Urology Services Inquiry

Oral Hearing

Day 59 – Wednesday, 13th September 2023

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

Gwen Malone Stenography Services

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THE HEARING COMMENCED ON WEDNESDAY,
13TH DAY OF SEPTEMBER, 2023 AS FOLLOWS:

CHAIR: Good morning everyone.

MR. WOLFE KC: Your witness this morning is Mr. David Cardwell and he'll take the oath. 10:00

MR. DAVID CARDWELL, HAVING BEEN SWORN, WAS DIRECTLY EXAMINED BY MR. WOLFE AS FOLLOWS:

10:00

MR. WOLFE KC: Good morning, Mr. Cardwell.

THE WITNESS: Good morning.

1 Q. Thank you for coming along to the Urology Services Inquiry. The first thing to do is to connect you with the statements that you have provided to the Inquiry to 10:01 date and to have you adopt those as part of your evidence, if you're content with that. So starting with your primary witness statement in response to Notice 16/23. We can find that at WIT-99184. And you'll recognise that? 10:01

A. Yes.

2 Q. We have put an annotation on the top of it to indicate that you have added to that statement with an addendum which I'll bring you to just presently. So let's go to the signature page for this statement, it is at 10:01 WIT-99215. You'll recognise that as your signature?

A. That's correct.

3 Q. And it is dated 15th August 2023.

A. Yes.

4 Q. Are you content to adopt that statement as part of your evidence subject to the revisions referred to in your addendum?

A. I am, yes.

5 Q. Thank you. Then the addendum received from you late last week I think, it's at WIT-100354. There you go. And it runs through to WIT-100366 -- yes, it is 366 in the series because you have added a document to it. But the signature page, if we go to WIT-100356. So, much of this statement is taken up with correcting some formatting issues around paragraph numbers; isn't that right? 10:02 10:02

A. That's correct, yes.

6 Q. It's not terribly substantive. I think the one substantive point is to add a document in association with the Patient 102 Datix, which we'll come to in a moment? 10:03

A. Yes, that's correct

7 Q. Isn't that right?

A. That's right. 10:03

8 Q. Thank you. So as appears from your statements, Mr. Cardwell, you had your hands on, I suppose, aspects of some of the key instruments of governance or some of the key tools of governance in what has been, I suppose, a fairly lengthy career so far within the Craigavon Hospital Trust and subsequently the Southern Trust; isn't that right? 10:03

A. That's correct, yes.

9 Q. And some of those key instruments or tools of

governance are Datix, SAIs and complaints processes?

A. Yes.

10 Q. And you have a detailed overview of each of those that you are going to assist the Inquiry with this morning. Let's start with your current employment, you're currently employed within the Southern Trust as a Band 7 Clinical Governance Manager within the Acute Directorate; isn't that right? 10:04

A. Yes, that's correct.

11 Q. You have been in that role since about April 2019? 10:04

A. April 2019, yes.

12 Q. Yes. I note from your statement that relatively recently you interviewed for the Coordinator's role within Acute, that's the role we heard so much about yesterday from Trudy Reid, but you having been offered that role, declined to take it up? 10:04

A. That's correct, yes.

13 Q. You have helpfully for the Inquiry set out a table identifying your career history, a bit of a summary of your job descriptions and those who you reported to or who you managed in staff terms. Just to familiarise the Panel with that, it may ease their note taking, it's WIT-99242. We can see how it is set out, starting with the role of Patient Client Liaison Manager which was the first post that you had within the Southern Trust; isn't that right? 10:05 10:05

A. That's correct, yes.

14 Q. So looking at your statement, you have been employed within the health service since August 1993, initially

in a range of administrative posts but the post at the top of this table is your first role within the Southern Trust?

A. Within the Southern Trust, that's right.

15 Q. And that primarily involved the management of complaints; is that right? 10:06

A. Yes.

16 Q. That was everything from receiving complaints by phone or in writing, allocating the complaint to an operational team for investigation, coordinating and drafting response for the approval of the Assistant Director of Acute Services and you led a complaints team? 10:06

A. Yes, that's a summary of the post.

17 Q. Yes. I appreciate it is a summary and I don't want to do injustice to, I suppose, the fullness and complexity of your roles, but at this stage I'm at broad brush strokes and we'll delve into some of the finer detail. 10:06

A. Okay.

18 Q. You moved to a Clinical Governance Officer role in July 2011; isn't that right? 10:07

A. Yes, that's right.

19 Q. And again we can see it set out here. That post of Clinical Governance Officer, that was a post you entered into after the changes that were brought about following a review of clinical and social care governance within the Trust in 2011? 10:07

A. Yes, that's following that review I took up that post.

20 Q. Yes. I suppose one of the products of that review was

that, as I understand what you are saying in your statement, the day-to-day responsibility for clinical and social care governance had previously resided within the Medical Director's office or sphere of influence and that changed as of 2011 and clinical and social care governance was placed within the remit of the operational teams?

A. Yes.

21 Q. And in Acute there was obviously an acute governance office? 10:08

A. Yes. Up until 2011 we were managed and responsible to the Medical Director. Although we worked within a specific Directorate providing a service to that Directorate. In 2011, then governance was integrated into the Directorates and I took up a post within the Acute Services Directorate. 10:09

22 Q. Yes. I want to pick up on an aspect of that which you mentioned to me in consultation recently and that was what you described as the removal of a middle tier of management and the implications of that. I'll ask you questions about that in a moment. But the role of Clinical Governance Officer which is summarised on the screen for us, that had you reporting to the Coordinator? 10:09

A. That's right, yes. 10:10

23 Q. And initially that was Margaret Marshall?

A. It was, yes.

24 Q. Then that post of Coordinator was removed from the structure because of budgetary considerations?

A. Yes.

25 Q. And then eventually, after a 18-month or two-year hiatus Trudy Reid came into the post; isn't that right?

A. That's right, yes.

26 Q. Your role within that post continued to involve the management of complaints; isn't that right? 10:10

A. Yes, it did.

27 Q. But your duties expanded into the administration of the Datix system?

A. Datix system, yes. Risk registers, which we had not been involved prior to that. And then general governance training. 10:10

28 Q. Yes. I read at 5.3 of your statement that you supported the Coordinator in the management of incidents and the complaints process? 10:11

A. Yes. In respect of the complaints process, yes, that would have been the processing of complaints. And in respect of the incidents, that would have been the administrative system, i.e. Datix.

29 Q. Right. You became a Senior Governance Officer by reason of the fact that the post was rebanded to Band 6 in or about 2016; isn't that right? 10:11

A. That's correct, yes.

30 Q. Did that add to your duties or was that simply a rebanding of the post or re-evaluation of the post? 10:11

A. It was a HR process through the `Agenda for Change` where the post was put forward for rebanding. The duties remained similar to what they were from 2011 to 2016.

31 Q. Finally in your career history, I suppose, it has been your recent appointment, your 2019 appointment to Clinical Governance Manager and that's the post you remain in?

A. Yes. 10:12

32 Q. And you have described that as primarily involving the management of Serious Adverse Incidents?

A. That's correct, yes.

33 Q. On your descriptions that appears to be an end-to-end role from the screening of incidents, the notification 10:12 of SAIs to the HSCB, as it then was, and now the SPPG?

A. Yes.

34 Q. The coordination of the review teams, assisting chairs with the drafting of reports and facilitating family engagement? 10:13

A. Yes, that's correct.

35 Q. When I say end-to-end, there is obviously an important bit at the end of an SAI in terms of learning and the implementation of action plans?

A. Yes. 10:13

36 Q. As I understand it, those elements don't fit particularly within your responsibilities?

A. No. We have additional staff who are now employed by the Acute Services Directorate to take up actions as a result of Serious Adverse Incidents and 10:13 recommendations.

37 Q. Yes. And I'll maybe touch upon that later in your evidence.

A. Okay.

38 Q. Could I have up on the screen, please, WIT-99189. And you say, Mr. Cardwell, at paragraph 5.5 that:

"Reflecting on the content of the job descriptions, I do not consider these are an accurate reflection of the duties and responsibilities."

So this is talking about your job descriptions for --

A. Yes.

39 Q. -- your various posts? You say: 10:14

"There were a lot of duties in these job descriptions and given the volume of work within the Directorate, it was not possible without a workable structure below the level I was at to have completed all of the duties 10:14 listed. I consider this remains the current situation, especially with my current post which does not detail the day-to-day responsibilities that I have. I consider that I was and still am frequently working above the level that was described in the job 10:14 descriptions."

Now, just on that piece of analysis, did this become a particular problem after the reorganisation of governance in 2011? 10:15

A. I think so. Because prior to 2011 each person within the governance team had a defined role. I know from 2011 it still was a defined role but it was broadened. So essentially what I was being asked to do in 2011 was

to continue with my complaints role but add on to that incidents, risk registers and also governance training. And with the volume of complaints, MLA and MP inquiries that were coming into the Acute Services Directorate that was taking up to 80% of my time. So it left very little room for anything else of a proactive nature to be carried out.

40 Q. One of the, perhaps the key impediment to you fulfilling the terms of your job description, as you have highlighted here, was the absence of a workable structure below the level you were working at. Just help us to understand what that means, is that anything to do with the point I highlighted earlier, following the 2011 review there was, I think as you have told me, the removal of a middle tier? 10:15 10:16 10:16

A. Yes. Well, essentially when I refer to a workable structure below the level that I was at, I'm referring to people who were able to assist me with my role, as in admin support. In relation to the 2011 governance review, essentially what was in place prior to that was a Band 7 Risk Manager with admin support and then there was myself, Band 6 Patient Client Liaison Manager with admin support. Those two roles were removed from the revised governance structure and replaced with an 8B Governance Coordinator. So essentially those two posts were removed at that time. 10:17 10:17

41 Q. Okay. Focussing in on the deficit as it affected you, you - and I don't want to globalise your various job descriptions if it is unhelpful - but could you tell

us, I suppose looking forward from 2011, what aspects of your job descriptions which would have encouraged you to be proactive in your role and to engaging proactive governance tasks, which aspects had to be put to the one side, you simple couldn't go them because you didn't have the support or you couldn't do them as well or as fully as you would have liked to have done? 10:18

A. Well, as I saw it, it was in relation to the follow-up and learning from specific complaints mainly. Because that subsumed 80% of my role even though I was in the general governance role from 2011. So it was things like the learning from complaints, the proactive, being out meeting with staff, making governance visible. 10:18

42 Q. And as you have said, the admin support --

A. Yes. 10:19

43 Q. -- wasn't available to you. Did that then get you tied up with more admin than was perhaps usual for a post of your nature?

