



# Urology Services Inquiry

## Oral Hearing

**Day 49 – Tuesday, 6<sup>th</sup> 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.

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**Gwen Malone Stenography Services**

I N D E X

P A G E

Mrs. Noleen Elliott

Examined by Mr. Wolfe KC (cont'd)

3

Questions by the Inquiry Panel

53

1 THE INQUIRY RESUMED AT 10:00 A.M. ON TUESDAY, 6TH JUNE  
2 2023 AS FOLLOWS:

3  
4 CHAIR: Good morning, everyone.

5 09:50

6 NOLEEN ELLIOTT, HAVING PREVIOUSLY BEEN SWORN, CONTINUED  
7 TO BE EXAMINED BY MR. WOLFE KC AS FOLLOWS:

8  
9 MR. WOLFE KC: Good morning, Mrs. Elliott. I want to  
10 start this morning by looking at the area of DARO and 10:00  
11 how results were managed within Mr. O'Brien's office.  
12 If we can start by looking at your explanation of how  
13 DARO should work. DARO is Discharge Awaiting Results  
14 for Outpatients; is that what the acronym means?

15 A. I think actually "order" is the last. 10:00

16 1 Q. Okay. So Discharge Awaiting Results Order?

17 A. Yes.

18 2 Q. I am obliged, thank you for that. If we look at your  
19 witness statement at WIT-76334. Just above the page at  
20 12.1, you are explaining how the process works. 10:01

21  
22 "If a patient is awaiting results prior to a decision  
23 regarding follow-up treatment being made, they must be  
24 recorded as a discharge".

25 10:01

26 That is the code, D-I-S --

27 A. Yes.

28 3 Q. -- that would be included. "And not added to the  
29 Outpatients waiting list for review".

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That was instruction that you were given by the service administrator; is that right?

A. That's correct.

4 Q. You say in answer to the question "Have you experience of these systems being bypassed, whether by yourself or others", your direct answer to that is: 10:01

"I am aware that the SOP for DARO was not fully implemented while working for Mr. O'Brien. That was at the request of Mr. O'Brien. Mr. O'Brien would have stated on his letters that he was booking an investigation (e.g. scan, blood results, etc), and review in a specific time, i.e. 3 months, 6 months, etc. In such cases, Mr. O'Brien did not want me to DARO these patients and requested that they be put on the Outpatient waiting list to be seen in the specified time. He was adamant that the patient was not to be discharged and should be on a waiting list for review as requested". 10:02

You are saying there in clear terms that there was a DARO system, your line management expected you to implement it but Mr. O'Brien was telling you to bypass that and to ignore that? 10:02

A. That's correct.

5 Q. What was his rationale for that, to the best of your understanding? Did he explain that to you?

A. Yes. Well, it was the word "discharge", the fact that

1 the patient was discharged and not on any waiting list.  
2 He would have said that that was lost then to  
3 follow-up, as well as he would have said that he wanted  
4 to review the patient irrespective of what the test  
5 indicated. So, the fact that they were taken off any 10:03  
6 review waiting list, he didn't accept that.

7 6 Q. So his approach was what, then, in the alternative?  
8 A. The patient was, for instance to take an example, if  
9 the patient was sent for a CT scan, the CT scan to be  
10 to be done in three months and he would have asked me 10:04  
11 to put the patient on the Outpatient review waiting  
12 list for review, say, in four or five months, whatever.  
13 It would have been a short time after the scan would  
14 have been due to be reported on.

15 7 Q. Okay. why did he favour that approach? 10:04  
16 A. He favoured that approach because the patient was on a  
17 waiting list, what he had requested. Irrespective of  
18 the scan result, he still wanted to see the patient.

19 8 Q. Even if that was unnecessary from a clinical  
20 perspective? 10:04  
21 A. Whenever the scan -- yes, he would have always wanted  
22 to review his patients.

23 9 Q. Regardless of outcome?  
24 A. I cannot ever remember anybody being discharged from a  
25 result if they were already on a review waiting list. 10:04

26 10 Q. Did the system work effectively, in your view?  
27 A. It had its pitfalls because obviously of the long  
28 waiting lists for review appointments.

29 11 Q. We will maybe see some of that in a moment. In terms

1 of management's awareness of his disregard for the DARO  
2 system, you have said in your witness statement, if you  
3 just go to 12.3 -- yes, in front of us. This is your  
4 explanation:

5  
6 "The DARO reports would have been sent out by the  
7 service administrator to the secretaries on an ad hoc  
8 basis for the secretary to validate and return. I  
9 would have had approximately 60 patients on DARO report  
10 (mainly from specialist registrar and staff grade  
11 doctors and some from Mr. O'Brien). Other secretaries  
12 would have had considerably more patients on their DARO  
13 report. Therefore, I believe that management would  
14 have been aware that the SOP for DARO was not fully  
15 implemented by Mr. O'Brien due to the vastly reduced  
16 numbers on Mr. O'Brien's DARO report".

17  
18 You are suggesting that if the service administrator  
19 compared one clinician with another, they would have  
20 seen that Mr. O'Brien's DARO returns were significantly  
21 less. Is that what you are saying?

22 A. That's correct. The DARO report that was sent to the  
23 secretaries was sent in its totality, so it was all the  
24 consultants' DAROs was on the one report, so it was  
25 very easy to cross-reference to see that one  
26 clinician's DARO was sitting with 300 on it and  
27 Mr. O'Brien's was sitting with 60. There was another  
28 consultant that was similar to Mr. O'Brien.

29 12 Q. Let's just maybe look at that. If we go to a DARO

1 report, WIT-77755. This is Ms. Cunningham writing to  
2 all the secretaries; is that right?

3 A. That's correct, yes.

4 13 Q. 11th May 2016. She is saying:

5  
6 "Please see the attached DARO report updated today and  
7 filter as appropriate. It is essential that this  
8 report is actioned upon receipt and validation  
9 confirmed by return email to me by the end of the  
10 month. If patients are no longer appropriate for DARO, 10:07  
11 they must be reinstated or removed from DARO as per the  
12 DARO SOP".

13  
14 what is the work exactly you are being asked to do here  
15 by validating? 10:07

16 A. So, on the DARO report, all the patients are identified  
17 individually.

18 14 Q. would it help if we scroll down so you can illustrate  
19 it?

20 A. Yes. 10:08

21 15 Q. I think. Yes.

22 A. So you can see there --

23 16 Q. The first two entries are Mr. O'Brien; isn't that  
24 right?

25 A. Yes, yes. You can see there the patients are actually 10:08  
26 identified with their hospital number. Then over on  
27 the last line, it tells you what we were expecting  
28 back. In that case it was a PSA that was expected back  
29 in May '15. So, what we would have done as

1 secretaries, we would have checked up if that PSA --  
2 now, I am not sure what date that DARO was but if it  
3 was after, if the DARO was after May '15, then you  
4 obviously checked. Sometimes that was the reason we  
5 put the date in there, because obviously some of the 10:08  
6 tests are required in the future. So if that DARO  
7 report was done and produced in May and it was a CT  
8 that was expected in September, you knew that you  
9 didn't need to look that up because it was in the  
10 future. 10:09

11  
12 You would have went through and checked the results.  
13 If the results was actioned and a letter done, then you  
14 would have removed them off the DARO as per the results  
15 letter. If there was no results letter done, then you 10:09  
16 left that for the clinician. So you would have printed  
17 off the result and left it for the clinician to advise  
18 on the outcome.

19 17 Q. If a patient has been put up on DARO, you are awaiting  
20 the results of the CT scan and if that CT scan comes in 10:09  
21 and the clinician actions the CT scan, how would you  
22 know about that?

23 A. Well, when the CT scan comes in, we always check what  
24 the status is with the patient. So, you would have  
25 looked up PSA and seen this patients is on DARO. So I 10:10  
26 would have handwritten on the bottom, "Patient on DARO,  
27 please advise". Once the clinician then done the  
28 results letter, that results letter determined what  
29 action was taken or what the outcome of that was,

1           whether it was a discharge, a review, or a... I am  
2           trying to think what else there would have been. You  
3           wouldn't really have anybody put on a waiting list  
4           following that. It would have been review or discharge  
5           probably. 10:10

6    18   Q.    You would use the DARO system in that case to keep  
7           track of what has been done in the case?

8           A.    That's correct. If you need the cooperation of the  
9           clinician.

10   19   Q.    Yes. So if the patient isn't on DARO -- 10:11

11           A.    Hm-mhm.

12   20   Q.    -- and the CT scan results come in, and if the action  
13           required as a result of the CT scan results hasn't been  
14           followed up by the clinician, how would you know?

15           A.    Well, in Mr. O'Brien's case if the patient wasn't on 10:11  
16           DARO, there were obviously on a review waiting list.  
17           If the scan came back and there was something untoward  
18           or something serious on the scan, Mr. O'Brien would  
19           have asked me to arrange an appointment earlier than  
20           the expected appointment. So he very regularly would 10:11  
21           have asked me to put people as an extra patient on to  
22           my PR slots on the review clinics.

23   21   Q.    That system relies on the clinician advising you  
24           whereas the DARO, if you go to the trouble of inputting  
25           on DARO, there is a tracked record of a patient; is 10:12  
26           that right?

27           A.    There is but you still need the cooperation of the  
28           clinician. I think this is something that has come up  
29           on other people's evidence, that the clinician didn't

1 need to be involved. You have to have the involvement  
2 of the clinician.

3 22 Q. But if you have the patient on the DARO system, at  
4 least that has the merit of the safety net of letting  
5 people know that something has to happen to that 10:12  
6 patient?

7 A. Yes, because they will come up the next month on the  
8 DARO.

9 23 Q. Of course.

10 A. And the next month if they are not actioned. 10:12

11 24 Q. And questions can be asked?

12 A. Yes.

13 25 Q. Whereas on the approach that Mr. O'Brien seems to have  
14 preferred, that patient could be lost unless he  
15 remembered about it. Is that fair? 10:13

16 A. Yes. That is very much up to the clinician to action,  
17 yes.

18 26 Q. You were explaining to me how the service could have  
19 used this system to deduce that Mr. O'Brien wasn't  
20 playing ball with it? 10:13

21 A. Yes.

22 27 Q. I fear that I might be jumping ahead into a second  
23 report, just to help you with Mr. O'Brien's total.  
24 Forgive me that; there is no trick in it, it is just my  
25 referencing. If we go to WIT-77866. Just scroll up a 10:13  
26 page. Stop there, please. Mr. Haynes has got 194  
27 cases?

28 A. That's correct.

29 28 Q. I think, off the top of my head, Mr. Glackin might have

1 had more than that?

2 A. 300 odd.

3 29 Q. If you just scroll on up. I don't think we need do it  
4 but if we scroll down slowly down to the end of  
5 Mr. Haynes' list, we can see -- and remember this is a 10:14  
6 report for 2019; isn't that right?

7 A. Hm-mhm.

8 30 Q. No, it may be 2016. I will come go back.  
9 Mr. O'Brien's, scroll down, comes to a total of 73  
10 cases? 10:14

11 A. Yes. If you bear in mind there, if you notice on the  
12 descriptor at the end, a lot of those were other  
13 clinicians doing backlog clinics for Mr. O'Brien. You  
14 can see that the very last entry was Personal  
Information  
Redacted by that was  
15 actually Mr. Suresh. A lot of those 73 weren't even 10:15  
16 Aidan's. It was nothing to do with Aidan, if you know  
17 what I mean.

