Urology Services Inquiry

Oral Hearing

Day 56 – Wednesday, 28th 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 WEDNESDAY, 28TH JUNE 2023 AS FOLLOWS:

CHAIR: Good morning, everyone. Morning, Mrs. Burns.

MR. WOLFE KC: Morning, Chair. Morning, members of the Panel. Good morning, Mrs. Burns. 10:05

MRS. DEBORAH BURNS CONTINUED TO BE QUESTIONED BY MR. WOLFE KC, AS FOLLOWS:

10:05

1 Q. MR. WOLFE KC: We concluded yesterday by looking at the circumstances and the reasons for taking Mr. O'Brien out of a requirement to triage, save for referrals that were intended directly for him. That decision was reached in February 2014 and it was your understanding 10:05 that that decision continued to hold and be applied all the way through until you left the building, I suppose, in August 2015, subject to an e-mail you received in August of 2015, which we'll look at presently. And I just wanted to take you to Mr. O'Brien's understanding 10:06 of what had happened in terms of his interaction with you around that issue and invite your comments. It's his witness statement to this Inquiry at WIT-82605 and if we could start at paragraph 610, please, and he's talking about you being replaced by -- sorry, you 10:06 replacing Dr. Wright and having a number of informal meetings during this time. And just if I can pick up then where he says you were appreciative that these roles, that is the roles of Lead Clinician at NICaN,

Chair of the MDT and MDM:

"...consumed more time than the total allocated for administration in proposed job plans. Mrs. Burns was keen that I would be successful in having a Trust MDT and MDM meet approval at National Peer Review in June 2015. He was also keen to ensure that we can implement the Trust plan arising from the regional view of Adult Urology Services. He was appreciative of the additional contribution that my colleague, Mr. Young, and I had made since providing Outpatient clinics at Southwest Acute since January 2013 and it was in this context that she appreciated that it was not possible for me to additionally complete the triage of all referrals directed to me. She arranged for Mr. Young to undertake the triage of those referrals. Mr. Young generously agreed. So far as I can recall, he continued to do so from early 2014 and for a period of six months or more." 10:07 10:07 10:08 10:08

So, he's indicating that that arrangement lasted for perhaps a little over six months, and that seems to be the evidence, the state of the evidence before this Inquiry and that comes as something of a surprise to you in a sense that you didn't know about that in real time. 10:08

The points he makes about the reasons for coming out of triage and they were essentially -- he's essentially

saying you recognised that his other work was pressurised and didn't allow him the space to triage. We see in the note of Julian Johnston's meeting with you yesterday something of a sense of that, albeit it came with the descriptor "to save face" or words to that effect. I want to ask you whether your reason for taking Mr. O'Brien out of triage was based on an assessment that his workload was, in fact, too heavy, or, in the alternative, did you not assess that in any great detail? You had a problem. Patients were not being triaged. Mr. O'Brien should have been doing the triage, but he wasn't, regardless of his workload, and you just wanted it solved. So, the choice in the question is: Was his workload too much, in your view, or was he, for whatever reason, in your mind not doing triage, it was creating a problem, and it just needed resolved? 10:09 10:10 10:10

A. So, I think, like I said yesterday, he wasn't doing triage. That wasn't --

2 Q. I should say wasn't doing it quickly enough? 10:10

A. Quickly enough, yes. Sorry, he wasn't doing it quickly enough. The patients were, therefore, suffering on that, in that specialty on that red flag, and we could -- that was one aspect that we could address, so that needed addressed. Previous attempts by his colleagues to address it hadn't worked, so it was up to me to address it. 10:10

In terms of how I addressed that, I have the greatest

respect for the consultant body. I've worked with them for many years. They all work extremely hard and their work is significant and they take decisions every day in terms of people's care and treatment. So, people I work with in health, I have a great respect for, so I was not going to humiliate Mr. O'Brien by saying, you know, "You just can't -- you're not performing this." So, we talked over how busy he was with other things, what he was committed to. In my view, everyone else, in the main -- although we have an episode of ophthalmology not triaging either -- in the main, everyone else was keeping up. So, was he too -- too busy -- no, I would have said not. Did I want to absolutely push that home to him? No, I just needed the outcome that he wasn't going to triage, and to try and get him to continue to work with us 10:11 10:11 10:12

3 Q. Thank you. That's clear. You mention pharmacy -- sorry, opht --

A. Ophthalmology, yes!

4 Q. Yes, it's a word I can never quite say from a young age! "Ophthalmics" is easier for me. You mention that ophthalmics had a problem with triage? 10:12

A. Yeah.

5 Q. And I want to explore with you now how the system of the default triage, as it's been called, and I understand from you that's a troublesome descriptor and we'll look at the IEAP and you can explain why you think the term "default" in this context is somewhat troubling. But I think your primary position is that 10:13

what the Inquiry understands as having happened, in circumstances where triage isn't being done in Urology, a practice grew up whereby patients were placed on a waiting list in accordance with the general practitioner or the referrer's classification and we understand - and this is routine emergence, not red flag - we understand that, in the main, those referrals were not followed up. In other words, the triager - and here we can say Mr. O'Brien, largely - was not then pushed to do the triage and, so, the referrals sat. You knew nothing about that? 10:13 10:14

A. No, but I don't agree with just how you've described it there because I think some of the evidence shows that the process, the reminder to triage and the process for triaging, which is commonly known as the default, which came out from Anita Carroll, was my understanding from reading the evidence is that - and her e-mails - is that was applied to all specialties. So there's no mention of that. And, anyway, as you say, when you read her flow chart, it is just implementing IEAP anyway for slow triage, however. So, first of all, I think it was for all specialties, from what I can see. Secondly, in the SAI that you talked about yesterday, the one that was the lady was referred in October '14, in that SAI there actually is evidence of tracking of triage and that it didn't come back on two subsequent follow-up e-mails to different people to get it back. So, I think some efforts may have been being made to get referrals back, but not in line with the flow chart 10:14 10:15 10:15

that was produced in February.

6 Q. Okay. The primary point of the question, I think, and thank you for clarifying what you think was going on in some of the cases --

A. Yeah. 10:16

7 Q. The primary question was in terms of not following up on --

A. Yes.

8 Q. -- urology referrals that hadn't been triaged as part of the process, or the omission to follow them up, that 10:16 aspect was unknown to you?

A. Unknown to me.

9 Q. Yes. And let me just take you through the ophthalmics issue, first of all, and we can see where that sits in in terms of your understanding of what was going on in 10:16 Urology.

So, if we go to WIT-98402 and, on 13th February, if we go to the bottom of the page, please -- well, the 12th February. So you're being copied into an e-mail. It 10:17 just happens to be the week before you're speaking to Mr. O'Brien about taking him off triage. So there's various e-mails around this ophthalmics issue and this is a convenient place to start. So there's obviously conversations going on about a problem within 10:17 ophthalmics and you're being told about it:

"Catherine is going to run an indepth report. There are 238 patients currently not triaged, of which 153

are over two weeks and 85 are waiting less than two weeks. The longest waiter for triage is 20 weeks."

And just scroll up, please. This is really of, I suppose -- the substance of it is not terribly important for the Inquiry; it's the fact that where it is to lead to that becomes important. So you say this must be escalated to Belfast as soon as possible. Can you help us a little bit, just having said that it's not terribly important -- 10:18

A. Yeah.

10 Q. But, in essence, what's going on here, can you remember, with ophthalmics?

A. Ophthalmology was what we would have called a visiting service, so, it was -- we had possibly, maybe, one or two, or maybe not, ophthalmologists employed by the Trust, but it was a visiting service provided by Belfast, but it was a full service so we did day surgery as well. And so that's why I would have said immediately escalate to Belfast, because that clinical management line, you know, equivalent to CD/MD/Lead Clinician would have been in Belfast. So, it was immediate to get why they aren't triaging -- why is somebody waiting 20 weeks not triaged and what are we going to do about it? So, that was the basis of that. 10:18 10:19 10:19

11 Q. Okay. And so there's this -- these e-mails are essentially "Let's get the facts straight, let's run a report --

A. See where we are first.

12 Q. -- let's establish what's going on."
A. Yeah.
13 Q. A couple of days later, we get to a description of a process that needs to be, if you like, implemented so that the waiting list problem around these patients is cured. 10:19

So, if we go to WIT-98404 and Anita Carroll is writing to a number of people. You're one of the recipients of this e-mail. I understand you're on leave that day. 10:20
A. That's right.
14 Q. -- and for a couple of days after that. And what she's saying is -- and, again, this is in the context of the ophthalmics issue, is that your understanding?
A. That is definitely my understanding. When you read the range of e-mails about ophthalmology, you can see that people were quite surprised that we had this 283 backlog and it came as a bit of a we mightn't have our eye on that ball thing. And I actually think there's an e-mail before that from, maybe, the 15th from Anita to someone else - to Heather, maybe - about, you know, "Here's what we originally reminded clinicians about triage, but in light of our discussions maybe we should amend that" and then she goes on in this one: 10:20 10:20

"I attach a draft process. I suggested to Heather that we should move to the position of accepting the GP categorisation on referrals. If these have not been returned..." 10:21

-- so I think what they were trying to do there is devise a system to make the triage times much more visible.

15 Q. And if we scroll down the page then, this is the process. Now, the referral is received into the Booking Centre, sent to the consultant and I understand the IEAP time limit is -- is it 72 hours? 10:21

A. Yes.

16 Q. But, here, this process is saying if the patient hasn't been -- sorry, if the patient has been triaged within a week, then obviously you appoint. But what happens in circumstances where triage hasn't happened? And this is a process of escalation here. So, if the answer is "No", we follow the right-hand pathway and it goes to the secretary to remind the consultant, etc., and then it goes back to the service administrator if it's still "No". And then if the service administrator has received a response within a week, it's an appoint. But, if not, it goes up the line to the OSL. If the patient has been triaged within four weeks - again, appoint - and, if not, it goes up the line to the RBC supervisor and the service administrator, etc. 10:22 10:22 10:23

So, at what point, if at all, does this system deal with the situation where the answer remains "No"? Does the patient make it on to a waiting list? 10:23

A. So, when the -- it doesn't -- it hasn't said there "appoint". But did it go -- up at the top, did it say

appoint to if no -- no, it doesn't say "If they're not appointed, appoint a GP." But the IEAP advises that. So the 2008 guidance from the Department advises that. I think the bottom box is important because it is the confirmation of the IEAP which is -- the very bottom box is Katherine Robinson is the Booking Centre Manager and Head of Service; and the Assistant Director, it goes to the Assistant Director as well, so that's obviously an escalation for an assistant director to take an action, their functional services. 10:24

17 Q. Yes, if we can take a look at the IEAP -- it was a protocol introduced in 2008?

A. '08.

18 Q. TRU-00840. [Short pause] So, that's what I call the Executive Summary then of it, and let me bring you to the process for dealing with referrals. So if we go down five pages to 00845 and this is the management of Outpatient services and I think the points that are of interest are 3.4 and 3.5. So: 10:26 10:27

"All referrals should be received at HRO and registered within one working day of receipt, enabled to be tracked through the system. GP priority must be recorded at registration. All outpatient referrals will be prioritised and returned to the HRO within three working days." 10:27

So that sentence is a description of triage.

A. Yeah.

19 Q. "Following prioritisation, referrals must be actioned on and pass an appropriate correspondence issued to patients within a working day."

10:27

3.5 then:

"Where clinics take place, referrals can be viewed less frequently than weekly. A process must be put in place and agreed with clinicians whereby GP prioritisation is 10:28 accepted in order to proceed with booking urgent patients."

So, that's the important point. If triage is delayed for any reason, go ahead and accept the GP 10:28 prioritisation in order to book the patient.

A. I think there's another bit in it --

20 Q. Okay.

A. It's either an appendix or there's another bit where it actually describes maybe a bit more about delay in 10:28 triage. I could be wrong, I could be making that up, but I think not. Does anybody...

21 Q. I'm not sure.

A. Maybe further on does it discuss it with delay or -- there is another part which -- I mean, it's basically 10:29 saying the same thing, but it's saying that in a nine -- this was developed when the Department was aiming for a nine-week outpatient booking. You have to give three weeks' notice to a patient for a reasonable

offer. And, so, that brings you to six. And then you're back up against it because you're booking six weeks in advance for your clinic leave. So, that was why and we were working at around about the 14, we were working to 15 weeks. So the actual waiting time was short and you didn't have much time to book the three-week appointment in advance, so you had to go ahead and book. 10:29

22 Q. Yes. And maybe this isn't --

A. I think there's another point. 10:29

23 Q. -- we can maybe try and find that.

A. Yeah.

24 Q. I think we all understand what the protocol -- I think maybe this isn't quite the text that you had in mind. But the point of the -- the avenue the protocol allows Trusts to go down is where the referral comes in and triage or "prioritisation" is the word used here -- 10:30

A. Yes.

25 Q. -- doesn't take place within the expected timeframe, it is nevertheless important to allow the patient to find his or her way into the system to get on board for treatment purposes. And, so, you can, in that circumstance, use the GP categorisation; is that your understanding? 10:30

A. That's my understanding, but that will prove an issue if your waiting time goes out for all waiting lists. So, if you're urgent and you're routine and everything goes out, then your patient will still be on the waiting list, but they could be on the wrong waiting 10:31

list, which I think then occurred. But when we were working to a short waiting time, you needed this because you had to book three weeks ahead and six weeks in advance of the clinic. So you had to do this.