A. Essentially yes, because of the lack of admin support I would have been doing some general admin tasks as well as trying to fulfil the role of Governance Officer. 10:19

44 Q. Mm-hmm. Now, you reflect within your statement that, for example at paragraph 15.1, that you considered it, in your experience, clinical governance has been underresourced, as you have said, duties in your job description that you haven't been able to fulfil? 10:19

A. Mm-hmm.

45 Q. You say, at 15.2 of your statement, that, since the

inception of the Trust you consider that there could be what is described as an "element of instability" within the Acute Governance Team and you illustrate that by saying that:

10:20

"Since 2012 there have been six Directorate Governance Coordinators and an extended period when there was no Directorate Governance Coordinator in place."

And that was the period between Mrs. Marshall leaving her post and Mrs. Reid taking it up? 10:20

A. Yes.

46 Q. Against that context and that experience, what was it that you were seeing or recognising as, I suppose, the shortfall in governance activities, not just in your own role, and you have outlined that already, but across the piece, what did you think or what did you observe as being a deficit in the governance environment? 10:21

A. Well, to me it was the collation of information between various strands of governance that would have put you in a better position to look at complete trends. Mrs. Reid had referred to it as the triangulation of information. In relation to the visibility of governance, I believe that could have been better than what it was as well. 10:21 10:21

47 Q. Are you in a position to say what the, I suppose, practical consequences or risks were in association with those kinds of deficits, what was the impact of

this?

A. Well, the impact probably was that, you know, there was information there, it could have been used to identify specific issues. But because of the lack of resources and the ability to marry up that information, the opportunity maybe wasn't used as fully as it should have been. 10:22

48 Q. Yes. Let's move on to talk about the Datix system.

A. Yes.

49 Q. Could you help us by, I suppose, giving us a brief outline of, for the uninformed, what Datix is and what's its purpose as a governance tool within the Trust? 10:22

A. Yes. The Datix system is an IT system that we use within the governance team to capture issues in relation to incidents, complaints, risk registers, the litigation team can also use it. The information governance team can also use it for subject access and Freedom of Information requests. So it's really a repository for information from which you then can run various reports. 10:23 10:23

50 Q. So used to its fullest potential, what kind of practical advantages does a Datix system afford the Southern Trust in the operation of its governance arrangements? 10:23

A. Well, used to its full potential it should be able to identify trends and highlight areas of concern, using information from all strands of governance.

51 Q. So, complaints information?

A. Yes.
52 Q. Is it in there?
A. Yes, complaints information is held on that, yes.
53 Q. Yes. Incident reports are held in it?
A. Yes, incident reports. Each time a member of staff reports an incident, then it is held on the Datix system. 10:24
54 Q. Yes. Used properly, you should be able to use it to extract, as you say, trends?
A. Trends and information in relation to particular wards or departments or particular clinicians. 10:24
55 Q. Yes.
A. But I would have to caveat that with the information is only as good as the -- the system is only as good as the information that is put in to it. 10:24
56 Q. Yes.
A. So there are issues around data input.
57 Q. Yes. And you, your primary period of working with the Datix system directly as part of your day-to-day role is 2011 to '19? 10:25
A. 2011 to 2019.
58 Q. Yes.
A. So in respect of complaints, I would have been using the Datix system to run reports, both for the Department of Health, the SPPG, the HSCB at that time, and also Acute Services senior management. In respect of incidents, it would have been more an administrative role in relation to Datix. So it would have been making sure that Ward Sisters, Department Managers, 10:25

Head of Service had the right access levels and permission levels to receive notification of incidents. It would have been assisting staff with moving incidents from one particular area to another area if we found that the incident needed to be investigated by more than one service area. And in respect of risk registers, it would have been adding new risks to the risk register and then also receiving updates from Heads of Services on a regular basis and updating those on that system. 10:26

59 Q. In your experience over that eight-year period, do you feel that the Datix system was used by the Trust to its fullest potential?

A. I would consider that the system had more potential than what was used. I would also point out that there were a number of Datix systems, in that we started off with an original Datix system which belonged to one of the Community Trusts and that was developed to meet the needs of the entire Southern Trust. We then moved from that system to what was described as the Datix new system. Some information was kept on that. Then we moved from the Datix new system to the Datix developer system which contained some information. So not all information is kept in the same place. At this point I don't know that we're using the most recent version of Datix. I think there has been upgrades but we haven't been given those just yet. 10:26 10:27 10:27

60 Q. Yes. So you had that level of complication associated with different versions or different types of Datix

system?

A. Yes.

61 Q. In terms of the ability of the Trust to exploit, I suppose, the data potential, the trend building potential that this kind of repository offered - and plainly that would be important for a Trust to know where the hot spots are, where the risks are, where the problems are - was the ability or the resource available within Acute, to the best of your knowledge, to exploit that potential to its fullest? 10:28

A. No, I don't think it was. I think Datix and its management from the input of information, the quality assurance of the information that's input to the system and then getting that information back out into a meaningful report, the capacity wasn't there to deliver that. 10:28

62 Q. Yes. One of the problems perhaps is one you have pointed to in your statement at paragraph 8.5, you said that you would have received feedback frequently from staff who would have complained that the process of completing a Datix was cumbersome? 10:29

A. Yes.

63 Q. And obviously there is an investigator's guide and I don't need to bring it up on the screen. For the panel it's WIT-99436. It certainly looks somewhat opaque and cumbersome on the face of it. What was that complaint or could you better explain that kind of feedback you were getting from users of the system and what was its implication? 10:29

A. Well, I think the feedback that I would have been receiving would have been through conversations with the likes of Ward Managers and staff at ward level. And also during the training sessions that I would have provided in relation to Datix. And the staff would have been saying that they found the system cumbersome to use. It was time limited, in that whenever they logged in to submit an incident they only had 60 minutes to complete that. But in a busy ward environment, you know, they might start off with the good intention of submitting an incident but then be called off to deal with some clinical task. And, then, by the time they got back the system would have timed them out. There was probably, maybe, not a great awareness of what the staff at ward level, what their expectations were in relation to the reporting of incidents. So whenever they come to actually log on to the form and submit, and in some particular occasions it may have asked them information which they hadn't readily at hand, and if you can understand there were certain boxes on the form that were mandatory so if they hadn't that information to hand then they couldn't get past that. 10:30 10:30 10:30 10:31

64 Q. Yes. The Inquiry has observed some evidence, perhaps small in number in terms of the cases, of what might be described as underreporting, a failure to complete a Datix, notwithstanding the need to do so judged by the facts of a case. I'll show you an illustration of that later. Do you think there was any particular 10:31

disincentive associated with the cumbersome nature of the Datix entry arrangements, a disincentive to reporting on incidents?

A. I don't know that there was. Because prior to 2011 it was a paper-based system where it probably would have taken longer to complete the paper form than what it would have to have completed the form online.

65 Q. There is training associated with Datix or for users of Datix, is that primarily targeted at those with investigation responsibilities? 10:32

A. There are two levels of training and they were instigated by the Directorate Governance Coordinators at certain points. There was training in relation to general governance which would have touched on the Datix system. And then there was also training in relation to someone who is investigating a Datix incident and how they work their way through that process and what elements they should consider in their investigation. That was sporadic in its nature. And in my current role now since 2019, whilst in 2019 there were a number of sessions organised but when Covid kicked in then those were put on hold. So training now is just on an ad hoc, on request basis. 10:33 10:33

66 Q. And it is not mandatory for Datix users?

A. It's not mandatory, no. But it's something that I feel that should be mandatory. It's an IT system that's used by the Trust and I think that that system should be supported with appropriate IT training. 10:33

67 Q. Yes. I suppose more positively, in terms of your

ability to use the system.

A. Yes.

68 Q. I note from your statement, for example, at paragraph 9.9, that with Dr. Boyce's support in 2012, along with Mrs. Marshall and Mrs. Kerr, you began the process of developing a report for each division within Acute and this included information on the risk register, major and catastrophic incidents and that kind of data. Who was that directed to? 10:34

A. That was directed towards the Director of Acute Services and the Assistant Directors. 10:34

69 Q. And that would have gone to them weekly, would it?

A. No, at that stage that was a monthly report and that would have went to the Assistant Directors and Director for the monthly meeting that they had in relation to governance. 10:35

70 Q. So that went to the monthly governance meeting?

A. Yes.

71 Q. Yes. Again, were you able to exploit the system to identify trends or particular areas where issues were repeated? 10:35

A. At that particular stage, at that early stage the report wouldn't have been as detailed as what it was in 2016 when Mrs. Reid developed it further.

72 Q. Yes. I think you have said in your statement that Mrs. Reid transformed the nature of the report? 10:35

A. Yes.

73 Q. Made it more, I suppose, accessible or pictorial I think is the word you used?

A. More visual, that at a glance that you could identify, in relation to incidents, if there was one particular incident that was a cause for concern or if there was one particular ward or department where there was a spike in incidents on a particular month in that particular year.

74 Q. Yes. So you saw Mrs. Reid's development of the system --

A. Yes.

75 Q. -- as a positive? 10:36

A. Yes, yes, it was a positive natural progression from the information that we had to having more information. In 2015 we also had the development of weekly reports in relation to incidents that were in the Datix system and also major and catastrophic incidents, along with a weekly report on current complaints and those were shared with the Director and Assistant Director on a weekly basis. 10:36

76 Q. Sorry, when was that?

A. That was in 2015. 10:37

77 Q. Yes. So from your side of the computer, if you like, you were doing your best to exploit the system or exploit that resource?

A. Yes.

78 Q. To get information out. I suppose it is another question as to how well that information was used to those to whom you disseminated? 10:37

A. Yes.

79 Q. That was, I suppose, outside of your job description,

is that right?

A. That would have been outside of my remit. I'm not aware of what the process would have been in relation to the dissemination of that, on what action was taken.

80 Q. Yes. You also sought to enhance, I suppose, the utility of Datix for those using it by developing dashboards; is that right? 10:37

A. Yes, that's correct. The Datix system has the facility on it to have a dashboard for each particular Datix user. 10:38

81 Q. Help us - sorry to cut across you - to understand what a dashboard means in this context and what is its benefit?

A. Okay. A dashboard essentially is a suite of reports that can be made available to staff basically at the touch of a button without having to run background reports for staff. So essentially, if I was a Ward Manager, I could have logged on to my Datix and it would have brought me up my top 10 incidents for the last year, it would have brought me up then further detail in relation to medication incidents and what type of medication incidents those were. It could have brought me up information in relation to falls, pressure sores, and other information in relation to how many Datixes that particular Ward Manager had in the system and at what stage those were in the Datix system. 10:38 10:39 10:39

82 Q. Let me move on now to the process for screening Serious Adverse Incidents.

A. Yes.

83 Q. Your role in respect of screening of incidents has only commenced as of about 2019; isn't that right?

A. That's correct, since I have taken up my current post.

84 Q. Before that the responsibility appears to have resided with the Coordinator? 10:40

A. The Coordinator and in the absence of the coordinator, then it would have been two lead nurses in Governance at that stage.