18 31 Q. Just help me with that. what entry are you pointing  
19 to?

20 A. Do you see the last entry for Aidan? 10:15

21 32 Q. Yes?

22 A. That is PSA March '18/QSS kidney.

23 33 Q. So the right hand column?

24 A. Actually the very last Personal  
Information  
Redacted by

25 34 Q. That is Mr. Suresh? 10:15

26 A. He did that clinic and put that man or that patient on  
27 DARO. There are seven entries within that number of 73  
28 like that.

29 35 Q. what you are saying in terms of the Trust's knowledge

1 of Mr. O'Brien's departure from DARO is if anybody  
2 looking at that was asking himself the question which  
3 consultants are using DARO and which aren't, they could  
4 do a simple subtraction sum with an awareness of  
5 Mr. O'Brien's large practice and work out that 73 is 10:16  
6 indeed a very small number?

7 A. Yes.

8 36 Q. Thank you. Could I ask you about your compilation of  
9 the Backlog Reports as they referred to DARO. If we go  
10 to WIT-77948. This is a report from 8th June 2015. 10:16  
11 You are telling the reader that DARO has been validated  
12 in respect of the cases on this document?

13 A. That's correct.

14 37 Q. We know that Mr. O'Brien was largely - I think you  
15 allowed for some exceptions - largely not using DARO? 10:17

16 A. That's correct.

17 38 Q. What do you mean when you say DARO has been validated  
18 for these cases if Mr. O'Brien was largely not using  
19 DARO?

20 A. Because as I described in my statement, the registrars 10:17  
21 and the specialist doctor or the staff grade doctors  
22 that were doing clinics under Mr. O'Brien's name were  
23 DARO-ing. So there still was -- there was always  
24 entries for Mr. O'Brien on the DARO report. It was  
25 those entries that I was validating. 10:17

26 39 Q. So, cases that are carried out by or looked at by his  
27 registrars or, on occasions, by locums, perhaps by  
28 tenured consultants such as Mr. Suresh as a favour or  
29 to help out or whatever it was --

1 A. It would have been mainly extra clinics put on.

2 40 Q. So they would still fall under Mr. O'Brien's name as  
3 such, and those were your responsibility to validate in  
4 accordance with DARO?

5 A. Yes, that's correct. 10:18

6 41 Q. Do you think it was entirely clear to management that  
7 Mr O'Brien wasn't using DARO, that he was bypassing it,  
8 because clearly you are saying on this, results are  
9 being validated according to DARO, the report, the  
10 central report, albeit with a smaller number, is 10:18  
11 showing DARO validations; you have DARO cases under  
12 Mr. O'Brien's name. Should you not have been raising  
13 with management more explicitly that DARO was being  
14 bypassed?

15 A. When we talk about validating DARO, for every entry 10:19  
16 that was on the DARO, I had to put an explanation in  
17 another column for our service administrator. There  
18 was a very detailed report went back for the validation  
19 of DARO. The service administrator, it would have been  
20 very obvious to me that there was a disparity or a 10:19  
21 difference in the numbers. Should I have highlighted?  
22 I thought, well, it is blatantly obvious there, and it  
23 wasn't that there was anything new. There again, I  
24 took over working for Mr. O'Brien when he has already  
25 been a clinician for years so there was nothing new in 10:20  
26 not using DARO.

27 42 Q. Certainly by 2019, management are writing to you and  
28 others to underline their view that DARO should be  
29 used. Let's just look at how that played out. If we

1 go to WIT-22786 and just look at the email at the  
2 bottom of the page. It is 30th January. You are one  
3 of the recipients, we can see in the last penultimate  
4 line of the address column with the email. Collette  
5 McCaul, she was the service administrator; is that  
6 right? 10:20

7 A. That's correct.

8 43 Q. She is clarifying the process in relation to DARO.

9  
10 "If a consultant states in the letter I am requesting 10:21  
11 CT, bloods etc and will review with the result, these  
12 patients all need to be DARO-ed first pending the  
13 result ... and not put on the waiting list for an  
14 appointment at this stage. There is no way of ensuring  
15 that the result is seen by the consultant if we do not 10:21  
16 DARO. This is our fail safe to patients are not  
17 missed. Not always does a hard copy of the result  
18 reach us from Radiology etc so we cannot rely on a  
19 paper copy of the result to come to us.

20 10:22  
21 "Only once the consultant has seen the result should  
22 the patient be then put on the waiting list for an  
23 appointment if required, and at this stage the  
24 consultant can decide if they are red flag appointment,  
25 urgent or routine, and they can be put on the waiting 10:22  
26 lists accordingly.

27  
28 "Can we make sure that we are all following this  
29 process going forward".

1 Your response to this seemingly was to pass this email  
2 to Mr. O'Brien; is that right?

3 A. That's correct, yes.

4 44 Q. You didn't reply to it directly yourself?

5 A. No, because to me it was out of my control to reply, 10:22  
6 you know. I needed the cooperation of the clinician if  
7 I was to comply with that.

8 45 Q. Yes. But you didn't tell your management I am between  
9 a rock and a hard place here, which instructions do I  
10 follow? 10:22

11 A. As far as I know, at that stage they already knew.  
12 They already knew that I was between a rock and a hard  
13 place.

14 46 Q. Certainly the email from Mr. O'Brien - just let's  
15 scroll up, please - might suggest that. Thank you. 10:23  
16 Just down a little bit. Mr. O'Brien responds to  
17 Ms. McCaul. What Mr. O'Brien writes is:  
18

19 "I have been greatly concerned, indeed alarmed, to  
20 learn of this directive which has been shared with me 10:23  
21 out of similar concern".  
22

23 That is you sharing the email with Mr. O'Brien?

24 A. (Witness nodded).

25 47 Q. You suggested you had a similar concern to him. What 10:23  
26 was that concern that you had?

27 A. I think it was the fact that I needed the cooperation  
28 of the clinician. It is not something I could have  
29 done without his approval because at the end of the

1 day, his DARO would have been sitting with 300 odd, and  
2 if he wasn't going to action it, where did that leave  
3 me?

4 48 Q. Okay. You had no particular concern about the DARO  
5 system itself, your concern was how am I going to 10:24  
6 operate it if Mr. O'Brien doesn't cooperate with me?  
7 A. Yes. Well, there is pitfalls with the DARO as well,  
8 and historically people have been sitting on DAROs for  
9 years before clinicians sign them off.

10 49 Q. So again that -- 10:24  
11 A. That has been happened in surgery, yes.

12 50 Q. That is not a pitfall of DARO, is it?  
13 A. It is a pitfall of the system of the way it's managed,  
14 I suppose.

15 51 Q. It is a pitfall of the clinician not actioning? 10:25  
16 A. But that did happen.

17 52 Q. Yes, yes. Nobody is suggesting that DARO can compel a  
18 clinician to take the action. DARO is a safety net  
19 which allows the system to have visibility on the  
20 patient so that the patient doesn't get lost? 10:25  
21 A. They are not lost but they are not sitting on a review  
22 waiting list. So, they are sitting in a no man's land.

23 53 Q. Until the clinician takes action?  
24 A. Exactly. If the clinician doesn't take action, the  
25 patient doesn't be treated. 10:25

26 54 Q. The alternative is as Mr. O'Brien practised, which is  
27 to take it out of the DARO system and manage it  
28 according to his approach, which was, as you conceded I  
29 think earlier, which was at risk of the patient being

1 lost?

2 A. It is not at risk of a patient being lost, it is at  
3 risk of the patient being seen in a timely fashion due  
4 to the long waiting lists. If the waiting lists  
5 weren't so long, everything would have worked fine. It 10:26  
6 was just the fact that he had such long waiting lists.

7 55 Q. The purpose Mr. O'Brien writes of the reason for the  
8 decision to review a patient is indeed to review the  
9 patient.

10

10:26

11 "The patient may indeed have had an investigation  
12 request to be carried out in the interim and to be  
13 available at the time of review of the patient. The  
14 investigation may be of varied significance because of  
15 the review of the patient but it is still a clinician's 10:26  
16 decision to review the patient".

17

18 He is making the case, as I think you outlined earlier,  
19 that these matters should stay with him; he should have  
20 control of the leavers in terms of when and for what 10:27  
21 reason the patient should be seen?

22 A. That's correct, yes.

23 56 Q. He sets out further concerns.

24

25 Mr. Haynes is brought into this debate. If we scroll 10:27  
26 up. He explains that the process is now a urology  
27 process but a Trust-wide process. It is intended in  
28 light of the reality that patients in many specialties  
29 do not get a review at the time intended and many cases

1 take place years after the intent to ensure that scans  
2 are reviewed and in particular unanticipated findings  
3 actioned. Without this process, there is a risk that  
4 patients may await review without a result being looked  
5 at. There have been cases (not urology) of patients' 10:28  
6 imaging not being actioned and resultant delay in  
7 management of significant pathologies. As stated, this  
8 is a Trust-wide governance process that is intended to  
9 ensure there are no unactioned significant findings.  
10 There is no risk in the process described". 10:28  
11

12 Did Mr. O'Brien speak to you after he had raised his  
13 objection with Ms. McCaul?

14 A. He did, yes.

15 57 Q. Did he change his approach? 10:29

16 A. No, he didn't.

17 58 Q. Did he show you Mr. Haynes' explanation?

18 A. I can't remember seeing this until I got it in my pack.

19 59 Q. All right. So, was there any debate between you and  
20 Mr. O'Brien about the difficulty you faced? You had 10:29  
21 instructions from your service administrator to follow  
22 a particular process, and Mr. O'Brien, notwithstanding  
23 his knowledge of what the Trust was saying back to him  
24 through his Associate Medical Director, Mr. Haynes, was  
25 that explained to you at all? 10:30

26 A. No. Although I had a meeting with Katherine Robinson  
27 and we had a workaround of how I would be kept sort of  
28 assured that I knew where things were. So the system  
29 we set up was that whenever a result came in --

1 whenever a patient attended a clinic and there was a  
2 scan ordered, I always kept the chart in my office  
3 awaiting results. So those were kept on a shelf in my  
4 office. Once the result came in, that chart then was  
5 moved to another shelf which was tracked as "result 10:30  
6 with AOB to see". So, that was my reassurance that  
7 Mr. O'Brien had got that scan result or that blood  
8 result. Then, periodically I would have went through  
9 those charts to see if there was any action taken. So,  
10 that was my safeguard around the DARO. 10:31

11 60 Q. You would have, as the ultimate check, inquired into  
12 whether action had been taken by Mr. O'Brien or by the  
13 testers, by the radiology or pathology?

14 A. Well, once the scan result came in, it was obviously --  
15 it was always left on Mr. O'Brien's desk, and the chart 10:31  
16 then was tracked to "result for AOB to see", so I knew  
17 that he had that result. That was my reassurance that  
18 that result is definitely in. The results awaiting --  
19 or the shelf with awaiting results, periodically when I  
20 would have got time, I would have went through those, 10:32  
21 checking up if the scans had come through, if there was  
22 something outstanding for a long time, bearing in mind  
23 there was quite a long waiting list for some of these  
24 scans.

25 61 Q. If the result has come in and you have marked it as 10:32  
26 essentially transferred over to Mr. O'Brien, would you  
27 have taken any steps after that?

28 A. No.

29 62 Q. So, you wouldn't be in a position to know whether

1 action had been taken by Mr. O'Brien in light of the  
2 results?

