Urology Services Inquiry

Oral Hearing

Day 14 – Thursday, 1st December 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.

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Gwen Malone Stenography Services

THE INQUIRY RESUMED ON THURSDAY, 1ST DAY OF DECEMBER, 2022 AS FOLLOWS:

CHAIR: Morning, everyone. Good morning, Ms. Gillan, I understand that you have joined the DOH-team. Welcome. Mr. Wolfe.

MR. WOLFE KC: Good morning, Inquiry, good morning, Mr. Haynes, and thank you very much indeed for coming back, hopefully to finish the first phase of your evidence today.

MR. MARK HAYNES, PREVIOUSLY SWORN, CONTINUED TO BE EXAMINED BY MR. WOLFE KC AS FOLLOWS:

Q. Just to recap, you will recall that on our first two days we were working across a timeline, exploring your involvement in the issues concerning Mr. O'Brien and the wider governance issues within the Trust, commencing from your time in the Trust in 2014, becoming Associate Medical Director in October 2017, and we had reached that point in the timeline in October 2018, when you had, I think, discovered that there was a monitoring arrangement in place pursuant to the commencement of the MHPS investigation the year before, so I want to take up at that point again.

Could I have up on the screen, please, TRU-279139. In fact, take me down a page to 40.

You can see, Mr. Haynes, that this is a dictation report that has been circulated. Scroll up to 39, please. This is Wendy Clayton reporting to Ronan Carroll and Martina Corrigan in respect of a Return to Work action plan which had been issued in February 2017 in respect of Mr. O'Brien. She is saying:

"See below dictation report. There are approximately 82 charts in the office on Level 2, do you need me to try and find out how long they have been there?"

Just scroll down, please, so I can see the whole table. Thank you. That is the dictation report for that month. We can see alongside Mr. O'Brien's name that there are 17 discharges awaiting dictation and clinic letters to be dictated, 91.

Let's take it on up into 39. Okay. Ronan Carroll copies you and Mr. Young into this. He advises that:

"Aidan needs to be spoken with and asked to address dictation as soon as possible and return notes" -- which were in his office -- "possible notes are for dictation and he is in the Craigavon Area Hospital tomorrow."

You respond to that e-mail, just scrolling up. What you say to Ronan is:

"Neither I or Michael have been involved in any of the conversations surrounding this issue since the start due to the potential conflict working relationship issues it would create. It would not be appropriate for us to become involved now. Colin"

That's Colin Weir, who was the Clinical Director; isn't that right?

"... along with the Medical Director have held all previous meetings. I would suggest that it should be approached through the same personnel as previously. I need to ensure had an any meeting is appropriately documented and it would be worth liaising with Human Resources to ensure things are done correctly."

That is you, Mr. Haynes. You are the Associate Medical Director. Typically can I suggest that these things of issues about under-performance by Clinicians within your team, if I can put it in those terms, would, quite properly, come to you as Associate Medical Director, but you are saying here that "there are reasons why the issues shouldn't come to me"?

A. What I'm saying there is that there was a process that had superseded, if you like, the normal process, and that that same process should be followed rather than, if you like -- so you already had a process that was being followed that involved a Clinical Director and a Medical Director, and they had held meetings with

Mr. O'Brien previously about this issue and following that through, so rather than address it at a point along it, bring in new people to have potentially the same conversations and potentially risk starting again, if you like, a clean slate, that everything should follow through the same personnel and process as before.

1 Q. Yes. Just moving up the page, I think Mr. Young adds a comment. Mr. Young was Clinical Lead within Urology. Again, typically, if things aren't going well with a colleague, Mr. Young, but for this process, would have been the kind of person who the system might look to, to speak to the Clinician guilty of the shortcoming?

A. Yeah.

2 Q. He said: "Martina has been keeping an eye on this but with her being off it does not appeared to have been tracked. In fairness it was a close system on who knew to do."

Can you help us with that little phrase? Is that that it was the issue, or the management of the issue was kept to the small group you referred to?

A. I presume that's what Mr. Young is referring to.

3 Q. He agrees with your comments. Can I take you to, just in this sequence or this period of time, again. Those e-mails were 18th October. You started the day -- if we can go to 279130. We have looked at that e-mail just a short time ago. Ronan Carroll asking for action

in respect of this dictation issue. Then up the page what you say here is:

"The NCAS report" -- that's the MHPS report -- "into his practice has been received by the Trust and presented to him", and you have been notified of that by the Case Manager Ahmed Khan, but you haven't been told the full detail of the report. Mr. O'Brien is now to respond.

"In his meeting when he was presented with the report he cited multiple examples that he claims is evidence of inappropriate and clinically unsafe practice by a number of his colleagues".

You haven't been told who.

"He has also made it clear he will be fighting every allegation."

You say, as much as you say about the monitoring plan in the other e-mail which was sent, I think, a few minutes before this one in the early -- well, for some people the early hours of the morning, not for you, I suspect:

"Michael and I cannot it be involved in tackling the behaviour and we need to be 100% that everything is done to the book with HR input."

A couple of questions arising out of that. First of all, you are hearing Mr. O'Brien has concerns about inappropriate and clinically unsafe practices in respect of a number of colleagues. Was that ever vouched or further explained for you?

A. So, I have referenced it there. There's reference to it in some of the responses Mr. O'Brien had given, I think, to the Julian Johnson set of SAIs, and there's reference to it in another document that Mr. O'Brien tabled at a meeting, at a departmental meeting. But on none of them occasions did he cite who that was referencing. I think what I'm saying there is, essentially, outlining, as I've said, this was being tackled down one process. In with this he is now essentially throwing accusations which potentially are going to be at myself and Michael, who have been asked then to come in late into the process which then placed us in a very difficult position where we don't know what these allegations are and we've not been party to the management of him to this point.

4 Q. Just sticking with allegations of this kind. If a Clinician is seriously concerned about unsafe practice on the part of a colleague, that should be followed through with an Incident Report, perhaps, or perhaps a complaint to the Medical Director. Were any of those things done, to the best of your knowledge?

A. To the best of my knowledge, none of them typical routes, as you say, we have outlined multiple ways in

which concerns can be raised. It becomes, as with anything, as AMD if I am one of them potential routes that a concern can be raised by and potentially the allegation is about me, then it needs to go down than alternative route and, to the best of my knowledge, that wasn't formally done other than these very vague accusations of inappropriately and clinically unsafe practice.

Q. To your point that you cannot be involved, and Michael Young can't be involved, is it fair to say, and we will explore this as we go on, that what you are saying here is that you can't be the person going to Mr. O'Brien and addressing these issues, but, nevertheless, you retained, as we shall see, a background role. You were certainly a recipient of information with regard to derogations from the action plan, and you were to make suggestions in respect of that. Is that fair?

A. Yes. As I say, essentially one thing to maintain that consistency that it's being tackled by a team, a group of individuals from the start, and that should be consistent through. As we go through, as you know, I've fed in and you referenced there I've maintained concerns in terms of how data has been collected about, in terms of the monitoring. But it just felt difficult to -- progressively more difficult to me where, now, at this point now I have been told, as well as having concerns myself, as well as having raised some of the concerns that fed into what was part of that monitoring plan, and part of the MHPS report, I have now got

allegations being thrown against me placing me in a difficult position in the middle here, potentially against me. I haven't been told clearly.

6 Q. Could we just go down a few pages to 279134. Mr. Carroll is saying:

"I would like this dealt with today or at least a plan in place."

Again, you set your position out earlier. Can you recall whether that call to arms, or call to sort this out with a plan, how that was addressed?

A. I can't recall off the top of my head. Just scrolling down, was that the one before from Wendy to --

7 Q. Yes.

A. -- to all? So I am unsure. Looking at that now, I may have interpreted that e-mail from Ronan as a reply to Wendy.

8 Q. Yes.

A. As in, can you go and speak to Colin?

9 Q. This is going to be an e-mail-heavy morning, at lest the first part of it, so I apologise in advance. If we could go to TRU-258911. Again, 18th October, and Mr. Carroll is explaining that the -- we started this morning by looking at the backlog. Mrs. Corrigan had been off for some time and the backlog, which was documented in Mrs. Clayton's starter e-mail, accrued during her absence. Mr. Carroll is replying to some, I suppose, criticism from Mr. Gibson. Mr. Gibson was

stationed in the Medical Director's office, and Mr. Carroll is explaining:

"With Martina having been off since June, the overseeing function has not taken place and in the day-to-day activities was overlooked. We need to understand why this dictation has not gone out. This could explain the volume of notes or there may be some other reason"

I think that should say "has not gone out".

This is your reply:

"According to Simon there were monitoring and supervision arrangements put in place and which we confirm to a range of interested parties."

You are making it clear:

"I wasn't one of these interested parties, neither from Colin's e-mail was he or Michael, from his."

"If the Clinical Lead in the Service, the Clinical Director" and yourself, "the Associate Medical Director, weren't, I'm not sure who was".

"I can only assume given the Trust's previous failings in tackling behaviours in this case the arrangements

were robust, and regularly monitored at multiple levels and clear back stops for sickness, et cetera, so it wasn't reliant upon only Martina."

Does that e-mail suggest an element of surprise that, although you were Associate Medical Director, nobody had troubled you with information that there was a plan in place, even if you weren't to be an active participant in enforcing the plan?

A. I think possibly surprise, possibly frustration. I think the table -- sorry, just taking back to Wendy's e-mail. That was a table cut from a monthly report relating to September, and I think one of the notable things there is that the clinics not dictated went back to June. So there were multiple reports before that September one which, presumably, and I think from memory, didn't highlight the clinics in June hadn't been dictated. I have mentioned previously about my concerns that the data wasn't robust in how it was collected. I think there was probably an unwritten sense of frustration from myself that, actually, I felt that the data wasn't robust and actually, it's been evidenced here. We have had okay June, July, August backlog reports, and then in September there's 92 dictations dating back to June, so something has happened in how that data has been collected at that point. As I say, I suspect there is a sense of frustration that everything that was then coming back to myself where perhaps, if it had come to me at an

earlier point I might have suggested or raised concerns as to how the data was being collected and suggested methods for it to be a little bit more robust, and again, an additional sense of frustration that we kind of -- everything has hinged on one person, and one person goes and what happened?

10 Q. Yes. I think you are answering the question I'm about to ask. The system in place, dependent upon one person to monitor and to escalate, which falls apart in her absence, can't have been a robust or an effective system?

A. Or as I think is stated, wasn't done in her absence. I think it's important, Martina -- in terms of this monitoring, that Backlog Report data wasn't generated by Martina, that was generated by others. If we haven't got a clear understanding of how that data is being generated, a clear understanding of why it's being generated by the individuals collecting that data, then you get poor quality data, and that's illustrated. The data collection was not robust, and the process for that data collection, if you like, to be assimilated and put together, was reliant on one individual.

11 Q. Yes. I think it's important to keep in mind the dates here and what's happening around this time. MHPS has just reported. Dr. Khan has issued determinations which, to some extent, were blocked by the issuance of a grievance. Dr. Khan is both Case Manager and Acting Medical Director with Mrs. O'Kane to take up the reins

or Dr. O'Kane at the start of the new year. Lots of things happening. Just on this evidence that this monitoring plan has run into difficulties, anything done by you or anybody else to try and fix it?

A. Again, the monitoring plan was put in place by individuals, and the management of that monitoring was by individuals that wasn't myself. I think I have suggested I have got concerns there. Did I actively take it off someone else and change it? No, I didn't.

12 Q. Mm-hmm. Because we will see, in the course of the morning, that those concerns are maintained throughout the next year, leading to a meeting in early January 2020, when, as we see, the concerns are put out on the table and an arrangement is suggested to try to address it at that point.

Just let's scroll up, please. No, I think I haven't got the page.

There was a suggestion by Mr. Weir that he would meet with Mr. O'Brien but he wished to be fully briefed and advised in respect of what sanction, if any, might be applied or discussed. Do you know whether that meeting happened?

A. I don't know. I know Colin did meet with Aidan on occasions, but I don't know whether specifically at that point.

13 Q. Yes. As you say, we do know that he met on occasions with Mr. O'Brien. Could I ask you to look at the

following set of e-mails: TRU-251540, starting at the bottom of the page, please. Again, we are recalling that MHPS has just reported, Mr. O'Brien is appraised of the outcome, and what comes next in terms of a conduct hearing. Mr. Carroll is writing to Esther Gishkori, who is the Director of Acute, Colin Weir and Michael Young. Ronan has been speaking to Mr. Young, who has advised him that morning that he received phone calls from Mrs. O'Brien on the Saturday evening, and Michael O'Brien, who I understand is the son of Mr. O'Brien, on the Monday evening, and both of those phone calls centre on Mr. O'Brien's investigation.

"Give me a ring if you require anything further."

It's just signed off.

Mr. Weir then records that he met with Mr. O'Brien in Mr. Weir's office. Mr. O'Brien requested the meeting, and the conversation centred around the investigation. I am conscious a moment or two ago I asked you whether Mr. Weir had met with him to discuss the shortfall on dictation, but that isn't this meeting. Mr. O'Brien requests this meeting. Mr. O'Brien has recorded the meeting, which is of some benefit to the Inquiry, I suppose, although I understand that you and others are somewhat upset by the fact that recordings of conversations have taken place.

A. I think what you have got here is, Mr. O'Brien

initiated a meeting with an agenda, and a tape-recorder effectively in his pocket. It also documented below that, you've got family members putting pressure on individuals within the service. I think there was a lot -- why hadn't someone asked, do you mind if I record this conversation? that would be reasonable, I wouldn't have an issue with it. The fact that you've had meetings where the agenda has perhaps been led by someone who knows they are recording it, with their own agenda and own intended outcome, it's a bit underhand. It's a bit frustrating.

14 Q. The surreptitious nature of the recording that you allude to, just to be clear, there are at least two other meetings involving you which were recorded, your consent wasn't sought?

A. Two meetings and a phone call, and never at any point were we made aware that a recording was being taken.

15 Q. Yes. Mr. Weir seems upset about the nature of Mr. O'Brien's approach in this meeting. He feels that he should not have made this approach, that "his questioning and responses could undermine the investigation and action plan."

I assume that's a reference to the MHPS investigation and subsequent plans that were never brought into fruition for an action plan.

"He put me in a difficult and awkward position and having met Mr. Young and knowing his experiences, he

says, I cannot meet or discuss anything with Mr. O'Brien, anything other than day-to-day activities in his work as a Urologist."

He asks: "Can we be protected from this as I suspect evidence is being gathered from us and I will make the Medical Director aware."

Is it fair to say there was a degree of concern and suspicion between colleagues at that time?

A. I mentioned, I think on day 1 I was here, a fear this awareness of the connections around Mr. O'Brien. I mentioned an awareness that a previous AMD had been accused of bullying when he tried to address things. So, there was an awareness of, if you like, those around Mr. O'Brien. We've got an investigation, if you like, taking place, and we've now got family members making contact with individuals within the team. We've got a concern from Mr. Weir that a meeting is being sought in his understanding to discuss one thing but the conversation heading down an agenda, that's recorded. I think it just illustrates an approach of Mr. O'Brien that really backs that -- why there was that underlying awareness and fear of, actually if I try and tackle anything with him, what am I going to be hit with? We have got allegations of unsafe practice, without names, against the individuals in the Department potentially, again throwing another barrier to people addressing his practice.

16 Q. From his perspective, is it reasonable to suggest that he felt let down and suspicious of colleagues?
A. I think if we were to look on the whole, I would say there is plenty of reason for Mr. O'Brien to feel let down, but let down that actually we'd failed to address things at a much earlier stage and things had got to this point. You know, as we said in the retained swab SAI, while it wasn't a recommendation of the SAI it was the issue recognised of not acting on Radiology results. Had that been addressed for Mr. O'Brien at that time, it would have prevented him having the same issue happen at a later date. How much he's fed into that inability to address it, that's another subject but there's lots of reason to feel that he's been let down, but ultimately the reason the investigation was happening at that time was down to the way he had behaved and his action and his clinical -- his practice.
17 Q. When you say he has lots of reasons to feel let down, and then you go on to explain it by reference to the swab issue, in part. Is that you suggesting that he's entitled to feel let down because he wasn't more firmly managed or more firmly directed?
A. I feel we've let him down by not having more firmly managed it at earlier stages and us getting to the point where we are now. Whether he felt let down for that same reason, I suspect not.
18 Q. Yes. Just putting up the page again. I think you come in on this issue. Yes. You are writing to Dr. Khan

and Simon Gibson, Acting Medical Director and his manager, and you are saying to them:

"Are you aware of this? Surely this behaviour, phone calls from wife and his son/legal adviser to Mr. Young below with Mr. Weir shouldn't happen. How can we, his colleagues, be protected?"

Did you get any satisfactory or any response to that?

A. I can't recall. I think there was --

19 Q. Just scroll down. I don't think I have seen a response to it. Yes. No. So the question is, I interrupted you there.

A. I can't remember whether it was specifically related to there, but I think at some point Mr. O'Brien got a letter saying that he wasn't to make contact with individuals in that way.

20 Q. So far as you are aware, did that kind of behaviour desist?

A. As far as I'm aware, I was never contacted in that way. As far as I'm aware, it did desist. We know that the recording of conversations didn't.

