# HSE Your Service Your Say
## Anonymised Complaints Casebook Q3 2019

Welcome to the third edition of the 2019 HSE complaints casebook. This casebook sets outs a selection of complaints, nine from Hospital Groups and six from Community Healthcare Organisations, which were investigated and/or reviewed along with their outcomes. The casebook is part of the HSE's commitment to use complaints as a tool for learning and to facilitate the sharing of that learning.

The cases included in this edition, although each unique, have an underlying theme regarding communication and the provision of information. The findings suggest that some of these complaints could have been avoided if full information had been provided to the service user/patient. The cases below also highlight issues regarding the proper application of the HSE's complaints management process which resulted in unnecessary investigations and reviews as well as poor complainant experience.

These cases have brought about some important practice changes but have raised issues that require further attention and improvement.

The casebook will be widely circulated to staff within the HSE and shared with Complaints Managers who will consider how the findings and recommendations can be applied to their service area and used as a quality initiative.

We hope that this casebook and subsequent casebooks will continue to develop and will offer a valuable insight into the issues that give rise to complaints and will assist in guiding decision making to improve services and the service user experience.

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## *Hospital Group*

**Category:** Safe and Effective Care and Accountability (complaint process)
**Status:** Partially Upheld

**Background to Complaint**

This patient had been treated as an inpatient for seventeen months primarily in a mental health facility. Due to other clinical conditions the patient was also treated during that time as an inpatient in the local acute hospital for approximately five months which comprised of four separate episodes of care over the seventeen month period. During the admissions to the acute hospital the patient was reviewed regularly by the mental health services. Unfortunately, the patient passed away. Following the patient's death the family made complaints to both services regarding the care and management provided to their relative during this seventeen month time period. In the acute service this was initially managed as a stage two complaint, but as the family remained dissatisfied with the response, a stage three review was requested and undertaken.

**Investigation**

1. Review of initial complaint to acute services and response from the hospital
2. Review of the clinical records from acute hospital
3. Meeting with the family by review team from acute services.

During the meeting between the review team and the family members the outstanding issues related to the acute care provided had been discussed and explained in detail. Initial misunderstandings had been clarified to the satisfaction of those present however it became apparent that the family were still distressed and very upset with their contact and meetings with the mental health services. The reviewers agreed to contact the CHO on the family's behalf and to advise that in their view, a further meeting would be required to address outstanding issues. Following conversations with the CHO QPS Manager and senior management team it became evident that they had closed out on this case and believed the issues had been resolved satisfactorily. However following discussions related to the clarity of explanations previously provided to the family and misunderstandings around the impact that the clinical conditions could have had on the deceased person's mental health, a further meeting was arranged to address the concerns raised.

**Outcome and Learning**

This case demonstrates the challenges in managing interrelated issues that arise in different services (Acute and CHO). The family had to make two complaints with a number of overlapping issues to two different services who did not appear to them to be communicating with each other. They subsequently met with reviewers/staff from both services for what was, essentially, the same issues.

This issue of a 'no wrong door approach' is for consideration nationally and further development is needed in the management of complaints when issues span both community and acute services in order to achieve complete resolution. However, it is recognised that this may be easier to achieve for statutory services and more complex for when voluntary hospitals are involved due to GDPR issues.

## *Hospital Group*

**Category:** Communication and Information
**Status:** Partially upheld

**Background to Complaint**

A parent attended a Local Injury Unit with their child who had sustained a shoulder injury over a weekend.

An X-ray didn't appear to show any obvious break, treatment was given as appropriate while awaiting official x-ray report from the radiologist.

Three days later the official ray report showed a break. While the treatment administered was appropriate the parent had taken their child on a foreign holiday and was very upset to receive the news via phone call. The parent also felt that they had to attend a hospital abroad. This incurred an expense.

**Investigation**

The complaint was reviewed by the complaints manager, clinical manager and Consultant in charge of the unit. On investigation it was unclear if the parent had been told it was a possibility that their child had sustained a break and that it could only be confirmed on review by a radiologist. While the treatment was appropriate the parent's issue was that if they had been informed that there was any doubt they would not have gone on holiday. It is the policy of the unit that all patients are informed that an official radiology result is necessary in some cases to out rule injury if not clinically obvious.

**Outcome and Learning**

The parent was offered a review for their child by the consultant with clinical governance for the unit or a fracture clinic appointment but declined both.

