Urology Services Inquiry

Oral Hearing

Day 40 – Tuesday, 25th April 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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THE INQUIRY COMMENCED AT 10:00 A.M. ON TUESDAY, 25TH APRIL 2023, AS FOLLOWS:

CHAIR: Good morning, everyone. Ms. McMahon.

MS. McMAHON: Chair, if I just give a bit of background of where the evidence is now moving into, a new module. Chair, we are now moving on from evidence regarding the MHPS process and surrounding events to hear evidence about the governance structures and processes put in place by the Trust or developed by Trust staff in their attempt to ensure the smooth running of systems of operational and clinical governance. In short form, this evidence seeks to demonstrate Trust governance in action. 10:01 10:01

The Inquiry will appreciate, however, that demarcations around themes and subject matters is not entirely possible, given the commonality of themes running through the entirety of the timeframe falling within your terms of reference. 10:01

By way of just one example, the Inquiry will have heard evidence from Ronan Carroll which touched upon MHPS and systems around governance, and his knowledge of the issues around non-dictation of clinics, triage, and notes at home. This overlap is unavoidable but, as far as possible, repetition of evidence will hopefully be kept to a minimum. There is, however, a caveat to that hope in that we must allow all relevant witnesses to 10:02

comment on their own evidence and the evidence of others, most particularly within three scenarios.

Firstly, when they have specific knowledge of issues of concern and must explain that knowledge and any subsequent actions by them or others. Secondly, when they wish to criticise others so that they may explain the basis for their criticism. And, thirdly, when they themselves or the systems they operate are subject to criticisms by others so that they may respond. 10:02

It may also be the case that other witnesses from within the areas of practice or operations covered in this part of the governance module may require to be called. 10:03

The position regarding that will be reviewed by you, Chair, once you have heard the evidence from witnesses currently time-tabled as to what further evidence and witnesses you require to hear from so that your terms of reference can be properly satisfied. 10:03

Within this context, we move into this new module of evidence which will run at this stage up until the end of June this year, in which you will hear from a variety of Trust staff deployed in a broad range of roles, the evidence from whom will serve to inform the Panel's consideration of defined aspects of their terms of reference. Most specifically, paragraph B of those 10:03

terms requires the Inquiry to evaluate the corporate and clinical governance procedures arrangements in the context of the circumstances which give rise to the Lookback Review. This includes the communication and escalation of the reporting of issues related to potential concerns about patient care and safety within and between the Trust, the HSBC, PHA and the Department of Health. It also includes any other areas which directly bear on patient care and safety, and an assessment of the role of the board of the Trust. 10:04

Within the confines of terms of reference B, the touchstone for what falls within the remit of the Inquiry's consideration is any governance area bearing on patient care and safety. This is reinforced by the language of terms of reference C. 10:04

Lastly, paragraph F of the terms ask that the inquiry identify any learning points and make appropriate recommendations as to whether the framework for clinical and social care governance and its application are fit for purpose. To fulfil this term, the Inquiry will need to look at both the governance framework and the way in which it has been applied or could have been applied, question whether that application has been effective in resolving the issues, and assess the reasons for any identified failures. 10:05

Moving back to the witnesses. The key feature of the

witnesses the Panel will hear from in this module is that they all operate, or are accountable for, or exercise governance responsibilities regarding systems which have the capacity to impact directly on patient care and safety, and from which risks may arise should those systems fail. The Inquiry will hear from witnesses that there existed a disconnect in fully appreciating that systems failings directly impacted on patient care. This manifested as a failure to appreciate that issues which may ostensibly be viewed as administrative problems or system failings were, in fact, directly or potentially harmful in that they represented an existing or increasing risk to patient care and safety. The Inquiry may wish to consider the effect that view had on both the response to the problems faced and the urgency or lack of in which matters were addressed. 10:05 10:06 10:06

The witnesses you will hear from have been called in groupings which are generally arranged, should the sequencing hold, to move from those operating the systems of governance towards those who carried responsibility for those systems. The thinking behind this is so that the Panel may have a better understanding of how systems and individuals worked, and how, if at all, problems found their way to those with responsibility and authority to address non-concerns. By presenting the evidence in this way, it is hoped the Panel will be better placed to 10:06 10:07

understand who knew or should have known what, and what was done or could and should have been done in response.

The following are examples of some of the areas of practice and procedure illustrating governance systems and practices that the Panel has written evidence in relation to and to which witnesses in the next module will speak. Firstly, on the issue of medical and health records, the Panel will hear how systems of governance operate around the creation, retention, and general handling of healthcare records. Storage and access to records will also feature, given that patient records were removed from known to unknown locations, and that some of those records were unable to be found when needed, including for clinical reasons. 10:07 10:07 10:08

How records are tracked and traced will also be explained, including the gaps in those systems which allow records' locations to be untraceable at times, and allowing notes to be removed, kept in cars and at home without being properly monitored. It is also hoped that staff who operated, and some of whom still operate, these systems will provide insight and learning from their experience which might inform inquiry recommendations. 10:08 10:08

The Inquiry will also hear evidence of systems of operation recording triage, and how staff responded to

problems to try to problems to try to, in their view, keep the process going. The Panel will hear that issues around Mr. O'Brien's noncompletion of triage were longstanding, going back many years, were widely known by Trust staff, and that periods of compliance with the system were followed by slippage and compliance. This longstanding knowledge led to staff developing their own systems of working to attempt to manage shortfalls in how the triage system operated. 10:09

These included individuals introducing informal approaches to triage management, as well as more formal attempts by more senior staff to develop workarounds. The appropriateness and effectiveness of both informal and formal approaches to the problems with triage will be something the Panel will wish to reflect on. 10:10

The way in which data about dictation completed by consultants post patient appointment will also be explored so that the Panel may better understand how non-dictation might slip under the radar, given both the way in which the material is fed back to the record centre and the weakness in relying on individual secretarial feedback. 10:10

Regarding secretarial support, the Panel will hear evidence regarding the function and management of secretarial staff, and the inherent vulnerabilities in a system depending on secretarial staff identifying the

noncompletion of work or non-adherence to systems of practice by consultants.

You will also hear from Mr. O'Brien's secretary, who will detail her own systems of work and experience of working with Mr. O'Brien, including on private patients, triage, dictation of clinics and the handling of patient notes. 10:11

The Inquiry will hear evidence of the cancer tracker system, its functions and limitations, such as not tracking progress beyond first treatments. You will also hear from the multidisciplinary team coordinator how multidisciplinary team operated; how outcomes were agreed collectively and actioned, and of lacunas in the system allowing treatments and treatment plans previously agreed at MDTs to be diverted from post meetings without being brought back to the MDT for a collective or consensus view of that divergence. 10:11 10:11

Issues around the quoracy of MDTs and the potential impact on patient care will also be explored will witnesses. 10:12

Chair, you will also hear from nursing staff attached to Urology Services. The use and benefits of the clinical nurse specialist generally will be explored, as will Mr. O'Brien's reliance or otherwise on these nurse specialists. The Inquiry will also hear evidence 10:12

of workarounds introduced for Mr. O'Brien's clinic, where it is reported that his clinic "slots were longer and he reviewed less patients per clinic", an arrangement which apparently came about as an arrangement between Mr. O'Brien and Martina Corrigan as there had been previous issues around clinics overrunning, affecting staff and patients. 10:12

Evidence regarding the benefits of nurse-led services and the impact of that on urology capacity will also be heard. 10:12

Operational Support Service Lead and medical staffing witnesses will set out the general systems around medical and departmental staff performance and standards allowing activities, trends, and waiting lists to be better understood. 10:13

The head of Cancer Service will explain both cancer performance indicators and the existence of delays for patients with a suspected cancer getting access to a first appointment within Urology Services. She also explains in her evidence that patients should have a key worker urology cancer nurse specialist as part of a key performance indicator. 10:13

The Panel will hear from a consultant radiologist that, in his view, management did not take concerns seriously within the Trust, and often failed to act or did not

communicate that they had done so, and that problems with quoracy at MDT was a longstanding concern.

The Director of Pharmacy also had a governance role, and considered that in relation to a triage issue she was involved with in 2017 that there was a failure by the medical directors and the Director of Acute Services to engage fully with and address the problems identified at the time. 10:14

In this module you will also hear from the Director of Performance and Reform, who has provided written evidence to the Inquiry that in her experience in the Southern Trust, the clinical and social care governance arrangements were in a state of flux for a number of years, and that some challenges may have resulted from frequent changes in the leadership roles supporting the Medical Director at Assistant Director level, including those with responsibility for clinical and social care governance. The Inquiry may wish to consider this possibility. 10:14 10:15

The way in which governance issues were brought to the SMT and the Trust Board, or the lack of a mode for doing so, will also be explored with this witness, and also with the Acute and Social Care Governance Manager and Head of Governance. 10:15

Specifically in regard to the Trust Board, evidence

will be heard from the Board Assurance Manager who states in her evidence that:

"Overall mistakes were made in that the information provided to Trust Board was not timely and lacked sufficient detail". 10:15

Of particular interest to the Panel will be the knowledge of senior staff and members of the senior management team who might be reasonably considered to be in a position to address the governance concerns and patient risks arising. To this end, the Panel will hear from assistant directors and directors with direct knowledge of issues germane to your terms of reference, Chair, and from whom the Inquiry will learn of responses or failures to respond to the governance issues arising, some existing for many years. 10:15 10:16

Finally, the Panel will also hear again in this module from the Head of Service in Urology, Martina Corrigan 10:16

Permeating the witness statement and evidence will be examples of culture. The Inquiry will wish to consider the impact on the operation of governance that the culture amongst individuals and within an organisation has. As was stated in the opening to the Inquiry, in this context culture means not only that the correct standards are set and measured but also that practices are questioned, that learning takes place through audit 10:16

and from error, and that there is a focus on improvement and good clinical and non-clinical leadership. It also means that staff are valued, trained, and that their interactions with each other and with the patients are considered and respected. 10:17

Chair, you may also consider that a sound culture requires that patients are afforded the opportunities to be partners in their care and to know that they can be heard. These issues will be explored with appropriate witnesses. 10:17

The Panel will not hear evidence from any witness from the Trust Board before the end of June, from other bodies, such as former HSBC. The Trust Board is, of course, a fundamental aspect of the governance system and represents the pinnacle of accountability for patient care, safety and risk. This is because the board is required by standing orders to have in place integrated governance structures and arrangements that will lead to good governance, and ensure that decision-making is informed by robust information covering the full range of corporate, financial, clinical, social care, information, and research governance aspects. 10:17 10:18 10:18

The aim is that this will better enable the board to take a holistic view of the organisation and its capacity to meet its legal and statutory obligations as

well as clinical, social care, quality, safety, and financial objectives. Given the Board's overarching responsibility, in the interests of sequencing it is perhaps about best to enable the Panel to hear as broad a range of evidence from key players in the governance oversight and systems and how they operate within the Trust structures before calling board and other ancillary body witnesses.

10:18

Having set out the background of the evidence in general terms, the specifics of this week are we will hear today from Helen Forde, Head of Health Records. Tomorrow the Inquiry will hear from Esther Gishkori, a spillover witness from the MHPS module and from whom evidence on that aspect will be heard, before finishing the hearing week on Thursday with evidence from Katherine Robinson.

10:19

10:19

Ms. Forde is ready to give her evidence, so if I can ask that she take the oath. Thank you.

10:19

HELEN FORDE, HAVING BEEN SWORN, WAS EXAMINED BY MS. McMAHON BL AS FOLLOWS:

1 Q. MS. McMAHON: Mrs. Forde, you have helpfully provided a Section 21 response. Your role that's relevant most specifically to the Inquiry is Head of Health Records but I will take you to that response. WIT-61168. We will go to number 78 of 2022. Hopefully the signature

10:20

will be WIT-61205. Do you recognise that as your statement?

A. I do.

2 Q. You gave that on the 21st of October 2022?

A. Yes. 10:21

3 Q. You wish to adopt that as your evidence today.

A. Yes.

4 Q. There was also some additional documents provided on your behalf on Friday?

A. Yes. 10:21

5 Q. And just for the Panel's note, those documents can be found at TRU-164836 through to 164941.

In general terms, just to frame your evidence before we get into some of the detail, you were the Head of 10:21 Health Records, you have an awareness around the storage of notes and charts and tracking --

A. Yes.

6 Q. -- and the policies and procedures around that, and the governance system around trying to locate charts and 10:21 make sure they are where they should be. You also have some experience of the Datix - it is said differently - fill in IR1's, and issues being escalated?

A. Yes.

7 Q. You have some knowledge in relation to Mr. O'Brien. 10:22 You also provided a statement to MHPS. Just, before going into your employment history, do you know Mr. O'Brien? Do you have knowledge of him outside of your own professional capacity?

A. On a personal level, he was my father's consultant.

8 Q. Okay. Now, I just want to take you through some aspects of your job description. Rather than take you to each detail, I'll read them out and we'll get a sense of what your role was. 10:22

Your employment history you've set out in your Section 21. You were the Head of Admin Service from 2007 to 2009. Then you became the Head of Health Records October 2009, and then you retired in December 2020. 10:22 From February 2021 until currently, you work as an admin manager with the Lookback Review Team?

A. I finished there on the 25th of October last year, 2022.

9 Q. So you're not working within the Trust at all? 10:23

A. No.

10 Q. Your job description, which we can go to, WIT-61168, you set out your role. 4.3:

"The role of the Head of Health Records was to ensure 10:23 the provision of comprehensive, efficient and effective Health Records service, which included responsibility for ward clerks, out-patient receptionists, Emergency Department and Minor Injuries admin staff for the Acute Directorate in the Southern Health and Social Care 10:23 Trust".

That's quite a broad range within the Trust. How many sort of staff would you have had that you were

responsible for?

A. Approximately 150.

11 Q. Would you have had managers beneath you that were responsible for subsections of that?

A. I had four Band 5s. 10:24

12 Q. We'll go on to look at the way in which you interacted with them shortly but just to give the Panel a sense of the scope of your work. You also say that you have responsibility for: 10:24

"The storage, issue and retrieval of patient charts. My two health records managers, Pamela Lawson and an Andrea Cunningham, are responsible for the day-to-day management of the service. The role of Health Records is to provide safe and secure storage of charts, ensure 10:24 they are available as required, and to manage the life cycle of the chart in line with Good Management, Good Records Framework".

The reference to the Good Reference Good Management 10:25 Framework is a departmental guidance document?

A. That's right.

13 Q. If I can summarise it by saying that its aim is to ensure that departments from their own systems in place? 10:25

A. Yes.

14 Q. Systems of good governance around record keeping, record retention and record storage?

A. Yes.

15 Q. The idea is then that the Department of Health and the Trusts and the divisions within the Trust develop their own systems. We'll go on to look at some of those shortly. But that was the framework that everything fell down from, as far as you are aware, for policy and procedures? 10:25

A. Hm-mm.

16 Q. Now, you've said in your statement also that from 2009 to 2013, you had responsibility for health records service, and referral and booking service. This was changed to health record service and staff, and Emergency Department or A&E, and Minor Injuries admin staff and ward clerks in 2013 as part of an admin review. Now, do you recall that admin review and why there was a change in the structure of your responsibility? 10:25 10:26

A. Yes, there was an admin review. I think it was just sort of restructuring and trying to centralise admin. Previously ward clerks had been medical, surgical and gynae. Then, sort of it was really just to centralise and look at efficiencies. 10:26

17 Q. In your previous role with the responsibility for referral and booking service, were you involved in issues around triage around that time?

A. Yes, I would. Katherine Robinson was the manager of the booking centre and so I would have been aware of the issues with triage. Then, Katherine dealt with the heads of service with regard to that. 10:26

18 Q. Just looking at that at the moment, that four-year

period, when you say you were aware of issues around triage, can you give us a little bit more detail and background around that?

A. We would have had a Tuesday meeting with Dr. Rankin and the heads of service would have been present. We were very performance driven at that stage. There were the PTLs; we had to have all patients seen within nine weeks and in-patients within 13 weeks. So, it was very heavily monitored to make sure that we did manage to meet all of the deadlines. That all sort of was governed by the IEAP. One of the areas in IEAP was triage had to be completed within 72 hours. So, Katherine and the referral booking team every week provided statistics which showed how many referral letters there were, what was untriaged, what was triaged, number of new routines and urgent, and that was presented at the Tuesday clinic or the Tuesday meeting. It was aware there that there was an issue with Mr. O'Brien's triage and that it wasn't being done on time. 10:27 10:27 10:28 10:28

19 Q. And from your role of responsibility around that time, do you recall any action being taken at any level to deal with any of the outstanding issues around triage then?

A. It would just have been flagged. I can't remember the detail. I know I had sort of emailed -- there was one incident I had emailed Martina just to say, look, they are still tracing it, the staff are busy, they don't somewhere time to continually chase up the records, and 10:28

Martina was saying like, you know, Katherine had already flagged this to her and she was dealing with it.

20 Q. So, when you say it was flagged, you're speaking about Martina Corrigan you flagged it too? 10:29

A. Yep.

21 Q. Did you flag it to anyone else, or did she that you were aware of?

A. I can't say specifically yes, but she would have been -- I would imagine she would have been talking to 10:29 her Assistant Director, and my Assistant Director Anita Carroll would have flagged it as well to then Heather Trouton, the Assistant Director.

22 Q. So your understanding was that it was known at that level by assistant directors? 10:29

A. Oh, yes.

23 Q. And also it was your experience that nothing was effectively done by the time the review came about, and booking and referrals split away from your responsibility? 10:29

A. Yeah.

24 Q. We spoke just a moment ago about the policies and I want to go through a couple of the policies. You've provided some further policies on Friday through the Trust and we'll just look at some of them. 10:30

Now, these record movement policies can be found, the first one at TRU-164836. Now, this would have been within your time; it's dated March 2007. I'm not going

to take you through all of the policy, you'll be glad to hear and the Panel will be glad to hear, but what this part of your evidence is intended to do is to provide a framework for the Panel's understanding of what was expected to be done so that they can look at then at what was done. The main areas of interest are the movement of charts both within the hospital, the tracking of charts and the moving of charts outside the hospital or to other Trust locations. I just want to highlight some of the issues or some of the provisions that the Trust required throughout the years. 10:30 10:31

On the first page - just move down slightly - you will see the headline. The title of this is the Policy For the Safeguarding, Movement and Transportation of Patient, Client, Staff Trust Records, Files and Other Media Between Facilities. You will see the publication date there is August 2006. This is really one policy captures all. 10:31

10:31

The introduction states 1.1:

"The aim of this policy is to ensure that staff safeguard all confidential information whilst travelling from one facility location to another during the course of their working day". 10:32

Then we see at 1.4:

"It is the responsibility of all staff to familiarise themselves with the contents of this policy".

