DRAFT

ASC 28/6/04

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 have been referred by the Coroner to 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 require further 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 environment with confidentiality applied to appropriate aspects.

### Methodology:

This exercise will be:

- overseen by a Steering group established by the Trust Chairman which through its membership aims to promote an open examination of the Trust's processes and systems.
- 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.
- 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 the management of the Lucy Crawford case and associated systems. It will be steered by those directly involved and, reflecting on learning to date, will also include details of:

- complaints handling process
- litigation process (including preparation for Inquest)
- media/public relations processes and
- related 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. Their role will be to endorse and oversee the implementation of the recommendations and to provide regular reports to DHSSPS and WHSSB on the implementation of the recommendations.

The Crawford family will also be provided with the opportunity to view and comment on findings and recommendations to allow their perspective to be taken into consideration.

## Membership of Steering Group:

The following members have been identified:-

- **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 6 months from the Steering Group's initial meeting with a view to ongoing structured implementation.