Urology Services Inquiry

Oral Hearing

Day 55 – Tuesday, 27th June 2023

Being heard before: **Ms Christine Smith KC (Chair)**

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

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THE INQUIRY RESUMED ON TUESDAY, 27TH DAY OF JUNE, 2023 AS FOLLOWS:

CHAIR: Good morning, everyone. Mr. Wolfe?

MR. WOLFE KC: Chair, your witness this morning is Mrs. Deborah Burns, and she will take the oath. 10:07

MRS. DEBORAH BURNS, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE, AS FOLLOWS:

10:07

1 Q. MR. WOLFE KC: Good morning, Mrs. Burns.

A. Hello, good morning.

2 Q. Thank you for attending the Inquiry this morning to give your evidence. The first thing we will do is to reintroduce you to your witness statements or your 10:07 Section 21 responses, of which there is one substantive and one addendum. So starting with the substantive at WIT-96868, and you will recognise that as the front page --

A. Yes. 10:08

3 Q. -- with a little legend or message at the top explaining that you put in an addendum --

A. Yes.

4 Q. -- recently, 26th June, and we will go to that shortly. Let's go to the last page of this document. We will 10:08 find that at WIT-96938, and you will recognise your signature?

A. Yes.

5 Q. And it's dated 9th June 2023 and it's customary to ask

you do you wish to adopt that statement as part of your evidence to the Inquiry?

A. Yes.

6 Q. Thank you. And then your very short addendum statement correcting what really is a typographical error or a date error -- 10:08

A. Yeah.

7 Q. It's WIT-98538 and 22nd June and, again, that's your signature at the bottom of the page?

A. Yes. 10:09

8 Q. We can see it correcting a date error. And, again, do you wish to adopt that as part of your evidence to the Inquiry?

A. Yes, please, yeah.

9 Q. Thank you. Now, your current job and employer, Ms. Burns, who is that? 10:09

A. So I work now for Northern Ireland Hospice and I am the Director of Care and Quality Governance.

10 Q. And you have been in that role from 2017, is that right? 10:09

A. Yes. Yes.

11 Q. And we can see, and we don't need to open this, but we can see from your statement at paragraph 4.1 that you are, going right back, I suppose, a physiotherapist by profession or trade? 10:10

A. Yes, many years ago! Yes.

12 Q. Yes. And you qualified in 1993 with a bachelor of science in physiotherapy; obtaining a master's in business administration, with a specialism in health,

ten years later in 2002?

A. Yes.

13 Q. And we can also see that prior to taking up the four roles which I'm going to speak to you about in the Southern Trust, you had a number of posts across the Northern Ireland Health Service as a physiotherapist -- in the South Tyrone Hospital? 10:10

14 Q. In the Down and Lisburn Trust, a senior physiotherapist role, and then getting into management-type roles, of which you've made your career, I suppose? 10:10

A. Yes, that's right.

15 Q. Patient Access Manager in the Craigavon Hospital; Head of Modernisation in the Craigavon Hospital; and then Director of Operations from 2005 to 2007, at which point the Southern Trust was formed, isn't that right? 10:11

A. Yes, that's right.

16 Q. And let's just sketch out the four posts that you held in the Southern Trust, and then we'll go into a little bit more detail about them. So the first role you took up in 2007 through 2010 was Assistant Director of Performance and Improvement, isn't that right? 10:11

A. That's right, yes.

17 Q. And then you moved on to what I judge to be a short or relatively shortly contained project manager role?

A. Yes. 10:11

18 Q. -- in 2010 through 2011?

A. Yes.

19 Q. Yes. I know sometimes you'll look at me as if "Is that right?" if you've a --

A. No, it is right. It was so short that I don't actually remember the Project Manager title, as such, and I wrote that -- I had thought that it merged into the AD for Clinical Governance, but I guess it must have been a year where it was called something else.

20 Q. Yes.

A. Yeah.

21 Q. And, as you say, the next thing on the list in terms of your career --

A. Yes. 10:12

22 Q. -- was Assistant Director of Clinical and Social Care Governance?

A. Yes.

23 Q. And that was -- you were in that post for roughly two years, 2011 through to the spring of 2013? 10:12

A. Yes.

24 Q. -- when you took up the post, which I think we're primarily interested in --

A. Yes.

25 Q. -- which is the Director of Acute Services? 10:12

A. Yes.

26 Q. And you took up that post in March/April 2013?

A. March, yeah, March.

27 Q. And stood in that through to August 2015?

A. Yes. 10:13

28 Q. Thank you. So -- and then you moved on beyond the Southern Trust into private sector and, ultimately, in 2017, to the Hospice?

A. The Hospice, yes.

29 Q. Yes. So, just briefly on the Director Performance Role which you took up in 2007, you helpfully sketch out aspects of that in your witness statement?

A. Yes.

30 Q. But, in essence, you explain that the role was focused on the PFA target achievement? 10:13

A. Yes.

31 Q. The monitoring of those performance objectives?

A. Yes.

32 Q. And reporting within and across the Trust, and then externally to Commissioners in terms of those performance objectives? 10:13

A. Yeah, that's right.

33 Q. And in that respect, you reported, as you were to report in your subsequent jobs, to the Chief Executive? 10:14

A. Yes, although she was the Director of Performance at that time.

34 Q. Yes.

A. Yes.

35 Q. That's Mairéad McAlinden? 10:14

A. Mairéad McAlinden.

36 Q. So that was your, I suppose, upon the formation of the Trust --

A. Yes.

37 Q. -- your first steps into senior management? 10:14

A. Yes. I suppose so. In terms of the previous -- I mean, the Trust became one of those very large organisations, and, yes, that would have been my first corporate role, as such, which was right across the

Trust, which would have looked at things like mental health, children's, women's health. So, yes, that was my first corporate role. I think -- I mean, each job you're in, you think it's huge, don't you? And I think when we were in Craigavon as a hospital trust, we thought that was quite large as well, but this was much broader. 10:14

38 Q. Mm-hmm. And, I suppose, we'll go on and talk later this morning about some of the performance challenges that you were to experience within Acute -- 10:15

A. Yes.

39 Q. -- and the scale of that role and the build-up of demand and, if we're thinking about Urology in particular, the difficulties in --

A. Yes. 10:15

40 Q. -- in developing capacity to meet that demand?

A. Yes.

41 Q. Going back to, as I say, your first steps into the Southern Trust in that corporate performance role, I suppose you are well-placed to help us understand whether there was a big change -- was there a big change over the period of years in terms of what the Trust had to face in providing services to its population? 10:15

A. Yes, there was, a really big change. I can't remember the date, but it would have been when Craigavon was a trust of its own, just prior to joining the merger of the Southern Trust, the five Trusts, that was when the performance era really started within both the 10:15

Department and the Commissioner -- the Health Board at that time -- and they brought over some people from the UK and the Trusts were met with regularly -- I think it might even have been weekly or fortnightly -- and we would have attended those meetings and looked at patient access times in terms of Outpatient, Day Surgery, Inpatient and in terms of your ED and your waiting times, and then also for mental health outpatients and those things. So it was really building that performance culture at that time, yeah. So it was -- now, when we were -- 2007, it had begun, but we were building on that. 10:16 10:16

42 Q. And in terms of the pressures on this particular Trust, is it, and this will be blunt and simplistic, but is it -- 10:17

A. Yeah.

43 Q. -- is it fair or accurate to -- for the Inquiry to have developed a picture of things getting increasingly difficult or pressurised for the Trust in terms of meeting the demand of the local populations as compared with the resources available to meet that demand, or was it always a very difficult environment in which to do healthcare? 10:17

A. I think -- me, personally, I was a big believer in patient access to the Service. The NHS was set up to be free at the point of delivery and, when you need it, you need it. So I actually thought that someone bringing accountability to that was a good thing. I don't think and I don't recall -- in fact, I probably 10:18

recall the opposite -- I don't recall the Southern Trust in my time was under any more pressure than any other Trust in Northern Ireland. There was specialties across the region that were definitely struggling and Urology across the region, but you know that because you saw how many regional reviews had been done in that period. It was definitely struggling, and it was struggling in terms of manpower, in terms of training. It was just struggling.

10:18

44 Q. Yeah?

10:18

A. And I guess in performance as well, there's a hearts and minds thing, isn't there? So some specialties are more adaptable to change and were adaptable to looking at the wider waiting lists, as opposed to just the patient in front of you, and some weren't. And that tended to be a specialty thing as well, but that would have been across Northern Ireland. And, like, today still there's issues, isn't there, with certain specialties, you know.

10:19

45 Q. Okay, thank you for that. We will come to look at some of the particular difficulties, perhaps through the performance reports that you had to engage the Commissioner with in a short time.

10:19

A. Yeah.

46 Q. But thank you now for that. In terms of the Project Manager's role -- and I hear the caveat you add in the description of that earlier --

10:19

A. Yes.

47 Q. But within your statement, you describe this as

a project to review clinical and social care governance systems and processes --

A. Yes.

48 Q. -- across the Trust, in light of the findings from Mid Staffs in the Francis report. So that role which you stepped into was established in that era, in that context of a perceived need to improve how public healthcare providers were delivering and were they delivering safely, was there -- 10:20

A. Definitely that was my recollection. I think there was also -- I can't remember if it's in the statement -- there was a review in the Western Trust in relation to the similar type issues. Mid Staffs, he had just started his Inquiry in 2010, but everybody was conscious of the issues of that. So it was filtering out as he was doing his Inquiry. And there was a number of other elements to that. So, yes, we were very conscious, is my recollection, that, alongside performance, you needed to move governance as well, and that's really important. So, at that time, governance sat under the Medical Director and then, under the new structure, it sat more -- the corporate part of it sat more with the Chief Executive. 10:20 10:20 10:20

49 Q. Mm-hmm. Let's just step through that a little more slowly, if you don't mind. Let's just pick up on the -- so there's a Terms of Reference for this review that you were undertaking -- 10:21

A. There was, yes.

50 Q. -- as the Project Manager. We will pull that up, it's

WIT-97035. And you can see at -- there's a context. And if we just scroll down through that:

"The process is designed to ensure the identification and effective control of risks within the Trust Assurance Framework."

Your particular role, as it turned out, was to be appointed as this Project -- in this project management role, isn't that right, it was intended for three months. And -- 10:21 10:22

A. I see that there, yeah.

51 Q. And, over the page, it sets out the aim of the review is to assess the effectiveness of the Trust's clinical and social care governance mechanisms across a range of areas and issues. And we don't need to spend too much time descending into the weeds of that, but it was a wide-ranging -- 10:22

A. It was right across the Trust and it was reporting -- that reported into SMT, so that was all the Directors. So what I did was bring progress reports to them and ideas and thoughts as we were moving through that about how we were going to redesign. And the essence of the redesign was to put -- to get more ownership in the directorates, in the clinical directorates. Not to have governance done to you, but for you to be doing governance in the clinical directorates and for you to be accountable for your governance and your clinical directorates, not to have a separate governance team 10:22 10:23

sitting over here, almost doing to you. I mean, the common theme was we had an incident reporting system which was paper-based at that time and the common thing was that people said the IR1s went into a black hole and never came back. So what we wanted to do was have those reviewed in each of the clinical divisions and owned by them and then elevated up as and when.

52 Q. Mm-hmm.

A. So it was all about, like, ownership in the clinical divisions because you can't have governance done to you because you could never -- you can't do it like that. 10:24

53 Q. Yes. And the next step in the process was for you to write a consultation document and we can see that. It's at WIT-96952 and it's called "A System of Trust". And you set out the background for that, if we go to WIT-96956, just scrolling down, and you explain that four basic questions were considered in the examination of current roles and responsibilities? 10:24

A. Yes.

54 Q. And you set those out, just scrolling down. And you go on in the report to set out the rationale for change, if we go through to WIT-96958, and what you say is that, during your review that you carried out, it was evident that although there was no major operational shortcomings identified with respect to patient safety and quality of care, a number of significant system and organisational issues emerged? 10:25 10:25

A. Yes.

55 Q. Workshops led to recommendations and developed pathways

for change, and then you summarise the recommendations. And I think you explained earlier that I suppose at the core of this was bringing governance closer to --

A. Yeah.

56 Q. -- the centred decision-making? 10:26

A. Yeah, absolutely, because when we say -- when I said there was no major operational shortcomings -- in essence, when you look across, looking in, you couldn't see any major, you know, Mid Staffs disasters where patients were high mortality rate and dying. But what 10:26 you could see, for example, was if a significant incident was reported, it took too long to process that; it took too long to review that, to get the learning out, to move it forward, and there wasn't so much ownership of that where it happened. Because, at 10:27 the end of the day, we can have failure all day long, and we will have in this system, but it has to be with the people that are doing that task then daily have to be the reviewers and have to be the learners. So they have to review it and that was where we weren't getting 10:27 it. So the clinicians themselves in the teams weren't doing that, and that's what we wanted to try and do. I guess in the Professional Executive Director role, again, if you held "I am the Director of Social Work, I am the Director of Nursing, as well as an operational 10:27 portfolio" -- yes, you may be, but how does an acute nurse feel and action what you're trying to direct them to do? So it's all about in their context, in live time. It has to be done on the shop floor.

57 Q. Yes. And I want to take you to the structures that you were proposing, and they are set out at WIT-96961. Just at the top of the page, you explain that the three core components of the Trust's Clinical and Social Care Governance Model had been populated with the proposed structure to deliver them. How the new structure will actually work in practice is then described. You say:

"It is essential that the concepts described earlier, decision-making --" 10:28

A. Yes.

58 Q. "-- to the point of service delivery is possible by those who can effect change and learn from it."

A. Yes.

59 Q. "Clarity and singularity of accountability, communication and Trust-wide patient safety learning and organisational intelligence are the foundations of how the CSCG needs to function." 10:28

So perhaps a lot to unpack there. Maybe if I bring you to the diagram that helps to illustrate that, you can explain what you're getting at there. So if we go down two pages to 963 in the sequence and this is, I suppose, the structure that you're setting out. There's an operational and professional side reporting up to the corporate. So what -- what was new here? What were you attempting to do with this structural change? 10:29 10:29

A. So can you scroll down a wee bit?

60 Q. Of course, yeah.
A. Do you see the Operational Directors and their teams?
61 Q. Yes.
A. Previously, it was just centralised and it worked out of the Medical Director's office, which was quite an -- it was a normal way to do business but the Medical Director had a, what would you say, he had a number of people in his office that were Clinical Governance people. They did not live and work and breathe in these operational directorates. They did not have day jobs that was at the bedside. So what we were trying to do was take the AMDs, the CDs, the ADs, the Heads of Service that were on a daily basis staffing the wards and putting in what was going to happen and support them in each of their directorates to do governance, by putting in then the new structure in their directorate but putting it into each directorate and getting them to be accountable for their own governance. Obviously in an organisation that size then, you needed -- the Chief and the SMT needed an overall view of the governance of all of the operational directorates and then that's where the small central office came out. But it devolved it down, or it tried, or it intended to.
62 Q. So this was very new, a very new way of working. In fact, it was, it's fair to say, it was a radical change?
A. Yes, and I think that's what has struck me the most, this was a radical change, and we were just at the

10:30 10:30 10:30 10:31 10:31

start of this journey. It took -- it takes time to build that. It takes time for people to realise that governance is your business and somebody is not going to do it for you.

63 Q. Yes. And just continuing through the paper, obviously we can see -- just scrolling up -- the post just before reporting to Chief Executive's office, so the Assistant Director in CSCG, that's the post that you were to take up then -- 10:31

A. Yes. 10:32

64 Q. -- and we'll come to that in a moment -- to, after the project finished, that was the post you stepped into?

A. Yes.

65 Q. Yes. And just you also set out in this paper some of the key structures or mechanisms -- 10:32

A. Yeah.

66 Q. -- to support the CSC agenda?

A. Yes.

67 Q. And they are described in this paper and the Inquiry will recognise some of them and, I suppose, I wanted to allow you to point out that they have their origin in this paper. So if we go to WIT-96982 and, here, you describe supporting infrastructure -- the Trust was to introduce a web-based Datix, and we've heard Datix described as, interchangeably, I think, with Incident Reporting. Is it more -- is it more than that? 10:32 10:33

A. So the system itself is Datix. Datix is a common enough system used across the UK for governance in the

Health Service. In the Hospice, for example, we use a different system, but hospices in general tend to use it. So it's the name of the system. The IR1s that you will hear a lot about, those are the actual -- what's the word -- they are the actual templates that you record, for example, an incident on. So it's just part of the Datix and it's just like a template that you record and it prompts you to answer questions about the incident that you're trying to report. But also we had -- we eventually put complaints on Datix that more people -- a group of people that were reviewing a complaint, a group of clinicians, could all look at their own and others' work on that complaint and come up with a learning out of that together. So you can have, you know, risk registers today -- like, I have my risk registers on all my governance components on my governance system. 10:33 10:34 10:34

68 Q. Mm-hmm. So, I suppose, in a nutshell, the introduction of this facility offered the potential to deal with, I suppose, the incidents and the issues which are part of governance -- 10:34

A. Yes.

69 Q. -- in a more manageable, efficient way?

A. Yes, because this meant that this was put on -- well, we endeavoured to put it on everybody's desktop. So an admin person, a ward sister, a nurse could go to a desktop, pick up the Datix icon and could type in something and that was the whole encouragement, was to do it, because if something is less than satisfactory 10:35

-- it doesn't have to be a major incident, it doesn't have to be catastrophic -- if it's a less than satisfactory experience for a patient or you think it's just not good enough, then we can put it in here. And then what happened was it went -- the electronic system in each division, you designed it that it would go to various people and highlight to them that these incidents had occurred lower down the chain in their area and then they could review them. So it was making it much more accessible and visible and prompting you to look at incidents in your area. 10:35 10:35

70 Q. Yes. And this -- I wanted to start with Datix because it seemed to me that it wrapped around a lot of what you were intending to do, although I think it comes towards the end of this paper. Let's go back further up to look at some of the other structures and mechanisms to support the CSC agenda that you were discussing. Complaints, if we go to WIT-96974, so you were -- again, the Panel will have an opportunity to read this paper in some detail if it hasn't already, but, I suppose, what you were trying to do here was introduce new systems around the handling of complaints and how they would be processed? 10:36 10:36

A. Yeah. Is that -- that was -- is that -- just remind me, is that -- I had put that in why we would envisage -- it was the second module to go on. 10:37

71 Q. Yeah, just scroll up there and you can see the immediate context for this.

A. Yes.

72 Q. So, I suppose, what -- I hope I have prefaced this right by saying you're setting out a series of processes --

A. A series of processes -- it was a rollout -- it was going to be an implementation. So "incidents", as far as I can remember, went first; then "complaints". But the major thing, if you just scroll down a wee bit there, the major thing there is that everybody is aware of the complaint, but the main focus -- just scroll down another a wee bit -- 10:37

CHAIR: If you want to move the microphone with you, that's great. It's just that there is a stenographer, who isn't present in the room, who's trying to take a transcript of all you're telling us.

