Urology Services Inquiry

Oral Hearing

Day 40 – Tuesday, 25th April 2023

Being heard before: Ms Christine Smith KC (Chair)
Dr Sonia Swart (Panel Member)
Mr Damian Hanbury (Assessor)

Held at: Bradford Court, Belfast

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1 THE INQUIRY COMMENCED AT 10:00 A.M. ON TUESDAY, 25TH
2 APRIL 2023, AS FOLLOWS:
3
4 CHAIR: Good morning, everyone. Ms. McMahon.
5 MS. McMAHON: Chair, if I just give a bit of background 10:01
6 of where the evidence is now moving into, a new module.
7 Chair, we are now moving on from evidence regarding the
8 MHPS process and surrounding events to hear evidence
9 about the governance structures and processes put in
10 place by the Trust or developed by Trust staff in their 10:01
11 attempt to ensure the smooth running of systems of
12 operational and clinical governance. In short form,
13 this evidence seeks to demonstrate Trust governance in
14 action.
15 10:01
16 The Inquiry will appreciate, however, that demarcations
17 around themes and subject matters is not entirely
18 possible, given the commonality of themes running
19 through the entirety of the timeframe falling within
20 your terms of reference. 10:01
21
22 By way of just one example, the Inquiry will have heard
23 evidence from Ronan Carroll which touched upon MHPS and
24 systems around governance, and his knowledge of the
25 issues around non-dictation of clinics, triage, and 10:02
26 notes at home. This overlap is unavoidable but, as far
27 as possible, repetition of evidence will hopefully be
28 kept to a minimum. There is, however, a caveat to that
29 hope in that we must allow all relevant witnesses to

1 comment on their own evidence and the evidence of
2 others, most particularly within three scenarios.
3
4 Firstly, when they have specific knowledge of issues of
5 concern and must explain that knowledge and any 10:02
6 subsequent actions by them or others. Secondly, when
7 they wish to criticise others so that they may explain
8 the basis for their criticism. And, thirdly, when they
9 themselves or the systems they operate are subject to
10 criticisms by others so that they may respond. 10:02
11
12 It may also be the case that other witnesses from
13 within the areas of practice or operations covered in
14 this part of the governance module may require to be
15 called. 10:03
16
17 The position regarding that will be reviewed by you,
18 Chair, once you have heard the evidence from witnesses
19 currently time-tabled as to what further evidence and
20 witnesses you require to hear from so that your terms 10:03
21 of reference can be properly satisfied.
22
23 Within this context, we move into this new module of
24 evidence which will run at this stage up until the end
25 of June this year, in which you will hear from a 10:03
26 variety of Trust staff deployed in a broad range of
27 roles, the evidence from whom will serve to inform the
28 Panel's consideration of defined aspects of their terms
29 of reference. Most specifically, paragraph B of those

1 terms requires the Inquiry to evaluate the corporate
2 and clinical governance procedures arrangements in the
3 context of the circumstances which give rise to the
4 Lookback Review. This includes the communication and
5 escalation of the reporting of issues related to 10:04
6 potential concerns about patient care and safety within
7 and between the Trust, the HSBC, PHA and the Department
8 of Health. It also includes any other areas which
9 directly bear on patient care and safety, and an
10 assessment of the role of the board of the Trust. 10:04
11
12 Within the confines of terms of reference B, the
13 touchstone for what falls within the remit of the
14 Inquiry's consideration is any governance area bearing
15 on patient care and safety. This is reinforced by the 10:04
16 language of terms of reference C.
17
18 Lastly, paragraph F of the terms ask that the inquiry
19 identify any learning points and make appropriate
20 recommendations as to whether the framework for 10:05
21 clinical and social care governance and its application
22 are fit for purpose. To fulfil this term, the Inquiry
23 will need to look at both the governance framework and
24 the way in which it has been applied or could have been
25 applied, question whether that application has been 10:05
26 effective in resolving the issues, and assess the
27 reasons for any identified failures.
28
29 Moving back to the witnesses. The key feature of the

1 witnesses the Panel will hear from in this module is
2 that they all operate, or are accountable for, or
3 exercise governance responsibilities regarding systems
4 which have the capacity to impact directly on patient
5 care and safety, and from which risks may arise should 10:05
6 those systems fail. The Inquiry will hear from
7 witnesses that there existed a disconnect in fully
8 appreciating that systems failings directly impacted on
9 patient care. This manifested as a failure to
10 appreciate that issues which may ostensibly be viewed 10:06
11 as administrative problems or system failings were, in
12 fact, directly or potentially harmful in that they
13 represented an existing or increasing risk to patient
14 care and safety. The Inquiry may wish to consider the
15 effect that view had on both the response to the 10:06
16 problems faced and the urgency or lack of in which
17 matters were addressed.
18
19 The witnesses you will hear from have been called in
20 groupings which are generally arranged, should the 10:06
21 sequencing hold, to move from those operating the
22 systems of governance towards those who carried
23 responsibility for those systems. The thinking behind
24 this is so that the Panel may have a better
25 understanding of how systems and individuals worked, 10:07
26 and how, if at all, problems found their way to those
27 with responsibility and authority to address
28 non-concerns. By presenting the evidence in this way,
29 it is hoped the Panel will be better placed to

1 understand who knew or should have known what, and what
2 was done or could and should have been done in
3 response.
4
5 The following are examples of some of the areas of 10:07
6 practice and procedure illustrating governance systems
7 and practices that the Panel has written evidence in
8 relation to and to which witnesses in the next module
9 will speak. Firstly, on the issue of medical and
10 health records, the Panel will hear how systems of 10:07
11 governance operate around the creation, retention, and
12 general handling of healthcare records. Storage and
13 access to records will also feature, given that patient
14 records were removed from known to unknown locations,
15 and that some of those records were unable to be found 10:08
16 when needed, including for clinical reasons.
17
18 How records are tracked and traced will also be
19 explained, including the gaps in those systems which
20 allow records' locations to be untraceable at times, 10:08
21 and allowing notes to be removed, kept in cars and at
22 home without being properly monitored. It is also
23 hoped that staff who operated, and some of whom still
24 operate, these systems will provide insight and
25 learning from their experience which might inform 10:08
26 inquiry recommendations.
27
28 The Inquiry will also hear evidence of systems of
29 operation recording triage, and how staff responded to

1 problems to try to problems to try to, in their view,
2 keep the process going. The Panel will hear that
3 issues around Mr. O'Brien's noncompletion of triage
4 were longstanding, going back many years, were widely
5 known by Trust staff, and that periods of compliance 10:09
6 with the system were followed by slippage and
7 compliance. This longstanding knowledge led to staff
8 developing their own systems of working to attempt to
9 manage shortfalls in how the triage system operated.
10 10:09
11 These included individuals introducing informal
12 approaches to triage management, as well as more formal
13 attempts by more senior staff to develop workarounds.
14 The appropriateness and effectiveness of both informal
15 and formal approaches to the problems with triage will 10:10
16 be something the Panel will wish to reflect on.
17
18 The way in which data about dictation completed by
19 consultants post patient appointment will also be
20 explored so that the Panel may better understand how 10:10
21 non-dictation might slip under the radar, given both
22 the way in which the material is fed back to the record
23 centre and the weakness in relying on individual
24 secretarial feedback.
25 10:10
26 Regarding secretarial support, the Panel will hear
27 evidence regarding the function and management of
28 secretarial staff, and the inherent vulnerabilities in
29 a system depending on secretarial staff identifying the

1 noncompletion of work or non-adherence to systems of
2 practice by consultants.
3
4 You will also hear from Mr. O'Brien's secretary, who
5 will detail her own systems of work and experience of 10:11
6 working with Mr. O'Brien, including on private
7 patients, triage, dictation of clinics and the handling
8 of patient notes.
9
10 The Inquiry will hear evidence of the cancer tracker 10:11
11 system, its functions and limitations, such as not
12 tracking progress beyond first treatments. You will
13 also hear from the multidisciplinary team coordinator
14 how multidisciplinary team operated; how outcomes were
15 agreed collectively and actioned, and of lacunas in the 10:11
16 system allowing treatments and treatment plans
17 previously agreed at MDTs to be diverted from post
18 meetings without being brought back to the MDT for a
19 collective or consensus view of that divergence.
20 10:12
21 Issues around the quoracy of MDTs and the potential
22 impact on patient care will also be explored will
23 witnesses.
24
25 Chair, you will also hear from nursing staff attached 10:12
26 to Urology Services. The use and benefits of the
27 clinical nurse specialist generally will be explored,
28 as will Mr. O'Brien's reliance or otherwise on these
29 nurse specialists. The Inquiry will also hear evidence

1 of workarounds introduced for Mr. O'Brien's clinic,
2 where it is reported that his clinic "slots were longer
3 and he reviewed less patients per clinic", an
4 arrangement which apparently came about as an
5 arrangement between Mr. O'Brien and Martina Corrigan as 10:12
6 there had been previous issues around clinics
7 overrunning, affecting staff and patients.
8
9 Evidence regarding the benefits of nurse-led services
10 and the impact of that on urology capacity will also be 10:12
11 heard.
12
13 Operational Support Service Lead and medical staffing
14 witnesses will set out the general systems around
15 medical and departmental staff performance and 10:13
16 standards allowing activities, trends, and waiting
17 lists to be better understood.
18
19 The head of Cancer Service will explain both cancer
20 performance indicators and the existence of delays for 10:13
21 patients with a suspected cancer getting access to a
22 first appointment within Urology Services. She also
23 explains in her evidence that patients should have a
24 key worker urology cancer nurse specialist as part of a
25 key performance indicator. 10:13
26
27 The Panel will hear from a consultant radiologist that,
28 in his view, management did not take concerns seriously
29 within the Trust, and often failed to act or did not

1 communicate that they had done so, and that problems
2 with quoracy at MDT was a longstanding concern.
3
4 The Director of Pharmacy also had a governance role,
5 and considered that in relation to a triage issue she 10:14
6 was involved with in 2017 that there was a failure by
7 the medical directors and the Director of Acute
8 Services to engage fully with and address the problems
9 identified at the time.
10 10:14
11 In this module you will also hear from the Director of
12 Performance and Reform, who has provided written
13 evidence to the Inquiry that in her experience in the
14 Southern Trust, the clinical and social care governance
15 arrangements were in a state of flux for a number of 10:14
16 years, and that some challenges may have resulted from
17 frequent changes in the leadership roles supporting the
18 Medical Director at Assistant Director level, including
19 those with responsibility for clinical and social care
20 governance. The Inquiry may wish to consider this 10:15
21 possibility.
22
23 The way in which governance issues were brought to the
24 SMT and the Trust Board, or the lack of a mode for
25 doing so, will also be explored with this witness, and 10:15
26 also with the Acute and Social Care Governance Manager
27 and Head of Governance.
28
29 Specifically in regard to the Trust Board, evidence

1 will be heard from the Board Assurance Manager who
2 states in her evidence that:
3
4 "Overall mistakes were made in that the information
5 provided to Trust Board was not timely and lacked 10:15
6 sufficient detail".
7
8 Of particular interest to the Panel will be the
9 knowledge of senior staff and members of the senior
10 management team who might be reasonably considered to 10:15
11 be in a position to address the governance concerns and
12 patient risks arising. To this end, the Panel will
13 hear from assistant directors and directors with direct
14 knowledge of issues germane to your terms of reference,
15 Chair, and from whom the Inquiry will learn of 10:16
16 responses or failures to respond to the governance
17 issues arising, some existing for many years.
18
19 Finally, the Panel will also hear again in this module
20 from the Head of Service in Urology, Martina Corrigan 10:16
21
22 Permeating the witness statement and evidence will be
23 examples of culture. The Inquiry will wish to consider
24 the impact on the operation of governance that the
25 culture amongst individuals and within an organisation 10:16
26 has. As was stated in the opening to the Inquiry, in
27 this context culture means not only that the correct
28 standards are set and measured but also that practices
29 are questioned, that learning takes place through audit

1 and from error, and that there is a focus on
2 improvement and good clinical and non-clinical
3 leadership. It also means that staff are valued,
4 trained, and that their interactions with each other
5 and with the patients are considered and respected. 10:17
6
7 Chair, you may also consider that a sound culture
8 requires that patients are afforded the opportunities
9 to be partners in their care and to know that they can
10 be heard. These issues will be explored with 10:17
11 appropriate witnesses.
12
13 The Panel will not hear evidence from any witness from
14 the Trust Board before the end of June, from other
15 bodies, such as former HSBC. The Trust Board is, of 10:17
16 course, a fundamental aspect of the governance system
17 and represents the pinnacle of accountability for
18 patient care, safety and risk. This is because the
19 board is required by standing orders to have in place
20 integrated governance structures and arrangements that 10:18
21 will lead to good governance, and ensure that
22 decision-making is informed by robust information
23 covering the full range of corporate, financial,
24 clinical, social care, information, and research
25 governance aspects. 10:18
26
27 The aim is that this will better enable the board to
28 take a holistic view of the organisation and its
29 capacity to meet its legal and statutory obligations as

1 well as clinical, social care, quality, safety, and
2 financial objectives. Given the Board's overarching
3 responsibility, in the interests of sequencing it is
4 perhaps about best to enable the Panel to hear as broad
5 a range of evidence from key players in the governance 10:18
6 oversight and systems and how they operate within the
7 Trust structures before calling board and other
8 ancillary body witnesses.
9
10 Having set out the background of the evidence in 10:19
11 general terms, the specifics of this week are we will
12 hear today from Helen Forde, Head of Health Records.
13 Tomorrow the Inquiry will hear from Esther Gishkori, a
14 spillover witness from the MHPS module and from whom
15 evidence on that aspect will be heard, before finishing 10:19
16 the hearing week on Thursday with evidence from
17 Katherine Robinson.
18
19 Ms. Forde is ready to give her evidence, so if I can
20 ask that she take the oath. Thank you. 10:19
21
22 HELEN FORDE, HAVING BEEN SWORN, WAS EXAMINED BY MS.
23 McMAHON BL AS FOLLOWS:
24
25 1 Q. MS. McMAHON: Mrs. Forde, you have helpfully provided a 10:20
26 Section 21 response. Your role that's relevant most
27 specifically to the Inquiry is Head of Health Records
28 but I will take you to that response. WIT-61168. We
29 will go to number 78 of 2022. Hopefully the signature

1 will be WIT-61205. Do you recognise that as your
2 statement?
3 A. I do.
4 2 Q. You gave that on the 21st of October 2022?
5 A. Yes. 10:21
6 3 Q. You wish to adopt that as your evidence today.
7 A. Yes.
8 4 Q. There was also some additional documents provided on
9 your behalf on Friday?
10 A. Yes. 10:21
11 5 Q. And just for the Panel's note, those documents can be
12 found at TRU-164836 through to 164941.
13
14 In general terms, just to frame your evidence before we
15 get into some of the detail, you were the Head of 10:21
16 Health Records, you have an awareness around the
17 storage of notes and charts and tracking --
18 A. Yes.
19 6 Q. -- and the policies and procedures around that, and the
20 governance system around trying to locate charts and 10:21
21 make sure they are where they should be. You also have
22 some experience of the Datix - it is said differently -
23 fill in IR1's, and issues being escalated?
24 A. Yes.
25 7 Q. You have some knowledge in relation to Mr. O'Brien. 10:22
26 You also provided a statement to MHPS. Just, before
27 going into your employment history, do you know
28 Mr. O'Brien? Do you have knowledge of him outside of
29 your own professional capacity?

1 A. On a personal level, he was my father's consultant.
2 8 Q. Okay. Now, I just want to take you through some
3 aspects of your job description. Rather than take you
4 to each detail, I'll read them out and we'll get a
5 sense of what your role was. 10:22
6
7 Your employment history you've set out in your Section
8 21. You were the Head of Admin Service from 2007 to
9 2009. Then you became the Head of Health Records
10 October 2009, and then you retired in December 2020. 10:22
11 From February 2021 until currently, you work as an
12 admin manager with the Lookback Review Team?
13 A. I finished there on the 25th of October last year,
14 2022.
15 9 Q. So you're not working within the Trust at all? 10:23
16 A. No.
17 10 Q. Your job description, which we can go to, WIT-61168,
18 you set out your role. 4.3:
19
20 "The role of the Head of Health Records was to ensure 10:23
21 the provision of comprehensive, efficient and effective
22 Health Records service, which included responsibility
23 for ward clerks, out-patient receptionists, Emergency
24 Department and Minor Injuries admin staff for the Acute
25 Directorate in the Southern Health and Social Care 10:23
26 Trust".
27
28 That's quite a broad range within the Trust. How many
29 sort of staff would you have had that you were

1 responsible for?
2 A. Approximately 150.
3 11 Q. Would you have had managers beneath you that were
4 responsible for subsections of that?
5 A. I had four Band 5s. 10:24
6 12 Q. We'll go on to look at the way in which you interacted
7 with them shortly but just to give the Panel a sense of
8 the scope of your work. You also say that you have
9 responsibility for:
10 10:24
11 "The storage, issue and retrieval of patient charts.
12 My two health records managers, Pamela Lawson and an
13 Andrea Cunningham, are responsible for the day-to-day
14 management of the service. The role of Health Records
15 is to provide safe and secure storage of charts, ensure 10:24
16 they are available as required, and to manage the life
17 cycle of the chart in line with Good Management, Good
18 Records Framework".
19
20 The reference to the Good Reference Good Management 10:25
21 Framework is a departmental guidance document?
22 A. That's right.
23 13 Q. If I can summarise it by saying that its aim is to
24 ensure that departments from their own systems in
25 place? 10:25
26 A. Yes.
27 14 Q. Systems of good governance around record keeping,
28 record retention and record storage?
29 A. Yes.

1 15 Q. The idea is then that the Department of Health and the
2 Trusts and the divisions within the Trust develop their
3 own systems. We'll go on to look at some of those
4 shortly. But that was the framework that everything
5 fell down from, as far as you are aware, for policy and 10:25
6 procedures?
7 A. Hm-mm.
8 16 Q. Now, you've said in your statement also that from 2009
9 to 2013, you had responsibility for health records
10 service, and referral and booking service. This was 10:25
11 changed to health record service and staff, and
12 Emergency Department or A&E, and Minor Injuries admin
13 staff and ward clerks in 2013 as part of an admin
14 review. Now, do you recall that admin review and why
15 there was a change in the structure of your 10:26
16 responsibility?
17 A. Yes, there was an admin review. I think it was just
18 sort of restructuring and trying to centralise admin.
19 Previously ward clerks had been medical, surgical and
20 gynae. Then, sort of it was really just to centralise 10:26
21 and look at efficiencies.
22 17 Q. In your previous role with the responsibility for
23 referral and booking service, were you involved in
24 issues around triage around that time?
25 A. Yes, I would. Katherine Robinson was the manager of 10:26
26 the booking centre and so I would have been aware of
27 the issues with triage. Then, Katherine dealt with the
28 heads of service with regard to that.
29 18 Q. Just looking at that at the moment, that four-year

1 period, when you say you were aware of issues around
2 triage, can you give us a little bit more detail and
3 background around that?
4 A. We would have had a Tuesday meeting with Dr. Rankin
5 and the heads of service would have been present. We 10:27
6 were very performance driven at that stage. There were
7 the PTLs; we had to have all patients seen within nine
8 weeks and in-patients within 13 weeks. So, it was very
9 heavily monitored to make sure that we did manage to
10 meet all of the deadlines. That all sort of was 10:27
11 governed by the IEAP. One of the areas in IEAP was
12 triage had to be completed within 72 hours. So,
13 Katherine and the referral booking team every week
14 provided statistics which showed how many referral
15 letters there were, what was untriaged, what was 10:28
16 triaged, number of new routines and urgent, and that
17 was presented at the Tuesday clinic or the Tuesday
18 meeting. It was aware there that there was an issue
19 with Mr. O'Brien's triage and that it wasn't being done
20 on time. 10:28
21 19 Q. And from your role of responsibility around that time,
22 do you recall any action being taken at any level to
23 deal with any of the outstanding issues around triage
24 then?
25 A. It would just have been flagged. I can't remember the 10:28
26 detail. I know I had sort of emailed -- there was one
27 incident I had emailed Martina just to say, look, they
28 are still tracing it, the staff are busy, they don't
29 somewhere time to continually chase up the records, and

1 Martina was saying like, you know, Katherine had
2 already flagged this to her and she was dealing with
3 it.
4 20 Q. So, when you say it was flagged, you're speaking about
5 Martina Corrigan you flagged it too? 10:29
6 A. Yep.
7 21 Q. Did you flag it to anyone else, or did she that you
8 were aware of?
9 A. I can't say specifically yes, but she would have
10 been -- I would imagine she would have been talking to 10:29
11 her Assistant Director, and my Assistant Director Anita
12 Carroll would have flagged it as well to then Heather
13 Trouton, the Assistant Director.
14 22 Q. So your understanding was that it was known at that
15 level by assistant directors? 10:29
16 A. Oh, yes.
17 23 Q. And also it was your experience that nothing was
18 effectively done by the time the review came about, and
19 booking and referrals split away from your
20 responsibility? 10:29
21 A. Yeah.
22 24 Q. We spoke just a moment ago about the policies and I
23 want to go through a couple of the policies. You've
24 provided some further policies on Friday through the
25 Trust and we'll just look at some of them. 10:30
26
27 Now, these record movement policies can be found, the
28 first one at TRU-164836. Now, this would have been
29 within your time; it's dated March 2007. I'm not going

1 to take you through all of the policy, you'll be glad
2 to hear and the Panel will be glad to hear, but what
3 this part of your evidence is intended to do is to
4 provide a framework for the Panel's understanding of
5 what was expected to be done so that they can look at 10:30
6 then at what was done. The main areas of interest are
7 the movement of charts both within the hospital, the
8 tracking of charts and the moving of charts outside the
9 hospital or to other Trust locations. I just want to
10 highlight some of the issues or some of the provisions 10:31
11 that the Trust required throughout the years.
12
13 On the first page - just move down slightly - you will
14 see the headline. The title of this is the Policy For
15 the Safeguarding, Movement and Transportation of 10:31
16 Patient, Client, Staff Trust Records, Files and Other
17 Media Between Facilities. You will see the publication
18 date there is August 2006. This is really one policy
19 captures all.
20 10:31
21 The introduction states 1.1:
22
23 "The aim of this policy is to ensure that staff
24 safeguard all confidential information whilst
25 travelling from one facility location to another during 10:32
26 the course of their working day".
27
28 Then we see at 1.4:
29

