

Oral Hearing

Day 48 – Monday, 5th June 2023

Being heard before: Ms Christine Smith KC (Chair)
Dr Sonia Swart (Panel Member)
Mr Damian Hanbury (Assessor)

Held at: Bradford Court, Belfast

Gwen Malone Stenography Services certify the following to be a verbatim transcript of their stenographic notes in the above-named action.

Gwen Malone Stenography Services

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Mrs. Noleen Elliott

Examined by Mr. Wolfe KC

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Lunch adjournment

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1 THE HEARING COMMENCED ON MONDAY, 5TH JUNE 2023, AS
2 FOLLOWS:

3
4 CHAIR: Good morning, everyone. I understand, ladies
5 and gentlemen, that there may be an issue about the 10:17
6 heating in here. We have the air-conditioning on and
7 we'll reassess just how cool it is at the break. The
8 door is shut, so hopefully the room will cool down
9 substantially from what it was when you all came in
10 first thing this morning. We'll just see what it is 10:17
11 like at the break time and see whether we need to take
12 any further steps. Mr. Wolfe.

13 MR. WOLFE KC: Thank you. Good morning, Panel. Good
14 morning, Ms. Elliott. Your witness this morning is
15 Noleen Elliott and she'll take the oath. 10:17

16
17 NOLEEN ELLIOTT, HAVING BEEN SWORN, WAS EXAMINED BY
18 MR. WOLFE KC AS FOLLOWS:

19
20 1 Q. MR. WOLFE KC: Good morning again, Ms. Elliott. I'm 10:17
21 going to put up on the screen for you your witness
22 statements. The first of them is dated 28th October
23 2022, WIT-76306. Sorry, back a page. Let's just
24 correct that for our reference. There we go, apologies
25 for that. That's the first page of your initial 10:18
26 witness statement. You can see the note that you have
27 provided us with two further statements or addendum
28 statements, which I'll turn to presently. We can go to
29 the last page, which is hopefully WIT-76362. You'll

1 recognise your signature at the bottom of the page?

2 A. Yes.

3 2 Q. That is your first witness statement, subject to the
4 amendments that I am going to refer you to, do you wish
5 to adopt that statement as part of your evidence? 10:19

6 A. Yes.

7 3 Q. Thank you. The addendum statement or the first
8 addendum statement of 20th April of this year is at
9 WIT-91961. That makes some minor corrections to your
10 initial statement and refers to some further emails; 10:19
11 isn't that right?

12 A. That's correct.

13 4 Q. If we go to the last page of that, WIT-91962, again
14 your signature. Do you wish to adopt that as part of
15 your evidence? 10:20

16 A. Yes, please.

17 5 Q. Thank you. Then received late last week, your second
18 addendum, WIT-96807. The last page, just over the
19 page - scroll down, there we go - and again, subject to
20 correction, do you wish to adopt that? 10:20

21 A. Yes please.

22 6 Q. Thank you. The Inquiry is also aware that you provided
23 a witness statement to Dr. Chada as part of the MHPS
24 investigation. We'll just refer the Inquiry to that,
25 WIT-77961. That's the first page. The Inquiry is 10:21
26 aware that this statement would, like the others as
27 part of that investigation, have followed an interview
28 with Dr. Chada and then this would have been written up
29 for your consideration and you signed it if you agreed

1 with it?

2 A. Yes, that's correct.

3 7 Q. We can see that you signed it three pages further on at
4 WIT-77964. Again, do you recall making that statement?

5 A. I do. 10:21

6 8 Q. And is it an accurate statement?

7 A. Yes.

8 9 Q. Thank you. Now, I'm going to ask you some questions
9 about your employment history.

10 A. Mm-hmm. 10:22

11 10 Q. We'll get into questions then about how you did your
12 job and communication issues in your job this morning.
13 First of all, you explain that you have worked in the
14 National Health Service in various roles since 1987; is
15 that right? 10:22

16 A. That's correct.

17 11 Q. When the Southern Trust formed, you took up a role as
18 the clinical audit facilitator in 2007?

19 A. Yes, we transferred over. I was the clinical audit
20 facilitator in the Legacy Trust and I automatically 10:22
21 transferred over then to the Southern Trust.

22 12 Q. Yes. It would be helpful for us just to have your
23 statement on the screen, I'm going to refer to a few
24 aspects of it. WIT-76319. Just scroll to the bottom
25 of the page, please. You're explaining your various 10:23
26 roles; transferred to the clinical audit department and
27 then to the central reporting department. Just over
28 the page, you then, in 2009, were appointed to a risk
29 management officer role. Was that in the same

1 department?

2 A. It was in Governance. That was just due to a
3 restructuring of the governance structure. The job
4 I was in the central reporting didn't exist so they
5 appointed me then as risk manager, risk officer. 10:23

6 13 Q. In the first of those roles, you were responsible in
7 part for establishing processes for the management of
8 serious adverse incidents within the Datix framework;
9 is that right?

10 A. Yes. Initially when I worked in the central reporting, 10:23
11 we would have populated the Datix from handwritten IR1
12 forms, and also took the complaints from patients over
13 the telephone. Then, when I became the risk management
14 officer, I would have produced reports for the Acute
15 Services Directorate and the divisions within that. 10:24

16 14 Q. As you explain here, just four or five lines down,
17 responsible for quality assuring adverse incident data
18 inputted into Datix, producing monthly reports,
19 Director and Assistant Directors and heads of service
20 ad hoc reports, for example, pursuant to Freedom of 10:24
21 Information requests?

22 A. That's correct.

23 15 Q. If I can categorise it, was this a back office
24 administrative role or were you engaging with how the
25 SAIs were being conducted? 10:25

26 A. No. It would have been a back office job.

27 16 Q. Were you able to get a sense of how the Datix system
28 was reporting, how effective was it for the purposes of
29 addressing concerns?

1 A. Yes. I would have quite regularly been asked to check
2 Datix for trends, and to check if there was incidents
3 that were cropping up on a particular theme. I would
4 have done that very regularly for the risk manager.

5 17 Q. Mm hmm. 10:25

6 A. Obviously at the request of the Director. So, I would
7 have done searches all the time.

8 18 Q. At that stage - that was within this Trust in any
9 event - early in development of Datix and SAI, you had
10 in part set it up? 10:26

11 A. Yes.

12 19 Q. In 2007?

13 A. Yes. Datix was purchased, as far as I know, whenever
14 the Trusts did amalgamate, so we were the first users
15 of Datix. 10:26

16 20 Q. Did you see any difficulties or deficiencies in the
17 system at that early stage?

18 A. No. It was very -- well, I thought it was a very good
19 system. It was very easy to do searches. I suppose
20 because we were in from the start, we got very familiar 10:26
21 with how to do searches and were quite often asked, as
22 I say, to do such things.

23 21 Q. In 2011 you moved to another role within Governance, is
24 that right, Patient Safety and Quality Officer?

25 A. Yes. That was again following another restructuring of 10:27
26 Governance.

27 22 Q. If we just scroll down slowly, please, we can see
28 reference to it. You were responsible for the
29 management of the standard and guideline database?

1 A. That's correct.

2 23 Q. And you produced data for the six-monthly
3 accountability report to the Trust Board. Was that the
4 mainstay of your role, the standards and guideline
5 database? 10:27

6 A. There was also the management of medical devices. So
7 we would have, along with the manager, been responsible
8 then for the governance regarding medical equipment.

9 24 Q. Within the various governance roles that you undertook,
10 was there any interest in governance at that time, and 10:28
11 this is 2007 through to 2011, was there any interest in
12 assessing risk to patients in any of the work that was
13 performed by you in particular? By that, if there were
14 long waits for patients - and maybe long waits wasn't
15 as much of a problem in those days - was that something 10:28
16 that the department looked at?

17 A. Well, when I would have been populating the Risk
18 Register in my role as the risk management officer,
19 yes, there would have been reference made to especially
20 the outpatient waiting lists. If I can remember 10:28
21 rightly, urology always was mentioned in those risks,
22 and they would have been on the acute Risk Register.
23 If I can remember rightly, I think that was upgraded to
24 the corporate Risk Register when things started getting
25 progressively worse. 10:29

26 25 Q. Yes. You moved then in August 2012 into a completely
27 different role; isn't that right?

28 A. That's correct.

29 26 Q. Of a consultant secretary in urology?

1 A. Yes, that's correct.

2 27 Q. You stayed within urology through to August 2020?

3 A. Yes.

4 28 Q. During that period of eight years or so, you worked to
5 a number of consultant urologists; is that right? 10:29

6 A. That's correct.

7 29 Q. You've referred to them in your statement.
8 Mr. Connolly, I think, was possibly the first?

9 A. Yes.

10 30 Q. That's for a short period of time? 10:29

11 A. Yes. He then moved to the Belfast Trust.

12 31 Q. Yes. Then there were some locums and you have
13 mentioned then Mr. Suresh. And then, for the longest
14 period of time, Mr. Aidan O'Brien from August 2014; is
15 that correct? 10:30

16 A. There was actually the beginning of September. I think
17 it was the 1st or 2nd or 3rd September.

18 32 Q. Yes.

19 A. '16.

20 33 Q. What brought you to that area of work? 10:30

21 A. I was a full-time secretary with Mr. Suresh. All
22 through my governance employment, I was always four
23 days a week so I really wanted to go back to four days.
24 Mr. O'Brien's secretary, who had fell ill and left the
25 service, was four days, so that's why I transferred 10:30
26 over to work for Mr. O'Brien.

27 34 Q. Sorry, I didn't quite mean that. I meant what brought
28 you out of the governance area of work into the
29 secretarial work? What caused you to move into that

1 area?

2 A. well, to be honest, the standards and guidelines role
3 I found was very -- it wasn't very a rewarding job.
4 I was setting up meetings and spending the whole day
5 trying to set up a meeting, for it to be cancelled on 10:31
6 the eleventh hour. I was going home manys a night
7 thinking what did I do today that made a difference.
8 So, I just wanted to change.

9 35 Q. Okay. More recently in September 2020, you have taken
10 up a role as consultant secretary in the breast surgery 10:31
11 unit; is that right?

12 A. That's correct, yes.

13 36 Q. I'll ask you something about that towards the end of
14 your evidence. We know, Mrs. Elliott, that various
15 discussions would have taken place with you in relation 10:32
16 to Mr. O'Brien's work, and this morning and today is
17 another such opportunity to discuss aspects of his work
18 and aspects of how the Trust systems and arrangements
19 acted in relation to Mr. O'Brien's interface with
20 patients, and you obviously had eyes on aspects of all 10:32
21 of that. It is the case, isn't it, that when you have
22 been asked about Mr. O'Brien's work and whether he had
23 shortcomings, or whether he did things in the way that
24 the Trust might have expected, you have become upset
25 and emotional from time to time; isn't that right? 10:33

26 A. That's right.

27 37 Q. I want to ask you about that. Dr. Chada, when she gave
28 evidence to the Inquiry -- can I just bring up on the
29 screen, please, TRA-03644. She recalled when you came

1 to see her that you were really very anxious about the
2 whole process. She says:

3
4 "I think that you had felt that..."

5
6 She felt that you were in a difficult position in terms
7 of divided loyalties and those types of things.

8
9 "Doctors and secretaries tend to have a very special
10 relationship and I think it is difficult for
11 secretaries to feel in some way they're, I don't know,
12 just not being loyal. Certainly, the secretary found
13 it difficult."

14
15 Is that right? Do you find it difficult speaking to
16 people about Mr. O'Brien's work?

17 A. Not particularly, no. I get emotional because I'm hurt
18 at the way even I was treated just by other people.

19 38 Q. Yes. Is this in the context of being asked questions
20 about Mr. O'Brien's work?

21 A. Yes, partly so. Just the whole process, I find it
22 difficult because I was sworn to secrecy and told not
23 to talk about it, so I felt very isolated.

24 39 Q. Yes. Just let me understand what that means. So sworn
25 to secrecy, by who?

26 A. Well, the emails I got about the MHPS process was
27 highlighted in strict confidential and I wasn't allowed
28 to talk to anybody about it.

29 40 Q. Yes, and you respected that?

1 A. I did. well, I confided in one friend who was outside
2 the urology service.

3 41 Q. Yes. You felt isolated?

4 A. I did.

5 42 Q. And unsupported; is that fair? 10:35

6 A. Yes, I did.

7 43 Q. Leaving the MHPS aside, as a product of Mr. O'Brien's
8 exclusion from work and his return to work, there was a
9 monitoring arrangement put in place which looked at
10 things such as Mr. O'Brien's approach to triage, his 10:36
11 approach to dictation, his retention of patient charts.
12 Were you aware of that process?

13 A. No.

14 44 Q. You weren't. I want to ask you about that process in
15 terms of (a) whether you were aware - and you say you 10:36
16 weren't - but in terms of the demands made of you by
17 other people who were aware of it and its impact on
18 you.

19

20 Let me start with an email that was sent in 2018. It's 10:37
21 TRU-279352. Just scroll down. This is 4th December
22 2018. Colette McCaul, she was the service --

23 A. The service administrator.

24 45 Q. Just to be clear, you worked within the Functional
25 Services Department? 10:37

26 A. That's correct.

27 46 Q. And she was one of the managers within that?

28 A. That's correct.

29 47 Q. Yes. She's attaching backlog reports for urology.

1 Backlog reports at that time were looking at issues
2 such as typing, dictation, compliance with DARO, that
3 kind of thing?

4 A. In 2018, yes, I was aware that dictation -- lack of
5 dictation was to be added to that backlog report. 10:38

6 48 Q. We'll see as we go on this morning, and we'll look at
7 dictation as a standalone issue.

8 A. Okay.

9 49 Q. You, I think, would say that you weren't aware until
10 2017 and beyond that that an absence of dictation or 10:38
11 dictation yet to be performed was to be included in
12 these reports?

13 A. That's correct.

14 50 Q. Yes. Prior to 2017, you weren't highlighting dictation
15 that hadn't been performed; isn't that right? 10:39

16 A. That's correct.

17 51 Q. If we scroll on up and we'll see what Mark Haynes says
18 about this. So, he is raising concerns with Colette
19 McCaul about the reliability of these backlog reports.
20 He says: 10:39

21
22 "Sorry if my next question sounds awkward and
23 I appreciate I may have asked this before. Could you
24 describe the method by which the information is
25 collated. I can see how you have obtain the waiting to 10:39
26 be typed information but, for instance, how is the
27 information on results to be dictated and collected?"

28
29 He makes a number of points around that, and he says

1 that he is concerned:

2 "That the data presented doesn't fit with my impression
3 of practices. I regularly see patients coming into
4 Outpatients with scan results that have been performed
5 often months earlier, requested by someone else, but no 10:40
6 results letter or action ever done and no sign-off
7 either on ECR or on the paper copy."

8
9 We know that Mr. Haynes concerns in part were related
10 to Mr. O'Brien. Let's just scroll up and see how this 10:40
11 develops. Colette McCaul says "We're going to look at
12 this a bit further and then get back to you". She asks
13 for an example of a patient who has come to your clinic
14 but no result letter or action ever done. Mark
15 responds to that. He gives an example of a CT 10:41
16 performed on 13th March 2018, reported two days later
17 on 20th March, and then in July a GP letter is brought
18 to his attention. That is his concern, that there has
19 been a delay in processing the dictation of this case.

20
21 Then if we scroll up. Keep going, keep going, please.
22 She then -- sorry, Katherine Robinson then replies and
23 she says to Mr. Haynes:

24
25 "We've looked into this. We cannot establish if the 10:42
26 result ever came back to Mr. O'Brien in either hard
27 copy or email. I thought radiology flagged these up to
28 be looked at; am I correct? I can't find it in
29 Noleen's office. That said, the secretary has a huge

1 issue with her management i.e Colette McCaul and
2 I asking her questions and is extremely upset and feels
3 we are harassing her. I am trying to get through as
4 I don't know how we can possibly get proper info
5 without the secretary helping. The secretary doesn't
6 want to be involved. I suspect like all of us, there
7 is no choice."

10:42

8
9 This is management within your department talking about
10 your cooperation with efforts to get to the bottom of
11 dictation issues. They are saying that you feel
12 harassed by their questions and that they seemingly
13 can't rely on your input to get to the bottom of it; is
14 that fair?

10:42

15 A. Well, this is just one of the cases. Like, I was
16 getting phone calls practically every couple of hours.
17 So it is not that this was an isolated case, it was the
18 fact that I was getting so many enquiries and I was
19 telling them the same thing every time, that the
20 results were left with Mr. O'Brien, there was nothing
21 more I could do. So it's not that I wasn't
22 cooperating, it was the fact that -- it was the way
23 I was being asked to do things. Like, for instance,
24 I would have -- they would have sent me an email saying
25 go and check his office and count the charts. You
26 know, it was like as if they weren't giving him any
27 respect, they were treating him very poorly. I thought
28 anyway.

10:43

10:43

10:43

29 52 Q. Yes.

1 A. It was just the way I was being asked to do things, and
2 this was just one of those incidents. I would have --
3 I obviously did do a search for that particular result.
4 So it's not that I didn't help them, it's just I was
5 upset at them continuously asking me. 10:44

6 53 Q. Why were you upset? Were they not, I suppose, in
7 management terms entitled to conduct enquiries to try
8 to get to the bottom of issues such as dictation, and
9 needed your eyes and ears and knowledge?

10 A. Yes, I accept that. But it was, as I say, it was the 10:44
11 way they were conducting the -- asking me the
12 questions.

13 54 Q. What was the way that you?

14 A. Well, they would have said "Is he in his office"? You
15 know, that's the way they would have asked me. "Is he 10:45
16 in his office. Go and check how many charts is in his
17 office". That was the literally every other day I was
18 getting these calls until it got -- and like, I knew
19 that the charts weren't moving in his office, there
20 were no different from one day to the next, but you 10:45
21 were just constantly being asked.

22 55 Q. So you felt, am I right in thinking, that they were
23 asking you to go behind his back?

24 A. Yes.

25 56 Q. And did you feel that that put you in, if you like, a 10:45
26 compromising position because you were his secretary?

27 A. Yes. Well, I would imagine any secretary would feel
28 the same way as I felt.

29 57 Q. Yes. There was a meeting between you and Mrs. McCaul

1 later that year in December 2018. Let's just look at
2 that, WIT-22720. This is 14th December 2018. You
3 asked to see Mrs. McCaul in your office; isn't that
4 right?

5 A. Well, I think I had a conversation with her and then 10:46
6 I got upset, and she said she would come around and see
7 me.

8 58 Q. This is you explaining that you can't cope, feeling
9 very harassed by all the questions asked by Mrs. McCaul
10 on the previous Friday regarding Mr. O'Brien. Do you 10:46
11 agree that that is the reason for the conversation?

12 A. Yes. As I say, I'd got upset on the phone and then
13 she'd said she would come around and see me, yes.

14 59 Q. She's explaining that you, as Mr. O'Brien's secretary,
15 were the direct link for the information that she was 10:47
16 trying to obtain from you, and you explained by
17 response that you were finding it overwhelming and you
18 again use the phrase "harassed". You said you felt
19 that you couldn't do this any more, you might need to
20 go off. You said, according to this note, that you no 10:47

21 longer wanted to be involved and if management wanted
22 the information, that they should come and get it
23 themselves, "not sitting in their ivory tower getting
24 us to do their dirty work". Just scrolling down. You
25 had a loyalty to Mr. O'Brien "as her consultant", and 10:48
26 you felt that they were "trying to get her", that's
27 you, "to shop him".

28

29 Is that an accurate account of what you were trying to

1 get across?

2 A. I don't know about the shop him, I don't know where
3 that came out of, but I certainly felt I didn't like
4 the sneaking about behind his back. I don't see why
5 the monitoring couldn't have been upfront. He knew he 10:48
6 was being monitored so what was the problem with asking
7 him the questions or being open, instead of saying 'is
8 he in his office, go and check his office when he is
9 not there'. I don't like that style of management.

10 60 Q. Mm-hmm. Just so I am clear, did you have a loyalty to 10:49
11 him so that you weren't prepared to provide the
12 information, or were you objecting to their requests
13 because of the way the requests were made?

14 A. It was the way the requests were made, the fact that it
15 was the sneaking behind backs; I didn't like that. 10:49
16 I would provide the information if it was asked, you
17 know, if it was upfront and he knew about it. It was
18 the fact that I was being asked to go behind his back
19 and check things. I didn't agree with that.

20 61 Q. As a result of this meeting, did they stop asking you? 10:49

21 A. They did, yes. Well, on the checking of the office,
22 yes, they did.

23 62 Q. Specifically, the checking of the office was in respect
24 of charts?

25 A. Charts in the office, yes. 10:50

26 63 Q. You say you didn't know about the action plan but the
27 rule was that charts weren't to be taken home, charts
28 weren't to be stored in his office; charts were to
29 remain in his office for the shortest amount of time

1 consistent with his ability to do the work?