If I can just stop there and ask you about that issue. Were you aware of these policies being made available to staff, any staff or medical staff? 10:32

A. No.

25 Q. No. Do you remember if there was any training given to staff around the requirements of these policies?

A. Not that I am aware of. 10:32

26 Q. Would it be the case that if there was training around records and charts and movement and transport and storage, that it would likely have to come from your department?

A. Because that encompasses all of the health, not just health records but all records, I would have imagined that would have come from information governance. 10:32

27 Q. And did you ever know them to provide any training on these issues?

A. Not that I can remember. 10:33

28 Q. Did you ever attend any?

A. No.

29 Q. Now, you'll see the guiding principles then at 2.1. It states: 10:33

"Everyone working for or with the HPSS who records, handles, stores, or otherwise comes across information has a personal common law duty of confidence to patients and clients and to his/her employer. This

applies equally to those, such as students, or trainees, on temporary placements".

2.2: "Staff must notify their line managers immediately on suspicious of loss of any confidential information". 10:33

If we go over the page. 2.3. 10:33

"Managers must ensure staff are aware that disciplinary action may be taken when it is evident that a breach in confidentiality has occurred as a result of a member of staff's neglect in ensuring the safeguarding of confidential information". 10:34

Were you ever aware during your time in charge of records of anyone being disciplined for breach of confidence, or for the way they have handled or stored charts or records specifically for that purpose? 10:34

A. Not disciplinary action. We may have spoken to some of our staff. Like, say you have been going along a corridor and you might have seen a trolley of charts left unattended, so you would have spoken to that individual. But in my area, nothing that led to disciplinary. 10:34

30 Q. Now, paragraph 3 deals with the tracking and tracing of records. You'll see that it provides that there must be an effective tracking system in place, and this was

in 2007.

Would it be fair to say in shorthand that the tracking system more or less stayed the same, that it depended on individuals? 10:35

A. Yes. The tracking system that we had for health records' charts come from our patient administration system which had been in for several years and was totally reliant on staff input.

31 Q. What way does that work? If a chart is to be moved or is taken away, how does that reveal itself to the system so that you know where it is? 10:35

A. It has to be individually put into the system. So if the chart was in your office and I took it, I would have to track it then to my office and I would have a tracking code for my office. Then, when someone would look to find that chart, they could look up the system and they'd see it would be in my office. Now, not all nurses and doctors would have access to PAS, so it would be that they would leave that; they would tell the ward clerk I am taking this chart, or they would tell -- they should tell the secretary. It would be the same with any member of staff who didn't have access to PAS, they should tell someone "I have taken this chart", and then get it tracked to the appropriate area. 10:35 10:36 10:36

32 Q. Do all staff in all locations have their own identifiable code?

A. Yeah. And if, say, you had opened up a new service or

you had an office and you were going to have charts, you just had to check with or tell the Health Records manager and they would have given you your own specific tracking code.

33 Q. I'm sure for the system to function efficiently, it must have been the case, for example, secretarial offices had their own code -- 10:36

A. Yes.

34 Q. -- but not every location within the Trust had a code. A code was allocated if a chart was anticipated to travel to that location rather than every office having a code? 10:37

A. No. If you take, for example, the admin floor where there were several heads of service there, the tracking code would have been the secretary's office. There was a general secretary's office. If they had been looking for a chart, it was tracked to that office and then sent to that office. 10:37

35 Q. So, floors also had a tracking code as well, the actual floor as well as the office, just so I can understand this? 10:37

A. That was admin floor, and there were several offices there. But say if the Head of Service had been looking for a chart, they wouldn't have phoned themselves, they would have said to the secretary "Would you get that chart for me, I need it for a complaint", or whatever, and then the secretary would have -- the secretary just on the admin floor would have asked for it. 10:37

So, that's just an example of a general tracking code, so that one tracking code would have done for the admin floor. But if you went up to one of the wards, there would have been a tracking code for the ward, the secretary's office, the consultant's office, maybe the junior doctor's office.

36 Q. So, the system operated either specifically to a location or an individual, or could also identify a general area --

A. Yes. 10:38

37 Q. -- where the chart was, which it could then be tracked down within that area?

A. Yes.

38 Q. Is that a fair representation of it? Was that system in place when you took up post? 10:38

A. Yes.

39 Q. You'll see, if we move slightly down, just on the bullet points there, the third from the bottom, "Files should be returned as soon as possible". 10:38

Something like that perhaps sounds like commonsense, but was there ever any memo sent out to staff or any directions to staff around returning charts whenever they had finished with them?

A. No, because normally you wanted the charts out of your office as quickly as possible due to storage space. We also had two health records porters who went round all of the offices every day to pick up any charts that were ready to go back to Records. 10:39

40 Q. Now, the track and tracing provisions in this 2007 policy clearly established that there should be a system in place that the record of who removes the files, logged out to the person who remove updated by the borrower if they are passed on. So, if I was a consultant and passed the file to my secretary, then it is my responsibility or her responsibility, but one of us most ensure that we log it onto the new code -- 10:39

A. Yeah.

41 Q. -- before being sent back. There's also provision in this policy in the next section for movement outside the work base. It is anticipated the charts under this policy charts can be moved outside the work base, and it gives some examples of when that may be the case. For example, a different Trust facility and the SWAH clinics that the Panel have heard about, that would fall within Trust property but offsite? 10:40 10:40

A. Yes, because SWAH wouldn't be one of our Trust facilities. It is an independent site from the Southern Trust. 10:40

42 Q. The movement of records to that would be covered under the policy for clinical need?

A. Yes.

43 Q. So, if we just move over to TRU-164898. This is the forerunner policy checklist to the 2012 Version 2 policy. You'll see on the front page - just move down slightly - the date policy submitted to the Policy Scrutiny Committee, 14th of January 2008. Members of the Policy Scrutiny Committee in attendance underneath 10:41

includes your direct line manager Anita Carroll. Just further on down the page, it was presented to the SMT on the 8th of February 2008 and approved by them.

Now, this policy has a couple of additions. We'll just go to one example of this at page TRU-164901. Relevant for the purpose of the Panel's considerations, 1.3 is a new paragraph in this policy in 2012, The Removal of Notes and Records. At 1.3 it says: 10:41 10:42

"May also include from time to time the necessity to store confidential information overnight in staff member's own home".

Was that your understanding that the policy and the Trust provisions did allow for notes to be stored, dependant on necessity, in an individual's home? 10:43

A. Yes, but, you know, under exceptional circumstances. It wasn't sort of something that would be done regularly. 10:43

44 Q. Just a plain reading of the policy. I know you have said exceptional circumstances, and lawyers dance on the head of pins, but the requirement there is "necessity to store". Would you agree that that would seem to suggest that the possibility for people to keep notes at home as far as necessary for them to fulfil their duties, at least on the face of that policy, seems to fall within that? 10:43

A. Yes.

45 Q. Were you aware that people were keeping notes at home just generally? Was that something that was on your radar as Head of Health Records?

A. The only person that I would have had any knowledge of taking the actual hospital acute record out and having it at home would have been Mr. O'Brien. There were a couple of occasions where my staff did take them, but that was for an exceptional circumstance in that there was a clinical to be held in Kilkeel. They were the Daisy Hill charts. The person who lived in Kilkeel that was going to be at the clinic. The weather wasn't good, so they had asked could they take those particular charts for that clinic home that night, keep them overnight and then take them with them to the clinic in Kilkeel the next morning. That was agreed, we had discussed it. It was put into a tamperproof box, they were to keep it in a secure area in their house, take it straight to the Kilkeel clinic and then bring it home. So, if there had been something like that, I would have been aware of that. Or permission would have been asked to take the charts home for a specific reason. 10:44 10:44 10:44 10:45

46 Q. We will come on to look at some of the explanations from others around why notes may have been taken overnight, or taken home, some of which are operational necessity, like you've described, because of the geographical area that the Trust covers. We'll look at that shortly. 10:45

I just want to make sure that we have 5.5, TRU-164903. This was in the previous policy but I just want to draw the Panel's attention to it. 5.5. This is under Safeguarding of Patient Client Staff Records Transported Between Facilities and Locations. Before that 5.4, the transport boxes you have referred to "are used by Health Records departments. Each box is securely sealed using the tamper evident seals by Health Records staff and collected from the Health Records Department on a daily basis by Trust transport staff". 10:46 10:46

Then 5.5:

"Charts must be securely transferred by SHSCT transport vans or, on occasion, staff personal cars. Charts should never be left in a vehicle on view to the public and must be stored in the locked boot when being transported". 10:46

Again, none of these are entirely surprising as they allow for the movement of charts. The overarching theme of the policies that we've looked at and the one that we'll go on to look at, which I think predates your time - or post-dates your time - is that records, people know where they are, that they are correctly coded to their location, that they are kept for the minimum amount of time necessary, that they are returned to their home, or I think you refer to them as 10:47 10:47

libraries?

A. Yes.

47 Q. And that if they are moved, the policies provide for the safe and secure storage and transport of those records. It would be clear from the policy, I think, that it is envisaged that some records can be transferred in personal staff cars. The focus is on the way in which they are transferred: Not left in public sight; that they are secure. Also, if they are at an individual's home, that they are secured at that location. 10:47 10:48

Would you agree that they are the overarching principles for handling of records?

A. Yes. 10:48

48 Q. I just want to again look at the Trust policy. This one is dated the 8th of January 2019 and can be found at WIT-61321. Now, this is version 2.2. Again, it says that they may also include overnight at a staff member's home and that staff are bound by the duty of confidentiality. 10:49

Did anyone ever mention about professional duties around record keeping for nurses or doctors, the GMC Guidelines, or the NMC? Is that ever something that you were aware of, that there was another layer of responsibility around records? 10:49

A. There's the Records Management Procedure and there would be details in that. One of the examples was that

if you were to write in the chart, it should be done within a short period after the event, about 24 hours. So, there was a Records Management Procedure as well.

49 Q. Also, you've provided us with other policies. The Data Protection Act 1998 policy, which again provides a framework for data storage and retention and use and destruction, that your policies must adhere to? 10:50

A. Yes.

50 Q. I think in light of that there have been subsequent policies developed by the Trust that seem to reflect the evolving legal landscape on that. GDPR; phrases you will be very familiar with? 10:50

A. Yes.

51 Q. Now, just for the Panel's note there is a further Records Management Procedure document Version 4, 30th December 2020, WIT-61329. I don't need to take you to it. I think the Panel get the point that the policies reflect the original policy and serve to widen the scope ever so slightly to mention new developments. For example, that 2020 document actually now refers to: 10:51 10:51

"This guidance has been developed as a minimum standard and should be read in conjunction with the Trust records management policy and relevant professional standards from regulatory bodies, for example, Nursing and Midwifery Council". 10:51

Panel, that reference is WIT-61332. That policy also reflects the increased move towards people keeping

their own records at home, for example, Maternity Services, Community Services. That is specifically referenced in that policy at WIT-61340. That's just for the Panel's note.

10:52

There is, in fact, a March 2023 Records Management Policy which you have provided, but you weren't in the Trust at that time so I can't ask you any questions on a document you're not familiar with. It's on the same terms, you won't be surprised to hear, except it anticipates the introduction of electronic tracking and tracing, and the hope that that will take away the human element of potential error and tracking.
I am going to ask you about that later on because I know that was something that you were particularly interested in.

10:52

10:53

The Trust also has, for the Panel's note, an Information Technology Security Policy dated 1st March 2023. You can find that at WIT-61375, for your note. Again, that sets out what requires to be done in a significant amount of detail. If I can be presumptive to say having read it, the overarching principles that we discussed earlier remain the same throughout?

10:53

A. Yeah.

10:54

52 Q. That's the sort of policies and procedures backdrop relevant to your role. I hope that wasn't too tortuous to take you through that but it is important that the Panel are aware exactly what the Trust expected and

how, if at all, that information found its way to the staff so that they would know. Your evidence is that in your experience, you operated the system but you don't know if the requirements were disseminated to the other staff personnel. Would that be right? 10:54

A. Yes.

53 Q. One of the reasons why I just wanted to take a bit of a run through that was there does seem to be mixed messages, if I can put it that way, from staff as to what they understood the position to be. By way of 10:55 example, if I can take you to a comment by Heather Trouton at WIT-12137 at 446. She says:

"While there were not clear Trust guidelines forbidding the taking of patient notes home, there were guidelines on how patient notes were to be tracked and managed". 10:55

Heather Trouton is someone you know?

A. Yes.

54 Q. Then at 12144 on the same theme. 465.

10:55

"There were not sufficient legal robust actions in place to address this issue". About removal of notes. "It was reliant on Mr. O'Brien understanding the risks for patient safety associated with no patient notes being available in hospital for emergency admission and 10:56 other clinics, and being vigilant in returning patient notes in a timely manner. There was no mechanism put in place to fully ascertain the situation regarding patient notes retained at Mr. O'Brien's home".

Now, you've included in your documents guidance that I think you provided to Records Management for including in doctors' inductions?

A. Yes.

55 Q. To provide them with information on good practice when dealing with a chart. I'll have to come back to that. I'll come back to that. I know where it is; I have written down the wrong note. What that does is provide in shorthand good practice. We'll look at it but it's not a long document?

A. No. We had asked if we could actually take part in the junior doctors' induction, just to go over some of the things with regards to records and dealing with results and discharge letters. Unfortunately, the induction was too long so instead of having -- taking part in it, we came up with a document and a poster and asked for that to be included and given to all the junior doctors, so at least it would be a mechanism for us to give them information.

56 Q. When was that? When did you ask that?

A. I can't remember.

57 Q. Hazard a guess. Was it within the last five years?

A. I have been away two and a half now.

58 Q. You have a think while I now, having helpfully been given the correct evidence, ask for it to be put up. WIT-61473. The Panel can see the way in which you have provided it. It is very clear document in setting out each heading of when a doctor may have cause to be near

any paperwork, if I can put it that way. You cover the discharge letter, then follow-up, test, investigations, changing the discharge letter, and then you go on to patient documentation. I'll just read those paragraphs 5 and 6 out. 10:58

"It is everyone's responsibility to ensure the safekeeping of patient charts. Therefore, if you take a chart out of the trolley, you must put it back where it came from. Please do not leave patient documents 10:59 lying around work stations or wards. This poses a risk of information going missing, being misfiled, and can cause serious breaches in patient data confidentiality". 10:59

Then specifically on patient charts.

"We have five sites in the Southern Trust and each site at one time had their own chart, so you will be working with charts from those areas. The majority of the 10:59 charts are now filed in speciality order but some of the older CAH and BPC charts are filed in chronological order. A filing protocol has been provided on each ward for your reference, and the ward clerk will also help you if you need guidance on where to look in the 10:59 chart".

There is nothing specific about there being codes on that document. Was this because doctors are not

allocated codes right away, or because they don't need to know this at this stage, or was it just deemed to be not really needed for an induction sheet?

A. Do you mean a tracking code?

59 Q. Yes. 11:00

A. The doctor wouldn't have been given a tracking code. The chart would have been tracked to the ward so they didn't need to have their own tracking code. Really, we were trying to keep that as concise as possible because sometimes you do have a big long document, 11:00 people don't read it.

60 Q. Yes.

A. So we were hoping to just keep it succinct.

61 Q. And was it your own initiative? Were you approached --

A. No. 11:00

62 Q. You suggested that this training might be helpful?

A. Well, it was something my managers and I at one of our meetings talked about and said it would be good if we could take part in the induction, and then right, well, we can't take part, well, let's at least provide some 11:00 documentation. So, our team provided it.

63 Q. Do you think that's something that might be helpful if the issue around documentation, confidentiality, patient data, was specifically addressed at induction for doctors so that they understood the way systems 11:01 operate to allow them to engage with them?

A. Yes, I think it would be useful.

64 Q. Now, as well as seeking to influence those people that used your systems of operation, you also line-managed

quite a few people. I just want to move on to the way in which you met your governance requirements around your staff. Now, you met your managers regularly, you've said in your statement, on a one-to-one?

A. Yes. 11:02

65 Q. When you say regularly, would that have been weekly or monthly?

A. We would have had a regular one-to-one monthly meeting but most days, or two or three times a week, would have telephone conversations. 11:02

66 Q. You talked about work plans as well. Are they work plans from your managers that you engage with them in, or is it work plans, your own work plans, you're referring to?

A. We would have had like our managers' work plans. So, 11:02 we would have sat down and just said, right, what needs done for this year, what do we try to achieve. I was Head of Health Records, I had four managers. We would say what needs done. You might have had one of the girls from ED would do -- well, two would say, right, 11:02 we'll go ahead and make the coding consistent for all of the recording on the ED system. Somebody might have went on and done something individually or in groups.

So, it was really just there's the day-to-day work but 11:03 then what actually did we want to achieve on top of the day-to-day work to, you know, as a way of improving our service.

67 Q. It might be helpful if we look at some of those. You

provided them recently. If we look at TRU-164924. These are Health Records key priorities for 2015. We'll look at 2015, 2016 and 2017 in order to identify the similarity in issues. If we look at number 45. We see numbers on the left-hand side. I think the way they have been printed out, I think the later date. Here we are, Key Priorities 2015. Let's go down to number 45, please, on that one. This is a familiar document to you, it's a work plan set out. 11:03

A. Yes. 11:05

68 Q. You'll see the left-hand side there is a number 45 and the ward clerk. One of the issues there is:

"To validate charts tracked to each ward to ensure tracking is up-to-date and complete". 11:05

And then down to 51.