3 A. Well, if he had have highlighted on the result back to  
4 me to book this patient for the next available clinic,  
5 then yes, that would have been tied up with the chart 10:32  
6 and sorted. But anything that I didn't get back still  
7 remained on that shelf with the descriptor "result for  
8 Mr. O'Brien to see".

9 63 Q. Anything that didn't get back from results remained on  
10 the shelf? 10:33

11 A. Yes, yes, that's correct.

12 64 Q. Katherine Robinson, in her account to the Inquiry -- if  
13 we could just go to the WIT-60388. She says at 28.4:

14  
15 "The issues with use of DARO were frustrating and 10:33  
16 worrying. The secretary spoken to on at least two  
17 occasions to say that she should be following the  
18 instructions from her line manager and not the  
19 consultant regarding administrative processes.

20 Although I have a log of these interactions, I do 10:34  
21 acknowledge that it is difficult for in the management  
22 of consultant secretaries is not easy due to the  
23 relationship of being managed by a different group of  
24 people. On this basis the issue was escalated to Mr.  
25 Haynes, the clinical director and this was reinforced. 10:34  
26 The secretary then did comply".

27  
28 Let's just look at that, first of all. Were you spoken  
29 to on two occasions or at least two occasion to the

1 best of your recollection?

2 A. Yes. That would have been one of those meetings that I  
3 would have spoken with Katherine Robinson and the  
4 workaround was organised. To say that "the secretary  
5 did comply", it was not with the DARO, it was the 10:34  
6 workaround.

7 65 Q. Right. So, you're confident DARO wasn't used by  
8 Mr. O'Brien, the workaround was you to keep visibility  
9 on the movement of the charts --

10 A. Yes. 10:35

11 66 Q. -- as results came in or if they didn't come in?

12 A. That's correct.

13 67 Q. Could I bring you to a document that we looked at  
14 yesterday, WIT-22816. This is the note of the meeting  
15 where, as we explained yesterday, as we looked at 10:35  
16 yesterday, you were asked whether you had changed some  
17 entries on Mr. O'Brien's behalf. You tried your best  
18 to explain your understanding of that. You were asked  
19 about the DARO function, and you explained that you  
20 didn't use - that is Mr O'Brien and yourself - didn't 10:35  
21 use all administrative processes, in particular the  
22 DARO function. You go on to say that:

23

24 "AOB hated using this function so Noleen had only  
25 approx 50 on her DARO list because she only used it 10:36  
26 when registrars sent patients for results. For AOB's  
27 patients she used the outpatient waiting list as per  
28 AOB. This method was felt by them to be their safety  
29 net".

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An example is recorded there.

If we go scroll on down to results, and this explains your workaround; is that right?

10:36

A. That's correct.

68 Q. "On receipt of paper form of results, these would be passed to AOB and the chart would be tracked to CAOBS".

Is that his office?

10:36

A. That is the secretary's office.

69 Q. Your office.

"With "result for AOB to see". This was proof that AOB had been passed the actual result. These charts remained in the secretary's office until the result was returned for Noleen for further action. Routine results never made their way back to Noleen, only urgent ones. Periodically Noleen went through the charts in the waiting results section of her office to chase up anything outstanding. It was explained to Noleen that this was not foolproof and this is why DARO was introduced some years ago".

10:37

10:37

Do you understand the view that this approach was not foolproof?

10:37

A. Yes.

70 Q. That DARO was the better approach from the administrative perspective?

1 A. From the administrative perspective, yes.

2 71 Q. You are aware, I think, that the serious adverse  
3 incident reviews that took place in 2020 and into 2021  
4 identified two cases where results hadn't been  
5 actioned. Let me just briefly bring you to the 10:38  
6 conclusions reached in those reviews. If we turn to  
7 WIT-84298, we are referring here to service user C.  
8 Just scroll down a little, please. It says:

9  
10 "Service user C had a delayed diagnosis of metastatic 10:39  
11 prostate cancer following successful treatment of renal  
12 cancer. This was due to non-action on a follow-up CT  
13 scan report".

14  
15 Then just below that, Patient I had a delayed diagnosis 10:39  
16 of prostate cancer due to a non-action on a  
17 histopathology result at TURP. Service User C on the  
18 site that is in front of you, we refer to that patient  
19 as Patient 5, and Service User I is Patient 8.

20 A. Okay. 10:39

21 72 Q. Can I just ask you about the processes that you and  
22 Mr. O'Brien managed by looking perhaps briefly at the  
23 circumstances of Patient 5. Mr. O'Brien, in his  
24 response to the Inquiry in respect of Patient 5, sets  
25 out an account of his interaction with you on these 10:40  
26 issues. If we go to AOB-82738. If we just go to the  
27 top of the page, please. The situation is that  
28 Mr. O'Brien has arranged for a CT scan for this  
29 gentleman. That CT scan was performed on 17th

1 December - top of the page - 2019. It was reported on  
2 11th January 2020. He explains, going to the second  
3 paragraph, that you would have retained this patient's  
4 chart in your office to awaiting the report of the CT  
5 scan; is that right?

10:41

6 A. Yeah. That would have been in the awaiting results  
7 shelf.

8 73 Q. So that chart would have been sitting on the shelf and  
9 you would be waiting on the result coming from  
10 radiology; is that right?

10:42

11 A. Yes, that's correct.

12 74 Q. But the results in terms of the system, Mrs. Elliott,  
13 do they come to you by email?

14 A. No, by post.

15 75 Q. By post.

10:42

16 A. It was only the Radiology Department would have  
17 e-mailed anything that was really like red flags, sort  
18 of needed urgent attention, those were e-mailed. But  
19 all the other results came through via post.

20 76 Q. This is a patient who had a history of renal cancer and  
21 the scan is pointing up a concern that he may have  
22 metastatic disease of the prostate, and suggesting, as  
23 Mr. O'Brien observes here, the need for further  
24 evaluation and the need for perhaps bone scan. So,  
25 that is something for him to consider.

10:43

26  
27 Just in terms of process then, the paper copy arrives  
28 with you of the results. You record the receipt of  
29 those results, do you?

1 A. Yes. They would have been date-stamped. They wouldn't  
2 have been recorded on any database or anything, they  
3 were just date-stamped.

4 77 Q. On a hard copy you put a stamp?  
5 A. Yes. 10:43

6 78 Q. With a date on it, okay. Then do you move the chart  
7 into Mr. O'Brien's office or how does it work?  
8 A. No, it would have been moved then to the "results with  
9 Mr. O'Brien to see" shelf.

10 79 Q. Within your office? 10:43  
11 A. Within my office.

12 80 Q. If these results are written up or recorded on 11th  
13 January, do they reach you fairly promptly after  
14 that --  
15 A. Yes. 10:44

16 81 Q. -- in the normal way?  
17 A. Normally they would have been the same week. Within a  
18 week at least.

19 82 Q. If you put them on the results received shelf or "for  
20 Mr. O'Brien to see" shelf, how does he get to know then 10:44  
21 that you are holding a set of results that he has to  
22 see?  
23 A. The result was left on his desk. So the result went,  
24 the paper copy of the result --

25 83 Q. Oh I see. 10:44  
26 A. -- went to his office.

27 84 Q. So you continue to hold the chart?  
28 A. Yes.

29 85 Q. He gets the result?

1 A. Yes. Now bearing in mind this was whenever Aidan  
2 didn't want any charts in his office because he was  
3 being monitored for the number of charts in his office.  
4 86 Q. Well, if he needed to check back on the chart to see a  
5 fine detail or whatever to remind himself of something, 10:45  
6 was the chart was close at hand, you were holding it?  
7 A. It wasn't really relevant in 2018 because NIECR was  
8 operational by then so all information would have been  
9 there.  
10 87 Q. So, I think the paper copy of the result is now with 10:45  
11 Mr. O'Brien within presumably the day you receive it?  
12 A. Yes, the same day, unless I was on leave or the post  
13 was held, you know, not opened.  
14 88 Q. But it would be date-stamped, so that would be the day  
15 it would go? 10:45  
16 A. To his office, yes.  
17 89 Q. Yes. Then it is on his side of the court to action?  
18 A. Yes.  
19 90 Q. Now, if he anticipated reviewing that patient in  
20 January, what would you expect the next step to be from 10:46  
21 him to you?  
22 A. He would have either e-mailed and asked me to put the  
23 man on the next available clinic, or it would have been  
24 hand written on the result, 'please book this man to my  
25 Friday oncology clinic' or whatever. So there was 10:46  
26 either an email back to me or the result came back to  
27 me with a hand written note on it.  
28 91 Q. Just returning to what Mr. O'Brien says about this.  
29

1 "My secretary had retained Patient C", or service user  
2 C - we call him Patient 5 - "hospital chart in her  
3 office to await the report of the CT scan so this chart  
4 would be available for his intended review in January.  
5 She transferred the chart with the report of the CT 10:47  
6 scan to my office on some unspecified date following  
7 receipt of the report".  
8  
9 Can I just ask you about unspecified date. Do you know  
10 what that means? 10:47  
11 A. I don't know what that means, no.  
12 92 Q. If we obtained the report, would we see a date on it?  
13 It should be date-stamped?  
14 A. The report should be date stamped, yes. But tracking,  
15 I am not sure about the tracking of the chart, to be 10:47  
16 quite honest. To me, the chart being tracked is  
17 irrelevant. If the report went into Mr. O'Brien's  
18 office, it is irrelevant whether there was a chart  
19 attached or not.  
20 93 Q. Yes. Where he says "as she did not track the transfer 10:47  
21 of the chart from her office to mine, it has not been  
22 possible to determine when it occurred", what you are  
23 saying is your approach is not to transfer the chart,  
24 it is to transfer the report?  
25 A. Yes. 10:48  
26 94 Q. The report will have a date stamp on it?  
27 A. That's correct.  
28 95 Q. And that will be the date that you would place it in  
29 his office, place it on his desk.

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He says:

"It is probable that it was during February 2020 due, once again, to my not being able to review SUC during January 2020 due to the inadequacy of outpatient review capacity. In fact he still remained on the list for review at my oncology review clinic in June". And I think that should say 20 20 and not 2019? 10:48

Help me with this, if you can. If the result goes on to his desk, date-stamped, you would expect some action to flow from it in a case such as this where there is a need for follow-up investigations for the patient? 10:48

A. Well, this is an example of a patient that wasn't on DARO. So he was already - if you are saying that is June 2020, he was already on for review in June 2020. If that particular result warranted that patient to be brought, his plan to be brought forward, then Aidan would have let me know to bring that patient forward or to book him to the next available clinic, which was obviously an oncology review because he was on the oncology review waiting list. 10:49

96 Q. As regards this particular case, you didn't receive any follow-up instructions from Mr. O'Brien?

A. No, mustn't have whenever -- well, I am not aware of any follow-up, no. 10:50

97 Q. Help me with the rationale that is set out here, if you can. Mr. O'Brien is saying it is probable that the chart came to his office during February due to him not

1 being able to review the patient during January 2020.  
2 Do you understand what that means?