1 "It is the responsibility of all staff to familiarise
2 themselves with the contents of this policy".
3
4 If I can just stop there and ask you about that issue.
5 Were you aware of these policies being made available 10:32
6 to staff, any staff or medical staff?
7 A. No.
8 25 Q. No. Do you remember if there was any training given to
9 staff around the requirements of these policies?
10 A. Not that I am aware of. 10:32
11 26 Q. Would it be the case that if there was training around
12 records and charts and movement and transport and
13 storage, that it would likely have to come from your
14 department?
15 A. Because that encompasses all of the health, not just 10:32
16 health records but all records, I would have imagined
17 that would have come from information governance.
18 27 Q. And did you ever know them to provide any training on
19 these issues?
20 A. Not that I can remember. 10:33
21 28 Q. Did you ever attend any?
22 A. No.
23 29 Q. Now, you'll see the guiding principles then at 2.1. It
24 states:
25 10:33
26 "Everyone working for or with the HPSS who records,
27 handles, stores, or otherwise comes across information
28 has a personal common law duty of confidence to
29 patients and clients and to his/her employer. This

1 applies equally to those, such as students, or
2 trainees, on temporary placements".
3
4 2.2: "Staff must notify their line managers
5 immediately on suspicious of loss of any confidential 10:33
6 information".
7
8
9 If we go over the page. 2.3.
10 10:33
11 "Managers must ensure staff are aware that disciplinary
12 action may be taken when it is evident that a breach in
13 confidentiality has occurred as a result of a member of
14 staff's neglect in ensuring the safeguarding of
15 confidential information". 10:34
16
17 Were you ever aware during your time in charge of
18 records of anyone being disciplined for breach of
19 confidence, or for the way they have handled or stored
20 charts or records specifically for that purpose? 10:34
21 A. Not disciplinary action. We may have spoken to some of
22 our staff. Like, say you have been going along a
23 corridor and you might have seen a trolley of charts
24 left unattended, so you would have spoken to that
25 individual. But in my area, nothing that led to 10:34
26 disciplinary.
27 30 Q. Now, paragraph 3 deals with the tracking and tracing of
28 records. You'll see that it provides that there must
29 be an effective tracking system in place, and this was

1 in 2007.
2
3 Would it be fair to say in shorthand that the tracking
4 system more or less stayed the same, that it depended
5 on individuals? 10:35
6 A. Yes. The tracking system that we had for health
7 records' charts come from our patient administration
8 system which had been in for several years and was
9 totally reliant on staff input.
10 31 Q. What way does that work? If a chart is to be moved or 10:35
11 is taken away, how does that reveal itself to the
12 system so that you know where it is?
13 A. It has to be individually put into the system. So if
14 the chart was in your office and I took it, I would
15 have to track it then to my office and I would have a 10:35
16 tracking code for my office. Then, when someone would
17 look to find that chart, they could look up the system
18 and they'd see it would be in my office. Now, not all
19 nurses and doctors would have access to PAS, so it
20 would be that they would leave that; they would tell 10:36
21 the ward clerk I am taking this chart, or they would
22 tell -- they should tell the secretary. It would be
23 the same with any member of staff who didn't have
24 access to PAS, they should tell someone "I have taken
25 this chart", and then get it tracked to the appropriate 10:36
26 area.
27 32 Q. Do all staff in all locations have their own
28 identifiable code?
29 A. Yeah. And if, say, you had opened up a new service or

1 you had an office and you were going to have charts,
2 you just had to check with or tell the Health Records
3 manager and they would have given you your own specific
4 tracking code.
5 33 Q. I'm sure for the system to function efficiently, it 10:36
6 must have been the case, for example, secretarial
7 offices had their own code --
8 A. Yes.
9 34 Q. -- but not every location within the Trust had a code.
10 A code was allocated if a chart was anticipated to 10:37
11 travel to that location rather than every office having
12 a code?
13 A. No. If you take, for example, the admin floor where
14 there were several heads of service there, the tracking
15 code would have been the secretary's office. There was 10:37
16 a general secretary's office. If they had been looking
17 for a chart, it was tracked to that office and then
18 sent to that office.
19 35 Q. So, floors also had a tracking code as well, the actual
20 floor as well as the office, just so I can understand 10:37
21 this?
22 A. That was admin floor, and there were several offices
23 there. But say if the Head of Service had been looking
24 for a chart, they wouldn't have phoned themselves, they
25 would have said to the secretary "Would you get that 10:37
26 chart for me, I need it for a complaint", or whatever,
27 and then the secretary would have -- the secretary just
28 on the admin floor would have asked for it.
29

1 So, that's just an example of a general tracking code,
2 so that one tracking code would have done for the admin
3 floor. But if you went up to one of the wards, there
4 would have been a tracking code for the ward, the
5 secretary's office, the consultant's office, maybe the 10:38
6 junior doctor's office.
7 36 Q. So, the system operated either specifically to a
8 location or an individual, or could also identify a
9 general area --
10 A. Yes. 10:38
11 37 Q. -- where the chart was, which it could then be tracked
12 down within that area?
13 A. Yes.
14 38 Q. Is that a fair representation of it? Was that system
15 in place when you took up post? 10:38
16 A. Yes.
17 39 Q. You'll see, if we move slightly down, just on the
18 bullet points there, the third from the bottom, "Files
19 should be returned as soon as possible".
20 10:38
21 Something like that perhaps sounds like commonsense,
22 but was there ever any memo sent out to staff or any
23 directions to staff around returning charts whenever
24 they had finished with them?
25 A. No, because normally you wanted the charts out of your 10:39
26 office as quickly as possible due to storage space. We
27 also had two health records porters who went round all
28 of the offices every day to pick up any charts that
29 were ready to go back to Records.

1 40 Q. Now, the track and tracing provisions in this 2007
2 policy clearly established that there should be a
3 system in place that the record of who removes the
4 files, logged out to the person who remove updated by
5 the borrower if they are passed on. So, if I was a 10:39
6 consultant and passed the file to my secretary, then it
7 is my responsibility or her responsibility, but one of
8 us most ensure that we log it onto the new code --
9 A. Yeah.
10 41 Q. -- before being sent back. There's also provision in 10:40
11 this policy in the next section for movement outside
12 the work base. It is anticipated the charts under this
13 policy charts can be moved outside the work base, and
14 it gives some examples of when that may be the case.
15 For example, a different Trust facility and the SWAH 10:40
16 clinics that the Panel have heard about, that would
17 fall within Trust property but offsite?
18 A. Yes, because SWAH wouldn't be one of our Trust
19 facilities. It is an independent site from the
20 Southern Trust. 10:40
21 42 Q. The movement of records to that would be covered under
22 the policy for clinical need?
23 A. Yes.
24 43 Q. So, if we just move over to TRU-164898. This is the
25 forerunner policy checklist to the 2012 Version 2 10:41
26 policy. You'll see on the front page - just move down
27 slightly - the date policy submitted to the Policy
28 Scrutiny Committee, 14th of January 2008. Members of
29 the Policy Scrutiny Committee in attendance underneath

1 includes your direct line manager Anita Carroll. Just
2 further on down the page, it was presented to the SMT
3 on the 8th of February 2008 and approved by them.
4
5 Now, this policy has a couple of additions. We'll just 10:41
6 go to one example of this at page TRU-164901. Relevant
7 for the purpose of the Panel's considerations, 1.3 is a
8 new paragraph in this policy in 2012, The Removal of
9 Notes and Records. At 1.3 it says:
10 10:42
11 "May also include from time to time the necessity to
12 store confidential information overnight in staff
13 member's own home".
14
15 Was that your understanding that the policy and the 10:43
16 Trust provisions did allow for notes to be stored,
17 dependant on necessity, in an individual's home?
18 A. Yes, but, you know, under exceptional circumstances.
19 It wasn't sort of something that would be done
20 regularly. 10:43
21 44 Q. Just a plain reading of the policy. I know you have
22 said exceptional circumstances, and lawyers dance on
23 the head of pins, but the requirement there is
24 "necessity to store". Would you agree that that would
25 seem to suggest that the possibility for people to keep 10:43
26 notes at home as far as necessary for them to fulfil
27 their duties, at least on the face of that policy,
28 seems to fall within that?
29 A. Yes.

1 45 Q. Were you aware that people were keeping notes at home
2 just generally? Was that something that was on your
3 radar as Head of Health Records?
4 A. The only person that I would have had any knowledge of
5 taking the actual hospital acute record out and having 10:44
6 it at home would have been Mr. O'Brien. There were a
7 couple of occasions where my staff did take them, but
8 that was for an exceptional circumstance in that there
9 was a clinical to be held in Kilkeel. They were the
10 Daisy Hill charts. The person who lived in Kilkeel 10:44
11 that was going to be at the clinic. The weather wasn't
12 good, so they had asked could they take those
13 particular charts for that clinic home that night, keep
14 them overnight and then take them with them to the
15 clinic in Kilkeel the next morning. That was agreed, 10:44
16 we had discussed it. It was put into a tamperproof
17 box, they were to keep it in a secure area in their
18 house, take it straight to the Kilkeel clinic and then
19 bring it home. So, if there had been something like
20 that, I would have been aware of that. Or permission 10:45
21 would have been asked to take the charts home for a
22 specific reason.
23 46 Q. We will come on to look at some of the explanations
24 from others around why notes may have been taken
25 overnight, or taken home, some of which are operational 10:45
26 necessity, like you've described, because of the
27 geographical area that the Trust covers. We'll look at
28 that shortly.
29

1 I just want to make sure that we have 5.5, TRU-164903.
2 This was in the previous policy but I just want to draw
3 the Panel's attention to it. 5.5. This is under
4 Safeguarding of Patient Client Staff Records
5 Transported Between Facilities and Locations. Before 10:46
6 that 5.4, the transport boxes you have referred to "are
7 used by Health Records departments. Each box is
8 securely sealed using the tamper evident seals by
9 Health Records staff and collected from the Health
10 Records Department on a daily basis by Trust transport 10:46
11 staff".
12
13 Then 5.5:
14
15 "Charts must be securely transferred by SHSCT transport 10:46
16 vans or, on occasion, staff personal cars. Charts
17 should never be left in a vehicle on view to the public
18 and must be stored in the locked boot when being
19 transported".
20 10:47
21 Again, none of these are entirely surprising as they
22 allow for the movement of charts. The overarching
23 theme of the policies that we've looked at and the one
24 that we'll go on to look at, which I think predates
25 your time - or post-dates your time - is that records, 10:47
26 people know where they are, that they are correctly
27 coded to their location, that they are kept for the
28 minimum amount of time necessary, that they are
29 returned to their home, or I think you refer to them as

1 libraries?
2 A. Yes.
3 47 Q. And that if they are moved, the policies provide for
4 the safe and secure storage and transport of those
5 records. It would be clear from the policy, I think, 10:47
6 that it is envisaged that some records can be
7 transferred in personal staff cars. The focus is on
8 the way in which they are transferred: Not left in
9 public sight; that they are secure. Also, if they are
10 at an individual's home, that they are secured at that 10:48
11 location.
12
13 Would you agree that they are the overarching
14 principles for handling of records?
15 A. Yes. 10:48
16 48 Q. I just want to again look at the Trust policy. This
17 one is dated the 8th of January 2019 and can be found
18 at WIT-61321. Now, this is version 2.2. Again, it
19 says that they may also include overnight at a staff
20 member's home and that staff are bound by the duty of 10:49
21 confidentiality.
22
23 Did anyone ever mention about professional duties
24 around record keeping for nurses or doctors, the GMC
25 Guidelines, or the NMC? Is that ever something that 10:49
26 you were aware of, that there was another layer of
27 responsibility around records?
28 A. There's the Records Management Procedure and there
29 would be details in that. One of the examples was that

1 if you were to write in the chart, it should be done
2 within a short period after the event, about 24 hours.
3 So, there was a Records Management Procedure as well.
4 49 Q. Also, you've provided us with other policies. The Data
5 Protection Act 1998 policy, which again provides a 10:50
6 framework for data storage and retention and use and
7 destruction, that your policies must adhere to?
8 A. Yes.
9 50 Q. I think in light of that there have been subsequent
10 policies developed by the Trust that seem to reflect 10:50
11 the evolving legal landscape on that. GDPR; phrases
12 you will be very familiar with?
13 A. Yes.
14 51 Q. Now, just for the Panel's note there is a further
15 Records Management Procedure document Version 4, 10:51
16 30th December 2020, WIT-61329. I don't need to take
17 you to it. I think the Panel get the point that the
18 policies reflect the original policy and serve to widen
19 the scope ever so slightly to mention new developments.
20 For example, that 2020 document actually now refers to: 10:51
21
22 "This guidance has been developed as a minimum standard
23 and should be read in conjunction with the Trust
24 records management policy and relevant professional
25 standards from regulatory bodies, for example, Nursing 10:51
26 and Midwifery Council".
27
28 Panel, that reference is WIT-61332. That policy also
29 reflects the increased move towards people keeping

1 their own records at home, for example, Maternity
2 Services, Community Services. That is specifically
3 referenced in that policy at WIT-61340. That's just
4 for the Panel's note.
5 10:52
6 There is, in fact, a March 2023 Records Management
7 Policy which you have provided, but you weren't in the
8 Trust at that time so I can't ask you any questions on
9 a document you're not familiar with. It's on the same
10 terms, you won't be surprised to hear, except it 10:52
11 anticipates the introduction of electronic tracking and
12 tracing, and the hope that that will take away the
13 human element of potential error and tracking.
14 I am going to ask you about that later on because I
15 know that was something that you were particularly 10:53
16 interested in.
17
18 The Trust also has, for the Panel's note, an
19 Information Technology Security Policy dated 1st March
20 2023. You can find that at WIT-61375, for your note. 10:53
21 Again, that sets out what requires to be done in a
22 significant amount of detail. If I can be presumptive
23 to say having read it, the overarching principles that
24 we discussed earlier remain the same throughout?
25 A. Yeah. 10:54
26 52 Q. That's the sort of policies and procedures backdrop
27 relevant to your role. I hope that wasn't too tortuous
28 to take you through that but it is important that the
29 Panel are aware exactly what the Trust expected and

1 how, if at all, that information found its way to the
2 staff so that they would know. Your evidence is that
3 in your experience, you operated the system but you
4 don't know if the requirements were disseminated to the
5 other staff personnel. Would that be right? 10:54
6 A. Yes.
7 53 Q. One of the reasons why I just wanted to take a bit of a
8 run through that was there does seem to be mixed
9 messages, if I can put it that way, from staff as to
10 what they understood the position to be. By way of 10:55
11 example, if I can take you to a comment by Heather
12 Trouton at WIT-12137 at 446. She says:
13 "While there were not clear Trust guidelines forbidding
14 the taking of patient notes home, there were guidelines
15 on how patient notes were to be tracked and managed". 10:55
16
17 Heather Trouton is someone you know?
18 A. Yes.
19 54 Q. Then at 12144 on the same theme. 465.
20 10:55
21 "There were not sufficient legal robust actions in
22 place to address this issue". About removal of notes.
23 "It was reliant on Mr. O'Brien understanding the risks
24 for patient safety associated with no patient notes
25 being available in hospital for emergency admission and 10:56
26 other clinics, and being vigilant in returning patient
27 notes in a timely manner. There was no mechanism put
28 in place to fully ascertain the situation regarding
29 patient notes retained at Mr. O'Brien's home".

1
2 Now, you've included in your documents guidance that I
3 think you provided to Records Management for including
4 in doctors' inductions?
5 A. Yes. 10:56
6 55 Q. To provide them with information on good practice when
7 dealing with a chart. I'll have to come back to that.
8 I'll come back to that. I know where it is; I have
9 written down the wrong note. What that does is provide
10 in shorthand good practice. We'll look at it but it's 10:57
11 not a long document?
12 A. No. We had asked if we could actually take part in the
13 junior doctors' induction, just to go over some of the
14 things with regards to records and dealing with results
15 and discharge letters. Unfortunately, the induction 10:57
16 was too long so instead of having -- taking part in it,
17 we came up with a document and a poster and asked for
18 that to be included and given to all the junior
19 doctors, so at least it would be a mechanism for us to
20 give them information. 10:57
21 56 Q. When was that? When did you ask that?
22 A. I can't remember.
23 57 Q. Hazard a guess. Was it within the last five years?
24 A. I have been away two and a half now.
25 58 Q. You have a think while I now, having helpfully been 10:58
26 given the correct evidence, ask for it to be put up.
27 WIT-61473. The Panel can see the way in which you have
28 provided it. It is very clear document in setting out
29 each heading of when a doctor may have cause to be near

1 any paperwork, if I can put it that way. You cover the
2 discharge letter, then follow-up, test, investigations,
3 changing the discharge letter, and then you go on to
4 patient documentation. I'll just read those paragraphs
5 5 and 6 out. 10:58
6
7 "It is everyone's responsibility to ensure the
8 safekeeping of patient charts. Therefore, if you take
9 a chart out of the trolley, you must put it back where
10 it came from. Please do not leave patient documents 10:59
11 lying around work stations or wards. This poses a risk
12 of information going missing, being misfiled, and can
13 cause serious breaches in patient data
14 confidentiality".
15 10:59
16 Then specifically on patient charts.
17
18 "We have five sites in the Southern Trust and each site
19 at one time had their own chart, so you will be working
20 with charts from those areas. The majority of the 10:59
21 charts are now filed in speciality order but some of
22 the older CAH and BPC charts are filed in chronological
23 order. A filing protocol has been provided on each
24 ward for your reference, and the ward clerk will also
25 help you if you need guidance on where to look in the 10:59
26 chart".
27
28 There is nothing specific about there being codes on
29 that document. Was this because doctors are not

1 allocated codes right away, or because they don't need
2 to know this at this stage, or was it just deemed to be
3 not really needed for an induction sheet?
4 A. Do you mean a tracking code?
5 59 Q. Yes. 11:00
6 A. The doctor wouldn't have been given a tracking code.
7 The chart would have been tracked to the ward so they
8 didn't need to have their own tracking code. Really,
9 we were trying to keep that as concise as possible
10 because sometimes you do have a big long document, 11:00
11 people don't read it.
12 60 Q. Yes.
13 A. So we were hoping to just keep it succinct.
14 61 Q. And was it your own initiative? Were you approached --
15 A. No. 11:00
16 62 Q. You suggested that this training might be helpful?
17 A. Well, it was something my managers and I at one of our
18 meetings talked about and said it would be good if we
19 could take part in the induction, and then right, well,
20 we can't take part, well, let's at least provide some 11:00
21 documentation. So, our team provided it.
22 63 Q. Do you think that's something that might be helpful if
23 the issue around documentation, confidentiality,
24 patient data, was specifically addressed at induction
25 for doctors so that they understood the way systems 11:01
26 operate to allow them to engage with them?
27 A. Yes, I think it would be useful.
28 64 Q. Now, as well as seeking to influence those people that
29 used your systems of operation, you also line-managed

1 quite a few people. I just want to move on to the way
2 in which you met your governance requirements around
3 your staff. Now, you met your managers regularly,
4 you've said in your statement, on a one-to-one?
5 A. Yes. 11:02
6 65 Q. When you say regularly, would that have been weekly or
7 monthly?
8 A. We would have had a regular one-to-one monthly meeting
9 but most days, or two or three times a week, would have
10 telephone conversations. 11:02
11 66 Q. You talked about work plans as well. Are they work
12 plans from your managers that you engage with them in,
13 or is it work plans, your own work plans, you're
14 referring to?
15 A. We would have had like our managers' work plans. So, 11:02
16 we would have sat down and just said, right, what needs
17 done for this year, what do we try to achieve. I was
18 Head of Health Records, I had four managers. We would
19 say what needs done. You might have had one of the
20 girls from ED would do -- well, two would say, right, 11:02
21 we'll go ahead and make the coding consistent for all
22 of the recording on the ED system. Somebody might have
23 went on and done something individually or in groups.
24
25 So, it was really just there's the day-to-day work but 11:03
26 then what actually did we want to achieve on top of the
27 day-to-day work to, you know, as a way of improving our
28 service.
29 67 Q. It might be helpful if we look at some of those. You

1 provided them recently. If we look at TRU-164924.
2 These are Health Records key priorities for 2015.
3 We'll look at 2015, 2016 and 2017 in order to identify
4 the similarity in issues. If we look at number 45. We
5 see numbers on the left-hand side. I think the way 11:03
6 they have been printed out, I think the later date.
7 Here we are, Key Priorities 2015. Let's go down to
8 number 45, please, on that one. This is a familiar
9 document to you, it's a work plan set out.
10 A. Yes. 11:05
11 68 Q. You'll see the left-hand side there is a number 45 and
12 the ward clerk. One of the issues there is:
13
14 "To validate charts tracked to each ward to ensure
15 tracking is up-to-date and complete". 11:05
16
17 And then down to 51.
18
19 "Complete database of location of records".
20 11:05
21 Okay. That's complete; that was obviously rolling
22 issue?
23 A. Yes.
24 69 Q. If we go back up to 2016, which is the first of those
25 pages. There is mention there at 35, "Update risk 11:05
26 register for each area". I'll come on to that but I
27 see it marked down as a specific item in your
28 department. Number 26:
29

1 "Validate charts tracked to each ward to ensure
2 tracking is up-to-date and complete".
3
4 Then in 2017. There we are, number 18, and in this,
5 11:06
6 "Missing lists, complete an up-to-date list of all
7 records which are lost".
8
9 34, and 39, please.
10 11:06
11 "Work on overdue track charts to get them returned to
12 the libraries, and validate charts tracked to each
13 ward".
14
15 So, over the three years it's obviously a fairly 11:07
16 significant part of your work?
17 A. Yes.
18 70 Q. I know the Inquiry has heard evidence around specific
19 charts and tracking in relation to Mr. O'Brien, but
20 from a departmental position would you agree that the 11:07
21 validation and the tracking of charts was something
22 that was ongoing over the years during your tenure?
23 A. Yes. We tried -- we tried to keep our housekeeping
24 up-to-date but unfortunately, due to staffing levels,
25 if anything was to fall, it would be that where the 11:07
26 core business would be to get the chart for the
27 patient. But these things would have been put onto the
28 work plan because you didn't want them to fall off the
29 radar and they could be reviewed and what can we do.

