Urology Services Inquiry

Oral Hearing

Day 51 – Thursday, 8th June 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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THE INQUIRY RESUMED ON THURSDAY, 8TH DAY OF JUNE, 2023 AS FOLLOWS:

CHAIR: Morning, everyone. MS. McMahon.

MS. McMAHON: Good morning. The witness this morning is Patricia Kingsnorth, who was the Clinical and Social Care Governance Coordinator until June 2021 in the Trust. She wishes to take the oath. 10:06

PATRICIA KINGSNORTH, HAVING BEEN SWORN, WAS EXAMINED BY MS. McMAHON AS FOLLOWS: 10:07

1 Q. MS. McMAHON: My name is Laura McMahon and I am junior counsel to the Inquiry. Thank you for coming along today to give evidence. 10:07

You have already provided two Section 21 replies, and I just want to take you to those and to your signature and confirm if they are your evidence.

A. Okay. 10:07

2 Q. The first one can be found at WIT-92011, and that's Notice 2 of 2023. If we go to WIT-92063, you will see it signed in typed form dated 3rd May 2023. Do you recognise that as your statement?

A. I do. 10:08

3 Q. And do you wish to adopt that as your evidence?

A. I do.

4 Q. You then provided an addendum statement at WIT-96809; again your name at the top of that. If we go to

WIT-96810, we will see your signature at the bottom there and the date is 2nd June 2023. Do you recognise that as your signature?

A. Yes I do.

5 Q. And do you wish to adopt that as your evidence? 10:08

A. Yes.

6 Q. Thank you for that. Now, you have provided a lot of information in your Section 21. Obviously the Terms of Reference are central to governance, which is one of your roles in relation to aspects of the Trust. I just 10:08 want to highlight parts of your statement and bring out a little bit more about that in the evidence.

If we start just with your background and your subsequent role as the coordinator. You qualified as 10:09 a general nurse and then became a midwife?

A. That's right.

7 Q. Then you were appointed as the clinical risk midwife in May 2011?

A. Yes. 10:09

8 Q. And then you were the Lead Midwife for Community and Midwifery Services in December 2014, and that was a managerial role?

A. It was.

9 Q. In January 2019 you began your role as the Clinical and 10:09 Social Care Governance Coordinator with the Trust?

A. That's right.

10 Q. And you retired from that role in June 2021?

A. I did.

11 Q. Just in relation to the role as a clinical risk midwife, which was the first certainly title that jumps out that has governance implications, was that the focus of that particular role that you took up in 2011?

A. Yes. In other Trusts it is actually referred to as a governance midwife. The post was purely for clinical governance within the maternity and gynae settings, and it was -- I was responsible for setting up the structure, typing it, being involved in Datix reviews, and I had piloted the Datix system that had come into the Trust at that time as well. I worked with my colleagues who were obstetricians and with my midwifery managers to review Datix incidences, and to share learning through those incidences and cascade that learning through the system. 10:10

That would have been, I would have sat down with a consultant obstetrician a number of times a week, on both sites, in Daisy Hill and the Craigavon site, to review clinical incidences and then to extract immediate learning. The learning would have been shared directly through e-mail to the staff. But it may well have taken up 'do you know we need more information here'; even though it might have come through as a minor incident, we need more information here. So, that might have prompted what we would have called at that time a round table discussion. That meant you got the team who were involved in the incident into the room and you drilled down what

happened? How did that happen? You know, what processes were in place? So you were trying to process map out what had caused the incident.

12 Q. We will come on to look at the detail of the way in which the Datix system operates under your most recent role as well. Just in relation to that role when you were the clinical risk midwife, you had some SAI training at that point? 10:11

A. Yes. Yes. Yes.

13 Q. Now, your job description for your role as, if I just use the shorthand, Governance Coordinator, if you don't mind, can be found at WIT-92070. You will see at the top the job summary. I am just going to read from this: 10:11

10:12

"The post holder will have responsibility for driving forward and coordinating all aspects of the Trust CSCG agenda within the Acute Directorate with and on behalf of the Service Director and the Assistant Director with Responsibility for Governance. They will provide an internal and external directorate focus with a prioritisation linking implementation and review, and monitoring of both the operational and professional governance agenda for the directorate. 10:12

10:12

"The post holder will, on behalf of the Director, provide a key challenge function to the service teams within the directorate to ensure that areas where performance improvement in relation to CSCG is required

are identified and addressed. They will contribute to developing corporate and operational strategy, policy and decision-making within the Trust with respect to the CSCG agenda within the directorate, and as an integral part of the Trust CSCG working body, and through close collaboration with the Trust Corporate Assistant Director for CSCG. They will be responsible for advising on and actively participating in planning, delivering, reviewing and monitoring both directorate and corporate CSCG plans, and will act as a focal point for the Director of Acute Services and the Trust Corporate Assistant Director of CSCG in respect of any issues relating to the development, implementation, performance, management and assurance of CSCG plans, systems and procedures and their associated improvement plans." 10:13 10:13 10:14

Quite a lot in that but I think some of the key issues, if we look at then, it will break the role down a little bit, and then we can see the boundaries of your responsibility. 10:14

A. Mm-hmm.

14 Q. If we just move down, please.

"The post holder will provide enhanced CSCG support and performance improvement, expertise and intervention in this area to their directorate and to corporate CSCG projects where required. They will provide their directorate and the organisation with a suite of 10:14

intelligent information analysis which demonstrates realtime performance in relation to all areas of CSCG, including incidents, complaints, risk litigation, audit, clinical indicators and Patient Safety."

That last line seems to cover the remit of the areas that you have oversight of and involvement in; would that be fair?

A. That's right, yes.

15 Q. You are also required "...to collaborate with the Trust Senior Management Team and the Trust CSCG manager to develop the organisation's capacity for continuous improvement in the area of CSCG and to facilitate a culture of openness and learning from experience using dynamic leadership and facilitation skills." 10:15

I think they encapsulate the ethos of your role, to ensure that there are proper systems in place to alert and also to learn from, and that there's improvement made as a result of any investigation or findings. 10:15 Would that be a fair summary of that?

A. Yes.

16 Q. So people have talked about closing the circle.

A. Yes.

17 Q. I think the beginning and the end of the circle, 10:15 certainly from a governance framework perspective, maybe sits with you. Would that be fair?

A. Yes.

18 Q. Obviously others are responsible for implementation but

to see things through, you are the person who is anticipated would carry out that task?

A. To a certain extent as a facilitator. What I would have done is I would have liaised with the Assistant Directors and the Heads of Service to see where were they at, because operationally they are the ones delivering on it. I would have not held them to account but held them to account in so many words, just go back and say, well, where are we with this? Have we got this in place? What do we need to do to get that kind of stuff. I would have been prompting them because they were busy with their day-to-day running of the service; that I had to keep prompting them with regards to what needs to be done, where we are at with say, for example, clinical audits, you know the internal audits, or RQIA responses or action plans; what are we at with those? Have we embedded that? Do we need to provide training to your staff, because we would have provided training in that as well. So, that kind of stuff. 10:16 10:16 10:16 10:17

19 Q. One of your roles would have been to ensure that any systems of investigation or interrogation that were carried out were undertaken with principles of good governance in mind?

A. Yes. We don't use the term "investigation", we would use "review", because investigation kind of implies that you are using a microscope to go down into every minutiae. When you are doing a review, say a Serious Adverse Incident Review, people always think that it's 10:17

an investigation and they always -- they think that you are going down to every single minutiae and you're not. You are doing a review of the care, you are trying to find out from a root cause analysis point of view what were the factors involved, what were the mitigations, what was the training, what was the equipment like on the day, what was the staffing like on the day, what was the -- what was going on in people's heads. 10:17

You know, a review gives a more clearer case as opposed to setting expectations. When you talk about investigations, it kind of makes it sound like you are doing a police investigation, which we are not. 10:18

20 Q. I suppose when you consider the potential consequences of outcomes of SAIs for individuals and for patients, would you agree that the more significant those outcomes or recommendations or findings are for either a clinician or a patient, then the higher scrutiny that should be applied to the process by which those recommendations were reached? Would you agree with that? 10:18

A. I would, yes.

21 Q. I just want to go now to your statement and it will explain in your words your understanding of your duties. In relation to what I have read out, and I am sure you are familiar with your job description, do you accept that as being an accurate reflection of your role? 10:18

A. There was a lot in the job description, and it would

have been -- it would have -- I would have had to have more hours in the day to complete absolutely everything that was in the job description. I would have had needed to have all the resources to be able to do all the things that the job description would have implied. You know, that wasn't possible given, from my tenure in post of, you know, less than two years of getting all that information, of being able to do things as proactively that I wanted to do, because when I came into post you were more firefighting and reactive to things that were going along as opposed to having the ability to go in and say right, okay, I will have everything here all singing and dancing. That wasn't possible. 10:19 10:19

22 Q. Just now you have raised that point, we will maybe deal with it now. When you did take up your post, you say you were firefighting. What was the position when you went into post in January 2019? 10:20

A. Okay. When I came into post, I was taking over from Trudy Reid and there was 35 SAIs, not including the two Urology SAIs as well, that needed to be completed. Some of them needed to be started, they were in various stages of completion. There was one governance nurse, a Band 6 governance nurse, myself and a Band 5 administrative staff. 10:20 10:20

From a hand-over point of view, Trudy was able to give me 45 minutes of a hand-over. Now, I had a very good line manager who was Tracey Boyce, and she was very

supportive and very good in keeping me right in what I needed and, you know, any training or how to do. You know, I had experience of doing SAIs. My experience of doing SAIs was, you know, meeting with the families, taking them through the process. When I came into post here, I wasn't able to do any of that, you know. The patients had previously been contacted by letter. I was busy trying to get the reviews up and running and that's very difficult to do when only one person is writing the reports with a Chair, you know. That was an impossible task nearly. 10:21 10:21

Now, I did have two Band 7s that started a few months later but neither of them had governance experience. One of them was a complaints manager but he didn't have SAI experience. So, you had to go through the whole training process with them, SAI training, you know, taking them through step by step of what needed to be done and making sure there was processes in place, you know, like standard operating procedures and things to say this is how we do it, this is how we conduct it. 10:21 10:22

So, if you were asking was I able to do my job from my job description fully at that point, no.

23 Q. We mentioned earlier that you had some SAI training as a clinical risk midwife and then you came into this role, you say you got the 45-minute hand-over, there were 35 SAIs outstanding. Did you have any training on SAIs between 2011 and taking up that role or indeed up 10:22

until your retirement in 2021?

A. So, I would have had training from 2011 to 2014 with regards to, you know, human factors training, patient safety, attending patient safety conferences, litigation with regards to maternity services and root cause analysis training. So when I came into post then, there was a two-day SAI training and that helped me greatly. That was very good training, two full days of SAI training. 10:23

24 Q. In the post we are referring to in 2019? 10:23

A. Yes, that was the beginning. I think it was February time that I had conducted that training or undertook that training.

25 Q. That's February 2019?

A. Yes. 10:23

26 Q. The 35 SAIs that were outstanding, were they old SAIs, were they all coming in together? Was there a particular reason given to you as to why the number was so high, and also there hadn't been movement in those particular cases? 10:23

A. I think the resources was the big issue because Trudy was trying to do all those, you know, chair -- not chair but facilitate those SAIs on her own. You know, that was an impossible task to begin with. I had to pick up the pieces from that, so I did speak to Esther, 10:24 who was my director at the time, and say you do realise I have come into this? Because I know that I'm held -- I hold myself accountable for my work and I know that she holds me accountable for my work as well, so

I needed her to understand what I was coming into. It was a difficult task to undertake, so new into the job that this was -- I mean, we had to start all over again with all of those SAIs.

27 Q. What was Mrs. Gishkori's reply when you indicated that workload to her at the outset? 10:24

A. Well, I was assured there were two Band 7s that were going to come into post to help me, but also she had assured me there was going to be a governance review. There was a governance review had taken place at the beginning of probably May/April time of 2019 to look at our services, and to see. So I was kind of hopeful that something more would come through that. 10:24

28 Q. Were the staff appointed, the two Band 7s?

A. They were. 10:25

29 Q. And when were they appointed?

A. The end of March, I think, and May time.

30 Q. The review, what was the outworking of that in terms of how you were able to carry out your job effectively? You have mentioned the 2019 review. What improvements or did you see any improvements after that? 10:25

A. Well, there was improvements from the viewpoint that we started getting moving through those current SAIs, and then getting those finished, completed and sent to the Board and to the families. It never really sat comfortably with me getting those reports out to families because I would have built up a rapport -- in my last job, I would have built up a rapport with families, they would have known him, they would have 10:25

phoned me, I would have been able to contact them and say this is where we are at with the review. With these people, I was coming cold to them, do you know what I mean. The first thing they were hearing from me was a phone call, which was really difficult for them to take in, you know. We did a review of an incident that happened maybe two/three years ago and we were only completing it in 2019.

31 Q. Just specifically if I can go back to the previous question, just to get a little bit more information about that. There were two Band 7s appointed in 2019, and the review. Which had the greatest impact on your ability to engage with these 35 SAIs and also do the other work that was expected of you? 10:26

A. The two Band 7s definitely. The review ended up not producing any fruit, you know. It didn't affect our service at all. 10:26

32 Q. You didn't see any difference in either operationally or policy-wise for you?

A. No. No. 10:27

33 Q. Were you involved in that review? Did anyone speak to you about that and ask for your suggestions or improvement ideas?

A. Yes. Yes.

34 Q. Did you see those reflected in the review? 10:27

A. No, not really.

35 Q. So, the staffing issue that you inherited from Trudy Reid then improved in your time and you were able to grapple, but for you one of the downsides, and it is

one of your key duties, is liaising with the families?

A. Yes.

36 Q. And the difficulty then cold-calling families?

A. Yeah. Yeah.

37 Q. If we can just go to your witness statement then at WIT-92013, paragraph 1.5. You have mentioned what your role is but what this does is - for the Panel's note - it expands slightly to show the areas that you were responsible for. We have looked at what was expected from you, and then this is the application of all the areas you were expected to do that in. 10:27 10:28

A. Mm-hmm.

38 Q. If I can just start with 1.5(b):

"My role was to provide clinical and social care governance within the acute setting. This included Medicine and Unscheduled Care, Emergency Department, Surgery and Elective Care including Urology, Maternity and Women's Health, Diagnostics and Cancer Care. This was a vast remit which included management of complaints, incident reporting, SAIs, equipment management and standards and guidelines within all of Acute Services, some of which standards and guidelines were relevant for the whole Trust. I had a number of teams to manage. There was a Complaints team comprising a Band 6 Complaints Manager, a Band 5 Complaints Officer, a Band 3 Complaints Assistant and a Band 2 Administrative Assistant. I was also responsible for a Band 7 Standards and Guidelines 10:28 10:28 10:28

Manager, a Band 5 Governance Officer For Standards and Guidelines, and a Band 7 Equipment Manager. There was also the SAI team which initially included a Band 6 Governance Nurse and Band 5 Governance Officer Administrative Support, and myself, until two recently recruited Band 7 Governance Managers came into post in March and May 2019. 10:29

"My general role encompassed general oversight of incident reporting, complaints, Ombudsman complaints, and action plans. It included the development of Trust guidelines following recommendations from adverse incidents, for example the Conscious Sedation Guideline. I was responsible for maintaining and updating the directorate and divisional Risk Registers. The Corporate Risk Registers were managed the Trust Board level. A report of the Risk Registers was included in monthly governance papers for the Acute Clinical Governance Meeting and for the Acute Governance Meeting for each Assistant Director and their relevant divisions. Within these governance papers, a report on current complaints, including Ombudsman complaints and any outstanding complaints, was provided to ensure that the divisional Assistant Directors were aware of any delays or backlogs in complaints processes." 10:29 10:30 10:30

Then you say:

"I was also involved in providing responses to the HSCB and RQIA as part of my assurance role."

So, a pretty broad remit. In relation to the Risk Registers, were you responsible for populating the Risk Registers with information, or what precisely was your role? 10:30

A. So, I was there -- the Risk Registers were populated by the operational teams. What would happen is they would come to me and say I need this added on to the Risk Register, so my team would add them on to the Risk Register for them. But they needed updated, they needed reviewed. So, my role was to go and say this is your Risk Register, where are we at with this risk? What are mitigations in place to reduce the risk? What are you doing about improving the situation or how are we moving this forward? 10:31 10:31

A risk can't stay on a Risk Register and nothing happening with them. There has to be an action, if you know what I mean, to follow through. It can't sit there forever and hope that somebody is looking at it. It needs to be reviewed, somebody needs could be constantly reviewing it. 10:31

39 Q. And was that you? 10:31

A. Yeah. Well, I was going to them and saying -- I was going to, say, the assistant directors and saying where are we at with this risk; is it still a risk; have you put mitigations in place; have they been resolved?

