



Oral Hearing

Day 58 – Tuesday, 12th September 2023

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

Held at: Bradford Court, Belfast

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I N D E XP A G E

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1 THE HEARING COMMENCED ON TUESDAY, 12TH DAY OF
2 SEPTEMBER, 2023 AS FOLLOWS:

3
4 CHAIR: Good morning everyone. Welcome back. I hope
5 everyone had a relaxing summer break and is ready for
6 lots of hard work this term. I know we are.

10:00

7 MR. WOLFE KC: Good morning everybody. And good
8 morning panel. It is, of course, great to be back.

9 Your witness this morning is Mrs. Trudy Reid. You'll
10 recall, members of the panel, that last term we were
11 engaged in what we called Module 3 which was
12 governance, governance processes in action and

10:00

13 Mrs. Reid was due to come to speak to us in June, a bit
14 of an emergency happened in a particular area of her
15 work and we're glad to see her here today. And
16 I understand she'll take the oath.

10:00

17 CHAIR: Okay. Thank you, Mr. Wolfe.

18
19 MRS. TRUDY REID, HAVING BEEN SWORN, WAS DIRECTLY
20 EXAMINED BY MR. WOLFE KC AS FOLLOWS:

10:01

21
22 MR. WOLFE KC: Good morning, Mrs. Reid.

23 A. Good morning.

24 1 Q. We're going to start this morning by looking at the
25 witness statements which you have provided to the
26 inquiry and get you to adopt those. So starting with
27 your response to - the initial response to the Section
28 21 notice. If we can bring up on the screen, please,
29 WIT-95194. The notice was March of '23 and if we go to

10:01

1 WIT-95266, you'll see your signature?

2 A. Yes.

3 2 Q. Now, you put in an addendum statement to correct
4 aspects of that but subject to that addendum statement,
5 do you wish to accept that or adopt that statement as 10:02
6 part of your evidence today?

7 A. Yes, thank you.

8 3 Q. And then the addendum which came to us on
9 8th September, WIT-100367. Okay. And this is, you
10 will recognise the addendum witness statement which 10:03
11 came in last week?

12 A. Yes.

13 4 Q. The signature page is WIT-100372. Again, would you
14 wish to adopt that statement as part of your evidence?

15 A. Yes, thank you. 10:03

16 5 Q. Now, you're currently employed as the Director of
17 Medicine and Unscheduled Care Services with the
18 Southern Trust?

19 A. Yes.

20 6 Q. And you took up that position in January of 2022? 10:03

21 A. Yes.

22 7 Q. Now, we have you here today to speak about a different
23 role, you were appointed as Acute Directorate Clinical
24 and Social Care Governance Coordinator on 4th April
25 2016; isn't that right? 10:04

26 A. Yes. And apologies, it was January '23.

27 8 Q. January '23 you took up your most recent post?

28 A. Yes.

29 9 Q. So that's the post of Director of Medicine and

1 Unscheduled Care?

2 A. That's right.

3 10 Q. Self-evidently we'll call the post that you took up in
4 2016, Governance Coordinator for short, if that makes
5 sense to you? 10:04

6 A. Yes.

7 11 Q. And your commencement in that post at that time, April
8 2016, is obviously of some significance in the
9 Inquiry's timeline, because it was after about that
10 time when the Trust began a process or we can see the 10:04
11 beginnings of a process which examined some of the
12 shortcomings which the Trust believe existed in
13 association with Mr. O'Brien's practice and that led
14 into, after the close of that year, into early 2017,
15 into an MHPS process which continued almost to the end 10:05
16 of your tenure as the Governance Coordinator. So it's
17 an important period in the interest of the Inquiry.

18

19 So let's just ask you about that role. The job
20 description that we have for the role appears to be 10:05
21 that of your successor, Patricia Kingsnorth. We don't
22 appear to have a job description --

23 A. No.

24 12 Q. -- issued to you.

25 A. No. 10:06

26 13 Q. Is that right?

27 A. That's correct.

28 14 Q. Yes. I just want to look at your successor's job
29 description briefly and you can maybe sketch in for us

1 the key components of the role that you took up in
2 April '16. So that job description is to be found at
3 WIT-92070. I should say, just before we look at this,
4 to put the other temporal pillar in place, you
5 continued in this role until January 2019; isn't that 10:06
6 right?

7 A. Yes.

8 15 Q. And you were replaced by Patricia Kingsnorth?

9 A. Yes.

10 16 Q. If we scroll down to the job summary, your 10:06
11 responsibility or at least the description of the post
12 holder's responsibility was one of driving forward and
13 coordinating all aspects of the Trust, clinical and
14 social care governance agenda within the Acute
15 Directorate. Is that, as a strapline, something you 10:07
16 recognise about the role that you were engaged in?

17 A. Yes.

18 17 Q. It goes on to talk about providing internal and
19 external directorate focus or prioritisation linking
20 implementation, review and monitoring of operation and 10:07
21 professional governance agenda for the directorate,
22 again is that -- it's a bit, I suppose, buzzwordy, but
23 is that what the job entailed?

24 A. That would be my understanding of what the job was to
25 entail. 10:08

26 18 Q. Yes. In your own words, perhaps, sketch out how you
27 envisaged the job as you applied for it and how it
28 worked out in practice, in terms of the, if you like at
29 a high level, the kinds of role you were fulfilling

1 within the Directorate?

2 A. The role was to ensure that clinical and social care
 3 governance was at the heart of what we were doing, it
 4 was part of the -- the main element of the role was to
 5 look at the governance within the Acute Directorate, 10:08
 6 identifying what needed to be done and make
 7 improvements as they -- you know, in any gaps that
 8 there were within the governance structures at the
 9 time. The post had been vacant for a number of years
 10 prior to me coming into the post and initially it was 10:09
 11 focussed on the small team that were there, were two
 12 lead nurses who focussed on the SAI process. When
 13 I took up post, I wanted to look at the entirety of
 14 clinical and social care governance from risk
 15 management, education and training, standards and 10:09
 16 guidelines, making sure they were appropriately
 17 implemented, complaints, making sure they were
 18 completed, looking at the SAI process, making sure that
 19 we had terms of reference for all of the groups that
 20 were sitting. So the entirety of the governance 10:10
 21 structure. So initially when I joined it was very
 22 focussed on the SAI process and responding to
 23 complaints.

24 19 Q. And you wanted, plainly, to broaden that out?

25 A. Yes. 10:10

26 20 Q. As we'll see as we go through your evidence in the
 27 course of today, incidents and the management of
 28 incidents, and some of those incidents would become
 29 SAIs, some of them could be dealt in other ways, some

1 of them were in the form of complaints, that was, as
 2 I would understand from your Section 21 response,
 3 really at the core of your team's workload and the most
 4 resource intensive aspect of the role?

5 A. It was. But to be proactive you need to look at all of 10:10
 6 the other elements of governance to make sure that
 7 standards and guidelines are implemented to ensure that
 8 we have robust processes to ensure that the quality and
 9 safety of the care is of the standard that we would
 10 want. The SAI process was a retrospective process 10:11
 11 looking at where an incident had happened and to
 12 identify the learning from that and then to make
 13 recommendations to mitigate it from happening again.

14 21 Q. Mm-hmm. So if you just scroll down, I want to take you
 15 to one -- if we just move to the next page, please. 10:11
 16 Under the key duties, the first key duty, perhaps,
 17 importantly, is, you were to "Take the lead within the
 18 Directorate in providing assurance to the organisation
 19 that all aspects of CSCG are of a sufficiently high
 20 standard of compliance and to ensure that the Trust 10:12
 21 CSCG systems and processes are embedded within the
 22 Directorate and they are providing timely assurance and
 23 alerts to both the service director and the
 24 organisation."

25
 26 We get a sense of how you found the ground, so to
 27 speak, within your Section 21 statement. I suspect you
 28 are going to tell us today that your ability to provide
 29 the kind of assurance that things were operating at a

1 sufficiently high standard of compliance was not,
2 despite your best efforts, was not available to you
3 because of resource issues?

4 A. Yes. I couldn't have provided an assurance in the
5 organisation that all aspects of clinical and social 10:13
6 care governance were robust within the Acute
7 Directorate. There was a very small and limited team
8 available, at times it was me and one other part-time
9 person, so things in relation to audit for assurance
10 wouldn't have been robust at the time. And there was 10:13
11 an internal audit report that highlighted that the
12 Audit Committee hadn't met for some time within the
13 Acute Directorate and then that was one of the actions
14 that I put in place to try and make the system more
15 robust and try to provide a form of assurance to the 10:13
16 Acute Director and, therefore, SLT.

17 22 Q. Yes. And we'll come to look at some of the challenges
18 that you faced, particularly around resources, IT, that
19 kind of thing, the initiatives that you did get up and
20 running and how they fared. The Audit Committee, for 10:14
21 example, you got that up and running again but it
22 collapsed at a certain point and we'll look at that.

23
24 But just to, before we move on in terms of the job
25 description, and I don't want to be a slave to the 10:14
26 document, but in terms, did you see your job as,
27 I suppose, one part ensuring that the systems and
28 structures of governance were adequate, extracting data
29 and lessons and learning and then on the other part

1 actively trying to ensure that governance had a
2 visibility within the Directorate?

3 A. Yes.

4 23 Q. Is that a reasonable description of how you saw the
5 job?

10:15

6 A. It is, when I went into the post that was what
7 I envisaged that we would do. Although lots of it was
8 very reactive in relation to reviewing incidents, the
9 SAI process, but I did work to improve the structures
10 within the system at that time.

10:15

11 24 Q. Yes. Let's just look briefly at where you were coming
12 into this post. You've set out, I think helpfully for
13 the panel, a summary of the roles that you held, if we
14 can find that at WIT-95275. You're a nurse by
15 profession?

10:15

16 A. Yes.

17 25 Q. You qualified back in September 1989. If we just
18 briefly scroll down through this, we can see that, for
19 example, you then moved into a number of management
20 roles within the Southern Trust. We can see from
21 October 2009, for a two-and-a-half-year period you were
22 head of service in general surgery. Then you
23 temporarily, for about nine months or so, held the post
24 of Assistant Director within the Surgery and Elective
25 Care Service. In terms of your qualification for the
26 role of Governance Coordinator, how would you describe
27 that? Did you feel comfortable coming into this post
28 in 2016, that you were sufficiently well equipped for
29 what was, I suppose, a middle management role

10:16

10:16

- 1 specifically focussed on governance?
- 2 A. As a nurse I've worked in multiple specialities. So
- 3 I have worked in care of the elderly, medicine, I did
- 4 my intensive care course, worked in theatres and had a
- 5 broad experience, worked in infection control in the 10:17
- 6 acute setting and in community. So I felt I had a good
- 7 clinical background. I had good relationships with the
- 8 clinicians within the Trust, with the team that I was
- 9 going to be working with. But as with any post, when
- 10 you move into a new post it's always a learning curve. 10:17
- 11 So I attended courses on the SAI process, human
- 12 factors, patient safety, read widely and tried to
- 13 develop my skills and abilities within my knowledge of
- 14 clinical and social care governance to equip me with
- 15 the necessary elements that I needed to do the job. 10:18
- 16 26 Q. I should say, scrolling down, your next post in the
- 17 list was as Head of Service within trauma and
- 18 orthopaedics?
- 19 A. Yes.
- 20 27 Q. Did those Head of Service roles, I suppose, open your 10:18
- 21 eyes to some extent to the kinds of governance issues
- 22 that might be, I suppose, problems for you or a problem
- 23 for you that you would need to solve in the coordinator
- 24 post?
- 25 A. For example, as Head of Service in trauma and 10:18
- 26 orthopaedics we would have had our various meetings
- 27 with the clinicians and the multiple disciplinary team
- 28 where we would have looked at incidents, looked at
- 29 complaints, reviewed their audit information, looked at

1 the M&M process and learning out of that and put in
 2 place actions that would be required to mitigate risk
 3 within that service. So that equipped me with the
 4 knowledge of, you know, how the meetings that we ran
 5 within the Directorate should look like in relation to 10:19
 6 governance. And that would have been a full MDT
 7 meeting where we presented -- where the clinicians
 8 would have presented cases and had discussions in
 9 relation to the governance issues within that
 10 particular service. 10:19

11 28 Q. So is it fair to say that enabled you, when you came
 12 into the coordinator's role to be in a position to ask
 13 the pertinent questions I suppose?

14 A. It did. And I think that I sort of experienced a
 15 number of various services meant that you could ask, 10:20
 16 does that feel right? You know, there was that
 17 general, clinically does that feel right? Have we
 18 asked the right questions? Have we delved deeply
 19 enough?

20 29 Q. We know that when you took up this post in 2016 it had 10:20
 21 been vacant or it had been suppressed for budgetary
 22 reasons for a number of years. You say in your
 23 statement that you didn't receive a handover as such?

24 A. No.

25 30 Q. Is it right? 10:20

26 A. That's correct. Dr. Boyce would have been supporting
 27 the Director at the time but there was no formal
 28 handover from a previous sort of full-time coordinator.

29 31 Q. Just in terms of the importance of a handover, Patricia

1 Kingsnorth, when she gave evidence she said from a
2 handover point of view, you handing over to her as you
3 were exiting you were able to give her 45 minutes of a
4 handover. First of all, are handovers important in
5 your view? And the handover that you provided for
6 Patricia Kingsnorth, was that adequate? 10:21

7 A. Handovers are important. And I think in retrospect
8 45 minutes probably wasn't enough. Although I was
9 there on the end of the phone or if she needed any
10 other guidance or support at the time. 10:21

11 32 Q. We'll come to your interaction with Dr. Boyce in a
12 moment. I just want to go back to some of your
13 experiences as Head of Service and as Assistant
14 Director for Surgery, albeit on a temporary basis. You
15 would have had some engagements with the problems of
16 urology during those postings? 10:22

17 A. Yes. Not in probably a very in-depth way. But I would
18 have been asked to support the team at different
19 occasions. And again from the evidence file there are
20 some examples of that. As a nurse I would have
21 supported the Sister within 3 South. If Martina needed
22 some assistance with that or if Martina was maybe on
23 holidays, I would have been asked to, by the Assistant
24 Director at that time to address any issues that might
25 have come up. 10:22
10:23

26 33 Q. Yes. We can see, I don't need to touch on this in any
27 great detail, but you would have appreciated, perhaps
28 like other areas within the Trust, that urology had a
29 particular issue with backlogs?

1 two processes ongoing. So the junior doctors would
2 also have looked on the computer system, which was
3 probably quicker and more alive at the time and
4 potentially transcribe the result into the notes. So
5 Jane has identified there that there were a number of
6 unsigned forms and the request was for the clinicians
7 to speak to the junior doctors to try to address and
8 review those unsigned forms.

10:26

9 36 Q. Was there any concern that these reports or results --
10 presumably results from diagnostics?

10:26

11 A. Yes.

12 37 Q. Was there any concern that lying amongst the 1,000
13 unsigned results were results that hadn't been
14 actioned?

15 A. There was that potential to be there. It was really
16 difficult to know which results were reviewed online or
17 which were -- you know, which hadn't been.

10:26

18 38 Q. I spoke a minute or two ago about, I suppose, the
19 insights that were able to gain in these roles before
20 you became Governance Coordinator and we'll look later
21 today at the work that you did around results and
22 diagnostics and your attempt to have a policy or an
23 operating procedure adopted around that and how you
24 fared with that. But is that an example, I suppose, of
25 a governance issue that caused you some trouble at the
26 coalface and you had to work up solutions?

10:27

27 A. Yes.

28 39 Q. Can you remember the outcome of this and whether it did
29 lead to any cases where results had not been actioned?

1 A. From that particular incident I can't remember.

2 40 Q. Okay.

3 A. But it was one of those ongoing issues that we needed

4 to continue to monitor.

5 41 Q. Yes. Another issue that came across your desk this 10:28

6 time, just looking at the dates when you were Head of

7 Service for Trauma and Orthopaedics, November 2015,

8 you're copied into correspondence which spoke to the

9 implementation of a process around triage, that is

10 obviously of interest to the Inquiry. Let me just open 10:28

11 that document and ask for your comments, please. It's

12 AOB-00886. If we scroll down we can see that you're in

13 the list of people who get the email below. And it is

14 Anita Carroll writing and she's explaining that some

15 areas of the service are particularly poor in triaging 10:29

16 referral letters and she's asking if it could be agreed

17 with clinicians that where referral letters are not

18 returned within a week or thereabouts - the standard

19 should be within 72 hours - that the regional booking

20 centre -- is that a referral booking centre? 10:30

21 A. Referral and booking centre.

22 42 Q.

23 "...will add patients to the waiting list with the

24 priority type dictated by the general practitioner.

25 Given that waiting lists are now much longer than they 10:30

26 were previously, this could cause problems so it is in

27 everyone's interests to try and encourage quicker turn

28 around of triage."

29

1 Is that an issue that caused you any pause to thought,
2 to think at that time or was that just, I suppose,
3 another straw in the wind coming across your desk that
4 didn't cause you to intervene?

5 A. At that stage that wouldn't have been an issue within 10:30
6 the trauma and orthopaedic service. But it was within
7 others, as we now -- as we know. The IEAP did allow
8 for urgent and red flag patients to be added to the
9 waiting list as per the GP's instructions. But we now
10 know that the patients who were added with the GP 10:31
11 criteria that weren't upgraded then did come to harm.
12 And when we look now approximately 8% of referrals are
13 upgraded across the Trust and some services have a
14 higher, such as breast and haematology, have a higher
15 increase than that, but on average about 8% of routine 10:31
16 referrals are upgraded.

17 43 Q. Yes. You appreciate, because you were the coordinator
18 on the serious adverse incident reviews that looked at
19 the case of the five patients who had not been
20 upgraded? 10:32

21 A. Yes.

22 44 Q. Or hadn't been triaged and, therefore, hadn't been
23 upgraded and were then to contact malignant disease, so
24 you appreciate that the problem with what we have in
25 front of us on the paper was that, in the absence of 10:32
26 triage, the patients were added to the waiting list in
27 accordance with the general practitioner's
28 classification?

29 A. Yes.

1 45 Q. But there was no follow-up to, in this case,
2 Mr. O'Brien, or with the urology service to ensure that
3 the triage was actually performed?
4 A. Yes.
5 46 Q. And we'll look at your role in the SAI that followed a 10:32
6 bit later today. But do you find that surprising, that
7 the Trust and those charged with supervising the need
8 for triage could have, some might say naively, failed
9 to recognise the need to push to actually get the
10 triage done? 10:33
11 A. I think, and with sort of the value of hindsight, you
12 know, efforts were made to improve the triage.
13 Patients who -- when the referral comes in you're not
14 automatically added to a waiting list. So I think this
15 was an attempt to have patients on a waiting list so 10:33
16 they didn't get lost in the system and had at least an
17 attempt to make sure they were assessed and treated.
18 But with the value of hindsight and the knowledge of
19 the amount of patients who are upgraded, it wouldn't be
20 something we would do now. 10:34
21 47 Q. Mm-hmm. Now, coming into this role then as Coordinator
22 of Governance within Acute, you, perhaps quite quickly,
23 appreciated that there were conversations ongoing about
24 the appropriate structure for Acute Directorate
25 governance and the need to resource that structure. 10:35
26 I'll show you an example, I think it's from 4th April
27 2016, perhaps the very day you started in your role.
28 If we could have up WIT-88277. As I say, I don't think
29 you're -- you're not copied into this?

1 A. No.

2 48 Q. You probably haven't yet entered your office or you are
3 just about to enter your office or maybe it's close to
4 the end of your first long day. But we can see that
5 Dr. Boyce is putting on paper a structure and we'll
6 look at the structure briefly. She says:

10:35

7
8 "It incorporates a lead nurse role into the structure
9 which I know that some of you are worried about."

10:36

10
11 She left the Band 7's role in as an option and she
12 personally doesn't think lead nurses would be able to
13 cope with the amount of governance work that needs to
14 be done on top of their other roles. She refers to an
15 "SAI investigation backlog that still needs to be
16 addressed" and "we haven't started on the implementing
17 lessons learned piece". So she's looking for
18 discussion around that. If we just scroll down and we
19 will see the structure that she is sending forward. On
20 to the next page, please. So if we could have that on
21 one page, thank you.

10:36

10:36

22
23 I suppose we don't need to look at this in slavish
24 detail, I can bring you to another proposed structure
25 from May 2018 and we'll maybe look at that in a moment
26 to see what mischief that was seeking to address. But
27 can you help us, I suppose, with this: You coming into
28 the post after the coordinator role had been suppressed
29 for a year-and-a-half for budgetary considerations,

10:37

1 what was Dr. Boyce looking to achieve in terms of
2 putting a governance resource into the Directorate and
3 what ultimately was achieved, if anything, during your
4 tenure in terms of that governance resource?

5 A. So from this Dr. Boyce was trying to improve the 10:38
6 resource within the governance team so that we could
7 address the SAI backlog, start to identify lessons
8 learned, start to implement them, make sure that
9 recommendations were followed, that we had, you know, a
10 good complaints process, learning from that audit, 10:38
11 improve the standard and guideline function, make sure
12 that there was education and training for the staff
13 within the Acute Directorate in relation to governance,
14 and that we had the appropriate information systems and
15 processes in place to identify where there were risks 10:39
16 and put plans in place to mitigate it. And to do that
17 it needed more than me and the lead nurses that were
18 there at the time. Some of it was to be embedded
19 within the divisions and a report to me as well.

20 10:39
21 The lead nurses within the divisions had a significant
22 workload and part of their role would have been
23 clinical governance. But this was to be another layer
24 on top of that to be able to provide that assurance
25 that the Director would have needed. So the Band 7s 10:39
26 then would have been there to help support the Sisters
27 and work to the lead nurses and up to the Heads of
28 Service and Assistant Director, in relation to
29 reviewing their incidents and identifying learning and

1 appropriately close off the learning from any incident
2 that there was.

3 49 Q. Yes. I suppose the last part of the question was, what
4 was achieved during your tenure in terms of trying to
5 meet, I suppose, the standard implied within this 10:40
6 document, the ideal that Dr. Boyce was pursuing?

7 A. Throughout my tenure there were a number of people. So
8 when I started first there was two lead nurses helping
9 with the SAI processes, one of those returned to their
10 original role quite quickly. The other, there was 10:40
11 requests for them to go back in May of that year, of
12 2016. However, they were able to stay on until the end
13 of 2017, with a period of unplanned leave in the
14 middle. At various occasions we had a Sister from one
15 of the wards came to assist with governance. 10:41

16 Unfortunately, she had a period of unplanned leave and
17 left quite quickly. We had two members of staff who
18 would have worked to address complaints and issues at
19 ward level or where patients phoned in to try to
20 proactively address their concerns in relation to 10:41
21 governance or the early processes of complaints. They
22 were moved into the team in July, June/July 2017. And
23 unfortunately one of them had a period of sick leave
24 and retired.

25
26 So at various stages throughout my tenure there would
27 probably be 103 weeks of unplanned leave within the
28 team and on occasions there was myself and one
29 part-time Band 7 to assist with the elements outside 10:41

1 the complaints process. The complaints team was a
 2 small team but remained largely unchanged throughout
 3 that tenure.

4 50 Q. Yes.

5 A. We did eventually, towards the end, get approval to 10:42
 6 appoint two permanent Band 7s into the process, into
 7 the team and they were recruited towards the end of my
 8 tenure into Patricia Kingsnorth's tenure.

9 51 Q. Yes. Just for your note, jumping slightly ahead on the
 10 speaking note that you have in front of you, I am sort 10:42
 11 of going between page 3 and page 8 for the moment, but
 12 you set out your staffing complement within your
 13 Section 21 statement at WIT-95197, and just as you have
 14 said just now, you had staff to cover complaints, you
 15 had staff to cover standards and guidelines, staff to 10:43
 16 cover equipment management, point of care testing and
 17 SAIs?

