Acute Division Correspondence
20/4/04.

Sperrin Lakeland

Mtg Eugene Fee – Director of Acute Hosp.
Hugh Mills – CEO.
Jim Kelly – Med Director
Bridget O'Rawe – D. Corp Services.
– CSA (lawyer).

Mtg following discussion with letter from CMO.
- look at incident surrounding Lucy Crawford died ?4yrs ago
- Trust want to review ~~seen~~ the case ? investigation. E
- want to look at corporate bit as have looked at clinical issues.
- want it to be independent of Trust.

Reflective exercise
- Managing the process
- What happened re learning
- Human factors model.

Independence
wider C&SCG issues.

CMO issued guidance on hyponatraemia.
Structure around the review.

Steering group.
- Board/Council/non-exec chair/Med Dir
CEO/Trust team/GAT/Supp team.

B Rawe Team

- Chair as sponsor
- Comms Strategy
- Family ~~[illegible]~~.

008-046-106

DHSSPS

Anne Brown Correspondence

CONFIDENTIAL - Sperrin Lakeland Trust

Friday 23rd April 2.00
Meeting with Hugh Mills CEO, Eugene Fee, Director of Services SLT, Peter Stewart MA, Howard Arthur Director of Patient Safety NCGST.

Discussed issues surrounding the Lucy Crawford case and suggested way forward. Agreed approach using Root Cause. Asked if there were any other issues within the Trust that may have cause for concern. Advised there had been a maternal death [redacted] potential issue of not having transferred the mother to another unit earlier as this was a premature birth. Asked if the CMO had been made aware of this incident in light of the fact of the Lucy Crawford case? Both were unaware and I advised that perhaps they should inform the CMO.

Friday 21st May
Telephone call form Hugh Mills

Thursday 10th June 15.00
Meeting with Margaret Kelly – Director of Nursing WHSSB
Have concerns with Sperrin Lakeland that are wider than the Lucy Crawford issue. Also is now aware of a Maternal Death and with patient safety issues in Anaesthetics. WHSSB feel in a difficult position due to not having accountability for performance management of the Trust. Have had informal discussions with the Dept about their concerns.

Advised that they still have accountability for the population on whose behalf they commission services and therefore can ask the Trust to look into issues. A number of options are available

- Write formally to the Dept with their concerns
- Ask the Royal College for assistance in looking at a specific service area
- Formally write to the Trust

Advised that I would speak to the Dept 'off the record' via the Planning and Performance Mgt route / DCMO

Friday 11th June 10.30
Spoke with Ian Carson DCMO re the above concerns and the position of the C&SCG Support Team in undertaking the Root Cause Analysis work in the Trust re Lucy Crawford and the impact the other incidents may have on the organisation's ability to move forward. Spoke with Jonathan Bill Deputy Director re the same. Agreed that we would speak to Noel McCann, Director on Monday.

Monday 14th June 13.00
Meeting with Jonathan Bill and Noel McCann re the above issues. Agreed that Noel would speak 'off the record' to Andrew Hamilton.

Thursday 17th June 13.30
Discussion re the above with Noel McCann who is due to meet with Andrew Hamilton at 3pm.

Friday 18th June 13.30
Telephone call from Dr Ian Carson – DCMO

Andrew Hamilton came to see him with concerns about the Trust. Asked me to telephone Andrew. Ian has sent him a copy of the Support Team's objectives.

Friday 18th June 16.45
Telephone discussion with Andrew Hamilton. Equally has concerns.

Monday 21st June 14.00
Meeting with Andrew Hamilton
Advised of Support Team involvement to date and concerns around the commitment of the organisation. Asked what role the Dept were taking in relation to accountability and performance management. Advised of the duty we all have to the organisation and the local population, asked if the Dept felt confident of the role it had taken to date if we were asked by an external review. Links made to Bristol.

Meeting with Noel McCann 15.00
Advised of above

14th July 14.30

Discussed with CMO & DCMO re: Sperrin Lakeland.

Concerns about 2 other cases that have recently come to light

1) Man [redacted] died. Cause – unsure of whether case was referred to coroner or if PM was carried out.
(DCMO made aware by passing remark in a meeting!)

2) Child [redacted] Child subsequently died. Unsure if PM was carried out. CMO informed of death 2 days ago.

Both incidents occurred [redacted]

Concerns around nursing issues as G&F grade on paediatric unit are on long term sick.

Discussed with Judith Hill CNO

CNO discussed with DofN (WHSSB). Had received a telephone call 2 weeks ago from CEO SL Trust who had received a letter from Paediatricians in the Trust with concerns re: Nursing staffing levels. Suggested that if unable to cover services move to an Ambulatory care model.

