

SENIOR MANAGEMENT TEAM

Date: Tuesday, 31st August 2004
Time: 9.15am
Venue: Seminar Room, WHSSB HQ

AGENDA

- 1. [REDACTED]
- 2. [REDACTED]
- 3. [REDACTED]
- 4. [REDACTED]
- 4.1 [REDACTED]
- 5. Items for Discussion
 - 5.1 [REDACTED]
 - 5.2 [REDACTED]
 - 5.3 [REDACTED]
 - 5.4 [REDACTED]
 - 5.5 Root Cause Analysis – Margaret to update SMT
 - 5.6 [REDACTED]
 - 5.7 [REDACTED]
- 6. [REDACTED]
- 6.1 [REDACTED]
- 7. [REDACTED]

Enc

Refer

SCTs.

① John Townsend's letter

~~1~~ - Reply ASAP.

- use next couple of weeks to
he up loose ends.

② Staff consultation / review

→ Diff to SM7 → need context

→ Be as specific as possible

→ think about quieting etc

WESTERN HEALTH AND SOCIAL SERVICES BOARD

**NOTES OF SENIOR MANAGEMENT TEAM MEETING, HELD ON TUESDAY, 31st AUGUST 2004
AT 9.15AM IN THE SEMINAR ROOM, BOARD HEADQUARTERS**

Present: S Lindsay, E Gallagher, D Burke, B McConnell, M Gormley, M Kelly, H Doherty
Apologies: [REDACTED]

ISSUE	CORE POINTS FROM THE DISCUSSION	ACTION
1. (i) [REDACTED]	[REDACTED]	[REDACTED]
(ii) [REDACTED]	[REDACTED]	[REDACTED]
(iii) [REDACTED]	[REDACTED]	[REDACTED]
(iv) Sperrin Lakeland Clinical Review	Helena to clarify with Andrew Hamilton's Office if a copy of the Terms of Reference for the Risk Assessment (Draft 3) had been received for comment.	H Doherty [REDACTED] APP [REDACTED] have been [REDACTED]
(v) [REDACTED]	[REDACTED]	[REDACTED]
(vi) [REDACTED]	[REDACTED]	[REDACTED]

ISSUE	CORE POINTS FROM THE DISCUSSION	ACTION
5. Root Cause Analysis	<ul style="list-style-type: none"> • [REDACTED] • Copies of the draft Terms of Reference for the Root Cause Analysis Development Programme (Sperrin Lakeland) had been circulated by Margaret in advance of the meeting for views. • A lengthy discussion took place regarding the Terms of Reference and SMT articulated its concerns particularly around the need for the Trust to disentangle a number of issues. • The following points were noted:- <ul style="list-style-type: none"> - A Case Management Review needs to be carried out into the L. C. Case for Trust staff, using anonymised case studies. - Out of which the learning should be applied to a Root Cause Analysis into the L. C. case, involving those staff who were involved in the case - It may be necessary to seek legal advice on applying the learning - Action Plan must be developed to support the staff involved • Issues to be mindful of:- <ul style="list-style-type: none"> - Need to be sensitive to the family - Coroner has not made public his findings – there could be implications for the Coroners report - There could also be implications for staff involved in the L. C. case - Legal implications for the family / expectations of the family • Margaret to speak with Jenny Irvine, Chair of the Steering Group and develop our comments into a letter to the Trust 	M Kelly