85 Q. Yes. If we go to WIT-99282. You'll be familiar with this document. It's a document which I understand Mrs. Reid developed to assist her staff with the process of moving through various stages of an adverse incident? 10:40

A. Yes. 10:41

86 Q. We'll maybe touch upon these definitional sections which sit on the left side of this screen, because they are relevant to decision making at screening. But I want to move forward at this stage to the third page of the document, WIT-99284. And at the bottom of the page it describes what I take to be broadly your responsibilities for processing a case through the various stages. It doesn't obviously name you by name but you are to, at 4: 10:41

10:42

"Coordinate all stages of the SAI review process, including all the way through to report submission stage."

A. At that particular point when that document was developed, in 2017, I wasn't in an SAI role.

87 Q. No.

A. That is referring to the Acute Clinical and Social Care Governance Office of which there were a number of staff. So I would have considered that to be the role of the, at that time, the Directorate Governance Coordinator and the lead nurses. 10:42

88 Q. Of course. But it is now your role?

A. Now. 10:42

89 Q. I mean, this document remains --

A. Yes, now. Currently --

90 Q. -- part of the process?

A. Yes, currently, in 2019, that would be my role, point 4: 10:43

"Coordinate all stages of the review process, including the family engagement and report compilation."

91 Q. Yes. You have explained in your witness statement that you understand that screening became formalised in 2018 and you explain that all Datix incidents for Acute are, I suppose as part of this formalisation, are now reviewed on a daily basis? 10:43

A. Yes, that's correct. Since I came into post in April 2019, accompanied by another Band 7 Clinical Governance Manager, and then we were joined by a third one in July 2022, part of our role is to review the Datix as they appear on a daily basis. We identify those ones that 10:43

are created by the reporter as major and catastrophic and those are automatically added to a screening sheet for discussion at the screening meeting. There can be at times those that will come through that are created in significant, minor or moderate. But at a first look of them you just feel that there is something that is not just right for that particular patient. And then you will liaise with the Assistant Director or Divisional Medical Director to ask them if they want this added to the screening. 10:44

92 Q. Yes. So let me just look a little closer at that because we have seen and observed yesterday that there might have been, at least historically, some difficulties around how cases were managed at or about this interfacing in the process. The question, I suppose, is, were cases getting to screening? 10:45

A. Yes.

93 Q. Or were they not quite reaching there and when they were getting to screening, were they exiting via the wrong doors, should they have been going into the SAI process and instead of going out? Some cases went out and were dealt with, if you like, informally, some informal fix or solution was maybe found rather than taking the case into a formal SAI. So you are saying that there is, I suppose, a greater efficiency in how cases are managed once they appear on Datix, there's now something of an urgency to move them into screening, particularly if they come with the label of major incident or catastrophic incident? 10:45 10:45

A. Yes, I would say from 2019 the system has improved greatly in relation to being able to capture those particular incidents that need to be screened.

94 Q. You properly make the point that, even if incidents don't come with that label of major or catastrophic, there can be a cadre of cases that are nevertheless to be appropriately reviewed for the purposes of one of the levels of SAI. I suppose what you are pointing to is that, even if the case is not major or catastrophic, near misses, where perhaps no harm has resulted may nevertheless reflect underlying weaknesses in a clinical system? 10:46 10:47

A. Yes, that can do. We also would use complaints, clinical negligence cases, coroner's cases as well and other sources of feedback to inform the screening team as well. So, you know, if a complaint comes in it can be escalated to us asking does it need to be screened. Similarly in relation to clinical negligence cases, the litigation team would make us aware of those and then we would determine if it needed to be added on to the screening sheet as well. So we're not just using the Datix system for the purposes of identifying issues, we're taking a wider approach. 10:47 10:48

95 Q. Tell us a little more about that kind of conversation? Obviously the catastrophic and the major speak for themselves. 10:48

A. Yes.

96 Q. But you, wearing the responsibilities of the hat that you have, if you see something come your way, whether

through Datix or elsewhere, that gives you an uneasy feeling, do you have the authority to say, right, that's going to screening and we can fight the bit out there or do you alternatively or perhaps as well as ask for further investigation? 10:48

A. Generally what we do is we'll ask for further investigation and that would be from the Assistant Director or Divisional Medical Director. If there is an answer coming back we're not entirely happy with, we can discuss that with our Directorate Governance 10:49 Coordinator, who then will then take up the conversation with the relevant Assistant Director or Divisional Medical Director.

97 Q. One can see, perhaps, that in any environment where resources are far from limitless, where there is a 10:49 pressure on staff who have other responsibilities, that that can perhaps create a tension, if we can avoid doing that work we will be better able to do this work which is more pressing; can you help us understand whether the culture within the Southern Trust allows 10:50 for careful consideration of those cases that might be line ball calls, in terms of whether do we have to deploy all these resources on that SAI or could we, arguably, get away with not doing an SAI in this case? Do you see what I mean? 10:50

A. Yes. Well, I can only speak from my current role in 2019 and I wouldn't consider it as a tension. I would consider it more as a point of doing the right thing for the patient. From my point of view, I think the

conversations now are more clear and transparent in relation to issues that go to screening.

98 Q. I'll come back to that point in a minute. Let me read from something Mrs. Reid has said. She said from the commencement - this is paragraph 1.23 of her statement at WIT-95199. She says from the commencement of her role - I'll read from the screen: 10:51

"From the commencement of my role - she says - I highlighted that the resources available within the governance team did not allow for development of robust governance systems and processes and did not allow for timely screening, reviews or report writing. Limited staffing resources prevented proactive work streams to support changes to reduce risk or monitor implementations of actions from learning. The risk was consistently escalated during my tenure." 10:51 10:51

I just want to stick with the first bit of that, resourcing to ensure timely screening. Does that remain a problem? 10:52

A. No, I don't consider that it remains a problem because we now have regular weekly screening meetings with each division on a set day of each week. And there are three Clinical Governance Managers who are able to facilitate those meetings. We have recently got some additional admin support to work up the screening sheets and gather the information for us so that we're able to present the cases at those weekly meetings. 10:52

99 Q. So how long would it generally take or on average take from your determination that a case should be screened or reaching agreement with others that a case should be screened to an actual decision on screening to be reached? 10:53

A. The decision in relation to whether a case meets the criteria can vary because when the initial case is discussed at screening the clinicians may ask for additional information or they may want to speak to staff who were involved in the incident at that 10:53 particular time. So there's not a definite rule of thumb which says if this incident is on the screening sheet today a decision must be made today.

100 Q. So the problem that you paint isn't necessarily one of getting the personnel in the same room to commence the 10:54 exercise. The exercise, however, can be complex from case to case because of the particular factors involved?

A. Yes, that can be the case. And then at times incidents may sit across more than one division. For example, 10:54 something may sit across the emergency department, the patient then may have went to the surgical department and radiology may have been involved in there somewhere. So that means that that particular case needs to be discussed at those three screening teams. 10:54

101 Q. Thank you. Now, there's also a formality in the process associated now with the completion of, I suppose, documents that will give an audit trail to decision making?

A. Yes.
102 Q. If we could maybe just briefly look at those, WIT-99291. Is that a format for you to use to keep, I suppose, a timeline on developments?
A. Yes. That's our screening sheet and that will list all the patients that are to be screened, it will give some information in relation to the background of the case and then as the screening meeting happens, it will include a screening update. The column at the very right-hand side will include attachments and that could be scans from patients notes or any other relevant information that is necessary to help the screen team make a decision. Once cases are screened in as Serious Adverse Incidents, they remain on that screening sheet until they are completed; in other words, the report has been signed off by the Director and submitted to the family and the SPPG in draft format. And we use that tool to keep the momentum going in relation to SAI investigations. And we also use that to highlight any difficulties that we may come across in the course of an SAI investigation that requires a decision or advice from the screening team. 10:55 10:55 10:56 10:56
103 Q. And scrolling down, just the next page is the template form that allows you to record the reasons why a case is to be screened in or screened out? 10:57
A. Yes.
104 Q. Just so we can see the full form, please?
A. Yes, that form is our screening template that records the date of the incident, the date that it was

screened, the incident reference number, the grade of the incident, who actually were the screening team, who was in attendance on that particular day, who made the decision. It gives a summary of the incident, a summary of the discussions, the level and type of review, if it is going forward as an SAI. And if it is going forward as an SAI, who the review team are.

105 Q. Now, you explain in your statement that a screening meeting must be attended by two clinicians, an Operational Manager and a member of the governance team and that could be you or it could be one of your associates? 10:58

A. Yes, that's correct.

106 Q. You explain that quorum is important, the meeting can't proceed in the absence of the four nominated members; is that right? 10:58

A. Yes, that's correct. Certainly the meeting can proceed without the quorum but that will be just providing updates to those people who are there. But when you come to actually screening an incident, the meeting needs to be quorate for a decision to be taken. What happens at those meetings, there is usually the Divisional Medical Director and then there would be Clinical Directors from different specialties attending. Therein lies the challenge between one speciality and another speciality, so they are able to discuss the case and offer challenge in relation to cases. 10:58 10:59

107 Q. That's what I was going to ask you about. You describe

the format as multidisciplinary in nature?

A. Yes.

108 Q. So help me to understand that. If it is a urology case?

A. Yes. 10:59

109 Q. Will a urologist be in attendance?

A. Yes, the Clinical Director for Urology will be in attendance now, from 2019 onwards.

110 Q. Yes. What's the make-up of the other clinician attending? 11:00

A. Yes.

111 Q. Is that person potentially someone who has no knowledge of those involved in the case and no speciality in the subject matter?

A. Well, yes, it can be. It can be a Clinical Director 11:00 for anaesthetics, it can be a Clinical Director for general surgery, it can be a Clinical Director for ENT. And then we have the Divisional Medical Director there as well overseeing that. When I refer to multidisciplinary team, usually the Assistant Directors 11:00 are from another profession, for example nursing or midwifery or they could be from an administrative background. And from our point of view, we're there from an administrative point of background to ensure that the process is followed. 11:01

112 Q. Is the aim of the meeting to achieve a consensus and if that's not possible, and maybe that's not your experience, but who is the key decision maker if it is not a consensus approach?