3 A. No, no, sorry. I have no recollection of that  
4 happening.

5 98 Q. If the results are available within days of them being 10:50  
6 reported on 11th January, was it Mr. O'Brien's habit,  
7 to the best of your understanding, to review results  
8 quickly, or did he tend to wait until he had a review  
9 clinic arranged or review appointment arranged for the  
10 patient? 10:51

11 A. No. It's general practice that a clinician looks at  
12 their results on a daily basis, you know. It was very  
13 hard for me to monitor that because Mr. O'Brien would  
14 have taken the results with him in his briefcase. The  
15 results were never left in his office so it was very 10:51  
16 hard to monitor.

17 99 Q. On a case such as this, results have come in, he wants  
18 to review him in January. How would that review be set  
19 up? who would make the arrangements for that?

20 A. So, Mr. O'Brien had full control of his oncology 10:52  
21 review, so the majority of those patients would have  
22 been patients for review following the MDM, and then  
23 there would be the additional slots where he would have  
24 reviewed this type of patient. There was always a  
25 review backlog there, and this is obviously what he is 10:52  
26 speaking about when he says that he hadn't the  
27 capacity.

28 100 Q. The result has come in; he wants to review him, it  
29 suggests here. He has, if you like, the role or the

1 authority to make an appointment for this patient but  
2 he has to have the capacity, he has to have the space  
3 to do so?

4 A. That's correct.

5 101 Q. Are you interpreting that as saying he simply didn't 10:53  
6 have the space to fit this patient in?

7 A. No. This was an ongoing problem with the oncology  
8 clinic. Mr. O'Brien would have endeavoured to have the  
9 full day. His oncology clinic was always on a Friday,  
10 and he very, very regularly would have had an all-day 10:53  
11 oncology clinic to try and clear up this backlog.  
12 This was all extra work that he would have done over  
13 and above.

14 102 Q. Do you have visibility on the needs of the patient in a 10:53  
15 situation like this? This patient had suspicion of  
16 metastatic prostate cancer, he needed a bone scan; that  
17 didn't come to light and wasn't actioned until July or  
18 August 2020. This was obviously a period of some  
19 destabilisation within the Trust with COVID,  
20 Mr. O'Brien retired and the circumstances around that. 10:54  
21 But in general, if we can look at it perhaps, where a  
22 review isn't possible because of the capacity reasons  
23 that Mr. O'Brien is suggesting there, and you agree  
24 with that, what happens in the meantime for a patient  
25 where the scan results are saying further action is 10:54  
26 required, this patient may have cancer?

27 A. Well, to me that is very much up to the clinician to  
28 make the arrangements around that. That is not  
29 something a secretary would have within her remit. We

1           certainly did not have the time to chase up every  
2           single result and see that it was actioned.

3 103 Q.    If that patient had been on DARO, the service would  
4           have had visibility of the fact that results had come  
5           in from radiology; isn't that right? 10:55

6           A.   That's right, yes.

7 104 Q.    And would have had visibility that those results hadn't  
8           been actioned because the case still remained on DARO?

9           A.   Yes. So our service administrator -- the narrative,  
10          should that person have been on DARO, how I would have 10:56  
11          validated that DARO would have been "result with Mr.  
12          O'Brien to see and action". Now, that happened on a  
13          regular basis but our service administrator never came  
14          back to say why has this not been actioned, so I'm not  
15          sure whether it would have went anywhere. All right, 10:56  
16          it would have been noted on the DARO but whether those  
17          sorts of things were ever actioned, I am not concerned  
18          -- I am not convinced that they were.

19 105 Q.    Before leaving this, can I ask you two more questions  
20           in relation to this area? When results come in, is it 10:57  
21           any part of your function to plan something, to make a  
22           quick assessment from a non-clinical perspective of how  
23           urgent a case might be?

24          A.   Well, unless it really jumped out at you, we would have  
25          generally just read the conclusion. We certainly 10:57  
26          hadn't time to sit and read all the results. It was  
27          very, I have to say ad hoc as to what time we had to  
28          read. We are not clinicians, so not all things I  
29          suppose that were red flag or of concern were

1 highlighted by the secretary.

2 106 Q. In terms of the cancer tracker, would you have any  
3 engagement with the cancer tracker when results came  
4 in, particularly where results suggested an unexpected  
5 course or a serious course for a patient? 10:58

6 A. This is just if they were a newly diagnosed cancer.

7 107 Q. Or in Patient C's case, where there had been a history  
8 of cancer and this was a situation where there was a  
9 suspicion of metastatic disease from the primary.

10 A. I am not convinced, I am not sure if this patient was 10:58  
11 on a tracking system within the MDT. I can't really  
12 comment on that because I am not sure.

13 108 Q. Yes, but what I'm saying is regardless of whether the  
14 patient is on a tracking system, if you as the  
15 secretary see something untoward in the result, do you 10:59  
16 have any role - I am thinking here from the perspective  
17 of an additional safety net - to get the thing moving  
18 with the cancer tracker?

19 A. No, no. No role, if that's what you are saying.

20 109 Q. You had no role in that respect? 10:59

21 A. No. I never referred anything to the cancer tracker  
22 for MDT discussion.

23 110 Q. Can I leave that area and ask you about your role in  
24 respect of private patients. Mr. O'Brien had a private  
25 practice; is that right? 10:59

26 A. Yes, a private outpatient practice.

27 111 Q. And he saw patients in his own home?

28 A. That's correct.

29 112 Q. You have said in your witness statement at WIT-76345

1 that you had no input into his private practice; is  
2 that right?

3 A. No. Apart from when patients would have rang me asking  
4 for a private appointment, I would have diverted them  
5 then to his private practice number. That was 11:00  
6 sometimes by email.

7 113 Q. We can see some examples of that, perhaps just briefly  
8 look at these, TRU-294353. Just to the bottom of the  
9 page, please. You're writing to Mr. O'Brien:  
10  
11 "The above patient was ringing regarding his review  
12 appointment. He attended your SWAH clinic on 13th of  
13 October '14 and was told that you review him in early  
14 2015. There is no outcome logged on PAS. I have  
15 attached his PSA results for your information, can you 11:01  
16 please advise".

17  
18 This is a case where the patient has been seen in  
19 October, it is now May and there has been outcome from  
20 Mr. O'Brien, there has been no dictation? 11:01

21 A. That's correct.

22 114 Q. And you can't see anything about that episode on PAS.  
23 Scrolling up the page, then. Have you assumedly  
24 fielded a call from the patient because you are now  
25 writing to Marita, that is Mrs. O'Brien? 11:01

26 A. That's correct.

27 115 Q. And the above patient has requested a private  
28 appointment, he has attended Mr. O'Brien's clinic on  
29 the 13th, I think that should say October, 2014.

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Was Mrs. O'Brien Mr. O'Brien's secretary as such for private purposes?

A. That's correct, yes.

116 Q. We had a brief look at that yesterday, and you suggested in your statement to Dr. Chada that there was a typo in respect of -- 11:02

A. The chart requested.

117 Q. The chart requested.

A. You see Mrs. O'Brien, or the O'Briens, if I use that terms, they never requested the charts from me, it was from Leanne Hanvey. This is why I think that was a typo because I wouldn't have known who requested that, you would have just assumed that it was Mr. O'Brien. 11:02

118 Q. Although you know perfectly well that Mrs. O'Brien is the liaison person quite often in respect of private patients; that is why you are writing to her? 11:02

A. Yes, yes, as for the appointments system, yes.

119 Q. That was a not infrequent transaction between you and her? 11:03

A. Especially towards the beginning of my tenure with Mr. O'Brien. It sort of slacked off as time went on. There was less and less requests for these sort of appointments.

120 Q. And Mr. O'Brien had a private patient typist who did all of the typing in respect of his private work; isn't that right? 11:03

A. That's correct.

121 Q. And that was Mrs. Hanvey?

1 A. Miss Hanvey.

2 122 Q. Miss Hanvey, I beg your pardon. She worked within the  
3 Trust as a secretary in her own right?

4 A. In urology, yes.

5 123 Q. Obviously the private patient work was additional to 11:03  
6 her day job; is that right?

7 A. That's correct.

8 124 Q. Could I ask you about TRU-296740. This is 24th  
9 September 2018, and the query is in relation to private  
10 patient typing. You have said, "I have attached letter 11:04  
11 which were on G2"; that is the digital dictation  
12 system?

13 A. That's correct.

14 125 Q. "I note that you actually saw this patient privately  
15 and wonder if these should be on your private patient 11:04  
16 letterhead paper instead. There were no recent  
17 episodes on PAS for me to link this to. Can you please  
18 advise".

19

20 Just if we scroll I think up, please. It is down, I 11:04  
21 beg your pardon. So, this is the letter that you have  
22 typed; this is a letter to the general practitioner on  
23 behalf of this patient. If we scroll just down a  
24 little, maybe. Mr. O'Brien has evidently seen this  
25 patient privately in September 2016. If we scroll down 11:05  
26 to the end of the letter, please. More recently,  
27 because this letter is 2018 - just scroll up to the end  
28 so we can see when it has been typed - so you are  
29 typing this following dictation on 22nd December 2018.

1 Mr. O'Brien, having seen the patient more recently,  
2 there is a letter to the patient on the next page which  
3 suggests he had spoken to the patient by telephone --  
4 A. Yes.  
5 126 Q. -- in September 2018. This has been typed up, this is 11:06  
6 the result of that private consultation being typed up  
7 by you. So, you appear to be concerned that you are  
8 typing up the outcome of a private patient encounter;  
9 is that right?  
10 A. Yes. At that time, yes. It was clarified by 11:06  
11 Mr. O'Brien.  
12 127 Q. What was your concern and tell us how it was  
13 clarified?  
14 A. All right. So this gentleman had no open outpatient  
15 episodes so therefore he wasn't on a waiting list. 11:06  
16 Whenever we type letters, we have to link it with an  
17 outpatient episode. Now, this man was actually on a  
18 waiting list and had been on a waiting list for many  
19 years for a TURP. That doesn't come up. Whenever you  
20 ask the PAS system for the outpatient episode, you 11:07  
21 don't see the waiting list episode. This is why I  
22 thought this man hasn't been seen for years so why am I  
23 typing a letter? But it turned out because he was on  
24 the waiting list for so long, Mr. O'Brien needed to  
25 reassess his symptoms, hence why he wanted to repeat 11:07  
26 the flexi and the urodynamics. So, Mr. O'Brien  
27 clarified that the telephone call was actually a  
28 virtual NHS appointment and that was how then I came to  
29 type that letter. The reason he had seen Mr. O'Brien

1 privately in the interim was because he was a neighbour  
2 of Mr. O'Brien's, or he lived very close to Mr.  
3 O'Brien, so it was out of just courtesy that he had saw  
4 him in his own home when he was experiencing  
5 difficulties during his long wait on the waiting list. 11:08

6 128 Q. So, your concern that you were typing up a private  
7 patient episode was resolved by Mr. O'Brien telling you  
8 that what, in fact, had transpired was a NHS remote  
9 telephone conversation?

10 A. Yes. 11:08

11 129 Q. Was that recorded as such?

12 A. As far as I am aware, yes. I would have had to have  
13 opened up and attached that then to an open episode,  
14 outpatient episode.

15 130 Q. This patient has obviously been seen for flexible 11:08  
16 cystoscopy and urodynamic studies within three weeks of  
17 him being seen by Mr. O'Brien remotely by telephone in  
18 September. You have explained that there were no PAS,  
19 no PAS episodes to link this case to when you were  
20 typing this letter; was that unusual? 11:09

21 A. As I say, I didn't appreciate that he was on the  
22 waiting list for surgery. When someone is put on the  
23 waiting list for surgery, they don't generally have an  
24 outpatient episode open as well; it is either one or  
25 the other. They are either coming in for surgery or 11:09  
26 they are coming in for review. It was because  
27 Mr. O'Brien wanted to reassess this man's symptoms  
28 because he was on the waiting list for so long that  
29 that episode, outpatient episode, had been to be

1 reopened to enable him to do this.

