Place on file (LC case).

Developing Media Strategy

Issues for discussion/agreement

1. Corporate position : agreeing form of words which portray SLTs position/attitude
   - aims and principles
   - what is it we're seeking to achieve.

2. Engagement : policy position
   - who will we speak with/respond to
   - will we be proactive – how
   - who will lead
   - what are the mechanics of how

3. Specific view on UTV request
   - do we agree
   - who do we front

4. Key Messages
   - shorter and longer term.

Discussion Notes

1. Seek to demonstrate openness and accountability
   Seek to show empathy and understanding
   Seek to show support to staff
   Seek to demonstrate willingness to reflect and learn
   Seek to instil public confidence in services.

2. ? local press? Impartial reporter? Regional media?

3. "damned if we do, damned if we don't"
   - what do we achieve if we do?
   - How will it be played out/represented if we decline?

4. Some thoughts:
   - We know now and acknowledge that the treatment little LC received in our care led to her death – we are on the record in that regard.
   - The death of a child is a rare occurrence – we are determined to learn and apply any lessons to practice and systems.
   - We acknowledge, with the benefit of hindsight that aspects of how we handled our initial investigation and subsequent complaints could

have been better and despite our efforts we were insufficiently sensitive to the Crawfords family's needs.

- Important to recall this event was 4½ years ago – practice and service provision is constantly changing and updated.

What is Different now?

- Improvements in fluid managed introduced in Trust in 2001, reinforced followed CMO guidance in 2002.
- Introduced changes to complaints handling with advocate providing more personal contact, face to face discussions.
- Further development of our arrangements for adverse incident reporting in 2002.
- Establishment of Trust quality CSCG committee in 2001 in advance of NI Quality legislation in 2003.
- Introduction of Consultant appraisal in 2002
- Further enhancements to adverse incident reporting in 2004 and linkage to DHSSPS being formalised.
- Also secured significant investments in services – specific points re Paediatrics.

Action By Trust

What did we do and what are we doing now?

- initial external opinion
- advised whssb
- Coroner's office determined no PM required
- Sought to engage family on 8 separate occasions

View on Resignations/sackings?

Our philosophy has always been one based on openness – being able to identify adverse incidents when they occur, enabling our professional staff to identify omissions/errors in order that we can change/modify practice etc. If we seek to 'blame' individuals we will only serve to undermine the openness we are endeavouring to cultivate.

- Independent RCA exercise.

Director of Corporate Affairs
September 2004

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