A. Well, usually it is a consensus decision in relation to cases that meet the criteria of an SAI.

113 Q. The criteria for SAIs we've seen a moment or two ago. Put it back up on the screen at WIT-95417. The test, I suppose, is familiar to you. As I was suggesting earlier, the evidence before the Inquiry, Trudy Reid, for example, yesterday, was accepting that some cases appear to have taken a wrong turn during her time, even though she would have been in conversation with some of the clinicians and despite her experience as an experienced Governance Coordinator, she felt the test was not maybe properly applied and standing back with some hindsight was able to acknowledge that. In your role do you see that you have, I suppose, a responsibility to police the screening panel to ensure that the standard to be applied is adhered to? 11:02 11:02 11:03

A. Yes. Well, I would consider that the Clinical Governance Managers have a challenge function within their role now, since 2019, to question decisions that are being made by the screening team. 11:03

114 Q. And is that a frequent occurrence, that you are asking the hard questions?

A. Yes, well we do from time to time ask the hard questions. But as I had said earlier, the majority of cases that now go for screening there is a consensus decision in relation to those. 11:04

115 Q. Could you present us with a scenario where you felt the need to ask hard questions or perhaps refer to this test and how it is to be interpreted?

A. Well, I suppose whenever you look at cases where patients, there has been an incident but they haven't come to harm but there's really a systematic, an area in the system and just all but for good luck that they didn't come to harm, that you really need to focus, to highlight that there could be an unexpected serious risk to a patient as a result of the system.

116 Q. Do you get a sense that - I don't want to tar everybody with the same brush - but do you have a sense that sometimes clinicians are pushing towards ruling cases out of the SAI process because harm hasn't resulted and that you have to pull them back and say well, it's not necessarily about actual harm, it's about risk?

A. Mm-hmm. Not in my experience from 2019.

117 Q. It's not a problem?

A. No. I don't consider it to have been a problem since then.

118 Q. Yes. You make the point in your witness statement that there is, I suppose, no audit or quality assurance process in place attached to the screening exercise, do you think that that would be a useful thing?

A. Well, yes, that would be a useful tool. From the point of view of those ones that are declared a serious adverse incident, they are notified to the SPPG and they can almost do an audit and sometimes will come back to us and ask questions in relation to why is this an SAI or can I have more information in relation to that. But I suppose from the point of view of the ones that are screened out, at this time there's no process

for it going back to review that decision.

119 Q. Do you think that resources available, that would be an important next step in maturity or maturing or the development of a good SAI screening system?

A. Well, it could be, yes, but again that would probably come down to the level of resources and who would you bring that to for a specialist opinion. 11:06

120 Q. Now, at the other end of an SAI we obviously have the need for learning. You have explained in your witness statement that learning should be shared at morbidity and mortality meetings within the relevant service and that's usually a recommendation of the SAI; isn't that right? 11:07

A. Yes, that's correct. Usually whenever we are looking at the recommendations for SAI reports, one of those recommendations will be that it is shared at the relevant or more than the relevant morbidity and mortality meetings for learning. 11:07

121 Q. Yes. One of the things that we've noted in association with a number of the SAIs is a, a number of SAIs that have emerged from urology, is the delay in moving from screening to the learning stage. The learning stage can only come, the full learning stage can only come at the conclusion of the report and some of the reports have been delayed by two, two-and-a-half, three years sometimes from the date of incident? 11:08

A. Yes. 11:08

122 Q. Is that delay or the risk of delay in completing an SAI process a feature of the Trust's world today?

A. I would say less so today than what it was back in 2016 to 2019. We now have in place three Band 7 Clinical Governance Managers and their role is really to move forward the SAI process. Those people weren't in post at that particular time. The main delay that we would now face would be in relation to the establishment of a team and getting a first meeting of the review team. But once we get the first meeting of the review team, we're generally inclined at that first meeting to agree a date for the second meeting and third meeting which is usually two to three weeks after the first meeting. So we find that we're getting through them a bit faster than what was previously. 11:09 11:09

123 Q. Mm-hmm. It's been suggested to the Inquiry that perhaps the most significant impediment to moving cases forward is the availability of the lead responsible officer on the review, who is inevitably a clinician? 11:10

A. Yes.

124 Q. And usually a busy, committed clinician; is that something that is just inevitable or are there ways of driving momentum and encouraging expedition that you have now recognised that perhaps weren't a feature of some of the cases we have seen? 11:10

A. Yes. Well, I think when you're using a working clinician, that will increase the length of time, because if they have not got protected time to carry forward this SAI review, we are really depending on their clinical commitments and trying to fit this in around that. What we have been doing since 2019 is 11:10

doing a lot of the preparatory work, in that we are writing the timelines, we're making the packs. So we're doing some of the groundwork for the Chairperson in advance of the first meeting. Obviously they'll still need time to prepare for the first meeting and review the information that they have available. But I find that that can quicken the process.

125 Q. You may be familiar with a proposal that came forward in or about 2018 written by Dr. Boyce and proposed into Mrs. Gishkori at that time that suggested some protected time for, maybe, a panel of 10 SAI chairpersons? 11:11 11:12

A. Mm-hmm.

126 Q. Is that -- and we understand that that never came to fruition. Is that something that has ever been part of the conversation subsequently? 11:12

A. I wasn't aware of that proposal until Mrs. Reid, I heard her evidence yesterday. We do now have three Trust chairs who can provide assistance to chair Level 2 and Level 3 SAI reviews. But prior to yesterday I wasn't aware of that proposal. 11:12

127 Q. And the three that you refer to?

A. Yes.

128 Q. Are they, if you like, standing chairs who can be called upon, maybe, in rotation and do they have protected time? 11:13

A. Yes. Two of those chairs are retired clinicians so they do have protected time. Another of those chairs is a current practising clinician and they do have

protected time as well. And we can call on those chairs for Level 2 and Level 3 investigations. But I would have to say that a lot of our investigations start out at a Level 1 and we're not able to access those chairs for those Level 1 reviews, which puts us back into the situation that we're waiting on a clinician from a particular area to chair.

129 Q. So work has been done to try and address delay?

A. Yes.

130 Q. I talked briefly about learning just before I stepped into that, you have explained the M&M route for disseminating learning from a case. As I understand it there is another route to disseminate learning and you have referred in your witness statement to a procedure or policy issued by the Medical Director in July 2022 which promotes shared learning via a template, if we could just briefly look at that. The policy is to be found at WIT-99448. Just scroll through this. If we go down to 5.1 in the sequence. And the purpose of the policy is set out at the bottom of the page: 11:13 11:14 11:14 11:15

"The purpose is to ensure that the safety lessons learnt from internal and external sources are appropriately and widely shared across the Trust. Any improvements required in response to lessons learnt will be implemented through an action plan and compliance audited." 11:15

And we can see then a flowchart at 5.8 in the sequence,

WIT-99458. So the issue comes in, it might be an incident investigated, lessons learned, identified, and then a shared learning template developed and sent to the corporate governance office and various other steps that follow. 11:16

If we look then at the template, WIT-99459. So this, I suppose, commits the service area to thinking through what has emerged and setting out in specific terms the lessons that are to be taken from an incident. And 11:17
that can be circulated around the Trust into different Directorates or different services, is that your understanding?

A. Yes. My understanding is that that template is to be completed, then shared with the corporate governance 11:17
team, who will then disseminate that to the relevant Directorates via the Directorate Governance Coordinator, that's my understanding of the process.

131 Q. Yes. Is that process picked up and used with every SAI outcome now to the best of your knowledge? 11:17

A. At the present I don't believe that it is for every SAI. Particular SAIs will recommend that there is a shared learning template and on that occasion it will be completed. There is an expectation from the corporate governance team that one is completed for 11:18
every SAI. But I know within the Acute Directorate there have been discussions with our Governance Coordinator in relation to when is the right time to complete the shared learning template. Because if you

understand some of our -- well all of our reports go to families and the SPPG in draft format and there may then, following a challenge by either the family or the SPPG, be changes to the learning as a result of a particular SAI, so that just hasn't been ironed out at the minute.

132 Q. Yes. Can you give any examples of the types of learning which has been shared to date?

A. Yes. There's one in the system which is requiring a shared learning template and that's in relation to a patient who wore contact lenses and came to harm as a result of those not being removed. As part of that SAI report there was a recommendation that that should have a shared learning template. But again because that SAI hasn't been signed off yet by the SPPG, that hasn't been done yet. 11:19

133 Q. Yes.

A. But it will in due course.

134 Q. Yes. There's plainly a value in sharing lessons of general application -- 11:20

A. Yes.

135 Q. -- around the Trust. That's presumably the thinking?

A. Yes.

136 Q. In terms of the need to make changes within a service, that is sketched out typically in the action plan or the recommendations of a serious adverse incident and you will recall the piece I read from Trudy Reid about, in her time, the inability to support the actions that flow from an SAI or necessarily flow from an SAI and 11:20

the ability to be proactive around that, has that recently changed within Acute?

A. Yes. I'm only a small part of the Acute governance team as it stands at the minute. But my understanding is that there are a number of additional staff who have been employed to follow up the action plans and recommendations as a result of Serious Adverse Incidents initially and then other areas such as complaints. 11:21

137 Q. How many have been employed in that role? 11:21

A. Currently three Band 5 Governance Officers, with another to be appointed.

138 Q. Yes.

MR. WOLFE KC: It's 25 past eleven, perhaps a convenient time for a short break. 11:21

CHAIR: Yes. If we come back again at 20 to 12 then.

SHORT BREAK

THE HEARING RESUMED, AS FOLLOWS, AFTER A SHORT BREAK: 11:24

CHAIR: Thank you everybody.

MR. WOLFE KC: Could we have on the screen please TRU-255361? We can see, Mr. Cardwell, from this email that you had a part to play in association with 11:41 drafting letters to the families connected with the nine Serious Adverse Incidents that were reviewed under, I suppose, the leadership of Dr. Hughes in 2020 and into 2021. Mrs. Kingsnorth, was she the

facilitator of that SAI?