A lot of time they would have been resolved. A lot of the times they would have said, yes, we have new equipment and that is sorted and we can take that off the Risk Register now. Or they might have said no, that needs to stay on a wee bit more because we need capital funding to put measures in place, something along the lines of, for example, say flooring in a bathroom on the wards does not meet infection control standards, you know. Well, I would want to know why has Estates not effectively sorted the floor out, why is it sitting there for this length of time? 10:32 10:32

40 Q. How would you have approached them? What would be the frequency that you would do that? How would you communicate with the relevant owner of the risk to be updated, and then what steps would you take if the risk was just dormant? 10:32

A. Generally speaking, you would have reviewed them every few months. Now, sometimes that might have been three-monthly. You had to give people time to get the work done. This is the Health Service, it doesn't take -- things don't change overnight. A lot of the risks might have been on there for a number of months, possibly years if it was something to do with needing capital funding. 10:33 10:33

So, as part of my role, I would have met with the assistant directors and said, you know, can I meet with you today to go through your Risk Registers? There would have been an appointment made in their diary to

meet with me because they knew that's what we were going to do. Equally, every month those Risk Registers were put into the governance papers and the clinical governance papers so everybody was aware of them. So, when something was highlighted in the Risk Registers, I would have met with them and said do you know, can we move some of these forward; where are we at with them; can we update this? Sometimes they would come back to me and said we have identified new risks, we need to put it on the Risk Register, can you help us with that, and we would help with the wording and the templates in putting it on. 10:33 10:33

41 Q. If they gave you a narrative as to why the risk either hadn't moved or had moved, or indeed had increased --

A. So, that would have been added in then. 10:34

42 Q. The actual wording would have reflected what was either done or not done?

A. Yes.

43 Q. It would have been on the Risk Register; that's your understanding of it? 10:34

A. Oh, yes, yes. There would have been constant updates put on the Risk Register. It's nearly like an Excel document where you can add in information to update it.

44 Q. What was the process, if there was one, around escalating risks to the Corporate Risk Register? Who was that undertaken by and how was that done? 10:34

A. I would have met with the Director as well to go through the Directorate Risk Register. Before I met with the Director, I would have previously met with the

Assistant Directors so that I knew when I was going to her and saying, these are on your registers, these are the other registers, these need to be escalated, and that would have been a conversation with the Director to say whether or not that would be escalated to the Corporate Risk Register.

45 Q. Who makes that decision? Is that your decision or the Director?

A. No, that would have been a director decision.

46 Q. You don't provide any advice from a governance perspective to say this is very longstanding, or I can read across, if you could read across to other registers and see that there is a systemic problem. Did that ever arise?

A. It didn't arise but things like -- one that I can remember was during Covid, some of the doctors had expressed concerns about there's going to be issues with patients who are not being seen in the system, who are going to come in with cancers or very ill, who aren't diagnosed; that was escalated to the Corporate Risk Register, you know. So if they come to me with that, I come to the Director, that's escalated. It's not that the Director would say to me no, I'm not listening to you, you know, there was a conversation that would have been had.

47 Q. And would you have sight of all the Risk Registers across the areas of responsibility we have just read out?

A. Yes. Yes.

48 Q. If anyone was to identify themes, would it be you in relation to risk?

A. Yes.

49 Q. But you say in your experience that didn't happen, but the Covid example is an example that probably would have impacted all of those areas? 10:36

A. Yes. Yes.

50 Q. You have mentioned you generated reports for the monthly Acute Governance Meeting. Just in looking at the constituent parts of your responsibility, I know you have used the word "facilitation" a few times but it's more than being a conduit of information, I think, you are definitely sleeves up, looking at governance, having an oversight role? 10:37

A. Yes. 10:37

51 Q. Your responsibility would include identifying concerns arising and following learning through?

A. Yes.

52 Q. You say at WIT-92014, and this is the point I have just made... I think I have just read the same paragraph out again. It's in relation to the Risk Registers and your responsibility around those. 10:37

If we move on to your internal audit responsibilities at WIT-92030, paragraph 3.3. You say: 10:38

"I was responsible for updating the internal audit responses and RQIA responses for the Trust on behalf of the Acute Directorate. I was involved in the

management of Standards and Guidelines, and there were two meetings a fortnight to ensure that the Acute Assistant Directors and Acute Director were aware of the Trust's responsibilities and responses required regarding risk standards and guidelines." 10:38

Experience of the appetite around discussing risk standards and guidelines that maybe hadn't been implemented, were those subjects frequently spoken about? Were they spoken about with an awareness of the 10:39 potential seriousness of them? Just generally give us a feel of the appetite.

A. Standards and guidelines for the Trust, there was a huge number of them that we --

53 Q. We will go on to talk about the standards and 10:39 guidelines but just at the moment I want to concentrate on the context of those meetings when you brought issues up. What was the culture at the meetings around discussing risk and, for example, things that hadn't been implemented? We will look at the guidelines just 10:39 in a moment.

A. I think the ADs were very mindful of the standards and guidelines, that a lot of them were outstanding. They were trying their best to get things moving forward. I don't think there was any lackadaisical approach, if 10:39 that's what you mean. I mean, people were taking these very seriously. These are Patient Safety issues that should be delivered on, so there was no doubt in anybody's head that these needed to be looked at.

Things like having a change lead to lead on the standards and guidelines when they came into the Trust was always an issue because you had to have a consultant, a clinician, to lead on those. You were asking a consultant to do that as well as their day job, as well as being overstretched as it was. There was quite a bit of work involved in the change lead process, you know, to drive forward the standards and guidelines. There was so many of them that sometimes one change lead -- or one consultant was being asked to deliver on maybe four or five guidelines, which although looking at it from the outside, you would think, well, that's not an awful lot of work but it really was quite a significant amount of work for them to do. 10:40 10:40 10:40

In a way, you could nearly say that the resources issue of the times for the change lead was, you know, impacting on the delivery of the implementation of the guidelines in its entirety, in its fullness. That's why some of them were partially approved and some were waiting on responses from the region. You couldn't actually completely implement them because they needed buy-in from either GPs or from the Board, so those ones would have sat. I'm thinking of the SG -- or the NG12 of the suspected cancer one; that was partially implemented by the Trust. They needed buy-in from GPs and from the Board for that to get over the line. 10:41 10:41

There was a lot of that in the standards and guidelines as well.

54 Q. We will look at NG12 as an example in a moment because I think you probably remember it was mentioned in one of the SAIs -- 10:42

A. Yes.

55 Q. -- as being the standard, and we will look at that.

There was a report carried out in December 2018 by a previous Medical Director, Interim Medical Director, 10:42 Dr. Khan, at the time. It was just before you came into post, I think, was it?

A. A year and a bit, I think.

56 Q. If we look at that at TRU-252195. He produced a report entitled "Management of Trust Standards and 10:42 Guidelines". I just want to read out a couple of extracts from the report.

A. Okay.

57 Q. You will see at the high level context, he says, first of all: 10:42

"The purpose of this paper is to provide a report to Governance Committee which sets out the Trust's position on implementation and compliance to standards and guidelines received from 1st September 2016 to 24th 10:43 October 2018."

He is taking a snapshot in time in order to look at the issues around the implementation. The high level

context is, he says:

"The volume of standards and guidelines has become increasingly challenging for providers and commissioners to manage within existing risk management and clinical governance arrangements. In August 2016 SMT agreed to revise processes to manage standards and guidelines and strengthen systems by introducing risk stratification of each standard and guideline by operational teams, multilevel standard and guideline compliance reporting, identification of barriers to compliance, and modernisation of the corporate standard and guideline database to facilitate corporate reporting, ensuring the consistency of information captured and to free up administrative time." 10:43 10:43 10:44

You will see that in the Acute Directorate at paragraph 4 of TRU-252199, he has indicated that there are:

"... 311 standards and guidelines recorded on the corporate database as having applicability to the Acute Directorate. Of these 311, 89, 28%, of these standards and guidelines are recorded as not requiring a compliance position or risk assessment completed as they are for dissemination only or have been superseded by another guideline. 79, or 25%, of these standards and guidelines have been indicated as being fully compliant by the Acute Directorate, and 146, or 47%, of these standards and guidelines are recorded as either 10:45 10:45

partially compliant, non-compliant or compliance being reviewed."

Is this a report that you are familiar with at all?

A. It wouldn't have been one I would have been familiar with in my tenure. 10:45

58 Q. The findings there of almost 50%, almost half of standards and guidelines as being either partially or non-compliant or compliance being reviewed, does that sound like a familiar figure for you? 10:46

A. Yes, but I wouldn't be able to stand over the exact figures from in my time. Because that was 2018, so I wouldn't be able to stand over was ours slightly different or had they improved any.

59 Q. If we go to the Directorate Risk Register of July 2019 at WIT-94611. If I can read the extract from that rather than we all strain our eyes trying to find that. It says: 10:46

"As of April 2018, there are 1,609 standards and guidelines identified on the Trust register. 74%, which is 1,193 of these, are applicable to Acute Services Directorate. Of these, 34%, 405, remain at a partial or non-determined level of compliance, with many identifying significant external barriers impeding the Trust's ability to comply." 10:47 10:47

I think you have mentioned some of those external barriers are buy-in from GPs, and you have also

mentioned, I think, the Board as well?

A. Yes.

60 Q. HSCB?

A. Yes, about implementing certain processes. You know, you were tried to waiting on those processes being fully implemented. 10:47

61 Q. From the figures provided in April 2018 to Dr. Khan's report eight months later, the figures have risen from 34% to 47%?

A. Mm-hmm. 10:48

62 Q. Did you ever undertake a similar sort of analysis to find out what the standards and guidelines situation was while you were the coordinator?

A. I hadn't, no, but my standards and guidelines manager did do, and she would have produced reports for me and then for my senior colleagues as well every two weeks. These would have been discussed then. 10:48

63 Q. Would they have been discussed in percentage terms of the total not yet implemented, or partially complied or needing reviewed? 10:48

A. Yes.

64 Q. The figures that I am bringing you to from 34 to 47, do these sound about right in your recollection of the amount outstanding?

A. Yes. 10:49

65 Q. You mentioned NG12, which deals with suspected cancer and referrals.

A. Mm-hmm.

66 Q. If we look at TRU-97052. Again, that's one of those

you almost need a telescope for. If you take it from me, it remains non-compliant. If we go to the actual document, it's been exhibited by Mr. O'Brien at AOB-76720. This was introduced in October 2015. Would you be familiar with this before I ask you a few questions? Not the detail of the actual NICE guidelines but the name NG12.

A. Yes, from the SAI reports, yes.

67 Q. You remember that from the SAI reports in what context?

A. That was to do with the triaging of letters, the CCS system that GPs would have had for triaging letters into the Trust. It was in relation to that aspect of it.

68 Q. Was it one of the guidelines that the Review Team looked at as being applicable for referral and review --

A. Yes.

69 Q. -- in suspected cancer?

A. Yes.

70 Q. If we just go to the previous page to get the date of the email. This is an email from Fiona Reddick on 15th October 2015. Obviously you are not included in this because you weren't in post. The Panel see a lot of familiar names in the email trail. She says:

"Dear all, please see attached new NICE referral guidance for suspect cancer NG12, which has been endorsed by the Department as applicable in Northern Ireland. This has been discussed at regional network

site specific group meetings, and comments on the implementation of the guidance have been requested. I would be grateful if you could circulate this guidance to Cancer MDTs and teams so that all can view and comment back by 30th October 2015 so that a collective Trust response can be made."

Mrs. Reddick is asking for feedback, I think, on the provision of the NICE referral guidance which has been endorsed by the Department? 10:51

A. Mm-hmm.

71 Q. I know you weren't involved in this but is that something that is normally done if guidelines come out? Would that come through you, that you would ask people for feedback, or is this a different way of doing it? 10:52

A. That wouldn't be the way I would be familiar with it being done. Generally speaking, the guidelines would come in through the Trust, and then the guidelines manager, at that time would have been Caroline Beattie, she would have collated the information and produced an action plan as such, you know, that stratified the non-compliance/compliance with the RAG rating of where we were at with it. Then, she would have brought it to the table every two weeks. These would have been discussed with the senior -- when I talk about senior management team, I talk about the Assistant Directors and the Director of Acute. That would have been discussed then of how we move forward with these guidelines and how we can comply with them and

implement them. It would have come through the standards and guidelines channel as opposed to a head of service channel, as in this case.

72 Q. It's just a different route but the same thing --

A. A different route but the same thing. 10:53

73 Q. -- Mrs. Reddick is asking for feedback on how they can be implemented?

A. Yes.

74 Q. Rather than the guidelines themselves. I don't think they are up for negotiation when they have been 10:53 sanctioned by NICE and the Department?

A. No. Absolutely.

75 Q. It's really about how do we make these real, how do we bring them to where we need to go?

A. Yes. 10:53

76 Q. What would your role be in relation to that when you have guidelines -- if we take a guideline that you were ready to implement and it was all ready to go, what steps do you take then to roll that out?

A. A lot of the times it would be, you know, making staff 10:53 aware of it because you can't just introduce a guideline without anybody being aware of it, because you can't expect people to have 'oh we have just read that'. They might need training; there might need to be meetings with the staff involved, particularly the 10:53 operational staff, and that would be the consultants, the lead nurses, the heads of service, the ward sisters, and then cascade that through the system into the staff on the ground.

There would be quite a bit of background work into sharing that information to make sure people are compliant because when you introduce a guideline, you are holding people to account to follow that guideline, 10:54
so you can't just send it through in an email. It has to be shared and it has to be discussed. Where these would have been discussed at the governance forums, then they would have been discussed at the divisional governance meetings, and then they would have been 10:54
shared with the lead nurses and the ward sisters at the nurses' meetings. And they would have been discussed at Acute Clinical Governance meetings, so that would have gone down the medical route from the Associate Medical Direct, Clinical Directors, consultants, and 10:54
then cascaded down the medical staff from that viewpoint, cascading down the nursing staff from that viewpoint, and then making sure that everybody was aware of these guidelines before they were fully implemented. 10:55

77 Q. That awareness initially is driven by you and your team?

A. Driven by the -- yeah.

78 Q. Do you have oversight then of whether it's actually implemented? 10:55

A. Well, I would have attended the governance meetings, the, say, lead nurse forums and the divisional governance meetings to see where we were at with that and how we were. There would have been a feedback

mechanism, how we are getting on with that, you know, that kind of stuff.

79 Q. Was it ever the case that people came back to you, directorates and divisions came back to you and said we don't have capacity to implement this guideline, there are issues around this? 10:55

A. In my time, no. I haven't experienced that, people coming back and saying absolutely not, it's not going to work.

80 Q. What's the process by which you reassure yourself that guidelines not only have been made aware to the correct people but that they are actually being used and being used properly? 10:55

A. Yeah. So to be fair, there was -- it wasn't a clear -- we didn't have an audit trail of are those being used; are those working well? Ideally, you would want to be able to go down the system and say right, okay, where are we at with these guidelines, let's audit them, let's see how well they are working, what are the issues with them. But in my time, I didn't have the time to do that and neither did the audit team, to be able to do all that sort of stuff. So, you were relying very much on the operational teams coming back to you and saying, look, that's not going to work. 10:56 10:56

Generally speaking, in maternity they have their own guidelines committee, and guidelines are shared through that committee and they are discussed and they are circulated through, and then there is feedback through

the system. It was more difficult to do that for me with such a broad remit, so that's why the guidelines team were particularly good and particularly active at following through on that.

81 Q. I think you have a cipher list in front of you, a patient cipher list? 10:57

A. I do.

82 Q. If you could just look at Patient 12. Don't say their name.

A. Mm-hmm. 10:57

83 Q. Is that a name you are familiar with?

A. Only from the SAI Review. I would never have met this patient on a -- I think I'd made one phone call to this patient's family.

84 Q. Do you remember when around that was? 10:57

A. The phone call that I would have made would have been 26th October in 2020.

85 Q. I am just going to read an extract from the findings, so, a summary. Just for the Panel's note, it can be found at WIT-93394. It just makes a reference to NG12 10:57 and I just want to put it on record.

A. Okay.

86 Q. It says:

"The reference to CG27 guidance has been replaced by 10:58 NICE guideline NG12 suspected cancer, recognition and referral, but despite being endorsed by the DHSS PSNI and accepted by the regional urologists, it has yet to be implemented. Its use as a triage standard should

result in fewer red flagged cases, which should ease some of the pressure on waiting lists. Its adoption will take place in primary care and should form the basis of the electronic CCG referral tool."

10:58

Now, that was an issue arising in 2016 and the report was only signed off in 2020?

A. That's right.

87 Q. Is that one of the ones you inherited in the 34 --

A. No. It was one of the ones that was ongoing but my counterpart was still facilitating that SAI. Trudy was facilitating that SAI so I didn't actually get sight of that until much later in 2019. 10:59

88 Q. As a benchmark, would that period of time completing an SAI be extended? 10:59

A. Extensive, yes. Yes.

89 Q. You can see in that the learning, the summary report, the reference to NG12. We can learn a couple of things about it from that summary. First of all, it was endorsed by the Department and accepted by the regional urologists. If it was implemented, its use as a triage standard would actually reduce red flag cases and would ease the pressure on the waiting lists, and yet it's not implemented. 10:59

11:00

Can you just explain or do you know anything about why that hasn't actually been implemented and what the hold-up is?

A. I wouldn't be the best person to speak to on this one.

I think probably the Standards and Guidelines Manager would have been better to tell me what the hold-up was in all of this. I would have only had a high level view as opposed to the minutiae of the detail of it.

90 Q. Even from a high level view, there are clearly statements in that paragraph that indicate that this would have a potentially significant impact on patient care, and when that's brought into play, that must surely always have a beneficial outcome for Patient Safety, reducing patient risk, increasing long term health for patients if they are seen more quickly. 11:00 11:00

Would that be a standard and guideline, given the issues that the Inquiry are grappling with that touch on issues in this paragraph, would that be a guideline which one might focus on and say let's get this one over the line given the established or the anticipated benefits and the state of play at the moment? Would that be something that would be on your radar at all at a high level? 11:01 11:01

A. Yes, from the viewpoint of the recommendations from the SAI, and that's why -- but I wouldn't be the person who would be implementing that learning, but I would be following up with the heads of service to say where are we at with this guidance; what is the hold back; what's the issues? What's come back to me with regards to NG12 were they were needing responses back from GPs and from the Board, that there were aspects before they could fully implement that. 11:01

91 Q. Did someone put that in writing? Did you e-mail someone and they wrote back and said this hasn't been done because the GP and the HSCB aren't on board or have concerns, whatever the reason is, but those are the two things that are holding back? Is that your understanding of the position? 11:02

A. Yes, yeah.

92 Q. Now, we looked at the very small chart, the Excel sheet where this risk was recorded. It's recorded at that point as low risk. Does that reflect -- well, you tell me what it reflects when you say "low risk". When one looks at the potential benefits of a guideline like that, do you think is that something that should be up at the top of someone's high list of getting it done? 11:02

A. So, I don't have the detail of where we are at with regards to triage letters. That wouldn't have been in my remit. I understand that there were systems and processes put in place with regards to the triage because the CCG is an electronic kind of triage system that comes through, is my understanding of it. I don't have that much experience using it because I have never used it; I have only ever heard about it. Someone who has more knowledge on that system would be better to address that with you. I don't want to lead you down a different road when I can't answer the -- can't answer to the detail of that. 11:03 11:03

93 Q. That's okay. It wasn't the detail really I was asking about. I'll just go back to it on that sheet that we saw that guideline, the standard, was marked as a low

risk.