26 Q. Yes. And in circumstances where you have this elongated waiting list, it becomes extremely important to get the triage -- 10:31

A. Exactly.

27 Q. -- done?

A. And back. Even though your patient -- it's delayed, even though your triage is delayed, it still needs to be chased and come back because it could alter which waiting list your patient is waiting on, which would then alter their time. But at least at the time when you're waiting to get it back, it's placed. But you have to chase, like it said in their process. 10:31 10:32

28 Q. Yes. And, as we know, in the referrals that went to Mr. O'Brien, the problem, as the MHPS investigation discovered, was the absence of the chase. Now, you have quibbled with that somewhat and you pointed to Patient 10's case and said, well, there is evidence that there was some follow-up to try and get the triage back in that case, and I don't argue with you on that. But as we can see -- 10:32

A. Not enough. 10:32

29 Q. -- not enough. It didn't come back?

A. No. It didn't follow their process. It didn't follow the flow chart. It didn't escalate or it didn't say it escalated to the Assistant Director.

30 Q. Yes. Just before we move on to what your understanding of that was and whether you had an understanding that that was what was happening in Urology, I want to take you back to an e-mail you wish to draw our attention to. It was issued in September 2013 -- 10:33

A. Yeah.

31 Q. And it's TRU-278624. Just to orientate the Panel, we started this sequence by looking at the problem in ophthalmics around 13th February or so, and, at that time, Anita Carroll is writing to you to say this had been the earlier version -- 10:33

A. Yeah.

32 Q.

"...but in light of discussion, I will amend."

10:34

So, she's referring to the e-mail below on 13th September when it appears that a general message is sent out, perhaps acknowledging broader triage issues. It may not have been an ophthalmic issue at that point, but there's a general concern to ensure that triage is being managed appropriately. So, this comes out across management. I think your name is -- 10:34

A. It is, and it goes to clinicians as well, it goes to AMDs.

33 Q. Yeah. So maybe we should have taken it in that order. What was happening in September and how did it connect in to February? 10:34

A. I don't know.

34 Q. Okay.

A. I've no recollection and I couldn't find anything. So, I'm not sure, to be honest. However, when she writes back and says to Heather on 13th February and says -- this is after discussion -- "maybe we should amend this", I guess that's when 17th February came out. 10:35

35 Q. Yes. Okay. So, I've described the problem in urology?

A. Yeah.

36 Q. Mr. O'Brien is Urologist of the Week, or he takes his turn to be Urologist of the Week at various points after the autumn of 2014. One of the responsibilities 10:35 of that role is to triage. He triages the red flags. The urgents and routine cannot be done, in his view. That is known to the Booking Centre and while, for the sake of argument, there might have been some chase on that, ultimately, the service was left with a 10:36 significant number of urgent and routine referrals un-triaged. So, that was the issue which was explored as part of the MHPS investigation. And if I can turn to that now, if we go to TRU-00675 and the penultimate paragraph, bottom of the page, please. So, Dr. Chada 10:37 writes that:

"During the course of the investigation, it became clear that a number of people within the Trust were aware of problems in respect of Mr. O'Brien's adherence 10:37 to the triage process. The Referral & Booking Centre were not receiving referrals back within the agreed targets from Mr. O'Brien when he was Consultant of the Week. In order to manage this, a decision was taken

during 2015 to introduce a default process whereby all patients were placed on the waiting list according to the GP categorisation of urgency, if the referral was not received back from the consultant urologist. This default process was adopted and agreed by the Director of Acute Services at the time, Ms. Debbie Burns, and number of other senior Trust staff, according to some witness interviewed. The rationale for this decision was to put in place a safety net to ensure patients were added to the waiting list. The reasons underpinning this decision will be dealt with later in the report." 10:37 10:38

And if I can go on just for completeness:

"As a consequence of the concern identified in respect of Patient 10 and the subsequent investigation referred to in Section 2, a lookback was undertaken to determine if there were any other un-triaged referrals that same week. It was discovered that there were others un-triaged and this, in turn, led to a review of all referrals. A large number of un-triaged referrals were subsequently located in an office drawer in Mr. O'Brien's office by Mrs. Martina Corrigan." 10:38 10:39

Then, over the page, the figure put on that is:

"In total, it was found that there were 783 un-triaged referrals dating back to June 2015."

So, I suppose the charge there, Mrs. Burns, is that you not only knew of this, but had approved of that as a process. And we can see within the report and the appended statements that Martina Corrigan, Anita Carroll, Katherine Robinson, Eamon Mackle and Heather Trouton all speak to you having -- the descriptions may vary to some extent, but they all speak to you having at least a knowledge, if not an approving hand in the development of this approach to meet the mystery of triage not being done. 10:39 10:40

First of all, were you asked to speak to Dr. Chada as part of this investigation?

A. No. I had left the Trust at that time. I guess the other thing to say is, Dr. Chada saying there it's 2015 -- if we're referring to the February, 17th February 2014 process, that was obviously 2014. If that's what she's referring to. It's not clear what she's referring to because it continues to chase the triage. I've read everybody's witness statement. As you say, they all vary a little bit. I think possibly in her interview with Julian Johnston, Martina Corrigan stated that it was developed between her and maybe possibly Anita and Katherine in a room by themselves. 10:40 10:40 10:41

37 Q. Would you like me to take you -- maybe it would be helpful to go to that?

A. It's just to demonstrate that -- I think everybody's recollection may be different but --

38 Q. Let me take you to that, in fairness to the point you wish to make. It's WIT-98395 and it would appear that, like you, Dr. Johnston interviewed a number of witnesses or a number of personnel, perhaps, is the best way to put it -- 10:41

A. Yes.

39 Q. -- for the purposes of his SAI investigation?

A. Yes.

40 Q. This isn't what I wanted to bring you to. Just scroll up to see the page number again... Yes, sorry, if we 10:42 can go to WIT-98517? That's it. So he's interviewing Martina Corrigan. Sorry, he's interviewing Martina Corrigan with Trudy Reid present. Can you just scroll through to the next page? There's a background set out in terms of the triage issue and down to where 10:42 it's highlighted in yellow, I think -- yes. So, if I can pick up just before that on what Dr. Johnston has recorded, I think you would say that, if he's got it right, Mrs. Corrigan has got it wrong?

A. Yeah. 10:43

41 Q.

"During Mrs. Burns' time as Interim Director of Acute Services, the un-triaged letters built up again. Mrs. Burns met with Mr. O'Brien and Martina Corrigan and very firmly told him to triage." 10:43

We've seen your e-mail of 21st February essentially excusing Mr. O'Brien from triage --

A. Yeah.

42 Q. -- and putting it in the hands of Mr. Young to sort out?
A. Yeah.
43 Q. And Mr. Young took it on. So, highlighted in yellow, Dr. Johnston picks up on the point: 10:43

"According to the Debbie Burns interview, she told Mr. O'Brien to stop triaging."

It would appear, on the face of that note, that 10:43
Mrs. Corrigan was inaccurate in rehearsing the history of February 2014. But it's the next point, I think, you wanted to make:

"Mrs. Carroll, Mrs. Robinson and Martina Corrigan met. 10:44
Mrs. Carroll considered what are we going to do - if Mr. O'Brien is not triaging patients, then they were not going on to any waiting list, urgent/routine. They were the only people in the room. While the process of putting people on the waiting list without triage meant 10:44
that people did not get missed, which was good to be on a list, it meant that there was no way of picking up who was triaged or what was the extent of the non-triage."

10:44

So, you're pointing to this note --
A. This is one example of others where there seems to be some confusion about the process, who devised it and when it was devised. There is another note from Anita

O'Brien -- or, sorry, Anita Carroll. I think it's in her witness statement or it's in Dr. Chadah's report where she confirms that Anita Carroll confirmed the process in I think it was November 2015. So unless there was a second process, I'm unaware. The point there at the end of that which says there was no way the triage -- or the extent of the non-triage -- that's not correct because the process, you can monitor the triage and whether you get it back or not and there was people assigned to do that and to escalate. So, everybody's recollection seems different. 10:45 10:45

44 Q. Yes. So what you take from this note, as I understand your position, is that here is Mrs. Corrigan explaining how she and two others, Mrs. Carroll and Mrs. Robinson, got together -- they were the only people in the room -- and grappled with "What are we going to do with Mr. O'Brien's non-triage?", and you would say that that suggests that they came up with -- 10:45

A. I'm not sure because I wonder is that a later process in November? Yes, it's either they came up with it or it's another process that they devised later when they knew he was still continuing to triage when I had left and they decided in November 2015 to do something else. 10:46

And the other point that I just wanted to make, if it's okay to make it now, is that if they assign 17th February to me in their statements, actually that's probably -- I mean, I was on leave, the e-mail went out, it didn't come from my office -- but it's okay, 10:46

because it's actually the IEAP rules. It was correct if it had have been implemented. It would have been okay.

45 Q. Yes.

A. So, after getting over the shock of everybody's like assigned it to me when I didn't know, when you look at it, it's an okay process, that one. 10:46

46 Q. Yes. So what I understand you to be saying is that this 17th February e-mail in the context of ophthalmics, if it was announcing to the world that: "Where we have a problem with non-triage, it's okay to follow the IEAP procedure" -- 10:47

A. Yes.

47 Q. You've no difficulty with that?

A. No. And the other -- 10:47

48 Q. But the part of the equation that you think, the important part of the equation that was missing from what was done in urology was the failure to pursue to get the triage done in a context where you certainly have a risk -- 10:47

A. Yes.

49 Q. -- of the need to upgrade patients?

A. Yes.

50 Q. Again, in a context where the waiting list pressures puts upgraded patients in jeopardy, if they're not upgraded? 10:48

A. Yes. And I've had another thought. I wanted to say as well that the process came out on 17th February. I was going to meet Aidan to stop him triaging on 20th

February. Therefore, I did not need this process for urology because I was addressing urology and the individual in a separate way. So, this process seems to have got attached to urology. I am 100% sure, I think -- well, that's not -- I'm fairly certain that the 17th process was for all specialties, and it wasn't going to be needed for urology because I was going to stop Aidan on the 20th. 10:48

51 Q. Can I bring you to something that Mrs. Corrigan says in -- 10:49

A. Yeah.

52 Q. -- in her witness statement to the Inquiry? I haven't brought you and I don't think I need to bring you to what each individual says --

A. No. 10:49

53 Q. -- in their statements to Dr. Chada. You would accept the broad proposition --

A. Yes.

54 Q. -- that while there's differences between them --

A. There's differences. 10:49

55 Q. -- they're essentially saying that you had knowledge of this process and its application to urology, and you disagree.

Mrs. Corrigan, at WIT-26271, if we scroll down the page please, she's being asked about -- just scroll down further, please. Yes, that's fine, just before that. She's being asked to account for her attendance at various meetings, or her recollection of attendance at 10:49

various meetings. And so she can remember, she says, for example, attending a meeting -- an exception where Mr. O'Brien was in attendance, but she can remember attending with you and Mr. O'Brien in your office and the discussion was triage and he was asked how he could be assisted. And:

"There were no formal notes of that meeting, but Mrs. Burns sent an e-mail to Mr. Young the next day advising him of the discussions and asking him for his help."

So, that was the meeting of 20th February 2014.

If we go down the page then, she says:

"These meetings were informal and they were to discuss how we could ensure that..."

-- sorry, referring to Mrs. Burns, Mrs. Carroll, Mrs. Trouton. So these are another set of meetings.

A. Okay.

56 Q. And she's saying:

"These meetings were informal and were to discuss how we could ensure that patients who Mr. O'Brien was failing to triage were not disadvantaged and it was at these meetings that a work-around was agreed that patients would be added to the Outpatient list

according to the clinical priority the GP had assigned to them. And when the letter was returned following triage, if this clinical priority then changed, a similar change would accordingly be made on the waiting list. It was also from these meetings that Mrs. Trouton and Mrs. Carroll developed the escalation for triage." 10:52

So, it's non-specific. The Inquiry may note it. It appears to be a different recollection than the recollection that was given to Dr. Johnston. Again, do you recall sitting down with - just scroll back, please - Anita Carroll, Mrs. Trouton, Mrs. Corrigan to discuss a process of this kind in the context of Mr. O'Brien? 10:52

A. No, I have no recollection of that and I just have to go by my documentary e-mail evidence. But just to say 55.5 doesn't agree -- it contradicts the paragraph above where we stop him triaging, because you don't need a triage process then to manage him, you've stopped it. 10:52 10:53

57 Q. Yeah. Could I bring you to the e-mail that you received from Fiona Reddick?

A. Yeah.

58 Q. It's at WIT-98509. And maybe if you'd just go down a little just to get the context, down two pages, please, to 11. So, it's August -- it starts off in June. There were -- it records, and you're not in the chain at this stage, but it records that: 10:53

"Referrals are not coming back."

I think the total -- eight referrals are not coming back and Mr. O'Brien is the responsible clinician.