21 Q. If I could turn to TRU-251546. The Revalidation Team is writing to you, Mr. Haynes. Presumably that's a task you have to go through in your role as Associate Medical Director. It's with regard to the revalidation of Mr. O'Brien, and you are asked to complete and return an attached form. Just scroll down until we see the form, please. You are asked to certify whether

there are any concerns or information about Mr. O'Brien that may impact on the Responsible Officer's revalidation decision. If we can go to TRU-251542, please. Your response is to write to the Medical Director's Office. Maria O'Kane is in post as Medical Director at or about this time, so she's copied into this. You are saying:

"As you are aware, I have limited involvement in the ongoing investigations. Would you have any recommendation for me as to how to respond?"

It's fair to say that you didn't feel competent to complete that form because, as you've explained, you have been largely kept out of the monitoring process?

A. More that form is a means for us to provide, if you like, reassurance to the Responsible Officer that there aren't any investigations that we are aware of into the individual who we are signing it about. I was aware that there was an investigation into Mr. O'Brien and, therefore, could not sign a form saying, 'I am not aware of any investigation into Mr. O'Brien'.

22 Q. I think that process stretches for a number of months and we will come back to it later. We explored, on the last occasion, your concerns about the robustness of the data and, I suppose, how comprehensive it was in terms of the use of backlog reports. I think you first raised that issue in 2018. We looked at it on the last occasion. The issue comes up again. If we go to

WIT-55742 at the bottom of that page, please. On 4th December you are part of a list of people receiving the backlog reports and the Administrator says:

"No major outstanding backlog. Results to be dictated are from the middle to the end of November. And the audio typist is currently on results to be typed area of backlog."

I'm not sure what that means. The point is this, you respond -- just scrolling up, please. This is, I think, a repetition of the point you'd made less than 12 months earlier. You are interrogating, I suppose, the data that's been sent to you. You apologise if the question sounds awkward but you say:

"Could you describe the method by which the information is collated? I can see how you obtain the waiting to be typed information but, for instance, how is the information on results to be dictated collected? Is this based on e-sign-off data or some other method? I am concerned that the data presented doesn't fit with my impression of practices. I regularly see patients coming to Outpatients with scan results that have been performed, often months earlier, requested by someone else but no results letter or action ever done and no sign-off either on ECR or on the paper copy. Similarly, how is the clinics awaiting dictation data obtained?"

You have copied this to Martina Corrigan:

"As I have spoken to her about this so she will be able to help if my question isn't clear."

Again, help us with this. I know that, and we will come to it in a moment, you go on to refer to a specific example of a problem, the case of Patient 92, that fitted within the mould of this concern. Just unpack that e-mail for us, if you could.

A. I think there's another e-mail as well along the same lines --

23 Q. If it helps we can --

A. I was just going to, just say, so we have created a Backlog Report that we are using to provide, if you like, our system with assurance that when patients have got, for the results to be dictated, results have come back, something has been done with them, but I'm not clear how that's being generated. I'm not clear how I could parachute someone in to collect that data and provide an instruction as to how they provide that data. Therefore, I'm not entirely certain that that data is robust. I have cited examples there of we are saying everything is up to date, but we see people come to clinic, and it hasn't been signed on ECR, it hasn't got a signature on the paper report, so it doesn't look like this data is correct. But without understanding how the data is being collected, it comes back to my

concern of what we are using to monitor our services isn't robust. I was going to said, I have said in another e-mail, you could actually say it's accurate because if someone never does a letter on a result, and it waits until they are seen in clinic, then they haven't got any results awaiting dictation because they never do a letter. There is no-one awaiting a dictation because that's their practice, they don't do it. It's very different from my practice, as I have outlined before, where I do do them letters. Again I think I have said in another e-mail, I know how the data is generated for myself by my secretary, but I don't know whether that's the case across the board.

24 Q. You allude to a particular problem of a colleague, and I assume that that's Mr. O'Brien?

A. I don't think I have actually said a colleague. I have referenced a colleague, as in it's a colleague.

25 Q. Mm-hmm.

A. So one of my colleagues. I haven't specified who. I don't know when I have written that whether I have had in my mind a specific colleague.

26 Q. Okay, that's fair. Can we scroll up, please. You get a response from Mrs. McCaul. She says:

"If you could, I would be grateful of an example of a patient who has come to your clinic but no result letter or action ever done".

That would be great so that they can see what's going

on. You refer to the case of Patient 92. We have heard specifically on the last occasion your evidence in respect of that, but essentially a CT scan had been ordered, performed and reported upon promptly. This was a patient of Mr. O'Brien, for whatever reason, he didn't action the results. Fast forward several months, and her general practitioner, I think, is red-flagging her into the system and she has renal cancer, I think. Fortuitously, it's dealt with.

That was clearly an example of a patient you had in mind. Let's just scroll up, please. You say:

"I should add that although this case is an individual who may have had concerns raised about previously, he is not alone."

This is a wider issue of not addressing CT outcomes?

A. This is my concern, as we've talked, AMD for Surgery and Elective Care looking across an entire surgical service that actually that may not be the only case of Consultants who are not acting on results. If we have got a monitoring process in place that's providing us with system-wide assurance, it shouldn't be focused on an individual, it should be focused on everyone within the system, to provide that system-wide assurance. If you want to get that system-wide assurance, you have to know how you are collecting the data.

27 Q. You give a specific answer back in respect of that

particular patient. It raises issues about, I suppose, the upset being felt by Mr. O'Brien's secretary in this context. You elaborate upon your concern:

"My concern that there are individuals who think that the reported results for dictation data is robust, it isn't. The number is generated at best for some as a guess. Because this regular report is taken by senior personnel in the Trust as robust, it is seen as a monitoring tool within the Governance processes that results are being actioned and communicated to patients in a timely manner, with no risk of un-actioned significant results. I fear your team are at risk if we have a situation where a patient comes to harm because a result isn't actioned and subsequent investigation reveals a large number of un-actioned results, your team would be open for criticism for reporting inaccurate information."

You are putting the problem at their door. They have got to worry about the fact that they are not doing their job as well as it could be done. Equally, what lies behind that is a significant Patient Safety issue?

A. Yeah. I don't think I'm putting it at their door. I am trying to highlight why my concern is of relevance to the individuals who are collecting this data. Again, if we haven't provided guidance as to how the data is to be collected and what the data is being collected for, then the individuals collecting the data

aren't necessarily at fault in the way that they do it. If we provided very clear guidance as to how that data is collected, what it's for and what that Patient Safety relevance is, and it's not collected appropriately or accurately, then it's down to the individual. But when we don't provide that guidance, then the lack of guidance creates the issue.

28 Q. Just to be clear, this is the kind of data that is being relied upon, at least under the category of dictation, for the monitoring of Mr. O'Brien?

A. This is part of the data that's included within the Backlog Report. I mentioned earlier today the clinics awaiting dictation. How can we go in September and have clinics awaiting dictation from June, but they weren't reported on in a July or an August report?

29 Q. So the risk here is of under-reporting?

A. Under-reporting.

30 Q. I think that's the end of the sequence. Just scroll up that I can check. We will come back to that one. That was December. Was that issue of data reliability, and potential under-reporting, resolved?

A. I know I had conversations. I think I met with Catherine and the team to talk through or, if you like, flesh out why and what my concerns were. During Mr. O'Brien's time, I don't think we got to what I would be confident on as a 100% robust method of collating that data. Within Urology, for our Radiology results I am now satisfied we have a 100% reliable process for that.

31 Q. But that wasn't achieved during Mr. O'Brien's time?
A. That wasn't achieved, no.
32 Q. Before I move to March, further thoughts as something of an aside. In terms of the dictation of letters, a letter is dictated, or should be dictated following Outpatients or perhaps any other major milestone in the patient's care pathway, for the purposes of the General Practitioner it's directed to the General Practitioner?
A. Generally you would write to the referrer and you would copy in individuals involved in the patient's care. Generally the GP would always get a copy. If they are not the primary addressee, they'd got a copy of the letter. For instance, a patient under the care of Urology, the Oncology team, as well, they get a letter that's addressed to the Oncologist but copied to the GP.
33 Q. Just in terms of the patient, is the patient the recipient of a letter of the nature I have described, or not?
A. It's good practice that they should be. They are not always. Certainly before I came to Craigavon, in Sheffield it was standard practice that all patients were copied into GP letters. It's not a standard practice, although I do copy many of my patients into my letters but that's not standard practice across all Consultants in Northern Ireland.
34 Q. In terms of your standard practice, is there a criteria that determines whether you will write to the patient as well as the GP, or is it hit-and-miss? Is it, for

example, a major result goes to the patient or not? What influences?

A. All results I write directly to the patient and copy to the GP in my practice. From clinic consultation, then I generally copy in a large proportion but not necessarily all. I couldn't give you a clear, this is why I don't copy patient X in, but I copy in a large proportion.

35 Q. This is an area the Inquiry's interested in and they may have some questions for you beyond what I have. Just in the Northern Ireland context, it's not, to the best of your understanding, standard across your colleagues to copy patients in?

A. Not in the same way as it was just across the board when I worked in Sheffield, that every patient got copied into GP correspondence.

36 Q. Do you know whether that's because of a different culture, is it because of a different rule or guideline, or is it something you just don't know?

A. I don't know. I suspect it's culture rather than a guidance, but that would be a suspicion.

37 Q. Thank you. Could I go to WIT-55773, please. The bottom of the page, please. A Higher Clerical Officer in the Red Flag Appointments office writes on 29th March saying:

"There are 24 referrals from 22nd March needing triage for Urology on the ECR, can you escalate please?"

Ms. Graham then escalates that to the team of Urologists, repeating largely the same message. Then you come in and say to the Medical Director:

"This relates to one of the Aidan O'Brien issues. He has been On-Call since 22nd March and should have been doing the triage."

Just up the page. No, I think that's the end of it.

You, by this stage, are aware of the monitoring plan from the tail-end of the previous year, and you recognise that this is a deviation which needs some form of explanation or action. So, while you are not involved directly in the monitoring, the information properly comes to your attention as Associate Medical Director?

A. The information came to my attention as a member of the team of Urologists.

38 Q. Yes.

A. Rather than escalated to me as Associate Medical Director. That's why all the Consultants are copied in.

39 Q. Yes. You, amongst that list of colleagues then, pops on your AMD hat because nobody else is going to refer it to Dr. O'Kane?

A. Yeah.

40 Q. It's in that mode that you forward to her. Dr. O'Kane becomes involved in these concerns about deviation,

a couple of days later. If we can start at WIT-55769, please, at the top of that page. We have that one. Keep going, yes, thank you.

She is asking you has this happened in this way before, and you respond by setting out the wider context. Is it fair to say that Dr. O'Kane, new to the Trust and new to the job of Medical Director, needed certain help along the way from the likes of you to appraise her of the issues in the background?

A. I think that would be the role of any of us in position when a new Medical Director takes up post.

41 Q. Because her question to you seems to belie, I suppose, a lack of knowledge, in the sense that we have had, by this stage, a well-documented, through the MHPS process, explanation of the triage shortcomings going back over a significant period of time. She's asking what appears to be, on the face of it, a rather naive question -- I hope that's not unfair to her -- that it certainly seems to suggest that she is not yet up to speed on the triage issue which has clearly been a historic issue?

A. I'd be making assumptions on -- it could be as you say, or it could be has this happened in this way before since the monitoring started?

42 Q. Yes. You certainly take it back to June 2015, set out the full context, and you go on to say that:

"Red flag referrals must be completed daily."

You go on: "I think this is reflecting aspects of the monitoring plan that all referrals received by Mr. O'Brien will be monitored by the CBC in line with the above time scales and a report will be shared with the Assistant Director of Acute Services", et cetera.

You refer to the escalation e-mails issued by Mrs. Graham and you say that you "would assume that this is being shared with the Director of Acute Services and escalated to the MHPS Case Manager."

It's not clear to you that that has been done, and you say:

"Anecdotally, certainly the e-triage is not completed by 4pm on the Friday of his on call week. Indeed, looking now there are 79 referrals on e-triage received between 21st March and 27th March that have yet to be triaged, including 16 red flags."

I think this e-mail is the 31st March, so there's time yet. You say:

"I am now aware of the reporting and escalation that may have occurred to this following the return to work."

Moving up the page again, please. At that stage,

Mr. Haynes, can you recall any further interaction with the Medical Director's office with a view to trying to resolve this, or do you know whether Dr. Khan, as Case Manager, became involved?

A. I can't recall off the top of my head. One of the things that I am aware of now, and I may have become aware of, is we asked, I think on day 2 I was here, about the monitoring plan and whether I felt the expectation with regards to triage was okay, and I said that you needed some, if you like, some slack. You needed some recognition if you had a busy On-Call week 24 hours might not be achievable. I believe a derogation was agreed that actually he did need some slack, so it may have been this hadn't been escalated because it hadn't quite reached the derogated thresholds. The other thing on this is, as I said, this came through our Red Flag office and escalated through Vicki Graham. It wasn't escalated through the monitoring processes that this hadn't been done. This had come through a separate route to my attention rather than through a monitoring process to Dr. Khan.

43 Q. Yes. It's clear that, although you appropriately allow the soft landing for the busy week, you do appear to have concerns that triage isn't being done in accordance with the requirements of the plan.

If we move to May of that year. If we go to WIT-55765. If we can just go to the bottom, please. Actually, bring it to the top so Mr. Haynes, can see the context

for this.

There's been a meeting on 24th April 2019. You are not in attendance at that. It appears that those persons have been, and there's action notes following the meeting. It's unclear, to me at least, what the nature of that meeting was. Could it have been in relation to the validation issue?

A. I don't know, not being at that meeting or party to the e-mail trails around that meeting.

44 Q. Yes. If we just scroll down and see some of the issues that were being discussed. It's perhaps issues arising out of the MHPS. Then the last bullet point is something I wish to ask you about.

"One of the headline issues from the meeting is the need to seek assurance from Acute. Question is there an agreed job plan and Simon" --

That's Simon --

A. Gibson.

45 Q. Gibson, of course. "... is to check with you on behalf of Dr. O'Kane is the 2017 action plan being followed and all monitoring arrangements in place. Siobhán Hynds reported that Martina Corrigan is ensuring monitoring arrangements are still in place, with no exception reports flagged to the Case Manager. It was agreed that the Case Manager should periodically seek this assurance."

It seems to be reported here that no exception reports are flagged to the Case Managers, that's certainly how you interpret it. If we scroll up the page, please. Dr. O'Kane writes to a list of people, including yourself, and says that:

"Ahmed or Mark as his AMD should seek regular assurance rather than me and then inform the MDO. AOB-is still undertaking assessments of private clinic at home as per the request, sign-off of transfers from private to public practice. She" -- that is Dr. O'Kane -- "has brought this to the attention of Urology and they have asked for a rationale as to why the GMC has suggested his practice is stopped before this is progressed."

On the first issue, you intervene, Mr. Haynes. If we just scroll up. You explain as regards the job plan:

"Mr. O'Brien does not have a signed-off job plan. Discussion has occurred and the job plan has been awaiting doctor agreement since November 2018. I am second sign-off and so would not be requested to sign it off until he and his Clinical Director have signed it."

What was holding up that?

A. I can't recall the exact issues but I know the CDs, I think it was still Colin Weir --

46 Q. Yes.
A. -- had met and attempted to come to an agreement on the job plan, but that had got held up. I don't know whether that was got to a point and then didn't happen, or got to a disagreement. I can't remember.
47 Q. The action plan is then discussed in your e-mail. You say that you are not currently in a position to provide the reassurances requested. You weren't party to the action plan and have only recently been made aware of its contents, that is within the last six months.

"Having been made aware of its contents I am aware of instances where the actions regarding concern 1" -- that is triage -- "have not been met.", and you refer to attached e-mails.

"Specifically, triage of all referrals must be completed by 4 o'clock on the Friday". Et cetera.

"Given that I am aware of aspects of the action plan not being met, I am concerned the statement that there had been no exception reports flagged to the Case Manager" -- that was the minute contained in the earlier e-mail from Dr. O'Kane --
"... the implication being that either there has been an agreed deviation from the action plan and monitoring is now occurring against different standards, or that the monitoring and/or escalation process has not functioned as it should. As I was not party to any of

the previous discussions, if I become part of this I need an initial briefing with all and also some run-through of monitoring to date. Through this briefing I need to understand the process as it is at the present and how despite evidence, there appeared to have been exceptions and the reporting process appears to have failed to flag these to the Case Manager."

It appears to be right to say that the Case Manager has not been brought into these matters as he should or has been anticipated by the monitoring plan?

A. That's my interpretation of it. As you say, them action notes from that meeting, they have said there's been no exceptions and yet I, as I have stated there, am aware of exceptions, and so it appears that monitoring process hasn't flagged these.