"Complete database of location of records".

11:05

Okay. That's complete; that was obviously rolling issue?

A. Yes.

69 Q. If we go back up to 2016, which is the first of those pages. There is mention there at 35, "Update risk register for each area". I'll come on to that but I see it marked down as a specific item in your department. Number 26: 11:05

"Validate charts tracked to each ward to ensure tracking is up-to-date and complete".

Then in 2017. There we are, number 18, and in this, 11:06

"Missing lists, complete an up-to-date list of all records which are lost".

34, and 39, please.

11:06

"Work on overdue track charts to get them returned to the libraries, and validate charts tracked to each ward".

So, over the three years it's obviously a fairly significant part of your work? 11:07

A. Yes.

70 Q. I know the Inquiry has heard evidence around specific charts and tracking in relation to Mr. O'Brien, but from a departmental position would you agree that the validation and the tracking of charts was something that was ongoing over the years during your tenure? 11:07

A. Yes. We tried -- we tried to keep our housekeeping up-to-date but unfortunately, due to staffing levels, if anything was to fall, it would be that where the core business would be to get the chart for the patient. But these things would have been put onto the work plan because you didn't want them to fall off the radar and they could be reviewed and what can we do. 11:07

And if you couldn't do everything, at least can we try and do a few things every year.

71 Q. Was it because of the vulnerabilities of human nature that the chart issue - and we'll see it when you're raising it with your managers later on - just didn't go away? 11:08

A. Oh yeah. It was ongoing.

72 Q. Right up to 2019?

A. Yes.

73 Q. By the time you left, the situation would have been -- was it the same; was it enhanced? 11:08

A. No, there were always issues with tracking. The system, the patient administration system, it's an old system and there is no flexibility within it and it is very reliant on human input. Before I had left, I put in a business case for iFIT and that actually is where you have a label with a chip in it and that's attached to a chart and it's all wifi driven. If you are taking the chart from one area to the other, the wifi picks it up and actually updates the code. So, you don't need that manual input and you would know then when a chart has moved from one location to the other. 11:08 11:09

The business case was passed and it was waiting for money and then Covid hit. But iFIT is actually being implemented very shortly within the Southern Trust, which will be fabulous and will resolve the tracking issues. 11:09

74 Q. Who will be able to provide us with more up-to-date

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

the potential that they had just gone off the radar?

A. That's mostly just good housekeeping. One of the things that we had also done was to get a full list of all of the tracking codes and start to delete them because they were old tracking codes, say for consultants who had left. All that is just part and parcel of your housekeeping.

80 Q. Well, if I could ask you in this context: Whenever issues arose in the subsequent years, and would have been happening during this period of time, 2015-2017, when it became clear that large volumes of notes were not where they might be expected to be, if I can put it like that, were you surprised at that? 11:11

A. I was aware that Mr. O'Brien had charts at home.

81 Q. That's a slightly different answer, I suppose. What I am trying to find out from you is how confident you were in the governance systems that you operated with your staff? In other words, were you being told what you needed to know in order to make proper decisions? When I asked were you surprised, the follow-up to that is, I suppose, would you have been expected to be told that charts weren't available or were not where they should be? If we just deal with the not available but not where they should be, no one is looking for them but they were not where they should be, were you surprised to know that the numbers where as reported? 11:12 11:13

A. Would you repeat that question again?

82 Q. The context of the question is you, as a manager, are line-managed by Anita Carroll. We will look at her way

of managing you to see if those governance systems were robust enough for her to know what was going on. Looking from you to your staff, I want to understand if the systems that you operated in managing the staff allowed you to know exactly what was going on. So, when you subsequently heard that notes were being kept at home, significant numbers of notes, did that come as a surprise to you, and would you have expected your staff to tell you about that, and, if so, how would you expect to know? 11:13 11:14

A. No. My staff would have told me that there were charts that were in Mr. O'Brien's office. I wouldn't have known the extent of it. To do that, we would have needed to have went through all of the charts in his office, his secretary's office, the whole of the Urology Department. But no, my staff would have told me that he did have charts at home. 11:14

83 Q. We'll look at the issues that you have raised in your statement about staffing, how difficult that was, and how that impeded on your ability, in your view, to carry out your good governance. When you say your staff let you know, if I'm looking at these systems of governance that you have mentioned in your statement, your open door policy, visits of the department, Head of Service monthly meetings, one-to-ones, work plans, professional development plans; what mode was in place for your staff to tell you this? How did they let you know or did they just tell you? 11:14 11:14

A. They just told me.

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

the chart in and he is going to bring it in tomorrow. Informal. In hindsight, probably a more formal system would have been better but that's how we operated.

87 Q. Was there any sense that it was dealt with informally because nobody wanted to really take it on? 11:17

A. No, that's just how we operated. The records would pull at that stage maybe 19,000, 20,000 charts, just Craigavon alone, in a month. Like, it was a huge amount. It just wasn't -- Mr. O'Brien just wasn't the only person there. There was still huge amounts, and 11:17 oh, by the way, there is another chart that was out at his house.

88 Q. I am conscious that we are looking back and scrutinising things in a detail that your day-to-day operation of running that department and the number of 11:17 staff that you wouldn't have allowed at the time, but the Panel is keen to understand what might have been known, what could have been known, what might have been done. That's the context that I am asking the questions in. I do appreciate that sometimes if the 11:18 information is not there, it's simply not there, but if the Panel are to make recommendations, they need to understand how that may be remedied in the future.

A. In response to that, yes, I think we operated maybe more informally than we should have but it was given 11:18 within the constraints of time that we had to operate. It would have been better, you know, here's a query to be followed up with an email to be addressed formally up the line, but we just... It may sound like an excuse

but we didn't have time; it was get the job done as quickly as you could.

89 Q. We'll look at some of the emails that you did send around staffing and capacity and inability to do that. I think you mention later on in your statement that you could have monitored more closely had you had the capacity and had some sort of staff freed up to do that. We'll look at your attempts to try and sort that out. 11:19

At the moment, you also met your head, your direct line manager, Anita Carroll, you met her one-to-one on a monthly basis?

A. Yes.

90 Q. There was also a monthly meeting with her and other Heads of Service. You've said in your statement: 11:19

"Where Datix complaints and risks were discussed as part of the agenda, these discussions were to provide information and learning to the team for cascading through the service". 11:19

I suppose in light of what we have just talked about when you mentioned risk there in particular, was the issue of patient risk and lack of awareness about the location of notes something that was ever discussed at those meetings? 11:20

A. It would have been raised but because of one of Heads of Service was over security and catering, the other

was sterile services, Katherine and the secretaries and the booking, we were a very diverse group. Some of my issues might not have really been relevant to them, such as the catering issues wouldn't been relevant to me. It would have been more generic terms that we would have made discussions about.

91 Q. What about on your one-to-ones with Anita Carroll, would that have been the opportunity, I suppose for you and Ms. Carroll to discuss risk? I am conscious that we are framing it in that way now but were those words actually used? Did anyone say this is a patient risk, there is a risk of harm, this is not just a notes issue? Or was it we need to get these notes, we need to find them, we need to get them in?

A. I think our big drive at the time would have been we need to get the chart.

92 Q. You've mentioned in those meetings with the other Heads of Service and Anita Carroll -- and something that's come up with other witnesses and I just want to ask you around that as well, about the learning from Datix and complaints for learning to the team for cascading through the service, was there a way in which Datix outcomes were fed back to your department as relevant to your department? Did you find out what happened to any Datix that was ever submitted?

A. Well, if they were submitted from my area, I would have been the one to have closed them. There would have been no formal mechanism for other Datix, you know, for a feedback.

93 Q. If you closed them, having been satisfied that they were suitable to close, would you then have passed that learning or warning or information on to the relevant staff in your department?

A. Oh yeah. That might be again not in a formal way but it would have been telephone conversation with the manager associated with it. 11:22

94 Q. I think you have mentioned in your statement as well that complaints generally generated in your department were ward clerks or maybe someone's attitude? 11:22

A. They were minimal.

95 Q. Minimal, yes.

CHAIR: Ms. McMahon, I am just wondering if this is an appropriate time for a short break?

MS. McMAHON: It is, yes, thank you. 11:22

CHAIR: Back again at 11.40, ladies and gentlemen.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Everyone. Ms. McMahon. 11:27

MS. McMAHON: Thank you, Chair.

Ms. Forde, we had mentioned at the beginning that you had taken up post and for a period of time, I think from 2012 to 2013, you would you have been the line manager for Noleen Elliott? 11:41

A. No.

96 Q. She started in 2012. And were you responsible for secretaries at that point?

A. No.
97 Q. Were you responsible for them after that at any stage?
A. No. I had no responsibility for secretaries.
98 Q. Who did that fall to?
A. I think probably at that time the OSLs, the Operational Support Leads. 11:42
99 Q. So it wouldn't have fallen under Katherine Robinson at all at any point?
A. Not until 2013.
100 Q. Whenever there was the reshuffle? 11:42
A. Yes.
101 Q. We had talked about the need for you to receive timely and accurate information about charts and about things that were relevant to your governance duties, and the way in which some of your staff tried to do 11:42
workarounds. I just want to take you to an example of someone trying to find charts that were missing. If we go to TRU-164938. This is a one-to-one meeting with Pamela Lawson, 13th December 2018. This is just an example of the sort of topics you would be speaking to 11:43
your managers about and the issues they would be bringing to your attention. If we go onto the next page, please. Just the entry there:

"Missing List Update. Database updated. List of 11:43
missing charts to be given to staff for them to look out for when going round wards, offices".

Would it be fair to characterise that of an informal

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

talk about there are the ones that although we have looked for them, we can't find them. It was really just always keeping a look for in case those particular ones came along. We had an alert system as well for the missing charts, that you had a tracer in where the chart should have been so if that chart ever got back to Records and was filed, the person filing it found the alert card and were able to pull it out, and then we would have done a bit of investigation just to find out where it would have been or try to find a story as to how it did get missing. 11:45 11:46

106 Q. What happens if someone comes into the hospital and needs care in ED, Emergency Department, or a clinic, and their chart just simply can't be found. Is there a system for that? 11:46

A. We would have a pages and label system. You would have done a thorough search, first of all, to find the chart. Then it would have been reported to the supervisor. The supervisor would have done a thorough search as well. If the chart couldn't be found, then the Health Records Manager was notified and they would have done a search; maybe two people have searched all of the different areas. So, you really did do a big search before you accepted that the chart was missing. When eventually then you couldn't find it, unable to provide the consultant with some information, we had the pages and labels system where you were to provide two pages where the consultants would have written on. If it was a review patient, you would have went on to 11:46 11:46

NIECR and pulled out the last few letters of that clinic appointment, and then gave some the patient labels as well. If it was a new patient, you would have had the referral letter and anything that might be relevant to that particular visit. 11:47

107 Q. I suppose there are two caveats to that. The first one is if the patient is not on that system --

A. Then there is no history.

108 Q. -- if they hadn't been reviewed for a long time so they didn't find their way onto that, then there would be no history, as you say -- 11:47

A. Yes.

109 Q. -- that might be available if the charts were available. Secondly, I suppose the difficulty with that is that is that a new chart starting or does that then, if the charts are found, join the existing chart? 11:48

A. It would join the existing chart.

110 Q. Was there ever an occasion when a doctor wouldn't see a patient because they didn't have charts? Was that not something that you would have known about? 11:48

A. There would have been some occasions.

111 Q. I think you've sent emails about that. We'll look at that particular one. I think you have given us two examples so we will look at that.

11:48

The record of missing charts, we can look at an email from you at TRU-164920. You'll see that it's from you to Yvonne Hanna and Anita Carroll on 17th January 2017. You said:

"I have spoken to Martina today regarding the missing charts from Mr. O'Brien's house. There are 13 missing. Pamela Lawson has searched Mr. O'Brien's office and his secretary's office thoroughly for these charts but they cannot be found. These charts have no urology episode on the PAS". That is the Patient Administration System? 11:49

A.

"Martina says that Mr. O'Brien used the CAH chart for his private patients. Anita, Pamela is going to add these to her 13 missing list and we will place alert tracers in the libraries for them, so if they return to Records, we will be alerted to this". 11:49

At the bottom of that email you have explained what you have just explained to us about the alert tracer card; if the chart is recovered, then the card is removed and you look into what might have happened. 11:49

Those 13 charts, were you ever told what the outcome was of those?

A. No. I chased that up again in a few months' time to see had there been any update but they still hadn't appeared. 11:49

112 Q. If these are the same charts that were referred to in the MHPS report, it would seem that there was a satisfactory answer for that of where they might have been; not with Mr. O'Brien. But you have no knowledge

of that?

A. No.

113 Q. But that email is an example of the way in which you communicated with your staff and with your supervisor, your superior -- 11:50

A. Yes.

114 Q. -- if there was an issue.

There is also another email at TRU-164919. This is from Siobhán Hanna to you and Anita Carroll and CC 11:50 Clare Graham in.

"Thanks Helen". We might need to move down. Okay, it's on the same date".

11:51

"Thanks, Helen. It is good to know that Pamela has been involved and a thorough check has been made. Hopefully the remaining 13 case notes will be returned soon. I have copied Clare into this email as it was agreed last week that if any records remained 11:51 outstanding, Dr. Wright would meet with Clare to discuss how this would be handled".

That is Clare Graham. What was her position within the Trust? 11:51

A. She was Head of Information Governance.

115 Q. Do you know if Dr. Wright met with Clare Graham? Was there any feedback to you about that?

A. No feedback.

116 Q. I just want to give the Panel some references from other witnesses and their views on the system because obviously it's not your system but the system that you operate. These references and extracts will allow the Panel to understand the way in which others viewed the system or experienced it. 11:52

First of all, the MHPS investigation made the following comments at TRU-00695, the second paragraph. 11:52

"I also interviewed the Head of Health Records, Mrs. Helen Forde and the Referral and Booking Centre Manager Mrs Katherine Robinson. I was able to establish that there was no clear system for tracking notes through PAS. Notes may be tracked out on PAS to a staff member without knowledge of their location. There is no mechanism for Medical Records staff to be able to determine that a bulk of records is tracked out to one individual for long periods of time". 11:52 11:52

I think that's fair comment given the evidence this morning; would you agree with that?

A. Well, the fact that it says there is no mechanism, we could have run a tracking code and it would have shown the number of charts tracked out and the time that they would have been tracked out. That was something I had said in my Section 21 that yes, I didn't run that report, we didn't have the staff to uphold it. I also felt that if I had done it, I would have made my staff 11:53

do several hours of work but I didn't think there would be any benefit from it or anything would change. So, I would disagree with that last statement. There was a mechanism that you could see the number of charts tracked out to an individual tracking code. 11:53

117 Q. Would it be fair to say that there was no mechanism being used?

A. Yes.

118 Q. But there was one available; would that be a better reflection? 11:53

A. Yes.

119 Q. We will come on to the staffing and the issue around that.

Heather Trouton at WIT-12145. Would you have had any 11:54 engagement with Heather Trouton in your line of work? Would you have any dealings with her, if I put it that way?

A. I would have known her. We would have chatted.

120 Q. Did she have any direct responsibility for your area? 11:54

A. No.

121 Q. 470.

"Regarding patient notes, this issue was not remedied, I believe this to have been due to a disregard on the 11:54 part of Mr. O'Brien for the needs of other clinicians and services who may have needed patient notes. As the remedy necessitated a change of mindset of Mr. O'Brien, the only other option would have been to check

Mr. O'Brien on leaving the building each night. This was not practicable, nor should have been required in relation to an experienced clinician".

That's obviously Mrs. Trouton's view and the Panel can take their own view. Mr. O'Brien has provided answers to the issue around charts which we will look at, but this is what other people considered to be the issues. 11:55

Anita Carroll at TRU-00779. She told MHPS, paragraph 12 of that page: 11:55

"In terms of notes within PAS and case note tracking, charts are generally tracked out to an address which on the system may have just been Aidan O'Brien. There would be no way of knowing that notes are not in the office or in the secretary's office. The only time an issue regarding charts might be escalated to me is if a chart is to be pulled for a clinic and it can't be found. Generally, staff would check with the secretary for the chart if it can't be found. I am aware the secretary may have said Mr. O'Brien had that set of notes at home and he would bring them in. There was no specific issue being flagged to me on a regular basis about charts". 11:55 11:56 11:56

Do you agree with that statement by Ms. Carroll?

A. Well yes, the charts would have been -- they would have been tracked out to Mr. O'Brien's office and we would

have checked with the secretary. If there were any missing, then I would have escalated then to Anita.

122 Q. And her last sentence "There was no specific issue being flagged to me on a regular basis about charts".

A. Well, I suppose it defines what you talk about regular. We had the Datix going through, and any time a Datix had went through, I notified Anita just to let her know there is another one through and she would have escalated it on to Martina, Heather, Debbie, Eamonn Mackle. 11:56 11:57

123 Q. Are you saying Anita Carroll wouldn't have known about the charts issued but for the Datix?

A. No, I would have told her.

124 Q. Given you met her regularly, and if I can say the longstanding - and please correct me if I'm wrong - the Trust-wide issue around charts, would that be a fair thing to say, it was not confined necessarily but was a broader issue? 11:57

A. Well, this issue is really about the charts being at home. That sort of to me is a separate issue then to charts being mistracked. 11:57

125 Q. Let's look at what Ms. Carroll did know from your perspective. Did she know that charts were vulnerable to not being where the code said they were?

A. Yes. 11:58

126 Q. Did she know that some charts couldn't be found?

A. Yes.

127 Q. Did she know about the system of pages and labels if charts couldn't be found and the patient was at a point

of clinical need?

A. I'm not sure if she would have been aware of that level of detail.

128 Q. Did she know that there is a possibility that patients may not be seen if the charts weren't found? 11:58

A. Yes.

129 Q. We've seen the reference to charts and tracking charts and databases being made to try and keep on top of the issue; as you call it good housekeeping. We've seen that over the evidence at least 2015, '16, '17 with 11:58 your managers. She would have known about that during that period of time?