18 A. So from 2018 the point of care testing and equipment
 19 management person came into post.

20 52 Q. Yes. But what you have said just now, and as appears 10:43
 21 from your Section 21 response, your staffing resource
 22 was punctuated by difficulties. I think you are saying
 23 insufficient staff?

24 A. Yes.

25 53 Q. Excessive unplanned leave? 10:44
 26 A. Yes.

27 54 Q. The use of seconded staff rather than dedicated staff?

28 A. Yes.

29 55 Q. A lack of continuity, in that staff were moved at short

1 notice or unhelpfully but unavoidably moved from one
2 governance area to another?

3 A. Yes.

4 56 Q. I think it's the thrust of what you are saying, and
5 we'll look at the scale of the work in a moment, but
6 when measured against the scale of the work your
7 staffing resource wasn't sufficient?

10:44

8 A. It wasn't sufficient and it was something I escalated
9 on a number of occasions.

10 57 Q. Yes. You have said, if we go to your witness
11 statement, WIT-95252, at 7.1. I think this is perhaps
12 a helpful summary of your sense of it:

10:44

13
14 "The Acute Directorate is very busy, with significant
15 resources required for day-to-day operational
16 management of the service. There had been a focus on
17 performance and finance in recent years, however good
18 performance increases efficiency and flow of patients
19 both electively and non-electively reduced waiting
20 times and risk. There was a verbal commitment to
21 governance but operational challenges and available
22 funding limited time to proactively manage and respond
23 to governance issues."

10:45

10:45

24
25 And then you highlight what is said in a Clinical and
26 Social Care Governance Assurance Template which you
27 completed in 2018. We'll go there now. So is it fair
28 to say that, while you were receiving what you say
29 there was a verbal commitment, the actual reality on

10:46

1 the ground was that that commitment wasn't translated
2 into the number of bodies you needed to do the role
3 and, I suppose, the kind of skill sets that you needed
4 in order to achieve the kinds of proactive governance
5 that you talk about?

10:47

6 A. That's correct.

7 58 Q. The Clinical and Social Care Assurance Template,
8 governance assurance template, that was a document
9 issued by Dr. Khan in 2018; is that right?

10 A. That's correct.

10:47

11 59 Q. In his role as Medical Director at that time?

12 A. Yes.

13 60 Q. We could have a look at that now if we go to WIT-96612.
14 This is your email to Dr. Khan and Margaret Marshall
15 and forwarding the completed template. If we go down
16 to the next page, please? Can you just help us
17 orientate on where this has come from? We can see
18 along the left-hand margin - and I'll scroll down in a
19 moment after I say this - we can see that a number of
20 governance activities such as SAIs, standard and
21 guidance compliance, complaints management, clinical
22 audit are to be measured against your view of the
23 strengths, weaknesses, opportunities and threats to
24 that area, is that right?

10:48

25 A. Yes.

10:48

26 61 Q. We'll just observe that. So across the top,
27 "strengths, weaknesses, opportunities and threats"
28 against various questions. And strolling down we can
29 see "SAI investigations". Next page, please.

1 "Standard and guidance compliance", "complaints
 2 management", "clinical audit". And that's that. So if
 3 we go back to the top of the page. And obviously we
 4 don't have the time this morning to go through it
 5 exhaustively and the panel will read it. But I think 10:49
 6 you refer elsewhere in your statement, it's at
 7 WIT-95263 at paragraph 8.6, that this document
 8 illustrates the weaknesses, challenges and gaps that
 9 you faced within your Directorate?

10 A. Yes. 10:50

11 62 Q. And within your role, I suppose, specifically of
 12 governance. It is notable as against SAI
 13 investigations you haven't felt able to say anything in
 14 terms of strengths?

15 A. The challenge at the time was significant. There was a 10:50
 16 large backlog of SAI reports. They weren't able to be
 17 progressed in a timely manner. And the patient and
 18 family engagement isn't what I would have wanted for
 19 those patients and families.

20 63 Q. Yes. You point out the core weaknesses: 10:50

21
 22 "Staff do not have sufficient training to make them
 23 confident with the SAI process, particularly for chairs
 24 of SAI panels and it is difficult releasing staff to
 25 attend SAI meetings." 10:51

26
 27 That's difficult to your staff or operational staff?

28 A. Operational clinical staff.

29 64 Q. Yes. Is that then pointing in the direction then of

1 particular problems with the SAI process? Was it
2 almost facing a situation of near collapse because of
3 these problems or is that too strong?

4 A. Collapse is maybe strong but there was a significant
5 backlog of SAIs, I think at that stage probably about 10:51
6 33. The small team, myself and one other at the time,
7 it was a challenge for us to be able to support all of
8 the chairs, help draft the timelines, help with
9 drafting the reports, supporting the chairs and
10 supporting the members of the panel. And again to 10:52
11 getting the teams released to have the meetings in a
12 timely manner and support them in writing, you know,
13 finalising the reports, it was a huge challenge at the
14 time.

15 65 Q. You look at opportunities, particularly in the realm of 10:52
16 training and you talk about threats in terms of
17 resource, including clinician time. Maybe later today
18 I want to look at it in a bit more detail, at what
19 those problems actually mean, whether they were
20 resolved. But could you give us, I suppose, a snapshot 10:53
21 now? Were you able to get to grips with any of these
22 problems? I understand, for example, that you did
23 manage to develop a suite of training?

24 A. Yes. So when I started in the acute governance role
25 there had been very limited training in relation to 10:53
26 SAIs, so I sourced training from a company in England
27 to provide training and then identified a company more
28 locally to provide two-day and single day training. So
29 it was more awareness and then a more in-depth training

1 for chairs on the management of the SAI process. But
2 it was still a challenge to get chairs and other
3 members for the SAI process. Some of that was time
4 driven, they had busy clinical roles. And then there
5 were other challenges where, if there were issues, they 10:54
6 had to go to Coroner's Court, that again created a
7 challenge. And one of the elements that made them less
8 willing at times to become members of SAI panels.

9 66 Q. Let me just step out of this document a moment and
10 bring you back to the structure. I talked about two 10:54
11 structures that I'm aware of, maybe there are more,
12 that were floated by Dr. Boyce during your tenure and
13 I think this one from May 2018 endeavours to develop
14 some resource around the SAI issue in particular.
15 WIT-95323. Can you remember that? We can see along 10:54
16 the -- I think if we scroll up. I'm guessing to some
17 extent here. Scroll up first of all to see Dr. Boyce's
18 commentary. Further up please. No. Just go back then
19 to that. I think specifically -- back on to the
20 structure, yes. 10:55

21
22 So in the red boxes -- if we can have that all on the
23 screen, please? So the red boxes on the left-hand
24 side, I think that was --

25 A. Yes. 10:56

26 67 Q. The idea there was to allow some protected time for the
27 Chair of the SAI and that was directed at, I suppose,
28 the problem that you have highlighted in that template
29 to Dr. Khan, that the SAI process was struggling, at

1 least in part, because of an inability of chairs to
 2 commit the time needed to get SAIs through from start
 3 to finish in a better timeframe than was currently the
 4 case?

5 A. That's correct. What we wanted to do was have perhaps 10:56
 6 four hours of a clinician's time per week to focus on
 7 governance and SAIs and that would have meant that they
 8 had that very focussed time to review the evidence,
 9 organise, hold the meetings, and draft the reports and
 10 that, in my opinion, would have made a more robust 10:57
 11 process.

12 68 Q. If we just scroll down to 2.4, the next page down.
 13 I think that's where Dr. Boyce's commentary is hiding.
 14 As is, perhaps, captured in that third paragraph:
 15 10:57

16 "Introduction of additional posts would allow the Acute
 17 Governance Team to introduce proactive governance
 18 activities, such as governance dashboards, incident
 19 trend analysis, additional governance training and
 20 learning events to trends/patterns identified from the 10:58
 21 Trust Incident Reports."

22
 23 And then scrolling down specifically. I think just go
 24 on down. Over the page then. Yes. So on the SAI
 25 issue there was 0.5 of a governance PA was intended for 10:58
 26 10 consultants to address the problems that you were
 27 currently experiencing with the availability of
 28 consultant medical staff for SAI chairs and other
 29 governance working groups.

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During your tenure did you see any progress with these structures?

A. No. Within the structures, the only two posts that were progressed were the two Band 7 nurses for governance. The PAs for the consultants didn't materialise.

10:59

69 Q. If we go back to our template then at WIT-96613. If we move down the page then and we go to - yes, go to "Standard and Guideline Compliance", you comment that the Acute Directorate has robust processes in place in relation to standards and guidelines, and you talk about many proactive service improvement work streams being in place. But there were problems setting aside this as well and this template refers in particular to the issues around the database?

10:59

A. Yes.

70 Q. I think that is a familiar -- or it will be a recurring theme in the course of today, problems with the Datix --

11:00

A. Yes.

71 Q. -- facility as well. which we'll maybe look at later. And you also talk about the lack of a "dedicated cross divisional meeting to discuss S&G..." - and that's standards and guidelines - "...and that can lead at times to fragmentation." And you then are asking for a database which is fit for purpose and additional resource to support the standards and guidelines process. Again did any of these suggestions for

11:01

- 1 improvement come to fruition in your time?
- 2 A. No. We had one very dedicated person who managed the
3 standards and guidelines process for us at the time,
4 with some admin support, and the database remained
5 until very recently and still is functioning. It was 11:01
6 more of an Excel spreadsheet, I suppose, as opposed to
7 a database and had significant problems. It was so
8 large. So at the minute there is approximately 3,022
9 guidelines on that database of which 2,800,
10 approximately, are linked to the Acute Directorate and 11:02
11 many of those have very significant recommendations.
12 Some of them have 70, some of them have 300
13 recommendations, none of which come with funding or
14 limited within Northern Ireland.
- 15 72 Q. Yes. You alluded to, however, just now, reading 11:02
16 between the lines of your statement, you're speaking in
17 praise of the work performed by a Caroline Beattie --
- 18 A. That's right.
- 19 73 Q. -- in the area of standards and guidelines. I suppose,
20 notwithstanding the challenges that you reflect on this 11:02
21 template, I think what you are telling us in your
22 statement that, for example - and we don't need to
23 bring this up, I can simply say it, WIT-95223 - you
24 talk about the good work of establishing working
25 groups -- 11:03
- 26 A. Yes.
- 27 74 Q. -- to implement actions around standards and
28 guidelines. You talk, at paragraph 3.126 of your
29 statement, about establishing a forum encompassing lead

nurses, midwives, allied health professionals,
radiography to ensure that the actions needed to
implement standards and guidelines was shared and
embedded with frontline staff?

A. Yes.

11:03

75 Q. Were those initiatives that you took forward?

A. Yes. So whenever I went into the acute governance role
the worry was that the recommendations stopped at a
certain level and sometimes what you find within
governance is it doesn't filter down to the wards and
departments. So this was our attempt to make sure that
the lead nurses and midwives and AHPs were fully
appraised and involved in developing the actions from
the recommendations.

11:04

76 Q. One of the things I suppose you had a concern about, as
reflected in your statement at paragraph 3.96, was that
it wasn't always possible to provide assurance audit
that guidelines that I suppose had been adopted by the
Trust were actually being adequately implemented by
frontline staff?

11:04

A. So to provide assurance you need to try and develop an
audit and make sure that the audits are completed to
identify that all of the actions are taking place and
within the Acute Directorate there wasn't the resource
to be able to sufficiently do that. For some standards
and guidelines there were very robust audits but for
others there weren't.

11:05

77 Q. And we can see, if we just scroll down on this template
again to "Audit", this time I suppose in the context of

1 the clinical audit sphere, you say there were examples
2 of good audit, but in terms of weaknesses you comment
3 that:

4
5 "Engagement with the Senior Management Team and support 11:06
6 from the Medical Director for audit work to support,
7 for example, an audit conference which has recently
8 not..."

9
10 I think you maybe didn't finish that sentence. But it 11:06
11 doesn't appear to be in praise of the support or the
12 lack of support from SMT and Medical Director's office?

13 A. When I went into the role and started to review what
14 audit processes were in place I spoke to one of the
15 previous audit leads and they highlighted that they 11:06
16 didn't feel the support was there for audit. There had
17 been an audit conference within the Acute Directorate
18 previously, but they felt that the support wasn't there
19 and, therefore, the engagement -- while audit
20 continued, the engagement at that level they didn't 11:07
21 feel was sufficient for them to continue to run the
22 audit conference.

23 78 Q. Yes. You say that:

24
25 "There is a lack of administrative support or 11:07
26 administration support for all forms of audit. More
27 positively, clinical teams are still supportive of the
28 audit with additional administrative resource and it is
29 necessary to have an IT system to support audit."

1
2 I suppose this is written, I think I said early
3 in November - October 2018 - just after the last
4 meeting of the Audit Committee on 22nd September 2018,
5 just after that last meeting had happened and then, as 11:08
6 I heralded in my earlier remarks, the Audit Committee
7 collapsed, I just want to look at that briefly. You
8 appear to recognise in your witness statement the
9 importance of resources to support audit, you talk
10 about audit being the cornerstone of assurance and 11:08
11 clinical audit is a way to find out if healthcare is
12 being provided in line with standards, it's at
13 paragraph 3.129. You go on to say that, when you
14 started in your role, you recognised that there was
15 limited audit support in acute, although there had 11:08
16 previously been a strong commitment to it. Did you get
17 any understanding of why the support for audit had
18 fallen away? Or what was it that had fallen away to
19 leave audit in the poor state in which you found it?
20 A. I think at that time there seemed to be a move from 11:09
21 audit to quality improvement. I think that was sort of
22 nationally, it wasn't just locally. The resource sort
23 of followed the quality improvement lines as opposed to
24 the audit at the time. So any resource that would have
25 gone towards the teams in relation to developing and 11:09
26 recording, doing posters and presentations in relation
27 to audit seemed to disappear and be focussed towards
28 more a QI approach. And they are not mutually
29 exclusive, one feeds the other and vice versa.

1 79 Q. I was just going to ask that. Was audit not viewed or
2 how did things become so skewed that audit wasn't
3 viewed as an integral part of quality improvement?
4 A. It should be. But the resource went to focus on
5 quality improvement training, supporting the quality 11:10
6 improvement as opposed to supporting the audit element
7 of that.

8 80 Q. Now you go on to say, at paragraph 1.4 of your
9 statement, that you facilitated the development of an
10 acute Audit Committee. The first meeting got off the 11:10
11 ground on 22nd September 2017, but you say due to a
12 lack of administrative support and attendance the last
13 meeting was held on 22nd September 2018. So it lasted
14 but a short year. I suppose, first of all, what was
15 your ambition for the Audit Committee, what were you 11:11
16 seeking to achieve with its commencement?

17 A. I wanted to refocus audit, to have a process of
18 oversight of audit and that audit would be linked to
19 standards and guidelines and risk identified within
20 SAIs or complaints or incidents that we identified. So 11:11
21 in that way there would be an oversight, that the
22 recommendations would be known and actioned and that
23 the teams would have felt engaged, would have developed
24 some administrative support for them, provided some
25 form of spreadsheet or database to hold all of those 11:12
26 recommendations to ensure they were actioned.

27 81 Q. Yes. During that year did you feel the Audit Committee
28 was getting somewhere or, if we look at some of the
29 reasons why it collapsed, and you set those out in your

1 statement at 3.63, you seem to point to a lack of
2 leadership, Mrs. Gishkori was not always in attendance
3 for all or part of the meetings. There was no
4 additional admin support additional for clinicians to
5 facilitate audit. This meant that meetings were often 11:13
6 not even quorate, leading to its failure. So was it,
7 despite your efforts, not to put too fine a point on
8 it, almost born to fail?

9 A. Yes. I think if we go back to the meeting I had with
10 the audit lead previously, the support at senior level 11:13
11 was really what they wanted and the administrative
12 resource to help with the audit function, because audit
13 can be resource intensive. So without either of those
14 elements it's my understanding that that's why the
15 Audit Committee didn't continue. I think if I had been 11:13
16 in the post for longer I would have had another attempt
17 at trying to further bolster that.

18 82 Q. Mm hmm. Given its collapse and failure, what deficit
19 do you think that left residually within the systems
20 for assurance within acute governance? 11:14

21 A. Without proactive joined-up audit it could leave a
22 large gap in assurance. So not everything that we
23 would have needed to audit was audited and we wouldn't
24 necessarily have had oversight of all of the local
25 audits that were ongoing. 11:14

26 83 Q. You say, maybe bring it up on the screen, WIT-95257,
27 you said, at 7.23, that:

28
29 "The lack of Audit Committee meant that there was no

1 local acute oversight of audit activity meaning that
2 triangulation of data was challenging. This impacted
3 on the ability to identify risk and manage."

4
5 was that a message that you were able to, I suppose, 11:15
6 formulate at the time, that you recognised this at the
7 time and did you send that message, give that message
8 to anyone in authority?

9 A. I would have highlighted to Tracey and Mrs. Gishkori
10 that I felt the Audit Committee was an essential 11:15
11 element of our governance.

12 84 Q. Yes.

13 CHAIR: Mr. Wolfe, can I just check whether you are
14 planning to take a short break this morning?

15 MR. WOLFE KC: I was wondering whether to press on or 11:16
16 15 minutes.

17 CHAIR: Take the break now and come back at 25 to 12.

18 MR. WOLFE KC: Perfect.

19
20 SHORT BREAK 11:16

21
22 THE HEARING RESUMED AS FOLLOWS AFTER A SHORT BREAK:

23
24 CHAIR: Thank you everyone. Mr. Wolfe?

25 MR. WOLFE KC: Mrs. Reid, I have just spent the first 11:35
26 part of your evidence taking a snapshot at some of the
27 challenges that you faced and the issues that you faced
28 when you commenced into the role. Can I draw your
29 attention to the remarks of Dr. Charles or

1 charlie McAllister who was appointed Associate Medical
2 Director with responsibility for surgery and elective
3 care in or about the same time that you took up your
4 post. I think he sent an email on 9th May 2016, let's
5 just look at that, it's WIT-14875. If we scroll down 11:36
6 to No. 6 he highlights that:

7
8 "Within urology there are issues of competencies,
9 backlog, triaging referral letters, not writing
10 outcomes in notes, taking notes home and questions 11:36
11 being asked regarding inappropriate prioritisation on
12 to NHS of patients seen privately."

13
14 He also talks within this note of - I think if we just
15 go to the bottom perhaps - of a "significant backlog of 11:37
16 instant reports, SAIs, creating a governance risk."

17
18 And somewhere in there, sorry I can't see it, he talks
19 about "no real functioning". No. 1. There you go.
20 The top line: 11:37

21
22 "No real functioning structure for dealing with
23 governance."

24
25 Just take a moment perhaps to digest that. But he's 11:38
26 highlighting some specific issues in urology, if I can
27 ask you about that first of all. Did you have any
28 heads-up as you came into your post of particular
29 issues of a governance nature or clinical issues that

1 required a governance response within urology?

2 A. There was nothing formally handed over to me when

3 I took up post that there was anything specific that

4 needed addressed immediately.

5 85 Q. Yes. And obviously we'll come on this afternoon to 11:38

6 look at how you did become involved in some urology

7 issues. The absence of a real function structure for

8 dealing with governance, as he sets out there, and

9 delays and a backlog of incident reports is a landscape

10 that you would recognise. Would you accept the 11:39

11 characterisation that he has placed on paper here?

12 A. Yes, there were a backlog of Datix reports and SAIs at

13 the time. The meeting with Mr. Reddy, he wouldn't have

14 been just as familiar with the internal workings of

15 that. But the screening didn't routinely happen weekly 11:39

16 within surgery and elective care at the time initially.

17 86 Q. Yes. So he's describing, I suppose, a difficult

18 environment into which he is entering and it was a

19 difficult environment for you?

20 A. Going into a post where there was already a backlog of 11:39

21 SAIs and then a backlog of Datixes that needed

22 addressed meant there was SAIs that developed out of

23 that that had to be progressed as well.

24 87 Q. Yes. I want to ask you specifically about, I suppose,

25 the reporting arrangements within governance, in terms 11:40

26 of, I suppose, your relationship with Dr. Boyce and

27 Mrs. Gishkori and how that worked or, alternatively,

28 didn't work for the betterment of the governance

29 issues. You have said in your witness statement that

1 Governance Coordinators in other Directorates reported
 2 directly to the Directorate Director and it was your
 3 anticipation that that would be the same but you
 4 reported to Dr. Tracey Boyce and you have described her
 5 as being your Line Manager on behalf of Esther Gishkori 11:41
 6 who was the Director of Acute. Did you have any
 7 understanding of why that was the structural reporting
 8 arrangement?

9 A. My understanding was that in the absence of a Clinical
 10 and Social Care Governance Coordinator that Tracey 11:41
 11 helped support Debbie Burns, the previous Director with
 12 governance at that time when the post was vacant and
 13 that continued on then, wherever Mrs. Gishkori came
 14 into the post, Tracey continued to support her with
 15 governance. And then when I came into post 11:41
 16 Mrs. Gishkori asked Tracey to continue on in that role
 17 and I would report to her.

18 88 Q. Yes. Tracey Boyce, in her evidence, has spoken about
 19 the difficulties that that arrangement placed on her,
 20 she had her job as Director of Pharmacy and she has 11:42
 21 told the Inquiry that this arrangement whereby you
 22 reported to her as opposed to directly to Mrs. Gishkori
 23 arose because Mrs. Gishkori was not prepared to take
 24 back direct responsibility for the acute governance
 25 lead for your role. Is that how you understood it? 11:42

26 A. Yes.

27 89 Q. Was there a tension around that that affected working
 28 relations?

29 A. Not that was very obvious on a day-to-day sort of

1 meetings and workings. Although I do know Tracey had a
 2 large remit and I know she would have liked to have
 3 been able to hand back that responsibility and focus on
 4 her pharmacy role.

5 90 Q. Mm-hmm. From Mrs. Gishkori's perspective, she said 11:43
 6 that she had Assistant Directors as such for other
 7 aspects or other tasks, I suppose, or business areas
 8 within the Acute Directorate and, I suppose, looking
 9 into the complexity and volume of governance related
 10 issues she made it clear from the beginning, I suppose, 11:43
 11 of her tenure, in the summer of 2015, that she believed
 12 that there should be an Assistant Director for
 13 Governance, in the same way that there was for other
 14 business activities. Do you understand or sympathise,
 15 I suppose, with the view that an Assistant Director, 11:44
 16 albeit informally as opposed to a formal appointment of
 17 Dr. Boyce to that role was a helpful means to ensure
 18 that, despite the challenges within governance, there
 19 was, I suppose, that resource there, at least at the
 20 early stages of your role, to help ameliorate the kinds 11:44
 21 of difficulties that were in place?

22 A. I can see with the volume of incident complaints and
 23 SAIs, audit requirement, all the elements of
 24 governance, why you may want an Assistant Director.
 25 But on top of an already heavy portfolio, an Assistant 11:45
 26 Director wouldn't -- with that added on would have been
 27 a challenge. So you could see that you may want a
 28 focussed post, but -- and again each Director will,
 29 within their other Directorate will have their own

1 structures. However, I felt that I could have
2 supported Esther in that governance role. It was nice
3 to have Tracey initially to help support that
4 transition. But I could have continued to support her
5 in that role.

11:45

6 91 Q. So what you appear to be saying is that the creation of
7 this de facto Assistant Director's role in the shape of
8 Tracey Boyce was not entirely necessary. From your
9 perspective you needed resources elsewhere, it wasn't
10 at that interface with Mrs. Gishkori?