A. That's okay, thank you. The biggest thing here is that the response is agreed with the service team, the AD, the MD and the Director and it sits in that Directorate until they get that done. But they have to do it, and then it comes up, which is not someone coming into their Directorate or managing that for them or sending it out to a complaints office outside; it is them around the system doing this. 10:38

73 Q. MR. WOLFE KC: Yes. It gives ownership to the --

A. Ownership and accountability and -- yeah. And you have to review your own practice. Somebody else is not reviewing you and writing the response to the patient. You have to do that, which was a big issue -- involvement with families was a big issue. 10:38

74 Q. Incident Reporting comes next in your list, if we just

scroll down to the next page, and you're explaining that this area of work would change significantly from the current process and you were going to pilot and roll out web-based Datix for incident management during the next six to nine months. And then you set out a vision for what the process will be when the web-based system is in place. So again a big change from what you described as a kind of a paper-based system to something much more -- 10:39

A. Yeah.

75 Q. -- efficient and visible?

A. Yes, they used to write their IR1s and they used to then -- a governance person from the Medical Director's office, I think, would have came and collected those, collated them, looked at them, produced the reports. In this, they sit within the Directorate and you have to do it in the Directorate. And then there is a responsible for to you produce a report for the corporate SMT to oversee it as well, so again it is putting it back into the service. 10:39

76 Q. Yes. Just briefly working through some of the others, Standards and Guidelines is something else that you --

A. Yeah.

77 Q. -- did some work on, if we go down to the next page. So you indicate the Trust receives a significant volume of standards and guidelines from a range of external bodies and you are describing here a process, a new process for how these would be handled in Trust? 10:40

A. Yes, that's right.

78 Q. And the detail is there. Risk Management on the next page, again you are describing a new process?

A. Electronic register -- again, that has to come up from the Directorate itself. So it has to come up from the Clinical Directorate. It has to be them putting their own risks and identifying them, not anybody else working in to them to say "This is your risk." And they are responsible for reviewing that, so the whole idea was to get them on this cycle of regular review of their risk registers. 10:41

79 Q. Thank you. And then just scroll down so that the Panel can see some of the other, if you like, headlines. We don't need -- so there's a piece on Standards and Quality Training and Education. Clinical Indicators and Audit was -- again, can you think as to what the, what was it at the heart of that change or development? 10:41

A. Well, the Clinical Indicators and Audit, I think we were -- what we were trying to do there was get the Executive Directors, which we talked about, the Medical Director, the Director of Nursing, Director of Social Work, to take a little bit more accountability and visibility in what they wanted that workforce to do across the piece, right, so across corporately in each of the clinical divisions, but then each again of the Directorate Governance teams were responsible for doing those audits and seeing where they came up against those standards, how they measured up. So -- because a social worker in children's is going to work very different to social worker in adults. So what is the 10:42 10:42

focus there in terms of the professional status of that social worker and how can that be measured in individual directorates? And it needs the context of the clinical thing. It needs the context of your daily job to make sure that you're measuring the right things.

80 Q. And -- thank you. If we again just keep scrolling through, there was a system, if we go through to 96982, you brought forward -- 10:43

A. Yeah.

81 Q. I think it's a document we're familiar with, although we may not have seen it before in this context. So you appended to this paper some work which had been done, as we understand it so far, within Human Resources on a Trust -- a set of Trust guidelines for managing poor professional conduct and performance, which was to sit alongside or to be a partner to MHPS. So that document here -- "Process Pen" refers to Appendix 3 and Appendix 3 97001 -- WIT-97001 is the -- we are familiar from our MHPS module with this screening process and how it might lead to a formal investigation. If you scroll down -- 10:43 10:44

A. Yes.

82 Q. -- and over the page, there's informal process. In a sense, this document is new at that time but the -- 10:44

A. The basis of it was MHPS, do you know? But what we were actually trying to do there was again encourage this in the Directorate. If you go back to that second bullet point where we described that, the whole point

was it's the guys working alongside you that need to understand and discuss with you if there is a problem because they understand that problem the best and they understand the context in which you're working and they are also the most likely to be able to effect any change to that because, if a team has to change, it has to change. So what we were trying to do is not again get it done to them, but get them to do it up the ways.

83 Q. Mmm.

A. And bring it up by putting HR and NCAS alongside them. But I guess to do that, you have to recognise that you have an issue. 10:45

84 Q. Yes. So, from this set of proposals through -- which you'd set out in this paper, can we assume that they were largely adopted by the Trusts? 10:46

A. They were accepted, yes. Now, the speed and implementation is a whole different ball game! But, yes, they were accepted and we were, like, working our way through those. And definitely I think you're correct in saying that Incident Reporting was the first one that we did. 10:46

85 Q. Yes. And within your role then as Assistant Director for Clinical and Social Care Governance between 2011 and the spring of 2013, you've explained in your statement that it was your role or your responsibility to implement -- 10:46

A. Implement, yes.

86 Q. -- the review findings across the Trusts, including processes, structures and supporting IT?

A. Yeah.

87 Q. And, in that role, what were the challenges? Was it a straightforward matter to implement these radical changes to how governance was to be done within the Trust? 10:47

A. No, it was really tricky. It was -- I mean, it was a bit like the performance era and that takes, it takes time, it takes consistency, it takes -- no, it was very difficult. Was everybody accepting of these processes? Did people want to add this on? I mean I have read in 10:47 other evidence where in -- after my time in 2016/2017, they talked about giving additional PAs to consultants or 0.5 of a PA. We didn't do that at the start because we wanted to see: Can we buy you into actually this is part of your job role anyway? Now, there's a tossup 10:48 between adding on a bit and paying you to do it, or you winning the hearts and minds and saying "This is part of my role anyway." I mean -- so, the whole thing just takes time to slot together, not just -- I mean, IT's not my thing, but, even that, but it was interesting 10:48 reading people's statements about the use of IR1s and, you know, saying "Oh, well, I wrote the IR1" and it nearly felt like they came to an end-point there. No, the IR1 is to flag -- "I need to then talk with my line manager, they need to come back to me, we need to see 10:48 what we're going to do about it." But they felt like they had discharged their duty just by doing it. So we hadn't got the culture there yet. It wasn't there yet. They hadn't the ownership.

88 Q. Yeah, I think you're alluding to the IR1s that were filed in relation to Mr. O'Brien retaining patient charts at home, and we'll come and look at that in a little detail. But you highlight, I suppose, some of, by using that example, a difficulty in changing the culture or changing -- 10:49

A. Yeah.

89 Q. -- the understanding of what is to be done. I mean, does that -- I mean, looking back on it, do you think these what might be described as teething problems or difficulties were just inevitable, or was there training shortcomings in how the Trust went about it? 10:49

A. I don't think -- I don't recall the detail, to be honest, of the training and the rollouts. What my -- what I recall was, we were at a time when, you know, for example, 2014, Francis was -- they were accepting the Duty of Candour and it was so broad -- we still haven't got it in Northern Ireland! So, like, we were at a zero or minus starting point, so we were, like, building our culture. And it was very similar to the challenges that you faced at the start of the performance culture. And while people said the, you know, the written IR1s, you know, went into a black hole, that was great when they could say that. When it was popping up on their e-mail that they had an IR1 notification and needed to do something with it, clearly history tells us, for example, in 2014 there was a backlog of unopened IR1s! So it didn't change the -- it takes time to change their actions and their 10:49 10:50 10:50

responses. You can put in all the systems you want, but you have to build a culture where -- and I think it was just very early in those days and it was very early in Northern Ireland as well -- across the UK because Francis was only just coming out and, if you look back now -- if you look at it with a 2023 lens, it's completely different. But that was a different time and we were learning different things, so I think -- I don't think that -- I honestly can't tell you the detail that went into the rollout. I mean, certainly we were writing -- "writing" is the wrong word. We were producing 450 IR1s a month across Acute in 2014 when I look at the reports, so I don't think we had any -- we didn't have -- obviously, the quality of those and what they were reporting, you could dive into that. But I don't think there was an issue about not reporting. It was still building on the "What am I doing about that then?", the ownership of it, and "What is my responsibility and role in that?". And you can put in the system, but it doesn't necessarily mean that people are going to change their role and responsibility and how they view it.

10:50 10:51 10:51 10:51

90 Q. Mm-hmm. Well, we will come, maybe, and look at some specific examples of --

A. Yes.

10:51

91 Q. -- the problems that were encountered in individual situations. But keeping it on the general for the moment, so what you've described so far in your evidence is a Trust recognising, in light of

developments externally, that we need to look at what we're doing here?

A. Yes.

92 Q. -- and through you and others producing a, I suppose, a radical change to the system. And I think what you're then highlighting is that we have these wonderful systems, but changing behaviours is not something that can be achieved overnight? 10:52

A. No.

93 Q. And what stands out for you in terms of your memory of this through your work as the Assistant Director whose first 18 months trying to ensure that these systems and mechanisms were working -- is it a positive memory of an organisation and colleagues doing their best to wrestle with a new way of doing things? 10:52 10:53

A. It's like every change, isn't it? Some people are good at adopting change. Some people are not good at adopting change. You get a complete mixture. I mean, I think this was difficult for clinical staff because you had to take the ownership because it was back with you. And, clearly, everyone was super busy, there was super demands on your time. You had lots and lots and lots of patients and so this was "And do you want me to be responsible for another element?", and I think, clearly, when you ask people to look at it in a different way, that takes time and, no, not everybody is going to be receptive to that. 10:53 10:54

94 Q. You move into a new role as Director of Acute in --

A. Yes.

95 Q. -- in April, March/April 2013. That seems a relatively short time to be -- to have spent in the Governance role at corporate level with new changes -- "changes", perhaps, is the expression -- really only starting to take root. Why did you move into the Acute Directorate, if I may say so, so quickly after really only 18 months into taking the Governance role? 10:55

A. I think that if you look at my CV, you will see there that every two to three years I generally changed my role and moved on. I guess, at that time, I was ambitious and I really cared about health and I had an aim to be a chief executive and we went through the various -- you know, so I went through kind of like a career path that would take you to that, and then life changes and things happen and then that's not what's for you. So I guess that was why. I mean, could I effect governance in the Directorate of Acute? Yeah, totally -- as a director, totally, I could. 10:55

96 Q. Yes.

A. And did I leave it all behind me? No, because it's something that I'm quite keen on. So I didn't leave it behind. But I had a career path in my head that I wanted to follow and that was probably a good step towards that. 10:56

97 Q. Focusing then on the context of Acute, you moved into that role replacing Dr. Rankin, isn't that right? 10:56

A. That's right, yeah.

98 Q. And, as you have described in your witness statement, that's a heavy role. You have seven Assistant

Directors, at least eight Associate Medical Directors. It's a three-hospital site or acute services that run across three hospitals. Significant budget responsibilities and significant staffing responsibilities. Obviously, it's a very challenging role. In terms of governance within it, you explain in your statement that the quality and governance of the services would necessarily have been devolved, devolved to Assistant Directors and, in turn, working with the professional staff? 10:57

A. Yeah.

99 Q. In Urology, governance is devolved to, during your time, Heather Trouton -- she was your Assistant Director -- and, on the professional side, Mr. Mackle was the Associate Medical Director and, during your time, he had two Clinical Directors? 10:58

A. That's right.

100 Q. -- Mr. Brown and Sam Hall. And in terms of how you kept visibility on issues, obviously not just within Urology but across Acute, you had daily engagement with the Chief Executive? 10:58

A. Yeah.

101 Q. Weekly meetings and Trust Board meetings and one-to-one meetings?

A. Yes. 10:58

102 Q. You had daily -- well, you had contact with the Medical Director?

A. Yes.

103 Q. Regularly?

A. Yes, yes, mm-hmm.

104 Q. And perhaps daily contact with the senior professional staff?

A. Definitely, yes.

105 Q. And if we just bring up your witness statement at WIT-96894 and, just at the bottom of the page, you are explaining, I suppose, the confidence or assurance you had in the systems of governance which were in place within Acute, and you say that: 10:59

10:59

"During my tenure as Director of Acute Services..."

-- and you refer to your role in respect of governance arrangements set out above, and you say: 10:59

"Having undertaken the role of Assistant Director at CSCG previously, I was assured that the systems and processes in place in respect of CSCG were appropriate and even progressive, given the context of the Mid Staffs Inquiry or recent Trust-wide review and our level of reporting compared with other Trusts and issues of governance through the Commissioner." 11:00

A. Yes.

106 Q. And you say: 11:00

"During my tenure and in my recollection, the Trust was never identified as an outlier in terms of reporting of incidents, SAIs or complaints, all indicators of

governance."

A. Yes.

107 Q. And then you go on to talk about a backlog of incidents that was discovered? 11:00

A. Yeah.

108 Q. And a plan was drawn up to address that. And I want to ask you in terms of the comparison you are drawing with other Trusts, was it your sense that other Trusts in Northern Ireland were in some sense behind what the 11:01 Southern Trust had been able to achieve?

A. I think that certainly in respect of our level of reporting, as the AD of, as the AD of governance, I would have went to regional meetings with the lead for governance in the commissioning body, and all of 11:01 the Trusts would have went to that. And in terms of that and our progress and how we were reporting and our methodology for doing SAIs, yeah, we were spot on and leading, is my recollection at that time.

109 Q. The emphasis, perhaps, and if we just scroll back to 11:01 the bottom of the page, is on systems and processes, perhaps. Is there -- is there a distinction to be drawn between the quality of those systems which, as you suggest here, may well have been a state-of-the-art or at least progressive by comparison, is there 11:02 a distinction to be drawn between that and the ability of people who have to work those systems to produce, I suppose, quality outcomes in a timely fashion and to be able to move those outcomes into learning and action?

A. So I've given an awful lot of thought to this since I've done all this reading around it and, if you think about it, that review was called "A System of Trust" and we've just said earlier you can have the best systems and processes in the world -- unless people access them and see them through -- so what we could see was, yes, we're accessing them; yes, we're learning from them and we're learning in better time frames -- so, for example, I looked at a report that, as AD of Governance, an SAI of a child death that I picked up that had happened in 2008, we didn't get that finished until 2012. We were doing better in those things in terms of levels of reporting, time frames, addressing, but culture and responsibility and action in my daily work takes time. It takes time and it was new to them and it was placed firmly with them, and when you said about governance was delegated ---

110 Q. I think I used the word -- I think I've used your word, "devolved"?

A. Devolved, okay, devolved -- yes, it was devolved to your individual area. My ability to see across 4,500 staff, see across 200 million, three hospital sites, I have to have a different view than my Assistant Director and I have to have a different view to her however many Heads of Service she has, and I have to prioritise different things. But at each level you need to know and address and identify and own the stuff that you need to do. And that isn't a system and a process, that's a culture and a development and a --

11:02 11:03 11:03 11:03 11:04

it's a system -- it's a people system, for people, so there's always going to be, inevitably, variation.

111 Q. One thing you said in your statement, and I think it would be helpful if you elaborate on it, if you can, it concerns the, if you like, the performance context -- 11:04

A. Yeah.

112 Q. -- and its impact on operational delivery, governance and that kind of thing?

A. Yeah.

113 Q. So it's at WIT-96897. And what you say at paragraph 35.6, just at the bottom of the page, is that you have extracted from the February 2015 performance report -- that's the report that goes to the Commissioner, isn't it? 11:05

A. Yes. 11:05

114 Q. And you have said that:

"I believe this is important context for reviewing operational delivery, governance and performance."

11:05

A. Yes.

115 Q. And we can bring you to the performance report, if you want, but --

A. No, I --

116 Q. -- you've helpfully summarised it within your statement. 11:05

A. Yeah.

117 Q. So just scroll down through it and we can see the number of referrals you're getting, the number of

red flags you're getting, the number of investigations that are conducted, MRI/CT. You set out cancer performance against regional commissioning standards. The target is 95%. You're lagging a little behind at 91% for the 62-day. You talk about the ED, the Emergency Department 4-hour wait target -- it's set the highest or the lowest in the region? 11:06

A. Highest.

118 Q. Is that good?

A. Excellent. 11:06

119 Q. Okay.

A. Compared!

120 Q. Compared.

A. -- relative. It's not good if you are -- if you are the patient waiting over 4 hours or if you're the 12-hour wait. That's why I put that in. 11:06

121 Q. Yeah.

A. Governance is not devolved or separate to performance, and you don't do one or the other. They are interlinked. How quickly you can see a patient when they need you is as important as how you see them. But those two things are completely conjoined into a patient experience and the outcome for that patient. So performance and governance are not two separate things and they don't -- I've read witness statements -- they don't knock off against one another. And I guess that was an issue because people felt that with these huge numbers, that it was difficult, maybe, to do governance as well as do the numbers. 11:07 11:07

122 Q. Okay, just so that I understand you, you've set out, and I've only touched on aspects -- it runs on to the next page, but I think the Panel get the point -- you're setting out -- are you setting out here the challenging performance environment in which Acute Directorate operated? 11:07

A. Both. So, this is the number of patients that you're going to see, so you're going to get 900 red flags in a month. So you have to see those red flags, and then we have to look to make sure that there isn't any other patients that should have been red flags. That's complicated because you have already got 900 that you can't process over here in 62 days! So trying to take the people up the hill of -- I know it seems like the numbers are overwhelming, but I really need you to look over here as well to the governance aspect -- that's pretty complicated. So they are trying to do both these things and they are -- that inevitably gives you the full patient experience and outcome, both of those things. 11:08 11:08

123 Q. Mm-hmm.

A. The patients are one of thousands and thousands, but they are also individual to their experience. But it's -- that's very complex, isn't it, to get a system to move and march like that, that would allow me to march like that all of the time, because you would have variability. 11:08

124 Q. Okay. And so how do you, as Director, and your senior team try to influence that? Because we see obviously

coming through this Inquiry some of the shortcomings in terms of patient experience, so --

A. Definitely.

125 Q. -- a patient who ought to have been red-flagged --

A. Yes. 11:09

126 Q. -- doesn't get red flagged. Diagnostics and treatment is delayed for whatever period of time, just to take that as an example.