A. Yeah. She would have known that there were tracking issues because we would have escalated up. I'm really just sort of saying look, this is awful, this hasn't 11:59 been tracked. I had sent emails then just to the Heads of Service and copied the ADs in.

130 Q. Might she have known that charts could have been brought home?

A. With Mr. O'Brien, yes. 11:59

131 Q. When you say Mr. O'Brien specifically, if we park that issue at the moment. There was a possibility that any consultant could bring a chart home the way the system operated?

A. Yes, there was. 11:59

132 Q. You can't know what you can't know, I suppose, so it would be unfair of me to ask you if anyone else did bring charts home if you can't ask answer that. Was it ever brought to your attention that anyone else brought

charts home?

A. No, it was never brought to my attention.

133 Q. Do you take that to mean then that they didn't, or no one just knew if they did?

A. My impression is that consultants did not bring charts home. 12:00

134 Q. Where did you gain that impression?

A. I started off in the Trust as an audio typist and was a medical secretary for a few years. During that time, really I didn't see any consultants taking charts home. 12:00 They would have had them in their office at work.

135 Q. I suppose at its height you could say that your experience, the custom and practice of consultants that you had knowledge of, didn't bring charts home?

A. Yes. 12:00

136 Q. But also the system that operated in Health Records could have allowed that to happen without you know?

A. Yes. Yes.

137 Q. Would that be fair?

A. Yes. 12:00

138 Q. The MHPS found on this issue at TRU-00702. This is the bottom of the page.

"Senior managers were aware Mr. O'Brien took clinic notes to his home after the SWAH clinics and there were 12:01 delays in notes being brought back. However, there is not a robust system in place for determining how many charts are tracked out to one consultant, nor how long the notes were gone for. As such, managers were not

aware of the extent of the problem".
Is that a fair comment?
A. Yes.
139 Q. I think you're probably aware at this stage about Mrs. Corrigan going and looking for notes in Mr. O'Brien's office and trying to track things down. Were you aware of that at the time that that was happening? 12:02
A. No, just whenever I read it in the work bundle.
140 Q. She refers to that in her evidence at WIT-26288. This was her, Mrs. Corrigan, trying to check about Mr. O'Brien's compliance with the action plan. She said down at the bottom at paragraph (a): 12:02

"The two areas that in my opinion were weak where as follows: The method I had to use in respect of the storage of patients records issue. This was difficult to monitor as it was dependent on manual checks. Whilst I was doing this, I found no issues. However, if a set of patient notes had been case note tracked to Mr. O'Brien's borrower's code but they were not in his office, I had no way of knowing where they were as any member of staff could have picked them up from his office and not changed the borrower's code, and this would have led to issues of trying to locate those notes". 12:02 12:03 12:03

Again, that seems to be an accurate description of possibilities?

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

A. That's right.

146 Q. It was more to get everything online, a centralised system. It didn't assist you greatly in that system, except that information was kept electronically?

A. It was a better system than the original one which was maybe 30-years-old, which was just you put a tracer card in and you took a chart out. So, this was definitely much better. It's like any IT systems, it's the people operating it. 12:05

147 Q. Just in terms of suggestions for improvement, did Anita Carroll ever make any suggestions? We are going to go on shortly to see that you have requested staff and help around the number of agency staff you had to use; agency staff not staying. You obviously put a lot of work into your some of your emails about working time equivalents, what was needed for you to manage your service. I'm sure it may be something that managers hear all the time. Did Ms. Carroll ever come back with any other suggestions if she wasn't able to give you staff or put people into full-time posts? 12:05 12:06 12:06

A. We would have had a good working relationship like that and we could have discussed, and she said maybe I could redeploy somebody for that. It was helpful to be able to just sit and talk through issues with her and get sort of another idea. Sometimes you are sort of embedded in your own area that it is the person looking in can give those suggestions. But we were financially tied in that. Even if Anita had agreed that I could have three staff, Finance would not have progressed it 12:06

because if you didn't have the funding in your budget, it didn't get through the scrutiny so it didn't get to Recruitment.

148 Q. Just for the Panel's note, Mrs. Corrigan also makes reference to the electronic system, the iFIT that you are referring to at WIT-26290. We don't need to go to it but I'll just read it out for Ms Ford's note as well. She says: 12:07

"In my opinion I think there was an over-reliance on one individual who had a demanding operational day job. This should have been more fully considered and appreciated as a risk. While I believe I am a very diligent and hard-working member of staff, the system failed when I went off on extended sick leave revealing a weakness in the system". 12:07 12:07

If we just stop there. The weakness in the system for the charts existed whether Mrs Corrigan was off or not, really? 12:08

A. Yeah.

149 Q.

"The storage of patient notes was always a concern of mine. Whilst in principle the Trust supported the move to an electronic tagging, there was never the funding made available to implement this so I had to use the workaround of physically visiting Mr. O'Brien's office at 6.30 a.m. on a Friday morning to perform a check, something which also didn't happen when I was off". 12:08

But you had no knowledge that that was actually taking place?

A. No.

150 Q. If you just bear with me a second. I just want to look at a couple of emails you've sent to staff, TRU-164912. This is an email from you on the 24th of February 2015 to lots of people, including Trudy Reed, Louise Devlin, who is a former Head of Service? 12:08

A. That would have been to the Heads of Service. 12:09

151 Q. All of them, are they including your managers or just the Heads of Service?

A. There's...

152 Q. I don't see Pamela Lawson. Oh, she is CC-ed in?

A. Yes. 12:09

153 Q. Tracking of patients charts on PAS.

"Would you please remind all your staff that it is absolutely crucial that every chart is tracked when moved from one location to another. Recently, due to a 12:09 chart not having its tracking codes updated, a patient's operation was cancelled. The chart was later found in a different service and in a different building. The consultants have stated that from now on if the chart is not available, they will not operate on 12:10 the patient.

"If you take a chart, you must track it to the new tracking code. If you don't have access to pass to do

this, then you must leave a message for a member of staff from the area that you have taken the chart from giving them details of where the chart is going and asking them to track this for you. This is not just a request to help staff when looking for charts, but this has a direct impact on the care we are providing to our patients. No chart, no surgery, no appointment. Would you please circulate to all your staff". 12:10

You sign that off. I don't think you could have been much clearer in that email in setting out the repercussions of -- and you have provided evidence there that someone actually missed an operation, a booked operation, that was cancelled because of that? 12:10

A. Yeah.

154 Q. Was that the first time that you were aware that an operation was cancelled or was there something about that that triggered this email?

A. No, that would have been a specific event where the operation was cancelled. I had explained before there if there was a chart missing, about the Records member of staff would have looked for it, the supervisor, the manager, they really did do everything that they could to get the chart. For this to happen, you know, they would have taken it very badly. It would not only have upset them but also they would have wasted so much time. It just had to be spelt out. You know, look, it's not -- sometimes when you talked about tracking a chart, that it was just that's Records having a bit of 12:11 12:11

a moan.

155 Q. Is that what you felt?

A. Sometimes, yes. It was a bit of a moan, that's them moaning again. So this was, look, it's not just us moaning, this actually happened, a patient was prepared for their surgery; they came in today and it was cancelled because somebody hadn't tracked the chart properly. 12:11

156 Q. So, this is the real life consequence for that?

A. Yes. 12:12

157 Q. If I understand what you are saying correctly, your experience was that at times people were a little lax or a little indifferent to attempts to track charts?

A. Yes.

158 Q. Was that because it was such a common problem? 12:12

A. I just don't think sometimes people saw the importance of it. "Sure I'll take that chart and I'll leave it back", and then you forget to leave it back and then something else happens. Sometimes the admin processes just weren't taken -- weren't followed as well as other processes might have been. 12:12

159 Q. Do you think there was - and disagree with me if you do disagree - do you think there was a lack of respect for aspects of your work or the admin process, that people just didn't give it the due diligence it deserved? 12:13

A. Yeah. I think it was that it wasn't given the due diligence.

160 Q. Do you think there was any impact on the culture towards charts and admin, because there didn't seem to

be any sanctions for people who were perhaps a bit - I want to say lackadaisical because I can't think of the word that is not lackadaisical - but who were a little bit casual in their use of charts? There was nothing done if you didn't bring your chart back home or put it in the library or code it properly, so perhaps a failure to sanction was a bit of an acquiescence?

A. Yes, and sometimes I think we could have been a victim of our own success. We would have done KPIs out, and like I've said, Craigavon library alone would have been pulling 19,000 a month but our percentage rate of charts would have been 99.5% availability. That would have been an average. So, we did get an awful lot of charts but the staff really worked hard to make sure that they did that. Maybe if we just hadn't searched and searched and searched and that percentage had went down, maybe then people would have taken notice because there could have been more noise in the system.

161 Q. And more impact?

A. Yes.

162 Q. So your diligence was your downfall in some respects?

A. Yes.

163 Q. When you talk about staff looking for charts and tracing and tracking, were people specifically employed for that purpose?

A. Yes.

164 Q. What were the numbers employed? What sort of part of the budget did that take up, just looking for charts?

A. You see, everybody in Health Records had to look for

charts. It was divided into sections in that, well, maybe you got the surgical charts, I got the medical charts, someone else got the rheumatology charts. So, those were your clinics and you were responsible for them. You got every chart that was actually in the library, and then we had the missing list staff. So, if the chart wasn't in the library, two other girls were responsible for going out round the service to look for those charts. So, that one was tracked to Mr. Mackle's office, so you went there. One of the reasons it was divided like that was to have fewer people going round wards, efficiency, and also infection control that you had a limited number of people had been to the wards. So, we would have had those two people and they were fully employed going out looking for the charts that were tracked outside of the libraries. Then, when they couldn't find them, that's when they would have came back and you went through the supervisor, the manager, or maybe look, I'll go and have another look. Sometimes a colleague went; sometimes a fresh pair of eyes could make a difference.

12:15
12:15
12:16
12:16

165 Q. Did they ever find charts in public places, locker rooms or changing areas or things like that?

A. No.

166 Q. You have said in that email, "Consultants have stated that if the chart is not available, they will not operate on the patient". Was that said to you or fed through to you? How do you know that?

12:16

A. That would have been said through to the manager

because if, say, in an event like that, the manager would have spoken to the consultant to explain what was happening, it couldn't be found. So, the consultant would have said that.

167 Q. Would that have been general surgical consultants, or you don't know where that originated from, that statement? 12:17

A. I don't, no.

168 Q. Do you know if it was acted upon? Do you know if the consultants didn't actually operate if they couldn't get a chart after that? 12:17

A. We were very successful in getting the charts for certain -- particularly for operations. You know, you really did go to the end. But there would have been occasions where maybe say if you didn't have one, they would have operated on. I do remember there was a case in Daisy Hill and the chart was pulled for the Daisy Hill theatre but, for some reason, the chart was actually sent to Craigavon for surgery when the patient was in Daisy Hill, but the consultant did operate. 12:17 12:18

169 Q. The chart was just sent to the wrong location?

A. Yeah, yeah.

170 Q. I want to look at some emails where you have escalated the issue. If we go to WIT-61511. It should be an email starting the 9th of October. I'm sorry, I've just remembered I wanted to go to an email just to finish that last set of questions off. That last email we looked at about the warning shot, if I call it that, was in 2015. There is another one at TRU-164915, so 12:18

the Panel has a note of this. This is the 24th of January 2016. Again, subject notice, "fast tracking of charts" from you to lots of people. Even more people, I think, in this one. There are 41 more added. You've included Anita Carroll, Ronan Carroll and Heather Trouton and Ann McVey, and nine more? 12:19

A. It would have been all the Assistant Directors.

171 Q. So everybody is in this?

A. Yes.

172 Q. You have said similar. 12:19

"Would you please remind all your staff of the importance of tracking a chart when moving from one location to another. If your staff do not have the functionality to track charts on PAS, they must leave details for one of the admin team who will then update PAS. If a chart is moved without being tracked, then Records, secretarial, ward clerk staff will not be able to find it and this can lead to appointments and admissions being cancelled. I would be grateful if you could emphasise the importance of this with all staff". 12:19 12:20

That is a year later. It is fair to say the issue is not resolved?

A. That's right. 12:20

173 Q. We will go back to the escalation point WIT-61511. These emails are around the escalation around Mr. O'Brien's charts, and they start on the 9th of October. Barbara Mills; who is Barbara Mills?

A. She would be one of the Health Records officers.

174 Q. She is writing to Pamela on 9th October 2013.

"Hi Pamela. This chart tracked to Monica but not there or in his office. Noleen to ask AOB. Any word on this chart"? 12:21

Barbara replies to Pamela.

"He brought chart in on Friday and it's now tracked to his clinic in Armagh for today. I had to go up on Friday to speak to Noleen and then had to speak to Sarah out in Thorndale to finally locate chart". 12:21

Just so I can ask as we pass that. Whenever Mr. O'Brien, it seems quite clear on this, brought the chart in and it is now tracked to Armagh for that day, is Mr. O'Brien or his secretary responsible for changing the tracking code of that? 12:21

A. No. That chart, whenever Records would have picked it up, they would have tracked that chart. Also not just only tracked it, but sent it off to Armagh for the clinic. 12:21

175 Q. Pamela Lawson to you then, "Another IR1 going in for this one". So at this point there has is clearly been a development where you're logging Datix, IR1s, for charts that are missing. Was that just in relation to Mr. O'Brien? 12:22

A. Because these were at home.

176 Q. If I can just ask you so I'm clear about the answer and the Panel are clear, what was it about them being at home that raised it to an IR1 as opposed to being somewhere else but not coded in the hospital?

A. If it was somewhere else we would have had to search for it, so we would have taken time but at least we could have got it. If it had been Mr. Mackle's office instead of Mr. Hewitt's office, staff would have done the search and they would have got it. But if it was in Mr. O'Brien's home, they couldn't actually get that chart because it would be outside the Trust facilities. 12:22 12:23

177 Q. If we're looking at that from a governance angle, was it your view that being at home was a greater risk?

A. Yes.

178 Q. Than the chart being elsewhere in the hospital -- 12:23

A. Yes.

179 Q. -- but findable?

A. Yes.

180 Q. So that was the reason why IR1s started going in about the charts. 12:23

If we look at WIT-61193. This is your Section 21 about what you would do if you have a concern about an issue relevant to patient care and safety and governance. 12:24

"I would gather all the information and if it is an issue that would cannot be resolved within my own area, this should be raised with the Head of Service for the specific area while also informing my own assistant

director. A Datix would be raised detailing out the issue. Due to the formation of the Datix reporting system, all those with responsibility for the concern would be notified for their input into the investigation of the issue. For example, if the Datix is coded as a breach of confidentiality, this would trigger Datix to include the information governance team". 12:24

When you say in that paragraph "all those with responsibility for the concern", does that include on this occasion Mr. O'Brien, that he would be contacted and asked about it specifically? 12:24

A. No. I think for that, you would have put in the location of the area, which would have been Urology Clinic, and then that would have triggered on to Martina. 12:25

181 Q. Is it possible that a Datix could have been raised about a chart or a record because of its suspected location without Mr. O'Brien knowing that anybody had raised a concern about that? 12:25

A. Say that again, sorry.

182 Q. Well, I'll put it another way. Would you have always been satisfied that Mr. O'Brien personally knew that concerns were being raised about charts or records under his code, or his office code or his secretary's code, before raising a Datix? Would you have made sure he had an answer? 12:25

A. Well, we would have asked, first of all --

183 Q. Asked, when you say asked --
A. -- to see did he have the chart at home and if the answer was yes, then the Datix went in.
184 Q. And can the Panel take it when you say asked, spoke to Mr. O'Brien? 12:26
A. Yes, either via one of the Health Records staff or through the secretary to say have you got this chart at home, and if it was yes, well then, the IR1 went in because he had said it was at home.
185 Q. Was it possible for other people to say the chart was at his home without him knowing? 12:26
A. No, he would have been asked.
186 Q. Always?
A. Yes. It would have been him saying that, because that would have been unfair. 12:26
187 Q. You say at WIT-61190, at the very top of that page:

"It had not been our practice to complete a Datix when the chart was at Mr. O'Brien's home but as the problem continued, we started to complete a Datix each time a 12:27
chart was in Mr. O'Brien's house, commencing in May 2013 and continuing until we were told not to complete any more Datix by the Director of Acute Services at the time, Debbie Burns".

12:27

Now, just to take the first part of that extract, there had been a system in place where, if the chart was at home, you tried to get it back?
A. Yep.

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

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

really just a bit more formality to the whole system of rather than me going in next door to Martina to say, you know, that chart was at home or sending an email. It was just another bit of formality.

199 Q. If I'm hearing your answer correctly, you didn't expect anything to happen by putting a Datix in, it was to log another incident without any expectation that someone would provide any help? 12:31

A. Well, it was hoped that the formality would maybe step it up a gear and that something would -- things would improve. 12:31

200 Q. Had Ms. Burns ever spoken to you before about any aspect of your management role?

A. We would have been in contact. She might have been asking for statistics for ED or, say, triage times for ED. You know, there would have been different things. Like, if Debbie was walking past the door and she wanted some information, she would have asked you. 12:32

201 Q. And was it her style of management that a decision such as that would be given in that informal manner? 12:32

A. Yeah.

202 Q. It was?

A. Well yes. You know, the Acute is very, very busy. Like I have said before, maybe some things should be more formal but that was just our day-to-day business. 12:32 It was walk along, get something done and on you go. There just wasn't the time for sitting down and going through a full process, or I hearby notify you or anything like that. It really was get it done.

