Norris, Hilary

From: Brenda.Jeffers[redacted]
Sent: 28 October 2004 10:08
To: andrew.hamilton[redacted]
Subject: utv insight

Importance: High

UTV INSIGHT.doc

----- Forwarded by Brenda Jeffers/LEGAL/DFP on 28/10/2004 10:09 -----

Tanya Stewart

28/10/2004 10:03

To: Brenda Jeffers/LEGAL/DFP@DFP
cc:
Subject: utv insight

(See attached file: UTV INSIGHT.doc)

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DHSSPS

002-021-120

UTV INSIGHT – WHEN HOSPITALS KILL

Summary

The fatal administration of sodium chloride has led to the deaths of 3 children in the past 8 years, Adam Strain, Lucy Crawford and Rachel Ferguson

Sperrin Lakeland Trust covered up the reason for the death of Lucy Crawford who was admitted to Erne Hospital suffering from a tummy bug.

Allegations.

1. Dr O'Donaghoe, Erne Hospital:

    a. Administered the drug via a drip that led Lucy to collapse around 3 am. The wrong fluid had been administered and too much of it.

    b. Solution in drip changed to saline but "far far too much " given – half a litre over 1 hour to 9 kilo child

    c. The hospital realised at the time of her collapse that the fluids were to blame but failed to advise the parents: instead they were told she'd stabilised. Although she was already brain-dead she was transferred to the Royal Victoria Hospital

    d. Took his junior doctor, Dr Malech, aside and told him he could alter his notes. Asked if he had professional medical insurance and told his junior he could blame him if he wished but would not.

    e. Lied to parents – said he couldn't understand Lucy's death even though he knew the cause.

2. Dr Donncha Hanrahan, RVH

    a. Failed to state proper cause of death on the death certificate: cited natural causes e.g. gastroenteritis

    b. Failed to inform the Coroner of the mistakes made in Erne Hospital – misled him as to the cause of death which meant that no formal post-mortem examination was carried out.

    c. The Royal conducted its own post-mortem examination. The report written by Dr Caroline Stewart, Dr Hanrahan's Registrar, states death due to hyponatraemia. This information was not passed to the Coroner.

3. Sperrin Lakeland Trust

    a. Failed to investigate properly. Review it instigated flawed as:

i. Not independent- conducted by Dr Murray Quinn, Altnagelvin Hospital who had clinic in Erne every week. On the programme Dr Quinn states he was "sweet-talked into writing a summary which is not the complete discretion I had at that time".
ii. Failed to comment on the drop in Lucy's sodium levels at around 3 am
iii. Assessed fluid intake differently from other experts – did it over a period of 7 hours rather than 4.
iv. Failed to explain the death- its findings were inconclusive. Yet the consultant paediatrician engaged by the Crawford family, Dr Dewi Evans, states he had sufficient information to determine the cause of death.

b. Role of Brigid O'Rawe – responsible for dealing with complaints and protecting Trust's corporate identity – conflict of interest.

c. Delay and inaction – Dr Muhammad Ascar examined Lucy's notes and knew the cause of death – in accordance with protocol hand-delivered all evidence he had in an envelope to Hugh Mills, the Chief Executive of the Trust. Trust did nothing for 6 months, after which Dr Ascar threatened to report Dr O'Donoghoe to the General Medical Council. At this stage Trust obtained report(s) from Royal College of Paediatricians.

d. Failed to disclose report(s) from Royal College of Paediatricians to the coroner.

e. There was also an implication that the Trust had pushed the whistle-blower, Dr. Ascar, out

4. <u>Department/ Chief Medical Officer</u>

a. Failed to bring Trusts to account; instead protected them. Set up a working group in 2001 to look at the deaths but Chief Medical Officer claimed not to have known cause of Lucy's death until 2003 when Rachel Ferguson died. If Department did know, it failed to inform the Coroner. It was the Coroner who referred Dr O' Donoghoe to the GMC at inquest into Lucy's death.

b. Chief Medical Officer wrongly blamed deaths on the "abnormal reactions" of the particular children involved.

c. She also claimed that the medical profession in the UK was not aware of the problem however an article was published in the British Medical Journal in 1993

d. Failed to learn lessons from deaths of Adam Strain and Lucy Crawford that may have prevented death of Rachel Ferguson. No warnings were issued after deaths of the first 2 children. Dr Campbell has said that if

there had been an early inquest into Lucy's death, Rachel may not have died. However, the Coroner was given misleading information by the RVH

