Witness Statement Ref. No. 296/1

NAME OF CHILD: Claire Roberts

Name: Denise Lynd

Title: Mrs

Present position and institution:

General Manager Health & Social Care Records, Belfast Health & Social Care Trust

Previous position and institution:
[As at the time of the child's death]
In 1996 I was working as Information Manager in Belfast City Hospital Health Care Trust
Was in this post from 3rd April 1996 to 29th February 2004

Membership of Advisory Panels and Committees:
[Identify by date and title all of those between January 1995 - October 2012]

None

Previous Statements, Depositions and Reports:
[Identify by date and title all those made in relation to the child's death]

None

OFFICIAL USE:
List of previous statements, depositions and reports:

Ref:	Date:	

IMPORTANT INSTRUCTIONS FOR ANSWERING:

Please attach additional sheets if more space is required. Please identify clearly any document to which you refer or rely upon for your answer. If the document has an Inquiry reference number, e.g. Ref: 049-001-001 which is 'Chart No.1 Old Notes', then please provide that number.

If the document does not have an Inquiry reference number, then please provide a copy of the document attached to your statement.

(1) Please describe the role, function and accountability of your post, including those individuals to whom you report, and who reports to you.

I am responsible for strategic and operational management in relation to Health & Social Care Records. This role includes:-

- Developing strategies, policies, standards and procedures for records management consistent with legal and statutory requirements and best practice.
- Operational management of Health Records departments in hospital based areas including Medical Records Libraries/Medical Legal departments, Appointments booking and reception, Waiting list offices and PAS Support.

I currently report and am accountable to the Co-Director of Information who reports to the Director Planning, Performance & Informatics (Acting).

Three Senior Health & Social Care Records Managers report directly to me i.e. Senior Health & Social Care Records Manager Libraries/Medical Legal, Patient Access Manager Outpatients and Patient Access Manager Inpatients/Day cases.

(2) Is there a written job description for your post? If so, please provide copy of the same.

Yes see copy attached – please note my title has changed since this JD was written in 2007

(3) In respect of the Patient Administrative System (PAS) in place at the Royal Group Hospitals (RGH)/Royal Belfast Hospital for Sick children (RBHSC) in relation to both 1996 and now, please:

(a) Provide details of how the PAS operates;

At present, the PAS in the RGH is used by each of the Hospitals on the site to record patient demographics and activity i.e. RVH, RBHSC, School of Dentistry (SOD) and RJMH.

The system is accessed by a wide range of staff with levels of access and functionality determined by their role e.g. an appointments officers' access to functions on the system to book and manage appointments would be different to a nurse at ward level wanting to enquire about a patients whereabouts in a ward or an up and coming appointment.

Staff access PAS from their desktop and access is strictly controlled by usernames and passwords. Passwords are required to be renewed every 90 days. Changes to functionality cannot be made unless approved by Senior Managers as appropriate, and these requests are dealt with through the PAS Support Team once relevant paperwork giving approval is

completed.

In 1996 I did not work in the RGH and so I cannot comment on how the system operated then.

(b) What is the purpose/ function of the PAS, including what kind of information it stores, what it is used for and by whom;

PAS is an administrative system first implemented in the late 1980's. PAS does not hold clinical data but it does record some clinical coding based on diagnosis and procedures (if any were carried out). Clinical data is held in the patient's medical casenote.

PAS records demographic information (e.g. name, home address, date of birth) in respect of patients who have been referred to or have attended Hospital whether on an in-patient or out-patient basis. PAS is made up of various modules to record activity in relation to each patient (referred to 'episodic' activity) e.g. Outpatient referral/attendance details, waiting list details (in/day and out), admission/discharge details, clinical coding. Each episode is linked to a Consultant and Specialty. Most of this information is recorded in 'real time'.

The system is used to provide and print documents in respect of episodes of care for example labels and letters. It is also used to assist in the tracking of the patient's medical casenote.