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

208 Q. I know your answer is very general but I do need an answer as to who would be expected to take action when they are getting Datixes that charts are at home, consultants are saying they won't operate if they don't have the chart, operations have been cancelled, there is an example of notes not being available in casualty for someone, and you have indicated that a risk existed when charts weren't available, and was increased if those charts were at home. When we look at that in the round, who should have done something with these Datixes? Who was responsible for taking action? 12:35 12:35

A. Well, from me, I escalated then to Martina and also informed Anita. So, if Martina wasn't in a position to be able to do it, then she would escalate it to the Assistant Director, who was Heather Trouton. Anita had also emailed Heather Trouton at times just to say here is an issue that is still continuing. Those are the people that I would expected to take action, and should it not have been able to do actual action but for them to escalate further up the chain to the Clinical Director, the Associate Medical Director. Which they did but nothing ever seemed to happen. 12:35 12:36

209 Q. How do you know they did?

A. Well, just with my work bundle, reading through that.

210 Q. We looked through the email, the two emails that you have indicated the patient risks specifically. Anita Carroll, Heather Trouton, Martina Corrigan are all sighted on those, and thereafter Debbie Burns told you to stop filling in Datixes. Would it be unfair for me 12:36

to characterise it as being slightly disingenuous for Anita Carroll to say acquiesce to that direction, nothing is being done, when actually she is one of the people that could have done something?

A. But she did escalate. 12:37

211 Q. Did she ever speak to Mr. O'Brien?

A. No, but that wouldn't be how we worked. We worked probably in silos. It wouldn't have been for her to speak to the consultant, it would have been the AD for that area to speak to the consultant. Just as if there 12:37 was an issue with one of my ward clerks on the ward, I wouldn't have expected another Head of Service to speak to them, I would have wanted to have been informed of that issue and then I, as the Head of Service for that area, would have spoken to that person. 12:37

212 Q. The Inquiry has heard evidence and likely will hear more evidence about those twin tracks of governance and accountability, clinical and operational, if I can use those shorthands. Is this a real-life example of one of the disadvantages of there being twin tracks when 12:37 trying to deal with problems that actually cut across both?

A. Yes, it could be, but then you could have two or three people doing the one thing and nobody knowing what anybody is doing. 12:38

213 Q. Well, Martina Corrigan knew on this occasion, and she is the Head of Service. She could have spoken to the medic, so there is some join in at the top. If it was a ward clerk bringing notes home, could you have gone

to them directly?

A. Oh, yeah.

214 Q. If it was a secretary, you could have gone to them directly. If I understand you correctly, what stopped you going to Mr. O'Brien directly was etiquette and lines of management. Would that be fair? 12:38

A. Yes.

215 Q. Do you think Mrs. Carroll could have done more?

A. No. I'm happy that she supported me in everything and that she escalated as far as she could within her chain of command. 12:39

216 Q. Now, you've support in your view around the difficulty of getting things done when there are different chains of command. If we could go to WIT-12157. This is from Heather Trouton. I may have the page wrong but I have the extract here which I'll read out for you: 12:39

"Both the Head of Service and I as non-medics found it very difficult to challenge Mr. O'Brien's clinical practice. We were reliant on his clinical colleagues to provide that clinical challenge, and this I believe did come but only at a later stage when a number of new consultants came into post who had experience outside the Trust and outside Northern Ireland who knew what was acceptable practice and what was not and who were not afraid to speak up". 12:40 12:40

The actual detail of that extract is about clinical practice but I think the point reflects what you're

saying, non-medics dealing with medics. Was it your experience that that was something that didn't happen?

A. Yes.

217 Q. Do you think that that was a culture thing as well, that there was a culture -- not perhaps just in this Trust but there was a culture that only medics could deal with medics? 12:40

A. I think, yes. Short answer, yes.

218 Q. I just want to ask you about AOB-01660. There is a reference here about running a report on the volume of notes tracked to all surgeons and I just want to ask you if you have any knowledge of that. It is an email dated 19th July 2017. It's from Ronan Carroll to Martina Corrigan and Colin Weir. You are not privy to this but just because it cuts across your area. 12:41 12:41

"Martina, Colin. 3rd of February chart is almost six months so having notes in his office is against the action plan he received". Then there is an extract from that. "Why the need to have this volume of notes in his office. AOB has not raised any workload concerns so again why the volume of notes in his office. Because this was not managed previously, 13 sets of notes tracked to AOB are unaccounted for. We know this and we are allowing it to happen again. 12:42 12:42 Helen Forde is running a report on the volume of notes tracked to all surgeons so we can have a comparator. My view is all the notes need to be returned".

If we leave the 13 sets of notes, we have spoke about it earlier, but there is reference there you running a report to the notes tracked to all surgeons. Do you remember this? I know it was six years ago but do you remember doing this? 12:42

A. Yes, I do. Ronan had spoken to Anita, Anita had asked me to do it and I had included that, I think, in the last bit of evidence, that there was a table there of number of consultants and numbers of charts.

219 Q. When they talk about the notes to all surgeons, it was about having charts tracked out and not brought back rather than having them at home? 12:43

A. No, it was to the number of charts and their tracking code. So you ran a report to their tracking code to see how many reports they had in the offices because Ronan there was talking about the consultants having notes in their office. 12:43

220 Q. And you provided that. The context to that, I maybe should have taken you to this email first but I'll do that now. At this point, 2017, you are being asked to look at all the notes tracked out. If we look at TRU-01603. This is an email from Martina Corrigan to Debbie Burns and Eamonn Mackle on 5th September 2013. Now, this is four years prior to this and this is specific about notes at home. For the Panel's note, top of the page. 12:43 12:44

"Debbie, I will speak with him again". If we can go on down. The 27th August 2013, we will have to start

there so it makes more sense. From you to Heather Trouton and Martina Corrigan with Anita Carroll in.

"Please see below. Mr. O'Brien continues to have charts at home. This is causing problems for Records as per Pamela's email. What can be done to resolve this". 12:44

Anita to Debbie. "Debbie, how do you think it's best to deal with this? Should the HOS discuss with Mr. O'Brien. Can they arrange to get charts back or do we need to discuss at governance as part of the problem is they aren't even tracked out". 12:45

Now, when they say they aren't even tracked out, does that mean they don't have a code or the code were they are tracked to isn't the location where they are? 12:45

A. The code isn't the location where they are.

221 Q. That's to Debbie Burns. That date seems to be after Ms. Burns has told you to stop filling in Datix. Is that May 2013? 12:45

A. Was it not '14 she said? I can't remember.

222 Q. It may have been. We'll check that in a second. If we move up, please. This is from Debbie Burns on 3rd September to Martina Corrigan, Eamonn Mackle and Robin Brown. 12:45

"I know you've tried before. This is a governance issue. Robin, can you discuss again with Mr. O'Brien

or do we need to escalate"?

This is an example then of the medic approach --

A. Yeah.

223 Q. -- we discussed earlier. Robin Brown replies to Debbie Burns. 12:46

"So he doesn't copy Martina Corrigan or Eamonn Mackle, or Robin. He doesn't copy them".

12:46

He just replies through Debbie Burns: "I will try to get to meet the week after next. I am surgeon of the week next week".

Debbie Burns goes back to Eamonn Mackle and Martina Corrigan. 12:46

"We need this addressed".

Then Martina says: "Debbie, I will speak with him today and then let Robin follow up on this. One of the things that was said before is that he is not the only consultant who brings a chart home but I suppose with Aidan it is more the amount he brings home and the length of time he keeps them for. I will let you both know how I get on". 12:46 12:47

Because of the subsequent Datixes, the problem persisted then. I think you are right on the May 2014

date. If we go, we will see the Datixes and all of the dates and the stopping point. That would be useful for the Panel. WIT-61509. This is a recent email, just before you left, was it, 4th December 2020 from you to Pamela Lawson and Andrea Cunningham. You say to Andrea Cunningham and Pamela Lawson: 12:47

"Do you remember when AOB took charts home we did a Datix out and we were then told to stop this. Well, out of the urology review, that is one of the things that is coming out as being useful, so this would be for charts that can't be found. How many a week do you think that would be? Any thoughts on this?" 12:48

And then you are provided from Pamela Lawson to you, she gives you the dates? 12:48

A. There is an additional date in there too on 4th October '16.

224 Q. There is another one in that?

A. Yeah. 12:48

225 Q. The dates are a bit all over the place but if we look up to the year '13 and the first one in that year is 20th May?

A. 8th May.

226 Q. 8th May, sorry, you're right. 8th May, 20th May, 16th May. So there is four that month, four Datixes with various numbers. Then in June, none in July, August, September, October, November and December. Then January '14. February, April '14. July '14, August 12:49

'14. Then none until '16?

A. We had stopped recording them, and then the one in '16 and '19 had went in. I had asked, you know, I couldn't remember what had happened and I think it was just pure frustration again, you know, still continuing, and just put a Datix in. 12:49

227 Q. 1st August 2014 was the last, so that gives us a timeline that may be extends beyond our May 2014 belief about Debbie Burns?

A. Yes. 12:50

228 Q. If she did say it in May, then there were more after that, but they were certainly stopped in August 2014?

A. Yes.

229 Q. Said there was another one needed on that list. What was the date? 12:50

A. It was 4th October '16.

230 Q. Were these all filled in by Pamela Lawson?

A. Yes.

231 Q. Would she have said to you I'm filling in another IR1 each time? 12:50

A. Yes, and they would have come to me.

232 Q. Right, okay. For you to send on?

A. Yes.

233 Q. I think you've said that in your statement - for the Panel's note at WIT-61189 - at paragraph 22.1 that you completed the Datix until August 2014. You say that the 2016 and 2019 ones were out of frustration that the problem still existed? 12:51

A. Yes.

234 Q. Was it more frustrating having been instructed to stop filling in Datixes to see the problem continue and not be able to do anything?

A. I don't know. In one hand, you're taking time to sit down and fill something like this in, and then you're told don't do it but you haven't seen an outcome or anything change as a result of filling them. So, you can nearly think what's the point; it is another thing to do. It's just another thing to do. 12:51

235 Q. Those two episodes in 2016 and 2019, should the Panel take that as meaning that there were only two episodes? 12:52

A. No. It is just...

236 Q. How do you know that? How are you aware of that, that those two triggered frustration in some way that they found their way on to IR1s and there were others that didn't? Can you explain that? 12:52

A. I had spoken to the manager and she said I just was frustrated that day and fed up and just put another one in.

237 Q. But behind the scenes the problem maintained? 12:52

A. Yes.

238 Q. Again for the Panel's note, there is another email about the implications of charts missing for clinics. AOB-00483. These are emails from you to Anita Carroll, 11th November 2013. You write: 12:53

"Just to keep you in the loop as this may be going to Debbie, but I've said to Martina a patient was attending clinic this morning but the chart was tracked

to Mr. O'Brien in the Thorndale unit. When records looked for it his secretary said she thought Mr. O'Brien had that chart at home and she would ask him to bring it in for the appointment at 9:00 a.m. this morning. The chart didn't arrive in records and the doctor refused to see the patient without the chart. Pamela went to speak to the doctor and asked if he would see the patient as she had got as much information as she could for the appointment. Mr. O'Brien's secretary is off today so eventually Pamela got Mr. O'Brien's number and phoned him to inquire about the chart. He had brought it in but had taken it over to the old Thorndale unit to have a letter typed. Pamela then went over there this morning, got the chart and then brought it round to the doctor, and he informed Pamela that he was going to write to Debbie about this". 12:54 12:54 12:54

I presume that is the doctor going to write to Debbie about this? 12:54

A. Yes.

239 Q. That is just a further illustration of that. I'm just going to move on to a separate issue. Perhaps it might be convenient to break now, Chair?

CHAIR: We'll come back then at 1:55, everyone. 12:54

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon, everyone.

240 Q. MS. McMAHON: Mrs. Forde, if I could just go back to an issue we were discussing just before lunch about the Datix issue. You had mentioned in passing, and I'm not sure if I closed that off myself, you were the person that closed off the Datixes. 13:55

A. Yes.

241 Q. That, in effect, shuts them down in the system as though they are dealt with. When you did that, was it on foot of finding the chart or having it returned?

A. It was more that we used the Datix as a flag to issue 13:56 the fact that a chart was not where it should be, that it was at home. We always got the chart, Mr. O'Brien always did bring the chart in so. But to be honest, it was shut down because we used it as an escalation mechanism. So, it was shut down for that point of 13:56 view.

242 Q. Just so I'm clear, I don't want to have unfairly characterised who might have known or done something about it, but if you raised the Datix this afternoon and the chart was returned tomorrow morning and you 13:56 closed that Datix off, would that mean that it didn't, in fact, escalate up the management chain at all; that no one else would have known about it, effectively?

A. No, it automatically went to everyone once you raised the Datix. It depends on how it was coded. A simple 13:57 example is if, say, we had misfiled a piece of paper in a chart, you would have recorded that as a Datix. Because that was coded as misfiling of a piece of information, that automatically triggered a record to

be sent to or triggered the Datix to be sent to the information governance because that with regard to confidentiality.

The Datix was built-in a framework that the coding then triggered who would actually get that Datix or who would have sight of it. Say some things might have happened on a ward, and I would have got a copy of that Datix because it happened on a ward and I had ward clerks. 13:57

243 Q. Perhaps if we look at one and then we can get a better idea what that means in practice. Go to TRU-164940. This is from the batch of documents just recently provided. I think you've had a look at those?

A. Hm-mm. 13:58

244 Q. It is filled in by Pamela Lawson. When it comes up, you will see that. As I understand from your earlier evidence, you would have known about this whenever Ms. Lawson was completing it. We might be able to see it better from the screen; it is very small writing when it's printed out. We can see the details of the person reporting the incident, Pamela Lawson. Then if we just move down, what happened when and where. 13:58

"Consultant had chart at home. Earned approval status in holding area. Awaiting review". 13:58

What does that entry signify, do you know, or is that an IT issue?

A. No, that's what the status of it. It has been raised but it hasn't been signed off yet.

245 Q. The incident date is 14th January 2019?

A. Yes.

246 Q. At 12:30. Acute Services. The division is Functional Support Services. Health records. The site for this is Armagh Community Hospital? 13:59

A. Mhm-mhm.

247 Q. The location is Urology Clinic. The upshot of this is that a chart has been confirmed as being in the house of a consultant and this Datix has been opened. 13:59

If this were closed, if I would be looking at it would I be able to see something else on this? How would it look different if you had received that chart and closed the Datix? 13:59

A. Well, all mine were closed so that one should be closed. I don't know why that is still saying an awareness. But no, all those details would still be there and there would be nothing else added unless there was the action taken is recorded, what's the learning. So, all of that has been recorded. 14:00

248 Q. It doesn't indicate on that that the chart has been returned?

A. No. The chart -- requested that his secretary has asked for the chart. 14:00

249 Q. So, custom and practice is built up if the secretary was asked, there is an assumption that she would actually bring it in or the chart would be brought in?

A. Yes, but that would be followed up by Health Records because they would need the chart for the actual clinic. So it would be we've requested the chart, so the person who was looking for that chart then would be told, right, Mr. O'Brien will bring that in tomorrow, so they would have a wee note to go and get the chart tomorrow.

250 Q. If we are looking at this and the symbols on it would indicate that perhaps it is not closed, how do we know who this would escalate to if it were to remain open? What tells us that? Is it the Directorate, the Director of Acute Services or Functional Support Services? How would we know who would get this?

A. Well, that will automatically come to me because my manager has completed that.

251 Q. Yes.

A. So, that will automatically come to me as an email to say Datix received. Then anybody that the coding there, the division services, the speciality and the site, anybody coded to those codes would get an email as well to say a Datix has been raised.

252 Q. That would normally include Directors and Assistant Directors, would it?

A. It depends what the coding actually would be.

253 Q. My earlier questioning around Anita Carroll and Heather Trouton may be incorrect. If they are not coded into this, then they might not be aware that it exists?

A. I would always have -- that was my mechanism for raising the Datix but I would always have notified both

of them - mostly Martina - just to say, look, the chart was at home.

254 Q. So even if you do raise it, the chart appears on your desk five minutes later, you close it, a code is still sent that one was raised? 14:02

A. Yes.

255 Q. Even though the problem at that point has been resolved?

A. Yes.

256 Q. There is still a record? 14:02

A. Yes.

257 Q. That was effectively the purpose of you doing this?

A. Yes.

258 Q. To set out a paper trail of times when you couldn't find the chart and it was at home? 14:02

A. Yes. Just to make the whole process a bit more formal rather than just a conversation.

259 Q. You've mentioned something about Mr. O'Brien always bringing charts in. I am going to come on to that now. We were talking in general terms this morning about the 14:02 system of charts and how that operated but I just want to go to your witness statement at WIT-61194. You've been asked questions about concerns arising from urology. We just go down to 26.1. You've said:

14:03

"The only concern I had regarding Urology Services was the fact that Mr. O'Brien kept a large volume of charts in his office and also took charts home without telling anyone. I do have to comment that when we needed a

chart for an admission or for an outpatient clinic and asked Mr. O'Brien to bring the chart back to the hospital, he always did so the following day. We were only aware of a chart being in Mr O'Brien's house if we went to retrieve it if we needed it for an admission or 14:03
outpatient clinic and went to look for it in Mr. O'Brien's office. After a search of his office and his secretary's office, if the chart could not be found, the Records staff or the secretary would contact Mr. O'Brien to see if he had it in his house, and then 14:04
he would be requested to bring the chart with him the next day. I can only comment on the charts that Health Records requested Mr. O'Brien to return from home, and cannot comment on how often or how quickly Mr. O'Brien would return charts not requested by Health Records to 14:04
the hospital".

You say again at 30.2:

"When asked to bring a chart in from home, Mr. O'Brien 14:04
always brought it in the next day. However, there was an instance where a patient was in the Emergency Department and the chart was requested. As it was in Mr O'Brien's house, we had to contact him urgently and fortunately he had not left the house at the time and 14:05
was able to bring the chart into the hospital with him. The Head of Service, Martina Corrigan, was aware of this. This is the only example of an emergency request for a chart that was in Mr. O'Brien's house".

Do you know if there was a Datix raised for that particular incident, the Emergency Department?

A. I think there was but I can't be 100% sure.

260 Q. What you're saying there is on every occasion that Mr. O'Brien was contacted -- was it by you or by Ms. Lawson? 14:05

A. It would have been, say, one of the girls who was looking for the chart and couldn't find it might have said to the secretary would you check with him, or it could have been with Mrs Lawson. It wasn't by me because they were responsible just for getting the charts. 14:05

261 Q. It was always brought in by Mr. O'Brien or sent in?

A. It was, yes. 14:06

262 Q. It always appeared. Were you aware of any times out of hours or at weekends when charts were sought that weren't there that may have been in Mr. O'Brien's house?