1 And if you couldn't do everything, at least can we try
2 and do a few things every year.
3 71 Q. Was it because of the vulnerabilities of human nature
4 that the chart issue - and we'll see it when you're
5 raising it with your managers later on - just didn't go 11:08
6 away?
7 A. Oh yeah. It was ongoing.
8 72 Q. Right up to 2019?
9 A. Yes.
10 73 Q. By the time you left, the situation would have been -- 11:08
11 was it the same; was it enhanced?
12 A. No, there were always issues with tracking. The
13 system, the patient administration system, it's an old
14 system and there is no flexibility within it and it is
15 very reliant on human input. Before I had left, I put 11:08
16 in a business case for iFIT and that actually is where
17 you have a label with a chip in it and that's attached
18 to a chart and it's all wifi driven. If you are taking
19 the chart from one area to the other, the wifi picks it
20 up and actually updates the code. So, you don't need 11:09
21 that manual input and you would know then when a chart
22 has moved from one location to the other.
23
24 The business case was passed and it was waiting for
25 money and then Covid hit. But iFIT is actually being 11:09
26 implemented very shortly within the Southern Trust,
27 which will be fabulous and will resolve the tracking
28 issues.
29 74 Q. Who will be able to provide us with more up-to-date

1 information on that? Would that be Anita Carroll?
2 A. Yes.
3 75 Q. When did you start asking for a system like that? When
4 did you become aware of iFIT?
5 A. The Royal would be one of the first hospitals to get 11:09
6 it. Then we went to a visit to the Royal just to see
7 that. So, '18, '19, I think. In or around that.
8 76 Q. So, it tracks charts as they move around the hospital
9 passing certain points?
10 A. Yes. 11:10
11 77 Q. If the charts leave the hospital building, it
12 recognises the chart has left the building but not
13 where it's gone?
14 A. So, if it left Craigavon, it would recognise that it
15 had left the Craigavon building. But if the chart was 11:10
16 to be held in South Tyrone, then whenever the charts
17 would go into South Tyrone, it would be picked up
18 there, so we would know it was in a different location.
19 78 Q. So it sounds as if it is almost impossible to get rid
20 of the human element of chart tracking, but iFIT, in 11:10
21 your view, you would certainly fill the gap of what's
22 currently the position?
23 A. Yes. It would be a great improvement.
24 79 Q. Whenever you look at these entries on the work plans -
25 and we'll look at some later on - what was in your 11:11
26 mind? Was it that you knew where the charts were,
27 people just weren't bringing them back? Or was it a
28 mixture of you hoped you knew where they were and
29 people weren't bringing them back, but also there was

1 the potential that they had just gone off the radar?
2 A. That's mostly just good housekeeping. One of the
3 things that we had also done was to get a full list of
4 all of the tracking codes and start to delete them
5 because they were old tracking codes, say for 11:11
6 consultants who had left. All that is just part and
7 parcel of your housekeeping.
8 80 Q. Well, if I could ask you in this context: Whenever
9 issues arose in the subsequent years, and would have
10 been happening during this period of time, 2015-2017, 11:11
11 when it became clear that large volumes of notes were
12 not where they might be expected to be, if I can put it
13 like that, were you surprised at that?
14 A. I was aware that Mr. O'Brien had charts at home.
15 81 Q. That's a slightly different answer, I suppose. What I 11:12
16 am trying to find out from you is how confident you
17 were in the governance systems that you operated with
18 your staff? In other words, were you being told what
19 you needed to know in order to make proper decisions?
20 When I asked were you surprised, the follow-up to that 11:12
21 is, I suppose, would you have been expected to be told
22 that charts weren't available or were not where they
23 should be? If we just deal with the not available but
24 not where they should be, no one is looking for them
25 but they were not where they should be, were you 11:13
26 surprised to know that the numbers where as reported?
27 A. Would you repeat that question again?
28 82 Q. The context of the question is you, as a manager, are
29 line-managed by Anita Carroll. We will look at her way

1 of managing you to see if those governance systems were
2 robust enough for her to know what was going on.
3 Looking from you to your staff, I want to understand if
4 the systems that you operated in managing the staff
5 allowed you to know exactly what was going on. So, 11:13
6 when you subsequently heard that notes were being kept
7 at home, significant numbers of notes, did that come as
8 a surprise to you, and would you have expected your
9 staff to tell you about that, and, if so, how would you
10 expect to know? 11:14
11 A. No. My staff would have told me that there were charts
12 that were in Mr. O'Brien's office. I wouldn't have
13 known the extent of it. To do that, we would have
14 needed to have went through all of the charts in his
15 office, his secretary's office, the whole of the 11:14
16 Urology Department. But no, my staff would have told
17 me that he did have charts at home.
18 83 Q. We'll look at the issues that you have raised in your
19 statement about staffing, how difficult that was, and
20 how that impeded on your ability, in your view, to 11:14
21 carry out your good governance. When you say your
22 staff let you know, if I'm looking at these systems of
23 governance that you have mentioned in your statement,
24 your open door policy, visits of the department, Head
25 of Service monthly meetings, one-to-ones, work plans, 11:14
26 professional development plans; what mode was in place
27 for your staff to tell you this? How did they let you
28 know or did they just tell you?
29 A. They just told me.

1 84 Q. Did you see charts being not available or not where
2 they should have been as a patient risk?
3 A. Yes.
4 85 Q. From the outset, this was something that was in your
5 awareness? 11:15
6 A. It was. With NIECR, it was starting to be implemented
7 then in about July 2013. That did provide an awful lot
8 more information then for consultants and for their --
9 if they were going for an out-patient clinic or for
10 surgery. It did mitigate it to a certain extent. But 11:15
11 it was always that our role was to provide the chart
12 for the attendance.
13 86 Q. Now, if that's a risk that you could see, would you
14 expect that to be reflected on some of the documents
15 that were fed up to you as the Head of Health Records? 11:16
16 Would you expect someone to identify that as a risk?
17 Leave the risk register aside slightly because I know
18 that you had a view of the risk register and we'll look
19 at it in a moment. Just by way of rather than relying
20 on somebody coming into your office or passing you in 11:16
21 the corridor and saying there is a lot of charts
22 missing, would you have expected there to be a system
23 in place where you could verifiably show that to your
24 line manager and say this is the problem, this is the
25 patient risk? 11:16
26 A. Ideally yes, there should have been more formality to
27 it. But that just wasn't how we worked, it would have
28 been we are looking for a chart for this clinic and
29 it's at Mr. O'Brien's house, we've asked him to bring

1 the chart in and he is going to bring it in tomorrow.
2 Informal. In hindsight, probably a more formal system
3 would have been better but that's how we operated.
4 87 Q. Was there any sense that it was dealt with informally
5 because nobody wanted to really take it on? 11:17
6 A. No, that's just how we operated. The records would
7 pull at that stage maybe 19,000, 20,000 charts, just
8 Craigavon alone, in a month. Like, it was a huge
9 amount. It just wasn't -- Mr. O'Brien just wasn't the
10 only person there. There was still huge amounts, and 11:17
11 oh, by the way, there is another chart that was out at
12 his house.
13 88 Q. I am conscious that we are looking back and
14 scrutinising things in a detail that your day-to-day
15 operation of running that department and the number of 11:17
16 staff that you wouldn't have allowed at the time, but
17 the Panel is keen to understand what might have been
18 known, what could have been known, what might have been
19 done. That's the context that I am asking the
20 questions in. I do appreciate that sometimes if the 11:18
21 information is not there, it's simply not there, but if
22 the Panel are to make recommendations, they need to
23 understand how that may be remedied in the future.
24 A. In response to that, yes, I think we operated maybe
25 more informally than we should have but it was given 11:18
26 within the constraints of time that we had to operate.
27 It would have been better, you know, here's a query to
28 be followed up with an email to be addressed formally
29 up the line, but we just... It may sound like an excuse

1 but we didn't have time; it was get the job done as
2 quickly as you could.
3 89 Q. We'll look at some of the emails that you did send
4 around staffing and capacity and inability to do that.
5 I think you mention later on in your statement that you 11:19
6 could have monitored more closely had you had the
7 capacity and had some sort of staff freed up to do
8 that. We'll look at your attempts to try and sort that
9 out.
10 11:19
11 At the moment, you also met your head, your direct line
12 manager, Anita Carroll, you met her one-to-one on a
13 monthly basis?
14 A. Yes.
15 90 Q. There was also a monthly meeting with her and other 11:19
16 Heads of Service. You've said in your statement:
17
18 "Where Datix complaints and risks were discussed as
19 part of the agenda, these discussions were to provide
20 information and learning to the team for cascading 11:19
21 through the service".
22
23 I suppose in light of what we have just talked about
24 when you mentioned risk there in particular, was the
25 issue of patient risk and lack of awareness about the 11:20
26 location of notes something that was ever discussed at
27 those meetings?
28 A. It would have been raised but because of one of Heads
29 of Service was over security and catering, the other

1 was sterile services, Katherine and the secretaries and
2 the booking, we were a very diverse group. Some of my
3 issues might not have really been relevant to them,
4 such as the catering issues wouldn't been relevant to
5 me. It would have been more generic terms that we 11:20
6 would have made discussions about.
7 91 Q. What about on your one-to-ones with Anita Carroll,
8 would that have been the opportunity, I suppose for you
9 and Ms. Carroll to discuss risk? I am conscious that
10 we are framing it in that way now but were those words 11:21
11 actually used? Did anyone say this is a patient risk,
12 there is a risk of harm, this is not just a notes
13 issue? Or was it we need to get these notes, we need
14 to find them, we need to get them in?
15 A. I think our big drive at the time would have been we 11:21
16 need to get the chart.
17 92 Q. You've mentioned in those meetings with the other Heads
18 of Service and Anita Carroll -- and something that's
19 come up with other witnesses and I just want to ask you
20 around that as well, about the learning from Datix and 11:21
21 complaints for learning to the team for cascading
22 through the service, was there a way in which Datix
23 outcomes were fed back to your department as relevant
24 to your department? Did you find out what happened to
25 any Datix that was ever submitted? 11:21
26 A. Well, if they were submitted from my area, I would have
27 been the one to have closed them. There would have
28 been no formal mechanism for other Datix, you know, for
29 a feedback.

1 93 Q. If you closed them, having been satisfied that they
2 were suitable to close, would you then have passed that
3 learning or warning or information on to the relevant
4 staff in your department?
5 A. Oh yeah. That might be again not in a formal way but 11:22
6 it would have been telephone conversation with the
7 manager associated with it.
8 94 Q. I think you have mentioned in your statement as well
9 that complaints generally generated in your department
10 were ward clerks or maybe someone's attitude? 11:22
11 A. They were minimal.
12 95 Q. Minimal, yes.
13 CHAIR: Ms. McMahon, I am just wondering if this is an
14 appropriate time for a short break?
15 MS. McMAHON: It is, yes, thank you. 11:22
16 CHAIR: Back again at 11.40, ladies and gentlemen.
17
18 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:
19
20 CHAIR: Everyone. Ms. McMahon. 11:27
21 MS. McMAHON: Thank you, Chair.
22
23 Ms. Forde, we had mentioned at the beginning that you
24 had taken up post and for a period of time, I think
25 from 2012 to 2013, you would you have been the line 11:41
26 manager for Noleen Elliott?
27 A. No.
28 96 Q. She started in 2012. And were you responsible for
29 secretaries at that point?

1 A. No.
2 97 Q. Were you responsible for them after that at any stage?
3 A. No. I had no responsibility for secretaries.
4 98 Q. Who did that fall to?
5 A. I think probably at that time the OSLs, the Operational 11:42
6 Support Leads.
7 99 Q. So it wouldn't have fallen under Katherine Robinson at
8 all at any point?
9 A. Not until 2013.
10 100 Q. Whenever there was the reshuffle? 11:42
11 A. Yes.
12 101 Q. We had talked about the need for you to receive timely
13 and accurate information about charts and about things
14 that were relevant to your governance duties, and the
15 way in which some of your staff tried to do 11:42
16 workarounds. I just want to take you to an example of
17 someone trying to find charts that were missing. If we
18 go to TRU-164938. This is a one-to-one meeting with
19 Pamela Lawson, 13th December 2018. This is just an
20 example of the sort of topics you would be speaking to 11:43
21 your managers about and the issues they would be
22 bringing to your attention. If we go onto the next
23 page, please. Just the entry there:
24
25 "Missing List Update. Database updated. List of 11:43
26 missing charts to be given to staff for them to look
27 out for when going round wards, offices".
28
29 Would it be fair to characterise that of an informal

1 way of your staff trying to track down charts?
2 A. Yes.
3 102 Q. Would that have been commonplace?
4 A. We had a list of missing charts. Really, if you had
5 all of the staff, what you would have done was said 11:44
6 start at the top of the hospital and work your way
7 through to try and find all of these. We would have
8 had staff going out when they were looking for charts,
9 just in general for clinics or whatever, always
10 remember those names and if you come across them 11:44
11 somewhere where they shouldn't be, at least then we
12 would have found the chart again.
13 103 Q. Bring it home, as it were?
14 A. Or retrack it.
15 104 Q. When you say they are missing, they are coded out to 11:44
16 someone or a location but they are not at that location
17 or with that person?
18 A. That's right.
19 105 Q. This was -- well, I don't want to use the word
20 "widespread", but the fact that Ms. Lawson is bringing 11:44
21 it up on a one-to-one, you don't seem to surprise to
22 see it. Was it a regular occurrence that charts had to
23 either be looked for, or, if they were inadvertently
24 come across, they would be brought back to where they
25 should have been or recoded? 11:45
26 A. It would have been an occurrence because with the
27 volume of charts that we pulled and were responsible
28 for, some did get missing and, you know, you kept
29 looking until you found them. The database that we

1 talk about there are the ones that although we have
2 looked for them, we can't find them. It was really
3 just always keeping a look for in case those particular
4 ones came along. We had an alert system as well for
5 the missing charts, that you had a tracer in where the 11:45
6 chart should have been so if that chart ever got back
7 to Records and was filed, the person filing it found
8 the alert card and were able to pull it out, and then
9 we would have done a bit of investigation just to find
10 out where it would have been or try to find a story as 11:46
11 to how it did get missing.
12 106 Q. What happens if someone comes into the hospital and
13 needs care in ED, Emergency Department, or a clinic,
14 and their chart just simply can't be found. Is there a
15 system for that? 11:46
16 A. We would have a pages and label system. You would have
17 done a thorough search, first of all, to find the
18 chart. Then it would have been reported to the
19 supervisor. The supervisor would have done a thorough
20 search as well. If the chart couldn't be found, then 11:46
21 the Health Records Manager was notified and they would
22 have done a search; maybe two people have searched all
23 of the different areas. So, you really did do a big
24 search before you accepted that the chart was missing.
25 When eventually then you couldn't find it, unable to 11:46
26 provide the consultant with some information, we had
27 the pages and labels system where you were to provide
28 two pages where the consultants would have written on.
29 If it was a review patient, you would have went on to

1 NIECR and pulled out the last few letters of that
2 clinic appointment, and then gave some the patient
3 labels as well. If it was a new patient, you would
4 have had the referral letter and anything that might be
5 relevant to that particular visit. 11:47
6 107 Q. I suppose there are two caveats to that. The first one
7 is if the patient is not on that system --
8 A. Then there is no history.
9 108 Q. -- if they hadn't been reviewed for a long time so they
10 didn't find their way onto that, then there would be no 11:47
11 history, as you say --
12 A. Yes.
13 109 Q. -- that might be available if the charts were
14 available. Secondly, I suppose the difficulty with
15 that is that is that a new chart starting or does that 11:48
16 then, if the charts are found, join the existing chart?
17 A. It would join the existing chart.
18 110 Q. Was there ever an occasion when a doctor wouldn't see a
19 patient because they didn't have charts? Was that not
20 something that you would have known about? 11:48
21 A. There would have been some occasions.
22 111 Q. I think you've sent emails about that. We'll look at
23 that particular one. I think you have given us two
24 examples so we will look at that.
25 11:48
26 The record of missing charts, we can look at an email
27 from you at TRU-164920. You'll see that it's from you
28 to Yvonne Hanna and Anita Carroll on 17th January 2017.
29 You said:

1
2 "I have spoken to Martina today regarding the missing
3 charts from Mr. O'Brien's house. There are 13 missing.
4 Pamela Lawson has searched Mr. O'Brien's office and his
5 secretary's office thoroughly for these charts but they 11:49
6 cannot be found. These charts have no urology episode
7 on the PAS". That is the Patient Administration
8 System?
9 A.
10 "Martina says that Mr. O'Brien used the CAH chart for 11:49
11 his private patients. Anita, Pamela is going to add
12 these to her 13 missing list and we will place alert
13 tracers in the libraries for them, so if they return to
14 Records, we will be alerted to this".
15 11:49
16 At the bottom of that email you have explained what you
17 have just explained to us about the alert tracer card;
18 if the chart is recovered, then the card is removed and
19 you look into what might have happened.
20 11:49
21 Those 13 charts, were you ever told what the outcome
22 was of those?
23 A. No. I chased that up again in a few months' time to
24 see had there been any update but they still hadn't
25 appeared. 11:49
26 112 Q. If these are the same charts that were referred to in
27 the MHPS report, it would seem that there was a
28 satisfactory answer for that of where they might have
29 been; not with Mr. O'Brien. But you have no knowledge

1 of that?
2 A. No.
3 113 Q. But that email is an example of the way in which you
4 communicated with your staff and with your supervisor,
5 your superior -- 11:50
6 A. Yes.
7 114 Q. -- if there was an issue.
8
9 There is also another email at TRU-164919. This is
10 from Siobhán Hanna to you and Anita Carroll and CC 11:50
11 Clare Graham in.
12
13 "Thanks Helen". We might need to move down. Okay,
14 it's on the same date".
15 11:51
16 "Thanks, Helen. It is good to know that Pamela has
17 been involved and a thorough check has been made.
18 Hopefully the remaining 13 case notes will be returned
19 soon. I have copied Clare into this email as it was
20 agreed last week that if any records remained 11:51
21 outstanding, Dr. Wright would meet with Clare to
22 discuss how this would be handled".
23
24 That is Clare Graham. What was her position within the
25 Trust? 11:51
26 A. She was Head of Information Governance.
27 115 Q. Do you know if Dr. Wright met with Clare Graham? Was
28 there any feedback to you about that?
29 A. No feedback.

1 116 Q. I just want to give the Panel some references from
2 other witnesses and their views on the system because
3 obviously it's not your system but the system that you
4 operate. These references and extracts will allow the
5 Panel to understand the way in which others viewed the 11:52
6 system or experienced it.
7
8 First of all, the MHPS investigation made the following
9 comments at TRU-00695, the second paragraph.
10 11:52
11 "I also interviewed the Head of Health Records, Mrs.
12 Helen Forde and the Referral and Booking Centre Manager
13 Mrs Katherine Robinson. I was able to establish that
14 there was no clear system for tracking notes through
15 PAS. Notes may be tracked out on PAS to a staff member 11:52
16 without knowledge of their location. There is no
17 mechanism for Medical Records staff to be able to
18 determine that a bulk of records is tracked out to one
19 individual for long periods of time".
20 11:52
21 I think that's fair comment given the evidence this
22 morning; would you agree with that?
23 A. Well, the fact that it says there is no mechanism, we
24 could have run a tracking code and it would have shown
25 the number of charts tracked out and the time that they 11:53
26 would have been tracked out. That was something I had
27 said in my Section 21 that yes, I didn't run that
28 report, we didn't have the staff to uphold it. I also
29 felt that if I had done it, I would have made my staff

1 do several hours of work but I didn't think there would
2 be any benefit from it or anything would change. So, I
3 would disagree with that last statement. There was a
4 mechanism that you could see the number of charts
5 tracked out to an individual tracking code. 11:53
6 117 Q. Would it be fair to say that there was no mechanism
7 being used?
8 A. Yes.
9 118 Q. But there was one available; would that be a better
10 reflection? 11:53
11 A. Yes.
12 119 Q. We will come on to the staffing and the issue around
13 that.
14
15 Heather Trouton at WIT-12145. Would you have had any 11:54
16 engagement with Heather Trouton in your line of work?
17 Would you have any dealings with her, if I put it that
18 way?
19 A. I would have known her. We would have chatted.
20 120 Q. Did she have any direct responsibility for your area? 11:54
21 A. No.
22 121 Q. 470.
23
24 "Regarding patient notes, this issue was not remedied,
25 I believe this to have been due to a disregard on the 11:54
26 part of Mr. O'Brien for the needs of other clinicians
27 and services who may have needed patient notes. As the
28 remedy necessitated a change of mindset of Mr. O'Brien,
29 the only other option would have been to check

1 Mr. O'Brien on leaving the building each night. This
2 was not practicable, nor should have been required in
3 relation to an experienced clinician".
4
5 That's obviously Mrs. Trouton's view and the Panel can 11:55
6 take their own view. Mr. O'Brien has provided answers
7 to the issue around charts which we will look at, but
8 this is what other people considered to be the issues.
9
10 Anita Carroll at TRU-00779. She told MHPS, paragraph 11:55
11 12 of that page:
12
13 "In terms of notes within PAS and case note tracking,
14 charts are generally tracked out to an address which on
15 the system may have just been Aidan O'Brien. There 11:55
16 would be no way of knowing that notes are not in the
17 office or in the secretary's office. The only time an
18 issue regarding charts might be escalated to me is if a
19 chart is to be pulled for a clinic and it can't be
20 found. Generally, staff would check with the secretary 11:56
21 for the chart if it can't be found. I am aware the
22 secretary may have said Mr. O'Brien had that set of
23 notes at home and he would bring them in. There was no
24 specific issue being flagged to me on a regular basis
25 about charts". 11:56
26
27 Do you agree with that statement by Ms. Carroll?
28 A. Well yes, the charts would have been -- they would have
29 been tracked out to Mr. O'Brien's office and we would

1 have checked with the secretary. If there were any
2 missing, then I would have escalated then to Anita.
3 122 Q. And her last sentence "There was no specific issue
4 being flagged to me on a regular basis about charts".
5 A. Well, I suppose it defines what you talk about regular. 11:56
6 We had the Datix going through, and any time a Datix
7 had went through, I notified Anita just to let her know
8 there is another one through and she would have
9 escalated it on to Martina, Heather, Debbie, Eamonn
10 Mackle. 11:57
11 123 Q. Are you saying Anita Carroll wouldn't have known about
12 the charts issued but for the Datix?
13 A. No, I would have told her.
14 124 Q. Given you met her regularly, and if I can say the
15 longstanding - and please correct me if I'm wrong - the 11:57
16 Trust-wide issue around charts, would that be a fair
17 thing to say, it was not confined necessarily but was a
18 broader issue?
19 A. Well, this issue is really about the charts being at
20 home. That sort of to me is a separate issue then to 11:57
21 charts being mistracked.
22 125 Q. Let's look at what Ms. Carroll did know from your
23 perspective. Did she know that charts were vulnerable
24 to not being where the code said they were?
25 A. Yes. 11:58
26 126 Q. Did she know that some charts couldn't be found?
27 A. Yes.
28 127 Q. Did she know about the system of pages and labels if
29 charts couldn't be found and the patient was at a point