Staffing levels put in place by the Trust, which are now acceptable?.

Discussed with CNO & Janice Smith re assurance that they are happy with what is in place. CNO asked same of WHSSB.

Later Discussion with DCMO

Action Points suggested

1) Dean Sullivan checking medical staffing levels;
2) Need discussion with CNO as is investigating further nursing issues;
3) PS (Clive Gourdy) to ask CEO SL Trust for information on clinical incidents ahead of guidance going to the service.
4) ? Meeting to be convened between DHSSPS/WHSSB and SL Trust;
5) Minister to be briefed re: additional cases;
6) Leadership in DHSSPS to be identified;
7) CHI type review commissioned by the trust under guidance of Andrew Hamilton to be clarified re: Terms of Reference.

Monday 6th September

Discussed with Jane Fox
Had telephone discussion with Jenny Irvine non-executive chairing steering group

Tuesday 7th September

Contacted Dean Sullivan (secondary care) left message.
Contacted Margaret Kelly (WHSSB) left message.

Wednesday 8th September

Discussed with Ian Carson DCMO with concerns around the continuation of RCA work re Lucy Crawford. Advised I would be speaking to Dean Sullivan and Margaret Kelly and would get back to him.

Telephone discussion with Dean Sullivan. He is not aware of why Sperrin Lakeland have decided to change looking at the L.C. case. Unhappy if this was to be the case. Understands that Hugh Mills CEO is on Annual leave until next week. Work of the wider review of trust services to be undertaken. Will be updated next week following CEO and Andrew Hamilton's return from leave.

Tuesday 21st September

Sperrin Lakeland – Lucy Crawford
Telephone discussion with Diana Cody

Explained that organisation wanted to undertake general RCA training initially and then do a specific piece of work looking at the corporate issues with staff involved with L.C

Advised that press release sent out by non- executive was not seen by NI C & SCGST and concerns about how LC case was being communicated.

Diana Cody expressed concern that the trust did not have the skills to deal with the constant media attention and therefore any suggestions on solutions would be helpful.

Suggestion: Session with Steve O'Neill re: looking at the issues facing the organisation. Agreed to discuss with CEO this approach.

Discussed with Jonathon Bill QPI unit

Happy for team to pay and facilitate one day with the trust re: concerns and for them to think further how they may wish to take this forward.

Discussed with Hugh Mills and offered some Communication facilitation around the Strategic issues facing the Trust

- Pending Insight Programme
- GMC Inquiry
- Inquest into Maternal Death
- New Hospital
- Sustaining services

Hugh advised that he needed to discuss with Bridget O'Rawe

6th October 2024.

9.00 Am. Mtg with Hugh Mills.

Discussed offer of communications sessions for SLT. Didn't appear keen to accept offer. Advised that MH were managing the process of Lease.

Expressed my unhappiness at Press Releases from SLT still being issued without the knowledge of CESC& support team despite clear direction to the steering group that anything issued should be in agreement with all parties.

HM advised that he was unaware & chair of the steering group speaking to the press. I also expressed concerns of part of steering making decisions that were not explicit or minuting all members. In addition the steering group needed to have wider representation. Advised that I would be discussing these issues with the steering group later that morning.

Mr Ambrose Owens

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Dear Ambrose

12. Nov. 2004

INQUIRY INTO THE DEATHS OF LUCY CRAWFORD, RAYCHEL FERGUSON AND ADAM STRAIN

We spoke recently about whether you presently needed original or photocopies of papers held by Departmental Directorates relating to the deaths of the children named above. You confirmed with me that you are content with copies at present but that originals should be held in a safe place ready for disclosure to the inquiry at any point. I have arranged for this to be done in respect of the papers held by the Clinical & Social Care Governance (CHSCG) Support Team, a copy of which has already been sent to you. You already hold the originals of the other papers which were held by this Directorate.

You will remember that the recent request for the papers from Secretary had an associated tight return timeframe. At that time one of the CHSCG team members was not available and held some papers relating to the Lucy Crawford case. I have received a copy of these today and enclose them with this letter for inclusion with the other copies of papers you hold in the CHSCG Support Team file. They should be inserted at section 5 of the file under "General communication". The original has been associated with the other original papers (copies of which you already hold in the file) and is being held ready for disclosure at whatever stage is deemed necessary.

If I can be of any further help please let me know.

Pat Swann
Assistant Director

DHSSPS

008-046-112

Peter Simpson.

* Clinical Governance - relevant papers to be forwarded.

* Guidance on - serious adverse incidents
  - adverse incident reporting - (people who were seriously ill) & who died whilst in care or in other facilities directly under the care of HPSS facilities