A. If there had been, I would have been notified so I would have to say no. 14:06

263 Q. Okay. So you would have been informed when you came in on your next shift?

A. Yes.

264 Q. I just want to take you to what you said in your MHPS statement. TRU-00794. Again, there is just a slight deviation; I just want to give you the opportunity to speak to it. At paragraph 8: 14:06

"In terms of notes, the only tracking code was for

Mr. O'Brien's office for charts tracked out to him. The only time we would know if a chart wasn't there was if we needed it and went looking for it. I know it would have been a regular occurrence that Mr. O'Brien would have had charts at home. He generally would have returned them the next day if a chart was being looked for".

Just the point that you have used the word "generally" and you have used the word "always" in your statement. Is there a split of a difference in your use of those words? 14:07

A. No. If I had to choose a word, it would be "always".

265 Q. Do you know why you used the word "generally" in the statement at that point? 14:07

A. I have no idea, no.

266 Q. I know we've spoken about the system and the policies around transferring notes. It would seem that parallel to that that custom and practice developed around the movement of notes, consultants taking notes with them for clinics. I just want to read out some extracts from Mr. O'Brien's statement, what he says was the position. 14:08

Before I do that, were you involved in or do you know about the incident of notes being put in the bin from charts by Mr. O'Brien? 14:08

A. I only knew about that in the work bundle, but that happened in 2009 and I didn't have responsibility for

the ward clerks at that time.

267 Q. If we go to WIT-82553, it's probably best because Mr. O'Brien explains some scenarios and system then I will read paragraphs and, at the appropriate time, I will stop and ask you to comment, is that is okay. 14:09
At 433, he says:

"I fully accept that in an ideal world, records should not be kept at home, other than perhaps for a very short period if it is not possible to carry out work 14:09
required by reference to the records while at the Trust premises. However, I worked in a service that was far from ideal which led to me often working from home. In more recent years, with the increasing reliance on electronic care records, it became easier to work 14:09
remotely without having paper records to hand".

Then if we go over to paragraph 435, and this is where he explains some of the systems.

14:09

"First in relation to records held at home, I was primarily based at Craigavon Area Hospital. I also conducted out reach clinics at Southwest Acute Hospital in the Western Trust. SWAH was exactly 50 miles distance my home and travelling from home to there 14:10
through several towns in the early morning and returning each evening took 70 minutes each way. Travelling to an outlying hospital with the additional time demands that that involved added significantly to

the length of my day. I was unaware of any definite systems employed by the Trust in relation to the transfer of records between hospitals, and perhaps particularly to a hospital in another Trust. There was no written direction to me in relation to when or how or when they should be returned".

Just at that point, I think we clarified this morning that you weren't involved in providing, or know of any training that was provided, about the policy requirements for record movement and storage? 14:10

A. That's right.

268 Q. If you were looking at the structure of the Trust, where would you say responsibility for disseminating that sort of information would lie? 14:11

A. Well, I cover things like that with induction for my staff, so I would have imagined induction.

269 Q. Induction then within each directorate and maybe department even; at that level?

A. Yeah. 14:11

270 Q. Would there be somewhere where it might sit at home with information of governance, or would that not be their remit to ensure that policies are understood, if I could say, at ground level?

A. It may possibly may be general training every three years, something like that. But with a big organisation the way we are, it would be very difficult particularly to get a lot of doctors together to take part in the training. 14:11

271 Q. Given that we saw this morning that the policies are very particular about individuals being responsible, legally responsible, for handling and storage and the retention of notes and confidentiality, do you think that the staff that you work with are aware of that, that that responsibility attaches to them as individuals? 14:12

A. Yes. And with the recent change in the GDPR, one of the changes was that you as an individual are legally responsible. So, I had asked the Head of Governance if her team would come and give training sessions on that new policy just to my staff. 14:12

272 Q. If we narrowed that down just by questioning the Head of Governance, would that perhaps be a natural home then to feed out information from policies around data protection and governance generally around records? 14:12

A. Well, I had specifically asked for that.

273 Q. And they felt able to deliver that training?

A. Yes.

274 Q. Do you think it would be a good idea if there were specific training programs or continuing professional development points, or some way in which the Trust could bring home their policy aspirations to people who actually operate - I don't use that word medically - who actually work in the Trust so that they better understand their obligations and their responsibilities? 14:13 14:13

A. Yes. I think we could improve the training aspect. We do have e-learning for some of the things but maybe

more specific training on this. Or, you know, make sure it is included in the junior doctors' induction.

275 Q. By the time you left in 2020, did you have any knowledge of any training that was in place at that point such as that? 14:14

A. No. No.

276 Q. Just the main point from that, I suppose, from your perspective as a manager was that you instigated the request rather than it being something that was available? 14:14

A. Yes.

277 Q. And there may be changes now, you just don't know, I suppose, having left?

A. No.

278 Q. Would that be something that Ms. Carroll could speak to in her evidence? Could she explain what the position is now, or perhaps Martina Corrigan? 14:14

A. Well, that would be for their particular areas rather than in general. So you would be looking at Functional Support Services or urology and ENT, but that leaves surgery, orthopaedics, medical. It wouldn't give what's happening within the full of Acute Services. 14:14

279 Q. I suppose one of the things about your former role is that it cuts across so many of the services in the Trust? 14:15

A. Mhm-mhm.

280 Q. Notes and records are pretty fundamental in the hospital environment. If there was training, it could be reflective of the requirements of policies and

procedures but applicable to everyone who had reason to have notes or records at all in their possession for even just transferring them between wards or units?

A. Yes.

281 Q. 437 is the next paragraph. 14:15

"The clinic at SWAH took place once each month on a Monday. The medical records personnel at CAH would deliver the charts for the patients attending the clinic to my office in CAH on the preceding Friday for 14:16 me to take to SWAH three days later. I was provided with a container on wheels in which to transport the charts".

Does CAH fall under your remit? 14:16

A. Yes.

282 Q. And is what's described here a system that you recognise?

A. Yes.

283 Q. Was that one that was put in place by you or others to 14:16 reflect the geographical layout of the service provision of the Trust?

A. We would have internal transport between all of the facilities on the Southern Trust. We would also have internal transport to go down to the Royal in Belfast, 14:16 but we would have no internal transport to go to SWAH. So, the clinics -- the charts were going down on a Friday but we had no way of getting them down there or to have them down there first thing on a Monday

morning, so this was a workaround.

284 Q. When you say there was no transport, was it a funding issue?

A. No, it was just the transport didn't go there.

285 Q. I am going to have to ask you to explain that to me. It didn't go there because? 14:17

A. They never had a need to go to there. We would have had transport drivers and they did regular pick ups from Health Records twice a day, and they would have went between the sites. So, you know, they would have been picked up in Craigavon, those charts went to the clinics for Daisy Hill, those ones went to South Tyrone and Armagh. Then there was sort of the Southern Trust transport did go down to the Royal in Belfast, but they hadn't went to SWAH. Really for going down to Belfast, it would have been for their labs and some of the specific tests. So, there just wasn't a transport run to SWAH. 14:17 14:17

286 Q. If the consultants weren't to take the notes, the Trust would have had to put something in place to get the notes to the clinic, would they? 14:18

A. Yes.

287 Q. Were the consultants assisting the Trust, doing them a favour, in bringing the notes?

A. Yes. 14:18

288 Q. He then goes on to say at 438:

"As a result of the significant pressure I was under, I did not have time to complete all work required on

records while at SWAH as insufficient time was allocated to allow me to adequately review patients, including new and cancer patients, and complete administration work within clinic time. Initially the clinic commenced at 10.00am with 16 patients attending until 5.00 pm. More recently in an attempt to review as many patients as possible, I had 18 patients attending with the clinic starting earlier at 9.30". 14:18

Mr. O'Brien is then indicating the volume of patients he was seeing; this is within the context of having notes at home. 14:19

440.

"I also conducted an outreach clinic at Armagh Community Hospital in Armagh. This clinic also occurred once monthly on a Monday morning. It was a general Urology Review clinic with 12 patients attending between 9.00 and 1.00pm. This clinic was different from the one at Southwest Acute Hospital as the patient's clinical records were delivered by Trust transport, though occasionally none were delivered at all due to oversight. The problem I had with completing administration relating to the patients attending this clinic was that the room had to be vacate had by 1.00pm to prepare for a dermatology clinic which began at 1.30. As I did not have any elective session during the afternoon of that Monday, I 14:19 14:19

brought the patients' records home to complete administration, which I was able do remotely".

Now, this is slightly different from the previous example, on this occasion there is Trust transport. Would it would be anticipated that the transport would pick the charts up at the end of the clinic? 14:20

A. Yes.

289 Q. Mr. O'Brien is saying that sometimes the notes didn't turn up for the clinic. Was there any understanding that if the consultant wanted to bring the notes home, they could do that? 14:20

A. No. Simply it would be as with all of our clinics, the clinics would have been bundle up, labelled and put into Health Records in Armagh Community and into the one of the tamperproof boxes to wait for transport to pick it up and bring it back to the Craigavon site. 14:20

290 Q. Transport would pick up the box rather than know how many charts to pick up, so they wouldn't say we left 50 in this morning, there's only 30 there? 14:20

A. No.

291 Q. It doesn't work like that?

A. No, it is by boxes.

292 Q. So it is sealed?

A. Yes. 14:21

293 Q. So you wouldn't have known then that there was charts missing until they arrived back?

A. No. Even at that, the boxes were just unpacked and they would be -- that would go to the consultant's

secretary for her to type the letters. So it was just be taken out of the box, put into the pigeonholes, and the Health Records porters would have delivered them to the appropriate office.

294 Q. They had an internal life until they completed the cycle for the clinics -- 14:21

A. Yes.

295 Q. -- before finding their way backs. Then at 441.

"I had a busy outpatient clinic at CAH", just to say Craigavon, "each Friday when I would have patients attending for flexible cystoscopies and urodynamic studies concurrently with patients attending for oncology reviews. Having remained at the hospital to undertake as much administration as possible, I found it tempting to bring home some records, usually of those patients who had attended for flexible cystoscopies and urodynamic studies so that I could join my family for the end of the week dinner at 8.00pm and with a view to being able to complete the administration from home remotely so as not to have to return to the hospital over the weekend". 14:21 14:21 14:22

Is that another clinic where Transport would have picked the notes up? 14:22

A. That's actually in Craigavon itself. So, the Health Records porters would have just picked them up.

296 Q. They would have brought them back in the trolley either to the secretaries, or wherever they needed to go for

dictation, if that was appropriate?

A. Yes.

297 Q. When Mr. O'Brien did this particular example, having had the notes with him, were those notes were coded out, are they coded out to the clinic or to him? 14:22

A. They would have been coded out to that urodynamic clinic.

298 Q. So when he took them home, effectively, strictly looking at the system, you wouldn't have known where they were? 14:23

A. No.

299 Q. Would that then have involved some investigation to find out the names of the patient, who the consultant was, contact the secretary, get some confirmation that the notes were at home? 14:23

A. Yes. Well, we would have had -- say that that patient had come up to another clinic, then we would have looked for that patient, seen where it was tracked out to and that would have started your searches for right, well, where would the cystoscopies go to; you check the 14:23 secretary, then his office, so it would have started that whole trail of searches.

300 Q. So on each occasion it triggered a separate set of steps --

A. Yep. 14:23

301 Q. -- in order to get to the conclusion that they must be at home?

A. Yes.

302 Q. He then mentions that he has the notes of private

patients at 442. He then says at 443:

"It was accepted in the context of the formal investigation report that if notes were requested from me, I would return them promptly", and that accords with your evidence. He then says: 14:23

"It was clear by March 2016 the Trust was aware of the practice and indeed appeared to have concerns". He refers to the letter he received in march 2016. 14:24

Then he says that paragraph 446:

"I accept it was not best practice to have kept NHS patient records at home. There is no suggestion there was any security breach in relation to these records. The records were stored in my private office at my home, which is totally secure". 14:24

We know from the policies this morning that keeping notes at home was permissible, if necessary, and there was requirements that they are kept in safe storage, offsite. Does the Trust have any particular requirements of what storage at home should consist of in order to meet those requirements? 14:24

A. Well, it would be somewhere where there would be no -- nobody else would have access to. I gave you an example where one of my staff had to take some charts home but we had those in the secure box, sealed, and

that had to be kept in their house so they would have known if anybody in the family would have opened it or anybody would have access to it. But it's really that you would have an area where the general public or other members of the family then wouldn't be able to go in and view the notes. 14:25

303 Q. In the transport to the home, would there be an expectation of travels in a secure box?

A. Yes.

304 Q. And stays in that secure box in a private room? 14:25

A. Yes.

305 Q. Do the Trust provide those sort of boxes to consultants?

A. We provide them for the outpatient clinics and any charts going off the site, but we haven't had to provide them to consultants because, apart from this one individual, I have no knowledge of any other consultant needing them for anything, or to take charts home. 14:25

306 Q. Did you provide them for the SWAH clinic where the consultants transported them? 14:26

A. Yes.

307 Q. So, Mr. O'Brien could have one of those boxes provided to him?

A. Yes. 14:26

308 Q. And he actually refers to this at paragraph 449 where he says:

"Thirdly, in relation to patient records in my car, it

was necessary for me to carry records with me when travelling to and from outlying clinics as well as between my home and Craigavon Area Hospital. I wish to emphasise that patient records were never left in my car at any location. They were placed in the container provided in the boot of my car on departure and removed on arrival at the destination".

So, Mr. O'Brien is saying there that he accepts that it wasn't best practice for him to take notes home but when he did, he set out his reasons. The Panel can consider those and carry them onto the terms of the policy.

14:26

14:27

Mr. Mackle also refers to the SWAH clinic in his evidence. WIT-11745. I'll just read this out for the Panel. Paragraph 26 says:

14:27

"In 2013 Medical Records complained that an ongoing problem with Aidan O'Brien was patient hospital charts in his house and he was advised that this was not permitted. Following the expansion of the Urology Service to become Team South, outpatient clinics were provided in Enniskillen and patient records therefore needed to be transported to the clinic and back to Craigavon afterwards. The Trust transport was used for all other peripheral surgical clinics but for this service it had been arranged that after the clinic, the consultant would bring the charts back to Craigavon.

14:27

14:27

Following dictation of the letter to the GP, the outcome for the patient would be recorded, for example put on waiting list for surgery, discharged or review arranged. Aidan O'Brien, however, was bringing the charts to his how after the clinic but not completing the dictation, which also meant patient outcomes were not recorded. The Trust became aware in late 2015 of it as a problem but only discovered the extent of the problem following Heather Trouton and my letter in March 2016. He returned the charts. 14:28

Mr. O'Brien also told the MHPS investigation that he had kept notes at home but, in his view, this didn't impact on patients' clinical management plans or their care. Panel, that can be found at TRU-00696. You'll just see very top of the page: 14:28

"Dr. O'Brien confirmed he did not have these". These are 13 sets of notes which we dealt with this morning. That's the line this was accepted by the Trust and the Review Team, that I had mentioned to you earlier today. 14:29

Then this line:

"Mr. O'Brien accepted he had kept notes at home but asserted that this did not impact on patients' clinical management plans, or care". 14:29

Given the evidence we've looked at today in your

emails, would you agree with Mr. O'Brien?

A. As long as we were able to get the chart, then it didn't impact on clinical management. Also, the fact that with the availability of NIECR since 2013, and having letters in patient centre, we were able to get more information if a chart wasn't there, that we could provide another clinician with other information.

309 Q. Given the emails we looked at this morning where we said that you had said that if an operation was cancelled, consultants would say they won't operate if they don't get charts, do you agree with that statement? 14:30

A. Well, then no.

310 Q. I want to move on to the staffing issues. You've mentioned this in your statement and I just want to give the Panel a flavour of the competing demands on your staffing allocation in relation to what you were trying to contend with generally, given the size of your department. I just have a few emails to take you through. 14:30 14:31

First of all, TRU-164909. This is an email from Pamela Lawson to you. The Panel will note the context of the few emails we are talking about; emails back and forth capacity, agency staff, people leaving, people not being replaced, and also a document I think you created was a table of additional services with no funding, which sets out all the extra work you do without having funding for that work. 14:32

164909. This is from Pamela Lawson to you on 24th March 2014.

"Helen, I just want to make you aware of the situation here at the moment. You know we've lost", and she names two members of staff. "ENT reception needs covered this week and a member of staff is on leave". Someone else is moved to cover maternity leave. She has somebody moved to cover ENT. "The day on Wednesday we will have to take out core staff to cover Tuesday, Thursday and Friday". Someone is off sick from Outpatients Department. Another person is on leave so she is sending over cover from Monday, Tuesday, Wednesday, Thursday and Friday. That person also has to cover someone else in another department on the Monday, Tuesday, Wednesday, opposite days, as that person is off sick. "That leaves me down to one supervisor". Someone else has been off from the 28th February on sick leave but hopes to be back soon. She is also taking two staff out of filing/portering two days a week "as we really have to get the week done here as charts are already on top of bays again because the filing rooms are overflowing. We've taken on a new breast clinic which we still haven't been informed about, which is 35 patients per week" and we'll look at that when we look at your table that you created. 14:32 14:32 14:33 14:33 14:33

"There is an ENT consultant and this means extra

clinics and arranged admissions every week for him. We cannot continue like this. I want to decrease the issue desk a bit so I am asking you to agree to my proposal of only getting charts for other sites that are needed for clinics. Secretaries on other sites will also provide charts for us as they send their charts over for clinics to us. However, Craigavon secretaries will have to either come down and get their own charts or provide us with the charts required for clinics, in which case I will be able to get two members of staff on to clinics and issue desk. Can you let me know as soon as possible please". 14:34 14:34

There is a lot going on in that email?