A. Yeah.

127 Q. So I suppose you would have to understand that that's happening? 11:09

A. Yes, you do. So then that would take us into the processes behind triage, for example, in that case. And there was processes to be done, and they were set out, and they were to be monitored. Am I monitoring them? No, because it's only one tiny part. 11:09

128 Q. And sorry to bring you back -- maybe that's a rabbit hole that's maybe unhelpful at this point. I suppose, what the more general question is that, against a challenging delivery background and demand background that you explain, and we'll go on to look at in more detail, perhaps, in a moment, what is it that you built in to the system of governance to enable you to be alerted to the potential for things not to be going well and to address them? 11:10 11:10

A. Yeah, so I thought a lot about this. So, ironically, the review was called "A System of Trust". Ironically, we've just talked about you have to devolve large portions of that. And what then, when you go into the

Director post, what you have to do is try and pull all the strands together. So we had the month -- so we pushed -- "pushed" it down is the wrong word. We tried to get governance live in the divisions with the clinicians and then make sure that it comes up to the director level in the monthly meetings where you look at and you review the incidents there seems, the numbers, how long you're taking to address them, your SAIs, what topics. But, again, SAIs, if you look at the reports, we were maybe dealing -- well, we had 40 -- I was maybe dealing with 40 complaints at one time and I signed each complaint off personally myself, the final letter, and I used to do it on a Friday night and I'll always remember it! And you also had, maybe, 10 SAIs a month across the Trust, ongoing. Those SAIs were catastrophic. Patients had died there and then. It wasn't retrospectively, but they had died there and then and there was learning in that death and that potentially that death should not have happened or could not have avoided or prevented. So we felt -- I felt we were actively doing it. 11:11 11:11 11:11 11:12

129 Q. Mm-hmm. So the --

A. But there was trust on down the system because you can't see and do everything.

130 Q. Yeah. So the forum for trying to get to grips with whatever was coming up from -- 11:12

A. Was the monthly, yeah.

131 Q. -- was the monthly. Just a small point, perhaps -- Mrs. Gishkori, in her evidence, makes the point that

she really introduced the weekly governance meeting. You had it on a monthly footing, is that right?

A. Okay, so I had it on a monthly meeting because, at that meeting, I had the most senior clinicians, my AMDs or their CDs, and my ADs. If you think about governance, you are only going to run the report monthly. If you're writing 450 incidents, you're only going to be reviewing those on a monthly basis. We had 12 weeks to address an SAI to produce a report to feed back. So it's not going to change within a week and I wouldn't put my most expensive resource in weekly to do that. There would be no point. 11:13 11:13

132 Q. Let me just bring up I think what I anticipate would be, I suppose, a typical agenda for your monthly governance, WIT-97372. I think I've managed to pick on one which you didn't attend; it was towards the end of your tenure. But is it typical -- is this typical of the agenda that you would have overseen, SAIs -- 11:13

A. Yeah.

133 Q. -- looked at. Now, maybe just parking the -- just stopping there. Mr. O'Reilly, just perhaps by way of a random example, I suppose the question is: In terms of the governance meetings that you were overseeing and chairing, was there an appetite for challenge? SAIs are being reported. Was it just a box-ticking exercise or was there -- 11:14 11:14

A. No, it wasn't a box-ticking exercise. Definitely not. Was there -- if you look at the set-up of this meeting, I chair it. The ADs are there to support their AMDs.

But if you look, the AMDs, the Associate Medical Directors, have to present their SAIs in their area, and the rest of the AMDs then are encouraged to say, "What do you think about those findings?", "Do you think we've got to the root of that?", "Do you think that was acceptable/not acceptable?", "What are we going to learn from that?", "Is there any learning for me in my division in that?". So what we were trying to do was put these very senior medics in a place where they could peer-review and challenge. Did that happen? We were growing the culture. They were learning how to do it. It was 2013, 2014, 2015. We were learning.

134 Q. Yeah. I mean, there is an example there at B, it seems. I'm not asking you to comment on the specific example, but Mr. O'Reilly is saying that the report analysis is completely contrary and doesn't make sense and the conclusions are flawed?

A. But that's a good open debate, you know.

135 Q. Say that again?

A. Can you move it down a wee bit?

136 Q. I can, yes. It moves into a series of approvals of SAI reports, but I suppose the question is --

A. Yeah, so he's saying there: "I've read this now, this has been presented to me. Me, as AMD in this area, no, not happy with that." Needs to go back to his teams, needs a -- and should have had a surgical opinion on admission. So did you go down that route? Did you go down that alley with the team? This needs to go back to the team, and also an external opinion needs to be

sought. So, in that, we did bring external clinicians as well to review our most major and controversial because sometimes it's just too difficult to challenge your own teams, so you need someone else to come in from outside. And that was good, I would have said to you that was good in 2015. 11:16

137 Q. Yes. And I think you say in your statement that as a forum, these Acute governance meetings -- this is paragraph 38.2 of your statement -- we don't need to bring it up, but these meetings afforded more time and space for the AMDs to be involved to present their SAIs, report on Audit Committee business and clinical patient safety, and are you presenting a generally positive understanding of the ability to learn through these forums and effect change? 11:17

A. I am -- I think I'm presenting to you that the systems and processes were in place and we were encouraging the people involved to work the systems and the processes and we were giving them the forum and the time, the -- how they individually do that and address that takes time and takes challenge and you have to build trust within that group of clinicians with each other to be able to do that. And those were all things that we were trying to do. But, yes, was the basic skeleton of what we -- to implement those things and were they being given the vehicle -- yes, they were there -- well, I felt they were there, sorry. 11:18

138 Q. And then just for completeness, and you can pick up on any -- I suppose, the question is is this a typical

agenda for this kind of meeting?

A. Yes.

139 Q. And so we have the SAIs, they're discussed -- approved or not, as the case may be. And then scrolling down, we can see then that there's a complaints opportunity to deal with complaints; incident management position; and you can see the rest. Again, is this a standing agenda, essentially? 11:18

A. Yeah, the items in bold were the standing items. So Risk Registers, Acute Medical Audit Committee, Standards and Guidelines, those were all monthly standing items. This was to bring this forward into this senior forum to get that discussed. 11:19

140 Q. We know that -- we'll go and on and look at triage as a specific issue as we go on today -- 11:19

A. Yeah.

141 Q. -- that, without descending into the minutiae of it --

A. No.

142 Q. -- that a system was implemented. You appear not to have own about the system that was implemented, but is that the kind of thing that should have come on to an agenda such as this to be discussed or to be ratified or not? 11:19

A. So I guess we're opening a Pandora's box with this one. So we say or it is repeatedly said there was a default system. The default system on -- of February 2014 that came out from an AD across and was to be discussed with clinicians in the e-mail was actually a mirror of IEAP, which was the standards and guidelines of the time. So 11:20

did it need to come through here for reapproval? No, because it was an implementation of the already standing systems and processes. Things that are new to the system -- for example, at point 6, Regional NEWS Trigger Reset Guidance. So this had come out of -- like, there was regional learning letters and the use of the MEWS and NEWS system and there was changes to be made. So that was across the region, so we were going to talk about how we were going to do that. But that actual process -- and I know I say I don't recall that, I can see I'm included in two e-mails, but I was on annual leave at that time -- 11:20 11:21

143 Q. Yes, we will come back to deal with that --

A. No, because it was an IEAP reiteration.

144 Q. Yes, okay. So this is a meeting that anything radical or new should come before this? 11:21

A. Yeah, and also -- yes, and regional and issues that we had. So the AMD is to identify the top ten priority audits for their division. What are you doing? What are you auditing in your division, and why? And tell your colleagues and your peers why you're doing it and bring the results forward so we can discuss how well we're doing. Incident management is an internal thing, so internal things could come, but SAIs go out as well. So it was both internal broad management, but that was a system and process reiteration. 11:21 11:22

145 Q. Yes. I'm interested in hearing more in terms of how SAI process in general was used as a tool --

A. Yes.

146 Q. -- to get to grips with the shortcomings, and you have explained already how the SAI process was, I suppose, focused on the most catastrophic cases, the most --

A. Yes.

147 Q. -- the most difficult and serious cases. So I want to do that through a case called [redacted]? 11:22

A. Yeah.

148 Q. -- which you briefly mention in your statement. And I suppose this might be a convenient time just to break and we'll look at that after the break? 11:22

CHAIR: I think we'll take 20 minutes, so we will come back at quarter to.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 11:35

MR. WOLFE KC: Thank you.

149 Q. I want to start the next section of evidence by drawing your attention to and seeking your observations on a Serious Adverse Incident Review.

A. Yes. 11:46

150 Q. -- which I don't think, to the best of my recollection, the Inquiry has looked at before. It was touched upon in your Section 21 and we're going to look at it now, perhaps for two main reasons: First of all, it may reveal something of the appetite for challenge that 11:46 existed with yourself and other of your colleagues; and, secondly, it appears to touch upon some of the governance themes within Urology that were, perhaps, never to be resolved during the period of time that we

are looking at, and I want to seek your observations in relation to that.

So, if we can pull up the front page of this SAI Review. It's TRU-278671 and it's marked "Draft". The lead reviewer was Mr. Glackin, and we will see that the -- we can see that the incident relates to the period 2012 to 2014. There are two Urologists referred to within the report, a Dr. Two and a Dr. Three. 11:47

A. Mm-hmm. 11:48

151 Q. I am advised by the Trust's representatives that Dr. Two is Mr. O'Brien and Dr. Three is Mr. Connolly, who is no longer with the Southern Trust; he left the Southern Trust at a point within the treatment of this patient, and I will explain that in due course. 11:48

A. Okay.

152 Q. So let's step to the summary of the incident which was the subject of review. If we down two pages to 73 in the sequence and just at the top of the page, the Executive Summary. So in August 2012, a patient aged 64 underwent right radical nephrectomy for renal cell carcinoma. Histology revealed a Grade 3 tumour. Follow-up management plan included regular CT scans and clinical reviews. The patient was reviewed in February 2013. At this time, a CT scan was arranged for May 2013, and this was to be followed by a clinical review in June 2013. The patient did have a scan in May 2013, as arranged, but was not reviewed in June 2013. On 24th August 2014 -- in other words, more than 12 months 11:48 11:49

later, concern that the patient might have recurrent disease. The patient's general practitioner referred back to the Southern Trust Urology Service. Metastatic recurrence was identified on a CT scan.

11:50

So I just want to step through some of the key issues or one might call them alleged shortcomings within the treatment --

A. Yes.

153 Q. -- just to orientate, not only you, but the Panel. So if we go down three pages to 76 in the sequence and just go about halfway down, so -- thank you. And so it can be seen that following an MDM, it was agreed that the patient, who was discharged from hospital that day, should be reviewed by -- that is Mr. O'Brien -- who would arrange further CT scanning in November 2012, after which the case would be reviewed again at MDM. It says:

11:50

11:51

"Although the patient's discharge letter was not typed until the following 3rd April 2013, a letter containing the MDM discussion of the 6th of September '12 and management plan was sent to the general practitioner. The Review Team have said that they are of the opinion that it is good practice for a discharge letter to be sent to the general practitioner within a few months of patient discharge."

11:51

11:51

Is that something with which you would agree?

A. Yes.

154 Q. And moving then on to the next page and just to go to the top of the page, please, so it says:

"The Review Team accept that there was an intention to scan at intervals." 11:52

And that was appropriate. Dr. Three, that is Mr. Connolly:

"...indicated that he would review the patient in June 2013." 11:52

And the Review Team agreed that this was acceptable. But here is the problem:

"The CT scan was carried out on the 16th May 2013." 11:52

Skipping down a little:

"A report was generated on the 17th of May and it should be sent by hard copy to Dr. Three's secretary for action by Dr. Three." 11:52

That is Mr. Connolly.

"But the Review Team could find no record of the CT report of the 16th May being signed off or actioned in the clinical record. Mr. Connolly, the Consultant who 11:53

had requested the scan, had left the Trust before the result was generated. An arrangement had not been made to forward such results to another Consultant. There had been no formal transfer of cases, nor was there a system in place to generate results work lists through which outstanding results can be readily visualised and actioned."

So that's a second issue on top of the delay in dictation, perhaps a more significant issue here of not arranging for the handover of the patient's results -- 11:53

A. Yeah.

155 Q. -- to a new Consultant when the referring Consultant had left for a new position. We can then move on to the bottom of this page, please, and we can see that the issue of Clinical Nurse Specialists features and it's described that there's a recovery package for regional transferring cancer follow-up and it says: 11:54

"It is recognised that the rollout and sustainability of this strategy is dependent on adequate numbers of Clinical Nurse Specialists in adult cancer being trained and in post. There is a lack of such specialists regionally and that this is hampering the implementation of the recovery package." 11:54 11:55

And then if we just, in that vein, go to TRU-278678 -- just down a page, I think -- yes. So if we just go down the page a little and we'll come back up in

a minute. So go on down. So the point about nursing is repeated then more specifically in the case of this patient, where it says that:

"A key worker was not identified in the patient's care records. The Review Team cannot speculate if an identified CNS or key worker might have identified the patient for earlier review. However, it is conceded that the development of this role is central to effective and efficient follow-up..." 11:56

-- which is a learning which the Trust was to see again in 2020 and 2021 -- after your time, obviously, in the context of a series of SAIs --

A. Right. 11:56

156 Q. -- that was conducted at that time. And if we can go up the page just briefly to pick up on a further concern expressed by the Review Team in the context of communication, it said: 11:56

"Dr. Three's..."

-- that's Mr. Connolly --

"...Outpatients letter indicated assurances given to the patient that there was no evidence of cancer recurrence on that specific date, 8th February 2013. From the medical notes, it is unclear what information had been given to the patient regarding diagnosis, 11:56

follow-up, potential treatments and prognosis. Neither the MDM record of the 6th September 2012 nor in the letters to the patient's GP from Mr. O'Brien or Mr. Connolly indicate what discussions took place with the patient." 11:57

So setting this all out then, it leads to a particular conclusion if we go down the page down to the next page, please, and we have the conclusions. It says: 11:57

"The SAI investigation was undertaken to investigate why a follow-up patient review which was planned for a patient at the Southern Trust Urology Service in June 2013 did not take place. The Review Team have concluded that the systems and processes in place for 11:58 organising follow-up appointments were followed. The patient was placed on the correct waiting list for review. However, there was an ongoing issue with capacity and demand for this service. Uro-Oncology review clinics were established to address this in 11:58 February of 2013. However, the wait for the review remains lengthy. The Review Team have established that the patient would not have been called for review from the newly created waiting list until December 2014, by which time the patient had already been re-referred 11:58 with symptoms of metastatic disease."

So you were concerned by those conclusions and you thought that the emphasis was not quite -- and that's

probably an understated adjective -- not quite in the right place, is that fair?

A. Yes, I think I might have sent an e-mail back to the first draft that I received to the person who was facilitating the Review Team. 11:59

157 Q. Yes. Let's just look at your e-mail because, here, the emphasis, as we can see, is on --

A. Capacity.

158 Q. -- the delay in the system in getting patients back in for review? 11:59

A. Yeah.

159 Q. The problem here, as I've highlighted, was a scan was referred forward. It came back in April '13, and it was missed because it didn't reach the hands of a consultant within the Urology team, Mr. Connolly having 12:00 left. And this conclusion is suggesting, well, regardless of that problem, the patient wasn't going to be seen anyway until December 2014 --

A. Yeah.

160 Q. -- because of the waiting list issue. So, let's go to 12:00 your commentary on that. If we go to TRU-278669 and towards the bottom of the page, please, you say:

"I am not happy with this review on a number of fronts. These comments are not for sharing, but, Tracey..." 12:01

-- that's Tracey Boyce?

A. Yes.

161 Q.

"...can you review, please, and see what you think and then take forward in my absence."

As you are on leave. And you say:

12:01

"This review feels like Urology team have no part to play in this at all. None bar one minor issue of the recommendations falls to them."

You point out that the scan results issue is not included, and you ask some questions around that. 12:01

"The handover within a team of senior clinicians needs to be addressed, but this is not a corporate issue, surely? Surely this is a team issue?" 12:01

And you say:

"The Urology Oncology reviews, I have not heard before now that they are well out of time. I have been told 12:02 the waiting list has been separately made, but the backlog was another issue. Again, Urology have not highlighted."

So let's just ask for your elaboration on that, to be clear, when you think about it -- 12:02

A. Today, I probably wouldn't have put all those exclamation marks in! But -- so this, I think, came to me in --

162 Q. 2015, yes.
A. Yeah, in March. So I think this really describes really well the journey that we were on. Mr. Glackin would have been the Chair of that Review because he wouldn't have been involved in that patient's journey. 12:02
So he was a very skilled Urologist. He understood the context in which that team was operating, and he could peer review how that had went. But it demonstrates very well, I think, the discussion that we had earlier, which is governance means that you can have all the 12:03
systems and processes, but you have to accept a responsibility of actioning them individually and the Urology team, I didn't feel, took those responsibilities. They tried to -- and they were correct and I'm not saying they were wrong -- there was 12:03
20,000 people from a performance report that I read, 20,000 people on a review backlog, 80-something percent of those were not seen in their clinically indicated time -- they had made attempts to pull out another subset waiting list, which was Uro-Oncology Review, so 12:04
they were trying, but they had no capacity to see that person in that time frame. And I accept that. And I guess I accepted -- and David Connolly leaving and no replacement for a period emphasises that capacity and demand mismatch. But there is other things that we 12:04
could do that were glaringly obvious, which was, you know, I couldn't read there the CT scan, so if the CT scan had have been reviewed, we didn't have PACS, we didn't have an electronic system, I get all that. It

was a paper report going from X-ray to this guy. He wasn't there. Nobody lifted it. But -- and so it wasn't signed off on PACS or anything because we didn't have those electronic systems at that time. So I didn't know if that CT scan was relevant. Did it show 12:04
up then or was the disease progression not visible then? The handover within the senior team, I -- my sentiment is you don't need someone from a corporate office to tell you that when you are one man down, the team needs to share out that work. I understand that 12:05
sharing out that work seems like an impossibility in the situation where you are at with where you have an overwhelming demand for your service. However, it doesn't mean that you don't try or you put a system in place to try and do that, which is why I didn't think 12:05
that would be a corporate issue because each team is different. When a consultant leaves, one may be right in the door behind him and you may have a replacement -- he might have been retiring and plans might have been put in place. Someone might just be leaving 12:05
unexpectedly, no replacement, so it would be a team issue for the period of time that you were down a man.