48 Q. Put it this way: If there has been escalation to the Case Manager, you would be expected to be told about it?

A. I don't think within that monitoring process I would necessarily have expected to be explicitly told because I wasn't -- we have said I wasn't within that monitoring process. What I would have expected, given that I was aware that there were escalations of triage not having taken place, I would have expected that that would have been escalated to the Case Manager, and I was surprised to see the suggestion in the action notes that no exception reports have been flagged to the Case Manager. As I have said, the implication

being that there was an agreed deviation from the plan that I wasn't aware of that amended action plan expectation, or that the process and escalation has failed.

49 Q. Certainly nobody has written back to this e-mail to say, you're quite wrong in your inference, we're all over this, The Case Manager has been actively concerned about this and is getting ready to meet with Mr. O'Brien. None of that kind of thing happens?

A. If there's no reply, then no.

50 Q. I think that's the end of the sequence. Come September, Mrs. Corrigan e-mails Dr. Khan to highlight further deviation relating to concern 1 in the action plan and concern 3, that's the use of dictation. If we just have the e-mails up, please. If we go to WIT-55761, and go to the bottom of the page, please. Martina Corrigan is writing to Dr. Khan in his role as Case Manager, 16th September 2019, and she says:

"I am escalating this to you".

She is attaching e-mails showing where she has asked Mr. O'Brien to address the issues. So the two in red obviously are the difficulties, concern 1 not adhered to, "please see escalated e-mails as of today Monday 26th September Mr. O'Brien has 26 paper referrals outstanding and on e-triage, 19 routine and 8 urgent referrals. And on dictation, concern 3: Mr. O'Brien continues to use digital dictation on his clinics, but I have done a spot-check today" and she has identified

the following. I won't read those results out, but you can see from clinics from July into August and September, there are dictation issues. Of course, those dictation issues are subject to the frailty of the reporting system that you have highlighted earlier, which risks under-reporting. Just scrolling up, please, to see how this issue develops. Dr. Khan thanks Martina and asks Siobhán Hynds and Simon Gibson to meet with him urgently.

Over the page. Dr. Khan is alerting the Medical Director that this is an issue, saying Mr. O'Brien has failed to adhere to two elements of the agreed action plan and explains that he has requested an urgent meeting with two of the managers.

Dr. Khan explains that he has discussed the case. Ms. Hynds has requested further information from Martina, and they wait for this. He understands that the Trust grievance process is on hold, and that is the reason why the MHPS conduct hearing can't proceed.

Scrolling on up, please. Within this e-mail, Mr. Haynes, you have obviously been appraised of this issue. Dr. Khan has communicated with you and you have confirmed, I think, that there's a number of non-adherence to the agreed action plan. Dr. O'Kane is asking for a teleconference on this issue.

Just focusing on this e-mail here. Mr. Haynes, you write in at this point to alert Dr. O'Kane of another issue that has come to your attention concerning Patient 112. His name appears on the e-mail. That e-mail raises a concern that the MDM decision or recommendation was for Mr. O'Brien to see this patient and conduct a biopsy, and there was no evidence on the system that that had been done. Mr. O'Brien hadn't dictated on that issue, so colleagues were none the wiser as to what was happening in that case, and it was causing a concern. Ultimately that case was considered by Mr. Gilbert, who we heard from yesterday, who was asked to give an opinion as to whether it ultimately amounted to a Serious Adverse Incident for review, and he decided that it didn't meet the threshold for SAI but, at that time, concern, as indicated in your e-mail, had arisen because nobody knew what was going on. Is that fair?

A. Yes. It's in the context of the monitoring. There was an MDT outcome, a clinic appointment had happened and no letter had been generated from that appointment. The appointment was on 16th June and we were in October here -- sorry, 16th August and we were in October. As it transpired, things had happened, but there was just, as per the action plan of a dictation being generated from the Outpatient consultation, that hadn't happened and, as a result, we weren't aware what was happening and the cancer tracker wasn't aware what was happening for this patient.

51 Q. Just scroll up the page, please. I think that's the end of that sequence. Can you remember becoming involved in a meeting then to address that deviation?

A. The planned teleconference in October 2019.

52 Q. Yes. September.

A. My recollection is, I couldn't phone into that. I wasn't at that.

53 Q. Come the end of the month, WIT-5753, you are alerting Dr. O'Kane to a further Incident Report that's about to be generated. That's a different case, is it, to the one I have just alluded to? That one was arising out of consideration of a case at the Belfast MDM?

A. Yeah. My memory is that was a patient with testicular cancer, who had had his surgical treatment and needed referral to the Oncology team. That's my memory.

54 Q. It's clear, is it, Mr. Haynes, that there's various concerns being generated around Mr. O'Brien's practice at this time. It's all clearly visible to senior management, including the Medical Director, but pausing for a moment. Was anything concrete being done to address any of these matters directly with Mr. O'Brien?

A. In terms of, I think it was Patient 112, the e-mail before, as I had said in there, I had contacted Mr. O'Brien myself to find out what was happening with that patient. In terms of addressing the non -- each of these is about not conforming to the action plan. Here, the bits in red are Outpatients in August 2019 and the letter is dictated a month later. Whether any of them were directly taken up with Mr. O'Brien,

I don't know. My assumption was that that went through the Case Manager as that was the process for managing against the action plan.

55 Q. We know from your evidence, and an e-mail a short time ago, that you said, 'if I'm to become involved at this stage, I will require a full briefing and brought up to speed on what has happened in respect of the plan historically'. Did anyone take you up on that proposal?

A. Not that I recollect.

56 Q. In terms of the intervention of the Medical Director, while she's clearly apprised of these issues, are you aware of anything being done to challenge Mr. O'Brien at this stage in respect of what are being reported and escalated as shortcomings?

A. Not that I'm aware of.

57 Q. You did a piece of work in respect --

CHAIR: Mr. Wolfe I am just wondering is this an appropriate time to take a break?

MR. WOLFE KC: Yes, by all means, it is. I didn't realise the time.

CHAIR: Yes. We can come back in 15 minutes, please. Ten to.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIR: Mr. Wolfe.

MR. WOLFE KC: Thank you. Could we have up on the screen, please, WIT-55763. Yes, thank you.

Mr. Haynes, in this context of further concerns having been raised by Ms. Corrigan and escalated to Dr. O'Kane, she having arranged for a meeting, I think to take place a couple of days later. It appears you've gone and done some work in relation to issue of dictation in particular. Can you help us just in terms of why you saw fit to do that?

A. I think it was, as I've said before, I was concerned that the data that was informing the process wasn't necessarily robust so what I have gone and done is, what I have considered a more robust review, I think of two clinics. Yes, two Outpatients clinics.

58 Q. If you scroll down -- sorry to cut across you -- we can see the results.

A. Those were a considerable period before the point at which I reviewed them consultations.

59 Q. I think if you look at the document *in toto*, I think what it establishes is that, over that period of the two clinics, only five out of 20 letters have been dictated. Given the dates of those clinics, would you have expected to see dictation in respect of all of the patients concerned?

A. You would have expected to have seen a letter for each patient and, as I have highlighted, where the letters are available, the dictation has been done a period after the clinic, so we can see one there on the screen where the clinic attendance took place on 20th August and the letter was dictated on 19th September.

60 Q. Yes. We will come on later to look at the fine print

of the action plan in respect of that, but that's outside of the time limit, even though it's ultimately done.

If we could go to TRU-279848, and just at the bottom of the page, please. I think arrangements are being put in place for a meeting. Back to the issue of Patient 112, and you are saying that an IR1 is going in that day. Dr. O'Kane is writing to the group, which includes the Case Manager, Dr. Khan, and yourself, amongst others. She's asking for a meeting to be arranged. You have less flexibility, it seems, and she sets out an agenda. Let's just look at the agenda briefly. She is asking for an outline of the escalation plan in relation to managing this and other potential exceptions within the Service following on from the MHPS. She wants an update on the recommended review of administrative processes which were described in the MHPS redacted report and referred to recently in GMC correspondence. That's taking us back to Dr. Khan's determination where he said that there had been failures at all levels of management in terms of the administrative systems, and he wanted an independent review of that. Twelve months later, that hasn't got off the ground and, in fact, wasn't to get off the ground until the summer of 2020. She wants an update on the progress of SAI reports which have arrived within the Trust recently, and she wants an outline of management of any potential risks to Patient

Safety.

I think you are right, I think you've said you weren't able to attend that meeting, ultimately?

A. The telephone one, no, I didn't.

61 Q. Unfortunately, we've looked, and we will follow this up with the Trust, there doesn't seem to be a record, that we can find, relating to the outcome of that meeting by way of a minute or otherwise. Given that you were to be an attendee, did you receive any feedback, to the best of your recollection, in terms of what had been decided?

A. Not to the best of my recollection. I've also had a look in the e-mail archive to see if I could find anything and I couldn't find anything related to that.

62 Q. Yes. It does appear to be, I suppose, the moment where many of the key overseers of these issues are sitting down, whether remotely or otherwise, to have an important discussion of where we go from here in respect of Mr. O'Brien's reported shortcomings, and indeed other issues. Thinking about that, nothing at all that you can remember coming your way in terms of how this is to be handled?

A. Not that I can remember specifically. As I have said, I have looked to see if I can find anything in the archive and haven't been able to, to date.

63 Q. We understand that. Indeed, you comment upon it, in your statement, that Mr. McNaboe he was, by this stage, the Clinical Director?

A. Yeah.

64 Q. He had taken over from Mr. Weir, and you understand that he was to meet with Mr. O'Brien. I will just help orientate you on this. You say in your statement at paragraph 62.9, if we go to WIT-53937, just at the bottom of the page, please. This paragraph reflects or at least charts the progress over the period that I have spent most of this morning already dealing with, but you deal with it concisely in this paragraph and I will just read it out:

"Soon after commencing as Medical Director, in early 2019 Maria O'Kane spoke to me regarding Mr. O'Brien and the MHPS investigation and concerns being escalated to the GMC. However, I do not know/recall whether this conversation took place before or after the concerns were escalated to the GMC. I became concerned" -- as we have seen this morning -- "that the secretarial 'backlog report' was being used as part of the monitoring of Mr. O'Brien and I remained concerned that Mr. O'Brien was not always dictating on outpatient attendances at the time of the clinic. I was also concerned that there was a high likelihood that he was not acting on all results requested in his name and this was not being adequately monitored in the backlog report."

That was exemplified by Patient 92, for example. Then you go on to say:

"I raised concerns regarding the robustness of the data contained therein - namely, the 'results awaiting dictation' and 'clinics waiting dictation'" -- We have seen that -- "and raised these on a number of occasions ;"-- We have seen that. "indeed, some of these concerns predated the use of this report as part of the MHPS monitoring process. I am aware that, as a result, Mr. McNaboe, Clinical Director, did meet with Mr. O'Brien with regard to lack of compliance with the requirement to dictate after every clinic attendance. I do not recall being involved in the out-workings of this meeting."

Mr. McNaboe, you suggest, has met with Mr. O'Brien. I just want to show you Mr. O'Brien's perspective on that. Could we go to WIT-82593, please. Mr. O'Brien recites the terms of the action plan. I am catching the last paragraph there, and I will read that:

"It is my view, in order to ensure that the Trust continues to have an assurance about Mr. O'Brien's administrative processes and management of his workload, an action plan should be put in place with the input" -- sorry, that's the outcome of the MHPS.

Mr. O'Brien comments that the Return to Work Plan from 2017 came to an end at the conclusion of the investigation process. The plan was to be in place

from the commencement of MHPS until the end of the MHPS process, and then, as we know, Dr. Khan provided, in his determination, for a new action plan, monitoring and an agreed job plan. That recommendation didn't take place. Is Mr. O'Brien, technically at least, right to say that, as far as he was concerned, there was no action plan in place at this time? Or to put it another way: there was an action plan in place so far as the Trust was concerned, but he suggests that there ought not to have been?

A. My thoughts would be it would be open to interpretation. The MHPS report had come out and he'd raised a grievance about it, so whether that grievance meant that that report was finalised and accepted and, therefore, the previous action plan come to date I guess would be something that different parties may have different opinions on. Whether or not there's an action plan in place, the expectations of the plan are reasonable expectations of any individual. To suggest that, because an MHPS action -- a new action plan hasn't been put in place, therefore I don't need to do any dictations on any patient and I don't need to action any results, just strikes me as a strange position to take.

65 Q. He may not be going as far as that. He seems to limit his remarks to the absence of an action plan. He says here at 571, just working through some of the his perspective -- it's coincident in time with the processes we have been looking at this morning, so he

says that the recommendation made by the Case Manager for a further action plan to be agreed with the input of NCAS. He was not approached by the Trust to agree any such plan. So far as you are aware, that is correct, is it?

A. Mm-hmm.

66 Q. He comments about the Return to Work Plan requiring triaging. He says he did try to triage all red flag referrals on a daily basis, but it wasn't always possible. He says in endeavouring to comply, he took off each Friday following Urologist of the Week as an annual leave day in order to complete as much as possible within the week. However, doing so was at the cost of losing an Oncology Review clinic as well as a clinic for patients attending urodynamic studies and flexible cystoscopies.

Was the Trust aware that he was working in that way, or were you aware?

A. I didn't know he was taking each Friday off as annual leave, specifically to do that. As we have discussed before, he chose to do triage in the way that he did which was more time consuming and could have triaged in a quicker way, albeit maybe not the way he wanted to, but he could have triaged in a quicker way and not come up against as big a workload issue as highlighted.

67 Q. Would you accept that his way of triaging was, nevertheless, a more thorough way of getting to grips with the patient needs in terms of investigations and

next steps?

A. I've said within my statement that I am a believer in advanced triage. I would do it in a different way to Mr. O'Brien. He took it to a virtual consultation, which is not triage. Contact, phoning patients, as I think he said somewhere, phoning 60-odd patients in a week is doing virtual -- is doing a telephone clinic for them 60 patients. That's taking it from being triaged to essentially consulting a patient at the point of referral. So triage is getting patients on to the right pathway, be that a red flag pathway, and to me, advanced triage is where investigation is required, arranging that investigation to expedite the pathway for the patient when they come into contact with the Service.

68 Q. Just scrolling down, please. He talks about the dictation issue. He accepts that that continued to remain a problem, says that was because of the limited time actually available to remain on location at outreach clinics. He says that the Return to Work Plan required his "... secretary would actually choose who would be admitted for surgery, and, as she was unable to do this, I continued to select patients for admission while my secretary continued to conduct all the administrative tasks which arose as a consequence".

Do you follow what that means?

A. Yeah. When I plan my operating list, I do it in conjunction with my secretary. What my secretary does

is brings to my attention those patients who are at the top of the waiting list, largely at present it's red flag, so suspected cancer or cancer procedures only, and then I advise what would fill the waiting list from that group of patients who are at the top.

69 Q. Is he suggesting here that his secretary acts in a different manner?

A. No, I think he's suggesting that he has a process. I presume that his secretary tells him who the patients are at the top of the waiting list and he says what can be fitted on to that theatre list, what would be appropriate to do.

70 Q. He goes on to say:

"The one aspect of the Return to Work Plan which could have been done differently was in relation to triage". He makes the point that this was a missed opportunity to deal with triage in a different way. I know you sympathise with the view that triage could be done in a different way by putting a greater onus on the primary care sector to get it right, I suppose, from the outset. I think you are sympathetic to that point broadly?

A. I think there's lots of ways triage can be approached differently, and that starts at the point of the initial referral. It does so also then extend to if you have the initial referral that's right most of the time, then some of that pre-attendance investigation can be arranged appropriately without involving

a Consultant.

71 Q. He goes on then at paragraph 577 to say that no issue was raised by the Trust with him in relation to any potential breach of the plan until November 2019, when he received e-mails from Ms. Corrigan, Head of Service, and he sets out the e-mail. Although we have, over the course of the past couple of hours, observed that multiple people within the management system are aware of many occasions when there have been departures from what was expected, he's only getting called up for this, if this is correct, by the end of 2019. Have you any reason to doubt the correctness of that? There's no other intervention with Mr. O'Brien prior to that, after MHPS had reported that you are aware of?

A. Not that I am aware of.

72 Q. Ms. Corrigan is setting out for Mr. O'Brien the deviations, and concern 1 and concern 3, triage and dictation respectively. She is asking for a meeting between herself, Mr. McNaboe and Mr. O'Brien. Mr. O'Brien e-mails back on 5th November asking for the nature of the deviation, although it's set out there. He indicates his willingness to attend, despite the stress of having to do so in the midst of a cancer review clinic, but indicating in his response whatever the issues they wished to discuss, there could have been no deviation from the Return to Work Plan, given that it had expired one year previously. He's bringing to Mrs. Corrigan's attention his view that, whatever may have been the expectations of him, it wasn't the

subject of an action plan. We have spoken about that. He says that he duly attended Mr. McNaboe's office at the allotted time on 8th November but found it locked. He didn't receive a follow-up invitation to meet with them in order to discuss issues which, from their perspective, appeared to have arisen. Just to finalise this section. He accepts that during the autumn of 2019 he may have been somewhat slower in administration than otherwise had been the case, due to personal circumstances. He points to his own personal difficulties within the family.

