Urology Services Inquiry

Oral Hearing

Day 10 – Wednesday, 16th November 2022

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.

____

Gwen Malone Stenography Services

1 THE INQUIRY RESUMED ON WEDNESDAY, 16TH DAY OF
2 NOVEMBER, 2022 AS FOLLOWS:
3
4 CHAIR: Good afternoon, everyone.
5 MR. WOLFE KC: Good afternoon. Your witness today, 14:05
6 Chair, and into tomorrow, is Mr. Mark Haynes,
7 Consultant Urological Surgeon. I think he is going to
8 take the affirmation.
9
10 MR MARK HAYNES, HAVING AFFIRMED, WAS EXAMINED BY 14:05
11 MR. WOLFE KC AS FOLLOWS:
12
13 1 Q. There should be some water for you there, Mr. Haynes.
14 I am going to start this afternoon by welcoming you to
15 the Inquiry. Thank you for coming along to give your 14:05
16 evidence. The Chairman, Ms. Smith, is sitting in the
17 middle, and you can see the names of her Panel members.
18
19 You have, in advance of today, prepared a Section 21
20 response, which I will, in shorter terms, call 14:06
21 a witness statement, and you will know what I mean by
22 that. Can that be brought up on the screen for
23 Mr. Haynes? It's at WIT-53861. You will no doubt
24 recognise that, Mr. Haynes. If we could shuffle along
25 to the back of it, at the last page. WIT-53959, and 14:06
26 that is your signature?
27 A. Yes.
28 2 Q. Before I ask you whether you wish to adopt your
29 statement, I understand that you have one or two

1 observations to make in relation to it?
2 A. Yeah. Sorry, in going through it again, I picked up
3 a couple of corrections, so at 5.1.B, which covers my
4 appointment as AMD, it should read "until August 2021"
5 not 2017. 14:07
6 3 Q. Let me slow you up. It's 5.1.B, the typo, it should
7 read 1st October '17 to August?
8 A. '21.
9 4 Q. '21. Delete '17 and insert August '21. Okay.
10 A. The second one is at 62.7. This paragraph -- 14:07
11 5 Q. Just wait until we get there. So it's WIT-53937?
12 A. This paragraph refers to late 2016 and then into early
13 2017, and when I read that I realised the line
14 relatively soon after later starting at AMD is
15 incorrect. It should read instead "in late 2016" as at 14:08
16 that 5.1.B I only started as AMD in 2017.
17 6 Q. Okay. Are those the only corrections you wish to make?
18 A. Those are the only corrections that I have noted that
19 I wish to make. Additionally, I would just like to
20 take the opportunity to, in person, apologise for being 14:09
21 late with my statement, despite the extensions I was
22 given.
23 CHAIR: Thank you very much, Mr. Haynes.
24 MR. WOLFE KC: In light of all of that, Mr. Haynes, do
25 you wish to adopt your statement as part of your 14:09
26 evidence to the Inquiry?
27 A. Yes, I do.
28 7 Q. Another housekeeping matter. You should have in front
29 of you a cipher list. That's a list of patient names,

1 giving them a number instead of a name when you wish to
2 refer to them. In short terms, when you wish to refer
3 to a patient, use the patient number, even if it takes
4 you a bit of time to try and find it. I realise the
5 list isn't in alphabetical order. At various points, 14:10
6 I will bring documents on to the screen. In fact,
7 there's one in front of us containing a patient's name
8 which has not yet been redacted. Clearly, no-one in
9 this chamber should use the patient's name; always use
10 the patient number. We are, all of us, subject to the 14:10
11 Restriction Order handed down by the Inquiry.
12
13 You are here with us, Mr. Haynes, through to tomorrow.
14 In essence, the Inquiry wishes to obtain, through your
15 evidence, a better sense of the Clinical and 14:10
16 Administrative issues and incidents of concern relating
17 to Mr. O'Brien and the way he practised, which led,
18 eventually, to the events of 2020; the Early Alert and
19 the announcement of this Inquiry. You were in post for
20 six years by 2020, and by that time, I will be 14:11
21 suggesting to you, that you had an opportunity, both as
22 a colleague and as a manager, to witness what the Trust
23 has referred to as concerns at close quarters.
24 Hopefully you will be in a position to assist the
25 Inquiry, along with your other colleagues, in terms of 14:11
26 how the Trust addressed those concerns, and whether
27 they were adequately addressed, from your perspective;
28 and if not adequately addressed, what could and should
29 have been done differently, and what may have impeded

1 the implementation of an adequate response.
2
3 This is undoubtedly going to be the initial phase of
4 your evidence. I have spoken to you, for the record,
5 on Monday of this week, and there's many issues that we 14:12
6 won't be covering this afternoon, including, for
7 example, the Governance structures, MDM, that's the
8 multidisciplinary way of working. Some issues will be
9 touched upon but briefly, and will need to be revisited
10 in due course. 14:12
11
12 Let me start by asking you some questions about your
13 career to date.
14
15 You took up post at Craigavon in the Southern Trust in 14:12
16 2014; isn't that right?
17 A. Yes. I started work in Craigavon on 14th May 2014.
18 Prior to that, I was a Consultant in Sheffield Teaching
19 Hospitals and I'd started there, having finished my
20 training on the South Yorkshire training rotation. 14:13
21 I started as a Consultant in Sheffield on 1st April
22 2010.
23 8 Q. When you moved to Craigavon, it was into the position
24 of Consultant Urological Surgeon; isn't that correct?
25 A. Yes, yeah. 14:13
26 9 Q. You have told us in, your witness statement, that
27 within that role, you had no management
28 responsibilities at all?
29 A. Not when I initially took up post.

1 10 Q. In the role of Surgeon, you were responsible on the
2 Medical side of management to the Associate Medical
3 Director, who, at that time, was Mr. Mackle, and then
4 Dr. McAllister; isn't that right?
5 A. Yes. 14:14
6 11 Q. On a day-to-day basis, there was a contact with
7 Mr. Young in particular, Mr. Michael Young, who was the
8 Clinical Lead within Urology?
9 A. Yes.
10 12 Q. Then on the operational side, you were accountable to 14:14
11 the Director of Acute, who at various points was
12 Mrs. Burns and Mrs. Gishkori?
13 A. Yes.
14 13 Q. I suppose, on a more local level within the Service
15 itself, you had frequent contact with Mrs. Corrigan? 14:14
16 A. Yes.
17 14 Q. Who is the Head of Service. At that time in 2014 you
18 joined a Consultant team that comprised Mr. Young,
19 Mr. O'Brien, Mr. Suresh, Mr. Glackin; isn't that right?
20 A. Yes, that's correct. 14:15
21 15 Q. Then later that year you were joined by Mr. John
22 O'Donoghue?
23 A. Yes.
24 16 Q. As time moved on, you entered into the managerial
25 sphere within Acute and then, more specifically, within 14:15
26 that part of Acute that covered Urology. Let me just
27 briefly step through that, and then we will focus on
28 aspects of it. As I understand it, from 1st June 2016
29 through to 30th September '17, you were Clinical

1 Director within Surgery and Elective Care?
2 A. Yes.
3 17 Q. But you were on the side of the fence dealing with
4 Trauma, Orthopaedics and General Surgery but not
5 dealing with Urology? 14:16
6 A. Yes, that's correct.
7 18 Q. Whereas you continued to practice as a Urologist, that
8 managerial role was on the other part of Acute dealing
9 with those?
10 A. The other part of Surgery and Elective Care. 14:16
11 19 Q. Yes. I think it was Mr. Weir who was Clinical Director
12 covering Urology at that time?
13 A. Yes.
14 20 Q. Again, just stepping through your career during those
15 years. In April 2017, you took up a post in the 14:16
16 Belfast Trust dealing with nephron sparing surgeries;
17 is that right?
18 A. Started providing part of my week within Belfast Trust,
19 it wasn't a separate post but part of my working week
20 was providing nephron sparing surgery in Belfast Trust. 14:17
21 21 Q. Was that every week?
22 A. That was every week. There was a Thursday and a Friday
23 when I would have done activity at various points
24 during the period of time since then. It was initially
25 intended as a temporary one year arrangement to cover 14:17
26 a sabbatical period, but at various points it's been
27 every Friday and alternate Thursdays, and evolved now
28 to a position where it's all day Thursdays and all day
29 Fridays.

1 22 Q. Just moving along that timeline. As you have told us
2 already today, 1st October 2017 you took up the
3 managerial position of Associate Medical Director
4 within Surgery and Elective Care and that did cover
5 Urology? 14:18
6 A. Yes.
7 23 Q. Just before taking up that role, in September 2017 you
8 became Chair of NICaN in that particular area of NICaN
9 covering Urology; is that right?
10 A. Yes. I became Chair of the NICaN Urology Clinical 14:18
11 Reference Group. I chaired my first meeting in
12 September 2017.
13 24 Q. What kind of time commitment did that take from you?
14 A. Within my job plan, for instance, now it occupies a two
15 hour period of each week. The reality is, from 14:19
16 week-to-week, it can occupy anything from considerably
17 more to just about that, two hours or sometimes less.
18 25 Q. You still hold that post?
19 A. Still hold that post, yes.
20 26 Q. I see from your witness statement that in August 2021, 14:19
21 you took up the position of Divisional Medical Director
22 within Surgery and Elective Care. Is that in essence,
23 or was that in essence, the same position with
24 a different name as Associate Medical Director, or was
25 there a tweak to it? 14:19
26 A. It was in essence fulfilling the same role, but the job
27 descriptions were, if you like, redeveloped or made
28 more specific.
29 27 Q. Yes.