2 A. well, I know that now but that was never -- I never
3 knew that was ever an issue, that charts weren't to be
4 held in consultant's office. That was never an issue
5 in my whole time working in urology. 10:50

6 64 Q. Yes. I think the distinction is they weren't to be
7 stored in his office but the action plan allowed them
8 to be held in the office but for the shortest amount of
9 time consistent with his need to do work on patient
10 charts. 10:51

11
12 To cut a long story short, you were unhappy with the
13 way that you were being asked to address this issue,
14 you felt that this would involve you sneaking around
15 behind Mr. O'Brien's back, you raised objection to that 10:51
16 and your objections were listened to eventually; is
17 that right?

18 A. That's fair, yeah.

19 65 Q. A meeting took place on 8th October 2019. I just want
20 to draw your attention to it and ask for your comments. 10:51
21 It's WIT-34252. If we scroll down to paragraph 560,
22 this is a statement from Mrs. McClements. She's
23 explaining that at this meeting in October 2019,
24 Dr. O'Kane, who was at that time the Medical Director,
25 noted that you had not engaged with the monitoring of 10:52
26 the action plan, and this required - your
27 non-engagement - required Mrs. Corrigan to go on to the
28 electronic care record to check if notes - I take that
29 to be dictations or records following clinical

1 episodes - whether they had been uploaded. Now,
2 I should, just for completeness, take you to the note
3 of the meeting she's referring to, TRU-252529.

4
5 Just scroll down, thank you. This meeting is taking 10:53
6 place in a context late 2019 where Mr. O'Brien is said
7 not to have complied with the action plan with regard
8 to the dictation requirement aspect of the plan. There
9 were a number of dictations from clinics in the late
10 summer of 2019 which were found to be outstanding. As 10:54
11 I said, as per Mrs. McClements' statement, you can see
12 at number 3:

13
14 "Martina can only monitor what she is given. His
15 secretary has not engaged. Martina has had to go on to 10:54
16 ECR to check if notes are uploaded."

17
18 I wanted to give you the opportunity to respond to
19 that. Is it fair to say that you hadn't engaged with
20 the action plan or the monitoring aspects of it? 10:55

21 A. I don't think that's very fair. It was the actual
22 counting of notes in the chart that I objected, it
23 wasn't the looking up of details regarding patients.
24 I never refused to look up details on patients.

25 66 Q. As regards dictation, for example, although you say you 10:55
26 weren't aware of the action plan itself, were you
27 feeding information into the system using the backlog
28 reports --

29 A. I was.

1 67 Q. -- to say when dictation hadn't been completed or was
2 outstanding?

3 A. Yes. After December '16, I filled in that backlog
4 report fully with the undictated clinics.

5 68 Q. Yes. 10:56

6 A. By that time, Mr. O'Brien had started -- in March '17,
7 he had started using the digital dictation so it was
8 very easy for me to populate that.

9 69 Q. Yes. As regards the action plan, there were several
10 aspects as regards triage by, let's say, 2019 when this 10:56
11 record which we have in front of us had been written.
12 As regards triage did you have any role to play in
13 terms of reporting failure to complete triage on time?

14 A. No. The monitoring of triage was done by the Referral
15 and Booking team, so I didn't feel I needed to monitor 10:56
16 that.

17 70 Q. In terms of charts in Mr. O'Brien's office, whose
18 responsibility was that after you raised the issue in
19 late 2018?

20 A. Whose responsibility for counting those charts? 10:57

21 71 Q. Yes, and for monitoring.

22 A. I have no idea, I was never told.

23 72 Q. Yes. As you have said as regards your role in
24 dictation, you were completing the backlog return?

25 A. I was, yes, albeit very rushed because of the pressures 10:57
26 of work. So you were sitting with maybe 20 urgent
27 letters to be typed and you got the email to say give
28 us your backlog within a day, it was very hard to
29 prioritise, to not do the actual typing and concentrate

1 on the backlog. So, sometimes there could have been
2 errors on the backlog but I certainly tried my best to
3 do it as accurate as possible.

4 73 Q. We'll come to look at some of those reports and the
5 system that was applied in a short period of time. 10:58
6 Just to be clear, where it is suggested here that you
7 were not engaging, you think that's an unfair comment
8 to make about you?

9 A. Yes.

10 74 Q. Could I bring you to some meetings that you had in 10:58
11 September 2020 after Mr. O'Brien had retired and issues
12 arose in respect of his practice that required
13 investigation. You recall that you were asked to
14 attend a number of meetings in relation to such issues?

15 A. I attended one meeting and that was with Katherine 10:58
16 Robinson and Anita Carroll; she zoomed in because bear
17 in mind this was in the tail end of the Covid
18 restrictions. Then the second meeting was a telephone
19 call with Melanie McClements. As far as I know, that
20 was it. 10:59

21 75 Q. Let me look at that. If we pull up Mrs. Anita
22 Carroll's witness statement, first of all. WIT-21337.
23 At the top of the page, please. Mrs. Carroll records
24 in paragraph 50.2 that:

25 10:59
26 "In one-to-one in September 2020, Katherine Robinson
27 shared a note of a meeting with me. The meeting took
28 place on 1st September 2020. Katherine Robinson spoke
29 to Noleen Elliott regarding a complaint received from a

1 member of nursing staff alleging that Noleen was
2 unhelpful. Katherine Robinson then phoned Noleen, who
3 advised Catherine that she was stressed over the
4 investigation. As Mrs. Robinson felt this conversation
5 did not end well, she contacted Noleen on 2nd September 11:00
6 2020. During this conversation Noleen advised she had
7 changed some data on PAS at the request of Mr. O'Brien,
8 and on the detail of these changes. Katherine Robinson
9 advised she should not be doing this and reminded her
10 that she needed to follow instructions from the line 11:00
11 manager. Noleen says she found this difficult as she
12 worked with Mr. O'Brien for a long time and she felt
13 she had loyalty towards him."

14
15 Now, I want to look at that statement and the notes 11:00
16 that accompany it. I am going to bring you now to the
17 notes relating to that. A note was made by
18 Mrs. Robinson in relation to the 2nd September
19 conversation.

20 A. Hmm. 11:01

21 76 Q. If we bring that up, it's WIT-22812. Just scrolling
22 down, the 1st September telephone call we've looked at.
23 Then 2nd September. Following the conversation on the
24 1st, Mrs. Robinson rings you back and says:

25 11:01

26 "On reflection, I rang Noleen to see how she was
27 because our conversation did not end well the previous
28 day and that she was stressed and she was stressed
29 about the investigation. I advised it was nothing to

1 do with her but as long as she was doing what she was
2 supposed to be doing, she was okay. She said AOB asked
3 her to change some things and she did. I advised she
4 should not have done this and that she had to do the
5 right thing and also that she should be taking her 11:02
6 instructions from her line management team. She said
7 it was difficult because she works so closely with AOB.
8 I said I appreciate that but she still should have
9 advised her line manager that she had, who had to do
10 the right thing or we could not protect her. 11:02
11 I reminded her that I had also told her this before."
12

13 Context: September 2020, management are trying to get
14 to the bottom of the concerns that they had, rightly or
15 wrongly, in respect of Mr. O'Brien's practice. 11:03

16 A. Yes.

17 77 Q. And they were speaking to you. Did you tell them that
18 you had made some changes on PAS at the direction of
19 Mr. O'Brien?

20 A. Yeah. I was really shocked when I saw this in my 11:03
21 bundle, because my recollection of what I said that day
22 was that Mr. O'Brien had sent me emails, sort of
23 annually or six monthly, and it would have been asking
24 me to upgrade routine patients that were on his routine
25 waiting list to urgent, and that was simply the change. 11:03
26 The reason I highlighted that to her was because you
27 can imagine the waiting list in urology was years long,
28 so if you had a routine patient that was on the waiting
29 list, say five years, and they were upgraded to urgent,

1 that then had an impact on the urgent waiting list.
2 I felt that I needed to let management know that this
3 was why they were being changed. I actually had
4 emailed Sharon Glenny, who was the officer responsible
5 for waiting lists, to let her know that this was 11:04
6 happening. So, that's what I was speaking about there.
7 But to me it was nothing untoward, it was normal
8 practice. If there was a patient that symptoms had
9 changed in the course of them being on the waiting
10 list, that they needed then upgraded to urgent, and 11:04
11 that was simply what I was referring to there. So, to
12 me that was taken out of context.

13 78 Q. Yes. There is a further note that might assist you in
14 this respect, if we go down three pages to WIT-22816.
15 This is a meeting - you recall, I think, when I asked 11:05
16 about meetings a short time ago - that came the next
17 day, the day after 2nd September telephone conversation
18 for which we have just seen the note?

19 A. Yes.

20 79 Q. Here, if we just stay with the first main paragraph, it 11:05
21 begins with questions about how long you had worked for
22 Mr. O'Brien, and you advised five years. Mrs. Carroll,
23 Anita Carroll:

24
25 "... recognised the relationship between consultant and 11:05
26 secretary but said they needed to discuss with you
27 administrative arrangements and get a clear position on
28 paperwork, admin functions and how things worked, in
29 particular to get a feel for what was stressing Noleen

1 and also the fact that she had advised Katherine
2 Robinson the previous day that Aidan O'Brien had asked
3 her to change some things. When asked about this at
4 this meeting, she denied that she changed things but
5 advised she didn't use all administrative processes, in 11:06
6 particular the DARO function."

7
8 So, again here is a gloss on the notes of
9 2nd September. If I understand your explanation of
10 what you said on 2nd September, this note doesn't do 11:06
11 justice to your explanation either; is that fair?

12 A. Yes, but as I say, to me the changes that Mr. O'Brien
13 asked me to do, to me wasn't anything out of the
14 ordinary whereas they were making it out as if I was
15 doing under cover. It wasn't that. It was simply that 11:07
16 someone, as I said the routine patient, would end up on
17 an urgent waiting list with a waiting time of four to
18 five years. I didn't see that as being anything that
19 needed any action or...

20 80 Q. Yes. I just want to try to understand then where the 11:07
21 apparent confusion, or on one view the inaccurate note,
22 if it is inaccurate, has come from. Trying to think
23 through this, you have said to us this morning that the
24 only changes I was making to the PAS waiting lists was
25 in respect of patients who had languished on those 11:08
26 waiting lists for a number of years and may have
27 deteriorated or their circumstances may now be worse,
28 and Mr. O'Brien was saying that needs to be upgraded
29 from routine to urgent?

1 A. Yes.

2 81 Q. 'The patient is now, if you like, in worse
3 circumstances than he or she was four years earlier'?

4 A. Yes.

5 82 Q. That's the change that you made? 11:08

6 A. That's the change I made.

7 83 Q. Now, you spoke to Mrs. Robinson on 2nd September. Is
8 that how you explained it or did you not explain it at
9 all?

10 A. I'm not very -- I couldn't remember. I can't remember. 11:08
11 But obviously it was noted there so it would have been
12 discussed, yeah. It was the fact that I had emailed
13 Sharon Glenny; it was letting them know that this was
14 something I have done and I have checked with
15 management. 11:09

16 84 Q. You have mentioned Mrs. Glenny a couple of times. Is
17 was that something you were Mrs. Glenny prior to these
18 investigations in 2020?

19 A. Oh, yes.

20 85 Q. So, is this something way back in time? 11:09

21 A. Yes, it was. I think it was 2017.

22 86 Q. Yes.

23 A. But it must have been I was prompted, Katherine
24 Robinson must have prompted me to see was there
25 anything that Mr. O'Brien asked me to do that I wasn't 11:09
26 comfortable with. I don't know what prompted me to
27 mention that. I said the only change I ever made with
28 the PAS was when...

29 87 Q. So if she's asking you whether you had ever taken an

1 administrative step on Mr. O'Brien's behalf that you
2 were uncomfortable with, she presumably was asking you
3 was there anything untoward going on. Is that what
4 she's getting at?

5 A. I don't remember how she asked me but she must have 11:10
6 asked me was there anything -- did I ever do anything
7 like change anything on PAS on Mr. O'Brien's
8 instructions. I don't know how it was worded, but
9 obviously --

10 88 Q. Yes. 11:10

11 A. -- that's whenever I brought that up.

12 89 Q. Yes. When you get to this note, it's recording you,
13 I suppose, as denying that you ever changed it?

14 A. Well, I think it was probably the way it was worded
15 there because I wasn't aware that Mrs... I wasn't aware 11:10
16 that they knew about this. Obviously whenever that was
17 brought up, I thought there's nothing untoward with
18 what I had done so why are they even discussing that.

19 90 Q. The note doesn't record, as I understand this note in
20 front of me at -- just scroll down to get the page 11:11
21 number for the record. WIT-22816. This note doesn't
22 go on to explain that the change that you were talking
23 about was the change to patient prioritisation or
24 status, it goes on to talk about the DARO function?

25 A. Yes. 11:11

26 91 Q. "When asked about this issue she denied that she
27 changed things but advised she didn't use all
28 administrative processes, the particular the DARO
29 function".

1 A. Yes, and that was well known within urology.

2 92 Q. What you are saying is that Mr. O'Brien, so far as you
3 are concerned, never asked you to take any untoward
4 step or any step that you were uncomfortable with?

5 A. No. 11:12

6 93 Q. And you feel that Mrs. Robinson, on 2nd September, has
7 got the wrong end of the stick?

8 A. Yes.

9 94 Q. When asked about this on 3rd September, can you help me
10 with the note just in summary, you can't understand the 11:12
11 note; is that fair?

12 A. Well, it must have been the way it was worded to me,
13 did I make changes that I wasn't happy with. Well,
14 I didn't, I didn't make any changes that I wasn't happy
15 with. 11:12

16 95 Q. On the other hand, you are telling them one thing that
17 you are aware of that Mr. O'Brien doesn't comply with
18 is --

19 A. The DARO.

20 96 Q. -- the DARO requirement or the DARO process, which, as 11:13
21 you know, Trust management wanted him to implement but
22 he didn't?

23 A. That's correct.

24 97 Q. We'll look at DARO presently. In terms of your
25 relationship with Mr. O'Brien, it was a close working 11:13
26 relationship?

27 A. It was, yes. We got on very well.

28 98 Q. As we have seen, when you were, I suppose, asked to
29 provide information about him to assist the Trust in

1 understanding his practice, you would say I would have
2 been content to do it but I'm not somebody who runs
3 around behind people's back?

4 A. That's correct.

5 99 Q. Because I would feel that that's the wrong thing to do? 11:14

6 A. Yes.

7 100 Q. You feel a certain amount of loyalty to Mr. O'Brien in
8 that context?

9 A. Yes, and as does all the secretaries in the Trust.

10 101 Q. Yes. To who? 11:14

11 A. To their consultants.

12 102 Q. To their consultants. Is it fair to say that loyalty
13 to Mr. O'Brien wouldn't come at the expense of taking
14 steps to protect him when you knew that wouldn't be
15 justified? 11:14

16 A. No, not definitely. I was loyal to all the consultants
17 I worked for.

18 103 Q. You would say, as we have seen, that, for example, on
19 dictation when it is explained to you how it was to be
20 done, you always filled in the reports to show when 11:15
21 Mr. O'Brien hadn't performed dictation?

22 A. Yes.

23 104 Q. Mr. O'Brien was asked about your attendance at this
24 Inquiry on the day he was giving evidence. You
25 attended on the day he gave evidence? 11:15

26 A. I did. I contacted Aidan to ask him would it be okay
27 if I came down the day he was giving evidence, just to
28 familiarise myself, because I was due to come up the
29 next week. It was mainly to let him know that I was

1 going to attend that day.

2 105 Q. why did you contact him to ask was it okay as opposed
3 to, for example, your legal team?

4 A. I don't know. I suppose in hindsight I should have but
5 that's just what I did. 11:16

6 106 Q. Yes. At any stage have you discussed your evidence
7 with Mr. O'Brien?

8 A. No.

9 107 Q. Not at all?

10 A. Not at all. 11:16

11 108 Q. Very well. Now, let's take some time to look at your
12 responsibilities as a secretary to a urology
13 consultant. You helpfully set those out in your
14 witness statement, if we go to WIT-76338. At paragraph
15 19.1, you describe them. Just scroll down. Over the 11:16
16 page, please. You have indicated that you worked, did
17 you say five days a week for Mr. O'Brien?

18 A. No, four days a week. I was off on Mondays.

19 109 Q. You have explained in your witness statements some
20 early difficulties in settling into the role of 11:17
21 secretary to consultants?

22 A. That's correct.

23 110 Q. Could you summarise those for us?

24 A. As I say, I was new to clinicals. I had never worked
25 in clinical before so it was all new to me. I shared 11:17
26 an office with two other secretaries and one
27 audiotypist. I just found it difficult that I wasn't
28 getting the support from the other secretaries and it
29 had to be sought elsewhere.

1 111 Q. In what way were they failing to provide you with
2 support?
3 A. They -- I don't mean to be rude but they ostracised me,
4 they just ignored me, and there was a bit of difficulty
5 at the start. 11:18

6 112 Q. Yes. If we look at your statement. If we scroll down,
7 WIT-76337. Just scroll down. You have explained that
8 across the line managers you have had in this role,
9 some were more supportive than others?

10 A. That's correct. 11:19

11 113 Q. What was the problem in lack of support or variable
12 support from line managers in this role?

13 A. Well, I would have brought my concerns regarding the
14 atmosphere in the office to at that time Jane Scott,
15 and there was face-to-face meetings with her. At one 11:19
16 time she actually told me that we're not going to let
17 them beat us. But I just said -- tried my best to
18 settle into the role. I would have stayed on to maybe
19 ten o'clock at night to try and learn the job because
20 I didn't want to fail. 11:19

21 114 Q. Yes. I think elsewhere in your statement you explain
22 that training, in your view, for the job was not all it
23 should have been?

24 A. No. It was literally an audiotypist with a day --
25 like, an hour here and there. It was an audiotypist 11:19
26 that used to work in urology and had moved to ENT, so
27 it was her that done the majority of the training.

28 115 Q. The Inquiry has heard about various aspects of
29 Mr. O'Brien's practice that gave a rise to concern,

1 triage, dictation, use of DARO, Outpatients, various
2 things. Taking any one of those, say dictation, did
3 you receive any particular training around how that was
4 to be managed from a secretarial perspective in terms
5 of your relationship with Mr. O'Brien?

11:20

6 A. Well, in my roles with the other consultants, they
7 would have generally have done their dictation
8 following their clinics, so there wasn't really an
9 issue there. The dictation would have been done in its
10 totality, the whole clinic would have been dictated at
11 the one time, and therefore the typing was done for
12 that whole clinic at the one time. The difference in
13 Mr. O'Brien was that he would have dictated the urgent
14 dictation and the routine dictation wouldn't have been
15 done until later, and that was the difference in the
16 two roles.

11:21

11:21

17 116 Q. Yes. What I'm asking you, you talked about the
18 shortcomings in the training that you received when you
19 entered into the job, what I am saying is that
20 Mr. O'Brien has certain activities that he is expected
21 to perform in the administrative clinical arena?

11:21

22 A. Mm hmm.

23 117 Q. You are his right-hand person in terms of producing
24 product as a result of his activities?

25 A. Yes.

11:22

26 118 Q. What I am asking you is was there any training provided
27 to you in order to enable you to understand what your
28 responsibilities were when he had done his bit, or
29 indeed if he hadn't done his bit?

1 A. I knew what my responsibilities were when he had done
2 his bit. As regards was it my responsibility to chase
3 him up when he didn't do his bit, I wasn't aware that
4 that was my role.

5 119 Q. Yes. If we scroll down and over the page, you have 11:22
6 explained at various points in your statement that
7 the hours that you worked in this role as, in
8 particular, secretary to Mr. O'Brien --

9 A. Mm hmm.

10 120 Q. -- you were working more hours than you were contracted 11:23
11 for quite often in order to get the job done. Is that
12 a fair summary?

13 A. That's correct. I would have worked extra hours
14 particularly with Mr. Connolly because Mr. Connolly was
15 a new consultant in the Trust. He was given quite a 11:23
16 bit of long waiters and he was doing a lot of extra
17 clinics at that particular time, so there was a lot of
18 work generated there. With me only coming into the
19 post, it was a learning curve and I had to work very
20 long hours just to keep up with his workload. So it 11:23
21 wasn't always -- it wasn't just Mr. O'Brien that
22 I worked the extra hours for, it was the other
23 consultants as well.

24 121 Q. There was no additional remuneration for working
25 extra hours unless it was beyond contract? 11:24

26 A. That's correct. If it was an extra clinic put on the
27 system, yes, we would have got remuneration for that.
28 But Mr. O'Brien would have done a lot of extra work
29 that he obviously wasn't paid for and it wasn't classed

1 as extra. An example of that would have been when
2 consultants were off an annual leave, we'd have had
3 then a theatre list go astray; Aidan would have stepped
4 up and took on extra theatre sessions. Another example
5 of that would have been his urodynamics. He'd have 11:24
6 usually had one urodynamic, half a session a week,
7 which was a Friday, and he would have done all day
8 Friday for urodynamics if Mr. Young happened to be on
9 annual leave. Equally, his urooncology clinic, on a
10 Friday he would have done all day on urooncology should 11:25
11 there have been a backlog of patients to be seen.
12

13 Those were all extra sessions that Aidan did over and
14 above that weren't classed as extra, if you know what
15 I mean, by management. So therefore, I wasn't -- 11:25
16 I couldn't class them as extra so I had those extra
17 duties then --

18 122 Q. I see.