A. Yes. 14:34

311 Q. I think it gives a flavour of creative juggling of staff to try and keep services ongoing. Is that email exceptional or would you read that as something that typically might have crossed your desk?

A. That would be a bad state of affairs because there is staff left and staff on sick leave and some going on annual leave. That would be we're really tight for staff at the minute, I am going to have to put in some different provision here to actually manage the day-to-day business. But we would have regularly had periods where we did have difficulties with staff and shortages. 14:35 14:35

312 Q. If we look at another email - TRU-164910 - from Helen. I think I have missed the top of it. This one is from

you to Anita Carroll, 14th May 2014.

"We are having problems with the staffing in Craigavon Health Records. One agency left, porter is now on sick leave, another member of staff to leave at the end of the month and two more want to reduce their hours due to health reasons, so that would create another vacancy. Another clinic that has to be taken on. Urology has been added on". 14:36

You say: "There are some of the figures that shows the activity in Craigavon per month. This is the total number of charts per month that are pulled and filed in Health Records. So there is a large volume and I know you will ask, so yes, we are doing comparisons across the sites and moving staff to meet the need". 14:36

I presume that justification has to underscore any request for anything, by the tone of your email.

"But also I would like to have some permanent members of staff as all of our replacements have been agency and it does leave us vulnerable as they want to have permanent posts". 14:36

Was that something that was longstanding, the failure to fill permanent posts? 14:37

A. This was during the Comprehensive Services Review where there was a lot of financial efficiencies required and

we weren't allowed to recruit permanent staff. We could go to bank and agency. That did leave a lot of problems because if obviously someone was from agency or someone was a bank member of staff and they got a permanent post somewhere else, they went to it. So, we would have had a large turnover of staff. Even that led to issues because you had to get the member of staff in, get them trained until they knew the system, and then were functioning and then somebody else left and you had to get them in again. So, it was really asking there, look, can we go to get some permanent staff in just to get a wee bit of stability. 14:37 14:37

313 Q. Was it on the basis that it is more expensive to fill permanent posts than it is to bring people in who leave and bring people in who leave? 14:38

A. It was more just keeping costs down and not having permanent staff, so could staff from other areas be redeployed into this if there was the opportunity.

314 Q. Was that as a result of looking at the budget in a shorter term, in order to keep the books right rather than long-term planning? 14:38

A. Now, it wasn't just in our area, it was across the board. So, it was how can we make savings.

315 Q. Okay. If we look at TRU-164913. This is an email to Debbie Burns from Anita Carroll on 2nd April. You're copied in as well as Dennis Stinson. 14:38

"Debbie, would you be agreeable to this form. A full-time ward clerk is on maternity leave from 3 South

and we really need to have this replaced. We have done some workarounds and reduced cover in other areas to make up the shortfall in the hours as we can't get the full hours covered as it is maternity leave, but we would need to get cover in for the O.6 WTE". 14:39

This is another example of workarounds being sanctioned at a high level?

A. Yes. During that particular time if someone went on maternity leave, you are only allowed to replace half of their post. So, the full-time person had left for maternity, we would have got a 0.5 of a replacement. That was just it for your scrutiny. So, then we said right we will do that, we will reduce that, we can actually get the funding of that increased to 0.6, which is the minimum that we could do with. 14:39

316 Q. Is that still the position, if someone goes off on maternity leave, you get half a post replaced?

A. No. But we were under very strict financial restraints at that time and it was difficult. 14:40

317 Q. Is the position now like for like? If a post is available, then available, whatever the reason for the absence?

A. I'm not sure.

318 Q. You're not sure. You've forgotten; you've wiped it? 14:40

A. See, in two and a half years, I don't know if things have changed or not.

319 Q. I appreciate that. Once you retire, you turn away.

TRU-164915. Sorry, TRU-164914, I think. This is from Anita Carroll to you on 7th September 2015. She says:

"That's fine, Helen. I know it sounds awful. I'll get Aideen to give us some time". 14:40

She is answering your email below where you have asked her about staffing levels. 4th September 2015, your email to Anita Carroll. You say: 14:41

"When I come back, I'd really like a bit of time with you to go through the staffing levels and confirm what we can do re getting staff made permanent and also about the staffing levels". 14:41

You mentioned someone was talking to the unions and the discussion came up about staffing levels. Three people are on long-term sick, one on maternity. Someone else is two WTE off on sick leave and one person leaving. 14:41

"Helen McCall, met with her on Wednesday and Kelly, and both wanted to talk about the pressures on the post and the amount of work to do and something has to be done. I advised her to talk", names two individuals, "and get some points down where change could make a difference and how could the team work together to help things. Two people to discuss the activity levels of the Renal Unit soon". Someone is concerned about agency staff leaving, and you have to make a decision about getting 14:41

the secretarial post filled.

"Covering ward means only limited sometimes available and some wards have been complaining about the lack of support. I try not come to you with staffing issues but things just seem to be really busy and we can't progress with anything, we're just keeping going. I know there is the financial situation is grim but would just like to sit and talk things through in case there's something I'm missing that would help". 14:42

So again, that email reflects a service, you say it was stretched to its outer boundaries?

A. Yes.

320 Q. Is that what it felt like working there at the time? 14:42

A. Yes.

321 Q. What impact did that have on the culture?

A. People were discontent and we did have a high turnover. At one point the staff in my area, a lot them are Band 2s, so they were trying very hard to get to Band 3 as well, so that would be a better post. They were a fabulous team and they did really take their work seriously and had a great pride in their work, so it was very difficult when they were stretched and stretched and more added on and posts not replaced. So, it was difficult. 14:43

322 Q. You do say in your statement that you could have implemented a system that would have allowed you to track charts and find out where they were and trace

them?

A. Yep.

323 Q. But for the capacity within your department?

A. It's as I say there, we can't progress anything. To me, that would have been the general housekeeping, keeping everything right. Also, it would have been lovely to have progressed things for the staff themselves, even a wee bit of additional IT training or something. But we were just so busy, you got your core business done, and just about. 14:43 14:44

324 Q. Do you remember how the staff felt at that time when people were moving about and trying to cover people who were off? Was there a sense of people being demoralised?

A. Oh, yes, yes. 14:44

325 Q. Do you think that impacts on their ability do their job?

A. They are not happy. Our figures, our stats, were always high, we always did produce the goods. But the workforce weren't happy. 14:44

326 Q. You, as the head of this, we talked this morning about -- looking now at staffing and the impact of you getting an insight into your day-to-day, the Panel can see what you were juggling. Also, then when there were issues and you had senior management telling you to not progress those issues, how did that impact on you? 14:45

A. It was difficult because you wanted to keep your managers and ultimately your staff motivated. You wanted to keep yourself motivated as well. You just

had to get on with it, but I always had a stance of you never ask your staff to do something that you wouldn't do yourself, so I would -- I've covered minor injuries, I've done a nightshifts in ED, I have filed charts because when you were at your very crux, you just couldn't sit in your office and see your staff suffer. So, my managers and I would have actually went onto the shop floor.

327 Q. So, people were shown goodwill; could it be described as that? 14:46

A. Yes.

328 Q. That was to try and keep the system going?

A. Yes.

329 Q. We'll just come onto the table that you made of additional services with no funding. TRU-164935. What was the background to this chart? 14:46

A. We had to go through -- or we were very strictly monitored with regards to performance. There were timeframes that everybody had to be seen in. All the services were trying to think how can we improve our service, how can we get more staff or more patients through the system. So, they would have been looking at what can we do, can we increase that clinic, can somebody else, can they see two more reviews a week, or else would you have had new consultants coming in, or a new service to try and divert the patients from one clinic maybe to a nurse-led clinic. So, quite rightly the services were trying to do the best and to meet the timeframes. But if they increased a clinic, you might 14:46 14:47

have, say, there's one, the leukaemia MDM, five a month, some are saying what's five a month, you can do that. But when you added that five onto the 82 onto the month, on to the 30. For me, it was a mechanism to show this is why we are complaining, this is why we'll 14:47
turn round and say, no, you can't have an extra 10 patients a month, we can't do it because collectively it adds up to, I think, that was 2.44 whole time equivalents. But it was nearly just to show this is our struggle, this is where we were and this is the 14:48
funding that we need just to keep even and in light of the changes that have been made.

330 Q. Who was this table made for?

A. I would have shared that with Anita.

331 Q. If we look at some of the examples just so we can see. 14:48
You have mentioned the leukaemia MDM. If we look at No.4, new physician with an interest in rheumatology but there is no funding for that aspect of the work. That adds 69 patients a month. No. 10, Clinical Decision Unit; the charts have requested an average of 14:48
16 per day which increases your workload by 480 a month. Dermatology, a new consultant, 176.

So, these are all capacity. You are already -- these are on top of the staffing issues? 14:49

A. Yes.

332 Q. So you have the staffing issues and then the additional capacity put on with no funding?

A. Yes.

333 Q. It's clear from reading that that your department has no control over any of this?
A. No.
334 Q. Are these decisions that are -- I don't want to say foisted upon you but to which you are subjected made by others? 14:49
A. Yes.
335 Q. Did anyone ever come to you and say we're going to do this, it is going to increase your capacity by X, do you have the ability to manage that? 14:49
A. No. It was this is what we need to do to manage our service and to get the patients through and meet the timeframes.
336 Q. If a new clinic was put on and you weren't funded to service that, it was beneficial to patients but it stretched your staff even further? 14:50
A. Yes.
337 Q. There is one other email if we can just look at, where you have attempted to drill down into the actual time it takes for staff to track charts. That's at TRU-164934. It's from you to Pamela Lawson and Kate Waters. 14:50

"Could we take a four-week period and keep a tally of charts which haven't been tracked and where time has been wasted looking for a chart which hasn't been tracked, something like below but if you want to add in more columns work again. It is just so we get a picture of what happened with the chart. Thanks". 14:50

Then you have asked that to run from 15th December and have it to you by the 20th. You have provided a template there. Was that chart filled in; was it completed, do you recall? 14:51

A. We did do some of that. I did look through my documents but I couldn't find it.

338 Q. Okay. We mentioned earlier - just moving on to -- is there anything you would like to say about staffing or resources or capacity at this point in your evidence, 14:51 given what we've talked about all day?

A. That's the reason why we didn't do sort of the additionals and the extras and that good housekeeping. It really was we just survived; we weren't resourced for it. Even in the work plan there were quite a few 14:51 things written about storage and moving charts here and there. Storage was a huge issue with regards to Health Records and you never have enough. So, we got a new facility and it was setting that up. Everything takes time. It's not just bundle a few charts and put them 14:52 somewhere else. You had to create space, get your filing system. So, we would have spent a lot of time in storage and that was difficult as well. It's something we weren't resourced for either.

339 Q. Now, I did mention risk register. I just want to come 14:52 back to it. I won't take you to risk registers that don't record the charts at home or charts not tracked because I am taking you to something that's not there; you know that yourself.

A. Yes.

340 Q. I want to give you the opportunity to explain why, because you've clearly in your evidence identified both charts not being located and charts at home as representing, perhaps if I could put it as an escalating risk for patient safety and care, but you didn't put it on the risk register. According to your statement - I don't need to go to this but, for the Panel's note, WIT-61196 - as it wasn't something you could control or effect a change. Could you just explain a little bit your understanding of the risk register was only something if you could do something about it -- 14:53 14:53

A. Yes.

341 Q. -- that you put it on? 14:53

A. Yes. We had, my managers and myself, we had our own risk register. That would have been things like the bay in records broke down, what would we do, how would we mitigate a risk? How would we make sure our equipment was okay? Those were things that we could control, so that was on my risk register. 14:53

With regards the issue of Mr. O'Brien having his charts at home, I couldn't control it, the only thing I could do was escalate it. That's my impression of the risk register. It would say in the documentation that the risk should sit with the appropriate directorate or service. To me, the risk was that the chart was at home and not on a Trust facility. I couldn't control 14:54

that because I didn't have the line management for the consultant, therefore I didn't have it on my risk register. But Anita had highlighted it to Heather to say should you have that on your risk register.

342 Q. And do you know if she did? 14:54

A. I don't know.

343 Q. Did you ever see it on a risk register?

A. No.

344 Q. Can you see now that it might have appropriately sat on yours? 14:55

A. In hindsight, yes. If I had referred it to Anita to have sat on her risk register, then it would have been discussed at the AD governance meeting. If it had sat on my personal one, it wouldn't have went, it just would have just been discussed with ourselves. 14:55

345 Q. So your understanding of the risk would have been it was sitting with people who couldn't do anything about it?

A. Yes.

346 Q. In order for something to be done about it, it had to go up? 14:55

A. Yes.

347 Q. And you don't know if it did go up on to Ms. Carroll's?

A. No. Well, I know I didn't put it up.

348 Q. Would she have known about it as a risk? 14:55

A. Yes, she would have known but that's why she escalated it on to --

349 Q. To Heather Trouton, I think. There are some emails there for the Panel's note just; emails escalated to

Martina Corrigan and Anita Carroll. The references are and WIT-11964; WIT-61499 to 61506.

You did say you raised these issues with Martina Corrigan, but there are no notes of that, it was orally, you spoke to her about it? 14:56

A. Yes. We worked in offices beside each other.

350 Q. Now, Heather Trouton, in her statement at WIT-12156, says that she on reflection she can see both the frustration of the staff and Mr. O'Brien struggling. I will just read out this paragraph at 499: 14:56

"When I read the emails of that time from myself and others, I can see a frustration regarding the lack of capacity across the board; a frustration with the practice of Mr. O'Brien regarding delays in triage, leaving patient notes at home, and his often dismissive attitude to core systems and processes which were very often regionally directed and locally agreed. I can also see a relatively small number of clinicians and managers working extremely hard to manage many services, elective and unscheduled care flow across two acute hospitals, underfunding and staffing constraints. 14:57 14:57

"I also see a consultant who struggled to adjust to the use of technology and to working in a multidisciplinary team who were there to support his practice, to allow his expertise to focus on the aspects of care that only he could do, leaving other aspects of care that could 14:57

be done by others to those others. I believe that he genuinely struggled to adjust to the volume of patients needing to be managed. I think that while other consultants adjusted their practice to meet time slots at clinics, Mr. O'Brien was just unable or unwilling to adjust". 14:58

Were you aware of there being problem with consultant's use of IT systems or seeking help in that record?

A. No. 14:58

351 Q. Is that something that you would have any involvement in seeking to familiarise consultants with?

A. No.

352 Q. Do you know who does?

A. If I have staff member coming in, they will get training on PAS and Patient Centre, but that's the only IT training we would get, so I would assume that there would be no IT training for consultants. 14:58

353 Q. Just one other area I want to deal with. Waiting times pressure is another thing you've mentioned, where you have said that every Trust was under immense pressure to ensure that all patients were seen in an appropriate timeframe. That's at WIT-61179. What we've mentioned earlier, clinics were set up at short notice which was good for patients but put great strain, as you've said, on all staff, including Health Records staff, because they had to get the charts at short notice for newly arranged clinics and make sure charts were at the right hospital for the clinic. 14:59 14:59

"Staff could not plan their workload as would have to make a journey for just one chart due to the timeframe they were working to".

A. Yes. 14:59

354 Q. In real terms for someone like me who doesn't know the way that system operates, the waiting time, the turnaround time is much tighter; is that what it is?

A. It was really -- you had to have your patients your outpatients seen within nine weeks, and that was very 15:00 stringently monitored. Everything had to be done to make sure that every patient did not breach. So, right up to the very last, you would have been trying to get additional clinics. Maybe for some reason a consultant maybe was meant to be on leave and wasn't on leave and 15:00 would have said do you know what, I can do a clinic tomorrow for you. That would have been finding that out today; the booking centre would have had to start phoning patients to get them in, so Records couldn't get the chart until slots were booked. 15:00

The way Records would work is that you have your set amount of clinics. Say I pull 20 clinics this week, I would have pulled up my pulling list, and then the pulling lists are in numerical order. You took your 15:01 list and you had eight libraries to go around. You went and there is all the charts for this library, you put them into the trolley. So you were actually efficiently working round the eight libraries and

coming back with your trolley full of charts for these 20 clinics.

But you would have been pulling maybe five days ahead, so you had a wee bit of leeway just to do that. 15:01
Whereas if you were having a clinic that was going to take place at nine o'clock in the morning and you were finishing at 5:00, you had to keep a wee eye, there is another one added in, I will run down to that, I will run down to that library and you didn't have time to do 15:01
your other 20 clinics, so you became inefficient. You did get the clinics pulled but you were doing it individually rather than en masse. So, it was just an inefficient way of doing things.

355 Q. Heather Trouton says: 15:02

"The culture of Acute Services was a culture that was focused on performance and financial efficiency".

Do you agree with that? 15:02

A. Yes.

356 Q. For the Panel's note, that is WIT-12157.

I'm very close to finishing but there is one other topic that I just want to cover. I wonder if we can 15:02
just have a short break at this point, if you don't mind?

CHAIR: Okay. We'll come back at 3.20 then.

MS. McMAHON: Thank you.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

CHAIR: Good afternoon. Ms. McMahon.

MS. McMAHON: Mrs. Forde, the end is in sight. Just a couple of things to finish off with. First of all, I'm grateful to Mr. McGarvey who found a reference to you reporting the Emergency Department need for notes that weren't available. The Panel can find that at WIT-61506, an email dated 21st January 2015. 15:24 15:25

The other thing I want to turn to just briefly is the data that was collected about other surgeons around notes being coded out to them. I think if we look at emails between you and Ronan Carroll and Anita Carroll dated 19th and 20th July 2017. They can be found at TRU-164929. They go on until 164932. 15:25

These are series of an emails working backwards. I think this is the start of it, from you to Anita Carroll dated 19th July 2017. The subject is "Example of charts tracked out to consultant's office". You have put a list of consultants there. Mr. O'Brien is not on that list. Some consultants have zero against their name, one has 96, one has 61. I'm not sure if that's the same Mr. Young from urology, he has 26. 15:26 15:26

Were you asked to collate this data for a reason?