And from August then, if you scroll back up the page to -- there's an escalation process and, if we go on up to '09 in the sequence, and so Fiona Reddick is writing to you --

A. Yeah. 10:54

59 Q. It's 2nd July and she's explaining that she wants to give you the heads-up. It says:

"Rang Aidan to get an update as to where the red flag referrals are. Some of them are now sitting at day 8 and we have no account of what is happening. This is the escalation process within Cancer services. Aidan is aware of this from previous conversations. He is dealing with them and processing investigations as he triages, but he just needs to let us know and keep informed so that we can track accordingly. He is bringing them in shortly but is very cross at this process and tells me that he is coming to speak to you. The escalation process worked well across all other areas." 10:55 10:55

So, I suppose, Mrs. Burns, you have been at pains to tell us that one of the reasons why it feels strange to you that other people were talking about the need to

address Mr. O'Brien's failure to triage during 2014 and into 2015 was because you had an understanding that he had stopped --

A. And we'd looked at an e-mail from Martina.

60 Q. And, we did, we looked at an e-mail from Martina in March 2015 where it said that Mr. O'Brien is not triaging. And here you have, shortly before you leave the Trust in August, but here you have a clear indication that he is triaging. He is, according to this, delaying in returning red flags. He's not mentioning routine or urgent in this context. And he is cross, very cross, and is coming to see you. So you're getting a heads-up that you might have your door rapped shortly. So this tells you, in clear terms, that he is triaging? 10:56 10:56 10:57

A. Yeah, I agree with you. And I said in my statement that I've missed that, I guess. I think I probably missed it, "I just want to give you the heads-up." Once it's sorted -- Fiona is saying "I've sorted it", but I should have knew, I should have read it more carefully and knew from that that he was obviously triaging red flags, which he, in my book, shouldn't have been. So, yes, I missed that one, definitely. 10:57

61 Q. And can you recall him calling with you to discuss his concerns? 10:57

A. I can't, but there was a lot of consultants knocked on my door on a very regular basis. So, no, I can't, to be honest.

62 Q. Tying all of this together, plainly if triage wasn't

being done to the extent that it wasn't being done, that should have been drawn to your attention?

A. Yes.

63 Q. The fact that he was triaging at all should have been drawn to your attention? 10:58

A. Yes.

64 Q. And the fact that staff were not following up to ensure that triage was completed for routine and urgents should have been a matter for significant discussion at Governance? 10:58

A. Yes, as it had been when it had been brought forward before. I think that's the issue. They brought forward the ophthalmology. We looked at it. We sorted it. We could sort these things. But you can only sort what you know. 10:59

65 Q. I suppose that's the point. You say "didn't know", but what does that say about the state of communications and/or governance in the directorate which you led for two years? Is it just one of those things, one of those errors in a wheel turning too fast, or does it 10:59 suggest that it was a directorate where people weren't understanding risk and cutting corners?

A. No, I -- no, I don't think that anybody in my team was deliberately cutting any corners. Was it a wheel turning very fast? Yes. But that's what service is. 11:00 I've very much considered -- when I saw the breadth of stuff that came across my desk and the responses that I gave, which is "If you need any help, come back to me", blah-blah-blah, I just think -- you could say to

yourself, you could self-reflect and say "Was I not approachable?", but they did approach me with the same issues previously and we addressed them. I don't know why they didn't address -- I don't know why they didn't follow through on their own process and I don't know why they didn't address this one. Because we were addressing issues and dealing with it and I have no problem doing that. But you could self-reflect and say, "Well, you know, was it my issue or was my system not good enough?". But I don't have the evidence, I don't think, to say that critically. This was one issue in a wheel turning fast. 11:00 11:01

66 Q. Could I just, in this context, draw your attention to Dr. Khan's observations?

A. Yeah. 11:01

67 Q. Dr. Khan was the Case Manager for the MHPS process and he took delivery of Dr. Chadah's report and made his determination. If we go to AOB-01923 and if you scroll down the page, please, to his conclusions. And clearly this is late 2018 when he's writing this. You have left the Trust three years, but he's reflecting back on the situation which was investigated by Dr. Chada, which included triage, and he says that: 11:02

"The report highlights issues regarding systemic failures by managers at all levels, both clinical and operational. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr. O'Brien. No one 11:02

formally assessed the extent of the issues or properly identified the potential risks to patients."

So, you can see how that conclusion derives from a situation where the triage for normal -- sorry, for routine and urgents isn't being done and that continues -- 11:03

A. Yes.

68 Q. -- into the following year, after you've left --

A. Yes. 11:03

69 Q. -- and the five further patients are identified for SAI purposes where they should have been upgraded to red flag. But the seeds of the problem had been sewn, I suppose, during your watch, albeit you have maintained that you knew nothing about it. But in the round, do you accept the gravamen of his conclusions there that this really represents systemic failures to get to grips with what was an issue that was certainly visible to some of your staff? 11:03

A. I've thought quite hard about that and I suppose my reflection is that, 2013 to 2015, albeit I completely understand that the triage started to build up un-triaged in that period, I didn't feel or believe that we were aware of or contributing to systemic failure, no. I believed myself that we dealt with each issue that came forward and we put a solution that should have stopped that issue. I understand entirely that if people do not then work that system or process that you put in -- and that's back to where we started 11:04 11:05

on the first day, which is on each level there is a requirement for each person to do their job in the fullest sense -- and if that then, if that doesn't happen and then that is what is termed the systemic failure, well then it is. But I don't know that it is, although there was a group of people that clearly knew that triage wasn't being undertaken, I appreciate that entirely, and that it led to more significant issues. 11:05

70 Q. Thank you for that. If we can move on then just to one final issue with you, and that's the second thing you were trying to get to grips with Mr. O'Brien through your staff, and that's his retention of charts at home. 11:06

A. Yes.

71 Q. Did you appreciate that the handling of patient records was governed by policy within the Trust, that it was the subject of a policy governing the safeguarding of patient files? 11:06

A. Yes.

72 Q. And you became aware of this issue during 2013 and I just want to explore what was done about it and how significant you regarded it. So, if we go to TRU-01612 and just if we scroll down, you're in the post only a matter of several weeks and Martina Corrigan's telling you that: 11:06

11:07

"Charts being removed from the Trust by consultants has been a problem for years. The last time that Helen spoke to me..."

-- and that's Helen Forde, is it?

"...about this, I spoke to Aidan and advised him of the issues, which he did say he would stop it. And it did stop for a while, but I had asked Helen if it happened again to raise it with me, and also to raise an IR1. Unfortunately, there are three charts now in Aidan's house and I'm not sure if anyone has spoken to him about it..." 11:07

11:08

-- and she would check. She said she is:

"...happy to talk to Aidan, but think we may need to involve Robin as well."

11:08

-- that's Robin Brown again, the CD. And if we just scroll up the page and you instruct to go ahead and raise as soon as possible. So, that's telling her to speak to Mr. Brown and get it sorted that way.

11:08

The issue comes back to again, I think -- let me just get the e-mail out, WIT-98414. Yes, so, this is also May 2014. Just scroll down, please. So:

"Consultant taking charts at home. Further IR1 has been put in today for two charts." 11:09

Scrolling up, and you're saying to Martina:

"Can you speak to me?"

So, do you have a memory at all of what's in these e-mails, of digging around this issue and seeing what was at the root of it? 11:09

A. No, I don't, sorry.

73 Q. Into September of that year, if we go to WIT-98407, and just scrolling down -- so, again, the same issue:

"How do you think it's best to deal with this? Should the Head of Service discuss it with Mr. O'Brien? Can they arrange to get charts back?" 11:10

And then your advice or your response up the page is that: 11:10

"I know you've tried before, Martina, and this is a Governance issue. Robin, can you discuss again with Mr. O'Brien, or do we need to escalate?" 11:10

So what's your -- can you divine what your thought processing is here?

A. So I think it's just as it is there. I mean, this keeps coming back. It's interesting because when I read these e-mails, the only person that actually really raised it to my table was Anita. Each time, I think -- I think if you go back through all the e-mails, each time it was only Anita brought it forward. And I write to Martina, Eamon and Robin and 11:10

say, "Guys, you've tried before. It's a governance issue. Sort it, or do we need to escalate?" -- so, escalate, I'm not sure if this is the time or it's the --

74 Q. There is then a further issue. A Dr. Convery has arrangements for a clinic with a patient and the chart can't be found? 11:11

A. That's right.

75 Q. And he, as I understand it, was placed in a position of maybe having to withdraw from the engagement with the patient if the chart couldn't be found, and that creates an issue. And we can look at that and how it's handled at WIT-98417. 11:11

A. See this one but, this is me trying to get the clinical leadership to lead the clinical teams. So we're clearly saying to Eamon and Robin, "It's a governance issue, guys, and, you know, what are you going to do -- or do we need to escalate because can you not do it?". So I know that this looks like I'm repeatedly pushing this off my desk, but, I mean, I'll be very honest, a chart at home in 2013/14 wasn't a particularly massive issue when what was coming across the desk was much more significant than that. In isolation -- I understand, in hindsight, that you can see there that it was a repeated thing and I understand that. However, again, even repeated charts at home in that era of 2013, I'm not sure. However, I was trying to put it to the clinical guys to deal with their clinical colleagues. And then we come to November and it wasn't 11:11 11:12 11:12

happening and...

76 Q. So if you could just scroll to the bottom. So Anita is copying you in. We could go further back, I think, but I've explained the context. It's Dr. Convery's issue. And there's, I suppose, a sense in Anita Carroll's e-mail of exasperation or of "What do we do now? We really don't know what we now do." And up the page: 11:13

"I have spoken both to Mr. O'Brien and Mr. Young as Clinical Lead for Urology. Mr. O'Brien advised he would cease the practice. I could ask Mr. O'Brien to discuss, but I don't think it would have any effect." 11:13

And then you, Mrs. Burns, you say: 11:13

"See my e-mail view."

And I think we've seen it separately -- your view was that Medical Director is the place to go with this?

A. Yes. 11:14

77 Q. And Anita Carroll agrees, I think, to escalate it to Dr. Simpson. "It might be worth a try."

A. Yes.

78 Q. Now, have you any knowledge of the issue reaching Dr. Simpson's desk? 11:14

A. No, I think there is an e-mail from Heather to me to say "Okay, I'll check with Robin, and then I'll escalate." And I think then there was an e-mail trail that I wasn't copied into where they, the clinicians

and Heather, decided they wouldn't escalate at this point.

79 Q. Yes, and we saw that yesterday. That was the e-mail that dealt with both charts and triage?

A. Mm-hmm. 11:14

80 Q. And Mrs. Trouton indicated that she was holding off referring to Mr. Simpson. She was giving it over to Dr. Brown and Dr. Young to try and sort it out before this next step or this more serious or, perhaps, draconian step of referring it to the Medical Director. 11:15 But tell me as, I suppose, a broader reflection, was there, in the culture that existed in the time, a degree of hesitancy --

A. Yeah.

81 Q. -- around grappling with what, as you've suggested, may 11:15 not have been on the face of it the most serious issue, albeit there are other issues that lay behind retaining the charts at home which I may wish to explore with you in a few moments --

A. Absolutely. 11:15

82 Q. -- but was there a culture of hesitancy in terms of effectively challenging the clinician who was out of line?

A. Yes. So, his clinical colleagues -- because if you look, I don't get any e-mails back from my Clinical 11:16 Director or Eamon, the AMD, about this issue. Nobody comes back to me clinically and says, "Right, right, right" or "We can't do this." And, so -- and the only person that continues to escalate this is Anita, which

seems strange that the clinical teams themselves don't -- yes, so, there was and in my --

83 Q. So, just maybe steer it this way, if I can -- operationally, people are saying to him, Anita, Heather, Martina "This has got to stop" -- 11:16

A. Yeah.

84 Q. But if it doesn't stop, is the other side of the line up, is it the medical or professional management that ought to step into it?

A. It's a joint responsibility. So, it was always set up 11:17 that way from the beginning of the Trust. We were trying to get -- I think in those days it was called a triumvirate where you had the most senior -- I think that was what it was called -- the most senior nurse, the most senior clinician and the manager. And I think 11:17 it was around, maybe, Mid Staffs and that that we've talked about that a lot. And this was the whole emphasis that we were trying to get in the Trust, was to play these guys into their roles, the clinical guys. But there was a real reticence for them to do that. I 11:17 mean, talking to John Simpson to talk -- Eamon had one-to-ones with John to talk to John Simpson and say, "Look, Aidan's giving me a headache here. Come along with me and we'll meet with him." That wouldn't have seemed that difficult, and it wouldn't possibly be 11:17 difficult now and now when I'm e-mailing my consultant teams I'm getting a different response. But then, no, it was like the end of the world to call John Simpson.

85 Q. Yes. You were in frequent contact with the Medical

Director's Office?