19 A. -- on the back of that.

20 123 Q. Your secretarial colleagues, did they perform extra 11:25
21 duties in the same way on occasion without
22 remuneration?

23 A. Not that I'm -- everybody was very secretive within the
24 secretarial, nobody ever talked about what overtime
25 they got. I'm not aware of what overtime people got 11:25
26 and what they didn't.

27 124 Q. We've heard that perhaps unique among the urologists,
28 Mr. O'Brien had one whole time secretarial support, in
29 other words yourself?

1 A. I did see that, yes.

2 125 Q. And that the other urologists had 0.5 whole time
3 equivalent. Mr. Mackle, for example in his evidence,
4 and I don't need to bring this up on the screen but it
5 is WIT-11770 at paragraph 93. Is that the case, that 11:26
6 the other urologists lived off half the whole time
7 equivalent secretarial support and Mr. O'Brien had one
8 whole time secretarial support?

9 A. Certainly not in my time. There were five or six
10 secretaries - I am trying to think - and out of them, 11:27
11 so Mark Haynes, Mr. Haynes, Mr. O'Donoghue, Mr. Suresh
12 and Mr. Young had one whole time equivalent secretary.
13 Mr. Glackin, his secretary done 32 hours out of 37, so
14 it would have been probably about 0.85 whole time
15 equivalent. And then I was 0.8, which was 30 hours, as 11:27
16 a secretary for Mr. O'Brien.

17
18 Now, in the course of 2018, the audiotypist working in
19 urology was upgraded for one day a week to a personal
20 secretary role for the Monday that I was off. I would 11:28
21 say for about six months during 2018, he would have had
22 one whole time equivalent until she then left and moved
23 to another job, another full-time secretary role post.

24 126 Q. Just so I can understand this, you are saying that
25 Mr. Haynes and Mr. O'Donoghue, for as long as you know, 11:28
26 had one whole time?

27 A. And Mr. Suresh.

28 127 Q. And Mr. Suresh. Mr. Glackin had somewhat less than
29 that?

1 A. 32 hours I think she worked.

2 128 Q. And Mr. O'Brien --

3 A. 30 hours.

4 129 Q. -- had less than Mr. Suresh, Mr. O'Donoghue and less
5 than Mr. Haynes? 11:29

6 A. Yes.

7 130 Q. Except for a period of six months or so?

8 A. It was about six months the audiotypist was upgraded to
9 a secretary for the Monday, for the one day a week that
10 I wasn't there. 11:29

11 131 Q. Yes. Leaving aside that six-month period, was
12 Mr. O'Brien required to bring all his administrative
13 needs to you or did he have access to audiotypists, for
14 example, outside of your support?

15 A. Well, but the audiotypist generally would have -- well, 11:29
16 this girl that was upgraded was an audiotypist, so she
17 would have covered me on the Mondays I wasn't working.
18 But Aidan would have tended to have kept the
19 administrative work to when I came back on the Tuesday.

20 132 Q. Yes. 11:30

21 A. Unless it was something very urgent, he very seldom
22 would have asked that audiotypist to have carried out
23 any scheduling or anything like that that was over and
24 above typing and so forth.

25 133 Q. You are describing the period after you came to 11:30
26 Mr. O'Brien in 2014?

27 A. Mm-hmm.

28 134 Q. Did you understand his administrative needs prior to
29 your taking up the role?

1 A. Well, his previous secretary, certainly Monica was four
2 days a week. For how long, I'm not sure when she
3 started that. I think she might have been full-time
4 and then reduced her hours but I'm not sure when that
5 was. 11:30

6 135 Q. If we could look at some other aspects of Mr. Mackle's
7 comments. Go to WIT-71447. At paragraph 37 he
8 describes Mr. O'Brien as slow to embrace technology.
9 He can recall that at one stage, Mr. O'Brien's
10 secretary used to have to print out emails, and he 11:31
11 didn't have a computer in his office.
12

13 Did Mr. O'Brien have a computer in his office when you
14 took up your role?

15 A. He did, yes. 11:31

16 136 Q. He says that rather than dictate a short note to his
17 secretary, he was known to write longhand. Is that how
18 you received your --

19 A. No.

20 137 Q. -- work from Mr. O'Brien before the digital dictation 11:31
21 came in?

22 A. No. We would have communicated quite regularly by
23 email was our main source of communication. So, he
24 would have emailed me requests.

25 138 Q. To dictate? 11:32

26 A. No, it would have been usually administrative things
27 like putting people on waiting lists.

28 139 Q. Yes, we'll come to that. But in terms of --

29 A. Dictation?

1 140 Q. -- dictation, how did he?
2 A. It would be on tape.
3 141 Q. He would communicate by tape?
4 A. Yes. Up until 2017.
5 142 Q. After that, what way did he work? 11:32
6 A. He was trained up on digital dictation in March of '17,
7 and he used digital dictation thereafter.
8 143 Q. Mr. Mackle records that he was slow to utilise it,
9 Mr. O'Brien was slow to utilise it. Was that your
10 experience? 11:32
11 A. It wasn't evident to me that he was any slower.
12 I shared an office with Mr. Young's secretary and
13 I can't remember exactly when Mr. Young started to use
14 digital dictation but to me it was around the same
15 time. I didn't think that Aidan was the last person. 11:33
16 Certainly that didn't occur to me, that he was slow to
17 embrace technology.
18 144 Q. You have referred already to Mr. O'Brien's approach to
19 dictation, he would do the urgent and leave until later
20 the non-urgent, and we'll look at that in a bit more 11:33
21 detail. That was a contrast with other consultants of
22 whom you had experience?
23 A. Yes.
24 145 Q. Was there any other contrasts between Mr. O'Brien's
25 approach and the approach adopted by other consultants 11:33
26 with whom you were familiar in terms of his
27 administrative or clerical practice?
28 A. He would have been very thorough. I would say he was
29 one of the most thorough consultants I ever worked

1 with. He always arranged his own inpatient elective
2 lists and then he would have asked me to send for the
3 patients, but he organised that himself. Whereas with
4 Mr. Suresh, who I'd have worked for for the longest
5 time, he would have sat down with me and we'd have 11:34
6 looked at the inpatient list, and he would have -- it
7 was a different ways of doing things. He would have
8 said 'oh, we'll have that man and that man' and so
9 forth. But Mr. O'Brien done that himself, usually over
10 the weekend. So whenever I'd have come in on a 11:34
11 Tuesday, he would have sent me the list of the patients
12 he had rang over the weekend for admission the
13 following wednesday.

14 146 Q. Yes. Now, you have said in your statement, just if we
15 could bring it up, how you saw your role. It's 11:35
16 WIT-76340. At paragraph 21.1, you say:

17
18 "I believe my role was as a facilitator for the
19 operational clinic aspect of the Urology Service.
20 I provided support for the consultant to ensure the 11:35
21 smooth running of his work and ensuring work was kept
22 up-to-date where possible."

23
24 would you agree with me that in your role,
25 communication was a very important aspect of your work; 11:35
26 you needed to communicate with a range of people to get
27 the job done, as you describe, in facilitating the
28 operational and clinical aspect of the service?

29 A. Yes. I would have been in contact with the MDT

1 coordinator, with nurses, with theatre staff. You
2 know, I would have sent mostly by email. There was
3 very little actually telephone conversations with other
4 staff. But yeah, I would have communicated quite a bit
5 by email with other professionals. 11:36

6 147 Q. We just in ease of the Inquiry's note, we can see in
7 your statement at WIT-76339, just back a page, we get a
8 flavour at 20.1 of the types of liaison, communications
9 maybe, that you had with the service administrator.
10 That's most recently Mrs. McCaul; is that right? 11:37

11 A. Our current one would have been Orla Poland. As you
12 can see, there was a quite a few staff changes. So
13 I can't remember, I am sorry --

14 148 Q. Yes.

15 A. -- whenever the exact times. 11:37

16 149 Q. That's an example of who that person is. Mr. O'Brien
17 was somebody who would have been in regular contact,
18 you say on a daily basis, by phone and email?

19 A. Yes.

20 150 Q. You would have had face-to-face contact with him at
21 least twice weekly. His office was approximate to
22 yours; isn't that right? 11:37

23 A. Yes, it was just across the corridor.

24 151 Q. Yes. You went to Urology team monthly scheduling
25 meetings? 11:37

26 A. That's correct.

27 152 Q. You had liaison with clinical nurse specialists?

28 A. Mm hmm.

29 153 Q. On a daily basis, you explained?

1 A. Yes.

2 154 Q. With the specialist registrars?

3 A. Yes.

4 155 Q. And other consultants. Just scroll down. Also liaison
5 with the cancer tracker -- 11:38

6 A. Yes.

7 156 Q. -- and the patient assessment team booking office
8 staff. I think you have mentioned that you would have
9 had informal meetings with your fellow secretaries.
10 Just scrolling back up, informal meeting with the... 11:38

11 A. Well, there would have been those ad hoc staff
12 meetings.

13 157 Q. Yes. Informal staff meetings.

14 A. They were very irregular.

15 158 Q. Okay. Not very often at all? 11:38

16 A. No.

17 159 Q. Was there any opportunity to meet with your secretarial
18 colleagues to share perspectives?

19 A. Very little opportunity. The most of those -- I think
20 two of those meetings were actually to actually 11:39
21 introduce a new member of staff, as in a new service
22 administrator. To me, that was the reason behind the
23 meeting as opposed to a meeting with us. But I feel
24 there should have been more engagement between the
25 service administrator and the secretaries. 11:39

26 160 Q. Yes. We see that in your statement in a number of
27 places as one of your reflections on your career
28 working in this part of the Trust.

29 A. Mm-hmm.

1 161 Q. what would that have looked like for you, greater
2 connection with the service administrator? what way
3 should that have been taken forward and for what end?
4 what did you think was missing?

5 A. I think there was an ignorance from the service 11:39
6 administrator to how busy the secretary actually was.
7 I think they were adding more work and more work
8 without realising how fast and how demanding our jobs
9 were.

10 162 Q. Did you see an increase over time in what was expected 11:40
11 of you?

12 A. Very much so, yeah.

13 163 Q. And what do you put that down to?

14 A. Well, certainly whilst working with Mr. O'Brien, just 11:40
15 his extra work that he undertook created extra work for
16 me. Also the triage. And whenever the e-triage came
17 on board, there was a lot of extra work generated from
18 that. So there was different factors that created
19 extra work.

20 11:41

21 Then we lost a lot of audio support. Whenever
22 I started working in Urology, I think there was three
23 audiotypists and that ended up as one. It's not even a
24 one full-time, it's one part-time. That's the way it
25 was when I left the service. We had one part-time 11:41
26 audiotypist.

27 164 Q. We know that in January 2017, it was discovered, or at
28 least it was catalogued, that Mr. O'Brien hadn't
29 completed dictation on, and the numbers vary depending

1 on who you are asking. But arguably several hundred
2 clinical episodes hadn't been dictated, or had been
3 dictated, some had been dictated relatively recently to
4 that point in time. But at a certain point in time,
5 there were 61 clinics for which there were no outcomes. 11:42
6 Did that not in a sense reduce your work if Mr. O'Brien
7 wasn't dictating when he should have been?

8 A. I don't think that's particularly correct. It was 61
9 clinics that the outcome sheet --

10 165 Q. Let's leave that detail to the side and we'll come back 11:42
11 to that.

12 A. Okay.

13 166 Q. But would you agree with me that Mr. O'Brien wasn't
14 dictating in a timely fashion, or at all with some
15 patients, for a long period of time? 11:42

16 A. Yeah, there was dictation outstanding, yes, but that's
17 not to say that he wasn't dictating at all. He was
18 dictating.

19 167 Q. I don't argue with you on that. What I am asking you
20 is if he's not dictating, does it not reduce your work? 11:43

21 A. Not necessarily because we have the clinics that the
22 registrars are doing. You have the flexible cystoscopy
23 lists, which was one every fortnight, that the
24 registrars did as well. There was other work.

25 168 Q. Of course, of course. Your colleagues in the 11:43
26 secretarial pool have consultants who are dictating all
27 of their clinical episodes, Mr. O'Brien's not dictating
28 all of his clinical episodes; does that not reduce in
29 part the work that you were doing?

1 A. Well, you could argue and say Aidan's letters tended to
2 be longer than the other consultants. The majority of
3 Mr. O'Brien's letters would have been one to two pages,
4 whereas I saw other consultants' letters and they would
5 be about four lines. So there was a difference there 11:44
6 in the length of the dictations that Mr. O'Brien would
7 have completed.

8 169 Q. You were a port of call at one point in time for a
9 period of time in respect of Mr. O'Brien's failure to
10 triage, or tardiness with regard to triage? 11:44

11 A. Yes.

12 170 Q. Again, did that create work for you which, if he had
13 been doing the job as expected, ought not have troubled
14 you?

15 A. Minimal. Whenever I would have got an email on triage 11:44
16 or whatever, I would have forwarded that to Aidan if he
17 didn't already have it. Or if it was a single triage,
18 I would have printed the triage that was attached off
19 and left it on his desk.

20 171 Q. So, that was a minimal demand on your time? 11:45

21 A. Yeah, it was. I didn't really take anything to do with
22 the monitoring of those. That was already done by the
23 Referral and Booking Centre.

24 172 Q. Yes. Now, I want to look in a bit more detail at some
25 of the groups who you had to communicate with as part 11:45
26 of your role. Shall we take a break now?

27 CHAIR: we'll break now, ladies and gentlemen.

28

29 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

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CHAIR: Right. Can I just check with everyone before we start again if they are content with the temperature in the room, or is it still a little hot for people? If you feel very uncomfortable, please feel free to take off your jacket, ladies and gentlemen, if it gets too uncomfortable. Mr. Wolfe?

12:01

MR. WOLFE KC: Hello again, Mrs. Elliott. I am going to ask you some questions now just so we can get a better understanding of how the mechanisms of communication worked in order to get things done for patients, whether that's benign patients, cancer patients, and your role within all of that. You have explained, I think I've touched on already, that you had daily liaison with the cancer nurse specialists?

12:02

A. The clinical nurse specialists.

173 Q. Sorry, I had the wrong term, regarding booking biopsy appointments and treatment for patients in Thorndale?

A. That's correct.

174 Q. You liaised with the cancer tracker on a weekly basis regarding red flag patients. You had daily liaison with the booking office, just to take some examples.

12:02

12:02

All of these kinds of communications to get things done for patients, were they as straightforward and routine as they perhaps ought to have been or did you encounter difficulties in how the system worked?

12:03

A. No, they were all very straightforward and routine, yes.

1 175 Q. Yes. In terms of communications with secretaries in
2 other departments, perhaps a referral is going from
3 Mr. O'Brien to another department or vice versa, was
4 that again something that worked well?

5 A. Yep. All new referrals would have went to the Referral 12:03
6 and Booking Centre. If it was to another speciality,
7 yes, they all went to there apart from the red flags.
8 If there was a new red flag to another speciality, that
9 would have been sent to the red flag team, but it was
10 at all done by email. 12:04

11 176 Q. Yes. No great difficulty with the systems of
12 communication on that?

13 A. No, not at all.

14 177 Q. To help us understand how Mr. O'Brien organised his day
15 case procedures, as I understand from what you have 12:04
16 maybe said already he would look at his list, identify
17 the patients who he thought had priority or ought to
18 have priority, identified them for you, and then what
19 comes next?

20 A. He would have identified the patients on his own. 12:04
21 Like, I wasn't involved or I didn't assist him in that,
22 he did that himself. He would have rang those patients
23 and organised their admission. As I said before, that
24 was generally done over a weekend. He would have then
25 e-mailed me the list of patients that had agreed to 12:05
26 attend. It was very straightforward, I would have then
27 just sent out the letter. Sometimes, especially with
28 the inpatient elective list, he would have specified if
29 someone was on a blood thinning product and asked me to

1 highlight on the letter when they were to come off
2 that. So, he would have already discussed that with
3 them but he would have asked me then to put that on the
4 letter as well, just for...

5 178 Q. Did you have to make contact with the booking office 12:05
6 for the purposes of theatre or was that all done by
7 Mr. O'Brien?

8 A. No, the booking office would have been the Outpatient
9 appointments. The booking office had nothing to do
10 with the elective inpatient. 12:06

11 179 Q. Who takes the step of arranging the procedure then?
12 A. The list, the actual theatre list?

13 180 Q. Yes.
14 A. Yeah, I would have generated the theatre list. That
15 would have been sent to the ward. If it was 12:06
16 inpatients, it would have been sent to day surgery for
17 the day surgery list, and to all other relevant staff,
18 for example, the pre-assessment nurses. There was a
19 whole raft of people that got that list. Then it was
20 put on the TMS waiting list, which is the theatre 12:06
21 management list. So, that was done by myself as well.

22 181 Q. Was there any central control or allocation when it
23 came to patients to be selected for theatre or any
24 other procedure?

25 A. No. Each consultant had their own specific list, so 12:07
26 there was no central list. Mr. O'Brien had his own
27 waiting list, Mr. Young had his own and so on.

28 182 Q. Was it your responsibility to contact patients when
29 arranging flexible cystoscopies?

1 A. Yes, they would have generally more patients. You
2 would have 10 to 12 patients on a flexy list. I would
3 have rang the patients and organised a time that suited
4 them.

5 183 Q. Again, that was patients identified for you by 12:07
6 Mr. O'Brien and then you following up and making the
7 contact?

8 A. He generally would have given me extra patients so that
9 if it didn't suit a particular patient, then I had a
10 reserve if you know what I mean, to fill up the list. 12:08

11 184 Q. What was the purpose of making that contact? Was it
12 simply to tell them to come in?

13 A. Well, that, and I was able to give them a time that
14 suited. For instance, if it was a patient from
15 Enniskillen driving 60 odd miles, I wouldn't have give 12:08
16 them a 8:30 appointment, I would have tried to organise
17 a time that would have suited them. Also, because
18 you're dealing with an elderly population, a lot of
19 them couldn't drive so they needed family to take them
20 to the appointments. To me, it was very beneficial in 12:08
21 those terms, that you were able to give them a time
22 that suited them.

23 185 Q. In terms of patients contacting you, were there
24 scenarios where patients needed to get in contact with
25 Mr. O'Brien but you were the person who, if you like, 12:09
26 fielded the call? Were you the recipient of calls from
27 patients?

28 A. Yes. All consultants' secretaries took the calls for
29 their consultant. That was just the way it was set up.

1 You would never give out, or I certainly never did give
2 out Mr. O'Brien's personal mobile number to anyone.

3 186 Q. Was your contact details as Mr. O'Brien's secretary
4 provided to patients, or did they just phone in to
5 central administration and are directed to you? 12:09

6 A. Some would have come in through the switchboard but a
7 lot of Aidan's patients would have been long-term
8 patients that obviously had the number. The number
9 would have been on the clinic letters or any results
10 letters that went to patients. 12:10

11 187 Q. Can I put a couple of scenarios to you. If patients
12 were phoning in distressed, they are on the waiting
13 list, did Mr. O'Brien facilitate you with a message to
14 be given to such patients, a fixed message to be given
15 out to patients, or how were such calls fielded? 12:10

16 A. So, I would have received the call from the patient and
17 if it was just a general query on where am I on the
18 waiting list, that was addressed by myself. We were
19 actually given a narrative from management to say to
20 patients about the extremely long waiting lists and we 12:10
21 would get to them as soon as we could. But if it was a
22 patient ringing regarding a change of symptoms, a
23 deterioration in their symptoms, I always emailed that
24 information to Aidan.

25 188 Q. Mm-hmm. 12:11

26 A. And no, I generally would not have got a reply back.
27 If the patient had asked me to speak to Mr. O'Brien,
28 I would have put their details, their telephone number
29 on the email and basically left that up to Aidan if he

1 wanted to follow that up or not.

2 189 Q. Yes. You've spoken in your statement at WIT-76337 that
3 you could field maybe 20 calls per day give or take,
4 and you put that down as a consequence of the long
5 waiting list. If we just scroll down to 17.3. There 12:11
6 you are. You believe that this build-up of calls was
7 as a result of growing waiting lists?

8 A. Very much so, yes.

9 190 Q. Is this, are you suggesting, really an increase over
10 time to this large number per day? 12:12

11 A. Well, I'd say even when I started working with Aidan,
12 his waiting list never really changed. There was
13 never -- there wasn't really an increase, it was
14 always -- there was as big a waiting list when
15 I started as when I finished. But a lot of them would 12:12
16 have been stent queries, where people had stents in and
17 they were in pain, and ringing up about that and when
18 they were going to be brought back in to have their
19 stent removed. A lot of them would have been not
20 necessarily the long waiters. It would have been those 12:12
21 sort of patients.