A. Ronan had spoken to Anita to say he would just like to

see what charts were in offices. Now, having read through the work bundle, I see that Ronan had been talking to Martina about charts in Mr. O'Brien's office and he must have -- they must have decided they wanted to get a comparison. So he had asked Anita, then Anita had come through to me just to get some of the information. So I got this and then they came back and said they wanted a few of the urology ones. There was a bit of backwards and forwards and then there is the final list. 15:27

357 Q. As we move up the top?

A. Yes.

358 Q. These are, I think, general surgeons?

A. Yes.

359 Q. He that number of 96, is that quite high? 15:27

A. Yes, but Mr. Epanomeritakis would have had a lot of charts in his office. I'm not sure of the way working; him and his secretary would have a lot of charts. I think it is to do with results.

360 Q. There is another number there, 61; it's quite a high figure as well? 15:28

A. It depends on their systems of work, you know, if they are waiting for things to come back or if they have a lot of correspondence with other consultants that they keep the chart for reference for. 15:28

361 Q. The issue for you is knowing where the chart is?

A. Yes.

362 Q. Rather than why it is there?

A. Yes.

363 Q. Then, Ms. Carroll has got back to you, copying Mr. Carroll in, saying: "Thanks Helen. Ronan do you need more". He replies: "These are mostly GS", I presume that is general surgeons. "What about his peers". He names Haynes, Glackin and Mr. O'Donoghue. 15:29

So, you have narrowed it down at this point. You reply and say there you go, Mr. Glackin 34, Mr. O'Donoghue six and Mr. Haynes zero. Then Anita asks: "Why so different. Do any secretaries have tracking codes or is it only doctors?" 15:29

Is that an unusual question from your boss to ask about the way charts are allocated out?

A. No, because it would be specific. I know that, yes, a secretary will have a tracking code and the doctor will have a tracking code. Other people might know, well, there are tracking codes but they wouldn't need to know the specifics of what the tracking codes are. 15:29

364 Q. Up until 2017, it does -- well, I'll suggest that it does reveal perhaps a lack of understanding about the way in which charts are tracked? 15:30

A. Yes.

365 Q. Up until 2017, charts not being available and being missing has been certainly apparent on the documents we have gone through today. I think you then explain, if we just move up. You say: 15:30

"The majority of charts are in the secretaries' office

and they have their own tracking code and then the consultant has his or her own tracking code for their office". If we move up.

Then she says:

"For example, if you look at Mr. Haynes, how many are with the secretary and for AOB how many with his secretary?"

That would involve you then looking at the secretarial code, I imagine?

A. Yes.

366 Q. If we move up, you provide the answer. Haynes secretary 87, AOB secretary 154. Again, your lack of concern as you're revealing it now, because you know where the charts are if you need to get them; do you understand what the purpose was of seeking these particular figures?

A. I think it was just to compare to see was Mr. O'Brien's out of the ordinary in comparison with the other consultants.

367 Q. But there was no suggestion before this email trail to trigger it that charts were being looked for and couldn't be found?

A. No. This was just as a comparator.

368 Q. Just as a comparator. Again, another document recently just provided by the Trust, TRU-164933. This is an email of 9th October 2017. Again, was this a request

or was this just the way that you kept data as the manager? Did someone ask for this?

A. No, someone would have asked for this. It was just sort of a bigger list of the consultants.

369 Q. All of the consultants in Acute? 15:32

A. That wouldn't be all of them. That would be just be a few of them; just a sample.

370 Q. Okay. If we just move down, is that Mr. O'Brien at number 19?

A. Yes. 15:32

371 Q. His figure is 36. There is someone else at 46, and 16. Number 4 is 51. There are four others with higher figures. Again, without any other context, what would this tell me by looking at this? Just who had a number of charts in their office that had been tracked out? 15:32

A. Yes.

372 Q. It doesn't tell you what you don't know, which is what hadn't been tracked out or what you can't find?

A. That's just the tracking code there. You see under "code", you would put that in and just request to run. 15:33 It would give you a list of all of the patients who are under that code, and then a tally at the end to say there were 25 on this list. That is all it tells you.

373 Q. Did you ever have to deal with another consultant about not being able to find charts? I know we have talked 15:33 about the charts at home and that was your particular concern, but just generally?

A. Well, if a chart was missing and you saw the consultant, you would have said have you any charts.

Like that would just have been a routine thing. If you were looking for a chart that you couldn't find, anybody at all you could ask, you would have asked them.

374 Q. Was it a particular problem with our consultants? 15:33

A. No.

375 Q. You've mentioned some things about improvements that could be made, and you obviously can add to that if you've had time to reflect. But just for the Panel's note - I don't need to bring it up - it's WIT-61199. 15:34 You've suggested some having confirmation that the concern that has been raised and an outcome of the discussion provided. I presume that means that is in the context of having escalated something and somebody getting back to you; is that what you mean by that? 15:34

A. Yes.

376 Q. And to see a change of practice with the concern being resolved. I'll read the paragraph out rather than give you my bullet points. You say: 15:34

"Improvement could come in the way of having confirmation that the concern is raised and an outcome of the discussion provided, and to see a change in practice with the concern being resolved". 15:35

Is this up until the time that you retired, you felt there had been no change in that first part of that paragraph?

A. Well, yes, there wasn't an awful lot of feedback about

anything. You know, in general you would have raised a concern or here's an issue, but there wouldn't have been much in feedback and really nothing in formal feedback if there were issues.

377 Q. "I feel that concerns should be raised in a more formal platform with formal feedback being received regarding the concern rather than verbal conversations". 15:35

Was there a lot of chat rather than things written down? Was that your experience, at your level? 15:35

A. Yes, and again due to the busyness of the service. And also I would say due to lack of admin support for Heads of Service and ADs.

378 Q. Do you think when a concern was written down, it was taken more seriously? 15:36

A. It may not have been taken more seriously but I think this shows you that at least you would have had a trail and you could have proven what you did. Like I've had to say to you, yes, my conversations would have been nipping into the office and saying. That's less formal than here is a piece that you could follow up on. It's easier if you have something documented to be able to follow up and say, well, what action has been taken, what has happened from the last time we raised this. Whereas the way we dealt with informal conversations doesn't give rise to that opportunity. 15:36 15:36

379 Q. Was the culture such that people tended to follow other people's example of just dealing with things

informally?

A. Well, yeah.

380 Q. You say:

"In hindsight I feel I should have been much more formal in my approach to this concern, detailing every conversation, asking for follow-up, requesting a formal meeting to discuss when things did not change". 15:37

That's specific to the issues that arose in the charts and the charts at home? 15:37

A. Yes. I would say in general. You know, this has given an opportunity that you can look back and say what would you do. You know, meetings, having them typed up, we didn't do that. But again, we didn't have the time and we didn't have the resource. If I were to arrange a meeting, I would have had to arrange it, book the meeting, take the notes, do the agenda, make sure the follow-up actions were done. You just didn't have time to do it as well as it should have been done. 15:37

381 Q. The way you describe it, to do it properly was more work?

A. Yes.

382 Q. Obviously you held your post for a long time. Is there anything else, any other suggestions or anything else, information you want to give to the Panel to help them in their consideration of all the issues and their recommendations? 15:38

A. I think just a more formal structured approach. Maybe

like even our documentation that we kept, if there would have been a central area that not everyone had their own minutes or had to pull. I think if you just went and it was all stored in one area, you knew you got the most up-to-date set of minutes or information that was available. It would have reduced everybody pulling out minutes, getting paper copies, something like that. But I do think more admin support for the Heads of Service would have helped a lot. 15:38

383 Q. I don't have any further questions. The Panel may have some questions for you. 15:39

CHAIR: Thank you, Ms. McMahon. Sorry, we can't release you just yet. I am going to ask Mr. Hanbury if he has some questions for you.

15:39

MRS. HELEN FORDE WAS QUESTIONED BY THE PANEL AS FOLLOWS:

384 Q. MR. HANBURY: Just a couple of questions for you. Hopefully nothing too taxing.

15:39

Notes in bin, I know this was before your time in charge. One of the problems as clinician, especially when you see complicated patients on the ward, there are huge heaps of paper notes, or at least were 10 plus years ago. Obviously ward clerks are under your supervision. So, did they have instructions to sort of weed -- not exactly weed but do something with what we call fat notes - a prescriptive term - to make them more easy and efficient to be looked at by the 15:39

clinicians looking after them in the ward?

A. Yes. Whenever -- if a patient was due to be admitted we had a standard that was if the chart was any thicker than that, then it had to be made into what would we would have called a reserve chart. That would have been done in Health Records before it actually went to the ward. So, you would have had -- and there was like a protocol of what you took out and put into the reserve and what you kept in the current chart. Then whenever the chart was on the ward, the ward clerk would have filed it up but they would have also created reserve charts. We would have training for ward clerks in how to create a reserve chart. There would have been occasions that maybe they were really, really busy or short-staffed, records would have helped in that case too. But we did have a protocol on how to create a reserve chart and staff were trained in it. 15:40 15:40 15:41

385 Q. So when Mr. O'Brien complained about that complicated patient and couldn't find anywhere to write, do you recognise that as... 15:41

A. That was before I was over the ward clerks.

386 Q. So that may have been a problem at that time.

A. Yes.

387 Q. Okay. Thank you. I think you should be congratulated on your 99.5 availability. That's a massive achievement with such a busy hospital, I have to say. The temporary notes rings a bell with working in a similar-sized hospital as Craigavon. Your description of how you make up what we call a red set or a 15:41

temporary set, obviously if you have the referral letter and some old letters on the EPR, then you can do your best, but if you haven't got the letters, on the EPR?

A. Well, if there weren't any letters, then we wouldn't have any recent history because ECR went back to back to 2013 but we were using Patient Centre to write letters prior to that, so you would have checked there to see if there was any outpatient letters. That would have been the history going back prior to 2013. It wasn't recent. 15:42

388 Q. But if there had been a problem with dictation, then that could have impacted that particular scenario, possibly?

A. Yes. 15:42

389 Q. Thank you. Was there sympathy for the surgeons digging their heels in and not doing surgeries when the full set of notes weren't available? Did you feel that was reasonable or unreasonable?

A. It depended. I think it was sometimes you sort of thought you could have seen the patient with the information that we have given you, but then there are other times, you know... It didn't happen that often but, you know, you had more of a sympathy for the patient. 15:42 15:43

390 Q. Absolutely. I was trying to draw out a distinction between seeing a patient in a clinic, and I agree with you, and doing a fairly major surgical procedure where not having one bit of information might be important.

Any other dangers of temporary sets of notes that you saw?

A. Just you have missed -- you could miss some pertinent information. Not everything on NIECR. You would have the pulmonary tests, and cardiac rehab tests. So that information would have been in the chart and not available on ECR. 15:43

391 Q. If you were thinking about a big operation on a less well person? 15:43

A. Yeah.

392 Q. Thank you. I'd say you are quite unusual for having an EPR for quite a long time actually. The interesting thing for me sort of looking down is actually if you have had an EPR for 10 years, the clinicians and you are still very reliable on the paper notes, which would sort of suggest that EPR wasn't completely relied on in a way that one might assume. Any comment on that? 15:44

A. The issue we had, because I did try to go -- our ethos in Records was let's try and go paper light; never thought we would get paperless. We had approached some consultants to say could you do your clinic without the actual hard copy notes? Some of the consultants had said yes, they could. However, the respiratory consultant said I could do without the note but I don't have the results of the pulmonary functions test and I need that. We had went to a rheumatologist and he said I could do the clinic without the notes. However, if I give an injection, I need to be able to put the 15:44 15:44

reference code somewhere, and our NIECR does not let you record any information on it. So, if we had a recording module where they could have typed in the serial number, or they could have typed in the height and weight and urine of a patient, they could have done without the paper note, but until we get in compass where you can actually record under the electronic record, we weren't in a position to go without the chart. 15:45

393 Q. Not without thinking about it. Final question from me. Mr. O'Brien's private practice was slightly unusual. What were your thoughts on him requesting Southern Trust notes to take to his house for private consultations and actually writing in them too? 15:45

A. Well, that would not be the usual practice. I could understand if he wanted to look for the private notes to get a history, but your chart was not for private patient or medico-legal recording, it was purely for the clinical work and activity within the Trust.

394 Q. Is that covered by any Trust protocol that you are familiar with? I know we talked about protocols earlier. 15:46

A. No.

395 Q. Again, were you aware of any other consultants who practised privately like that? 15:46

A. I know that there were consultants who worked privately but not aware that any of them ever actually used the notes to record anything in. They may have requested the notes for a history, but not to record.

396 Q. Thank you. That's all I have for you.

CHAIR: Thank you. Dr. Swart.

397 Q. DR. SWART: I am equally impressed that 99 point something of notes were available. I don't know of any hospital I have worked with where that's been the case. 15:46

Going back to Datix, it seems strange there was an issue that kept occurring and Datixes were recorded and yet there was an instruction to stop recording them. The purpose of Datix, as you know, is to learn. Did you go, as Head of Health Records, to any Trust-wide meetings where you talked about the value of Datix or otherwise and the learning across other departments and things of that nature. 15:47

A. No. 15:47

398 Q. Was that facilitated?

A. No. To be honest, a lot of regional meetings were stopped due to financial constraints and travel. There was a period of time where really we didn't travel at all. 15:47

399 Q. I mean, within the Trust, though. Generally there will be a Trust-wide meeting where directorates, divisions, whatever you call them, can learn from each other because it is not always immediately obvious to people what happens to a Datix, as you've described. 15:47

On the same vein, you're head of Medical Records; this generally falls under information governance in its broadest sense. Were there meetings, quarterly, twice

a year or something, where you could discuss the strategic issues around the management of records, around IG issues, where you had senior management present, for example?

A. There was an information governance meeting which was held, I think, quarterly. Then, my Assistant Director, Anita Carroll, she was present at those meetings. 15:48

400 Q. But you weren't there?

A. No.

401 Q. So you didn't have the opportunity to go to that sort of forum and talk about where you are going to go? 15:48

A. No.

402 Q. No. Okay, thank you. In a similar vein, do you think the people in senior management of the Trust actually understood the issues of Records on the ground? How much contact did you have in terms of being able to explain the reality in where you work, as we have indeed heard today? 15:48

A. I just don't think it would have been held -- it wouldn't have had the profile that meeting the targets, meeting the financial stability, having beds for patients. I think Records fell a lot lower down in the pecking order. 15:48

403 Q. You have described about, I think you called it silos - other people have used the same term - where you felt that the reporting lines were separated from each other, different levels of staff. Quite a lot of people have described an inability to challenge medical staff. Did you feel that medical staff were treated 15:49

differently from other staff with respect to discipline; disciplinary procedures, for example?

A. Well, they definitely would have been treated much different to my staff.

404 Q. How did you feel about that? 15:49

A. Well, I think it's unfair. We are all members the Trust and we are all on the payroll.

405 Q. What do you think the disadvantage is of that atmosphere in terms of patient care?

A. There is a lack of control then at the top if the consultants have one way of working but it doesn't match or marry with how the Trust wants to take forward. 15:49

406 Q. Where does that impact, do you think? Where do you think the impact is felt in the end? 15:50

A. Well, I suppose ultimately it would be with the patient.

407 Q. Another thing. There is a sense that nobody had the ability to direct Mr. O'Brien to do something completely differently. I think you have said the responsibility for that was in the medical line. Do you think there was any reason why that didn't happen from your perspective? What was your view? 15:50

A. My impression would be an unwillingness to challenge.

408 Q. Okay. Lastly, what was your sense of where you could get your direction from? You're head of a very important department, it may not have been high in the pecking order, but where did you seek your inspiration for strategic direction from if you didn't go to any of 15:51

these forums like that? Who gave you that?

A. Well, I would have talked to my Assistant Director. I would have talked to the Head of Information Governance. Any chance I had or any opportunity to talk to say somebody, say from the Royal or the City, I would have used that. 15:51

409 Q. Were there any regional meetings at all to actually talk?

A. Very few. We did have a meeting about the contract of the offsite storage. I would have known the girls there and we would have all taken the opportunity to say what are you doing, what is your problem. A more informal basis. 15:51

410 Q. Did you have any exposure about what the thinking was about the strategic direction of the Trust as a whole? 15:52

A. No.

411 Q. Were you part of that?

A. No.

412 Q. CHAIR: Just a few questions. The 13 missing are charts that were tracked out to Mr. O'Brien and it's accepted across the board that he didn't have them. How did they come to be tracked out to him? 15:52

A. It was his secretary that actually tracked those charts out to him.

413 Q. Okay. You talked about this new system of iFIT. It strikes me that while iFIT that you've described, the system that you have described which may or may not be operational soon, will be able to track a chart as it moves around the hospital premises and if it's 15:52

transported by Trust transport to SWAH, then it will be able to tracked around that facility, but it really wouldn't address the issue of charts being held at home, would it?

A. No. The only thing it would show is that it's not in --

414 Q. It went out of the building?

A. Yes.

415 Q. But it wouldn't say where?

A. No. 15:53

416 Q. All you would have, presumably, would be the last person to whom it was tracked out, in a similar way under the old system?

A. Yes.

417 Q. Just one final question just about the Trust transporting of documents. Can you offer us an explanation as to why there wasn't a transport run to the South Western Acute Hospital? 15:53

A. I would presume that they just didn't have the capacity to take on a run like that for one clinic.

418 Q. Were there other clinics from the Southern Trust that were held in SWAH?

A. No.

419 Q. Just those urology ones?

A. Yes. 15:53

CHAIR: Thank you very much, Mrs. Forde, that has been very helpful. I think we have concluded your evidence unless there is something else that you wanted to ask?

MS. McMAHON: No, I am finished.

CHAIR: Thank you, Ms. McMahon. Ladies and gentlemen, just to alert you...

MS. McMAHON: It has been confirmed that we are unable to sit tomorrow.

CHAIR: Okay. I just want to make it clear that it's due to counsel's unavailability tomorrow. We won't be sitting tomorrow and we will sit again on Thursday morning okay. Thank you. 15:54

THE INQUIRY ADJOURNED TO 10:00 A.M. ON THURSDAY 27TH APRIL 2023 15:54