[redacted]

Re Confidential

From: O'Donnell, Bridget [Bridget.O'Donnell[redacted]
Sent: 24 June 2004 11:49
To: [redacted]
Subject: Root Cause Analysis


1stmtgmemo.doc


Briefing Note.doc


Trng Prg.doc


Ag30Jun.doc

Hi [redacted]

Please find attached information in relation to the root cause analysis meeting, Sperrin Lakeland to be held on 30th June.

I would appreciate that all of this inforamtion remains confidential.

Please confirm that you have received this e-mail.

Also for futurre contact the e-mail address for Anne O'Brien is Anne.O'Brien[redacted]

If you ahve any further queries, please feel free to contact me.

Many Thanks

Kind regards

Bridget O'Donnell
Business Assistant
NI Clinical & Social Care
Governance Support Team

Tel:
Fax:

[redacted]

SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST

ROOT CAUSE ANALYSIS EXERCISE: L.C. CASE STEERING GROUP MEETING

To take place on Wednesday 30th June, Syndicate Room, Ramada Hotel, Shaws Bridge, Belfast, at 2.30pm

AGENDA

1. Confirmation of Membership

2. Agreeing terms of reference

3. Review of Confidential Briefing Note (encl)

4. Root Cause Analysis (R.C.A) Work Plan
   - Key Groups/Individuals
   - Timescales
   - Process
   - Reporting arrangements

Ag30Jun/RCAEx

SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST
Trust Headquarters, Strathdene House, Tyrone & Fermanagh Hospital,
Omagh, Co Tyrone BT79 0NS
Tel: [redacted] or Ext. [redacted] Fax: [redacted]
e-mail: rmclean[redacted]

CONFIDENTIAL MEMORANDUM

TO: Mrs Jennifer Irvine, Non-Executive Director (Chair)
Dr Diana Cody (A) Medical Director
Mrs Margaret Kelly, Chief Nurse, WHSSB
Ms Jayne Fox, CSCG Support Team (on behalf on Ann O'Brien)
Mr Howard Arthur, Director of Patient Safety & Team Resource Management, CSCG Support Team, (G.B).
Ms Sue Norwood, Training & Development Manager Global Air Training

FROM: Rebecca McLean, CSCG Project Officer

DATE: 22nd June 2004

SUBJECT: **RCA EXERCISE: L.C CASE STEERING GROUP MEETING – 30th JUNE 2004**

Find enclosed agenda and related papers for the meeting, which is to take place in the Ramada Hotel, Shaws Bridge, Belfast at 2.30pm. These include:

- Terms of Reference
- Confidential Briefing Note
- Safer Systems & Processes – Root Cause Analysis using a Human Factors Approach – A Training Programme Developed from Lessons Learned in Commercial Aviation.

Rebecca McLean

Rebecca McLean
Clinical & Social Care Governance Project Officer
Encs.

SPERRIN LAKELAND
HEALTH AND SOCIAL CARE TRUST

ROOT CAUSE ANALYSIS EXERCISE: L.C. CASE STEERING GROUP MEETING

To take place on Wednesday 30th June, Syndicate Room, Ramada Hotel, Shaws Bridge, Belfast, at 2.30pm

AGENDA

1. Confirmation of Membership

2. Agreeing terms of reference

3. Review of Confidential Briefing Note (encl)

4. Root Cause Analysis (R.C.A) Work Plan
   - Key Groups/Individuals
   - Timescales
   - Process
   - Reporting arrangements

Ag30Jun/RCAEx

DRAFT 5

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 are currently subject to consideration by the GMC, after referral by the Coroner. 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.

This proposed Root Cause Analysis (RCA) exercise is being commissioned for this purpose.

Principles:

This exercise will be:

- overseen by a Steering group established by the Trust Chairman (membership set out below)
- undertaken in a manner to provide independent analysis
- focused on the Trust's process and systems, as per the agreed scope set out below
- used to inform regional authorities, as appropriate, of any relevant/pertinent lessons for wider dissemination
- undertaken in a way to ensure early transference of lessons emerging from the analysis rather than await final report production.