11:46

11 A. No, I felt I could have provided that interface as a
12 Governance Coordinator to Mrs. Gishkori. If she had
13 wanted that as an Assistant Director role that would
14 have been her prerogative within her Directorate. But
15 the team, to make governance work it needed the people
16 below that to help carry out the function of the
17 governance team.

11:46

18 92 Q. You then, as I understand it, would have met with
19 Tracey Boyce on a weekly basis. Was it on a Wednesday
20 typically? Whatever the day it was. And was that to,
21 I suppose, bring her up to speed with governance
22 developments within your remit in the week that had
23 just gone by and what lay ahead?

11:46

24 A. Yes. So it would have been to highlight any new
25 incidents, complaints, issues, concerns, if there was
26 any guidance that I needed she could have helped
27 support that so we could have brought that to
28 Mrs. Gishkori to make sure she was fully appraised of
29 any issues within the Directorate.

11:47

- 1 93 Q. Then you met with Mrs. Gishkori the next day, is that
2 right, to have a formal update with her so that she
3 could bring any issues to the centre, to the Board or
4 to the Senior Management Team or the Governance
5 Committee as part of her Director responsibilities? 11:48
- 6 A. The plan was to meet with Mrs. Gishkori on a weekly
7 basis to appraise her and update her on any issues
8 within the Directorate or if there was something urgent
9 I would have made it my place to contact her if
10 something arose. 11:48
- 11 94 Q. In terms of that relationship between you and
12 Mrs. Gishkori, was her insertion of Dr. Boyce between
13 you, creating this further level, was that a difficulty
14 for you in terms of how you practised your
15 responsibilities? Or did that work seamlessly? 11:48
- 16 A. I think reporting directly to -- would probably have
17 been more straightforward. But quite often Tracey and
18 I would have gone together to meet Mrs. Gishkori so
19 Tracey would have known what I would have known, if
20 there was anything additional that Mrs. Gishkori needed 11:49
21 to know I would have been able to add it, add in at
22 that stage. But in occasions where I couldn't have met
23 or I wasn't able to, Tracey may not have had the level
24 of detail that I would have had in relation to
25 investigations and incidents and reviews. 11:49
- 26 95 Q. In terms of Mrs. Gishkori's interest in the governance
27 agenda, in other words the issues that were churning up
28 on a weekly basis, the kinds of developments on the
29 ground, such as complaints, reports, incident reports,

1 that kind of thing, or the kind of longer term
 2 structural problems that you faced around resources,
 3 for example, were you able to capture Mrs. Gishkori's
 4 interest on those governance issues or does the
 5 insertion of an Assistant Director suggest that she was 11:50
 6 less than fully interested in the governance concerns?

7 A. When we met she showed interest. But there were
 8 papers, such as the one that you highlighted in
 9 relation to the structures, that I wouldn't have seen
 10 that Tracey would have worked on with Esther. So she 11:50
 11 appeared interested. She wasn't always able to meet.
 12 And that was a challenge at times. So having Tracey as
 13 another layer just made it another meeting that I had
 14 to facilitate on a weekly basis. Although Tracey was
 15 very, very supportive. 11:51

16 96 Q. Yes. In terms of Mrs. Gishkori's experience in
 17 governance, when asked by myself whether there was any
 18 deficit in Mrs. Gishkori's engagements with, for
 19 example, the problems within urology services,
 20 Dr. Boyce thought that there was a failure to 11:51
 21 adequately engage and she put that down to a lack of
 22 governance experience on the part of Mrs. Gishkori and
 23 she said - and this is at TRA-05849 - that she felt
 24 that Mrs. Gishkori was overwhelmed with the post of
 25 Director and that might have been due to a level of 11:52
 26 inexperience. Did you sense that her ability to work
 27 through governance issues with you was at all impacted
 28 by any noticeable lack of experience with the concerns
 29 that you were raising?

- 1 A. I think the depth of support and information that
2 I would have got from Tracey would have been more than
3 Esther. So whether it was a time element because our
4 meetings were often short and sometimes didn't happen.
5 So if I needed specific governance advice I would have 11:53
6 gone to Dr. Boyce.
- 7 97 Q. Were there, over the period of time that you worked
8 with Mrs. Gishkori, and she was in place when you
9 started, she may have gone off on sick towards the end
10 of your tenure? 11:53
- 11 A. Yes.
- 12 98 Q. But were there any key messages or key concerns that
13 you were bringing to her attention, any consistent
14 themes that you were bringing to her attention and if
15 so, what were they? 11:54
- 16 A. The resource for governance was something that
17 I frequently brought to Mrs. Gishkori. To be able to
18 fully fulfil the requirements of clinical and social
19 care governance there wasn't sufficient people in the
20 team. There were issues in relation to the IT systems 11:54
21 that we had, the ability to triangulate information,
22 delays in progressing SAI reports. Initially we didn't
23 have terms of reference for the Governance Committees.
24 There was some guidance that we needed, internal
25 guidance in relation to the management of the SAI 11:54
26 process. The lack of audit within the Directorate was
27 another issue that I would have brought to
28 Mrs. Gishkori.
- 29 99 Q. Obviously she couldn't just draw down resources

1 automatically, but can I ask you do you feel that you
 2 got a sympathetic hearing in terms of the issues that
 3 you raised and do you know whether she set out to
 4 pursue them on your behalf and on behalf of, obviously,
 5 the Directorate?

11:55

6 A. I'm aware at the time that there was significant issues
 7 in relation to finance within the Trust and savings had
 8 to be made so getting the financial resource to bolster
 9 the team may have been a challenge. And I know there
 10 were some discussions with the Director of Nursing and
 11 Older People at the time in relation to resource coming
 12 from that Directorate to help with the SAI process.

11:55

13 That offer, the people that were offered weren't able
 14 to take up the posts for a number of reasons. So
 15 I know at that stage she had attempted to get some
 16 resource then. The paper that you highlighted, that
 17 Dr. Boyce wrote, didn't go to -- well I'm not -- there
 18 is evidence that Mrs. Carroll subsequently brought that
 19 post, when Mrs. Gishkori was off, to the Chief
 20 Executive to see if we could bolster the governance
 21 team.

11:56

22 100 Q. This is the 2018 paper I showed you?

23 A. Yes.

24 101 Q. Are you suggesting that that hadn't been brought to the
 25 Chief Executive during Mrs. Gishkori's time?

11:56

26 A. I can't be sure. But I do know that Mrs. Carroll then
 27 subsequently sent the paper to the Chief Executive.

28 102 Q. Yes. You have said in your witness statement,
 29 paragraph 1.23, that, just as you have said a moment

ago, that you highlighted that the resources available to the governance team did not allow for the development of robust governance systems and processes. You go on to say, at paragraph 1.23, that:

"Limited staffing resource prevented proactive work streams to support changes required to reduce risk or monitor implementation of actions from learning."

And this risk, you say, was "consistently escalated during my tenure". Now "escalated" in what way, from you to Mrs. Gishkori

A. Yes, so I would have highlighted to Mrs. Boyce and to Mrs. Gishkori and I would have provided numbers of SAIs outstanding and the workload of the team at the time as evidence of the challenges at that time.

103 Q. Yes. When you talk about risk in this context, I suppose the risk that follows from being unable to proactively pursue governance issues, spell that out for us, what does proactivity mean in this context? Can you give us an example or two and what risk flows from the inability to pursue it?

A. So if we take some of the elements of governance. If we are looking at SAI reports, having them be able to be addressed and identify learning at an early stage and the recommendations be implemented and audited just to ensure that they were appropriately implemented is one risk. So delay in learning; delay in implementing recommendations; the inability to audit to provide

1 assurance; to ability to provide frequent and robust
 2 training to teams in how to complete a Datix
 3 appropriately; how to identify risk; how to mitigate
 4 that risk again was another challenge and would have
 5 been a risk.

11:59

6 104 Q. was it the case that, although you're talking the
 7 language of risk to Mrs. Gishkori, that while
 8 sympathetic, she didn't appear to be able to provide
 9 complete solutions, she talked about some initiatives
 10 that were tried, but did she appear to get it, that
 11 there was real risk here?

12:00

12 A. It would have been really challenging for her not to
 13 have got it because when you bring the number of
 14 outstanding SAIs, when you highlight the inability to
 15 audit to the level that we would have wanted to, it
 16 would have been really difficult for her not to have
 17 understood that risk. The challenge of providing the
 18 staff would have been a challenge from a financial
 19 perspective. But, again, how that was escalated
 20 outside and up to SLT I'm not fully aware of.

12:00

12:00

21 105 Q. Were there any solutions to the circumstances that you
 22 found yourself in as Coordinator that you thought were
 23 obvious and that could have been achieved with,
 24 perhaps, relative ease that were not pursued for any
 25 particular reason?

12:01

26 A. I think the main challenge was personnel and the
 27 ability to recruit and retain and train people. It was
 28 a significant risk and was something that -- so even if
 29 I think back to the lead nurse that we had in post to

1 start with, who was moved out of that post into another
 2 post, that person wanted to stay and could have stayed
 3 and had had significant time in the governance team.
 4 So that would have been one that could have easily been
 5 resolved. Although it would have put a challenge in 12:02
 6 another area. But I think with the backlog and the
 7 challenge within governance that was something that
 8 could have been maintained.

9 106 Q. I want to move now from that reporting structure to
 10 look briefly at the arrangements which were in place 12:02
 11 which enabled Mrs. Gishkori to connect with the various
 12 services that sat within direct -- sorry, within the
 13 Acute Directorate so that governance was, if you like,
 14 appropriately monitored and considered. Now, you said
 15 a moment or two ago that, when you came into post the 12:03
 16 terms of reference for the governance forums couldn't
 17 be found by you, perhaps they existed but they weren't
 18 readily available, is that right?

19 A. That's correct.

20 107 Q. Is that perhaps symptomatic of the lowly place to which 12:03
 21 governance arrangements within Acute had descended in
 22 the absence of a coordinator for 18 months or so?

23 A. I think not having a coordinator did impact on the
 24 ability to make sure that, you know, terms of reference
 25 and guidance and educational and all of the support 12:04
 26 that was required within the Directorate, not having
 27 that coordinator made a big impact, in my opinion.

28 108 Q. Yes. And there were two governance forums; isn't that
 29 right, within Acute

1 A. That's correct.

2 109 Q. There was the -- let me get this right. There was the
3 Acute Governance Committee?

4 A. Yes.

5 110 Q. It met on a Tuesday? 12:04

6 A. Tuesday afternoon.

7 111 Q. And Mrs. Gishkori chaired that meeting?

8 A. Yes.

9 112 Q. You were in attendance?

10 A. Yes. 12:04

11 113 Q. And her Assistant Directors were in attendance; is that
12 right?

13 A. That's correct.

14 114 Q. And then there was the similarly named but Acute
15 Clinical Governance Committee which met monthly? 12:04

16 A. Yes.

17 115 Q. And the same attendees plus medical staff, that's the
18 medical management?

19 A. Yes.

20 116 Q. You set out within your witness statement the terms of 12:05
21 reference for those committees which, I think it is the
22 same wording, that they were to develop, integrate,
23 promote and monitor all aspects of governance. So
24 could you tell me how that worked, how those committees
25 worked? Had they different functions and what was your 12:05
26 role in participating in those forums?

27 A. So in relation to my role, I would have helped develop
28 the agenda and the reports for the committees and
29 supported Dr. Boyce and Mrs. Gishkori and make sure

1 that the information that they needed was available for
2 the committees. The committees potentially could have
3 been one committee rather than two, with a collective
4 leadership model. The Friday morning committee would
5 be what I would view to be the most appropriate where 12:06
6 you have the operational management teams and the
7 medical management teams working together to ensure
8 that we had robust governance processes in place.

9 117 Q. You say you provided reports to those committees,
10 I think we have an example of a report. So that 12:06
11 I understand this, you provided the report first of all
12 to Mrs. Gishkori and then brought that into the meeting
13 then later in the week? Is it the same report?

14 A. The reports -- so whenever the reports, the agenda --
15 I would develop the agenda. So Mrs. Gishkori wouldn't 12:07
16 have specifically asked for an awful lot of information
17 to go into the agendas. I would have looked through
18 the month to see what the governance issues were at the
19 time, briefly discussed with Mrs. Boyce what needed to
20 go on to the Governance Committee and then circulated 12:07
21 the papers in advance.

22 118 Q. Yes. We can briefly scroll through. You're providing
23 the committees with a lot of information; isn't that
24 right?

25 A. That's correct. 12:07

26 119 Q. WIT-95572. So this is 10th October 2018. If we scroll
27 down then we can see -- just can we highlight that, the
28 top of it. So across quite a number of pages, and
29 maybe it's not terribly helpful to scroll down through

1 it, it's information gathered across complaints?

2 A. Yes.

3 120 Q. Ombudsman requests, major incidents?

4 A. (WITNESS NODS)

5 121 Q. Incidents awaiting review or in review per division? 12:08

6 A. Yes.

7 122 Q. An overview of the SAIs, including those in progress
8 and those awaiting screening?

9 A. (WITNESS NODS).

10 123 Q. Rejected SAIs and closed SAIs. So a lot of 12:08
11 information, patients names included, obviously blanked
12 out here, and descriptors of the issues arising. In
13 each of those meetings was it simply an opportunity to
14 take stock and say this is where we are across each of
15 the Assistant Directors and the relevant Medical 12:09
16 Managers or what were the nature of the discussions in
17 terms of active forward-looking work?

18 A. So some of the reports were to highlight where we were,
19 the number and extent of the workload that we had.
20 There would have been some specific discussions around 12:10
21 certain cases or how we could further progress the
22 workload that we had. There would have been other
23 reports in relation to patient safety audits that were
24 carried out and actions taken. We would have discussed
25 some of the standards and guidelines work that was 12:10
26 required, challenges in relation to chairs. In
27 relation to SAI reports we would have gone,
28 particularly in the Friday morning meeting with the
29 medical teams, we would have reviewed the SAI reports

1 and there would have been a challenge in relation to
 2 areas that they felt maybe could have been strengthened
 3 within those reports.

4 124 Q. Was it an opportunity for you, in either forum, to get
 5 any key governance messages across? Because, as I view 12:11
 6 this and as I view your role, and I think you have told
 7 us this in your Section 21 response, it was very much a
 8 matter for each service to look after its own
 9 day-to-day governance activity and you see, I suppose,
 10 the results of that through the complaints coming 12:11
 11 through and how they are processed, the incident
 12 reports and how they are processed but you are not
 13 actually in the service itself, you are dependent upon
 14 what's coming out in terms of reports. So in
 15 governance terms what were the messages that you were 12:11
 16 getting across at these forums?

17 A. So, for example, if we identified a problem or a trend
 18 in, for example, incidents that would have been
 19 highlighted at this forum and the work of any of the QI
 20 groups in relation to trying to address those would 12:12
 21 have been identified and discussed. Another example
 22 would be the delays in sort of diagnosis work that we
 23 looked at, the action planning to try and help mitigate
 24 those. Results sign-off was another key element that
 25 we would have discussed at those meetings, the risks of 12:12
 26 not and how we were going to progress work to improve
 27 result sign-off to give us some evidence that action
 28 was being taken and to reduce risk.

29 125 Q. As a forum, take the Friday meeting you referred to,

1 you have people attending that from a range of
 2 different services and one person's concern or area of
 3 interest or challenge may be different from that of a
 4 person from a different service within Acute, was this
 5 an appropriate way to manage governance within Acute or 12:13
 6 do you think that stepping back from it with the
 7 benefit of your experience that there were, perhaps,
 8 more sensitive tools or more effective tools that might
 9 have been used to address governance within each
 10 service? 12:14

11 A. I think the purpose of that overarching governance
 12 meeting was to share the risks of something could
 13 happen in one area, it could potentially happen in all
 14 of the areas. So, therefore, it was important that we
 15 shared the learning from complaints, incidents, SAIs, 12:14
 16 standards and guidelines were sort of spread across a
 17 number of areas. So it was a meeting where all of the
 18 senior leaders could get together to look at the
 19 overarching risks within the Directorate and feed their
 20 expertise into that. 12:14

21 126 Q. We'll come back to that point about the work within
 22 each individual service in a moment. I want to ask you
 23 some questions about how the Acute Directorate fitted
 24 into, if you like, the corporate structure from a
 25 governance perspective. The Trust had a Governance 12:15
 26 Committee, as I understand it, Mrs. Gishkori would have
 27 attended that committee?

28 A. Yes.

29 127 Q. And at a point in time Mrs. Gishkori -- or Dr. Boyce

I should say attended as well. She might well have attended wearing her pharmaceutical hat but she also attended to assist with Acute. In terms of your role as Coordinator of governance within Acute, how did you fit into the governance arrangements corporately?

12:15

A. The Assistant Director for Corporate Governance would have had a forum with the governance coordinators that we would have met to discuss issues. In relation to the Governance Committee, the papers would have come down for comment, any reports that they were sending out would have been sent down for factual accuracy checking, they would have asked for information that I would have supplied to them and then if Mrs. Gishkori had wanted anything escalated to the Governance Committee, that would have -- she would have let me know. And if there were queries or anything I needed to get to her for the Governance Committee, I would have met with her beforehand with Tracey Boyce to highlight if there was anything on the papers that she needed to be familiar with.

12:16

12:16

12:16

128 Q. Did you get a sense that, if you like, the corporate took an interest in what was happening in the satellite areas such as Acute?

A. I think there could have been a more robust view of each of the Directorates and Acute in particular because it is particularly large Directorate.

12:17

MR. WOLFE KC: Chair, do you need a break?

CHAIR: Yes, thank you. I think it might be the air conditioning, it is just caught in my throat.

SHORT BREAK

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

12:18

CHAIR: Apologies everyone. Hopefully the sweet that I am now sucking will do the trick! If I suddenly start again I'll make a sharp exit. Thank you.

MR. WOLFE KC: Okay. I was asking you, Mrs. Reid, about the relationship between the Directorate, that is the Acute Directorate and corporate governance, so the Governance Committee. You were saying that the relationship between that committee or that area of the Trust with the Acute Directorate could have been more robust when you think back on it. What do you mean by that? 12:26

A. Reflecting, I think how the Acute Directorate escalated to the Governance Committee would have been a vital link. The systems within the Southern Trust, the IT systems and all of the reporting systems and the amount of data analysts and all of those things that we had would have been a real challenge. So, therefore, the main element of escalation would have been from Mrs. Gishkori to the Governance Committee to highlight any issues or concerns that she had within her own Directorate. I think that's how the Governance Committee would have learned of issues so, therefore, that element was the vital link, that escalation. 12:27

Q. Yes. Are you suggesting that's a vulnerable link or

1 it's a vulnerable way to do business or to communicate
 2 about it issues, that it is prone to, I suppose, people
 3 not seeing the point of reporting upwards or seeing it
 4 as important or valuable enough to report upwards, is
 5 that what you are alluding to?

12:27

6 A. I think that because of the systems that we have within
 7 the Southern Trust that was probably the key element of
 8 how we would have -- how the Governance Committee would
 9 have learned of issues that were within any of the
 10 Directorates. And the Acute Directorate as one of
 11 those.

12:28

12 130 Q. And when you - I am just trying to get a better sense
 13 of your point - describe that relationship as not being
 14 sufficiently robust in one of your earlier answers?

15 A. It would have been very person dependent, so it would
 16 have been dependent on the Director escalating those
 17 issues. The corporate governance team would have been
 18 able to review complaints. There was a process where
 19 we brought in a team to look at complaint themes and
 20 trends and so the governance team, the corporate
 21 governance team would have looked at some of that and
 22 provided those reports to the Governance Committee.
 23 But if there was key significant issues within a
 24 Directorate, those would have been escalated by the
 25 Director.

12:28

12:28

12:29

26 131 Q. Can you give us an example of something you think ought
 27 to have been reported in that wasn't perhaps? Or to
 28 put it another way, can you think of examples of things
 29 that were reported in but weren't given the urgency or

1 the stress or the emphasis that you would have liked,
2 issues within the Acute that really should have been in
3 the face of the Board's Governance Committee because of
4 the lack of robustness in the communication structures
5 didn't quite get there, the message didn't quite get 12:29
6 delivered?

7 A. Even something as simple as the resource within the
8 team, I'm not quite sure how robustly that was
9 escalated within the Governance Committee because
10 that's something that they should have been appraised 12:30
11 of. If I'm thinking of some of the SAIs we had, I'm
12 not sure if some of those would have been escalated and
13 the importance of those highlighted at the time.

14 132 Q. Yes. Put it this way: Did anybody at that level come
15 directly to you to say I hear that you're the person to 12:30
16 speak to, you're on the coalface leading and
17 coordinating the governance team, I hear you have a
18 stack of problems in being proactive or doing
19 governance in the way that you think is safest, can we
20 help you, was there any conversation like that with you 12:30
21 directly?

22 A. Not in that way, not in that -- I would have again
23 highlighted at the coordinator's meeting with the AD
24 some of the challenges that there were. The 2018 paper
25 in relation to, that we discussed earlier, that was 12:31
26 sent through to Dr. Khan as the Medical Director who
27 would have been responsible for governance within the
28 Trust at that time.

29 133 Q. Yes. That's a neat join to where I want to move to.

1 we can bring it up on the screen please so that we can
2 see it, just to get the point you're making, WIT-92503,
3 this is where you talk about relationships with the
4 Medical Director's office. Let's see if I can, it
5 might be WIT- -- yes, thank you. You say:

12:32

6
7 "During my tenure it is my experience that professional
8 issues being addressed through professional lines were
9 not always known to the Acute Clinical Governance Team
10 and vice versa."

12:32

11
12 I know you have corrected the spelling of "versa" in
13 your addendum statement. You go on to say:

14
15 "The Medical Director would have had governance
16 processes such as appraisal and latterly I became aware
17 of what I now know to be maintaining high professional
18 standards process."

12:32

19
20 So I want to just better understanding what you are
21 getting at there, particularly with the first sentence.
22 It is the case that while you had some interaction with
23 the medical directors, and, for example, we saw how
24 Dr. Khan engaged you in relation to the governance
25 template earlier this morning, but it was very much a
26 limited interface is how you describe it elsewhere in
27 your statement?

12:33

28 A. Yes, that's correct.

29 134 Q. Does that suggest that standing back on this with the

1 benefit of thinking about what you now know, for
2 example, about how the Medical Director's office
3 essentially ran the MHPS process in connection with
4 Mr. O'Brien and how other matters on the professional
5 side of the line were managed, are you pointing to 12:34
6 something of an unhelpful disconnect between your
7 governance role and the governance roles and agenda of
8 the Medical Director's office?

9 A. I think they could have been more transparent. As a
10 Clinical Governance Coordinator you're in a role where 12:34
11 you see lots of confidential information, you're able
12 to maintain that confidentiality and I think having a
13 process where the issues in relation to clinicians was
14 more -- if we'd have been more aware of it it would
15 have been helpful because, therefore, when you are 12:34
16 reviewing incidents et cetera you are maybe more aware
17 to look for issues in relation to key practices or
18 clinicians that might have helped both ways.

19 135 Q. Yes. So there wasn't a forum as such for you to meet
20 the Medical Director on a regular basis? 12:35

21 A. No.

22 136 Q. And I think you pointed to some examples where you
23 might have engaged with the Medical Director but they
24 tended to be on very discrete and narrow issues as
25 opposed to giving you both the opportunity to exchange 12:35
26 more general concerns, perhaps, about governance themes
27 or clinical themes that touched upon the governance
28 arrangements?

29 A. At that time, yes, that's correct.

1 137 Q. Yes. You're now obviously working at Director level
 2 within the Trust and we have some heard evidence
 3 already about changes in terms of how governance is
 4 done?

5 A. Mh-mhh.

12:35

6 138 Q. Is that - and I call it something of a disconnect
 7 between the Medical Director's office and the
 8 Directorate governance arrangements - is that
 9 disconnect now a problem of the past or does it still
 10 exist do you think?