And the Uro-Oncology reviews, look, they did the right thing. They tried to create a subset waiting list. I 12:06
didn't know that they had done that and I had no report visible to me because, to be quite frank, reviews were virtually impossible to manage at that time because they were not a PFA target. The Department and the

Commissioner were not requiring us to report on them. We produced our own reports, a high level report which is how I know 20,000 were behind their clinically indicated time frame, but there was no emphasis on them from the Department. There was no funding nor resource to address them. And so, I mean, there is an e-mail in my evidence, which I think it's 2014, where suddenly the Commissioner comes up with money to see 700 reviews in Urology. Which 700 reviews would you pick? And I didn't know that they had created a Uro-Oncology waiting list, which technically was a good thing to do, but it didn't address the issue because they were still sitting there and not being seen, and nobody had highlighted they weren't being seen. 12:06 12:06

163 Q. So -- sorry to cut across you -- 12:07

A. No, I'm finished.

164 Q. Just to put a little bit of structure on this one can see from your e-mail that you are challenging the conclusions and the emphasis in those conclusions. This is a draft SAI? 12:07

A. Yeah.

165 Q. Can I say this: In the time available to us, we haven't investigated where your concerns went to and I am going to bring you on to Dr. Boyce's concerns as well and we will do that further investigation because it might be relevant to ask you -- 12:07

A. So I --

166 Q. -- about Mr. Glackin. Can you help us in terms of --

A. So I checked back then when I was reading around this

and this one, I think -- I think, but definitely check -- I think this one didn't come back for final approval to that August governance meeting that you referenced, the August '15. So it would have come back then in its final draft to the AMD/AD director team for sign-off. So it wouldn't have been actioned. The actions wouldn't have been addressed until it was fully approved. 12:08

167 Q. Okay. And we will look at that and address it, perhaps, with Mr. Glackin and, if we need to come back to you, we will. 12:08

A. Yeah.

168 Q. I suppose, let's look at the recommendations because they're relevant to what Mrs. Boyce, who you invite -- Dr. Boyce, who you invite to have some comments on this. Just before we do, just scroll up the page, and we can see that your perspective on the shortcomings of this report isn't, perhaps, shared as much by Paula Fearon. Paula Fearon? 12:08

A. I'm not sure -- Paula Fearon was in the Acute Governance team. 12:09

169 Q. Yes.

A. But I'm not sure of her grade or her band.

170 Q. But I think it important to highlight in that, in fairness to Mr. Glackin, that she has a slightly different perspective to you? 12:09

A. Absolutely, and everything that Mr. Glackin concludes in terms of the CNSs and the ability to see the reviews, that's all completely correct. Is it the only

thing that we -- we can't change that, actually, at that time. That isn't going to be a learning for us. We can point out the deficits of the system as a whole, but we could change other things within our team that would make a difference. 12:09

171 Q. Yes. And let's look at the recommendations then. If we go to TRU-278680 and, at the top of the page, five recommendations. So:

"• A robust system for managing overdue Uro-Oncology review is established. 12:10
• The handover of patient case numbers required before a patient leaves the Trust, this arrangement must be formalised and robust.
• Follow-up radiology reports must be actioned if required and signed off by an appropriate person. 12:10
• A timely discharge letter should be dictated for every Urology patient.
• The Review Team recommends a communication record is designed and instigated for use with Uro-Oncology patients and named key workers." 12:10

Now, as regards those recommendations, Dr. Boyce has some comments, particularly in relation to 3 and 4, which I will turn to now. But is it your evidence that, in terms of working through these recommendations, you had left the Trust -- 12:11

A. Yeah.

172 Q. -- by the time this final report was available?

A. Yes, as far as I'm aware, it came to the August '15 one and I was either leaving or left.

173 Q. Yes.

A. Because --

174 Q. I have just been passed a note which says this SAI was eventually approved at the 13th August meeting, which was your -- 12:11

A. Right, that was that one.

175 Q. -- your thinking?

A. Yeah. 12:11

176 Q. And we will ask the Trust, if we haven't got it already, for the final form of the report.

A. Yes.

177 Q. So, the -- some of those recommendations and some of those issues, as might be apparent to you, both predated and postdated this incident. So the notion that all Radiology reports must be actioned if required, et cetera, is something you knew something about prior to this particular SAI, and we will look at that in the context of the retained swab case in just a moment. 12:12 12:12

A. Yeah.

178 Q. A timely discharge letter should be dictated for every Urology patient. Again, that is an issue -- it may not be correct to say it was live before this incident, but it certainly -- 12:12

A. It's live now.

179 Q. It's certainly something which the Trust became aware of in the context of Mr. O'Brien's practice after this,

and I want to ask you some questions about that. But just before I do so, let's just look at what Dr. Boyce said at your invitation in respect of this SAI. If we go to her e-mail, which we find at TRU-278668, and she prefaces her remarks then with a good report, but she can see what you are getting at, and she sets out a number of questions and comments. I just want to pick up on two. If we scroll down slightly, she refers to, in the context of page 9, she says: 12:13

12:14

"I don't think we can say the systems processes for follow-up appointments for..."

-- you will recall that I read out the conclusion?

A. Yes. 12:14

180 Q. And she makes the perhaps obvious point that if they had been followed, CT would have been seen and this would not have happened -- that's a, perhaps, obvious point on what you also regarded as the misplaced emphasis of where the problem lay overall, is that fair? 12:14

A. I think that's fair. I think probably -- yes, the CT should have come back to someone in that team and there should have been an arrangement for that. When you view that, depending on what it says -- and, again, we don't know what it says -- if that person needed to come back, there would still be the issue of capacity to bring that person back, but it would be very clearly obvious that they needed to, if the CT was clear in its 12:15

report, which I don't think we established there.

181 Q. Yes. And maybe an updated final report will help us to understand that better. But I drew attention earlier to recommendations 3 and 4. Recommendation 3 relates to the need to action and sign off Radiology reports? 12:15

A. Yes.

182 Q. And recommendation 4 related to the use of timely discharge letters?

A. Yeah.

183 Q. And she makes the point in 3 and 4 -- this is page 10: 12:16

"We are relying on people to do the right thing, which is the weakest safety net..."

-- and she asks the question: 12:16

"Did the team consider anything stronger in terms of making sure this didn't happen again?"

So, for example, alerts for unread Radiology reports/ 12:16 monitoring of discharge letter performance. So at least one of those aspects, the Radiology is something, as I say, you were familiar with and the Inquiry is by now familiar with the history of that through a number of incidents and with a number of patients. Are you 12:16 able to assist us at all -- I know the final report was signed off in August, you weren't there, but was there any attempt in your time to correct those two issues in the context of this case?

A. No, because, as far as I was concerned, we hadn't got the right conclusions yet, and you have to get the clinicians to own the conclusions. So I can't implement things like -- I can't -- you could -- you could try and tell them to do something about unread Radiology reports, but they would have to accept that and then go and do it. Monitoring of discharge letter performance is interesting and I think the concept of how much -- these are senior people, these are senior clinicians. Telling a patient -- telling a GP how their patient is doing and what's happening with them is probably, in my book, quite basic. Do you need me to check that you are doing that? At what level do I stop checking what you are doing? And, I suppose -- I suppose, you know, that's the struggle with governance, isn't it, how much do you audit and check and how much do you try to develop and build the culture of "Do the right thing, even when nobody's looking"? And I guess these are senior people, they're senior clinicians, this is in the best interest of that patient in front of them and -- yeah. 12:17 12:17 12:18 12:18

184 Q. I suppose, what you're putting your finger on is the extent to which the organisation can afford to place certain issues on trust by reference to professional obligations? 12:19

A. Yeah.

185 Q. And which issues do you select to spend, I suppose, valuable resources on by developing some kind of governance system or scheme?

A. That's right, and I think that's a really basic thing. I mean, PACS came in later for Radiology, so it made the signing off and tracking of Radiology reports more visible and a lot easier for the clinicians because they could click on their desktop. But if we haven't put that system in place yet or it isn't there, does that still exclude you from doing that or trying to do that? So we can put -- the Trust, as the organisation, can put the systems and processes in place and make those better and improve them. Whether you operate those and stay within those guidelines or not is your senior clinician professional decision. Do I write a discharge letter each time I see a patient? I mean, and the SAI were even querying did they even talk to the patient about the diagnosis. But it is ten years ago, so, yeah! 12:19 12:19 12:20

186 Q. Just in fairness, because you did become involved in the follow-up to what we know as the Patient 95 case -- the name as you consult the list doesn't really matter -- 12:20

A. No.

187 Q. It shouldn't be, it shouldn't be used in any of your answers, but one can see that, just to remind the Panel, there was an SAI which originated in 2010?

A. Yeah. 12:20

188 Q. It concerned the circumstances in which a swab was retained in the cavity of a patient. The SAI reported. The focus -- the focus was on the in-theatre process for, I suppose, counting in and counting out swabs.

There was no focus on the issue of whether and when a consultant should read the reports of a CT, the report of a CT scan, which would have pointed out or at least given an indication as to why this patient was in difficulty, and it was in that context in which the Commissioner engaged with the Trust to see whether that aspect of reading and actioning CT results was something that the Trust was going to do something about. So do you agree with that as the context? 12:21

A. That's right, and if that -- that discussion about that particular SAI, that SAI wasn't closed by the Commissioner, I think, until maybe 2014 they were still asking us what we were doing. 12:21

189 Q. Yes.

A. So, again, we -- definitely the clinicians needed an electronic system, they needed it visible, they needed all the help they could get, but also there is professional responsibility. 12:22

190 Q. Yes. You wrote, just to make the point clear, you wrote in 2011 -- 12:22

A. Yes.

191 Q. -- when you were in the -- your performance role, was it? You had maybe just come into the --

A. Had I come into the Governance? I had come into the Governance, that's why I was writing about that, yeah. 12:22

192 Q. Yes. And we can see your letter to Dr. Diane Corrigan of the Public Health Agency in 2011?

A. Yes.

193 Q. WIT-98527. And it's November 2011, and you're thanking

her for her engagement in relation to the report and you are pointing out what I have just said?

A. Yes.

194 Q. Although this issue of subsequent action following the diagnostic report isn't a recommendation, the Trust has recognised the need for assurance around this, and you have set out the actions that follow. And you have said that: 12:23

"The current practice of consultant surgical staff in relation to the review of diagnostic results has been scoped and this baseline practice is being widened to all four Acute divisions where appropriate. Initial scoping indicates that in the main consultant surgeons are reviewing diagnostics in a timely manner, although variances in how this is being done have been highlighted. As a result of the above findings and with the added impact of online results being available for diagnostics for PACS and order comms..." 12:23 12:24

A. Yes. 12:24

195 Q. "...it is timely that the Trust undertakes a thorough review of practices, which may include Trust protocol being provided..."

-- and you will be happy -- the Trust will be happy to share any conclusions on this work. 12:24

You do highlight in this letter, some variances. We can see, for example, Mr. O'Brien's view of this, if we

go to TRU-259876. And as you said in your letter, the Trust was, in a sense, scoping out what the view of clinicians was, but, here, I think it's Mrs. Corrigan setting out the principle as the Trust believed it to be -- sorry, it's Mrs. Trouton, sorry, scroll down. So she is telling a number of managers that they should: 12:25

"...check with their consultants that investigations which are requested, that the results are reviewed as soon as the result is available and one doesn't wait until the review appointment to look at them." 12:25

And then if we scroll on upwards, please, we can see -- keep going -- we can see that Mrs. Corrigan passes that on. And that then we can see, scrolling up, that Mr. O'Brien writes in respect of this on 25th August 2011 and raises what he says are his concerns and he sets out several reasons all in the form of questions, and it seems to be principally questions around the practicalities of how this would be done and how much time is available to do it. What we do know, Ms. Burns, is, if I can fast forward it to after your time -- 12:26 12:26

A. Yes.

196 Q. -- this is 2011. We have seen, a few minutes ago, the problem with the SAI -- I don't wish to use the initials of the patient -- in 2015? 12:27

A. Yeah.

197 Q. It's, if you like, a slightly different problem in that

there was no handover done?

A. No.

198 Q. And it's still broadly the same issue. It's a CT scan report which wasn't actioned -- it fell between the cracks -- the broader point being that the system, the organisation didn't pick up on the fact that the scan wasn't read and actioned. So, one, two -- and then jump forward to 2020 and there was a histopathology report, as well as a CT scan, two different patients, and the reports weren't read or actioned arguably in a timely fashion -- there may be some debate about that, but that's what the SAI reviewers found and there's a context around that. But, I suppose, it comes to this: Are you able to assist the Inquiry in terms of why something that seems relatively basic but very important cannot be effectively grappled with using a system that can spot the danger and challenge in a timely fashion? 12:27 12:28 12:28

A. So I think my recollection on this one is that when Diane Corrigan pointed it out in 2011, Acute did , as they said, a broad-brush, "What are you guys doing?". And you can kind of -- I think that e-mail is 2011 where they say "The vast majority of you are doing this because this is the right thing to do and -- but there is obviously individual variation." So it comes down to I guess that issue that we talked about about how much do you audit, how much do you sit on each individual clinician's shoulder to look what they're doing at each individual juncture, and who does that of 12:29 12:29

their practice to ensure that the variation is completely eradicated? You could write a protocol. Would that make the individual do the action? I don't think it would, because he had already been told. So I'm not sure what -- I actually genuinely am not sure how you eradicate individual variation. I don't know if that answers the question but it is a -- you can easily write a protocol. Can you take the -- you can take the horse to water -- can you make them drink individually? No. I guess. Could you be monitoring that? Yes. But where does that stop? 12:30 12:30

199 Q. And is it around this kind of line, particularly where it presents as a risk to patients and a recognised risk, that the Trust has a call to make, the employer has a call to make in terms of whether is this -- whether this is a matter for -- 12:30

A. I mean, to be fair, in these cases, like you say, between SAI 1 and SAI 2, I'm aware of the swab and the other one, the review -- I mean, the swab was with the one consultant. The second one was a handover. The person had left, the scan went back, nobody picked it up. So those are a little different in terms of process. So, to be honest, I'm not sure I know the answer to that question -- and I'm not sure where you draw the line. Which aspects of their clinical practice do you audit and which do you not? And it comes back to skilled clinicians, experienced, doing the right thing for their patients individually. And you would imagine that if the patient was in your care, 12:31 12:31

which was the case with the swab, you would look at the test. And the other one, I guess there should have been a team process to review when another man wasn't there.

200 Q. So, we came in to looking at those cases because I think you were telling us that incidents -- perhaps, to a lesser extent, a different -- in a different way, complaints and analysis of that -- 12:31

A. Yeah.

201 Q. -- and then feeding that through governance meetings, was an indicator, in your time, that the -- 12:32

A. Yeah.

202 Q. -- Trust -- the Acute Directorate was sensitive to these mechanisms and had an appetite to grapple with cases? 12:32

A. And if you say to your people, your 200 consultants "are you reviewing your scans appropriately?" and the vast majority answer comes back "Yes, we are", and you have one incident in whatever time period, although those are catastrophic and they needed addressed individually at the time, but they are not a trend. 400 a month IR1s not being reviewed is not a trend. I know that sounds quite, ehm... If you go out and you say to your experienced staff "You're doing this, aren't you?" and the vast majority come back and say "Yes" and you send a reminder and say "You need to do this because this is good patient care" -- 12:32 12:33

203 Q. That seems to put it, as Dr. Boyce indicated, at the level of trust which is a weak safety net?

A. Yes, it's a weak safety net, but you can't have a safety net for everything. That's the point. You cannot audit everything. That is why the individual clinician has to accept their role and responsibility in doing the best they can for each individual patient. 12:33
You can't audit every part of their practice.

204 Q. Do you think that this particular example is something -- I don't mean the case, I mean the process -- the failure, and you might be right that it's relatively isolated, but is that something of such significance 12:34
that it just has to be got right and, therefore, it has to be monitored?

A. It could be that, in hindsight, you could say that. But if you have -- if the vast majority are coming back and saying "Yeah, we do this" and there's peer pressure 12:34
and we're saying "Tell your people you really must do it" and "Your CD and your AMD says you must do it" and "It's good patient care" -- "I don't know" is the answer. There's a line somewhere and in hindsight is a wonderful thing, isn't it. 12:34

205 Q. In 2014, moving to a --

A. Yeah.

206 Q. -- a slightly different topic, but in the context of incident reporting, you became aware that there was a backlog -- 12:35

A. Yeah.

207 Q. -- of cases, and I want to ask you about that. If we go to WIT-96900 and, at paragraph 37.5, you say that you believed you had clear visibility of what was

reported whereby it was dealt with at a high level, given the size of the Directorate and its span over three sites?

A. Yeah.

208 Q. "I believe that one indication of this is the detection of an incident review backlog in the plan and implementation to work through this as evidenced at paragraph 40.3. I also believed the Trust placed significant emphasis on clinical and social governance..." 12:35 12:36

-- and that goes into the Mid Staffs or the post Mid Staffs developments.

A. Yeah. 12:36

209 Q. If we could just then go down then over the page to 38.5, you say -- you are referring to the team that had been put together to deal with clinical and social care governance and you say that it was this team that escalated the incident review backlog in October 2014, showing their effectiveness and understanding of the system. And I was, I suppose, taken by what might be described as the constructive view or the positive view that you were taking of this incident or appeared to be taking of this incident. So hearing Dr. Boyce's evidence, I think she said circa 300 cases, incident reports -- 12:36 12:37

A. Mm-hmm.

210 Q. -- of various kinds?

A. Yeah.
211 Q. -- have been trapped within the system, if you like, because nobody realised they were there and they weren't opened?
A. No. No. 12:37
212 Q. And is that not right?
A. The positive thing is, because we had the Datix system, they weren't sitting in a pile. They saw them, they ran a report, they were visible on the report. And what had actually happened, which tracks back exactly 12:37 to what we were saying earlier, each individual division had a system and people that needed to address those and they got an e-mail alert every time they put one through. They had ignored those. They may not have had time -- whatever they had perceived -- they 12:38 hadn't opened the incidents. But we had seen those, they were visible, they were sitting there ready to action and we were able to put a backlog review in action. So they didn't disappear into the black hole, they actually came up and we were able to deal with 12:38 them. And out of them came a small number of SAIs. So there was further learning. It's positive because the governance system was growing. We had a backlog to address, we just didn't leave it or didn't know it wasn't there or -- it was there and we addressed it. 12:38 And the interesting thing for me was, if this isn't too much, is that it was at the time when Tracey and her team were there that this was discovered and when you look -- I looked -- I went and looked at the breakdown

of the incident backlog and the incident backlog was highest in the IMWH division, which was Maternity and Women's Health, and they were the very division that had a risk midwife attached to it.

213 Q. If we just pull up your statement on that, I think it's at -- if we go to WIT-96902, it's just on down the page. Scroll down. Keep going. Maybe it's not just here. On down. Keep going. Yes, I think this is -- is this where you set it out? 12:39

A. Yeah. 12:39

214 Q. So you make a point against -- that's integrated maternity and women's health -- 33.7% of the -- is that of the unopened --

A. Of the unopened backlog belonged to IMWH, but they had a person who was dedicated or part of their role was dedicated to do that. And in further transcripts you can see -- I mean, it tracks back to is it more resources or is it just doing the right thing with what you have, or is it a mixture? 12:40

215 Q. Okay. So let me try to understand this in the context in which you're saying it. Dr. Boyce's view of this was that this backlog had not been escalated before, was unknown to you until someone on her team spotted it? 12:40

A. Yeah. 12:40

216 Q. And so that suggested to her that, within the local areas --

A. Yeah.

217 Q. -- people either weren't understanding their job or

were too busy or whatever the explanation --

A. There was an issue, yes.

218 Q. -- might be. And so you had the need for the governance people to respond, but they're responding, if you like, out of time. There's delay in dealing with these things. The learning isn't getting through. The significant -- there could be significant issues in there? 12:41

A. There was, yeah.

219 Q. So this isn't, as I understood her evidence, a good news story. Of course, it was caught, but it's an indication, perhaps, of the strains within the governance system and things not working properly? 12:41

A. Okay, so, for me, it's not like that. So, for me, the backlog is from the 1/1/2014. So, for me, it's we actually see it's visible. We get it. We can address it. We are early in our governance journey. There was people there in those divisions to address it. They weren't -- that culture wasn't there where they were spot on doing it, but we went back and we revised that. It's not going to be perfect -- it's, like you said to me, it takes time, it's not going to be perfect right away, but we have got on to it here. But the interesting thing for me is when you then try to say "Okay, so we've got this problem now, we're going to address it" -- what would solve this? Well, you're looking at it thinking the division that had most resources, it didn't solve it for them. 12:41 12:41 12:42

220 Q. So you're saying --

A. So is it a resource issue or is it a hearts and minds integrity doing the right thing issue, or is it we need to recognise and do more work on the culture of governance that you've got to be all over this -- it's in your job, in your daily job in the division. There was an example of a -- I did an SAI on a child death due to non-accidental injury just before I came into the director post and there was a child protection nurse in the Trust, and the clinical team discharged the child and the child came back two days later and, sadly, died. And when we reviewed that SAI, a lot of the clinical team pointed to but it's -- it's the child protection nurse's job. The child protection nurse had no clinical -- no clinical time allowance in her job plan. Her job plan was raising awareness of child protection, training how to deal with it on the ground and getting the clinicians to challenge parents and families and follow the correct reporting procedures. In their heads, they thought, "No, actually, she should have picked up the child and dealt with it." So, I'm not sure that having a risk midwife to do your IR1 opening and resolving for you is the right thing. It's not. It's your problem in your clinical team. So it's not all about resources is just the point that I'm trying to say. It's not all about having 20 governance people in the Acute Directorates. It's about have we got the people doing governance actively during their day. 12:42 12:43 12:43 12:43 12:44

221 Q. The system of doing governance within or the

arrangements for doing governance within Acute was to be the subject of a brief review?