Scope:
The root cause analysis will examine:

- adverse incident investigation process
- complaints handling process
- litigation process (including preparation for Inquest)
- media/public relations processes and
- related cpd/cme processes regarding updating of professional standards

- Key staff involved in the processes set out above will be invited to participate and contribute to the RCA exercise
- Currently the Trust is approaching the family to assess their preparedness to engage with this process
- Findings for the RCA will be presented to the Steering group along with any recommended remedial actions.
- A final report will be provided to the Trust Chair and Chief Executive and the CSCG committee for adoption.

Membership of Steering Group:
The group will be chaired by a Non Executive Director of the Trust. The following additional members have been identified to secure independent views, a consumer perspective and professional overview:

- Trust Medical Director
- Chief Nurse, WHSSB
- Chief Officer, WHSSC
- Representative of the CSCG Support team

Process & Resources:

- External expertise on RCA methodology will be sourced via the NI CSCG support team. The Trust will meet costs in this respect.
- Guidance and support will be provided by the CSCG support team representative – costs for this will be met by the Director of the NI CSCG support team.
- Limited administrative support will be provided by the Corporate Affairs directorate through the CSCG Project Officer.
- A workplan will be agreed with the RCA Consultant(s) at an early stage. This will include:
  - Core groups for engagement/participation
  - Timescales/key timelines
  - Reporting arrangements

Timescales:

- The exercise should be completed within 4-6 months of initiation.

SPERRIN LAKELAND

HEALTH AND SOCIAL CARE TRUST

LATE LUCY CRAWFORD CASE

Confidential Briefing Note

Case Background:

Lucy was referred for admission to the Children's Ward, Erne Hospital by the on-call General Practitioner, Dr Kirby, with a history of fever, vomiting and drowsiness on 12 April 2000 at 7.30pm.

She was commenced on IV Fluids at approximately 11.00pm. Dr O'Donohoe carried out the introduction of the IV as the junior medical officer had been unable to do so. Lucy was moved to a side ward later, following a bout of diarrhoea. At about 2.55am on 13 April 2000 Lucy's mother alerted staff to her observations that Lucy appeared to be having a fit.

Medical staff, at the Erne Hospital, were involved in an attempt to stabilise Lucy. She was transferred to the ICU/HDU at the Erne Hospital while transfer was arranged to the Paediatric Intensive Unit at Royal Belfast Hospital for Sick Children. Lucy's transfer was managed by a Consultant Paediatrician and an ICU Nurse from the Erne Hospital. Lucy left the Erne Hospital at around 6.30am, arriving at Belfast after 8.00am on 13 April 2000.

Following a period of care, at the Royal Hospital, Lucy was extubated at 1.00pm on 14 April 2000 and died at around 1.15pm on the same day.

Adverse Incident Review:

Following Lucy's death, Dr O'Donohoe, Consultant Paediatrician, advised Dr Kelly, Medical Director, Sperrin Lakeland Trust. Dr Kelly advised Mr Mills, Chief Executive and Mr Fee, Director of Acute Hospital Services, requesting that Mr Fee establish a review of Lucy's care at the Erne Hospital. - In 2000 the practice of adverse incident review was relatively uncommon with N.I. This represented an evolving practice being led within the Trust, by the Medical Director under the Clinical & Social Care Governance arrangements. - Later the same day, 14 April 2000, Mr Fee agreed to jointly co-ordinate a review with Dr Anderson, Clinical Director of Women & Children's Services. The review included; a case note review; review of written comment from staff involved in Lucy's care; discussions with other relevant staff; an independent external opinion on specific clinical matters from Dr M Quinn, Consultant Paediatrician, Altnagelvin Trust. The Trust concluded that there had been communication difficulties and there was poor record keeping.

A report on this review was finalised on 31 July 2000. A range of actions were developed including a plan to meet with the Crawford family to share the outcome of the review. This had not yet happened at the point at which the family invoked the complaints procedure.

Dr O'Donohoe had also met with the family, at their request, during May 2000.

Complaints Process:
Contact was initiated via WHSSC in September 2000. In the period from September 2000 – March 2001 eight letters were issued by the Trust in correspondence with the family and the Council.