It was agreed that the unit manager would put up signage to reflect the above policy. There would also be renewed awareness with all staff of this policy.

While the hospital apologised to the family for the inconvenience and perceived lack of communication, the treatment was appropriate. The complaint was partially upheld. The parent was happy with the response.

## *Hospital Group*

**Category:** Communication and Information
**Status:** Not upheld but recommendations made

**Background to Complaint**

A patient attended the Emergency Department (ED) with symptoms of a urinary tract infection. They had recently moved to Ireland. Before attending the ED they had contacted the local General Practitioner (GP) but they had no available appointments for new patients.

After 4 or 5 hours waiting the patient left the hospital on the advice of another patient and went to a GP the following day.

The patient received an invoice from the Hospital. The patient wanted to confirm that the invoice issued was correct since they did not receive any attention and was not informed that they would receive an invoice when they left the Emergency Department. The patient emphasised that they were new to the country and did not know the system.

**Investigation**

The complaint was investigated by the Complaints Officer. The patient's Healthcare Record was checked and it was noted that they were triaged by the ED Triage Nurse. Standard observation tests were performed including Blood Pressure, Temperature check, Oxygen saturation and a Urine test to check for infection.

The Finance Department were asked to put the bill on hold while the complaint was under investigation. The Finance Department confirmed that all patients who present and register at the Emergency Department incur a statutory €100 charge. This is an Irish government levy applied to all Emergency Department presentations without a referral from a GP.

**Outcome and Learning**

On this basis a decision was made not to waive the patient's invoice for this admission to hospital. A copy of the Guide to the Emergency Department charges was sent to the patient for their information.

The Complaints Officer recommended that the Finance Department update this information on Patient Charges Information Leaflet to address this issue which had given rise to several similar complaints.

## *Hospital Group*

**Category:** Safe and Effective Care / Accountability (feedback process)
**Status:** Compliment

**Background to Complaint**

A Patient e-mailed the Patient Advocacy Department of a hospital acknowledging the care they had received when they had a surgical procedure carried out on the day ward.

"*I had a surgical procedure carried out. l was under the care of the staff of the day ward. I want to thank all of the staff involved in my care including the non-medical staff. Not only were my physical needs addressed but and as important my emotional and mental needs were also addressed. I don't know what the procedure is in place to let all of them know how well they worked on the day but I would like them to know how much I appreciate their work"*

**Investigation**

The Patient Advocacy Department shared the feedback with the Consultant, Anaesthetist Staff and day ward staff thanking them for the care, compassion and commitment shown to this patient.
The department acknowledged receipt of the correspondence to the patient with an undertaking to share with the staff involved.

**Outcome and Learning**

This positive feedback to staff was very meaningful and boosted morale. It also served to remind staff that the impact of holistic care of a patient is of highly valued.
In addition, the feedback highlighted the importance of team work and aiming to provide a patient with the best experience possible in varying circumstances.
The Hospital committed to reviewing the information provided regarding its feedback processes so that it can make it is easier for patients to provide feedback. This includes reviewing the hospital's website.

## *Hospital Group*

**Category:** Dignity and Respect / Safe and Effective Care / Accountability
**Status:** Dignity and Respect, partially upheld; Safe and Effective Care, not upheld; Accountability, not upheld

**Background to Complaint**

A patient complained about lack of privacy in the Emergency Department when being treated for a finger injury, and also disputed the payment of the invoice.

**Investigation**

The patient's complaint was acknowledged. The invoice was put on hold pending outcome of examination of the complaint. The complaint was forwarded to relevant consultants for response to issues raised.

*Lack of privacy in Emergency Department* - explanation given that overcrowding in Emergency Departments is a national issue and it is common practice to treat minor injuries involving the hand, toe and foot on chairs to reduce waiting times and for the patient's convenience. An apology was made to the patient as they felt that their privacy was breached whilst in the Emergency Department. This element of the complaint was partially upheld.

*Treatment of finger injury* - the patient was given an analgesic and it was appropriate and common to offer additional analgesia, if required for patient's comfort. During treatment, equipment was accidently dropped. The equipment was changed as were the nurse's gloves. It is best practice that equipment is changed after dropping and that clean gloves were used. Following review of the medical chart, discussions with NCHD involved in the patient's care as well as a review of x-ray performed in another hospital, it was concluded that the Consultant made the correct clinical judgment that an additional x-ray was not necessary and had treated the injury appropriately. This element of the complaint was not upheld.

