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Our ref: *LS 3*
Date: *30 April 2004*

Dr H Campbell
Chief Medical Officer
DHSSPS
Castlebuildings
Stormont Estate
BELFAST
BT4 3SQ

Dear Dr Campbell

Thank you for your letter of 01 April 2004. I apologise for the delay in responding.

Attached you will find the information, compiled by Jim Kelly on the response of the Trust to concerns relating to Dr Jarlath O'Donohoe's professional and personal conduct 2000-2002. Jim has also provided information on the contribution Jarlath has made to our Paediatric service since this time.

Currently Dr O'Donohoe is on sick leave, however I have received a report from our Occupational Health Consultant recommending his return to work for teaching and non-clinical duties. I am discussing this with Dr Diana Cody, current Medical Director and Eugene Fee.

One of the specific issues for the Trust which we mentioned at our meeting was the Trust's process for selection of other Consultants to provide external opinions for the type of internal review we conducted following Lucy Crawford's death. We feel it would be essential that arrangements are established for the identification of suitable clinicians, some of whom may be from outside N. Ireland. I would welcome your views on whether such panels would be co-ordinated by your office and if this will be part of the Department's guidance on "Adverse Incidents: Notification and Follow up Action".

RESPONSE TO CMO ~ KEY POINTS

In response to concerns raised relating to Dr. O'Donohoe's professional and personal conduct during the period 2000 – 2002 the following actions were taken by the Trust.

- Other key senior professionals (medical and nursing) within the paediatric service were interviewed to ensure children were not being put at risk. In particular the lead paediatrician during this period (Dr. Halahakoon) and the senior sister confirmed that they did not feel Dr. O'Donohoe's practice was unsafe.
- A number of consultant locums supported the two permanent paediatricians during this period. None of these locums expressed concerns relating to the professional competency of Dr. O' Donohoe
- The LC case was reviewed by Dr. Murray Quinn who alongside his report provided the opinion that there was no requirement for precautionary suspension
- Cases giving rise to initial concern, including the LC case, were formally reviewed through the Royal College of Paediatricians at the request of the Trust (Dec 2000) and a report provided to the Trust by the RCP nominee Dr. Moira Stewart RVH in May 2001. The Medical Director met with Dr. Stewart (Jun 2001) to check aspects of the report and to clarify if any deficiencies warranted precautionary suspension or referral to the GMC. The advice was that this action was not required.
- A formal health check through Occupational Health was undertaken to ensure there were no medical issues of concern.
- The Trust sought advice from CSA legal advisors (Nov 2001) on correct steps relating to ongoing risk management of the concerns.
- The WHSSB was advised of the LC case in May 2000 and the report from Dr. Quinn. They were additionally advised in 2001 of the RCP involvement and the subsequent report provided. Detailed discussions took place between the Medical Director and the Dir. Of Public Health Dr. Mc Connell on next steps in managing ongoing concerns.
- The Royal College of Paediatricians was asked in Feb 2002 to provide a more in depth assessment of Dr O'Donohoe's competence and practice because of further concerns raised by a Staff Grade in paediatrics. The college detailed Dr. Stewart (RVH) and Dr. Boon (Royal Berkshire Hospitals) to investigate and provide advice to the Trust. The two paediatricians visited the Trust on the 24th & 25th of June 2002 interviewing a wide variety of staff including a local General Practitioner, reviewing clinical notes and previous incident reports and viewing the clinical environment. After their visit they met with the Chief Executive and the Medical Director to advise a number of proposed actions but advised that GMC referral or suspension was not required.
- The Trust worked with the WHSSB 2002/2003 to increase investment in the paediatric team and successfully recruited three permanent paediatricians during 2003, redefined roles and responsibilities of the paediatricians and increased secretarial support.
- Dr.. O'Donohoe during the period 2003 – 2004 was acting as lead paediatrician for the Trust and demonstrated significant commitment to the change agenda including introduction of new policies and procedures. He was very active in enhancing junior doctor training and led the Trust through a successful RCP training inspection Dec 2003. He has actively participated in appraisal.
- There were no issues of concern relating to professional competence or personal conduct raised since 2002 and all his colleagues are keen to see him return to work as soon as possible. (Dr. O' Donohoe is currently on sick leave)

Dr J Kelly, Medical Director 2000-2003 *21 April 2004*

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.

bor/mmcg/0702