12:36

11 A. On a Thursday morning there is a new forum where the
 12 Medical Director's office and the Governance
 13 Coordinators, and it has now become a more extended
 14 group, meet to review the governance issues of the
 15 week. So that's a forum for the Medical Director and
 16 his team to meet with the Governance Coordinators, the
 17 Standards and Guidelines Team to review the incidents,
 18 the complaints and issues of the week across all of the
 19 Directorates. It is also a forum where the Directors
 20 are able to share their experiences. So where there are
 21 cross-Directorate issues that could impact on the other
 22 Directorates that's also highlighted at those meetings.

12:36

23 139 Q. Okay. That suggests a more integrated and joined-up
 24 way of sharing common issues?

25 A. It is. And it is a weekly meeting, it happens at 8:30
 26 on a Thursday morning.

12:37

27 140 Q. Yes. I've touched on it briefly but I want to just go
 28 back on it in a little bit more detail, I want to ask
 29 you how much oversight did you have of governance

1 activity and the application of governance standards
2 within each service within Acute?

3 A. Probably the service where I had most oversight would
4 have been medicine and unscheduled care. We had an
5 Assistant Director there who would have invited me to 12:38
6 her governance meetings and we would have provided
7 reports to those. So that was the area where probably
8 we had the most oversight.

9 141 Q. And why were they -- was this a voluntary arrangement,
10 inviting your input at that level? 12:38

11 A. Yes, yes. The other Directorates probably not as much.
12 I think reflecting on one of your previous questions as
13 to what would have made a difference more locally would
14 have been an increase in the governance team where you
15 would have had a governance person within the 12:38
16 Directorate at their meetings helping support them and
17 then feeding back out to the Acute clinical governance
18 meetings.

19 142 Q. Yes. We'll go on to look at a number of the
20 initiatives you took forward, for example around delays 12:39
21 in diagnosis and patient care and the impact of that
22 and how you filtered that down to the services. But
23 what you're telling us through your statement, for
24 example at paragraph 3.19, was that as Acute Governance
25 Director you weren't involved in the day-to-day 12:39
26 governance issues arising within, for example, urology.

27
28 "This would have been with the urology team at their
29 operational meetings. If incidents or complaints were

escalated or identified, these were taken to the screening meetings for review."

So that was essentially the way you got to learn about what was happening in a service?

12:40

A. That's correct.

143 Q. Obviously there's other methods. You had access to Datix within your team?

A. Yes.

144 Q. And Mr. Cardwell would have had full visibility, complaints would have come through your team as well?

12:40

A. Complaints Mr. Cardwell would have had full view of. Incidents he probably wouldn't because he was more focussed on the complaints element of it. When I came into post, on a daily basis we tried to scroll through all of the incidents at a very high level to see if we could identify anything that immediately sort of looked as if it was an area of concern. But on a daily basis there were multiple Datixes came in so it was a very high level view of them.

12:40

145 Q. Yes. I think it's probably important to put in context, I suppose, the scale of the work that faced your team, if we can go to your statement, WIT-95238. You set out, just going down, the significant workload faced by your small team, that's across the three and a bit years of your tenure. I think adding it up, it comes to something in the region of - I think scroll down on to the next page - I think it is 15,591 incidents reported. That's incidents going through

12:40

12:41

- 1 Datix, is that how you have achieved that?
- 2 A. Yes.
- 3 146 Q. Of which 44 over the period, I think, is the figure you
4 have given became serious adverse incident reviews; is
5 that right? 12:42
- 6 A. There would have been -- so those would have been the
7 SAIs submitted, not the SAIs in process.
- 8 147 Q. Yes.
- 9 A. And on one, in one governance report in 2018 there were
10 33 outstanding SAIs being drafted at that time. 12:42
- 11 148 Q. Yes. And a substantial number of complaints, enquiries
12 and political representative queries?
- 13 A. Yes.
- 14 149 Q. So obviously that sets the work of your small team in
15 some context. But I wonder when you look back at 12:43
16 matters and how you and your team were able to do your
17 work somewhat divorced, as you have accepted, from the
18 day-to-day governance activity within each service, is
19 there a better way of doing governance, providing that
20 superintendence, if you like, or overview from the 12:43
21 governance office within Directorate to the teams?
- 22 A. Having an adequate resource to be able to be embedded
23 in those teams, work closely with the teams on a
24 day-to-day basis and having appropriate IT systems and
25 data analytic capacity would have made a difference and 12:44
26 maybe would have identified issues quicker and allowed
27 us to address risk in a better way.
- 28 150 Q. Yes. Was there any alternative mechanism by which you
29 would get to hear of problems within a service?

1 obviously you have the complaints, incidents, SAIs, the
2 screening meetings, you have the Friday meeting at
3 which you get to see the whites of the eyes of those
4 who are on the ground within each service, but was
5 there a good level of, I suppose, informal 12:44
6 communication, did you talk to each other or was that,
7 I suppose, hampered by the stretch and pull of your
8 commitments and the smallness of the team?

9 A. So at the time when I was in Governance we were based
10 on the administrative floor which was where all of the 12:45
11 Assistant Directors and Heads of Service were based, or
12 the majority of them, so that made person-to-person
13 conversations in the corridor possible. However, the
14 small team did definitely impact on the ability to have
15 more, you know, the level of informal and formal 12:45
16 discussions that I would have liked.

17 151 Q. Obviously, where an issue of risk to patient safety
18 arises, it arises out of an operational environment and
19 you plainly are divorced from operations, but we know
20 that, in the case of Mr. O'Brien, that issues were 12:46
21 bubbling away in the background and as we saw from
22 Dr. McAllister's report in, just as you were taking up
23 your post, not sent to you, I'm not suggesting that,
24 but we know that these issues are in the background; do
25 you think in the culture of the Trust at that time that 12:46
26 enough emphasis was placed on the need to share,
27 disseminate, communicate concerns to, for example,
28 those in the governance environment who could suggest
29 perhaps, ways of dealing with these issues?

1 A. I don't think so. I think at the time it was felt that
 2 the issues could be addressed within the sort of
 3 division that they were happening in on many occasions.
 4 So things were escalated, you know, when a Datix went
 5 in or if there was a significant issue where there were 12:47
 6 poor outcomes.

7 152 Q. Some issues we will see and I'll take you to some of
 8 the incidents specifically in the course of this
 9 afternoon's evidence, some issues which on the face of
 10 it should have at least had the ceremony of a Datix, an 12:48
 11 incident report being completed, some incidents which
 12 on the face of it perhaps ought to have gone down the
 13 road of a serious adverse incident review, and I'll
 14 give you the opportunity to comment on the specific
 15 incidents this afternoon; do you, upon reflection, see 12:48
 16 any concern around the fact that each individual
 17 service had an element, perhaps a significant element
 18 of autonomy in terms of how it exercised its decision
 19 making, in, for example, how it handled issues that
 20 arose which, when you think about it now, the 12:49
 21 governance office might have taken a different view?

22 A. Yes, I think when you look at the structure that Tracey
 23 had suggested, having governance officers embedded in
 24 the Directorates that had reporting line responsibility
 25 to the Governance Coordinator might have highlighted 12:49
 26 issues earlier.

27 153 Q. We spent some time earlier this morning talking about
 28 what I think you have positioned on the centre of the
 29 stage as being the main challenge to proper governance,

1 proactive governance, and that was staffing and
2 staffing resource and the problems that came with that.
3 One of the other issues you have touched on and I'll
4 deal with in a bit more detail now was technology and
5 data management and that kind of thing. One of the 12:50
6 issues that you point up in your statement at 1.7 was
7 that the Datix system at the time was a number of
8 versions behind the other Trusts in Northern Ireland.
9 It has recently been upgraded from version 12.2 to
10 14.12/, obviously these things get improvements and 12:50
11 add-ons over the period of time. I suppose the thrust
12 of the point, ignoring the fine detail of that, is that
13 the Datix facility available to you made for
14 difficulties. The way in which, as you said earlier,
15 standards and guidance was documented made it difficult 12:51
16 for you. Could you tell us more about that, was that
17 simply again resourcing issues that you, if you like,
18 complained about but it remained unchanged?

19 A. Within the Trust the Datix system was, that we used for
20 incidents, was behind. But within Datix there is a 12:51
21 number of modules. So you have complaints, you have
22 incidents, you have litigation, and they were all on
23 slightly different systems so it made triangulating
24 that information between all of those systems a
25 challenge. The Datix system that we had at the time 12:52
26 also made it challenging to report and set up
27 dashboards for the wards, departments and the Assistant
28 Directors a challenge, so that they could see trends
29 and be able to triangulate the information between, for

1 example, the litigation, complaint and an incident.

2
3 The M&M process sat on another system. The standards
4 and guidelines was an Excel spreadsheet. The cancer
5 tracking system was another system. And the PAS system 12:52
6 that we used for recording patient appointments et
7 cetera is again an old system. So the systems didn't
8 speak to each other to allow us to triangulate that
9 information.

10 154 Q. Yes. Did you have any analytics, data analytics 12:53
11 support? I suppose you're shaking your head. No?

12 A. No. Within the team we had -- Mr. Cardwell was
13 probably our expert on the Datix system and we worked
14 together to see if we could develop some dashboards for
15 the wards and departments and ADs to see if they could 12:53
16 at least see their information on a graphical fashion.
17 Because lots of reports, as you will have seen, are
18 lines and lines and lines of information, names and
19 detail. And it's only when you get a really expert in
20 data analysts that actually the information tells you 12:53
21 the story. Because information can be presented in
22 many ways to tell different stories. So the expertise
23 of a data analyst is really important to get the actual
24 facts to the people that need them in a timely manner
25 and in a manner that actually tells a story that people 12:54
26 can identify the risks.

27 155 Q. Yes. You say in your statement, at paragraph 1.7,
28 leaving aside the Datix issues you talk about "audit
29 data and reports were mostly manually recorded"?

1 A. Yes.

2 156 Q. Ultimately it seems to come to this, you use this word
3 which we're hearing a lot about, triangulation,
4 "triangulation of risks was therefore challenging".
5 You seem to put a lot of store by the need for good
6 data access and good data analysis; why was that? why
7 is that?

12:54

8 A. Very simply, it's really challenging to identify risk
9 when you can't see it from the different systems all
10 aligned. So you may have a large amount of information 12:55
11 but to identify from one system to another to another
12 and pull that all together is really, really
13 challenging and without being able to pull the
14 information together you don't get the overall picture
15 and, therefore, you can't see the overall risk. So 12:55
16 some of the issues that had been identified, you know,
17 with good data systems may have been easier to
18 identify. But again it's as good as the information we
19 put in so, therefore, making sure that your staff have
20 the appropriate training to make sure that they know 12:55
21 how to identify risk, how to fill in an information
22 form so that you have got a clinician name to identify
23 if it's a clinician or identify if it's a specific
24 issue in relation to a medication or the sort of
25 recording of the deteriorating patient, all of that is 12:56
26 really, really vital to be able to really identify the
27 risks that we have.

12:55

12:55

12:56

28 157 Q. Do you know whether - obviously long out of the job you
29 were doing in Acute Directorate - do you know whether

1 the picture has changed markedly within the Trust or
 2 broadly in terms of its ability to access good data
 3 analysis for the purposes, as you say, of better being
 4 able to triangulate risk issues?

5 A. It is still a significant challenge. The systems 12:56
 6 haven't changed that much. If you look at the
 7 demonstrations of the new Datix system that's
 8 available, you can put everything from your incidents,
 9 complaints, litigation, safeguarding, audit,
 10 recommendations, everything can go on it and be 12:57
 11 potentially triangulated and have reports coming out of
 12 that. So we don't have the most modern version of
 13 that. In relation to audit, again we need to continue
 14 to develop a system to put our audit recommendations
 15 on. And data analysts are really challenging to employ 12:57
 16 and we have a very limited team of probably one person.
 17 And again even having IT specialists who can put
 18 applications across data to, such as one of the click
 19 applications that will pull information from one or two
 20 systems into a report that is pictorial, for example, 12:58
 21 again there is a challenge with being able to resource
 22 those people within the organisation.

23 158 Q. Yes. Just before lunch, if I could maybe take you to
 24 two initiatives that you pushed, I think I am right in
 25 saying. One was around delays in treatment and care. 12:58
 26 You say in your witness statement, by September 2016
 27 you were only in the job, I suppose, four or five
 28 months. You were working with Dr. Boyce and
 29 Mrs. Trouton in relation to delays in treatment and

1 care, and you have attached a spreadsheet to your
2 evidence to support or to illustrate, I suppose, what
3 you were doing, if I could maybe bring that up briefly,
4 WIT-95352. You touch briefly on this area in your
5 witness statement at paragraph 1.24, and I think it's 12:59
6 an area which the Inquiry is interested in.

7
8 Could you help me to better understand, I suppose, the
9 motivation for this work and what your objective was in
10 doing it? 12:59

11 A. So I would have looked at a number --

12 159 Q. Just maybe to start you. What I understand we have in
13 front of us is a series of SAI reports that have been
14 finalised or some not completely finished and you set
15 out the outcome. And then, let's go to an example down 13:00
16 at the bottom of the page, if you scroll down please.
17 Take the patient at the bottom of the page, and we
18 shouldn't say her name. It concerns an issue to do
19 with unexpected result or an unanticipated result from
20 diagnostics. The recommendation on the right-hand side 13:00
21 of the document is that -- have we lost it? So the
22 recommendation - just highlight the far right - so the
23 recommendation, I'm not sure if this recommendation
24 came from the SAI or is it something that you were
25 working on. It's to send, it's for the radiology 13:01
26 department to send electronic notification on
27 unexpected abnormal findings to the referring clinician
28 etc. Can you help us to understand what your, the
29 group that you assembled, was doing in addition to

1 these SAI outcomes?

2 A. So the report is a report from the Datix system to
3 identify any potential delays in diagnosis or
4 treatment. I can't remember exactly why I ran it at
5 the time. But it was to illustrate that there was
6 potentials there for delays in assessment, treatment
7 and care.

13:02

8 160 Q. And that's just one example, isn't it?

9 A. So that's one example of one of the Datix incidents
10 from that. Some of those were screened as SAIs, some
11 were dealt with through the operational teams
12 identifying an issue and coming up with their
13 recommendation through the Datix review system within
14 their own areas.

13:02

15
16 So when we identify that there had been a number of
17 incidents where patients potentially had delayed
18 assessment or treatment, decided to set up a group to
19 look at how we could prevent that or mitigate that
20 happening again. So we brought together administrative
21 staff and operational staff to look at the potentials
22 where this could happen. Having been a head of service
23 before and understanding the patient journey, there
24 were a number of areas where we could put reports in to
25 help identify where there had been delays in
26 identifying those. And the other element that came out
27 was the sign-off of results, so to make sure that
28 results were appropriately reviewed and signed off as
29 per the GMC recommendations.

13:02

13:03

13:03

- 1 161 Q. Yes. And so was this a case of, if you like,
 2 identifying some of the more common traps which could
 3 lead to delays in treatment and care --
- 4 A. Yes.
- 5 162 Q. -- and highlighting those for each service to enable 13:04
 6 them to get on with the business of creating solutions
 7 on the ground with their clinicians?
- 8 A. Yes.
- 9 163 Q. Is that an example of, I suppose, the kind of proactive
 10 work that you had in mind for a properly functioning 13:04
 11 governance unit?
- 12 A. It is. It was reviewing trends within the incidents
 13 and, when you identify those, it is putting action,
 14 reviewing what had happened, putting actions in place
 15 to help mitigate the risks. So that was one. There 13:04
 16 was issues in relation to insulin. And again with QI
 17 projects set up to reduce the risks of issues in
 18 relation to insulin prescribing and administration,
 19 again looking at falls. Again we looked at all of the
 20 trends in relation to falls and put QI projects in in 13:05
 21 relation to that. So there is a number of things.
 22 Absconding patients was another report that we would
 23 have run, violence and aggression. So it was to look
 24 and see different elements of the patient journey,
 25 different elements of incidents within the Datix system 13:05
 26 to develop action plans.
- 27 164 Q. Sticking with this one - just the last couple of
 28 questions before lunch - were you able to take it
 29 further or would you have liked to have taken it

1 further to work with individual services to ensure that
 2 they were actually doing the work to deliver real
 3 change or real solutions around this problem of delays
 4 in treatment?

5 A. It would have been nice once we had developed the 13:06
 6 action plan to be able to work with the teams to ensure
 7 that all the actions were put in place. The resource
 8 within the team meant, when the action plan was
 9 developed, it was handed over to the teams to implement
 10 the actions and unfortunately the resource didn't allow 13:06
 11 us to continually go back and evaluate that that was
 12 happening.

13 165 Q. Yes. Because, to take this kind of example - and
 14 I think if we were to go back into the sheet there is a
 15 second example of Patient 128, I know that was an SAI, 13:06
 16 just back into the sheet and go down a page. The
 17 reference is WIT-95353. So at the very top entry, this
 18 is a case that goes by the name of Patient 128. You
 19 can see, going to the right-hand side, and again this
 20 was a delay in treatment because there wasn't a 13:07
 21 handover between a leaving clinician at a point in time
 22 when a diagnostic report had been sought and it was the
 23 subject of an SAI. But I suppose the question, the
 24 point I was going to make to you is that there were to
 25 be further instances of delays in care because 13:08
 26 diagnostic tests, while received by the clinician - a
 27 number of them relate to Mr. O'Brien in 2020 and the
 28 2020 series of SAIs - those delays in care were still
 29 happening, is that something you recognised or were

1 able to do anything about?

2 A. So in relation to results and result sign-off, when
3 I was in post we worked with the Medical Director's
4 office to see if we could implement policy or guidance
5 in relation to electronic sign-off --

13:08

6 166 Q. Yes.

7 A. -- which would have given a level of assurance as to
8 results that were or were not signed off, the paper
9 copies, if they were received, if they got lost in the
10 post, if they got lost on the desk, were they signed
11 off, were they reviewed is a really hard process to
12 follow. So, therefore, electronic results sign-off is
13 one of the ways that we could have audited our ability
14 and escalated where results weren't signed off. The
15 NIECR system in itself is challenging to get reports
16 from. And while the Southern Trust is probably one of
17 the trusts, it is the trust that has signs of the most
18 electronic results, there is still large gaps in that,
19 some of it to do with the system itself and others to
20 do with just clinicians physically going in and hitting
21 the sign-off button.

13:09

13:09

13:09

22 167 Q. Yes. Maybe after lunch, because I don't want to
23 prolong, we'll go to the electronic sign-off work that
24 you did. Can I summarise what I think you are saying
25 is that you from a governance perspective and with the
26 limited team around you did a good deal of work around
27 identifying the pitfalls that lead to delays in
28 treatment and care, but at the end of the day it is for
29 the service itself to go the next step of putting in

13:10

1 place the solutions?

2 A. Yes. It would be nice if the team had been able to go
3 back and regularly review the recommendations and get
4 assurance that the actions were in place but the
5 resource didn't allow for that.

13:10

6 MR. WOLFE KC: Yes, okay. Sorry for overrunning.

7 CHAIR: Ten past two, Ladies and Gentlemen.

8 MR. WOLFE KC: Thank you.

9

10 LUNCHEON ADJOURNMENT

13:10

11

12 THE HEARING RESUMED AFTER THE LUNCHEON ADJOURNMENT AS
13 FOLLOWS:

14

15 CHAIR: Good afternoon everyone.

14:08

16 168 Q. MR. WOLFE KC: Good afternoon, Mrs. Reid. I want to
17 bring you to a draft guidance document which I think
18 you were responsible for developing around diagnostic
19 test and electronic sign-off and some questions arising
20 out of that. So it is WIT-95358. Just while we're
21 getting that up on the screen. There it is. What
22 prompted this area of work and what was your role in
23 taking it forward?

14:11

24 A. It was part of the delays in diagnosis work.

25 169 Q. So it came out of that work stream that we talked about
26 before lunch?

14:11

27 A. It did. And it was to try and implement guidance that
28 the clinicians could follow to help evidence sign-off
29 of results.

1 170 Q. Yes. We can see, if we just scroll down we'll touch on
2 some of the headlines in it. If we can go to page 6.1
3 in this series. So it is three pages further on.
4 There is the guidance document title page. And then,
5 if we go to 6.1 we can see that the purpose of the 14:12
6 document is set out. And you say the intention of the
7 document -- did you actually draft this or did you use
8 the services of?
9 A. So I trawled various documents from various Trusts to
10 see what was available and what other Trusts were 14:12
11 doing.
12 171 Q. Yes.
13 A. And, therefore, took another Trust document and
14 modified it so that it would work for the, potentially
15 work for the Southern Trust. 14:12
16 172 Q. Did I see in my readings was it Salisbury Trust?
17 A. Yes.
18 173 Q. Was that a precedent you picked up and worked from?
19 A. Yes.
20 174 Q. So you say: 14:12
21
22 "The intention of the document is to enable all
23 Clinical Acute Directorate Trust staff in ensuring that
24 all diagnostic tests undertaken within the organisation
25 are appropriate and managed to minimise the risk to 14:13
26 patients and to improve patient outcome and quality of
27 care."
28
29 Were you seeing within some of the incidents coming

1 through by way of report, some leading to SAIs no
2 doubt, that failing to sign-off on diagnostic tests and
3 to take the necessary next step, which might be a new
4 care pathway or whatever it might be, you saw failures
5 around that? 14:13

6 A. Yes. And obviously the potential for that to happen.
7 If we look at the email from earlier with the results
8 setting unsigned, it was the potential that this could
9 have been a more robust process for evidencing
10 sign-off. 14:13

11 175 Q. Yes.

12 A. It is not to say that it wasn't. People didn't look at
13 results. But this would have given us an assurance.

14 176 Q. Yes. The Inquiry is aware of, for example, a never
15 event took place in 2010 where the difficulty might 14:14
16 have been spotted earlier if the results of a scan had
17 been read and actioned, that was part of the
18 conversation in 2011 and you're doing this work in
19 December - or, sorry, you're doing this work in 2018 or
20 thereabouts. Had there been progress around that issue 14:14
21 of diagnostic tests and signing off on them and taking
22 the necessary actions before you took up the mantle or
23 had it, to the best of your knowledge, sat unworked
24 with, sat without progress?

25 A. There was no guidance developed. But when you look at 14:15
26 the reports sent through by BSO it did evidence that
27 there was some sign-off but it still needed some
28 improvement.

29 177 Q. Yes. So you were building into this document an

emphasis on the use of electronic sign-off as a way to audit and monitor compliance and to be able to, I suppose, identify the teams or perhaps the individuals that were not practising safely, is that...

A. That is possible within the reports you can get from BSO on sign-off on ECR.

14:15

178 Q. Yes. Just scrolling down the next page, you set out the duties resting with the Acute Directorate and you explain those. Over on to the next page, you set out the duties of the clinicians. Keep scrolling down. Then, on page 67 in this sequence, you make the point at the bottom of the page that:

14:16

"It is the responsibility of the clinician or other individual accessing a result to act on that information in an appropriate and professional manner. If the individual who accesses the result cannot take appropriate action it is important that they bring this to the attention of someone who can."

14:16

So that's a key working principle, if you like, putting an onus on the clinician who has sought the investigation to action the results. And then, at 68, over the page, you provide for audit, I think. Just scrolling down. Yes.

14:17

So this paper, you've told us in your witness statement, wasn't approved?