1 of clinical need?
2 A. I'm not sure if she would have been aware of that level
3 of detail.
4 128 Q. Did she know that there is a possibility that patients
5 may not be seen if the charts weren't found? 11:58
6 A. Yes.
7 129 Q. We've seen the reference to charts and tracking charts
8 and databases being made to try and keep on top of the
9 issue; as you call it good housekeeping. We've seen
10 that over the evidence at least 2015, '16, '17 with 11:58
11 your managers. She would have known about that during
12 that period of time?
13 A. Yeah. She would have known that there were tracking
14 issues because we would have escalated up. I'm really
15 just sort of saying look, this is awful, this hasn't 11:59
16 been tracked. I had sent emails then just to the Heads
17 of Service and copied the ADs in.
18 130 Q. Might she have known that charts could have been
19 brought home?
20 A. With Mr. O'Brien, yes. 11:59
21 131 Q. When you say Mr. O'Brien specifically, if we park that
22 issue at the moment. There was a possibility that any
23 consultant could bring a chart home the way the system
24 operated?
25 A. Yes, there was. 11:59
26 132 Q. You can't know what you can't know, I suppose, so it
27 would be unfair of me to ask you if anyone else did
28 bring charts home if you can't ask answer that. Was it
29 ever brought to your attention that anyone else brought

1 charts home?
2 A. No, it was never brought to my attention.
3 133 Q. Do you take that to mean then that they didn't, or no
4 one just knew if they did?
5 A. My impression is that consultants did not bring charts 12:00
6 home.
7 134 Q. Where did you gain that impression?
8 A. I started off in the Trust as an audio typist and was a
9 medical secretary for a few years. During that time,
10 really I didn't see any consultants taking charts home. 12:00
11 They would have had them in their office at work.
12 135 Q. I suppose at its height you could say that your
13 experience, the custom and practice of consultants that
14 you had knowledge of, didn't bring charts home?
15 A. Yes. 12:00
16 136 Q. But also the system that operated in Health Records
17 could have allowed that to happen without you know?
18 A. Yes. Yes.
19 137 Q. Would that be fair?
20 A. Yes. 12:00
21 138 Q. The MHPS found on this issue at TRU-00702. This is the
22 bottom of the page.
23
24 "Senior managers were aware Mr. O'Brien took clinic
25 notes to his home after the SWAH clinics and there were 12:01
26 delays in notes being brought back. However, there is
27 not a robust system in place for determining how many
28 charts are tracked out to one consultant, nor how long
29 the notes were gone for. As such, managers were not

1 aware of the extent of the problem".
2 Is that a fair comment?
3 A. Yes.
4 139 Q. I think you're probably aware at this stage about
5 Mrs. Corrigan going and looking for notes in 12:02
6 Mr. O'Brien's office and trying to track things down.
7 Were you aware of that at the time that that was
8 happening?
9 A. No, just whenever I read it in the work bundle.
10 140 Q. She refers to that in her evidence at WIT-26288. This 12:02
11 was her, Mrs. Corrigan, trying to check about
12 Mr. O'Brien's compliance with the action plan. She
13 said down at the bottom at paragraph (a):
14
15 "The two areas that in my opinion were weak where as 12:02
16 follows: The method I had to use in respect of the
17 storage of patients records issue. This was difficult
18 to monitor as it was dependent on manual checks.
19 Whilst I was doing this, I found no issues. However,
20 if a set of patient notes had been case note tracked to 12:03
21 Mr. O'Brien's borrower's code but they were not in his
22 office, I had no way of knowing where they were as any
23 member of staff could have picked them up from his
24 office and not changed the borrower's code, and this
25 would have led to issues of trying to locate those 12:03
26 notes".
27
28 Again, that seems to be an accurate description of
29 possibilities?

1 A. Yes.
2 141 Q. Mrs. Corrigan would have been aware of issues with
3 charts and notes before this point?
4 A. Yes.
5 142 Q. Yes. Of course, I can ask her when she comes to give 12:03
6 evidence but one reading of that could be taken to mean
7 that she realised the frailties of the system when she
8 had to try and operate it, if I can put it like that?
9 A. Yes.
10 143 Q. But you're confident that she was aware of the 12:03
11 frailties of the system before she was trying to do it
12 herself, as it were?
13 A. Well, yes, because Martina in her previous job had
14 access to PAS and was aware of the system and could use
15 it. 12:04
16 144 Q. Did she ever make any suggestions about possible
17 changes to the system or how it may work differently?
18 A. No, but, to be honest, we were tied in with PAS and it
19 was a very inflexible system. If you did want to make
20 any changes, you would have went back to the software 12:04
21 company, it could have been 50,000 to make a change.
22 So really, iFIT was the best solution when it came
23 along. PAS, it's like our mainframe database for the
24 hospital and the hospital activity, so we wouldn't have
25 moved from that. Anything that would have changed the 12:04
26 case note tracking would have had to have been a new
27 system.
28 145 Q. PAS wasn't initially set up to facilitate the
29 monitoring of notes?

1 A. That's right.
2 146 Q. It was more to get everything online, a centralised
3 system. It didn't assist you greatly in that system,
4 except that information was kept electronically?
5 A. It was a better system than the original one which was 12:05
6 maybe 30-years-old, which was just you put a tracer
7 card in and you took a chart out. So, this was
8 definitely much better. It's like any IT systems, it's
9 the people operating it.
10 147 Q. Just in terms of suggestions for improvement, did Anita 12:05
11 Carroll ever make any suggestions? We are going to go
12 on shortly to see that you have requested staff and
13 help around the number of agency staff you had to use;
14 agency staff not staying. You obviously put a lot of
15 work into your some of your emails about working time 12:06
16 equivalents, what was needed for you to manage your
17 service. I'm sure it may be something that managers
18 hear all the time. Did Ms. Carroll ever come back with
19 any other suggestions if she wasn't able to give you
20 staff or put people into full-time posts? 12:06
21 A. We would have had a good working relationship like that
22 and we could have discussed, and she said maybe I could
23 redeploy somebody for that. It was helpful to be able
24 to just sit and talk through issues with her and get
25 sort of another idea. Sometimes you are sort of 12:06
26 embedded in your own area that it is the person looking
27 in can give those suggestions. But we were financially
28 tied in that. Even if Anita had agreed that I could
29 have three staff, Finance would not have progressed it

1 because if you didn't have the funding in your budget,
2 it didn't get through the scrutiny so it didn't get to
3 Recruitment.
4 148 Q. Just for the Panel's note, Mrs. Corrigan also makes
5 reference to the electronic system, the iFIT that you 12:07
6 are referring to at WIT-26290. We don't need to go to
7 it but I'll just read it out for Ms Ford's note as
8 well. She says:
9
10 "In my opinion I think there was an over-reliance on 12:07
11 one individual who had a demanding operational day job.
12 This should have been more fully considered and
13 appreciated as a risk. While I believe I am a very
14 diligent and hard-working member of staff, the system
15 failed when I went off on extended sick leave revealing 12:07
16 a weakness in the system".
17
18 If we just stop there. The weakness in the system for
19 the charts existed whether Mrs Corrigan was off or not,
20 really? 12:08
21 A. Yeah.
22 149 Q.
23 "The storage of patient notes was always a concern of
24 mine. Whilst in principle the Trust supported the move
25 to an electronic tagging, there was never the funding 12:08
26 made available to implement this so I had to use the
27 workaround of physically visiting Mr. O'Brien's office
28 at 6.30 a.m. on a Friday morning to perform a check,
29 something which also didn't happen when I was off".

1
2 But you had no knowledge that that was actually taking
3 place?
4 A. No.
5 150 Q. If you just bear with me a second. I just want to look 12:08
6 at a couple of emails you've sent to staff, TRU-164912.
7 This is an email from you on the 24th of February 2015
8 to lots of people, including Trudy Reed, Louise Devlin,
9 who is a former Head of Service?
10 A. That would have been to the Heads of Service. 12:09
11 151 Q. All of them, are they including your managers or just
12 the Heads of Service?
13 A. There's...
14 152 Q. I don't see Pamela Lawson. Oh, she is CC-ed in?
15 A. Yes. 12:09
16 153 Q. Tracking of patients charts on PAS.
17
18 "Would you please remind all your staff that it is
19 absolutely crucial that every chart is tracked when
20 moved from one location to another. Recently, due to a 12:09
21 chart not having its tracking codes updated, a
22 patient's operation was cancelled. The chart was later
23 found in a different service and in a different
24 building. The consultants have stated that from now on
25 if the chart is not available, they will not operate on 12:10
26 the patient.
27
28 "If you take a chart, you must track it to the new
29 tracking code. If you don't have access to pass to do

1 this, then you must leave a message for a member of
2 staff from the area that you have taken the chart from
3 giving them details of where the chart is going and
4 asking them to track this for you. This is not just a
5 request to help staff when looking for charts, but this 12:10
6 has a direct impact on the care we are providing to our
7 patients. No chart, no surgery, no appointment. Would
8 you please circulate to all your staff".
9
10 You sign that off. I don't think you could have been 12:10
11 much clearer in that email in setting out the
12 repercussions of -- and you have provided evidence
13 there that someone actually missed an operation, a
14 booked operation, that was cancelled because of that?
15 A. Yeah. 12:10
16 154 Q. Was that the first time that you were aware that an
17 operation was cancelled or was there something about
18 that that triggered this email?
19 A. No, that would have been a specific event where the
20 operation was cancelled. I had explained before there 12:11
21 if there was a chart missing, about the Records member
22 of staff would have looked for it, the supervisor, the
23 manager, they really did do everything that they could
24 to get the chart. For this to happen, you know, they
25 would have taken it very badly. It would not only have 12:11
26 upset them but also they would have wasted so much
27 time. It just had to be spelt out. You know, look,
28 it's not -- sometimes when you talked about tracking a
29 chart, that it was just that's Records having a bit of

1 a moan.
2 155 Q. Is that what you felt?
3 A. Sometimes, yes. It was a bit of a moan, that's them
4 moaning again. So this was, look, it's not just us
5 moaning, this actually happened, a patient was prepared 12:11
6 for their surgery; they came in today and it was
7 cancelled because somebody hadn't tracked the chart
8 properly.
9 156 Q. So, this is the real life consequence for that?
10 A. Yes. 12:12
11 157 Q. If I understand what you are saying correctly, your
12 experience was that at times people were a little lax
13 or a little indifferent to attempts to track charts?
14 A. Yes.
15 158 Q. Was that because it was such a common problem? 12:12
16 A. I just don't think sometimes people saw the importance
17 of it. "Sure I'll take that chart and I'll leave it
18 back", and then you forget to leave it back and then
19 something else happens. Sometimes the admin processes
20 just weren't taken -- weren't followed as well as other 12:12
21 processes might have been.
22 159 Q. Do you think there was - and disagree with me if you do
23 disagree - do you think there was a lack of respect for
24 aspects of your work or the admin process, that people
25 just didn't give it the due diligence it deserved? 12:13
26 A. Yeah. I think it was that it wasn't given the due
27 diligence.
28 160 Q. Do you think there was any impact on the culture
29 towards charts and admin, because there didn't seem to

1 be any sanctions for people who were perhaps a bit - I
2 want to say lackadaisical because I can't think of the
3 word that is not lackadaisical - but who were a little
4 bit casual in their use of charts? There was nothing
5 done if you didn't bring your chart back home or put it 12:13
6 in the library or code it properly, so perhaps a
7 failure to sanction was a bit of an acquiescence?
8 A. Yes, and sometimes I think we could have been a victim
9 of our own success. We would have done KPIs out, and
10 like I've said, Craigavon library alone would have been 12:14
11 pulling 19,000 a month but our percentage rate of
12 charts would have been 99.5% availability. That would
13 have been an average. So, we did get an awful lot of
14 charts but the staff really worked hard to make sure
15 that they did that. Maybe if we just hadn't searched 12:14
16 and searched and searched and that percentage had went
17 down, maybe then people would have taken notice because
18 there could have been more noise in the system.
19 161 Q. And more impact?
20 A. Yes. 12:14
21 162 Q. So your diligence was your downfall in some respects?
22 A. Yes.
23 163 Q. When you talk about staff looking for charts and
24 tracing and tracking, were people specifically employed
25 for that purpose? 12:15
26 A. Yes.
27 164 Q. What were the numbers employed? What sort of part of
28 the budget did that take up, just looking for charts?
29 A. You see, everybody in Health Records had to look for

1 charts. It was divided into sections in that, well,
2 maybe you got the surgical charts, I got the medical
3 charts, someone else got the rheumatology charts. So,
4 those were your clinics and you were responsible for
5 them. You got every chart that was actually in the 12:15
6 library, and then we had the missing list staff. So,
7 if the chart wasn't in the library, two other girls
8 were responsible for going out round the service to
9 look for those charts. So, that one was tracked to
10 Mr. Mackle's office, so you went there. One of the 12:15
11 reasons it was divided like that was to have fewer
12 people going round wards, efficiency, and also
13 infection control that you had a limited number of
14 people had been to the wards. So, we would have had
15 those two people and they were fully employed going out 12:16
16 looking for the charts that were tracked outside of the
17 libraries. Then, when they couldn't find them, that's
18 when they would have came back and you went through the
19 supervisor, the manager, or maybe look, I'll go and
20 have another look. Sometimes a colleague went; 12:16
21 sometimes a fresh pair of eyes could make a difference.
22 165 Q. Did they ever find charts in public places, locker
23 rooms or changing areas or things like that?
24 A. No.
25 166 Q. You have said in that email, "Consultants have stated 12:16
26 that if the chart is not available, they will not
27 operate on the patient". Was that said to you or fed
28 through to you? How do you know that?
29 A. That would have been said through to the manager

1 because if, say, in an event like that, the manager
2 would have spoken to the consultant to explain what was
3 happening, it couldn't be found. So, the consultant
4 would have said that.
5 167 Q. Would that have been general surgical consultants, or 12:17
6 you don't know where that originated from, that
7 statement?
8 A. I don't, no.
9 168 Q. Do you know if it was acted upon? Do you know if the
10 consultants didn't actually operate if they couldn't 12:17
11 get a chart after that?
12 A. We were very successful in getting the charts for
13 certain -- particularly for operations. You know, you
14 really did go to the end. But there would have been
15 occasions where maybe say if you didn't have one, they 12:17
16 would have operated on. I do remember there was a case
17 in Daisy Hill and the chart was pulled for the Daisy
18 Hill theatre but, for some reason, the chart was
19 actually sent to Craigavon for surgery when the patient
20 was in Daisy Hill, but the consultant did operate. 12:18
21 169 Q. The chart was just sent to the wrong location?
22 A. Yeah, yeah.
23 170 Q. I want to look at some emails where you have escalated
24 the issue. If we go to WIT-61511. It should be an
25 email starting the 9th of October. I'm sorry, I've 12:18
26 just remembered I wanted to go to an email just to
27 finish that last set of questions off. That last email
28 we looked at about the warning shot, if I call it that,
29 was in 2015. There is another one at TRU-164915, so

1 the Panel has a note of this. This is the 24th of
2 January 2016. Again, subject notice, "fast tracking of
3 charts" from you to lots of people. Even more people,
4 I think, in this one. There are 41 more added. You've
5 included Anita Carroll, Ronan Carroll and Heather 12:19
6 Trouton and Ann McVey, and nine more?
7 A. It would have been all the Assistant Directors.
8 171 Q. So everybody is in this?
9 A. Yes.
10 172 Q. You have said similar. 12:19
11
12 "Would you please remind all your staff of the
13 importance of tracking a chart when moving from one
14 location to another. If your staff do not have the
15 functionality to track charts on PAS, they must leave 12:19
16 details for one of the admin team who will then update
17 PAS. If a chart is moved without being tracked, then
18 Records, secretarial, ward clerk staff will not be able
19 to find it and this can lead to appointments and
20 admissions being cancelled. I would be grateful if you 12:20
21 could emphasise the importance of this with all staff".
22
23 That is a year later. It is fair to say the issue is
24 not resolved?
25 A. That's right. 12:20
26 173 Q. We will go back to the escalation point WIT-61511.
27 These emails are around the escalation around Mr.
28 O'Brien's charts, and they start on the 9th of October.
29 Barbara Mills; who is Barbara Mills?

1 A. She would be one of the Health Records officers.
2 174 Q. She is writing to Pamela on 9th October 2013.
3
4 "Hi Pamela. This chart tracked to Monica but not there
5 or in his office. Noleen to ask AOB. Any word on this 12:21
6 chart"?
7
8 Barbara replies to Pamela.
9
10 "He brought chart in on Friday and it's now tracked to 12:21
11 his clinic in Armagh for today. I had to go up on
12 Friday to speak to Noleen and then had to speak to
13 Sarah out in Thorndale to finally locate chart".
14
15 Just so I can ask as we pass that. Whenever 12:21
16 Mr. O'Brien, it seems quite clear on this, brought the
17 chart in and it is now tracked to Armagh for that day,
18 is Mr. O'Brien or his secretary responsible for
19 changing the tracking code of that?
20 A. No. That chart, whenever Records would have picked it 12:21
21 up, they would have tracked that chart. Also not just
22 only tracked it, but sent it off to Armagh for the
23 clinic.
24 175 Q. Pamela Lawson to you then, "Another IR1 going in for
25 this one". So at this point there has is clearly been 12:22
26 a development where you're logging Datix, IR1s, for
27 charts that are missing. Was that just in relation to
28 Mr. O'Brien?
29 A. Because these were at home.

1 176 Q. If I can just ask you so I'm clear about the answer and
2 the Panel are clear, what was it about them being at
3 home that raised it to an IR1 as opposed to being
4 somewhere else but not coded in the hospital?
5 A. If it was somewhere else we would have had to search 12:22
6 for it, so we would have taken time but at least we
7 could have got it. If it had been Mr. Mackle's office
8 instead of Mr. Hewitt's office, staff would have done
9 the search and they would have got it. But if it was
10 in Mr. O'Brien's home, they couldn't actually get that 12:23
11 chart because it would be outside the Trust facilities.
12 177 Q. If we're looking at that from a governance angle, was
13 it your view that being at home was a greater risk?
14 A. Yes.
15 178 Q. Than the chart being elsewhere in the hospital -- 12:23
16 A. Yes.
17 179 Q. -- but findable?
18 A. Yes.
19 180 Q. So that was the reason why IR1s started going in about
20 the charts. 12:23
21
22 If we look at WIT-61193. This is your Section 21 about
23 what you would do if you have a concern about an issue
24 relevant to patient care and safety and governance.
25 12:24
26 "I would gather all the information and if it is an
27 issue that would cannot be resolved within my own area,
28 this should be raised with the Head of Service for the
29 specific area while also informing my own assistant

1 director. A Datix would be raised detailing out the
2 issue. Due to the formation of the Datix reporting
3 system, all those with responsibility for the concern
4 would be notified for their input into the
5 investigation of the issue. For example, if the Datix 12:24
6 is coded as a breach of confidentiality, this would
7 trigger Datix to include the information governance
8 team".
9
10 When you say in that paragraph "all those with 12:24
11 responsibility for the concern", does that include on
12 this occasion Mr. O'Brien, that he would be contacted
13 and asked about it specifically?
14 A. No. I think for that, you would have put in the
15 location of the area, which would have been Urology 12:25
16 Clinic, and then that would have triggered on to
17 Martina.
18 181 Q. Is it possible that a Datix could have been raised
19 about a chart or a record because of its suspected
20 location without Mr. O'Brien knowing that anybody had 12:25
21 raised a concern about that?
22 A. Say that again, sorry.
23 182 Q. Well, I'll put it another way. Would you have always
24 been satisfied that Mr. O'Brien personally knew that
25 concerns were being raised about charts or records 12:25
26 under his code, or his office code or his secretary's
27 code, before raising a Datix? Would you have made sure
28 he had an answer?
29 A. Well, we would have asked, first of all --

1 183 Q. Asked, when you say asked --
2 A. -- to see did he have the chart at home and if the
3 answer was yes, then the Datix went in.
4 184 Q. And can the Panel take it when you say asked, spoke to
5 Mr. O'Brien? 12:26
6 A. Yes, either via one of the Health Records staff or
7 through the secretary to say have you got this chart at
8 home, and if it was yes, well then, the IR1 went in
9 because he had said it was at home.
10 185 Q. Was it possible for other people to say the chart was 12:26
11 at his home without him knowing?
12 A. No, he would have been asked.
13 186 Q. Always?
14 A. Yes. It would have been him saying that, because that
15 would have been unfair. 12:26
16 187 Q. You say at WIT-61190, at the very top of that page:
17
18 "It had not been our practice to complete a Datix when
19 the chart was at Mr. O'Brien's home but as the problem
20 continued, we started to complete a Datix each time a 12:27
21 chart was in Mr. O'Brien's house, commencing in May
22 2013 and continuing until we were told not to complete
23 any more Datix by the Director of Acute Services at the
24 time, Debbie Burns".
25 12:27
26 Now, just to take the first part of that extract, there
27 had been a system in place where, if the chart was at
28 home, you tried to get it back?
29 A. Yep.

1 188 Q. You took a pragmatic approach, would that be fair?
2 A. Yes.
3 189 Q. Tried to get chart back. Was there something in and
4 around May 2013 that caused you to abandon that more
5 casual, or informal I'll call it, approach to resolving 12:27
6 the issues and to go to Datix? What was it about that
7 time that made that happen?
8 A. I think just it had been a regular occurrence and there
9 was a frustration about it. So, the staff and the
10 managers would have been, you know, these charts are at 12:28
11 home, we can't get them, it's extra work having to look
12 for them, first of all, then request them, then go back
13 and pick them up. So we would just have chatted and
14 raised it with Anita, and we had agreed that, well,
15 let's just make it more formal, let's put the Datix in 12:28
16 and have a mechanism of recording that.
17 190 Q. There is a sentence there about being told not to do
18 that any more by the Director at the time, Debbie
19 Burns. What is your recollection about how that came
20 about? 12:28
21 A. I was sitting in the office, Debbie was walking past
22 the door and she had said just, "look, don't be putting
23 any more Datix in". She had said that Mr. O'Brien was
24 working with her and she didn't want him annoyed, and
25 just not to be doing it any more. 12:29
26 191 Q. What was her line of management to you at the time?
27 A. Well, I reported to Anita and then Anita reported to
28 Debbie.
29 192 Q. So this is your boss's boss?