In these correspondence the Trust continued to encourage the family to participate in a meeting with Trust staff so that the findings of the internal review, based on the information available, at that time, could be shared. These offers were not availed of.

On 10 January 2001, Mr MacCrossan wrote to Mrs Crawford, on behalf of Mr Mills, Chief Executive, enclosing a summary report, prepared by Mr Fee, Director of Acute Hospital Services in relation to Lucy's care. This concluded by encouraging the family to participate in a meeting to discuss the facts, as known and contained in the summary.

This was followed up with a further offer of a meeting in the letter from Mr Mills to the Crawford family on 30 March 2001. This was not availed of.

A criticism of the Trust has been the decision not to provide a copy of the external report of the independent consultant. At the time the decision was not to issue the report, but rather seek to meet face to face to discuss its content. This was a genuine attempt to avoid the potential misunderstanding or misreading of its content. A copy of the report has since been sent, via Solicitors, on 30/03/04.

Litigation:
The family instigated legal proceedings on 27/04/01 which concluded in an out of court settlement in December 2003. An aspect of the settlement was an acceptance by the Trust of its liability in the matter. During the course of the legal proceedings the Trust became aware of, and was then formally advised that the Coroner had indicated his intention to reopen Lucy's case for an inquest. (Prior to this the death certificate had been agreed with and signed by the Coroner's office). An important concept to bear in mind is that of the Bolam principle. This involves testing the standard of clinical practice at the time. Research publications in the BMJ in early 2002 highlighted the emerging trend in adverse outcomes for children treated with Solution 18. Additionally the death of Rachel Ferguson in 2001, at Altnagelvin Hospital, and subsequent inquest resulted in guidance being issued by the CMO regarding the cessation of the use of the particular fluids used. This practice has been changed within the Trust in 2001 as a result of the Medical Director recognizing similarities in the outcome of the two cases.

In the course of litigation the Trust received correspondence on behalf of Mrs Crawford via a Consultant at the Erne Hospital and her G.P. The Patient/Client Advocate made contact with the family G.P. to ensure effective support was in place. Based on legal advice the option of mediation, considered at the time, was not taken. Mrs Crawford was written to, advising of this. The letter of 28/03/03 indicated the Trusts wish to meet following conclusion of litigation. A further letter was sent on 30/03/04 reminding Mr & Mrs Crawford of this offer.

At the conclusion of the litigation, the Trust indicated its intention to issue an apology to the Crawford family. Legal advice, based on discussions with the family's legal representatives was not to do so at that time. A letter of apology was issued on 19/04/04 after the conclusion of the inquest.

Coroner's Inquest:

The Coroner's Inquest commenced on Tuesday 17 February and concluded on Thursday 19 February 2004. The Coroner, Mr John Lecky concluded that the cause of death was:

1a) Cerebral Oedema
b) Acute Dilutional Hyponatraemia
c) Excess Dilute Fluid
2) Gastroenteritis

He also stated that he would share all the papers with the Chief Medical Officer and write to her to highlight the need for practice to be reviewed. Furthermore he advised that he would also refer all papers to the General Medical Council. The Trust is co-operating with both the CMO and GMC in consideration of this case.

The Trust plans to reflect on the Coroner's findings to assess what additional lessons can be learned from Lucy's tragic death beyond those identified in the initial review and the introduction of practice changes in line with the Chief Medical Officer's guidance. It also intends to reflect on process and systems issues highlighted.

Media/Public Information:

Careful consideration has been given at all stages to the likelihood of press and public interest in this case. The approach has been to protect confidentiality, as appropriate, not to seek to publically counter the family's assertions, and to seek to inform/reassure public understanding of the issues.

Chief Executive
27th May 2004

bor/lmcd/0735

ROOT CAUSE ANALYSIS STEERING GROUP MEETING

To take place on Wednesday 6th October, in the Conference Room, Cedar Villa, Tyrone & Fermanagh Hospital, Omagh

AGENDA

1. Apologies
2. Minutes from meeting held on 2nd and 3rd August 2004
3. Matters Arising
4. Development Programme Update
5. Any Other Business