Norris, Hilary

From: Carson, Ian
Sent: 27 October 2004 17:43
To: Hamilton, Andrew
Subject: FW: Terms Of Reference - Sperrin Lakeland

Andrew,
I had Anne O'Brien in the office today, expressing concern that the SL Trust continue to put difficulties (e.g ongoing ammendments to Terms of Reference) in the way of progressing the Root Cause Analysis (RCA) exercise in regard to the LC case. Also, in light of a letter to me (dated 15 Oct 2004, with attached TOR for the Risk Assessment) which I received today inviting me to participate in the Risk Assessment, I asked Anne to send me the TOR for the RCA exercise, and they are attached below.
In light of our knowledge of likely next steps, I have concerns that the RCA will be 'compromised/overtaken' by a new inquiry - and I wonder whether the RCA exercise should be set aside to allow the new investigation to proceed.
Yours, Ian.

-----Original Message-----
From: O'Donnell, Bridget
Sent: 27 October 2004 14:10
To: 'ian.carson[redacted]
Subject: Terms Of Reference - Sperrin Lakeland

Ian

Anne O'Brien has asked me to forward you the TOR.

Please note that these are the ammended TOR, however further ammendments were discussed at the last meeting but we have not yet received ammended terms or the minutes from this meeting. We will chase this up.

Regards

Bridget O'Donnell
Business Assistant
NI Clinical & Social Care
Governance Support Team

Tel:
Fax: [redacted]

DRAFT

SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST

ROOT CAUSE ANALYSIS EXERCISE: LC Case

TERMS OF REFERENCE

Background:

On 20/02/04 the Coroners Inquest concluded its findings on the circumstances nature and cause of the tragic death of Lucy Crawford. Aspects of the clinical care are currently subject to consideration by the GMC, after referral by the Coroner. The Trust is co-operating fully with the GMC in this regard.

It has been acknowledged, in the course of the management of this case, that a number of process and systems issues warrant examination and reflection.

A root cause analysis is proposed and independent expertise is being commissioned to gain understanding of the clinical and non clinical systems and processes which were in place at the time of and following Lucy's death.

Principles

The above process will be facilitated with the clear aim of improving clinical practice and care whilst highlighting and drawing on areas of good practice. It will be an open and honest process which is fully inclusive of all, promoting open communication within a supportive and confidential environment

Methodology:

This exercise will be:

- overseen by a Steering group established by the Trust Chairman which through its membership aims to promote an open and honest examination of the trusts processes and systems.
- Regularly reviewed, to ensure that any early lessons are filtered expediently to the relevant parties. This will be in addition to any final outcomes and recommendations.

- Used to inform regional authorities and any other external organisations, as appropriate, of any relevant/pertinent lessons for wider dissemination.

Role of Analysis

The root cause analysis will begin with a comprehensive examination of the practice of the Trust which will be steered by those directly involved although, reflecting on learning's to date, will also include details of:

- complaints handling process
- litigation process (including preparation for Inquest)
- media/public relations processes and
- related cpd/cme processes regarding updating of professional standards

Moving on, findings from the root cause analysis will build on positive changes already implemented and other areas of good practice. This will allow an action plan to be developed which will be communicated by the steering group to the Trust Chairman, Chief Executive and Clinical & Social Care Governance Committee. Their role will be to endorse and oversee the implementation of the recommendations and they will be accountable to the Chairman of the steering group and the Western Health and Social Services Board.

The Crawford family will also be provided with the opportunity to view and comment on the findings prior to implementation, allowing for any appropriate adjustments to be made.

Membership of Steering Group:

The following members have been identified to support independent views and secure a professional overview.

- **Jennifer Irvine - Chair**, Trust Non-Executive Director
- **Dr Diana Cody**, Trust Medical Director (Acting)
- **Margaret Kelly**, Western Health & Social Services Board
- **Sue Norwood**, Global Air Training
- **Howard Arthur**, Clinical Governance Support Team (G.B)
- **Jayne Fox,** N.I. Clinical & Social Care Governance Support Team

Timescales:

- The exercise, along with endorsement of any recommendations should be completed within 4-6 months from the steering group's initial meeting with a view to ongoing structured implementation