*Invoice for treatment* - this element of the complaint was not upheld since the treatment of the finger injury was appropriate. In line with Health regulations, the invoice for Emergency Department attendance was re-instated.

**Outcome and Learning**

The Emergency Department is to review the space available to examine patients and remind the ED team of the importance of maintaining patients' privacy.

## *Hospital Group*

**Category:** Communication and Information
**Status:** Partially upheld

**Background to Complaint**

A patient complained about bleeding following an attempted procedure.

**Investigation**

The patient complaint was acknowledged in writing. The complaint was forwarded to the relevant consultant for response to issues raised.

*Bleeding following an attempted procedure* – The patient was seen in the Emergency Department following a fall. Review of the medical chart showed that patient was examined and x-rayed. A provisional diagnosis was considered. A particular procedure was indicated and was attempted to be carried out. A complication arose and the procedure could not be completed. Bleeding resulted, which is not uncommon for such a procedure. The patient's treatment was discussed with treating team and after a period of observation was referred to the surgical team. The surgical team completed the necessary treatment and appropriate follow up has been arranged for the patient.

**Outcome and Learning**

The complaint was partially upheld.

The Emergency Department is to review the information provided to patients when consenting for particular procedures so that they are fully informed of any potential side effects.

## *Hospital Group*

**Category:** Improving Health
**Status:** Upheld

**Background to Complaint**

A parent attended an OPD clinic with their child. An acknowledgement of the *'exceptional service they provide to our children with their knowledge and* expertise' was made by the parent. The parent also recognised the *'wonderful efforts to encourage an environment of health promotion and preventative medicine, educating us and empowering us to be healthier.'* The parent also provided feedback regarding the vending machine and commented that there was '*an unhealthy selection of snacks in the waiting room of the children's clinic.*' They further commented that *'children were getting upset and pestering their parents for the unhealthy treats'* and that the visible availability of the vending machine in the waiting room was *'sending out an unhealthy message to the children'.* They suggested to move the vending machine to another area.

**Investigation**

The parent was thanked for the positive acknowledgement of the paediatric services.
Comments in relation to the vending machine were taken on board. It was explained that the vending machine had been installed in the outpatient department as a result of a significant number of requests by members of the public attending clinics. Many parents felt that the department is located a considerable distance from the nearest shop and wished to have access to snacks while waiting for appointments.

**Outcome and Learning**

It was agreed that the location of the vending machine is not appropriate in the waiting room where it is visible to young children. The location of the vending machine has been changed.

***Hospital Group***
**Category:** Accountability
**Status:** Upheld

**Background to Complaint**
A child attended hospital after having attended the private rooms of a Consultant and was admitted as a private patient. The parent of the child disputed the hospital charges as they child was not accommodated in a private room. The parent advised that they were happy to pay the private fee to the Consultant but did not feel that the private fee should apply to the accommodation as they were in a multi-occupancy room.

**Investigation**
The Complaints Officer received confirmation from the Admissions Office regarding the private status of the patient. The Private Insurance Form was signed on admission by the parent agreeing to the charge.
A letter had also issued to the parent advising of the paperwork completed and signed by the parent on admission and the levy/charge remaining outstanding.

**Outcome and Learning**
Recommendation was made that communication by staff when admitting patients and requesting signature on admission regarding Public V Private Charges should be improved so that patients are clear as to the charges being incurred. In addition staff should clarify to patients the difference between "Private to Consultant" and "Private to the Hospital" regardless of the accommodation type.

## *Hospital Group*

**Category:** Safe and Effective Care
**Status:** Upheld

**Background to Complaint**

A patient attended a diagnostics area for scans as referred to by an internal Consultant. The patient realised following scan that they had insurance cover for the orthopaedic procedure in an external Private Hospital and so opted to receive treatment there. When the patient requested various scans/reports they were advised that these would not be available to the external private hospital.

**Investigation**

The Complaints Officer confirmed that patient did attend and had scans completed in public hospital. The Complaints Officer liaised with Diagnostic Area to advise that regardless of what hospital the patient chose to attend in the future, results and scans were personal information to the patient and the patient was entitled to access and receive copies of same.

