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 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 Clinical and Social 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

DHSSPS

- **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.