2 131 Q. How does Mr. O'Brien arrange a remote telephone  
3 engagement with a patient on the NHS when his previous  
4 interaction with him in 2016 had been private? How does  
5 that come about? 11:10

6 A. That would have been done -- we would have done that  
7 retrospectively. So, the clinicians would have rang  
8 patients. There was never -- I know there are some  
9 consultants where they set up virtual clinics. So, the  
10 secretary sets the clinic up and then the patients know 11:10  
11 they are going to be rang on such and such a day at  
12 such and such a time. But that didn't happen in  
13 urology. The clinicians would have rang the patients  
14 and then we would have set up the episode after,  
15 retrospectively. 11:11

16 132 Q. So, this is an Outpatients remote conversation?

17 A. Yes.

18 133 Q. Mr. O'Brien presses on with that and then he tells you  
19 about it and you record it retrospectively; is that  
20 right? 11:11

21 A. Yes, that's right. This was a new concept that sort of  
22 came in and then was increased, the usage was increased  
23 during COVID. Virtual clinics were only really  
24 starting to come in in the latter stages just before  
25 COVID hit. 11:11

26 134 Q. Are you saying that this patient had been on the  
27 waiting list for cystoscopy since when?

28 A. I can't remember because there was actually another --  
29 there is another email from my service administrator

1 saying that this man was never put on the waiting list,  
2 and it is the same man because it went that far back.  
3 Whenever you have someone on the waiting list quite a  
4 while, there are -- whenever you go into PAS, you can  
5 only see about six episodes. Sometimes you have to 11:12  
6 scroll down maybe three or four pages before you get  
7 the actually waiting list episode.

8 135 Q. Were you able to find him on the waiting list?  
9 A. Oh yes, he was on the waiting list, yes, but it was, I  
10 don't know -- this was '18. I have a funny feeling it 11:12  
11 would have been 2014. I am not 100% sure but I think  
12 it was 2014.

13 136 Q. Yes.  
14 A. I don't know, did Mr. O'Brien refer to it at the  
15 beginning of the letter? 11:12

16 137 Q. Let me scroll up.  
17 A. Maybe it was '16. I think he referred to this man is  
18 on the waiting list. Maybe not.

19 138 Q. By the end of '15, or by April '15, he reported  
20 significant improvement and then in '16 he reported 11:13  
21 recurrence of former symptoms. Scroll down. Then he  
22 prescribed medication. Scrolling down.

23 A. If you notice there on the bottom of that first page,  
24 he had said there - scroll up, please - "he would be  
25 better served". Yes, so last paragraph there, "I 11:13  
26 advised that he would be better served by his prostate  
27 resected". So, it could have been September '16 there,  
28 according to that.

29 139 Q. Your concerns that this was a private patient episode

1 were resolved for you when you spoke to Mr. O'Brien.

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If we could look at your witness statement, please, at WIT-76342. Here you explain at 24(i) that you were responsible for putting patients on the waiting list for surgery, and preadmitting patients when requested by Mr. O'Brien?

11:14

Did you follow that approach for patients who had seen Mr. O'Brien privately and were coming into in the NHS system? was it your responsibility to list them for surgery and pre-admit?

11:15

A. No, because I wouldn't have seen those private letters so I didn't get a chance to do the outcomes of those private letters.

11:15

140 Q. Right.

A. That wasn't within my job, you know. I didn't see those.

141 Q. Help me with this. If we go to your amended statement at WIT-96807 and if we scroll down, please, you're explaining it at answer 2. Just scroll down a little bit further. Your first answer in your original statement is set out first.

11:15

A. Hm-mhm.

142 Q. You said:

11:16

"Initially I have stated however the patients Mr. O'Brien had seen privately were not on the Trust PAS waiting list. I was able to check the chart

1 tracker on PAS to see when the patient's chart was  
2 tracked to Mr. O'Brien's filing cabinet by Leanne  
3 Hanvey, who did all Mr. O'Brien's private patient  
4 typing and this is the date that I used to put the  
5 patient originally as seen as a private patient by Mr. 11:17  
6 O'Brien on the NHS waiting list".

7  
8 You say you want to change that. You have added:  
9 "However if the patient(s) Mr. O'Brien had seen  
10 privately were not on the PAS waiting list, I was able 11:17  
11 to check on the chart tracker on PAS to see when the  
12 patient's chart was tracked to Mr. O'Brien PP filing  
13 cabinet by Leanne Hanvey. This was the date I used to  
14 put the patient originally seen as a private patient on  
15 to the NHS waiting list". 11:17

16  
17 Can you help us to understand the distinction that you  
18 are drawing here?

19 A. Well, that very case that we were speaking about last  
20 was one case where that patient was on the waiting 11:18  
21 list, so this was me just the correcting that not all  
22 private list patients were not on the waiting list. It  
23 was only when they were not on the waiting list that I  
24 used this method of putting them on the waiting list.

25 143 Q. Okay. I think that maybe we were confused. I was 11:18  
26 asking whether you had a role in putting patients  
27 moving from the private into the NHS onto the waiting  
28 list and preadmitting them. Is that what you are  
29 describing here?

1 A. Yes, sorry.

2 144 Q. That when a patient had been indicated for a procedure,  
3 your role kicked in at that point?

4 A. Sorry, could you please repeat that? Sorry.

5 145 Q. When a patient originally seen by Mr. O'Brien as 11:19  
6 private --

7 A. Yes.

8 146 Q. -- was moving into the NHS for a procedure --

9 A. Hm-mhm.

10 147 Q. -- you had a role at that point? 11:19

11 A. No.

12 148 Q. No. What are you describing here?

13 A. It was whenever I was preadmitting, so when Aidan gave  
14 me the theatre list for his next theatre session and  
15 the patient wasn't on the waiting list, this was 11:19  
16 whenever I checked the tracking of that chart and  
17 determined that it was a private patient. Then, I  
18 needed a date to add that patient to the waiting list.  
19 Because I had no way of knowing when the patient was  
20 seen, I - and I know it now to be wrong - I used the 11:19  
21 tracking date that that chart was tracked to  
22 Mr. O'Brien's PP cabinet as the date of the patient  
23 going on the waiting list. I now know that to be  
24 incorrect.

25 149 Q. Why is that incorrect? Let me put a scenario to you. 11:20  
26 Mr. O'Brien sees a private patient on a Saturday and he  
27 decides that the patient should come in for a  
28 procedure, and he takes a view on the priority of that  
29 patient.

1 A. Hm-mhm.

2 150 Q. He will then contact you; is that right?

3 A. No, he never -- no. As I say, I did nothing. I had  
4 nothing to do with his private practice.

5 151 Q. Okay. The private patient is moving to the NHS, he is 11:20  
6 an NHS patient, he needs a procedure.

7 A. Hm-mhm.

8 152 Q. You have to pre-admit that patient for that procedure;  
9 no?

10 A. Only when he is being preadmitted, which isn't at the 11:21  
11 time of the consultation. You never would have a  
12 patient coming to see him on a Saturday and put on the  
13 following Wednesday. So there was always a time lapse.

14 153 Q. The patient is coming in for the procedure within the  
15 next month or so? 11:21

16 A. It is not. It would never be months.

17 154 Q. Would it not?

18 A. Well, not to my knowledge, no.

19 155 Q. Well, take that as the scenario. How do you arrive at  
20 a waiting list date for that patient? 11:21

21 A. Right, I'll give you the scenario. So, Mr. O'Brien's  
22 --

23 156 Q. Just in terms of what you are describing here, you have  
24 the chart coming back into the private patient cabinet;  
25 isn't that right? 11:22

26 A. Yes, by Leanne Hanvey. I had nothing to do with the  
27 tracking of that chart. So, I needed a date to put  
28 that patient on the waiting list. I hadn't time to run  
29 around the hospital looking for Mr. O'Brien to find out

1 a date. As I say, I incorrectly used the date the  
2 chart was tracked into the filing cabinet as the date  
3 of admission. I just needed a date so that I could  
4 pre-admit the patient.

5 157 Q. Okay. If that was a mistake on your part to use the 11:22  
6 date when the patient's chart arrives in the private  
7 patient filing cabinet, if that was a mistake, what  
8 should the date have been?

9 A. The date the patient was attended for consultation.

10 158 Q. What consultation? 11:23

11 A. Private consultation.

12 159 Q. That should --

13 A. Of which I didn't know.

14 160 Q. If the patient had seen Mr. O'Brien four weeks earlier,  
15 six weeks earlier, and a decision had been made that 11:23  
16 that patient should go for a procedure, that is the  
17 date you should have used?

18 A. That's correct. The date as in with the NHS as well.  
19 It is the date that the decision was made for the  
20 procedure is the date they go on the waiting list. 11:23

21 161 Q. What you were finding with many patients who had their  
22 origin in his private practice was that there was no  
23 record on PAS, on the PAS waiting list?

24 A. Some people would have maybe went to him privately 11:24  
25 because they weren't being seen, they are on the long  
26 waiters outpatient waiting list. So there could have  
27 been some people with episodes opened, new appointments  
28 waiting that had went to see him privately. But I  
29 would assume Leanne Hanvey should have closed those

1 down. As I say, that was out of my control because I  
2 didn't take anything to do with his private work. It  
3 was when they transferred into the NHS that I became  
4 involved.

5 162 Q. You have said that your approach is wrong, or was 11:24  
6 wrong?

7 A. Well, I know now it to be. When I say wrong, it is  
8 inaccurate, is probably a better word.

9 163 Q. When did you come to that view?

10 A. Well, whenever all this came up in the Inquiry, I 11:25  
11 thought I need to put my hands up here and say what I  
12 had done.

13 164 Q. Who told you you had taken the wrong approach?

14 A. Well, I knew myself that it wasn't an accurate date.

15 165 Q. In terms of your training in respect of the handling of 11:25  
16 private patients or advice given to you by the Trust in  
17 respect of private patients, can I draw your attention  
18 to this brief guide for administrative staff? It is  
19 TRU-165872. This was sent to administrative staff and  
20 shared with secretaries in 2014. It is a very brief 11:26  
21 one-page document. Just scroll down. What you need to  
22 do, it says you need to "Ensure the status of private  
23 patient is recorded on the PAS system".

24

25 First of all, do you remember getting this guide? 11:26

26 A. I don't, no.

27 166 Q. Were Mr. O'Brien's private patients recorded on the PAS  
28 system as private patients?

29 A. On the waiting list? If they were on the waiting list,

1 or?

2 167 Q. well, I can only use the language in front of me.

3 A. I don't understand it. "Please ensure the status of  
4 private patient is recorded"; I don't know what that is  
5 referring to. 11:27

6 168 Q. Is the patient on the PAS system; if he or she is  
7 private, that should be labelled as such?

8 A. You see, once the private patient came in under the  
9 NHS, they were an NHS patient, they were no longer a  
10 private patient. So I don't understand that because 11:27  
11 they were no longer a private patient and they were  
12 treated equally to other patients.