1 A. Yes.
2 193 Q. And what was your reaction to that?
3 A. I think it would have been twofold. Like, on one hand
4 you went "for goodness sake, nothing has been done" and
5 then, on the other hand, well, sure what's the point of 12:29
6 filling them in because nothing is being done.
7 194 Q. Did you wonder what she meant by what she said, she
8 didn't want him annoyed? Or that she was working with
9 him, or what that meant?
10 A. I don't know. She just said she was working on him 12:30
11 with something. I don't know if it was something to do
12 with Urology Services or what it was.
13 195 Q. Could it have meant that she was working with him to
14 try and resolve the chart issue?
15 A. No, I didn't take that out of it. I took it that he 12:30
16 was being helpful to her in some other way.
17 196 Q. Were you surprised by her response to that?
18 A. I don't think so. No, it wasn't surprise. It was more
19 just frustration and, you know, nothing is being done.
20 197 Q. And the other Datixes you had put in up until this 12:30
21 point, had there been any outcome from those?
22 A. No.
23 198 Q. Who do they go to? When you were filling those in,
24 what was your expectation of what would happen for
25 those? 12:31
26 A. It was more like a mechanism for recording something.
27 The Datix is put in for a near miss, so it can be trip,
28 slip, fall, a near miss. The near miss was that we
29 nearly missed having a chart for the clinic. It was

1 really just a bit more formality to the whole system of
2 rather than me going in next door to Martina to say,
3 you know, that chart was at home or sending an email.
4 It was just another bit of formality.
5 199 Q. If I'm hearing your answer correctly, you didn't expect 12:31
6 anything to happen by putting a Datix in, it was to log
7 another incident without any expectation that someone
8 would provide any help?
9 A. Well, it was hoped that the formality would maybe step
10 it up a gear and that something would -- things would 12:31
11 improve.
12 200 Q. Had Ms. Burns ever spoken to you before about any
13 aspect of your management role?
14 A. We would have been in contact. She might have been
15 asking for statistics for ED or, say, triage times for 12:32
16 ED. You know, there would have been different things.
17 Like, if Debbie was walking past the door and she
18 wanted some information, she would have asked you.
19 201 Q. And was it her style of management that a decision such
20 as that would be given in that informal manner? 12:32
21 A. Yeah.
22 202 Q. It was?
23 A. Well yes. You know, the Acute is very, very busy.
24 Like I have said before, maybe some things should be
25 more formal but that was just our day-to-day business. 12:32
26 It was walk along, get something done and on you go.
27 There just wasn't the time for sitting down and going
28 through a full process, or I hearby notify you or
29 anything like that. It really was get it done.

1 203 Q. Did you speak to Anita Carroll who was your direct line
2 manager about that instruction?
3 A. Yes.
4 204 Q. Could I call it an instruction from Ms. Burns; would
5 that be fair to characterise that as an instruction? 12:33
6 A. Yes. I took that as an instruction to stop. So I told
7 Anita that we have been told to stop, and then I told
8 Pamela again that we had been told to stop.
9 205 Q. So in the absence of those Datix being submitted, there
10 was no formal record of concerns around charts at home 12:33
11 after that point?
12 A. That's right.
13 206 Q. What was Anita's response whenever you told her what
14 Ms. Burns had instructed you to do?
15 A. I think she felt something like I did. Well, there had 12:33
16 been no outcome from filling them in and all we were
17 doing was giving ourselves another job to do with no
18 outcome.
19 207 Q. When you talk about an outcome, from a lay person's
20 perspective an outcome would suggest that someone had 12:34
21 to do something. Who would that person be who would
22 have to do something as a result of the Datixes you
23 were filling in?
24 A. The issue with the Datix was the fact that the charts
25 were at home and unavailable, so my outcome would have 12:34
26 been get the charts back in. So, it would have been
27 someone with responsibility for the Urology Service to
28 do something and say, right, we need to get the charts
29 back, and to take action in that way.

1 208 Q. I know your answer is very general but I do need an
2 answer as to who would be expected to take action when
3 they are getting Datixes that charts are at home,
4 consultants are saying they won't operate if they don't
5 have the chart, operations have been cancelled, there 12:35
6 is an example of notes not being available in casualty
7 for someone, and you have indicated that a risk existed
8 when charts weren't available, and was increased if
9 those charts were at home. When we look at that in the
10 round, who should have done something with these 12:35
11 Datixes? Who was responsible for taking action?
12 A. Well, from me, I escalated then to Martina and also
13 informed Anita. So, if Martina wasn't in a position to
14 be able to do it, then she would escalate it to the
15 Assistant Director, who was Heather Trouton. Anita had 12:35
16 also emailed Heather Trouton at times just to say here
17 is an issue that is still continuing. Those are the
18 people that I would expected to take action, and should
19 it not have been able to do actual action but for them
20 to escalate further up the chain to the Clinical 12:36
21 Director, the Associate Medical Director. Which they
22 did but nothing ever seemed to happen.
23 209 Q. How do you know they did?
24 A. Well, just with my work bundle, reading through that.
25 210 Q. We looked through the email, the two emails that you 12:36
26 have indicated the patient risks specifically. Anita
27 Carroll, Heather Trouton, Martina Corrigan are all
28 sighted on those, and thereafter Debbie Burns told you
29 to stop filling in Datixes. Would it be unfair for me

1 to characterise it as being slightly disingenuous for
2 Anita Carroll to say acquiesce to that direction,
3 nothing is being done, when actually she is one of the
4 people that could have done something?
5 A. But she did escalate. 12:37
6 211 Q. Did she ever speak to Mr. O'Brien?
7 A. No, but that wouldn't be how we worked. We worked
8 probably in silos. It wouldn't have been for her to
9 speak to the consultant, it would have been the AD for
10 that area to speak to the consultant. Just as if there 12:37
11 was an issue with one of my ward clerks on the ward, I
12 wouldn't have expected another Head of Service to speak
13 to them, I would have wanted to have been informed of
14 that issue and then I, as the Head of Service for that
15 area, would have spoken to that person. 12:37
16 212 Q. The Inquiry has heard evidence and likely will hear
17 more evidence about those twin tracks of governance and
18 accountability, clinical and operational, if I can use
19 those shorthands. Is this a real-life example of one
20 of the disadvantages of there being twin tracks when 12:37
21 trying to deal with problems that actually cut across
22 both?
23 A. Yes, it could be, but then you could have two or three
24 people doing the one thing and nobody knowing what
25 anybody is doing. 12:38
26 213 Q. Well, Martina Corrigan knew on this occasion, and she
27 is the Head of Service. She could have spoken to the
28 medic, so there is some join in at the top. If it was
29 a ward clerk bringing notes home, could you have gone

1 to them directly?
2 A. Oh, yeah.
3 214 Q. If it was a secretary, you could have gone to them
4 directly. If I understand you correctly, what stopped
5 you going to Mr. O'Brien directly was etiquette and 12:38
6 lines of management. Would that be fair?
7 A. Yes.
8 215 Q. Do you think Mrs. Carroll could have done more?
9 A. No. I'm happy that she supported me in everything and
10 that she escalated as far as she could within her chain 12:39
11 of command.
12 216 Q. Now, you've support in your view around the difficulty
13 of getting things done when there are different chains
14 of command. If we could go to WIT-12157. This is from
15 Heather Trouton. I may have the page wrong but I have 12:39
16 the extract here which I'll read out for you:
17
18 "Both the Head of Service and I as non-medics found it
19 very difficult to challenge Mr. O'Brien's clinical
20 practice. We were reliant on his clinical colleagues 12:40
21 to provide that clinical challenge, and this I believe
22 did come but only at a later stage when a number of new
23 consultants came into post who had experience outside
24 the Trust and outside Northern Ireland who knew what
25 was acceptable practice and what was not and who were 12:40
26 not afraid to speak up".
27
28 The actual detail of that extract is about clinical
29 practice but I think the point reflects what you're

1 saying, non-medics dealing with medics. Was it your
2 experience that that was something that didn't happen?
3 A. Yes.
4 217 Q. Do you think that that was a culture thing as well,
5 that there was a culture -- not perhaps just in this 12:40
6 Trust but there was a culture that only medics could
7 deal with medics?
8 A. I think, yes. Short answer, yes.
9 218 Q. I just want to ask you about AOB-01660. There is a
10 reference here about running a report on the volume of 12:41
11 notes tracked to all surgeons and I just want to ask
12 you if you have any knowledge of that. It is an email
13 dated 19th July 2017. It's from Ronan Carroll to
14 Martina Corrigan and Colin Weir. You are not privy to
15 this but just because it cuts across your area. 12:41
16
17 "Martina, Colin. 3rd of February chart is almost six
18 months so having notes in his office is against the
19 action plan he received". Then there is an extract
20 from that. "Why the need to have this volume of notes 12:42
21 in his office. AOB has not raised any workload
22 concerns so again why the volume of notes in his
23 office. Because this was not managed previously, 13
24 sets of notes tracked to AOB are unaccounted for. We
25 know this and we are allowing it to happen again. 12:42
26 Helen Forde is running a report on the volume of notes
27 tracked to all surgeons so we can have a comparator.
28 My view is all the notes need to be returned".
29

1 If we leave the 13 sets of notes, we have spoke about
2 it earlier, but there is reference there you running a
3 report to the notes tracked to all surgeons. Do you
4 remember this? I know it was six years ago but do you
5 remember doing this? 12:42
6 A. Yes, I do. Ronan had spoken to Anita, Anita had asked
7 me to do it and I had included that, I think, in the
8 last bit of evidence, that there was a table there of
9 number of consultants and numbers of charts.
10 219 Q. When they talk about the notes to all surgeons, it was 12:43
11 about having charts tracked out and not brought back
12 rather than having them at home?
13 A. No, it was to the number of charts and their tracking
14 code. So you ran a report to their tracking code to
15 see how many reports they had in the offices because 12:43
16 Ronan there was talking about the consultants having
17 notes in their office.
18 220 Q. And you provided that. The context to that, I maybe
19 should have taken you to this email first but I'll do
20 that now. At this point, 2017, you are being asked to 12:43
21 look at all the notes tracked out. If we look at
22 TRU-01603. This is an email from Martina Corrigan to
23 Debbie Burns and Eamonn Mackle on 5th September 2013.
24 Now, this is four years prior to this and this is
25 specific about notes at home. For the Panel's note, 12:44
26 top of the page.
27
28 "Debbie, I will speak with him again". If we can go on
29 down. The 27th August 2013, we will have to start

1 there so it makes more sense. From you to Heather
2 Trouton and Martina Corrigan with Anita Carroll in.
3
4 "Please see below. Mr. O'Brien continues to have
5 charts at home. This is causing problems for Records 12:44
6 as per Pamela's email. What can be done to resolve
7 this".
8
9 Anita to Debbie. "Debbie, how do you think it's best
10 to deal with this? Should the HOS discuss with 12:45
11 Mr. O'Brien. Can they arrange to get charts back or do
12 we need to discuss at governance as part of the problem
13 is they aren't even tracked out".
14
15 Now, when they say they aren't even tracked out, does 12:45
16 that mean they don't have a code or the code were they
17 are tracked to isn't the location where they are?
18 A. The code isn't the location where they are.
19 221 Q. That's to Debbie Burns. That date seems to be after
20 Ms. Burns has told you to stop filling in Datix. Is 12:45
21 that May 2013?
22 A. Was it not '14 she said? I can't remember.
23 222 Q. It may have been. We'll check that in a second. If we
24 move up, please. This is from Debbie Burns on
25 3rd September to Martina Corrigan, Eamonn Mackle and 12:45
26 Robin Brown.
27
28 "I know you've tried before. This is a governance
29 issue. Robin, can you discuss again with Mr. O'Brien

1 or do we need to escalate"?
2
3 This is an example then of the medic approach --
4 A. Yeah.
5 223 Q. -- we discussed earlier. Robin Brown replies to Debbie 12:46
6 Burns.
7
8 "So he doesn't copy Martina Corrigan or Eamonn Mackle,
9 or Robin. He doesn't copy them".
10 12:46
11 He just replies through Debbie Burns: "I will try to
12 get to meet the week after next. I am surgeon of the
13 week next week".
14
15 Debbie Burns goes back to Eamonn Mackle and Martina 12:46
16 Corrigan.
17
18 "We need this addressed".
19
20 Then Martina says: "Debbie, I will speak with him 12:46
21 today and then let Robin follow up on this. One of the
22 things that was said before is that he is not the only
23 consultant who brings a chart home but I suppose with
24 Aidan it is more the amount he brings home and the
25 length of time he keeps them for. I will let you both 12:47
26 know how I get on".
27
28 Because of the subsequent Datixes, the problem
29 persisted then. I think you are right on the May 2014

1 date. If we go, we will see the Datixes and all of the
2 dates and the stopping point. That would be useful for
3 the Panel. WIT-61509. This is a recent email, just
4 before you left, was it, 4th December 2020 from you to
5 Pamela Lawson and Andrea Cunningham. You say to Andrea 12:47
6 Cunningham and Pamela Lawson:
7
8 "Do you remember when AOB took charts home we did a
9 Datix out and we were then told to stop this. Well,
10 out of the urology review, that is one of the things 12:48
11 that is coming out as being useful, so this would be
12 for charts that can't be found. How many a week do you
13 think that would be? Any thoughts on this?"
14
15 And then you are provided from Pamela Lawson to you, 12:48
16 she gives you the dates?
17 A. There is an additional date in there too on 4th October
18 '16.
19 224 Q. There is another one in that?
20 A. Yeah. 12:48
21 225 Q. The dates are a bit all over the place but if we look
22 up to the year '13 and the first one in that year is
23 20th May?
24 A. 8th May.
25 226 Q. 8th May, sorry, you're right. 8th May, 20th May, 16th 12:49
26 May. So there is four that month, four Datixes with
27 various numbers. Then in June, none in July, August,
28 September, October, November and December. Then
29 January '14. February, April '14. July '14, August

1 '14. Then none until '16?
2 A. We had stopped recording them, and then the one in '16
3 and '19 had went in. I had asked, you know, I couldn't
4 remember what had happened and I think it was just pure
5 frustration again, you know, still continuing, and just 12:49
6 put a Datix in.
7 227 Q. 1st August 2014 was the last, so that gives us a
8 timeline that may be extends beyond our May 2014 belief
9 about Debbie Burns?
10 A. Yes. 12:50
11 228 Q. If she did say it in May, then there were more after
12 that, but they were certainly stopped in August 2014?
13 A. Yes.
14 229 Q. Said there was another one needed on that list. What
15 was the date? 12:50
16 A. It was 4th October '16.
17 230 Q. Were these all filled in by Pamela Lawson?
18 A. Yes.
19 231 Q. Would she have said to you I'm filling in another IR1
20 each time? 12:50
21 A. Yes, and they would have come to me.
22 232 Q. Right, okay. For you to send on?
23 A. Yes.
24 233 Q. I think you've said that in your statement - for the
25 Panel's note at WIT-61189 - at paragraph 22.1 that you 12:51
26 completed the Datix until August 2014. You say that
27 the 2016 and 2019 ones were out of frustration that the
28 problem still existed?
29 A. Yes.

1 234 Q. Was it more frustrating having been instructed to stop
2 filling in Datixes to see the problem continue and not
3 be able to do anything?
4 A. I don't know. In one hand, you're taking time to sit
5 down and fill something like this in, and then you're 12:51
6 told don't do it but you haven't seen an outcome or
7 anything change as a result of filling them. So, you
8 can nearly think what's the point; it is another thing
9 to do. It's just another thing to do.
10 235 Q. Those two episodes in 2016 and 2019, should the Panel 12:52
11 take that as meaning that there were only two episodes?
12 A. No. It is just...
13 236 Q. How do you know that? How are you aware of that, that
14 those two triggered frustration in some way that they
15 found their way on to IR1s and there were others that 12:52
16 didn't? Can you explain that?
17 A. I had spoken to the manager and she said I just was
18 frustrated that day and fed up and just put another one
19 in.
20 237 Q. But behind the scenes the problem maintained? 12:52
21 A. Yes.
22 238 Q. Again for the Panel's note, there is another email
23 about the implications of charts missing for clinics.
24 AOB-00483. These are emails from you to Anita Carroll,
25 11th November 2013. You write: 12:53
26
27 "Just to keep you in the loop as this may be going to
28 Debbie, but I've said to Martina a patient was
29 attending clinic this morning but the chart was tracked

1 to Mr. O'Brien in the Thorndale unit. When records
2 looked for it his secretary said she thought Mr.
3 O'Brien had that chart at home and she would ask him to
4 bring it in for the appointment at 9:00 a.m. this
5 morning. The chart didn't arrive in records and the 12:54
6 doctor refused to see the patient without the chart.
7 Pamela went to speak to the doctor and asked if he
8 would see the patient as she had got as much
9 information as she could for the appointment.
10 Mr. O'Brien's secretary is off today so eventually 12:54
11 Pamela got Mr. O'Brien's number and phoned him to
12 inquire about the chart. He had brought it in but had
13 taken it over to the old Thorndale unit to have a
14 letter typed. Pamela then went over there this
15 morning, got the chart and then brought it round to the 12:54
16 doctor, and he informed Pamela that he was going to
17 write to Debbie about this".
18
19 I presume that is the doctor going to write to Debbie
20 about this? 12:54
21 A. Yes.
22 239 Q. That is just a further illustration of that. I'm just
23 going to move on to a separate issue. Perhaps it might
24 be convenient to break now, Chair?
25 CHAIR: We'll come back then at 1:55, everyone. 12:54
26
27 THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:
28
29 CHAIR: Good afternoon, everyone.

1 240 Q. MS. McMAHON: Mrs. Forde, if I could just go back to an
2 issue we were discussing just before lunch about the
3 Datix issue. You had mentioned in passing, and I'm not
4 sure if I closed that off myself, you were the person
5 that closed off the Datixes. 13:55
6 A. Yes.
7 241 Q. That, in effect, shuts them down in the system as
8 though they are dealt with. When you did that, was it
9 on foot of finding the chart or having it returned?
10 A. It was more that we used the Datix as a flag to issue 13:56
11 the fact that a chart was not where it should be, that
12 it was at home. We always got the chart, Mr. O'Brien
13 always did bring the chart in so. But to be honest, it
14 was shut down because we used it as an escalation
15 mechanism. So, it was shut down for that point of 13:56
16 view.
17 242 Q. Just so I'm clear, I don't want to have unfairly
18 characterised who might have known or done something
19 about it, but if you raised the Datix this afternoon
20 and the chart was returned tomorrow morning and you 13:56
21 closed that Datix off, would that mean that it didn't,
22 in fact, escalate up the management chain at all; that
23 no one else would have known about it, effectively?
24 A. No, it automatically went to everyone once you raised
25 the Datix. It depends on how it was coded. A simple 13:57
26 example is if, say, we had misfiled a piece of paper in
27 a chart, you would have recorded that as a Datix.
28 Because that was coded as misfiling of a piece of
29 information, that automatically triggered a record to

1 be sent to or triggered the Datix to be sent to the
2 information governance because that with regard to
3 confidentiality.
4
5 The Datix was built-in a framework that the coding then 13:57
6 triggered who would actually get that Datix or who
7 would have sight of it. Say some things might have
8 happened on a ward, and I would have got a copy of that
9 Datix because it happened on a ward and I had ward
10 clerks. 13:57
11 243 Q. Perhaps if we look at one and then we can get a better
12 idea what that means in practice. Go to TRU-164940.
13 This is from the batch of documents just recently
14 provided. I think you've had a look at those?
15 A. Hm-mm. 13:58
16 244 Q. It is filled in by Pamela Lawson. When it comes up,
17 you will see that. As I understand from your earlier
18 evidence, you would have known about this whenever
19 Ms. Lawson was completing it. We might be able to see
20 it better from the screen; it is very small writing 13:58
21 when it's printed out. We can see the details of the
22 person reporting the incident, Pamela Lawson. Then if
23 we just move down, what happened when and where.
24
25 "Consultant had chart at home. Earned approval status 13:58
26 in holding area. Awaiting review".
27
28 What does that entry signify, do you know, or is that
29 an IT issue?

1 A. No, that's what the status of it. It has been raised
2 but it hasn't been signed off yet.
3 245 Q. The incident date is 14th January 2019?
4 A. Yes.
5 246 Q. At 12:30. Acute Services. The division is Functional 13:59
6 Support Services. Health records. The site for this
7 is Armagh Community Hospital?
8 A. Mhm-mhm.
9 247 Q. The location is Urology Clinic. The upshot of this is
10 that a chart has been confirmed as being in the house 13:59
11 of a consultant and this Datix has been opened.
12
13 If this were closed, if I would be looking at it would
14 I be able to see something else on this? How would it
15 look different if you had received that chart and 13:59
16 closed the Datix?
17 A. Well, all mine were closed so that one should be
18 closed. I don't know why that is still saying an
19 awareness. But no, all those details would still be
20 there and there would be nothing else added unless 14:00
21 there was the action taken is recorded, what's the
22 learning. So, all of that has been recorded.
23 248 Q. It doesn't indicate on that that the chart has been
24 returned?
25 A. No. The chart -- requested that his secretary has 14:00
26 asked for the chart.
27 249 Q. So, custom and practice is built up if the secretary
28 was asked, there is an assumption that she would
29 actually bring it in or the chart would be brought in?