A. No, not before I left. And still isn't approved.

14:17

- 1 179 Q. In doing this work did you consult with other
2 interested personnel, whether on the clinical side or
3 operational teams or other governance people?
4 A. We had a working group with an operational staff and
5 clinicians. The document went to the Friday morning 14:18
6 governance meeting as well for discussion.
- 7 180 Q. Mm-hmm.
8 A. There are challenges with ECR which impact on the
9 ability to fully implement the guidance. But it was
10 progressing the journey to try to improve the sign-off. 14:18
- 11 181 Q. Mm-hmm. Amongst your working group was there any
12 discussion with the clinical side about the feasibility
13 of complying with electronic sign-off?
14 A. There was. And again the challenge of the volume of
15 results was an issue. How ECR was set up in relation 14:18
16 to you getting your own results back and identifying
17 them. Making sure that the appropriate clinics were
18 aligned and results were aligned to correct clinicians.
19 So those were the things that the team that worked with
20 the BSO were highlighting to try and amend. 14:19
- 21 182 Q. Was any issue raised with you by anybody on the
22 clinical side about the administrative time available
23 to clinicians to work with this system?
24 A. That was part of the challenge at the time. The more
25 clinicians that sign off, so if you start at junior 14:19
26 doctor at ward level and they sign off the first lot of
27 results, the ones that escalate to the consultants are
28 those that the juniors are concerned about or can only
29 be, you know, those that are left unsigned. So if you

1 implement the process early in the journey and
2 everybody signs off the results as they go, it reduces
3 the impact on the clinician.

4 183 Q. So you would contend that it is in many respects for
5 the senior clinician possibly a labour saving or a time 14:20
6 saving device if the results that come to them are
7 restricted to the most complex?

8 A. If everybody signs off it should limit. It still is an
9 administrative burden but one that, you know, the GMC
10 requires the clinicians to address and sign off and 14:20
11 action the results. Now whether that is electronic.
12 There's no specific reference that it has to be
13 electronic but it is a way that we can audit sign-off.

14 184 Q. Is it any more of an administrative burden than working
15 with the paper? 14:21

16 A. Paper can be quick, if it is sitting on your desk and
17 it is just a matter of scrolling down it can be
18 quicker. Logging in to a system, uploading the results
19 can take longer. Probably something the clinicians
20 would maybe be able to answer better than me. 14:21

21 185 Q. Yes. So what, to the best of your understanding, was
22 it that has prevented and during your time did prevent
23 this policy from being adopted, what were the arguments
24 that you were hearing against?

25 A. Some of them were technical difficulties with the NIECR 14:21
26 process to make sure the results were appropriately
27 aligned and others were time. And then I moved on and
28 potentially the impetus for moving the guidance along
29 potentially was lost.

1 186 Q. But you say it is still an area that is not the subject
 2 of policy or of a written policy?

3 A. Electronic sign-off isn't written into guidance at the
 4 moment. It's something that we are reviewing.

5 187 Q. Does that, therefore, remain an area of risk or 14:22
 6 vulnerability?

7 A. It means that we can't evidence that all of the results
 8 are signed off.

9 188 Q. Now, I want to bring you for a period of time this
 10 afternoon to the area of the serious adverse incidents, 14:22
 11 I want to engage you with a number of incidents and
 12 take your view on whether things could have been done
 13 better, whether in terms of how things were screened
 14 and sometimes not screened and whether you recognise
 15 the problems of delay, whether in screening or in 14:23
 16 bringing a SAI review to a conclusion. First of all,
 17 your statement suggests that you felt it necessary to
 18 put in place a number of, if you like, building blocks
 19 to provide a better foundation for the processing of
 20 adverse incidents than was in place when you commenced 14:23
 21 your role. I suppose by that I mean, for example, you
 22 developed internal guidance on the management of the
 23 reporting of serious adverse incidents, we'll look at
 24 that. And you also developed an action plan template
 25 and a quality improvement template, as well as engaged 14:24
 26 in training for the staff. So let's look at some of
 27 those building blocks.

28

29 Before we do, how would you describe the arena of SAIs

1 when you took up your role in 2016? We've heard about
 2 backlogs. Was it underdeveloped in terms of its, if
 3 you like, the expertise around it and the
 4 professionalism, perhaps, with which staff were unable
 5 to approach these issues?

14:24

6 A. There was a backlog and we had our lead nurses
 7 supporting the chairs and helping with drafting the
 8 SAIs. They were exceptionally hard working and made
 9 all of the efforts they could to progress the SAIs as
 10 efficiently and professionally as they could. There
 11 had been some training for the lead nurses but the
 12 level of training until the organisation in relation to
 13 SAIs I think at that stage had been limited so that was
 14 one of the things that we started to progress
 15 when I came in to the role, particularly in the Acute
 16 Directorate because it's a large Directorate with
 17 multiple incidents that needed reviewed and SAIs in
 18 progress.

14:25

14:25

19 189 Q. Mm-hmm. Lead nurses in that role, was that deliberate?
 20 Is it a particular accident of history? How did that
 21 come about?

14:25

22 A. Possibly more an accident of history. There was a
 23 reorganisation within Debbie Burns' time and two lead
 24 nurses in their roles were moved in to help the
 25 governance and the SAI process in particular.

14:26

26 190 Q. So these were Nurse Managers who --

27 A. Yes.

28 191 Q. -- were perhaps recognised as having, I suppose, the
 29 skill set and the experience, perhaps, that would lend

1 itself to contributing to an SAI process?

2 A. As lead nurses they would have reviewed incidents and
3 helped the ward Sisters and their teams to identify
4 risks and develop action plans. So it would have been
5 another step up from that to proactively support the 14:26
6 chairs and SAI.

7 192 Q. As I say, you developed in turn guidance on the
8 management and reporting of SAIs. If we could just
9 take a look at that, WIT-95417. This is, I suppose, a
10 definitional section to the guidance. You define an 14:27
11 adverse incident there on the left-hand column and you
12 say, in the last line:

13
14 "The following regional criteria will determine whether
15 or not an incident constitutes an SAI." 14:27
16

17 And the list is not exhaustive. Just perhaps an
18 obvious point to make from the definition that, in
19 order for a case to fall within the SAI process, it's
20 not necessary that the patient or the client should 14:28
21 have come to harm

22 A. No.

23 193 Q. It's 4.2.2. A risk of harm to the client or a member
24 of the public may be sufficient?

25 A. Yes. 14:28

26 194 Q. If we scroll down to the bottom of the page:

27
28 "Serious incidents of public interest or concern."
29

1 Again it doesn't have to be harm to a person. But to
2 take an example, the process may be important
3 A. Yes.
4 195 Q. And if there are any particular case, gaps in the
5 process or a failure to comply with the process or if 14:28
6 the process has a shortcoming in some shape or form
7 that might be sufficient to attract the public interest
8 reason for a SAI review?
9 A. Or risk of potential harm.
10 196 Q. Going through the document, if we just -- I'm not sure 14:29
11 if we need to go -- you create a number of pieces of
12 guidance, so, for example, how reports are to be
13 written is an aspect. Just to remind me, if you could
14 just maybe move through it slowly. Obviously the early
15 alert process and it is defined. The types of people 14:29
16 who need to be informed, the roles and responsibilities
17 of various staff. And then guidance on the support for
18 staff who are caught up in an incident. Contact
19 details. Then the role of the chairperson, who can be
20 either an internal or external independent. 14:30
21
22 One area, correct me if I am wrong, it maybe doesn't
23 seem to have been covered in any great detail within
24 the guidance is the roles and responsibilities in the
25 context of screening. I'm thinking in particular 14:31
26 whether any work was done around the application of the
27 test for an SAI, if you like, the - I hesitate to call
28 it the legal test - but the test set out and we've just
29 looked at the fact that it doesn't require actual harm;

1 do you think that those charged with screening
2 responsibilities fully appreciated the niceties of the
3 guidance around the applicable test?

4 A. They would have because most people involved in the
5 screening would have attended the SAI training. which 14:31
6 would have included the definitions of what an SAI is.
7 And again the guidance would have been shared to the
8 Operational Assistant Directors and the AMDs and CDs.

9 197 Q. Yes. And, moreover, step back from the application of
10 the screening test, do you think most of the staff, or 14:32
11 certainly let's focus, perhaps, on clinicians, do you
12 think they were well versed on the requirement to make
13 reports, to use the IR 1 into the Datix system to file
14 a report when it was appropriate to do so?

15 A. I think they would have. 14:32

16 198 Q. And where would their knowledge come from? Is that
17 something that's part of the medical training or is it
18 part of, if you like, the rollout of the expectations
19 upon you as an employee of the Trust when you come into
20 employment? 14:33

21 A. Like, in general at that level clinicians know they are
22 to report incidents. The Datix system is widely
23 available, it's on every laptop screen so anybody
24 within the organisation can report an incident. As
25 I came into the post we did more general rollout 14:33
26 training for all disciplines in relation to reporting
27 of incidents and risk.

28 199 Q. You have said in your statement that when you came into
29 post there was no central repository, if you like, or

1 filing system, in plain terms, for SAIs and the
2 recommendations that flowed from them. You saw a
3 deficit, a problem with that, why was it a problem?
4 A. For me the history of what happens, so knowing what
5 incidents we'd had in the past, knowing what the 14:34
6 recommendations were and evidencing that they were
7 implemented was important. Sometimes whenever we were
8 asked for an update on an action plan for an SAI it may
9 have been similar to an incident that had happened more
10 recently and, therefore, that history wasn't readily 14:34
11 available. So as I identified -- as we got new cases
12 we put those on to an Excel spreadsheet and then added
13 ones as we historically went back and found others.
14 200 Q. Mm-hmm. So it is about, I suppose, proper information
15 management so that the cases were visible to you? 14:34
16 A. Yes.
17 201 Q. And your team. On the issue of action plans, you
18 developed an action plan template. Why was that
19 necessary?
20 A. On occasions whenever the HSCB had asked for an update 14:35
21 on an SAI it was difficult to find the action plans and
22 action plans varied, so it seemed a reasonable thing to
23 develop a template. And then, as the recommendations
24 came through, the governance team would have populated
25 that template to make it easier for the operational 14:35
26 teams to have it accessible.
27 202 Q. Yes. So - and I'll give the Panel the references,
28 I don't think we need to look at the documents, I think
29 they are fairly straightforward. For the spreadsheet,

1 I suppose, of SAIs, it can found at WIT-95628 and the
 2 action plan template at WIT-95783. So this was a
 3 process, I suppose, of professionalising and putting
 4 the house in order in terms of good administration
 5 around SAIs. I suppose a more substantive concern and 14:36
 6 what you describe in your witness statement as your
 7 particular concern, one of the, I suppose, main
 8 learnings you take out of your role was around the
 9 timelines and there was insufficient resources to allow
 10 you or your team to provide oversight of actions. So 14:36
 11 the timelines issue was one of getting the cases
 12 screened quickly enough but once that had been done and
 13 the SAI had come out the other end, your main concern
 14 was around the follow-up, the inability, because of
 15 your resources, to provide oversight of actions? 14:37

16 A. Yes.

17 203 Q. Was that something you were able to mould the process
 18 around during your tenure or were there any solutions
 19 to be found to enable a governance input to ensure that
 20 actions were indeed followed up and implemented? 14:37

21 A. At the time the resource didn't allow for us to do
 22 that. If there were specific actions that we were
 23 asked to follow up in relation to, you know, from
 24 either Dr. Boyce or if the HSCB had asked for
 25 particular cases then we would have reviewed, gone back 14:38
 26 to the teams, asked for the updates. But it was
 27 limited in what we could achieve.

28 204 Q. We'll hear from Mr. Cardwell tomorrow and I think he
 29 has particular evidence to give around, I suppose,

1 happily, a change around that?

2 A. Yes.

3 205 Q. That happened, perhaps, relatively recently with the

4 appointment of three new staff into governance --

5 A. Yes. 14:38

6 206 Q. -- to take forward and support action planning?

7 A. That's correct. So we have appointed three new Band 5s

8 recently and their role is to help work with the

9 Operational Directorates to ensure that the

10 recommendations are implemented, but equally that there 14:38

11 is evidence that they are implemented.

12 207 Q. I suppose the third building block that, and you have

13 touched on this already in the course of your evidence,

14 was the arrangement of training for key personnel in

15 the SAI process or those who are likely to be brought 14:39

16 into the SAI process. Who did you direct that training

17 to?

18 A. It was open to all the members of staff but

19 particularly we were interested in making sure that the

20 senior members of staff within the Directorate, the 14:39

21 ADs, the AMDs, the Associate Medical Directors and the

22 Clinical Directors or anybody who wanted to Chair an

23 SAI and on occasions if we knew that we had people

24 coming up to be chairs we would have tried to

25 facilitate them on to the next available training. 14:39

26 208 Q. Yes. In terms of your role around SAIs, so we see in a

27 number of the incidents that we will look at in a

28 moment you are the governance person who forms part of

29 the four or five people who make up the SAI review

1 team?

2 A. Yes.

3 209 Q. And I think your role is given as Coordinator --

4 A. Yes.

5 210 Q. -- in the SAI review context. So what were the kinds 14:40

6 of tasks that you had to conduct in that role?

7 A. So even from the very start it would have been

8 developing timelines for the Chair so they had all the

9 necessary information in a chronological order, as to

10 sequence of events that led to a particular incident, 14:40

11 reviewing the notes, having what was available,

12 organising the meetings, addressing any queries the

13 Chair had, drafting initial drafts on occasions of the

14 SAI, making sure that it was shared with the people

15 involved so that they could comment on factual 14:40

16 accuracy. It would then have been making sure that it

17 was presented to the Friday morning governance meetings

18 so that this review of the SAI and any queries or

19 challenges that the clinicians there felt maybe hadn't

20 been addressed. And then back and then finally sharing 14:41

21 the SAI with the families.

22 211 Q. So it was really end-to-end?

23 A. It would have been.

24 212 Q. Yes. Was it inevitably you from -- directly you who

25 was the Coordinator on the SAIs during that three-year 14:41

26 period or were you able to share the burden?

27 A. So at times whenever we had some of the teams in, so

28 one of the lead nurses in particular would have been

29 the coordinator at quite a number of the SAIs. More

1 latterly probably me for the Level 3s and 2s. And then
 2 when there was me and a part-time person, she would
 3 have done some.

4 213 Q. Okay, you've put the various building blocks in place
 5 to try and improve the setting in which SAIs can be 14:42
 6 conducted. But you say in your statement that there
 7 was a real challenge quite often to get the process off
 8 the ground, for example screening meetings would be
 9 regularly cancelled, your recollection is that surgery
 10 and elective care would tend to cancel meetings more 14:42
 11 often than others and they'd have to be re-arranged.
 12 You brought this issue to Mrs. Gishkori's attention
 13 perhaps on a number of occasions, we see it on the
 14 weekly governance committee meeting agenda for November
 15 2018, no doubt there may be other examples. What was 14:43
 16 the problem there in terms of delays before you get to
 17 screening? Was it simply a case of the practicalities
 18 of bringing four or five diaries together to get an
 19 agreed date?

20 A. That would have been one of the issues. So medicine 14:43
 21 and unscheduled care would have had a routine time,
 22 date and times for theirs. Surgery and elective care
 23 initially wouldn't have been as sort of focussed on a
 24 particular day. And then the clinicians' diaries,
 25 sickness, absence, annual leave, clinical commitments, 14:43
 26 it was quite a challenge on occasions to get them all
 27 together to get a robust screening meeting.

28 214 Q. Another feature of some of the cases that we'll look at
 29 shortly is, I suppose, the delay from - let me not call

1 it a delay - the passage of time between incident and
 2 final report. Obviously you have a lot of steps in the
 3 middle, you have to assemble the material, get the
 4 timeline, get the screening done and then research,
 5 interviews, analysis, drafting, maybe multiple drafts, 14:44
 6 lots of steps till you get to the final report. Some
 7 cases have taken three years to produce an outcome,
 8 again can you, in the generality, not necessarily
 9 referring to any particular case, but what is the
 10 problem there in realising the prompt delivery of an 14:45
 11 SAI outcome?

12 A. I suppose that's one of my sort of greatest regrets,
 13 that many of the SAIs took such a long time. It was
 14 essentially resource, resource of the governance team,
 15 myself and a small team, the number of SAIs, the 14:45
 16 complexity of some of them, the timelines, then diary
 17 management, sometimes getting a Chair. So if you start
 18 from the initial, we screen, we have to decide there is
 19 an SAI, we have to decide who the panel is, who the
 20 Chair is. There were challenges in always getting 14:45
 21 chairs, particularly if there was an external Chair
 22 required. Then organising the meetings, getting the
 23 diaries aligned. If we had to interview individuals in
 24 relation to the SAI it was getting their diaries
 25 aligned as well. So steps, small steps all along the 14:46
 26 way all slipped over time and unfortunately and
 27 regrettably the SAIs took too long.

28 215 Q. Yes. I suppose more often than not you're looking to
 29 an experienced clinician to Chair an SAI?

1 A. That's correct.

2 216 Q. Perhaps a clinician with other clinical and governance
3 commitments; was that part of the problem, getting
4 clinicians, who are no doubt to be thanked for putting
5 his or her hand up to do the SAI when it is undoubtedly 14:46
6 something that they maybe wouldn't necessarily have
7 wanted to do? Is there a solution to be found? Have
8 you thought about whether there is a better way of
9 doing it, rather than calling ad hoc on clinicians out
10 of the blue, perhaps, to become involved? 14:47

11 A. So the clinicians all have very busy clinical schedules
12 and they did the SAIs within that diary commitment that
13 they had. So that is why one of the governance
14 structures looked at having some time set aside for
15 people to be -- for chairs to have that half PA a week 14:47
16 to help facilitate governance and SAIs. The other
17 element was to have professional chairs, for want of a
18 better phrase. And the Trust now does have some people
19 who Chair SAI meetings, that's their -- that's what
20 they do, they have the time and the commitment to be 14:48
21 able to do that.

22 217 Q. Because if we start with the principle that the SAI
23 review is taking place in order to provide learning and
24 an opportunity to do better in the future in respect
25 of, for example, a clinical issue or a behavioural 14:48
26 issue or a technical issue, whatever it might be, the
27 learning obviously has to take place in a considered
28 environment, you don't just rush out with the
29 conclusions right away, it has to be considered and

1 thought about. But three years down the line or
2 two years down the line is, would you agree, not much
3 benefit if there is a real problem there that needs
4 addressed?

5 A. They do need to be timely, to identify the learning in 14:49
6 a timely manner so that mitigations can be put in place
7 to reduce the risk of it happening again. So two years
8 is too long.

9 218 Q. This question might come up again in some of the
10 specific cases, but was there ever an opportunity or a 14:49
11 method by which learning could be extracted relatively
12 quickly or a change made relatively quickly and then
13 let the SAI get on with the task of taking perhaps a
14 more considered view, is that built into the Trust's
15 thinking or approaches? 14:50

16 A. There could have been rapid debriefs following an
17 incident to identify immediate learning and that did
18 happen in some services, such as obstetrics. The
19 Emergency Department would have sometimes had rapid
20 debriefs as well. So that is something that could 14:50
21 improve timeliness. Some of the more complex issues
22 where you're delving into very complex systems,
23 processes maybe take a bit longer.

24 219 Q. One thing you have done for us as part of your witness
25 statement is to provide a table setting out, I suppose, 14:50
26 the SAIs and sometime complaints that crossed your desk
27 with respect to urology. No doubt there's many others
28 in other services. But just to take a look at that
29 table, it's at WIT-100377. This is the table from your

1 addendum statement, you took an opportunity to correct
 2 your earlier table. You set out the SAI number, the
 3 relevant consultant and what it led to, an SAI review
 4 in the majority of them. We can see that Mr. O'Brien
 5 wasn't alone in being relevant to an SAI review.

14:51

6 We see Mr. Glackin named, Mr. Suresh named. I want to
 7 ask you this: You see in that table I think a total of
 8 eight SAIs relating to Mr. O'Brien and aspects of his
 9 practice; did you see in realtime that this cluster of
 10 SAIs - I know that five related to the one issue, for
 11 example - but did you see in realtime any concerns
 12 about the number of SAIs in such a short period of time
 13 particular to one consultant?

14:52

14 A. It would have been unusual to have that many for one
 15 consultant. The five at the top would have came out of
 16 one SAI where we identified an issue in relation to
 17 non-triage of referrals and tracked back to a
 18 particular week to identify that there were a number of
 19 patients hadn't been triaged and those were five of
 20 those patients.

14:53

21 220 Q. Yes. Does the existence of such a number, albeit, as
 22 you say, five came out of, if you like, the one
 23 process, does that suggest to you that the Trust ought
 24 to have taken that information and asked questions
 25 about the practice of that clinician beyond the instant
 26 SAIs and before 2020 when further concerns were
 27 investigated after they emerged in the summer of that
 28 year?

14:54

29 A. It's back to looking at trends and if you see a trend

1 where a particular incident or clinician is repeatedly
 2 coming, then it is something you need to investigate
 3 further.

4 221 Q. Yes. I mean, leaving aside the specifics of this
 5 Inquiry or the urology itself, is that problem of 14:54
 6 interrogating the data, marrying up concerns that are
 7 arising in different parts of the system, is that part
 8 and parcel of what you talked about earlier in terms of
 9 interrogating data and triangulation?

10 A. It is. It's everything from the quality of the input 14:55
 11 into the Datix system. So if you don't put a
 12 particular clinician's name, a particular nurse's name,
 13 if it is a medication, if that's not very clear, then
 14 when you go to run your reports that information is
 15 missing. If the information between the litigation 14:55
 16 system, the incident system and the complaints system
 17 isn't all talking to each other and you can't pull off
 18 one report from it, again that leads to a challenge in
 19 identifying risks within the system, whether it is
 20 process, piece of equipment, or a clinician. 14:55

21 222 Q. In Mr. O'Brien's case, I know you as the Governance
 22 Coordinator, it's important to say you don't just have
 23 these eight O'Brien SAIs and there is several others
 24 belonging to other clinicians or relating to other
 25 clinicians, you have all of the SAIs coming into your 14:56
 26 department from throughout the Acute Directorate; but
 27 it is fair to say that the operational teams, so within
 28 urology you will have the Head of Service, you will
 29 have the medical management, they should be sensitive,

1 should they not, to the fact that here is a clinician
 2 who has six SAIs relating to triage issues, another to
 3 do with the communication around and the management
 4 around a stent patient, another one to do with
 5 preoperative assessment and the problems that arose in 14:57
 6 that case. So the operational team would be better
 7 equipped to be alive to clusters of concern?

8 A. Within their own service, yes, they would be able to
 9 identify particular incidents, again whether it was a
 10 clinician or some other element of patient care. 14:57
 11 I think maybe what they might not be aware of is that
 12 something that's unusual within their area or, you
 13 know, are these numbers relevant in all specialties.

14 223 Q. Do you think the Trust continues to remain vulnerable
 15 to an inability to bring together different strands of 14:58
 16 information, some might call it intelligence, around
 17 the practitioners who may be putting patients at risk?

18 A. I think, because of the systems that we have in place
 19 at the minute, the Datix system, while it has improved,
 20 the ability to triangulate all the information is still 14:58
 21 a challenge. And again without good data analytics to
 22 help pull all the reports together, to evidence the
 23 trends, it could remain a challenge and does remain a
 24 challenge.

25 224 Q. I want to now ask you about some specific incident 14:59
 26 reporting and I apply the health warning that you may
 27 not have had direct involvement in all of these cases
 28 and I'll do my best to help you with the context.