First of all, on that, I think you highlighted earlier, and we have seen working through this, that the administrative difficulties to which he alludes predated the autumn and were obvious to those looking at it from late the previous year, when Mrs. Corrigan had been absent during that year. You pointed, I think, to clinics in June that hadn't been dictated by the autumn. Leaving the accuracy of that to one side, Mr. McNaboe tells us, in his Section 21 response -- I will not open it. The reference, members of the Panel, is WIT-15750, at paragraph 55.4. He says:

"I did talk to Mr. O'Brien about this" -- this being the deviation -- "very informally in the hospital corridor and he assured me that he would catch up very soon. I never had to speak to him again about this

issue."

Plainly, Mr. Haynes, by the end of that year, as we have seen through these e-mails, that there has been, I hesitate to use the word "constant", but a regular flurry of activity around deviations, but the activity, it seems, doesn't appear to reach the point where Mr. O'Brien is being formally challenged to address the concerns that were there. Is that a fair synopsis?

A. I think from what you have run through there, a meeting was intended to happen that didn't happen, and Mr. McNaboe has outlined that he did raise that, but in a less formal way.

73 Q. I mean, this was a year where MHPS had reported. The actions around that were stymied by the grievance, a referral had been made to the GMC. They are matters dealing with the past shortcomings, but the shortcomings, as we have observed, were continuing and present, and yet the Trust's reaction to it seems to have been no more than a passing informal meeting in a hospital corridor and an assurance that, I will catch up. Do you think that was adequate or sufficient?

A. No. I thought at the time that the formal meeting was what was being arranged. I didn't fully appreciate, when I was advised that it had been raised with him, that it had been done in an informal manner.

74 Q. We haven't seen the minutes or a record of the meeting that had been set up. I hope it's safe to infer that the response of that meeting was to delegate

Mr. McNaboe to go and speak to Mr. O'Brien. It doesn't appear, from what you have said in your Section 21 response, that you don't recall taking any active involvement in that process? In other words, you didn't speak to Mr. McNaboe afterwards to ascertain what had resulted?

A. I was assured that it had been raised with him.

75 Q. In terms of the assurance, and I think it's fair to allow you the fact that you only received an assurance, but did you or anybody else inquire into the value of that assurance or how that assurance from Mr. O'Brien was tested? Because if you think about the context here, the Trust has had a period of years, thinking back to the early part of your evidence, of shortcomings in practice. That's validated through the MHPS process. Then, on the face of it, there has been some improvement around the private patient issue, around the issue of retention of patient notes, but two of the cardinal issues of concern, dictation and triage, are still predominantly causing difficulties for the Trust, and yet there doesn't appear to have been any firm grappling with it?

A. Yeah. I do know, I was aware that he had raised, as I say, that actually the action plan shouldn't even be in place still, so as I say, effectively I shouldn't be being monitored. Again, I'd say raising issues with the process rather than an issue or a recognition that, whether the process that was being used to monitor him was right or wrong, the expectations were reasonable

and he wasn't meeting them. Knowing how he had, as I have said, as we have covered earlier in terms of how he'd responded with the previous contacts through his family members, with individuals in the investigation, the approach to the MHPS investigation of raising a grievance and stymying that, this was potentially another, if you like, all thrown in to create problems with the process rather than addressing the problem.

76 Q. The Medical Director's office is the area, the core area of responsibility for professional practice, isn't it, and the information is flowing into that office. Just so we are clear, you did not attend any meeting with the Medical Director and colleagues that sat down to try to get some kind of control on what was happening here? That kind of meeting didn't occur?

A. The meeting we have referenced here was, I think it was at a 24-hour notice on a day when I was operating and, therefore, I wasn't able to phone into that.

77 Q. Sorry, I'm not pointing the finger at your non-attendance at that meeting. What I'm, rather, asking is, one might imagine that, on the background of MHPS, determinations arising out of MHPS not taken forward, followed up with continuing shortcomings, perhaps there ought to have been some form of meeting convention, bringing all these issues on to the table attempting to dissect it and saying, does he need help? Are patients at risk? Are there any other areas of his practice that we really should be looking at? That doesn't appear to have happened?

A. Yeah. That doesn't appear to have happened and, as I've reflected previously, that sort of wider step back of what do we know, what might we not know, what more do we need to do to gain assurance about the why the practice wasn't done?

78 Q. If we go to WIT-55825, please. This is the backlog report for October being circulated on 4th November. One can see, again, what appears to be significant dictation issues. You are telling Dr. Khan this is relevant for oversight for October. Dr. O'Kane is asking for a view from Dr. Khan and Mrs. Hynds, and she's asking Ronan Carroll to describe the system managed process in place to capture the relevant information agreed with Case Managers. Siobhán Hynds puts it quite bluntly:

"Mr. O'Brien is clearly deviating from the action plan that was put in place as a safeguard to avoid this and he is also an outlier in terms of his other Urology colleagues."

She asks: "Has there been any discussion with Mr. O'Brien about this?"

We know, from what Mr. O'Brien and Mr. McNaboe said, there was supposed to be a meeting. Mr. McNaboe claims there was an informal in the corridor. Dr. O'Kane asks Mr. Gibson to coordinate a meeting, which is to be minuted, and she is asking for a description of the

detail of the management plan around this, the expectation regarding compliance and the escalation. She says:

"It would be important before all of you meet with Mr. O'Brien that you have this process well-described and documented. Process mapping, this might be the most useful approach."

She touches on the triage issue:

"While I appreciate there's a divergence in views about the process we have in place to manage referrals, he is being asked to comply with this as it is until it is collectively agreed that the system should be changed."

Dr. O'Kane, at the end of a year in her post, doesn't, on the face of it, appear to understand the process for monitoring and the shortcomings of it, and the dynamics of it and the action points arising out of it. Her response, notwithstanding the evidence of deviation from it, is to sit down and have a process meeting before we can meet with Mr. O'Brien. Is that your understanding of what was happening here?

A. Yeah. My understanding is that we have a clear understanding ourselves of what we are monitoring and how we are monitoring it before we sit down with Mr. O'Brien to run through what we are monitoring and how we are monitoring it.

79 Q. We have the action plan, which I think is tolerably clear in what it expects. How did you respond to this? Was this a frustration that this was the route that was being taken rather than going to the problem itself?

A. I can't recall how I responded to that. I know we did meet that group.

80 Q. Yes. The meeting took place on 24th January. It's important to say, isn't it, given what we know now, that where you have a clinician who is viewed by the Trust as a potential risk to patients, or at least his practice or the shortcomings in his practice causes risks or may cause risks for patients, with every passing day, not to be too melodramatic, there are risks for patients not being addressed. Is it fair to look at matters in that way?

A. Yes.

81 Q. Because the SAIs that emerge from June 2020 and into the autumn, they all relate to patients in the main who are being treated at this time. They are in the system at this time. The shortcomings revealed through the SAI process could have been nipped in the bud, corrected, if the information coming into the Medical Director's office about shortcomings in other areas of practice had been weighed, appreciated and the subject of a more comprehensive examination. Is that, again, a fair analysis?

A. I think that's a fair analysis. I think it's also fair to say that, for other clinicians, if they had the same concerns raised informally directly with them, would

put their house in order.

82 Q. Yes.

A. That didn't happen either. If it was raised with me, if I wasn't dictating my clinic letters, I wasn't up to date with my results, I'd take action.

83 Q. Yes. Yes, you would --

A. I wouldn't expect a system to make sure that I take action; I'd expect I would take action.

84 Q. Yes. No doubt that's right. The system has to have an intelligence and a sensitivity to the person or persons they are dealing with, not to personalise it to Mr. O'Brien. If you have a clinician who, historically, hasn't given any trouble, any difficulty, then your assurance might be taken as read, but if the history is of a personality, and you have reflected it in your statement, who does things unconventionally, who doesn't listen to what you regarded as good advice around DARO, for example, around new policies coming in in respect of different types of procedure, it takes a different approach, doesn't it?

A. It has to, yeah.

85 Q. The meeting that took place on 24th January is at WIT-55822. This is Mr. Gibson reporting back to Dr. O'Kane in respect of that meeting. Just scroll down, please. Three issues are considered. Consideration is given to the backlog report. I think your views are indirectly reflected in that, about uncertainty around the reliability of that report. Ultimately it was felt, just reading from the bottom

three lines of the second paragraph, "that there may have been inaccuracies in the data provided by staff, data was never independently verified and there was no electronic method of collecting this data. It was never raised in the Patient Safety meetings in Urology and was not regularly discussed at the Urology Speciality meeting."

Although you had, no doubt, conscientiously raised this issue on at least two occasions, and you may say more, in 2017 and again in 2018, and it was part of conversations in that year, it wasn't an issue that was being addressed? I don't say it was your responsibility to address it, but it wasn't being addressed by, assumedly, the Medical Director's office or whoever else?

A. It hadn't been addressed. I think that paragraph there describes, it was the initial intent of the backlog report wasn't strictly as it was then being utilised as it was there to quantify workload across secretarial and audio typist teams to keep on top of any backlogs.

86 Q. But yet, it was being used as a baseline for assessing compliance with the monitoring plan. At the same time, though, your concern about it was that it was unreliable in the sense of potentially under-reporting incidents or under-reporting failed dictation, and other issues around that. The information that it did give up in respect of Mr. O'Brien's practice, and he's admitted some difficulties around dictation during that

year, but that was bad enough, wasn't it? The short falls in dictation, even without factoring in the under-reporting, was bad enough to justify intervention?

A. Even though there were shortfalls in terms of under-reporting, and there were shortfalls in terms of the reliability of the data, the backlog report had identified issues in relation to Mr. O'Brien's practice and compliance with the action plan.

87 Q. The next issue is headed "expectation regarding compliance". It said:

"None of those present at the meeting were aware of any written standards in relation to what was considered reasonable for dictation of results or letters after clinics. The Trust has never stated a standard, and those present were not aware of any standards set externally by Royal Colleges or other organisations. Therefore on the occasions when this data was considered there was no agreed standard to use as a gauge against reported performance."

Just so I am clear about this, this meeting is talking about the response of the Trust as an organisation, or put it another way, the failure of the response of the Trust as an organisation to Mr. O'Brien's shortcomings, and this is being put forward as an explanation for why the issue hasn't been grappled with?

A. I think it's being put forward as an issue that we need

to address in terms of, if we are going to monitor any individual's performance, we need to be clear what that standard you are monitoring against is.

88 Q. Sorry to cut across you. The standard was made abundantly clear in the action plan?

A. That's where my next sentence was coming to.

89 Q. We share the same view. I don't see any dissent from the sentiment expressed there. It's almost as if we can't challenge Mr. O'Brien because we are not sure of the standard we have set for him, whereas, in fact, that standard was -- let's open it up, TRU-00732.

A. I think it's a reflection of how we expected Mr. O'Brien to approach being challenged on not meeting the standard, and that would be challenging whether the standard existed. He'd already challenged whether he should be monitored against the action plan, and, therefore, if there was no other standard against which to be holding him to, that we anticipated that that would be an approach he would take to being challenged on it.

90 Q. Scroll down to concern 3, please. This is, as you recall, the action plan that was developed, I think in February 2017, on the eve of the MHPS investigation getting off the ground. It records the statistics on absence of dictation for a period of 18 months stretching into 2016. What it tells Mr. O'Brien he must work to is that all clinics must be dictated at the end of each clinic/theatre session using digital dictation. It explains this has been set up in his

office with his laptop, and training being provided or organised.

"This dictation must be done at the end of every clinic and a report via digital dictation will be provided on a weekly basis to the Assistant Director of Acute Services, Anaesthetics and Surgery to ensure all outcomes are dictated. An outcome plan/record of each clinic attendance must be recorded for each individual patient."

As I think you have agreed with me, the standard was clear. Are you saying that the, I suppose, perhaps a fear reflected in the meeting was if we challenge him in respect of this standard he will point to the absence of a Trust standard beyond this action plan?

A. Yeah. The absence of a standard beyond the action plan, and he's already challenged that the action plan shouldn't be the thing that he's held to.

91 Q. Does that betray a lack of appetite to confront?

A. I don't think it betrays a lack of appetite to confront. I think it betrays a recognition that when we confront, what we are going to be faced with is this, and it's just going to be sent back to us on, well there isn't a standard so what are you holding me to?

92 Q. Is the Trust, as the employer, not entitled to set the standard?

A. I would agree, yeah.

93 Q. Presumably this standard reflects the working norm of most consultants?

A. Yeah. Most consultants wouldn't need to be told a standard exists.

94 Q. Going back to the final point at the meeting of 24th January. WIT-55822 again. Just down to the third and final point "escalation". It says:

"As there was some cynicism in relation to this, the validity of the data combined with the lack of standard to assess compliance, there was no agreed process for escalating any concerns regarding non-compliance in relation to the monthly backlog report. It should be noted that those present agreed that the weaknesses identified in the current process described above may cause challenges when taking forward this issue with Mr. O'Brien."

Looking back at this, Mr. Haynes, is this of the quality of Alice in Wonderland stuff? A clear action plan had been set for an employee. He was deviating from the standards, and yet the Trust, as represented by the people at this meeting, are running scared of their own action plan. Meanwhile, the Trust must have realised that the shortcomings are putting patients at risk?

A. As I said, I think that paragraph outlines the concerns about the backlog report as well as there not being a recognised guidance in terms of how the data was

created. There wasn't an escalation process alongside that backlog report for Mr. O'Brien or any other individual. There was a recognition that the action plan existed, absolutely, but Mr. O'Brien challenged whether that action plan remained valid. Without clarity on that challenge of his, there wasn't anything, any additional standard to fall back on as a standard to monitor against. It was the action plan which did exist, was clear, but the individual being managed was also clear that, in his mind, that action plan had ceased to be valid.

95 Q. But if you think back to 2016 and 2017, there were no standards written down then. There was just a realisation, to take, for example, dictation, Mr. O'Brien wasn't doing the dictation. There was 600 examples of that over an 18-month period. We don't need to reach to some rule book to see if there's a written-down standard. It's clear that he is not doing it, let's exclude him from practice, and move into an MHPS process. We have that MHPS process. I don't say nothing changes, there's some improvements around some of the aspects, but the outcome of this, it appears, is that we can do nothing. That simply doesn't make sense, does it?

A. I think what it's saying is not that we can do nothing, but we need to be clear what our process and expectations are when we raise this with him.

96 Q. Yes. He retires six months later. Was there any intervention between January and July, or was there any

other work done around these issues in that space of six months to enable you to grapple with the shortcomings?

A. I can't recall, unfortunately, that period of time. All of our time got taken significantly with the impact of the coronavirus pandemic, and I have no doubt that shifted time and focus away, as we moved into March and had to shift services.

97 Q. The conclusions sets out a number of things to be taken forward. It says:

"If these are taken forward this would allow an opportunity to identify if there are any concerns starting to emerge so that appropriate supports to be offered to Mr. O'Brien to ensure concerns do not continue."

You are unable to help us in terms of what became of what appear to be concluding recommendations?

A. No.

98 Q. Mr. O'Brien, in the early months of that year 2020, was considering retirement and you became aware of that. I want to ask you some questions out of the following e-mail correspondence. If we go to TRU-258959. Perhaps the next page, I think.

On 15th April, Mrs. Corrigan is reporting to you and others, Mr. Young and Mr. Carroll, that Mr. O'Brien's application for pension benefits is all in hand and he

will be processed on as a leaver on the system from the 30th June. You will just need to let me know if it has been agreed for him to return to work following retirement and, if so, on what date as we will need to reinstate him to the payroll"?

Can you help us with this? As I understand it, notwithstanding a retirement and the receipt of pension benefits, there was an arrangement by which retired doctors might be able to return to the workplace as a locum or as an employee?

A. On occasion consultants may retire and then return on a part-time basis as an employee, to provide some service.

99 Q. Yes. That was clearly something that was being discussed. If we can just scroll up the page, please, thank you. Mr. Carroll directs a question to Martina Corrigan with you copied in:

"We are taking Aidan back? Yes?"

You respond at the top of the page there:

"Needs more discussion that can be had at present. In short, yes, but with strings attached and these strings need to be clear and accepted before he is offered anything."

What does that last line tell us about your thinking or

the discussions that perhaps were being engaged in behind this e-mail?

A. I'm not sure if much discussion was happening at that moment, as the first line says. Again, recognising the time, it was in April 2020, but what my second line says really reflects what you've said there about the January 2020 meeting, that if he was to come back, then there needed to be a very clear expectation of what and how he performed and how he was monitored, and that had to be agreed in advance before he was offered anything.

100 Q. Does the fact that it was even being contemplated that he could return, albeit with strings attached, suggest that it was your view, and perhaps the wider Trust's view, that things were not so bad about his practice and his performance that his return could not be contemplated?

A. I think, as in many specialties, it reflects that, with the loss of a Consultant and as it remains to date, no replacement having been appointed, that we would lose capacity to deliver for patient need and move us further away from patient demand with our capacity. The thought process was, can he be managed? Can his delivery of care be managed in a way that maintains safety, given what we know, but enables some service to still be delivered?

101 Q. You were open to him returning at that point, albeit you had to work out what strings could be attached to it?

A. I had a clear view that there needed to be strings,

that there needed to be a very clear way of managing his performance and what them expectations were, and he needed to agree them before any offer was forthcoming. I had personal reservations that, given what I knew from before, that them strings would never be agreed. I was also aware of the issue we have in terms of meeting patient demand, and so felt I had to explore whether there was a means of solving the shortfalls that we knew at the time, but still enabled some service to be delivered to patients.