**Outcome and Learning**

Staff to be refreshed and made aware of relevant legislation pertaining to personal information and access to same e.g. FOI & GDPR

## *Community Healthcare Organisation*

**Category:** Safe and Effective Care / Accountability (complaint process)
**Status:** Not Upheld

**Background to Complaint**

A complaint was made to a community service regarding the fact that their relative was not receiving enough hours of home support or assistance with meal provision when the main carer was unable to be there in the late afternoon and early evening. Also there was no replacement cover for annual leave. The complaint was investigated by a Complaints Officer and a report setting out the findings and recommendation was issued. The Home Support Service was not able to address all aspects of the complaint as some of these fell outside the range of services available. The complainant was dissatisfied with the response and requested a HSE Internal Review.

**Investigation**

The Review Officer met with Complainant in their home and agreed Terms of Reference to guide the review. The Review Officer also met key personnel involved in the complaint including the Complaints Officer who conducted the original investigation. All relevant documentation was reviewed and although all correct procedures had been followed in the management of the complaint there was no record of any meetings with the Complainant or interviews with relevant personnel. It was also discovered that following the initial letter of complaint, the Complainant had applied for Home Support increase on two more occasions, which were approved. The appropriate home support hours were given for the Complainant's relative's care needs. During the Stage 3 internal review process the Review Officer was made aware that the complaint had also been referred to the Ombudsman.

**Outcome and Learning**

The Review Officer found that although correct 'desktop' procedures were followed the report lacked input from the Complainant and relevant personnel to provide a more comprehensive response and explanation around the Home Support Service provision. It was felt that this lack of detail resulted in the Complainant seeking a HSE internal review.

The Key learning from the review was to highlight the importance of engagement, communication and feedback with the Complainant and relevant personnel during the complaint process and providing a comprehensive explanation and response. The review by the Ombudsman did not uphold the complaint.

## *Community Healthcare Organisation*

**Category:** Safe and Effective Care / Communication and Information
**Status:** Not Upheld

**Background to Complaint**
A Service User had an expectation that they would receive a PHN Service following discharge from Hospital for post -operative care. However, this care from the HSE PHN service was not part of the referral letter received following discharge. The Service user made a formal complaint regarding this.

**Investigation**
Following the complaint made by the Service User, the Complaints Officer determined that the PHN service had not been furnished with complainant's discharge details and was therefore unaware of the information that had been provided to the Service User following discharge and how this might have resulted in inaccurate expectations.

As part of the investigation process a meeting was arranged between the PHN and the Service User to discuss the referral letter received following discharge from hospital. The main issue for the Service User was their expectation that the HSE PHN Service would deliver post-operative care. The PHN provided an explanation around eligibility. Access to the local HSE PHN Service was also explained to the Service User who was under 65 years of age, had no medical card but had private medical insurance. Service Users who are under 65 years and have no medical card are expected to attend their local Practice Nurse for postoperative care in a private capacity.

This issue was resolved locally whereby an agreement was reached in relation to shared care. A PHN Service would be provided once a week and the Service User would self-care on the remaining days. The complaint was not upheld.

**Outcome and Learning**
There is a need for an agreed pathway of care and discharge information for adults < 65 years old with a clinical need who may have private health insurance, so that patients are informed and understand that they may not meet the eligibility criteria to access HSE community Services such as PHN Service following discharge from Hospital.

## *Community Healthcare Organisation*

**Category:** Improving Health
**Status:** Partially Upheld

**Background to Complaint**

A complaint was raised as a result of the attendance by a parent with their child for a school vaccination programme. In the course of the vaccination process the parent noted that lollipops were on display and clearly visible at the site. The parent subsequently made a complaint about the lollipops being visible at the venue during the vaccination programme.

**Investigation**

The Complaint Officer considered the relevant policy in this respect and confirmed that while lollipops could be made available, exceptionally in these circumstances, they should not be visibly on display. As a result a recommendation was made to review the policy on the use and availability of lollipops for children in the context of vaccinations to better reflect organisation wide policy and practice around healthy eating.

**Outcome and Learning**

In this case the key learning was the need to ensure that local practice and related policies were regularly monitored and reviewed and revised to appropriately reflect the position nationally.

