[redacted]

From: [redacted]
Sent: 29 July 2004 15:21
To: McConnell Bill; Hatrick Jayne; Gormley Michael; Gallagher Eugene; Burke Dominic;
Cc: Bonner Brendan; [redacted]
Subject: Jenny McGonigle; Curry Evelyn; Harkin Patricia; Love Anne
ROOT CAUSE ANALYSIS - SPERRIN LAKELAND TRUST

Please find attached, for your information, the amended Terms of Reference relating to the Root Cause Analysis in Sperrin Lakeland Trust together with a copy of the notes of the first meeting.

Margaret

Amended TOR 22 7 04.doc

Notes - 1st meeting 30 6 04....

Draft Only

HEALTH AND SOCIAL CARE TRUST

MINUTES OF ROOT CAUSE ANALYSIS STEERING GROUP MEETING
Held on 30th June 2004, at the Ramada Hotel Belfast at 2.30pm

Present:

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

In attendance:

Rebecca McLean, (Group Administrator) Trust CSCG Project Officer,

1. Confirmation of Membership

Brief introductions were provided by two of the members – Howard Arthur and Sue Norwood, who had travelled from England and had first hand experience in RCA and would be facilitating the process on behalf the steering group. They provided the other group members with a background of their roles and work involvements.

It was acknowledged that Margaret Reilly form the Western Health and Social Council (WHSSC) had been invited to be a member of the steering group by the Trust Chairman, Harry Mullan. The WHSSC acknowledged that while they wished to contribute to the process they did not wish to be a member of the group. They did however reserve the option to alter this opinion and would welcome the opportunity to study the terms of reference when they were completed.

b. Other Discussions

Focus of RCA: A lengthy discussion regarding the commissioning of the root cause analysis took place. It was agreed that the death of Lucy Crawford (L.C.) was the main influence for the Trust to commission the RCA. It was stressed that media pressures should not bind the RCA and the analysis should examine the wide range of systems and processes that had influenced the L.C Case, both before and following the incident. Sue and Howard explained that an aspect of the analysis would involve using a range of case studies, some of which may be from the aviation industry. It was clarified that the skills learned from these other case studies would be used to learn specifically from the L.C. Case. It was however concluded that the L.C. case would remain the main focus/case study of the analysis.

The Human Factor - It was agreed that the RCA should take into account the family's experience in addition to the viewpoints of staff/professional involved. Involvement of the family in the analysis would be very much welcomed, however it was recognised that this may be difficult for them, and ways of facilitating this were discussed.

General Aspects of the RCA – Points raised regarding aspects of the RCA included:

- Time and cost implications
- Training for staff that would be used to assist in mapping and the development of an action plan.
- Support for staff – It was acknowledged that some members of staff might require professional support, e.g. counselling as the RCA may raise personal issues. Occupational health should be made aware of this probability.

2. Agreeing the Terms of Reference

It was agreed that the draft terms of reference required significant changes and the family and staff involved in the case should be kept fully aware of these. The group had reservations that the initial draft terms of reference had already been shared with the family prior to being approved, however recognised that the Trust desired the process to be as open and transparent as possible. The steering group agreed that they would wish to oversee any correspondence to the family with reference to the process and to be involved with any press releases relating to the analysis.

Action: *Steering group to oversee correspondence to the family and become involved with press releases relating to the analysis.*

Suggestions were made to amend the terms of reference and these would the recorded and altered by Rebecca McLean, acting administrator for the group with the assistance of Jayne Fox.

Action: *Rebecca McLean and Jayne Fox to liaise and amend the terms of reference and forward to all group members for comments before being presented to the Trust Chief Executive and Chairman for consideration.*

After deciding on the amendments required for the terms of reference it was suggested that clarification was required from the Trust to ensure that any recommendations from the RCA would be fully implemented.

Action: *Meeting to be arranged before the next steering group meeting between Dr Cody, Jenny Irvine, Jayne Fox and the Trust Chairman, Mr Harry Mullan and Chief Executive, Mr Hugh Mills to confirm Trust commitment to RCA.*

3. Review of the Confidential Briefing Note

This item was noted but not discussed.

4. RCA Work Plan

Sue and Howard identified several areas for future action, e.g. letter to be sent to family to advise of work of group and staff/professionals involved to be briefed. However these future actions would be clarified at the next steering group meeting, when Sue and Howard would present the project plan.

Date of Next Meeting – Agreed to take place on 2nd and 3rd August at an Erne Hospital venue. (Venue to be finalised by Rebecca McLean)

The meeting closed at 4.50pm.

ROOT CAUSE ANALYSIS STEERING GROUP
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. 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 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 will fully examine the Trust's processes and systems.
- The Steering Group will develop an approach to encourage the co-operation, involvement and participation of all parties which will include the Crawford family.

- Continuously reviewed by the Steering Group, to ensure that any early lessons are shared for action with 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. Inform the DHSSPS and other appropriate organisations of any relevant/pertinent lessons for wider dissemination.

Role of Analysis

The root cause analysis will begin with a comprehensive examination of Lucy Crawford's care and associated systems and practice of the Trust reflecting on learning to date, which will include details of:

- complaints handling process
- litigation process (including preparation for Inquest)
- communication processes and
- related cpd/cme (Continuous Professional Development) processes regarding updating of professional standards.

Findings from the root cause analysis will be informed by changes already implemented and 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. The role of the Clinical & Social Care Governance Committee will be to endorse and oversee the implementation of the recommendations. The Chief Executive will provide regular reports to DHSSPS and WHSSB on the implementation of the recommendations.

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
- **Diana Cody**, Trust Medical Director (Acting)

- **Margaret Kelly**, Chief Nurse Western Health & Social Services Board
- **Sue Norwood**, Training and Development Manager Global Air Training
- **Howard Arthur**, Director of Patient Safety, NHS Modernisation Unit (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.