1 A. I think on appointment as AMD it's for an initial
2 period of three years and so, as a general rule,
3 a re-advertisement and re-interview for those posts.
4 28 Q. I'm struggling a little to hear you, Mr. Haynes. Is
5 everything okay on the stenography? Yes. 14:20
6
7 Then in December 2021, you took up a role described as
8 Divisional Medical Director Urology Improvement on
9 Secondment. Could you help us with that? Do you still
10 retain Divisional Medical Director role in addition to 14:20
11 this other role?
12 A. I was seconded across to specific responsibilities
13 within relation to Urology and Urology Improvement at
14 that point, with Ted McNaboe who was a Clinical
15 Director has been seconded to be the Divisional Medical 14:21
16 Director for Surgery and Elective Care.
17 29 Q. The Urology Improvement role then, is it fair to say
18 that that role has been created to deal with the issues
19 that have arisen out of 2020 and the kinds of issues
20 being looked at within this Inquiry? 14:21
21 A. Yes.
22 30 Q. We will maybe have an opportunity to deal in more
23 detail with that in due course. Rewinding slightly to
24 your appointment on 1st October 2017 as Associate
25 Medical Director. That post had lain vacant for 14:22
26 roughly a year. Dr. McAllister gave up the role or
27 stood down from the role in late 2016, is that right,
28 that the post was vacant?
29 A. Yes. The post was vacant and as was communicated to me

1 and the Clinical Director at the time, we were to
2 essentially act within our roles and escalate to the
3 Director for Acute Services or Medical Director at the
4 time for the professional issues.
5 31 Q. To what extent during that period of vacancy were you 14:23
6 acting up in the role or carrying out, even informally,
7 some of the aspects of the Associate Medical Director
8 role?
9 A. Ultimately without an Associate Medical Director, the
10 two of us, the two Clinical Directors inevitably would 14:23
11 have had to take on some of the roles and functions of
12 the Associate Medical Director, as would the Medical
13 Director have, if you like, acted down and taken on
14 some of them roles.
15 32 Q. In terms of the role itself, could we have the job 14:23
16 description on the screen for us, please? It's
17 WIT-53997. Before we look at the job description
18 itself, Mr. Haynes, how do you see that role looking
19 back on it now, leaving aside the job description?
20 I suppose, in a nutshell, what did the role involve? 14:24
21 A. A whole host of things. I mean, from a professional
22 management perspective, there was the oversight of Job
23 Planning and that side of the professional, if you
24 like, contractual parts. There were Governance aspects
25 to the job. There were also, inevitably, operational 14:24
26 day-to-day aspects in terms of running Services,
27 particularly as -- this started in October 2017, but if
28 we move into 2018 and 2019, operationally we had
29 challenges within Surgery and Elective Care relating to

1 bed pressures, relating to delivery of theatre time.
2 Then obviously moving into 2020, Covid created an
3 operational issue. There were, if you like, strategic
4 and professional aspects, but there was very much an
5 operational aspect to it as well. 14:25
6 33 Q. In terms of some of the professional aspects, could
7 I scroll down, please, to WIT-53997? Just let me have
8 the top of the page. Sorry, yes, we are on that page.
9 Then down to the second paragraph, please. The job
10 summary, if I could step to the second paragraph says: 14:26
11
12 "Specifically the AMD will be responsible and
13 accountable for the medical staff within the Speciality
14 and their role in the provision of services. As
15 a Senior Medical Leader within the Trust the AMD will 14:26
16 work closely with the Director, Assistant Directors of
17 Acute Services to provide medical management within the
18 Directorate and contribute to the overall provision,
19 direction and performance of the organisation."
20 14:26
21 If I skip on to the next sentence:
22
23 "The AMD will also be responsible for the safety and
24 capability of the medical workforce within the
25 Speciality, providing the Director of Acute Services 14:26
26 with defined information for assurance purposes to the
27 Medical Director."
28
29 In terms of the professional aspect of the job, how

1 were you able or how did you try to pursue the idea
2 that you would be responsible for the safety and
3 capability of the medical workforce?
4 A. Within each Service, within Surgery and Elective Care,
5 each team would have had Patient Safety Meetings or 14:27
6 previously called Morbidity and Mortality Meetings
7 which would occur monthly and would be regular
8 discussions within that team of patients where they
9 suffered morbidity, so perhaps a complication of an
10 operation or an unexpected re-admission after an 14:27
11 operation, and would also discuss deaths within the
12 Service while inpatients. That meeting would discuss,
13 and from each Speciality, escalate any concerns or
14 raise any concerns through that which would have come
15 through. In terms of my role within that was ensuring 14:28
16 that they happened, that the Clinicians were available
17 to attend them, and that there was a Patient Safety
18 Lead for each of the Specialities within Surgery and
19 Elective Care.
20 14:28
21 Aside from them, there's the SAI process or the instant
22 reporting process, which ultimately can lead to SAIs.
23 There was a screening element or a responsibility with
24 the AMD to go through instant report forms as part of
25 a team, assessing them for those which required 14:28
26 a further look into as an SEA or SAI, or those that
27 perhaps didn't meet that threshold or criteria. Once
28 the SAIs and SAIs had reported, they came through the
29 Acute Clinical Governance meeting and as an AMD, along

1 with other AMDs, I would have sat on that, which is
2 where the reports were presented and signed off. Then,
3 following them reports, recommendations, some would
4 have responsibilities within me or the teams working as
5 part of the Clinical Teams within Surgery and Elective 14:29
6 Care.
7
8 There was the complaints processes as well. We'd have
9 an awareness of complaints within Specialties and
10 within the Services. They would be reviewed through 14:29
11 the Assistant Director. We had meetings where the
12 complaints within the Specialties would be -- you'd
13 have some oversight of what complaints were about, so
14 if there was any themes from them -- I've lost train of
15 thought now, sorry. 14:30
16 34 Q. You are describing the various issues that could come
17 before either of those two forums, either Patient
18 Safety or the Governance Committee?
19 A. Yes. Then there was also some oversight of litigation.
20 We were made aware of any litigation, potential 14:30
21 litigation, and also made aware of any outcomes of
22 litigation again to be able to look for themes.
23 35 Q. Is there potential within that kind of system where
24 perhaps you are getting individualised reports of
25 patient endangerment, or a complaint, or a risk; is 14:31
26 there a potential within that system to draw separate
27 straws in the wind together and to identify perhaps in
28 an individual practitioner a cause for concern?
29 A. Unfortunately, my experience is that the potential of

1 that lies within the individuals who are perhaps
2 receiving all of that. I think it's pertinent too, as
3 you said, the AMD role; if you have a period of time
4 without one, and as I have said in my statement, "and
5 no handover", so I'm perhaps unaware of things that 14:31
6 have come before me, so I'm starting with a fresh page,
7 and so if it's reliant on me to draw strands together
8 or a pattern together, it will take a period of time
9 for me to develop that pattern recognition.
10 36 Q. Does the Head of Service on the Operational side, did 14:32
11 Mrs. Corrigan attend either of those kinds of meetings,
12 or were these Clinical meetings?
13 A. So, the Patient Safety meetings, Mrs. Corrigan would
14 have attended but covered both ENT and Urology, so
15 would not have attended all of one Speciality, so would 14:32
16 have attended one sometimes, and one another time.
17 I mentioned that the Assistant Director would have had
18 meetings, and I mentioned complaints. There would be
19 a regular meeting of him with the team where she would
20 have been part of that meeting. 14:32
21 37 Q. Just scroll down to WIT-5399, just two pages down,
22 under the heading "Clinical Governance
23 responsibilities". This draws out some of the systems
24 and processes I think you were referring to,
25 Mr. Haynes. It says in the second paragraph: 14:33
26
27 "You will be directly responsible to the Director of
28 Acute Services for Patient Safety. This includes
29 ensuring processes are in place to identify, review and

1 take remedial action when Patient Safety issues arise."
2
3 If we can focus for a moment on the kinds of issues
4 relating to Mr. O'Brien that we were coming across your
5 desk or if not coming across your desk, were known to 14:33
6 the Service from October 2017, did any of those -- and
7 pick any item at all, whether it's a Triage issue or
8 a dictation issue or a failure to action on
9 investigations -- would those kinds of issues have come
10 across any of the forum that you have just described? 14:34
11 A. Specifically in relation to Mr. O'Brien, the SAIs
12 reports when finalised did come through Acute Clinical
13 Governance, but that was a considerable time later than
14 that point. The concerns that had been raised and were
15 part of the MHPS process were already being managed 14:34
16 through the Oversight Group who were involved with that
17 process. I was outside of that. That process was
18 happening, I was aware it was happening but I was not
19 part of that process. There was an assumption or --
20 from me that that was being managed through that 14:35
21 process rather than through my responsibilities.
22 38 Q. Yes. You have made the point in your witness
23 statement, I think at WIT-53902 -- we don't need to
24 bring this up on the screen -- at para 33.5, that in
25 this role you weren't a line manager as such? 14:35
26 A. No.
27 39 Q. You have gone on to explain that -- maybe we should
28 bring this piece up on to the screen. It's WIT-53902.
29 Focus in on 33.5. Yes. You say on the third line

1 down:
2
3 "When I commenced this role there rapidly became a live
4 issue in relation to Mr. O'Brien and due to the
5 proximity of my direct day-to-day working relationship 14:36
6 with him and my role in relation to the identification
7 of concerns, the Medical Director (who was then
8 Dr. Richard Wright) did not directly involve me in this
9 process with the Clinical Director and Medical Director
10 continuing this." 14:36
11
12 You go on to say that you have, however, been involved
13 in other staff management issues.
14
15 I just want to unpack that a little, because it perhaps 14:37
16 informed how you approached the Mr. O'Brien issues as
17 they continued. Dr. Wright was in post as Medical
18 Director when the MHPS process commenced in early '17.
19 You took up the AMD post, if I can call it that, at the
20 end of that year, in October 2017. By that stage the 14:37
21 MHPS investigation was essentially six months old and
22 indeed you'd contributed to it, which we will look at
23 in a moment. Just so we are clear here, there was an
24 action plan which was the subject of monitoring from
25 Mr. O'Brien's return to work at the start of that year, 14:38
26 and that was held by Mrs. Corrigan, and if she had
27 a concern, she was supposed to escalate to Dr. Khan; is
28 that your understanding now?
29 A. That's my understanding now, yeah.