1 A. Yes, but that would be followed up by Health Records
2 because they would need the chart for the actual
3 clinic. So it would be we've requested the chart, so
4 the person who was looking for that chart then would be
5 told, right, Mr. O'Brien will bring that in tomorrow, 14:00
6 so they would have a wee note to go and get the chart
7 tomorrow.
8 250 Q. If we are looking at this and the symbols on it would
9 indicate that perhaps it is not closed, how do we know
10 who this would escalate to if it were to remain open? 14:01
11 What tells us that? Is it the Directorate, the
12 Director of Acute Services or Functional Support
13 Services? How would we know who would get this?
14 A. Well, that will automatically come to me because my
15 manager has completed that. 14:01
16 251 Q. Yes.
17 A. So, that will automatically come to me as an email to
18 say Datix received. Then anybody that the coding
19 there, the division services, the speciality and the
20 site, anybody coded to those codes would get an email 14:01
21 as well to say a Datix has been raised.
22 252 Q. That would normally include Directors and Assistant
23 Directors, would it?
24 A. It depends what the coding actually would be.
25 253 Q. My earlier questioning around Anita Carroll and Heather 14:01
26 Trouton may be incorrect. If they are not coded into
27 this, then they might not be aware that it exists?
28 A. I would always have -- that was my mechanism for
29 raising the Datix but I would always have notified both

1 of them - mostly Martina - just to say, look, the chart
2 was at home.
3 254 Q. So even if you do raise it, the chart appears on your
4 desk five minutes later, you close it, a code is still
5 sent that one was raised? 14:02
6 A. Yes.
7 255 Q. Even though the problem at that point has been
8 resolved?
9 A. Yes.
10 256 Q. There is still a record? 14:02
11 A. Yes.
12 257 Q. That was effectively the purpose of you doing this?
13 A. Yes.
14 258 Q. To set out a paper trail of times when you couldn't
15 find the chart and it was at home? 14:02
16 A. Yes. Just to make the whole process a bit more formal
17 rather than just a conversation.
18 259 Q. You've mentioned something about Mr. O'Brien always
19 bringing charts in. I am going to come on to that now.
20 We were talking in general terms this morning about the 14:02
21 system of charts and how that operated but I just want
22 to go to your witness statement at WIT-61194. You've
23 been asked questions about concerns arising from
24 urology. We just go down to 26.1. You've said:
25 14:03
26 "The only concern I had regarding Urology Services was
27 the fact that Mr. O'Brien kept a large volume of charts
28 in his office and also took charts home without telling
29 anyone. I do have to comment that when we needed a

1 chart for an admission or for an outpatient clinic and
2 asked Mr. O'Brien to bring the chart back to the
3 hospital, he always did so the following day. We were
4 only aware of a chart being in Mr O'Brien's house if we
5 went to retrieve it if we needed it for an admission or 14:03
6 outpatient clinic and went to look for it in
7 Mr. O'Brien's office. After a search of his office and
8 his secretary's office, if the chart could not be
9 found, the Records staff or the secretary would contact
10 Mr. O'Brien to see if he had it in his house, and then 14:04
11 he would be requested to bring the chart with him the
12 next day. I can only comment on the charts that Health
13 Records requested Mr. O'Brien to return from home, and
14 cannot comment on how often or how quickly Mr. O'Brien
15 would return charts not requested by Health Records to 14:04
16 the hospital".
17
18 You say again at 30.2:
19
20 "When asked to bring a chart in from home, Mr. O'Brien 14:04
21 always brought it in the next day. However, there was
22 an instance where a patient was in the Emergency
23 Department and the chart was requested. As it was in
24 Mr O'Brien's house, we had to contact him urgently and
25 fortunately he had not left the house at the time and 14:05
26 was able to bring the chart into the hospital with him.
27 The Head of Service, Martina Corrigan, was aware of
28 this. This is the only example of an emergency request
29 for a chart that was in Mr. O'Brien's house".

1
2 Do you know if there was a Datix raised for that
3 particular incident, the Emergency Department?
4 A. I think there was but I can't be 100% sure.
5 260 Q. What you're saying there is on every occasion that 14:05
6 Mr. O'Brien was contacted -- was it by you or by
7 Ms. Lawson?
8 A. It would have been, say, one of the girls who was
9 looking for the chart and couldn't find it might have
10 said to the secretary would you check with him, or it 14:05
11 could have been with Mrs Lawson. It wasn't by me
12 because they were responsible just for getting the
13 charts.
14 261 Q. It was always brought in by Mr. O'Brien or sent in?
15 A. It was, yes. 14:06
16 262 Q. It always appeared. Were you aware of any times out of
17 hours or at weekends when charts were sought that
18 weren't there that may have been in Mr. O'Brien's
19 house?
20 A. If there had been, I would have been notified so I 14:06
21 would have to say no.
22 263 Q. Okay. So you would have been informed when you came in
23 on your next shift?
24 A. Yes.
25 264 Q. I just want to take you to what you said in your MHPS 14:06
26 statement. TRU-00794. Again, there is just a slight
27 deviation; I just want to give you the opportunity to
28 speak to it. At paragraph 8:
29 "In terms of notes, the only tracking code was for

1 Mr. O'Brien's office for charts tracked out to him.
2 The only time we would know if a chart wasn't there was
3 if we needed it and went looking for it. I know it
4 would have been a regular occurrence that Mr. O'Brien
5 would have had charts at home. He generally would have 14:07
6 returned them the next day if a chart was being looked
7 for".
8
9 Just the point that you have used the word "generally"
10 and you have used the word "always" in your statement. 14:07
11 Is there a split of a difference in your use of those
12 words?
13 A. No. If I had to choose a word, it would be "always".
14 265 Q. Do you know why you used the word "generally" in the
15 statement at that point? 14:07
16 A. I have no idea, no.
17 266 Q. I know we've spoken about the system and the policies
18 around transferring notes. It would seem that parallel
19 to that that custom and practice developed around the
20 movement of notes, consultants taking notes with them 14:08
21 for clinics. I just want to read out some extracts
22 from Mr. O'Brien's statement, what he says was the
23 position.
24
25 Before I do that, were you involved in or do you know 14:08
26 about the incident of notes being put in the bin from
27 charts by Mr. O'Brien?
28 A. I only knew about that in the work bundle, but that
29 happened in 2009 and I didn't have responsibility for

1 the ward clerks at that time.
2 267 Q. If we go to WIT-82553, it's probably best because
3 Mr. O'Brien explains some scenarios and system then I
4 will read paragraphs and, at the appropriate time, I
5 will stop and ask you to comment, is that is okay. 14:09
6 At 433, he says:
7
8 "I fully accept that in an ideal world, records should
9 not be kept at home, other than perhaps for a very
10 short period if it is not possible to carry out work 14:09
11 required by reference to the records while at the Trust
12 premises. However, I worked in a service that was far
13 from ideal which led to me often working from home. In
14 more recent years, with the increasing reliance on
15 electronic care records, it became easier to work 14:09
16 remotely without having paper records to hand".
17
18 Then if we go over to paragraph 435, and this is where
19 he explains some of the systems.
20 14:09
21 "First in relation to records held at home, I was
22 primarily based at Craigavon Area Hospital. I also
23 conducted out reach clinics at Southwest Acute Hospital
24 in the Western Trust. SWAH was exactly 50 miles
25 distance my home and travelling from home to there 14:10
26 through several towns in the early morning and
27 returning each evening took 70 minutes each way.
28 Travelling to an outlying hospital with the additional
29 time demands that that involved added significantly to

1 the length of my day. I was unaware of any definite
2 systems employed by the Trust in relation to the
3 transfer of records between hospitals, and perhaps
4 particularly to a hospital in another Trust. There was
5 no written direction to me in relation to when or how 14:10
6 or when they should be returned".
7
8 Just at that point, I think we clarified this morning
9 that you weren't involved in providing, or know of any
10 training that was provided, about the policy 14:10
11 requirements for record movement and storage?
12 A. That's right.
13 268 Q. If you were looking at the structure of the Trust,
14 where would you say responsibility for disseminating
15 that sort of information would lie? 14:11
16 A. Well, I cover things like that with induction for my
17 staff, so I would have imagined induction.
18 269 Q. Induction then within each directorate and maybe
19 department even; at that level?
20 A. Yeah. 14:11
21 270 Q. Would there be somewhere where it might sit at home
22 with information of governance, or would that not be
23 their remit to ensure that policies are understood, if
24 I could say, at ground level?
25 A. It may possibly may be general training every three 14:11
26 years, something like that. But with a big
27 organisation the way we are, it would be very difficult
28 particularly to get a lot of doctors together to take
29 part in the training.

1 271 Q. Given that we saw this morning that the policies are
2 very particular about individuals being responsible,
3 legally responsible, for handling and storage and the
4 retention of notes and confidentiality, do you think
5 that the staff that you work with are aware of that, 14:12
6 that that responsibility attaches to them as
7 individuals?
8 A. Yes. And with the recent change in the GDPR, one of
9 the changes was that you as an individual are legally
10 responsible. So, I had asked the Head of Governance if 14:12
11 her team would come and give training sessions on that
12 new policy just to my staff.
13 272 Q. If we narrowed that down just by questioning the Head
14 of Governance, would that perhaps be a natural home
15 then to feed out information from policies around data 14:12
16 protection and governance generally around records?
17 A. Well, I had specifically asked for that.
18 273 Q. And they felt able to deliver that training?
19 A. Yes.
20 274 Q. Do you think it would be a good idea if there were 14:13
21 specific training programs or continuing professional
22 development points, or some way in which the Trust
23 could bring home their policy aspirations to people who
24 actually operate - I don't use that word medically -
25 who actually work in the Trust so that they better 14:13
26 understand their obligations and their
27 responsibilities?
28 A. Yes. I think we could improve the training aspect. We
29 do have e-learning for some of the things but maybe

1 more specific training on this. Or, you know, make
2 sure it is included in the junior doctors' induction.
3 275 Q. By the time you left in 2020, did you have any
4 knowledge of any training that was in place at that
5 point such as that? 14:14
6 A. No. No.
7 276 Q. Just the main point from that, I suppose, from your
8 perspective as a manager was that you instigated the
9 request rather than it being something that was
10 available? 14:14
11 A. Yes.
12 277 Q. And there may be changes now, you just don't know, I
13 suppose, having left?
14 A. No.
15 278 Q. Would that be something that Ms. Carroll could speak to 14:14
16 in her evidence? Could she explain what the position
17 is now, or perhaps Martina Corrigan?
18 A. Well, that would be for their particular areas rather
19 than in general. So you would be looking at Functional
20 Support Services or urology and ENT, but that leaves 14:14
21 surgery, orthopaedics, medical. It wouldn't give
22 what's happening within the full of Acute Services.
23 279 Q. I suppose one of the things about your former role is
24 that it cuts across so many of the services in the
25 Trust? 14:15
26 A. Mhm-mhm.
27 280 Q. Notes and records are pretty fundamental in the
28 hospital environment. If there was training, it could
29 be reflective of the requirements of policies and

1 procedures but applicable to everyone who had reason to
2 have notes or records at all in their possession for
3 even just transferring them between wards or units?
4 A. Yes.
5 281 Q. 437 is the next paragraph. 14:15
6
7 "The clinic at SWAH took place once each month on a
8 Monday. The medical records personnel at CAH would
9 deliver the charts for the patients attending the
10 clinic to my office in CAH on the preceding Friday for 14:16
11 me to take to SWAH three days later. I was provided
12 with a container on wheels in which to transport the
13 charts".
14
15 Does CAH fall under your remit? 14:16
16 A. Yes.
17 282 Q. And is what's described here a system that you
18 recognise?
19 A. Yes.
20 283 Q. Was that one that was put in place by you or others to 14:16
21 reflect the geographical layout of the service
22 provision of the Trust?
23 A. We would have internal transport between all of the
24 facilities on the Southern Trust. We would also have
25 internal transport to go down to the Royal in Belfast, 14:16
26 but we would have no internal transport to go to SWAH.
27 So, the clinics -- the charts were going down on a
28 Friday but we had no way of getting them down there or
29 to have them down there first thing on a Monday

1 morning, so this was a workaround.
2 284 Q. When you say there was no transport, was it a funding
3 issue?
4 A. No, it was just the transport didn't go there.
5 285 Q. I am going to have to ask you to explain that to me. 14:17
6 It didn't go there because?
7 A. They never had a need to go to there. We would have
8 had transport drivers and they did regular pick ups
9 from Health Records twice a day, and they would have
10 went between the sites. So, you know, they would have 14:17
11 been picked up in Craigavon, those charts went to the
12 clinics for Daisy Hill, those ones went to South Tyrone
13 and Armagh. Then there was sort of the Southern Trust
14 transport did go down to the Royal in Belfast, but they
15 hadn't went to SWAH. Really for going down to Belfast, 14:17
16 it would have been for their labs and some of the
17 specific tests. So, there just wasn't a transport run
18 to SWAH.
19 286 Q. If the consultants weren't to take the notes, the Trust
20 would have had to put something in place to get the 14:18
21 notes to the clinic, would they?
22 A. Yes.
23 287 Q. Were the consultants assisting the Trust, doing them a
24 favour, in bringing the notes?
25 A. Yes. 14:18
26 288 Q. He then goes on to say at 438:
27
28 "As a result of the significant pressure I was under, I
29 did not have time to complete all work required on

1 records while at SWAH as insufficient time was
2 allocated to allow me to adequately review patients,
3 including new and cancer patients, and complete
4 administration work within clinic time. Initially the
5 clinic commenced at 10.00am with 16 patients attending 14:18
6 until 5.00 pm. More recently in an attempt to review
7 as many patients as possible, I had 18 patients
8 attending with the clinic starting earlier at 9.30".
9
10 Mr. O'Brien is then indicating the volume of patients 14:19
11 he was seeing; this is within the context of having
12 notes at home.
13
14 440.
15 14:19
16 "I also conducted an outreach clinic at Armagh
17 Community Hospital in Armagh. This clinic also
18 occurred once monthly on a Monday morning. It was a
19 general Urology Review clinic with 12 patients
20 attending between 9.00 and 1.00pm. This clinic was 14:19
21 different from the one at Southwest Acute Hospital as
22 the patient's clinical records were delivered by Trust
23 transport, though occasionally none were delivered at
24 all due to oversight. The problem I had with
25 completing administration relating to the patients 14:19
26 attending this clinic was that the room had to be
27 vacate had by 1.00pm to prepare for a dermatology
28 clinic which began at 1.30. As I did not have any
29 elective session during the afternoon of that Monday, I

1 brought the patients' records home to complete
2 administration, which I was able do remotely".
3
4 Now, this is slightly different from the previous
5 example, on this occasion there is Trust transport. 14:20
6 Would it would be anticipated that the transport would
7 pick the charts up at the end of the clinic?
8 A. Yes.
9 289 Q. Mr. O'Brien is saying that sometimes the notes didn't
10 turn up for the clinic. Was there any understanding 14:20
11 that if the consultant wanted to bring the notes home,
12 they could do that?
13 A. No. Simply it would be as with all of our clinics, the
14 clinics would have been bundle up, labelled and put
15 into Health Records in Armagh Community and into the 14:20
16 one of the tamperproof boxes to wait for transport to
17 pick it up and bring it back to the Craigavon site.
18 290 Q. Transport would pick up the box rather than know how
19 many charts to pick up, so they wouldn't say we left 50
20 in this morning, there's only 30 there? 14:20
21 A. No.
22 291 Q. It doesn't work like that?
23 A. No, it is by boxes.
24 292 Q. So it is sealed?
25 A. Yes. 14:21
26 293 Q. So you wouldn't have known then that there was charts
27 missing until they arrived back?
28 A. No. Even at that, the boxes were just unpacked and
29 they would be -- that would go to the consultant's

1 secretary for her to type the letters. So it was just
2 be taken out of the box, put into the pigeonholes, and
3 the Health Records porters would have delivered them to
4 the appropriate office.
5 294 Q. They had an internal life until they completed the 14:21
6 cycle for the clinics --
7 A. Yes.
8 295 Q. -- before finding their way backs. Then at 441.
9
10 "I had a busy outpatient clinic at CAH", just to say 14:21
11 Craigavon, "each Friday when I would have patients
12 attending for flexible cystoscopies and urodynamic
13 studies concurrently with patients attending for
14 oncology reviews. Having remained at the hospital to
15 undertake as much administration as possible, I found 14:21
16 it tempting to bring home some records, usually of
17 those patients who had attended for flexible
18 cystoscopies and urodynamic studies so that I could
19 join my family for the end of the week dinner at 8.00pm
20 and with a view to being able to complete the 14:22
21 administration from home remotely so as not to have to
22 return to the hospital over the weekend".
23
24 Is that another clinic where Transport would have
25 picked the notes up? 14:22
26 A. That's actually in Craigavon itself. So, the Health
27 Records porters would have just picked them up.
28 296 Q. They would have brought them back in the trolley either
29 to the secretaries, or wherever they needed to go for

1 dictation, if that was appropriate?
2 A. Yes.
3 297 Q. When Mr. O'Brien did this particular example, having
4 had the notes with him, were those notes were coded
5 out, are they coded out to the clinic or to him? 14:22
6 A. They would have been coded out to that urodynamic
7 clinic.
8 298 Q. So when he took them home, effectively, strictly
9 looking at the system, you wouldn't have known where
10 they were? 14:23
11 A. No.
12 299 Q. Would that then have involved some investigation to
13 find out the names of the patient, who the consultant
14 was, contact the secretary, get some confirmation that
15 the notes were at home? 14:23
16 A. Yes. Well, we would have had -- say that that patient
17 had come up to another clinic, then we would have
18 looked for that patient, seen where it was tracked out
19 to and that would have started your searches for right,
20 well, where would the cystoscopies go to; you check the 14:23
21 secretary, then his office, so it would have started
22 that whole trail of searches.
23 300 Q. So on each occasion it triggered a separate set of
24 steps --
25 A. Yep. 14:23
26 301 Q. -- in order to get to the conclusion that they must be
27 at home?
28 A. Yes.
29 302 Q. He then mentions that he has the notes of private

1 patients at 442. He then says at 443:
2
3 "It was accepted in the context of the formal
4 investigation report that if notes were requested from
5 me, I would return them promptly", and that accords 14:23
6 with your evidence. He then says:
7
8 "It was clear by March 2016 the Trust was aware of the
9 practice and indeed appeared to have concerns". He
10 refers to the letter he received in march 2016. 14:24
11
12 Then he says that paragraph 446:
13
14 "I accept it was not best practice to have kept NHS
15 patient records at home. There is no suggestion there 14:24
16 was any security breach in relation to these records.
17 The records were stored in my private office at my
18 home, which is totally secure".
19
20 We know from the policies this morning that keeping 14:24
21 notes at home was permissible, if necessary, and there
22 was requirements that they are kept in safe storage,
23 offsite. Does the Trust have any particular
24 requirements of what storage at home should consist of
25 in order to meet those requirements? 14:24
26 A. Well, it would be somewhere where there would be no --
27 nobody else would have access to. I gave you an
28 example where one of my staff had to take some charts
29 home but we had those in the secure box, sealed, and

1 that had to be kept in their house so they would have
2 known if anybody in the family would have opened it or
3 anybody would have access to it. But it's really that
4 you would have an area where the general public or
5 other members of the family then wouldn't be able to go 14:25
6 in and view the notes.
7 303 Q. In the transport to the home, would there be an
8 expectation of travels in a secure box?
9 A. Yes.
10 304 Q. And stays in that secure box in a private room? 14:25
11 A. Yes.
12 305 Q. Do the Trust provide those sort of boxes to
13 consultants?
14 A. We provide them for the outpatient clinics and any
15 charts going off the site, but we haven't had to 14:25
16 provide them to consultants because, apart from this
17 one individual, I have no knowledge of any other
18 consultant needing them for anything, or to take charts
19 home.
20 306 Q. Did you provide them for the SWAH clinic where the 14:26
21 consultants transported them?
22 A. Yes.
23 307 Q. So, Mr. O'Brien could have one of those boxes provided
24 to him?
25 A. Yes. 14:26
26 308 Q. And he actually refers to this at paragraph 449 where
27 he says:
28
29 "Thirdly, in relation to patient records in my car, it

1 was necessary for me to carry records with me when
2 travelling to and from outlying clinics as well as
3 between my home and Craigavon Area Hospital. I wish to
4 emphasise that patient records were never left in my
5 car at any location. They were placed in the container 14:26
6 provided in the boot of my car on departure and removed
7 on arrival at the destination".
8
9 So, Mr. O'Brien is saying there that he accepts that it
10 wasn't best practice for him to take notes home but 14:27
11 when he did, he set out his reasons. The Panel can
12 consider those and carry them onto the terms of the
13 policy.
14
15 Mr. Mackle also refers to the SWAH clinic in his 14:27
16 evidence. WIT-11745. I'll just read this out for the
17 Panel. Paragraph 26 says:
18
19 "In 2013 Medical Records complained that an ongoing
20 problem with Aidan O'Brien was patient hospital charts 14:27
21 in his house and he was advised that this was not
22 permitted. Following the expansion of the Urology
23 Service to become Team South, outpatient clinics were
24 provided in Enniskillen and patient records therefore
25 needed to be transported to the clinic and back to 14:27
26 Craigavon afterwards. The Trust transport was used for
27 all other peripheral surgical clinics but for this
28 service it had been arranged that after the clinic, the
29 consultant would bring the charts back to Craigavon.

1 Following dictation of the letter to the GP, the
2 outcome for the patient would be recorded, for example
3 put on waiting list for surgery, discharged or review
4 arranged. Aidan O'Brien, however, was bringing the
5 charts to his how after the clinic but not completing 14:28
6 the dictation, which also meant patient outcomes were
7 not recorded. The Trust became aware in late 2015 of
8 it as a problem but only discovered the extent of the
9 problem following Heather Trouton and my letter in
10 March 2016. He returned the charts. 14:28
11
12 Mr. O'Brien also told the MHPS investigation that he
13 had kept notes at home but, in his view, this didn't
14 impact on patients' clinical management plans or their
15 care. Panel, that can be found at TRU-00696. You'll 14:28
16 just see very top of the page:
17
18 "Dr. O'Brien confirmed he did not have these". These
19 are 13 sets of notes which we dealt with this morning.
20 That's the line this was accepted by the Trust and the 14:29
21 Review Team, that I had mentioned to you earlier today.
22
23 Then this line:
24
25 "Mr. O'Brien accepted he had kept notes at home but 14:29
26 asserted that this did not impact on patients' clinical
27 management plans, or care".
28
29 Given the evidence we've looked at today in your

1 emails, would you agree with Mr. O'Brien?
2 A. As long as we were able to get the chart, then it
3 didn't impact on clinical management. Also, the fact
4 that with the availability of NIECR since 2013, and
5 having letters in patient centre, we were able to get 14:30
6 more information if a chart wasn't there, that we could
7 provide another clinician with other information.
8 309 Q. Given the emails we looked at this morning where we
9 said that you had said that if an operation was
10 cancelled, consultants would say they won't operate if 14:30
11 they don't get charts, do you agree with that
12 statement?
13 A. Well, then no.
14 310 Q. I want to move on to the staffing issues. You've
15 mentioned this in your statement and I just want to 14:30
16 give the Panel a flavour of the competing demands on
17 your staffing allocation in relation to what you were
18 trying to contend with generally, given the size of
19 your department. I just have a few emails to take you
20 through. 14:31
21
22 First of all, TRU-164909. This is an email from Pamela
23 Lawson to you. The Panel will note the context of the
24 few emails we are talking about; emails back and forth
25 capacity, agency staff, people leaving, people not 14:32
26 being replaced, and also a document I think you created
27 was a table of additional services with no funding,
28 which sets out all the extra work you do without having
29 funding for that work.

