

Witness Name: **Dr Wojtek Rakowicz**
Statement No.: **1**
Exhibits: **INQ0101407, INQ0101408, INQ0102075**
Dated: **19/06/2024**

THIRLWALL INQUIRY

WITNESS STATEMENT OF DR W P RAKOWICZ, LEAD MEDICAL EXAMINER, NORTH + MID HANTS

I, Wojtek Rakowicz, will say as follows: -

Introductory comments

1. I have been Lead Medical Examiner for North & Mid Hampshire since April 2020 when I set up the new service.
2. Prior to this I had 5 years' experience as Associate Medical Director for Governance at Hampshire Hospitals NHS Foundation Trust. In this time I was Trust Mortality Lead and set up the Mortality Surveillance Group in 2017, which I chaired until 2020. I also chaired the Serious Event Review Group (2017-20).
3. I am also a Consultant Neurologist, providing a comprehensive consultant-led adult neurology service at Royal Hampshire County Hospital, Winchester since 2013 and previously at Imperial College Healthcare NHS Trust (2003-13).
4. In 2022 I was appointed honorary adviser to the Secretary of State for Transport's Honorary Medical Advisory Panel on Driving and Disorders of the Nervous System, advising DVLA on policy and decisions regarding fitness to drive of people with neurological conditions.
5. I attach a brief CV (Appendix 1): **INQ0101407**

The Medical Examiner system is working well

6. The medical examiner has become an established and important part of the quality assurance framework for reviewing deaths and is effective in preventing deaths and serious incidents in hospital.

7. The Medical Examiner service is a uniquely valuable resource because we are independent of the Trust; we are able to review the entire record of recently deceased patients; to talk directly to one of the clinical team involved in the deceased's care; and to seek out any concerns from the next of kin. And all this happens in "real time".
8. Our North & Mid Hampshire service has flagged up both individual cases where problems with quality of care were identified and more systematic issues arising in parts of the hospital, neither of which had been picked up by existing governance mechanisms. These have led to investigations and changes that have resulted in an improvement in the quality of care for future patients.
9. The service of course reports to the Regional Medical Examiner. We also have quarterly regional meetings with the Senior Coroner and the Lead Medical Examiners and Lead Medical Examiners Officers of four Acute Trust in the region.
10. But we have found that, in order to be effective, we have needed to foster active links with our host Trust at all levels. On a day-to-day basis, contact with the Trust is via 'live' feedback to the Trust's Governance team.
11. Our escalation plan allows for feedback of information to individual clinical areas and teams and also, where relevant, to Clinical and Educational Supervisors. But where governance issues arise, the Governance Team is our single point of contact.
12. The Trust has welcomed the introduction of the Medical Examiner service and we have found it easy to communicate with the Board and Management teams.
13. The formal mechanism we have established for keeping the Board abreast of our findings and concerns is a quarterly report to the Trust's Mortality Oversight Board, which both the Lead Medical Examiner and the Lead Medical Examiner Officer attend *ex officio*.
14. In addition, we have a 6-monthly meeting with the Trust Chairman; and, where necessary, we are able to escalate ongoing concerns to the Chief Medical Officer.

Scope for development of the Medical Examiner system

15. While it is axiomatic that the Medical Examiner system is independent of the Trust, it can only provide assurance as part of the existing governance framework. For this reason, in a process that is still evolving, we have found it helpful to define the rules of engagement between the Medical Examiner service and our host Acute Trust's Clinical Governance systems.
16. To this end we have set up a quarterly **Medical Examiner Service Liaison Group** to provide:
- a single point of contact with the Trust
 - a mechanism to track individual concerns and to look for emerging trends
 - a forum to explore informally soft intelligence, which the ME service is in a unique position to pick up
 - a possibility to highlight for particular ME attention during their scrutiny areas where Trust concerns may be brewing
 - a conduit through which the Medical Examiner service can both escalate broader concerns and monitor on a regular basis feedback about the outcome of concerns they have raised
 - an opportunity for the Medical Examiner to consider at an early and local stage if a Trust response has adequately addressed the concerns that were escalated
17. Our experience has been that this formal regular exchange of information improves the quality of this interaction and strengthens the work of both the Medical Examiner service and the Trust's Governance team, while maintaining independence. This is achieved in at least two ways.
18. First, the Terms of Reference of the Medical Examiner Service Liaison Group and Escalation plans which we have developed (Appendix 2) provide clarity about how INQ0101408 issues are best articulated, responded to, escalated and monitored.
19. Secondly, we have a forum in which soft intelligence can be frankly and openly reviewed and challenged; and triangulated with other governance data. In other words, soft intelligence can be weighed up simultaneously from both an independent and a Trust perspective by the people most in touch with monitoring quality of care.

20. The result is that, where possible, qualitative information can be quantified or, where this is not possible, another plan of enquiry agreed to allow a better understanding of what is going on. It is then the responsibility of the Trust's Governance team to minute any concerns, obtain data that may be required, implement agreed plans, and to monitor progress against any of these items with an Action Tracker.
21. In other words, the Medical Examiner Service Liaison Group provides a forum that allows the Medical Examiner Service to better fulfil its role as both monitor and mirror to the individual teams and to the Trust as a whole.
22. Based on our local experience, in order to fulfil its role we would expect an effective Medical Examiner team to be able to demonstrate their own appropriate training in and experience of Clinical Governance; and to regularly reflect on the question of what does a governance 'red flag' look like?
23. In this regard, we are fortunate in North & Mid Hampshire to have four Medical Examiners with extensive experience of Clinical Governance, mortality review and of Structured Judgment Review methodology in particular.