A. Yeah.

86 Q. But you didn't draw this to his attention?

A. No, because it's not a big enough issue for me to draw -- that doesn't sound right. It's a bit like the reaction to me meeting Aidan O'Brien in February '14 to say stop triaging. I did that when all else failed. But, if you remember, Martina said that was an exceptional meeting. I did not go about meeting the Medical Director with individual consultants unless we had a significant clinical practice issue that we -- we were trying to play them into this space. This is clinical management. 11:18 11:18

87 Q. But if we -- if we broaden this out and we now recognise as of January 2017 - obviously after your time - but this is where it was going -- 11:19

A. I appreciate that.

88 Q. -- if it wasn't cured, 300-odd sets of notes at home, a failure to dictate on many of the clinical encounters that lay within those patient charts, concerns about private patients and how they were managed within the system, that was why Mr. O'Brien was holding on to some of those charts and there's a whole controversy around whether private patients coming essentially from his private practice at home into the -- so, there were issues lying behind the reason why those charts were at home, leaving aside ultimately the volume of them. If the digging had been done in your time, it would have been appreciated, surely, that this was a bigger issue 11:19 11:19

than even the inconvenience of putting the Dr. Converys of this world when he wants to see a patient and doesn't have a chart -- is that a fair comment that this wasn't adequately grappled with on your watch and you had the opportunity to do so? 11:20

A. In hindsight, you could make that comment, yeah. Would I have changed anything at the time in the context? No. I've reflected so hard on this. So, whether that's a cop-out on my part or not, I'm not sure, but I don't think I would have managed those individual 11:21 charts any differently. There wasn't certainly an IR1 then, there was 300 at home! And there wasn't any indication from any secretary or administrative Head of Service that there was no dictation coming from that office. None of those things were indicated. But I 11:21 can clearly see how, with hindsight, this could be the root of the problem. But, to be quite honest with you, I wouldn't have dealt with this any differently at the time.

89 Q. As we know, you met with Mr. O'Brien on 20th February. 11:21 If we look at WIT-98486, we can see that Mr. Mackle is copying you in to what Anita Carroll had sent to him on 12th February, a week earlier, and I wondered was he sending this to you on 20th February knowing that you were meeting with Mr. O'Brien later that day -- and he 11:22 sets out for you on my count, if we could just scroll down, 24 incident reports that had been raised in the course of the previous, well, less than a year from May 2013. Conscious that your e-mail generated as a result

of meeting Mr. O'Brien doesn't mention --

A. No.

90 Q. -- charts at all --

A. No.

91 Q. -- you think, on your evidence yesterday, that it was inevitably a meeting that traversed topics quite apart from triage, because you certainly got round to speaking to him about whether he needed additional administrative help. And that perhaps implies that his ability to manage dictation or the reasons why he had charts at home might have been a subjective conversation; are you able to assist us any further on that? 11:22 11:23

A. No, I just need to say I don't remember an issue on, you know -- I don't remember me understanding that the charts at home were an issue with dictation. I haven't seen anything on that. I honestly believe the way Eamon sends that, and it has been requested from Anita, because she says "as requested", that he was saying to me, "Here is this, can you talk to him about this as well on the 20th?" because he knew I was meeting him. I assume that I would have done that. But, honestly, I can't tell you because I've no recollection. So, I can't tell you honestly. 11:23 11:23

92 Q. We know that, if we take it forward to August 2014 -- just we'll pull this up, WIT-61189 -- that may not be the right reference. In fact, I don't think it is. But Helen Forde is writing to you -- oh, there it is there at the bottom of the page, sorry. So she's 11:24

recording:

"Governance processes relevant to my role related to my staff completing a Datix chart required for clinic was found to be in Mr. O'Brien's house." 11:24

And she said:

"In the period 8 May '13 through 1st August '14, there were 29 Datixes completed relating to 63 charts." 11:25

Scrolling on down, she goes on to say:

"It had not been our practice to complete a Datix when the chart was at Mr. O'Brien's home, but as the problem 11:25 continued we started to complete a Datix each time a chart was in Mr. O'Brien's house, commencing in May 2013 and continuing until we were told not to complete any more by the Director of Acute Services at the time, Debbie Burns." 11:25

So, two points, I suppose -- even after your meeting with Mr. O'Brien in February, we can see that the number of Datixes being completed increases from the total that were before you when Mr. Mackle sent his 11:25 e-mail. So, if the issue was discussed between you and Mr. O'Brien --

A. It wasn't successful!

93 Q. -- it wasn't resolved?

A. No!

94 Q. And was the completion of a Datix, in your view, an appropriate step?

A. Yes. Anything that's less than satisfactory in a patient journey or in any environment in this area, you need to do that because it needs to be addressed? 11:26

95 Q. If we can go to WIT-61190 and, again, this is Helen Forde's statement. And if we go to 22.3, it's recorded that, repeating the point just made, that they were asked to stop completing the Datixes at that time by you. A conversation on the corner. She can't recall the date. She tries to put some date parameters around it. 11:27

"Debbie Burns stated that Mr. O'Brien was being helpful to her and she didn't want him annoyed. I had an experience about this, as my staff were annoyed about having to search for charts to find that they were not in the office and therefore their time was wasted in the search and having to chase up to get the chart the next day from Mr. O'Brien and the situation did not improve. However, my manager was filling in a Datix each time this was occurred but nothing was being achieved, and so her time was being wasted." 11:27 11:27

So a couple of things there. The first thing, primarily, you directed an end to the completion of IR1s is the account given by Mrs. Forde. Do you recall doing so?

A. Absolutely no recollection, no. But I don't believe I would have -- you know, I can't say one way or the other because I wouldn't remember or record our conversation. But, I mean, against everything that we've looked at on the System of Trust and my enthusiasm for governance, I would think that would be very unlikely, but I can't say either way because I have no recollection.

96 Q. Yes. The suggestion is that Mr. O'Brien was otherwise being helpful to you and that was, perhaps, the reason for stopping it, that you didn't want Mr. O'Brien to be annoyed by being troubled with this issue. 11:28

A. Well, that completely defeats the purpose of the incident reporting.

97 Q. But perhaps if you had a view of the incident as not being terribly significant in the grand scheme of things -- 11:29

A. Look, we were producing 450 incidents a month. I wasn't going to see these Datix because I only reviewed major and catastrophic. So in the Governance meetings on the monthly, I would have had a high level summary. I was never reviewing 450 Datix, so I wouldn't have seen these because these weren't graded "major" or "catastrophic". So why would I have said to stop them because I wasn't seeing them? 11:29

98 Q. Well, perhaps the point is if you're taking a view that that retention of charts at home is not the most significant issue in the world and we can work around Mr. O'Brien, is it --

A. But I didn't say that. I said --

99 Q. Is the point, though, just to follow her --

A. No.

100 Q. -- assertion through, is the point that you think it's disproportionate to be poking Mr. O'Brien with these Datix, these incident reports, when there's more important things to be worried about and he's otherwise being cooperative with me? 11:30

A. No. So, two things: Each time charts at home came to my desk in my e-mails, I said "That's a Governance issue - sort it." So, in my head, it's a Governance issue. And the second thing is -- now, I've lost that train. 11:30

CHAIR: Mr. Wolfe, I'm conscious that we've been sitting for an hour and a half now and I know you've a little more to do, but I'm just wondering if Mrs. Burns requires a break? 11:30

THE WITNESS: Yeah, I've lost that one. Yes, please.

CHAIR: We'll take 15 minutes then until a quarter to twelve. 11:31

MR. WOLFE KC: 15 minutes.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

MRS. BURNS CONTINUED TO BE QUESTIONED BY MR. WOULFE KC, AS FOLLOWS: 11:43

101 Q. MR. WOLFE KC: Just to conclude with this chart issue, could we have up on the screen, please, TRU-00779, and

just go down to paragraph 13? And this is the interview which Anita Carroll gave to the MHPS process and she records:

"A few times, Mr. O'Brien's name would have came up." 11:47

This is in the context of charts at home.

"So I suggested we put a Datix in to alert that a chart was not available for clinic. I was advised to refer 11:47 such issues to the Head of Service. Debbie Burns told my Head of Health Records, Helen Forde, not to put in Datixes in the system for charts. Helen shared this information with me and I accepted that maybe this wasn't the right mechanism for flagging the issue." 11:47

I think your view is that it was an appropriate mechanism. You don't recall instructing the staff to discontinue the use of this mechanism, but their memory or one of their memory and then passing the instruction 11:48 on to somebody else is there before us. But let me ask you about incident reporting in this context. We see a sizable number of incident reports, albeit they stopped at a certain point in time. But the issue isn't resolved. The issue, as we see, amounts to 300 charts 11:48 come January 2017. What should have been done with the incident reports, given that the same theme is described in each of them?

A. I'm going to answer that and I need to also say I want

to go back to the other thing as well about -- I don't think I reflected myself very well in terms of my view of missing charts. Every time I reply to a missing chart e-mail, and they were only from Anita, I said it needed sorted and it needed escalation and it was a governance issue. So that is a governance issue. So, it wasn't a governance issue that was going to come across my desk to dive into and sort, because at that time it wasn't significant enough. Triage where red flag cancers are being delayed, at that time, rightly or wrongly in my priorities as Director of Acute Service, there's a whole different ball game, the missing charts for a clinic. 11:49 11:50

102 Q. So you have to use your resources wisely in terms of the fights you pick? 11:50

A. I'd say I pick, but I'm not afraid of a fight! But, also, I needed to play, and I guess that comes back to your original question there, I needed to play my team into taking up the fight -- and it's not a fight, it's a challenge. It's a fair challenge. 11:50

103 Q. Yeah.

A. So, I just wanted to correct that in case I had misrepresented myself or said it poorly. In terms of this, it is always -- so, in incident reporting and in the system of trust and what was designed to happen in that process was that, as we said, there was -- and it is so disheartening to read back now people's statements of their views of that time because clearly I did not deliver the vision of governance to Helen and 11:50

her staff, and possibly others, because they seem forlorn, they seem to stop at putting in the Datix. The point of putting in the Datix and gathering the information is that it alerts further people up her chain. So if her staff, and I do believe it was her staff put in the Datix, so it would have been the Band 2 or 3s doing the clinics would have put in the Datix, that would have went in an e-mail chain and alerted Helen Forde to the fact that this was a theme because it would have kept popping into her inbox. And somewhere between Helen Forde, her person, the Band 3s and Anita, my expectation would be that that evidence is gathered and we say this is now a major issue, because this is happening all the time and a theme. So even if each individual incident is only being graded minor and therefore I'm never going to see it, in that team there is an incident report process for them to review those, pick out their themes and then deal with the major themes. And the whole purpose of it is that you action it, you just don't write the Datix. And if you can't action it, then you come and say it's not actionable and you either have a discussion, I assume with Martina or Heather -- even better, Eamon and Robin, which we obviously hadn't in work -- and then, as we said, I said John Simpson. 11:51 11:51 11:52 11:52 11:52

104 Q. So, what you're describing is the availability of a governance system to record and identify an issue of concern, but what you're suggesting is that it wasn't satisfactorily used in the sense that it wasn't all

brought together and, if you like, brought to a head as a formal matter for discussion and correction?

A. Yeah. It's clear to me from reading these statements and it was -- it's depressing -- but we did talk yesterday about it was 2014. So it was early days. 11:53
And the culture was early days. But we're still talking here. People's reflection is I wrote the Datix, I did my job. No. The writing of the Datix is just the first element. The Datix is there then to escalate, escalate, escalate -- and deal/sort. And 11:53
that, unfortunately, in 2014, we hadn't -- I hadn't managed to sell that vision to them. And if you reflect even further, isn't it peculiar that we didn't write Datixes about triage? So it was there, we were trying to play these people into the use of this 11:54
system, but the system doesn't do it for you; you still have to have the challenging conversations and put it together and sort it.

105 Q. And there is, I suppose, a common theme or a common denominator between the two issues we've considered 11:54
with you and your broad reflection, perhaps, is that both triage and the chart at home issue was not properly managed by your staff. And you might suggest that one explanation for that is that Governance was at an early stage of development and the key skills or the 11:54
key instincts weren't sufficiently well honed by this point?

A. I think that's really important. I need to say that this is the most painful process I've ever had to do.

My staff were excellent. They were a brilliant team. They worked really hard. They went over and above. Does that mean that you got everything right? Did it mean that they understood exactly what we were trying to sell them? Was it too early? Did they have the medical management and the medical leadership to support them in that? Was that stepping up at the same time? No, probably not. All those things were not coming together as they should. Did the staff set out to do a poor job here? No, definitely not. But we didn't get it over the line. We were too early. We hadn't grasped the concept of what the governance was. 11:55 11:55

106 Q. When we hear this being said candidly by you, it perhaps brings our minds back to the, I suppose, the contested evidence yesterday. We have in one corner, if you like, Tracey Boyce saying Governance wasn't fit for purpose -- 11:56

A. Yeah.

107 Q. -- within Acute and you're, I suppose, driven to accept with these two examples of administrative process by the clinician that things were not right on his part, and, yet, the Governance people, people who were supposed to govern the system, who were aware that things weren't right, and those issues weren't grappled with satisfactorily? 11:56 11:57

A. Where I disagree with Tracey is that governance is part of your role in your day job. So, if you are a Band 3, if you are a Booking Centre manager, if you're a head of service, if you're a director, it is part of your

day job. You can have administrative people in Governance sitting in an office collating reports for you -- you still have to have the challenging conversation about that report. So, you have to learn to do that. So where Tracey was saying Governance wasn't fit for purpose and it felt like she was saying there wasn't enough people -- it's not an add-on, it's an in the job/on the job role. And while they were writing the Datix, the on the job people, they just weren't following it through and addressing it, and that takes time and culture and support, and it felt -- it feels now, reflecting on that, it looks like it was too early then. To me, it's still an issue today. When I work with my teams, it's still an issue to have that challenging conversation with your consultant colleague, but we know that we have to do it and it's more instilled that it is required to be done and that's probably from all the learning that we've gained in the intervening ten years.