1 40 Q. You are coming into post in October 2017 with the
2 responsibilities, as we have just observed, of ensuring
3 that your medical workforce was fit for purpose, were
4 safe practitioners. Are you saying that, in terms of
5 Mr. O'Brien's performance, and the concerns that 14:38
6 related to him, you were essentially out of bounds if
7 you were to come into that area? Was it made clear to
8 you that that's nothing to do with you?
9 A. Not so much made clear that that's nothing to do with
10 you, but there was a process and a system and 14:39
11 individuals who were managing Patient Safety issues in
12 relation to him specifically. Therefore, my role as
13 not part of that, stemming from the decision that
14 I wasn't part of it because of my place in raising the
15 concerns and being part of the team, being a colleague 14:39
16 as well, was that I was not part of that management of
17 either the monitoring or any escalation from there.
18 The monitoring of the Patient Safety concerns for
19 Mr. O'Brien, to my understanding, were outside of my
20 remit. 14:39
21 41 Q. We will come on to look at it, it may well be tomorrow.
22 Certainly by 2018 and into '19, you are taking an
23 involvement and you do have a voice in conversations to
24 do with apparent deviations from the monitoring plan;
25 is that fair? 14:40
26 A. Yes. I guess as I grew in my role as AMD and became
27 aware of the monitoring process and the systems that
28 were being used to guide that monitoring process,
29 I became concerned that some of the assurance we were

1 taking was perhaps not based on robust data.
2 42 Q. To summarise, and so we are clear, in your role as AMD,
3 you were not part of the monitoring arrangements
4 pursuant to the action plan, but there came a point in
5 time when you became involved or were asked to become 14:41
6 involved, and you provided commentary and input in
7 terms of the robustness of the evidence that was being
8 gathered?
9 A. Yes.
10 43 Q. In terms then of the role of AMD, you were conducting 14:41
11 that role in addition to a busy urological practice
12 which had you both in Craigavon, and no doubt the
13 satellite hospitals of the Southern Trust, and in
14 Belfast once a week, you were Chair of NICaN and you
15 had this AMD role. Thinking about it with some 14:42
16 hindsight perhaps, was that a role that you were
17 capable of performing effectively, given your other
18 commitments?
19 A. I think, as I have included in my statement, I never
20 felt I was in a position to give the time required to 14:42
21 be Associate Medical Director, and part of that was
22 driven by the waiting list, the length of time our
23 patients are waiting for urological treatment, so I was
24 always reluctant to pull back from any clinical work
25 because of the direct impact that I could see on 14:42
26 patients on a day-to-day basis. The inevitability of
27 that was that I was not giving the time that would have
28 been, I think, required to be AMD.
29 44 Q. You say in your statement that until relatively

1 recently, November 2021, you did not include the full
2 three PA requirement, which was in your job plan, to
3 this role. Is another way of saying that is that you
4 weren't able to fully commit all of the hours available
5 to you on the job plan to that role? 14:43
6 A. No. My job plan was full, and rather than take
7 something out to replace it with AMD time, I left the
8 AMD time as less than the 12 hours. I didn't have my
9 job plan being for hours that I didn't exist in the
10 day, if you like. 14:44
11 45 Q. You did the hours required for the AMD role, but they
12 just didn't feature?
13 A. I did what I was able to and what I needed to, often
14 working in my own time, and indeed I often displaced
15 some of my own clinical work into my own time in order 14:44
16 to enable me to deliver activity as AMD.
17 46 Q. Is it fair to say that as you performed what appears to
18 have been an important managerial role, given the
19 issues that this Inquiry has to consider, at an
20 important time for Urology, that you were always in 14:44
21 danger of making compromises of that role because of
22 your Clinical commitments and responsibilities?
23 A. I think that's fair to say, and I've reflected in my
24 statement that there would have been meetings that
25 I was not able to get to because they clashed with my 14:45
26 clinical work, which continued.
27 47 Q. At one point, it was October 2018, you indicated to the
28 then Director of Acute, Ms. Gishkori, that you were
29 minded to resign your position as Associate Medical

1 Director, citing workload pressures and performing far
2 in excess of what could be considered realistic or
3 sustainable. Do you recall that?
4 A. Yes, I do.
5 48 Q. The reference, I don't need to bring it up, but just 14:46
6 for the record, is TRU-163344. Just before I ask you
7 the question. Ms. Gishkori has commented on your
8 contribution as Associate Medical Director. If I could
9 have up on the screen, please, WIT-23380, and focus on
10 para 47 if you would for me, please. I'm sorry I don't 14:46
11 have the question that prompts that answer, but I think
12 we probably get a sense of what the question was. It
13 was probably something to do with how she encountered
14 staff in the team, and she says:
15 14:47
16 "Mark Haynes was the AMD for Urology. We were supposed
17 to meet monthly, however he rarely attended scheduled
18 meetings and he rarely attempted to make any informal
19 contact with me. He was unable to provide time."
20 14:47
21 Is that fair comment?
22 A. As I say, I have reflected and commented that I would
23 often not be able to attend meetings. The Acute
24 Clinical Governance meeting, which was one of the
25 meetings I have mentioned earlier in relation to SAIs, 14:47
26 takes place on a Friday morning at the same time as
27 I have an operating list in Belfast Trust which makes
28 it very difficult for me, certainly made it very
29 difficult for me to attend pre-Covid when video

1 meetings weren't so common. Post Covid, it's still
2 a challenge for me to attend but with Zoom meetings and
3 the like I'm able to attend. It facilitates
4 attendance.
5 14:48
6 The second part of the sentence I don't recognise at
7 all. I regularly went up to Ms. Gishkori's office
8 without an appointment, just on spec to find out if she
9 was there to keep her up-to-date on issues from my
10 perspective. The e-mail in which she referred to as, 14:48
11 indeed I forget the line in it from her but comments
12 implores on me or asks me not to make a decision until
13 she has spoken to me and stresses how much she values
14 my input and opinions, which doesn't seem to tally with
15 me rarely attempting to make informal contact. 14:48
16 49 Q. To assist you, we can bring that e-mail up. It's
17 TRU-163344. I think it's part of that series of
18 e-mails. Just scroll through that. Is that a single
19 page? If we maybe go up 43 -- yes, it's the middle
20 e-mail. Yes, is that the comment you are alluding to? 14:49
21 A. That's the comment.
22 50 Q. You have written to her earlier that afternoon
23 indicating your proposal to resign your post. She is
24 asking you to defer your decision because in part she
25 would miss you and always values your view and 14:50
26 opinions".
27
28 You obviously didn't ultimately follow through with
29 your proposal to resign. Did she talk you out of it or

1 did you just think better of it?
2 A. In all honesty, I can't completely remember. I would
3 have had a conversation with Esther Gishkori. I would
4 have had a conversation with many individuals at that
5 time. My memory is that I was talked out, on an 14:50
6 assurance that all recognised that I wasn't able to
7 give the time that I needed to, but they understood
8 why, as I think I have said in my e-mail below, I am
9 a Urologist first.
10 51 Q. Yes. You have talked about your inability to go to the 14:51
11 Friday Acute Governance Meeting, is it fair to describe
12 that as kind of one of the core pillars of the
13 Governance Framework at which an Associate Medical
14 Director would rather be expected to attend if he can?
15 A. Yes. It would be myself or my Deputy, which would be 14:51
16 one of the Clinical Directors and the issue with clash
17 with Clinical activity was not just myself but also
18 affected the Clinical Directors who worked with me, and
19 we did make a request or an attempt to get the timing
20 of that meeting either changed, or at least rotated 14:51
21 through the week so different Clinicians, Clinical
22 Directors and Associate Medical Directors would be
23 impacted by the clash with Clinical activity on
24 different months. Unfortunately, that was
25 unsuccessful. 14:52
26 52 Q. Yes. In terms of the other, if you like, formal pieces
27 of the Governance Framework, the other meetings that
28 make up the discussion fora for addressing Patient
29 Safety issues primarily, were there any other such

1 meetings that you were regularly unable to attend
2 because of your Clinical commitments?
3 A. I have mentioned the Patient Safety meetings in my
4 statement and I have commented that there have been
5 occasions and there are occasions where there is 14:52
6 a clash where the Patient Safety meeting in Belfast
7 Trust is at a different session to the Patient Safety
8 meeting in Craigavon or in Southern Trust, and
9 therefore I could be conducting Belfast activity at the
10 time of the Southern Trust Patient Safety meeting and 14:53
11 therefore not able to attend. There is also reality
12 that the activity that I do in Belfast is primarily
13 cancer activity, and a decision had been made to
14 continue particularly cancer operating if it clashed
15 with Patient Safety meetings. For instance, the Friday 14:53
16 morning when I am doing cancer surgery I still have an
17 operating list to attend and carry out.
18 53 Q. Your inability to attend those meetings, I suppose,
19 gives rise to the question: how suitable a role was
20 this for a busy Clinician? 14:53
21 A. I think that's a very good question and I think others
22 have reflected on having that same clash of Clinical
23 activity with their Clinical Management activity.
24 54 Q. You are holding a thought there. Do you want to
25 finish? 14:54
26 A. I think there is always -- in order to provide
27 leadership as a Clinician, the Clinician needs to, in
28 some way have, if you like, that respect of the team.
29 You need a Clinician who is a Clinician in a Clinical

1 Management position. Ultimately, on this subject,
2 I think we would need to be stronger in our expectation
3 of Clinicians that actually in order to take this on
4 you need to withdraw from being the full-time Clinician
5 that you are. 14:54
6 55 Q. That's perhaps a helpful general reflection. Could
7 I -- could I ask the question maybe more provocatively.
8 In terms of what we are facing up to within this
9 Inquiry, which is an exploration in part of whether the
10 Governance System within the Trust was fit for purpose. 14:55
11 Was your absence from the wheel of some of these key
12 meetings, and perhaps other Governance-related
13 activity, does that offer some kind of explanation, at
14 least in part, for any ineffectiveness of the
15 Governance Framework? 14:55
16 A. Specifically in relation to Mr. O'Brien?
17 56 Q. Yes.
18 A. I don't believe so, because I was alive to and aware of
19 the issues in relation to the concerns. My absence,
20 say, from the Acute Clinical Governance didn't mean 14:56
21 that I was not aware of the SAI reports and their
22 recommendations. I was very aware, because, as you
23 know, I was on that SAI team.
24 57 Q. Yes. Of course an inability to make formal meetings is
25 perhaps just one part of the job. How did you go about 14:56
26 conducting the role even informally? Did you make
27 a point of ensuring your antenna was alive in receiving
28 necessary information from colleagues?
29 A. In terms of informally, I have mentioned that I would

1 regularly come up to the Director for Acute Services'
2 office informally to touch base there. I'd regularly
3 go to the Assistant Director's Office and the Heads of
4 Service Office and touch base with them. I'd
5 informally regularly make contact with the Clinical 14:57
6 Directors, both by telephone, in person, by e-mail. As
7 surgeons, the Clinical Directors are also surgeons, we
8 would often see each other in theatres when our
9 sessions were at the same time and we would be able to
10 catch up and touch base at that time as well. The 14:57
11 informal network was much easier to maintain than the
12 formal network, which had rigid dates and times sat to.
13 58 Q. I am conscious that you have said you weren't a line
14 manager for any of your Urological colleagues. At any
15 point, knowing what you knew about the reported 14:58
16 shortcomings in Mr. O'Brien's practice, did you ever
17 face-to-face him on any of those issues in your role as
18 AMD?
19 A. I didn't. When these issues were raised with him, they
20 were raised by his direct line manager which would have 14:58
21 been his Clinical Director.
22 59 Q. Just for the record, that was Mr. Weir moving on to
23 Mr. McNaboe?
24 A. Yes, but I didn't directly raise them with him.
25 60 Q. Was that because you didn't see it as your 14:58
26 responsibility or was it some kind of reticence or
27 perhaps professional embarrassment to do so?
28 A. I was a working colleague of Mr. O'Brien and I was
29 aware of how he worked, as you know, from the concerns