102 Q. What kind of strings did you have in mind?

A. The strings I would have expected would have been along the lines of a robust monitoring plan, as we've discussed, that he agreed in advance as to how and what them expectations would be.

103 Q. There then followed a conversation on 8th June, less than two months after this e-mail. AOB-56497. This is a telephone conversation between you and Mr. O'Brien, with Mr. Ronan Carroll present. It's being recorded by Mr. O'Brien without your permission and consent?

A. Yeah.

104 Q. And transcribed for us on behalf of Mr. O'Brien's legal team. I needn't take you through it all but if we scroll down a little bit, please. Essentially you are telling him that, I have taken the issue of essentially his ability to return to work forward with a number of conversations within the Trust, with HR and at Medical Director level. Unfortunately, the practice of the Trust would be that they don't re-engage people while

there's an ongoing HR process.

In the interests of time, I don't need to take you to it all, but you go on to allude to the MHPS process having been rendered incomplete by the grievance to the Trust. You also refer to the GMC process. Those features of Mr. O'Brien's employment were known in April, less than eight weeks earlier, when you and presumably others were open to his return, albeit with strings attached. What had changed in the interim?

A. I think in my April e-mail I've have said "needs more discussion". I don't think that was sent after a discussion with a wider group. That was initial thoughts of myself. What changed between April and June was multiple conversations, as I have transcribed there from the telephone conversation. What I haven't alluded to there in the telephone call, and I guess that was more on a protecting my colleagues, but I'd also had conversations with my Consultant colleagues within the team as to whether, given what we knew about Mr. O'Brien's practice, re-engaging him would be appropriate, and we all had concerns about that. I'd had conversations with the Medical Director, albeit telephone conversations, around them same concerns, and ultimately came to a view myself that it would be wrong to re-engage him, given everything we had around Mr. O'Brien. Part of the conversations with our HR team would have been along the lines of, are we able to turn down this offer? Is that acceptable?

105 Q. Who ultimately is the decision maker in that context; is it the Trust management Medical Director level or is it you as Associate Medical Director?

A. I think ultimately my view would be taken as the guide for whoever made that decision, and ultimately that was a decision that I was happy was the right decision, was not to re-engage him, given what we knew.

106 Q. You, having reached that view on the basis of conversations with others, do you have to communicate that to others for approval? Presumably the HR function has some input on it because it's an application, presumably from Mr. O'Brien offering his services to the organisation?

A. Yeah. I've liaised with HR to check that it's okay for us to decline that.

107 Q. Yes. I think you were asked to write to Mr. O'Brien or put the decision in writing. If we could have up on the screen, please, TRU-163341. This has recently been received from the Trust. I can't put a context around it, but I can surmise that the day after your discussion with Mr. O'Brien, you go to Zoe Parks to seek advice on how to put the position in writing to him. And Zoe Parks, is she in the HR function?

A. Yes.

108 Q. What we haven't been able to ascertain is, is the process from April to the decision communicated to Mr. O'Brien in June. Presumably, there would have been e-mail communication between you and HR and you and Medical Director's office leading to the decision that

he can't be accepted back?

A. I think it's more likely that it was telephone conversations.

109 Q. You don't think any advice was given to you in writing?

A. Not that I can recall. As I have said, some of them I had conversations with my colleagues in the team as well.

110 Q. Who would you have been dealing with, just to be clear, having these discussions with?

A. I would have had conversations with Dr. O'Kane. I would have had conversations with Zoe, as in an e-mail there.

MR. WOLFE KC: Okay. I think I can bring that issue to an end

CHAIR: If we come back then for ten past two, please.

THE INQUIRY ADJOURNED FOR LUNCH

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIR: Good afternoon, everyone.

MR. WOLFE KC: Good afternoon, Mr. Haynes. Is it fair to say then that, in your discussions with Mr. O'Brien, explaining to him that the Trust had a practice of not re-engaging people who were the subject of ongoing HR processes, that was really a convenient phrase to explain your decision that he couldn't come back because he wasn't trusted to deliver clinical service in accordance with what was expected of him?

A. Yeah, I think that summarises. The ongoing processes were part of it, but what was behind the processes was his established behaviour and concerns, and we actually didn't feel we could mitigate them in order to re-engage him.

111 Q. The suggestion that the Trust had a practice, was a somewhat manufactured phrase to explain what was really a decision on your part? There was no such practice. The Trust didn't have a policy or practice?

A. I don't think the Trust had been in that position before and so, essentially, was having to have create a view unique to Mr. O'Brien, and that was, given everything that was going on around Mr. O'Brien, that it wouldn't be appropriate to re-engage him.

112 Q. Your conversation with Mr. O'Brien on 8th June came one day after you received an e-mail from him concerning ten patients who were to be added to a list for surgery in Daisy Hill Hospital as part of an initiative during

Covid to clear some of the backlog; isn't that right?

A. We were still in the early stages of the pandemic. There was no backlog-clearing at this time. The only elective surgery that was happening within the Trust was happening in Daisy Hill Hospital. In addition to that, there were, by that time, independent sector contracts across the region which were assigned to patients from Trusts, but each Trust, and within the Southern Trust I had established it, had a process of, whereby we had to work across specialties to assign a very limited available Theatre capacity to patients according to need. There was a variety of things that were guiding how that was done. There were documents that were regularly updated by the Federation of Surgical Speciality Associations regarding what type of procedures should be done, and within the Trust we had a process whereby I, essentially as the AMD for Surgery and Elective Care, acted, if you like, as the gatekeeper for access to the Trust's in-house, inpatient capacity. Each speciality had a nominated representative who would let me know the patients who required or met the criteria for needing surgery at that time, and then we would look to assign the available capacity amongst the specialties according to them patients as highlighted.

113 Q. Yes.

A. So his e-mail came in that context.

114 Q. Let's just open the e-mail to see where we are. TRU-252800. Pick it up so I can see the bottom e-mail

in full. Thank you. This is Mr. O'Brien writing to -- who are those women? Are they in the booking office?

A. I can't recall.

115 Q. He is saying he has:

"Added a list of ten patients to the existing list of patients for urgent admission submitted to Tony Glackin on Thursday, 4th June. Mark Haynes has already arranged to have the first of those patients" -- I don't need to mention her name -- "admitted to Kingsbridge and I have scanned and attached completed green forms for the remaining nine patients."

Just scroll down, the green forms are attached. A series of green forms for each of the ten patients.

What are the green forms and their significance, Mr. Haynes?

A. The green form is, if you like, is the administrative paperwork that would accompany the decision to add someone to a waiting list. If I have done an Outpatient consultation and I have agreed with the patient that they are to be added to a waiting list, that form would be filled in at that point, dated at that point, and then that form would go with the notes to my secretary, who would add the patient administratively to the waiting list with the detail provided on that waiting list form.

116 Q. Are you saying on the day I -- or you, more

particularly, puts a patient on the waiting list, say 1st November, the green form should be completed on that date?

A. That would be the practice that you would expect.

117 Q. What does the green form initiate? Any procedure or check?

A. The green form in itself provides that. If you like, it's the entry point to the waiting list. It's the information that's used to add patients to the waiting list. In any patient interaction there's a number of things that would need to be done at the end of that. We have talked about dictation of correspondence to GPs. If you add someone to a waiting list, then the waiting list form would need to be completed. If someone needs a CT scan requesting, the CT request needs to be done. Then there's the outcome of the clinic, so you would have an outcome sheet which records what the follow-up or plan for the patients that you have seen. Similarly for an inpatient. An emergency admission who needs adding to a waiting list, then that green form is the means by which it's raised to the secretary and added on to the waiting list. It also contains some information around the management of patients who are on blood-thinning medication pre-operatively.

118 Q. Presumably that's significant as part of a pre-theatre assessment?

A. Yes, it feeds into how any blood thinning medication will be managed as part of a pre-op assessment.

119 Q. I think we can see that from each of these forms, we can see that they are all dated. That's signed and dated, Mr. O'Brien, 7th June, that's one patient. We are familiar with the next patient, who is Patient 1. We can see, again, 7th June. I think it's probably accepted that they are all 7th June. You tell us in your witness statement -- I don't need to turn up the statement, it's WIT-53938, paragraph 62.11. You tell us, Mr. Haynes, that you were concerned about two patients who were contained on the list. Can we scroll back up, please, to the list itself? The patients that you are interested in telling us about are, in the middle of that list, Patient 105 and Patient 104. You can see on the cipher list beside you which is 104 and 105. What was your concern when you looked at this list?

A. What was unusual was that, as I said, at this time I would receive e-mails from the nominated representatives in general for each speciality of patients who needed access to Theatres. What was unusual here was, I, rather than the details just contained within there or on a single Excel file of the patients who needed surgery and the details of how much time they needed, was I'd received the green forms. When I looked at them green forms there are two dates on the green forms. There's the date at the bottom which is the day that it's been completed, but in the top right-hand corner is the date that the patient is to be added to the waiting list, and that would

correspond to the date of the interaction when they should have been added to the waiting list. Again, in the context of concerns regarding Mr. O'Brien and the administrative workload associated with consultations with patients, that flagged a little bit of an alarm with me, actually here have we got patients who aren't being added to the waiting list when they have had their consultations?

At the time I had access to a copy of the download of the waiting list as of a date in May, as I think I have referenced within the e-mail. Within the e-mail I have suggested that I have attached it but I don't appear to have actually attached it, so I have missed it off the attachments. What I've done is, I have looked at these patients where I have got a date when they should have been added to a waiting list, and I have looked at that waiting list download for May and identified that them two patients aren't on that file that I have got. So, it raised a concern to me that could we have some patients who should be on a waiting list that we don't know about, although Mr. O'Brien knows about? Could there be a group of patients that are in danger of being lost?

120 Q. Yes. I think the e-mail in which you refer to the waiting list that you were scrutinising, I think that's referenced in your e-mail to Dr. O'Kane. If I could pull up TRU-252799. You say:

"Attached to the green forms, as mentioned and highlighted, are cases in particular that should have been added to the waiting list at the date indicated. Also attached in addition to the waiting list forms is a full Urology waiting list as of 11th May 2020. As far as I can tell, the patients highlighted should have been added to the waiting list on the dates shown but they are not on the waiting list and I believe had been added to the waiting list more recently on the back of the e-mail below."

Dealing with Patient 104, does the date highlighted, Mr. Haynes, indicate the day that that patient had been seen in clinic by Mr. O'Brien and should have been added to the waiting list?

A. The date highlighted corresponds to the date on the top right-hand corner of the green form for that patient.

121 Q. Okay.

A. Which corresponds to a consultation or patient episode.

122 Q. Yes. Above that is Patient 105, and his engagement with Mr. O'Brien was in September of the previous year. You've indicated that you were working off a waiting list for 11th May, but you haven't attached it here. Have you been able to locate that waiting list?

A. I haven't been able to locate that. The waiting list itself exists on the patient administration system. The Excel file that I would see is a report obtained off there. It would have been obtained at the time. I haven't been able to locate one for that date, for

11th May.

123 Q. The Trust has been able to recently supply us with two waiting lists, one for 6th May, which is the week before the one you were scrutinising, and one for 22nd May. Just put them up -- maybe we won't put them up on the screen, I don't think it's necessary. It's full of patient names, just to avoid that. What I can say to you is that both of those documents, one dated, as I say, 6th May and the other dated 22nd May, so they straddle the waiting list that you say you were looking at. We can locate on that waiting list the name of Patient 105, but we can't locate on it the name of Patient 104. These waiting lists -- and maybe you could help us with the whole concept of waiting lists. These waiting lists are described as Urology PTL inpatients and day cases without filter. Can you help us with that and compare it with what you think you were looking at?

A. I had a look at them two waiting lists and when they were forwarded to me as we'd found them, I think it's 6th May one, in the format that it was downloaded, there was a filter applied to one of the fields, so when searched for these two patients with that filter applied, neither patient came up. When I unchecked that filter, one patient came up. So, really looking at that, and I am trying to work out why the 11th May one I've clearly looked at a document and not identified two, but we have got two documents that straddle that date and one of these two patients is on

that document and the other isn't. It's possible that that 11th May document also had that same filter applied and I hadn't recognised it and taken it off, and so didn't identify the patient when I searched for them. That's why it's comments on the filter, filter off.

124 Q. Yes. You will have considered Mr. O'Brien's response to your analysis. What he says, and I don't need to bring it up on the screen, but the reference for your note is WIT-82405, paragraphs 18 and 19. He said that the claims that the two patients weren't on the waiting list is misplaced and untrue, and he says any competent and impartial consideration of the medical records and correspondence held by the Trust would have indicated that these patients were on the inpatient waiting lists on PAS in the ordinary way.

Do you now accept that or do you have reservations about it?

A. I accept that there's correspondence, as Mr. O'Brien, has provided, that shows that things had been done. What I would say is, I've -- what I have done at that time, and the reason I had a concern, was that the green form had a date in the top right-hand corner of when someone should be added to the waiting list and a date at the bottom dated 7th June, where that green form should have been filled in at the time. In the context of the concerns about Mr. O'Brien, me having a concern that there is an aspect of work that hasn't

been considered previously and needing further assessment, was appropriate, and looking into it further was appropriate. It is possible that they were on a waiting list on PAS, and the document I had to look at of 11th May did not contain the full waiting list. That wasn't, if you like, a wilful oversight on my part. I was looking at what I felt was and what I believed to be the waiting list. My concern was founded on the green forms and, if you like, backed up by that review. The subsequent piece of work did identify additional concerns, as we know, with regards the outcome or administrative workload regarding patients under the care of Mr. O'Brien. Then subsequently them concerns, if you like, were added to or were overtaken by concerns regarding additional patients towards the end of June 2020, early July 2020.

125 Q. Yes. I just want to bottom out the waiting list issue so that we all understand it from your perspective, in case it needs to be dealt with again. You accept the possibility, and perhaps the probability, until we get our hands on 11th May waiting list, if we can get that, that you were possibly looking at a filtered waiting list, and, therefore, didn't see the two patients on that filtered waiting list?

A. On the files you have got, the 6th May and is it 22nd May?

126 Q. Yes.

A. One of them patients is on them two files.

127 Q. Yes.

A. In the format that that 6th May file was e-mailed when we found it, there was a filter applied which had taken one -- a patient who was on that wasn't visible and didn't appear in a search.

128 Q. Yes.

A. That's a possibility that that was also the case on the 11th May. It doesn't explain why the second patient wasn't on either of them documents.

129 Q. Yes.

CHAIR: I am not very clear on this and I am sure it's my fault and not yours. What is the purpose of the filter?

A. The waiting list is vast and within the waiting list there are a variety of different categories for admission and things. Why a filter was applied, I don't know, but in the format that -- generally, if we want to search a waiting list manually, hundreds of patients to go down, so you don't search it by manually going through, you will generally go to one of the fields, bring up the filter, and either do a word search or exclude things you don't want to look at. In the Excel file, say you want to filter out on the procedure type or procedure code, you can filter it by that so you bring up that filter, you can select all or you can un-select ones you don't want to select.

130 Q. MR. WOLFE KC: If you wanted to only look at patients for stent replacement, for example, maybe that's a poor example. Give us an example?

A. Say, for example, you wanted to look at numbers of men

awaiting bladder outflow surgery you could go to the M code, and I think it's M65 point something.

Mr. Hanbury might -- You can filter for the M65, select only the M65 code and that will bring up every patient awaiting bladder outflow surgery, so it will bring that waiting list down to just that. Similarly, you could look for the patients that are on the urgent waiting list by changing the filter to just urgent or just routine.

CHAIR: Again, just so that I am clear, though, who applies the filter? The person who is searching the document, presumably?

A. I don't generate that list. That list is provided to me and that may have been on part of a shared drive that I had access to. At some point, someone's done a search or a query of, I think it's a boxy query it's called, but essentially told the database which patients they wanted to be downloaded from the waiting list into an Excel file, and that's generated an Excel file. If you then do some work and you apply a filter and don't remember to turn it off and save it somewhere, then that would be applied. There's a large number of columns across the top and if you don't spot that there's a filter on, then you may miss it. It can be obvious if it's excluded large numbers because your numbered column on your left might go to 227, 306, in terms of the numbers with big gaps in between, but if it's a smaller number excluded it might not be obvious to you.

CHAIR: Okay, thank you.

MR. WOLFE KC: I hope people understand why I am not bringing this up, it's just full of names. I will certainly bring it up if anybody wants it up on the screen. The references, I don't think I gave them earlier, for the pages that I'm looking at, and you will be conscious that the waiting list, as Mr. Haynes has described, is quite a thick document, but the waiting list for 6th May 2020, it's the Urology PTL inpatients and day cases waiting lists, without filter is TRU-163379. Thereon, about two-thirds of the way down the page, you will see the name of Patient 105, and the same descriptor of the waiting list but for the later date of 22nd May 2020 is at TRU-163385. Again, it's the same patient who features, Patient 105, but Patient 104 is not to be found on that waiting list. The missing piece in the jigsaw is the waiting list you actually scrutinised on the day, which you believe was dated 11th May or generated 11th May. I suppose, if you weren't conscious that it was filtered, or may have been filtered, you can't help us with what the filter was?