22 191 Q. I'm going to look at stents in a moment. Just in terms
23 of the variety of calls that you could get, some were
24 what's my position on the waiting list, and the Trust
25 had essentially handed you a narrative to explain the 12:13
26 position. Where it was patients who needed an answer,
27 whether because their symptoms had developed or their
28 disease progressed --

29 A. Mm-hmm.

1 192 Q. -- or, for example, a stent case, those are questions
2 you would have set out for Mr. O'Brien generally by way
3 of email?
4 A. Yes, that's correct.
5 193 Q. And leave him to follow it up? 12:13
6 A. Yes. If a patient had rang more than once, I usually
7 done a search on my email trail, found the previous
8 email and then would have continued on the email trail,
9 you know, if it was about that same patient to let him
10 see that the patient had been ringing more than once. 12:13
11 194 Q. Mrs. Corrigan, for example, and maybe some others,
12 reflected in part of their evidence that Mr. O'Brien
13 carried out tasks such as the scheduling patients for
14 theatre which should have been passed to you to do.
15 I'll just bring it up on the screen so that we have 12:14
16 exactly what she said. TRU-00747. This is her
17 statement to Dr. Chada. At paragraph 17, just so we
18 can see that, please. Generally reflecting upon
19 Mr. O'Brien's attention to detail, his letters could be
20 pages long. In terms of the scheduling of patients, 12:14
21 she says:
22
23 "Schedules his own patients and phones them personally
24 to arrange for them to come in for a procedure. This
25 is something his secretary should be doing. I am aware 12:15
26 of conversations with patients where Mr. O'Brien would
27 discuss the care of animals while the patient was in
28 hospital."
29

1 The impression given there was an excessive attention
2 to detail, contacting patients to arrange their entry
3 to hospital when other clinicians would be delegating
4 that to the secretarial resource so that the clinician
5 could better use his time for other activities.

12:15

6
7 Do you recognise the contrast in practice between
8 Mr. O'Brien and others in this respect?

9 A. Yeah. Well, as I said before, Mr. O'Brien did ring his
10 patients himself. But certainly in my previous roles,
11 I have never scheduled without the consultants picking
12 the patient himself. So, as regards the scheduling, a
13 secretary has -- I have never been scheduling on my own
14 without the input of the consultant.

12:15

15 195 Q. It's the piece after that I'm most interested in.

12:16

16 A. Yes. Well, as I said before --

17 196 Q. When you were with Mr. Suresh, would he have contacted
18 the patients to go into the ins and outs of coming into
19 hospital or was that left to you?

20 A. That was left to me after the patients were selected
21 for the list.

12:16

22 197 Q. Yes.

23 A. The only thing I would add to that was that Aidan would
24 have done that scheduling in his own time generally on
25 a Saturday or a Sunday. So, it wasn't impacting on his
26 working time in the Trust.

12:16

27 198 Q. How do you know that?

28 A. Because patients would have -- whenever I would've rang
29 them or they would have been in touch, say if I would

1 have rang them after the procedure to book a results
2 appointment, they were very complimentary of
3 Mr. O'Brien and said he was a decent man and he rang me
4 at twelve o'clock on Saturday or ten o'clock on Sunday
5 night, and they felt special because they felt as if a 12:17
6 consultant was giving them preferential treatment. You
7 know, they just felt as if 'imagine a consultant
8 ringing me on his own time on the weekend'.
9 199 Q. Yes. But other consultants were doing their dictation
10 during that period? 12:17
11 A. I don't know what other -- well, other consultants --
12 200 Q. Is that not the point, that while Mrs. Corrigan is
13 highlighting that Mr. O'Brien is doing activities that
14 really could have been delegated to you, like other
15 clinicians, other aspects of his practice were falling 12:18
16 behind? He was using his time, as she would suggest,
17 unwisely. What I am asking you is did you see that in
18 his practice?
19 A. Not his working time. He did it in his own time. Were
20 they expecting him to do his dictation then in his own 12:18
21 time? I don't know. If it had been during his working
22 time, yes, I would have said that would have impacted
23 on his working load but it was the fact that he was
24 doing that in his own time at the weekends.
25 201 Q. I see. Now, can I ask you about two specific patient 12:18
26 scenarios that the Inquiry has heard something about
27 and just get your perspective on it. You have in front
28 of you a cipher list. Patient 16. The daughter or
29 family of Patient 16 wrote a complaint to the Trust on

1 5th December 2016. In a nutshell, Patient 16 had a
2 stent inserted in March 2015 before the onset of
3 chemotherapy treatment, which finished in November of
4 that year, at which point it was indicated that his
5 stent should be revised or would be ready for revision. 12:19
6 The family's complaint - and they have given evidence
7 to the Inquiry through Patient 16's daughter - their
8 complaint in part was in relation to what they regarded
9 as failures of communication in the ensuing six months
10 before his stent was revised on 28th June 2016? 12:20

11 A. Mm-hmm.

12 202 Q. I just want to orientate and refer you to the findings
13 of the serious adverse incident that reviewed that
14 matter. If we could have on the screen, please,
15 PAT-000110. If we just scroll down, please, it says 12:20
16 that, if you pick up there:

17
18 "The last dose of chemotherapy was given on 8th October
19 and the letter to Consultant Urologist 13", which is
20 Mr. O'Brien, "was sent on 26th November." 12:21
21

22 If you scroll down, the review had some difficulty in
23 assessing whether Mr. O'Brien received that letter. It
24 goes on to say:
25 12:21

26 "So there is no evidence that he received and/or
27 acknowledged the letter."
28

29 Scrolling down. An email was sent to Mr. O'Brien on

1 30th September indicating that the patient was on a
2 waiting list for 15th October, and the patient's
3 daughter rang. "There appears to be no record of a
4 response to this email".

12:22

5
6 It then goes on:

7
8 "On 4th March", this is 2016 now, "an email to
9 Mr. O'Brien's secretary indicated the patient had
10 requested a date to come in for removal of stent.
11 There was no apparent action taken at this time".

12:22

12
13 over the page, please. It says, the third paragraph:

14
15 "On 10th May 2016, a further email sent to Mr. O'Brien
16 from his secretary informing him that the patient rang
17 the office and asked for an appointment to have his
18 stent removed. There's no apparent action taken at
19 this time."

12:22

20
21 Then eventually, end of June, the patient is contacted
22 and brought in for stent revision.

12:23

23
24 I suppose the questions that arise out of that from
25 your perspective, whether this case or generally, do
26 you recognise a pattern here of the patient's family
27 ringing in raising the concern with you, two or three
28 times in this case, and no apparent response from
29 Mr. O'Brien? Does this fit into the scenario you

12:23

1 described earlier that the patient would phone or
2 contact you and you would then e-mail Mr. O'Brien?

3 A. That's correct, yes.

4 203 Q. Yes.

5 A. And I would have -- because there was three episodes 12:23
6 here, I would have brought the patient's name up on my
7 email search and I would have sent the subsequent, next
8 email on on the back of the previous email.

9 204 Q. In that kind of scenario, do you do any more than
10 simply draw Mr. O'Brien's attention to the further 12:24
11 contact with the family?

12 A. That's all. That was all I would have done, yes.

13 205 Q. Do you have any role to play in trying to expedite
14 admission or prioritisation for the patient?

15 A. No. 12:24

16 206 Q. For example, could you contact the department in the
17 hospital dealing with admissions to ensure that this
18 patient is seen to, or does this have to come through
19 Mr. O'Brien?

20 A. All elective care comes through the consultant. I'm 12:25
21 not aware of any secretary scheduling patients over and
22 above the consultant's approval.

23 207 Q. If we could go to the evidence of the patient's family
24 member herself. TRA-00118. Just in the middle of the
25 page, the family member is saying: 12:25
26

27 "The communication from ourselves. Both dad would have
28 rang and I rang and whatever and you never got a
29 response to that. You know, the message was relayed

1 obviously but no one, the secretary didn't come back to
2 say, 'well, the consultant, you know, he's on a waiting
3 list, he will be seen in a couple of months. In the
4 meantime maybe you should try this'. So it was that
5 lack of reciprocation of communication which was
6 particularly upsetting."

12:26

7
8 I am sure on a human level, you could understand how
9 that was. Do you have any understanding of why
10 Mr. O'Brien wouldn't have been dealing with your emails
11 raising these issues as quickly as the family would
12 have liked?

12:26

13 A. I can only say that there was numerous patients in the
14 same boat as this particular patient. It was a case of
15 demand outstretching the resources. So once I passed
16 it over to Mr. O'Brien, I assumed then that he took it
17 on board and escalated where needed. That certainly
18 wasn't a role that the secretary would have done.

12:27

19 208 Q. There appears to be no facility or provision within
20 your relationship with Mr. O'Brien to arrive at a
21 situation where he's communicating to you a message to
22 be given back to the family, at least in this case and
23 maybe I shouldn't extrapolate beyond this case. You
24 have described a situation where you do your bit, you
25 send the message on and it's up to him. A better
26 scenario would have been if you were supplied with a
27 reply from Mr. O'Brien so at least you could assure the
28 patient or their family that they have not been
29 forgotten about and there will be action?

12:27

12:27

1 A. Yes. Well, Mr. O'Brien would have tended to have
2 spoken directly to patients in these circumstances and
3 that's how I saw these sort of queries, that
4 Mr. O'Brien would have got in touch with the patient.
5 But he'd never come back to me and said 'will you ring 12:28
6 the patient and tell me them X, Y or Z', he would have
7 done it himself. So, I never expected a reply back
8 asking me to speak with a patient and tell them when
9 they were going to be seen; he would have done that
10 himself. 12:28

11 209 Q. Could I draw your attention to the recommendations that
12 emerged out of that serious adverse incident. If we go
13 to PAT-000115. Just at the bottom of the page, please,
14 just zoom into that. Recommendations 2 and 3 in
15 particular I would seek your observations on. It says: 12:29

16
17 "The Trust should develop written policy or guidance
18 for clinicians and administrative staff concerning
19 writing clinic or discharge letters to ensure all
20 clinical teams or clinicians directly involved in the 12:29
21 patients' care are copied into the correspondence,
22 especially if they are referred in the letter."

23
24 That recommendation arises out of the confusion that
25 occurred at a stage in the case in terms of whether 12:30
26 Oncology and Urology were on the same page in terms of
27 what needed to be done. Correspondence wasn't
28 necessarily going to the right place, or at least there
29 was uncertainty as to whether it was going to the right

1 place. Do you know whether the Trust has since written
2 policy or guidance for clinicians and administrative
3 staff in this respect?

4 A. I don't recall anything regarding that, no.

5 210 Q. Recommendation 3 says: 12:30

6

7 "The Trust will develop written policy or guidance for
8 clinicians and administrative staff on managing
9 clinical correspondence, including email correspondence
10 from other clinicians and healthcare staff. This 12:31
11 guidance will outline the systems and processes
12 required to ensure that all clinical correspondence is
13 actioned, receipt acknowledged, reviewed and actioned
14 in an appropriate and timely manner."

15 12:31

16 Again, have there been any developments around that?

17 A. I have no recollection of any guidance being issued
18 since this.

19 211 Q. Go back to the particular circumstances of this case.
20 When you emailed Mr. O'Brien, and maybe for other cases 12:31
21 as well, would you have even had an acknowledgment to
22 say what he was going to do, even if he wasn't giving
23 you a message to carry back?

24 A. No.

25 212 Q. Do you agree that a requirement for that kind of thing 12:32
26 would be helpful to patients?

27 A. An acknowledgment that he received it?

28 213 Q. And a message to carry back to patients as to what
29 might happen next?

1 A. Well, I suppose it would have kept me in the loop but
2 I assumed that he was contacting the patients.
3 I suppose, yeah, it would have been a point of keeping
4 me in the loop as to what was happening.

5 214 Q. Yes and, of course, that's an important part of it. 12:32
6 But I'm actually cutting right through this to the
7 important people in the scenario --

8 A. The patients.

9 215 Q. -- who are the patients, who are kept in the dark for
10 the better part of six months before treatment arrives 12:32
11 having corresponded at least three times, according to
12 the SAI, if not more, if the patient's evidence to the
13 Inquiry is correct. They are in the dark. You are
14 kindly taking the emails and the telephone calls and
15 passing them on but you are getting nothing back? 12:33

16 A. I take your point, yes. It was leaving the patients in
17 the dark.

18 216 Q. In terms of this serious adverse incident report and
19 its recommendations and lessons to be learned, you're
20 obviously a player or a protagonist in the various 12:33
21 communications that took place?

22 A. Mm-hmm.

23 217 Q. It's not to say that you were at fault in any way, you
24 did your job in receiving the messages and passing them
25 on. Did you ever yourself receive any indication, 12:33
26 first of all that there was an SAI review, and,
27 secondly, that there are lessons to be taken from that
28 review in terms of how we handle this case?

29 A. No. This particular one, no. Or any SAI.

1 218 Q. That's what I was going to ask. In respect of this
2 case, did you know there was a SAI?
3 A. No, but Aidan did ask me a question regarding the
4 initial Oncology letter. I think it's this case.
5 219 Q. It is, yes. 12:34
6 A. Where it was date stamped but not signed by
7 Mr. O'Brien.
8 220 Q. Yes.
9 A. And it was filed.
10 221 Q. So only through that kind of question? 12:34
11 A. I knew, yes, because he started asking me the question
12 where this -- how this happened.
13 222 Q. But you're telling the Inquiry that the Trust didn't
14 sit down with you --
15 A. No. 12:35
16 223 Q. -- or your fellow administrative staff or secretarial
17 staff to say, listen, there is lessons to be learned
18 from this kind of scenario?
19 A. No.
20 224 Q. Could I bring you to another stent case and the name of 12:35
21 this patient is Patient 84. He wrote a letter of
22 complaint to the Trust on 19th September 2016. If we
23 just bring up, please, PAT-000200. Just scroll down.
24 Yes. His scenario was that he had a stent inserted in
25 Easter of 2016 and his expectation was that it would be 12:36
26 removed within six weeks. It wasn't removed within
27 that period. He had two emergency admissions during
28 August of that year when he fell ill, and I think there
29 was at least a risk of septicemia, if not septicemia,

1 in the case. what he says about communication in that
2 case is set out at the bottom of this page. If we just
3 scroll down, please. He was worried about his severe
4 signs and symptoms so he contacted Mr. O'Brien's
5 secretary and asked could he speak to Mr. O'Brien or a 12:37
6 member of his team for some medical advice and to
7 discuss the symptoms. He goes on to say:

8
9 "... as I was concerned something was wrong.
10 Unfortunately, the secretary said I would not be able 12:37
11 to speak to anybody in the medical profession but
12 I should contact my GP and that she would send an email
13 to Mr. O'Brien. I felt my issues were not being taken
14 seriously and I was being neglected."

15 12:37
16 He goes on to say that he recontacted you, having
17 spoken to his GP, and you told him that he was on a
18 waiting list for stent removal but the information was
19 not available. He was again informed that an email
20 would be sent to Mr. O'Brien. So, he goes on holiday 12:38
21 and things are getting worse. Just scrolling down,
22 please. He says that:

23
24 "Upon return from holiday I phoned the secretary again
25 expressing concerns. Again the same response, she 12:38
26 would send an email to Mr. O'Brien who would phone me
27 directly and let me know when the appointment was
28 arranged".
29

1 He goes on in the last paragraph:

2

3 "In desperation for knowing I was unwell, I had to
4 continue making calls to the secretary but I would made
5 to feel like a nuisance and never actually got to speak 12:39
6 to a medical professional or get an appointment for
7 surgery."

8

9 That's an indication of his experience when he came to
10 give evidence to the Inquiry. I needn't bring it up on 12:39
11 the page but it is TRA-00088-89, he described his sense
12 of being fobbed off by his contacts with you and with
13 the Trust. Is that again a scenario you recognise, a
14 patient starting off seeking information, you e-mail
15 Mr. O'Brien, his situation deteriorates, you are again 12:39
16 e-mailing, keeping Mr. O'Brien in good contact with
17 what's going on --

18 A. Yes.

19 225 Q. -- but Mr. O'Brien isn't coming back to you to give a
20 message back to the patient? 12:40

21 A. That's correct. I've checked up on this and the first
22 two contacts this patient had with me was regarding his
23 holiday to Spain. He basically -- it was a case where
24 he was concerned about having the stent in whilst on
25 holiday. 12:40

26 226 Q. Yes.

27 A. If I can remember rightly, the third contact was
28 actually his wife attending my office, because she was
29 a member of staff and she had come into the office, and

1 I had said to her that I would e-mail Mr. O'Brien.
2 That was just prior to his -- that was when she had
3 told me about the episodes of infection, but there was
4 certainly no mention of deterioration or anything in
5 the two previous correspondence -- 12:41

6 227 Q. Yes.
7 A. -- with the patient.

8 228 Q. Yes.
9 A. But, yeah, it was the same case. I would have e-mailed
10 Mr. O'Brien as soon as I got those calls and that day 12:41
11 of the attendance in the office by his wife.

12 229 Q. Yes. Would you accept that the patient had good reason
13 to feel that he was being fobbed off?
14 A. I wouldn't say fobbed off. I see there where it
15 mentioned that I said that he couldn't speak with the 12:41
16 clinician. I would never have said that, I would have
17 said that a clinician was not available. Because
18 clinicians generally didn't sit in secretaries'
19 offices, they were on the busy ward. Unless it was
20 something really urgent, they wouldn't have time to 12:42
21 take telephone calls from all the people that would
22 have rung in. So, the best thing for me to do there
23 was to e-mail Mr. O'Brien, and that's what I did.

24 230 Q. Again, when you look at an example like that in this 12:42
25 further stent scenario which, as you have indicated
26 already, already was a particular cause of
27 communication into you and into the hospital, can you
28 recognise in that scenario a better way of dealing with
29 things with regard to the patient?

1 A. You mean going back to the patient and telling them
2 that we have you on the waiting list?

3 231 Q. Yes. Well, let me hear it from you. We have a number
4 of patients who have given evidence to the Inquiry of
5 putting communication into Mr. O'Brien's office, you're 12:43
6 fielding the call in whatever level of discomfort or
7 distress or worry, and nothing is coming back the other
8 direction to give them, at least in a timely fashion a
9 basis to relieve their concern. Can you see in those
10 scenarios a way of doing things better, and in your 12:43
11 experience what would that look like?

12 A. I don't know because to me, you can't promise someone
13 something that you can't deliver. There was no point
14 in me saying yes, you'll be admitted within a month
15 when we don't know if that was achievable because 12:43
16 obviously red flags took priority. I would prefer to
17 give no information than the wrong information, so that
18 was the reason. I would never have said yes, you'll be
19 admitted within one months, two months or three months
20 because nobody knew because of the demands on the 12:44
21 service. But I take your point that, yes, patients
22 want answers but it's very difficult to give them an
23 answer that you can't stand over.

24 232 Q. Whether it's Mr. O'Brien or any other clinician, in a
25 scenario where you are putting the grievance or the 12:44
26 concern to the clinician in following your job
27 description, should something come back to you or
28 through another process to ensure that the patient is
29 acquainted with what's going to come next and when, or

1 do you not see that as important?

2 A. well, if we're speaking about Aidan, I would have
3 assumed Aidan would have contacted the patient, or that
4 that was the general thought process. I am trying to
5 think back to Mr. Suresh, if I would have got a similar 12:45
6 call, I can't even remember, if he would have come back
7 to me and asked me to communicate with the patient.
8 I'm not sure.

9 233 Q. I'm not asking you now about what happened because we
10 know in the two scenarios I have presented to you that 12:45
11 you didn't get a message back.

12 A. No.

13 234 Q. what should fill that gap? should consultants or
14 clinicians generally be expected to provide you with an
15 answer to communicate back? 12:45

16 A. In the ideal world, yes, but when you're working with a
17 service that you can't give an answer, because nobody
18 knew what red flags were coming through, and stents
19 tend to have been pushed back to accommodate red flags.
20 That seemed to have been the general flow of things, 12:46
21 that stents were sort of second in priority to red
22 flags. So, it was very difficult to give a definitive
23 time of when someone was going to be brought in.

24 235 Q. But these patients don't even seem to have received a
25 message that we haven't forgotten about you? 12:46

26 A. I know, I take your point. I would have tried to
27 reassure them on the phone to say you're on the waiting
28 list and we will be in touch as soon as we've got a
29 date. That was all I could -- that's as much

1 information I could give.