A. Yes, that's correct.

139 Q. So your role, was it limited to assisting with drafting of letters?

A. My role was actually just to make sure the letters were processed on the day that Mrs. Kingsnorth asked them to be processed. I wasn't involved in the actual cases or had any awareness of them. The instruction from Mrs. Kingsnorth was to prepare the letters for signature and get them to the Director's office. That is normally done by a Governance Officer, but Mrs. Kingsnorth on that occasion asked me to have oversight of that to make sure it was done. 11:42 11:42

140 Q. As I thought. Thank you. Could I then ask you about the case of Patient 102? You have a list, a designation list in front of you. It's a case we discussed with Mrs. Reid yesterday, I want to seek your input on it because at that time, as you have explained, you had an administrative responsibility in terms of processing cases through the various stages and there were various stages with this Datix. So we can see -- and this is a document you helpfully added to your addendum statement, WIT-100357. To orientate ourselves we can see that it is recorded that Mr. Haynes opened the Datix, or reported the Datix I should say on the - reported the incident is maybe the better expression, on 21st October and the description, to summarise, suggests that a patient who the decision of the MDM was should be referred for 11:43 11:43 11:44

and directly referred for radical radiotherapy, didn't receive his appointment. His general practitioner wrote in on 16th October 2015, I suppose almost a year after the MDM decision, and it was, as is suggested here, discovered that no correspondence was created in respect of this appointment.

So can you help us to understand the steps that you took. We can see, for example, at WIT-100362, into the middle of the page please, that the incident has - just up a bit - the incident has been categorised as major? 11:45 11:46

A. Yes.

141 Q. Who gives that designation to the case, is that you or the reporting clinician?

A. That would have been the reporting clinician who would have assigned it as a major incident. 11:46

142 Q. Yes. Then if we look at -- sorry, just before we do look at the email trail or communication trail that followed. This was 2015?

A. Yes. 11:46

143 Q. If you saw a "major" on an incident report coming in to Datix today, am I right in understanding your evidence from earlier as indicating that that would go straight on to a screening list?

A. Yes, that's correct. If that incident was presented to me today in my current role with a grading of major, that would go straight on to the screening list. 11:47

144 Q. Yes. Then if we could go to WIT-100364, if we go to the bottom of the page. Could you help us to

understand what's going on here? Obviously these are a series of communications, starting on 18th November. The fact that we see the same message, is it three or perhaps four times, does that reflect that the communication is going to different people? 11:48

A. It does, yes. It is the same message on 18/11/2015 that has went to three or more staff.

145 Q. Yes. The message, just help us to understand what's going on here, given your knowledge of the particular facts of the case. The message is that: 11:48

"I have moved this to FSS for investigation and close."

So that is Connie Connolly saying this?

A. Yes. Connie Connolly's role was lead nurse in governance and she would have been in place at that time in the absence of the Band 8 being Governance Coordinator. She has opened the incident on the 18/11 and she has looked at that. She has obviously had a discussion with someone or may have thought that the 11:48 11:49 incident related to the non-processing of dictation and that's the reason why she's moving that to FSS, which is functional support services which covers administration, for that team to investigate as to why there was no letter typed. 11:49

146 Q. Mm-hmm.

A. Subsequent to that, Mrs. Forde then came back.

147 Q. Does it help us if we scroll up?

A. Scroll up, yes please. On up to the bottom of the

previous page.

148 Q. Is it -- I'm not sure, so is that, there is another message then on the 18th. I think if we work with the one that's at the bottom of the screen at the moment?

A. Yes. 11:49

149 Q. So this is a feedback message from Connie Connolly, again she says:

"The feedback is being directed to Martina." 11:50

A. Yes.

150 Q. That's Martina Corrigan, Head of Service.

A. Yes.

151 Q. In urology or covering urology. Explain to us what is happening now? 11:50

A. Well, that's correct. Mrs. Connolly then has received feedback from functional support services to say that it would appear that no dictation was done following the --

152 Q. The multidisciplinary meeting? 11:50

A. -- the patient episode.

153 Q. Yes.

A. "Will need reviewed by yourself and Governance will support if needed". 11:50

So Mrs. Connolly is sending that to Mrs. Corrigan for her to investigate as to why there was no dictation done.

154 Q. Mm-hmm. I suppose pause here to ask the question: Why

is this sort of being batted around various investigations as opposed to, simply, there has been a miss here in terms of the -- or a shortcoming in terms of the treatment of the patient?

A. Mm-hmm. 11:51

155 Q. Is this trying to allocate, I suppose, or establish the relevant department with interest in the case?

A. Yes, it's really trying to establish the relevant department. And whenever the incident was reported it was reported as a surgery and elective care incident 11:51 but those people who needed, in functional support services to investigate from their end wouldn't have access or wouldn't have been privy to this Datix. So that incident then needed moved from surgery and elective care to functional support services for them 11:51 to do their bit of the investigation.

156 Q. And it is the role of Mrs. Connolly, Connie Connolly, I suppose, to oil the wheels of this in terms of the administration, moving it back and forward between these two interested parties? 11:52

A. Yes. Well, Connie would have had the discussions with the relevant teams and then quite often she would have contacted me and asked me to move a particular incident from one area to another area. And that's how I became involved. 11:52

157 Q. So, 18th November, the ball is back on Mrs. Corrigan's side of the court?

A. Yes, yes.

158 Q. I think if we scroll up. So the next entry of note is

the 11th December, where you come into it?

A. Yes. Yes. So I had then received an email from Helen Forde who was Head of Health Records with responsibility for administrative services and she had asked me to forward the incident to Martina Corrigan with the message to say that I think this should go to Martina Corrigan as it says there was no correspondence for the appointment. So it wasn't that the secretary didn't type it, I think it was that it wasn't dictated. So that would need to go to the Head of Service for urology to discuss with the consultant. And that's the message I had sent to Martina. 11:53 11:53

159 Q. Yes. So again it rather prompts the question that it having been established, at least at this stage - obviously an SAI investigation might put a more nuanced picture around this. And I know, for example, Mr. O'Brien would say that in fact the referral should have reached the relevant place via something called the CaPPS system. 11:53

A. Yes. 11:54

160 Q. Leaving that to one side, what you were confronted with on 11th December is some clarity that there was no dictation?

A. Yes.

161 Q. And the suggestion was that that was causal or causative of the shortcoming. So why at this stage are you not just saying it's into SAI for screening? What further investigation is required and why do you think it's necessary that Martina Corrigan should speak to 11:54

the consultant?

A. Well, at that particular time, in 2015, I was in the Band 5 governance role so I wouldn't have been wearing the hat that I am wearing today. So my task would have been simply to move the incident from one area to another area and follow that up with an email. Which is what I have done there on 11th December to Martina. 11:55

162 Q. Yes. So, are you suggesting that at that time, I suppose, the authority to call this case into a screening meeting -- 11:55

A. Yes.

163 Q. -- rested with the service as opposed to the governance office?

A. Yes, it would have rested with the service. But you can see from the emails provided by Connie Connolly that she has offered support to the service to take this forward. 11:55

164 Q. Yes.

A. But that hasn't happened.

165 Q. We can see then, do we read the next entry on 20th March as a reminder to Martina Corrigan to deal with this? 11:55

A. Yes. There's a reminder from Mrs. Vivienne Kerr then to Martina Corrigan to say that the Datix is coded under urology. 11:56

166 Q. And Vivienne Kerr is again somebody - one of your colleagues in Governance?

A. Yes, at that stage she would have been my equivalent, she would have been a Band 5 in Governance.

167 Q. Yes. If we can go to WIT-100360, just back a few pages then. So it records three months after the last email communication

A. Yes.

168 Q. That date of final approval closed. You're closing this? 11:56

A. Yes.

169 Q. This incident, on 17th June 2016?

A. Yes.

170 Q. You're satisfied that this incident was never screened for the purposes of SAI? 11:57

A. Well, no, I'm not --

171 Q. Sorry, I mean now, today?

A. Oh, yes, yes. Now, today, yes, I'm satisfied that it hasn't been. 11:57

172 Q. Yes. Can you help us to understand today why this incident was closed in the absence of a screening decision?

A. Okay. At the beginning I would emphasise that I am extremely aware that the decision for closing of an incident rests with the operational team. In relation to this particular incident you will see on 17th June that I have went on and put in a final approve and a closed date. I can't explain why that has been done. I have conducted a thorough search of my email archives. Occasionally Heads of Service would have come to me and said can you do A, B or C on Datix and I would have facilitated that. Usually there was an email trail to back that up. In this particular 11:57 11:58

instance, as I say, I have conducted a thorough search and I can't find any email from anyone to say 'David, can you go on and close this incident'. All I can say is that, with the volume of incidents, the volume of work at that time, something has prompted me on 17th June 2016 to go on and close that incident. I just wouldn't have went on randomly and closed an incident without being asked to do so.

173 Q. Is it likely, do you think, that you would have sought an explanation as to why it is to be closed? 11:59

A. Yes. It would have been my normal practice to have sought an explanation as to why it had been closed. And I would have been asking for some information in relation to the outcome of the investigation to include that on the Datix report form. 11:59

174 Q. Yes. We have seen examples, perhaps yesterday, I think, of a case which didn't go the SAI route, I think Mrs. Reid, in fairness, thought it probably should with some hindsight.

A. Yes. 11:59

175 Q. But written into the record was, if you like, an administrative fix to the problem or a suggestion of a practical step that would be taken to hopefully prevent the problem recurring, is that what you would have expected to have done, using this form to record the reasoning? 12:00

A. Yes, to record the outcome from Martina's investigation which I now subsequently know didn't take place.

176 Q. Yes. I mean she says candidly that she didn't speak to

Mr. O'Brien --

A. Yes.

177 Q. -- about the incident. It was a major incident on Mr. Haynes' grading?

A. Yes. 12:00

178 Q. It's difficult, is it, to conceive of any good reason that you could have been given to have avoided a screening decision in a case like this?

A. Yes, that's correct.

179 Q. Bluntly from your perspective, recognising the test for an SAI -- 12:00

A. Mm-hmm.

180 Q. -- this should have gone down the SAI route?

A. Yes. Knowing what I now know in my current role from 2019, yes, this should have been screened for an SAI and would have met the criteria. 12:01

181 Q. Yes. You have made the point that the service area or the operational team had, I suppose, the strength or the power to determine these issues. Back in 2015/2016 you are having these conversations, or you think you would have had a conversation, would it have been any part of your role at that point to say, no, hold on a minute, this doesn't feel right, this is one that we need to look at in screening? 12:01

A. Yes, if I had have felt there was an issue that it would have been escalated to, in the absence of the coordinator, then to the lead nurse at that stage. But, as I say, I can't recall exactly and I have no evidence to suggest what did or did not happen at that 12:02

particular time, at that time.

182 Q. We asked you in your witness statement to think about a case called Patient 93. Patient 93 was a patient who had been referred into the urology service as a routine case and that there was a failure to triage that case. 12:03 The suggestion in Mr. Haynes' correspondence at that time was, well, if it had been triaged it would have been upgraded to a red flag.