13 169 Q. So, there is no method on the PAS system to record  
14 alongside the patient's name that they are a private  
15 patient? 11:28

16 A. well, if they were attending a private consultation  
17 they wouldn't be on the PAS system.

18 170 Q. But if they are coming into the hospital, for example,  
19 from the Republic of Ireland, they are a private  
20 patient? 11:28

21 A. I'm not aware of that.

22 171 Q. No.

23

24 "For booked patients with a Republic of Ireland  
25 address, ensure the patient is recorded as private on  
26 PAS", to take that example. 11:28

27 A. I don't remember ever anybody from the Republic of  
28 Ireland being on my books.

29 172 Q. So you know, I suppose the broad question is this: Are

1 you saying that you are not aware of any method to use  
2 the PAS system to label the patient as a private  
3 patient?

4 A. Not at that time, no. The only time I would have said  
5 somebody was transferred over to the private sector was 11:29  
6 whenever there would have been an episode opened and  
7 they would have been seen privately, then you would  
8 have said attended AOB privately and closed down that  
9 episode.

10 173 Q. If we look at WIT-96807 and if we scroll down to 11:29  
11 paragraph 3, please. In terms of your role in dealing  
12 with private patients coming into the NHS, you have  
13 explained how you came by using the chart hitting the  
14 cabinet as the date for waiting list purposes, and you  
15 have said, I think, that that was wrong? 11:30

16 A. Hm-mhm.

17 174 Q. You have said at paragraph 3; "then there was the  
18 introduction of the transfer status form" and you are  
19 not sure of the date?

20 A. Well, this was post inquiry -- or and post MHPS 11:30  
21 process.

22 175 Q. Could I just draw your attention to the following  
23 documents briefly. If we go to TRU-267692. This is a  
24 copy of a transfer status form, the transfer of private  
25 patients to NHS status. It is contained at Appendix 4 11:31  
26 of a guide relating to paying patients, which was  
27 introduced in 2016. The Inquiry has material which  
28 shows that the private patient transfer form in one  
29 shape or another was in operation from at least as far

1 back as 2009/2010, and the form has changed in its  
2 appearance over the years but has been included in a  
3 number of guides for practitioners in 2011, 2014, and  
4 this one is from 2016. Is it fair to say that you only  
5 began to see the use of these forms in the period after 11:32  
6 the MHPS investigation?

7 A. Yes, that's correct.

8 176 Q. Did you see them coming through your office?

9 A. Yes. Mr. O'Brien would have left them for me, and I  
10 would have put the patient on the waiting list and then 11:32  
11 they had to go down to the cashier's office. That is  
12 where they went after I had done my bit.

13 177 Q. So, describe the circumstances in which they would have  
14 been used, as you understand it.

15 A. Just as it says, the transfer from a private patient 11:32  
16 into the NHS. So this was now the last -- the date of  
17 the last private consultation there, that obviously  
18 would have been the date that the patient was put on  
19 the waiting list. It would have been the NHS waiting  
20 list so they would have been... I don't believe we were 11:33  
21 ever said that you had to highlight them as a private  
22 patient because they were not a private patient. Once  
23 they hit the NHS waiting list, they were treated --  
24 they were an NHS patient irrespective of what happened  
25 prior to that. 11:33

26 178 Q. Prior to you starting to see these forms after the MHPS  
27 investigation, prior to that what was the method used  
28 by Mr. O'Brien to move the patient from private into  
29 NHS?

1 A. Nothing that I was aware of. When the patient was  
2 being pre-admitted that I used the method that I have  
3 described before.

4 179 Q. How would the system have known that the patient was  
5 transferring his or her status? 11:34

6 A. It didn't know until they were admitted.

7 180 Q. Did you understand that the regulation of this area  
8 required the Medical Director's office to give approval  
9 to the transfer?

10 A. No. No. 11:34

11 181 Q. That wasn't something you were aware of?

12 A. No, and I actually worked with two other secretaries in  
13 the office that had the same; their consultant done  
14 private work. None of them -- they actually started  
15 using these forms after Mr. O'Brien was using them. To 11:35  
16 my knowledge, no secretary was aware that this is what  
17 was required.

18 182 Q. Just looking at one of the principles set out in the  
19 form, or in the guidance, if you go to TRU-267673, it  
20 says that... just go over the page, sorry. Where a 11:35  
21 change of status is required, the form we have just  
22 looked at must be completed and this has to go to the  
23 medical director for approval.

24

25 Just go back to the previous page. There it is. 11:36  
26 4.4.1.

27

28 "A patient seen privately in consulting rooms who then  
29 becomes an NHS patient joins the waiting list at the

1 same point as if his/her consultation had taken place  
2 as an NHS patient".

3  
4 I am thinking back to the period before you became  
5 aware of the transfer of status form. In your role, 11:36  
6 were you able to ensure that when a private patient  
7 comes in to the NHS, that he or she joined the waiting  
8 list at the same point as if her consultation had taken  
9 place in the NHS?

10 A. Yes. I would have been aware that there was no 11:37  
11 preferential treatment for private patients. That is  
12 why I say that the date I used for putting that patient  
13 on the waiting list was inaccurate, and that was a  
14 fault of mine.

15 183 Q. The date you used, the more recent date, if you like, 11:37  
16 you are concerned that that would give the impression  
17 that a private patient had been advantaged --

18 A. Yes.

19 184 Q. -- in some way?

20 A. Yes. 11:37

21 185 Q. Do you have a means of ascertaining or satisfying  
22 yourself that private patients hadn't been advantaged?

23 A. Sorry?

24 186 Q. Are you able to ascertain from your position that  
25 private patients weren't advantaged? 11:38

26 A. I don't know whether they were or not because I have  
27 never seen dates to check that out. I don't know when  
28 patients were seen. Because I wasn't involved in  
29 Mr. O'Brien's private practice, I cannot comment on



1 A. Well, I think they just started to strip away any  
2 support we had.

3 191 Q. This is on the administrative side?

4 A. Yes. So we started off with four, I think four  
5 audiotypists; we ended up with one, and we were just 11:41  
6 expected to work harder and harder.

7 192 Q. You have reflected in your statement at WIT-76358 that  
8 the move to the Breast Service, I suppose, has led to  
9 an improvement in your working environment and you find  
10 it to be a more effective service. What are the 11:41  
11 differences that you are observing from a position as a  
12 medical secretary in that service by contrast with the  
13 urology service?

14 A. It is basically the difference in day and night.

15 193 Q. Could you give us one example of how things work better 11:42  
16 and are better for patients because you're able to do  
17 your job as a secretary in a better way to work?

18 A. Because you had more time to do it, more time to check  
19 on things. We attend the MDT meetings so you are very  
20 much aware of the cases that are discussed at MDT and 11:42  
21 you follow it up. It is just a pleasure to work in  
22 compared to urology.

23 194 Q. Okay. I have no further questions for you. The Chair  
24 will speak to you.

25 CHAIR: We will have some questions. I am going to 11:42  
26 give you the option, if you'd like us to take a short  
27 break and come back in about 15 minutes.

28 A. Okay.

29 CHAIR: Okay. I don't know how long we will be but I

1 just thought you had a long enough morning and we will  
2 take a short break. 12:00.

3  
4 THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

5 12:00

6 THE WITNESS WAS QUESTIONED BY THE PANEL AS FOLLOWS:

7  
8 CHAIR: I am going to hand you over, first of all, to  
9 Mr. Hanbury, who has some questions for you.

10 195 Q. MR. HANBURY: Thank you very much. Just a personal  
11 view that I have could not have survived 30 years in  
12 the world of urology without a good secretary, so I am  
13 sort of coming from that. I have some sort of clinical  
14 operational questions for you. First of all, in the  
15 office, it is obviously a shared office, we have  
16 visited it. You shared it with Mr Young's secretary as  
17 well; who was the other secretary?

12:00

12:01

18 A. Mr O'Donoghue's secretary. Towards the end there was a  
19 lot of change. Mr O'Donoghue's secretary, and then  
20 Mr Tyson's secretary who replaced Mr. Suresh. So,  
21 there was -- at the end there was four secretaries in  
22 the one office.

12:01

23 196 Q. I mean, you mentioned the atmosphere. You could  
24 discuss operational issues with the other secretaries  
25 for advice and what would you do with this and what  
26 would you do with that. Did those sort of  
27 conversations happen?

12:01

28 A. Yes. The previous referral I made to the atmosphere  
29 was another office. It wasn't that office.

1 197 Q. Right.

2 A. I moved offices whenever I went to work for

3 Mr. O'Brien.

4 198 Q. That was the one you ended up with, that was a sort of

5 helpful and supportive atmosphere? 12:02

6 A. Very much so.

7 199 Q. Was it? Okay, thank you. You mentioned working four

8 days a week but presumably the audiotypist didn't

9 really pick up much of the Monday queries. Did you

10 have to pick up five days' worth of work in four days? 12:02

11 A. Yes. Well, apart from the short period of time in 2018

12 when the audiotypist was upgraded to a secretarial post

13 for about six months before she then got a secretarial

14 post in another speciality. But she was very good and

15 would have done a lot more administrative work on the 12:02

16 Mondays. But that, as I say, was for a short period of

17 time. Then the audiotypist that replaced her when she

18 left would have just took messages. So, I would have

19 got a raft of messages when I came in on Tuesday

20 morning for me to contact patients. 12:03

21 200 Q. So she had taken messages but not actually done

22 anything about it?

23 A. No.

24 201 Q. What about when you were on annual leave, for example?

25 A. Annual leave the other secretaries would have covered. 12:03

26 We all had to cover each other.

27 202 Q. All right. Thank you. You said interestingly

28 yesterday how could a secretary encourage the

29 clinician? I think you can do that quite well but it

1 needs face-to-face. There seemed to be a big culture  
2 of e-mailing rather than discussion face-to-face; is  
3 that a fair observation? You said you saw Mr. O'Brien  
4 sort of twice a week but he was in, say, four days a  
5 week, and your offices were very close? 12:03

6 A. That's correct but he very seldom was in his office.  
7 Well, obviously he had the clinic activity and those  
8 clinics were all held in the Thorndale Unit. He had  
9 his all day theatre list. He usually would have come  
10 up maybe midday on his theatre day; just pop in more or 12:04  
11 less. A lot of these, the popping into like the  
12 office, was like a courtesy pop in. As regards  
13 one-to-one and face-to-face consultations, there were  
14 very limited.

15 203 Q. If I could just draw you on that. The popping in, that 12:04  
16 is a good opportunity for you. Would he say how's  
17 things, is there any worries, any nasty results type of  
18 thing?

19 A. Yes. For instance on the undictated clinics,  
20 periodically I would have said 'any chance of you 12:04  
21 sorting those clinics out'. That would have been my  
22 chance then, you know, to have, I suppose what you  
23 would say encouraged.

24 204 Q. But then also if you had had a worrying result, for  
25 example, that you had picked up or jumped out as you 12:04  
26 say, would you say actually do you mind having a look  
27 at those two, for example. Is that something you did  
28 regularly?

29 A. Yes. Sometimes if there was something that jumped out,

1 I would have actually went down to the clinic, to the  
2 urology clinic down in Thorndale if I thought there was  
3 something that really needed his immediate attention.  
4 That was done on a regular basis, especially on a  
5 Friday because I knew I was going to be off on the 12:05  
6 Monday. He always had his oncology clinic on a Friday  
7 so I quite often attended that clinic with urgent  
8 issues.