A. Yeah.

222 Q. -- and maybe "overhaul" is too strong a word, in 2014?

A. Yeah. 12:44

223 Q. We can -- we can see that, if we turn to WIT-98369, just scroll up until we see the previous page, sorry, this is a consultation paper --

A. Yeah.

224 Q. -- on the Directorate structures within Acute. The 12:45 timing is May to June 2014. And if we go, as I say, back to the next page and to the third bullet point, the purpose of this, scrolling down please, is to -- it's a consideration of whether to increase the capacity. This is an aspect of it. I shouldn't -- 12:45 I should make clear it's not just about governance, it's about other structures --

A. It's the whole thing, yeah.

225 Q. Yeah. And one of the proposals was to increase the capacity within Clinical and Social Care Governance by 12:45 the appointment of a full-time AD for Clinical and Social Care Governance and to stabilise the Clinical and Social Care Governance management arrangement in the Acute Directorate. So, what -- why was this -- what was the driver for this at this time? 12:46

A. So this is a review that all Directorates did. Now, I think I said earlier, and I don't think that's right so I'd have to go back, but I think there was an issue in the Western Trust and there was a review in the

Western Trust. And I don't know of the topic, but I remember vaguely. And it came back to SMT, our Chief Exec. Director forum and they said they would do a review of the structures. This bullet point here is because I had been the full-time Assistant Director for Clinical and Social Care Governance 2011 to '13 and, when I left to take the Director role, I'm not sure, I think they might have seconded to it -- I don't think they'd put a full-time person back in it -- and they were saying, "No, we need to put a corporate person back in this because of the ramifications of the Western Trust." And then to do that, I think the person that was the governance -- 12:46 12:47

226 Q. So Margaret Marshall was --

A. That's it. 12:47

227 Q. -- was temporarily holding two jobs?

A. Two jobs, Acute and Corporate, and we wanted to say "No" to that. We wanted to say put the Corporate one in and get the Acute Directorate their own arrangement full-time. 12:47

228 Q. And the --

A. So it was just putting back nearly or putting something more akin to what we had had in the System of Trust.

229 Q. Yes. And the upshot of it was, and this is -- I want to ask you ultimately about Dr. Boyce and her view of how governance worked in Acute -- 12:47

A. Yes.

230 Q. But this role that we're looking at on the screen, as we see if we go to the response to this consultation at

WIT-98383 and at the bottom of the page, please -- so:

"The Assistant Director of Governance will undertake a coordinating and lead role in relation to supporting and providing a challenge at a corporate level. It is agreed that the current Director of Pharmacy will assume this role and that this will be supported by the existing Governance team and three Band 7 Risk Nurse Midwife posts, who will report directly to the operation of ADs, who will retain operational responsibility for the deliverance of the governance agenda within their own division." 12:48 12:49

So I think within your statement you go on to say that Dr. Boyce was involved in all of the earlier discussions around this and during the consultation and took up this AD role with effect from the 1st October 2014? 12:49

A. So this consultation document, this is separate to the previous one that we were looking at. So the previous one was the Trust one. This is the Acute Directorate's response to the changes because there was changes in the Executive Professional Director's role as well in the Trust-wide one, and then we needed to follow that through in the Directorate ones. So this is our response and we did this in May and June as well in response to what they were proposing. 12:49 12:50

231 Q. Okay.

A. And so this is purely to do with Acute, this one, yeah.

232 Q. And the upshot of it was -- we can see your PA's communication around this, WIT-98524. And so from October 2014, it's explained that:

"The Acute Directorate's Governance team will be coordinated by Tracey Boyce and Mrs. Carly Connolly, and Mr. Paul Smith will join this team." 12:50

So the two -- those two are nurse --

A. Lead nurses, yes, they were at the level of lead nurse in the Acute Directorate already. 12:50

233 Q. And:

"Their key areas of responsibility will continue to support the Director in the management, investigation and learning from complaints and incidents. This team will also continue to support the director with respect to Directorate Risk Registers." 12:51

Now, what I wanted and what the Panel is, perhaps, interested in hearing from you is, when we hear from Dr. Boyce in relation to these developments -- 12:51

A. Yeah.

234 Q. -- and, in particular, the responsibilities she felt were placed upon her, it was the tenor of her evidence that this was not workable? 12:51

A. Yes.

235 Q. And she said that, if we just pull up her Section 21 response to orientate ourselves, WIT-87671, and, at

paragraph 43.5, she said:

"The fact that the Governance lead post..."

-- that was the post held by Margaret Marshall, as we understand it -- 12:52

"...had been given up as a saving in 2014 demonstrated a lack of understanding of the importance of good clinical governance..." 12:52

-- in her opinion.

"It was impossible for me to take on the full role of the Governance lead on top of my substantive post as 12:52 the Director of Pharmacy."

And she goes on to say:

"My registration as a pharmacist could have been at 12:52 risk if I did not ensure the safe running of the pharmacy service. The best I could do was to offer every Tuesday morning in my diary to assist the members of the Acute Governance Team as best as I could." 12:53

So do you recognise in all of this the challenge in perhaps shoe horning Governance responsibilities for the Directorate on top of what was already a busy pharmacy portfolio for Dr. Boyce?

A. Yes. So I have the greatest of respect for Tracey. She was excellent in her role. She had specific interest and was very, very helpful around the Director table about governance and was very supportive to me in that role because she had an interest in it, a bit like myself. So, I -- it's interesting for me to read her perceptions of how she felt. I can only go from the documentation and process that we worked through. So we worked through a consultation from May into June in the Acute Directorate, myself and my Assistant Directors, of which she was one. I honestly don't recall and, unless there is written evidence or e-mails to say, you know, I don't recall these sentiments at all. And, in actual fact, the two -- the two lead nurses would have augmented the Governance team and I think that was one of the positives for me in terms of when you go back and say to me "You seem to view the incident backlog identification as a positive" -- the incident backlog occurred when the Governance Coordinator was in post and was identified when Tracey and the augmented team came into post. I would say that's a win for that team. So, I honestly didn't hear this sentiment. Nor did I view it as such. I thought we were augmenting and putting lead nurses more into the divisions, more to make it live in the clinical thing again, trying to push this clinical aspect of it. So I don't remember those sentiments, no, and that wasn't my recollection of the aim. 12:53 12:54 12:54 12:54 12:55

236 Q. If we maybe just scroll up the page, there's a number

of points that she marshals in support of her view. She starts at 43.1 by saying -- and this view, as I understand it, straddles both the time when you were in post as Director, and then moving on from August 2015 into Mrs. Gishkori's role as Director of Acute, where she says that, in her view: 12:55

"The Governance arrangements in the Acute Directorate were not fit for purpose."

12:55

And she puts this down to what she says is the chronically under-resourced team, having regard to the tasks expected of them. And she gives some examples of that: Clinical staff not having protected time for governance activities; the impact on her, as we saw down the page, with regard to her pharmacy duties. She points out that -- I think she's saying that the backlog was a symptom of the strains within Governance and, just scrolling down the page, she says at 43.6, she says of the two Band 7 Governance Officers -- there was Mr. Smith and Carly Connolly -- she says of them that they were inexperienced in the role. So, she's painting a less positive picture, a much less positive picture of the governance climate -- 12:56 12:56

A. I understand. 12:57

237 Q. -- than you are?

A. Yes, I understand that.

238 Q. Does that surprise you?

A. So when I read back and thought about it, yes, it

really did, because -- and I've thought a good bit about this. So, again, I am wondering what lens people are using to look at 2013/2014. Are they using a 2023 lens? I don't know. We had just completed a massive review of governance and were implementing that. We were -- the culture of Clinical and Social Care Governance was fairly young in Northern Ireland and Mid Staffs had just been published and there was lots and lots and lots of recommendations. I honestly think, I honestly believe -- maybe it was because of my corporate positions, but I just think I have a different view. I was benchmarking us against other Trusts in Northern Ireland. I was at the regional meetings. I was looking across the system. And to be honest with you -- and then it comes back again to the question that obviously is there for the Inquiry: If you are doing governance -- so if you scroll up, she says that when the bed pressures came on, that -- but when you are under pressure clinically, governance has to come up further to the fore because you have to make the right choices. You have limited resources, but you are trying to make the right choice clinically for the patients. So I don't agree with that. In my head, governance is an action on the day at the time you're seeing the patient. And you could have 20 risk midwives -- it won't make this obstetrician do the right thing here. You might find out quicker he's not, but it won't make him do the right thing. Governance has to be owned and actioned. I'm not sure that

12:57 12:58 12:58 12:58 12:59

creating more auditors and more -- is the best way forward. So, no, I have a different view. I also have a different view of where we were at at that time. Things have moved on. Mind you, we still don't have a duty of candour in Northern Ireland. But things have moved on. Clinicians' views of governance has moved on. There's been numerous inquiries, we've learned from those. I just have a different view.

239 Q. Mm-hmm. Mrs. Gishkori, when she gave evidence --

A. Yeah. 12:59

240 Q. -- she spoke in terms of Mrs. -- I don't need to bring it up on the screen, but it's in the transcript at TRA-06868 where she talked about governance in Acute being at the bottom of the pile. She said:

13:00

"The finances just weren't there. We had to work with whatever we had. It was all about putting money into front-facing, which was of course important."

So is that something that you recognise? It comes through perhaps Dr. Boyce's view as well. Why, for example, is a range of governance responsibilities being added on to her pharmacy responsibilities? Was this problem one of resources? Or do you go back to your point that it's more to do with people doing their own job in [inaudible] governance? 13:00 13:01

A. Tracey was a very experienced lady, she had a real interest and a passion for governance. If you are

trying to build a culture, you need people with passion with you on that journey; she was one of those, she was very good, she was very well respected by the clinicians. So if I needed somebody really senior to help me with that vision of governance, she was it. So what I did instead was take the 8B or 8A, or whatever that person was, out, and give her more resources in the lead nurses that were closer to the patient. So, in my estimation, that was a good move because she had had -- I perceived her to have the same view as me in governance, in that it had to happen in the teams. It's not somebody looking over your shoulder. So we were trying to build the culture of that, so that's one of the reasons that that was done. In terms of Mrs. Gishkori's evidence, I can't speak to when she came in, I can't speak to when she came in. Performance and governance are completely tied together. They are two sides of the one coin. They have to work together. When the pressures are higher, the governance has to be better, you have to consider it more. Who gets the last bed in the ED has to be around clinical priority and has to be based on good governance.

13:01
13:01
13:02
13:02
13:02

241 Q. Could I put one specific issue to you around this: In the years that follow --

A. Yes.

242 Q. -- Dr. Boyce is proposing changes to the structure?

A. Yes, I read that.

243 Q. I think we sent you some of that material.

A. Yes, I read that.

244 Q. There was a proposal in, I think it was 2016, to reintroduce a Band 8 Governance Coordinator role?

A. Yes.

245 Q. And she got the finance for that. Trudy Reid came in to that position. But, in 2018 -- 13:03

A. Yes.

246 Q. -- things were still not right, in her view, and if we look to the structures she proposed then, at WIT-14754, maybe not entirely helpful without bringing you to the report that -- the short report that she makes on that, if we just scroll down the page, please. So, an enhanced government structure model for discussion, and what she says is, and this was the -- I suppose the tenor of her evidence and some of the supporting e-mails that I didn't trouble you to read, but the sense of it was: "We are not being proactive enough"? 13:03 13:04

A. Yes.

247 Q. "SAIs, complaints are coming through. We have recommendations. We are not dealing with those, we are not able to deal with those"? 13:04

A. Mm-hmm.

248 Q. I think it was Mrs. Gishkori's evidence that audit had more or less collapsed in -- in Acute. So, as we can see there in this short paper: 13:04

"The introduction of additional posts would allow the Acute Governance Team to introduce proactive governance activities such as governance... incident trend

analysis, additional governance training and learning events relating to trends, patterns identified from Trust incident reports."

Are those the kinds of important things that weren't being done but which ought to have been done, or are they luxury extras that -- 13:05

A. No, they are not luxury extras; they are part of it. But, remember, we only created the vision and we only started to implement it in '12, '13. So, in '18, you can review and look and say, yeah, now, I am past the -- at least we are doing the SAIs and the complaints and the incidents, now I need to do more proactive stuff, I need to build my capacity to do governance more proactively, certainly, absolutely, the whole world knew more about Clinical Governance in 2018 than it did in 2014, absolutely, definitely. Those are things you need, but you have to start somewhere. So, in '11, '12, '13, we couldn't even get clinicians to challenge SAIs and get the learning out of what was clearly evident and, yes, it was reactive, but you had to get that before you go proactive, you have to buy them into the system, so it takes time, that's absolutely completely correct. And if in '18 was the time to do that, good, do it, but we were very young and immature in '13, '14, with our governance system. And just one more thing: The other thing is, I guess the other thing that surprised me, and I don't know why, but I have no recollection, and that's not to say

she didn't, but I don't have any recollection of Tracey representing those views that Acute Governance in '14 wasn't good enough at the AD director table, I don't remember us having those discussions. In hindsight, you may look back, but the system was where it was at that time in its maturity. Tracey is a very honourable person and she was very good at speaking up at the Directorate meetings. I would have thought, if she held a view at that time, like "I don't want this job and I can't do it and it's going to damage my registration", she would have said. I have no recollection of that. What she thought post that, that might be different, I'm not sure, but, yes, these are all very good things to have, but right at the beginning of the journey we were starting with the basics. 13:07 13:07 13:07

249 Q. Okay. To summarise, then: You would -- to summarise, you thought that at 2014, into 2015, governance within Acute Directorate was where it ought to have been in terms of the maturity of the developing processes? 13:08

A. Was it perfect? No. Was it as good as it could be? No. Were we trying to make it as good as it could be at that stage? Yes, probably. Do I look back and think, oh, my goodness, there was gaping holes there. No, I don't, rightly or wrongly. So I think for where we were at, it was good, and probably as good as it was going to be at that time with the journey we had to go. 13:08

MR. WOLFE: Very well. So I think it's coming up to ten past one. We maybe overstepped a little bit, but

we got that area finished.

CHAIR: Okay. Are you fine to come back this afternoon at quarter past two?

A. How long would it be this afternoon?

MR. WOLFE KC: I will speak to you in the break. 13:09

CHAIR: Well, we will plan to come back, ladies and gentlemen, at quarter past two, and then we will double-check.

THE INQUIRY ADJOURNED FOR LUNCH 13:09

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIR: Good afternoon, everyone.

250 Q. MR. WOLFE KC: We touched very briefly this morning, Mrs. Burns, on the whole issue of pressures within the Acute Directorate in terms of the ability to deliver on performance requirements of the Commissioner -- 14:18

A. Yes.

251 Q. And I want for the next short period of time just to examine that in the context of Urology specifically. 14:19

A. Yes.

252 Q. You would probably agree that it's a truism that a service facing these kinds of stresses that we will look at really in that context becomes even more dependent upon having good governance in place to ensure that, during these kind of stressful times, that things are going as well as they can be from a patient safety and risk perspective. And you say just if we could take as our starting point your statement at WIT-968880, and if we scroll down to 15.1, please, and so maybe just -- what you say, just at -- from reviewing e-mail documentation, during your tenure as Director of Acute, it would appear that problems persisted -- those were the problems you were aware of, I think, as Assistant Director in Governance -- and that the Commissioner was aware of these issues, including -- and then over the page, you say "staffing vacancies", and this is specifically within Urology, one consultant down, three specialty doctors down, one 14:19 14:19 14:20

general practitioner with a special interest down, and two specialty nurses, and you say this staffing shortage meant capacity was reduced while demand for services was growing, leading to a continued backlog. And that wasn't just a local picture. I think you have described in your statement that it was a regional problem as well?

A. Yeah.

253 Q. And you say that this problem, give or take, and I know -- I will refer you in a moment to an improvement you were able to make around consultants in late 2014, but give or take that there were vacancy issues throughout your tenure? 14:21

A. Yeah, definitely.

254 Q. And you have described in your statement again that the challenges presented within not just Urology but in other services as well, impacting on waiting times for new outpatients and new elective, required almost -- these aren't your words -- but also micromanagement; you were meeting weekly with the divisions or receiving, perhaps, reports from the divisions telling you about the challenges and perhaps work-arounds to try to address them? 14:21 14:22

A. Yes, definitely, right across all the specialties. Yeah. 14:22

255 Q. And we can see, for example, in a couple of documents I'm going to pull out and invite your overview or comment a report to the Trust Board in March 2014, probably at or around the time you took -- a year into

your role --

A. A year, yeah.

A. -- I'm getting slightly mixed up. So a report to the Trust Board, a monthly performance management report, if we go to WIT-97194, and a report to the Trust Board, 14:23
26th March 2014, a monthly performance management summarise -- summary of the key issues for the Trust Board. And you say or the report says that:

"The report reviews performance at end February 2014 14:23
against the commissioning plans, standards and targets and provides an assessment of current performance."

And the report highlights a number of areas of risk, predominantly with respect to elective access 14:23
standards?