1
2 164909. This is from Pamela Lawson to you on 24th March
3 2014.
4
5 "Helen, I just want to make you aware of the situation 14:32
6 here at the moment. You know we've lost", and she
7 names two members of staff. "ENT reception needs
8 covered this week and a member of staff is on leave".
9 Someone else is moved to cover maternity leave. She
10 has somebody moved to cover ENT. "The day on Wednesday 14:32
11 we will have to take out core staff to cover Tuesday,
12 Thursday and Friday". Someone is off sick from
13 Outpatients Department. Another person is on leave so
14 she is sending over cover from Monday, Tuesday,
15 Wednesday, Thursday and Friday. That person also has 14:33
16 to cover someone else in another department on the
17 Monday, Tuesday, Wednesday, opposite days, as that
18 person is off sick. "That leaves me down to one
19 supervisor". Someone else has been off from the 28th
20 February on sick leave but hopes to be back soon. She 14:33
21 is also taking two staff out of filing/portering two
22 days a week "as we really have to get the week done
23 here as charts are already on top of bays again because
24 the filing rooms are overflowing. We've taken on a new
25 breast clinic which we still haven't been informed 14:33
26 about, which is 35 patients per week" and we'll look at
27 that when we look at your table that you created.
28
29 "There is an ENT consultant and this means extra

1 clinics and arranged admissions every week for him. We
2 cannot continue like this. I want to decrease the
3 issue desk a bit so I am asking you to agree to my
4 proposal of only getting charts for other sites that
5 are needed for clinics. Secretaries on other sites 14:34
6 will also provide charts for us as they send their
7 charts over for clinics to us. However, Craigavon
8 secretaries will have to either come down and get their
9 own charts or provide us with the charts required for
10 clinics, in which case I will be able to get two 14:34
11 members of staff on to clinics and issue desk. Can you
12 let me know as soon as possible please".
13
14 There is a lot going on in that email?
15 A. Yes. 14:34
16 311 Q. I think it gives a flavour of creative juggling of
17 staff to try and keep services ongoing. Is that email
18 exceptional or would you read that as something that
19 typically might have crossed your desk?
20 A. That would be a bad state of affairs because there is 14:35
21 staff left and staff on sick leave and some going on
22 annual leave. That would be we're really tight for
23 staff at the minute, I am going to have to put in some
24 different provision here to actually manage the
25 day-to-day business. But we would have regularly had 14:35
26 periods where we did have difficulties with staff and
27 shortages.
28 312 Q. If we look at another email - TRU-164910 - from Helen.
29 I think I have missed the top of it. This one is from

1 you to Anita Carroll, 14th May 2014.
2
3 "We are having problems with the staffing in Craigavon
4 Health Records. One agency left, porter is now on sick
5 leave, another member of staff to leave at the end of 14:36
6 the month and two more want to reduce their hours due
7 to health reasons, so that would create another
8 vacancy. Another clinic that has to be taken on.
9 Urology has been added on".
10 14:36
11 You say: "There are some of the figures that shows the
12 activity in Craigavon per month. This is the total
13 number of charts per month that are pulled and filed in
14 Health Records. So there is a large volume and I know
15 you will ask, so yes, we are doing comparisons across 14:36
16 the sites and moving staff to meet the need".
17
18 I presume that justification has to underscore any
19 request for anything, by the tone of your email.
20 14:36
21 "But also I would like to have some permanent members
22 of staff as all of our replacements have been agency
23 and it does leave us vulnerable as they want to have
24 permanent posts".
25 14:37
26 Was that something that was longstanding, the failure
27 to fill permanent posts?
28 A. This was during the Comprehensive Services Review where
29 there was a lot of financial efficiencies required and

1 we weren't allowed to recruit permanent staff. We
2 could go to bank and agency. That did leave a lot of
3 problems because if obviously someone was from agency
4 or someone was a bank member of staff and they got a
5 permanent post somewhere else, they went to it. So, we 14:37
6 would have had a large turnover of staff. Even that
7 led to issues because you had to get the member of
8 staff in, get them trained until they knew the system,
9 and then were functioning and then somebody else left
10 and you had to get them in again. So, it was really 14:37
11 asking there, look, can we go to get some permanent
12 staff in just to get a wee bit of stability.
13 313 Q. Was it on the basis that it is more expensive to fill
14 permanent posts than it is to bring people in who leave
15 and bring people in who leave? 14:38
16 A. It was more just keeping costs down and not having
17 permanent staff, so could staff from other areas be
18 redeployed into this if there was the opportunity.
19 314 Q. Was that as a result of looking at the budget in a
20 shorter term, in order to keep the books right rather 14:38
21 than long-term planning?
22 A. Now, it wasn't just in our area, it was across the
23 board. So, it was how can we make savings.
24 315 Q. Okay. If we look at TRU-164913. This is an email to
25 Debbie Burns from Anita Carroll on 2nd April. You're 14:38
26 copied in as well as Dennis Stinson.
27
28 "Debbie, would you be agreeable to this form. A
29 full-time ward clerk is on maternity leave from 3 South

1 and we really need to have this replaced. We have done
2 some workarounds and reduced cover in other areas to
3 make up the shortfall in the hours as we can't get the
4 full hours covered as it is maternity leave, but we
5 would need to get cover in for the 0.6 WTE". 14:39
6
7 This is another example of workarounds being sanctioned
8 at a high level?
9 A. Yes. During that particular time if someone went on
10 maternity leave, you are only allowed to replace half 14:39
11 of their post. So, the full-time person had left for
12 maternity, we would have got a 0.5 of a replacement.
13 That was just it for your scrutiny. So, then we said
14 right we will do that, we will reduce that, we can
15 actually get the funding of that increased to 0.6, 14:39
16 which is the minimum that we could do with.
17 316 Q. Is that still the position, if someone goes off on
18 maternity leave, you get half a post replaced?
19 A. No. But we were under very strict financial restraints
20 at that time and it was difficult. 14:40
21 317 Q. Is the position now like for like? If a post is
22 available, then available, whatever the reason for the
23 absence?
24 A. I'm not sure.
25 318 Q. You're not sure. You've forgotten; you've wiped it? 14:40
26 A. See, in two and a half years, I don't know if things
27 have changed or not.
28 319 Q. I appreciate that. Once you retire, you turn away.
29

1 TRU-164915. Sorry, TRU-164914, I think. This is from
2 Anita Carroll to you on 7th September 2015. She says:
3
4 "That's fine, Helen. I know it sounds awful. I'll get
5 Aideen to give us some time". 14:40
6
7 She is answering your email below where you have asked
8 her about staffing levels. 4th September 2015, your
9 email to Anita Carroll. You say:
10 14:41
11 "When I come back, I'd really like a bit of time with
12 you to go through the staffing levels and confirm what
13 we can do re getting staff made permanent and also
14 about the staffing levels".
15 14:41
16 You mentioned someone was talking to the unions and the
17 discussion came up about staffing levels. Three people
18 are on long-term sick, one on maternity. Someone else
19 is two WTE off on sick leave and one person leaving.
20 14:41
21 "Helen McCall, met with her on Wednesday and Kelly, and
22 both wanted to talk about the pressures on the post and
23 the amount of work to do and something has to be done.
24 I advised her to talk", names two individuals, "and get
25 some points down where change could make a difference 14:41
26 and how could the team work together to help things.
27 Two people to discuss the activity levels of the Renal
28 Unit soon". Someone is concerned about agency staff
29 leaving, and you have to make a decision about getting

1 the secretarial post filled.
2
3 "Covering ward means only limited sometimes available
4 and some wards have been complaining about the lack of
5 support. I try not come to you with staffing issues 14:42
6 but things just seem to be really busy and we can't
7 progress with anything, we're just keeping going. I
8 know there is the financial situation is grim but would
9 just like to sit and talk things through in case
10 there's something I'm missing that would help". 14:42
11
12 So again, that email reflects a service, you say it was
13 stretched to its outer boundaries?
14 A. Yes.
15 320 Q. Is that what it felt like working there at the time? 14:42
16 A. Yes.
17 321 Q. What impact did that have on the culture?
18 A. People were discontent and we did have a high turnover.
19 At one point the staff in my area, a lot them are Band
20 2s, so they were trying very hard to get to Band 3 as 14:43
21 well, so that would be a better post. They were a
22 fabulous team and they did really take their work
23 seriously and had a great pride in their work, so it
24 was very difficult when they were stretched and
25 stretched and more added on and posts not replaced. 14:43
26 So, it was difficult.
27 322 Q. You do say in your statement that you could have
28 implemented a system that would have allowed you to
29 track charts and find out where they were and trace

1 them?
2 A. Yep.
3 323 Q. But for the capacity within your department?
4 A. It's as I say there, we can't progress anything. To
5 me, that would have been the general housekeeping, 14:43
6 keeping everything right. Also, it would have been
7 lovely to have progressed things for the staff
8 themselves, even a wee bit of additional IT training or
9 something. But we were just so busy, you got your core
10 business done, and just about. 14:44
11 324 Q. Do you remember how the staff felt at that time when
12 people were moving about and trying to cover people who
13 were off? Was there a sense of people being
14 demoralised?
15 A. Oh, yes, yes. 14:44
16 325 Q. Do you think that impacts on their ability do their
17 job?
18 A. They are not happy. Our figures, our stats, were
19 always high, we always did produce the goods. But the
20 workforce weren't happy. 14:44
21 326 Q. You, as the head of this, we talked this morning
22 about -- looking now at staffing and the impact of you
23 getting an insight into your day-to-day, the Panel can
24 see what you were juggling. Also, then when there were
25 issues and you had senior management telling you to not 14:45
26 progress those issues, how did that impact on you?
27 A. It was difficult because you wanted to keep your
28 managers and ultimately your staff motivated. You
29 wanted to keep yourself motivated as well. You just

1 had to get on with it, but I always had a stance of you
2 never ask your staff to do something that you wouldn't
3 do yourself, so I would -- I've covered minor injuries,
4 I've done a nightshifts in ED, I have filed charts
5 because when you were at your very crux, you just 14:45
6 couldn't sit in your office and see your staff suffer.
7 So, my managers and I would have actually went onto the
8 shop floor.
9 327 Q. So, people were shown goodwill; could it be described
10 as that? 14:46
11 A. Yes.
12 328 Q. That was to try and keep the system going?
13 A. Yes.
14 329 Q. We'll just come onto the table that you made of
15 additional services with no funding. TRU-164935. What 14:46
16 was the background to this chart?
17 A. We had to go through -- or we were very strictly
18 monitored with regards to performance. There were
19 timeframes that everybody had to be seen in. All the
20 services were trying to think how can we improve our 14:46
21 service, how can we get more staff or more patients
22 through the system. So, they would have been looking
23 at what can we do, can we increase that clinic, can
24 somebody else, can they see two more reviews a week, or
25 else would you have had new consultants coming in, or a 14:47
26 new service to try and divert the patients from one
27 clinic maybe to a nurse-led clinic. So, quite rightly
28 the services were trying to do the best and to meet the
29 timeframes. But if they increased a clinic, you might

1 have, say, there's one, the leukaemia MDM, five a
2 month, some are saying what's five a month, you can do
3 that. But when you added that five onto the 82 onto
4 the month, on to the 30. For me, it was a mechanism to
5 show this is why we are complaining, this is why we'll 14:47
6 turn round and say, no, you can't have an extra 10
7 patients a month, we can't do it because collectively
8 it adds up to, I think, that was 2.44 whole time
9 equivalents. But it was nearly just to show this is
10 our struggle, this is where we were and this is the 14:48
11 funding that we need just to keep even and in light of
12 the changes that have been made.
13 330 Q. Who was this table made for?
14 A. I would have shared that with Anita.
15 331 Q. If we look at some of the examples just so we can see. 14:48
16 You have mentioned the leukaemia MDM. If we look at
17 No.4, new physician with an interest in rheumatology
18 but there is no funding for that aspect of the work.
19 That adds 69 patients a month. No. 10, Clinical
20 Decision Unit; the charts have requested an average of 14:48
21 16 per day which increases your workload by 480 a
22 month. Dermatology, a new consultant, 176.
23
24 So, these are all capacity. You are already -- these
25 are on top of the staffing issues? 14:49
26 A. Yes.
27 332 Q. So you have the staffing issues and then the additional
28 capacity put on with no funding?
29 A. Yes.

1 333 Q. It's clear from reading that that your department has
2 no control over any of this?
3 A. No.
4 334 Q. Are these decisions that are -- I don't want to say
5 foisted upon you but to which you are subjected made by 14:49
6 others?
7 A. Yes.
8 335 Q. Did anyone ever come to you and say we're going to do
9 this, it is going to increase your capacity by X, do
10 you have the ability to manage that? 14:49
11 A. No. It was this is what we need to do to manage our
12 service and to get the patients through and meet the
13 timeframes.
14 336 Q. If a new clinic was put on and you weren't funded to
15 service that, it was beneficial to patients but it 14:50
16 stretched your staff even further?
17 A. Yes.
18 337 Q. There is one other email if we can just look at, where
19 you have attempted to drill down into the actual time
20 it takes for staff to track charts. That's at 14:50
21 TRU-164934. It's from you to Pamela Lawson and Kate
22 Waters.
23
24 "Could we take a four-week period and keep a tally of
25 charts which haven't been tracked and where time has 14:50
26 been wasted looking for a chart which hasn't been
27 tracked, something like below but if you want to add in
28 more columns work again. It is just so we get a
29 picture of what happened with the chart. Thanks".

1
2 Then you have asked that to run from 15th December and
3 have it to you by the 20th. You have provided a
4 template there. Was that chart filled in; was it
5 completed, do you recall? 14:51
6 A. We did do some of that. I did look through my
7 documents but I couldn't find it.
8 338 Q. Okay. We mentioned earlier - just moving on to -- is
9 there anything you would like to say about staffing or
10 resources or capacity at this point in your evidence, 14:51
11 given what we've talked about all day?
12 A. That's the reason why we didn't do sort of the
13 additionals and the extras and that good housekeeping.
14 It really was we just survived; we weren't resourced
15 for it. Even in the work plan there were quite a few 14:51
16 things written about storage and moving charts here and
17 there. Storage was a huge issue with regards to Health
18 Records and you never have enough. So, we got a new
19 facility and it was setting that up. Everything takes
20 time. It's not just bundle a few charts and put them 14:52
21 somewhere else. You had to create space, get your
22 filing system. So, we would have spent a lot of time
23 in storage and that was difficult as well. It's
24 something we weren't resourced for either.
25 339 Q. Now, I did mention risk register. I just want to come 14:52
26 back to it. I won't take you to risk registers that
27 don't record the charts at home or charts not tracked
28 because I am taking you to something that's not there;
29 you know that yourself.

1 A. Yes.
2 340 Q. I want to give you the opportunity to explain why,
3 because you've clearly in your evidence identified both
4 charts not being located and charts at home as
5 representing, perhaps if I could put it as an 14:53
6 escalating risk for patient safety and care, but you
7 didn't put it on the risk register. According to your
8 statement - I don't need to go to this but, for the
9 Panel's note, WIT-61196 - as it wasn't something you
10 could control or effect a change. Could you just 14:53
11 explain a little bit your understanding of the risk
12 register was only something if you could do something
13 about it --
14 A. Yes.
15 341 Q. -- that you put it on? 14:53
16 A. Yes. We had, my managers and myself, we had our own
17 risk register. That would have been things like the
18 bay in records broke down, what would we do, how would
19 we mitigate a risk? How would we make sure our
20 equipment was okay? Those were things that we could 14:53
21 control, so that was on my risk register.
22
23 With regards the issue of Mr. O'Brien having his charts
24 at home, I couldn't control it, the only thing I could
25 do was escalate it. That's my impression of the risk 14:54
26 register. It would say in the documentation that the
27 risk should sit with the appropriate directorate or
28 service. To me, the risk was that the chart was at
29 home and not on a Trust facility. I couldn't control

1 that because I didn't have the line management for the
2 consultant, therefore I didn't have it on my risk
3 register. But Anita had highlighted it to Heather to
4 say should you have that on your risk register.
5 342 Q. And do you know if she did? 14:54
6 A. I don't know.
7 343 Q. Did you ever see it on a risk register?
8 A. No.
9 344 Q. Can you see now that it might have appropriately sat on
10 yours? 14:55
11 A. In hindsight, yes. If I had referred it to Anita to
12 have sat on her risk register, then it would have been
13 discussed at the AD governance meeting. If it had sat
14 on my personal one, it wouldn't have went, it just
15 would have just been discussed with ourselves. 14:55
16 345 Q. So your understanding of the risk would have been it
17 was sitting with people who couldn't do anything about
18 it?
19 A. Yes.
20 346 Q. In order for something to be done about it, it had to 14:55
21 go up?
22 A. Yes.
23 347 Q. And you don't know if it did go up on to Ms. Carroll's?
24 A. No. Well, I know I didn't put it up.
25 348 Q. Would she have known about it as a risk? 14:55
26 A. Yes, she would have known but that's why she escalated
27 it on to --
28 349 Q. To Heather Trouton, I think. There are some emails
29 there for the Panel's note just; emails escalated to

1 Martina Corrigan and Anita Carroll. The references are
2 and WIT-11964; WIT-61499 to 61506.
3
4 You did say you raised these issues with Martina
5 Corrigan, but there are no notes of that, it was 14:56
6 orally, you spoke to her about it?
7 A. Yes. We worked in offices beside each other.
8 350 Q. Now, Heather Trouton, in her statement at WIT-12156,
9 says that she on reflection she can see both the
10 frustration of the staff and Mr. O'Brien struggling. I 14:56
11 will just read out this paragraph at 499:
12
13 "When I read the emails of that time from myself and
14 others, I can see a frustration regarding the lack of
15 capacity across the board; a frustration with the 14:57
16 practice of Mr. O'Brien regarding delays in triage,
17 leaving patient notes at home, and his often dismissive
18 attitude to core systems and processes which were very
19 often regionally directed and locally agreed. I can
20 also see a relatively small number of clinicians and 14:57
21 managers working extremely hard to manage many
22 services, elective and unscheduled care flow across two
23 acute hospitals, underfunding and staffing constraints.
24
25 "I also see a consultant who struggled to adjust to the 14:57
26 use of technology and to working in a multidisciplinary
27 team who were there to support his practice, to allow
28 his expertise to focus on the aspects of care that only
29 he could do, leaving other aspects of care that could

1 be done by others to those others. I believe that he
2 genuinely struggled to adjust to the volume of patients
3 needing to be managed. I think that while other
4 consultants adjusted their practice to meet time slots
5 at clinics, Mr. O'Brien was just unable or unwilling to 14:58
6 adjust".
7
8 Were you aware of there being problem with consultant's
9 use of IT systems or seeking help in that record?
10 A. No. 14:58
11 351 Q. Is that something that you would have any involvement
12 in seeking to familiarise consultants with?
13 A. No.
14 352 Q. Do you know who does?
15 A. If I have staff member coming in, they will get 14:58
16 training on PAS and Patient Centre, but that's the only
17 IT training we would get, so I would assume that there
18 would be no IT training for consultants.
19 353 Q. Just one other area I want to deal with. Waiting times
20 pressure is another thing you've mentioned, where you 14:59
21 have said that every Trust was under immense pressure
22 to ensure that all patients were seen in an appropriate
23 timeframe. That's at WIT-61179. What we've mentioned
24 earlier, clinics were set up at short notice which was
25 good for patients but put great strain, as you've said, 14:59
26 on all staff, including Health Records staff, because
27 they had to get the charts at short notice for newly
28 arranged clinics and make sure charts were at the right
29 hospital for the clinic.

1
2 "Staff could not plan their workload as would have to
3 make a journey for just one chart due to the timeframe
4 they were working to".
5 A. Yes. 14:59
6 354 Q. In real terms for someone like me who doesn't know the
7 way that system operates, the waiting time, the
8 turnaround time is much tighter; is that what it is?
9 A. It was really -- you had to have your patients your
10 outpatients seen within nine weeks, and that was very 15:00
11 stringently monitored. Everything had to be done to
12 make sure that every patient did not breach. So, right
13 up to the very last, you would have been trying to get
14 additional clinics. Maybe for some reason a consultant
15 maybe was meant to be on leave and wasn't on leave and 15:00
16 would have said do you know what, I can do a clinic
17 tomorrow for you. That would have been finding that
18 out today; the booking centre would have had to start
19 phoning patients to get them in, so Records couldn't
20 get the chart until slots were booked. 15:00
21
22 The way Records would work is that you have your set
23 amount of clinics. Say I pull 20 clinics this week, I
24 would have pulled up my pulling list, and then the
25 pulling lists are in numerical order. You took your 15:01
26 list and you had eight libraries to go around. You
27 went and there is all the charts for this library, you
28 put them into the trolley. So you were actually
29 efficiently working round the eight libraries and

1 coming back with your trolley full of charts for these
2 20 clinics.
3
4 But you would have been pulling maybe five days ahead,
5 so you had a wee bit of leeway just to do that. 15:01
6 Whereas if you were having a clinic that was going to
7 take place at nine o'clock in the morning and you were
8 finishing at 5:00, you had to keep a wee eye, there is
9 another one added in, I will run down to that, I will
10 run down to that library and you didn't have time to do 15:01
11 your other 20 clinics, so you became inefficient. You
12 did get the clinics pulled but you were doing it
13 individually rather than en masse. So, it was just an
14 inefficient way of doing things.
15 355 Q. Heather Trouton says: 15:02
16
17 "The culture of Acute Services was a culture that was
18 focused on performance and financial efficiency".
19
20 Do you agree with that? 15:02
21 A. Yes.
22 356 Q. For the Panel's note, that is WIT-12157.
23
24 I'm very close to finishing but there is one other
25 topic that I just want to cover. I wonder if we can 15:02
26 just have a short break at this point, if you don't
27 mind?
28 CHAIR: Okay. We'll come back at 3.20 then.
29 MS. McMAHON: Thank you.