1 I've raised. I was also aware that he was a challenge
2 to challenge, and I knew that from discussions that we
3 would have had as a group. I also had an awareness of
4 his personal connections, if you like, with members of
5 his family within the legal profession, his personal 14:59
6 connections with the Chair of the Board, and the rumour
7 mill had told me that a previous AMD had been accused
8 of bullying when trying to tackle Mr. O'Brien. I guess
9 the answer to why didn't I personally tackle him when
10 I knew the Clinical Director was, is because I had to 14:59
11 work within a team with him, I didn't want to --
12 essentially, it was a fear thing. I didn't want to
13 find myself in a difficult small team working
14 relationship as a result of the other bits that I was,
15 if you like, aware of. I think, as I just said, 15:00
16 grapevine, it's that sort of rumour mill, grapevine
17 fear rather than anything documented, but that would
18 have played a significant part in it.
19 61 Q. Just two points there before I move on. It was a small
20 urological team of Consultants, I think six at that 15:00
21 point. Is it not inevitable, as Associate Medical
22 Director, that you are going to be dealing with
23 a professional colleague and you will need to be
24 dealing with a professional colleague on difficult
25 issues, and the job simply can't function unless the 15:01
26 post holder is prepared to rise above that and grasp
27 the nettle, difficult though that might be in human
28 terms?
29 A. I think so, but, as I said, when I came into post in

1 2014, and then as I came through and recognised issues,
2 these weren't new issues; these were issues that had
3 been attempted to be tackled with him before and had
4 become part of almost -- I hesitate to say, it's almost
5 accepted practice, he practised in this way and 15:01
6 everyone else practised in another way. You know, we
7 have talked about the notes at home. I'm not aware of
8 anyone else who would be taking notes at home and
9 storing them at home regularly, but that was accepted
10 practice and almost everyone knew. Of course I should 15:02
11 have tackled him personally, but I was coming in, if
12 you like, late to this, with a many year history of
13 other people attempting to tackle it to no success, and
14 it becoming part of normal working arrangements for
15 him. 15:02
16 62 Q. You do accept it essentially fell within your job
17 description, notwithstanding this history, to have
18 a fresh go at trying to tackle the issues?
19 A. Yes, and where other issues have arisen with other
20 individuals, not necessarily within Urology, I have 15:02
21 taken an active role in that, so it's specifically with
22 Mr. O'Brien I didn't.
23 63 Q. The second issue you raised just a short time ago,
24 which I intended to deal with later but I will deal
25 with it now. You've suggested through the rumour mill 15:03
26 I think was how you described it, a certain chill
27 factor in terms of being able to deal with him,
28 associated with what was known to be his family
29 connections to the legal profession and his social

1 contact, or whatever it might be, with what now is the
2 former Chair of the Board, Mrs. Brownlee. Was this
3 tearoom gossip, or at what level was this being
4 communicated to you and affecting your actions?
5 A. It was an awareness. It wasn't something that I recall 15:03
6 being formally communicated to me, but it was an
7 awareness that I had and others would have had.
8 64 Q. Are you able to say how it came to your notice or
9 attention?
10 A. I genuinely don't know how. I just know I was aware 15:04
11 of.
12 65 Q. In terms of the support that you receive from the
13 organisation, whether from the operational side or
14 otherwise, to fulfil this challenging role, was it
15 there? Was the support there to enable you to do as 15:04
16 good a job as you can or, looking back, can you
17 pinpoint anything that might have been done differently
18 to assist you in your responsibilities?
19 A. Within my statement I have commented, the Clinical
20 Managers do not, as a standard, have any administrative 15:05
21 support to assist us in terms of as we are undertaking
22 our role, and so, as daft as it sounds but in addition
23 to trying to do the bits that I've got to do, I'm also
24 managing my own diary and managing my own follow-up of
25 things I need to chase and follow-up which, as you've 15:05
26 outlined, when you are trying to do a job that needs 12
27 hours in a considerably shorter period of time,
28 inevitably, if someone is not reminding me to follow up
29 on something, things will slip off the radar. So

1 I think that administrative support for Clinical
2 Managers, which wasn't present, I think is required.
3 66 Q. You mention I think several times in your witness
4 statement that one of the things that I suppose to some
5 extent hamstrung you in the role was the absence of 15:06
6 a handover. Just unpack that a little. Does your
7 complaint in that respect suggest that you got your
8 Letter of Appointment and the next day you were AMD and
9 were just expected to know the role?
10 A. Yes. As I said, I've mentioned induction or handover, 15:06
11 I think I have mentioned both, so, yes, so essentially
12 you became AMD and you were in the role.
13 67 Q. No training, no orientation, no induction, no informal
14 chat about current and developing issues?
15 A. You would have had an informal chat, or I would have 15:07
16 had an informal chat with the Medical Director when I
17 was considering applying for the post of AMD then, but
18 I wouldn't have had an induction and handover from the
19 previous AMD. Obviously it was difficult at that time
20 because there hadn't been a previous AMD for 12 months 15:07
21 either.
22 68 Q. Knowing what you were to discover in relation to the
23 series of Mr. O'Brien issues as they became reported,
24 was there anything that was terribly new to you that
25 might have -- or put it another way. Was there 15:07
26 anything terribly surprising to you that could have
27 been alleviated or assisted with the handover?
28 A. I think a handover or an induction in terms of how you
29 fit within the -- as you have described the Governance

1 processes, would have meant that you are able to pick
2 it up much quicker rather than spend the first couple
3 of months learning that, to then become more effective.
4 It would increase your effectiveness from the off,
5 rather than learning to become more effective. 15:08
6 69 Q. It is fair to say that upon taking up the role, you had
7 a previous awareness of many things that were of
8 concern in relation to Mr. O'Brien?
9 A. Yes.
10 70 Q. You were aware of Triage issues, you were aware of 15:09
11 dictation issues, notes at home. One thing you say you
12 weren't aware of was the action plan and the monitoring
13 arrangements. I think we will come to this later. You
14 weren't aware of that until late '18 into '19,
15 something like that? 15:09
16 A. Yeah.
17 71 Q. Is that fair?
18 A. Yeah.
19 72 Q. Having looked at your career and your steps into
20 management within the Trust, let me go back to that 15:09
21 first year when you took up post in the Trust. So
22 2014, you were given the task, or maybe you assumed the
23 task, of writing a paper for presentation to the
24 Commissioners, Mr. Sullivan, in respect of the Adequacy
25 of Resourcing to the Southern Team in order to meet the 15:10
26 Demand in the context of the Implementation Plan for
27 Urology Services for Team South which had been
28 published four years earlier in 2010. You recall that?
29 A. Yeah.

1 73 Q. Before delving into this, if I was to draft a headline
2 to capture this evidence that you've set out in your
3 statement, from the commencement of your post and
4 currently today, Urology Services in Northern Ireland
5 and specifically in the Southern Trust, are wholly 15:11
6 inadequate. There was -- if I didn't put the word
7 resources in there, the resources to meet the demand
8 had been wholly inadequate?
9 A. Yes, the capacity to meet demand is inadequate and the
10 result is growing waiting lists for all aspects of our 15:11
11 Service.
12 74 Q. If we look at the presentation that you made to HSCB
13 back, I think it was September 2014. If you pull up
14 for me, James, WIT-54072. If you focus on the summary
15 at the bottom, please. 15:12
16
17 Within the paper that you provided, Mr. Haynes, you say
18 on behalf of the Trust:
19
20 "We have reviewed the Urology Services within the 15:12
21 Southern Trust and examined every aspect from the
22 perspective of aiming to provide a sustainable Service.
23 We believe the plan as described will enable us to
24 provide this while maximising the efficiency of
25 utilisation of Consultant time. In order to do this 15:12
26 there is a need for expansion of the Clinical Nurse
27 Specialist within the team. This explanation will
28 require training and funding, and without this the
29 Service cannot be provided in a sustainable manner.

1 However, even with this expansion and maximisal
2 efficiency of Consultant time, there is no currently
3 sufficient Consultant time available to provide
4 capacity for projected demand. Without providing this
5 capacity we will also not be able to deliver any 15:13
6 backlog reduction."
7
8 As I understand it, the proposal that the team was
9 putting forward was for a seven Consultant team. There
10 were two options, one embraced a seven Consultant team 15:13
11 using 11.4 PAs per week. It is the case that that
12 wasn't provided; isn't that right?
13 A. Yeah, that's right. At the time, I think there were
14 five posts. I can't be 100%, but I think there was
15 five posts funded recurrently and one post was funded 15:14
16 by the Trust at Risk, which was subsequently funded
17 recurrently. The projection was, as you say, in order
18 to meet projected demand I think it was 80 PAs a week
19 of Consultant time were needed, which could be
20 delivered as eight consultants delivering 10 PAs or 15:14
21 seven consultants delivering 11.4 PAs each.
22 75 Q. Just to correct myself slightly, that was not funded
23 until 2020?
24 A. The seventh post the funding came in in 2020, yeah.
25 76 Q. Yes. Presumably by the time it was funded, demand and 15:14
26 the waiting list had continued to expand so that the
27 seven that you were pitching for in 2014 -- if you
28 forgive that word -- may not have been adequate by 2020
29 when it was delivered?