A. Yeah.

94 Q. I am just wondering when you look at risk in relation to the potential benefits of guidance, or the necessity of it, what does the risk reflect? 11:04

A. The risk reflects what mitigations are in place to reduce that risk. So anything can be a high risk initially but if you have mitigations in place, for example you have staff who are triaging the letters as they are coming in, you have that oversight, then that 11:04 lowers the risk. That's why it was probably in as a low risk as opposed to a higher risk because of the mitigations. The work is already being done to reduce that risk, if you understand what I mean?

95 Q. If I can reflect your answer back just to make sure 11:04 that I understood you before I ask other questions. The risk reflects the fact that, in the absence of those standards and guidelines, there are systems in place which perhaps so mirror what the standards and guidelines might do for that to be considered any risk 11:04 or a low risk?

A. Low risk, yes.

96 Q. As a coordinator, as Governance Coordinator, were you satisfied that what was in place, especially following Patient 12's SAI, were you satisfied that, in fact, 11:05 that was an appropriate risk setting for NG12? Were you satisfied that what was in place already operated to ease the pressure on waiting lists and result in fewer red flag cases?

A. So, was I satisfied that it was at a low risk when there's mitigations in place? Yes is the answer to that. If there's mitigations in place that are working. My understanding was that the mitigations that were in place were working.

97 Q. So, the Trust were doing as much as it could because the GPs, where the primary care sits, for whatever reason there was some resistance --

A. Yes.

98 Q. To the adoption of it? Did you ever get to understand what that was from the GPs? 11:06

A. No.

99 Q. Who allocates the low risk in the standards and guidelines document; is that the Directors or the Assistant Directors? 11:06

A. The Assistant Directors and Directors. That would be a multidisciplinary decision. You might have Clinical Directors in there as well making that decision.

100 Q. Patient 12 was among a group at the time, and the outcomes of those five SAIs were within your tenure? 11:06

A. That's right.

101 Q. Are you able to explain to the Inquiry what steps were taken after those reports came out? From your role in governance, what did you think about the outcomes from a governance perspective, first of all, and what steps then did you take to either implement the recommendations or alter systems of working to reduce the responsibility of similar scenarios recurring? 11:07

A. So, an action plan was generated and shared with the

operational teams. There was two recommendations from memory, there was two recommendations that were for the Health and Social Care Board to action. When those reports went to the Health and Social Care Board, our understanding is that they look at it and they take the actions forward. In that case, that didn't happen until, I think, October time, whenever I was following up and saying now where are we with these? Have we implemented everything fully? The response was we were still outstanding with two of them. 11:07 11:08

So, I rang the Health and Social Care Board and said, you know, this guideline, can we have a meeting about it because there's two outstanding recommendations that haven't been actioned and we are quite concerned about that. We did have a meeting about it. For the first time that I'd ever been made aware was the Health and Social Care Board had come back and said you don't make recommendations on the Health and Social Care Board without discussing it with us first. Now, that wasn't written in any statute, it wasn't written in any SAI procedure that I was aware of. 11:08 11:08

102 Q. Who said that to you?

A. This had come back from one of the members in the Health and Social Care Board. 11:08

103 Q. And who was that?

A. Denise Boulter. This was new to me but I understand -- don't get me wrong, I can appreciate where they're coming from; I understand it is probably best to speak

to the Health and Social Care Board before you make recommendations of those. It's probably a good thing to do. I am not criticising them in that, it's just it's new to me.

11:09

So, we had to go through the whole process of these recommendations were made, they have been accepted by the Trust and they are implementing them, so there still needs to be work to be done. That was handed over to the Health and Social Care Board to implement those. 11:09

104 Q. What was the position by the time you had left in 2021?

A. It still wasn't completed by the time I had left.

105 Q. Was there ever any reason given as to why it hadn't been completed? 11:09

A. I can't recall. I am sure there was but I can't recall what the reason was.

106 Q. It's your understanding that the delay in the implementation was from the side of the HSCB, as then?

A. Only for those two recommendations. The rest of the recommendations were implemented. 11:10

107 Q. Now, specifically in relation to Urology and your governance responsibility around that, if we go to WIT-92031, paragraphs 3.8 and 3.9. I don't think it's contentious but you say: 11:10

"I believe the overall responsibility for governance in Urology rested with the Assistant Director of Surgery, Associate Medical Director and Clinical Directors, who

would then escalate appropriate issues to the Director of Acute Services, Medical Director and Chief Executive. I understand there is also a governance responsibility sitting with the Chair of the MDM for Urology to ensure that recommendations made at MDM are actioned." 11:11

You don't mention the head of service in your list there around governance. Do you have a working relationship with Mrs. Corrigan, the Head of Service in Urology? 11:11

A. It's not that I don't mention her. Governance is everybody's responsibility, as you know. But what I was talking about is ultimately, you know, that information sits with a higher level than a head of service, just. That's what I meant by that. 11:11

108 Q. Yes. I should say I wasn't pointing that out as some point-scoring exercise, I was trying to introduce the role of the Head of Service in relation to your particular -- 11:12

A. Yes. So I had a working relationship with Martina, yes.

109 Q. What did that look like?

A. We worked very well together. Anything that I needed or questioned, Martina was very good at coming forward. She was very efficient. 11:12

110 Q. Did you have regular meetings with her or any of the other heads of service?

A. Only from the action plan point of view would have been

my meetings with the heads of service, because they were the ones ultimately driving the action plans forward.

111 Q. You say at paragraph 3.9:

11:12

"There appeared to me to be a disconnect between what was happening regarding operational decisions within divisions and what was shared with the Acute Clinical Governance Coordinator. I was only made aware of any issues through the SAI processes or through Datix complaints. Each of these information routes might prompt me to seek further information on and/or clarification of the issue raised. The limitation inherent in these communication channels is that you are relying on someone telling you of any issues or submitting a Datix."

11:12

11:13

You can correct me if I am wrong, what you are saying there seems to be you got information by the established routes --

11:13

A. Yes.

112 Q. -- rather than any other way?

A. Yes.

113 Q. Dr. Rankin used a phrase yesterday in evidence of "soft intelligence", where she spoke to people and was visible, I suppose, and was seen and people came up to her. Was that a management style that you sought to adopt?

11:13

A. Yes. When I came into post first, my office was on the

administration floor so it was really -- I was in close proximity to the heads of service and to the Assistant Directors and to the Clinical Directors. So I frequently -- people would have -- I kept the door open obviously, but people would have come by and said 'Patricia, do you know such-and-such thing has just happened'? So, that soft intelligence is a good word for it. I would have been able to say 'Oh right, okay, I didn't know about that, what was the story'. So I was able to drill down on what was happening. That was really good from that viewpoint. 11:13 11:14

Space became an issue and we were moved off to a site further away from the hospital down in the Rowan. That close proximity -- I would have been up to the administration floor every day and did a walk around and said what's happening, what's going on on the ground, because there is a disconnect and not in a deliberate attempt not to tell you, it's just that people are caught up in the day-to-day runnings of the wards. Sometimes they don't appreciate that actually is an issue that we need to know about, that's an issue that you need to be sharing and escalating up. So, quite a lot of the time I would have had to dig down and try to find what was going on; was there anything happening on the ground that I wouldn't have known about from a Datix point of view or, as I say, in the night report. 11:14 11:14 11:15

114 Q. When you talk about the disconnect, were those informal

attempts at digging down successful at all?

A. Sometimes they were, yes. Then I would have said can you get somebody to put in Datix and we would have a record of it, and I would have escalated it to the director and said do you know that this has happened? What are we going to do about that and what's happening at the minute? It might be something like a safeguarding concern for a patient in the ward that staff in the ward think that's just operational that we don't need to know about from a governance perspective. But of course you do need to know from a governance perspective because you need to know patients are safe. 11:15 11:15

It's not that people were deliberately not telling you, it's just sometimes, because of the nature of the hospital and the work and the operationalisation of it, that might have been lost in the escalation, if you know what I mean. 11:15

115 Q. Were staff ever trained in how to identify governance concerns and which was the most appropriate route by which to draw that to the attention of the right people? 11:16

A. Obviously these would have been discussed at sisters' meetings, you know, to escalate concerns, to complete Datixes, this is when you need to be doing this. In maternity - and I'm sorry I keep going back to maternity because that's my background - but in maternity, you had a trigger list: These are the things that need to be reported, these are things that 11:16

are really important.

When I came into post in Acute, I had wanted some kind of guidance for staff, albeit a trigger list, to say, you know, if a patient is, say for example for surgery, if a patient has unintended injury during an operation, we need to know about it; if a patient has excessive blood loss during an operation, we need to know about it. Therefore, there should be a trigger list to advise staff, this is when you need to be putting in a Datix. Did the patient die on the table? Obviously you are going to know about that one. You know, things that are not as drastic, you need to know about because they are the ones that are significant. They might seem insignificant to somebody on the ground but they are significant because you have to look at, you know, what happened, why did that happen. 11:17 11:17 11:17

116 Q. Were you successful in bringing in a trigger list?

A. No.

117 Q. And why was that? 11:17

A. Because they said it was such a big area that they couldn't narrow it down to what needed to be significant. But I feel that you could have transported what's from the gynae trigger list over to surgery very easily. I was never successful from that viewpoint. 11:18

118 Q. In terms of staff -- I know you mentioned that the sister had meetings and there would be conversations around governance but, more widely, did you have

a sense that staff across all disciplines, ancillary staff, had an awareness of their own individual responsibility around governance to alert the appropriate people if they had concerns?

A. I think the ward sisters had and the ward managers had. I would have done direct face-to-face training with them on Datixes, but -- 11:18

119 Q. How often did you do that?

A. So that would have been done probably every few months. It would have been either me or Carly or David, the two Band 7s, that would have run that training with them. 11:18

120 Q. Just to clarify, Datix training every few months with staff on the ward?

A. Yes. Whilst they didn't get it every few months, they would have got it once, you were rolling out the training for staff to attend. It wasn't very well attended, you might have had maybe five or six people there at training. 11:19

121 Q. So was it optional?

A. It wasn't in their mandatory training, and perhaps it should have been. It is in maternity, mandatory training for midwives. 11:19

122 Q. Do you think that would help if it was mandatory?

A. I think it would because when I first came into post, I think there was a negativity around putting in a Datix. It nearly seemed to be that you were reporting somebody if you put in a Datix. You know, in maternity, that was the case. I had to change the attitude to staff and say, you know, hold on a minute, 11:19

this is not about a person or an individual, this is about a system and process, so we need to be looking at this, Datixes are not used as oh, I am reporting somebody because they did this and, you know, putting a negative slant on it. I would have seen Datix submissions as a positive because they were recognising there was a risk there, they were escalating the risk there and we were doing something about it.

123 Q. Would you have ever been able to, given that you had the global view of Datixes, would you be able to identify themes -- 11:20

A. Yes.

124 Q. -- or system weaknesses from across all your areas of responsibility?

A. Yes. Technically you can do that because we would have run reports off and said, right, okay, can you run a report and see what the themes are at the minute. The themes might have been -- at one stage we had a huge abuse to staff from relatives and patients and, you know, staff being assaulted and things like that. So that was very -- when we had produced a report on that, we realised that was quite significant, actually, people were getting battered every day in their working life. When I spoke to then the staff on the ground, so I went to the wards and I said what is this like, why am I getting so many incidents in about staff being abused, physically abused; some were beaten, some were hit over the head with objects. Like, it wasn't, like you know, a verbal abuse. Staff just took it in their

stride. They were like oh, well, that's normal. I mean, those Datixes that came through are just really a tip of the iceberg. So that's quite worrying of how our staff were working.

125 Q. Was it also quite worrying of how they viewed Datix and the effectiveness of that system and the outcomes in resolving issues of concern? 11:21

A. Yes. Yes.

126 Q. Did it show they had little confidence in it?

A. That exactly is what you are saying. So I had to go back and say, well, do you know what we are doing, we are escalating that to your senior managers. That is going through to the Director of Acute, that is going through to the Chief Executive of how you staff are working on the ground, so it is being monitored and we are looking at it and we are trying to make it a safer place for you to work in. Because staff just thought, sure what's the point? 11:22 11:22

127 Q. The Inquiry has heard some evidence around the use of Datix in an attempt to raise concerns around charts. I don't know whether you've listened in on any of the evidence of Katherine Robinson or Helen Forde, or were you able to listen in on those? 11:22

A. I was able to listen into Katherine's, yes.

128 Q. You will be familiar with that theme of the raising of the Datix, and it seems nothing arose as a result of that in August before your time? 11:22

A. Mm-hmm.

129 Q. You have talked about the range of things that can

happen in a hospital from. I think you mentioned dying on a theatre bed through to charts being missing. I am not giving any gradient to any of them. From a risk perspective and engendering confidence in staff that the route of complaint they choose is the most appropriate one, do you think having one system of Datix fits all?

A. That's a very good question, actually. The Datix system is very labour-intensive to complete it. So when staff were completing it, it's not just a quick form that they fill in, there's so many aspects to that form. It keeps getting added to and added to and added to, so staff get a bit weary trying to complete those Datixes, so that in itself is a drawback. Is it a one-size-fits-all? Possibly, possibly not. I don't know what other systems are out there that can -- but it's the best of what we have, if you know what I mean. We have to work with what we have.

130 Q. Your first initial trigger with the Datix is how it's categorised - major, catastrophic?

A. Insignificant, minor, moderate, major and catastrophic.

131 Q. And who denotes that?

A. The reporter.

132 Q. So if I am on a ward and maybe the warning signs haven't been put up and I think it's a care of the elderly ward, that could be catastrophic despite the fact it isn't, my own subjective interpretation of the potential of that risk informs the way in which I report it to you?

A. That's right.

133 Q. That goes to the top of the queue, does it?

A. It does, yes.

134 Q. Do you think that's an effective way? If training is not compulsory and staff are of subjectivity in their assessment of the risk, do you think that that is the most appropriate way for you to know what your priorities are on any given day? 11:25

A. Generally speaking with training, staff soon learn that that isn't the way to fill out the form. Although the example that you have given has occurred in different scenarios, it is quickly fed back to the staff on the ground what the matrix is for reporting. So much so that I have asked for the wards -- I have asked in my time for the wards to have the matrix pinned to the side of the computer so that when they are completing it, they understand what that actually means and what constitutes the rating of an incident. 11:25

Thankfully, they are few and bar between, those incidences that are catastrophic and major. It does warrant us going into it every day and saying is this a major incident, checking on it and going back to the head of service or going back to the lead nurse and saying this incident came in, can you give me more detail? It's came in as a major incident; is that a major incident; what has actually occurred to make that major incident? Very often they will come back and say well actually it's not, it was major -- it was 11:26 11:26

a major, say, blood loss, but the patient was treated, managed appropriately and is doing very well. That doesn't make that a major incident because a major incident would be where there's harm, long-term harm done to the patient.

I am not taking away from mental stress on patients and I don't mean to undermine patients' emotional aspect to any incident, but what I am saying is you have to have a matrix in place so you can grade these incidences through effectively so that they are not jumping the queue from an escalation point of view. But I will say that all incidences were reviewed -- in Acute were reviewed daily by my team, either by myself or my Band 7s. Every day, every working day they were reviewed. But, equally, every ward sister was responsible for reviewing every Datix that came through their system as well.

135 Q. Just in relation to the final point on the issue of staff understanding and compliance with governance systems in place to keep people safe.

A. Yes.

136 Q. It's publically reported about staff turnover in Trusts is quite high. Would that be your experience?

A. Sometimes, yes.

137 Q. And it's pubically reported significant dependence on agency staff?

A. Yes.

138 Q. Which obviously requires staff to move about sites.

Given the peripatetic nature of potentially quite a significant number of Trust employees, do you see that as a governance risk?

A. Yes. Yes.

MS. McMAHON: Chair, I wonder if that would be a convenient time? 11:28

CHAIR: A quarter to eleven then. We will take a short break.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 11:28

CHAIR: Thank you, everyone.

