

SPERRIN LAKE LAND  
HEALTH AND SOCIAL CARE TRUST  
Trust Headquarters, Strathdene House  
Tyrone & Fermanagh Hospital, Omagh  
Co Tyrone, BT79 0NS

RECEIVED  
- 5 AUG 2004

- 5 AUG 2004

3<sup>rd</sup> August 2004

REF: Root Cause Analysis Development Programme.

Dear Mr Lindsay

The Steering Group has discussed the draft Terms of Reference for the above and an amended version is enclosed for your information.

The Steering Group would appreciate any feedback you feel is appropriate.

Yours sincerely

  
Jenny Irvine

- cc. Mr Hugh Mills, Chief Executive  
Mr Harry Mullan, Chairman  
Mrs Maggie Reilly, Chief Officer, WHSSC  
Mr Steven Lindsay, Chief Executive, WHSSB  
Miss Karen Meehan, Chairwoman, WHSSB  
Dr Henrietta Campbell, Chief Medical Officer, DHSSPSNI  
Miss Judith Hill, Chief Nursing Officer, DHSSPSNI

Product ill defined

Thought was a care management review

Root cause analysis - is a tool.

Family involvement - skewed.

more focused

clarity the outcome

Support mechanisms for staff

what involvement of family

discoverable →

Want

Care management review of C. Crawford  
Case

Timing with Coroner's Report.

Asked to participate in review of C.C

Case but this is a R.C development.

Product - is not clear and deliver on

the

## 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 system issues warrant examination and reflection.

A root cause analysis is proposed and independent expertise is being commissioned to gain understanding of the 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.

*State clearly the questions*

- ◆ Used to 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 an indepth review of the circumstances associated with Lucy Crawford's care, with the view to building upon and sharing lessons learnt.

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 Clinical and Social Care Governance Committee, 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.