9 205 Q. Okay. All right, I will come back to that one. Just a  
10 few questions on the surgical admissions. You said 12:05  
11 most of the information came in via email. Was there  
12 an actual form or a card that the clinicians would  
13 write out and submit to you in paper form, or was it  
14 all done electronically? What was it?

15 A. Right. So, if a patient -- the Trust policy is that if 12:05  
16 a patient is added to a waiting list, there is a green  
17 form filled out. That is for the purpose of the  
18 pre-assessment unit, so that they could then pre-assess  
19 the patient and all the information would be on that  
20 form regarding if they were on a blood thinner or if 12:06  
21 they were diabetic and so forth.

22

23 Mr. O'Brien didn't normally use those green forms, or  
24 he very rarely used the green forms.

25 206 Q. What would happen with the green form if it was filled 12:06  
26 in, would that come to you or a central wait list?

27 A. It came to the secretary and then the secretary would  
28 have sent it down to the pre-assessment unit.

29 207 Q. Then would the patient be pre-assessed there and then

1 or with respect to the upcoming operation?

2 A. Well, it depended if they were red flag, they would be  
3 pre-assessed as soon as possible. If they were on a  
4 routine waiting list, there was no urgency. But there  
5 would have been a case where people were pre-assessed 12:07  
6 even though we knew they would not be coming in for  
7 that surgery for years. So, that gave that patient  
8 sort of a false hope that they were going to be  
9 operated on fairly soon. So that was like a fault in  
10 the system that caused a lot of extra phone calls to 12:07  
11 the secretary.

12 208 Q. Okay. But then say the green form had not been filled,  
13 then the pre-assessment people wouldn't know that  
14 various things needed done?

15 A. No, they would have known because they obviously were 12:07  
16 able -- once someone was put on the waiting list, it  
17 obviously fired up on their system.

18 209 Q. Right. Okay, I see.

19 A. The purpose of the green form was regarding any extra  
20 information as in the blood thinning products, 12:07  
21 diabetes, and those sort of bits of information that  
22 were relevant for the pre-assessment department.

23 210 Q. All right. So, for example, if someone needed a urine  
24 test before a ureteroscopy or a stent change, that  
25 would be on that green form? 12:08

26 A. No. Mr. O'Brien would have organised that on the  
27 pre-assessment note that he gave me. So, he would have  
28 sent me the email with the people that were to be  
29 pre-admitted, and on that he would have had

1 instructions for the ward staff. Say, for instance, a  
2 patient, as you say, was coming in for the afternoon  
3 session, he would have either brought them in the day  
4 before if they needed tests done the day before, or he  
5 would have brought them in early morning and asked the 12:08  
6 ward staff to do those tests prior to him going down to  
7 theatre.

8 211 Q. Right. That brings me on to my next question. He  
9 would e-mail you with a list of case for his operation  
10 list, for example the main session, what would roughly 12:08  
11 the interval have been between then and the theatre  
12 list? would it be the following week or month?

13 A. No. It was normally was -- he would have done it at  
14 the weekends. Say I got it on the Tuesday, it would  
15 have been for the following wednesday, so the wednesday 12:09  
16 week.

17 212 Q. So roughly 10 days?

18 A. Roughly 10 days.

19 213 Q. All right, which is fine for simple tests. Say if a  
20 patient needed something more sophisticated, like to 12:09  
21 see a consultant anaesthetist or if it was high risk,  
22 for example, how was that dealt with?

23 A. Aidan would have sorted that out himself with the  
24 anaesthetist, or he would have liaised then with  
25 pre-assessment. 12:09

26 214 Q. Was that enough time to get that?

27 A. Yes. He would have been very proactive in preparing  
28 patients for his theatre, and that wasn't always  
29 involving me.

1 215 Q. I accept that. We have heard from one of the  
2 anaesthetist in this Inquiry that they needed a  
3 reasonable amount of time to plug patients into  
4 clinics. Perhaps 10 days is pushing that a bit, or you  
5 couldn't comment on that particular aspect? 12:10

6 A. No.

7 216 Q. But roughly 10 days or so?

8 A. Roughly.

9 217 Q. Thank you. Another thing is that you organised the  
10 admissions for the local anaesthetic procedures like 12:10  
11 flexible cystoscopy, urodynamics.

12 A. That's correct.

13 218 Q. Was that because the Thorndale unit didn't have  
14 administration or support?

15 A. No, those flexis, those would have been the check 12:10  
16 flexis. They were done in our Day Procedure Unit which  
17 is a separate building from the Thorndale.

18 219 Q. My question is more general in that were there other  
19 people helping with this administrative load or --

20 A. It was always the secretaries. 12:10

21 220 Q. -- were you responsible for every single procedure?

22 A. Yes.

23 221 Q. So, there was really no further administrative  
24 assistance in --

25 A. No. 12:11

26 222 Q. -- day surgery, Thorndale, and you have already said  
27 about main unit. Thank you.

28 A. No. The secretary done all the pre-admitting.

29 223 Q. Also, I was surprised. Radiology, say it had a

1 nephrostomy change or something like that, usually they  
2 have their own admin systems; why did you have to do  
3 that?

4 A. It was always the case, I have never known to be any  
5 different. They would have let us know when to bring 12:11  
6 the patient in and we done the arrangements or set up  
7 the arrangements with the patient.

8 224 Q. That is enough on that. Filing. On your evidence, you  
9 said sometimes there was Lever Arch files full of six  
10 or 10 files full of results of filing. What were they, 12:11  
11 were they like routine bloods or X-rays or is that a  
12 mixture of everything?

13 A. That was filing that I inherited when I took up post.  
14 It was a mixture of oncology letters. I would have  
15 taken the oncology letters out and tried to address 12:12  
16 them because at that particular time, the oncology  
17 letters weren't on the NIECR system. We tried to work  
18 through it. There was people brought in to try and  
19 address back-filing, but to limited effect.

20 225 Q. Okay. Thank you. The results, you have already 12:12  
21 explained a lot about that. Going back to an abnormal  
22 CT scan, for example, and Patient 5, where a decision  
23 has been made and you have the charts, Mr. O'Brien has  
24 the abnormal result, and then he would write on it or  
25 e-mail you. What were the sort of options he could 12:12  
26 have given you? For example, an urgent appointment on  
27 Friday afternoon oncology?

28 A. Yes. It mainly was to make an appointment. He would  
29 have specified when.

1 226 Q. With a time scale, for example?  
2 A. Yes.

3 227 Q. Then you would have gone ahead and made that  
4 appointment; is that correct?  
5 A. I made the appointments for all the oncology reviews. 12:13  
6 That was done by the secretary, not the booking office.

7 228 Q. Thank you. But obviously you were directed to do that  
8 in whatever time scale?  
9 A. Yes.

10 229 Q. Was there another option for you to flag that up to 12:13  
11 re-discuss on MDM?  
12 A. No, we never heard.

13 230 Q. So what was the mechanism?  
14 A. It was --

15 231 Q. If he had had an abnormal report that he wanted to 12:13  
16 discuss at MDM, how would that happen?  
17 A. Mr. O'Brien himself, the clinician, would contact the  
18 cancer tracker to be added to the MDM.

19 232 Q. Right. That would be done by e-mail, would it?  
20 A. I am not too sure because we weren't -- the secretaries 12:14  
21 weren't involved in referrals to MDM. I am not sure  
22 how he did that or how any consultant did that.

23 233 Q. All right. Just on that same theme then, for example  
24 an abnormal pathology report in one of the other  
25 patients, it really doesn't matter which one. That 12:14  
26 piece of paper, if he had wrote on the report 'to  
27 discuss it at MDM', that wouldn't come through you,  
28 that would have to be done by Mr. O'Brien or the  
29 clinician?

1 A. Yes.

2 234 Q. Okay. Thank you. You mentioned the triage letters  
3 from Urologist of the week. Often that was up to an  
4 extra 60 letters is what you wrote?

5 A. That was where you would say Aidan did advanced triage, 12:15  
6 where he would have requested scans and then the letter  
7 was generated to be sent to the patient to keep them  
8 informed of what their next appointment would be, i.e.  
9 the scan.

10 235 Q. So that was informing the patient what was happening. 12:15  
11 Did the other urologists do that as well?

12 A. As far as I am aware, yes.

13 236 Q. They wrote to patients. Thank you.

14 A. In some cases, if it was routine or an urgent, if it  
15 wasn't red flag in other words, he could have started 12:15  
16 them on a treatment plan knowing that they wouldn't be  
17 seen for years potentially. So, he could have started  
18 them on like an antibiotic or a low dose antibiotic for  
19 those non-red flag patients.

20 237 Q. Okay. Thank you. You mentioned about the stents. 12:15  
21 Again, this is related to admissions and sort of  
22 distressed patients phoning in, a couple we have heard  
23 from you. Were you aware of the sort of difference of  
24 the types of stents or the reason that people have  
25 stents? Either routine change, or a stone potentially 12:16  
26 blocking the kidney which needs a ureteroscopy and a  
27 laser. They are two quite different scenarios.

28 A. It was never explained to us, we were like self-taught.  
29 You got to know as time went on. Those sort of things

1 were never explained to secretaries.

2 238 Q. Okay. I suppose the next question is the patients who  
3 had the regular stent changes, like one of the SAI  
4 cases, they are done roughly every six months. How  
5 would that appear to Mr. O'Brien as someone who needed 12:16  
6 their stent changed at a particular month, say six  
7 months after it had been put in?

8 A. So, the descriptor on the waiting list episode would  
9 have been change of stent and then the date, like  
10 October '15 or whenever it was due. So that would have 12:17  
11 appeared then on the waiting list list, you know, of  
12 patients.

13 239 Q. Is that on a paper list or is that electronic? How  
14 would have Mr. O'Brien have seen that?

15 A. The waiting lists were produced by management every 12:17  
16 month, or bimonthly maybe, but Mr. O'Brien would have  
17 kept his own waiting list. I produced the waiting list  
18 from the patient centre or the PAS system.

19 240 Q. And that is hard copy or electronic?

20 A. I would have printed that off for him. He would have 12:17  
21 requested it periodically.

22 241 Q. So, he was aware of who was overrunning and who was...

23 A. Yes.

24 242 Q. Okay. Thank you. That is all I have. Thank you.  
25 DR. SWART: I wanted to ask you a few things really 12:17  
26 about working in the office and getting all these phone  
27 calls from patients. It is very, very obvious that  
28 with these long waiting lists, people who are going to  
29 be ringing and I think you said you had a lot of phone

1 calls. Did you have a set way for the telephone to be  
2 answered if people weren't in the office? Was that set  
3 up in a way that there was always someone to take a  
4 phone call from a patient, or did you have an answer  
5 phone, or how did you do that? 12:18

6 A. There would have been an answer phone but when I was  
7 off on a Monday, the calls were always transferred.  
8 They would only have been put on answer phone for meal  
9 breaks.

10 243 Q. Were all those calls picked up then at the end of each 12:18  
11 period?

12 A. Yes. As soon as you would have returned to the office,  
13 you would have checked your answer phone.

14 244 Q. How did you feel about people ringing up and saying, 'I  
15 feel terrible, I am on this waiting list and nothing is 12:18  
16 happening'? How did you feel about that? Can  
17 you just go through how you dealt with it in terms of a  
18 pattern so that you could cope it?