A. No.

131 Q. Against what you have observed, let me take you to the records that Mr. O'Brien has supplied. I suppose there doesn't appear to be an argument from you, Mr. Haynes, that you now accept that Patient 105, if he's on the waiting list that straddles the date you are looking at, he must have been on the waiting list for 11th May?

A. Assuming the parameters for the waiting list file download were the same as those on 6th May and 21st May, because it's a download from the waiting list and the parameters are set by the person who pulls that off, it does the search of the database to make that Excel file. Assuming that the parameters were the same then --

132 Q. You mean the search parameters?

A. Yes. The Excel file is not the waiting list.

133 Q. No?

A. The waiting list exists on a different system. To interrogate that system and create an Excel file, then search parameters are put in to draw, to pull down a download.

134 Q. My interest is in the waiting list, not the Excel file.

A. I looked at an Excel file.

135 Q. Yes. What the issue is between you, who raised it, and Mr. O'Brien, who challenges it, you make the case in your correspondence to Dr. O'Kane, and subsequently to Mr. O'Brien, was, so far as I can see, both these patients are not on the waiting list, not on the Excel -- you don't refer to Excel file, you call it the waiting list. You presumably now accept that one of those patients, if he was on it in week 1 and on it in week 3, he must have been on it in week 2, in terms of the waiting list --

A. Yeah.

136 Q. -- when you were scrutinising the issue?

A. Yes, but I don't know whether he was on the file

I scrutinised.

137 Q. No, and I accept that point. But you make the broader point about the waiting list?

A. Yeah.

138 Q. The second of the patients, Patient 104, if we bring up AOB-37036. I think we can see the waiting list entry. Yes. This document received from Mr. O'Brien's representatives, it's referred to as the CURWL. That's a form of waiting list or a waiting list used by Mr. O'Brien?

A. That's a waiting list code on PAS.

139 Q. On PAS?

A. Yes.

140 Q. The name of the patient has been blanked out. It's Patient 104, who was seen by Mr. O'Brien in February, and he insists that this document establishes that that patient was also on the waiting list, or is also on the waiting list, but that name doesn't appear on either of the waiting lists that I've shown you this afternoon. Can you help us with this document and compare it to the waiting list documents that I've shown, although I haven't put them up on the screen but you are familiar with them. Is there different waiting list sets or how do we explain the different formats?

A. As I say, the waiting list itself exists on the patient administration system. The files I've looked at are downloads off that into Excel. I don't know what document format that is, that may be a print-off of the patient administration system, it may be off an Excel

file. The document I've referred to was an Excel file, which is a drawdown off the waiting list on the patient administration system.

141 Q. I have already made the point earlier, I don't wish to put this document up on the screen, but that is something you are familiar with, if you can see it across the room. Is that the Excel or is that the waiting list?

A. That's the 6th or the 22nd?

142 Q. That is the 6th and the 22nd?

A. That's the Excel file.

143 Q. That's the Excel file. What's your position on this issue ultimately, Mr. Haynes? You appear to accept that at least one of the patients was on the waiting list, albeit you didn't see him on the Excel file?

A. I think my position on this is: the e-mail triggered concerns with me because I had green forms, which were not typical with the communication for me, for the urgent bookable list that was being done at the time. On them green forms, them forms that should be filled in at the time of the patient interaction the date at the bottom was 7th June and the date at the top was different. I have conducted a review of a file that I had at that time, which I believed to be the waiting list and couldn't identify two patients who I felt should have been on that file. It's possible that that file was not complete and did not contain the whole waiting list, but I did not know that at that time. But I would say, given that the concerns that we had

regarding Mr. O'Brien, my approach to be concerned by having these waiting list forms with different date at the right-hand corner to the bottom, and not identifying them patients on the file that I had and believed to have, and compile the waiting list and managing that by escalating that I had a concern that there was administrative work relating to patient consultations not taking place and looking into it further, was appropriate. Whether that initial concern was right in that the file that I reviewed, did it not include everyone that it should have? I think I was right, given the history of Mr. O'Brien, to have a concern and to look further into it.

144 Q. It's fair to say that although you emphasise this afternoon the concern around the green forms, the prominent concern, as you wrote correspondence both to Dr. O'Kane and Mr. O'Brien at that time, was your claim that these patients aren't to be found on the waiting lists. I suppose maybe just comment on that, please, first?

A. Because the green form is the mechanism by which the patients are added to the waiting list, so my belief was that this form hadn't been filled in at the time and, therefore, these patients hadn't been added to the waiting list and that belief was, if you like, backed by I hadn't been able to identify them on that file that I had on 11th May.

145 Q. Yes. But you accept that it's entirely possible for patients to be on the waiting list, and it's a separate

issue whether the green form has been completed?

A. Yes, because the waiting list is a -- the green form is not the waiting list itself. The information on the green form is added to the waiting list on the patient administration system.

146 Q. Should I take your evidence to suggest that if it was only the green form that was causing a concern, because they are all dated on the same day, you would have actioned that for further investigation?

A. What I have done with them green forms and within the table that I've highlighted in that e-mail, is I have looked at all ten to check if they are on that Excel file from 11th May, and I have only flagged a concern with the two that weren't on that Excel file. It was the green form and the discrepant dates from the top to the bottom that raised a concern, and then that concern was further reinforced by me not identifying them patients on that Excel file, and I translated that into them not being on the waiting list.

147 Q. Given, I suppose, the fundamentality of this issue as a starting point for what was to unravel; further investigations internally, leading to certain conclusions and then the Early Alert, and ultimately public inquiry. Given that this is, in a sense, a starting point, should you have been more careful in respect of your interrogation of the waiting list before making the assertions that you did?

A. I would contend that this was part of a continued finding of, as we have been through already in terms of

concerns about not acting on results, not dictating from clinics, this was me flagging another concern along the same vein. I would contend that, for me, the nature of concerns changed in late June 2020 / early July 2020, when I saw Patient 1 in Daisy Hill and raised concerns there. The nature of the concerns changed, and I'd contend that it's them concerns that actually triggered really where the major change of, if you like, the nature of the concerns regarding Mr. O'Brien. This was a continuation of concerns that he wasn't on top of his administrative work.

148 Q. As I say, you raised this issue with Dr. O'Kane on 11th June by e-mail. As I have indicated, the issue which was at the heart of this came to your attention on 7th June when the e-mail came in. You spoke to Mr. O'Brien the next day, 8th June, to tell him what was bad news for him, that he couldn't come back to the Trust following retirement. You didn't speak to him during that meeting about the concern that had arisen the day before, about the waiting list issue, these two patients. Why not?

A. I'd raised my concern, as you say, on 11th June. Going back to the urgent bookable list process, at the end of each week there was a deadline for all specialties to let me know the patients that were to be looked at for that, so I tended not to interrogate the e-mails I got until I had everything in and then could look at what Theatre lists we had available and what the demand was across all specialties. I didn't interrogate that

e-mail until 11th June, and when I interrogated that e-mail I had concerns. At that time I would have looked at the needs for the breast surgical team, the colorectal team, the gynaecology team, the ENT team and the Urology team, and then put them together in terms of the time need and what we had available and the urgency, and looked to meet as many patients as we could, demand, and looked to see where patients could be managed, including what was available to us in the independent sector.

149 Q. When you wrote to Mrs. O'Kane on 11th June, that was to trigger a process which, administratively, was led by Mrs. Corrigan. She carried out some initial work at looking back at certain cases, and we will look at that in a moment. Did you know at this time, that is around 11th June, that Mr. O'Brien was not prepared to take the decision to refuse his return to work. He wasn't prepared to take that lying down. He was going to fight that?

A. I don't recall being aware of that. The decision to look into things further was really, as in the concern in my e-mail, if there are patients who haven't been added to the waiting list, and specifically with the group of patients that both were, which was patients who had had ureteric stents inserted as first step in their management of stones, then we needed to identify if there were any others because they needed to have their needs addressed, so that was the reason for that work. Initially one of the groups Martina Corrigan

looked at was emergency admissions who had had procedures and stent inserted, so we wanted to make sure that there were no patients sat with a stent in but actually not on a waiting list and not having their needs addressed.

150 Q. Were you ever advised that by 23rd June Mr. O'Brien's legal representatives were threatening injunctive proceedings to challenge the Trust's treatment of him?

A. I would have been made aware that there was contact from Mr. O'Brien's legal representatives, but I don't know when I would have been aware of that.

151 Q. Yes. We have had the previous year, 2019, and I think we reached a point this morning where you agreed with me that there had been, to put it bluntly or maybe generally, little activity to challenge Mr. O'Brien or to investigate whether there were any other concerns. Help me with this. Is it merely a coincidence in time that this deep dive into his practice, which Mrs. Corrigan led on and you assisted with, occurred at or about the time when he was threatening to go to court to challenge the treatment of him by the Trust?

A. Yeah, it's a coincidence in time. My concern was that there was patients -- that the risk of there being patients who needed surgical procedures, who were not on the waiting list, and patients who have stents in with stone disease are at significant risk of coming to harm if they get lost. My concern was that, and would have been triggered had I come across it at any other point. This concern, while we had concerns previously,

as we've highlighted of the letters not happening, of the scan results not being actioned, this was something that hadn't been identified on the previous look intos and so this was a new concern with a very clear and, if you like, immediate patient risk of patients who have got stents in who possibly were not on a waiting list.

152 Q. There were all sorts of triggers the previous year of a different kind. You say this is a concern of a different order. Ultimately, they all fall into Patient Safety issues; dictation, triage, not actioning results. Are you really saying that the threatened legal action was wholly unrelated to the investigation that you pursued in respect of his practice, or was there at least a suggestion that it would suit the Trust's purposes, the Trust's defence of any legal proceedings if we were to have in place some further evidence to show that he wasn't a safe practitioner?

A. That wasn't suggested to me. I think what instigated in June of 2020 was, to my mind, and as I have reflected in my statement, what we should have done at a much earlier point. We should have had a wider look into his practice.

153 Q. I don't wish to ask you about the content of any conversation, but did you ever meet the Trust's legal advisers at this time?

A. We did meet the Trust's legal advisers. I can't remember when. I can't remember whether it was at this time or at a later date.

154 Q. The work that was instigated arising out of all of

this, it was taken forward by Martina Corrigan initially. If we look briefly at that. TRU-160971. Just step through this relatively quickly. Thank you. She takes on a piece of work which looks at elective admissions in the first instance, and she identifies that in the period between 1st January '19 and May '20 there were 147 emergency cases in the care of Mr. O'Brien. Is that the way to interpret that?

A. She has looked at emergencies there, not elective.

155 Q. Yes. There were no concerns flagged with 101 patients, but there were some concerns flagged, and she sets out further particulars of those.

Mr. Carroll then, scrolling up the page, please, to page 70 in the sequence, Mr. Carroll asked her to, in order to have a complete picture, it would be his view that the elective patients also need looked at. Then going down to 993 -- it's just as easy to scroll down to page 993 in the sequence -- the full reference is TRU-160993. She attaches a spreadsheet for elective patients now and she provides a summary, some observations and she says:

"I have filtered 18 patients and sent them to Mark for a clinical opinion as I have a few concerns with respect to these."

You then look at those patients, isn't that right?

A. Mm-hmm, yes.

156 Q. Then if we go to TRU-258962, a couple of pages back.

Can you talk us through that, from memory?

A. So, what I have done there is them patients that Martina Corrigan has highlighted, I have had a look at them and I've summarised an opinion in terms of my view of what I have identified within them, and then further down, I think, I have for each patient, I have added a commentary for each patient. Within there, I think -- within my opinions, number 1 really summarises what we've covered before, which is a planned Outpatient review being the fail-safe for patient results being resulted and actioned rather than the result being reviewed and actioned before an appointment. Again, following on from that, the same sort of statement. "No process for review of results and communicating findings to patients and GP." A concern that the DARO process is not adopted. No discharge summaries dictated. A number of concerns that we'd have had through previously. Some concern that the outcome of a consultation has not been actioned, which I think is along the same lines as the concern I had when I saw the green forms; that outcomes of a consultation haven't been actioned.

157 Q. Then concern arising out of MDM reviews?

A. Yeah.

158 Q. This, of course, could have been any practitioner. It just happened to be Mr. O'Brien. What all of this points up is a governance framework which isn't capturing any of these issues. This was hidden to you up to this point and hidden to other managers in the

system?

A. This was a wider look into Mr. O'Brien's practice that, as I have reflected, we should have done at an earlier point, at the onset of the MHPS investigation.

159 Q. I suppose the point I'm making to you is that a more sensitive or a more responsive governance framework, had it been in place, it should have been picking up on things like this?

A. You would have hoped so.

160 Q. Subsequently then, on 11th July, you write to Mr. O'Brien. If we bring that up, please. 02534. You remember this letter, Mr. Haynes. Essentially, it summarises the concerns identified by the Trust, through you and Mrs. Corrigan, indicates that an MHPS process would be initiated, and asks for his initial observations while imposing restrictions in that he should no longer undertake clinical work and he should not access or process patient information. Did you ever receive a response to the issues? We can scroll down and see how the issues are set out. At the bottom of the page there, you enclose a summary of the concerns. The concerns identified will be managed in line with MHPS. You are at the initial Inquiry stage and you invite him to make any initial representations as I have said: "And once we have concluded our initial inquiries a determination will be made about next steps in the process."

Scrolling down, please. You categorise, just down at

the bottom -- sorry, that's the restrictions you were imposing. You ask him to notify the Trust if he's in possession of any files. In fact, he is in possession of two files at home, and they are subsequently collected. These are the concerns. Concern 1, patients identified with unnecessary delays regarding referrals for treatment. Then you set out what you found on a lookback of emergency and elective. You summarise that there. Then you have, by this stage, identified a number of potential SAIs which were ultimately to find their way into Dr. Hughes' and Mr. Gilbert's zone as part of their review.

The next step in the chronology was the Early Alert to the Department on the 31st of that month, 31st July. Did you have any part in composing that?

A. In terms of the chronology, between that review by Martina Corrigan, there is my escalation of concern regarding Patient 1 and I think it was -- I can't remember who the next patient down within there was. The IR1 certainly was completed on Patient 1 there at around that time. As I have said, we have Martina Corrigan's review findings, which again had concerns. Then I also had significant concerns about the patients who had found their way into that, who then found their way into that SAI process with Dr. Hughes and Mr. Gilbert. To me, they, if you like, raised the bar of the concerns, because things moved away now from just, if you like, it's not just, but from being not

doing what was required at the time of the consultation to practice of managing patients not being in line with MDT and resulting in patient harm, as far as I could see. My understanding is the escalation as an Early Alert was on the back of them two concerns. In terms of the wording of the Early Alert, I don't recall wording the Early Alert. I may have been in meetings discussing it. I may have been circulated at some point, but I don't recall feeding into the wording.

161 Q. Just to recap. We started with your evidence with your key reflection, as I called it. I think you've agreed with me that there was a missed opportunity here to conduct a comprehensive review of practice, and that opportunity existed in 2017 or, at latest, after the MHPS review reported. If that had been done, you said it is likely that the clinical practice which was identified in 2020 and which led to the lookback exercise, would have been identified earlier. I assume you stand by that reflection. It's quite clear, isn't it, that the review which Mrs. Corrigan dealt with administratively, and which you substantively contributed to with analysis across 18 patients, that was presumably not a straightforward exercise, but was done relatively quickly, without expenditure of great resources, and didn't require any particular legal consent or permission to get it done; this could have been done at any time?

A. That's, as I have reflected, the concern that I had then that triggered that, we should have done the same

at a much earlier stage.

162 Q. You, in your statement, have offered some, I suppose, further reflections about why this opportunity was missed. If I could take you briefly to your statement again at 74.1, WIT-53953. And you cite, I suppose, three primary factors:

"Having had the opportunity to reflect, do you have any explanation as to what went wrong with the Urology Services and why?"

You say the three factors are: "Insufficient capacity to meet demand; failure of the Trust processes to link concerns over time and address concerns when first identified; and the behaviour of Mr. O'Brien."

The first of those issues, you say that the demand capacity mismatch had the effect that colleagues were perhaps less attuned to all that was going on and were more likely to miss or fail to observe what might, in calmer times, have been more obvious. How do you explain that, or can you give us an example to illustrate what you mean?

A. It's on multiple levels. If we look at our complaints process as a potential source of identifying concerns, if, because we can't meet the demand for a service you will get lots and lots of complaints about primarily waiting time, then within them complaints there may be patients whose waiting time is contributed to by some

of the failings that we have identified with regards Mr. O'Brien's practice, but they have been masked that patients are all waiting five years for an Outpatient's appointment, a routine Outpatient's appointment, and five years on a waiting list for surgery, and so you might not recognise that there's an issue aside from the long waiting lists.