1 A. Probably would not be adequate by then. I think in
2 terms of looking at what is funded and what we are able
3 to provide, it's a very fine balance. We may be
4 funded, say, at 2019, we were funded for six
5 consultants, but because of challenges in nursing staff 15:15
6 recruitment we weren't able to provide within Southern
7 Trust the Theatres that were needed to meet the
8 requirements for them six consultants. Even if nine
9 consultants had been funded, the Trust would still have
10 not been able to provide the facility because of 15:15
11 shortages elsewhere. I guess if I was the Commissioner
12 it would be a very difficult thing to justify providing
13 funding for a Consultant post if you are not able to
14 provide the facility to deliver it. That's before you
15 then look at whether the post can be appointed to and, 15:16
16 again, as I've highlighted in my statement, we
17 currently have two vacancies within Southern Trust
18 Urology that we have not been able to successfully
19 recruit to.
20 77 Q. What kinds of risks does the mismatch create within 15:16
21 a Service?
22 A. It creates risks across every aspect of the Service.
23 We've touched on earlier the impact on an individual in
24 the Service taking up a Clinical Management role and
25 the ability of them to provide the time for that 15:16
26 Clinical Management role, because there's always a pull
27 from a delivering care perspective to deliver care.
28 The Service is always busy and patients are waiting
29 longer than we, as individual Clinicians, would like to

1 for many aspects of that Service, and so each
2 individual working in that Service is inevitably asked
3 and feels somewhat of a personal pressure to take on
4 additional work, and so each member of the team would
5 take on additional work. The impact of the waiting 15:17
6 times on patients is very real and so if we're not able
7 to meet the number of new patient referrals coming in
8 each month, essentially the process of Triage is, while
9 it's prioritising the patients who get seen first
10 against the patients who get seen later, it's almost 15:18
11 effectively pushing back or rationing the patients we
12 are seeing later, because if you can only deliver
13 a certain volume of care each month and that volume is
14 being taken up delivering care to those who have got
15 the more urgent categories of conditions, so say 15:18
16 suspected cancer referrals or they are clinically
17 urgent, patients who have routine referrals sit and
18 wait, and wait, and actually essentially get seen when
19 they became urgent so they get re-referred as Urgent.
20 15:18
21 On a surgical perspective, the impact of waiting
22 lengths of time within Urology is, if you look at the
23 Cancer work, if we are not able to operate rapidly for
24 cancers, there is always going to be a concern that
25 their disease progresses and requires more involved 15:19
26 treatment, but that same issue is very real for
27 patients with benign neurological conditions, so
28 patients with kidney stones, particularly patients who
29 are requiring more than one treatment for a kidney

1 stone, so patients may have a first operation where
2 they have a stent put in and then a planned second
3 operation to treat the stone and remove the stent, but
4 if them stents stay in for a period of time they
5 themselves can grow stones on and become more 15:19
6 complicated to treat and require more operating time.
7 You can almost create this vicious cycle within
8 surgical treatments of longer waits necessitating
9 longer treatments meaning you need more time to treat
10 the people that you are treating, meaning that you are 15:19
11 even further away from meeting the population demand.
12
13 I think there's also an impact, if you like, on the
14 sensitivity of individuals working within the system to
15 identify where things are going wrong, and that comes 15:20
16 across all things. Where we have got long waiting
17 times, inevitably we get a large number of complaints
18 and most of them relate to the length of time that
19 someone is waiting. If that is the major factor in the
20 complaint you might miss something else within there, 15:20
21 so it reduces the sensitivity from that perspective.
22 It also reduces the ability of you, as an individual,
23 to have an awareness of what's happening and what your
24 colleagues are doing, because you are so busy trying to
25 keep up with what you are trying to do that you haven't 15:20
26 got an oversight of other people's work. You haven't
27 got an in-depth knowledge of what how a colleague's
28 managing patients, so we are less sensitive as a system
29 to identify an issue.

1 78 Q. Yes. The question started in relation to risks. You
2 have helpfully taken us through patient, Clinician.
3 Just on that managerial role, surely in the case of
4 Mr. O'Brien, those concerns were so well known and so
5 frequently reported through the various systems that 15:21
6 I am going to look at in a moment, that the stress
7 created by the demand capacity mismatch can't afford an
8 explanation for why those concerns weren't better
9 grappled with. Is that fair?
10 A. Sorry, I didn't quite follow. Sorry. 15:22
11 79 Q. It's set out in your statement, I think, at paragraph
12 74.1, where you say:
13
14 "The capacity demand mismatch meant colleagues were
15 less likely to identify concerns." 15:22
16
17 I wonder, in the case of Mr. O'Brien, the concerns in
18 association with him were very obvious through the
19 various reporting systems that I'm going to examine
20 with you. The demand capacity mismatch doesn't provide 15:22
21 much of an explanation for failing to grapple with
22 those issues in a more timely and appropriate fashion.
23 A. As individuals identifying more of the same concerns,
24 it would have impact on us because we would not
25 necessarily have been seeing the patients, because 15:23
26 within the Service specifically at that time, and
27 generally in many Services, individual Consultants will
28 manage their own patients and so the opportunity, when
29 you are busy, particularly when you are busy just about

1 managing to do what you are doing for the patients
2 under your care, to look at someone else's patients
3 just doesn't present itself very often. The time that
4 you're able to perhaps take a step back when you see
5 someone do a more in-depth assessment of everything 15:23
6 over a prolonged period of time and identify the
7 concerns that had been identified with Mr. O'Brien,
8 perhaps you might not do it because you have got other
9 things to do. I'd agree the problems were known, but
10 within the Urologists for raising, if you like, more 15:24
11 concerns, the busyness of the individuals meant that,
12 I guess, the problems were known, I'm busy enough on my
13 own and I haven't spotted, I'm not going out of my way
14 to look for more problems at this moment because I'm
15 trying to keep up with what I'm doing. If that 15:24
16 follows?
17 80 Q. Yes. We will visit this in a little bit depth later,
18 but we do know that from June 2020, it did prove
19 possible to carry out, in a matter of a few days,
20 a comprehensive desktop review of some issues of 15:25
21 concern that hadn't materialised at the time of the
22 MHPS review were, in a sense, different but similar.
23 The essential point I'm putting to you is that while
24 the Inquiry may well understand the pressure created by
25 the absence of resources to deal with demand, it, in 15:25
26 a sense, may desensitise both management and individual
27 Clinicians, the issues were there to be discovered and
28 could have been discovered with relative ease?
29 A. Yes. As I have reflected in my statement, I personally

1 regret not recognising that a deeper look into
2 Mr. O'Brien's practice was required at the time of the
3 MHPS investigation being instigated. What was looked
4 into were the issues that had been identified, but we
5 didn't proactively look for other things. 15:26
6 81 Q. In terms of the difficulties posed for your patients by
7 the absence of adequate resources, you, both in your
8 AMD role and in your Chairmanship of NICaN, wrote
9 regularly to management, and indeed Commissioner, to
10 express concerns about the kinds of choices Clinicians 15:26
11 were going to have to make, or were increasingly having
12 to make, between two patients with both challenging and
13 traumatic conditions, but one having to be preferred
14 over the other. Is that something that caused you
15 a particular difficulty, those kind of choices? 15:27
16 A. It concerned me that we were in a position that we were
17 having to make those choices. As I have outlined in
18 correspondence, it places us in a vulnerable position,
19 we are having to make prioritisation decisions which we
20 do on the basis of the information available and we do 15:27
21 to the best of our ability, but inevitably there is
22 a risk of a patient, an individual patient coming to
23 harm as a result of that prioritisation decision.
24 82 Q. At one point on 11th October 2019 you wrote to
25 colleagues. The reference is WIT-55757. You wrote to 15:28
26 colleagues to say, in essence, if you believe that the
27 treatment of your patient is unreasonably delayed, you
28 should raise a Datix, perhaps to keep themselves right
29 within the system and as some kind of communication or

1 signal, perhaps to the Commissioners that all was not
2 well?
3 A. Yeah, I think the incident reporting system is, if you
4 like, the intelligence-gatherer for the system.
5 I think I've said in my statement that it had almost 15:28
6 become normalised for patients to wait a long time for
7 patient. If, if you like, the wider system is
8 normalised such that we kind of know it, we could
9 almost -- I felt we were in a vulnerable position to
10 not be flagging that patients are coming to harm 15:29
11 because they are waiting longer than they should, and
12 so I encouraged to flag that patients are coming to
13 harm because of the waiting times.
14 83 Q. Within this context, Mr. O'Brien in his statement, if
15 we could pull up WIT-82957. I have a rogue reference, 15:29
16 I think. I will read it out, I have a note of it. In
17 essence, Mr. O'Brien says in his statement that the
18 issues which arose in his practice were inextricably
19 linked to the inadequate system within which he was
20 working. We will no doubt ask him about that in the 15:30
21 fullness of time, but one supposes that he is
22 reflecting the fact that, given the pressures and
23 impossible choices placed upon clinicians working
24 within the system, with all its inadequacies that you
25 have described, the issues that arose in his practice, 15:30
26 such as Triaging, dictation, actioning
27 investigations -- to quote some examples -- the ability
28 to do that work as the system might expect or as the
29 employer might expect, was difficult, and perhaps he

1 might say impossible, given all of the other demands
2 that he had to meet. Does that resonate with you?
3 A. The description of being busy resonates with me, but
4 the lack of response of taking responsibility for bits
5 which you can take responsibility for and action, 15:31
6 doesn't. If we take actioning results, there are
7 systems that you can engage with to ensure that
8 patients are advised of their results. Electronic
9 sign-off is something that I'm sure will be touched
10 upon at some point. Essentially, through the 15:32
11 electronic care record, Northern Ireland electronic
12 care record, when a result becomes available there is
13 a tab on there where you can immediately have a list of
14 the patients who have had a scan under your care so you
15 can view the results and you can action them. Indeed, 15:32
16 by engaging with that system, as is described in
17 a relatively recent GIRFT document about Outpatient
18 Transformation, you can have some impact on the demand
19 for the system. Personally, I can make a decision to
20 see everyone back with the results of a scan, or I can 15:32
21 advise by letter the patients with a normal scan and
22 only see the patients who have an abnormal scan, and
23 that has an impact on the demand placed on the system.
24 There are individual practices and modes of practising
25 that you can do to impact on the wider Service. 15:33
26
27 In terms of the deficiencies or concerns about
28 Mr. O'Brien, dictating a letter at the end of a clinic
29 to me was always a practice that I've done since I was

1 a core trainee in my first clinics where I did
2 outpatients clinics. Not doing it is something that
3 would never cross my mind. Doing that immediately,
4 requesting any scans that are required immediately at
5 the time of that consultation, adding patients to the 15:33
6 waiting lists, in terms of completing the paperwork
7 required for that, they are things that you have to
8 take responsibility and, as a Clinician, you shoulder
9 responsibility for.
10 15:34
11 Additionally, if you are not able to do it, there is
12 a responsibility on us to raise with our employer that
13 we are not able to do it. If I'm not doing my Triage,
14 I need to tell my employer that I'm not doing my
15 Triage. It's incompatible to me with being a doctor to 15:34
16 not be able to do something and not actually hold my
17 hand up and say I can't do it.
18 84 Q. I will put the perspective you have just reflected up
19 on the screen, if I can get my references correct this
20 time. WIT-53874, please. At the bottom of the page, 15:34
21 11.1, if I can highlight what you are saying there.
22 It's in answer to a question of whether you had
23 knowledge of the IAP process. In terms what you are
24 saying is you realise that it was your responsibility
25 to return triage promptly with recognition that Red 15:35
26 flag referral triage should assume a higher priority.
27 You go on to suggest that normal and routine triage
28 might be dealt with a bit more time flexibility. You
29 go on to say you have always recognised