1
2 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:
3
4 CHAIR: Good afternoon. Ms. McMahon.
5 MS. McMAHON: Mrs. Forde, the end is in sight. Just a 15:24
6 couple of things to finish off with. First of all, I'm
7 grateful to Mr. McGarvey who found a reference to you
8 reporting the Emergency Department need for notes that
9 weren't available. The Panel can find that at
10 WIT-61506, an email dated 21st January 2015. 15:25
11
12 The other thing I want to turn to just briefly is the
13 data that was collected about other surgeons around
14 notes being coded out to them. I think if we look at
15 emails between you and Ronan Carroll and Anita Carroll 15:25
16 dated 19th and 20th July 2017. They can be found at
17 TRU-164929. They go on until 164932.
18
19 These are series of an emails working backwards. I
20 think this is the start of it, from you to Anita 15:26
21 Carroll dated 19th July 2017. The subject is "Example
22 of charts tracked out to consultant's office". You
23 have put a list of consultants there. Mr. O'Brien is
24 not on that list. Some consultants have zero against
25 their name, one has 96, one has 61. I'm not sure if 15:26
26 that's the same Mr. Young from urology, he has 26.
27
28 Were you asked to collate this data for a reason?
29 A. Ronan had spoken to Anita to say he would just like to

1 see what charts were in offices. Now, having read
2 through the work bundle, I see that Ronan had been
3 talking to Martina about charts in Mr. O'Brien's office
4 and he must have -- they must have decided they wanted
5 to get a comparison. So he had asked Anita, then Anita 15:27
6 had come through to me just to get some of the
7 information. So I got this and then they came back and
8 said they wanted a few of the urology ones. There was
9 a bit of backwards and forwards and then there is the
10 final list. 15:27
11 357 Q. As we move up the top?
12 A. Yes.
13 358 Q. These are, I think, general surgeons?
14 A. Yes.
15 359 Q. He that number of 96, is that quite high? 15:27
16 A. Yes, but Mr. Epanomeritakis would have had a lot of
17 charts in his office. I'm not sure of the way working;
18 him and his secretary would have a lot of charts. I
19 think it is to do with results.
20 360 Q. There is another number there, 61; it's quite a high 15:28
21 figure as well?
22 A. It depends on their systems of work, you know, if they
23 are waiting for things to come back or if they have a
24 lot of correspondence with other consultants that they
25 keep the chart for reference for. 15:28
26 361 Q. The issue for you is knowing where the chart is?
27 A. Yes.
28 362 Q. Rather than why it is there?
29 A. Yes.

1 363 Q. Then, Ms. Carroll has got back to you, copying Mr.
2 Carroll in, saying: "Thanks Helen. Ronan do you need
3 more". He replies: "These are mostly GS", I presume
4 that is general surgeons. "What about his peers". He
5 names Haynes, Glackin and Mr. O'Donoghue. 15:29
6
7 So, you have narrowed it down at this point. You reply
8 and say there you go, Mr. Glackin 34, Mr. O'Donoghue
9 six and Mr. Haynes zero. Then Anita asks: "Why so
10 different. Do any secretaries have tracking codes or 15:29
11 is it only doctors?"
12
13 Is that an unusual question from your boss to ask about
14 the way charts are allocated out?
15 A. No, because it would be specific. I know that, yes, a 15:29
16 secretary will have a tracking code and the doctor will
17 have a tracking code. Other people might know, well,
18 there are tracking codes but they wouldn't need to know
19 the specifics of what the tracking codes are.
20 364 Q. Up until 2017, it does -- well, I'll suggest that it 15:30
21 does reveal perhaps a lack of understanding about the
22 way in which charts are tracked?
23 A. Yes.
24 365 Q. Up until 2017, charts not being available and being
25 missing has been certainly apparent on the documents we 15:30
26 have gone through today. I think you then explain, if
27 we just move up. You say:
28
29 "The majority of charts are in the secretaries' office

1 and they have their own tracking code and then the
2 consultant has his or her own tracking code for their
3 office". If we move up.
4
5 Then she says: 15:30
6
7 "For example, if you look at Mr. Haynes, how many are
8 with the secretary and for AOB how many with his
9 secretary?"
10 15:30
11 That would involve you then looking at the secretarial
12 code, I imagine?
13 A. Yes.
14 366 Q. If we move up, you provide the answer. Haynes
15 secretary 87, AOB secretary 154. Again, your lack of 15:31
16 concern as you're revealing it now, because you know
17 where the charts are if you need to get them; do you
18 understand what the purpose was of seeking these
19 particular figures?
20 A. I think it was just to compare to see was Mr. O'Brien's 15:31
21 out of the ordinary in comparison with the other
22 consultants.
23 367 Q. But there was no suggestion before this email trail to
24 trigger it that charts were being looked for and
25 couldn't be found? 15:31
26 A. No. This was just as a comparator.
27 368 Q. Just as a comparator. Again, another document recently
28 just provided by the Trust, TRU-164933. This is an
29 email of 9th October 2017. Again, was this a request

1 or was this just the way that you kept data as the
2 manager? Did someone ask for this?
3 A. No, someone would have asked for this. It was just
4 sort of a bigger list of the consultants.
5 369 Q. All of the consultants in Acute? 15:32
6 A. That wouldn't be all of them. That would be just be a
7 few of them; just a sample.
8 370 Q. Okay. If we just move down, is that Mr. O'Brien at
9 number 19?
10 A. Yes. 15:32
11 371 Q. His figure is 36. There is someone else at 46, and 16.
12 Number 4 is 51. There are four others with higher
13 figures. Again, without any other context, what would
14 this tell me by looking at this? Just who had a number
15 of charts in their office that had been tracked out? 15:32
16 A. Yes.
17 372 Q. It doesn't tell you what you don't know, which is what
18 hadn't been tracked out or what you can't find?
19 A. That's just the tracking code there. You see under
20 "code", you would put that in and just request to run. 15:33
21 It would give you a list of all of the patients who are
22 under that code, and then a tally at the end to say
23 there were 25 on this list. That is all it tells you.
24 373 Q. Did you ever have to deal with another consultant about
25 not being able to find charts? I know we have talked 15:33
26 about the charts at home and that was your particular
27 concern, but just generally?
28 A. Well, if a chart was missing and you saw the
29 consultant, you would have said have you any charts.

1 Like that would just have been a routine thing. If you
2 were looking for a chart that you couldn't find,
3 anybody at all you could ask, you would have asked
4 them.
5 374 Q. Was it a particular problem with our consultants? 15:33
6 A. No.
7 375 Q. You've mentioned some things about improvements that
8 could be made, and you obviously can add to that if
9 you've had time to reflect. But just for the Panel's
10 note - I don't need to bring it up - it's WIT-61199. 15:34
11 You've suggested some having confirmation that the
12 concern that has been raised and an outcome of the
13 discussion provided. I presume that means that is in
14 the context of having escalated something and somebody
15 getting back to you; is that what you mean by that? 15:34
16 A. Yes.
17 376 Q. And to see a change of practice with the concern being
18 resolved. I'll read the paragraph out rather than give
19 you my bullet points. You say:
20 15:34
21 "Improvement could come in the way of having
22 confirmation that the concern is raised and an outcome
23 of the discussion provided, and to see a change in
24 practice with the concern being resolved".
25 15:35
26 Is this up until the time that you retired, you felt
27 there had been no change in that first part of that
28 paragraph?
29 A. Well, yes, there wasn't an awful lot of feedback about

1 anything. You know, in general you would have raised a
2 concern or here's an issue, but there wouldn't have
3 been much in feedback and really nothing in formal
4 feedback if there were issues.
5 377 Q. 15:35
6 "I feel that concerns should be raised in a more formal
7 platform with formal feedback being received regarding
8 the concern rather than verbal conversations".
9
10 Was there a lot of chat rather than things written 15:35
11 down? Was that your experience, at your level?
12 A. Yes, and again due to the busyness of the service. And
13 also I would say due to lack of admin support for Heads
14 of Service and ADs.
15 378 Q. Do you think when a concern was written down, it was 15:36
16 taken more seriously?
17 A. It may not have been taken more seriously but I think
18 this shows you that at least you would have had a trail
19 and you could have proven what you did. Like I've had
20 to say to you, yes, my conversations would have been 15:36
21 nipping into the office and saying. That's less formal
22 than here is a piece that you could follow up on. It's
23 easier if you have something documented to be able to
24 follow up and say, well, what action has been taken,
25 what has happened from the last time we raised this. 15:36
26 Whereas the way we dealt with informal conversations
27 doesn't give rise to that opportunity.
28 379 Q. Was the culture such that people tended to follow other
29 people's example of just dealing with things

1 informally?
2 A. Well, yeah.
3 380 Q. You say:
4
5 "In hindsight I feel I should have been much more 15:37
6 formal in my approach to this concern, detailing every
7 conversation, asking for follow-up, requesting a formal
8 meeting to discuss when things did not change".
9
10 That's specific to the issues that arose in the charts 15:37
11 and the charts at home?
12 A. Yes. I would say in general. You know, this has given
13 an opportunity that you can look back and say what
14 would you do. You know, meetings, having them typed
15 up, we didn't do that. But again, we didn't have the 15:37
16 time and we didn't have the resource. If I were to
17 arrange a meeting, I would have had to arrange it, book
18 the meeting, take the notes, do the agenda, make sure
19 the follow-up actions were done. You just didn't have
20 time to do it as well as it should have been done. 15:37
21 381 Q. The way you describe it, to do it properly was more
22 work?
23 A. Yes.
24 382 Q. Obviously you held your post for a long time. Is there
25 anything else, any other suggestions or anything else, 15:38
26 information you want to give to the Panel to help them
27 in their consideration of all the issues and their
28 recommendations?
29 A. I think just a more formal structured approach. Maybe

1 like even our documentation that we kept, if there
2 would have been a central area that not everyone had
3 their own minutes or had to pull. I think if you just
4 went and it was all stored in one area, you knew you
5 got the most up-to-date set of minutes or information 15:38
6 that was available. It would have reduced everybody
7 pulling out minutes, getting paper copies, something
8 like that. But I do think more admin support for the
9 Heads of Service would have helped a lot.
10 383 Q. I don't have any further questions. The Panel may have 15:39
11 some questions for you.
12 CHAIR: Thank you, Ms. McMahon. Sorry, we can't
13 release you just yet. I am going to ask Mr. Hanbury if
14 he has some questions for you.
15 15:39
16 MRS. HELEN FORDE WAS QUESTIONED BY THE PANEL AS
17 FOLLOWS:
18 384 Q. MR. HANBURY: Just a couple of questions for you.
19 Hopefully nothing too taxing.
20 15:39
21 Notes in bin, I know this was before your time in
22 charge. One of the problems as clinician, especially
23 when you see complicated patients on the ward, there
24 are huge heaps of paper notes, or at least were 10 plus
25 years ago. Obviously ward clerks are under your 15:39
26 supervision. So, did they have instructions to sort of
27 weed -- not exactly weed but do something with what we
28 call fat notes - a prescriptive term - to make them
29 more easy and efficient to be looked at by the

1 clinicians looking after them in the ward?
2 A. Yes. Whenever -- if a patient was due to be admitted
3 we had a standard that was if the chart was any thicker
4 than that, then it had to be made into what would we
5 would have called a reserve chart. That would have 15:40
6 been done in Health Records before it actually went to
7 the ward. So, you would have had -- and there was like
8 a protocol of what you took out and put into the
9 reserve and what you kept in the current chart. Then
10 whenever the chart was on the ward, the ward clerk 15:40
11 would have filed it up but they would have also created
12 reserve charts. We would have training for ward clerks
13 in how to create a reserve chart. There would have
14 been occasions that maybe they were really, really busy
15 or short-staffed, records would have helped in that 15:41
16 case too. But we did have a protocol on how to create
17 a reserve chart and staff were trained in it.
18 385 Q. So when Mr. O'Brien complained about that complicated
19 patient and couldn't find anywhere to write, do you
20 recognise that as... 15:41
21 A. That was before I was over the ward clerks.
22 386 Q. So that may have been a problem at that time.
23 A. Yes.
24 387 Q. Okay. Thank you. I think you should be congratulated
25 on your 99.5 availability. That's a massive 15:41
26 achievement with such a busy hospital, I have to say.
27 The temporary notes rings a bell with working in a
28 similar-sized hospital as Craigavon. Your description
29 of how you make up what we call a red set or a

1 temporary set, obviously if you have the referral
2 letter and some old letters on the EPR, then you can do
3 your best, but if you haven't got the letters, on the
4 EPR?
5 A. Well, if there weren't any letters, then we wouldn't 15:42
6 have any recent history because ECR went back to back
7 to 2013 but we were using Patient Centre to write
8 letters prior to that, so you would have checked there
9 to see if there was any outpatient letters. That would
10 have been the history going back prior to 2013. It 15:42
11 wasn't recent.
12 388 Q. But if there had been a problem with dictation, then
13 that could have impacted that particular scenario,
14 possibly?
15 A. Yes. 15:42
16 389 Q. Thank you. Was there sympathy for the surgeons digging
17 their heels in and not doing surgeries when the full
18 set of notes weren't available? Did you feel that was
19 reasonable or unreasonable?
20 A. It depended. I think it was sometimes you sort of 15:42
21 thought you could have seen the patient with the
22 information that we have given you, but then there are
23 other times, you know... It didn't happen that often
24 but, you know, you had more of a sympathy for the
25 patient. 15:43
26 390 Q. Absolutely. I was trying to draw out a distinction
27 between seeing a patient in a clinic, and I agree with
28 you, and doing a fairly major surgical procedure where
29 not having one bit of information might be important.

1
2 Any other dangers of temporary sets of notes that you
3 saw?
4 A. Just you have missed -- you could miss some pertinent
5 information. Not everything on NIECR. You would have 15:43
6 the pulmonary tests, and cardiac rehab tests. So that
7 information would have been in the chart and not
8 available on ECR.
9 391 Q. If you were thinking about a big operation on a less
10 well person? 15:43
11 A. Yeah.
12 392 Q. Thank you. I'd say you are quite unusual for having an
13 EPR for quite a long time actually. The interesting
14 thing for me sort of looking down is actually if you
15 have had an EPR for 10 years, the clinicians and you 15:44
16 are still very reliable on the paper notes, which would
17 sort of suggest that EPR wasn't completely relied on in
18 a way that one might assume. Any comment on that?
19 A. The issue we had, because I did try to go -- our ethos
20 in Records was let's try and go paper light; never 15:44
21 thought we would get paperless. We had approached some
22 consultants to say could you do your clinic without the
23 actual hard copy notes? Some of the consultants had
24 said yes, they could. However, the respiratory
25 consultant said I could do without the note but I don't 15:44
26 have the results of the pulmonary functions test and I
27 need that. We had went to a rheumatologist and he said
28 I could do the clinic without the notes. However, if I
29 give an injection, I need to be able to put the

1 reference code somewhere, and our NIECR does not let
2 you record any information on it. So, if we had a
3 recording module where they could have typed in the
4 serial number, or they could have typed in the height
5 and weight and urine of a patient, they could have done 15:45
6 without the paper note, but until we get in compass
7 where you can actually record under the electronic
8 record, we weren't in a position to go without the
9 chart.
10 393 Q. Not without thinking about it. Final question from me. 15:45
11 Mr. O'Brien's private practice was slightly unusual.
12 What were your thoughts on him requesting Southern
13 Trust notes to take to his house for private
14 consultations and actually writing in them too?
15 A. Well, that would not be the usual practice. I could 15:45
16 understand if he wanted to look for the private notes
17 to get a history, but your chart was not for private
18 patient or medico-legal recording, it was purely for
19 the clinical work and activity within the Trust.
20 394 Q. Is that covered by any Trust protocol that you are 15:46
21 familiar with? I know we talked about protocols
22 earlier.
23 A. No.
24 395 Q. Again, were you aware of any other consultants who
25 practised privately like that? 15:46
26 A. I know that there were consultants who worked privately
27 but not aware that any of them ever actually used the
28 notes to record anything in. They may have requested
29 the notes for a history, but not to record.

1 396 Q. Thank you. That's all I have for you.
2 CHAIR: Thank you. Dr. Swart.
3 397 Q. DR. SWART: I am equally impressed that 99 point
4 something of notes were available. I don't know of any
5 hospital I have worked with where that's been the case. 15:46
6
7 Going back to Datix, it seems strange there was an
8 issue that kept occurring and Datixes were recorded and
9 yet there was an instruction to stop recording them.
10 The purpose of Datix, as you know, is to learn. Did 15:47
11 you go, as Head of Health Records, to any Trust-wide
12 meetings where you talked about the value of Datix or
13 otherwise and the learning across other departments and
14 things of that nature.
15 A. No. 15:47
16 398 Q. Was that facilitated?
17 A. No. To be honest, a lot of regional meetings were
18 stopped due to financial constraints and travel. There
19 was a period of time where really we didn't travel at
20 all. 15:47
21 399 Q. I mean, within the Trust, though. Generally there will
22 be a Trust-wide meeting where directorates, divisions,
23 whatever you call them, can learn from each other
24 because it is not always immediately obvious to people
25 what happens to a Datix, as you've described. 15:47
26
27 On the same vein, you're head of Medical Records; this
28 generally falls under information governance in its
29 broadest sense. Were there meetings, quarterly, twice

1 a year or something, where you could discuss the
2 strategic issues around the management of records,
3 around IG issues, where you had senior management
4 present, for example?
5 A. There was an information governance meeting which was 15:48
6 held, I think, quarterly. Then, my Assistant Director,
7 Anita Carroll, she was present at those meetings.
8 400 Q. But you weren't there?
9 A. No.
10 401 Q. So you didn't have the opportunity to go to that sort 15:48
11 of forum and talk about where you are going to go?
12 A. No.
13 402 Q. No. Okay, thank you. In a similar vein, do you think
14 the people in senior management of the Trust actually
15 understood the issues of Records on the ground? How 15:48
16 much contact did you have in terms of being able to
17 explain the reality in where you work, as we have
18 indeed heard today?
19 A. I just don't think it would have been held -- it
20 wouldn't have had the profile that meeting the targets, 15:48
21 meeting the financial stability, having beds for
22 patients. I think Records fell a lot lower down in the
23 pecking order.
24 403 Q. You have described about, I think you called it silos -
25 other people have used the same term - where you felt 15:49
26 that the reporting lines were separated from each
27 other, different levels of staff. Quite a lot of
28 people have described an inability to challenge medical
29 staff. Did you feel that medical staff were treated

1 differently from other staff with respect to
2 discipline; disciplinary procedures, for example?
3 A. Well, they definitely would have been treated much
4 different to my staff.
5 404 Q. How did you feel about that? 15:49
6 A. Well, I think it's unfair. We are all members the
7 Trust and we are all on the payroll.
8 405 Q. What do you think the disadvantage is of that
9 atmosphere in terms of patient care?
10 A. There is a lack of control then at the top if the 15:49
11 consultants have one way of working but it doesn't
12 match or marry with how the Trust wants to take
13 forward.
14 406 Q. Where does that impact, do you think? Where do you
15 think the impact is felt in the end? 15:50
16 A. Well, I suppose ultimately it would be with the
17 patient.
18 407 Q. Another thing. There is a sense that nobody had the
19 ability to direct Mr. O'Brien to do something
20 completely differently. I think you have said the 15:50
21 responsibility for that was in the medical line. Do
22 you think there was any reason why that didn't happen
23 from your perspective? What was your view?
24 A. My impression would be an unwillingness to challenge.
25 408 Q. Okay. Lastly, what was your sense of where you could 15:51
26 get your direction from? You're head of a very
27 important department, it may not have been high in the
28 pecking order, but where did you seek your inspiration
29 for strategic direction from if you didn't go to any of

1 these forums like that? Who gave you that?
2 A. Well, I would have talked to my Assistant Director. I
3 would have talked to the Head of Information
4 Governance. Any chance I had or any opportunity to
5 talk to say somebody, say from the Royal or the City, I 15:51
6 would have used that.
7 409 Q. Were there any regional meetings at all to actually
8 talk?
9 A. Very few. We did have a meeting about the contract of
10 the offsite storage. I would have known the girls 15:51
11 there and we would have all taken the opportunity to
12 say what are you doing, what is your problem. A more
13 informal basis.
14 410 Q. Did you have any exposure about what the thinking was
15 about the strategic direction of the Trust as a whole? 15:52
16 A. No.
17 411 Q. Were you part of that?
18 A. No.
19 412 Q. CHAIR: Just a few questions. The 13 missing are
20 charts that were tracked out to Mr. O'Brien and it's 15:52
21 accepted across the board that he didn't have them.
22 How did they come to be tracked out to him?
23 A. It was his secretary that actually tracked those charts
24 out to him.
25 413 Q. Okay. You talked about this new system of iFIT. It 15:52
26 strikes me that while iFIT that you've described, the
27 system that you have described which may or may not be
28 operational soon, will be able to track a chart as it
29 moves around the hospital premises and if it's

1 transported by Trust transport to SWAH, then it will be
2 able to tracked around that facility, but it really
3 wouldn't address the issue of charts being held at
4 home, would it?
5 A. No. The only thing it would show is that it's not 15:53
6 in --
7 414 Q. It went out of the building?
8 A. Yes.
9 415 Q. But it wouldn't say where?
10 A. No. 15:53
11 416 Q. All you would have, presumably, would be the last
12 person to whom it was tracked out, in a similar way
13 under the old system?
14 A. Yes.
15 417 Q. Just one final question just about the Trust 15:53
16 transporting of documents. Can you offer us an
17 explanation as to why there wasn't a transport run to
18 the South Western Acute Hospital?
19 A. I would presume that they just didn't have the capacity
20 to take on a run like that for one clinic. 15:53
21 418 Q. Were there other clinics from the Southern Trust that
22 were held in SWAH?
23 A. No.
24 419 Q. Just those urology ones?
25 A. Yes. 15:53
26 CHAIR: Thank you very much, Mrs. Forde, that has been
27 very helpful. I think we have concluded your evidence
28 unless there is something else that you wanted to ask?
29 MS. McMAHON: No, I am finished.

1 CHAIR: Thank you, Ms. McMahon. Ladies and gentlemen,
2 just to alert you...
3 MS. McMAHON: It has been confirmed that we are unable
4 to sit tomorrow.
5 CHAIR: Okay. I just want to make it clear that it's 15:54
6 due to counsel's unavailability tomorrow. We won't be
7 sitting tomorrow and we will sit again on Thursday
8 morning okay. Thank you.
9
10 THE INQUIRY ADJOURNED TO 10:00 A.M. ON THURSDAY 27TH 15:54
11 APRIL 2023
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