PAS is used by a wide range of staff from different disciplines to record or view activity based on the requirements of their job role e.g. administrative roles for data entry, appointment processing and professionals for viewing to establish dates and times of treatment, diagnostic coding/ procedures.

Extracts of patient based information are taken from PAS and fed into a Regional data warehouse and the Trust has access to Belfast Trust data via a reporting tool called Business Objects used for statistical information and performance monitoring purposes.

(c) How the PAS might be interrogated to extract information (please include details of what search fields can be used to extract information);

Standard reports, created by the system supplier, can be run directly from PAS but these are limited in number. Most reports are run instead from the Regional data warehouse through Business Objects. This allows us to report against most but not all of the fields on PAS but is sufficient for the vast majority of clinical and business management reporting.

In a small number of cases where the fields required are not contained in the Business Objects enquiry tool, a system called Inquire is used for reporting. Inquire would provide these additional data fields from PAS not held in the Regional data warehouse. Business objects and Inquire reports are in most cases run by our Information Services Department and are not my responsibility.

(d) What kind of information can be extracted from it;

PAS provides lists for the purposes of administration and some statistical returns e.g. clinic lists for up and coming appointments or pre admissions lists so patient's casenotes can be pulled or created from Medical Records libraries in advance, ward lists for a given date

showing transfers/admissions to or discharges transfers out on a given date. It can also provide lists of patients on waiting lists in/day/out or current inpatients by ward at the time of the request.

(e) **With specific reference to the information that was recently obtained from the PAS in relation to the case of Claire Roberts, regarding the number of patients on Allen and Cherry Tree Wards on 21st, 22nd and 23rd October 1996, in particular those admitted under the care of Dr. Steen, please describe all steps taken to interrogate the PAS, how such interrogation was undertaken and in what manner, under whose direction and using what search fields;**

I was asked by Senior Trust Staff to investigate PAS to see if there were any reports available from the system to determine the number of patients on Allen and Cherry Tree wards on the 22nd October 1996 and in particular those admitted under Dr Steen.

I reviewed available reports on PAS and ran a 'discharged patients list' through the Patient Centre version of PAS (windows version). This report can be run by ward by date of discharge with a range of up to 3o days from the 1st date of discharge until the next.

The data items on the report included:-

Discharge Date, Discharge Destination, Discharge Method, Admission date & time, Name, Ward, Casenote number, Consultant Code, Consultant Name.

I ran a series of these reports by ward based on discharges from Allen ward or Cherry Tree ward from 22nd October until 21st November. By considering each patients admission date I was able to determine who was resident in each of these wards on the date in question and the Consultant attributed to their episode of care.

In order to ensure I had not missed any patients who may have been in either ward on the date in question who were not discharged but rather transferred to another ward on or after 22nd October 1996 I ran another series of report from PAS called Ward list for a date. The report is run by ward by a specific date and shows any transfers in/admissions or transfers out/discharges for the date specified. By cross checking the two reports I was able to identify two patients who were transferred out to another ward on or after the 22nd October 1996.

In the end I had identified 19 patients in Allen ward and 2 patients in Cherry Tree House on the 22nd October. 7 patients in Allen ward were attributed to Dr H Steen.

(f) **Confirm whether the PAS can be interrogated to determine which medical personnel are in attendance at clinics/ wards on given dates, and if so what depth of detail is included on the system.**

PAS does not record which medical personnel are in attendance at clinics/wards on a given date. Each episode of care is attributed to a named Consultant and Specialty but the patient can be seen by any of the medical personnel within the team.

(4) **Please state how details of the use of EEG, MRI and CT scans services are recorded? Can these records be accessed to disclose the name of any consultant whose patient**

underwent such a scan/examination, and can such records be accessed by ward, date and by reference to inpatients/out patients?

I cannot answer this question

(5) Please provide any further comments you may wish to make.

No further comment

(6) Please identify any further relevant documents or materials.

None

THIS STATEMENT IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

Signed: A. Donald Lloyd. **Dated:** 16/10/2012