29 A. Okay.

1 225 Q. And where you didn't have direct involvement, I suppose
2 I'm asking you questions about the practice that
3 emerges from it and whether you have comments to make.
4 And you do have what we call a patient designation
5 sheet in front of you and if I could remind you to try 14:59
6 and use the number. I will say the number to you and
7 if you try to repeat it.
8
9 So I'm talking now about a Patient 136. You refer to
10 this patient in your addendum statement. You very 15:00
11 helpfully looked at some documents in association with
12 that because it's a case, as I understand it, that
13 predated your appointment to the governance role. So
14 if we could bring up the Datix in -- sorry, start with
15 this screening sheet, it is WIT-95352. If we scroll 15:00
16 down to the bottom of the page please?
17 A. It's up. Rather than down.
18 226 Q. There it is, sorry. Do you see the case I'm referring
19 to?
20 A. Yes. 15:01
21 227 Q. So?
22 A. That's not a screening sheet, that's a report from
23 Datix that highlighted potential delays in diagnosis or
24 treatment in care.
25 228 Q. Okay. So that's the sheet we looked at this morning? 15:01
26 A. Yes.
27 229 Q. Yes. Okay. So it's a convenient starting point. So
28 if I read from the top entry:
29

1 "The patient was waitlisted for removal of a ureteric
2 stent on 17th November 2014. This request was
3 registered in the book in the Stone Treatment Centre.
4 A green booking form was also filled in at the same but
5 this was overlooked. The patient had to have the stent 15:02
6 in unnecessarily too long. He was reviewed in clinic
7 on that day..."

8
9 whatever the date was.

10
11 "...and realised that the stent was still in situ.
12 Arranged to remove the stent only today."
13

14 So that was to form part of an incident report and we
15 can see the Datix in association with that at 15:02
16 WIT-50465. The description of the incident is as
17 I have just read out. The person reporting it was
18 Mr. Suresh and if we scroll down. You have had an
19 opportunity to look at this. I think you have told us
20 in your witness statement that having considered this 15:03
21 Datix report, that that's what this document is?

22 A. Yes.

23 230 Q. It would appear to you that it wasn't screened?

24 A. Yes.

25 231 Q. We can see that if we -- scroll down please, I'll just 15:03
26 see if I can find the reference. Keep going. Yes. So
27 this was categorised as a "minor harm", it was
28 described as being "medium risk" and that's defined as
29 "expected to occur monthly". And then the "action

taken on review" is the next entry. If you just scroll down. It is described as not being an admin issue because the relevant forms had been completed. The wait is related to capacity. Then if we scroll down, it is said that the lesson learned is that:

15:05

"The issue having been discussed at a urological departmental and governance meeting, a new process was agreed that all patients that have a stent fitted need to be added to a waiting list with a planned date to come in."

15:05

So when we look at this one, it wasn't screened for SAI purposes. Do you believe it should have been screened, whether screened in or screened out, whether or not it became an SAI review it should have had a screening decision, is that fair?

15:05

A. If you're talking about the definitions of what you would screen an SAI for, yes.

232 Q. Is that the kind of case that you think ought to have had an SAI review or even an SEA?

15:06

A. It would have met the definition. But what the team appeared to have done here is looked for the early learning and implement it. They felt the early learning was and put an action in place to help prevent it happening again.

15:06

233 Q. Yes. So this was a patient who should have had his stent removed at a much earlier time. The presence of a stent, as we see from one of the next cases we're

1 going to look at, there is a significant risk of
2 infection, of sepsis with delay in removing the stent.
3 And there didn't appear to be a process in place to
4 effectively manage patients on to the waiting list with
5 a planned date. So all significant issues with a risk 15:07
6 of harm. Are you suggesting it is appropriate on
7 occasion to take the early learning, design a solution
8 and, if you like, avoid an SAI review?

9 A. The SAI review could have gone on in the background but
10 the important thing was that an early learning was 15:07
11 identified. If it had progressed to an SAI, there may
12 have been additional learning identified with an
13 external team looking at it.

14 234 Q. To what extent - and we talked about this early
15 perhaps - to what extent were you in a governance role 15:08
16 or a member of your team - and I recognise this
17 particular incident was before your time - to what
18 extent were you able to, if you like, police the
19 decision making, if a screening meeting had happened,
20 to ensure that the, if you like, the appropriate 15:08
21 standards were applied to decision making?

22 A. I would have challenged, you know if I thought
23 something clearly met the definition of an SAI I would
24 have challenged, and if I was particularly concerned
25 I would have highlighted at a meeting with Dr. Boyce or 15:08
26 Mrs. Gishkori if there was something that
27 I particularly felt very strongly about. In relation
28 to this one, looking at this in retrospect, the waiting
29 lists at the time were long. And again it looks as if,

1 this looks as if it is a capacity issue which an SAI
 2 may not have been able to resolve because the
 3 willingness at the time, even with waiting list
 4 management, remained a huge challenge.

5 235 Q. Of course. But these patients with stents in place -- 15:09

6 A. Mm-hmm.

7 236 Q. - need to be managed --

8 A. They do.

9 237 Q. -- in an orderly fashion?

10 A. They do. 15:09

11 238 Q. It appears that this was recognised, at least in part,
 12 by the urology processes that looked at it suggesting
 13 the need for a planned date?

14 A. That's correct.

15 239 Q. The next case that I want to look at is that of Patient 15:09
 16 16. Again that is another stent case. It comes with a
 17 background of, I suppose, greater complication than we
 18 are or were aware with the first case that we looked
 19 at. You were the coordinator on the SAI review that
 20 engaged with Patient 16's case? 15:10

21 A. Yes.

22 240 Q. That was an incident that came in initially as a
 23 complaint and it was directed -- you directed it to
 24 Dr. Boyce after Mr. Cardwell referred it to you and it
 25 was converted into a case for consideration for SAI. 15:10
 26 Now, we think from the paperwork - if we bring up
 27 WIT-95488. would you describe this as a screening
 28 form?

29 A. A screening form.

- 1 241 Q. Yes. It appears from the date at the bottom of the
2 page that it may have been screened on 5th April 2017.
3 Is that relatively quick or efficient for a screening
4 decision, in your experience?
- 5 A. No, you would want your -- your incidents should be 15:11
6 screened quickly so you can identify do they need an
7 SAI, what the early learning is. Because sometimes
8 even at the screening meeting you can identify some of
9 the learning that the teams can start to put in place
10 and then be able to progress to an SAI in a timely 15:12
11 manner to identify the full learning.
- 12 242 Q. Obviously these early months of 2017 had another
13 process relating to the work of Mr. O'Brien being
14 undertaken and we'll ask you in a moment about your
15 first knowledge of that. But you would have liked this 15:12
16 matter screened earlier than April; can you remember
17 any specific reasons why it wasn't screened earlier?
18 One might make the argument that given that all that
19 was going on around Mr. O'Brien's practice at that time
20 and the scrutiny that it was subjected to and the 15:13
21 commencement of MHPS and all of that, that there might
22 have been a greater urgency in looking at this
23 potential SAI?
- 24 A. I think, in general, from a governance team perspective
25 it was very busy. We were looking at the other cases 15:13
26 and from a screening perspective, I have to go back and
27 check, but there may have been delays in actually the
28 screening meetings happening as well. So the case
29 would have been come in, we would have done a timeline

1 and brought it to the screening meetings. And if you
 2 scroll down, it might be on that, if there was multiple
 3 screening meetings, or it may not.

4 243 Q. I don't think there is any other dates on this.
 5 A. Okay. 15:13

6 244 Q. There is some suggestion on the papers that there might
 7 have been a further meeting in July. But certainly the
 8 record here that we see in front of us is that:
 9

10 "The review team considered there was sufficient 15:14
 11 failings in systems and processes, including
 12 communication, within Urology Department to require an
 13 SAI review. "
 14

15 And that was in the context that we see with the brief 15:14
 16 summary of the incident that this was a case of a
 17 cancer patient who had received radiotherapy and was
 18 ready by, I think, December 2015 to have his ureteric
 19 stents replaced, but weren't replaced then until June
 20 2016. Obviously we have more material to understand 15:14
 21 the background to this case than the one I earlier drew
 22 your attention to. But are you reinforced in your
 23 view, perhaps, that the first case that I drew your
 24 attention to should also have been screened in for a
 25 SAI review, notwithstanding the suggestion of a 15:15
 26 solution which was talked about within the governance
 27 team?

28 A. It does, because the more you screen and the more
 29 in-depth view you have of your systems and processes

1 means you can identify earlier where you can put into
2 place an action that might prevent a similar incident
3 happening.

4 245 Q. Yes. We know that the final report for this incident
5 then from, I suppose, a standing start following 15:16
6 screening in April '17, the final report didn't issue
7 until 27th January 2020. If we bring up PAT-000100.
8 And date report signed off 27th January 2020. Was
9 there anything about the subject matter of this case
10 that justified in essence a three-year process? 15:16

11 A. No.

12 246 Q. Was it forgotten about or was there simply...

13 A. No, this case ran alongside the other cases with the
14 five patients with the SAI chaired by the same external
15 Chair. 15:17

16 247 Q. Dr. Johnston. And what do you put the -- what
17 explanation do you put around the three-year delay?

18 A. Lots of small to medium delays in organising meetings,
19 organising interviews, writing reports, getting the
20 right people in the room together to finalise the 15:17
21 report.

22 248 Q. The recommendations that came with this report we can
23 see at PAT-000116. If we can just scroll down to No.
24 6. No. 6 refers to:

25 15:18
26 "The Trust, with the HSCB, must implement a waiting
27 list management plan to reduce urology waiting lists."

28
29 We saw with the first case, Patient 136, that there was

1 something of that in the decision of the urology
2 governance team, they talked about developing a
3 specific return date or waiting list date for the
4 patient to come back in and yet Patient 16's case
5 happening a year or so after Patient 136's case, not -- 15:18
6 well, I was going to ask you are you aware of whether
7 anything had changed in the management of stent cases
8 or is the answer it wouldn't appear that very much had
9 changed?

10 A. I wouldn't have been sort of privy to the changes on 15:19
11 the -- you know, the addition to the waiting list, had
12 they a date on for this patient. There was multiple
13 communications back and forward between various teams
14 and missed opportunities in relation to administrative
15 processes in this patient. And the waiting lists were 15:19
16 still long at that time.

17 249 Q. Yes. But I suppose the point I'm making is that,
18 Patient 136, urology had looked at that one in 2015?

19 A. Yes.

20 250 Q. Came up with a view as to how stent patients should be 15:20
21 managed. Patient 16 is mismanaged in relation to his
22 stent?

23 A. Yes.

24 251 Q. And then three years after that you and your colleagues 15:20
25 are writing an SAI outcome which is still talking about
26 essentially the same thing, managing stent patients so
27 that they don't come to harm. Plainly the solutions
28 for these kinds of things belong to the service and the
29 ability of the service to escalate those issues up to,

perhaps, the top table, but do you recognise the difficulty here that actions were not being implemented or it would appear that actions are not being implemented to reduce the risk?

A. It would appear that similar things happened to these two patients and, therefore, the recommendations of the first may not have been implemented to prevent the second happening. 15:21

252 Q. Could I bring you to Patient 102. This would appear to be a case where again there was a failure to screen for SAI. If we go to WIT-100357. This is a Datix raised by or an incident report form raised by, I believe it was Mr. Haynes. If we scroll down. Yes. It says that the patient was discussed at a urology MDM on 20th November 2014. The recorded outcome was: 15:21

"A restaging MRI scan has shown organ confined prostate cancer. For direct referral to radical radiotherapy and then for out-patient review with Mr. O'Brien. Was reviewed by Mr. O'Brien in out-patients on 28th November 2014. No correspondence created from this appointment. A referral letter received from the GP nearly a year later stated that the patient had not received any appointments from oncology." 15:22

Now, I know that Mr. O'Brien's view is that the referral did go or should have gone via the CaPPS system, but leaving that to one side, we can see in this form an issue which -- it was being suggested the 15:23

issue was that the patient hadn't been referred for radiotherapy. If we scroll down to WIT-100364, just at the bottom of the -- sorry, the top of the page, I beg your pardon.

So, we will hear more specifically from Mr. Cardwell who has specific knowledge of this case, but I am seeking your input on it. I'm not sure you were directly involved with it. It appears that consideration was given to whether the investigation and the screening decision had to take place within the remit of functional services. You can see that Helen Forde has -- sorry, the entry for the 18th November, it records:

"The feedback is, Martina..."

That is the Head of Service in urology, Martina Corrigan.

"...I have taken this back to SEC..."

That's her service or part of where your her resides

A. Yes.

253 Q.

"...as it appears no dictation was done. Will need to review by yourself and governance will support if needed."

1 So the message in essence is this isn't anything --
2 this isn't a problem with typing, it's a problem with
3 the clinician and so it's over to Martina Corrigan to
4 deal with it with the urologist.

5
6 At the bottom of the next page then it says, this is a
7 feedback message back from David Cardwell. He says:

8
9 "I think it should go to Martina Corrigan as it says
10 there was no correspondence for the appointment, so it 15:25
11 wasn't that the secretary didn't type it. I think it
12 was that it wasn't dictated so that would need to go to
13 the Head of Service Urology to discuss with the
14 consultant."

15
16 And scrolling up the page I think there might be... 15:26
17 I think there is a reminder on the 23rd March -- sorry,
18 22nd March. The plain position is that the Trust
19 accept that this case wasn't screened. Martina
20 Corrigan's evidence to the Inquiry has been that she 15:27
21 knows that she never discussed it. And the reason she
22 didn't discuss it was because there was another ongoing
23 process at that time or the beginnings of an ongoing
24 process and she was seeking advice. This Datix form
25 doesn't contain any explanation as to whether screening 15:27
26 took place or why it didn't. But we can see if we go
27 to WIT-100360, at the top of the page, that essentially
28 the incident was closed on 17th June 2016. And we'll
29 obviously hear from Mr. Cardwell as to why he felt able

1 to close it.

2
3 would you accept that an incident such as this - and
4 I didn't bring you to the entry which suggests that the
5 incident was categorised as "major" - that it should 15:28
6 have been screened in for an SAI?

7 A. Yes, it should have been screened in for an SAI. It
8 would have met the definition to be screened to
9 identify learning.

10 254 Q. Would you agree that this Datix form should have been 15:28
11 populated with some explanation as to why it wasn't
12 screened or it should be documented elsewhere?

13 A. It should be -- if it wasn't screened it wouldn't be
14 documented within the screening form. So there should
15 have been something to indicate why it was closed. 15:28

16 255 Q. From a governance perspective was there anything in
17 place that would have ensured that cases such as this
18 were appropriately screened?

19 A. The cases like that should have been escalated from the
20 operational teams up into the governance team or -- and 15:29
21 I see some of the governance teams look as if they have
22 been involved in it. So again we would have brought
23 things to the screening meetings that, you know, looked
24 unusual and had a discussion to see did it need to be
25 progressed further. 15:29

26 256 Q. It's a little unfair to task you with these questions
27 in the absence of direct knowledge, but can you see the
28 problem, a major incident, not screened, and it would
29 appear no mechanism by which the operational team were

1 challenged to explain why it wasn't screened? Was it
2 possible in the environment in which you worked for
3 incidents such as this to either be shuffled away by
4 the operational team if it was, for example, too
5 inconvenient or simply, to take a more benign view of 15:30
6 it, forgotten about?

7 A. It would have been with the volume of Datixes that came
8 through, sometimes with the quality of information on
9 them, if they weren't escalated then there was a chance
10 that they wouldn't have been screened, as in this case. 15:31

11 257 Q. Could we turn to the case of Patient 137. This was
12 another case where the recommendation of the
13 multidisciplinary meeting in urology had not been
14 actioned, the practitioner concerned was Mr. Young,
15 Mr. Michael Young and it was noted by you in the table 15:31
16 that we looked at a few moments ago, indeed you were
17 the facilitator, I think I called it coordinator
18 earlier, but you were the facilitator for this matter.
19 If we look at the Datix that was raised, WIT-100386, if
20 we scroll down. It records that the patient was 15:32
21 discussed at the multidisciplinary meeting 12th January
22 2017.

23
24 "The outcome was that the patient was to be referred to
25 an endocrine MDM. Unfortunately this did not happen. 15:32
26 A further GP referral came in five months later,
27 12th May 2017, and brought this to Mr. Haynes'
28 attention, my attention, and a referral has now been
29 done. "

1
2 Now, if we go then to the incident checklist at
3 WIT-100393, again the incident is summarised, the key
4 point was that the referral wasn't made and the
5 situation was only recovered by the GP's intervention. 15:33
6 Scroll down please. Plainly there were a number of
7 discussions which you would have been party to,
8 I assume. It said that, if we look at 21st September
9 2017, it records that:

10
11 "The patient has been reviewed by the endocrine team
12 and is for discussion with radiology but likely outcome
13 will be ongoing surveillance."

14
15 So although there was this five-month delay in the 15:34
16 referral, it would appear that the patient hadn't come
17 to harm. So it says:

18
19 "Discussions concluded that while this is not an SAI
20 there is learning regarding the processes in MDM. This 15:34
21 incident is to be shared with Mr. Glackin, Chair of the
22 MDM for discussion regarding current processes."

23
24 Again, on 20th October 2017, outcome discussed at
25 screening, not SAI. 9th January, not SEA. Could you 15:35
26 try to help us, Mrs. Reid, with the thinking there? An
27 MDM decision hadn't been implemented, potentially
28 catastrophic effects if it hadn't been picked up on by
29 the GP. Happily, when he was ultimately referred he

1 was given a relatively clean bill of health, in other
 2 words no harm had been caused. Why, nevertheless, does
 3 that not enter the territory of an SAI review, having
 4 regard to the definition we looked at earlier?

5 A. Looking at the definition it should have been screened 15:35
 6 through as an SAI. I think in this case, and I think
 7 you can see from a number of, even after the decision
 8 that it wasn't, I have gone back on a number of
 9 occasions to see do we need to action anything, are
 10 they sure. And again, from memory, I would have 15:36
 11 escalated this through to meeting with Mrs. Gishkori as
 12 well. So, going by the letter of the definitions, it
 13 should have been screened through.

14 258 Q. The conclusion that appears to have brought an end to
 15 the process as such was that a letter would be given to 15:36
 16 Mr. Young, and we will look at that. But did you feel
 17 uncomfortable with how this was being talked through
 18 and the avoidance of an SAI or were you relatively
 19 content that in the absence of harm to the patient a
 20 letter to Mr. Young would address the mischief? 15:37

21 A. I probably, from memory, was uncomfortable. And
 22 I think, from what I can see here, I have gone back a
 23 number of times to ensure there was an action
 24 progressed in relation to the incident, even though it
 25 took quite a considerable time to get to that point. 15:37

26 259 Q. Hmm. Can you recall, because it's not clearly recorded
 27 here but it's maybe implied in the absence of harm to
 28 the patient, but can you recall the rationale for not
 29 pursuing an SAI?

- 1 A. From memory it would have been because there was no
2 harm caused to the patient in this particular instance.
3 The issue was being addressed through the operational
4 lines in relation to discussions with the chair of the
5 MDM and the specific correspondence with the clinician 15:38
6 involved.
- 7 260 Q. Hmm. When you see these two cases taken together,
8 Patient 102, which we have just looked at, and then
9 this one, Patient 137, one could suggest that the
10 service itself, the senior clinicians who sit on it 15:38
11 maybe hold the whip hand, if you like, in determining
12 where these things go and SAI processes can be avoided
13 if they want to take that approach, is that an overly
14 sinister suggestion or is that a fair analysis?
- 15 A. I think maybe overly sinister, but when you look back 15:39
16 and you see the cases going, you can see why you would
17 come to that conclusion.
- 18 261 Q. Yes. Whatever is the reason for it, I think you're
19 accepting that it's not good governance?
- 20 A. No, some of those cases should have been screened and 15:39
21 gone to SAI.
- 22 262 Q. The problem, I suppose, from the Trust perspective is
23 that in 2020, several years later, you have this
24 cluster of concerns about how the MDM was operating and
25 whether good processes were in place and here you have 15:39
26 two cases, different facts, obviously, but broadly
27 similar theme about the implementation of MDM
28 recommendations, the solution, as I say, was for a
29 letter to be given to Mr. Young and that didn't reach

1 him until 15th August 2018, let's pull up the letter,
2 it's WIT-100383, so 14th August. "The review team",
3 just reading:
4

5 "The review team looking at this concluded the 15:41
6 following MDM: Any actions must be progressed by the
7 consultant nominated as responsible for the action
8 required as per the outcome report from the MDM.
9 Referrals for specialist care need to be sent from
10 Consultant to Consultant." 15:41

11
12 And he is asked and Mr. Young is asked:
13

14 "Can you provide reassurance that you now have a
15 process in place to ensure that MDT outcomes for 15:41
16 patients under your care are actioned in a timely and
17 appropriate manner."
18

19 Now, you have said in your witness statement that you
20 see no evidence of a reply from Mr. Young? 15:41

21 A. No.

22 263 Q. Is that still the case?

23 A. Yes.

24 264 Q. Yes. Who was the assurance to be provided to?

25 A. Well, it would have been to Mr. Haynes because the 15:41
26 letter was sent by Mr. Haynes.

27 265 Q. Yes. Would you have expected to be informed if the
28 assurance had been provided?

29 A. Yes, it would have been good for completion of the

1 process to have updated Datix and the screening form
 2 with a response.

3 266 Q. So you must be left wondering whether in fact Mr. Young
 4 or indeed the urologists had a process in place to
 5 ensure that patients are properly referred? 15:42

6 A. That the actions from the MDM were actioned, yes.

7 267 Q. Yes. There was no closure on this from a governance
 8 perspective if the assurance wasn't provided?

9 A. No, not in my time.

10 268 Q. Could I take you to Patient 138. 15:43

11 CHAIR: Mr. wolfe, I am just looking at the time, it's
 12 quarter to four, would it be appropriate to take a
 13 short break at this point?

14 MR. WOLFE KC: Yes, it might help.

15 CHAIR: So we'll come back then at five to four, Ladies 15:43
 16 and Gentlemen.

17

18 SHORT BREAK

19

20 THE HEARING RESUMED AS FOLLOWS AFTER A SHORT BREAK: 15:56

21

22 CHAIR: Mr. wolfe?

23 MR. WOLFE KC: Thank you.

24 269 Q. Mrs. Reid, could I then bring you to the case of
 25 Patient 138. This is another incident report. You 15:56
 26 were the facilitator. Ultimately there's no SAI review
 27 and the subject matter is again a problem with the
 28 processes around the multidisciplinary meeting in
 29 urology. So if we could have up on the screen, please,

1 the Datix report, it is TRU-178398. If we just go to
2 the text please, thank you. So the position as
3 summarised here is that:
4

5 "The GP phoned Mr. Glackin's secretary on 25th October 15:57
6 2018 to enquire about the patient's follow-up. The
7 secretary looked into the patient's history and it was
8 discovered that this patient had had their bladder
9 surgery but that the patient's pathology had not been
10 discussed at the urology MDM which takes place on a 15:58
11 week's basis. The secretary then phoned the urology
12 cancer tracker to advise of this and asked why and how
13 this had happened. The tracker looked into the
14 patient's details on CaPPS and could see that the
15 patient was listed for a MDM discussion on 15:58
16 28th December 2017, but the outcome was to defer to the
17 next week with pathology which was not available at the
18 time of the MDM. Unfortunately, due to human error the
19 tracker did not schedule the patient for discussion the
20 following week and the patient was overlooked. The 15:58
21 patient's episode was closed off on CaPPS as they had
22 underwent the first definitive treatment, so that
23 oversight was not picked up via tracking. As this
24 patient was not discussed at the MDM, there was no post
25 surgical review appointment arranged and no follow-up 15:59
26 procedures arranged, if deemed necessary as per the
27 consultant."
28

29 So what we know is that when Mr. Glackin became aware

1 of this difficulty in October 2018 he arranged for the
2 patient to be assessed and further treatment or care
3 provided.

4
5 If we then look at the outcome to this, if we go to 15:59
6 WIT-100402. We can see, just scrolling down please,
7 that Mr. Carroll, who is the Assistant Director, he is
8 asking from this lesson what have we put in place to
9 reduce the risk of reoccurrence. Now we'll explore how
10 that develops. But before we get there, it's clear 16:01
11 that this case was the subject of consideration by
12 yourself and by the urology team but an SAI didn't
13 result. Do you know why that was?