139 Q. MS. McMAHON: Mrs. Kingsnorth, I just want to move on to a slightly discrete topic you have raised in your witness statement around issues around individuals' competence at their role. You are not really involved in that but I just want to highlight what you said around that. WIT-92030, paragraph 3.6. You say: 11:48

"There was a separate process followed through Human Resources when issues were identified regarding a staff member's competencies. As stated above at question 1I, the operational teams are responsible for the competency or professional issue with any registrant, and any issues of such a nature would be addressed through this route. Usually the Medical Director's office or Executive Director of Nursing would be made aware of any such issues. They would not be shared at my level in view of the confidential nature of them. 11:49 11:49

Of course, the problem with that is that it prevents one from having all the information when an SAI Review is conducted. The practice has now changed somewhat so that any staff member mentioned in an SAI has to discuss this at revalidation." 11:50

You are reflecting in that paragraph the existence of a relationship of confidentiality as an employee and among staff, but you seem to be suggesting that that confidentiality can sometimes get in the way of you having information that might be relevant to your role? 11:50

A. So, my previous experience, risk midwife, if there was a midwife, for example, who was undergoing a supervision of midwives' investigation or has been referred to the NMC, I might -- I would have been informed, look, there's a process going on about that midwife. It would have been very confidential, I wouldn't have known the detail about it but I would have known that this was happening. 11:50

11:51

When it comes to medical staff, that information isn't shared. I understand the confidential nature of it and I understand that everybody has the right to that confidentiality until the investigation is completed, but whenever you are doing a review, you are not necessarily aware if there are other issues that are going on. If you were getting all the information in, you wouldn't be aware that there's other issues going on in the background of a particular staff member. 11:51

140 Q. So if you are not on the Review Team, you are not aware of what the SAI is about; is that what you are saying?
A. No. If you are on the Review Team, you are aware of what an SAI is about, but if there are other issues with the staff member or a staff member who is involved in an SAI, you are not aware of that. 11:51
141 Q. So, you are aware of sort of single issues for the purpose of the SAI Review?
A. Single issues, yes.
142 Q. But not necessarily the background information -- 11:52
A. Other issues.
143 Q. -- that might inform that?
A. Yes.
144 Q. Does that apply for the MHPS process as well?
A. So, we would never have known about an MHPS, definitely not. It wouldn't be something that would be shared at my level. It would be kept with a tight cohort of people. 11:52
145 Q. Does that apply even if the learning or some of the issues that arise through the MHPS have a direct impact on your role and governance and perhaps patient care? Are you not informed of anything about the outcome of an MHPS? 11:52
A. Unless there is a staff member that has been -- their contract has been terminated, I wouldn't know. 11:52
146 Q. Do you think that there's a way of sharing information with you at your level as the coordinator, Governance Coordinator across Acute Services, that would allow you to carry out your role more effectively, assist in the

protection of patients with a reduction of risk, and also anonymise sufficiently to maintain the confidentiality of the individuals involved?

A. I think so. I can see the benefits of it if you were aware there were other issues because then you are kind of joining all the dots, aren't you? You don't have all the dots to join otherwise. 11:53

147 Q. Did you ever share that or mention that to anyone and say is there any way we can get beneath some of the more formal procedures that actually can highlight aspects of governance that need improved? Were they conversations that were had at any level? 11:53

A. No, because I didn't know what I didn't know at that stage, if you understand what I mean. So, it wouldn't have been on my radar to ask that question. 11:53

148 Q. By the time you had left the Trust, was there any movement in thinking that that sort of issue needs to be looked at, that there perhaps is a wider benefit from a governance perspective in bringing other people inside the tent, as it were, so that learning in an anonymous context can be rolled out? 11:54

A. Not in that context. Having said that, I was aware of a Medical Director's office contacting me and saying, you know, has so-and-so -- is there any complaints or any SAIs involving this staff member? But they weren't -- you were just asked to check out if there was any incidences with that. There was no information coming back, if you know what I mean, to say look, this is what's happening in that case. It might have prompted 11:54

you - that's only just before I left this started happening - that would have prompted you, oh, is there something going on? But you wouldn't have had any detail on that and you wouldn't have had any context where that's concerned, because very often the information was purely from they are revalidating, or it's for their appraisal; not necessarily that there's an investigation going on. 11:55

149 Q. There are occasions in hospitals when incidents happen that there's immediate learning from. Just a random example, maybe injection valves are the same colour and someone has mistakenly given - you are familiar with that sort of scenario - mistakenly given the one instead of the other - they might be a yellow colour and one slightly lighter - but the immediate reaction in that is to bring about change in colour codings so that the visual issue is reduced? 11:55

A. Mm-hmm.

150 Q. That's a learning that obviously needs to be rolled out, but it also can be done in a way that doesn't identify the initial -- 11:55

A. That's right.

151 Q. -- individual --

A. That's right.

152 Q. -- whose mistake highlights the governance concern. Do you think there's scope for that sort of approach from any formal process that might bring up governance concerns, a similar thing; generic learning sent out to everyone? 11:56

A. Yes. There is that -- there is that scope for that.

153 Q. Where would the change in attitude come from to bring that about? Who would need to lead that forward?

A. You need a whole cultural change in how we look at incidents and you need a cultural change in how we discuss incidents as well because, very often, instead of looking at, well, that's a human factors issue, people still have that kind of blame 'oh, you never guess what so-and-so has just done. That needs to stop. For you to have openness and transparency and good learning coming through, you need to accept we are human, human factors, people make mistakes; this is the mitigation we put in place; this is the learning that we put in place so that the whole stigma of being involved in a serious adverse incident is removed. Because there is a stigma for staff that are involved in it, they are quite stressed about it and they think that people are pointing the finger at them. Really, all you are trying to do is make things safer, makes systems and processes safer so you are reducing the risk of it happening again. That's is what families want as well. 11:56 11:57 11:57 11:57

154 Q. You say, if we go to paragraph 3.10, which is at WIT-92032:

11:57

"Whilst I do not believe there was any ever any intention to cover up issues, I believe that some serious issues were escalated to my senior colleagues rather than to me given the confidential nature of

them. The MHPS case regarding Mr. O'Brien is an example."

Just to bring that point home, again people who were more senior to you on the management rank were aware of this -- 11:58

A. Yes.

155 Q. -- and you weren't. Who did you report directly to?

A. Initially I reported directly to my line manager, who was Tracey. 11:58

156 Q. Tracey Boyce?

A. Tracey Boyce. Then after that was to Melanie McClements, she was my director then.

157 Q. In a sense, the essence of what you are saying in those two paragraphs is that confidentiality can actually inhibit good governance? 11:58

A. To a certain extent.

158 Q. Does it benefit it in any way?

A. It benefits the individual's rights.

159 Q. But in terms of the governance? 11:59

A. From a governance perspective, I don't see the benefit in it.

160 Q. If we just move on to the SAIs.

A. Okay.

161 Q. Just a couple of questions around your role generally in SAIs. Is it usually the case that SAIs always emerge from Datixes, or are there other ways in which an SAI can come about? We have obviously experience of the lookback in this scenario, which is a different 11:59

structure. How does a Datix or anything else become an SAI, in your experience?

A. So, it can come through complaints as well, or if an incident had happened in the ward at a time where we can escalate that through for screening before a Datix is submitted. So, yes, Datix complaints and, you know, somebody verbally coming forward and saying there was an incident that happened is how we would screen them. 12:00

Depending on the level of the Datix, generally speaking it would be the majors and catastrophics that would come in, but not necessarily. Some are moderate incidences that, by the nature of them, are brought forward to say this is an incident, you need more detail in it. That might be brought to screening as well once you have actually looked at the detail of it. 12:00 12:00

162 Q. Just tell us a bit about when you talk about brought to screening; what's the practical outworking of that?

A. Every week, every division had a set day for screening incidents. That has been in place from before my tenure. It would be attended by an Assistant Director, Associate Medical Director, Clinical Director, or Clinical Directors if there's more than one, and a governance person. There would always be a governance person at that screening meeting. What you would bring is a template of all the incidents that they have ongoing, all the SAIs that are open, and progress. They would get a progress report of this is an incident, the next meeting is occurring -- or an 12:00 12:01

SAI, the next meeting is next week or next month, or if there was any restrictions, in other words, we can't get hold of a Chair and we need somebody to chair that review, or the Chair has gone off sick and we need somebody. So, they would be discussed at that screening meeting. 12:01

Equally, new incidents would be brought forward and you would review those incidents with that multidisciplinary team and say, well, this Datix has come in, this is quite worrying, this worries me, can we look at that? We would provide a timeline of events to say right, okay, let's have a wee look at this, what actually happened. We would get the notes and we would draw up a high level timeline of the incident, so that when people are making decisions, they have something tangible to work from. Then, a decision might be made, well, let's review it from Datix and let's see if there's anything comes out of that. Or, you know what, we probably need to drill down and get more information, let's have a discussion with the staff on the ground about the incident and see what went wrong and what issues, you know, had occurred. Or they might say let's do a structured judgment review and see what that brings up. 12:01 12:02 12:02

Any of those responses can lead on to an SAI; do you know what, we have reviewed this, we think there is learning here, we think we need to go down the road of

an SAI. Then, a decision is made, some --

163 Q. Just in relation to the decision being made, is that a collective decision or does someone take the lead and say, yes, I think this should be --

A. They might say does that meet the criteria for SAI, in which case then we would say yes or no. 12:03

164 Q. But as a collective; is that a collective decision?

A. Usually a multidisciplinary decision.

165 Q. If there's any dissent around that or different views, is that just discussed and accommodated until you reach an agreement about the way forward? 12:03

A. Yes. Yes.

166 Q. The review screening process would be for all intents and purposes unanimous, and it would go on to the next stage? 12:03

A. It would. If there was any query -- I mean, they are very open and transparent meetings. They are very -- you know, it's not difficult to challenge, it's not difficult for them to challenge each other. They might come up and say, do you know what, I think maybe we need to do this first, or I think that is barn door, I agree with that, let's go down the road of an SAI. Then they would agree the level of an SAI and say, right, okay, maybe we could do a Level 1 here, find out what happened and why it happened and what measures are put in place. Or, do you know, this is much more complicated, we need to maybe do a Level 2 SAI because we need that whole root cause analysis approach to it. Or they might say, do you know what, this is a big 12:03 12:04

deal, I think this needs to be a Level 3 and we need to get a team from outside the Trust and we need to get a Chair from outside the Trust or an independent Chair or whatever. Those decisions would all be made at the screening meeting.

167 Q. And those meetings aren't minuted?

A. No, they are not minuted but the outcomes are recorded on an Excel spreadsheet.

168 Q. You have mentioned one of the difficulties in getting attendance at the meetings. In your statement at WIT-92035, paragraph 4.11, you say:

"Another drawback was that sometimes surgical screening was unable to take place due to the absence of either Clinical Director or Associate Medical Director or both. This was often due to competing clinical commitments. This meant that no decisions could be made regarding the screening of adverse incidents and to determine what the most appropriate method of addressing them also."

Would that have been a factor then in developing an SAI backlog - getting people's availability?

A. Yes, yes.

169 Q. Do you think there's a way around that at all? In your experience, given the availability issues across the board that the Inquiry have been hearing evidence about because of staffing pressures and other commitments, is there any way in relation to screening that it could be

done more effectively?

A. We did explore changing the day, you know, what day would suit better. Eventually that is what happened, they changed the day and things are working much more smoothly now. At the time it was we couldn't get a day to suit. There was all sorts of issues that prevented the staff from attending the screening meetings. I think, with the best will in the world, many of them phoned in. I know on one occasion, one of the Associate Medical Directors phoning in to the meeting en route to another clinic or whatever. I mean, the will was there to do it, it's just that their workload and capacity was making it difficult. 12:06 12:06

170 Q. One aspect of the benefits of Covid, I think, you have mentioned here as well -- 12:06

A. Absolutely, yes.

171 Q. -- is that people were able to Zoom in, and that improved the turnover?

A. And the surgical -- obviously the surgical elective was stood down so that made a big difference as well. Then eventually they changed the day to a more suitable day that worked. A change of job plans and things like that made it easier as well. 12:07

172 Q. You mention your involvement with SAI reviews at WIT-92016, paragraph 1.5L. You say: 12:07

"My direct involvement with SAI reviews was to facilitate the meetings, set up meetings, advise the Review Team of the governance processes to ensure

a robust report, and record notes of meetings. I would also meet with staff members to interview them for the SAI reviews, and I would record those meetings too. It would be my practice in this regard to ask the interviewee to check if I had documented the information correctly and in the proper context. It was obviously important not to misunderstand what had been said."

The anticipation in the last part of that paragraph is that you send the notes of meetings back to people, get them to confirm factual accuracy? 12:07 12:08

A. That's right.

173 Q. And that signs off those notes for the purposes of the review, if they are content with those? 12:08

A. That's correct.

174 Q. We will come to some of the incidents where that didn't occur in relation to Mr. O'Brien. We are obviously interested in the process and the governance around that, so that's what we are looking at. 12:08

Just the first part of that paragraph where you say your direct involvement was "to advise the Review Team of the governance processes to ensure a robust report and record notes of meetings". When you reference governance processes in that sentence, is that in relation to both governance processes that the SAI is done correctly, and also any governance processes that may be relevant to the substantive issues in the SAI? 12:08

A. That's right.

175 Q. You note the robustness of the report, that you want to be able to stand over that?

A. That's right.

176 Q. You say also that you would have had separate meetings with the Chair of the Review Panel to write up and review and assist with the administration of it? 12:09

A. Mm-hmm.

177 Q. So you really brought the information together, checked that everything was done properly, checked that people were happy with their contribution of that. I presume that's particularly significant with the potential outcomes for individuals of SAIs -- 12:09

A. That's right.

178 Q. -- both families, patients and any staff involved, that you want to be able to stand over robust process. 12:09

In relation to the SAI lookback review and the Urology Oversight Group, you say at WIT-92039, 6.2 -- it's actually in the first line. I have cut myself off halfway on the first line. I will start the sentence properly: 12:10

"As is also discussed in my response to question 1l, I attended weekly Urology Oversight meetings every Tuesday evening. The first meeting I attended was on 15th September 2020." 12:10

We move down.

"The purpose of the meeting was to discuss the issues surrounding the concerns with Mr. O'Brien. As discussed above, this was the first time I was made aware that an MHPS investigation had occurred previously in respect of Mr. O'Brien".

That chimes with your evidence on the confidentiality point.

Then at paragraph 7.5 at WIT-92043, you say:

"I cannot answer as to the effectiveness of the nine SAI reviews in terms of the implementation of the recommendations as I retired from my governance role and from the Trust in June 2021, before the recommendations could be substantially implemented"

A. That's right.

179 Q. I just want to ask you a little bit about that. The process, with the best will in the world, was anticipated to be completed within a very narrow window. You have reflected in your statement that for all of the Review Team, it was a very heavy workload on top of your existing workload. On that point, first of all, do you think there is any capacity or would be any assistance if people actually were stood down, people who were investigating it, from their normal workload to concentrate that on if operationally possible, because you seem to have been juggling quite a lot, as

was Dr. Hughes?

A. Yes. It really helped that the Chair was independent and the Chair was available to assist with the reviews because, if you can see from the meetings, we had meetings every two weeks to keep the momentum going. 12:12
Keeping a facilitator step down from this review would have been perfect. I had asked for it on numerous occasions but it wasn't possible, to be fair.

180 Q. Why was that not possible?

A. Because all the other work in governance still had to 12:12
be done, you know, so it wasn't possible for me to step down and then leave nobody to do the work. You would have needed to put somebody in place. That would have been brilliant if that had happened, but then you have to train that person. You need somebody in place who 12:13
knows what they are doing.

So, yes, an SAI Review with the timeframes. We were held to a very tight schedule to get these reports done, it was significant pressure. It would have been 12:13
ideal to be just doing that and nothing else.

181 Q. Given your commitment to that in relation to time and to the scope and the breadth of the work that had to be done for nine, did you have a sense of disappointment that you didn't see the recommendations implemented 12:13
before you left?

A. Yeah, very much so because I was really invested in this review. As I said in my statement, this is one of the best SAIs I have ever undertaken. To have the

level of communication with the families, I mean, I really -- I had bonded with so many of the families during that review, I wanted to see things come to fruition, I wanted to be able to work with some of them because some of them wanted to be involved in the recommendations as well, which was very admirable of them. But obviously retirement was beckoning.

182 Q. There was an introductory meeting for your team for the nine SAIs on 10th September 2020. That's at WIT-93794. We will see that the date is Thursday, 10th September 2020. Dr. Hughes, Fiona Reddick, Patricia Thompson and Patricia Kingsnorth. 12:14 12:15

Were you involved in any way with securing the services of any of the other team members? 12:15

A. That would have been a multidisciplinary decision with the ADs and the Directors. Whilst I was appointed as a facilitator, from memory there was a discussion about who the clinical nurse, would we go outside for that. But there was a new Clinical Nurse Specialist who had just started in the Trust, and Dr. Hughes was happy for her to come on board because she didn't know anybody in the Trust, she had no vested interest of it and yet, at the same time, she would have had feet on the ground to know where to access information should we ask. 12:15 12:16

The head of service would have been appointed by her line manager, Barry Conway. Again, a multidisciplinary decision of who was the best person to help with this,

and that's where Fiona had come in.

183 Q. Would it be your expectation that all of those individuals would know what they were signing up for?

A. It would have been my expectation that that would be done, yes. 12:16

184 Q. Did you hear Mrs. Reddick's evidence?

A. Yes.

185 Q. She indicated that she was just invited to a meeting, and it was only when she got to the meeting that she realised what it was about and what was anticipated. 12:16 Was that a surprise to you that she felt that way?

A. Yes. Generally speaking if you are being asked to be involved in an SAI, your line manager would have a conversation with you to see that you were comfortable with that, and I would have expected that. 12:17

186 Q. For the Panel's note, that transcript can be found at TRA-05717 line 13 to TRA-05722 line 22.

Whenever the members of the Panel are gathered together, is it a sense that everyone brings their 12:17 equal expertise to the process?

A. Yes.

187 Q. I know Dr. Hughes was the Chair but looking at the skill mix on the Panel, would it be fair to say that that was anticipated to reflect the issues that were 12:18 likely to be required to be considered for those nine SAIs?