11:57 11:57 11:58 11:58

108 Q. Do you think, thinking about your own role in this and conscious that Mr. Mackle in his statement to the Inquiry said he believed mistakes were made by himself, Heather Trouton, Gillian Rankin, yourself, Ester Gishkori, mistakes as he diagnosed them in failing to recognise the risks of the concerns that had been identified, do you think, thinking about your own role with that comment in mind, that you could have done better perhaps in terms of leadership, in terms of perhaps putting too much on trust with your staff? You

11:58 11:59

know the issue, you know that they know the issue -- triage, charts at home -- but the issue in each of those cases wasn't resolved satisfactory?

A. Mm-hmm, and that's been something really again that I've really reflected on. And, of course, I could sit here easily and say "Yeah". But, actually, when I really, really reflect on it and want to do, want to get something out of this Inquiry that helps the Health Service, I think that, the triage, they weren't able to do. It was a really glaring, obvious patient issue for me, so I did that for them. I stopped it. 11:59 12:00

This one, I honestly didn't see the charts at home -- it was an issue, I needed them to step up, address it. I didn't see, in hindsight, that he wasn't dictating and that there was all these other issues behind him having these charts at home because they weren't in huge volumes at that time. Are you saying to me would I have done it differently? Probably I wouldn't have done any actions differently because we -- I was -- we -- I was at my maximum in terms of dealing with what I had to deal with and, where I needed to step in, I had to prioritise where I stepped in, i.e. triage, because it's direct patient. Where it wasn't -- you're right, I didn't look for the problem behind it, but I was trying to play other people into it. In terms of did I sell my governance vision well enough -- obviously, clearly not. 12:00 12:00 12:00

MR. WOLFE KC: Listen, thank you for your candour on

that. I have no further questions. Subject to -- do you feel you need to say anything to clarify anything else?

THE WITNESS: No.

MR. WOULFE KC: I'm obliged, thank you for your time. 12:01

CHAIR: Thank you, Mrs. Burns. I'm afraid we can't let you go just yet, we have some questions for you. Mr. Hanbury?

MRS. BURNS WAS THEN QUESTIONED BY THE PANEL, AS FOLLOWS: 12:01

109 Q. MR. HANBURY: A couple of things to just run pass you. Mr. Wolfe asked you yesterday about the results not read and actions problem and there were two SAIs that we looked at. And, after that, I think you did a little survey of -- by the secretaries of the clinicians and whether this was a problem in other clinicians, not just Urology, and I think you mentioned yesterday that, in the majority, people were reasonable. Did you take that any further? Did you look at the few that weren't reasonable and -- 12:01

A. Yeah. So, in that role, if I remember correctly, that was the routine swab SAI that came from and I think that was 2010, 2011/12, so I wasn't the Director of Acute Services then, so I didn't actually undertake the survey. When I spoke to Dr. Rankin or we had the meeting, she said, you know, "Write back to Diane Corrigan, tell her we're doing this and we're 12:02

going to action it." I was in the Governance role, so I was in the in between. Now, could I/should I have spoken to Dr. Rankin and said we needed to pursue this? Possibly. Did I? No. Because I was a Corporate Governance role at that point. 12:02

110 Q. Right. So, I suppose, to be more specific, when Mr. O'Brien wrote that e-mail back saying -- listing a handful of reasons why it might be difficult, in his opinion, do you think that --

A. Who did he write -- could we have that e-mail? Who did he write to? Did I see it? 12:03

MR. HANBURY: Well, it was shown yesterday.

MR. WOLFE KC: It wasn't directed to Mrs. Burns, but I can bring up the e-mail, if you just allow me a moment to find it. 12:03

THE WITNESS: Sorry.

111 Q. MR. HANBURY: I suppose my question, it's a more general question, there was a clinician who was having problems with --

A. In my role as Corporate AD I didn't do anything about it at that time, no. 12:03

112 Q. But on reflection, what do you think should have happened at that point, as someone who -- to someone --

A. I think Dr. Rankin believed that she was reviewing that and dealing with that -- 12:03

113 Q. Mm-hmm.

A. -- as the responsible director. I think there's correspondence to say she was and she took that forward.

MR. WOLFE KC: It's TRU-259874.
THE WITNESS: And do you have the date of that?
MR. WOLFE KC: It's August '11 and it starts below that with correspondence, just take it down.
Martina Corrigan is popping that group into what comes before that, scrolling down and I think it's Mrs. Trouton, from memory, yeah. So, that's the -- scroll down, see the message. That's July 2011. 12:04
THE WITNESS: So while I'm not saying I didn't know about it and I wasn't involved in writing back to Diane Corrigan, I wasn't copied in those. 12:04
114 Q. MR. HANBURY: Okay, thank you. I suppose the clinical problem is it continued to be a problem?
A. It did.
115 Q. Thank you for that. Dictation/discharge summaries, you made a good point that there was lots of focus on outpatient letters but actually other things mattered too, discharge summaries, flexible cystoscopies, day surgery, inpatient. Was your experience that was a problem with other clinicians, did that come across your desk as a -- 12:04 12:05
A. It would have come across my desk as a director in terms of the capacity to do those things and in what order you did them. So, to be fair to the group of urologists, that was the bit of the modernisation that we talked about yesterday in the back end of 2014 into 2015, when they kind of reorganised their lists, reorganised the pulling of those patients, some of them could go for flexible cystoscopy before they came to 12:05

outpatients, so they tried to maximise their capacity to do that.

I know what you're saying, in terms of his -- when he saw a patient did he write a discharge summary and add them to a flexible cystoscopy list, for example, I wasn't aware of that issue. They did reorganise themselves and, as I said to you, they were meeting their new demand coming through the door, so, that was what I was looking at, I guess. I wasn't looking at individual patients, did you get booked for your flexible cystoscopy, as such, out of your clinic? 12:06 12:06

116 Q. Thank you. Just one more thing about the outpatient backlog and many departments had this sort of problem, as you rightly say, climbing the mountain. When they were doing the modernisation, working how many new to follow-up patients -- 12:06

A. Yes.

117 Q. Historically that ratio had been quite high, tried to get down to one new, two follow-up sort of thing? 12:06

A. That's right.

118 Q. It's interesting, when you were planning, or they were planning the new-style clinics, it was seven new, seven old, it was much more one-to-one. So --

A. I think the template -- 12:07

119 Q. -- there was a predictable problem with the template even then. Was that discussed or...

A. I think the template -- the template wasn't that it was seven and seven, the template meant that they saw on

one clinic seven new and seven review. So, that was their attempt to try and address, pull through some of their reviews that are listed. But we didn't have enough capacity to pull through all the reviews. They weren't reviewing -- seeing new and reviewing on a ratio of that, they were trying to see seven new in a clinic and pull some of their reviews forward and see, I think, seven more. That's my impression. 12:07

120 Q. That's sort of my point in a way because they needed to -- 12:07

A. But they would discharge them. Their review rate -- their new to review ratio was improving, was my recollection, but they were trying to pull through, validate and discharge those ones that were sitting on the huge review backlog by seeing them in the clinic and saying goodbye, hopefully. 12:08

121 Q. Right.

A. I'm not sure, we could be talking at cross purposes.

MR. HANBURY: I think I'll stop there.

CHAIR: Thank you, Mr. Hanbury. Dr. Swart? 12:08

122 Q. DR. SWART: I'm quite interested in some of the things you've said about medical culture. So, this is just an invitation for some observations, there's no right or wrong answer. Accepting that you worked in the Trust for a long quite time, you're passionate about governance and clearly in your eyes there was some issues in terms of bringing the doctors into the fold, just to put it very bluntly. 12:08

Can you tell me, in your time at the Trust, what was your observation around things like the role of the Medical Director in setting that culture, how well it was embraced, where you saw the problems with this, just from your perspective? Why was this so difficult? 12:09
Yes, it's a journey, everybody who's worked at a senior level in hospital will recognise it. Some of us trained at a time when nobody had ever even talked about governance --

A. That's right, mm-hmm. 12:09

123 Q. -- so, we had to, you know, come to the party later than others. So, what was your view of how that developed in the Trust and where perhaps there was some specific problems related to either Northern Ireland or the Southern Healthcare Trust, or whatever you think is 12:09 important, really?

A. As I said in my statement, I don't believe on looking back because I was the Assistant Director of Governance and went to the regional meetings, I don't believe particularly at that time Southern Trust was an outlier 12:09 of Northern Ireland, but Northern Ireland, as a whole, is also, at least seven years behind the UK in adopting these things. And we did touched on duty of candour, and we're still having a discussion about that. I think Northern Ireland, as a whole, and as a region at 12:10 that time, it was difficult.

I do think that at that time we were still very much in the model of hierarchical, medical, promotion, so, CD

role, AMD role, Medical Director role, was probably more about your stage of your medical career and how you had achieved clinically, rather than were you going to be the next best leader of men?

124 Q. Who did the consultants look to, in terms of who did they look up to to say, 'Yeah, I've got to do that now.' Did they look up to the Medical Director to say, 'Really, this is important and we realise we've got to mend our ways,' or was that not the case? 12:10

A. I don't think that -- I think my recollection was the review of governance indicates that we changed the seat for clinical governance from the Medical Director's Office. 12:10

125 Q. That's kind of why I'm asking.

A. Yeah. So, we changed the seat of clinical governance from the Medical Director's Office to the Chief Executive's Office, we then had a change in Medical Director. I think I commented on Julian Johnston's interview that the relationship -- and that was more -- that's not necessarily a style issue, that was more where we were at that time. That Medical Director was from a psychiatry background. 12:11 12:11

126 Q. Yeah.

A. And, of course, acute is everything.

127 Q. Yeah. 12:11

A. And swallows everybody for breakfast. So, if you were an acute clinician you possibly wrongly, but possibly didn't have the same respect for someone from a different discipline that wasn't working in an acute

and busy, loud environment and, so, --

128 Q. Okay, so you sat down with Medical Director quite often. Did you have conversations to say, 'Look, we've got a problem with the medical leadership in Acute in terms of really grasping the key roles relating to governance in the modern world'? 12:12

A. So, you will see there, and I referenced it earlier, there was an e-mail between the SMT members in July and I think that was our attempt to, we did a -- a number of us e-mailed the Medical Director and said, 'How can we look at this?' And the Medical Director wrote to the Director of HR and said, 'What do you think?' 12:12

129 Q. Right. So, the Medical Director wasn't sending communications out to the consultants and getting them together and saying, 'Look, there's this whizzy thing you've got to be part of now'? 12:12

A. No.

130 Q. No.

A. Not that I'm aware of.

131 Q. Was there a reluctance to involve the Medical Director in some of these issues? 12:13

A. Yeah, unnecessarily because it's a clinician -- lead clinician --

132 Q. Normally these with all come to the Medical Director's Office -- 12:13

A. At that time RO was coming in. Sorry to interrupt.

133 Q. That's fine.

A. At that time RO was coming in so the Medical Director then became the Responsible Officer. You felt that

that was slightly changing the dynamic but --

134 Q. But not really?

A. But not really, no.

135 Q. A slightly different tack. In England in 2008 it became mandatory that patients receive copies of all their letters? 12:13

A. Yes.

136 Q. Now, this has not happened in Northern Ireland?

A. No.

137 Q. Do you have any observations as to the reluctance around that because it is a quite a good safety net? 12:13

A. It's a really good safety net and it's really interesting that you raise that because in my field now, we're in specialist palliative care - I'm the Director of Specialist Palliative Care - specialist palliative care is very much about the patient and family understanding where they're at. 12:14

138 Q. It is.

A. That there is, you know, active treatment to undertake and how are we going to see this through? So, we have regular debates in our governance forum about giving the patient and family the letter. My clinicians today are extremely reluctant about that. 12:14

139 Q. Why do you think that is?

A. Well, they tell me that it is because of some sort of protection for the patient and the family and from the clinical -- and I regularly tell them, 'If I am your patient I want to know every single detail for myself please.' So, they come from at it from, like, you 12:14

know, we're protecting our patient but really, I think it's just the thought of getting used to actually saying out in black and white where you're out. They haven't just reached that point yet. And they are very good, my clinicians are very good at breaking bad news, they're very good at having those conversations but they still can't write it down.

140 Q. That's different from writing it, isn't it?

A. Yes, very. 12:15

141 Q. Again a slightly different thing: The peer review standards that are brought in, they were not being met in Urology. You can argue about paperwork compliance, but actually they weren't. Were you aware of that at that time?

A. No. 12:15

142 Q. Should you have been?

A. Probably, especially with the MDM and the discussion about the regional peer review. So, yes, but that was a group of --

143 Q. So, why weren't you? I bean you had a lot of different specialties, there would be more than one MDM involved here? 12:15

A. Absolutely.

144 Q. Did you not ask the question? Did you assume?

A. I probably didn't ask the question. 12:15

145 Q. Why didn't you ask the question?

A. I think that the MDM concept was relatively new and we were joining with Belfast at that time and it was a shared one.

146 Q. Again, were you aware, for example, that there wasn't comprehensive audit in Urology?

A. No.

147 Q. Should you have been aware of that?

A. Probably. 12:16

148 Q. Are these governance issues that should have been picked up by the clinical managers, in your view, or where should this have --

A. Clinical Managers.

149 Q. What should have made this happen? 12:16

A. We did have review of our MDMs. I mean we had a yearly review of that from external, from, I think it was the PHA reviewed it.