A. Yeah.

256 Q. And if we just go over the page, we can see that Urology -- you say just at the start of the first main paragraph there: 14:24

"...remains the greatest risk and is the subject of regular discussion with Health and Social Care Board, regarding both delivery of core SPA volumes and achievement of access standards." 14:24

And we can see then I think there are two reports, one for 2014 and one for 2015, showing to the Health and Social Care Board compliance with -- or not, as the

case might be -- targets and general performance issues. So if we look at the report for 2014, WIT-97199, and this is March report for February 2014 performance. So it's an annual report, this is; it straddles from 2013 through to 2014. If we just maybe 14:25
go to, for example, Cancer Services, WIT-97203, and we can see that this is a report dealing with the 62-day standard, access standard, and we can see at the top of the page, obviously, you are the lead director for this area. And the point is made in the third paragraph 14:25
that particular issues in Urology -- at the end of January, two patients, both Urology, were in excess of 85 days, with seven in excess of 85 days at the end of February. And it's explained that urological medical manpower issues continue to impact on performance and 14:26
while the Trust has been successful in recruiting a replacement fifth consultant post, the loss of middle grade staff and the special interest doctor continues to impact.

14:26

So, that's one example of an area of drift from the access standard that this report deals with. I mean, it's the case that the Trust tried to achieve 95% across Acute, is that right, or across Cancer Services, 95% -- 14:27

A. Yeah, this is a Trust Board, I think this is a Trust Board report and, you're right, it runs from financial -- it runs through the financial year April to March of the following year and the standard was 95% for 62

days, and that was the regional standard. So we were running at a baseline cumulative 12 to 13 of 97.7. But you can see there the different specialties that were also having some difficulties with it in terms of going over the 62 days. The 85 days is a backstop which the Department had put in. They didn't wish anybody to wait.

257 Q. Yeah.

A. So, yeah, that's right.

258 Q. And Urology in a number of cases was missing even that backstop, is that how to read this? 14:28

A. Yes, but there would have been some others that would have missed it too by, you know, small numbers. So there was -- at the end of January, there's two patients in Urology, and seven in excess of 85 days at the end of February. So that was definitely alarm bells there for that one. But if you look up above: 14:28

"...December with seven patients in excess of 62, three internal, haematology and lung as well as urology..." 14:28

-- lung was another regional issue.

259 Q. Yeah.

A. So, yeah, it's one of those specialties, absolutely.

260 Q. Yeah, I'm not seeking to suggest that Urology was an isolated case, but as the report to the Board points out, Urology suffered particularly -- 14:28

A. Not an isolated case, but it was repeatedly very difficult across a region to get it to achieve, yeah.

261 Q. Yes.
A. Definitely.
262 Q. And it's not the only area where the capacity shortfall was impacting. So if we go to WIT-97216 -- so there's a series of, as you will no doubt remember, a series of areas that are being measured for the purposes of report to the Commissioner and this page deals with elective care, inpatients and day cases, and we find that, in terms of Urology, if we go to the bullet points at the bottom, there were -- there's 220 patients in excess of the maximum 26-week backstop, with the longest wait of 64 weeks. So, it's -- it's not alone as a specialism in missing even the backstop, but it's got the most -- 14:29 14:30
A. The lion's share, yeah, it's the lion's share, yeah. 14:30
263 Q. And the longest waits?
A. Definitely, yeah.
264 Q. And if we go to WIT-97245, and looking at Urology, we can see that the explanation is given that the under-performance against SPA -- just remind us -- 14:31
A. So SPA is the contracted volume. So it's the total and it doesn't relate really -- well, technically they should have, but it didn't really relate to the access time. So it was your contracted performance. So clearly it was -- well, the both of them were always going to be hit, but if you didn't have -- if you didn't have one person's clinic that's worth going through and one person's elective worth going through, you were going to definitely miss your contracted 14:31

volume.

265 Q. Yeah. So it's measured at 1312 minus 15% against the volume, is that how to read that?

A. That's how to read that, yeah.

266 Q. Yes. And part of the explanation at least is associated with the significant loss of medical staff capacity associated with sick leave and vacancies at the middle grade? 14:32

A. Yeah, there was a consistent theme of middle grade could not be filled. You couldn't get middle grade Urologists. And, I mean, they really supported the consultants in their work and were senior trainees, you know, but they couldn't ever get those recruited. 14:32

267 Q. Yeah. And we could go to the 2015 report, but it's -- while the figures might be slightly different, it's essentially more of the same? 14:32

A. 2015, we had reorganised and we were definitely doing better. What the issue was in 2015 was -- and we reported this, the Urologists and myself reported that to the -- I don't know, number whatever Regional Review in June 2015, I think. We were actually -- had reorganised and were meeting the new demand coming through the door, so we were actually servicing what was coming through the door. We couldn't address the backlog that had built up and we needed a separate solution for the backlog because we had the capacity now to meet the new demand coming through, so we were definitely doing better. 14:32 14:33

268 Q. And just I want to maybe just step through that in --

just to make a number of points. First of all, it appears that significant effort was put into recruitment strategies and, if we look just briefly, just to touch upon it, an e-mail from Mrs. Trouton, August 2013, setting out staff vacancies and efforts to address that, if we go to WIT-97170. And so August 2013, I suppose the period immediately before this report is -- the report to the HSCB is finalised, but covering or taking a snapshot of vacancy and recruitment strategy during the currency of that report and she describes that -- just scrolling down -- I think we've seen this already in another form. So there's your staffing gap and she then sets out the actions taken to address the vacancies -- advertising -- starting at the top, sorry: Appointing a locum urologist, advertising various -- scouting for replacement special interest doctor. And it makes the specific point: 14:33 14:34 14:34

"We have not appointed two more specialist nurses as their activity to contribute to seeing patient is curtailed by the lack of medical support." 14:35

A. Yeah.

269 Q. So it's a chicken and egg situation? 14:35

A. Yeah, exactly.

270 Q. You can't bring the nurses in, although you may have ability to recruit them, unless you have the medical support. They work hand in hand?

A. That's right, mentorship and training, that's right.

271 Q. The good news, I suppose, reported in your statement was that, if we go to WIT-96882, if we go down to 16.2, you say that:

14:35

"In January 2014, after constant advertising, we had two successful consultants appointed..."

-- Mark Haynes and another Consultant. You successfully lobbied Mr. O'Sullivan at the Commissioner and with the CEO of the Southern Trust to have both funded?

14:36

A. Yes.

272 Q. So that brought you up to six, is that right?

A. That's right, and we were actually only commissioned for five and what we did was we said to the region, "Look, there is a regional shortage, so if you additionally fund us for the sixth post, we will look at trying to help the region with its problem." So there was different conversations with Dean and the Commissioner then over the latter part of '14 how we would do that. And when we got those people in post, then we were able to change the shape of our service and how we saw the new Outpatients. And that changed quite significantly, which meant we were then seeing the new demand coming through, but it did take the manpower to do that.

14:36

14:36

14:37

273 Q. Mm-hmm. Is it -- or I was going to put it in these terms to you -- it did appear something of a curiosity

that despite all these demand capacity gaps within the Southern Trust, in early 2015 the Southern Trust agreed to take on part of the slack created by the collapse of Urology in the Northern Trust?

A. Yes. 14:37

274 Q. Albeit that was for a short period of time?

A. Yes.

275 Q. And a limited number of patients, the Southern Trust agreed to assist the region in that respect?

A. Absolutely. 14:37

276 Q. And how was that -- how was that possible? Was that via the appointment of this new consultant or consultants?

A. So, I guess this goes to -- well, the NHS doesn't shut its door, does it? So it sees the patient at the point 14:38 of need, really at the point of delivery. So the Northern Trust had -- its Urology Service had collapsed and, as a region, we were just in a very poor state. So were we any different in Southern Trust to anybody else in the region? No. So if you looked at their 14:38 Urology figures, it wasn't particularly -- we were all in that boat. So what we said was we would take -- but it was very specific and we didn't -- I made the point to the Commissioner we were not taking a GP re-route; we were only taking the referrals for a short period of 14:38 time off that had already come into the Trust off the PAS system. So we weren't taking a reroute forever, but we were going to put our shoulder to the wheel and help, as everybody else was.

277 Q. Yes. You explain, if we go to -- go back a page in your statement, if we go back to -- scroll up the page, please, to D, yes, and you have reviewed the correspondence --

A. Yeah. 14:39

278 Q. -- in association with these recruitment developments and you say that, by 2014/2015, after the team grew to six consultants and changed to 18 job plan, they were making progress in service reform to meet actual demands, specifically implementing new clinics and 14:39 services [inaudible], but the backlog issues in outpatients and inpatient and day cases remained an issue, of which the Commissioner was aware and which required a separate solution. So, in terms of team job planning, can you help us with that concept as 14:40 specifically as your memory will allow? Was this essentially combining the forces of the six consultants which wouldn't otherwise be possible unless you had that critical mass?

A. That's right. 14:40

279 Q. And in developing services with that flexibility available to you?

A. That's exactly it, yeah, and they went -- I think one of the changes was they went to surgeon of the week. And then other changes were how they delivered their 14:40 Outpatient clinics, and they changed those to pool the patients together to specific types of clinics, rather than to specific people. So we were addressing it in terms of condition and diagnostic and that you needed

diagnostic before you came to the Outpatient clinic and how would that work and designed it differently that you could have those things in a different order so you weren't just queuing behind individual people. So it was much more a team approach to their job planning. And, I mean, they were enthusiastic about that and seemed to be working well with that, and we presented that to the final Regional Review that I was involved in -- I think that was May or June 2015. 14:41

280 Q. Yes. What was it, just so that we can understand it specifically, what was it that spiked the increase in Consultant numbers -- 14:41

A. Yeah.

281 Q. -- enabled you to tackle, if you like, the new demand in the new patients coming in the door, but prevented you from addressing the backlog? What was that problem? 14:41

A. Well, I guess there's only so much capacity that one person has and it doesn't matter how many clinics you have, you only have a finite capacity. And those patients, we were able to know that we would be able to meet the new demand and probably meet the new demand for two years, we predicted. Coming in on a monthly basis, we could address those in the correct access times and meet the bundle. The other big problem was, as I said to you earlier, the Commissioner didn't, in the initial stages of performance, they didn't look at the bundle that came with the patients. So we had no review Outpatient target, so, therefore, you kept 14:41 14:42

seeing the news and you kept seeing the red flags in the time period that they asked you and in the contracted volume. You were creating bundles then of reviews over here. Surgery as well, and inpatients and day cases, which you didn't have the capacity because this front end was going too quick and you couldn't keep it up here in the back end. So what happened then was the routine stuff went out and the reviews went right out and they didn't have the money, I assume, to address those, so they didn't target those. So there was no target for those. So nobody was talking about those or nobody was reporting those and there was no resource to deal with them. So we reorganised to deal with what we could at the front, but this backlog still remains and, like we said, it was 20,000 patients on a Outpatient backlog, which they were all churned into the system but we had no capacity to see. So you would have needed to address that in a certain way. At some points they used the independent sector -- you could address it in different ways -- but it needed addressed so to reset the whole system, and then we would have been on an even keel. 14:42 14:42 14:43 14:43

282 Q. And obviously you had visibility on these numbers of patients waiting on access outside of the --

A. Yeah. 14:43

283 Q. -- the backstop --

A. Yeah.

284 Q. Was there -- I'm sure there was awareness that those patients, the morbidity of those patients was

vulnerable?

A. Absolutely.

285 Q. Was there any work or any thought to do any work about attempting to get, if you like, a sense of purchase on or grip on where those patients were at and how we could best, I suppose, stratify the risks or get to the patients most at need? 14:44

A. Yeah, certainly. So as we talked there, you would get non-recurring money given to you randomly that would become available within the Department. So we were -- we referred to an earlier e-mail, I think it was 2014, where suddenly they said "We have some money here, go and see 700 reviews on the Urology backlog in Outpatients." And what they said was "Use the money efficiently"! So, in that case, what we would do was run some validation clinics with consultants and senior doctors on the phone to say: "Are you still there? How are you feeling? What's your symptoms? Do you still need us?" and catch up with you in your progress. So there was validation clinics, but those were random. It couldn't be planned to the extent because there was no resource for them, so you could only do those when you had a resource available, made available to you to do them. But, yes, everybody was completely aware of the risk, but you can only climb the mountain that is in front of you. 14:44 14:44 14:45 14:45

286 Q. Yes. I want to bring you now, with that context in mind, into some of the specific issues that crossed your desk regarding not only Mr. O'Brien but him --

A. No.

287 Q. -- and how issues around him were managed, where they were viewed as problematic to the service and the smooth running of the service. I want to take you back to 2009 and a meeting I know that you are familiar with through the papers and just ask you some questions about that. If we go to WIT-97159 and you are listed as being present at a meeting on 1st December 2009 and obviously, at that time, wearing the Assistant Director of Performance hat. And then the meeting, which is chaired by the Acting Chief Executive, looks at demand in capacity issues -- and just move through that -- and then some quality and safety issues. There is an issue to do -- just up slightly -- an issue to do with IV antibiotics, which the Inquiry has heard something about? 14:46 14:46 14:47

A. Yeah.

288 Q. And that is -- that was a situation where Mr. Young and Mr. O'Brien were said to be bringing in patients with chronic UTI difficulties and treating them prophylactically with antibiotics. The situation then or the discussion then turns to some other issues, including, notably, triage of referrals, red flag requirements for cancer patients, and chronological management of lists for theatre. Late 2009, triage of referrals, it's undertaken by one of the three consultants within the required timescale. One consultant's triage is three weeks and he appears to refuse to change to meet current standard of 72 hours. 14:47 14:48

Mrs. Trouton's evidence was that's a reference to Mr. O'Brien. It possibly doesn't much matter, save to say you were aware in 2009, perhaps several years before you dreamed that you would be in the Director of Acute Services role, but aware that triage is an issue then. And the issue hadn't moved on, one might venture to suggest, by the time you take the Director's role. Was that something, when you came into the Director's role, that you remembered, that this was part of the history? 14:48 14:49

A. No, what prompted it in the Director's role was the red flag cancers. So we couldn't meet -- we were breaching that 62-day thing and some of them were waiting way too long past the backstop in Urology. So when we really got underneath the skin of the red flags, it was because -- and I know it came after February, February '14, and came at the start of March, but I knew that we were looking at it -- wrote and sent me a report which said the journey, when you track the journey, it's the triage and appointing to the new Outpatient that are the -- 14:49 14:49

289 Q. Yeah, yeah, I didn't want sort of to --

A. I know.

290 Q. I'm going to take you to that. I suppose the simple question is, 2009, you're wearing a completely different hat. The issue of triage is one that remains to be tackled effectively when you take up the Director of Acute Services role in 2013 -- but had you -- I suppose, had you a memory that that was -- 14:50

A. Absolutely, no, I wouldn't have said so, no.

291 Q. Okay.

A. Don't forget, IEAP, which is a 72-hour triage target, it just came in in 2008. So again it was pretty new to them. And I think that's 2009, so they were adjusting. 14:50

292 Q. Yes, if we look at the action points, just scrolling down, you're placed in a drafting role to write to the consultants involved. The point is made that:

"If there is no compliance, further written correspondence to be drafted on issues of lack of conformance with triage and red flag requirements, setting out the implications of referral to NCAS if appropriate clinical action not taken." 14:50

14:51

So, any recall of how that developed at that time?

A. I actually don't remember this meeting at all. I only knew about it from the documentation. I think or I would say that I was there purely from my expertise in terms of access and waiting list management in general. 14:51

293 Q. Yeah.

A. The people that were going -- that the letter was going to come from would have been Gillian as his Director, and then the people that would have taken on the implications if it wasn't complied with was Kieran and the Medical Director and Gillian. I was there probably just to draft stuff from my expertise with waiting list management. 14:51

294 Q. Yes. Can I ask you just a discrete question about NCAS?

A. Yes.

295 Q. Was that an organisation that you were familiar with?

A. Yes. I didn't become familiar with it, I would have said, until my role as AD of Governance and as a result of some of the SAIs, we would have engaged with NCAS when people got into professional difficulty. 14:52

296 Q. Yes. Hopefully I sketch this out correctly, but there's a sense from some of the evidence that we have received that while NCAS was approached in the context of Mr. O'Brien's alleged shortcomings during the latter part of 2016, the 13th September 2016 -- after your time, of course -- 14:52

A. Yeah. 14:53

297 Q. -- notwithstanding an awareness of difficulties with his practice and perhaps, from his perspective, a sense that he was maybe overburdened in aspects of his work, but NCAS wasn't approached for help or advice until rather late in the game, it might be suggested. I suppose, the question we're interested to hear from you on was NCAS, if you like, mainstream? Was it known around the Trust or do you think that reaching for its services would have been something outlandish or unusual in the Trust at the time? 14:53 14:53

A. I knew it and was happy to work with them and, in terms of clinical practice issues, I guess, in my time, and this may be too general, in my time I didn't have particular issues with Mr. O'Brien's clinical practice.

It was his administrative processes, so the triage and the notes that I knew about. So, I'm not sure whether we would have engaged NCAS for those issues or not, and I wasn't that close to that. Probably even as the Director of Acute Services, I was mainly with -- you would have done that in conjunction with the Medical Director and the AMD.

298 Q. But NCAS as a service that could assist Trust, was that relatively well known or ought it to have been?

A. Well, it was definitely known. I'm not sure -- I'm not sure -- I mean, I'm not sure how often we used it. I used it once or twice. 14:54

299 Q. Could I bring you, by way of introduction, to the issues around Mr. O'Brien and how he was managed?

A. Yes. 14:55

300 Q. -- and how he ought to have been managed, to an interview you gave to Dr. Julian Johnston in, I think it was 2019 when he was reviewing some of the Serious Adverse Incidents that had emerged on a lookback of triage dating from 2016. 14:55

A. Mm-hmm.

301 Q. So it's some several years after the issue emerged and you're obviously coming back to be interviewed. You're no longer an employee of the Trust and you're thinking back on your time as Director. So with that context in mind, if we go to WIT-98393 and -- there you go -- you are being interviewed at the hospice and if we just scroll down, so you explain -- or it's explained to you that the interview was going to be confined to the 14:55

issue of triaging GP referrals and Dr. Johnston says he doesn't wish to venture into any other issues. And he asked you about the triage in your cancer referrals and how important they are and you say:

14:56

"Vital. Patients are often anxious and depend on the system to work, dealing with diagnosis and treatment in a timely fashion".

And: 14:57

"Where does triaging rank in importance for patients when comparing it to other medical staff issues?"

And you say: 14:57

"Very significant, very high up in the list in terms of importance."

And then you are asked: 14:57

"what system did you inherit who did not triage?"

And it's recorded:

14:57

"When Debbie was responsible for this area, urology was an outlier."

We see two words crossed out there and I'll come back

to that in a moment.

A. Yes.

302 Q.

"Urology had poor cancer performance data. Their cancer targets were a main issue and triaging was part of this." 14:57

And:

"However there were mitigations. They were short of staff. On call was an issue." 14:58

And then it's recorded:

"Aidan O'Brien was the most consistent offender. He did the work in his own time..." 14:58

-- emphasis on the word "his".

"Michael Young covered for him in the delays or non-performance of triaging." 14:58

Eamon Mackle, I think that refers to --

"...and Michael Young couldn't really tackle Aidan O'Brien. 14:58

Why was there a problem for so long?