2 236 Q. Could I broaden this out into stent cases more
3 generally. An issue arose in June 2020 which I want to
4 take your views on. AOB-02989. Just scroll on down,
5 please. This is an extract from a referral letter or 12:47
6 communication more generally that Mrs. O'Kane,
7 Dr. O'Kane, entered into with the General Medical
8 Council in respect of the circumstances which she
9 understood were revealed to the Trust in June 2020. It
10 says as regards the patient administration system and 12:47
11 record keeping:

12

13 "In an email dated 7th June 2020, Mr. O'Brien put
14 forward a list of ten patients for inclusion upon a
15 surgical waiting list. On the booking paperwork, some 12:48
16 of these patients appear to have been to diagnosed with
17 stents requiring treatment. There was concern that the
18 patients appear not to have been added to the Trust
19 waiting list for revision of indwelling ureteral stents
20 in a timely fashion. This raised concerns that other 12:48
21 patients might not also have been added to the Trust
22 waiting list for revision of their stents in a timely
23 fashion. Delay in this procedure increases the risk of
24 in patient morbidity. It appears that months have gone
25 by since they were recognised as requiring further 12:48
26 procedure or investigations and they have not been
27 processed in the interim.

28

29 "The specific concern was that there had been a failure

1 to adhere to standard administrative processes
2 following stenting and as a result these patients would
3 be unduly delayed, not dealt with chronologically but
4 potential lost to follow-up until they presented as
5 emergencies. "

12:49

6
7 I want to ask you generally what is your understanding
8 of the administrative process that should have been
9 followed by a clinician when they diagnosed or decided
10 that a patient would require a revision of their stent?

12:49

11 A. Well, these generally were patients that were already
12 admitted under an emergency and then the stent would
13 have been inserted, so they would have been coming from
14 the ward. Generally on the day before their discharge,
15 Aidan would have emailed me the full details of when
16 the patient was to be put on the waiting list, what
17 they were to be put on for, and the urgency. I would
18 have received that email the day before they were
19 discharged and inserted on the waiting list as per
20 Aidan's instructions.

12:49

12:50

21 237 Q. So at the point of discharge, recognising that there is
22 to be a stent revision in the future, you would have
23 been told of that by Mr. O'Brien?

24 A. Yes. He emailed me religiously. Then the chart would
25 have come to me after that when the patient was
26 discharged.

12:50

27 238 Q. Yes. Where would you place the patient in terms of a
28 waiting list?

29 A. They were put on the waiting list as per Aidan's

1 instructions, which was the day of discharge.

2 239 Q. Right. They would go on to the PAS Trust waiting list?

3 A. That's correct, yes.

4 240 Q. And you did that?

5 A. Yes. 12:50

6 241 Q. Are you aware of any patients not having been added to

7 the Trust waiting list for revision of their stents?

8 A. No. No, never.

9 242 Q. That has never happened?

10 A. Never. 12:51

11 243 Q. If we scroll on down.

12 A. Can I add that it was never under Mr. O'Brien, but

13 there would have been occasions whilst working with the

14 other consultants that the discharge summaries that the

15 junior doctors would have filled in sometimes didn't 12:51

16 always list that the patients were returning for a

17 stent removal, and the secretary would have picked it

18 up on the operation notes. So, that did happen prior

19 to working for Mr. O'Brien but never whilst working for

20 Mr. O'Brien. 12:52

21 244 Q. How do we understand the two cases that we have just

22 looked at in terms of the administrative procedure that

23 was to be followed with them? We have looked at

24 Patient 84 and we have looked at Patient 16. So, if

25 Patient 84 is discharged at Easter -- 12:52

26 A. Mm-hmm.

27 245 Q. -- you would have been told about that?

28 A. I would have been e-mailed by Aidan.

29 246 Q. Yes. You would have been told that he required stent

1 revision?

2 A. Yes.

3 247 Q. And would he enter on to the waiting list then at that
4 point?

5 A. Yes. It would have been removal of stent or change of 12:53
6 stent. We always -- I would have always put the
7 removal of stent as the first procedure so that it
8 flagged up on the waiting list, because those would
9 have had to have been brought back in a timely fashion,
10 or tried to. 12:53

11 248 Q. So it's a matter then from the waiting list for
12 Mr. O'Brien to identify a convenient point or an
13 appropriate point, taking into account other demands on
14 theatre --

15 A. Yes. 12:53

16 249 Q. For the removal or revision?

17 A. Yes. Yes.

18 250 Q. In terms of two patients that Mrs. O'Kane is referring
19 to here, do you know about those patients?

20 A. I took this very serious. Sorry. When this hit the 12:53
21 headlines, I actually was very annoyed about this
22 because it is the role of the secretary to put people
23 on the waiting list, and when I read this in the
24 headline news, I felt it was that I had done wrong.
25 So, I investigated it fully and no patients were not on 12:54
26 the waiting list. All ten patients were on the waiting
27 list at the time that they were supposed to be.

28 251 Q. Yes. Were you asked by the Trust about those cases?

29 A. No, never. I just took it on myself, I wanted to check

1 up for myself because I knew it was a role that I had
2 undertook.

3 252 Q. Yes. How did you become aware of the problem?
4 A. When it hit the headline news.

5 253 Q. Did you discuss it with Mr. O'Brien? 12:55
6 A. At the time, yes, because we were both very shocked.

7 254 Q. So what came first, the headline news or the discussion
8 with Mr. O'Brien?
9 A. The headline news.

10 255 Q. Then how did you discuss it with Mr. O'Brien? How did 12:55
11 it come about?
12 A. Well, I knew the ten patients because it was the ten
13 patients that he had copied me into the email for the
14 urgent bookable list. Now, bear in mind this was in
15 the middle of Covid, so these were ten patients that 12:55
16 Aidan had highlighted needed to be seen. So I knew
17 exactly what ten patients the headline news was
18 referring to. I went back on all my information to see
19 where they were and I got all ten on the waiting list.

20 256 Q. Yes. Mrs. O'Kane goes on in this document to say that 12:56
21 because of concerns, a lookback or a consideration was
22 given to whether there were other patients who fell
23 into this category. It says here of the total of 147
24 patients who had emergency procedures, 46 patients with
25 stents were reviewed and five patients in total were 12:56
26 identified as delay due to failure to adhere to
27 standard administrative processes. Were those cases
28 drawn to your attention?
29 A. No. I don't know what that means.

1 257 Q. Is it possible that the Trust has a different view
2 about what standard administrative processes means as
3 compared to the arrangement that you had with
4 Mr. O'Brien?

5 A. I don't know what they are talking about there with 12:56
6 standard administrative processes.

7 258 Q. But the process that you work with Mr. O'Brien was
8 that --

9 A. It was very robust because he was very, very particular
10 about his readmissions. I would say more so than any 12:57
11 other consultant.

12 259 Q. Very well.

13 MR. WOLFE KC: It's coming up to one o'clock if we
14 maybe break.

15 CHAIR: Again, two o'clock. 12:57

16 MR. WOLFE KC: Very well.

17

18 THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

19

20 CHAIR: Good afternoon everyone. 12:58

21 MR. WOLFE KC: Good afternoon, Mrs. Elliott.

22

23 Continuing with our theme of looking at the various
24 communications that you would have had in the course of
25 your job. We've looked at how you have communicated 14:02
26 with colleagues in certain respects, with patients.
27 I now want to ask you about communications with
28 management, particularly in the context of where you
29 have might have concerns about clinical practice or

1 aspects of clinicians' work. If we start with what you
2 say about governance, WIT-76340. At 21.2:
3
4 "Regarding governance, I believe everyone is
5 responsible for governance and when I felt there was an 14:03
6 issue that needed addressing, I would raise this with
7 my service administrator or consultant."
8
9 You gave a couple of examples. I won't use the name of
10 the clinician concerned but you raised a query with a 14:03
11 consultant when you were concerned regarding the
12 quality, the content of the letters generated. Over
13 the page. You spoke to Mr. Haynes about this issue and
14 he asked you to take certain steps. You raised an
15 issue with your service administrator regarding a 14:03
16 patient, and you explain that.
17
18 You, therefore, didn't have any difficulty within your
19 role in terms of raising issues when you felt they
20 needed to be addressed? 14:04
21 A. No.
22 260 Q. Regarding Mr. O'Brien, did you ever raise any concerns
23 about his practice?
24 A. No. Regarding the undictated clinics?
25 261 Q. Regarding any aspect of his practice. 14:04
26 A. Not to my knowledge, no.
27 262 Q. When you think about that now, did you have concerns
28 that you think you ought to have raised about his
29 practice?

1 A. Well, the concern regarding the undictated clinics,
2 I would have raised those with Mr. O'Brien himself. He
3 always assured that it was the non-urgent, the routine
4 dictation that was outstanding and there was nothing to
5 worry about. So that was the reassurance I got there. 14:04

6 263 Q. Mm hmm.

7 A. I can't think of anything else that I would have been
8 concerned about, apart from just long waiters and
9 patients contacting me about their concerns, but those
10 were raised with Mr. O'Brien. 14:05

11 264 Q. When he wasn't dictating on all of his clinics, you
12 were concerned enough to raise it with him?

13 A. Yes.

14 265 Q. But not outside of him. He gave you an assurance and
15 that satisfied you? 14:05

16 A. It did, yes.

17 266 Q. When he wasn't coming back to you when patients had
18 phoned in to you one, two, three, maybe more times and
19 were requiring answers, was that something you should,
20 with the benefit of at least hindsight, have brought 14:05
21 elsewhere?

22 A. I don't know because I understood the pressures that he
23 was under as a clinician in getting all the patients
24 seen on a timely fashion. It was something that the
25 Trust was well aware of, that there was long waiting 14:06
26 lists and there was a lot of pressures to get patients
27 seen --

28 267 Q. Yes.

29 A. -- in a timely fashion. That wasn't something unique

1 to Mr. O'Brien, it was something in the whole of the
2 Urology Service, that there was problems getting people
3 seen in a timely fashion.

4 268 Q. I get the context, what I am talking about is failing
5 to communicate with patients. You would have known 14:06
6 that he has failed to communicate with one of the
7 examples I gave you because you're getting a third
8 email on the issue, and you have rationalised that
9 that's not something I need to bring to anybody's
10 attention because he can't help it? 14:06

11 A. No. I didn't see that as being anything that
12 management could address.

13 269 Q. why not?

14 A. Because we hadn't got the answers. No one had the
15 answers. 14:07

16 270 Q. Had nobody within the Trust the ability to go back to
17 this patient or either of the patients to give them an
18 explanation?

19 A. well, I was giving them an explanation, that there was
20 a long waiting list and there was other priorities. 14:07
21 You know, I would have said that on my telephone call
22 with the patient, so there was nothing really more to
23 add to that or I didn't feel there was anything more
24 I could add to that.

25 271 Q. In terms of the IR1 process - you are obviously 14:07
26 familiar with it, the Datix arrangements from your
27 previous work - did you ever fill in a Datix with
28 regard to any issue when you were a secretary in
29 Urology?

1 A. No, I didn't.

2 272 Q. You have said in your witness statement, if we just
3 bring it up, WIT-76358, at 39.2:

4
5 "While working in the Urology Service, staff were not 14:08
6 actively completing instant report forms for any
7 concerns they may have. Instead staff raised their
8 concerns through the service administrator. I'm not
9 aware if IR1s were completed by the service
10 administrator. I feel the reporting of concerns or 14:08
11 incidents should all be reported through Incident
12 Reporting on Datix."

13
14 Your view is that incidents or concerns should be
15 reported using Datix? 14:09

16 A. Yes, but I was doing what other staff did, basically.
17 Our management, the service administrators and
18 Katherine Robinson, would have emphasised that if there
19 was a problem, they needed to know. So, that was the
20 first point of contact and then they would have 14:09
21 obviously taken it further. So, that was just sort of
22 the way the staff worked in Urology, and I just did the
23 same, I didn't step outside the box.

24 273 Q. Did anyone tell you not to complete a Datix?

25 A. No, nobody said not to but I just did what everybody 14:09
26 else did.

27 274 Q. And by everyone else, you are referring to your fellow
28 secretaries?

29 A. Other secretaries, yes.

1 275 Q. How do you know that's the way they worked? Is that
2 something you discussed amongst yourselves?
3 A. Well, we worked in the same office, the offices were
4 all shared offices, so yeah. But also the --
5 276 Q. How would that kind of thing come up? Explain to me 14:10
6 how you would get into a situation where you're
7 speaking to your fellow secretaries about the
8 circumstances in which a Datix might be completed but
9 you weren't going to do it.
10 A. I don't think the "Datix" word was ever mentioned as 14:10
11 far as I am concerned in Urology. I had the experience
12 of Datix but I don't believe the other secretaries did.
13 277 Q. Yes.
14 A. So they would have raised their concerns with their
15 service administrator and then that's why I just did 14:10
16 the same. I think probably they were ignorant to the
17 system.
18 278 Q. But I'm struggling to understand, you're telling me
19 that your fellow secretaries didn't use Datix?
20 A. Well, as I say, I don't ever remember the word "IR1" or 14:11
21 "Datix" used in the office.
22 279 Q. Yes.
23 A. And we were encouraged to let management know if there
24 was something that we were concerned about, so I just
25 continued then to do that. 14:11
26 280 Q. Yes. But what I am trying to get to --
27 A. Sorry.
28 281 Q. -- you said while working in Urology, staff were not
29 completing instant report forms. Is it fair to say you

1 are basing that assumption on the fact that the word
2 "Datix" was never used in your presence?

3 A. Yes, it's probably an assumption. But it's... I think
4 it's probably something that secretaries should be
5 trained on. 14:12

6 282 Q. Mm hmm.

7 A. It was just basically their ignorance to the system.

8 283 Q. Yes. You can't think of any circumstances when it
9 would have been appropriate for you to use Datix, or
10 can you? 14:12

11 A. Oh I could have used Datix, yeah. First of all, the
12 first point of call was to your service administrator.
13 Now, in fairness I had said that I wasn't aware of IR1
14 forms being completed. When I was preparing for this,
15 I did get to see that there was emails where the 14:12
16 service administrator would have come back and said
17 that an IR1 was raised.

18 284 Q. Yes.

19 A. So again --

20 285 Q. They were raising them, for example, in relation to 14:12
21 Mr. O'Brien retaining notes at home?

22 A. No, not specifically that. Other concerns I would have
23 raised. I can't remember the specifics but it would
24 have been -- for instance, one of them might have been
25 that wrong patient chart used at clinic. 14:13

26 286 Q. Okay.

27 A. It would have been those sort of clinical type
28 incidents.

29 287 Q. Now, I want to ask you more specifically then about the

1 whole issue of backlog reporting and delayed dictation
2 and your view of it.

3 A. Mm-hmm.

4 288 Q. I am particularly interested in the systems that were
5 in place governing that area and whether the systems 14:13
6 were well used by the Trust generally, and indeed by
7 yourself. You would appreciate, wouldn't you, that
8 following a clinical episode or clinical interaction,
9 the clinician has to record that?

10 A. Yes. 14:14

11 289 Q. It's important that certain people will know what is in
12 the clinician's mind following that clinical episode.
13 So, for example, the general practitioner may need to
14 be aware of what's happening to his or her patient?

15 A. Yes. 14:14

16 290 Q. There might be a need to put the patient on a waiting
17 list?

18 A. Yes.

19 291 Q. So, the dictation of the clinical episode might need to
20 cover that. There might be various people who need to 14:14
21 hear from the consultant after the clinical
22 interaction; is that correct?

23 A. That's correct, yes.

24 292 Q. In your experience with other consultants, would they
25 have been routinely dictating after each clinical 14:15
26 episode?

27 A. They would, yes.

28 293 Q. And Mr. O'Brien was different?

29 A. He was different, yes.

1 294 Q. He, I think as you explained earlier, dictated what he
2 explained to you as the urgent matters?
3 A. That's correct, yes.

4 295 Q. His explanation was that while there might be other
5 dictation, it fell into a non-urgent category? 14:15
6 A. That's correct.

7 296 Q. And he would dictate that later?
8 A. Yes. That would be on some clinics. This didn't
9 happen on all clinics.

10 297 Q. Yes. 14:15
11 A. I think it's important to point that out.

12 298 Q. Yes. Let's see how that worked. If we pull up onto
13 the screen, please, WIT-77963, at paragraph 19. This,
14 of course, is your statement to Dr. Chada. You say at
15 19: 14:16
16
17 "On occasion I would have mentioned to Mr. O'Brien
18 about typing for his clinics. Mr. O'Brien didn't do a
19 clinic letter for every attendance but he would put all
20 information into one long letter at the end of the 14:16
21 episode of treatment. When asked if Mr. O'Brien kept
22 the patient's GP informed during the course of a
23 treatment process, I advised that in some cases I don't
24 believe he would have written to the GP until the end."
25 14:16
26 Do you recall saying that?
27 A. I do recall saying that.

28 299 Q. Do you recognise a problem in not keeping the GP
29 informed after a clinical interaction?

1 A. Oh, yes, but this sort of fizzled out as time went on.
2 I wouldn't have said that this would have been an
3 ongoing problem well into my tenure with Mr. O'Brien,
4 it was more or less just at the start I noticed this.
5 But things started to improve where there would have 14:17
6 been a dictation for every episode.

7 300 Q. For how long was that a problem, to your estimation?
8 A. You see, I covered Mr. O'Brien's secretary for a couple
9 of months prior to me actually taking up post with him,
10 so I think it was basically more back at that time that 14:17
11 I would have noticed this. It was basically because of
12 the length of his letters, and the letters would have
13 very clearly paragraphed out each attendance. So, it
14 would have been back maybe to a couple of previous
15 consultations. But as I said, that tended to fizzle 14:18
16 out whenever I did take up post with Mr. O'Brien.

17 301 Q. So it wasn't a problem after September '14?
18 A. I couldn't tell you exactly when but I noticed things
19 changing.

20 302 Q. If we go back a little -- sorry, further on in your 14:18
21 statement, WIT... I'm going to your other statement,
22 I beg your pardon, your statement to the Inquiry,
23 WIT-76360. At 42.1 you say:
24

25 "Regarding undictated clinic letters, I was aware this 14:18
26 was a growing problem for Mr. O'Brien during 2016.
27 Mr. O'Brien reassured me that the urgent dictation was
28 completed and it was routine dictation that was
29 outstanding."

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Did you understand that distinction?

A. Yes.

303 Q. What was routine dictation?

A. It would generally have been a patient who was discharged from the service, like would have been for their consultation and discharged. Or people that were maybe to be added to the routine waiting list, which was years long. I appreciate that they weren't added in a timely fashion but whenever they would have been added, it would have been backdated to the date they were seen, so it wasn't that they were disadvantaged. 14:19

304 Q. Did you ever come across patients who hadn't been added to the waiting list who were disadvantaged?

A. Not that I can -- well, no. Well, apart from there was one urodynamics patient that was tied up in the backlog that was dictated during Mr. O'Brien's sick leave. But it was a patient to be put on for urodynamics so there would have been maybe a slight delay with that patient's admission. 14:19

305 Q. And was there --

A. As regards inpatients, no, they would have been routine. As I say, the routine waiting list was years long. Like I mean four or five or six years, I can't remember exactly at that point in time. 14:20

306 Q. And he wasn't dictating for those?

A. Well, those would have been in that route, what he called the routine dictation.

307 Q. Yes.

1 A. would have been people that would have been added to
2 the routine inpatient waiting list.

3 308 Q. Yes. What was your understanding of why they weren't
4 being done?

5 A. Due to lack of time. They would have been generally 14:20
6 the SWAH clinics, the South West Acute Hospital
7 clinics. That was an all-day clinic, morning and
8 afternoon. Mr. O'Brien would have been slow to dictate
9 those historically.

10 309 Q. Yes. 14:21
11 A. Simply because of capacity.

12 310 Q. Yes. But you were plainly fully aware of the issue by
13 2016; you knew there was a problem?

14 A. It was an issue when I took up post in '14.

15 311 Q. Yes. There was a growing problem by 2016? 14:21
16 A. I started noticing other clinics then joining that list
17 of incompletes. I should say incomplete clinics as
18 opposed to undictated clinics, because I think the
19 word "undictated clinics", it sounds as if none of them
20 were dictated. So, it was incomplete clinics. 14:22
21 I noticed, yes, in early '16 there was other clinics
22 being added to that list.

23 312 Q. Why were you raising it with him?

24 A. Because I wanted my work all tidied up and completed.

25 313 Q. You would have known how many patients Mr. O'Brien was 14:22
26 due to see at SWAH on whatever day of the week. Was it
27 a Monday?

28 A. It was a Monday, yes.

29 314 Q. Yes. You would have expected, as a general rule, to

1 have seen -- if he had seen ten, you would have wanted
2 to see ten dictations?

3 A. Yes, but the dictations would have come to me, been
4 drip-fed to me, so I wouldn't have got ten dictations
5 all in one go. You could have got two one day, three 14:22
6 the next. It could have went over a long period of
7 time and, therefore, very hard to monitor.

8 315 Q. Yes.

9 A. Plus at that time when I took up post, there was an
10 audiotypist working in another building, in a 14:23
11 standalone building and Mr. O'Brien would have brought
12 dictation to her to complete, so I wouldn't have had a
13 full picture of what dictation was outstanding.

14 316 Q. Yes. But the gap in dictation was sufficiently obvious
15 by 2016 that you raised it; you knew there was a 14:23
16 problem?