## *Community Healthcare Organisation*

**Category:** Accessing Services (Primary Care) and Communication and Information (CAMHS) and Accountability (complaint process)
**Status:** Primary Care – Not Upheld / CAMHS – Not Upheld

### Background to Complaint

A parent and their child were awaiting an appointment with Primary Care Psychology Services. The parent rang Primary Care Psychology Services and spoke with the Psychologist in relation to their concerns for their child and enquired when they would receive an appointment. The Primary Care Psychologist advised that the child should attend Child and Adolescent Mental Health Services (CAMHS) for assessment given the possibility of risk. The Psychologist further indicated that if the child was accepted to CAMHS they would be removed from Primary Care Psychology Services waiting list. However, if not accepted the child would continue to be waitlisted for the Primary Care Psychology Services.

The parent and their child attended an appointment with CAMHS and after this appointment the parent was very distressed by the behaviour and comments of the Psychiatrist. The parent then contacted Primary Care Psychology Services again and explained that CAMHS would not be accepting their child. The parent requested for their child to be seen by Primary Care Psychology Services.

The parent decided to submit a complaint. The complaint read as if the parent wished to complaint about the lengthy Primary Care Psychology Services waiting list.

After receiving an acknowledgement letter regarding their complaint the parent contacted the Primary Care Psychology Services stating that they had received a letter from the Complaints Officer assigned to the complaint. The parent clarified that the complaint was in relation to CAMHS and not in relation to Primary Care Psychology Services. The parent then contacted the Complaints Officer to advise them also.
Primary Care Psychology Services have since arranged to see this child within Primary Care and they continue to attend this service.

### Investigation

The complaint submitted to the mental health services was assessed as relating to both primary care and child and adolescent mental health services (CAMHS).

The Complaints Officer assigned to the primary care element of the complaint proceeded to investigate in relation to the relevant clinician in primary care, in line with Your Service Your Say. However, they did not contact the complainant as they assumed that they were not the lead for this complaint.

On receipt of the response from the Psychology Manager in Primary Care Psychology Services and following contact made by the complainant upon their receipt of the acknowledgement letter, the Primary Care Complaints Officer discovered that the complainant had no issues with Primary Care Psychology Services and that the complaint was solely in relation to CAMHS. Once this was clarified the Primary Care Complaints Officer issued the Primary Care complaint response with the recommendation to close the Primary Care element of this complaint.

The CAMHS' Complaints Officer investigated the matter and contacted the complainant to clarify what the doctor in question was expressing at the time of the engagement. The issue was more around communication

and understanding rather than dignity & respect. A follow up meeting was arranged with the Complainant, the team's Consultant Psychiatrist and the doctor in question to clarify any outstanding issues.

## Outcome and Learning

If the Complaints Officers had contacted the complainant on receipt of the complaint, then the complaint could have been channelled to the correct service which was CAMHS. Time and resources were expended by the Primary Care Services investigating where there was no issue. This caused annoyance for the complainant as they had not made a complaint regarding the Primary Care Services. A complaint can read completely differently to the way in which it was intended.

The Complaints Manager for the CHO area will now formally assign a Lead Complaints Officer if dealing with a complaint that involves more than one service and consequently the other Complaint Officers will feed into the Lead who will be responsible for contacting and updating the complainant with only one acknowledgement and response issuing.

**Recommendations:**

An informal phone call or meeting, within 48hrs, enables both the complainant and the Complaints Officer to clarify the issues involved at an early stage. This may facilitate a number of outcomes such as early and informal resolution, complaint withdrawal, referral to a more appropriate pathway or formal investigation if required.

## *Community Healthcare Organisation*

**Category:** Communication and Information
**Status:** Upheld

**Background to Complaint**

A Service User was attending community Mental Health services and was provided with a prescription by the Non Consultant Hospital Doctor (NCHD). At a subsequent multi-disciplinary Community Mental Health Team meeting it was advised that the patient should be offered a specific therapeutic intervention provided they were not on medication. It was therefore agreed that the previously prescribed medication be withheld until an evaluation of the impact of therapeutic intervention was done. It was agreed that the NCHD would contact the patient and advise against starting the medication. Unfortunately due to an oversight this communication was not made to the Service User. The Service User complained that they did not receive this information which could have impacted on their receiving the therapeutic intervention. Thankfully the therapy was able to be provided with no negative impact on the Service user.