A. Yes.

183 Q. And between Mr. Haynes and a number of medical managers 12:03 they discussed this case but it never made it into the SAI process, by contrast with some other triage cases of which we are aware. In fact, you have conducted some searches and you outline, at paragraph 11.2 of your statement, that, let alone it didn't reach the 12:04 SAI, it didn't even get reported into the Datix?

A. Yes, that's correct. I have completed a thorough search of Datix and I can find no incident report in relation to that patient.

184 Q. Yes. Is that simply a frailty or a vulnerability of 12:04 the system that's, if you like, to make up a word, unpoliceable; if clinicians aware of an incident that is worthy of comment decide, for whatever reason, not to commit that incident to a report into Datix, there's not much the governance team can do about it? 12:05

A. No. Well, if the governance team aren't aware of it they are not able to make sure it is directed to the correct process.

185 Q. I think I asked you questions about this general area

earlier and was asking you to comment on whether there was, in your experience, anything resembling a culture of underreporting, if I can put it in those terms, and that's not something that you are aware of or concerned about? 12:05

A. It's not something that I am aware of. And in relation to the incident relating to Patient 102, that would indicate that there was an awareness if there is an issue that a Datix report needs to be completed.

186 Q. Yes. 12:06

A. So I can't explain why there wasn't one completed in relation to Patient 93.

187 Q. Could I have on the screen then AOB-01281? Moving on now, Mr. Cardwell, to just look a little at an incident in time. I know that you weren't directly involved. 12:06 This was, this is the minute of what they called an oversight group meeting which determined that an investigation should be conducted into Mr. O'Brien's practice or certain aspects of his practice. It was determined at the meeting or agreed at the meeting that 12:06 it would be helpful if a search could be conducted for any previous incident reports, as you can see in the middle of the page.

A. Mm-hmm.

188 Q. And complaints to identify whether there were any 12:07 historical concerns raised. Now, in her evidence, I think Dr. Boyce thought that she might have referred that action to either yourself or Trudy Reid --

A. Mm-hmm.

189 Q. -- to complete and I think as it transpires or it appears to be visible from certain emails that between Vivienne Kerr and Trudy Reid they did the work. You think you were absent from work around that time, late December or early January? 12:07

A. Yes, I was. I was absent due to an immediate family member's bereavement.

190 Q. Yes. I want maybe to ask you some general questions about the ability to interrogate the Trust systems to extract that kind of information. What appears to have 12:08 been produced by a combination of Mrs. Reid and Mrs. Kerr is a series of complaints which were registered against various consultants and practitioners within the urology service. There wasn't produced any incident reports or previous SAIs. We 12:08 know because we have just looked at an incident report, that there was an incident report relating to Mr. O'Brien on the system. We know that there were two SAIs which predated this and one was in completion. We also know that I think you had recently taken delivery 12:09 of a complaint from a family of Patient 16 which was then subsequently to become an SAI. I'll just check I have that designation right. It is Patient 16.

A. Yes.

191 Q. I wonder could you help us, should your colleagues have 12:09 been able to bring together more than simply a collection of urological - or complaints from urological patients?

A. Yes. The system is set up in such a way that whenever

you have a complaint or incident there's an employee section on the Datix when you can record the members of staff who were involved in either the complaint or the incident. So by using the search criteria with the relevant clinician's name, you should be able to pull up all incidents and complaints that that person had been involved in. I'm not sure what criteria had been used for this particular search or why incidents hadn't been included in the report if they were asked for. 12:10

In relation to Serious Adverse Incidents, the system for capturing those and recording the information in relation to those wasn't as good as it could have been until Mrs. Reid came into the post in 2016.

192 Q. Yes. Thank you for that. I want to move now to your role in terms of handling complaints. Not the specifics of any particular complaint, apart from, I think, one I'm going to raise with you. But just to have, I suppose, your general observations on how the system of managing complaints operated within the Trust and whether it was working as well as it could have been. You have explained that you were - this is paragraph 5.3 of your statement - that you were responsible for the management of complaints, ensuring that they were investigated within set deadlines and set timescales. You helpfully set out for us what those timescales were, that during your time in complaints a complaint had to be acknowledged within two days? 12:11 12:11

A. Yes.

193 Q. It was then sent to the Head of Service and the consultant responsible for the patient's care for investigation?

A. Yes. 12:12

194 Q. It was copied to the Director of Acute Services and the Assistant Director or Directors with responsibility for the particular service area and then each complaint was registered on the Datix system?

A. Yes, that's correct. 12:12

195 Q. And then, if you were compliant with the timetable - and I know that was one of the issues we'll talk to you about - a full draft written response had to be available within 10 days.

A. Yes. 12:13

196 Q. For consideration and approval by Day 17. And then I think out by Day 20?

A. That's correct, that would have been the target, Day 20.

197 Q. Yes. You have indicated that the Trust performance was 12:13 managed by reference to those timescales; is that right?

A. In respect of the 20-day working target, that would have varied from time to time. We weren't as good at meeting the 72% within the 20 working days as we would 12:13 have wanted to have been but there were a number of reasons as to why that was the case.

198 Q. Yes. Sorry, what I meant was that there was an expectation or a performance management goal --

A. Oh, yes.
199 Q. -- to meet the 20-day target?
A. Yes.
200 Q. But you are highlighting, I think the figure that you give at figure 13.10 of your statement was that only 72% of cases met that 20-day response target? 12:14
A. 72% within the 20 working days was the response target.
201 Q. Yes.
A. But what I am saying is we didn't meet that expectation. 12:14
202 Q. I beg your pardon. I understand. So the target was to get 72% out?
A. Out within 20 days, yes.
203 Q. And that wasn't a target that you were able to meet?
A. No. No. 12:14
204 Q. What was the problem? Was it essentially sometimes complex cases and sometimes busy clinicians not responding?
A. There would have been a number of issues as you have described, busy clinicians, complaints which spanned one or more service area. If certain staff needed to be spoken to as a result of a complaint, that would have taken up a period of time. Whenever the draft responses then would have come back to me, the clinical information, I would have put that into a draft response for the Assistant Director. So depending on the availability of the Assistant Director to approve or not approve or in the case of those ones that maybe weren't approved, needed to go back maybe for further 12:15 12:15

work and then whenever the Assistant Director was content with the response, then it would have went to the Director for signature. So when you take into account all of these steps, particularly for complex complaints, 20 working days is not a long timeframe.

205 Q. Yes. Were you conscious that there were any particular pockets of tardiness within the Acute Directorate? Were you frequently experiencing difficulties in getting an expedited response?

A. I can't say that there was any one particular area that was different to another area. I think across the whole of Acute all the service areas experienced problems with having the time to respond to complaints.

206 Q. There was a particular case, and I'm sure Mr. O'Brien wasn't alone in being sometimes less than efficient in dealing with complaints, but there is a particular case which the emails suggest you were left with some frustration in terms of moving the matter forward. If we go to TRU-157105. I don't think we have a designation number for this patient so - oh, we do. Thank you. We're calling this Patient 110.

A. Yes.

207 Q. You're writing to Martina Corrigan in March 2016:

"As you know, we met them..."

That's the patient or the patient's family; is that right?

A. Yes, exactly.

208 Q. "...in February 2015..."

In other words a year beforehand:

"...and there were issues that need to be followed up but Mr. O'Brien has not yet provided a response to. I think we stopped reminding you around Christmas but we really need to draw this matter to a close." 12:18

Then if we scroll up. So there had been some discussion with Mr. O'Brien: 12:18

"Mr. O'Brien has the chart in his office and it is to be discussed after Easter."

12:18

If we just move forward, if we go to TRU-157170. It's now 2019, you're writing again and you are saying:

"This complaint has been ongoing now for over four years and we need to make all necessary efforts to expedite its closure as soon as possible. If we are unable to meet the family, I believe it would be better to write to them and explain the reason why rather than keep them lingering. If the matter progresses to the Ombudsman, I can imagine any report produced would not make good reading." 12:19 12:19

Now, I've picked up on those two temporal parameters, no doubt in the middle of those two temporal parameters

across the three years of them, 2016 and 2019, the complaint originating in 2015

A. That's right.

209 Q. No doubt it was a complex case, no doubt there was more activity than I have alluded to in these emails. But can you recall what the problem was here in bringing it to a conclusion? 12:20

A. Firstly I would say that four years is excessive and it shouldn't have taken four years to have responded to that particular complaint or any complaint. My understanding was that the complaint was made, the Trust then met with the family, they were then provided with a response to their complaint after that. The family then came back to us and asked for additional information. They weren't entirely satisfied with the response or the outcome of the first meeting. So as part of that the clinician needed to review the notes. During that time you will see that I have been reminding Mrs. Corrigan that there needs to be a response to it. A weekly reminder to her wasn't getting the results that we needed to get. So the complaint then, it wasn't forgot about, it was still kept on our re-opened complaints list. And then at a suitable point, which was the March of 2016, then I went to Martina to say that we need to try and get this wrapped up. I think there was then a further request for another meeting and there were some issues in relation to who should attend that meeting, what the outcome of that meeting was going to be. All of those 12:20 12:21 12:21

issues were within the urology service and I wouldn't have been privy to all those discussions.

Then, in January '19 , at that stage I'm conscious that I am moving on to this new role so I'm going through everything again to make sure that there's nothing missed, for want of a better word, and I am asking Ronan Carroll, who is the Assistant Director, and Martina for their assistance in getting resolution. 12:22

210 Q. Yes. To the best of your knowledge, was it resolved? 12:22

A. I then moved in April 2019 and I don't know what happened after that.

211 Q. Yes. As I said in prefacing my entry into this particular example, no doubt there are and were and will continue to be other clinicians who are less than efficient in responding and, indeed, other service managers who are not, perhaps, pushing matters as efficiently or as aggressively, perhaps, as they ought to. Is this a wholly exceptional case of a four year delay, and whether it was ever resolved you don't know, or are there other similar skeletons in the cupboard? 12:23 12:23

A. No, not that I am aware of. Certainly in all of my time in complaints I don't know of any other ones that would have taken this length of time. Certainly there are ones that do take a long period of time and that's not just exclusive to the urology service or Mr. O'Brien. But no, this four years is too long. 12:23

212 Q. You reflect in your witness statement, at paragraph 13.12, that this issue of the length of time, that you

considered at the time that the handling of complaints, that the length of time that it took for investigations to conclude was really, I suppose, the only issue which was problematic?