Eamon Mackle and Michael Young unable to really deal with Aidan O'Brien and this problem. They did not have a good working relationship. DB..."

-- that's yourself -- 14:58

"...Debbie Burns then tackled the issue..."

-- and you say or it's recorded:

14:58

"DB felt Aidan O'Brien was difficult to manage, with fellow clinicians finding it particularly difficult."

And I want to stop because we will come back to this note in a moment, but I suppose just a few procedural 14:59 issues. There's issues -- or there's words used and then struck out, which might suggest that that was the author or the note-taker's first draft; it was sent to you and you said "No, I wouldn't use the word 'maverick team'"-- it's a theory I'm floating? 14:59

A. It could be. All I can remember is that -- sorry, who was the gentleman that interviewed me?

303 Q. Dr. Johnston, Dr. Julian Johnston, who was a retired Consultant, I think from the City Hospital.

A. Yes. He -- I -- he only turned up to the meeting by 14:59 himself. I think there was supposed to be someone else there taking notes. I don't think they turned up on that day and it was just him and myself and this is still labelled "Draft" and I can't honestly tell you

did I ever see a final copy. I don't know. So probably you're right, it looks to me like that. I probably said -- this might have been one draft and I said "No, I don't think so", I don't know.

304 Q. What about the sentiments expressed -- 15:00

A. Yeah, I mean, the sentiments expressed are as we said: Urology was an outlier in terms of both regional and Trust performance and trying to get to grips with it. It had a poor performance data, that's what the -- the cancer data was a real problem and that's what drew my 15:00 attention to the triaging because it was so long and the mitigations are, as we talked of, short of staff, on call was a real issue, they had a high emergency workload, high emergency number of patients coming through ED. Mr. O'Brien did work in his own time, he 15:01 did his job plan in his own time, and I think their issues with dealing with him was -- and it's evidenced in some of the e-mails, if you read them, from some of the other clinicians, they thought he was a very good clinician, they thought if you were his patient he 15:01 treated you very well and they documented that. I think Robin Brown documented that in a particular e-mail and they felt he was a good Urologist. However, he worked differently and, I mean, that's described.

305 Q. I am struck because I see in your witness statement and 15:01 I don't know if we need to put it up on the screen, but I will go there if you need to, but it's at paragraph 31 of your statement at WIT-96891, just for reference. You said in that that you had no strong recollection

when you drafted your statement for us, obviously quite recently, you had:-

"...no strong recollection of medical and professional managers in Urology not working well together. Nor had I seen any documentation to suggest that this was the case."

Your overall recollection of that period, 2013 to 2015, was of an entire Acute Directorate working well in complex and difficult circumstances. But here we have, in fact, five years ago -- 15:02

A. No, those --

306 Q. Just let me finish the point, if you would.

A. Okay. 15:02

307 Q. -- it being recorded that they did not have a good working relationship, and I take that to mean Mr. Mackle and Mr. Young not having a good working relationship with Mr. O'Brien?

A. No, on a day-to-day basis, they got on fine. Michael Young and Aidan O'Brien had been there for a very long time together. They got on absolutely fine. In terms of challenge and peer review and difficult conversations, no, they found that very difficult to do. And when you go back to my witness statement, I think that question was in relation to relationships between management and clinicians, was it? 15:03

308 Q. Well, I think it was, if we can bring it up and there's no harm in doing that. If we go to WIT-96891 and if we

scroll down to 31.1, maybe just -- the question is:

"During your tenure, did medical professional managers in Urology work well together? Whether your answer is 'yes' or 'no', please explain by way of example." 15:04

So --

A. So I'm not saying anything different in that previous statement because the professional manager, I take it, is me, which always irks me a bit, and the medical 15:04 manager was Michael and Eamon -- and even Aidan in that bunch, we got on fine together. What they found difficult was challenging each other about their clinical and their performance. They worked well together. 15:04

309 Q. Yes.

A. -- as such.

310 Q. Okay, and I think it's entirely fair of you to explain the answer that way. It's clearly a little unfair of me, perhaps, to be swapping the context in that 15:04 indirect --

A. No, but it's important, and I also felt that my relationship with all of them was good. However, I was fairly frank and open with them and so I guess that was different to how they worked with each other. 15:05

311 Q. Yes. And so let's just go back to that record then of Julian Johnston's interview, it's at WIT-98393 and at the bottom of the page. So where you are describing a sense five years ago/four years ago when you were

interviewed by Dr. Johnston that Mackle and Young were unable to really deal with Mr. O'Brien and the problem of triage -- they did not have a good working relationship -- is that telling us that those two managers, if you like, one a Clinical Director -- 15:05
sorry, one a Clinical Lead, Mr. Young --

A. Yes.

312 Q. -- one the Associate Medical Director, being Mr. Mackle, struggled, when addressing this issue of triage with Mr. O'Brien, they didn't have a good 15:06
working relationship in that managerial context?

A. Yes.

313 Q. And is that symptomatic of a wider problem with medical management?

A. Yes, so these guys, when we first came -- when the new 15:06
Trust formed, it was we were trying -- and through the Governance review, we were trying to get a real emphasis on medical leadership and management and that's why one of the reasons why we brought the Governance down. But these guys in those, ten years 15:06
ago, it was nearly like still your most experienced and your -- it was very hierarchical and if you were towards this point in your career, then you would probably go for a Clinical Director or an Associate Medical Director. It wasn't about were you a good man 15:07
manager, had you leadership qualities; it was more about maybe your clinical authenticity. And there is a conversation at SMT and some e-mails back and forward in 2014 about the Directors talking to the Medical

Director, John Simpson, about how we could elevate and help these people in these roles to be better leaders and clinical managers, but that was a real big struggle back then. And I am not sure we have wholly cracked that today, but I think it is definitely better. There is more development and leadership development for senior clinicians. It's not just as hierarchical as it was, but at that time you didn't have to be a good man manager to be in these roles -- but, actually, that's what it was requiring. 15:07 15:08

314 Q. Could I ask you a specific question about relationships? We have heard from Mr. Mackle in his evidence and he has told the Inquiry -- indeed, he told Dr. Chada back at the time of the MHPS investigation in 2017 that he had been advised that Mr. O'Brien considered him to be harassing -- sorry, considered that Mr. Mackle had been behaving in a way which was harassing and bullying of him -- that is Mr. O'Brien -- and, in that context, he was maybe not so much required, but advised to take a step back from managing Mr. O'Brien directly and, indeed, Mr. O'Brien, for his part, has recorded in a conversation that these adjusted management arrangements so that Mr. Mackle had no direct involvement with him were approved by Dr. Rankin, your predecessor. Were you aware that that was a feature of their history and, in turn, that this had impacted on proper lines of management? 15:08 15:09 15:09

A. No, and -- no. And you would see from my e-mails and the documentation that, in my view, Eamon was the AMD

for surgery. I think the first CD was Robin and there was an instance where I said, "Guys, we need to address this with Aidan" and Robin comes back and says "I can't do it, I'm surgeon of the week, I can't do it for two weeks" and I just went straight to Eamon "You need to do it, we need it addressed." So, no. Unless that's a formal process, there's something written down, there's a HR history to that, Eamon was the AMD, Robin was the CD, that's who we worked with. So obviously, clearly, Robin was first port of call; then Eamon as the AMD. 15:10 15:10

315 Q. So nobody at any time gave you a sense that relationships between Mr. O'Brien and Mr. Mackle had hit the rocks to that extent?

A. Well, no, I assume that if it had hit the rocks to that extent, somebody would have sorted it out and dealt with it in a process, but, no. 15:10

316 Q. And, plainly, you would think it appropriate, coming into this directorship of Acute, that if what I have described was the position, you would have -- you ought to have been advised of that? 15:11

A. Yeah, well, you can't work around it. Because Eamon was the AMD and Robin was the CD, so that's how we worked, yeah.

317 Q. Yes. Your sense that, limiting my question here to Mr. Mackle, that he did not have a good working relationship with Mr. O'Brien and you described that as the ability to challenge him as a medical manager -- 15:11

A. Yeah.

318 Q. "You're not doing your job -- do it" --
A. Yeah.
319 Q. -- that kind of conversation, that is what you mean here?
A. Yes. 15:11
320 Q. And how did you, I suppose, discover that? How did you become aware that the relationship was not good in that sense or that, to put it another way, that Mr. Mackle did not command the -- did not have the necessary skills, if that's the right approach, to properly 15:12
address these matters?
A. I don't think, as we said earlier, I don't think that pertains to those two individuals particularly.
I honestly think that's -- that was a symptom of where the medical leadership management model was at that 15:12
time. So there would have been lots of issues between clinicians and medical managers in different divisions.
But, I mean, my recollection is of the February '14 conversation that I had to have with Aidan, I wouldn't have had to have that if it had of been successful 15:12
prior to that with his peers and his clinical managers.
So that's not a job that I would have done on a routine basis, spoken with a consultant and said "You need to adjust your practice, stop this, and do this." I had 200 consultants. That wouldn't be my role. That was 15:13
the role for the CD and the MD, but obviously I had to do it because it didn't happen.
321 Q. Okay, well, I think that pre-empts a question I was going to ask you in terms of why did you have to come

in and meet Mr. O'Brien in February 2014 -- and we'll come to that, but in direct answer to my question about how did you discover that their working relationship was poor in the sense that we have defined and described, it was by -- it was a product of inference, was it? Nobody came along and said to you "They're not getting on" in that context. It was you drew the inference that if Mackle hasn't sorted it out, then there's something wrong here in the relationship? 15:13

A. Yeah, yeah. 15:13

322 Q. Very well. You have used your witness statement to explain that, broadly, when it came to Mr. O'Brien and speaking to those responsible for managing him, and managing the issues, that there were but two issues that commanded your attention, broadly. One was triage -- 15:14

A. Mm-hmm.

323 Q. And one was the retention of patient charts at home?

A. Yeah.

324 Q. And I want to spend some time just looking at those. It might be convenient just to take a short break now to break up the afternoon in a natural kind of way? 15:14

A. Yeah. Yeah.

CHAIR: Half past three then? 3:30.

15:14

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

325 Q. MR. WOLFE KC: Mrs. Burns, could I bring you to the triage issue, please, and if we start, maybe, by

looking at a series of e-mails that went between Mrs. Trouton, Mr. Brown and Mr. Young in November 2013, WIT-98423, and if we start at the bottom of the page, please, and Heather Trouton is writing to Messrs. Brown and Young and the issue here is missing triage. And she records that she has personally spoken to Mr. O'Brien about his practice on various occasions and Martina Corrigan has also much more often. And just to summarise this -- sorry, she goes on also to say that an IR1 has been lodged -- this is the second main paragraph there -- with regards to health records or charts which cannot be found. And Mr. O'Brien, in an earlier e-mail, has acknowledged that the service has been very patient with him. And just going down the page a little and she's saying that, in the last paragraph, that she needs a response within a week. She needs Messrs. Brown and Young to speak with him or she says she will be forced to escalate to you and Mr. Mackle, and it has already been suggested that Dr. Simpson -- that's the Medical Director -- be involved? 15:33 15:34 15:34 15:34

A. Yes.

326 Q. And she hasn't progressed that to date, but may have to come to that unless a sustainable solution can be found. So, just to pull some of those strands together, when we look at the charts issue a little later, or perhaps tomorrow, we will see that there was a suggestion that the Medical Director should be pulled into this issue -- into the charts issue. 15:35

A. Yes.
327 Q. -- not the triage issue.
A. No.
328 Q. And you have a view to express about the reluctance or the failure to do that, and we will maybe deal with that at that point. But if we scroll back up and see how the doctors respond, Mr. Young, who was the Clinical Lead, says: 15:35

"I understand, I will speak." 15:35

And then a sentiment that you referred to earlier on Mr. Brown's part, that:

"Aidan is an excellent surgeon and I'd be more than happy to be his patient, so I would prefer the approach to be how can we help." 15:36

So, this triage issue, is this -- has this crossed your desk with Mr. O'Brien? It's now November '13. You're in the post six or seven months. Has this issue been raised with you, to the best of your recollection, by this time? 15:36

A. So I'm just looking at this again. I've read this in my statement. No, I -- I took this to be connected to my request to escalate to John Simpson in November, about charts, so I'm just seeing now that they were also saying in detail there about what he hadn't triaged. So, no, I don't think I was aware of that. 15:36

In fact, I wasn't aware of that, and I didn't see these e-mails, so then I still wouldn't be aware of it. The big thing for triage for me was the red flags. The only one I could see that he wasn't doing in time was red flags because I could see it. I do see that that's 15:37
titled "Triage" -- I had connected that totally to the charts e-mail.

329 Q. Yes. And we can see that, as I outlined, that Mrs. Trouton, who has taken the lead on trying to get this sorted out, has referred both to the charts in her 15:37
e-mail, as well as the triage but it's the --

A. Yeah, it's the triage that she says there, and I haven't --

330 Q. Yeah.

A. -- that he hasn't done since August. 15:37

331 Q. Yes. And what lies behind the e-mail is a series of referrals that haven't been triaged, as you say, going back to August and we can see that the title to the e-mail is "Missing triage". So you become involved with Mr. O'Brien in the early months of the next year. 15:38
You meet with him on the 20th February, isn't that right?

A. Yes.

332 Q. Do you have any memory of how that transpired -- by that, I mean your involvement. How did you, somewhat 15:38
unusually I think you've said already, become involved in face-to-face with a senior clinician to address his non-compliance with an expectation of the service?

A. Yes, so through '13, I could see e-mails were sent to

me about the charts at home, and it was through '13 then and somewhere in November, maybe, I said "Yes, this is a governance issue anyway. John Simpson, you're not -- Robin and Eamon have repeatedly asked you to deal with this. It's not sole escalated to John." And then -- but the one I could see is I said to you through the performance metrics was the red flags that were a way out past 85 days. So that's where you could see definitely weren't achieving on actual potential cancers -- not even GP routines, but ones GPs had identified as actual potentials. And when we looked at the pathway then, it was the two delays in the pathway were the triage and he wasn't doing it. 15:39 15:39

333 Q. Could I just pause you there just to assist you?

A. Yes. 15:39

334 Q. I think you've referred earlier in your evidence -- we looked at the 2014 performance report that went to the Commissioner?

A. Yeah.

335 Q. But I think you said in that context that you were also aware through Mr. Carroll, who was to produce a report in March after you'd met with Mr. O'Brien, that you were aware of the key messages that were contained in that report? 15:39

A. That's right. 15:40

336 Q. -- by the time you spoke to Mr. O'Brien?

A. Yeah.

337 Q. And let me bring Mr. Carroll's report up for you.

A. Yeah.

338 Q. WIT -- sorry, WIT-98500. And this report -- let me see is there an earlier page to it. I think it date from March. Yes, it's an e-mail to you --

A. 5th March.

339 Q. -- and others of the 5th March. And what he is saying on the cover e-mail is that: 15:40

"Here is an attached paper drafted by the cancer team. This outlines Urology cancer performance against the daily 62 target. Solutions are proffered as if required around table discussion." 15:40

And if we just briefly glance at an aspect of the report as regards triage, if we go down two pages to 501 in the sequence to 98501 -- down one more page, please. Down one more page -- 15:41

CHAIR: Do you have the number at the top of the page?

340 Q. MR. WOLFE KC: WIT-98501. So this is Mr. Carroll's report dealing with triage and explaining that the target for red flags is 48 hours and he's setting out, just scrolling down and we see the whole picture, and he's saying that the turnaround time within the target period of 48 hours is a mere 40% in round figures. What was -- you explained to us earlier he didn't need to wait for this report in March to make you aware of that? 15:42 15:42

A. I think there's another e-mail. There's another e-mail from Wendy Clayton, which is -- I think it's earlier -- and that was in the performance weekly meetings that we

had. Wendy Clayton was -- she was a support lead for cancer.

341 Q. Yes. I suppose, really, what I'm really asking you is regardless of the source of the information, what was it that, if you like, caused you to -- 15:43

A. She brought forward -- I think in that e-mail, there was at least three patients or more that were named that were waiting, you know, a huge amount of time. And this came onto my desk and I said "Meet me in the morning, get me a plan for these patients" and "This 15:43 isn't working for us, this Urology cancer isn't working, these patients are waiting too long." And I think that was just before that, it might have been January, and then we would have, you know, talked about why that would be and then we needed evidence and this 15:43 is what came after. But we would have knew that then, presumably, they would have said "Here's the breakdown." There's another bit to the bottom of that have, which is getting your first appointment, but you're already too late. You know, we can't see you in 15:43 the time frame because you haven't been triaged. But she sent me an e-mail and it was --

342 Q. Yes, and I think you deal with that in your statement. I'm sorry I can't --

A. No, it's fine. It's just it really struck me because I 15:44 remember --

343 Q. Yes, if you go to your statement, just to help you with that, WIT-96917, and you say at paragraph 49.13 that you didn't receive any evidence of issues with triage

through performance reports, apart from the cancer 62-day pathway red flag triage issue, which was reported by Wendy Clayton, who was an OSL, in January '14, and was further analysed by Ronan Carroll in the report that I just brought you to. 15:44

A. Yeah.

344 Q. And so I think that's your explanation for wanting to sit down with, first of all, your team and then to sit down with Mr. O'Brien. You're explaining that delays on triage is impacting on compliance with the 62-day target, is that it in a nutshell? 15:45

A. Yes, but it's not working for the patients, yeah. I mean, they're waiting too long, yes.

345 Q. And you address the meeting with Mr. O'Brien in your statement and let's go to that then, if we go to WIT-96869. And at paragraph 1.8, you say of that meeting that you called the meeting with Mr. O'Brien and Martina Corrigan in order to address the concerns. 15:45

"At this meeting, it was agreed that Mr. O'Brien would cease triaging referrals, save for referrals which specifically named him. This was for governance reasons and the patient may already have been known to Mr. O'Brien or the GP believed him best placed to deal with the patient. It was my understanding this essentially solved the problem with delay of triage and specifically of red flag referrals being delayed in the 62-day pathway, as Mr. O'Brien was no longer undertaking this." 15:46

So, just in relation to that, all Consultant Urologists in this team were expected to do their share of triage. This was, by the way, just to put it in context, before they developed the Urologist of the Week -- 15:47

A. Yeah.

346 Q. -- technique or process. It was to come -- I'm not sure if we have got a precise date for it, but it's to come in October or November, later this year?

A. Yeah, yeah. But I -- 15:47

347 Q. But in terms of -- you are obviously the -- the buck stops with you, I suppose, in the operational world?

A. Yeah.

348 Q. You're sitting down with an operational problem. Did you think anything of the fact that in taking triage 15:47 off him, as you suggest here, that you were putting a burden on the rest of the team?