150 Q. But the senior team in the Trust didn't sit down and challenge it? 12:16

A. No, but there was nothing flagged in those regional reports to say, You need to look at this, it's not very good.'

151 Q. No.

A. So, I guess we were probably wrongly, but the plate was very big, we were wrongly relying on someone coming in, looking at it and telling us it's time. A bit like our QA, you know? 12:16

152 Q. In your governance review, when you did your project and that was eventually adopted, you do mention some more proactive things. So, there's a lot of reactive stuff about incidents and all of that. But the proactive bit is ongoing collection of data and not necessarily audit but ongoing collection relating to 12:16

clinical outcomes. Did that ever go anywhere?

A. No, we struggled. I mean when I was there as director we literally struggled to change the format, for example, of the M&M meetings. Like, we literally struggled how we were reviewing death. So we were right at the beginning we were, like, trying to say how are we going to make that better and how are we going to make the challenge in the M&M. I mean at that time we weren't getting the lessons out of the M&M. So, we were trying to break nearly into that to say, 'Come on, guys, give us stuff out of M&M to pass around the clinical community.' 12:17 12:17

153 Q. So, you were trying to put some structure into the Department meetings?

A. Yes. 12:17

154 Q. But, again, you know, what was the involvement of the medical management line here, not just your clinicians, because clinicians rely on the leadership they get from medical managers really in most of these things. What was your sense of how many of them were really understanding this at that time? 12:18

A. I think that a lot of these people were extremely bright and extremely -- and at a level would understand, of course they would, I think it's in the doing and the challenging and the -- 12:18

155 Q. So, for example, when the default process came in for triage, I understand it was in the IEAP and all of that, but actually, you know, given the waiting list, these are large numbers of patients that haven't had a

prioritisation. Did the medical managers jump up and down about that and say this is risky or anything of that regard?

A. No.

156 Q. No. 12:18

A. But, remember, we said you wouldn't -- I mean if it is the one in the February, we said you keep following the track, you need to get it triaged, you still have to do it.

157 Q. But they must have been aware of all this? 12:19

A. Yes, and no --

158 Q. And there's an obvious risk?

A. Yes, obviously. And no, there wasn't.

DR. SWART: Okay. Thank you very much.

CHAIR: Mrs. Burns, I think my colleagues have covered 12:19 all the questions that I wanted you to answer and certainly you've given us very interesting information and food for thought over the past day and a half, so thank you very much for coming along. I know it wasn't been easy for you and we really do appreciate it. So 12:19 thank you.

THE WITNESS: Thank you.

CHAIR: Our next witness is due this afternoon, Mr. Wolfe, is that correct? She's due at two o'clock but I'm just wondering is there any opportunity for her 12:19 coming earlier or are you maybe not aware? There is. If we could start at half past one. Thank you, Mr. Lunny.

THE INQUIRY HEARING ADJOURNED FOR LUNCH

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

CHAIR: Good afternoon, everyone.

MS. McMAHON BL: Good afternoon. Back again is Martina Corrigan, former Head of Service with Urology. She was released from her oath on the last occasion so she'll need to take the oath again. 13:30

MS. MARTINA CORRIGAN, HAVING BEEN SWORN, WAS QUESTIONED BY MS. McMAHON, AS FOLLOWS: 13:31

159 Q. MS. McMAHON BL: Thank you, Mrs. Corrigan. Now, you were here before on the 23rd of February giving us evidence in relation to the MHPS module? 13:31

A. That's right.

160 Q. And we did manage to cover a couple of other topics on that day as well. And on that occasion you had identified your statements to date to the Inquiry?

A. That's right. 13:31

161 Q. Since then, you've provided us with two further statements and some documents which we'll come to shortly, but if I just ask you about those statements, the first one, number 7 of 2023, it can be found at WIT-94939. Your name is on the top and the signature 13:32 can be found at WIT-94950. That's dated 12th May and is that your signature?

A. Yes, it is.

162 Q. And do you wish to adopt that as part of your evidence

to the Inquiry?

A. Yes, please.

163 Q. The further statement can be found at WIT-98544 and this is a statement amending number 24 of 2022. Your name's at the top of that and your signature can be found at WIT-98547. We see that's dated 23rd June, and is that your signature? 13:32

A. It is, yes.

164 Q. And do you wish to adopt that as part of your evidence to this Inquiry? 13:33

A. Yes, please.

165 Q. Those particular statements were requested by the Inquiry in relation to discrete issues which we will come on to shortly?

A. Yes. 13:33

166 Q. So I'll leave those for the moment. What I'd like to do very briefly is just summarise the points from -- some of the main points from your evidence the last day, just to remind the Panel and everyone else of the areas that we have covered. I think you've had the opportunity to listen to a lot of the evidence? 13:33

A. I have, yes.

167 Q. So, if there's anything at the end of this that you'd like to alter or correct or clarify on these issues -- I don't intend to go into them again today, we've done them before -- but it's your opportunity to do so. So I'll just read out the main points and we'll know then the parameters that we have to cover for the rest of the time that I have you. 13:33

A. Okay, thank you.

168 Q. So, we covered the following: You're the Head of Service since 2009. You reported to various people, including Simon Gibson for a few days, then Heather Trouton until 2016, Ronan Carroll until 2021. Your directors were Gillian Rankin until 2013, Debbie Burns until 2015, Ester Gishkori until 2018, and then finally Melanie McClements, 2021. They are all names that we will be referring to later on. 13:34

A. Okay. 13:34

169 Q. You have explained your role and your current role and I'll come back to that shortly. You've referenced when you became aware of various issues in outline and today we'll take the opportunity to look at that in more detail. 13:34

You told the Inquiry that Patient 13 in 2017 rang alarm bells for you. You were aware of Patient 10 in December 2016 and you said it was sort of what started everything in December 2016. You didn't know about the five SAIs until 2020. You had nothing to do with the SAIs and you explained to the Inquiry her concerns requiring clinicians would be escalated and you described the lines of communication generally in your role. 13:34 13:35

You explained that in January 2016, you had a meeting with Richard Wright, Heather Trouton and Eamon Mackle and, after this meeting, you were tasked with drafting

a letter that was eventually to go to Mr. O'Brien, although on different terms than you drafted --

A. Yeah, sorry, just I wasn't actually at that meeting. It was Heather and Eamon were at the meeting and then, after the meeting, they came to me. 13:35

170 Q. Yes, thank you. My note is what you say and I interpreted it incorrectly. So the meeting in January 2016, after that you were tasked with drafting the letter on triage, backlog, charts at home and non-dictation, and that was the only version of the 13:36 letter that you drafted at that time?

A. That's right.

171 Q. But you subsequently updated the figures for the letter that was ultimately given to Mr. O'Brien in March?

A. That's right. 13:36

172 Q. But you didn't produce another draft. You had mentioned in your draft, and we went through this on the last occasion, that there was "a clinical issue for us", which is what you've said, "which didn't find its way into the final version given to Mr. O'Brien." Your 13:36 letter also contained the sentence:

"We are not sure if the priority given by the GP is correct..."

13:36

-- which also didn't find its way into the version given to Mr. O'Brien. You and Mr. Mackle met with Mr. O'Brien on 30th March 2016, as tasked to do by Mr. Wright -- Dr. Wright?

A. That's right, yes.
173 Q. Mr. Wright.
A. Yeah, Dr. Wright.
174 Q. You say that Mr. O'Brien was given four weeks to respond and the letter is silent on that issue on the face of the letter? 13:36
A. That's correct.
175 Q. You also spoke about the allegation of bullying allegedly made against Mr. Mackle in relation to Mr. O'Brien. We talked about the April 2016 staff changes when Mrs. Trouton moved and Mr. Mackle resigned from his AMD role, to be replaced both by Colin Weir and Charlie McAllister? 13:37
A. That's correct.
176 Q. You accepted in your evidence that the change in personnel at that point meant that the 2016 March letter was not followed up? 13:37
A. That's correct.
177 Q. You sent an e-mail to Mr. Carroll on 28th April 2016 saying that Mr. O'Brien had been asked to reply within four weeks of the letter given to him in March. You provided Colin Weir with the letter given to Mr. O'Brien in March 2016 on 15th June 2016, and you also gave evidence that you told Mr. McAllister about the letter also? 13:37 13:38
A. That's correct.
178 Q. Mr. Wright e-mailed you for an update on 9th August 2016 and, in September 2016, Simon Gibson undertook a scoping exercise tasked by Mr. Wright. You told the

Inquiry that you had no knowledge of the oversight meeting on 13th September 2016 until 1st December 2016.

You couldn't give Simon Gibson information on undictated clinics and charts at home "as it wouldn't be my area of expertise to know that information." 13:38

A. That's correct, yeah.

179 Q. You talked about data vulnerability and about how ten patients does not equal ten letters -- we discussed that? 13:38

A. Yeah.

180 Q. You were only aware of the 22nd December 2016 oversight meeting after it takes place and you assisted Ronan Carroll between December 2016 and January 2017 to fine tune the figures. At this point, there were 307 case notes from home, 783 letters in the drawer, and 66 clinics not dictated. 13:39

In January 2017, Mr. Wright asks Mr. O'Brien to bring notes in from home and return them to you? 13:39

A. That's right.

181 Q. And, at that point, that's when the 307 notes were returned?

A. Correct.

182 Q. Mr. Wright paid other consultants waiting list initiative payments to review the undictated clinics from January to June 2017, and Mr. O'Brien came back to work in February 2017. 13:39

Mr. O'Brien was given his Return to Work Plan on 9th February 2017 at a meeting with Dr. Khan and, following an oversight meeting, Mr. Carroll asked you to monitor that plan?

A. That's correct.

183 Q. Now, you explained that you could monitor the electronic triage and private patients issue as a desktop check because of the availability of that information on electronic format. You got the dictation information from Mrs. Robinson and you described the most discomfort came from case note tracking, as you had to do that physically?

A. That's right.

184 Q. And that was when you explained about attending Mr. O'Brien's office.

There was a return to work meeting with Mr. O'Brien and you and Mr. Weir on 9th March 2017. You gave an MHPS interview on 15th March 2017. You e-mailed Ronan Carroll on 5th May updating on your oversight role and to say that Dr. Khan wants monthly updates, not weekly. We talked about that.

A. Yes.

185 Q. -- and then the default of only in breach, which it ultimately came to, is that right?

A. That's correct, yes.

186 Q. You started to report by exception. I think that was as a result of Dr. Khan's requests?

A. It was, yes.

187 Q. Mr. O'Brien stated that he found his response to the action plan and its terms were quite demoralising, which he described in an e-mail of 12th July 2017, and in evidence on the last day you said that that e-mail represented a change in tone? 13:41

A. That's correct.

188 Q. The breaches of the action plan commenced post return to work in 2017. They continued into July 2017, into 2018, including while you were off for an extended period, and into 2019? 13:41

A. That's right.

189 Q. And, on the last occasion, I gave the Panel notes and references of those various breaches. I don't think they're in dispute.

A. Okay. 13:42

190 Q. But I can take you to those e-mails --

A. Yeah, no, it's okay, yeah.

191 Q. There was a meeting on 25th July 2017 after Mr. O'Brien's 12th July e-mail with you, Mr. Weir and Ronan Carroll, and an audio transcript was provided by 13:42 Mr. O'Brien. You were unaware that that meeting or, indeed, any meeting with you was being recorded?

A. That's correct.

192 Q. And you went off on a period of [redacted] leave from 25th June 2018 to 5th November 2018 and, during that time, 13:42 no one took over any monitoring of the Return to Work Plan. You accepted that Mr. Carroll could have done aspects of that remotely, as you had done, but he didn't. I don't think you had tasked that with anyone

else and it doesn't seem that anyone else stepped in?

A. That's correct, yes.

193 Q. There was a period in October 2018 when Wendy Clayton and Mrs. Kelly monitored in light of backlog reports?

A. That's right. 13:43

194 Q. But then you had come back to work after that. And you didn't consider the monitoring aspect that had been tasked to you as being time bound, but it ended in March 2020 due to Covid?

A. That's right. 13:43

195 Q. -- because people weren't coming in and there was a different landscape at that point?

A. That's correct.

196 Q. Do you think that's a fair summary of the areas we touched upon? 13:43

A. Yeah.

197 Q. Is there anything you've heard since then that alters any of that evidence or you wish to add?

A. No. No.

198 Q. So the purpose of today and tomorrow morning probably is to touch on other areas that have come up, other areas that we didn't get to in your statement, just to tease out your statement a little bit more and to identify some topics that may be of interest to the Panel. 13:43 13:44

A. Okay.

199 Q. You, I think you have heard the evidence of Mrs. Robinson, Mrs. Forde --

A. Mm-hmm.

200 Q. -- Noleen Elliott, and so you'll be aware that a lot of evidence has been given around processes?

A. Yes.

201 Q. And you'll also, given your current role, will be aware that the Inquiry's focus is on governance? 13:44

A. Yes.

202 Q. -- and what might have been done, what was done, what could have been done and how the systems interplay, or perhaps didn't, and where the fracture points might have been. So it's within that context that I want to 13:44 bring you to a couple of particular topics.

