Note: An addendum to this statement was received on 24 April 2023 and can be found at WIT-91999. Annotated by the Urology Services Inquiry.

UROLOGY SERVICES INQUIRY

USI Ref: Notice 79 of 2022

Date of Notice: 23 September 2022

Witness Statement of: Katherine Robinson

I, Katherine Robinson, will say as follows: -

SECTION 1 – GENERAL NARRATIVE

General

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

1.1 From 2007 I have had responsibility for the Medical Records Department and the Appointments office and later the Referral and Booking Centre. The Referral and Booking Centre was set up as a centralised booking office for the entire Trust (2009). From 2013 I have had responsibility for secretaries, audio typists and other administrative staff, e.g. Cardiac Investigation admin team as well. I no longer have responsibility for Medical Records at this time. These are support services working within the Acute Services Directorate. We have close links with specialty Heads of Service (HOS) and clinical colleagues.

I believe that the facts stated in this witness statement are true.

Katherine Robinson

Signed: _____

Date: ____18/10/2022_____

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No.79 of 2022

Date of Notice: 23 September 2022

Addendum Witness Statement of: Katherine Robinson

I, Katherine Robinson, will say as follows:-

1. I wish to make the following amendments to my existing response, dated 18th October 2022, to Section 21 Notice number 79 of 2022.

2. At paragraph 28.4 WIT 60388 I have stated "*On this basis this issue was escalated to Mr M Haynes the Clinical Director and this was reinforced*". This should be changed to "*On this basis this issue was escalated to Mr M Haynes the ~~Clinical Director~~ Associate Medical Director and this was reinforced"*.

3. At paragraph 29.1 WIT 60388, I have stated "*With regard to the DARO issue I engaged with Mr M Haynes, CD who reinforced the reasoning behind the use of this code etc.."* This should be changed to "*With regard to the DARO issue I engaged with Mr M Haynes, ~~CD~~ Associate Medical Director who reinforced the reasoning behind the use of this code etc.*"

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: Katherine Robinson

Date: 23.04.2023

Backlog Information

Specialty: Urology

Secretary's Name : Noleen Elliott

Date of Completion : 18th September 2014

Discharges Awaiting Dictation From Discharge Date	Clinics (no of charts) Awaiting Typing Oldest Clinic Date	Results Awaiting Dictation Oldest Result date	Daro: Validated	Filing – Give details of amount and type of filing, eg lab reports/consultant letters etc	Any Other Relevant Information
31 – Dating back to May 14	NIL	12		Approximately 10 lever arch files	I have a large amount of back filing which was here when I took up post with Mr O'Brien

Backlog Information

Specialty: Urology

Secretary's Name : Noleen Elliott

Date of Completion : 13th October 2014

Discharges Awaiting Dictation From Discharge Date	Clinics (no of charts) Awaiting Typing Oldest Clinic Date	Results Awaiting Dictation Oldest Result date	Daro: Validated	Filing – Give details of amount and type of filing, eg lab reports/consultant letters etc	Any Other Relevant Information
33 – Dating back to May 14	NIL	14		Approximately 10 lever arch files	I have a large amount of back filing which was here when I took up post with Mr O'Brien

Surgical	MYO	EE	CW	EM	AKN	DMK	GH	AL	Breast	Surgical Total
Discharges to be typed	0	0	24 (May 16)	7 (May 16)	6 (May 16)	4 (May 16)	22 (April/May 16)	10 (May 16)	0	**73**
Clinic typing	0	30 (May 16)	14 (May 16)	40 (May 16)	86 (May 16)	44 (May 16)	0	84 (May 16)	85 (May 16)	**383**
Discharges to be dictated	0	4 (May 16)	3 (April 16)	1 (May 16)	0	2 (May 16)	46+ (April/May 16)	0	1 (May 16)	**57**
Results to be typed	20 (May 16)	15 (May 16)	0	0	0	4 (May 16)	36 (May 16)	0	0	**75**
Results to be dictated	125 (Feb 16)	200 (Feb/March 16)	3 (April 16)	48 (March 16)	7 (May 16)	26 (March 16)	21 (April/May 16)	0	1 (May 16)	**431**

Urology	MH	JOD	KS	AOB	AJG	MY	Urology Total
Discharges to be typed	0	13 (April 16)	0	0	2 (May 16)	0	**15**
Clinic typing	1 (May 16)	36 (May 16)	0	0	22 (May 16)	1 (May 16)	**60**
Discharges to be dictated	0	0	0	15 (Feb 16)	6 (April/May 16)	13 (Feb 16)	**34**
Results to be typed	30 (May 16)	12 (April 16)	16 (May 16)	0	7 (May 16)	0	**65**
Results to be dictated	15 (May 16)	20 (May 16)	50 (May 16)	11 (March 16)	48 (April/May 16)	37 (Dec 15)	**181**