From the individuals working within the system, what they are constantly doing is having to prioritise and re-prioritise and re-prioritise need of patients they are seeing who are all waiting too long for treatment. Again, within that busy system, you wouldn't necessarily get the opportunity to, if you like, critically appraise another individual's management of patients because you are all busy just trying to keep on top of that that's coming, if you like, directly to your desk. I have highlighted and we have discussed how my working practice, my working week is, and that's just keeping on top of what's my practice. Spending time within that to actually have an eye on someone else's practice, you just don't get that opportunity as much.

163 Q. Can I maybe just debate that with you? I entirely take the point that all of the Clinicians in Urology are running to stand still and, respectfully, doing your best every day to keep patients well. When you have that strain in the system and strain on practitioners, you, more than ever, perhaps, need strong management,

supported by strong governance systems and sensitive governance systems, to pick up on the errors or the shortcomings in practice. I think as you reflected the last day, and maybe hinted at a moment or two ago, you weren't particularly well equipped, given your clinical responsibilities, to act as effectively as you would have liked as Associate Medical Director, given the job description you have, and it seems that although you and others are feeding information into the Medical Director's office, for whatever reason there wasn't a responsiveness there, perhaps. Obviously, it's a matter for the Inquiry to assess that, but based on what we looked at this morning, we saw that not until the end of 2019 was a casual challenge presented to Mr. O'Brien through Mr. McNaboe meeting him in a corridor. Isn't that the point? You may well be working in difficult circumstances, but you need to be supported by management and good governance?

A. Yeah. Okay, yes. The point I'm making is in terms of us, as individuals within the team, having, if you like, a critical oversight of each other's practice. When you are that busy you don't get that opportunity for critical oversight of each other.

164 Q. We heard yesterday, and we saw yesterday, if I could just bring up a document, WIT-84353. This is a record of your discussion with Dr. Hughes as part of his SAI Review. By that stage, of course, you were Associate Medical Director. This is a meeting taking place at the start of 2021. You identify yourself as the person

who raised the concerns. You say, about halfway down the page there:

"Mr. Haynes advised that there were a number of concerns about how Mr. O'Brien practised", but you were not "acutely aware about his lack of conformities to standard treatments."

Just at the very bottom of the page, you say:

"The MDT did disagree with Mr. O'Brien's decision-making regarding ADT. He recalled a disagreement with Mr. O'Brien in relation to his use of ADT for a patient and he said that Mr. O'Brien became entrenched in his decision-making and he never accepted their challenges."

Breaking that down -- and we see various other pieces of evidence given to Dr. Hughes -- there was a knowledge or an awareness within the MDT that Mr. O'Brien treated with Bicalutamide 50 milligrams instead of LHRH on occasions. We see that through a number of patients who were the subject of SAI. I think I'm right in saying that you observed that through the Bicalutamide audit that you conducted on behalf of the Trust. With that long preface, although you were working in these difficult circumstances, colleagues such as yourself, and you had a managerial hat to wear as well, were aware of shortcomings in his

prescribing practice, but, according to Mr. Glackin, while it was raised at the MDT, it was neither minuted nor escalated. Do you agree with that? There was a challenge to him. You say he didn't listen, he became entrenched, but it wasn't taken anywhere else?

A. My recollection of the event I was referring to there, was not so much about the type of ADT or the dose of ADT, it was more about the initiation of androgen deprivation therapy in a patient who was not suitable for curative treatment due to comorbidities or age, and the discussion was regarding watchful waiting or deferred androgen deprivation therapy rather than starting androgen deprivation therapy immediately. That was the discussion, rather than a, what type of androgen deprivation therapy started here.

In terms of the awareness, as I know now, the NICaN Urology Group had generated guidelines for androgen deprivation therapy while Mr. O'Brien was Chair of that group and, if you like, the reason or the trigger for that was concerns within the MDT structures regarding Mr. O'Brien's use of Bicalutamide, and specifically at a low dose. I think with regards the Bicalutamide piece, the prescription of Bicalutamide 50 milligrams for me became not so much the problem but the hallmark of the patients who hadn't been offered treatment that they should have been offered for their prostate cancer. For example, Patient 1, who my recollection is the MDT outcome was to commence hormones and be

referred for radiotherapy, he wasn't referred for radiotherapy but I could identify him because he had been started on Bicalutamide. That was, if you like, the hallmark of the patients who hadn't been managed according to the MDT guidance.

165 Q. Yes. What I'm suggesting to you is that the Bicalutamide as, if you like, the hallmark, if that had been poked at a little better, a little further, it would have revealed as, for example in Patient 1's case and there are perhaps several others, in fact others emerged from the SCRR process, going back many years, a decade, in fact --

A. Yes.

166 Q. -- and that would have revealed -- and the logic of this, no doubt Mr. O'Brien will explain, there were cases where patients seemed to be solely treated on 50 milligrams and no referral to radiotherapy for curative treatment. Again, going back to the point where we started on this, the demand capacity mismatch places everybody under stress, generating complaints about waiting lists, and you become desensitised, no doubt, to other things that would ordinarily spell difficulty or trouble for you, and you would maybe react. But you weren't wholly without information here, not just you but your colleagues, to better react to shortcomings in practice?

A. I think that, as you say, can be extended over many years, and the Bicalutamide issue was recognised by others across many years, but not escalated in the way

that it could have or should have been.

167 Q. I think that's the second point that you use to explain, I suppose, the contribution or contributory factors to this lack of reaction. You say at 74.3 of your statement that there was a failure of the system to meet old concerns with new ones, and an absence of handover, as you pointed out before, didn't assist. Is there anything more you want to add to that?

A. Sorry, I am just coming back to the busyness. As I say, there may have been as Urologists, an awareness. As I outlined, I recall a disagreement over a whether a patient should be started on hormones when really I felt they should be managed by watchful waiting, but we wouldn't have had an oversight of a large number of patients being managed as Outpatients primarily, who are never coming into the Inpatient environment for their prostate cancer. They would have come to clinic. They would have been started on whatever treatment they were started on. They would continue on follow-up as Outpatients for many, many years, without any Inpatient attendance and ever coming under the eyes of the rest of the team. There may have been, at various stages, the occasional patient who did come in as an Inpatient, but in a busy working environment where you are seeing the occasional patient, you may not link one thing to another. I've again reflected in my statement about another patient, Patient 4, where, when I reviewed his care later in 2020, I recognised that when he'd been in during an Inpatient stay in late 2019, what I'd thought

initially was simply an oversight and changed his hormone treatment, was not an oversight, it was actually a pattern of practice. It was only on having a much broader oversight of Mr. O'Brien's practice that I recognised that, whereas at the time that I saw that patient, he was one patient, an isolated event that I haven't perhaps linked across time, and it might be another year before I came across another such patient.

168 Q. Just continuing with this debate a little longer. Patient 1 comes into your MDM in late October 2019. You have set out the recommendation earlier. I don't need to bring up the MDM record. As part of the history set out there, Mr. O'Brien started that patient on 150mgs of Bicalutamide, not the generally-accepted approach, given local guidelines for hormone treatment. The note also records that the plan was, because of lack of tolerance of the drug, to start him on 50 milligrams, actually a day or two after the MDM. You saw a patient of Mr. O'Brien that we talked at some length about yesterday, Patient 6. Sorry to throw this at you without records. The fine detail of it doesn't matter, but, again, that was a patient you saw, was described as an MDM, but you sat alone in it because of attendance issues. Mr. O'Brien had had that patient on 50 milligrams of Bicalutamide, as he describes it in his witness statement, to relieve that patient's concern about the disease progression. Certainly Dr. Hughes and Mr. Gilbert, when we asked them about these cases yesterday, say, they are all examples of an

unconventional approach to prostate cancer management. Are you really saying that these clues weren't out there, or they were out there but the dots weren't joined up for you?

A. I think we are looking, with the benefit of hindsight, at some isolated dots. As you say, Patient 1 was started on Bicalutamide 150 and perhaps the dose reduced, but the expectation from MDT was that he was going to be referred for Radiotherapy but that didn't happen. The issue in terms of him not receiving potentially curative treatment was the non-referral for radiotherapy. Many patients will receive Bicalutamide 150 as their adjuvant hormone treatment prior to and after radiotherapy, so Bicalutamide 150 in that setting is a recognised treatment. At the point of the MDT, the patient's been started on some hormones. I can't recall whether the dose reduction was done before MDT or after MDT.

169 Q. It just stopped because of reaction issues before MDT, with a view to starting it. The MDT was 31st October, he was to restart after a break on 1st or 2nd November?

A. But there was still an expectation that he was to be referred for Radiotherapy, so the expectation would be that actually ideally and best outcomes for a high risk cancer as he had, would be for a period of adjuvant hormone treatment along with Radiotherapy. Some patients who can't tolerate adjuvant hormones may just have Radiotherapy alone, but they still have the Radiotherapy. He didn't get the referral for

Radiotherapy, but we wouldn't have been aware of that at the MDT. We would have been aware he had a tolerance issue with the commencement of hormone treatment and therefore him discontinuing it and a plan for how to reintroduce it would be perhaps reasonable. The Patient 6 I don't entirely recall. But again patients who are going to be started on hormone treatment for prostate cancer, a dose of Bicalutamide 50 milligrams would be used as a standard cover for testosterone flare associated with LHRH analogue injections, so a patient having been started on that medication and then having a diagnosis confirmed with a view to them starting on treatment, that wouldn't necessarily flag an alarm. It's when that's continued beyond that without the additional referral that was recommended that it becomes an issue, and that information isn't necessarily available at the MDT at the time that that patient is discussed.

170 Q. It's not an issue I intend to pursue terribly long with you today, but were you conscious that within your MDT there was an absence of tracking along the length of the patient's pathway? Was that a different system than you were used to in Sheffield, for example?

A. Tracking is different here and, unfortunately, is funded up to the point of the commencement of their first treatment. In men who are receiving hormones and radiotherapy, the first treatment is the initiation of their hormones, so they are only tracked to the point of initiation of hormones. They are not tracked beyond

that is my understanding. So, potentially that is a factor in this , that we weren't tracking subsequent treatment. It's a factor within many aspects where we are not tracking subsequent treatments after.

171 Q. The third issue that you raised as an explanation, or a partial explanation, for what had gone wrong was the behaviour of Mr. O'Brien. I think you have explained that previously and it came up again this morning in terms of what was perceived to be pressures being applied to Mr. Young and Mr. Weir by Mr. O'Brien and his family members. Is there anything else you want to say by way of elaboration on that?

A. No. I think, as I say, we have covered it before. I mean, again, even after the June phone call and being told we wouldn't have him back, and I think our contact was then was contact through the legal team. So everything that came escalated in the same, you know, again just demonstrating that the approach was, if you like, heavy-handed. It was very much straight in.

172 Q. Certainly those explanations are there to be considered, and no doubt the Inquiry will consider them. They do, would you agree with me, sit against a backdrop of management that was complacent, perhaps, disinterested, perhaps, or afraid, perhaps, to make the appropriate challenge to Mr. O'Brien when a lot of information, and we've had the debate about what was known and what wasn't known, but there was a lot of information known, and that must also provide a significant part of the explanation. Would you

agree?

A. Yeah. You highlighted there the potential, the fear bit and the practice over many years, and that has to be a factor, and that relates to the third point I've raised there in terms of the behaviour, the historic behaviour of Mr. O'Brien.

173 Q. You have been involved in what might be described as a clean-up operation following the exposure of these shortcomings, and, in particular, the impact on patients. You have been responsible for overseeing a Bicalutamide audit. You have participated in the Lookback Review and the work associated with that then in terms of going back to patients whose care or treatment is found to have been suboptimal and seeing whether different treatment needs to be given; you have done all of that. That has had a particular impact on your practice, has it?

A. Essentially, my Southern Trust Outpatient practice now consists almost entirely of Lookback Review patients and my post-MDT work. I don't see any new patients currently.

174 Q. That must have a deleterious effect on what would otherwise be your patients, the waiting lists and emergency work, and it must put a stress on the rest of the team?

A. For the new patient workload it puts a strain on the rest of the team. From patients under my care awaiting review appointments, I've, through my practice in Southern Trust, maintained a very short review backlog

through working practice that we touched on before, including virtual reviews and the like, as I think I mentioned the GIRFT review regarding Outpatient practice. I have long practiced that in terms of, rather than seeing patients where their care can be managed and follow-up can be managed remotely, I conduct remote monitoring. But as a result of the workload coming through the Lookback Review, my own review backlog has lengthened out because I haven't got the capacity to see patients from the Lookback Review and patients needing review within my care although I am retaining the post-MDT, the cancer patient reviews.

175 Q. Just a word on, I suppose, what is the state of the nation, which is Southern Trust, in terms of the various initiatives that have had to take place. Is lookback going to be expanded in terms of its temporal reach?

A. The first phase of the lookback is, I think, almost finished. Conversations have been occurring with the Trust and the Department regarding the second phase of the lookback, and I would be pretty confident that is going to be proceeding. The bit that is just, if you like, being clarified, is the prioritisation within that.

176 Q. That's in light of the RQIA's recommendation that it should go back further, perhaps to 2015, and the Royal College has found, upon a sampling exercise, that there are cases in 2015 that raise some concerns?

A. Yeah. You mentioned the SCRR process, and within there we have identified patients whose care dates back before then as well.

177 Q. With the SCRR process as it stands, I think we have had some new reports in recently, but is there any pressure being applied or impetus evident in terms of completing that exercise? The last we heard it was 53 cases that had been screened into that process, and certainly the last I looked we had in the low 20s of reports back to yourselves and then into the Inquiry. What is holding up progress?

A. The SCRRs are being done externally by clinicians, largely from elsewhere, so outside of Northern Ireland. My understanding is that, yes, they are being chased up and pressure applied but there are a number still outstanding.

178 Q. In terms of the governance systems and frameworks, you will be conscious that Dr. Hughes' SAI initiative produced recommendations and action plans, and no doubt they are being fed through the system and no doubt resources are an issue in respect of some of them, and we will hear from Dr. O'Kane next week, perhaps, in relation to those.

Has there been any noticeable change on your ground, if you like, on your Urology patch, which would assure the public that the kind of issues that have given rise to this Inquiry are not likely to be repeated because change has been made?

A. I've mentioned during my evidence that we have a process in place so that I can assure that I am assured and can assure anyone that we have our Radiology results being looked at, being actioned by the team, and that that process is a weekly process that is keeping the entire Urology team within Southern Trust up-to-date with -- I mentioned the aim, our target is for all results to be actioned within two weeks of the result being made available.

179 Q. Just to cut across you. Sorry. Would that cover the -- it is helpful to put these into scenarios. Would that cover the kind of scenario the Inquiry is familiar with with Patient 92, just to take that example?

A. Yes.

180 Q. Or the retained swab example? I can never remember that patient's identity.

A. Yes, so that would cover patients like Patient 92. Patients like Patient 5 as well. That covers that. In terms of the MDT outcomes, resource has been put into the MDT in terms of assurance checks, and assurance audits have been done following the Urology MDT that the actions or recommendations of the MDT have been carried out by the clinicians seeing them patients. That was summarised at the MDT's annual meeting earlier this year, I think it was -- I can't remember the date of it, it was a couple of months ago, but essentially it was that the individuals working are carrying out the recommendations as per the MDT outcome.

181 Q. If the recommendation to you yesterday was to start the patient on ADT, and refer for curative Oncology, curative radiotherapy I should say, and you failed to do so, how would the Clinical Lead or the MDT coordinator become aware of your failure?

A. There would be tracking for that outcome to ensure that that's happened. When that patient has come to clinic that outcome would be checked and that would be fed back, either escalated to me or through the MDT.

182 Q. What about the situation where you have taken the recommendation back to your Outpatients clinic, the patient has come in to see you, circumstances have changed and you can't implement the MDT recommendation, or you have thought of something else and you decide that's no longer appropriate. That was, in terms, part of some of the cases or a case before Dr. Hughes and Mr. Gilbert. Would that kind of scenario be covered by any change, or does that remain a matter of trusting the professional without any basis for assurance?

A. That patient should be brought back to MDT for confirmation of that change of plan through the MDT. I certainly know of examples myself where I've viewed the outcome, seen the patient and their staging, and taken them back to the MDT because I felt the MDT outcome, having reviewed things, required a different outcome, and so the patient was rediscussed.

183 Q. Was that always your practice or has that been the practice since?

A. That has been -- certainly would be my -- I hope

intended practice. There are many situations. I think that's one situation where I have reviewed the staging and felt that the appropriate management differs from the MDT discussion, and so I have taken that back to MDT. That's different to a patient being recommended that they should have treatment A, and a patient saying I hear you, I understand, but I'm not listening to you, I am going to not have treatment. That, historically, I would have documented in a letter the patient's decision-making but I wouldn't necessarily have taken that back to MDT. Now I would look to bring that back to MDT.

184 Q. In terms of disease progression, was it always the rule, if you like, and maybe an unwritten rule, but was it always the expectation that, with disease progression, it should come back to the MDT for further discussion?

A. Yes. My understanding and reading of MDT guidance is that, on disease progression, yes, patients should come back to MDT. That hasn't always happened, but that is something that we bring back to MDT now.

185 Q. Again, is that something that can be monitored or observed, from a governance perspective, to ensure that it's done?