A. So yes, in a way. You need to know from a nursing point of view, there always needs to be a nurse on the

Panel for any SAI. That's usually a lead nurse or somebody who can inform the actual running of the service and the actual day-to-day working of the service. So, Fiona was there to give us the expertise on the running of a cancer service and, you know, what processes and procedures are in place to keep that going. Patricia was in place as what happens on the ground, you know, what expertise that she could bring from that viewpoint. Then obviously we had to recruit a urologist as the expert, the subject matter expert for the team as well. That was ongoing before this first meeting. 12:18 12:19

188 Q. That subsequently became Mr. Gilbert?

A. Mr. Gilbert, yes.

189 Q. Now, you say you have heard Ms. Reddick's evidence. She did express some concern that -- well, I will just read from the transcript. I asked the question at the bottom of TRA-05718, starting at line 25. I say: 12:19

"When you have described your role in that process, was there an expectation that with your experience, you would go and speak to individuals to find out the evidence base or get facts from them about what the situation was on the ground? 12:19

Answer: No. The only time I was asked to find out information was in regard to where the patients - those patients in the SAI process - were on their pathway at that moment of time". 12:20

Chair, would you like me to call up this transcript so you can read it at the same time? I just realised it's not on the screen. I am reading from a copy.

CHAIR: If we have it available. I am not sure that all our transcript is available but if it is, yes, it's much easier. 12:20

MS. McMAHON: It will be TRA-051918 and 19. TRA-05719.

190 Q. I'll just pick up where I was reading.

"No. The only time I was asked to find out information was in regard to where the patients - those patients in the SAI process - were on their pathway at that moment in time. That was really the only time that I was asked to go away and discover additional information. 12:20

Question: So was it the understanding from the outset of your involvement with Dr. Hughes would be the only person who spoke to others at meetings with interested parties? 12:21

Answer: No. I wasn't -- that wasn't made clear to me, but I discovered it then subsequently in the report. I felt that I didn't have the opportunity to -- as part of the SAI Panel, I was denied that opportunity speak to others in tandem with Dr. Hughes. 12:21

Question: Do you know why that was?

Answer: I have no idea. 12:21

Question: Did you ever raise it with Dr. Hughes?

Answer: No.

Question: Did you know who he was going to speak to at any given time? Did he share that information with

you?
Answer: It wasn't very clear who the individuals were that he was -- it wasn't made clear.
Question: You have seen the recommendations of the SAI. You have seen the findings of the SAI, the recommendations? 12:22
Answer: Yes.
Question: Do you think that your particular role may have contributed more to the investigation if you would have been allowed to speak to people and undertake some of the investigatory work? 12:22
Answer: Yes. I think it would have been good to be involved in that discussion with others across, you know, specialties across the MDT. I think it would have been good to be part of that. If I was involved in the SAI Panel, it would have been good to actually fulfil that role". 12:22

I will just read this now because it comes up in one of the notes of a meeting of what Mrs. Reddick says does not reflect what she said. 12:22

"Have you ever attended MDTs with Mr. O'Brien being present at them?
Answer: Yes. I would have went to various MDTs. Indeed, Mr. O'Brien held the position as Chair for a period of time. As part of the peer review process, at times I would have went, you know, ad hoc. It wasn't, you know, planned. I just would have went if 12:23

my diary allowed me to go.
Question: Did you have a particular experience of Mr. O'Brien at those MDTs, the way in which he interacted? Did you form a view or share that view?
Answer: I always found Mr. O'Brien to be very professional towards me and very courteous. When he held the position as Chair of the MDT, we worked together on Peer Review documents, along with Mary Haughey, my service improvement lead, and he was always found to be very willing to work to get those documents ready and in preparation for Peer Review." 12:23 12:23

Then I will just take you to her evidence on this issue.

12:23

"Question: I wonder if we could go to WIT-84769. I just want to get the introduction page so that the Panel knows the context. This is a note of a meeting held on Monday, 4th January 2021 to discuss the complaint regarding Mr. O'Brien. Present are Patricia Kingsnorth, you, Hugh Gilbert and Dermot Hughes and then in attendance is Peter Rogers, who we now know is the note-taker for the meeting. Do you recall this meeting, first of all? 12:24
Answer: Yes 12:24
Question: This was a meeting in which the individuals, their context was set out and there was sharing of information gathered or gleaned to date about each individual scenario. I want to go to WIT-84769 again,

please. Just at the bottom of the screen you can see FR on the left. The sentence beginning FR, can you see that?
Answer: Yes
Question: FR voices how it is imperative to have good communication amongst MDT, which Mr. O'Brien neglected. Now FR, I presume, is the initials for you. Have you seen those notes at all before? 12:24
Answer: I have just seen them as part of this process in my evidence bundle. 12:25
Question: Just in the context of what you have said about Mr. O'Brien, is that a view you formed about Mr. O'Brien or do you agree that that note reflects your contribution?
Answer: I totally refute the word "neglected". I would not have used that. I know that's not part of my language, and particularly in healthcare that's quite a strong word, so I would totally refute that I used the word "neglected". I probably made that comment how it's imperative to have good communication amongst the MDT, but definitely I do not recall using the word "neglected". 12:25
Question: Is your recollection then that in your mind, there's a full stop after the word MDT, or do you recall going on to say something at all after that? 12:25
Answer: I don't honestly recall what would have been said after that. It's probably I couldn't, you know, say that. I couldn't, you know -- I just don't recall what was said after that but "neglected" wouldn't be

a word that I would use in regard to a peer colleague.
Question: Is it your recollection that it was Mrs. Kingsnorth who took the notes to the meeting; do you recall that?
Answer: Sorry?
Question: Patricia Kingsnorth took the notes to the meeting. Do you recall she was the note-taker at this meeting?
Answer: Yes. Generally Patricia Kingsnorth took the notes at those meetings, yeah.
Question: And I think her process was she wrote everything down and then typed it up subsequently, but you didn't get a copy to confirm that you were content with these notes at all at any point?
Answer: No". 12:26

This is an opportunity to say that you have since informed us through the Trust that you were not the note-taker for that meeting?

A. Mm-hmm, that's right.

191 Q. But Mrs. Kingsnorth's (sic) evidence is that she didn't get a copy of that in advance, and she obviously contests that. Were you involved in facilitating notes to individuals to get them to check for factual accuracy? 12:27

A. Yes. The notes would have been embedded in the agenda for staff to look at and check for factual accuracy if there was any issues with that. Fiona was at the next meeting where she would have received the agenda with

the embedded papers.

192 Q. We have seen other occasions when you have actually liaised with some of the medics about notes and sent them notes, and Martina Corrigan, and asked them to check those. Was that not something that was done routinely with everyone? 12:27

A. This was a review meeting. This wasn't an interview with Fiona, this was a review meeting. At the review meeting, the notes were checked at the next... The notes would have been sent out a few days in advance of the next meeting. The expectation is you read the notes and, if you have any issue with them, you come back and say I am not happy with the wording in those notes. 12:27

193 Q. Do you remember that meeting? 12:27

A. I vaguely remember the meeting. I don't remember the word "neglected". She could absolutely be right that the notes were not taken verbatim. I don't dispute anything that she is saying with regards to the wording. The notes were taken -- they could have been paraphrased by the person who was taking the notes on their understanding. But the papers are provided the next -- before the next meeting so staff can read through them. The expectation is they read through them and check the accuracy of them. 12:28 12:28

194 Q. We will come on to some notes later on. We can discuss that issue around.

A. Okay.

195 Q. There's another meeting on 12th October 2020. I think

this was the second meeting?

A. Okay.

196 Q. At WIT-93797. I just want to ask you about a screening point on this. There are two individuals, [redacted] who are removed following screening at this meeting. Do you recall this? 12:28

A. Yes. These were two cases that we weren't sure whether they met the criteria for SAI, and we had to get -- the plan was that a subject matter expert would review the notes and the scan images of the cases and then would have fed back whether or not these patients needed to be added as additional to the nine patients of the SAI. From memory, I think Mr. Gilbert looked at those charts and images and then fed back that whilst they were affected, they didn't actually come to -- I don't want to say come to harm, but they didn't meet the criteria for SAIs. So that was fed back then to the Oversight -- 12:29 12:29

197 Q. Did Mr. Gilbert screen them out effectively?

A. Yes. 12:29

198 Q. Or was that have a recommendation to your Review Team? What way does that work? Where is the actual decision-making around that because I think there's a note where you have said "Patricia K advised two ways we could do this: Have one on the Review Team or ask for an Oncology opinion. This won't delay the process getting oncologist". 12:30

So you were looking at options, I think, there?

A. Yes. I mean, my role as facilitator would be to provide those, do we get an oncologist on board, will that delay the process? Or do we just ask for an oncologist's view and get them to give us an opinion on each of the patients. 12:30

In the end, I think the subject matter expert and the Chair had agreed, well, it's not going to add anything to the review. That's why they didn't go down the road of either of those recommendations then. 12:30

199 Q. That's an example of them being screened out but by use of an external expert?

A. Yeah.

200 Q. Now, there is no mention in those notes of the CNS, the Clinical Nurse Specialist. It became an issue 12:31 subsequently and is reflected quite significantly in the findings, in the recommendations. Would you agree with that?

A. I would, yes.

201 Q. It's not mentioned at that meeting and it subsequently 12:31 became a rolling issue as meetings progressed. There is reference at the subsequent meeting, WIT-93806. If you move down, please, it will be three paragraphs from the bottom on the screen, reference to "Dermot ", where they are discussing the way in which individuals can be 12:32 looked at as they move through systems of care. Dermot, Dr. Hughes, says, or the note reflects:

"Dermot: Infrastructure different across Northern

Ireland is different. Breast cancer better resourced. There are different levels of investment with urology cancer."

Hugh says:

"10 to 12 years, breast cancer was draining all resources. However, it was extremely well set up, rigid how they handle them. Urology: There are different types of cancer. There are complexities, five cancers. Introduction of MTT. Should require a key worker for each patient. This would take a lot of investment. There is significant mismanagement of patients. Others need to look at themselves. Should look for more investment. Are these patients more/less deserving than other cancer patients?"

That's the introduction of the key worker issue. I am not quite sure who that's attributed to, it may well be the name Hugh that's on the note. That's the first mention of that.

Do you remember that issue finding its way up for discussion at these meetings?

A. To be honest with you, the nurse specialist really wasn't on our radar as such until we met with the patients themselves. We happened to meet Patient 1 and Patient 9, both of whom had pretty horrific stories to tell about their experience. I think that led on to

questioning whether there was a nurse specialist involved in their care which would have helped them gain maybe a different experience than what they had suffered.

202 Q. Did those patients mention the Clinical Nurse Specialist? 12:34

A. No. So they --

203 Q. Just for the baseline, did any of the nine patients mention clinical nurse specialists as an issue?

A. No. They didn't know to mention a nurse specialist because they didn't know of one. 12:34

204 Q. That's reflected in the notes. Why I am taking you through that is to show that the introduction of that issue was based on the experience of the difficulties in the pathway journey. 12:34

A. Yes.

205 Q. Would that be fair?

A. That is fair, yes.

206 Q. The key worker was identified as a potential remedy for that, or someone who may have made that pathway easier or less traumatic? 12:34

A. Yes.

207 Q. If we go to the meeting on 30th November 2020 at WIT-93817, we will see a question from you on this. You will see the note. At this meeting is Dawn Connolly, clinical governance manager? 12:35

A. So, she would have taken the notes of the meeting.

208 Q. Okay. It's difficult when paragraphs aren't numbered to try and find where we are. The sentence begins with

your name, that should make it easier to spot.

"Patricia Kingsnorth asked did most consultants use the specialist nurse key worker?" "Patricia Kingsnorth asked did most consultants use the specialist nurse key worker and Patricia Thompson advised her impression from hearing from others was that he did not like key worker". 12:36

That's the first perhaps formal bit of feedback from Patricia Thompson on this. There was no contribution in the previous meetings from her but in this one. Did anyone ask her where she got that information from? 12:36

A. So, looking back, I see where we weren't as robust at doing our reviews with regard to interviewing the clinical nurse specialists. Patricia was tasked to sound out in an informal way from the nurses of what -- of what way key nurses were utilised and by who, meaning consultants. She had come back and said there was -- I think it's on 30th November she comes back with the overall impression that Mr. O'Brien didn't use key nurses, you know, key workers or clinical nurse specialists in that capacity. 12:37

209 Q. The assumption was that she had gained that intelligence from others, given she was new in post? 12:37

A. Yes. Yes.

210 Q. Had she worked in the Trust previously?

A. No.

211 Q. If we go to page WIT-93821. Just you have referred to

what she said and I just want to read it in the record:

"Patricia Thompson advised", five paragraphs down; do you see that?

12:38

"... that she is only new to post and the consultant retired before she began. Patricia advised the general consensus was the consultant personally did not like key worker involvement. Dr. Hughes asked if key workers were available; if they were available and kept 12:38
out of the patient's care is worse. It would have been wonderful for these patients to have had a key worker. If resources were there and they cannot avail of it paints a different picture. Most people do not understand what is happening. Key worker is more 12:38
approachable and allows them to have a meaningful discussion. Those patients were not given that opportunity."

Then you asked: "Did most consultants use the 12:39
specialist key worker?"

Then she says: "Given impression from others he did not like the key worker."

12:39

Is it the case that you have no choice really but to rely on what Mrs. Thompson tells you as being accurate?

A. Yes.

212 Q. At the next page, 22, it says:

"Patricia Thompson advised that she came from a Trust where there was a good MDT teamwork which involved key worker."

12:39

So, Mrs. Thompson is coming along with her previous knowledge of the way key workers worked in a previous Trust. Was it your understanding that Dr. Hughes had an understanding of how key workers were also to operate?

12:40

A. Yes. I mean, he had a high regard for the clinical nurse specialists. He felt that they were the most approachable person to support someone on their cancer journey. Or even for patients with a suspected cancer, he felt that they were best placed to be that conduit, as such, with the service. So, he never -- he never criticised the clinical nurse specialists in any way during this review, nor did he want it to be seen that way. He wanted them to know that their expertise was so valuable. But of the nine patients that we had interviewed, none of them had experienced their expertise.

12:40

12:40

213 Q. The questions that I'm asking you are around the process by which the Panel considered the standard that Mr. O'Brien, or any consultant, should be assessed against, and the factors that the Panel took into account when deciding that. I think earlier today you gave evidence to say that although it's not an investigation, when an SAI is carried out, you would

12:40

look at who was on duty and those sort of factors. Now, there's no sense of that in all of these meetings. I don't want to waste your time and my time taking you through them. I think you will accept --

A. Yes.

214 Q. -- there's no sense rotas were looked at; who was on; was there a nurse available that day; was the patient actually seen by a different doctor. We will go on and look at one of the patients who wasn't seen by Mr. O'Brien after the MDT and wasn't given a CNS at that time. You will understand the thrust of the questions are around the integrity of the process that sets the standard by which Mr. O'Brien has been judged.

There's a question in those notes, do the other consultants use key workers? Was that ever considered and explored?

A. Yes. So there was questions asked directly to some of the consultants involved in their interviews. When it was brought to them that these patients didn't have a key worker, they all said that they used a key worker but they didn't deny that Mr. O'Brien -- nobody had come back and said, do you know, Mr. O'Brien does use key workers, you know, that's not true. We never got that feedback either.

215 Q. Did you get that from the nurses?

A. We did from the nurses, yeah.

216 Q. Did that not make one pause and think this is quite contradictory information, we need to do a deep dive or

a dip test into other files, or have a look generally? We will go on to look at why the CNS provision may not have been as the Panel may have anticipated it was. Was there ever any sense that we need to have a look at this, this is conflicting evidence? 12:43

A. So, yes, we did have discussions about that but the bottom line, as far as the Chair was concerned, was those nine patients didn't have access to a key worker. I accept what you are saying with regards to going down the road of digging more deeply. You are right, we should have done that it; I accept that. 12:43

217 Q. Would it have been helpful at the start to actually, on this issue, speak to the nurses at the start of this process rather than after everyone else had been interviewed? 12:43

A. So, the Chair didn't feel that he -- he didn't intend to interview the nurses as such. That meeting with the nurses was more of a 'this is the' -- this is the process that we've been going on, this is where our findings are and this is what's happening. As you can see from the notes of that meeting, they are not -- it's not an interview, it's more what do you have to say. This is what our findings are, what do you have to say? Then some of them fed back and said their opinions. 12:43 12:44

218 Q. The medics will speak to their recollection of the notes, they haven't been put to them. But some of the nurses have been called and they don't consider those notes of that meeting accurately reflect what they

said. They have presented evidence to the Inquiry, and gave oral evidence to the fact that there are a multitude of factors which may influence either the availability of a CNS, and indeed have explained the difference between a Cancer Nurse Specialist, which might be envisaged by Patricia Thompson and Dr. Hughes, I am not sure, we will find out, and the Clinical Nurse Specialist, who has their own list and carries out clinical, including invasive, procedures in Urology, and the tension between the roles and why they may not be available. 12:44 12:44

I just want to read you some of the summary detail of some of the points they have brought out in evidence that I am going to ask you at the end, and suggest to you that they might have been helpful to inform your view, and others' view, on whether the finding of no nurse specialist is really as bald in real terms as it might otherwise be. 12:45

12:45

The baseline for the CNS - which I don't think was established, if I can put it that way, by your process. I think individuals brought their own experience and assessed against that - but the baseline for the CNS, and we don't need to go to this, is the Regional Review of Urology Services in March 2009. For the Panel's note, that can be found at WIT-17628. That found that at least five CNSes should be appointed and trained. It wasn't until ten years later that that quota was 12:45

met. So, there was no appointment of any Cancer Nurse Specialist in 2017 when the posts were advertised, and they weren't filled. The two individuals who applied, Jason Young and Leanne McCourt, were employed as a charge nurse and ward sister. That despite the Trust 12:46
policy stating that the key worker was to be allocated by the CNS nurse at the MDM alongside the MDM Chair, that was never possible.