More general comments

24. When I first contacted the Inquiry, I explained that almost all my work is with adult deaths and we have very few deaths of babies at Hampshire Hospitals NHS Foundation Trust. I have been advised that the Inquiry is also interested in hearing more general comments and it is with this understanding that I am also responding to other questions in the Terms of Reference.
25. In my opinion the current governance structures are reasonably effective in identifying inadvertent problems in care. But they typically struggle to effect change in the local organisation, even when recurrent patterns and themes have been identified; and would be ineffective at picking up deliberate malicious action.
26. I have explained why, from my perspective, the Medical Examiner service needs better defined rules of engagement with their local healthcare providers; and agreed mechanisms of communicating with and escalating to existing governance and assurance systems (cf Paragraph 15ff).

Obstacles to effecting change at Trust level

27. There is often no formal link between Governance and forums which identify Trust management and spending priorities. In this way, Trust structures can inhibit practical change when real problems have been identified.
28. There is a tendency for governance-related changes to come about reactively rather than proactively. Further, the governance concerns are filtered, for example through successive committees. So, for a proposed development to be prioritised to the point of being agreed and funded, a change typically requires championing by one of the Trust (non-)executive team.
29. In other words, almost none of the persons tasked with allocating resources in a Trust decision has any direct contact with the individuals who are raising concerns or with the senior clinicians in governance who could provide perspective and context. So, while the organogram is respected, the experience of individuals working with patients and in governance is that their views about themes, patterns and what is important do not get through and are trumped by other Trust priorities.
30. The understanding and appreciation of clinical governance is superficial among clinicians and managers alike. The serious result is that senior clinical and non-clinical managers do not routinely have any training in or experience of mortality review, even where they may have sole responsibility for escalating or downgrading concerns that are raised in their areas.
31. Even where there is a clear mechanism for feeding back to the individual/team that has raised concerns, this rarely happens in practice. The result is that there is no sense-checking on the ground of the quality of decisions being made elsewhere; and the general lack of response reduces the probability that individuals will raise new concerns in the future.
32. Finally, I draw attention to the drain on governance resources resulting from the culture engrained at the highest levels that HSMR and SHIMI are markers of quality in healthcare. An inappropriately large governance resource is expended on answering queries, which perpetuate a fundamental misunderstanding of the huge limitations of these statistics and distract the team from dealing with issues of genuine governance concern.

Difficulties in picking up deliberate malicious action

33. Clinical governance can be difficult and it can be particularly difficult to fully appreciate the significance of issues at the time they crop up. This is exacerbated by the general noise resulting from the inappropriate importance attached to HSMR and SHIMI statistics (cf Paragraph 32).
34. The Medical Examiner review of deceased records is generally unlikely to pick up deliberate malicious action primarily because it is unlikely that such actions will be documented.
35. There is a secondary issue that the requirement for a proportionate review limits the amount of time available to scrutinize each set of records. But it would be unusual for a medical examiner to report that they had not been able to complete their work and, were this to arise, they would usually refer the records to the Clinical Governance team for consideration of a Structured Judgement Review.
36. I have explained that two key strengths of the Medical Examiner system are the ability to talk 'in real time' to (1) a member of the treating clinical team and (2) to the next of kin. These are likely to be key informants with respect to identifying a pattern of actions, omissions and events about which they may be uncomfortable.
37. Identifying patterns in a statistical way is extremely difficult both because of the variability / noise inherent in the data, particularly when the patient population of interest – i.e. inpatients – is made up of ill rather than healthy individuals. This is made worse by the inaccuracy of IT systems in recording changes in patient location or which clinical team is looking after them.
38. But with improved IT accuracy and with IT support, it might be possible to identify unexpected trends in Crude Mortality, a statistic more likely to be relevant to unexpected excess deaths than the HSMR or SHMI which are so widely discussed.
39. Based on our experience, a Medical Examiner Service Liaison Group is likely to provide an appropriate and independent forum for sense-checking concerns that may be being aired across the organization about individuals and trends.

40. The Group allows the Medical Examiner to satisfy themselves promptly that concerns have been acted on appropriately; and provides an immediate mechanism for holding the Trust to account for its response.

Facilitating appropriate challenge by the Medical Examiner service

41. It is not the role of the Medical Examiner service to duplicate the existing work of the CQC and NHSE. But for the function to be effective, its work should not stop at the point that it has informed other parts of the healthcare systems of any concerns. There need to be mechanisms by which it is able to appropriately and proportionately hold a healthcare provider to account.
42. Based on our experience, a system consisting of the following components would allow the Medical Examiner service to appropriately monitor and report on what they observe:
43. A requirement for Trust Boards to receive a report from the local Lead ME directly and in person every 6 months, summarising their findings and feedback from families/staff and specifying any concerns raised by families and any independent concerns that the ME service might have arising from its work.
44. A requirement for Boards to respond to concerns raised by the ME within 3-6 months.
45. A parallel requirement for ICS Boards to receive reports from Regional MEs to provide feedback on work involving local Trusts and local primary care referrals.
46. A parallel requirement for NHS England Board to receive reports annually from the National ME.
47. A governance structure to allow local MEs to escalate concerns to which they have not had a satisfactory response. While involvement of the Regional and National MEs is a given, an effective response is likely to require the involvement of the ICS, NHS England or CQC.
48. Strengthening of governance and structure around regional and national ME services to allow this to happen.

49. A requirement for the CQC to interview Lead Medical Examiners as part of their processes for inspecting Trusts and services.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

PD

Signed:

Dated: 19th June 2024

Appendix 1 Brief CV **INQ0101407**

Appendix 2 Medical Examiner Service Liaison Group (MESLG): Terms of Reference **INQ0101408**

Appendix 3 Medical Examiner Service Liaison Group (MESLG): Escalation process **INQ0102075**