue review sharing
- panel of experience for reviews (expertise/access)

Jim Kelly:

Medical Aspects:

Pre CSCG SLT trying to introduce some work

Dr O'Donohoe - contacted Med. Director

C.E. } informed
E. Fee }

Process of internal review with expert opinion

(NB Now standard practice)

WHSSB alerted - Bill McConnell

case/rev/initial findings/opinion

Re CMO - No mechanism for contacting Dr Campbell

M Reilly: Q - Why choose Dr Quinn - Senior Specialist natural area to turn to

M Reilly: Q - In retrospect would you choose again local

M Reilly: M Quinns - opinion discredited (via inquest)
- based on report

JK cannot defend poor practice, recording etc.

JK/EF met with MQ = reviewed again

Q - Does his review look at latest research areas of concern within med circles.

Also asked Royal College of Paeds - Report and background notes (end 2000-Spring 2001)

Their report - number of possibilities
aspects of fluid balance
sickness etc

did say: There is a debate about fluid (May 01) said the Royal changed their practice not using 18 routinely

FIRST TIME JK heard of this

then met with AHT re

March 01 - Lesson of the week

BMJ and near misses reported

June 01 - JK - letter to all Paed.

M Reilly: Q - Parents - how did child die
- call for new PM [June 01]

JK then when litigation proceeded

asked Dr Jenkins (Paed) (Antrim) - review March 03

His report outlined issues

incl - Rapid and effective med resp
did their best
agreed not fluids

M Reilly: Q - Listening to parents 12-3am
concerns raised

M Reilly: Q - Why/what between June 01 – March 03
re parents - information
- ? inform coroner about suspicion regarding fluid and hyponatremia

Hyponatremia
Sodium 137 recording
↓ Hypo resulted = fluids given
+ rate
↓
127 Drop not a problem normally
BUT IT WAS THE RATE IN 6-8HRS <u>WAS CRITICAL</u>

<u>Lessons</u>:

1. Reporting NI
2. Standardisation ext opinion
3. Worry re willingness of others to give info
4. Q - 2 reviewers rather than 1
5. No NI National Clinical Assessment
   Authority
   ? Dept - adopt UK System
   give clear pathway

Q - audit re reporting systems - under reporting etc. reasons

Change of practice
Defined routine of observation for children on admission

1st 24hrs

Standardisation

Prescription- varied opinion of what is intended

Need to:

- Protocol for inv parents
- alerting Coroner

H Mills:

- ongoing Lit (is a constraint)
- co-operated with CMO following findings
- GMC - findings sent to them
- Anne O'Brien CSCG Support Team engaged to review case

WHSSC:

- outcome of some of ideas tabled
- more review re complaints
- media
- ---- use of WHSSC

Agreed to meet later to discuss more fully the area of the complaint management (2.5 hours taken on the medical/care aspect of the case)

Meeting ended 6.50pm