A. Yes, and I think I said that in my e-mail to them the next day, maybe, and I said that I knew that that would be a pressure on them. But, to be honest, it's back to 15:48 what we said -- you really try to make the guys peer -- peer pressure is the wrong word, but peer manage each other. And we tried that through 2013 and we tried it and tried it and tried it, and we tried with the charts and we kept going back to them and saying 15:48 "Look, you can't do this -- we'll get John Simpson." And it didn't change and then these patients are waiting too long, so then nobody is going to have that conversation, so it has to be me. And, yes, they are

going to have to deal with that, but they haven't addressed it with him so, you know, so that's the consequence. There is only that much resource and the patients come first and, ehm... I had something else to say there. Yeah, on that day, on that day, I think there's an e-mail --

349 Q. Yes, and I'm going to bring you to the --

A. Yeah.

350 Q. I'm going to bring you to a couple of strands of evidence that I would like your comments on -- 15:49

A. Sorry, yeah.

351 Q. If we go to the e-mail, first of all, then, it's the next day, 21st February --

A. Yes.

352 Q. -- and WIT-97544. And just down the page, please. So you are writing to Mr. Mackle, Mr. Young and Martina. You describe a very helpful meeting with Mr. O'Brien yesterday. You say: 15:49

"Mr. O'Brien has agreed to not triage new referrals with exception of those named to himself. He is also to think if any additional administrative support would assist him." 15:49

You say: 15:50

"Michael, I know this might place an additional burden on the rest of the team, but appreciate you accommodating.

Thanks with your help with this situation.
Debbie Burns."

And then just to get some of the replies, Michael Young writes back: 15:50

"Get Martina to talk to me on this."

And then you tell Martina to discuss this as soon as possible, put the needs in place as soon as possible. 15:50
And then Martina says she would do so and they've got a bit of time on their hands because Mr. O'Brien isn't back on call until the 15th March. So, a couple of issues that emerge out of that. You're saying that Mr. O'Brien has agreed not to triage? 15:50

A. Yes.

353 Q. Is that the right way of it? Are you telling him not to triage or does it not -- are we splitting hairs with that? Were you trying to put a positive glow around this or -- 15:51

A. I would probably say the out -- when I was going into that meeting, my outcome was Aidan can't triage any more, it's great if Aidan can agree with me that he's not going to triage any more and he obviously -- I don't remember that meeting in detail, but obviously 15:51 what transpired, we were able to say Aidan has agreed not to triage.

354 Q. Yes.

A. It's best if you can take them with you.

355 Q. Yes. Dr. Johnston spoke to you about this meeting and it may be helpful to give the Panel a clearer indication of the dynamics of it. If we go to WIT-98393 and down to the bottom of the page, please, this is the description that's recorded here -- you met with Aidan O'Brien's colourful language: 15:52

"Following discussions, DB indicated that AOB had had to stop triaging. This was at the time NICaN guidelines were issued, which AOB had done a lot of work for chairing for Urology. Used this as a covering excuse which AOB thanked her for, saving face." 15:52

Can you help to unpack that for us?

A. Yeah, I'm pretty sure, I'm pretty sure now -- I don't remember the exact details of this meeting, but the colourful language, the only time Aidan and I ever had an interaction with colourful language, which was his, was way before that when I was Patient Access Manager and it was right at the start of performance and he had a lot to say about how he felt waiting lists should be managed. And he was very vociferous that day and I -- so this meeting, no, this meeting was what I say. The outcome was -- I needed the outcome that he stop triaging. I talked to him about how busy he was with his NICaN work because he was the chair, I think, of the regional group. I talked to him about I understood that, but these things were falling behind -- so, look, if you want to do this, you can't do that because 15:52 15:53 15:53

you're not doing it -- and we reached an agreement. And at the end of the day, you don't want anybody going out thinking -- you know, he is a senior clinician, he has to go out on board with me.

356 Q. So, is it right to say to some extent that you massaged the situation in the sense of saying, "Listen, I understand that you are very busy in Area A -- 15:53

A. And he believed he was, yes.

357 Q. -- yes, "It's creating a pressure in my world --

A. Big time. 15:54

358 Q. -- with triage, and you will understand if I ask you to sit that responsibility out." Was there any sense from him that he was failing in his obligations to the Trust, or did it not come to that in terms of how you handled it? 15:54

A. I'm not sure. I don't know, is the answer. We -- yeah, I'm not sure.

359 Q. If we go over the page, please.

A. I am not big into failure. If you are going to work with me and you do the solution that I need, that's probably okay. There's no point in humiliating you, I don't think. So I probably took the approach that I've got what I needed, the patient is going to be safer and I have offered him more help if he needs it because he says he is very busy, and we will go from there. 15:55 15:55

360 Q. Yes. So the meeting delivered the solution --

A. Delivered the solution that we needed.

361 Q. -- that you wanted?

A. Yeah.
362 Q. And just so that we don't have jump back to this note, it contains a number of other strands that emerge chronologically as we work through this issue and just it's helpful, now that we are on the page. You make the point to Dr. Johnston that, when you left the post, your post in August 2015, you were under the impression that Mr. O'Brien had not returned to triage, that your arrangement agreed in February '14 at the meeting still held? 15:55 15:56
A. Absolutely. I had never reversed that, no.
363 Q. Yes, and when you say "reversed" it, it almost sounds like you were laying down a rule of practice which was to govern the Urology team: "Mr. O'Brien, under no circumstances, triaged, except the personal triages that are coming to him, and if you want to depart from that, you speak to me"? 15:56
A. Probably didn't say that, but that would have been my thinking. You don't -- that's it, when the decision is made, the decision is made, and that's the way it goes forward, and I guess you'll probably come to them, but there's a couple of e-mails over -- 15:56
364 Q. I will.
A. -- the next while that I say, "what's this?" And somebody says, "no, he is not triaging". 15:57
365 Q. Yes. So that was the understanding of --
A. Reasonable reassurance, I guess, if I --
366 Q. Yes.
A. And there was no sign in the performance, there was no

sign in the cancer performance that we were drifting again.

367 Q. Yes.

A. We were good on the 85 days.

368 Q. Okay. And then this is, I suppose, again setting some of the themes that I have to explore with you down on paper. 15:57

A. Yeah.

369 Q. You are not aware of the IDP, and I know you don't like that abbreviation, that stands for informal -- I think it should be IDT, Informal Default Triage? 15:57

A. Yeah.

370 Q. And that's your position: you weren't aware of this IDT, and we will explain what that concept means through your evidence, so you weren't aware of it? 15:57

A. No.

371 Q. And you explain that you thought, now that you know what was going on with regards to IDT, you found it completely ridiculous because it would allow a cancer patient, who should have been red-flagged by the general practitioner, to go unchallenged by a consultant triage process, and you go on to discuss why Aidan O'Brien didn't triage, his inability, why did he not do it, and you have expressed your view as, at least as recorded here, as "eccentric, disorganised", that's a reference to Mr. O'Brien, and what was the basis for those adjectives? Was that your experience of the triage thing, the patient charts thing? Was it just -- 15:58 15:58

A. That was his style of practice. So, I mean, I had known Aidan since 2007 -- oh, no, wait, the previous -- when I was with Craigavon Trust, he was there, and, you know, these guys are just people, they have all different styles, same as we have different styles, and his style was very much his own style, he was looking in, I would have said he was disorganised, he didn't want any help, he didn't people to do stuff for him, he wrote in his own longhand, he wrote with fountain pen, he worked his hours at strange times of the day, he didn't work the same hours that most people work, he just had a strange style, but that's not -- that's just an individual style. 15:59 15:59

372 Q. Mm-hmm. And just to be clear, this broader description that you are offering Dr. Johnston, is in the context of a question asked in relation to triage? 16:00

A. Yeah, I know, I know, so probably it didn't answer his question.

373 Q. Did your concerns go beyond that?

A. Around his style, no. 16:00

374 Q. In terms of his style impacting on a requirement of practice, was it limited to triage? And obviously we will hear about patient charts.

A. The two things that I know about are triage and patient charts. 16:00

375 Q. Yes.

A. I never had any reports -- I never had -- as far as I remember, I don't have -- I didn't have any patient complaints or family complaints about Aidan and his

practice. Any patients spoke very warmly of him, everyone said that. His fellow clinicians, as we saw, spoke very warmly of him. I didn't have any concerns about his clinical practice, his administrative, and I know that impacts on his clinic, and I get it, but I suppose we were looking at charts and triage and we assumed we fixed triage.

376 Q. And just so that we finish this note and not have to go back through it, and you are asked a question: 16:01

"What is the evidence that the problem was referred to higher authority?"

And Dr. Johnston has recorded: 16:01

"John Simpson, MD at the time; Mairéad McAlinden, CEO; and Roberta Brownlee, Chairperson of the Board."

And then there's some elaboration on that: 16:02

"JS, not good relationship with the acute [inaudible] consultants."

He "cannot remember if JS was made aware of the problem." 16:02

You consider "the issue dealt with when Aidan O'Brien was taken off triage, no need to refer upwards. There were also other issues concerning Aidan O'Brien which

were being dealt with."

Can you help us with that, the suggestion, because it's in line with the answer, is that the three persons named were the higher authority to whom these issues or this issue was raised, but your answer then goes on to suggest that you are not at all sure if Mr. Simpson was aware of the problem, so do you see a problem in that note or do you have a recollection of what you said? 16:02

A. No, is the answer, but I don't -- I'm not sure why the names are at the start just listed and then not related, and I wouldn't have escalated the triage issue because I just said -- and I agreed with him, he wasn't triaging, so I can see why I would have said that, I don't need to refer because I have just -- we just stopped that, but I don't know why those names were there, no, sorry. 16:03

377 Q. Yes. For the avoidance of doubt, can you, for example, remember referring the issue to Mrs. Brownlee?

A. Definitely not, no, I can't remember it. I would be really doubtful and I wouldn't have -- why would I? 16:03

378 Q. And I think just finally for this note, you are asked about handing over the triage issue with Mrs. Gishkori, and you say "no", you considered "the issue dealt with so no need to hand that issue over to her". 16:04

A. No.

379 Q. Is that correct?

A. Yes, individual consultant 1 in 200 wouldn't have handed that over.

380 Q. And then I thought that was the end of the note. There's another piece going back to 2007.

A. Yeah.

381 Q. And you had an awareness of when, in a previous post in the Craigavon Hospital, you found a waiting list that was ten years long and you worked on this with Mr. O'Brien and cleaned it up and you found no serious issues? 16:04

A. That's not correct because that was that patient -- Outpatient access role in the old Trust, so that's not correct, because -- and that's -- really, it's to the colourful language, and we did -- there was only Michael and Aidan at that time, and that was before the bigger Trust, and there was a ten-year wait for Urology inpatients and we brought a team from Australia, a surgical team, and we set them up for a couple of months in south Tyrone and they addressed that ten-year waiting list. 16:04 16:05

382 Q. Yes. So, in terms of the quality of this note, there are some aspects of it you can -- 16:05

A. It's not great --

383 Q. If you just wait for the question. Some aspects of it you can say, while I don't have an independent memory of that meeting, that sounds right, but others -- other aspects of it jar with you, is that fair? 16:05

A. Yes.

384 Q. And just going back to what you said in the e-mail after the meeting with Mr. O'Brien, you make the point, and you have made it in your witness statement as well,

that, during the meeting with him, you offered him additional administrative support, or at least the possibility of talking about additional administrative support. Did he ever come back to you on that, to the best of your recollection? 16:06

A. I can't remember. I couldn't find anything, but I don't remember, so, honestly I don't know, but I don't think -- I don't think he did because I don't think we put anything in, but I'm not sure.

385 Q. Mm-hmm. And does the suggestion around that, as fairly contained in your contemporaneous e-mail, suggest that you got into discussion with him about other issues, quite apart from triage? In, maybe tomorrow, as it looks likely, we will looks at the charts issue, and I know that on the very day of the meeting Mr. Mackle sent you correspondence or forwarded you correspondence in relation to the charts issue? 16:06 16:07

A. Yes.

386 Q. So was this likely to have been a meeting that went beyond the triage and went into other, for example, issues that he was facing in the administrative sphere? 16:07

A. I think so, yes, definitely.

387 Q. And can you help us at all in terms of how he - that is Mr. O'Brien - was expressing himself or explaining himself in terms of administrative difficulties? 16:07

A. Well, I can in terms of when I read other people's, and his, statement, his witness statement of what he says about the pressures he had, he would have said yes, he had a lot on, the NICaN was very onerous, he spent

a lot of time prepping patients, all those things were known; you know, like, we would have known that he over-prepped for MDMs or he took a long time to do it, he was very meticulous in the NICaN stuff, so anything that was going to help him with his administrative load as opposed to, I could do that, I could help him with that. 16:08

388 Q. Yes. And as appears from your statement, and I think we have said it already, you believe that what emerged from that meeting was the rule going forward -- 16:08

A. Yeah.

389 Q. -- and earlier you referred to an e-mail that you received from Mrs. Corrigan, and if we can bring that up on the screen, please, WIT-98395. So just down below that, please. And Paula Clarke, if we can go to that, is writing to you on 26th March 2015, and she is in the role of Deputy Chief Executive for the Trust at that time. So this is roughly a year after you've met with Mr. O'Brien to direct, or with his agreement, no further triage.

A. Yeah.

390 Q. We know that Urologist of the Week has been introduced, roughly six months before you receive this series of correspondence?

A. Yeah.

391 Q. And we know, the Inquiry knows, that Mr. Young had stopped -- he had stepped in do the triage, pursuant to your intervention in February '14, but had stopped at some point in the autumn, so it's with those factors in

mind that we read this correspondence.

"Ms. Clarke was writing regarding a reference from a general practitioner today regarding a referral to Urology in December that the general practitioner chased up this week, to be advised this was still waiting for creating by Dr. O'Brien. It's left with the secretary to come back to him, but clearly this is not in line with our triage process time lines so can you follow up it, please."

So it's being indicated here that, as regards Dr. O'Brien, Mr. O'Brien, there are triage expectations resting with him that he's not compliant with. You forward this e-mail to Martina Corrigan, isn't that right? 16:11

A. Yes.

392 Q. If we scroll up, please. And you ask her for an update if the issue is resolved, and she writes to you on 29th March: 16:11

"I will look into this as Aidan hasn't been triaging and I have been advised that he was up to date. It may be a GP letter that he has been sent direct and I will check with the secretary tomorrow and let you know." 16:11

So, how did you interpret that e-mail?

A. So, I read that as Aidan is not triaging. Now, the "up to date" bit I probably should have said to myself,

well, up to date with what, but then she goes on to say a GP letter that was sent to him direct, so that could be a named one that he was still allowed to triage, but she thinks he was up to date with that, but she will check with the secretary, but my -- you know, looking at that at face value, I thought that's okay, he is not triaging, except named. 16:12

393 Q. And could I ask you about this: The development of the Urologist of the Week model --

A. Yeah, yeah. 16:12

394 Q. -- the Inquiry's understanding of that is that, for that week, all of the referrals coming into the Trust to be triaged, whether red-flagged, urgent or routine --

A. Yeah. 16:12

395 Q. -- sat with that Urologist of the Week, whoever it might be in that team, with the rest of the team getting on with the business of elective work and review clinics and what have you?

A. Yes. 16:13

396 Q. The Urologist of the Week was hived away from that activity?

A. Yes.

397 Q. That was a new way of working within Urology?

A. That's right. 16:13

398 Q. Which, as you indicated earlier, was an advantage, spun out of the increase in Consultant resource. Did you not know that that had happened?

A. I knew Surgeon of the Week had happened. If you go

back to the -- here is where I got confused when I was looking at the evidence. If you go back to the -- when I say in February '14 not to triage and Martina writes back it's okay, we have some time, he is not on call until the, whatever it is -- 16:13

399 Q. Yes.

A. -- I thought that that was Surgeon of the Week, but they must -- I don't know, I'm just piecing this together, but they must have been triaging normally when they were doing their week on call, not Surgeon of 16:14 the Week but their nights on call, I assume from that. So she didn't have to worry about taking him off triage if he was next on call, which was whatever date that was in March. Presumably, although I didn't get involved in the detail of the Surgeon of the Week, I 16:14 didn't know they were triaging on Surgeon of the Week, but I just assumed he still wasn't triaging, why would he go back to triaging?

400 Q. We know, of course, that Patient 10's case, this was -- I don't expect you to know the name, but of course we 16:14 will not mention it, her case became the index SAI for the purposes of looking at the triage issues and then there were, as we looked at, by Dr. Johnston's interviewing you, there was to be a further five patients contained within his SAI? 16:15

A. Yeah, mm-hmm.

401 Q. I suppose, the point I am making to you is that Patient 10's SAI spun out of a failure on the part of Mr. O'Brien to triage her case I think I'm right in

saying in October 2014?

A. That's right.

402 Q. So there's no doubt that --

A. No --

403 Q. -- there was an expectation on him to triage from the commencement of the UOW, Urologist of the Week, model; you didn't know that? 16:15

A. So, that SAI, it wasn't picked up until --

404 Q. It wasn't picked up until --

A. 26 -- 16:15

405 Q. January 2016, when Mr. --

A. So I read that SAI and, if you read that SAI, they say that he was triaging. They knew how many letters they had got into the booking centre in October '14. They knew there was eight. They knew he had triaged. They knew they didn't get eight back and they followed up with him. And I never knew that he was back on triage. He shouldn't have been. 16:16

406 Q. Yes. And what does that say about the state of governance and/or communication within Urology at that time if your understanding of the rules were "He shouldn't be triaging, my team should know he shouldn't be triaging" and yet Mr. Young had stopped assisting him and he took his place on the Urologist of the Week roster and expected to triage like everybody else? 16:16 16:17

A. So I think I read in the -- I got the MHPS, Dr. Chada's report quite recently there, and I read it, and I think is it in Heather Trouton's witness statement she says that the rest of the team, the Urology team, were not

prepared to triage for him any more. I think that's what it says.

407 Q. Okay.

A. And I'm pretty sure that's what it says. And I didn't know that. Nobody -- none of his colleagues, none of -- the Clinical Director, nobody came forward and said, "Do you know the way we agreed this with that team, they're not doing that any more?". So I wasn't going to know that then. But when I read back, they knew -- nearly everybody else knew. 16:17

408 Q. Yes. And what appears to have emerged from that development that he was now expected to triage was that red flags were done -- it would appear not always on time, but in a reasonably satisfactory way, but that routine and urgent referrals -- 16:18

A. Yeah.

409 Q. -- weren't done and that led, it would appear, to the service looking at how best to address that or how to address that in order to ensure that patients went onto a waiting list, and that's the default procedure that we're going to look at. I fear, Chair, with the best will in the world, we will probably be pushing beyond five o'clock and -- 16:18

CHAIR: Ms. Burns, I think you've had a long enough day. 16:19

A. Yeah, I will come back, if that's all right.

CHAIR: Yes, we'll come back tomorrow morning. Is ten o'clock okay?

A. Yes.

CHAIR: We'll see you then again at ten in the morning.

MR. WOLFE KC: Hopefully, we will get finished quite promptly tomorrow.

THE INQUIRY WAS THEN ADJOURNED TO WEDNESDAY, 28TH JUNE 2023 AT 10:00A.M. 16:19