14 A. I genuinely can't remember the specifics. However,
15 looking at the actions that were taken, it may have 16:01
16 been because the issue was identified and an action was
17 progressed in the development of a new guidance. But
18 I can't specifically remember the exact details.

19 270 Q. Yes. I'm not sure I can put my hand on the rationale
20 itself directly. But given that this was a patient 16:02
21 whose pathology had not been considered by the MDM and
22 was then lost to follow-up for ten months, and then had
23 to come back into the system, albeit that he hadn't
24 come to any harm, a significant risk had been created?

25 A. Yes. 16:02

26 271 Q. Again looking back on this, is this not an obvious case
27 for a serious adverse incident review regardless of the
28 happy ending?

29 A. It is.

1 272 Q. what we see, working through this, is that Mr. Carroll
 2 is asking the questions. If we go on up the page on to
 3 the next page -- sorry, just pause there. You're
 4 asking did we ever get an update. And then on to the
 5 next page, please. Sharon Glenny, was she the OSL? 16:03

6 A. Yes.

7 273 Q. In the cancer team. So she's telling Mr. Carroll who
 8 is asking what lessons have we learned from this and
 9 how are things going to be improved. He is told:
 10 16:03

11 "To improve systems and processes should we explore the
 12 possibility of having a report set up on business
 13 objects which will pull out all of the patients which
 14 have been closed on CaPPS during a certain time period
 15 and reasons for closing which can be screened by 16:04
 16 MDM/consultants."

17

18 And then that is batted about. Let's just go up the
 19 page. He's happy to discuss it at next Thursday's
 20 performance. And that's the regional meeting, is it, 16:04
 21 with the HSCB?

22 A. That might have been the local performance, cancer
 23 performance meeting.

24 274 Q. Right. Then we can see, if we go to the next page, WIT
 25 -- scroll up please. So he is saying - just stop 16:04
 26 there:

27

28 "I don't recall we discussed this at the last
 29 performance meeting."

1
2 The issue is going on without satisfactory
3 consideration, I am sure you would agree?
4 A. Yes.
5 275 Q. And he's asking, he won't let the issue go, he's asking 16:05
6 what systems and reports are employed in the other four
7 Trusts to prevent this happening. Then, Sharon
8 suggests that:
9
10 "We will keep this on the agenda for the meeting in 16:05
11 February. "
12
13 And then, finally, if we go up the next page, please,
14 just further on up. What Sharon Glenny reports is
15 that: 16:05
16
17 "On the back of this event Vicky met with the trackers
18 and discussed fail-safe measures and have agreed a
19 standard operating procedure. This has been circulated
20 among the tracking team and implemented." 16:06
21
22 I'm not sure what that looks like. But just from a
23 governance management perspective, do you think this
24 case was handled in a satisfactory manner?
25 A. No. Looking back, it should have been screened as an 16:06
26 SAI and gone through the SAI process to identify the
27 learning and make sure that the learning was
28 identified, shared and processes put in place to
29 prevent it happening again.

1 276 Q. Yes. I have just come across the note I wanted to
2 refer to you, if we go to WIT-100404, and this is the
3 screening form. It appears that you have discussed
4 this with Mr. Haynes. Just go over the page, please.
5 And 25th February, again discussing this with 16:07
6 Mr. Haynes:
7
8 "Patient did not come to any harm, therefore close."
9
10 Is it your view that that is a, thinking about it now, 16:07
11 an inappropriate analysis, that cannot be of itself a
12 good reason for closing this down?
13 A. No.
14 277 Q. Would you agree that the analysis of whether an SAI
15 review is indicated should also consider whether there 16:08
16 was a risk of harm?
17 A. It is, within the definitions it is.
18 278 Q. Yes. While that may not always lead to an SAI review
19 in every case, it is appropriate to look at the case
20 through that lens and not simply whether the patient 16:08
21 has come to harm?
22 A. It is.
23 279 Q. And when it comes to something as important as the
24 tracking of cancer patients through a MDM process,
25 where a patient can be lost to follow-up because of a 16:08
26 human error such as this, something that can very
27 easily happen, that's the kind of territory that needs
28 to be visited by the SAI system, would you agree?
29 A. I agree.

1 280 Q. Could I bring you briefly to Patient 93. Again it's a
2 case I'm quite sure that you have no direct knowledge
3 of, but if I can orientate you by bringing up
4 TRU-274730. Just at the bottom of the page,
5 Mr. Haynes, on 31st August 2016, is reporting into the 16:10
6 Head of Service, Mrs. Corrigan, a failure of triage.
7 Now, at this time the case of Patient 10, with whom you
8 have some familiarity, was, I suppose, midstream with
9 an SAI review being conducted by Mr. Glackin, again in
10 the context of a failure to triage on the part of 16:10
11 Mr. O'Brien. Mr. Haynes is reporting in another
12 failure to triage:
13
14 "GP referred in as a routine case but was not returned
15 from triage so was placed on the waiting list as 16:10
16 routine. If it had been triaged it would have been red
17 flagged or upgraded to red flag given the PSA readings.
18 The patient saw Mr. Weir for leg pain and the CT showed
19 metastatic disease from the prostate primary. Referred
20 to us and seen yesterday. As a result of no triage 16:11
21 delay in treatment of three and a half months. It
22 wouldn't have changed the outcome."
23
24 But Mr. Haynes is querying whether this should be an
25 SAI. Now, the upshot of this, Mrs. Reid, is that there 16:11
26 was no SAI, the case was batted around by email between
27 Dr. McAllister, Mr. Young and the Head of Service,
28 Mrs. Corrigan. Mr. Cardwell has searched and cannot
29 find on the system that a Datix or an incident report

1 was even raised on this one. So I think you would
2 agree with me that regardless of whether the outcome
3 would have changed, this should first of all have been
4 the subject of an incident report.

5 A. It should.

16:12

6 281 Q. It is really on all fours with the Patient 10 SAI and
7 the subsequent SAI involving the five gentlemen who
8 also come in as routine referrals and were upgraded.
9 It brings me, I suppose, back to the point I raised
10 with you earlier. Looking back on this now, do you
11 consider that the clinicians within urology were always
12 applying the test for either reporting an incident or
13 screening an incident into the SAI process in the way
14 that you would have liked?

16:12

15 A. Looking back and looking at the evidence that we have
16 now it doesn't appear to.

16:13

17 282 Q. And what do you think it says about governance within
18 urology if these incidents giving rise to risk of
19 patient harm are not being adequately scrutinised by
20 the system that you're charged with overseeing?

16:13

21 A. It left gaps that we could have potentially identified
22 significant risks earlier.

23 283 Q. Does it suggest that you either weren't or weren't able
24 to police the system that you were charged with
25 overseeing?

16:14

26 A. If some incidents weren't escalated then I wouldn't
27 have been able to identify. That particular one I
28 wouldn't have been aware of at all because it wasn't on
29 the Datix system. With challenge at the screening

1 process we would have got some. But there were others,
 2 as we can see today, that didn't get converted to SAI
 3 reviews. And that's a big regret.

4 284 Q. What do you put that down to?

5 A. In some ways it may have been an issue in relation to 16:15
 6 capacity, in others it may have been that the
 7 significance at the time wasn't considered. And with
 8 the value of hindsight and what we now know, if the
 9 incidents had been screened into the SAI process we may
 10 have identified the issue earlier. 16:15

11 285 Q. Have you any concern that clinicians would find it
 12 awkward or inconvenient to report, if you like, their
 13 colleagues into an SAI process or do you think the
 14 evidence doesn't support that?

15 A. I would like to think with their professional 16:16
 16 accountability that if they identified a risk that they
 17 would. From some of these it appears that on occasions
 18 that hasn't happened.

19 286 Q. Could I bring you to Patient 10's case. You may recall
 20 that, in terms of your involvement in this SAI, when 16:16
 21 you were relatively new in your post, you had to make
 22 contact with the Health and Social Care Board who were
 23 inviting the Trust to give consideration to appointing
 24 an external into the SAI review?

25 A. Mm-hmm. 16:17

26 287 Q. Do you recall that sequence?

27 A. I do, from having seen the evidence bundle.

28 288 Q. Yes. If he could pull up WIT-100378. Just scroll
 29 down. Róisín Farrell is within the Trust, is she

1 within corporate governance?

2 A. Acute governance.

3 289 Q. Acute governance. She points out to you that the DRO,
4 that's the person in HSCB with oversight of the SAI,
5 once you report an SAI in to the HSCB they appointed a 16:18
6 designated --

7 A. Responsible officer.

8 290 Q. Responsible officer. He or she has suggesting that the
9 Trust give consideration to adding someone outside the
10 Trust to sit on the Review Panel. You then report back 16:18
11 on how you dealt with that. If you scroll up the page,
12 you report that:

13

14 "Having discussed it with the DRO and discussed the
15 case at length, he appeared content with the team 16:18
16 membership we suggested."

17

18 And the team membership you suggested was all internal
19 personnel?

20 A. Yes. 16:19

21 291 Q. Led by Mr. Glackin?

22 A. That's right.

23 292 Q. And:

24 "He did state that he may, during the review , may want
25 to take the opportunity to ask for an independent 16:19
26 opinion if the team felt it useful, particularly in
27 relation to x-ray. However, he did appear content that
28 we start without an external representative."
29

1 Can you recall his or her thinking? Why was he or she
2 proposing this to you? Did he see anything in the case
3 that required a level of independence?

4 A. I just can't remember. I can't remember the exact
5 discussion. When I trawled through to see if I could 16:19
6 find any evidence of discussion, that was the only
7 thing that I had that would provide some evidence to
8 the panel.

9 293 Q. Yes. In terms of the interface more generally with the
10 HSCB, in the context of SAI reviews, what was the 16:20
11 nature of that relationship?

12 A. I felt I had a good relationship with the people that
13 I was in communication with. The challenge that we had
14 was the duration that it took to have the SAIs
15 completed. 16:20

16 294 Q. Yes.

17 A. And that was a constant interface. But we kept the
18 communication lines open. We would have met, had
19 discussed on the telephone to see what we could have
20 done to improve that. 16:20

21 295 Q. We needn't open up the fine detail, I can give the
22 panel the reference at WIT-61947. We can see that in
23 this SAI there is apparently frequent contact between
24 the DRO at the Health and Social Care Board and the
25 Trust as you walk through the various steps of this 16:21
26 process. Did you find that the relationship was one of
27 the HSCB challenging the Trust almost as a critical
28 friend or perhaps stronger than that or was it not that
29 kind of relationship?

1 A. It would have been that sort of relationship, there
2 would have been that challenge in relation to could we
3 improve the time frames of the SAIs, which was wholly
4 appropriate.

5 296 Q. Could I take you then to the SAI concerning Patients 11 16:21
6 to 15. You know the background to this SAI, the five
7 cases of missing triage. This case was moving off at
8 the same point as the MHPS process began. You were
9 the - I forget the term again - the coordinator?

10 A. The facilitator. 16:22

11 297 Q. Facilitator, I think is the word, on this one.
12 Dr. Johnston, as with Patient 16's case, was the
13 external reviewer. Why would you see fit to bring in
14 an external into this case when you didn't see the need
15 for it in Patient 10's case?

16 A. I'm trying to remember. I think the challenge was
17 getting somebody internally to sit on the panel was
18 exceptionally challenging. We tried a number of people
19 to see if they would chair the SAI and they couldn't,
20 so I contacted the Medical Director at that stage to
21 see if we could get someone else to Chair the SAI.

22 298 Q. In November of that year I think Dr. Johnston was,
23 presumably, trying to gather his thoughts and see where
24 the review would take him, he was interested in
25 obtaining further background on the whole triage issue 16:24
26 and on his behalf you sent an email, if we pull that up
27 on the screen please, TRU-257970. Just at the bottom
28 of the page. You are writing to Mrs. Trouton,
29 Mr. Carroll and Mrs. Gishkori. You explain that:

1
2 "As you are aware, we are doing an SAI on a number of
3 patients where triage and waiting list management may
4 have been a contributing factor. The Chair has asked
5 for any previous correspondence/investigation/action in 16:25
6 relation to the AOB triage and waiting list
7 management. "
8

9 And that was met by Mrs. Gishkori, if we scroll up that
10 page, please, saying, she's asking for clarification 16:25
11 and about which Chair is, is it the chair of the
12 investigation or the chair of the board, presumably.
13 Do you understand how she could have been confused
14 around that?

15 A. Not particularly. Because the chair of the 16:25
16 organisation probably wouldn't have been asking for
17 that level of information, it would have been the chair
18 of the SAI. I think the title is "confidential SAI" so
19 she would have known it would be in relation to that.

20 299 Q. Yes. And she doesn't appear receptive to the requests, 16:26
21 she is suggesting that a check is made with the legal
22 team as to whether any background material would be
23 shared. Do you know whether any advice was sought
24 around this?

25 A. I can't remember. But because I don't remember, 16:26
26 I don't think we did. And I don't think there would
27 have been a requirement. As part of the SAI process we
28 should have been sharing the information we had to
29 identify the learning.

1 300 Q. Mm-hmm. Presumably Dr. Johnston was looking, for
2 example, to know about the other SAI of Patient 10 and
3 the systems around triage and that kind of thing?
4 A. Yes.

5 301 Q. Did you see anything unusual in his request? 16:27
6 A. No.

7 302 Q. If we go to TRU-256445 and just scrolling down. You're
8 writing again pursuant to Dr. Johnston's request for
9 further information and you are specific now in what is
10 required. Then up the page Mr. Carroll writes to you: 16:27
11
12 "Can I ask that this SAI is "tight" on its remit? We
13 have another Trust process which will pick up on
14 several of the questions being asked."
15
16 I know there is a little bit of confusion around your 16:28
17 date of knowledge, in terms of knowing that there was
18 another process.
19 A. Yes.

20 303 Q. Does this help you to understand when you got a sense 16:28
21 of the fact that there was another process in place?
22 A. It does. I think that is probably the first time that
23 I would have been aware that there was another formal
24 process in place in relation -- but as to what that
25 exactly was, I now know it was MHPS, but I wouldn't 16:28
26 have the time.

27 304 Q. Yes. Again, Mr. Carroll's response, do you find that
28 surprising and do you understand the rationale now?
29 A. I understand the rationale now. The SAI was always

supposed to be around triage. Whenever it was first escalating the terms of reference it was agreed mostly to do with triage at the time.

305 Q. So this SAI, indeed the Patient 16 SAI, they were being managed, I suppose, entirely separately from the MHPS process?

16:29

A. Yes.

306 Q. Tracey Boyce has said in her evidence to the Inquiry that there was this disconnect between the acute governance team's role on the SAIs and the implementation of the MHPS process by the Director's office team and she says from what I understood at the time they had to be kept totally separate. However, with the benefit of hindsight, she thinks that a joint approach would have been beneficial. So, for example, the SAI concerning patients, the five patients, might have been expedited rather than taking the guts of three years. A more of a joined-up approach would have led to a more efficient and perhaps a more universal learning. Do you have any view about that?

16:29

16:30

16:30

A. My understanding is that the two processes sit separately, one is in relation to the professional management of the doctor, the other is in relation to learning from a clinical incident. I think as a governance coordinator you are aware of lots of very confidential, very sort of information and it would be good to understand other processes that are going on within the Trust to help triangulate all that information and perhaps share between the two processes

16:31

1 so that you have got a very robust rounded learning
2 from what was happening at the time.

3 307 Q. Now, the SAI review concerning the five patients had
4 reached the point of a draft report by May 2019,
5 TRU-264785. It's handed or sent to the then Medical 16:31
6 Director, Dr. O'Kane, and she has concerns as to the
7 quality of the report or some concerns as to the
8 quality of the report. Were you ever offered an
9 insight into what those quality concerns were?

10 A. I can't remember specifics. I do know from looking 16:32
11 through emails that the format of the recommendations,
12 so those that were relevant to HSCB were ones at the
13 top, then the Trust ones and then the ones specific to
14 the clinician. So I know that the layout of those
15 changed but I'm not aware that anything else was 16:32
16 significantly changed.

17 308 Q. Obviously, and perhaps for the reasons you have shared
18 with us already, this SAI review took rather too long
19 to reach a conclusion. I see you nodding your head.
20 You would agree with that? 16:33

21 A. Yes.

22 309 Q. One can see from emails that you were engaging with at
23 a relatively early stage with, for example, Katherine
24 Robinson, that you were trying to get to grips with how
25 the triage system had worked. Were you in the mind-set 16:33
26 of we need to try and ensure that this doesn't happen
27 again or trying to find solutions to ensure that the
28 risk of it happening again was mitigated?

29 A. It was to -- in order to make recommendations and to

1 help with the processes it's really important to
2 understand the entirety of the process, how the
3 referral comes in, how it gets to the clinicians, how
4 timely it is, how it is recorded afterwards. So that
5 was the initial part of that. And then that in itself 16:34
6 then helps lend to learning and putting into place
7 recommendations.

8 310 Q. So obviously this took into 2020 before the review was
9 completed; what assurance did you have that, leaving
10 aside Mr. O'Brien, but in the generality, that this 16:34
11 triage risk couldn't be repeated?

12 A. The only thing that we would have had in place would
13 have been the process in relation to the delays where
14 the missing triage would have been recorded and
15 escalated through to the operational teams. But 16:35
16 outside that.

17 311 Q. Yes. We know that Mr. O'Brien was the subject of a
18 monitoring plan to ensure that at least his practice
19 was supervised with regards to triage. But were you
20 not concerned more broadly to ensure that the problems 16:35
21 that gave rise to these SAIs couldn't be repeated by
22 another practitioner?

23 A. Yes. Though the reports should have gone through to
24 the Operational Directors and Assistant Directors so
25 that they would have been aware of who was and wasn't 16:35
26 returning triage to the teams.

27 312 Q. So was --

28 A. But I personally didn't ask for that assurance.

29 313 Q. Yes. We get a sense that, even during those days in

2016, and before that when the people you speak of were aware that triage wasn't being done, they knew that or had the ability to know that, but the problem as we explored, maybe, this morning was that they weren't following up to ensure that the triage was eventually done even though the patients were on, perhaps, a routine waiting list. Did you seek any assurance on that necessary follow-up?

16:36

A. No.

314 Q. Could I ask you just about a discrete point, TRU-257186. Just at the bottom of the page there. You're writing to Katherine Robinson and you are saying that Mark, that's Mark Haynes, has reviewed the, what I assume is the draft SAI report which you were writing up, it was your responsibility to take all of the opinions and write it up and before you forwarded it to Dr. Johnston you were seeking Katherine Robinson's input on a particular drafting point?

16:36

A. Yes.

315 Q. And the drafting point was essentially whether it was possible to understand relatively easily that triage had not been done. This is drafted to say that:

16:37

"Although there was a comment MTNL..."

which means?

16:38

A. Missing triage, no letter.

316 Q. Yes. So there is missing triage and no letter. Although that was inserted into the system, you were

making the point that:

"In the drafting, however, there was a potential that this could be overwritten with a new comment and this meant that there was no simple way of picking up who had not been triaged and nor was there a safety net for incorrect GP referrals."

Just on that last sentence and the first part of it, "this meant that there was no simple way of picking up who had not been triaged", that was Mr. Haynes' point and you were seeking Katherine Robinson's view on that?

A. Yes.

317 Q. It's fair to say that Katherine Robinson rebutted that. She was making the point, well it would have been perfectly obvious to our system, using the MTNL designation, that cases had not been triaged?

A. Mm-hmm.

318 Q. If we can scroll up to the top of the next page. Yes. And she writes back to you?

"I would prefer my original comments to stay. We did escalate and we were advised to go by GP priority. It is also incorrect to say that the comment "MTNL could not be viewed", it could on a PTL. The odd comment would have been overwritten when the patient was selected for booking. Anyone viewing PLTs were fully aware that there were loads not triaged."

1 So to those using the PTL system it was perfectly
 2 visible that, as she says, loads of triage was not
 3 being done? Do you know why or how Mr. Haynes came to
 4 form the view that the reverse was true, that it was
 5 difficult to see when it hadn't been done?

16:40

6 A. If you have ever seen a PTL of lots of patient, they
 7 are huge, sheets and sheets and sheets of patients and
 8 because it's a free text box there is the potential
 9 that the odd patient one would have been overwritten
 10 with another comment that may have been more urgent.

16:40

11 So more latterly we got PTLs in an Excel spreadsheet so
 12 we could have filtered them by missing triage, no
 13 letter. But it wasn't a simple report that we could
 14 have -- would have been really accessible. The Heads
 15 of Service and OSLs would have reviewed the PTLs on a
 16 regular basis and I would have done it for my service.
 17 But it would be something where you would have to look
 18 at those PTLs on a regular basis and understand the
 19 missing triage, no letter.

16:41

20 319 Q. Yes. But clearly Katherine Robinson and her team were
 21 aware?

16:41

22 A. Yes. And probably more laterally the Heads of Service
 23 and OSLs would have been aware as well.

24 320 Q. Yes. The MHPS process was, I suppose, triggered at an
 25 Oversight Committee meeting on that 22nd December 2016.
 26 You would have been, I suppose, blissfully unaware of
 27 that process, I think you are telling the Inquiry?

16:42

28 A. Yes.

29 321 Q. But at that meeting we can see - AOB-01281 - we can see

1 that - if you just scroll down please - that an action
2 was handed to Dr. Boyce:

3
4 "It was agreed to consider any previous IR 1s and
5 complaints to identify whether there were any
6 historical concerns raised."

16:42

7
8 Now, Dr. Boyce, in her evidence, thought that she would
9 have either asked you to conduct that piece of work or
10 perhaps Mr. Cardwell, David Cardwell, who she described
11 as being a real expert in the team.

16:43

12
13 Now could we go to AOB-01320, please? You are writing
14 to Vivienne Kerr and copying Tracey Boyce in. Vivienne
15 Kerr was within your governance team; is that correct?

16:43

16 A. Yes.

17 322 Q. And it's to her that you direct the query:

18
19 "Would you please check I have the correct patients?
20 I have put in patient hospital numbers for those
21 without, can you get me the hospital numbers?"

16:44

22
23 So if we scroll down just briefly, we will see the
24 first page of what you are sending through. I suppose
25 it's several pages, maybe more than several, of
26 complaints, data arising out of the urology service.
27 Does that email suggest that it was you who attempted
28 to carry out the work pursuant to the direction issued
29 at the Oversight Committee meeting to Dr. Boyce?

16:44

- 1 A. It does. And I would have asked, because my expertise
2 in the actual Datix system wouldn't have been as good
3 as David's or Vivienne's I would have asked them to run
4 a report to make sure that we got robust data from the
5 system. From memory, David was on leave then and it 16:45
6 may have been bereavement leave, so Vivienne would be
7 the next senior person that I could have asked to run
8 the data.
- 9 323 Q. Yes. Can you recall how you searched for material?
10 Because this appears to be limited to complaints data 16:45
11 and it is not limited to Mr. O'Brien and it doesn't
12 appear to include, for example, any Datix reports. We
13 saw Patient 102's Datix, for example, earlier, it
14 doesn't refer to any previous SAI that might have
15 involved Mr. O'Brien's practice. And we know he had an 16:46
16 involvement with the never event, which was Patient 95,
17 he had involvement with another patient, Patient 128,
18 which were each the subject of SAIs. Why was your work
19 limited to bringing back a report on complaints?
- 20 A. I would have asked for the report to be run that I was 16:46
21 asked to run. So I'm assuming that's what Tracey asked
22 me for and, therefore, that's what I provided. And if
23 I had asked for one report, if I had been asked for a
24 second I would have asked for both of them to be run at
25 the same time because Vivienne or David would have been 16:46
26 able to run those.
- 27 324 Q. Yes. I mean, the wording from the, I don't have it up
28 in front of me, but the wording from the oversight
29 group appeared to be we need to understand whether

1 there are any historical concerns here and IR 1s were
2 mentioned. Did you get a narrower message in bringing
3 back the complaints, do you think? Or did you look to
4 see whether there were incident reports or SAIs and
5 simply didn't find them?