"It was known by everyone that it was never going to be 12:46
possible, and was never done at any point because they didn't know who was going to be on duty the following week given their small number. The anticipation was that the key worker would be involved, allocated or given information of the patients at the first post MDM 12:47
appointment".

Again, the difference between the Clinical Nurse Specialist and the Cancer Nurse Specialist, that any nurse could be allocated as a key worker, it didn't 12:47
have to be a Clinical Nurse Specialist.

The consultants had different habits regarding key worker allocation and providing information to patients. I will just take you to that in 12:47
Mrs. O'Neill's Section 21 at WIT-80962. All of that paragraph, 50.4:

"With additional consultants in place, the demand for

key worker input increased as there were more consultants and therefore more patients to be seen at results clinics. Whilst still the role of CNS was oncology-focused, as a team we were conscious that I was unable to commit to providing a CNS to every consultant clinic. Where one-stop clinics ran in parallel to consultant results clinics, this restricted my key worker input further. At the start of any results clinic, it would have been my practice to inform the consultant of my availability or otherwise for the duration of the session. This combination of clinical activity and the necessity to perform the key worker role meant that (a), where possible, I would be available during the consultant/patient consultation and was present throughout the consultation; (b), most often, though not always, I was invited in at the end of the encounter to provide information, support and a contact number. This was not unique to any single consultant. (c) if I had a biopsy clinic, patient notes would have been set on a work counter with the request for me to meet the patient located in the waiting area, and provide key worker support in the form of written information, support and a contact number as soon as I was free. On occasions when I had not met the patient, I would have received phone calls over the following days from patients seeking clarification of the diagnosis/treatment plan which had been provided by the consultant. (e) At no time was there an expectation that I would attend any satellite

12:48
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sites, or cancer diagnosis may also have been discussed, and that included Banbridge Clinic, Armagh County Community Hospital, South Tyrone Hospital, or South West Acute Hospital (known as SWAH). In recent times, we have been able to provide a CNS to support the clinic at Armagh County Community Hospital. (f) nor was there an expectation that the CNS key worker had the responsibility to ensure that scans were requested or onward referrals completed." 12:49

I know there's a lot in that but that's information, can I say, that you didn't know before I have just read it out to you? 12:50

A. That's right, yes.

219 Q. Given your responsibility, and indeed all of your Review Team's responsibility, to ensure the robustness of the process, might that have been information that, if relevant and as relevant, might have reflected in the narrative of the SAIs to give a broader context? 12:50

A. Yes. I accept that, yes. 12:50

220 Q. One of the things that the nurses also explained was that they filled in an A4 sheet. Sometimes when they gave people information leaflets where they tick the box and didn't put it in the nursing notes but put it in the medical notes, so that there was a record that the patient had received information on specific types of cancer, and sometimes consultants gave that information instead, which had contact details on it, but they didn't fill in the sheet. 12:50

If you were looking at notes for proof of contact with a key worker, would that have been useful information to have as well?

A. Yes. 12:51

221 Q. Particularly in relation to the last paragraph there at (f), as we have seen from the notes, and I sort of short-cut them, but I think the point was accepted by you that there was a growing momentum as looking towards the CNS role as the possible answer to some of 12:51 the care pathway interruptions. Would that be fair?

A. I think so, yes.

222 Q. The nurses -- Kate O'Neill says there was no expectation that they had the responsibility to ensure that scans were requested or onward referrals 12:51 completed. I think that Dr. Hughes had used in his evidence "fail-safe", and that was rejected. I think there is a general understanding that there should be a way in which follow-ups are tracked, or triggered if not followed up? 12:52

A. Mm-hmm.

223 Q. But there was resistance in evidence from the nurses, given their lack of capacity and their inability to follow up through multidisciplinary tests, for example, that they may not be best placed to undertake that 12:52 role. Would that be information that might have helped inform discussions around recommendations?

A. Yes and no. Yes from the viewpoint of all that you have just said. No from the viewpoint of when you are

making a recommendation, you are wanting what's best practice out there. Dr. Hughes was coming from it from a best practice point of view. This is what the Trust has signed up to with the Peer Review. It's not wrong to make a recommendation that requires a fail-safe mechanism to keep patients safe. So, from that viewpoint, I think he was coming at it from a best practice point of view, and that maybe the Trust should find a way around of resourcing that rather than just saying, well, do you know what, it's a done deal, the Trust can't resource that, so therefore, you know, we're doing something -- 12:52 12:53

224 Q. I think we are saying the same thing. I think I started my question with the premise that it is best practice to keep on top of people's care pathway -- 12:53

A. Yes.

225 Q. -- to ensure that treatment is given timely, properly and as efficiently and effectively as possible. I will take you this afternoon, if we need to, but the global point around the recommendation is that - and you can disagree - there is a particular emphasis on the potential harm that these people experienced because of the lack of a Clinical Nurse Specialist, when, in reality from the evidence before the Inquiry, those Clinical Nurse Specialists would not have been undertaking those roles in any event had they been allocated. Would you accept that? 12:53 12:54

A. I would accept that, yes.

226 Q. Now, Fiona Reddick. I think Dr. Hughes mentioned that

he felt that she was the most compromised. You have said in your statement that your area was also being subject to some scrutiny, but Mrs. Reddick then went off and you lost her as part of the process. Did that deny you accessing information about the cancer tracking procedures as they were and are?

A. When Fiona went off, it did affect the recommendations. We kind of needed -- we needed her in the team to be able to say these things are workable, these things aren't workable, and we lost that aspect of it. 12:55

With regards to the cancer trackers, you know, we had to go back to people like Sharon Glenny to get information from that viewpoint. But yes, Fiona was greatly missed from the team when she went off. 12:55

227 Q. I think you have reflected some of that in your statement at WIT-92056, paragraph 19.2.

"However, I believe there was significant resource issues facing the Southern Trust that may not have been 12:55 faced by other Trusts. For example, during the SAI Review of the nine Urology patients and the overarching review, the Chair and I met with Urology MDT members, and some of them described noticing a considerable difference in resources in the Southern Trust in 12:56 comparison with Trusts in England, where there was good follow-up and where tracking was more robust, more of a priority and had administrative support. One doctor advised us that there were weekly trackers who would

liaise with consultants enabling them to meet their cancer timelines, whereas in our Trust the trackers were only funded in respect of 31-day and 62-day targets and not to act as a broader fail-safe system."

A. Mm-hmm. 12:56

228 Q. There are various parts of this system that are perhaps groaning under the weight of expectation around the care pathway oversight. Would that be fair?

A. That's right, yes.

229 Q. The Panel has heard evidence about the fairly recent realisation of cancer tracking to maximise being able to follow. I think, the evidence is that there's still room for improvement; that that process is not a fail-safe either. 12:56

12:57

Given that, the cancer tracking issue and the CNS issue, might the findings and recommendations from the nine SAIs more helpfully have provided systemic suggestions around care pathways generally that might have included CNS and less emphasis on the CNS providing the answer for all of those nine patients? 12:57

A. Yes.

230 Q. I see the time so I want to give the Panel two more references. The action plan around key workers can be found at WIT-85514. It's dated November 2016. These are just references, we don't need to go to these documents. You will see at 2016, work was ongoing to address that. Then the evidence of Leanne McCourt at WIT-85915 at paragraph 1.10. The point Mrs. McCourt 12:58

makes at that - and I will just read the reference from it - she had applied for and obtained a Band 7 Macmillan urology CNS post, taking up her post in March 2019, and that's the timeframe of the SAIs. She states: 12:58

"Unfortunately I was still responsible for managerial duties within the Thorndale Unit, meaning that my nurse-led activity was considerably curtailed until this aspect of my role was taken over by the manager of 12:58 the Outpatients Department in March/April 2021."

The previous reference to an action plan states exclusively: 12:59

"The key worker role is to ensure every new urology cancer patient has a key worker identified to support full implementation of the key worker role by ensuring dedicated time for telephone and face-to-face reviews and provision of clerical support. Work ongoing to 12:59 address."

It was a theme that also came out from Mrs. O'Neill's evidence, the lack of clerical and administrative support that ate into their time for providing their 12:59 nursing responsibilities. Is that a flavour of a potential information that might have found its way into a recommendation, or at least informed a recommendation?

A. I would accept that, yes.

MS. McMAHON: Chair, I just see the time. Perhaps that's appropriate.

CHAIR: Two o'clock, then. Thank you.

13:00

THE INQUIRY ADJOURNED FOR LUNCH

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIR: Good afternoon, everyone.

231 Q. MS. McMAHON: Good afternoon. 14:01

There are other issues around the factual accuracy and that of the notes. I think we have raised that briefly before. I think I more properly will take the witnesses that those notes are relevant to through that. You weren't the note-taker in most of these 14:01 meetings. They were, I don't want to say transcribed, but they were typed in by the note-taker who was present, which wasn't always you. We have heard of the ones that you took and you sent out to people to be checked, and they came back and were able to confirm 14:01 their accuracy or otherwise. I think with Martina Corrigan's note, she changed hers; it certainly looks more substantial. But, if necessary, I can speak to her about that. You discharged your function by giving her the opportunity to amend the note, if I can put it 14:02 like that?

A. That's right, yes.

232 Q. You mention at your statement at WIT-92027, paragraph 1.10, and this is a reference to the SAI being carried out by Dr. Johnston; do you recall this? 14:02

A. I do, yes.

233 Q. You say:

"As previously stated, I was aware that an SAI was

being carried out by Dr. Johnston into triage issues but I wasn't fully aware of what those issues were. I had asked my line manager, Dr. Tracey Boyce, and Martina Corrigan, Head of Service for Urology - I cannot recall the date but would guess it was in the summer of 2019 - if there were any clinical issues with Mr. O'Brien and was advised that the issues were purely administrative but that once a patient was seen by Mr. O'Brien, the care he provided was gold standard. I was assured there was monitoring in place in relation to the triage of letters and storage of notes to prevent reoccurrence, and that administrative support was in place. I was, therefore, reassured that there were no clinical patient safety issues and I believe that I was not informed about any other process involving Mr. O'Brien, in particular the MHPS process, during my tenure, until September 2020." 14:03 14:03 14:03

A. That's right.

234 Q. Is that an example of you being aware something was happening? 14:03

A. Yes.

235 Q. And you needed, in your role, to reassure yourself that if there were governance concerns, you should be informed of them?

A. That's right. I was made to believe that this was a historic event, it was dealt with, because it was, what, 2016/'17, and that there was measures in place to prevent recurrence. I was led to believe that everything was fine. And with regards to the care that 14:04

was provided, "gold standard" was the actual word that was used. That was very reassuring, obviously, if somebody says once somebody gets into their care, it's gold standard.

236 Q. It seems from that that you approached Tracey Boyce and Martina Corrigan for that reassurance. Is this an example of when you might helpfully be provided with information around governance issues to allow you to know you need reassurance? 14:04

A. Yes. 14:05

237 Q. If that's perhaps a clumsy way of saying it.

A. Yes. That would be right.

238 Q. Now, when there was a mention of monitoring in place of letters and storage of notes, is that an example of governance in action at operational level? 14:05

A. Yes.

239 Q. What would your role be in relation to that, if there was a role at all?

A. Generally speaking, that would have been parked with the operational team. With the benefit of hindsight, I mean audits in place to make sure that it was being done properly, that it was being maintained, that there was no further issues, Datix is coming in if there was issues with regards to, that all should have happened. But not on my time; there was none of that in my time. 14:05 14:06

240 Q. One way in which that may have manifested was could be feeding to you the outcome of the systems that had been put in place by others?

A. Yeah. Yeah.

241 Q. The Inquiry has heard ways in which issues were sought to be raised around charts was the raising of Datixes, and ultimately that was then halted at Craigavon?
A. That's right.
242 Q. And we have heard evidence on that. Have you heard -- you heard around that? 14:06
A. Some of it I've heard, yes.
243 Q. The allegation is that they were told to stop putting in Datixes on that issue because of the multiple nature of them, and it seems that there didn't seem to be 14:06 a resolution; they were resolved as they rolled along but the volume of them. Were you ever being aware of anyone told to stop Datixes in your time?
A. No, definitely not.
244 Q. And self-evidently from a governance perspective, that 14:06 would --
A. You wouldn't do that. You wouldn't be saying don't do that.
245 Q. The Inquiry also heard evidence from Katherine Robinson around the potential overreliance now on Datix. If I 14:07 can summarise her evidence fairly by saying that it was her experience that people were, I think she said, trying to cover themselves or making sure to keep themselves right by raising Datixes when anything arose, and partly because of the issues that have 14:07 arisen through this Inquiry.

They probably weren't in your time but given that there's a potential to overpopulate the Datix system

with issues that are really just a marker in case anything comes back, do you think that could put that system under more stress and perhaps even reduce staff confidence in its effectiveness as a problem-solving tool? 14:08

A. I can see how that can happen. I would be more worried about less Datixes being submitted than more. I think you have to find that balance of -- again it's back to training staff, isn't it, to see what are your triggers, what should be reported and what shouldn't be reported? I would be loathed to say don't fill them in because you are overloading the system, if you understand what I mean. I wouldn't want that message to go out. 14:08

246 Q. Now, you were copied into the original five SAI report. We don't need to go to this but for the Panel's note it's at WIT-55803, and there's e-mail correspondence of that. You were involved in discussing the recommendations arising from the SAIs with Martina Corrigan, do you recall that, or generally? 14:08 14:09

A. Generally I recall it, yes, but I don't know exactly which email you are referring to.

247 Q. Well, let's go to it, WIT-40596. If we can see, it's your reply. If we just scroll down. You will see the recommendations from the SAI, from Mark Haynes to you and Katherine Robinson, Martina Corrigan and Ronan Carroll? 14:09

A. Mm-hmm.

248 Q. He responds to bits with his name on it to alter or to

amend, better reflect the recommendations?

A. Mm-hmm.

249 Q. The email above that is the one that you send then back. "If you have a few minutes to discuss the recommendations below, please". 14:10

Now, what was your involvement with those recommendations and with the outworkings of them, if you could outline that?

A. So, 21st January was probably in and around the time of the reports going through Acute Clinical Governance, so there may have been some concerns about the wording of the recommendations. Recommendations need to be, as you know, that smart kind of format that they are specific and measurable and attainable and relevant and timely. If they are not, then the tendency would be to go back to the Chair and say can you reword it in a way that we can work with these recommendations. I think that's probably what's alluding to in this email. 14:10

250 Q. So, it was more to do with the structure of the wording of the recommendations -- 14:10

A. Yes.

251 Q. -- rather than any follow-through on the actual substance of them?

A. Yes. So, the wording is really important because if you say things like just out of a hat, 'all staff must comply with', I mean are you referring to all staff as clerical staff, administrative staff, domestic staff, you know what I mean. So, it's making sure that the 14:11

wording is clearer.

252 Q. Now, one of the recommendations in that email, just if we can look at recommendation 3:

"The Trust will develop written policy guidance for clinicians and administrative staff on managing clinical correspondence, including email correspondence from other clinicians and healthcare staff". 14:11

It's obviously an issue that has arisen as a result of that. Given the administrative slant of that recommendation, even though it has emerged as a result of a governance process through the SAI, would you have any involvement with the outworking of that to follow up on the policy or guidance? Would that fall under your remit at all? 14:11

A. No. That would fall under again the operational teams to implement that.

253 Q. So, it depends on the nature of the --

A. Yes. Yes. 14:12

254 Q. Would this have been a point at which you became aware that the SAIs were in relation to Mr. O'Brien?

A. Yes.

255 Q. Or aspects of his care?

A. Well, I would have been aware, around about the summertime, that these all related to one particular consultant with regards to the triaging and then the notes issue. But it was, as I say, seen as an administrative event and that, you know, if there were 14:12

supports put in place to help Mr. O'Brien, then this wouldn't happen.

256 Q. Did anyone speak to you about the possibility of thematic learning from those group of SAIs? Or from a governance perspective was there any, in particular, aspect of governance brought to your attention as a result of those? 14:12

A. Do you mean before the reports were completed?

257 Q. Yes, or subsequently.

A. No. No. 14:13

258 Q. At all?

A. Oh yes, afterwards, yes, but not before. We didn't get any early learning as such through. But I'm sure that did happen because the systems and processes were put in place from the historical time before the reports were even completed. So I would imagine, in my view, my understanding was that all those processes were already put in place before the review was completed. 14:13

259 Q. So there wasn't any need for --

A. No. 14:13

260 Q. -- any sort of intensive engagement with you --

A. Not at that point.

261 Q. -- that might have need improved. When you say at that point?

A. Not with that SAI -- 14:13

262 Q. Not with that SAI.

A. -- is what I'm saying.

263 Q. You mentioned one issue at WIT-92048. You say this is an example of an issue that was raised with you. You

say:

"As indicated at 11.3 above, I only raised one issue of governance and risk regarding Mr. O'Brien, the Bicalutamide issue mentioned by Mr. Gilbert in approximately October 2020. I raised it promptly through the Urology Oversight meeting. I received assurances that the Trust was addressing this issue by taking steps to identify how many people had been prescribed the drug and by conducting a review of each relevant patient. I understand they also alerted the HSCB and the Department of Health. The update on progress of these issues was discussed as an agenda item on their weekly Urology Oversight meetings." 14:14 14:14 14:15

Given our focus as set out this morning is on process and governance, how did this come to your attention? Just explain the process by which you became aware of this in your role as coordinator.