1 a responsibility to act on results and correspondence
2 in a timely manner, and a requirement to ensure that
3 you work within available processes to ensure
4 correspondence and results do not get overlooked, and
5 you go on to say, over the page, that a cardinal 15:36
6 principle perhaps is, if you are unable to meet an
7 aspect of your workload, it's your responsibility to
8 escalate this within line management structure.
9
10 A couple of points arising out of that. Even if I take 15:36
11 it from your last answer that Mr. O'Brien can't be
12 forgiven or excused for not doing Triage of routine and
13 urgents, for not dictating in all cases as timely as he
14 should have, not actioning results until a clinic date,
15 is it, nevertheless, understandable that Clinicians 15:37
16 working in this context have to think with a degree of
17 ingenuity and with a degree of flexibility to achieve
18 the throughput necessary to hit the waiting lists in
19 any meaningful way?
20 A. Absolutely, and within the vision presentation that was 15:37
21 agreed through the team, and I talked to the
22 presentation, Triage is covered within there. Part of
23 the discussion of Triage within there is about, if you
24 like, maximising the efficiency of the patient contact.
25 If a patient is referred for, for instance, blood in 15:37
26 their urine where they will always get a scan of their
27 kidneys and a telescope examination of their bladder,
28 why not arrange their scan before they attend for the
29 telescope examination so they have a single patient

1 contact where all results are available and decisions
2 can be made? That was one of the things we covered in
3 there. Indeed, we would have gone on to conduct that
4 Triage, and the way I conducted that Triage was I would
5 have, for that example of a patient with blood in their 15:38
6 urine, I had a group of standard letters that
7 I generated, so it didn't take me long to generate
8 a letter to the patient saying you are going to have
9 a scan. My Triage was electronic, or it is electronic
10 now. I would have already been in the Electronic Care 15:38
11 Record, I would have put on the request for the scan
12 and I'd have done the Triage. It would have taken
13 a few minutes longer than just doing the Triage, but it
14 wouldn't have taken the time of a 20-minute
15 consultation. It would have made the single contact 15:39
16 much quicker. Indeed, in a system where you have long
17 waits potentially, the very fact that you've organised
18 a scan beforehand, if it shows an abnormality, can
19 enable you to pick out those patients who absolutely do
20 need quicker treatment because you have found an issue. 15:39
21 For instance, in that patient with blood in the urine
22 example, if they had a scan that showed a kidney
23 cancer, you could bring them quicker forwards because
24 you knew you have a kidney cancer that you need to
25 treat. If the scan showed an abnormality in the 15:39
26 bladder that looked like a bladder cancer, you could
27 almost move them directly to an inpatient list with
28 a brief consultation to advise them of what was needed.
29 It made, if you like, the challenge of meeting demand

1 necessitated approaches that maximised the efficient
2 use of our time, and certainly that's the way
3 I approached work.
4 85 Q. In terms of Patient Safety then, what you are proposing
5 maintains a safe approach? 15:40
6 A. Yes.
7 86 Q. In terms of the second element of what I have just read
8 out, which is if you can't deal with the demands of the
9 job, then it's your obligation to raise that with
10 management, with the employer. It would appear, and 15:40
11 we'll develop this later perhaps, that Mr. O'Brien's,
12 let's call it inability, or to be neutral, to deal with
13 Triage in the way that he was expected to deal with it,
14 was known to the employer for some time. How that was
15 articulated in terms of his ability, or willingness, is 15:41
16 perhaps a debate for another day, but in terms of your
17 experience of working with him and knowing how
18 management within the Trust operated, was it a case
19 often of, we know his concerns but we are not prepared
20 to listen or not prepared to assist? 15:41
21 A. I think all members of the Urology team would have
22 expressed at various points that there was essentially
23 too much work to do, and Triage was part of that. As
24 you say, there were points in time where it had been
25 identified previously where he'd not been doing Triage, 15:42
26 and that had been found rather than raised as I'm not
27 doing this, is my understanding. I don't think it was
28 so much a, we know he's an issue that he can't do it,
29 it's every one of us has an issue that we have got

1 a lot of work. I think what was challenging was my
2 colleagues knew, for instance, how I did Triage, which
3 was trying to be as efficient as possible. Mr. O'Brien
4 had taken a view that he would phone all of these
5 patients, which inevitably meant that the patients, 15:43
6 when they got phoned, got a very good service because
7 they got essentially a consultation, but it also
8 inevitably took even more time than was required, and
9 so he'd made a choice to do it in a way that took
10 longer than was necessary, and he wasn't willing to 15:43
11 change the way that he did it to take less time and,
12 therefore, enable him to keep on top of it.
13 87 Q. His consideration was that it was necessary to do it in
14 this way because of the demands posed by the waiting
15 lists, if I don't Triage in a deeper, more meaningful 15:43
16 way with this patient, he will be flung on to the, as
17 you said, routine waiting list and unlikely to be seen
18 for an age?
19 A. I mean, ultimately, Triage, as I've reflected earlier,
20 in a system which is not able to meet demand means that 15:44
21 those with routine conditions on the information
22 available to you at Triage, wait many years to be seen.
23 That is inevitable. But to take that mismatch in
24 capacity and demand and turn it into a full telephone
25 consultation for every referral during a week to 15:44
26 mitigate that risk overloads an individual and creates
27 an impossible to deliver workload. At no point had
28 anyone suggested that that was the way it should be
29 done.

1 88 Q. Let me move on, Mr. Haynes, to what I take from your
2 statement to be a fairly fundamental or key reflection.
3 You have set it out at paragraph 77.1 of your
4 statement, which is at WIT-53957. You say, when
5 reflecting on what has happened within the Urology 15:45
6 Service, looking back from perhaps a position this
7 year, or certainly after 2020, you say:
8
9 "I regret not recognising in late 2017/early 2018 that,
10 in addition to the factors investigated in the MHPS, 15:45
11 there was a likelihood of additional issues that had
12 not been identified but which required investigation.
13 The fact that some aspects of good clinical practice
14 were absent in Mr. O'Brien's working patterns I feel,
15 in retrospect, ought to have raised the concern that 15:46
16 other deficiencies of good practice may also have been
17 present. If this had been recognised, and
18 a comprehensive review of practice been carried out at
19 the time, I feel it is likely that the clinical
20 practice which was identified in 2020 (and which led to 15:46
21 the Lookback exercise) would have been identified
22 earlier."
23
24 You will understand perhaps when I describe that as
25 a key reflection, could I just ask you about that 15:46
26 before looking further at what was known about
27 Mr. O'Brien? Essentially, you appear to be saying that
28 as a result of the MHPS process and the other processes
29 that give you as a manager and other managers within

1 the system the information or the intelligence to know
2 that there were things going wrong there, that should
3 have raised a suspicion that there may be other things
4 going wrong and we are not seeing the whole picture?
5 A. Yes, that's what I feel. 15:47
6 89 Q. We'll look, in the course of the rest of this afternoon
7 and maybe into tomorrow at that, but just to probe it
8 a little at this stage. It wouldn't have been too
9 difficult to conduct a comprehensive review? A review
10 itself would not have been a difficult exercise? 15:48
11 A. A review itself would not have been a difficult
12 exercise. There are different strands, though, to it.
13 As we will touch on in the 2020 and onwards, in terms
14 of identifying issues like the scan result that hasn't
15 had any action, that's a relatively straightforward 15:48
16 check in terms of looking to see has the scan been
17 reported, is there any evidence of the patient being
18 made aware? In terms of looking to see have the
19 outcomes from a Clinic been provided, have they been
20 carried out, is a letter dictated, they are relatively 15:48
21 straight forward. In terms of the Clinical
22 decision-making without a, if you like, an index
23 concern to guide you into which aspect of workload to
24 look at first, it would potentially be a bit of
25 a longer process, because you're needing to review the 15:49
26 Clinical management of a much broader section of
27 patients in order to identify concerns. As we will no
28 doubt come to when the first, to my mind, real shift in
29 concerns in relation to Mr. O'Brien came from

1 administrative processes, if you like, which of course
2 have patients at the end of them and Patient Safety at
3 the end of them, but actually the way the advice he was
4 giving, the treatments he was offering, there was
5 a shift in the summer of 2020 with the initial 15:49
6 identification of two patients who I had concerns about
7 their prostate cancer management. At that point,
8 because you have, if you like, a target group, it's
9 much quicker to do a targeted review of that group to
10 see if there are any more concerns. At that point in 15:50
11 '17/'18, without knowledge at that time of a target
12 group of patients where we might be highly likely to
13 find an issue, we would have had to review an entire
14 practice at a sample. It's something that could have
15 been done but it wouldn't have, perhaps, have been -- 15:50
16 I think you mentioned part that have June 2020 review
17 took two days. The actual review of the Clinical
18 decisions would have taken longer than that two days.
19 90 Q. Yes. We will go on to examine the kind of factors that
20 might have impeded or prevented a timely and more 15:51
21 thorough review in light of this key reflection. What
22 we can see from the papers, Mr. Haynes, is that you
23 raised many concerns about Mr. O'Brien using both the
24 formal mechanism such as a Datix leading to SAI and
25 informal communications as well, whether it was an 15:51
26 e-mail to the Head of Service or, as she reports,
27 conversations about things that arose in your practice
28 looking across it, at what Mr. O'Brien is doing. In
29 terms of your approach to this, do you approach these

1 matters having regard to your obligations under the
2 GMC's Good Medical Practice Guide? For example, you
3 are required as a practitioner to take prompt action if
4 you think that Patient Safety, Dignity or Comfort is
5 being compromised. Is that what, in a sense, drives 15:52
6 this, not necessarily the written word but that kind of
7 principle as a practitioner?
8 A. Yes. Each time I've raised a concern, it's about
9 fundamentally Patient Safety. It's a concern that
10 there is a patient risk associated with the concern. 15:52
11 91 Q. In your time practising in the Southern Trust, you've
12 referred, and I read it out a short time ago, about the
13 need for practitioners to work within the established
14 processes, to do the things that they are asked to do
15 in a timely fashion or to report if they are unable to. 15:53
16 In your experience, was Mr. O'Brien an outrider in that
17 respect or did you, within the Urology Service, find
18 that even periodically, other colleagues behaved in
19 a manner which might be regarded as irresponsible as
20 regards Patient Safety. 15:53
21 A. I never had cause to have the same concerns as I had
22 with regards Mr. O'Brien for any of my colleagues.
23 Within the evidence is an example of an exchange which
24 is around the DARO process which is one of the safety
25 nets for patients who have had scans done and are 15:54
26 waiting results. If I have seen a patient who is
27 having a CT scan, I might want to see them in clinic in
28 X months' time, but if I have requested a scan to be
29 performed in, say, December, administratively that is

