O'Donnell, Bridget

From: McLean Rebecca [RMcLean[redacted]
Sent: 01 July 2004 10:52
To: Cody Diana; Bridget O'Donnell (E-mail)
Subject: Terms of Reference - RCA

TofR.doc

This message is bound by the disclaimer below.

Dr Cody/Jayne
I have modified the T of R as requested to the best of my knowledge following yesterday's meeting. Please review and advise of any further ammendments. I will draw up the minutes and share the draft with Jenny.
Rebecca McLean
CSCG Project Officer
Tel:[redacted]

DRAFT

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.

A Root Cause Analysis will be carried out on the Lucy Crawford case, which will examine the contributory factors surrounding Lucy's death.

Methodology:

This exercise will be:

- overseen by a Steering group established by the Trust Chairman (membership set out below)
- undertaken in a manner to support an independent analysis
- focused on the Trust's process and systems
- 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.

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

Principles of the Root Cause Analysis:

- Openness
- Honesty
- Supporting environment
- Confidential
- Inclusivity
- Improving practice and care, and highlighting good practice
- Shared learning
- Provide staff with support

Role of Analysis:

The root cause analysis entails a review of when something goes wrong in the Trust and provides the opportunity to learn from this review. The Trust's culture is patient safety with no intention to cause harm.

Findings from the root cause analysis will build on changes already made following Lucy's tragic death. These will be presented to the steering group along with any recommended actions. These will be shared with the Trust Chairman, Chief Executive and Clinical & Social Care Governance Committee who will oversee the implementation of the recommendations. Lucy's family will also be provided with the opportunity to view and comment on the findings.

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
- **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 should be completed within 4-6 months from the steering group's initial meeting.