16:47

6 A. I genuinely cannot remember the conversation. However,
7 if that's what I have run, that's what I would have
8 been asked to run.

9 325 Q. And nobody came back to you to say is that the sum
10 total?

16:47

11 A. They mustn't have if I haven't gone back and provided
12 additional information.

13 326 Q. What was your query to Vivienne Kerr in relation to it?
14 If you scroll back, you're asking her for clarity on
15 whether you have the correct patients, can you remember
16 what that was about?

16:48

17 A. There must have been some patients where there were
18 hospital numbers not included.

19 327 Q. Okay.

20 A. I can't, sorry, I just can't remember.

16:48

21 328 Q. Can I take you to just one final issue. The MHPS
22 report led to a determination reached by Dr. Khan on
23 17th September 2018, in advance of him finalising his
24 report he asked you to provide him with the draft
25 reports in the SAIs which were ongoing at that time, do
26 you remember that?

16:49

27 A. Yes.

28 329 Q. And you acceded to his request?

29 A. Yes.

1 330 Q. You provided them?
2 A. I provided them with a caveat that Dr. Johnston hadn't
3 finalised them and may want to make further changes to
4 the report.
5 331 Q. Yes. Can you recall why Dr. Khan was interested in 16:49
6 seeing these reports, albeit in draft form?
7 A. My assumption was the process that was ongoing was
8 related to the SAIs and, therefore, he wanted to ensure
9 that they had similar information available.
10 332 Q. Yes. He has explained -- or you have explained that 16:50
11 Dr. Khan has requested them so they could cross
12 reference with the issues that were emerging from the
13 MHPS that's set out in an email from you, WIT-95704.
14 Did you have any qualms about providing them or did you
15 think it was appropriate to have this 16:50
16 cross-fertilisation or exchange of information given
17 that the issues were potentially similar across the
18 processes?
19 A. I had been in discussions with Dr. Wright before
20 Dr. Khan in relation to getting the external Chair so 16:51
21 they would have been aware of the SAI and that would
22 have been appropriate if there was learning to be had.
23 It maybe wasn't evident in their process what I would
24 have shared what I had.
25 333 Q. As regards his determination, we can see -- if I bring 16:51
26 you to his conclusions at AOB-01923. Just go to the
27 conclusion section. You can see there that:
28
29 "The investigation report highlights issues regarding

1 systemic failures by managers at all levels, both
 2 clinical and operational, within the Acute Services
 3 Directorate."

4
 5 It speaks about "missed opportunities to fully assess 16:52
 6 and address the deficiencies", "default processes in
 7 place". Then, at the last, at the bottom of the page
 8 he recommends that:

9
 10 "...the Trust conduct an independent review of the 16:52
 11 relevant administrative processes with clarity on roles
 12 and responsibilities at all levels within the
 13 Directorate and appropriate escalation processes."

14
 15 Now, did you receive a copy of the determination during 16:52
 16 your time within the Coordinator role? This is
 17 September 2018 he's writing, you leave the post in the
 18 early weeks of 2019.

19 A. That's right. I don't remember getting a draft of the
 20 report. And I have looked to see and I can't find 16:52
 21 evidence of it. So I don't believe I did.

22 334 Q. Yes. Given the subject matter of his critique, he's
 23 politely pouring scorn on the administrative processes
 24 within Acute, directing criticisms at managers at all
 25 levels and talking about in essence systemic failures. 16:53
 26 This was the kind of material that a Coordinator in
 27 Governance within Acute ought to have been receiving
 28 and your views sought out with a view to conducting or
 29 assisting in the triggering of this independent review

1 from MHPS; is that right?

2 A. That's correct.

3 341 Q. By this time both the RQIA and the GMC are looking to
 4 see whether the Trust has taken forward the review, the
 5 independent review of administrative processes and if 16:57
 6 not, why not. So at this stage you were plainly aware
 7 of the recommendations of Dr. Khan?

8 A. Yes.

9 342 Q. Did you receive any indication or explanation as to why
 10 the independent review had not been conducted by this 16:57
 11 time, February 2020, a year-and-a-half after the report
 12 of Dr. Khan had issued?

13 A. The only thing I was aware of was that an internal
 14 review had taken place but not an external review.
 15 I think that was, from memory, decided by the Director 16:57
 16 of Acute Services at the time.

17 343 Q. What you set out in this email is simply that, that
 18 there was an internal review but that did not comply
 19 with what Dr. Khan had intended. These emails tend to
 20 suggest that the Trust was perhaps caught on the hop, 16:58
 21 it had not done what it was supposed to do and was now
 22 coming under pressure from the GMC and the RQIA to take
 23 steps, is that fair?

24 A. I think the query from the RQIA at the time was what
 25 had we actually done. I think my query was, back to 16:59
 26 the Acute Services was, you know, would an independent
 27 review have identified other things that needed to be
 28 progressed, as opposed to an internal review.

29 344 Q. And presumably Dr. Khan asked for an independent

1 review?

2 A. He did.

3 345 Q. For good reason. This needed to be, I suppose the
4 processes needed to be stripped down by somebody who
5 was objective and external to the organisation or 16:59
6 external at least to the Urology Service and Acute to
7 get to the bottom of what went wrong. Again from a
8 governance perspective you would have concerns that
9 issues that had led to great difficulty identified
10 18 months earlier had not been visited by an 16:59
11 independent process for reasons that are not well
12 explained?

13 A. Yes, I think, you know, somebody coming in externally
14 looking at your systems and processes is never a bad
15 thing. It can identify weaknesses that you are not 17:00
16 aware of and that's the importance of an external
17 review, you may think your systems and processes are
18 robust but somewhere else may have something that is
19 more robust or that we could learn from.

20 346 Q. Now just finally reflecting back on your role within 17:00
21 Acute Directorate as Coordinator. You said in your
22 statement, WIT-95263 at paragraph 9.1 and 9.2, that
23 thinking about the state of governance during your
24 time, it would really have benefitted from a wholesale
25 review of the governance structures with a 17:01
26 recommendation to ensure that steps were taken to
27 ensure that it was fit for purpose. Paragraph 9.1:
28
29 "Recommendations on improvement required to ensure

1 governance structures were fit for purpose."

2
3 You illustrate in 9.2 the kinds of things that we have
4 talked about this morning that would have needed to be
5 in place. It was Tracey Boyce's evidence that 17:01
6 governance arrangements when scrutinised simply weren't
7 fit for purpose. Is that what you are saying at 9.1,
8 that's the view that you take, despite your efforts to
9 improve things?

10 A. It is. The staffing and the IT systems and the ability 17:02
11 to try and gain information and have data analysts
12 available to help and support that weren't in place to
13 make the system fit for purpose and identify the risks
14 that we have subsequently identified.

15 347 Q. Yes. Plainly, as we have heard from your evidence, you 17:02
16 took many initiatives to try and put things on a better
17 footing. Maybe just to end on a more positive note,
18 looking back on it, what would you say was your major
19 achievement, was it changing the cultures in any way or
20 was it a visibility of governance, was it any of the 17:03
21 sort of hard processes that you put in place?

22 A. I think I have regrets from that time. I regret that
23 the systems and processes didn't identify the risks
24 early. When I came into post it was very reactive, it
25 was looking at the SAIs and complaints. When I left we 17:03
26 had terms of reference for our meetings, we had
27 additional guidance and we had set up a number of
28 additional groups such as the Standards and Guidelines
29 Group to help implement guidance. We had a more robust

1 working arrangement with the M&M process where the M&M
2 findings would have come back to the governance team to
3 help identify information. We worked closely with the
4 litigation team, developed some training for people
5 attending the Coroner's Court and had a number of QI 17:03
6 projects going in relation to diabetes. We looked at
7 the delays, looked at the sign-off of results and there
8 were other systems and processes that we put in place
9 to help improve governance.

10
11 Being available on the floor and building those
12 relationships with teams I hope helped improve the
13 culture of governance within the Directorate at the
14 time.

15 MR. WOLFE KC: You will be glad to know I have no 17:04
16 further questions. Thank you for your evidence.

17 CHAIR: It has been a very long day but I am afraid we
18 all have some questions for you, Mrs. Reid. I am going
19 to ask Mr. Hanbury first of all.

20
21 MRS. REID WAS QUESTIONED BY THE PANEL, AS FOLLOWS: 17:04
22

23 348 Q. DR. HANBURY: Thank you, I have just got a couple of,
24 hopefully, quick clinical questions for you. You
25 obviously put -- thank you for your evidence today, it 17:04
26 is extremely interesting. With clinical audit you
27 obviously put a lot of effort into getting that up and
28 running, you must have been disappointed that it wasn't
29 taken on. Why do you think it didn't? Was it that the

1 clinicians didn't have time or they weren't given
2 enough time or were there other problems?

3 A. I think it was multifaceted. The audit was ongoing so
4 the clinicians were doing their audit, getting it into
5 a robust process where oversight was the challenge. 17:05
6 Time was one issue, clinical time. Administrative
7 support for the audit processes was another. Having a
8 robust data system in place to record was another. But
9 I think, and reflecting on the feedback, they didn't
10 feel that as a leadership team within Acute, and 17:06
11 potentially wider, there was support for them for
12 audit. And again the resource available was one of the
13 issues. But people turning up to their meetings or to
14 the conferences and things that they held in relation
15 to audit on the annual basis beforehand was what they 17:06
16 highlighted to me.

17 349 Q. Okay. Thank you. Moving on to SAIs. How did you
18 disseminate the learning points from the SAIs that had
19 been written up, what was the mechanism of that?

20 A. The SAIs would have been presented at the acute 17:06
21 clinical governance meetings with the AMDs and the CDs
22 and the reports went to the operational teams for
23 cascade. And then we developed the spreadsheet with
24 all the SAIs and all of the recommendations so that
25 that was available at every governance meeting that we 17:07
26 went to. And then it would have been for the
27 operational teams to cascade that down further.

28 350 Q. Thank you. You mention the difficulty getting chairs
29 for SAIs and having done one or two I appreciate that.

1 One of your initiatives was to put, I think, half a PA
 2 a week, which equates to about two hours a week, that's
 3 not very long to do all the interviews and things like
 4 that. I mean on reflection now do you think that --
 5 how much time do you think a clinician, a Chair for an 17:07
 6 SAI would need to get it finished within a timely
 7 fashion?

8 A. So to be clear, the 0.5 of a PA never came into being.
 9 It was an attempt to try and carve out some specific
 10 time for the SAI process, for people to have time 17:08
 11 within their job plans to allow them to do that.

12 351 Q. Mm-hmm.

13 A. It depended on the SAI. Some of the Level 1s could
 14 have been quick learning and turn around. Some of the
 15 Level 3 SAIs would have taken multiple meetings, 17:08
 16 multiple interviews, some of the interviews took
 17 an hour, two hours. And then there was the review of
 18 the information, the writing up, checking. So it
 19 depended on the SAI. But at least if they had some
 20 protected time. And more latterly we're looking at 17:08
 21 roles for -- you know, Chair roles alone so that they
 22 have that dedicated time to give to the SAI process.

23 352 Q. Thank you. A couple more. We have noticed that you
 24 didn't speak terribly much about published audits for
 25 departments. National audits and regional audits, 17:09
 26 there appears to be, some of the clinicians have told
 27 us there has been a negative pressure on submission to
 28 national audits, were you aware of that? Certainly in
 29 urology.

1 A. No. I know that the national audits, the corporate
2 governance team help support the clinicians in relation
3 to the national audits. There have been some GDPR
4 issues in getting the data across which has been a
5 limiting factor regionally. And the resource in 17:09
6 relation to notes and supporting some of the audits may
7 have been an issue. But I'm not aware that there was a
8 decision not to. Some of the audits maybe haven't
9 progressed for the GDPR issues. And there may have
10 been some resource issues in relation to some of the 17:10
11 audits, particularly the repeat audits where you are
12 auditing every year. Some of the services have
13 administrative support for those, such as the National
14 Fracture Database Audit, others don't.

15 353 Q. Okay. Thank you. One more question, if that's 17:10
16 alright. You have obviously put a lot of energy into
17 results sign-off and that is something a lot of urology
18 departments grapple with and it seems as though it has
19 not yet been taken on. I mean, many departments have
20 felt okay, let's concentrate on radiology first. 17:10
21 Because certainly looking at this Inquiry, if you had
22 cracked that nut that would have been quite a progress.
23 And as a clinician you need to see the radiology report
24 and the last letter or the notes and records before you
25 can make a decision and that all takes a bit of time. 17:11
26 So had you thought of that, just concentrating on the
27 to radiology particularly or was that not?

28 A. It is one element we had particularly looked at and
29 worked with the CD for radiology to try and draft a

1 meaningful guidance for that. And that will hopefully
 2 as we progress be one of the things that we look at,
 3 trying to look at where the greatest risk sits and
 4 identify that.

5 DR. HANBURY: Okay. Thank you very much. 17:11

6 A. Thank you.

7 CHAIR: Thank you. Dr. Swart?

8 354 Q. DR. SWART: I just want to ask you briefly, I am sorry,
 9 about the screening meetings again because this keeps
 10 coming up. It's not entirely clear to me who actually 17:11
 11 is responsible for making sure the right things come to
 12 the screening meeting, how did that work?

13 A. For me, the correct way of coming should have been from
 14 the operational teams up because they would have seen
 15 all of their incidents, all of their complaints and any 17:12
 16 issues they had in relation to audits that would have
 17 been presented so, therefore, it should have come up as
 18 a fail-safe, myself and my small team would have
 19 scanned through the Datix to see if there is anything
 20 particularly obvious and maybe brought something to 17:12
 21 them to say I wonder about this, or, for example, with
 22 one of the SAIs, David saw the complaint coming in,
 23 escalated up through me and then we sort of highlighted
 24 it through that process as well.

25 355 Q. And at the meeting who has the final decision as to 17:12
 26 whether it is a serious incident or not? Because we
 27 have seen a few examples where this whole issue of
 28 potential harm has clearly not been interpreted in the
 29 way one might interpret it now. It can be quite a

1 difficult decision in my experience, it's not always
 2 that easy. who has that responsibility at the meeting?
 3 who casts the vote, if you like?

4 A. So the Assistant Director and the AMD or CD at the
 5 meeting following review of the evidence, if there was 17:13
 6 something I was concerned about then we would have gone
 7 back another time. And there were occasions where
 8 I would have escalated through to Mrs. Gishkori and
 9 Mrs. Boyce to say, you know, there has been an
 10 incident, I am a bit concerned and gone back. 17:13

11 356 Q. So you provide some challenge?

12 A. Yes.

13 357 Q. What about, is there challenge or was there challenge
 14 from other clinical specialties? Again, you know, I'm
 15 just drawing on the experience of a multidisciplinary 17:13
 16 challenge because if it gets too cosy within a
 17 specialty that can be a problem. So what efforts were
 18 there to bring a wider group of clinicians to that
 19 screening meeting? Perhaps also to cover the problem
 20 of clinical representation. Did you have those 17:13
 21 discussions?

22 A. We did discuss screening meetings from memory. We
 23 never got it that they were cross divisional. We would
 24 have had occasional meetings where, if an incident
 25 happened across two divisions, we would have brought 17:14
 26 the two divisions together. But on occasions it would
 27 have been two separate screening meetings and we would
 28 have then tried to amalgamate the...

29 358 Q. And who gave you the challenge? I mean these are very

1 important meetings. where did you get your very senior
2 medical challenge from? who was saying have you really
3 got this right? I mean, where did that come from? Or
4 did it not come from anywhere?

5 A. I don't remember it coming particularly down. 17:14

6 359 Q. Okay.

7 A. We would have had discussions at the AD -- with the AD
8 of Clinical and Social Care Governance but there
9 wouldn't have been a huge challenge.

10 360 Q. Another theme relates to the actions and I think we 17:15
11 have heard from quite a number of people that this was
12 a bit of a recognised gap, lots of serious instance,
13 you get action plans, they go into the action plan city
14 in the sky which all Trusts have, you didn't have a way
15 of bringing them back and checking on them. Did you do 17:15
16 anything with regard to particularly high profile
17 serious incidents in terms of saying to the service,
18 well, it's your job to sort this out but I would like a
19 report back in a year, was that culture there at all or
20 were you just too busy to do that? 17:15

21 A. At the time there wasn't the resource to continually go
22 back. What I would have done if there were particular
23 SAIs where I felt there was something we could focus
24 on. So conscious sedation, for example, we got the
25 Conscious Sedation Committee up and going again and 17:16
26 looked at developing new guidance.

27 361 Q. So you tried to give it a home?

28 A. Tried to give it somewhere to move the actions on.

29 362 Q. Just on that, in terms of getting things changed and

1 getting things done, I'm sure you are aware there are
2 huge numbers of serious incidents across the UK and
3 I am particularly familiar with England, where there
4 are repetitive incidents and the National Patient
5 Safety Agency produces guidelines, stents is one of 17:16
6 them, radiology is another one and there's quite a lot
7 there in terms of recommendations and things which can
8 give more force, was there any Trust-wide forum for
9 looking at that in terms of what's happening in the
10 serious incident and error field? Did you have any 17:16
11 support for that?

12 A. So when the HSCB would have sent down learning letters
13 and alerts and the NICE guidance and those, initially
14 there had been a corporate group looking at that and at
15 a point in time that was stood down. So, then, within 17:17
16 the Acute Directorate we stood up our Standards and
17 Guidelines Group which would have addressed those.

18 363 Q. I am particularly thinking of things like stents. Was
19 there a clinician who said 'well hey, this is a well
20 known problem' or did you just not have that amount of 17:17
21 time to spend on it?

22 A. Within the Standards and Guidelines Group we would have
23 taken each of those or the learning letters and we
24 would have had a change lead, which would have been a
25 senior clinician, to look at that. We would have 17:17
26 reviewed the recommendations out of that, mapped
27 ourselves against where we stood, put action plans in
28 place, and where we weren't able internally to resolve
29 situations to do with either equipment or we would have

1 need an e-pro forma up to HSCB then

2 364 Q. So the stent one, for example, did any of that happen
3 for the stents, because that's a well known big
4 national issue?

5 A. I can't remember. But if it came in in my time we
6 would have put it through that process.

7 365 Q. Okay. So when you were in that role what was your
8 sense of the strategic importance of governance from
9 the Trust Board point of view? Did you have any sense
10 about how important this the governance was felt to be? 17:18

11 I know there was a lot of emphasis on performance and
12 there was a lot of emphasis on timescales for SAIs from
13 HSCB, but was there anything else coming down that made
14 you feel that governance was a really important thing
15 or were you entirely self-directed? 17:18

16 A. Within the Acute Directorate --

17 366 Q. I'm talking about Trust-wide?

18 A. It felt as if it was self-directed. So we took
19 responsibility for the governance within our
20 Directorate and would have fed up information. As to 17:18
21 whether there was a Governance Committee, I, on a
22 number of occasions, for a short period of time,
23 presented to the Governance Committee on particular
24 topics. But there didn't feel as if there was an awful
25 lot coming down at the time. 17:19

26 367 Q. And you describe a struggle with resource and a lot of
27 ideas and some difficulty with that, since then you
28 have moved on to different roles, what have you learned
29 in those roles that if you came to your job, your

1 Governance Coordinator job today that would allow you
 2 to do things differently or be more successful in your
 3 bid for resources? What have you learned?

4 A. So when I moved to the Clinical and Social Care
 5 Governance Assistant Director I worked with Dr. O'Kane 17:19
 6 at that stage as a Medical Director. We identified
 7 risks within the corporate governance structure, asked
 8 for an external person to come in, review the
 9 governance processes, give us recommendations and then
 10 we tried to implement those. Resources is still an 17:20
 11 issue. In the current financial constraints Trusts
 12 have significant cost savings to make. That remains a
 13 significant challenge. But I would ask for the
 14 external review to help evidence the gap and then work
 15 with senior leadership colleagues to request funding 17:20
 16 for the service that I have. But it is still a
 17 particular ongoing challenge at the minute.

18 368 Q. Last one. I mean if a member of the Trust Board came
 19 to you when you are in your governance role and said
 20 'How can you assure me that your consultants are 17:20
 21 following up to date standards and guidelines? What
 22 assurance can you give me?', what would you have said
 23 to them?

24 A. I would have highlighted the challenge of the resource
 25 that we had to do it. I can't remember the exact 17:21
 26 numbers back then, but now there are over 3,000
 27 guidance. 2,800, all of them are applicable to the
 28 acute service. They don't come with funding.

29 369 Q. But will you be able to assure him is what I am really

1 saying?

2 A. No.

3 DR. SWART: Okay. Thank you.

4 370 Q. CHAIR: Just a couple of questions from me and they are
 5 sort of linked. Going back to the whole issue of 17:21
 6 screening, do you think that part of the reason why the
 7 cases that we were looking at this afternoon weren't
 8 screened as SAIs was a reluctance on the part of
 9 clinicians that they may be asked to chair the SAI in
 10 the knowledge that they didn't have the time to do it 17:21
 11 and if they could resolve it more informally, that that
 12 was the road to take?

13 A. I hadn't thought of it in that way. I think if lessons
 14 were identified or learning is identified and they
 15 thought they could implement change, that that might 17:22
 16 have -- that may have been one of the things that they
 17 thought, okay, we know what's happened, we know how to
 18 potentially resolve that, and, therefore, we've done
 19 that bit and maybe leave the learning to some of the
 20 bigger cases where it was identified. So resource and 17:22
 21 the timeframe to do an SAI could potentially have been
 22 one of the reasons that they --

23 371 Q. It might have been something that they thought about?

24 A. -- took into consideration would have been screening.

25 372 Q. Or subconsciously even? 17:22

26 A. Potentially.

27 373 Q. Secondly, you said in answer to Mr. Hanbury about
 28 getting a bodies of chairs, if that's the right
 29 expression, but people who would Chair SAIs; are those

1 internal people that you are talking about within the
2 Trust or are you looking at external chairs who you can
3 call upon to come in and do SAIs?

4 A. So currently we have some retired clinicians who have
5 come in and agreed to do that for us to help progress 17:23
6 some of the SAIs. But there still is the requirement
7 to have the teams continue to input into them because
8 it is hugely resource intensive.

9 374 Q. So if you could wave a magic wand and resources weren't
10 an issue what would you like to see happen in terms, 17:23
11 first of all, generally in governance and more
12 specifically what do you think is the one thing that
13 would help prevent something like this inquiry
14 happening again?

15 A. I think resourcing the teams appropriately, having 17:24
16 sufficient resource to, both - at all levels, so making
17 sure we had the right resource to make sure that the
18 clinical workload was doable, having the resource
19 within the operational teams to make sure that there
20 was managerial time to make sure that actions were 17:24
21 taken. From a clinical governance team it's making
22 sure that the right number of people with the right
23 skill set, the right training, the right time were
24 available to review the incidents, take forward the
25 proactive work, the education, the training, the audit, 17:24
26 the triangulation of information, having data analysts
27 that can actually really delve into information and
28 show it in a meaningful way and having IT systems that
29 mean that information isn't a challenge of going to

1 lots of different systems to try and pull it together.

2 CHAIR: Okay. well, Mrs. Reid, you will be glad to
3 know, it's been a very long day for everyone here but
4 we are finished. So thank you very much for coming
5 along and I am glad you don't have to come back, I am
6 sure you are too. Okay. Ten o'clock tomorrow, Ladies
7 and Gentlemen.

17:25

8
9 THE HEARING WAS CONCLUDED

17:25