1 added on to the DARO list, and that's a list that the
2 secretarial team would check on a monthly basis to see
3 if that result has come back, and if it's had any
4 action done on the back of that. A reminder of that
5 process was circulated to the secretarial team, which 15:54
6 was forwarded on to Mr. O'Brien by his secretary, and
7 he replied to many, including me, essentially stating
8 that he wouldn't be engaging in that process. That was
9 the only reply in that manner that was received from
10 anyone. I addressed it directly to him in a reply and 15:55
11 also escalated, because at that time the MHPS process
12 would have been ongoing and so Dr. Wright was engaged
13 in that, so I forwarded it to Dr. Wright as well. It
14 was an example of, you mentioned I said we have got to
15 engage with the processes that are available to us, AND 15:55
16 it's an example where he wasn't engaging with that
17 process.
18 92 Q. That issue which I was going to go on to look at
19 specifically, that e-mail exchange between the pair of
20 you, that is relevant in the context of those SAI 15:55
21 cases, of which there are several, where results are
22 not being actioned and there's a development, usually
23 an adverse development, for the patient, and the matter
24 becomes more complex as a result clinically?
25 A. Yes. I described it there as a safety net. It is 15:56
26 a safety net. It shouldn't be the primary process
27 that's relied on to get the results back. In my
28 practice I'd have two steps before then. I have
29 described the electronic sign-off system that I use,

1 and my, if you like, next step in the safety net is the
2 hard copy paper report that would go to my secretary,
3 and she would check whether that's been signed off by
4 me electronically and actioned. Then the third step is
5 the DARO, so if the first two fail then the DARO list 15:56
6 is there as a back-up.
7 93 Q. Leaving that specific to one side for the moment, you
8 come into Southern Trust in 2014 and you report in your
9 statement that your experience of Mr. O'Brien is that
10 he has a non-standard way of working. You illustrate 15:57
11 that in a number of ways by, for example, indicating
12 that it was your experience that he didn't use
13 administrative services in the way that other
14 clinicians would. He didn't use the dictation
15 facilities. He took notes home so that they weren't 15:57
16 available to you when you were seeing a patient, those
17 kinds of things, and this was known to other
18 practitioners?
19 A. As became apparent to me after I started work and
20 working within the Department, it was the way he 15:57
21 worked. Progressively as I recognised that that was
22 the way he worked, I would have raised when -- so
23 during them times when we moved up to six when
24 Mr. O'Donoghue started, we would have tried to work as
25 a team and as individuals and as new starters, myself 15:58
26 and Mr. O'Donoghue, seeing some patients who
27 Mr. O'Brien had seen previously, and both of us raised
28 a concern, along with Mr. Glackin and Mr. Young when
29 they were doing it that you didn't have any

1 documentation about the decision-making that had gone
2 on before. There wasn't a letter available, and so it
3 made reviewing these patients very difficult. You
4 mentioned that I have raised concerns using the
5 incident reporting system, and indeed that very concern 15:58
6 I raised really in respect of two patients, 102 and
7 103, that there were no letters, and in 103 no letters
8 and hadn't been added to the waiting list although that
9 was the patient's understanding from a consultation
10 previously. 15:59
11 94 Q. Yes. Just looking at that issue, I want to just
12 signpost this. I want to look, tortious though it
13 might be, at a range of issues that you became aware of
14 and perhaps reported into the system, just so that the
15 Inquiry has your perspective on the shortcomings in 15:59
16 Clinical practice that you were experiencing, but also
17 in respect of some of these examples we will take
18 a deeper dive and expose your reflections on the
19 adequacy of the system for dealing with some of those
20 matters. That's the twin purpose of looking at some of 15:59
21 those matters. You have mentioned Patient 103, who you
22 address in your witness statement. If we could have up
23 on the screen WIT-54882. This issue first arose in
24 April 2016. This is Patient 103. You say you saw this
25 lady this morning on your ward round. You had no 16:00
26 dealings with her prior to that. You hadn't received
27 a referral there are no letters on the ECR and her
28 notes detailing previous consultations were not
29 available to you on the ward. You have gone on to

1 discuss a plan with her, et cetera.
2
3 This is you raising it with the Head of Service,
4 Mrs. Corrigan. Was that a patient of Mr. O'Brien's?
5 A. Yes. 16:01
6 95 Q. Why were you dealing with it?
7 A. I was the urologist of the week on that day.
8 96 Q. Why did you not raise a Datix in relation to that
9 matter?
10 A. I genuinely don't know. As I say -- 16:01
11 97 Q. Should you have?
12 A. I absolutely should have and indeed other Datixs that
13 I raised were about the identical issue. I mentioned
14 Patient 102, that was a similar no letters and no notes
15 issue, I believe. 16:02
16 98 Q. Yes. Just scrolling up the page, you are telling
17 Tracey Boyce about this issue. She was the Director of
18 Pharmacy, I think, at the time, but may have had
19 a Governance role as well. The timing of this, this is
20 when the Trust is about to develop Terms of Reference 16:02
21 for the MHPS. Are you contributing here a concern or
22 a piece of evidence relevant to what the MHPS might
23 look at?
24 A. Yeah. I was providing detail of one of my concerns and
25 an example to feed into that, development of the MHPS 16:03
26 Terms of Reference, I think.
27 99 Q. Do you know what the specific upshot of raising this
28 with Mrs. Corrigan was back in April of the previous
29 year?

1 A. No. I know what happened with the patient.
2 100 Q. Yes, but in terms of the problem?
3 A. No.
4 101 Q. The problem for you was, you didn't have notes at the
5 time that the patient was in the bed, or in the chair 16:03
6 at your clinic, and you couldn't find anything in terms
7 of dictation of an outcome from her previous clinic
8 with Mr. O'Brien; is that the problem?
9 A. Yeah, and this particular patient, as evidenced in my
10 e-mail, I was able to review the results and I was able 16:04
11 to come to a view as to how she needed to be managed,
12 but the opportunity that had been missed was, had she
13 been referred to me as she believed she had been or
14 added to the waiting list for her kidney to be removed,
15 as was the decision that had been made, had that 16:04
16 happened she may have avoided that emergency admission.
17 It took her to be admitted as an emergency for me to
18 become even aware of, if you like, her existence and to
19 be able to make a plan for managing her.
20 102 Q. In terms of the incidents that you were reporting into 16:04
21 the system, the first use of a Datix that I have come
22 across concerns Patient 102. If we could bring the
23 Datix up, it's WIT-54874. You can see your name as the
24 reporter and what you have said here is the "patient
25 had been discussed at urological MDM on 20th November 16:05
26 2014." So that's a year-and-a-half earlier. Sorry,
27 a year earlier, I beg your pardon.
28
29 "The recorded outcome ... was restaging MRI scan as

1 shown. Organ confined prostate cancer and he is for
2 direct referral to Dr. H for radial radiotherapy and
3 for outpatient review with Mr. O'Brien".
4
5 You have recorded: 16:06
6
7 "Was reviewed by Mr. O'Brien in outpatients on 28th
8 November 2014. No correspondence created from this
9 appointment. Referral letter from the GP received 16th
10 October 2015 stated that the patient had not received 16:06
11 any appointments from oncology. He has now been
12 referred to oncology."
13
14 Just to unpack that a little. This was a case MDM had
15 made a recommendation, Mr. O'Brien had sat down with 16:06
16 the patient at review. What was discussed at that, we
17 can't say from this but there was no referral to
18 oncology, which was the expectation of MDM, and a year
19 later, the GP is writing on the patient's behalf saying
20 where is the oncological referral? 16:07
21 A. Yes. Within there I have talked about the outcome for
22 direct referral. What that refers to is a process
23 where, at MDT, a referral to the oncology team would be
24 generated. Okay. If you like, the first part of the
25 referral for that patient was generated at the 16:07
26 multidisciplinary team meeting. Certainly for myself,
27 for those patients where I'm seeing them like we're
28 seeing there, I would also then generate a letter
29 referring the patient to the oncologist as well. For

1 whatever reason, the direct referral here either wasn't
2 received or wasn't actioned, and so no oncology
3 appointment was received. In there being no letter
4 generated from the outpatient consultation, either
5 telling the GP or the oncologist that they have seen 16:08
6 that the patient has been seen as against again
7 a backstop, a second attempt, the patient didn't get
8 any oncology appointment, and then I received a GP
9 referral on 16th October 2015, and from that,
10 I generated a referral as stated in the second part, by 16:08
11 e-mail and letter.
12 103 Q. So, two issues. First of all, at the MDM, it's the
13 responsibility of the coordinator, in conjunction with
14 the Chairman, to ensure an Oncology referral?
15 A. The direct referral would have been generated, yes. 16:09
16 104 Q. Yes. That will go to presumably Belfast?
17 A. Yes.
18 105 Q. The treating clinician, in this case Mr. O'Brien,
19 speaks to the patient and good practice or required
20 practice to generate a specific dictation after that, 16:09
21 either to Oncology or the GP or both?
22 A. At the very least, good practice would be to generate
23 a letter, I would say generate a letter to the GP, to
24 the referring team, to the team you are referring to,
25 but also generally -- or I would endeavour to copy 16:09
26 patients in where appropriate, where they like, so that
27 would be good practice. My personal view is that it's
28 actually required practice. Part of contemporaneous
29 documentation of any consultation is the letter

1 I generate at the end.
2 106 Q. If we scroll down on this one, I want to ask you
3 a wider question about the process of incident
4 reporting. You have said in your witness statement,
5 Mr. Haynes -- just for the note, it's WIT-53932, at 16:10
6 paragraph 61.3, you have said in your statement that,
7 to this day, you remain unaware of how this concern
8 that you had raised was dealt with. Is that a weakness
9 of the reporting system that you are suggesting, that,
10 if you like, the reporter, in this case you, doesn't 16:11
11 get to hear the outcome, or is it unique to this
12 individual case or is it more general than that?
13 A. I think it's more general that there isn't feedback
14 provided to the reporter. My own personal reflection
15 on that would be that, in not knowing how it's been 16:11
16 dealt with, I don't know whether I need to be alert to
17 more. I don't know whether there's a process to be
18 monitoring for me not to be alert to more. It can also
19 act as a deterrent for people to raise concerns if they
20 are raising an incident report and then never hearing 16:11
21 anything back. They don't know whether that five to
22 ten minutes they have spent in filling in the long
23 electronic form has actually generated any action at
24 the end.
25 107 Q. If we look at the format, if we go down to 54879. If 16:12
26 we could pick up on the, using the left-hand margin,
27 11th December 2015 entry. There is a series of
28 entries, just for the Panel's ear, which reports on
29 various transactions that take place in association

1 with this report. Mr. Cardwell is communicating with
2 the Head of Service, Mrs. Corrigan, and he is
3 describing this as a 'feedback message'. He has been
4 asked to send this to Mrs. Corrigan and it says, in
5 essence, that this is a matter that should go to the 16:13
6 Head of Service to discuss with the Consultant. That
7 would have placed an obligation on Mrs. Corrigan to
8 speak to Mr. O'Brien. The Trust has told us that she
9 has no recollection of doing so. Two points: You
10 didn't hear about it, you didn't hear the outcome. It 16:13
11 doesn't appear to have been screened for SAI purposes,
12 and Mrs. Corrigan can't recall and has no record of
13 addressing it with Mr. O'Brien.
14
15 First of all, applying your knowledge of the SAI 16:13
16 criteria, a failure -- whoever's fault it was and
17 regardless of whether harm was caused -- a failure to
18 refer a patient for radiotherapy, in contravention of
19 the MDM decision, is clear SAI territory, isn't it?
20 A. There's potential for harm or evidence of harm, and 16:14
21 there isn't evidence of harm, but within the SAI
22 criteria is that potential for harm, and so applying
23 that to here, absolutely, it would meet that criteria.
24 Again, on reflection, I think we have been too
25 reluctant to apply that potential for harm to the 16:15
26 screening of potential incidents than we should have
27 been. We should have been more alert to potential and
28 less focused on evidence of harm as the trigger for
29 screening into an SEA or SAI.