But I want to start, first of all, with something you mentioned at the beginning of your Section 21 when you talked about your Head of Service role. We can see 13:44 that at WIT-26164, paragraph 5.3. [Short pause]. So, this is a paragraph I want to read out because it involves you taking on another role --

A. Okay, yes.

203 Q. -- at that time? 13:45

A. Yes, mm-hmm.

204 Q. So you say at 5.3:

"In June 2016, due to the Head of Service for Trauma and Orthopaedics and Ophthalmology securing a new role, 13:45 Head of Governance, there was a new appointment to her post, Brigeen Kelly, and when she took up post she clearly stated that she would not be doing ophthalmology as part of your role, as she had all of

the nursing within surgery and elective care reporting through the lead nurses to her. When at a performance meeting the question was asked who the Head of Service was for Ophthalmology, the Assistant Director, Ronan Carroll, advised that I would be taking this on. I spoke to him after the meeting and, as this had been the first that I had heard of this plan, and he had advised that as it was a visiting outpatient service, it was felt that it could be added and was relevant to my role as Head of Outpatients." 13:45 13:46

Now, clearly, from that, you hadn't been given any prior notice?

A. No, I hadn't.

205 Q. Now, at that time, June 2016 - we just heard of the timeline, obviously - things were busy in Urology for you specifically, even though you had other areas under your remit. What sort of influence did the uptake of that role have on your duties at that time? 13:46

A. Well, to be fair, in June 2016, ophthalmology was a visiting service and it was nearly that you just were sort of the link between the Southern Trust and the Belfast Trust with regards to clinics, etc. So, sort of from 2016/17, that was more like -- I don't mean care taking; it would have been if there was any issues with regards to a consultant cancelling at the last minute or they needed more accommodation for more clinics -- because it was all visiting, we had no control over the consultants at all, it was all managed 13:46 13:47

from Belfast. But what happened in 2018, actually, just when I'd come back or returned from my [redacted] leave in November, was that there had been a consultation for Ophthalmology and it was agreed that the ophthalmology outpatients would be centralised in the Southern Trust, so all of the -- there was clinics in South Tyrone, in Craigavon and in Daisy Hill -- would be all centralised to Banbridge. And the day cases were going to become part of the day elective centres, which was a new concept and, again, that would be in South Tyrone. So it actually was -- it took a life of its own, really, in that I was involved in regional meetings; I was involved, because we had to do works in estates, I was involved with estates; I worked very closely with the Outpatient Head of Service -- or, sorry, the lead nurse and outpatient managers. So from sort of November 2018, it was a big part of my job. 13:47 13:47 13:48

Once it was centralised to Banbridge and once it was centralised to the -- which was in sort of the latter end of 2019/beginning of 2020, it eased off again, but during that time it was a very heavy part of my workload. 13:48

206 Q. So it expanded as time went on?

A. It expanded as time went on, yes, definitely. 13:48

207 Q. Now, given the way in which you found out that you would be taking it on -- and the Inquiry has heard also of other posts that people have been, perhaps, segued into, was that something that you found to be a feature

within the Trust, that posts, rather than being filled, were attached to nominated individuals, whether they welcomed that or not?

A. I agree with that. Because, actually, the job that I applied for originally was Head of Service for Urology and ENT and, ehm, two different types of specialties, but were manageable. In 2014 I was asked to take on Head of Outpatients because there was no Head of Service for Outpatients. So, again, they needed -- it was when we were moving to HRPTS, which is our human resource system, and they needed somebody sort of as a Head of Service level. And, again, because of my background, I'd come from the Western Trust and that was my background - I would have been the lead in Outpatients - I was asked to take that on. So, really from 2009, in I think it was about 2012, from memory, I can't exactly remember, it became Outpatients, which was in itself quite busy because, even though I had a very, very good lead nurse, it still was five different sites that you had to sort of have an oversight of. And the problem with it was, to be fair to everybody, you still had to visit them all and make sure that everything was going well, because I like to have a presence with the staff. So that was that. And then obviously then Ophthalmology was tagged on. So I went from having two specialties to having four quite large areas to manage, along with the operational day-to-day stuff like your bed management, your ED pressures, your on-call, etc. But, yes, I do agree, to answer your

13:49 13:49 13:49 13:50 13:50

question, it just seem to be -- you know, I'm just thinking back to a colleague of mine would have been Head of Service for General Surgery and then Breast was added on and then Endoscopy was added on. It was Head of Surgery and Oral Surgery, and then Breast and Endoscopy was added on to that as well.

208 Q. And your current role is now as the Assistant Director of Public Inquiry and Trust Liaison?

A. That's correct.

209 Q. And the job summary of that, just for the Panel's note -- in fact, we could go to it, it's WIT-26346. Just a small point just for clarity in relation to the job summary, it states at the top: 13:51

"In the first instance, the post holder will be responsible to the Executive Director of Nursing and allied health professionals for ensuring that the Trust meets the legal requirements of the Inquiries Act 2005 in respect of the statutory public inquiry regarding the practice of a Southern Trust Consultant Urologist." 13:51 13:52

Now, I'm sure you've been aware that on several -- on more than several occasions, the Chair has indicated that this is not an inquiry into the focus of clinical practice of Mr. O'Brien, and it's about the matters of clinical and corporate governance of the Trust. Just looking at that job summary, do you appreciate that it doesn't reflect the full Terms of Reference for the Inquiry? 13:52

A. I do, yes. I suppose, I had no input into this and I think it was before the Terms of Reference, it was June 2000 -- I was appointed on 29th May 2021, so I had no input. But I do appreciate that definitely, yes, I understand that -- and, I suppose, just to say as well that it's no longer the Executive Director -- there is now an independent director that I report to, Jane McKimm. Mrs. McKimm was appointed as -- because it was felt there was a conflict of interest with myself because that's actually Heather Trouton holds that post -- and then there's another layer with an independent director to the Inquiry, Margaret O'Hagan. 13:53 13:53

210 Q. I think that was the position when you last gave evidence as well?

A. That's right. 13:53

211 Q. The Trust had put a layer of individuals who had no direct contact with the issues subject of the Inquiry?

A. That's correct.

212 Q. So that remains the position. One of the aspects of the job is to liaise with external stakeholders, I think, and I think the Department of Health would be one of those. Is that your role to engage with those departments? 13:53

A. No.

213 Q. Not you? 13:54

A. Not anymore. I suppose, really, to be fair, the Trust liaison part of that post has dropped off and it's Mrs. McKimm that would do that part of the post. I am a member of the Urology Assurance Group, but that is

just on the basis of probably the lookback and just sort of the Inquiry, how the Inquiry is going. But we don't really discuss -- that's more to do with lookback.

214 Q. So the stakeholders, would they include Mr. O'Brien? Would there be any engagement under this job description with him? 13:54

A. Not from my perspective.

215 Q. Now, as I said on the last occasion, you were one of the few individuals who were there from 2009 right through. And you were involved in the establishment of Urology Unit in the Southern Trust under the Team South Plan? 13:54

A. I was, yes.

216 Q. And the Inquiry has heard information about that, but you were operationally responsible for the plan at the time? 13:55

A. That's correct, yes.

217 Q. And we don't need to go to it, but you say in your witness statement at WIT-261939 that your view is that the period of time that the team carried out the work, it achieved its aim. But when the exercise was complete, and funding was no longer available, the waiting time started to increase. So I just want to ask you a little bit about that. It sounds as if everything was done, from that, to set it up as envisaged, although we'll look at some of the staffing issues that didn't really come to fruition until 2020. But, initially, you thought that the team worked well 13:55 13:55

in trying to get the Urology Service established?

A. Yes, that's correct. I suppose, what I mean by that is the establishment of -- that we had taken on the southern part of Fermanagh so, ehm, really sort of your -- we would have said the BT74. So, the Enniskillen part of the population, we had taken that as a Trust on. And when we took it on, and I think I've said it in my statement, our waiting times were sort of nine weeks for an outpatient and potentially taking around 26 weeks for an inpatient day case. So, when it was all established and we had the staff and then we were able to maintain that for a short period of time, but then, like everything else, the demand really started to outstrip the capacity. 13:56 13:56

So, I think it was there was a focus on, from the external agency - like, the Department of Health - they would have had been involved in the weekly meetings with Dr. Rankin and ourselves and trying to set up the SBA, the Service Budget Agreement, and our Activity Agreements and there would have been a lots of focus and we were able to make it work. I think when that stopped, there was still a focus on performance, but there wasn't the same emphasis on, you know, on making it continue to work. So, for example, when we were raising issues with regards to the Fermanagh patients in the sense of that there was more and more referrals coming in, there was no appetite to address that with, you know, for example, particularly when we were short 13:56 13:57

of staff or, you know, when consultants left. But when you think about it, in 2009, we had three consultants and the thing was that we should have had five but we really didn't get them until 2012/13. So that capacity, that demand, we didn't have the capacity, so it started to increase but there was nothing done to try and address it with us

218 Q. And the Inquiry has heard information that there was an expectation there would be five consultants?

A. That's right. 13:58

219 Q. And five CNS, ultimately?

A. That's correct.

220 Q. And I think you said the consultants were full quota 20 --

A. I think it was 2012, the end of 2012/'13, yes. 13:58

221 Q. And the nurses were 2020?

A. 2020, yes.

222 Q. Now, you've mentioned about performance indicators and they were different for outpatients, elective inpatients and day cases? 13:58

A. Yes.

223 Q. So at least at that time, perhaps in 2009/2012, there was certainly an intense focus on meeting targets?

A. That's right, yes.

224 Q. And that was one of the issues around the IEAP, the turnaround for triage was something that was particularly focused on? 13:58

A. Yes, because it was the sense that because you'd such short waiting times, you needed to know what the -- so,

the way a clinic was set up -- so, say, for example, you've twelve patients, two of them might have been red flag, four urgent, and, whatever the remainder is - six routine. So you needed to have the patients triaged so that you could fit them into them slots, so that, for example, your red flag demand was met and your urgent was met. So because of the short waiting times, the triage, it was very important we turned it round quickly. 13:59

When the time started to slip a way out, very important still, but you had longer to get the triage back, if that makes sense? 13:59

225 Q. And that the impact of that, I suppose, the point is that the targets might have been set to benefit the patients --

A. Absolutely, yes.

226 Q. -- but the pressure on Urology teams, most particularly in the light of the context of not being staffed as envisaged -- 13:59

A. Yes.

227 Q. -- increased the pressure?

A. It did, yes.

228 Q. On the service and on the staff?

A. Yes, it did. 13:59

229 Q. And you've described it as a counting exercise and that patients risked being forgotten about in the midst of the targets. You also say that a lot of time was spent monitoring times and producing reports, or reasons why,

perhaps, performance targets hadn't been met. You say, and for the Panel's note, at WIT-26188, you say:

"In short, it was all about figures and the patients' needs risk getting lost in the midst of these figures." 14:00

Now, you make reference there to the patients' needs risk getting lost, but is there also a potential that the governance issues around the quality of care was also something that was a risk, given the focus? 14:00

A. Yes, I think what I was referring to with that is my memories are -- and, you know, if back in 2013 to probably 2015 you had asked me about any patients on the waiting list, the longer waiters I could nearly have told you their names because there was such a 14:01 focus -- I needed to focus in on them to go to the meetings with them. So you would have known, maybe, the longest waiter was a TURP but they didn't need to have a -- they weren't as urgent as the one midway down the list because he'd a catheter in so we needed to get 14:01 them seen, you know, quicker, clinically quicker, but we didn't have the capacity.

But from the Department of Health, the weekly meetings, which I didn't attend but our directors attended, and 14:01 then it fed back to us was there was a focus on we need to meet the targets and we need to make sure that we're meeting the budget -- or, sorry, the SBA that is set out. So if they said we needed to see 1,000 patients,

they wanted to know the reason why we weren't seeing 1,000 patients. But that's patients as opposed to -- and sometimes it's very hard to explain. So, for example, an inpatient list, you know, they said, right, you had to have five patients on an inpatient list, and that's the way they set their target. But if you had one big case, you couldn't put five on, you can only put on one and maybe a small case. But it was very hard to try and get that information from an operational person back to the Department because they only seen it as a figure that you had to see that many patients. And then when you didn't see it, we had to give the reasons why. 14:02 14:02

230 Q. There was also, you mentioned, a sense that the Trusts were compared with each other? 14:02

A. Definitely.

231 Q. And there was a sense of competition, that no one wanted to be the worst performing?

A. Yes. That was at the beginning, yes, of my tenure in Southern Trust, but it also -- I carried it from the Western Trust because that would have been in the Western Trust, you know, they would have come back and said "Oh, the Southern Trust are performing really well, they've no breaches" -- or then whenever I moved to the Southern Trust... So, you know, it was nearly like a competition. And, to me, the fact that we're actually talking about patients here was forgotten about. 14:02 14:03

232 Q. One of the key elements that was a performance target,

as you say, that had to be reported on was the return of triage, of patient letters, and that was a particular focus of yours?