ENT	TMcN	ER	SJH	DMcC	TF	PJL	MK	ENT Total
Discharges to be typed	12 (May 16)	6 (April/May 16)	5 (May 16)	16 (May 16)	4 (April/May 16)	18 (May 16)	7 (May 16)	**68**
Clinic typing	39 (May 16)	25 (May 16)	60 (April/May)	0	15 (May 16)	0	31 (May 16)	**170**
Discharges to be dictated	19 (May 16)	20 (April/May 16)	10	0	10 (April/May 16)	0	24 (April/May 16)	**83**
Results to be typed	24 (May 16)	10 (March/Apr 16)	0	0	5 (March/Apr)	0	0	**39**
Results to be dictated	44 (April 16)	30 (March 16)	0	12 (May 16)	15 (March 16)	9 (March/April 16)	12 (May 16)	**122**

Corrigan, Martina

From: Haynes, Mark [redacted]
Sent: 11 March 2019 17:03
To: OKane, Maria
Subject: FW: Urology backlogs Confidential

Scroll down for details – result not actioned.

From: Haynes, Mark
Sent: 15 December 2018 05:57
To: Robinson, Katherine; McCaul, Collette
Subject: RE: Urology backlogs Confidential

Thanks Katherine.

The issue for me is not whether or not it was ever received.

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 governance processes that results are being actioned and communicated to patients in a timely manner with no risk of unactioned 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 unactioned results. Your team would be open for criticism for reporting inaccurate information.

For Tony and me Liz / Leanne look at e-sign-off and the number outstanding on here, plus any sets of notes with hard copy reports and this is the number reported. Ironically although we are the most up to date with our admin, we regularly appear to be the ones who are most behind.

A question to all secretaries asking them how they get the numbers that they report would be a starting point, along with a meeting to highlight why this information is collected and the potential consequences of misreporting.

Mark

From: Robinson, Katherine
Sent: 14 December 2018 15:27
To: Haynes, Mark; McCaul, Collette
Subject: RE: Urology backlogs Confidential

Mark

We have looked into this. We cannot establish if the result ever came back to AOB either hard copy or email. I thought Radiology flagged these up to be looked at , am I correct? We cannot find it in Noelene's office. That said the secretary has a huge issue with her management ie collette and I asking her questions etc and is extremely upset and feels we are harassing her. I am trying to get Trudy as I don't know how we can possibly get proper info without the secretary helping. The secretary does not want to be involved but I suspect like all of us there is no choice.

K

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre

Stinson, Emma M

From: Robinson, Katherine [redacted]
Sent: 07 February 2019 14:48
To: Carroll, Anita
Subject: FW: Patients awaiting results

Realised I should have copied you into this.

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Robinson, Katherine
Sent: 07 February 2019 10:00
To: Haynes, Mark; O'Brien, Aidan; McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; [redacted]; Corrigan, Martina
Subject: RE: Patients awaiting results

Folks

Can I just back this up by saying that Dr Rankin introduced this process trust wide many years ago due as a result of safety issues with patients. It actually increases secretarial work load due to extra checks but this is in the best interest of patients. I am aware Mr O'Brien that your secretary in particular does not use DARO in all cases and will put patients directly on the review waiting list as per your instruction. I have expressed my concern with her not implementing the DARO process fully.

Collette McCaul is the Line Manager to Urology, ENT, Opthalmology and Oral Surgery, it is her responsibility to follow directives and remind staff of processes that are in place. Collette was merely doing her job.

Regards

Katherine

Mrs Katherine Robinson
Booking & Contact Centre Manager
Southern Trust Referral & Booking Centre
Ramone Building
Craigavon Area Hospital

t: [redacted]
e: [redacted]

From: Haynes, Mark
Sent: 07 February 2019 06:24
To: O'Brien, Aidan; McCaul, Collette; Robinson, Katherine
Cc: Young, Michael; Glackin, Anthony; ODonoghue, JohnP; [redacted]; Corrigan, Martina
Subject: RE: Patients awaiting results

Morning

The process below is not a urology process but a trust wide process. It is intended, in light of the reality that patients in many specialities do not get a review OP at the time intended (and can in many cases take place years after the intent), to ensure that scans are reviewed and in particular unanticipated findings actioned. Without this process there is a risk that patients may await review without a result being looked at. There have been cases (not urology) of patients imaging not being actioned and resultant delay in management of significant pathologies. As stated this is a trust wide governance process that is intended to ensure there are no unactioned significant findings. There is no risk in the process described.

If the patient described has their scan in May, the report will be available to you and can be signed off and the patient planned for review in June, there is no delay to the patients care. The DARO list is reviewed regularly by the secretarial team and would pick up if the scan has been done but you hadn't received the report, if the scan hasn't been done etc.

It may be ideal that such a patient described would be placed on both the DARO list and a review OP WL but PAS does not allow for this.