17 A. It wasn't that I raised it, it came to the service
18 administrator's attention because of one of the
19 dictations that Aidan had done whilst off on sick
20 leave. So, I'll try and explain. 14:24

21 317 Q. We'll come to that in a moment. Was it only by late
22 2016 that you saw a problem, or when did you get this
23 assurance from Mr. O'Brien?

24 A. I had got the assurance all the time. I constantly,
25 every time he would have come into the office, I would 14:24
26 have said 'any word on the dictation from the SWAH
27 clinics', and he would say 'oh yes, I'll see what I can
28 do'. Just the pressures of work, and I was very aware
29 of the pressures of work knowing what time I was

1 getting emails from Mr. O'Brien.

2 318 Q. Yes.

3 A. In the early hours of the morning.

4 319 Q. Yes. So, it was not. You didn't feel the need -- even 14:24
5 though you saw that dictations weren't coming back to
6 you in the numbers that ought to have been, you didn't
7 see the need to escalate it beyond Mr. O'Brien, you
8 didn't see the need to raise it with your service
9 administrator?

10 A. No, because I got the assurance from Mr. O'Brien that 14:25
11 it was routine dictation.

12 320 Q. Yes. But if I may say so, he is the one in default,
13 isn't he --

14 A. He is, yes.

15 321 Q. -- he is the one who has to keep the dictation up to 14:25
16 date. There may be good reasons to explain why he
17 hasn't. It's a point we'll come to in a moment in a
18 different way but he's reassuring you about his own
19 default; do you see a problem in that in terms of
20 governance? 14:25

21 A. Yes, but can I go on to say that there is another
22 mechanism that the management knew. You're probably
23 going to come to that.

24 322 Q. Let's come to that by degrees. Let me start with this:
25 You have mentioned already that there was a known 14:26
26 problem going back to 2014 when you started work?

27 A. Mm-hmm.

28 323 Q. Let's look at how that maybe emerged. If we go to
29 WIT-91971. At the bottom of the page, Conor Murphy is

1 writing to Marie Loughran on 4th November 2014, and
2 he's explaining about the use of DARO quality
3 monitoring reports?

4 A. That's correct.

5 324 Q. You are familiar with those? 14:26

6 A. This was a new concept that came in shortly after
7 I took up post with Aidan.

8 325 Q. Does it help to identify for the system where there is
9 missing attendance and disposal records?

10 A. Yes. Well, outcomes, outcomes/disposals. It's the 14:27
11 same thing.

12 326 Q. Yes.

13 A. Yes.

14 327 Q. If a clinician hasn't provided for an outcome in a
15 case, this system should spot that; is that it? 14:27

16 A. That's correct, yes.

17 328 Q. The point being made by Conor Murphy is that if that
18 step isn't performed by the clinician, if the outcome
19 isn't provided for, after six months that clinic
20 disappears off the system? 14:28

21 A. That's correct.

22 329 Q. It isn't picked up by the system.

23 A. It falls off the patient centre system. This is the
24 reason why a secretary is unable -- after six months
25 you are unable to see what letters were dictated and 14:28
26 what weren't. This was why I could never give an exact
27 number of what dictations were outstanding.

28 330 Q. Yes.

29 A. Because you'd no mechanism for doing that. However,

1 this report gives you the exact numbers.

2 331 Q. Yes. Well, we'll come to that. If we just scroll up
3 the page. You contribute to this; it's copied on to
4 Conor Murphy's, it's copied on to you and Elizabeth
5 Troughton. You say: 14:28

6

7 "I've attached the report with my action recorded.
8 Unfortunately Mr. O'Brien has not given me the outcomes
9 for the Enniskillen clinics. Therefore, I am unable to
10 complete." 14:29

11

12 A. Yes.

13 332 Q. You're writing that to Marie Loughran. Was she your
14 systems --

15 A. She's actually the same Marie Evans. She got married, 14:29
16 so she is Marie Evans. She was the service
17 administrator at that particular time.

18 333 Q. What are you telling her in specific terms in relation
19 to Mr. O'Brien's work?

20 A. Well, the exact same information I told them in 2016, 14:29
21 the outcome sheets were not available for those two
22 clinics. I think there was two Enniskillen clinics on
23 that list. The normal practice was Mr. O'Brien would
24 have given me the outcome sheet when he had completed
25 the dictation for that clinic. So whenever the outcome 14:29
26 sheet was missing, I knew that there was dictation
27 still outstanding. So this here is a report which
28 lists the patients that the clinic outcomes were
29 outstanding. So, therefore, the patients that were

1 dictated on, the outcomes were already done for them
2 from the clinic letter, but it was the non-dictated
3 clinics or non-dictated letters that were outstanding.

4 334 Q. You had to complete something called a backlog report.
5 Let's look at an example of one from 2014. TRU-164942. 14:30
6 This is shortly after you have started working for
7 Mr. O'Brien. We can see what it is asking you across
8 the top of the table. "Discharges awaiting dictation",
9 you've entered in 31 dating back to May. That's May
10 '14, so it's a total of 31? 14:31

11 A. Yes.

12 335 Q. "Clinics awaiting typing" and you have said nil.
13 "Results awaiting dictation", 12. You have left
14 "validated" blank, and approximately ten lever arch
15 files to be filed. You say under "any other relevant 14:31
16 information", "a large amount of back filing which was
17 here when I took up post with Mr. O'Brien".

18
19 what this table doesn't include is information
20 regarding missing dictation from clinics; isn't that 14:32
21 right?

22 A. That's right, yes.

23 336 Q. Subsequently you do provide that information, for
24 example in 2017 and 2018 and '19. why didn't you
25 include it in this table when it might have been 14:32
26 obvious to you, would it not, that this system wanted
27 to know what was going on in terms of demands on
28 secretarial staff and typists?

29 A. Well, I believe this backlog report was a secretarial

1 backlog report, and the purpose of that report was to
2 let management know where there was pressures on typing
3 and filing so that they could distribute the
4 audiotypists appropriately. So, if one secretary was
5 sitting with 100 letters to be typed, the audiotypist 14:33
6 would have been allocated to that particular secretary.
7 So, that's how I saw this report. I did not see it as
8 being a backlog of a consultant's work. It was just
9 that was the way I was told this report was, the reason
10 it was sent to me for. 14:33

11 337 Q. But if the consultant has dictation outstanding which
12 has to be done, surely this service needs to know that
13 that work is going to come in to the system and has to
14 be performed by a secretary or an audiotypist in due
15 course; did you not understand that? 14:33

16 A. Well, that was on the 3D report. I felt that this here
17 was a functional support report as opposed to a Urology
18 report. It was just that's how I saw this as being, a
19 secretarial report and not a holistic report for all
20 Urology Services. 14:34

21 338 Q. Let's look at the steps that you took towards the end
22 of 2016. If we go to TRU-255967, Katherine Robinson is
23 reporting to Anita Carroll, "see the attached list".

24
25 "This is a list of clinics that Mr. O'Brien has not 14:35
26 dictated on and hence no outcome to some of these
27 patients. There is a risk that something could be
28 missed so I am escalating to you although I know that a
29 lot of the time Mr. O'Brien knows himself what has to

1 happen with patients. Unfortunately this was not
2 highlighted on the Backlog Report."

3
4 we have just looked at an example of what a backlog
5 report looks like.

14:35

6
7 "The secretary assumed we knew because there has always
8 been issues with this particular consultant's admin
9 work from our perspective. As I learning from this the
10 discovery, I have asked all secretaries to provide this
11 information on the Backlog Report so we fully
12 understand the whole picture of what is outstanding in
13 each speciality. The secretary also advised that at
14 present Mr. O'Brien is working on some of his backlog
15 admin report as he is off recovering."

14:35

14:36

16
17 Just scroll down. Underneath this email is the list
18 that you sent forward. Scroll down. This is your
19 email, 15th December.

20
21 "Please find attached list of clinics with no outcomes
22 completed as per 15th December 2016."

14:36

23
24 Then beneath that again is the 61 clinics that featured
25 as part of the MHPS investigation. When you are saying
26 no outcomes completed --

14:36

27 A. It should have been actually "no outcome sheets". So,
28 the word "sheets" was missing off that email.

29 339 Q. It wasn't used?

1 A. I just omitted it. I don't know why. It is just an
2 error.

3 340 Q. You said no outcomes completed?

4 A. No outcome sheets completed. As I said, Mr. O'Brien
5 completed the outcome sheet at the end when he had 14:37
6 finished the dictation on the clinic.

7 341 Q. Let's understand the distinction you are now making.
8 You have said no outcome sheets completed is what you
9 should have said. Just scroll down.

10 A. No outcomes means no outcomes for any of the patients. 14:37

11 342 Q. What you have said is "no outcomes completed". What
12 would the reader of that understand?

13 A. Well, that was following a telephone conversation,
14 so...

15 343 Q. So "no outcomes completed" means no dictation completed 14:37
16 for those cases?

17 A. Well, that would, yes, but it actually should read "no
18 outcome sheets".

19 344 Q. Yes, I understand. I know you keep saying that.

20 A. It's an error I -- 14:37

21 345 Q. I am trying to appreciate the distinction.

22 A. But Mrs. Robinson would have been aware of what I meant
23 on the telephone conversation.

24 346 Q. So if you were saying no outcome sheets, what does that
25 mean? 14:37

26 A. The difference being no outcome sheets means that the
27 clinic wasn't completed. That wasn't to say that there
28 was already letters dictated on that clinic. As I say,
29 the urgents and the red flags would have been dictated

1 so it was the routine typing that was outstanding.

2 347 Q. Yes. What you are saying in real terms is of those 61
3 clinics, you hadn't received outcome sheets?

4 A. That's correct.

5 348 Q. You had received dictation for some of the patients who 14:38
6 would have been seen within each of those clinics?

7 A. That's correct.

8 349 Q. But you hadn't received dictation for all?

9 A. That's correct.

10 350 Q. It would be wrong to say that 61 clinics were not 14:38
11 dictated, what you are saying is that parts of those 61
12 clinics had not been dictated?

13 A. Yes.

14 351 Q. And you weren't in a position at that point to say how
15 many? 14:39

16 A. I couldn't. I had no way of knowing.

17 352 Q. Yes.

18 A. There was no mechanism for me. Because the clinic
19 dropped off the Patient Centre System after six months,
20 you had no way of bringing that up again, apart from 14:39
21 that 3D report.

22 353 Q. Yes. Apart from the email which we have just looked at
23 from, I think it was September 2014 when Mr. Conor --

24 A. Murphy.

25 354 Q. -- Murphy had written and you had responded. 14:39

26 A. Yes.

27 355 Q. That was, so far as I can see on our papers, your only
28 intervention to point out that clinics weren't being
29 dictated; is that fair?

1 A. Yes. There were subsequent reports sent and I would
2 have emailed Mr. O'Brien listing the clinics that were
3 outstanding. But yes, I didn't respond back to the
4 service administrator, nor was I asked from them to
5 clarify why these clinics were on that list.

14:40

6 356 Q. If we take a look at what Mrs. Carroll says about your
7 role in this respect. If we go to WIT-21302, at 24.9
8 she said:

9
10 "This incident demonstrated that the secretary was not
11 following standard process. The standard process to be
12 followed is that a consultant holds his clinic and
13 dictates a clinic letter to the GP on every attendance
14 on a timely basis. I would have expected that Noleen
15 Elliott, Mr. O'Brien's secretary, would have been
16 following up with her consultant Mr. O'Brien to advise
17 that he had not dictated on clinics. Also I would have
18 expected that when she was aware of delays in
19 dictation, she would have brought that to the attention
20 of her service administrator, Andrea Cunningham. If
21 this had happened, this would have been apparent on the
22 backlog report and would be visible to myself", and
23 those others she mentions.

14:40

14:41

14:41

24
25 Do you accept that criticism, that this was an aspect
26 of your role that you should have been performing?

14:41

27 A. Not really, no. As I said I looked -- I believe that
28 that backlog report was a secretarial backlog report.
29 I was never told that I was to highlight the backlog of

1 a consultant on that backlog report. There was that
2 mechanism of that 3D report that was already in the
3 system for the service administrator to see what was
4 outstanding.

5 357 Q. We'll come to that, what you call the 3D report, in 14:42
6 just a moment and we'll look at it in a bit more
7 detail. Is it not fair to suggest that an altogether
8 more visible way of bringing it to the attention of the
9 service that there is a problem in dictation is through
10 your good offices? Is that not a much more visible and 14:42
11 immediate way of identifying that a clinician, for
12 whatever reason, isn't providing timely dictation?

13 A. I think it is because I always knew that management
14 were aware of this. It wasn't -- it was nothing new
15 when I took up post with Mr. O'Brien. 14:43

16 358 Q. That might well be right.

17 A. It has always been the case, so I wasn't going to come
18 in and start report, report, report. It wouldn't have
19 sat well with me working for a clinician who management
20 knew there was issues regarding dictation, for me to 14:43
21 start reporting to this, that and the other.

22 359 Q. Was that part of the problem for you, that while you
23 recognised that there was a shortcoming in
24 Mr. O'Brien's practice or in his ability to comply with
25 the understanding around dictation, that you felt as 14:43
26 his personal secretary it would be seen as disloyal
27 or --

28 A. Well, to me I was there to facilitate and not to start
29 and cause problems. Look, I would have dictated --

1 I would have typed the dictation as soon as it arrived
2 with me. There was never any delay in that.

3 360 Q. What if the problems which flow from slow dictation are
4 causing problems for other people - patients, the Trust
5 itself in terms of its understanding of where patients 14:44
6 are at. If that's causing a problem, why do you not
7 feel it's within your responsibility to draw that out?

8 A. Well, I was getting the assurance from Mr. O'Brien that
9 there was nothing. It was routine dictation.

10 361 Q. So you now know that patients, they well be small in 14:45
11 number, suffered harm as a result?

12 A. I am not aware of that, no.

13 362 Q. Well, you have explained that there was one case, and I
14 think you may have referred to two cases --

15 A. There was one. It was a urodynamics case. 14:45

16 363 Q. -- where the patient should have been seen 12 months
17 earlier?

18 A. Not, 12 months earlier, no. Not 12 months earlier.

19 364 Q. Let's not argue about the precise --

20 A. It's that one urodynamics case. 14:45

21 365 Q. Yes.

22 A. Yes.

23 366 Q. I'll try and pull up the reference as we go and we can
24 look at it. You refer to the availability of another
25 system, what you call the 3D system, to give the same 14:46
26 information to the Trust as you are being criticised
27 for not providing?

28 A. That's correct.

29 367 Q. Let's just look at that. If we go to your second

1 addendum statement where you refer to this, I think for
2 the first time. WIT-96808. At paragraph 4, this is
3 what you're correcting, you're saying originally
4 Mr. O'Brien had dictated on the urgent dictation.

14:46

5
6 "These undictated letters were flagged up on the
7 Backlog Report. Mr. O'Brien went on sick leave in late
8 October 2016 and during his recovery in November and
9 December 2016, he started to address this backlog."

14:47

10
11 where you say that these undictated letters were
12 flagged up on the Backlog Report; is that correct?

13 A. No, that was post December '16.

14 368 Q. Yes. Okay.

15 A. So it was just I got that --

14:47

16 369 Q. So prior to that --

17 A. Prior to that, they weren't, no.

18 370 Q. You then changed this and provide the following
19 explanation:

14:47

20
21 "Mr. O'Brien had dictated on the urgent dictation and
22 continued to address this backlog until he went on sick
23 leave in November '16. These undictated letters were
24 flagged up on the data quality report. Outpatients
25 with no attendance, outcome disposal recorded."

14:48

26
27 You then refer us to that, and we'll look at that now.
28 Then you say:

29

1 "During his recovery from surgery in November and
2 December 2016, Mr. O'Brien continued to work through
3 the backlog in dictation."
4

5 Clearly nothing in your backlog report to flag up the 14:48
6 issue, what you are saying is the Trust should rather
7 have looked to this other document, the data quality
8 report.
9

10 Let's pull up that report for the period April 2015 to 14:48
11 February 2016. Let's just go to the first page of the
12 report to start with, WIT-76376. I choose this page
13 just so that the Inquiry can see the headings at the
14 top of the table. This document runs to several
15 hundred pages; isn't that right. 14:49

16 A. That's correct.

17 371 Q. It takes the reader across a number of different
18 clinics which are provided by the Trust.

19 A. That's correct.

20 372 Q. It's not just urology, as we can see from the examples 14:49
21 here. This report does what in terms of helping the
22 Trust to understand what's outstanding?

23 A. It's basically saying that this is the patient episodes
24 that haven't been disposed or the outcomes had not been
25 completed on. These patients -- I think that one does 14:50
26 actually identify the patient with the case note number
27 at the end. So all of these patients, outpatients or
28 episodes are sitting opened but not either added to a
29 waiting list, discharged, or on for a review

1 appointment. As you say, it went on to hundreds of
2 pages.

3 373 Q. Yes. If we go to urology entries, which are about 300
4 pages further on, just to illustrate the point that it
5 is a lengthy document. If we go to WIT-76603, we can 14:50
6 see that a number of urology consultants are mentioned.
7 If we go, for example, to the first O'Brien entry. If
8 we go to the fifth column, we see the coding or the
9 abbreviation AAOBU1. Is that an Armagh?

10 A. That's an Armagh clinic. 14:51

11 374 Q. So that means Mr. O'Brien has gone out to a satellite
12 clinic in Armagh.

13 A. Yes, and that would --

14 375 Q. Is that the date of the clinic sitting beside it then?

15 A. No, two columns over is the date of the clinic. The 14:51
16 date beside is the date they were referred in.

17 376 Q. Okay. 2nd November 2015 is the date of the clinic?

18 A. Yes.

19 377 Q. The fact that it appears in this report tells us that
20 the clinical episode is still open; it hasn't been 14:52
21 closed?

22 A. The outcomes haven't been completed.

23 378 Q. Yes. By outcomes completed, that means the patient
24 either hasn't been -- steps have not been taken to
25 discharge the patient or a step has not been taken to 14:52
26 add him to a review list or any other kind of list?

27 A. Yes.

28 379 Q. To take another example. If we go down, we find an
29 entry alongside Mr. O'Brien's name for 6th November,

1 the first, 6th November 2015. The entry is CAO UDS?
2 A. That's Craigavon urodynamics clinic. There was
3 generally three patients on that clinic, so that's all
4 three.

5 380 Q. There was a urodynamics clinic on 6th November 2015, 14:53
6 and again the episode hasn't been closed?

7 A. No.

8 381 Q. So the outcomes are still outstanding?
9 A. Yes.

10 382 Q. This data relates to the period from April '15 through 14:53
11 to February '16; is that right?

12 A. As far as I know. I'll take your word for it.

13 383 Q. This system of cataloguing outstanding clinical
14 episodes, you say, didn't rely on you to tell the Trust
15 that Mr. O'Brien was not completing his dictation? 14:54

16 A. Well, it was robust enough to know that the episodes
17 weren't closed for whatever reason. It could have been
18 a delay in typing or a delay in dictation.

19 384 Q. Yes. It didn't tell the reader what was going on in
20 SWAH, in the South Western Hospital? 14:54

21 A. Subsequent reports included SWAH. I don't think SWAH
22 was on this particular one for whatever... Obviously
23 whoever done the searches for this didn't include SWAH
24 in the search. The data quality department.

25 385 Q. So this report couldn't be relied upon by the Trust to 14:54
26 know that he wasn't completing his SWAH clinics in a
27 timely fashion -- completing his clinical outcomes in a
28 timely fashion?

29 A. From SWAH?

1 386 Q. Yes.

2 A. But subsequent reports did include SWAH. I don't
3 know -- this one not didn't include SWAH but other
4 reports that were received, I think maybe the first
5 one, remember it had two SWAH clinics on it, the very 14:55
6 first data quality report that came through. I don't
7 know, for some reason this one didn't but the others
8 did include SWAH. That was something outside my
9 control. It was the data quality people who populated
10 this report. 14:55

11 387 Q. What you are saying is that this system, properly used,
12 could have been availed of by Trust management to
13 interrogate or question the issue of why a clinic or a
14 patient attending a clinic hadn't received an outcome?

15 A. Yes. 14:56

16 388 Q. Hadn't received a disposal?

17 A. Yes.

18 389 Q. You would say that, as I understand your evidence,
19 there was no need for you to be telling the Trust that
20 Mr. O'Brien wasn't dictating because the Trust had this 14:56
21 system at its disposal and ought not to have required
22 you to be informing on Mr. O'Brien?

23 A. Yes. Well, I did -- do you remember, going back to
24 that email I had sent Marie Loughran where I had said
25 that Mr. O'Brien hadn't given me the outcome sheets for 14:56
26 the two Enniskillen clinics, and that was on the back
27 of this report.

28 390 Q. Yes. Why, having done that at one point in time in
29 2014 told the system, told the service Mr. O'Brien

1 isn't dictating on SWAH or isn't doing it quickly now
2 enough, why didn't you continue with that?

3 A. I don't know. Probably just the pressures of work and
4 I knew that everybody knew. I think I have said in my
5 statement that it was common knowledge. So therefore, 14:57
6 I -- the information was there for managers to see.
7 I didn't need to tell them where to look for it.