A. I think that's more difficult to monitor or observe because without having all of the patients follow-up being looked at on every occasion that they are seen, you wouldn't necessarily identify the patients who have progressed and, indeed, many of the patients we would

expect to progress and therefore progression is not an unexpected event, so you would perhaps have already have a plan for how progression is going to be managed, if that makes sense?

186 Q. Yes. Can you help us with the whole area of the Cancer Nurse Specialist. It was a critical issue explored by Dr. Hughes as part of his review. His conclusion was that Mr. O'Brien, in respect of the nine patients he was considering, had not made arrangements for the nurse to become involved. Some of the evidence that he received suggested that Mr. O'Brien excluded the nurse. That's by way of context. The MDM operational policy for the Trust, which was published, I think in 2016, puts an onus, at least on the written page of that document, puts an onus on the Clinical Lead and the core nurse member to ensure that a key worker uses the language of key worker is allocated. I understand in practice the key worker tends to be the CNS. Can you help me with that. Is that the way allocation was done in practice or, in the alternative, was the operational policy in a sense put to one side and it was really a matter for you, the treating Clinician, to put the contact information for the nurse into the hands of the patient, or indeed to make the introduction at the time of the clinic?

A. If we go before, before Covid I guess is a good timescale -- time frame, then patients would have come to a review clinic and, within that review clinic, there would have been patients who were on for

a general review and some patients who were on for post-MDT review. Practice for me would have been to highlight them patients as needing the key worker input and introduce them after the consultation and they would have gone and had a consultation with the key worker at that point. That's reliant on manpower. So sickness and things like that would have always potentially have an issue if someone wasn't available, and they would have been provided with the details for the contact with the key worker. Now we have got a bigger Nurse Specialist team than we perhaps had before, and the CNS team are aware of when them clinics are that patients are coming back post-MDT, they are aware of who them patients are, and they are available for them clinics. For myself, my clinic is in Armagh, so it's off site, and so I have the CNS in clinic with me throughout the clinic, so they are available for the entire every patient during that clinic.

187 Q. Just to be clear, although the operational policy which I assume you are familiar with, but take it from me the wording is "key worker allocated by" -- or "the responsibility for ensuring allocation is with the Clinical Lead and the core nursing member". Is that never how it worked?

A. The reality is, I'm not sure how the Clinical Lead can assign who the key worker is when they don't know who is going to be there in clinic on the day that the patient attends.

188 Q. Yes. Very well. Thank you, Mr. Haynes, for your

evidence. I'm sure the Panel have some questions for you.

MR. HAYNES WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

CHAIR: Thank you. I am conscious that we haven't taken a break this afternoon, but we will try to be as brief as possible, Mr. Haynes, just to get it concluded, if you don't mind sitting on for another while. Dr. Swart?

DR. SWART: Thank you very much for your detailed answers, I have just got some general questions really. The first one is about safety culture. Mr. Wolfe has already alluded to the fact that the key interests of the public will be are Urology Services at Southern Healthcare Trust safe? That will also be the key interests of the Trust Board. I know it's quite difficult to have exactly the right sort of measures of Patient Safety and embed them, but I think none of us would want a situation where we wait for harm and then resulting in investigations, so the idea would always be to have early warnings of safety issues. You have referred to that in a number of places in your evidence, but also in your S21. You referred to the importance of accurate data, intelligent information, both in terms of the administrative issues and the results and letters, and so on, but also in terms of outcomes, clinical outcomes in Urology. I would agree

with that. My question to you is: what efforts have you made to take that further? Have you been able to have any discussions with the Medical Director or other senior people in the Trust to put such things in place so you don't have to have such laborious processes?

A. With regards the outcomes data, I think we are in a very difficult position. We do not have the reliable hospital episode outcomes data available for us to even partake in the same outcomes monitoring arrangements that would be within Services in England and Wales. We don't have -- we discussed prostate cancer. If we looked at prostate cancer, we just don't have the capability to provide the data that would be provided to the National Prostate Cancer Audit, for instance. We are not going to fix that data availability rapidly, and so, if you like, the alternative approach is to approach with standardised audits of conditions and practices, and that's where we've been establishing within the Urology team, is an audit programme actually looking at them outcomes and using the standardised tools available. Again, if we look at prostate cancer or bladder cancer within the NICE guidance there are audit tools that can be used in that, and so they have been brought in to be part of a standard audit programme to look at that.

189 Q. I would imagine this is a trust-wide issue in terms of indicators so my question was really have you had support from senior people in understanding the importance of all of this and the fact that it would

actually help you in your day-to-day practice?

A. I think there's an understanding that it would help but understanding and being able to -- understanding it would help and being able to actually provide it is a different thing. We are limited by the tools we have available for data and outcomes capture.

190 Q. Just moving on the same safety theme, I think we all recognise increasingly that ensuring Patient Safety is a team sport, to use that phrase. You need everybody in the MDT and everybody in the Urology Department to participate in it. It must have had a huge, this whole Inquiry and all of the harm that's been identified, must have had a big impact on the Urology team. Do you feel like a team and how much support has been put in to help you work together most effectively to get over some of the issues that have been raised?

A. I think we feel like a team but we feel like a team who haven't got any substitutes and half the people have been sent off. We are short. We haven't got enough of us. We are and we do function as a team, and that's not just the clinicians, that's across the Medical and Nursing team. We function well as a team, we communicate well as a team, but we struggle to meet the mountain of work ahead of us, and that's the biggest challenge to us all.

191 Q. Was any support to put in to help the team in what must be extraordinarily difficult?

A. We have been offered support by the Trust through this but I don't think any amount of support is going to

takeaway from, you know, say, the anxiety of me over the weeks leading up to my first two days and starting, I think it was Thursday night my sleep started to be disturbed. On this occasion, no amount of support is going to impact on that. I have also highlighted that I don't sleep that late in the morning anyway. So no amount of support is going to change that and until, if you like, the spotlight has moved on there is going to be continue to be anxiety within the whole time working within Urology, and I would say not just in Southern Trust. Northern Ireland is small and across Urology we are a small team who all know each other, and so what effects us in Southern Trust has an impact on everybody else as well.

192 Q. Okay. Thank you.

CHAIR: Mr. Hanbury?

MR. HANBURY: Thanks very much for your interesting evidence. Just a few operational things about being a Urologist. I would like to start off being the Urologist of the Week, and this is something that most departments now do in England, as well as I am sure Northern Ireland. A lot of the evidence is how busy it is. Why did you decide to do the On-Call every night as well as the weekend rather than just 9:00 to 5:00? Also my second question is, I think you see the elective cases as well as all the emergencies, so that's quite a big workload. That was a team decision, was it? How did you come to that?

A. Yes, that was a team decision. As a small team, we

offer for services across the Trust, so for elective patients we are not all on site in Craigavon where our inpatient elective surgery is carried out, and so without having the back stop of the Urologist of the Week seeing all patients, then there's the potential that the Consultant who has operated on them is doing a session in south Tyrone or sitting here today who were operated on on Tuesday wouldn't be seen. So the patients I operated on on Tuesday are seen by the Urologist of the Week today. It doesn't stop us as the operating surgeon seeing the patient. It just ensures that every patient is seen for the elective care. In terms of the night stats, that's a subject for debate, where some people are very comfortable with doing a full week of On-Call. I am less comfortable. That might relate to my own personal circumstances and the fact that if I am busy at night, I can't drive so I don't drive home, I stay in the hospital, so I would, if I had a personal option, I would not do seven days in a row and would do intermittent days. I think there's the flip side of it in that, if you do On-Call night -- I am not sure what you have picked up from our practice, we don't have a Urology middle grade from 11 at night, so if you are called in on an On-Call night and actually it's an elective day the next day and you have got an operating list that's difficult as well. There are pros and cons of both seven days in a row or doing it once in seven.

193 Q. Thanks. A couple of operational things about MDMs. We

have heard a lot about it. It must be very frustrating for you as a team when you don't have Radiology and Oncology in your local. I just wondered what efforts you go to to get Radiologists or Oncologists remotely with video conferencing; is that easy or a struggle?

A. As you all know, the, sort of, remote working has exploded since 2020l. If there's any bonus of the pandemic it has been that. If we look at Radiology and Oncology, the issue wasn't so much whether they could be there, it was that there wasn't someone to do it. Someone couldn't be in two places at the same time. While you could have had an Oncologist link in, and we did indeed have Oncologists link in remotely, if there was a shortage of Oncologists then they couldn't link in because there wasn't one available to link in, and all of the Urology MDTs happen at the same time so there's an Oncology cover needed across each MDT.

194 Q. Okay. That brings us to second thing about specialist part of the MDT. Did you have an allocated section of time every week or how did that work? We have heard a lot about prostate and not much about kidney, for example. How did your small renal mass MDT work and who did you link in with?

A. In terms of the general MDT -- I will separate off the small renal mass MDT, because that was established as a separate entity, as it were. The general MDT, each local MDT will link into the specialist MDT for their patients. It's not so much at a set time, but there's regular communication during the MDT between the

coordinator in each Trust and the specialist MDT coordinator so Belfast know when Southern Trust are ready for them, and equally southern know when Belfast are ready, so link in and the patients are discussed at the point of link in. The small renal mass meeting was established really on the back of me coming in to Belfast Trust, working with Mr. Hagan the time at the time in terms of delivering the small renal cancer treatment, and really recognising that the management of the small renal mass was changing. There is more ablative treatments, suitability for various treatments was different, and so in order to discuss suitability for things like cryo-ablation, microwave ablation, IRE ablation, you needed a radiologist who did them, and so them patients actually went through the MDT normally and came to the small renal mass meeting where we discussed what options were available for the patients. Were they suitable for ablation because the Radiologist who did the ablation now didn't attend the MDT.

195 Q. That happens now --

A. The specialist MDT is split into disease types with small renal cancers being the first disease type discussed.

196 Q. Just one more on scheduling and pre-op assessment. You have eloquently illustrated the, sort of, complexities of waiting lists and things like that. I was interested that you seemed to do a lot with your secretary. Do you not have a waiting list office to prioritise so that stent change patients don't get

forgotten about, et cetera? That's one question?

A. That was the practice I would have been used to in Sheffield where we have a scheduling team that did it. In Southern Trust the secretarial team act in that scheduling role in liaison with the Consultant, and so the practice was somewhat different to what I had experienced in Sheffield where we added to a pooled waiting list, and the scheduling team scheduled patients with some discussion with the consultants but to the consultants' theatre list, according to each of our sub-specialist expertise.

197 Q. That's a slight change of culture to Northern Ireland. Okay.

A. Pre-Covid it was very much you managed your own waiting list. I would say now there is a lot more pooling and working across a single waiting list for the teams post-Covid. It's different to Belfast where we do have a scheduler in Belfast.

198 Q. Okay. Lastly, the Inquiry came to our attention for two cases, all surgical outcomes, not under your service. One theme we identified was somewhat preceptive admission arrangements, lack of pre-op assessment, or might have been available but the time wasn't allowed for it. Is that what happens in your service, can you reassure us?

A. It's across different categories and accepting that we prioritise or effectively ration types of surgery at the moment, red flag patients would be added to the waiting list and would get pre-operative assessment

done, because their pre-operative assessment will be done within time. The practice now, that green form is not a piece of paper any more. It's an electronic form that, on submission, goes directly to the pre-operative assessment team, so the red flag patients are sent their appointment for pre-operative assessment because the pre-operative assessment team have received that form. For the urgent patients, essentially where them patients are coming or likely to be called for, then pre-operative assessment is arranged in advance of that. The challenge is knowing, if you like, how many patients to have ready, because pre-operative assessment needs to be done within three months, I think is the guide for surgery. You can't get them all preoperatively assessed too early, you don't want to have every patient added to the waiting list preoperatively assessed at the time of adding to the waiting list, because lots of it will become out of date and you will use a huge resource doing something that then needs to be repeated.

199 Q. Specifically with complex major, with some cardiac comorbidities you would be able to schedule that?

A. Yes, indeed. If you had a patient who you knew had some comorbidities that was going to factor into that consent process, I would write to my colleague, Consultant anaesthetist who do the pre-operative assessment clinic and ask them to see them to have a discussion about the perioperative risks. Often I would see them back in clinic to have that discussion

again before we looked at scheduled surgery.

MR. HANBURY: Thank you very much.

CHAIR: Thank you. Mine is slightly more specific. We have heard this morning about the fact that Mr. O'Brien recorded a number of meetings that he had with a number of people without their knowledge. Unfortunately I don't have the reference, but there was a meeting of the Urology team, I think it was in 2018, if I have got that right. I can certainly find the references, I have left them in my office. Part of that meeting was recorded by Mr. O'Brien up until the coffee break, and after the coffee break the discussion was to be about triage. First of all, do you remember that meeting of the team around that time where a number of issues were discussed generally. I think Mr. Glackin was to provide document for you all to agree about the issues that needed to be looked at or actioned by management?

A. Yes. I think that's the September, from memory, meeting. I think it took place in the Stone Treatment Centre, is my recollection. Again, my recollection is Mr. Glackin did take handwritten notes and did provide a typed summary of that meeting.

200 Q. Yes. We have the benefit in the Inquiry of the transcript of, as I say, the first part of that meeting but certainly not the second part, so we are reliant on that note that was provided by Mr. Glackin. I wondered what your recollection was of the discussion within the team about the whole issue of triage and whether any

consensus was reached within the team? If you could maybe enlighten us a little bit about that?

A. I don't have a specific recollection and I can't remember what Mr. Glackin's note says right at this moment, but I think the whole team, I think it's consistent throughout. From when I started in 2014, the whole team were engaged in the establishment or the generation of the vision presentation to the Commissioner at that time, I think later in 2014, and I think that was a paper and a presentation, and within there triage is discussed and a proposal for triage discussed there. There would have been many points during that meeting where triage, and different approaches to triage were discussed. It will have come across really just discussing every aspect that impacts on it. There's the workload element associated with doing advanced triage, as I have mentioned, I mentioned how I do it, but there's also the workload element of what comes back from that. If you do advanced triage then you have got a certain volume of scan requests you are generating, and that's got to be factored in. There will have been discussion around how realistic taking on all of that workload is within a service where we are struggling. Ultimately, I don't think we came to a very clear, 'this is exactly what everyone will do', and we continued doing triage in the way that each of us felt most appropriate from that point.

201 Q. I appreciate that it is difficult, it's very hard to remember every single meeting you have ever been at

with your colleagues. From what you have been telling me it's likely, is it not, that in that meeting everybody would have said what way they triaged, and presumably Mr. O'Brien would have told his colleagues at that meeting, 'I'm only triaging the red flag cases'?

A. I don't have any recollection of him ever stating that at any point.

202 Q. Would it be fair for me to assume that, in some ways, it's less important to triage the red flag referrals that come in, and more important to triage the routine and the urgent to make sure that they aren't red flag?

A. I think that's a very reasonable suggestion. The urgent and routine, when you have waiting times as long as they are, if they should have been upgraded and aren't triaged, then they are at a greater risk than the red flag referral that's going to be seen on a red flag basis anyway, and therefore be seen more urgently.

203 Q. The other thing that I do remember is that the minute that was provided by Mr. Glackin, there was a section on triage where it says that the Consultant body wanted the Trust to set out what was expected in detail about triage, what was expected of the Consultants by way of triage when they were Urologist of the Week. Did you ever get anything back from management to say, 'this is what we expect you to do'?

A. Not that I recall. I think in that same meeting in the recorded bit, I did highlight that it's actually our responsibility. We are the Trust and it's for us to

tell the Trust what we think is appropriate and the Trust to say whether they agree. I think I'd have a view that actually that's our responsibility to agree what we feel is required and to inform the Trust because we are the Trust.

204 Q. Can one assume then if the minute says that the Trust should says out what it expects us to do that there wasn't agreement among you?

A. I would assume that. It may be in amongst, and in terms of a triage outcome, there is what type of triage? So is it a basic are they on a routine, urgent or red flag, or is there a more advanced form of triage happening, and what is the expectation in relation to that. The second part of that is timescales in relation to that. I guess the timescale aspect is something that we might have a view, but that would be fed or guided more from outside of the team. I think the reality of the team as it is now, I don't think we need to be told what them time scales are; we do it.

CHAIR: Mr. Haynes, thank you very much. Just for what it's worth, the Inquiry is very, very much aware about the anxiety of coming to speak to us, and we hope we haven't made it too painful for you. Thank you. I think then next Tuesday is our next sitting day.

MR. WOLFE KC: Next Tuesday at 10:00, yes. Could I just deal briefly with a very short housekeeping matter that arises out of my opening on day 7. The transcript for that day at 10:21, on day 7, recorded our observations that as regards Patient 16, there was

some uncertainty about the level of SAI associated with that patient. You will recall there's Level 1, 2 and 3. It had been reported to us at that time that this was an SEA or Level 1. In fact, it's now been confirmed, as we suspected, that it is a Level 3, so that's Patient 16. It may have started off as a Level 1 or an SAE, but it was upgraded to a Level 3.

CHAIR: Thank you, Mr. Wolfe. 10:00 on 6th December.

THE INQUIRY WAS THEN ADJOURNED TO TUESDAY, 6TH DECEMBER 2022 AT 10AM