A. So, during the SAI meetings with the Review Team, Mr. Gilbert would have went through every single case. Then he said what was pretty evident was the fact that this Bicalutamide was being used outside of licence, and that he felt that was a risk to patients with regards to accelerating the secondary growth of cancer. That was really quite worrying so I had asked was there any evidence on this, where was the evidence, could he find the evidence to at least support the SAIs so we knew what we were dealing with. Equally, it scared me 14:15 14:15

so I'd gone back and escalated it up through the system to say well, I mean, this isn't just a matter of those patients, the few patients that were affected in the SAI, it obviously has more far-reaching consequences to other patients, and do we need to look at that. That's when it would have gone through that system so that that Patient Safety aspect was going to be looked at and scrutinised. 14:16

264 Q. So this was an example of a process ongoing --

A. Yes. 14:16

265 Q. -- you identifying potential early learning or, at least potential need for medication?

A. Yes.

266 Q. And picking an issue out of the process --

A. Yes. 14:16

267 Q. -- to try and resolve it while the process was still ongoing in parallel?

A. Yes, because you couldn't risk leaving that without having more detail on it and more information.

268 Q. You were satisfied by the assurances given by the Trust? 14:16

A. Yes.

269 Q. Now, one of your roles and one of the roles that was undertaken by you in the nine SAIs was the liaison with the families and the contact with them. I think you have expressed earlier that that was a difficult role? 14:17

A. Yes.

270 Q. You say in paragraph 1.5BB -- scroll up a bit. Just I will tell you the point I wish to make while we are

waiting. In that you say you had to contact the nine patients whose care was subject to the SAI reviews, or their families, on 26th October 2020, to advise them of a leak to the Irish News about issues arising in the Southern Trust? 14:18

A. Yes.

271 Q. You relate in that that some of the patients were unaware that their care was subject to an SAI Review?

A. That's right.

272 Q. Those must have been difficult conversations? 14:18

A. It really was. I mean, the plan for us to do -- when you are doing an SAI, the best way to do it is to talk to the patient face-to-face and say, you know, we've concerns about your care that you were given and we are going to look, we are going to do a review into your 14:18 care, so at least the patients have a heads-up on what's happening. Then, you would follow that up with a letter and then possibly a phone call. But that was -- the leak to the Irish News had taken everything out of line or out of sequence. That meant then I had to 14:18 make a phone call and say, oh by the way, do you know, we are going to be looking into your care. That's quite shocking to say to any patient. No matter how sensitive you try to approach it, it's never an easy conversation for somebody either to hear or somebody to 14:19 give.

273 Q. Had you contacted those patients at all before, or had events overtaken you in the public domain and you were playing catch-up because of the newspaper story?

A. Yes, that's exactly it. We were playing catchup.
274 Q. So they hadn't been contacted by anyone by October 2020?
A. Some of the patients were aware and some of the families were aware because from about July onwards, whenever we started identifying some of the patients, those patients would have been made aware that their care would have been subject to review at their clinic appointment. So, our plan was to get patients seen at the next available -- as patients were being identified, then we were getting them seen at a clinic appointment. That phone call was a wee bit easier to deal with because you could say 'do you remember you were in with Mr. Haynes and you were having a -- and he talked you about the care you received'. So those patients were aware but for others, they hadn't -- one person was getting their appointment, I think it was that afternoon or the next day or something in close proximity. You know, it was hard for them. It was unfair that that's how they had to hear. 14:19 14:19 14:20 14:20
275 Q. Was that the first time they would have been aware that they were part of a group --
A. Yes.
276 Q. -- as opposed to an individual?
A. Yes, an individual, yeah. 14:20
277 Q. In relation to that, the article in the newspaper, were you ever advised of the source of that information to the journalist?
A. No.

278 Q. Did you ever ask about that or --
A. Oh well, yes. I mean you would say oh gosh, I wonder where that leak came from, but never was given any. Still don't know, still haven't a clue.
279 Q. Were there any steps taken by the Trust, given that information was put into the public domain - and perhaps you would agree with me that it certainly seems to touch on a governance concern - if information previously considered to be confidential found its way into the newspapers -- 14:21
A. Mm-hmm.
280 Q. -- were you ever given any reassurance by the Trust or are you aware of any processes put in place by them that would seek to mitigate against that happening again? 14:21
A. I wasn't made aware of any, no.
281 Q. Were you ever aware of any discussions among you or any other members of the SMT as to how you could maintain the integrity of the process going forward given how early in the process this information was made public? 14:21
A. My understanding was that that was being looked at from a higher level than me, and that, you know, it was being dealt with. But I was never kept in the loop or never informed of the outcome or what was going to be done about it. 14:22
282 Q. You say at WIT-92023, paragraph 1.5EE, this is in relation to your involvement with the nine SAIs and the engagement with Mr. O'Brien:

"I was also involved in a lot of correspondence with Mr. O'Brien's solicitors, who wanted copies of the notes for the nine SAI patients which were redacted to ensure confidentiality, along with the nine Datix submissions and the Terms of Reference for the SAI reviews, including details of the Review Panel members. Dr. Hughes also invited Mr. O'Brien to be interviewed as part of the review but he declined. Dr. Hughes agreed to and did provide a list of written questions for Mr. O'Brien. No answer to the questions was provided, however, and in view of the need to avoid undue delay, the report progressed without Mr. O'Brien's input with, I understand, the approval of the Trust SMT." 14:22 14:23

Just a couple of questions I want to ask in relation to this. 14:23

A. Mm-hmm.

283 Q. Were the notes -- clinical notes I presume you were speaking to when you mention notes? 14:23

A. Yes.

284 Q. Were the clinical notes of the nine SAI patients provided to Mr. O'Brien's solicitors?

A. They were.

285 Q. Now, you mention that Mr. O'Brien declined to attend. I just want to take you to Dr. Hughes', part of his transcript at TRA-01195. Bear with me until I get my bearings around this document, if you don't mind. You will see there that Dr. Hughes is confirming that the 14:23

Datix material that Mr. O'Brien requested was sent to him. There is a quote to Dr. Hughes. I will just read out part of the transcript. It's just to indicate to you what Dr. Hughes said on the issue of Mr. O'Brien's engagement and what was put to him, just so you are aware of his evidence.

A. Okay.

286 Q. At line 11, it says:

"Dr. Hughes: I do understand. I should say the Datix reports were not part of our review. We received post-triage so we were not retrospectively reviewing how it came to be in our review process so I'm not quite sure why. I can understand why some people would want to know that, but we certainly weren't asking questions about how our case was triaged into the process so I don't think that should have delayed the issue." 14:25

Mr. Wolfe then reads the following: 14:25

"It's recorded here", and the quotation is "we are progressing well with comments in Service Users A and B. Mr. Anthony is on leave next week and hopes to have comments to you on these two cases by the end of next week or the following week." 14:25

The Mr. Anthony referred to in that is one of Mr. O'Brien's legal team. Mr. Wolfe, after reading

that extract, says:

"It's clear from this correspondence that Mr. O'Brien is intending to cooperate with you and is cooperating with you; is that fair?" 14:26

Dr. Hughes says: "To that point, yeah."

I just want to read the continuation of this question from Mr. Wolfe: 14:26

"Yes. Then there followed some correspondence between the lawyers, Tughans for Mr. O'Brien, and the Director of Legal Services on behalf of the Trust". Then they bring a document up on the screen, which is a Business Service Organisation -- sorry, he is explaining here who the Director of Legal Services are. 14:26

"This is 5th March and the lawyers on behalf of the Trust say they intend sending the draft patient report and draft overarching report which recommendations to each patient and family on 8th March." 14:27

So, there's obviously a deadline imposed to try and get feedback? 14:27

A. That's correct.

287 Q. "Three days later. That's I suppose on back of the correspondence of 19th February saying Mr. O'Brien is mindfully working through these. In that period of two

weeks between those pieces of correspondence, had you or anybody else on your team, perhaps Ms. Kingsnorth, a case to see what was happening or are we going to have a response to the questions?"

14:27

So, basically did anybody follow it up at that point.

A. So no, I hadn't sent any further email, we hadn't heard any response so we had to take it back to -- because we were getting so much pressure from Trust Board to get these reports finished, I had taken it back to the Urology Oversight team and said we haven't heard anything yet, what should we do? Then the decision was made then we are going to have to go ahead with submitting the report without Mr. O'Brien, which was unfortunate because it would have been better if we had had his account.

14:27

14:28

288 Q. The evidence was at that point that there was correspondence indicating that Mr. O'Brien was working through. There had been, I think you considered it to be a delay in his response, and you wanted to get things -- or the team wanted to get things moving forward?

14:28

A. Mm-hmm.

289 Q. But there was no refusal from him --

A. No.

14:28

290 Q. -- to engage. So saying he declined to engage or be interviewed was maybe perhaps arguably putting it a bit high when the evidence would suggest that there was a delay?

A. I suppose "decline" is probably not the right word, and I accept that. But it was more that the face-to-face meeting was what I was referring to in there as opposed to the questions.

291 Q. Dr. Hughes said that he believed that you had corresponded. You say you hadn't after that point, it went back to the Urology group and the decision was made? 14:29

A. Yeah.

292 Q. He says: 14:29

"I did not.

Question: Okay. In any event, somebody had made a decision that these were going to be disseminated and published by this date, even implicitly, even if we don't have a response from Mr. O'Brien. 14:29

Answer: I think that's the case, yes.

Question: "Yes. Can you help us, what was the pressure for that?

Answer: I think the pressure was threefold. The Southern Trust were required to get clarity for the overarching supervision. I can't remember the name of the group, but the Department of Health. I think the other pressure was the families wanted access to these, especially those who had been recently bereaved. 14:29

Question: I started this sequence by pointing out the sections of your section which in terms said that Mr. O'Brien had been asked questions and, despite extended time limits or deadlines, he never responded.

The suggestion there is that Mr. O'Brien wasn't cooperating?
Answer: We didn't receive responses in the timelines I would have expected to relatively simple questions, and perhaps that on reflection is wrong. When I was writing my witness statement, I probably reflected part of that in that it would have been better to wait, so I think you do have a point. 14:30
Question: Just to be clear, in light of what we have seen from the correspondence, Mr. O'Brien was showing cooperation. Quite plainly he didn't dismiss your questions. It's been said on his behalf he is working through them. You are facing the competing pressure, twofold pressure of having to publish, and, with the benefit of some hindsight perhaps, it might have been better to wait? 14:30
Answer: Yes, I think that's fair.
Question: It might have been better to wait because if you had received responses from Mr. O'Brien, you would have obtained an understanding and Mr. Gilbert would have obtained an understanding of his thinking around treatments? 14:31
Answer: Yes. I think some of the issues that are clearly benchmarked against international standards probably wouldn't have changed because we were benchmarking against known best practice, and I don't think those views would have changed. I think the underlying question is why some of this happened, you know, why referrals weren't made, why nurses weren't 14:31

involved. I think that would have been appropriate, yeah."

Would you concur with Dr. Hughes' view that, on reflection, it might have been better to wait, and he says "Yes, I think that's fair"? Would you agree with that? 14:31

A. Absolutely. I mean, I did have a conversation with him saying I don't think it's fair for us to move on, but the pressures were being put on and we had to go ahead and publish it. But that wouldn't have been my decision to do that, and it wouldn't have been my wish to do that without Mr. O'Brien. Because if we were conducting an SAI, you do need to get that information. I think that's one of the drawbacks of SAIs, the timelines that are put on SAIs to prevent that happening. 14:32

293 Q. Was there an expectation that the report would be completed by January 2021, and where did that expectation arise from? 14:32

A. The Board had set that timeframe for us.

294 Q. Was there any reason why that timeframe was set?

A. I don't know.

295 Q. No. You have said in your witness statement at WIT-92059, paragraph 20.6: 14:33

"As stated in the first limb of this answer, the governance team was significantly under-resourced and this, I believe, was also true of the Urology Service.

I believe that staff were so busy dealing with the day-to-day issues and backlogs that they accepted that their specialty was under-resourced and tried to get on with the job. This was clear to me from the meetings Dr. Hughes and I had with the MDT and specialist nurses in the course of the nine Urology SAI reviews. I do now believe, having been involved in those nine SAI reviews, that the issues with Mr. O'Brien did not reflect the service provided by the other staff in the Urology Service. I also got the impression that some staff members in Urology were afraid to challenge a senior consultant like Mr. O'Brien with so many years' experience." 14:34 14:34

Where did you get the impression that some members of staff in Urology were afraid to challenge Mr. O'Brien? 14:34

A. That seemed to be the theme of conversations that were had. He was well-respected in his field. He was an older consultant with years of experience, and I think people were afraid to challenge. I think it's referred to in -- I can't remember where. 14:34

296 Q. Mr. Carroll mentions it?

A. Possibly. That, you know, he was known to be quite difficult, for want of a better word. I don't know Mr. O'Brien. I have never met him before in my life so I can't answer personally my experience of him because I don't have any. But I think people, either through respect or through fear or whatever, that seemed to be the impression that we were given. 14:35

297 Q. Did anyone say they were frightened of Mr. O'Brien?
A. People commented quite a bit about a fear of being threatened with legal systems. The word he had family members who were barristers or whatever, would be mentioned. Numerous people afraid to challenge in case there would be some recourse that way. 14:35
298 Q. Were those mentioned at interviews with the SAI?
A. No. That was the general consensus, if you know what I mean, amongst people in talking.
299 Q. When you say general consensus, who do you include in that group? 14:36
A. I think maybe Ronan and Martina, you know. That seemed to be the kind of impression that I was given.
300 Q. Both Mrs. Corrigan and Mr. Carroll have been sent Section 21s in relation to the issue of fear. Now, Mrs. Corrigan isn't able to recollect the source of that belief, and Mr. Carroll explains his belief around that based on, he says, interactions with two nurses -- 14:36
A. Okay.
301 Q. -- who both deny that. So I just need to put that on record, that that's the evidential position for the Inquiry. 14:37
A. Mm-hmm.
302 Q. But your evidence is that none of the SAI meetings, where people perhaps had the opportunity to say things like that, reflect that particular belief? 14:37
A. That's right.
303 Q. We have gone through it earlier on and I perhaps should have asked you at that point, but when you were talking

about the other specialty, cancer MDTs such as Breast MDT had considerably more resources than the Urology MDT, had you any understanding of or context why that might have been the case, or was that something out of your knowledge? 14:38

A. No, I think breast was seen as gold standard so the comments that were coming back were, you know, that there was a lot of resources put into that for breast cancer and it was working really well. It was more that aspect of it as opposed to any detail, you know, 14:38 operational knowledge on it.

304 Q. Was there any sense that if that is gold standard, then the service that they are providing should be reflected in the recommendations of the SAI, that's what everyone should be aiming at? Was that considered, or was it 14:38 did you not think as widely as that, or would that not be appropriate?

A. I think it was probably not considered in that the focus was on the Urology as opposed to other Cancer Services. That's only in my opinion, maybe Dr. Hughes 14:38 has a different opinion on that because he comes from a Cancer Services background, so he would have more information than I would have.

305 Q. Can I have just a second just to check any other issues. I have just been handed a reference that may 14:39 assist the Panel for a point of reference for the telephone contact with patients. That can be found at WIT-92829, if we just go to that, and the second row in the table. The contact was on the 26th of the 10th,

and they refer to an earlier clinic in July, 6th July 2020. That gives a timeframe from when someone was viewed or reviewed, and then the telephone call, just to give the Panel an example of that process. It had already started and was under way? 14:40

A. Yes.

306 Q. We don't need to go to this but you mentioned something in your statement, a urology meeting on 8th February 2021, which the Panel's note will find at WIT-93843, where you introduce Fiona Sloane. Do you remember this? 14:41

A. Mm-hmm.

307 Q. And advised she was going to be the link for the Urology patients?

A. Mm-hmm. 14:41

308 Q. Fiona Sloane would be attending the meeting with Dr. Hughes, Patricia Kingsnorth and the families. Then this part:

" Patricia Kingsnorth said once the internal review concluded, she would be taking a step back." 14:41

A. I was retiring; my plan was to retire. You know, from the January I had made that decision that I was retiring. My concern with this is that you build up a whole rapport with families whenever you are doing an SAI Review, and it's very, very difficult after the review is completed and they have got the report for me just to abandon them and say right, okay, I am gone. Our plan was, and the agreement of the Trust, was to 14:41

put in a family liaison person, and that was Fiona. The intention was that whilst the family were going through the report, and then subsequently we knew about the public inquiry, that there would be some kind of family liaison person there to support the families through it, because we appreciated how difficult it was for families. I felt it was very unfair just to say the report is completed now, you are on your own, because that's not the right thing to do.

309 Q. So, it was a hand-over that was slightly elongated to allow the families to adjust to a new contact? 14:42

A. That's right.

310 Q. I just want to go to some of your reflections in WIT-92061; 22.4. You say: 14:42

"I believe that the resources required to fail-safe the system could largely or perhaps entirely comprise Band 3 clerical staff. It doesn't require professionals to do it, just a clear process SOP to spell out what steps need to be taken and what actions need to occur if a misstep or breach is recognised." 14:43

Those don't seem to take a very simple solution but you must have a reason for advancing it as one?