8 391 Q. We have received evidence from Mrs. Robinson in respect
9 of this issue. I'll give the Panel the transcript
10 references, I don't need to bring them up on the 14:57
11 screen. It's TRA-05189 through to TRA-05196. Thinking
12 back to the Backlog Report that we have looked at, and
13 we'll look at some more recent examples of it, she is
14 saying while there isn't a specific column on that
15 table to address clinics awaiting dictation, that was 14:58
16 nevertheless an issue secretaries should have known to
17 report to add that information in to the table. You
18 don't accept that?

19 A. I didn't think of it at the time, no.

20 392 Q. In 2016/early 2017, were secretaries told to include 14:58
21 that information in the Backlog Reports?

22 A. Yes.

23 393 Q. And did you do so?

24 A. I did, yes.

25 394 Q. We can just look at a couple of examples of that. If 14:59
26 we go to WIT-77951. You use the far right column to
27 complete an entry for 25th May 2017, this "also see
28 attached list of clinics with no outcomes completed".
29 A. That was the list that was given to them in December

1 '16, so those outcomes, to my knowledge, were never
2 done by May '17.

3 395 Q. Okay. In 2019, WIT-77995. Not that. If we try
4 TRU-77995? Thank you. So again, you use the middle
5 column at the bottom "awaiting dictation" --

15:00

6 A. Mm-hmm.

7 396 Q. -- to convey the message that there were 16 patients
8 awaiting dictation from a clinic in September '19, and
9 again six from 27th September '19. That was how you
10 started to use the system after being told, the Trust
11 might say reminded, of the need to do this from early
12 2017; is that fair?

15:01

13 A. That's correct, yes.

14 397 Q. You have mentioned that, when we looked at the outcome
15 report for the Backlog Report, I should say from
16 May 2017, that you were including as an attachment to
17 it those clinics that hadn't been dealt with by the end
18 of 2016 are the ones you referred to in your
19 December 2016 email?

15:01

20 A. Yes.

15:02

21 398 Q. It was your understanding that even by that point in
22 time, May 2017, these matters had not been dictated or
23 completed. Why were you raising that point?

24 A. Because there was a further five to six months' delay
25 in those outcomes being done. I was aware that
26 Mr. O'Brien had given the Trust the outcome sheets, so
27 I couldn't understand why those outcomes weren't
28 completed as soon as those were received by the Trust.

15:02

29 399 Q. Do you now appreciate that those patients' cases were

1 the subject of consideration by other urologists and
2 that they worked up what had to be done with those
3 patients who hadn't been completed?
4 A. I didn't know at the time, no. I didn't know what was
5 happening those patients. 15:03
6 400 Q. And why should you have known?
7 A. Well, that was my work. Completing the outcomes of the
8 clinics was part of my work and that was taken off me.
9 401 Q. Right. In a sense, you were chasing them or seeking an
10 explanation? 15:03
11 A. Well, I thought my management needed -- in fact, I got
12 an email from Katherine Robinson in, I think it was
13 February '17, asking me if I had the outcomes done, so
14 she wasn't even aware that I didn't get the outcomes.
15 So, I had to put her right and say those outcome sheets 15:03
16 were never sent to me, they were sent to the admin
17 office and I was totally unaware as to what was
18 happening with them. So my line management didn't know
19 what the process was.
20 402 Q. You have said in your statement, if we just bring it 15:04
21 up, WIT-76360 at 42.1 - scrolling down - that you were
22 appreciative or appreciating that Mr. O'Brien was
23 working through the backlog --
24 A. Mm-hmm.
25 403 Q. -- during his sick leave, and you said with maximum 15:05
26 effect . what did you mean by that?
27 A. Well, I was conscious that he was off on sick leave and
28 still he was doing 10 to 15 letters a day. He would
29 have been bringing the charts into my office late on in

1 the evening. So, whenever I would have come in the
2 morning, those charts were sitting on my desk with the
3 dictation completed. Even though I had a locum that
4 was backfilling his sick leave, I then had this
5 additional work. So I was happy to get that work all
6 completed. 15:05

7 404 Q. Then you go on at 42.2 to say:

8
9 "This was all halted in late December 2016 by
10 management, I'm not sure who was directing this, and 15:05
11 Mr. O'Brien was subsequently suspended from his duty as
12 a consultant urologist."

13
14 Then you talk about the investigation being initiated.

15 A. Mm hmm. 15:06

16 405 Q. You say this backlog in dictation remained until at
17 least May and June '17, and you were never informed if
18 the dictations in clinical outcomes were ever
19 completely dealt with.

20
21 "I feel that Mr. O'Brien should have undertaken this
22 workload and I should have been allowed to complete the
23 administrative work associated with it." 15:06

24
25 So, you appear critical of the suspension of 15:06
26 Mr. O'Brien, the MHPS investigation and the fact that
27 this work was taken off you and Mr. O'Brien; is that
28 what you are saying?

29 A. Well, at that particular time in January, I didn't --

1 I wasn't aware that Mr. O'Brien was suspended. I was
2 actually told --

3 406 Q. I think the proper word is "excluded"?
4 A. Excluded.

5 407 Q. My fault. I used the word "suspended" but it is 15:07
6 "excluded".
7 A. Sorry. I was sent an email from Martina Corrigan to
8 say that Mr. O'Brien was having an extended sick leave
9 period. That was the reason I was critical of the
10 system because that was part of my work that was taken 15:07
11 off me and I couldn't understand why.

12 408 Q. But you are writing this statement --
13 A. Afterwards.

14 409 Q. -- many years later?
15 A. Yes. 15:07

16 410 Q. You are saying "I feel that Mr. O'Brien should have
17 been allowed to get on with this" . Do you accept that
18 by the end of 2016, notwithstanding Mr. O'Brien's
19 efforts during his sick leave to get to grips with the
20 outstanding clinics, that there was still a substantial 15:08
21 number of cases outstanding?
22 A. I never knew the total amount until obviously later.
23 I didn't know whether it was 10, 20, 30. I had no idea
24 how much dictation was outstanding.

25 411 Q. what you knew was that there were 61 clinics that had 15:08
26 some element of outstanding work; isn't that right?
27 A. Yes.

28 412 Q. Yes.
29 A. Well, it was reduced, I think, by the time it hit the

1 end of December.

2 413 Q. Yes.

3 A. Because he was working at it. So it was 61 at the
4 beginning of December --

5 414 Q. We can quibble this down, Mrs. Elliott, but let's get 15:08
6 on. When you wrote the email on 15th December, you
7 were aware of 61 clinics with some element outstanding;
8 isn't that right?

9 A. Yes, that's correct.

10 415 Q. Why are you complaining that you weren't and 15:08
11 Mr. O'Brien weren't able to complete that work when you
12 know that there were clinics outstanding for almost
13 two years in terms of the completion of them?

14 A. I think probably the reason I was so annoyed was the
15 fact that there was a further five to six months. So, 15:09
16 those patients were not seen to or addressed for a
17 further five to six months. If those outcome sheets
18 had have come to me, I would have had those done within
19 a week.

20 416 Q. Yes. 15:09

21 A. It was the fact that they were sitting for a further
22 five to six months, I couldn't understand why the Trust
23 would have let that happen.

24 417 Q. You referred us, I think earlier, to a particular case 15:10
25 that you identified where there was a problem caused
26 for the patient by a lack of dictation and a lack of
27 action on Mr. O'Brien's part. Can we just draw your
28 attention to that, please. It's WIT-77963. At
29 paragraph 21 you tell Dr. Chada:

1
2 "I recently had to request a chart from the Head of
3 Urology office for another clinic. When I received the
4 chart, I noticed that the patient should have been put
5 on the waiting list for urodynamics studies. This 15:10
6 patient was originally seen in June 2016 and should
7 have been on urodynamics waiting list. As the waiting
8 list was shorter than some others, this patient could
9 have had the procedure by the end of last year if he or
10 she had been put on the waiting list." 15:11
11
12 Mr. O'Brien saw the patient June '16?
13 A. That's correct.
14 418 Q. Should have put the patient on the waiting list at the
15 end of the clinical episode. In other words, he should 15:11
16 have dictated that night or the next day?
17 A. Mm-hmm.
18 419 Q. You're writing a statement in 2017 and reflecting that
19 you have only just noticed that this patient should
20 have been on the urodynamics waiting list, so that 15:11
21 patient has suffered some harm in not getting his or
22 her treatment in a more timely fashion?
23 A. Yes. The waiting list for urodynamics would have been
24 about eight to 12 months.
25 420 Q. What you are saying is this patient -- 15:12
26 A. It was much shorter, yes.
27 421 Q. -- would have been seen by the end of 2016?
28 A. Yes. Well, as I say, maybe six to 12 months. As
29 I say, the waiting list for urodynamics was shorter

1 than that of inpatients.

2 422 Q. Yes. Mr. O'Brien had assured you that all urgent cases
3 had been dealt with in terms of dictation?

4 A. Yes.

5 423 Q. Is this not a case of urgency? 15:12

6 A. Urodynamics wouldn't have been classed as an urgent
7 procedure.

8 424 Q. But you're not saying it's okay for this patient to
9 have slipped through the net and awaited several months
10 at the very least more than should have been the case 15:13
11 for his intervention? Are you saying this is an
12 acceptable way to have dealt with this case?

13 A. What do you mean an acceptable way? An acceptable way
14 in that it wasn't dictated and he wasn't put on a
15 waiting list? 15:13

16 425 Q. Yes.

17 A. No, it wasn't acceptable.

18 426 Q. And this could have been avoided with timely dictation?

19 A. Timely dictation. Plus if the outcomes for those
20 undictated clinics had been given to me in January '17, 15:14
21 I would have had this man on a waiting list. He had to
22 wait a further five months, five to six months. It was
23 May/June before they'd done the outcomes.

24 427 Q. Yes. Mr. O'Brien should have done it in June. If the
25 Trust had studied the paperwork and actioned it, it 15:14
26 could have been done in January?

27 A. Mm-hmm, yes.

28 428 Q. When you were speaking to Mr. O'Brien about these
29 matters and he was assuring you that his urgent stuff

1 was done, his non-urgent stuff could wait, would that
2 explanation have covered a case like that? would that
3 have satisfied you?

4 A. Probably not.

5 429 Q. Did you ever ask him to confirm that nobody was going 15:15
6 to come into difficulty or to harm or would be
7 excessively delayed by his inaction?

8 A. There would have been the odd email where patients
9 would have rang in to see where they were on the
10 waiting list, and I would have forwarded an email to 15:15
11 Mr. O'Brien to say the patient was on the phone, they
12 are expected to be on a waiting list but the dictation
13 wasn't done. So, there would have been those odd
14 occasions where the patient would have contacted me.
15 But that was very rare. It was rare, like. 15:15

16 430 Q. Yes. Could I move on and look at the issue of triage
17 with you, and GP referral letters. You have explained
18 in your witness statement that when you joined Urology
19 Service, the triage letters were forwarded to the
20 consultant through you, through the secretary? 15:16

21 A. That's correct.

22 431 Q. There was a change in that process in November '14 into
23 the early months of 2015 --

24 A. Mm-hmm.

25 432 Q. -- when the Urologist of the week system was 15:16
26 introduced. Let's just look at how that worked and
27 I am particularly interested in how the systems worked.
28 If we look at TRU-294285, this would be, would it not,
29 a fairly typical transaction in terms of chasing

1 triage. Alannah Coleman, is she from the Referral and
2 Booking Centre?

3 A. That is correct, yes.

4 433 Q. She is writing to you, 14th October 2014.
5 15:17
6 "Outstanding triage from Mr. O'Brien, please have these
7 returned as soon as possible".
8
9 Then you would e-mail Mr. O'Brien?

10 A. That's correct. 15:17

11 434 Q. Is that the way --

12 A. Well, I probably didn't e-mail them all but when it was
13 a list like that, I would have e-mailed. If it was
14 individual triage letters, I usually printed them off
15 and left them on his desk with the other triages. 15:17

16 435 Q. Yes. If, as we have seen in certain scenarios, there
17 is repeat emails to you --

18 A. Mm-hmm.

19 436 Q. - 'chase this, do this, it is outstanding three months
20 or whatever', was your formula the same? 15:18

21 A. Yes, those would have been printed off and left on
22 Mr. O'Brien's desk.

23 437 Q. When you are getting these repeat communications about
24 outstanding triage and you are printing off the email
25 and leaving it for him, was that to your mind an 15:18
26 effective system for addressing delayed triage?

27 A. Well, I had no other way of addressing it. I found
28 printing the email off and leaving it was the best way.

29 438 Q. Yes, but how effective was it in your view in terms of

1 getting a timely response?

2 A. well, probably when there was numerous printing off and
3 leaving, probably no, it wasn't very effective, but
4 I didn't take any responsibility to the monitoring of
5 those. It was just I was leaving them for him to do 15:19
6 and that was my input into the triaging.

7 439 Q. Yes. In terms of your role, we have seen it perhaps
8 already with patients phoning in, you are leaving
9 emails with triage, you are leaving emails, at any
10 point did you seek to engage in conversation with 15:19
11 Mr. O'Brien about those issues?

12 A. Oh, I would. If he had have come into the -- when he
13 came into the office, I would have usually highlighted
14 something like that, but that was as far as it went.
15 I would have said there is a -- especially if patients 15:19
16 rang, did you get that email about such and such; and
17 he would have said, yeah, he would take it on board.
18 There would have been interaction, yes, about
19 particular things that I was concerned about.

20 440 Q. What was your memory of the kinds of responses that you 15:20
21 would get around the triage issue from Mr. O'Brien?

22 A. I didn't really take much... what would you say;
23 I didn't follow up on triage because I knew that was
24 being monitored by the booking office. I was basically
25 passing on what was given to me and I left everything 15:20
26 else up to the booking office, between them and
27 Mr. O'Brien. And the red flag office obviously for the
28 red flag referrals.

29 441 Q. Just so we understand it, after late '14/early '15, how

1 did the system change in terms of chasing up with
2 Mr. O'Brien? If pre '14 you were expected to follow
3 up, what was the system after that?

4 A. After that the triage -- the appointments people would
5 have left all the triage letters down in the Thorndale 15:21
6 Unit, which was a building where the clinics were held,
7 the urology building. That would have been for the
8 Consultant of the week. whatever Consultant of the
9 week was on, they were left in a basket in the office
10 in Thorndale. So, the secretaries would have had less 15:21
11 interaction regarding triage. That was the same for
12 the red flag triaging.

13 442 Q. So the follow-up, if there needed to be follow-up, for
14 delayed triage was the responsibility of the red flag
15 people, or, if it was routine or urgent, the referral 15:22
16 and booking centre?

17 A. Mm-hmm.

18 443 Q. You did, it seems, receive some correspondence to try
19 to encourage you to chase up even after that time. If
20 we look at, for example, WIT-77945. This is 15:22
21 13th September 2016:
22
23 "Please see the list of current missing triage. If
24 possible could this be returned as soon as possible."
25 15:22
26 Obviously Mr. O'Brien is copied in as well. Are you
27 being expected to chase this?

28 A. Not to my knowledge. I don't think it's a secretary's
29 duty to chase triage. Just due to work pressures, we

1 just had not the time to do that.

2 444 Q. So as far as it went, as far as you are concerned, it
3 was just to ensure that Mr. O'Brien was aware of it?

4 A. Yes. As long as I saw he was copied into that,
5 I didn't need to act on that.

15:23

6 445 Q. Could I give you another example, TRU-294453. This is
7 a little earlier in 2016. Alannah Coleman - we'll not
8 use the patient's name obviously, maybe you would
9 remember it - is saying to you:

10

15:24

11 "This is my fourth time chasing a response to the
12 attached referral. I will leave this for you to sort
13 out."

14

15 Was that a referral for triage?

15:24

16 A. It was. That would have been an example of one of the
17 ones, when it was an individual patient like that,
18 I would have printed that off and left it on his desk
19 with the rest of his post. So, the fact that it was
20 the fourth one, then you can see I e-mailed him then
21 after the fourth one.

15:24

22 446 Q. Yes.

23 A. But the other earlier ones would have been printed off
24 and left on his desk with the post.

25 447 Q. Yes. I mean, it's probably obvious to the Inquiry that
26 Mr. O'Brien's travails with triage were longstanding
27 and that the system and its management knew about it?

15:24

28 A. Yes.

29 448 Q. Did anyone within management ever approach you to

1 invite you to be more proactive with Mr. O'Brien to try
2 to encourage earlier responses?

3 A. No. I don't know how a secretary can encourage any
4 clinician to do anything different than what he is
5 doing.

15:25

6 449 Q. Yes.

7 A. You know.

8 450 Q. Did you think it unfair that this was being placed
9 across your desk on repeated occasions, more notably
10 pre-2015, to follow up with Mr. O'Brien, or did you
11 just see it as --

15:25

12 A. I didn't think it unfair. Like, as I said, I actioned
13 anything I got. I left it on his desk.

14 451 Q. Yes.

15 A. But as regards trying to encourage anybody to do
16 anything, I don't think that was a secretary's job to
17 stand over him while he done it.

15:25

18 452 Q. Martina Corrigan has reported in her statement to
19 Dr. Chada - I don't need to bring it up but it's
20 TRU-00748 - that when she spoke to Mr. O'Brien in
21 January 2017, he directed her to his filing cabinet,
22 and in the third drawer of the filing cabinet there
23 were, she counted, 783 - the number isn't terribly
24 significant - a sizeable number of referral letters
25 dating back to June 2015.

15:26

15:26

26
27 Did you know that those referral letters were in his
28 filing cabinet?

29 A. I knew there was post. It was actually in his drawer

1 of his desk. I knew there was stuff there but I didn't
2 interfere with it. I didn't know what it was.

3 453 Q. Did you know that he wasn't triaging by and large
4 normal -- sorry, routine I should say, and urgent
5 referrals? 15:27

6 A. I knew there was a delay in him triaging them. I never
7 understood that he didn't triage. I knew that he
8 hadn't, he said he hadn't the time to do the triage,
9 but it wasn't that he didn't do any.

10 454 Q. What's your current understanding? 15:27

11 A. I think he still did some but not all of.

12 455 Q. So he did the red flag?

13 A. Well, definitely the red flags were. Albeit there may
14 have been a slight delay in the return of the red flags
15 but they were generally done in a timely fashion. But 15:28
16 it was the routine and the non-red flag, the routine
17 and the urgents, that I knew there was a big backlog.

18 456 Q. Were they not available to be observed in his office?

19 A. Well, as I say, I knew there was stuff in that drawer
20 but I didn't interfere with anything that was put away 15:28
21 in his drawer because that wasn't for me to start going
22 through.

23 457 Q. If you had been aware that he wasn't triaging at all on
24 routine and urgents, would that have been something
25 that you would have raised? 15:28

26 A. No, because the booking office were monitoring his
27 triaging. I didn't think it was a responsibility of me
28 to monitor triaging, it was already being done in the
29 booking office.

1 458 Q. The issue of the storage and management of patient
2 records was another issue which you would have been
3 familiar with as secretary for Mr. O'Brien. We know
4 that nearly 300, approximately 300 charts were returned
5 from his home in 2017 . Again, would you have had an 15:29
6 awareness that a significant number of charts tracked
7 to Mr. O'Brien were not kept in hospital but had been
8 brought to his home?

9 A. Yes, I was aware that there were charts in his home
10 because I frequently had to ask him to bring charts in 15:29
11 that were required for other clinics.

12 459 Q. Yes.

13 A. And that was happening on a very regular basis.

14 460 Q. Had you any sense of the scale of it?

15 A. Not the scale, no. I knew the outstanding -- you see, 15:30
16 it all ties up with the outstanding dictation, well,
17 the most of it, because the most of those charts at
18 home were from those undictated clinics, the SWAH
19 clinics.

20 461 Q. Yes. 15:30

21 A. I would say at least half of them were probably SWAH
22 charts -- or not SWAH charts, Craigavon charts
23 belonging to SWAH patients.

24 462 Q. Yes. There is obviously policy governing the handling
25 of and the safeguarding of patient files. I just want 15:30
26 to draw this to your attention and seek your response.
27 If we go to TRU-164900. This is the policy - you can
28 see its lengthy title - Policy for the Safeguarding,
29 Movement and Transportation of Policy Clients, SWAH

1 Trust Files and Other Trust Media Between Facilities".
2 This particular iteration is dated 2012. Is that
3 something that you would have had a working knowledge
4 of as a secretary with responsibility for handling
5 patient charts? 15:31

6 A. No, because I would never have had charts in my
7 possession removed to another facility. It wasn't
8 something I would have been familiar with, no.

9 463 Q. But you were responsible for holding charts in your
10 office; isn't that right? 15:32

11 A. In my office?

12 464 Q. Yes.

13 A. Yes, but that was on the Craigavon site.

14 465 Q. This policy is broader than the movement of charts.
15 Could I ask you this: Had you any training in data 15:32
16 protection issues, data management issues?