A. Yes.

213 Q. Is that right? Were there no other deficiencies in terms of the complaints process so far as you were concerned?

A. I suppose now, when you look at it now at this point of view someone is complaining about an issue in relation to clinical care that a consultant has given and you are sending that complaint to that clinician to response. And, of course, they have the right to reply. But it is almost like marking your own homework. However, the Assistant Director step in the complaints process was to make sure that clinical information going back out to patients was correct.

214 Q. Mm-hmm. So there was that element of scrutiny?

A. Yes. Yes.

215 Q. We had a patient come to the Inquiry to give evidence, his name is Patient 84. You can see, if we just bring it up on the screen, PAT-000225, he directed a complaint to the Trust on 19th September 2016. Without going into all of the fine detail, this was a case where there were -- a complaint where there was a number of issues but primarily and at the heart of it it was a patient who had a stenting procedure. The stents had to be removed. The patient had been given the understanding that they would be removed by a

certain date and that date moved and moved and moved until he got into some considerable medical difficulty, had to be admitted to hospital with infection, had to be re-admitted and was not, as you might expect, terribly happy with his treatment, leading to this complaint.

And you were at that time responsible for managing or coordinating complaints and we can see, for example, PAT - well it's three pages further on at 228 - we can see that your first step, I suppose, is to send out what I take to be a pro forma kind of response which might be politely described as a holding response or an acknowledgment? 12:27

A. An acknowledgment of complaint, yes.

216 Q. Yes. This was one of these cases where you were unable to comply with the 20-day aspiration. A number of holding letters were issued over the following months, leading to a substantive response on 1st December. If we could have that up on the screen please, PAT-000231. That would have been signed off by Mrs. Gishkori. Now, if we scroll down through it. Just further on down, on to the next page perhaps. 12:28 12:28

When this patient came to give evidence, and indeed in subsequent correspondence in response to this output, he took exception or he explained that he took exception to how his complaint had been dealt with and what was particularly sore with him was that his perception was of being made to feel guilty about 12:29

complaining because - and he drew this or he was caused to feel this - because he was told that, in essence, the service is struggling to meet demands and cancer patients have to come first, if you like, and that's perhaps contained within that paragraph, commencing: 12:30

"Mr. O'Brien confirms that ideally patients who have a stent inserted should have this removed and have this performed within four to six weeks later. However, the demand on the urology service is unrelenting, with an increased number of patients with suspected and confirmed cancer diagnoses requiring progression along their cancer pathway." 12:30

Just to show you how it was expressed by the patient when he came along to see us, if we go to TRA-00094. He came along at the opening week of the Inquiry and he says that, just scrolling down, he says: 12:30

"Obviously, when they brought in the cancer patient stuff and, you know, while obviously I have sympathy with them life threatening conditions and things but that wasn't I suppose - you shouldn't be made to feel guilty." 12:31

In other words, he took it as why are you complaining, there are people worse off than you. Did you draft the letter? 12:31

A. The information contained in the letter would have been

a direct lift from the information provided by the service area. Having read that now again, I accept that the patient would be annoyed by the content of the letter and I am sorry for that. I can understand where the patient is coming from. I think the attempts to explain the pressures on the urology service have not been communicated as well as they maybe could have been.

217 Q. I suppose linguistically it's a difficult balancing act, you perhaps want to communicate something of an explanation as to why the treatment has been delayed? 12:32

A. Yes. Yes. And that explanation had been given to various other patients who were waiting as well.

218 Q. Yes. I think what you are acknowledging this morning is that, from his subjective perspective, it's understandable that he would feel annoyed? 12:32

A. Yes.

219 Q. And maybe there is a learning here in terms of how you convey the message?

A. Yes, exactly. 12:33

220 Q. The complaints that came in to Acute were the subject of report to the Director and you have explained that weekly reports were used. If we go to WIT-99666, that is typical, is it, of a weekly report communicated into the Director's office? 12:34

A. Yes, that's correct.

221 Q. And the colouring, does that suggest, does the red suggest cases that have gone over the aspirational time limit?

A. Yes. Yes, those denoted in red are those that are over the 20-day response time target. Those denoted in amber are those which are due for response within the next ten-day period.

222 Q. And the rest? 12:34

A. The ones in white are relatively new cases, yes. And this was used to inform Assistant Directors in relation to the ones that they needed to have responses to. And you will see there, in relation to the current stage, that gave an update in relation to what the problem 12:35 was. Some of those that are over the 20 working days were with Assistant Directors for approval so that was going to be turned around within the next day or two. There was some with the Director for signature and again those were going to be turned around within the 12:35 next day or two as well.

223 Q. If we scroll on down, there was an opportunity then to provide some high level, I suppose, statistical analysis --

A. Yes. 12:35

224 Q. -- around the complaints. One can see in graphical form, just scrolling down, the -- is that the number of complaints per division within Directorates?

A. Yes. That's the entire in the Acute Services Directorate and you will see that's divided down into 12:36 the five divisions within Acute Services at that time.

225 Q. And is that an attempt to reflect the increase per ...

A. That actual chart is the individual divisional response rate.

226 Q. Right. Then scrolling on down, you are able to identify complaints per subject?
A. Subject, yes.
227 Q. Again at a fairly high level?
A. Yes, a high level, just really to indicate what the top five subjects were in that particular month compared to the same month in the previous year. 12:36
228 Q. And then sequentially by location?
A. Yes.
229 Q. Or department? 12:36
A. Yes.
230 Q. And profession?
A. Yes.
231 Q. Presumably, the importance of having an efficient and effective complaints unit is to enable the Trust to extract learning from them, that's perhaps one of the key reasons. There's obviously outward looking reasons as well. But sticking with the learning, the learning for the purposes of reducing or eliminating risk and providing for service improvement; that wasn't your responsibility, was it? 12:37 12:37
A. No, that would have been the service areas or the operational teams to take the learning from particular complaints and cascade that down through their systems.
232 Q. Was there a process by which that was done? Was it a work activity that was pursued on an ongoing basis, to the best of your knowledge? 12:38
A. Whenever the response to the complaint had been agreed, a copy of the final response would have went back to

the Assistant Director and the Head of Service for them to cascade down through their systems. But I would say at that particular time, with the volume of complaints that we were dealing with, and it wasn't just formal complaints coming into the Trust, it was MLA enquiries going through the Chief Executive's office as well, our main focus was on actually getting the complaints in, getting them allocated for investigation and getting them responded to.

233 Q. Mm-hmm. We know, we've heard from you today about the limits to the ability of governance personnel to be proactive? 12:38 12:39

A. Yes.

234 Q. And we heard from Mrs. Reid in that respect yesterday.

A. Yes. 12:39

235 Q. You are no longer in complaints?

A. No.

236 Q. But do you have any intelligence or information to share with us in terms of how well the learning to be extracted from complaints and the development of responses to, perhaps, issues that could be repeated if they are not fixed, how is that being handled? Is it being handled any better in 2023 compared to 2018? 12:39

A. I couldn't honestly comment because I don't have enough in-depth knowledge in relation to that. 12:39

237 Q. Thank you for that. Could I ask you about the interface with the SPPG, as it is now called, or the Health and Social Care Board, in association with complaints? If you could bring up on the screen please

the, I suppose, the statutory basis for the Health and Social Care Board's involvement in this area, it is WIT-99655. Pursuant to the HPSS Order 1990 there is a Health and Social Care Complaints Procedure Directions (Northern Ireland) 2009. If we scroll down to paragraph 15 of that direction at page WIT-99663, at paragraph 15, if you could just scroll and highlight please. 12:41

So it provides at 15(1) that: 12:41

"For the purposes of (a), (b), (c) and (d)."

And organisational learning is at (d): 12:41

"the relevant Health and Social Care body shall prepare reports at orderly intervals for consideration by its Board."

And then at 15(4), scrolling down: 12:42

"Trusts must provide the Board with such information relating to complaints as the Board reasonably requests for the purposes of monitoring and performance management." 12:42

And only limited by the Data Protection Act.

Had you any responsibility for reporting out then to

the HSCB? I think was it quarterly? Yes.

A. Yes. At that stage, whenever I was in the complaints role from 2008 onwards to 2019, we carried out what was called a closed report on complaints. So that would have been a report for all the complaints that were closed in the previous month. That would have been provided to our corporate governance team and then that would have been shared by them to the HSCB. My understanding was that this closed complaints report was then an agenda item at HSCB. And from time to time the Board would have come back and asked us for specific copies of complaints and responses. 12:43 12:43

238 Q. Yes. So there was that level of engagement or dialogue?

A. Yes. 12:43

239 Q. And possibly challenge from the HSCB?

A. Yes. Yes, there would have been. HSCB would have come back and asked specific questions in relation to specific complaints as a result of that monthly report.

240 Q. Yes. Just finally on complaints, you have said, at paragraph 1.3 of your statement, that the number of complaints in relation to urology was not excessive and were usually in relation to the length of time that patients had to wait for an appointment. There were no complaints regarding urology that stand out, to the best of your memory. So your sense of it was that the complaints were in association with waiting list-type issues; is that right? 12:44 12:44

A. Yes. That was my sense of it at that time. The

majority of the complaints were in relation to waiting times or waiting lists queries. And I suppose the accepted practice at that stage would have been when a complaint arose in relation to waiting times, then the patient would have been offered the next available appointment.

241 Q. So we can see, of course, that, and maybe you're not aware of this, that the risk registers from 2012 were highlighting that urology, perhaps in particular, it is certainly one of the few specifically named services, where there was this risk of patient harm identified both in association with in-patients, day cases and I think in respect of out-patients perhaps as well. 12:45

A. Okay.

242 Q. And that was then being reflected, I suppose, coming back the other way from the patients, to your memory? 12:45

A. Yes.

243 Q. You were getting a cluster of complaints around this?

A. Yes. But no more so than other areas within Acute Services. 12:46

244 Q. Right. Can I just finally take you back to Patient 102?

A. Yes.

245 Q. This was the Datix you accepted should have been screened on the face of it but wasn't. As I think I suggested in my opening remarks around that area, Mr. O'Brien is of the view that this referral did go via the CaPPS system, which was the system used by the multidisciplinary team to track the cancer patient 12:46

along the pathway. If you have to speculate in answer it's probably not terribly helpful but I'll ask the question in this way: Do you consider that the reason why the case was not screened for an SAI could have been because there had been a recognition that the matter had been the subject of a direct referral?

