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SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST

ISSUES FOR CONSIDERATION ARISING OUT OF MR FEE'S OBSERVATIONS OF THE PROCEEDINGS DURING THE INQUEST AT THE CORONER'S COURT, BELFAST ON 17 & 19 FEBRUARY 2004 THE LATE LUCY CRAWFORD

These issues could be divided into at least three categories:

- ✓ *Clinical*
- ✓ *Organisational*
- ✓ *Regional*

code of practice for staff.

- *The need to listen to the patient or the parent in respect of the presenting condition.*

- *The need to concentrate on the patient and not to engage in social or private conversations during period of contact with the patient. The can be perceived as showing disinterest.*

- *The need to consider the parents wishes in respect of being present during the care of children including emergency services resuscitation care.*

- *The need to keep the parent or family briefed in respect of what is happening particularly during or after a response to a sudden deterioration in the patients condition.*

- *The need to advise the patient or family at an early stage of the Trust's intention to carry out a clinical review and to seek their contribution particularly in relation to the description of any significant events such as the one that happened to Lucy in the presence of her mother at around 2.55am on 13/4/00.*

openness.

- *To consider how the outcome of any review is communicated with the patient or family.*

*legal view tends to advise against.

- *There is a need to consider carefully how external reviewers are chosen. Perhaps there could be a regional list for relevant specialties and disciplines.*

develop 'review team' concept.

situations where it appeared to them that the volume or type of fluid was inappropriate to a given patients clinical condition.

- *The need to create an action plan arising out of the deliberations of relevant clinical managerial staff in respect of this case. The action plan should include an agreed process for sharing the learning out of this case to all relevant staff and externally with other organisations.*

- *The need to standardise the monitoring arrangements in respect of patients on fluid replacement therapies including how this should be managed in respect of patients who are sleeping or unconscious.*

- *The need for a mechanism for services in Northern Ireland to share lessons learnt from such circumstances with the wider HPSS family. Dr Evans (expert witness, Cardiff) was unaware of the guidance developed by Dr Campbell and her team.*

- *There is a need to consider the requirements for legal advice in respect of correspondence to complainants when replying to issues of a serious nature.*

new procedures in 2002

- *There is a continuing need to work towards a regional retrieval service to support Paediatric Services particularly at the periphery of the Province.*

- *The need to further consider the availability of a helipad at the RVH to facilitate air transportation of patients in some circumstance.*

- *The need for agreement in respect of how many attempts a Junior Doctor should have in respect gaining an IV line before requesting support from a more senior colleague.*

- *In respect of the allegation that a member of nursing staff and a doctor engaged in social conversation during a part of the treatment. It should have been clarified that there had been at least one other member of staff involved in the patients assessment. This reference may have been relevant to a nurse rather than the individual accused.*

- *There is a need for nursing staff to consider the risks associated with documenting elements of care or proposed care based on information provided by colleagues.*

- *In preparing for the Coroner's Court, the Trust should have available a full set of information including case notes or copies of case notes in relation to the patient from other hospitals.* —

- *Consideration needs to be given as to whether or not there is the need to prepare a full set of papers for all Trust staff who will be appearing at such Hearings.* — *

An invitation should be extended to Mr G Carey and Mr V Ryan, Mr K Martin (Chairperson of the Clinical & Social Care Governance Committee)
Another Non-Executive Director ?Mrs J Irwin?
Dr Campbell (CMO) or her Representative
Mrs M Kelly (Chief Nurse, WHSSB) or her Representative
Ms M Reilly (Chief Officer, WHSSC)
Mr H Mills (Chief Executive & Chair of the Review Meeting)

Consideration will also need to be given as to how feedback on our Review and other relevant issues are related to the General Practitioner family.

The purpose of the Review should be to reflect on the issues surrounding the care of the Late Lucy Crawford. Identify the learning points and develop an Action Plan, which would include the dissemination of relevant information to relevant groups and organisations.

Eugene Fee
DIRECTOR OF ACUTE HOSPITAL SERVICES

23/2/04

? not directly involved.

? Anne O Brien may be able to facilitate reg. Bds. to QA, provide confidence - process.

How we convey this publically