A. So this goes back to the tracking. If a patient comes through -- and forgive me, I'm not totally au fait with the whole tracking system but my understanding is that, you know, where they are just tracking the patients that come through on the 31 and the 62 or the first 14:43

treatment, that there could be some kind of intelligence to say, well, that patient has to have a scan, can you make sure that scan is followed up; that patient has to have a review appointment, can you make sure that review appointment is carried up, because we know there was some of these cases that review didn't happen. Whether it happened because of Covid or whether it happened because they were lost to review, it still happened. If you had somebody in administration double-checking those is where I was thinking of from that viewpoint. It doesn't have to be -- you know, we are short on nurses, we are short on medical staff; it doesn't have to be those people to follow up on that because if they are given simple instructions of checking the system to see did that person get. Because it is looking at the PAS system to see did they get their appointment; did they attend for their scan; have they got an appointment then to discuss the scan results. They don't need to know too much detail but that was a very simplistic way of saying it, and, you know... 14:44 14:44 14:44 14:45

311 Q. Someone who would keep an eye on the system to push it along to make sure that anticipated reviews or dates were met, people were alerted to them, and any actions taken were marked so that the trigger, the alarm system, would alert if things didn't keep flowing? 14:45

A. Yes, and that could be fed back either to the MDT or to the consultant.

312 Q. In 22.5:

"I also believe there were too many individual processes, MHPS and/or insufficient joined-up thinking. For example the details of the MHPS process were kept confidential". 14:45

We raised that point before. The first point, there are too many individual processes?

A. It's not just MHPS; there's obviously nursing and midwifery processes as well. Any health professional, 14:46 allied health professional, have their own professional bodies that they would have investigations through. Also, HR have another process for other staff as well. You know, you have got your conduct or your capability processes or your disciplinary processes and things 14:46 like that. They don't necessarily all marry up and feed into each other. That's what I meant by that.

313 Q. Have you any suggestion as to what the answer may be or are you just identifying that those individual processes perhaps be joined-up thinking, and anything 14:46 that would unblock that would probably be helpful?

A. Yes.

314 Q. Then you say at 22.6:

"We should be an organisation with an effective 14:46 corporate memory so that when an adverse incident happens, that learning is not only shared through the division or area of practice but extended to all areas within the Trust. Lessons must be learned by all

teams, and action plans from recommendations should be kept live and revisited at least annually to prevent reoccurrence. Too often learning from adverse incidents is shared and there is some learning for a few years, then staff change roles and/or retire and corporate memory is lost, increasing the risk of problems reoccurring."

The issue of effective corporate memory is perhaps difficult to grapple with, and we did touch earlier on about the transient nature of healthcare staff in the current climate. 14:47

A. Mm-hmm.

315 Q. But your suggestion is that when you lose people who remember things, everyone thinks they are starting again? 14:47

A. Yes. Yeah.

316 Q. At 22.7 you say:

"On reflection, I should have probed further into the administrative issues regarding Mr. O'Brien to identify what other issues may have been revealed, but I was occupied with my heavy workload." 14:48

Obviously a benefit of hindsight now, but when you look back, you have described them as administrative issues, and there has been some evidence and some suggestion to different witnesses that administrative issues in the healthcare setting can very quickly, or perhaps 14:48

invariably, impact on patient care or patient safety, or at least the effective administration of healthcare. Would you accept that as well?

A. I would.

317 Q. Do you think, looking back, I know you were in the post just a little chunk of time, but when you look at it in the round, do you think there was enough clues of potential joined-up thinking that may have been overlooked, or do you think that you just didn't have sight of enough information from a variety of sources that allowed you to join that up? 14:48 14:49

A. I think I didn't have the information there to allow me to join that up, to be fair.

318 Q. I know you have left but do you think that by the time you had left, learning was such from a considerable number of SAIs that have developed themes over the years, do you think the learning was such that you would be confident that someone taking over from you would have sight of information and would be more across the detail so that they could have more of a global view on governance concerns? 14:49 14:49

A. I would hope so rather than I know.

319 Q. Was there anything came into place that reassures you around that?

A. During my tenure -- SAIs used to be shared with the division that it occurred in, and during my tenure they were shared with all M&Ms to make sure that everybody had sight of the SAIs and the learning from that as well. With regards to the action plans, you know, I 14:50

had asked that all the action plans be reviewed every year, and that they are shared with everybody frequently so that they are lived and they are in place and that they are not forgotten, because very often when an SAI happens, as I say, it's closed, it's finished, the action plan is agreed and it's sorted and it's parked. You can't do that in governance or in any healthcare system. So, I would hope that it's been.

320 Q. But rather than know?

A. But rather than know. 14:51

321 Q. Is there anything else that you have provided in written evidence or that we have talked about that you feel you need the opportunity to respond to, or raise or say, or have you any other observations you wish to share with the Panel? 14:51

A. I don't know whether it's appropriate but I do -- I know -- I just want the families to know that I am thinking about them because I can appreciate how difficult a time it is for them as well to undergo not only an SAI, which is traumatic enough, but an Inquiry like this, and that my thoughts are with them, with all of those patients and families. 14:51

MS. McMAHON: Thank you, Ms. Kingsnorth. I have no further questions but the Panel will likely have questions for you. 14:51

CHAIR: Thank you. We will hopefully not keep you too much longer, Mrs. Kingsnorth. Mr. Hanbury, do you have some questions?

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS

FOLLOWS:

322 Q. MR. HANBURY: Thank you for your evidence. Just a couple of clinical things. I was interested with your experience in the obstetrics and gynaecology life before the last job, and the comments you made on trigger lists and near-misses and things. Looking back with all your experience, how do you think we could use that, especially in urology but perhaps surgical disciplines? 14:52

A. Certainly I would feel in a specialty like surgery, you could have a trigger list as such that you can -- I mean, our trigger list in obs and gynae is used also as an audit tool, did we do what we should have done here; did we give the best care we should have done for this patient; how did this happen and what measures are put in place to stop it happening again. Then, from that then there's rolled out learning in theme of the week and things like that, you know, that is ongoing and is live and it keeps going. I can see how transferrable that is for Urology, looking at your near-misses. Your near-misses are a sure sign that your system is weak, and putting measures in place to see how you can prevent that happening because a near-miss one day is an actual event the next. 14:52 14:53 14:53

323 Q. Thank you. Just another couple of things. We have spoken a lot about the nine SAIs and I hear you accept that without Mr. O'Brien's comments, the nine SAIs are sort of weaker than it might otherwise have been.

Just moving on to a couple of the other ones. There was a case of a missed stent change, I think you will probably remember as that was during your time. We have heard quite a lot of time on waiting list management and how it was done. What were the outcomes from that that you remember?

A. I'm not sure of the whole operational part of where they were at because obviously with regards to the stent changes, they needed to make sure that those patients were followed up more robustly and that they weren't missed for long periods of time, that it had to come through. But I do understand that that was being worked at from an operational point of view. I couldn't -- I can't remember, to be honest with you, what the detail around it was. 14:53 14:54 14:54

324 Q. Presumably you were satisfied that the head of service was taking on some?

A. Yes.

325 Q. Thank you. The next group, I guess, is we have seen a couple of cases of early post-operative death, and they were looked at. There seemed to be a problem with pre-op assessment and perhaps the surgical WHO checklist? 14:54

A. Mm-hmm. 14:54

326 Q. Again, do you recall outcomes of that through you; how was that escalated, and did theatres come back to you of a surgical division?

A. I am not aware of those cases with regards to the

pre-operative deaths. That wouldn't come across in my time.

327 Q. Sorry, post-operative?

A. Post-operative deaths, sorry, post-operative deaths. That wouldn't have come across my table during my tenure of those ones. 14:55

328 Q. Okay. Thank you. Just lastly, there are three SAIs sort of based on those non-action of radiological results, and others before you struggled with that problem. 14:55

A. Mm-hmm.

329 Q. Not just fro Mr. O'Brien. What's your recollection of any action that came out of those?

A. Yes. I had many a conversation with the radiologists and with the Head of Service for Diagnostics, and the AD. My concern with that was when an abnormal finding is found on X-ray, the response is to send it to the secretary and to the consultant, but what if the secretary and the consultant are both off? Or what if the consultant is off and nobody is following up on that? I wanted a close of the loop of that. I know they were working towards that, to see if they could do something to make that better, because that was a big risk and that was a big issue for me. I had quite a lot of discussions and concerns about that. 14:55 14:56 14:56

I don't know what the outcome is because I have left but I know at the time we had robust discussions, shall we say, to close that loop because that loop was not

closed at that time.

MR. HANBURY: Thank you very much. That's all.

330 Q. DR. SWART: I am just interested in whether you have any observations about the atmosphere in obstetrics in terms of SAIs versus that in Acute Services, particularly in terms of what other learning might be transferred. You talked about triggers. I'm very aware that you have a lot of safety measures in obstetrics which aren't perhaps even seen in the same degree in the healthcare sector in the Southern Trust as far as I can see, and I think there's much more investment in governance generally -- 14:57 14:57

A. Yes.

331 Q. -- from my experience. Is there anything about that environment which is more facilitative for learning that people need to take note of, excepting your comments about triggers? 14:57

A. Yes. I mean obstetricians and gynaecologists, I am not saying they are more safety conscious than anybody else but we know that obstetrics is one of the highest legal claims parts. So, they are very focused in on that and to make systems and processes very safe. You have things like the Maternity Collaborative, and multidisciplinary work and multidisciplinary training to make that easier. 14:57 14:58

Equally, they are kind of used to -- because of the trigger list they are used to investigations going on, they are used to providing feedback and statements and

being involved in that whole review. Not so much Urology, but in surgery in general or medicine, it seems to be -- there seems to be still that fear aspect of it that requires a lot of reassurance, and reassurance from the viewpoint of finger-pointing. You know, you need to make sure that you are doing it from a systems viewpoint rather than just finger-pointing, because that's not good and it's not good for anybody. Equally, making sure that the learning is out there and shared back. 14:58

332 Q. But how would you transfer that? Can you think of anything practical, because it's quite an important issue, I think, for the future?

A. I'm just trying to think of what I had done at the start whenever I started as a midwife over ten years ago. I think our whole -- it was that putting your champions in place from your consultants and then setting that tone for learning. 14:59

333 Q. In that regard, for example, when you had your screening meetings, did anybody consider bringing a wider consultant body into that? Not just using CDs and AMDs, they are so busy, why not bring other people in; was that talked about? 14:59

A. It wasn't talked about, no, but it's a very good point.

334 Q. When you didn't have enough people to screen, how long do you think that delayed things, because there seems to be big delays in this system? 14:59

A. Oh, it was easily six months more.

335 Q. Okay.

A. You know.

336 Q. You have said that this was one of the best serious incident investigations you have been involved in. What was about it that made you say that?

A. From a family engagement. I suppose that was my big thing with SAIs, was the whole family engagement bit. The early learning being shared as well as we were going along, because that information was being drip-fed. I can see the restrictions with this SAI very clearly with the benefit of hindsight, but at the same time, I mean, we did look at a systems approach, this wasn't about finger-pointing. This was looking at our structures in place and that's why I feel that was a really good SAI. 15:00 15:00

I think the intention of the staff involved in the Review Team and the commitment that was there, I mean everybody worked so hard. At the same time, that feedback to families, keeping them in the loop, keeping them informed, to me that was an example of good practice of how to do it from a family engagement point of view. 15:00

337 Q. Thank you. That's really helpful. One of the things you talked about earlier on today was the issue of Risk Registers, which I am sure is not your favourite topic. There are a few things that keep a place on the Risk Register and seem to be insoluble, and I would think you must have seen frequent mention of long waiting lists and access to targets, not only not being met but 15:01

getting progressively worse. What discussions were had about how that should be handled in terms of possible harm to patients, because if there's ever anything that gives you a big risk of harm, it's that, and whether it's appropriate just to keep it sitting on a risk register?

A. No, nothing is appropriate to keep anything just sitting on a risk register. The discussions would have been with regards to, you know -- from the operational teams with regards to setting up weekend clinics and evening clinics, and trying to get, you know, extra PAs for staff, you know, to do those clinics.

338 Q. Was the harm to patients acknowledged openly; do you think?

A. Oh, yes. Yes, very much so. Yeah.

339 Q. Were there any discussions about assessing the status of patients waiting, for example?

A. I'm not sure of the nitty-gritty aspect of it, of actually going to those patients and seeing if they are on the waiting list. I can't answer that.

340 Q. Yes, okay. Did you have any discussions about a formal method of near-miss learning, not actually taking it to full incidents but actually encouraging staff to use that mechanism?

A. So, with regards to the workload that was there, that was something that I had wanted to do but we didn't have the opportunity to do that. They were discussed at things like M&Ms, the near-misses. In obstetrics we look at those with much more detail. But with regards

to the Acute side --

341 Q. It wasn't done, for example, for blood loss in surgery generally or things like that, as far as you know?

A. No.

342 Q. Okay. Lastly then, the Datix. Have you any idea how the Southern Health Trust compares to other Trusts compared to the number of Datix reported in each category? Did you look at that? Were you a good reporter or a low reporter? 15:03

A. I don't have the intel to that but I know some of our Datix teams would have sat on a regional group to see how that works. I'm not the best person to answer that. 15:03

343 Q. You weren't aware of that at all?

A. No. But I know that that was going on. 15:03

DR. SWART: That is all from me. Thank you.

CHAIR: Just following on from the last question about Datix and about people raising concerns, I mean it's clear we need to get away, as you describe it, from the finger-pointing to a more learning culture and 15:04 improvement culture, if you like, as a result of these issues. There is obviously a chill factor in terms of people using Datix and how that might be addressed. You have given the example of training people and talking about the trigger lists. I'm just wondering is 15:04 there a way the whole system could be simplified so that, you know, you can say, okay, you need to report this but you don't need to report every incident of it; if you report it once, you can be sure it will be

looked at. Or is there like a grading that you can put on? I am trying to think of a simplified example. Obviously there was an issue where, you know, every time cases weren't being triaged, that was being reported as a Datix and then there was an instruction to stop doing that. And perhaps - and I'm speculating until we hear the evidence on this - perhaps the reason for that oh well, we have heard this, we are doing something about it. Is there a way of feeding back you don't need to do this because we have it, it's under being looked at? 15:05 15:05

A. Oh, absolutely, absolutely. From that viewpoint, feeding back to staff, yes, of course, that would be done. For example, if there was an issue with regard to patient access and you knew that there was -- you wanted to ascertain how much of a problem this was, you would initially set out saying can we get the Datixes in to see what kind of a problem it is, and then you would be feeding back saying okay, Thank you very much, we have got an overview, we no longer need that information. That's the better way of doing it rather than just don't do that any more, because then you have no context of what is. 15:05 15:05

344 Q. You are just being told --

A. You are just being told to stop. 15:06

345 Q. You don't know why?

A. You don't know whether do I fill in Datix for this bit. That causes confusion in the system.

346 Q. I am just wondering again about the learning culture.

How much of the outcomes of SAI reviews or of Datixes are fed back down through the system in terms of not just to the people who are the subject of those reviews or who are the people who know about them for whatever reason, but how much of that learning is disseminated across the Trust, do you think?

A. In the general side, as I say, it would have been through M&Ms, but you are subject to who attends, how many people come. Now, Covid was great from the viewpoint of Zoom, they had loads of attendances because people came, you know, virtually to those meetings. As I say, in obstetrics they do it really well because they feed into -- the risk midwife goes back and says these are our themes, these are our trends, and then that is fed back to -- they have a closed Facebook page, social media, and it goes up. It's called Good Practice Matters. Some of the midwives had devised it and it's wonderful because all the midwives have access to it. It will be the themes, not only any communication coming through.

They also have a whiteboard in every area. It used to be years ago there was a ward diary that people would have put communication in, but this is on a whiteboard now so it's there for everybody to see this is the theme of the month. They also have like Friday feedback, where staff are e-mailed the meetings, you know. So the SAIs would be coming through there, the learnings would be coming through there to the staff on

the ground.

347 Q. Those, I presume, would be the SAIs that were relevant to that department?

A. No, it would be the SAIs that were relevant to MWH, maternity and women's health in particular. 15:08

348 Q. Yes.

A. But with regards to -- that's same thing could be transferrable on the general side, is what I am trying to say.

349 Q. Have you any idea of what kind of resourcing that might require? 15:08

A. I did explore it in my tenure of setting up that Facebook page, and IT shut it down very quickly and said, you know, that's not -- I don't know how they got away with it in maternity but we don't want you doing that in the general side. So, we didn't get down that road. 15:08

Equally you could do the Friday feedbacks in all of the wards; you could do the whiteboards in all of the wards; you could make sure that at your ward meetings, that information is disseminated - this was a recent SAI, this is the learning come through on the SAI. That can be done at ward level and it must be done at ward level, and it must be done all the time with the new staff that are coming through as well. It is a big resource but they are things that are not -- they don't cost an awful lot of money to do that. It's more time than money. 15:08 15:09

350 Q. But I suppose if the people who are on the ground don't have the time, you need other people and that costs money?

A. So, these are done kind of like lunchtime meetings and things like that. I mean, there's no reason why the Trust can't provide a wee lunch for somebody to come in. I know people bring their own but, you know... 15:09

351 Q. That's a whole other issue.

A. Don't go down that road.

352 Q. In any event, there are things that could be done if the will was there to make the learning more widespread across the Trust? 15:09

A. I think so.

353 Q. You talked also about the loss of corporate memory. How do you think that could be addressed, because there's clearly an issue that we have seen with the turnover of staff within the Trust. How do you prevent memory being lost, good practice being lost, good systems being lost? 15:09

A. Mm-hmm, that's a very good question that I haven't been able to answer myself, except through reliving those action plans, reliving those reports, you know, and making that visible on the ground to all staff. Years ago an SAI was only shared with staff involved. You know, that shouldn't be the case. SAIs should be shared. There should be nothing in an SAI that identifies individuals to stop that from being reported, you know, and shared through the system. 15:10 15:10

CHAIR: Thank you. You have given us lots of food for

thought, so thank you very much, Mrs. Kingsnorth.
Thank you, Ms. McMahon.

I think that finishes us until next Tuesday, ladies and gentlemen. Ten o'clock next Tuesday. Thank you. 15:11

THE INQUIRY WAS THEN ADJOURNED TO 10:00 A.M. ON TUESDAY, 13TH JUNE 2023