17 A. Yes.

18 466 Q. Safeguarding of patient charts?

19 A. We would have done, as part of the induction -- well
20 not, induction, corporate training, there would have 15:32
21 been modules on data protection. We would have had to
22 complete those as part of our KSF. As regards, that
23 would have been like a training module we would have
24 done on data protection and the handling of charts.

25 15:33

26 But as regards this policy, I don't ever remember
27 seeing it.

28 467 Q. This didn't come across your desk?

29 A. No.

1 468 Q. That will help expedite matters if we just briefly
2 touch on some aspects on it, and we'll see if these
3 kinds of principles or policy standards ever came your
4 direction in another way. If we can go over the page,
5 please, and we can see the guiding principle.

15:33

6
7 "The aim of the policy is to ensure that staff
8 safeguard all confidential information while travelling
9 from one facility location to another during the course
10 of their working day".

15:33

11
12 **Scrolling down:**

13
14 "The guiding principle is that staff working within
15 health and social services have an ethical and legal
16 obligation to protect the information entrusted to them
17 by users of the services. Staff must notify their line
18 managers immediately on the suspicion of loss of any
19 confidential information. The line manager must then
20 notify the Information Governance Team of any loss.
21 Managers must ensure that staff are aware that
22 disciplinary action may be taken when it is evident
23 that a breach in confidentiality has occurred as a
24 result of a member of staff's neglect ensuring the
25 safeguarding of confidential information."

15:34

15:34

15:34

26
27 would those kinds of guiding principles have been
28 broadly within your knowledge during your time as a
29 secretary?

1 A. Yes, they would.

2 469 Q. So if there was a suspicion of loss of any confidential
3 information, that was a matter to be raised with line
4 management?

5 A. Yes, that's correct. 15:35

6 470 Q. Is that something you ever had occasion to do as
7 secretary for Mr. O'Brien?

8 A. Never, no.

9 471 Q. Did you ever have occasion to be concerned that notes
10 had been lost? 15:35

11 A. No.

12 472 Q. I am going to explore that with you by reference to
13 some emails in a moment. Before doing so, can we go to
14 TRU-164906. It says at paragraph 8, if we can just
15 look at that, it's dealing with the transport and 15:36
16 storage for domiciliary visits. If we just go to the
17 last bullet point. Obviously, Mr. O'Brien didn't do
18 domiciliary visits but it says:

19

20 "Staff should not normally take health client records 15:36
21 home. Where this cannot be avoided, procedures could
22 be in place to safeguard that information effectively.
23 If records are being held by staff members home
24 overnight, then they must be kept in a secure place.
25 The responsibility for the records is held by the staff 15:36
26 member."

27

28 Did you consider it in any way inappropriate that
29 numbers of patient records were being held at

1 Mr. O'Brien's home, as it appears, routinely?
2 A. Yes. It's not normal practice, if that's what you are
3 asking, but it was something that historically went on
4 with Mr. O'Brien. I knew management knew it, so there
5 was no point in me raising any concerns because 15:37
6 management were aware of it.
7 473 Q. And which management do you say was aware of it?
8 A. Well, I knew Martina Corrigan knew the charts were at
9 home, and she was the Head of Service.
10 474 Q. You have said in your witness statement to Dr. Chada, 15:37
11 if we can bring it up, TRU-00790, at paragraph 11,
12 please. You are confirming that all notes tracked to
13 Mr. O'Brien were not stored within the Trust. You
14 said:
15 15:38
16 "It's widely known within the Trust that Mr. O'Brien
17 has notes in his house".
18
19 Then you explain the process.
20 15:38
21 "Leanne Hanvey types Mr. O'Brien's private patients
22 work. Mrs. O'Brien would e-mail her looking for
23 charts. Leanne would pull the charts and leave them in
24 Mr. O'Brien's office. The notes would be tracked out
25 to Mr. O'Brien's private patient cabinet in his office 15:38
26 but the notes wouldn't be there."
27
28 So, the situation was that a non-Trust employee,
29 Mrs. O'Brien --

1 A. I actually think that that's maybe a typo. I think
2 it's a typo. I don't know why I would have said
3 Mrs. O'Brien there. I'm sorry.

4 475 Q. Is it not the case that Mrs. O'Brien frequently would
5 have contacted you? 15:39

6 A. She would have contacted me, yes, about -- well,
7 I would have contacted her rather than her contact me
8 if a patient rang in requesting a private appointment.

9 476 Q. Yes. Is it not the case that she would have also --
10 A. I don't know. I wouldn't know there because it would 15:39
11 have been Leanne Hanvey that would have got that
12 request, not me. I didn't deal with any of
13 Mr. O'Brien's private work.

14 477 Q. Explain the typo for me. You are saying it shouldn't
15 be Mrs. O'Brien who e-mailed looking for charts? 15:39

16 A. As I say, I don't know who would have e-mailed looking
17 for the charts. I just assumed it would have been
18 Mr. O'Brien.

19 478 Q. Are you sure it's a typo, Mrs. Elliott?

20 A. Hold on. Can I read it again, please? 15:40

21 479 Q. You can, take your time.

22 A. I honestly don't know because I would never have had
23 sightings to those emails to know whether it was Mr. or
24 Mrs. O'Brien, because Leanne didn't work in the same
25 office as me. So, I don't know who requested the 15:40
26 chart. Irrespective, the chart would have been pulled
27 and left in the filing cabinet in Mr. O'Brien's office.

28 480 Q. Mm hmm, and the notes would be tracked out?

29 A. They were tracked to the PP cabinet.

1 481 Q. In his office?
2 A. In his office.
3 482 Q. Yes.
4 A. That was like a holding place for him. He would have
5 came and took those charts home. 15:40
6 483 Q. The system is told one thing, the charts are in his
7 office in a private cabinet but, in fact, you and
8 others knew --
9 A. They were at home.
10 484 Q. --perfectly well that that's not what they were tracked 15:41
11 to, they were somewhere else?
12 A. Well, at that time there was no tracking code for
13 anyone's home; there is now. But at that particular
14 time, there wasn't a tracking code for Mr. O'Brien's
15 house. That was the best way of knowing that that was 15:41
16 in Mr. O'Brien's house. If it was in that cabinet and
17 wasn't there, it was in his home, if that makes sense.
18 485 Q. That's in a sense distorting reality, isn't it? There
19 may well not have been a feature in the system to
20 record that patient notes are at home but isn't it the 15:41
21 case that patient notes should not have been routinely
22 at home, and certainly not for longer than overnight?
23 A. I accept that but, as I say, that was totally out of
24 my -- that was nothing to do with me because
25 I didn't -- I made it clear at the start that I was 15:42
26 having nothing to do with the private practice and
27 I didn't.
28 486 Q. Yes. But it was an issue --
29 A. I was aware of.

1 487 Q. You knew that notes were coming from records through
2 Mr. O'Brien's office to his home?

3 A. Yes.

4 488 Q. You would have realised that that was not appropriate?
5 A. Well, it wasn't normal practice. 15:42

6 489 Q. Yes. Did you ever challenge him in relation to this?
7 A. No.

8 490 Q. The emails that form part of the disclosure around your
9 work paint a picture, I don't know if you would agree
10 with me, of sometimes chaos and confusion and practical 15:43
11 difficulties ensuing from trying to find patient notes,
12 sometimes in urgent circumstances, and they are either
13 at home, Mr. O'Brien's home, and they are known to be
14 there?

15 A. Mm-hmm. 15:43

16 491 Q. In some cases there is confusion, and he disputes it
17 that they are there. Was it a chaotic situation owing
18 to this practice?

19 A. Well, it was an extra duty. I don't know if it was
20 chaos because usually the chart could have been sought 15:43
21 within a day. But it was extra work, yes.

22 492 Q. Let's just look at some of the examples. AOB-00483.
23 If we chart from the bottom of the page, please, a
24 patient was to be seen by Dr. Convery but the chart was
25 tracked to Mr. O'Brien in the Thorndale Unit. 15:44
26

27 "When the record was looked for, the secretary said she
28 thought Mr. O'Brien had that chart at home and she
29 would ask him to bring it in for the appointment at

1 9:00 a.m. that morning. The chart didn't arrive in
2 records and Dr. Convery refused to see the patient
3 without the chart. Pamela went to speak to Dr. Convery
4 and asked if he would see the patient as she had got as
5 much information as she could for the appointment. 15:45
6 Mr. O'Brien's secretary is off that day."
7

8 This is probably before your time?

9 A. It is, yes.

10 493 Q. "He'd brought it in but taken it over to the old 15:45
11 Thorndale Unit to have a letter typed. Pamela then
12 went over that there that morning and got the chart and
13 then brought it to Dr. Convey, who informed Pamela that
14 he was going to write to Debbie about this."

15 15:45
16 If we scroll up, we see that Anita Carroll becomes
17 involved and then, above that, Debbie Burns is asking
18 did the patient get seen.

19
20 "I think if we can't agree with him, John Simpson", 15:45
21 that's the Medical Director, "needs involved".
22

23 And so it goes on. I mean, plainly management were
24 aware of such issues back before you became engaged
25 with Mr. O'Brien? 15:46

26 A. That's correct.

27 494 Q. Did you see any particular efforts by management to try
28 and nip this situation in the bud?

29 A. No.

1 495 Q. Another example of a patient being inconvenienced, or
2 potentially inconvenienced, we can see at TRU-297194.
3 Just scroll down to the bottom, please. Mr. O'Brien
4 writing to you, Mrs. Elliott, November 2015, referring
5 to, we'll just call him "patient". The patient is
6 described as currently the longest urgent waiter on
7 CURWL. What waiting list is that?

15:47

8 A. That's Mr. O'Brien's in-patient waiting list.

9 496 Q. Mr. Haynes had reviewed him in June or July 2015,
10 that's four or five months earlier, with a view to
11 doing his procedure.

15:47

12
13 "He was unable to commit to doing so as his chart was
14 not available to him with the findings of urodynamic
15 studies done in January 2014. I had his chart at home
16 with the intent of discussing the findings with Mark.
17 In the interim, Mark has arranged to have to urodynamic
18 studies repeated tomorrow. I thought that I still have
19 the chart at home but I do not have. I cannot recall
20 bringing it into the hospital though it is possible
21 that I did so. Please ascertain whether it is
22 available."

15:47

15:48

23
24 This again a situation, Mr. Haynes isn't able to
25 intervene in the case without a chart, Mr. O'Brien
26 thinks he has the chart at home, can't find it there,
27 and he is asking you can you assist to find it; he
28 can't remember bringing it back into the hospital.

15:48

29 A. Mm hmm.

1 497 Q. Does this --

2 A. I can't remember anything about that case, I am sorry.

3 498 Q. You didn't raise it as a suspicious lost file?

4 A. Well, obviously it must have turned up. I don't know.

5 Was that in my pack? 15:48

6 499 Q. I can't say for sure.

7 A. I don't remember seeing that. I don't know what the

8 outcome of that was but obviously the chart was found.

9 I am not aware of it remaining missing.

10 500 Q. Were there any charts that remained missing, to the 15:49

11 best of your knowledge?

12 A. Well, I know from my pack there was 13 missing or

13 supposedly missing.

14 501 Q. Those 13 charts were raised with Mr. O'Brien at the

15 start of the MHPS investigation. Did Mr. O'Brien raise 15:49

16 those with you?

17 A. He would have asked me to invest -- to look into it and

18 see were they in the office. I would have done

19 searches of the office. Whenever I would have looked

20 through the PA system, the majority of the cases had no 15:49

21 urology episodes. So I think it was a mistracking. A

22 lot of them were before my time --

23 502 Q. Yes.

24 A. -- but I think it was just a mistracking of charts.

25 503 Q. Yes. Let's look at a small number of further examples. 15:50

26 If we look at TRU-297184. Just before we go there,

27 I am being alerted to a note in respect of the last

28 case I think we looked at. If we go to TRU-297196.

29 Sorry, it was at the top:

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"Checked the filing and this patient's chart is not there."

You may have no recollection of this one. In circumstances where there is suspicion that a chart may have been lost, as we showed you at the start under the general principles in that policy document -- 15:51

A. Mm hmm.

504 Q. -- a report should be made to management. No report made by you; is that fair? 15:51

A. That's fair, yes.

505 Q. Should a report have been made if you didn't find it?

A. I wasn't aware that a report should have been made with not having sight of that policy. 15:51

506 Q. Yes.

A. No, I didn't do -- I wouldn't have done anything about that.

507 Q. You would have left it to Mr. O'Brien to sort out?

A. Yes. 15:51

508 Q. If we go to TRU-297194. Sorry, wrong reference, TRU-297184. I beg your pardon. If we start at the bottom of the page, please. This is October 2015. Just scroll up. Mr. O'Brien has said:

"I brought a patient's chart to the clinic this morning. However, I do not have at home the charts of two other patients. Whilst it is possible that they are both in my office in the hospital, I think it is 15:52

1 more probable that one is with cancer tracker records
2 and the other is with Records."

3
4 Then later that day Mr. O'Brien writes to you and says
5 -- or the next day, I should say, 16th October: 15:53

6
7 "I am now eating very large amounts of humble pie,
8 seeking forgiveness. I had entirely forgotten that the
9 file of the first patient had come to see me privately
10 in July '15 and I now have brought in his chart. I had 15:53
11 also forgotten that the second patient's chart had been
12 requested for a private appointment but I did see him
13 at a clinic and I have brought in his chart as well.
14 Sackcloth for the rest of the day. Aidan."

15 15:53
16 Does that again point up that there was a degree of
17 chaos in terms of the traceability of these charts?
18 You, as the secretary, were aware that patient charts
19 were being taken home?

20 A. Mm-hmm. 15:54

21 509 Q. They could have remained there for long periods of time
22 and then, when they were needed, there was usually some
23 delay, maybe only a day but usually some delay, and in
24 some cases Mr. O'Brien didn't know whether he was
25 coming or going in terms of whether he had the charts 15:54
26 or not, as displayed by this colourful email?

27 A. Well, this email was literally only hours behind the
28 first email.

29 510 Q. Yes.

1 A. So I would have -- when I would have come in the next
2 morning, I would have had both those emails on my
3 inbox.

4 511 Q. Yes.

5 A. So he corrected himself literally within an hour from 15:54
6 his first email. So, it wasn't that there was a day of
7 me not knowing where these charts were.

8 512 Q. What we're doing for illustrative purposes,
9 Mrs. Elliott, is pointing to some interesting examples
10 of mismanagement of patient charts. I suppose what it 15:55
11 comes to with you is, as his administrative secretary,
12 medical secretary, knowing that patient charts were
13 being used in this way, is there anything more you
14 should have or could have been doing to address the
15 problem which was created? 15:55

16 A. I don't feel that I needed to report any of this
17 activity because it was widely known by management
18 already.

19 513 Q. You had no responsibility to challenge Mr. O'Brien in
20 respect of it, not least because it was a breach of the 15:55
21 policy to keep notes at home, charts at home for
22 lengthy periods of time, or, in the alternative,
23 because it was putting you to difficulty?

24 A. I know but -- well, I wasn't aware that it was
25 breaching any policy because I didn't see the policy. 15:56
26 As I say, he has been keeping records at home for years
27 and years before I was his secretary, and management
28 knew about it. So I didn't know what I was supposed to
29 do or who I would have escalated that to when it was

1 already known.

2 514 Q. I explained earlier this morning the various aspects of
3 the Return to Work Plan, which you didn't know anything
4 about on your evidence but which covered the aspect of
5 patient notes, patient charts. If I could just bring 15:57
6 you to the return to work monitoring plan so you can
7 see it. It's TRU-00733. If we go through to concern
8 2, just down a little bit, please. It said, and this
9 is now 2017.

10
11 "Mr. O'Brien is not permitted to remove patient notes
12 off Trust premises. Notes tracked out to Mr. O'Brien's
13 must be tracked out to him for the shortest period
14 possible for the managements of patients. Notes must
15 not be stored in Mr. O'Brien's office. Notes should 15:57
16 remain located in Mr. O'Brien's office for the shortest
17 period required for the management of a patient."

18
19 I think I outlined that to you this morning. Just on
20 that aspect of the action plan, in the summer of 2017, 15:58
21 management detected significant quantities, I think up
22 to 90 files but a significant quantity of patient
23 charts in Mr. O'Brien's office?

24 A. Mm-hmm.

25 515 Q. They convened a meeting at which this issue was 15:58
26 discussed. I want to seek your observations on
27 Mr. O'Brien's response to this concern. If we go to
28 AOB-56211, and if we just scroll down to (g) on the
29 left-hand margin, please. He's explaining that I don't

1 want the charts at all because -- sorry, because
2 "I don't know why charts are coming to my office at
3 all. There's no need for them to come into the
4 office".

15:59

5
6 If we go over the page, please, and go down to (f), it
7 records Mr. O'Brien saying:

8
9 "I was told by the secretaries actually that they are
10 told that's what they have to do by their line
11 managers"; in other words, bring charts in to
12 Mr. O'Brien's office in certain circumstances.

15:59

13
14 Do you recall the rule, as you understood it, or the
15 practice as you understood it in 2017?

15:59

16 A. From the outcome? I wasn't aware that they were
17 monitoring the charts or there was a rule that charts
18 weren't to be in the consultant's office. I was never
19 made aware of that.

20 516 Q. What were the circumstances, if any, that you would
21 bring charts into Mr. O'Brien's office?

16:00

22 A. The majority of the charts would have been from his
23 DARO report, and that would have been -- we had a locum
24 consultant who done a lot of extra clinics and it was a
25 DARO report that was generated out of that. Because
26 those weren't clinics that Mr. O'Brien done, I would
27 have habitually attached the chart with those results
28 when they went in. So, some of them would have been
29 those, some of them would have been clinics that were

16:00

1 awaiting dictation. Then there was charts in
2 pigeonholes. For governance reasons, there would have
3 been other various reasons why charts were there. If
4 it was an M&M discussion or maybe even a litigation
5 case, there would have been charts in the office; if 16:01
6 Mr. O'Brien had to provide a report for a litigation
7 case. So, there was various reasons why the chart was
8 there.

9 517 Q. Were you in position to observe whether the turnover of
10 those charts, in other words how quickly they moved in 16:01
11 and out, was achieved?

12 A. No, I was never made aware of that.

13 518 Q. Clearly you've said that you weren't made aware of the
14 requirement of the action plan that charts should stay
15 in the office for as short a time as possible? 16:01

16 A. No.

17 519 Q. You weren't made aware of that?

18 A. No.

19 520 Q. In terms of the questions that you were asked in 2018
20 in terms of keeping an eye on what was going on, and we 16:02
21 looked the first thing this morning at your concerns
22 about that --

23 A. Mm-hmm.

24 521 Q. -- what was the question posed to you with respect to
25 those activities? What were you being asked to do? 16:02

26 A. It was as I said. I would have got a telephone call,
27 'is he in his office, go and count the charts in his
28 office'. There was no explanation as to why they
29 needed to know that. That's why I was annoyed, because

1 I was asked to do something that I didn't know why they
2 needed that information or what was the purpose of
3 getting that information.

4 522 Q. Clearly this meeting took place between Mr. O'Brien and
5 Mr. Carroll and Mr. Weir, and they had this discussion 16:03
6 about the charts, and Mr. O'Brien is saying it's the
7 secretary who is bringing the charts in to me. Did
8 that situation lead to a conversation between you and
9 Mr. O'Brien in terms of the need to change or address
10 this practice? 16:03

11 A. Yeah, he would have said to me don't be bringing any
12 more charts into my office. I then, through
13 Mrs. Robinson, she had told me in future then whenever
14 a result came in, that I kept the chart in my office
15 and put it on a separate shelf and tracked it to result 16:03
16 for Mr. O'Brien to see, and the chart was retained in
17 my office with the result going to his desk. So, that
18 was my safeguard that Mr. O'Brien had seen that result.

19 523 Q. Yes, okay.
20 16:04

21 Chair, it's coming up on 4:05. Certainly standing in
22 his heat from my perspective, it certainly feels like a
23 long day and it may feel like a long day for
24 Mrs. Elliott on the receiving end of my questions. Can
25 we park events for today and reconvene in the morning? 16:04
26 Probably another hour, hour and a half on my part, and
27 I know that you all will have some questions.

28 CHAIR: That's fine by us. I just see there is a note
29 you are being handed that you might want to address

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before we rise for the day.

MR. WOLFE KC: I understand this is saying that we need confirmation that we're sitting tomorrow so we can get stenography set up. There is always a risk of a spillover into the morning.

16:05

CHAIR: We stated that we be going into tomorrow whenever this week was being timetabled or the revision of the timetable was arrived at. Unfortunately, I'm sorry, Mrs. Elliott, but we're going to have to see you again in the morning. Hopefully you will be away by lunchtime at the very latest. Thank you.

16:05

So ten o'clock? Does ten o'clock tomorrow morning suit everyone? Thank you.

16:05

THE INQUIRY ADJOURNED TO 10:00 A.M. ON TUESDAY,
6TH JUNE 2023