19 A. The usual thing was, first of all, to check that they  
20 were on the waiting list, and then it was to advise 12:19  
21 them of the length of the waiting list and that we were  
22 trying our best to get them seen as soon as possible.  
23 If they were to say to me that their symptoms had  
24 deteriorated, then that is when I would have involved  
25 Mr. O'Brien and e-mailed. 12:19

26 245 Q. When you told them, what was the reaction usually like?  
27 If you said, you know, you are on a waiting list, this  
28 is the length of it, did they get cross with you or  
29 would they get upset, or what happened?

1 A. Yes, you had various different emotions coming from the  
2 patients.

3 246 Q. Were you given any guidance as to how to deal with all  
4 of this?

5 A. Not really, no.

12:19

6 247 Q. I know you said that you e-mailed Mr. O'Brien a few  
7 times. We know from reading patient complaints  
8 generally that this is a problem, quite a big problem,  
9 within the Trust and probably in another hospitals.  
10 Quite a lot of the patients feel that they are being  
11 fobbed off generally. I am not talking now  
12 specifically about this situation.

12:20

13  
14 what is your view, having done this for quite some time  
15 and had these people ringing up, what is your view on  
16 how that should be dealt with?

12:20

17 A. I don't know how to deal with people when they are on  
18 such long waiting lists.

19 248 Q. How do you think people could possibly assess how much  
20 their symptoms have deteriorated, for example? Was  
21 there any way other than sending an email to  
22 Mr. O'Brien for you? What options do you think you  
23 had?

12:20

24 A. The options was for them to -- we were told to send  
25 them back to the GP.

12:20

26 249 Q. Did you do that quite often?

27 A. Oh yes. We would always have said if you have symptoms  
28 that you need addressed, go first to your GP but I will  
29 let Mr. O'Brien know. So, there was always that

1 narrative, that you advised them to first of all seek  
2 help from their GP.

3 250 Q. In effect, did you have some patients who rang up  
4 repeatedly?

5 A. Oh yes. 12:21

6 251 Q. When they are on their third or fourth time ringing up,  
7 what kinds of things did they say to you?

8 A. Well, a lot of it was frustration. It was frustration  
9 too on my part because there was nothing we could do.  
10 I think they accepted that, that it was out of our 12:21  
11 hands.

12 252 Q. Was there ever a time, for example, when you could  
13 liaise with some of the nurses or someone else to talk  
14 to them, because a lot of them would have had quite  
15 clinical complaints, I would think, and they would need 12:21  
16 someone to talk to. Were there any discussions about  
17 how that might be managed within urology, as far as you  
18 were aware?

19 A. We were never actually advised that we had the nurses  
20 there for a backup. That was never something that I 12:21  
21 was aware of, and I don't believe any of the other  
22 secretaries ever transferred to the clinical nurse  
23 specialist.

24 253 Q. What do you think; do you think that would have been  
25 helpful? 12:22

26 A. Well, I know now that that is expected and, yes, it  
27 would be very helpful. But at that particular time,  
28 those clinical nurse specialists were up to their eyes  
29 with work so they didn't need patient calls as well.

1           You know, they were under-resourced as well.

2 254 Q.    The other time you spoke to patients was when they were  
3           going to come in for their operations, and you said you  
4           would be sometimes advising them on some of their  
5           treatments like blood thinners. Did that generate any   12:22  
6           conversations with them where you were supposed to be  
7           giving them advice, because you are not trained in  
8           blood thinners. Can you describe how that was for you  
9           and whether you had any difficulties with that?

10          A.    No, I had no difficulties because Mr. O'Brien made the   12:22  
11          first phone call. He arranged the people, the patients  
12          to come in. He would have only asked me to remind the  
13          patient to come off the blood thinner on a specific  
14          day.

15 255 Q.    They didn't ask you any questions about that?           12:23

16          A.    No, because he had already that all explained in his  
17          first telephone call.

18 256 Q.    Now that you are with the breast team and it feels like  
19           night and day, as you described it, what do you think  
20           is responsible for the different culture in that           12:23  
21           department? I know you feel you have more support; is  
22           there anything else that you have noticed that is  
23           different about the way that department works?

24          A.    It works the same way but it is under less pressure.

25 257 Q.    Specifically, though, you told us that in the breast   12:23  
26           team you went to the multidisciplinary team meetings.  
27           Did you feel there was less of a hierarchy in the  
28           breast team in terms of everybody recognising the  
29           importance of everybody in the team?

1 A. Yes, there is certainly more use with the clinical  
2 nurse specialist; they play a big part in the breast  
3 team. As I say, I attended the MDM and it means that  
4 you are very aware of outcomes.

5 258 Q. What is the situation when the patient is ringing up 12:24  
6 there?

7 A. Less patients ringing because they are seen within two  
8 weeks. The turnover is extremely fast.

9 259 Q. Even so, you said a few things that indicate that the 12:24  
10 relationship with management, as you call it, wasn't  
11 fantastic. Who do you regard as management? Who is  
12 management? Do you mean the service administrators and  
13 people down that end? Do you mean the senior  
14 management of the hospital?

15 A. Well, the service administrators and then up to 12:24  
16 Katherine Robinson. Yes, that is who I see as my  
17 management.

18 260 Q. And that is where you feel that it wasn't very helpful.  
19 Do you think the Trust as a whole creates an atmosphere  
20 where all the staff feel valued? 12:24

21 A. Not particularly, no.

22 261 Q. Why do you feel that? What do you think the source of  
23 that is? I am sure they wouldn't set out to be like  
24 that.

25 A. I don't know how to describe or why it has went that 12:25  
26 way. I think everybody is just running about chasing  
27 their tail and nobody has time for anybody.

28 262 Q. Yes, okay. Thank you very much. That is all from me.  
29 CHAIR: I have only a couple of questions for you.

1 Just in terms of the clinical nurse specialists, we  
2 have heard that certainly in the nine SAIs, there were  
3 no key worker or clinical nurse specialist assigned to  
4 those patients. Can you assist us at all. We know  
5 that Mr. O'Brien did have some patients who had a key 12:25  
6 worker assigned. Can you assist us with how that  
7 happened; how a key worker was assigned in some cases  
8 and not others?

9 A. No. I wasn't aware that key workers needed to be  
10 assigned to cancer patients. This was all new to me. 12:26  
11 I never heard the word "key worker" ever used when  
12 working in urology.

13 263 Q. What about clinical nurse specialist or any other  
14 terminology, but somebody that that patient could ring  
15 up other than you to get help if they felt they needed 12:26  
16 it?

17 A. I wasn't aware of that. I knew the clinical nurse  
18 specialists were there and they did their role in  
19 biopsies and urodynamics, helping with urodynamics, but  
20 it was like as if that was their role. We were not 12:26  
21 aware that they needed to be involved.

22 264 Q. When you say "we", we know that other clinicians did  
23 use the clinical nurse specialist in that way as a key  
24 worker, so clearly presumably his secretary might have  
25 been aware? 12:26

26 A. I am not aware that the secretaries I shared the office  
27 with were aware.

28 265 Q. It wasn't something that was discussed?

29 A. I've never heard the word "key worker" ever used.

1 266 Q. Just in terms of the DARO system, you said that  
2 Mr. O'Brien always wanted to have a review of his  
3 patients and that is why he didn't use the DARO.  
4 Essentially what you are telling us is if a result came  
5 back and the result was all clear, there was really no 12:27  
6 need for that patient to be on a waiting list; isn't  
7 that correct?

8 A. That's correct, yes.

9 267 Q. So that patient being on the waiting list was then  
10 holding up someone else on the waiting list, in effect? 12:27

11 A. But Aidan would have made the -- he would have put them  
12 on for a review irrespective of the result.

13 268 Q. Do you see my point? If he is having a review slot for  
14 someone who really doesn't need it, and a quick phone  
15 call to say your tests are all back and they are clear, 12:27  
16 you are good to go, someone else could have had that  
17 slot on the waiting list?

18 A. That's right but to me that is not a secretary's call.

19 269 Q. No, no, I am not suggesting it is. What I am saying to  
20 you is that the DARO system was set up to ensure that 12:28  
21 those people who actually needed a review appointment  
22 were getting it. Would you accept that?

23 A. Well, Aidan would have used the DARO for those people  
24 that he knew was going to be discharged, albeit one or  
25 two patients; like, it wasn't vast amounts. But no, if 12:28  
26 a clinician says he wants to review, the secretary has  
27 to adhere to that. I can't comment on whether one  
28 patient deserves a review and another doesn't. It is  
29 not something I can comment on.

1 270 Q. Just in expanding on that a little bit, am I right in  
2 understanding that you did not feel that it was ever  
3 your role to challenge Mr. O'Brien?  
4 A. No, I never would have challenged him.  
5 271 Q. And whatever he told you to do, you did? 12:29  
6 A. Yes.  
7 272 Q. Thank you very much, Mrs. Elliott.  
8 MR. HANBURY: I've just one more on the theme of the  
9 results. We have heard in the Inquiry where things  
10 didn't go so well, but were there times that, say, 12:29  
11 negative results, as the Chair just said, were dictated  
12 on and you did letters so that patients were then  
13 advised? So, when you said Mr. O'Brien did use DARO  
14 sometimes --  
15 A. Oh yes, yes. Those patients would have been -- 12:29  
16 273 Q. -- and the CT came back and it was fine, for example,  
17 what would happen? Was there a letter?  
18 A. Yes, he would have discharged the patient. Now, that  
19 was very rare.  
20 274 Q. Okay, but would he dictate a letter to the patient -- 12:29  
21 A. He would.  
22 275 Q. -- to say it is fine?  
23 A. He would. But that was very rare, I am saying one or  
24 two patients maybe a month. It was very rare.  
25 276 Q. Thank you. If, for example, on the DARO system, say 12:30  
26 for a prostate cancer follow-up, and the clinician says  
27 I want to see you in six months' time and we will have  
28 a PAS test beforehand, under the DARO rules would you  
29 then have to see the PAS result and then decide?

1 A. Yes.

2 277 Q. But then if there is a huge backlog, that patient might  
3 wait for six months to come back?

4 A. Yes, that's correct.

5 278 Q. So it didn't -- 12:30

6 A. It didn't speed up the review appointment.

7 279 Q. So you ended up -- I mean, was the whole idea of  
8 follow-up by letter, is that what the... reading  
9 between the lines.

10 A. Sorry? 12:30

11 280 Q. Maybe it is an unfair question. If a patient waited a  
12 huge length of time even having had the results, there  
13 is still a problem, isn't there?

14 A. If it was a very high PAS, Aidan would have addressed  
15 that. If they had have been on the review waiting list 12:31  
16 to be seen in six months and the PAS came back high, he  
17 would have asked me to escalate that appointment and he  
18 would generally have said put him on my SWAH clinic for  
19 such and such a date. So, he did expedite a lot of  
20 appointments because of high or untoward results. 12:31

21 281 Q. As you say, the onus is then on the clinician to make  
22 that call?

23 A. Yes, yes.

24 282 Q. Thank you.

25 CHAIR: Thank you very much. Thank you, Mrs. Elliott. 12:31  
26 I am sure you will be very relieved to know that we  
27 have finished asking you questions. It is not quite  
28 lunchtime but near enough. Thank you.  
29

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Tomorrow morning, Mrs. McMahon is back, is that correct? Ten o'clock tomorrow.

THE INQUIRY ADJOURNED TO 10.00 A.M. ON WEDNESDAY, 7TH  
JUNE 2023

12:32