I have no issue (as a clinician or as AMD) with the process described as it does not risk a patient not being seen and acts as a safety net for their test results being seen.

Mark

From: O'Brien, Aidan
Sent: 06 February 2019 23:33
To: McCaul, Collette
Cc: Young, Michael; Glackin, Anthony; Haynes, Mark; ODonoghue, JohnP; [redacted]; Corrigan, Martina
Subject: FW: Patients awaiting results
Importance: High

Dear Ms. McCaul,

I have been greatly concerned, indeed alarmed, to have learned of this directive which has been shared with me, out of similar concern.

The purpose of, the reason for, the decision to review a patient is indeed to review the patient.
The patient may indeed have had an investigation requested, to be carried out in the interim, and to be available at the time of review of the patient.
The investigation may be of varied significance to the review of the patient, but it is still the clinician's decision to review the patient.
One would almost think from the content of the process that you have sought to clarify, that normality of the investigation would negate the need to review the patient, or the clinician's desire or need to do so.
One could also conclude that if no investigation is requested, then perhaps only those patients are to be placed on a waiting list for review as requested, or are those patients not to be reviewed at all?

Secondly, if all patients who have had an investigation requested are not to be placed on a waiting list for review, as requested, until the requesting clinician has viewed the results and reports of all of these investigations, when do you anticipate that they will have the time to do so?
Have you quantified the time required and ensured that measures have been taken to have it provided?

Thirdly, you relate that it is by ensuring that the results are 'seen' by the consultant that patients will not be missed. I would counter that it is by ensuring that the patient is provided with a review appointment at the time requested by the clinician that the patient will not be missed.

Perhaps, one example will suffice.
The last patient on whom I operated today is a Personal Information redacted by USI who has been known for some years to have partial duplication of both upper urinary tracts.
She has significantly reduced function provided by her left kidney.
She also has left ureteric reflux.
However, she also has had an enlarging stone located in a diverticulum arising by way of a narrow infundibulum from the upper moiety of her right kidney.
She has been suffering from intermittent right loin and flank pain, as well as left flank pain when she has a urinary infection.
Today, I have managed to virtually completely clear stone from the diverticulum after the second session of laser infundibulotomy and lithotripsy.
She is scheduled for discharge tomorrow.
I planned to have a CT scan repeated in May and to review her in June.
The purpose of reviewing her is to determine whether her surgical intervention has relieved her of her pain, reduced the incidence of infection, and as a consequence, reduced the frequency and severity of her left flank pain.
Review of the CT images at the time of the patient's review will inform her review.
It will evidently not replace it.

Lastly, I find it remarkable that your process be clarified with secretarial staff without consultation with or agreement with consultants who, by definition, should be consulted!

I would request that you consider withdrawing your directive as it has profound implications for the management of patients, and certainly until it has been discussed with clinicians.
I would also be grateful if you would advise by earliest return who authorised this process,

Aidan O'Brien.

From: Elliott, Noleen
Sent: 01 February 2019 13:17
To: O'Brien, Aidan
Subject: FW: Patients awaiting results
Importance: High

From: McCaul, Collette
Sent: 30 January 2019 12:33
To: Burke, Catherine; Cooke, Elaine; Cowan, Anne; Daly, Laura; Hall, Pamela; Kennedy, June; McCaffrey, Joe; Mulligan, Sharon; Nugent, Carol; Wortley, Heather; Wright, Brenda; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; Loughran, Teresa; Neilly, Claire; Robinson, NicolaJ; Troughton, Elizabeth
Cc: Robinson, Katherine
Subject: Patients awaiting results
Importance: High

Hi all

I just need to clarify this process.

If a consultant states in letter " I am requesting CT/bloods etc etc and will review with the result. These patients ALL need to be DARO first pending the result not put on waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO, this is our fail safe so patients are

not missed. Not always does a hard copy of the result reach us from Radiology etc so we cannot rely on a paper copy of the result to come to us.

Only once the Consultant has seen the result should the patient be then put on the waiting list for an appointment if required and at this stage the consultant can decide if they are red flag appointment, urgent or routine and they can be put on the waiting lists accordingly.

Can we make sure we are all following this process going forward

Collette McCaul
Acting Service Administrator (SEC) and EDT Project Officer
Ground Floor
Ramone Building
CAH
Ext Personal Information redacted by USI

41. **Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.**

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

41.1 I am not sure but I believe there were attempts to manage Mr O'Brien but I am not sure where exactly this fell short.

42. **Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?**

42.1 I do not believe I made mistakes as I escalated appropriately. I do believe admin services could have done things better though if we had greater resources. More auditing is a must going forward. I tried my best with limited resources to put a spot-check mechanism in place etc to try and ensure governance but this was not effective enough. There was a lot of focus in the Trust on targets, performance and bed management, I believe these issues distracted from governance issues and therefore governance was not always the primary focus.