**Investigation**

The Service User submitted a formal complaint to the HSE**.** The Complaints Officer engaged with the Consultant Psychiatrist and requested a report outlining the background and circumstances that gave rise to this matter. The Complaints Officer also engaged with the Psychiatrist and with the Acting Executive Clinical Director on the matter. It was agreed that this was a communication issue as following a multi-disciplinary meeting the agreed actions affecting the Service Users was not advised to them.

**Outcome and Learning**

The complaint was upheld by the service. An apology was issued both verbally and in writing. A number of actions and recommendation were implemented. The Service User was happy that the complaint had resulted in learning for the service and in a positive change to practice.

A review was undertaken by the local Community Mental Health Team of the recording of decisions made in relation to service users at MDT meetings in light of this complaint. This resulted in a change in practice and local policy.

A system is to be put in place by the Community Mental Health service to ensure that all agreed decisions taken at multi-disciplinary team (MDT) meetings in relation to services users are recorded and action taken appropriately. Decisions in relation to actions taken at MDT meetings will now be recorded in the medical notes of the service user by the member of the MDT who brought the case for discussion at the meeting as well as on the system used by nursing staff.

This new practice and procedure was agreed by the MDT and is now in operation.

## *Community Healthcare Organisation*

**Category:** Safe and Effective Care / Privacy / Communication and Information
**Status:** Not upheld but recommendations made

**Background to Complaint**

A service user availed of a mental health service as an in-patient for six nights. The Service User advised that their ex-partner had become aware of this inpatient admission and believed that this constituted a breach of confidentiality. The Service User also complained that there was a lack of time and attention afforded to them from the nursing staff on the night of admission. The Service User had issues with the assessment process and the fact that they were asked multiple questions in the acute unit, despite being asked these questions in the Emergency Department.

The Service User also raised concerns in relation to the communication process in relation to the acute unit and how it works, the assignment and role of a Key Worker and access to the nursing staff. The Service User complained about the negative experience of the care provided while they were in the unit and the fact that there was limited access to the bedroom during the day. The Service User also complained about the lack of recreational activities and access to Psychology and Occupational Therapy staff.

**Investigation**

All staff in the area are aware of the confidentiality and GDPR requirements in relation to personal information of service users. It is practice and policy that only nominated Next of Kin (NOK) are given information about a service user and that this is done with the service user's consent. The alleged breach was investigated but it could not be determined if a breach occurred. However, it was recommended that staff undergo training on GDPR using the HSELanD module.

The complaint relating to communication with nursing was investigated and it is understood that the Service User was met by a nurse on the night of admission and significant time was spent during this process and later on the ward. A check list was adhered to, in line with the *Admission Good Practice Checklist* and this formed part of the healthcare record. Conversations with the assigned Key Worker during admission as well as daily interactions with the Service User were recorded in the clinical file. Interactions with the nursing staff during the day and night (observing 4 times per hour) were also recorded in the clinical notes.

The Service regrets that the Service User had a negative experience of their stay in the unit. A copy of the independent regulatory body's recent inspection report was provided to the Service User. It was also explained to the Service User that the rationale for limiting access to bedrooms in the centre was to promote positive mental health, establish and maintain healthy sleep patterns and restore a daily routine.

In relation to the issue regarding access to Psychology and Occupation Therapy staff it is noted that the unit has a nurse and Healthcare Assistant (HCA) dedicated to the Day Ward including an Occupational

Therapist and a Social Worker. These professionals are available to service users as required. There was no evidence that the Service User had requested or was denied access to these professionals.

The facility also offers a range of recreational activities for service users. The facility has a Games Room and an Art Room which is available to service users. An Art Teacher also delivers a weekly class as well as additional recreation activities. It was noted that the Service User was provided with a yoga mat and was offered and participated in Yoga.

The Service User was discharged by the treating Consultant Psychiatrist and was referred for follow up review as an outpatient.

**Outcome and Learning**
In relation to this case the complaint was not upheld.

However, as a determination, following investigation, regarding a breach of confidentiality by a staff member could not be made; it was recommended that all staff should undergo GDPR training. An apology was given to the Service User in case the breach had happened but just could not be verified.

All staff within the unit are to be reminded by nursing and administrative management in relation to their responsibility in terms of service user confidentially and will be requested to provide evidence of undertaking the GDPR training online module for HSE staff which is available on HSELand.