1 108 Q. Could I address the same issue with you through an
2 examination of Patient 93? Just familiarise yourself
3 with that person. You have dealt with this in your
4 witness statement at paragraph 61.6. This was a case
5 that was referred into Mr. O'Brien, because he was 16:15
6 Urologist of the week, as a routine referral, when, in
7 fact, there was evidence of raised PSA and you believed
8 that it ought to have been red-flagged. We can see
9 that through your e-mail on the issue at TRU-278871.
10 You are e-mailing Martina Corrigan, 31st August 2016, 16:16
11 and you say:
12
13 "The story here is raised PSA referred by the GP on 4th
14 May", obviously just over four months earlier.
15 "GP referral as routine. Has not returned from Triage 16:17
16 so it was put on the waiting list as routine. If it
17 had been triaged would have been red flag upgrade".
18 And you set out the PSA and the PSA on repeat.
19
20 "The patient saw Mr. Weir for leg pain and the CT 16:17
21 showed metastatic disease from the prostate primary.
22 Referred to us" -- by which you mean Urology -- "as
23 a result of triage delay in treatment 3.5 months,
24 although it wouldn't have changed the outcome."
25 16:17
26 So, again, that is a case where you rather ought to
27 have completed within IR1, a Datix?
28 A. Yes.
29 109 Q. Just help me on this, because we picked up on two

1 examples where you haven't. Why would that be? Why
2 would you decline to use an available system resource
3 designed for this kind of thing?
4 A. I can't say why I didn't specifically use it for this
5 patient. I think the process of incident reporting is 16:18
6 not the most user-friendly, and I haven't checked but
7 I presume the reason I got the escalation within the
8 e-mail, is, I was Urologist of the week again so I was
9 on call. We know that one of the factors that
10 influences or I've seen papers about incident 16:19
11 reporting, one of the factors that affects the
12 likelihood of a report being completed is how busy
13 individuals are as well, as well as the aspects of
14 feedback from the instant reports that have been
15 provided and other features. I would have been busy at 16:19
16 the time. I would have been trying to, if you like,
17 juggle the competing demands and what I have done is,
18 I have identified a concern. I have raised it. I have
19 not raised it through the process I should have, but
20 I guess I have asked the question whether it should be 16:19
21 raised as an SAI. Within the system, instant reporting
22 is only one mechanism by which patients can be flagged
23 as concerns or find their way in, so complaints may be
24 a route by which patients find their way into an
25 instant reporting and subsequent investigation. 16:20
26 Litigation might be a way we find out about things.
27 Concerns raised to individuals, and I have given,
28 within my statement, examples where concerns about
29 different things, about other individuals were raised

1 directly with me and not through a reporting system.
2 Yes, it should have had an IR1 or an incident report
3 form completed, and indeed, other deficiencies of the
4 same thing did have indent reports filled in, but the
5 fact that it happened was raised, and we just didn't 16:20
6 triangulate that across into the same system as would
7 be used to investigate other things.
8 110 Q. Yes. In your view again, the application of the SAI
9 criteria in the case of a four month delay arising out
10 of a failure of Triage, is again clear territory for an 16:21
11 SAI?
12 A. It's that potential of harm.
13 111 Q. Yes. If we just focus for a moment on how it appears
14 to have been responded to. You get your e-mail off to
15 the Head of Service. Then if we could pull up 16:21
16 TRU-274751. Scroll down please? Scroll down further.
17 Is that as far as it goes?
18
19 Taking it from there, Mr. Carroll, who is Assistant
20 Director of Acute, I think, at that time, so he is 16:22
21 a senior manager on the operational side. He receives
22 this on the same day you've sent it. It's been
23 forwarded, I think, from Martina Corrigan. He is now
24 sending it on to Charlie, that's Charles McAllister.
25 He is the Associate Medical Director at that time, and 16:22
26 he invites him to read the series of e-mails and
27 picking up on your point, I think, that the patient
28 hadn't come to any harm by the delay, Mr. Carroll says:
29

1 "Suffice to say that although the outcome for the
2 patient would not have been any different this, as you
3 know, is not the issue that needs to be dealt with",
4 a point you have just agreed with me on.
5 16:23
6 Scrolling up, please, James. We get Mr. McAllister's
7 thoughts on it. His thoughts are that this should go
8 to Mr. Young first and then Mr. Weir second. Then up
9 the page again, and further on up until we reach
10 Mr. Young. Mr. Young responds by saying, here are his 16:23
11 points, the GP should have referred it as a red flag in
12 the first place.
13
14 "If the Booking Centre has not received a triage back
15 then I agree that they follow the GP advice." 16:24
16
17 Do you understand what he is saying there? He is
18 basically saying we have a Default Triage System in
19 place if the GP gets it wrong and if Mr. O'Brien isn't
20 triaging just stick it back into the routine list. 16:24
21 Would you agree with me that's essentially a failure to
22 triage?
23 A. That's exactly what this is. It's a failure to triage.
24 As he touches on later on, I think on point 5, because
25 of waiting times the impact of that failure to Triage 16:24
26 where that initial referral category, so Urgency
27 category is not appropriate for the condition, is that
28 the patient would have waited -- not being seen for
29 a year he said at the time so I assume that was an

1 approximation of the routine waiting list at that time.
2 112 Q. If he had not come back into the system incidentally
3 and saw, I'm not sure if it's the same Mr. Weir but
4 a Mr. Weir in respect of a leg complaint, and if he had
5 not been scanned, he would have languished on the 16:25
6 routine waiting list, all other things being equal and
7 not being seen and not treated for his cancer before he
8 died?
9 A. Not being seen and treated for his cancer until he
10 either attended as an emergency or got seen on that 16:25
11 routine waiting list, or it's possible that his disease
12 may have progressed in the interim while he waited.
13 113 Q. The default Triage system, was that something you were
14 aware of being operated in this way before you became
15 Associate Medical Director? 16:26
16 A. Evidently I was aware that patients were being put on
17 to a waiting list on the category of the GPs, as I have
18 commented on at the start of this e-mail. Whether
19 I was aware of there being a process specifically aimed
20 at how to tackle when Triage isn't referred, which is 16:26
21 that you just add them to the waiting list of the
22 category that they were referred on, I wasn't formally
23 aware of that until a later point, but I was aware,
24 because I was seeing patients in clinic, and as I have
25 commented within that e-mail, that the patient was on 16:26
26 a routine waiting list because the category that they
27 were referred on. I think in my incident report on
28 patient 10, I have commented on them being, it would
29 appear not triaged and seen on a routine -- I can't

1 remember whether it was routine or urgent but on that
2 basis, so I was aware that patients were being added to
3 the waiting list.
4 114 Q. Yes. Looking back at this, I know we can say that,
5 come 2017, the implementation of the monitoring plan to 16:27
6 keep active check on what was being done by Mr. O'Brien
7 on the Triage front, we can say that, with some
8 exceptions, that was being well-watched. Before that,
9 the introduction of this Default Triage System, to give
10 it its fancy name, was, in essence, the system bending 16:27
11 to Mr. O'Brien's will rather than the system addressing
12 the problem?
13 A. I think it wasn't addressing the problem; it was
14 ensuring that if that piece of paper, the referral,
15 never made it back and the patient wasn't on a waiting 16:28
16 list then patient would truly never get seen, so the
17 intention of the default system was to avoid the
18 patient who'd been referred, disappearing and being
19 lost completely. What it translated to happening was
20 that the non-return of triage didn't get tackled 16:28
21 because patients were already on a waiting list, and so
22 it became a, if you like, a soft -- a soft get-out of
23 addressing the problem without addressing it at all.
24 115 Q. Yes. I know that you weren't in a management position
25 within Urology at the time so you will forgive the 16:29
26 relative unfairness of the question, but when Mr. Young
27 says that, at point 7, "the patient was in fact seen
28 within a few months", I mean that was rather as
29 a result of accident rather than design?

1 A. Yeah, that was.
2 116 Q. The approach to this in terms of how your e-mail
3 setting this up for an SAI eventually falls flat in the
4 sense that this is where it stops, so far as we are
5 aware? 16:29
6 A. Yeah. As I said, the potential for harm doesn't appear
7 to have been followed through with escalating it
8 through the screening process and so it's come on, was
9 there actual harm? Because, through good fortune, he'd
10 seen another Clinician, Mr. Weir, and that consultation 16:30
11 had triggered a scan which had shown a significant
12 finding, which triggered Mr. Weir to make contact more
13 urgently and the patient to be seen more urgently, was
14 essentially that, if you like, that series of fortunate
15 events were used as an assessment of, well, because we 16:30
16 got lucky, it doesn't need looking at.
17 117 Q. Essentially, what we end up with is an under-reporting
18 of serious adverse incidents?
19 A. Yes.
20 CHAIR: It might be an appropriate time to rise for the 16:30
21 day.
22 MR. WOLFE KC: Yes.
23 CHAIR: So 10:00 tomorrow.
24 MR. WOLFE KC: Thank you.
25 CHAIR: Thank you very much, Mr. Haynes. 16:31
26
27 THE INQUIRY WAS THEN ADJOURNED TO THURSDAY, 17TH
28 NOVEMBER 2022 AT 10.00AM
29