A. I honestly can't comment in relation to that and I wouldn't have in a governance role access to the CaPPS system to look to see if a referral was or wasn't made. 12:47 12:48

246 Q. Yes. You have simply, I think you have said it already, simply no recollection --

A. No.

247 Q. -- of the reason given to you, if a reason was given to you, to explain? 12:48

A. No. I have no recollection in relation to any reason, if one was given at all.

248 Q. MR. WOLFE KC: Okay. Well, let me check my note. Thank you, I have nothing further for Mr. Cardwell.

CHAIR: Thank you, Mr. Wolfe. Mr. Hanbury? 12:48

MR. DAVID CARDWELL WAS THEN QUESTIONED BY THE PANEL, AS FOLLOWS:

249 Q. DR. HANBURY: Thank you very much. I have just got a couple of questions. You mentioned education on Datix and how it is not mandatory and certainly speaking as a clinician there are lots of us that found it quite hard. How did you train people, was it one-to-one or 12:48

small groups and would you have any comments about that?

A. There was a number of methods of training. There would have been group training where a session would have been advertised and staff would have booked on to that. 12:49 And then there would have also been individual training where new staff in posts would be coming in and part of their role would be to use Datix and they would have got one-to-one training.

250 Q. Trudy Reid, yesterday, mentioned that it is quite sort 12:49 of opaque from the report writing point of view. Would that be part of your training as well or were the clinicians not expected to go that far?

A. No, the training that Trudy Reid would have been referring to would have been training in relation to 12:49 the management and being part of an SAI review team panel. The training that I would have been providing would have been just in relation to the Datix system and how to navigate your way around that and what information to put in what boxes of the Datix system. 12:50

251 Q. Okay, thank you. Going on to the sort of screening of potential SAIs, I am just interested in what you said about the near misses, I think you said it could have gone badly wrong but actually didn't in the end. What was the, it may be an unfair question, but were they 12:50 automatically categorised as an SAI or was that subject to the clinician's debate, how was that established?

A. In relation to the actual outcome of the incident or?

252 Q. I suppose my point of view is near misses are often

very good learning points.

A. Yes.

253 Q. If it wasn't for the grace of god something would have gone horribly wrong so we need to stop it. And I am interested in how that went through the process into a learning point? 12:50

A. Yes. Well, up until 2019, sorry, I can't comment on that because I wasn't in the role that I am in at the minute. But from 2019 onwards, yes, certainly where patients haven't come to harm but there are near misses for whatever particular reason, yes, they can go to screening. 12:51

254 Q. And, therefore, would?

A. And would have a discussion in relation to whether it meets the criteria of an SAI or not. 12:51

255 Q. Okay. Thank you. Just one last thing. A never event, such as a retained swab or something or operating on a wrong limb, would that be automatically designated as an SAI?

A. Yes. 12:51

256 Q. Or is there sort of a different category?

A. No, a never event is automatically categorised as a serious adverse incident. And we work according to the SPPG's most recent guidance in relation to that.

257 Q. Thank you. The learning dissemination, I was just asking about that. You said that it was sort of cascaded down to the various teams, but how often would they have their morbidity and mortality meetings, would you know that? 12:52

A. They, to my understanding, are on a monthly basis. Each speciality would have their M&M meeting on a monthly basis.

258 Q. Mm-hmm. How would you make sure that the right learning went to the right departments or did it just go as a big file? 12:52

A. We, on completion of an SAI review report we send it to the M&M coordinator and ask them for it to be listed for discussion at whatever M&M meeting the review team panel have determined it needs to be. 12:53

259 Q. And that was in place?

A. Well, from 2019, I can't comment because I wasn't in the current role before 2019.

260 Q. Thank you. And lastly, just coming from Mr. Wolfe's point, there has been discussion of potential patient harm when they are on long waiting lists, but that doesn't really seem to have featured in Datix, that I have seen anyway. I mean, did that come across your radar? 12:53

A. That would be something that would be on the risk register and that would be, that is updated on a regular basis and those would be shared with the Acute Services Directorate team and there would be an expectation that they would keep an eye on those and provide updates. 12:53

261 Q. So that information would go up the food chain to the Director?

A. Yes.

DR. HANBURY: Thank you. That's all I got.

CHAIR: Thank you. Dr. Swart?

262 Q. DR. SWART: Thank you. Just a few questions about the complaints to start with. Clearly you had a big volume of complaints, from what I have seen of a lot of complaints, there is themes about waiting lists and communication comes through very strongly generally. Was it your practice to ring the complainants to actually agree the key point of the complaint with them at all or did you have a personal contact? 12:54

A. No. For those that came in by letter -- 12:54

263 Q. Mm-hmm.

A. -- then those, there was no contact with those complainants. Those that came in by telephone would have came in to a central reporting point for complaints, a central number and there would have been discussion with those people who were making the telephone complaints really to clarify what their issues were. 12:54

264 Q. Did anyone ever suggest that you might want to clarify in it person or did you just feel you didn't have time to do that? 12:55

A. Probably from the point of view of the ones that came in by letter that was a written statement provided by a complainant. The ones that came in by phone, that would have been clarified at the time. But I suppose time pressures didn't allow us to contact every complainant to. 12:55

265 Q. And just on a similar vein, you will know that it's sometimes very helpful to meet with the complainant and

the family. Was that a routine part of the culture? And when it was necessary, who organised it, did you organise it from governance or did the service organise it, how did that work?

A. Yes, there were occasions whenever complaints came in and we felt it would be more appropriate to meet with the complainant and their family to respond and that would have been followed up with a response at a later stage. 12:55

266 Q. Yes. 12:56

A. And I think that's evidenced in some of the patients on the list.

267 Q. Yes.

A. My team would have been responsible for making the arrangements for those particular meetings. 12:56

268 Q. And what level of medical input did you have in those meetings in general?

A. It would usually have been the consultant responsible for the patient's care who would have attended the meeting, accompanied by the Head of Service. Or if there were nursing issues, then it would have been the lead nurse or Ward Manager. 12:56

269 Q. And again still on the complaints theme, there is a lot of emphasis on the timeliness of the complaints, I can't see a lot of emphasis on the quality of the complaint response. Did you try to assess that? Did you ask people how satisfied they were with the complaint response? Or what's your general view of that, perhaps looking back now? 12:56

A. Looking back now, it's something that could be done and should be done. But really at that particular time, given the small number of resources that we had compared with the number of complaints and MLA enquiries we weren't in a position just to do that. 12:57

270 Q. Mm-hmm. Again you say you cascaded, it goes for cascade down to the teams. Learning from complaints is always a very hot topic and the learning is only as good as the quality of the discussion and the actions taken. 12:57

A. Yes.

271 Q. Did you seek any assurances that the complaint had been discussed at the right level and did you seek any assurance about the actions taken?

A. No, that wouldn't have been part of my role. That would have been the role of the Governance Coordinator. 12:57

272 Q. Okay. Were you aware as to whether that happened or not? Did you have any understanding about that?

A. No, I can't say that I did.

273 Q. Okay. Just coming on to Datix for a minute. Clearly you've got a lot of expertise in this area. The commonest complaint, in my experience about Datix, from staff on the ground is there's no point filling in that thing because nobody ever tells me what happens. What would you say to that staff member? What did you say to members of staff who complained like that? Because I am sure you had some. 12:57 12:58

A. Yes, we would have had staff making that exact complaint about Datix.

274 Q. Yes.
A. In my eyes it is the responsibility of the person who is investigating the Datix to provide feedback to the person who has reported it.
275 Q. Yes. So you would say that. Do you think that happened routinely? 12:58
A. No.
276 Q. Do you think feedback was provided?
A. No.
277 Q. No. And the screening meeting which we had lots of discussion about in the last couple of days, what was your impression of the degree of hierarchy at those meetings, was there deference to the most senior person, was there appropriate challenge, was there any problem with actually having open discussions? Just from at a personal perspective, how did it feel to you? 12:58 12:59
A. From a personal perspective, from 2019 onwards I considered those meetings to be very productive. The cases I considered to be discussed in an open and transparent manner. And I think that everyone has equal input to those discussions. 12:59
278 Q. Who would have the final say, though, if there was a difference of opinion?
A. I suppose it would be the Divisional Medical Director.
DR. SWART: Okay. Thank you very much. 12:59
CHAIR: Nearly finished, just a few questions from me, Mr. Cardwell.
279 Q. A couple of things, well first of all if I can just ask you about Datix. It has been updated but you're not on

the newest system, why is that? Is that a resource issue?

A. I would imagine so. I can't say for definite but I would imagine that is, and there would be a cost associated with that as well. 13:00

280 Q. The new Datix that is currently in operation, is it any less cumbersome to input the information than the previous one?

A. Not really, no.

281 Q. So would you accept then that in some ways it is perhaps not fit for purpose? 13:00

A. Yes, you could say that it is not fit for purpose.

282 Q. I mean, obviously the easier it is for people to make a report --

A. Yes. 13:00

283 Q. -- the more likely they are going to do it and if they are put off by a cumbersome system that requires a lot of training and that isn't particularly user friendly then it's not really going to be the most effective system, is that fair? 13:00

A. That's a fair point. But on reflection you still need to capture the key essence of what the incident is in a factual and concise manner.

284 Q. I accept that entirely. But if you're having to tick a box, if you're logged out after a certain period of time, then those are things that surely with the IT skills that people have nowadays could be improved? 13:01

A. Could be rectified, yes, I agree.

285 Q. Okay. The other thing, a comment that you made about,

if someone complained about the length of time that they were on a waiting list, they were given the next available appointment?

A. Yes.

286 Q. Are you suggesting that the way to get moved up the waiting list is to complain? 13:01

A. No, I'm not suggesting that.

287 Q. Okay.

A. What I am saying is that that was a resolution or a remedy that the service was able to offer to people who complained. It wasn't that, you know it wasn't just widely known that if you make a complaint you get moved up the waiting list, and that wasn't the case. 13:01

288 Q. So but what -- I'm sorry, maybe I'm not being clear on it. If I write in and complain, I have been on this waiting list for months, years, whatever, what are you doing about it, I would be given an appointment within a short period of time? 13:02

A. Yes. But I accept that that doesn't look at the root cause of why there is a long wait. 13:02

289 Q. My point, though, is that, if people know to complain, then they can leapfrog over the waiting list, essentially?

A. Mm hmm.

CHAIR: Okay, thank you. I have no further questions. Thank you very much, Mr. Cardwell, that's been informative on many levels. Mr. Wolfe, I think that's our witness list for today, am I right? 13:02

MR. WOLFE KC: Thank you, Mr. Cardwell. Ms. McMahon is

on duty tomorrow with our next witness.

CHAIR: Okay. Then ten o'clock tomorrow, Ladies and Gentlemen. Thank you.

THE HEARING WAS CONCLUDED 13:02