A. It was, yes.

233 Q. -- at that time. And in relation to Mr. O'Brien, you described that as being a constant battle? 14:03

A. It was, yes.

234 Q. -- with Mr. O'Brien to comply with that. And the focus then came from the expectation of meeting targets and then you had to chase that up? 14:03

A. That's right.

235 Q. There was -- or else explain it?

A. Yes, and that's exactly it. We would have had a weekly meeting with Katherine Robinson and Katherine would have given us the detail of the return triage. And 14:03 then that was presented at the bigger forum where there was quite a number of people -- all the other specialties, like, it's all the other specialties in Acute, so your Dermatology, Cardiology, etc, and it would have been I was an outlier because, you know, 14:04 there was a number of patients not returned from triage.

236 Q. And we'll go on to look specifically at your knowledge of that over the years. I think it's fair to say it was something that persisted since 2011 and something 14:04 that persisted right through. We touched on the staffing in Urology briefly and I just want to go to your statement at WIT-26196. So, you are asked:

"Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand, noting the deficiencies as you saw them?"

14:04

And you say at 16.1:

"In my opinion, the Urology Unit was not adequately staffed, but I can confirm that that was not due to funding from the Department of Health to implement the recommendations from the review. I have outlined below the reasons for my above statement."

14:05

And you say:

14:05

"When I took up my post in September 2009, the following staff were in post: There were three consultants, two registrars, one GP with a special interest, one lecturer practitioner in urological nursing, two urology nurse specialists."

14:05

And you indicate there that the Regional Review recommended that there was an increase in staffing as follows:

14:05

"Consultant urologists should increase from three to five."

And you say:

"This proved problematic as, although the funding was available, it took some years to get five consultants in posts. And even when the Trust was successful, some of the consultants only stayed for a short period of time." 14:05

And then at (b):

"The clinical nurse specialists were to increase from two to four." 14:06

I think it ultimately became five on review --

A. Yes.

237 Q. -- that that was the expectation, but you set that out and we'll look at that again. But one of the key points that identify was the impact on staff morale from the beginning of not having a sufficient workforce. And you describe that as the waiting list increased -- I think the figure you gave on the last occasion was, in 2009, the waiting list was nine weeks? 14:06

A. Yes.

238 Q. And, in 2021, the waiting list was four years?

A. Yes.

239 Q. At this point even, as you indicated, the waiting lists are starting to creep up? 14:06

A. Yeah.

240 Q. And they increased:-

"...which in turn led to more complaints and queries,

informal queries to members of Urology, which in turn impacted on their ability to provide the service because they had to deal with requests around waiting lists."

14:07

A. That's correct, yes.

241 Q. So, they were spending more time responding to queries instead of seeing the patients or following up on their admin.

14:07

You also make a reference to even when the Urology Team were staffed fully, there was an impact on the governance around the staff that were coming into the team, particularly from agencies?

A. That's correct, yes. 14:07

242 Q. We touched on this before, not with you but -- I can't remember who it was, but we had a conversation about the potentially detrimental impact on governance if an over-reliance on agency staff who, by their very nature, are transient in their employment. So, is that 14:07 your experience?

A. It was, yes. It was. They didn't have the loyalty to the team. They were, you know, came in, as you say, and there was always a fear that they'd get a better offer somewhere else and leave. You would get -- and 14:07 sometimes some of the consultants, for example, or the regs, I'm just thinking, who would have come along, they weren't very -- there's a number of complaints raised maybe with their clinical ability or the way

they seen patients or the way they actually spoke to staff or patients. I'm just thinking of a few incidents -- I have outlined it in my Section 21 -- but we had to let staff go. So, a lot of problems and, yes, did that -- and the other issue is, obviously, with agency, and it's no secret, they get paid a lot more than the substantive post holders. So, you have that sort of bit of disgruntlement in behind as well.

243 Q. Now, there had been a ward reconfiguration in 2009. I think it was just before you took up post? 14:08

A. Thankfully!

244 Q. Was it?

A. Yes, it was, it was in sort of March/April time 2009 and I took up post in September.

245 Q. Just when you said "thankfully", was there a little bit of fallout from that? 14:09

A. There was a lot of fallout from that and, I suppose, part of the reason I say "thankfully" is I do know, for example, the Urology Team were very aggrieved that they had lost their ward and had been sort of -- they were more 2 South and they were moved to 4 North and it had become quite apparent early on because I think it was the beginning of January/February 2010 when they made the agreement they actually did need a more dedicated ward rather than having the urology patients in with the colorectal and with the breast, etc. So, they did, there was a lot -- and even to this day, they would still talk about 2 South Urology was the worst thing they ever did, was reconfigure it or close it, or it

became 2 South/ --

246 Q. And saying that was the worst thing they ever did, was that backed up by any evidence to suggest that there had been any sort of detrimental impact on the quality of care and patient and safety as a result of the reconfiguration? 14:10

A. I don't think so. I think the biggest problem was that Urology -- when they reduced the beds, it was surgical beds they reduced, and I really can't remember the figures off the top of my head because I wasn't involved in it, but I think maybe it was something like 54 beds, it was reduced by 54 beds. So, the plan was you were going to have a day elective unit, which meant that you had the patients coming in on the morning of surgery, as opposed to coming in the night before or a few days before. So that worked very well. But then what happened was very quickly medicine spilled into surgery. So then, whereas pre the reconfiguration, there was loads of empty beds in Surgery and they were never filled because there were plenty of beds every else, so, as a result of that, I think, personally what -- because 3 South was my ward as well and the complaints were more to do with the nursing staff had instead of just Urology or just ENT to look after, because we merged the two, they had also Medicine to look after. So you might have had a stroke patient or a cardiology patient and it just meant that the retention of staff, because they were losing their surgical skills, and I do know Mr. O'Brien would have 14:10 14:10 14:10 14:11

said there was a team of urology-trained nurses and, unfortunately, with the amalgamation of the -- or the closure of 2 South, a lot of them took early retirement or a lot of them went off to work in theatres or day surgery. So, you lost that skill of urology. And we did our best over the years to try and up-skill the staff that we had, but the retention of staff -- and it's not to do with just Urology, it was across the board -- nurses just were leaving, we couldn't keep them. So you'd train them up, they'd know how to do catheters, they'd know how to sort of look after nephrectomy patients and things like that and then they'd move off to somewhere else. 14:11 14:12

247 Q. And is that mix of clinical patients medical, as you say, somebody maybe who had a CBA or stroke, somebody who's just post-op, who both have competing but very different needs, is that mix still the way the Trust operate their ward allocation? 14:12

A. From being on call, I know they have definitely moved to -- what they've done is they've put surgery into smaller wards. So instead of being in a 36-bedded ward, which Urology and ENT -- so what you had is Urology inpatients, you could have anything from, you know, maybe 14 inpatients up to maybe 22, maybe sometimes 30, if it was a really busy period of time. But then you might have had six ENT patients and then you have half a ward that's empty. So you've an ED that's bursting at the seams -- so what do you do -- you move them up. So now what they've done is they've 14:12 14:13

looked at all of surgery and said, "Right, we absolutely need 19 beds for Urology", so we put that into a 19-bedded ward, our area. So even if there's one or two empty beds, it's not worthwhile putting a medical patient in there. So they have -- I do know they have done a lot of work on it, yes. They've learnt from what has happened over the years.

248 Q. They've tried to pull it back slightly to the specialty that keeps the staff, as you say, that are appropriately qualified, and then staff retention by its nature may well be less of a problem? 14:13

A. Yes.

249 Q. The other thing that happened around 2010 was the centralisation of the radical pelvic urological surgery to Belfast? 14:14

A. Yes.

250 Q. You don't mention that in your statement, but I think that was -- it was during your time?

A. It was, yes. It was part of the recommendations of the 2009 review of Urology Services. 14:14

251 Q. Did you have anything to do with that particular decision-making or the out-working of that decision?

A. The decision-making, no. It was one of the recommendations and it's like the reasoning being that, and knowing this from working with consultants for most of my 36 years, is they need to maintain their skills. So, the amount of radical pelvic surgery or prostatectomies and your cystectomies was -- there wasn't enough to maintain it, the skills in the 14:14

Southern Trust.

Now, out-working of it in the sense of I wasn't involved in the setting up of the MDTs, the link between Belfast and the Southern Trust at the end of it, but I do know from working with the consultants, they were very aggrieved that that moved to Belfast, both Mr. Young and Mr. O'Brien. And the only thing that I had to do was make sure, on the theatre lists, that there was no radical pelvic surgery listed outside of -- that, if there was, then I had to escalate it. 14:14 14:15

252 Q. And who would you have escalated that to?

A. That would have been escalated to the Associate Medical Director, Mr. Mackle, or to Mr. Rankin, because that was during that period of time. 14:15

253 Q. Now, in April 2010, again the establishment of the Urology Cancer MDT and the Urology MDM was in a bit of introduction of more focus, I think?

A. Yeah.

254 Q. -- provision of care from the Multidisciplinary Team. Again, was that something that you were involved in or was that something that you had involvement in the out-working of? 14:15

A. I had no involvement in that at all.

255 Q. What about the move or the creation of the Urology Outpatient Service at the South West Acute Hospital in January 2013, were you involved in that? 14:16

A. I was, yes. I think I was involved, obviously, being Head of Service, but it was also the fact that I had

just literally come from working in the Western Trust, so I had still the contacts. So I would have met with Mr. Young and the clinical teams and the admin teams down in South West Acute to work through the setting up of the service. So, even the practicalities of, you know, how does a referral letter that's sent in by a GP -- at that stage, it was still being sent in to the Western Trust -- get to ourselves. And then the whole issue over the notes and how they were going to be available for the consultants because, at the start, it was going to be that they were going to use the Western Trust, but the Western Trust -- South West Acute were one of the first hospitals that's gone paperless, so then that didn't feed into our systems so we needed a written note for our consultants to either take with them or take back. So I would have been involved in a lot of meetings at that stage with them. 14:16 14:17 14:17

256 Q. When you talk about the charts, what was your understanding -- the Inquiry has heard evidence about this and you probably have as well, listening in, but what was your understanding of how it's been removed? What you've described there seems to be there's a necessity to bring paper-based clinical records to that location in SWAH? 14:17

A. Yes. And, I suppose, first of all, there's no transport -- there's a transport within the Southern Trust so if you need notes to go to Daisy Hill or to South Tyrone, that's within the remit of the Southern Trust. But it didn't go as far as the Western Trust 14:18

because it's a totally different Trust to ourselves. So, in the beginning, I agreed that I would bring the notes with me on a Friday evening when I was going home and I would leave them in a secure -- it was actually with the -- this was agreed with the management of the Western Trust, they would be kept in a secure location in the Southern or South West Acute -- SWAH, SWAH we call it, so I'll just -- being a Fermanagh person I'll call it a SWAH, it's easier! And so the notes were left and then what happened was either Mr. Young or Mr. O'Brien -- it was, actually, at the start, it was Mr. Pahuja who would have went to Enniskillen to do clinics along with Mr. O'Brien. So, in the beginning, they would have brought the notes back to the hospital with them on the Monday -- it was held on a Monday. Obviously then, towards the end, there was the issue that the notes didn't come back from the hospital from Mr. O'Brien. Because, in fairness to Mr. O'Brien, he lived this side of Craigavon, so he should have brought them in the next day, which didn't happen. 14:18 14:18 14:19 14:19

257 Q. Was there a sense that that was tolerated, Mr. O'Brien was taking them home or not bringing them in right away? No one really made an issue about it because it was a procedure that perhaps in some way assisted the Trust to get the notes there and back? 14:19

A. Yes, and, to be honest, I don't ever recall it being an issue. Nobody ever raised the fact that the notes were never coming back - ever - to me. I'm very sure of that, because if they had have been, I would have been

very happy to call and lift the notes on a Monday evening or preferably a Tuesday morning on my way back to work, but that was never raised as an issue with me.

258 Q. There are some e-mails from you to Mr. O'Brien in 2012 about notes, so maybe we'll look at those now just to -- 14:20

A. Yes, please do, yeah, because -- yeah, yeah, please do.

259 Q. -- I don't want to forget. If we go to AOB-00344, you said, first of all, that this was first escalated to you in 2013 in your statement but I think there's an e-mail from you to Mr. O'Brien. Just scroll down, please. There is an e-mail from Angela Montgomery, 6th February 2012, to you, copying in Jane Scott and Vicky Graham. It's: 14:20 14:21

"Hi Martina,
Vicky is unable to find the below two patients' medical notes following a day 4 appointment with Mr. O'Brien and can therefore not get a clear outcome. Can you please speak to Mr. O'Brien to see where these charts may be, as they are still tracked to Thorndale Unit?" 14:21

And if we just go up, we'll see you write to Mr. O'Brien and Gill O'Neill and Jane Scott on 6th February 2012 -- 14:21

A. Just to say they would be actually -- they wouldn't have been South West Acute notes, they would have been for the Thorndale. So day 4 is really your breaking bad news clinic. That's what we called it at that

stage.

260 Q. But this is an early alert of the notes issue, do you accept that?

A. It is, yes. I accept that, yeah.

261 Q. There's no outcome of that. Is that reflective of the fact that the notes probably appeared or -- 14:22

A. They probably did, yes, yes. I think and we've heard evidence and I know from myself that at that stage they've escalated it to me and, basically, what has happened there, I'm assuming, is he's brought the notes in and that's why there's -- because if the notes hadn't have come in, then they would have come back to me because Angela worked in the red flag team, her and Vicky, and they had very good -- or very good at escalating issues like that to me. 14:22

262 Q. I think we heard evidence from Helen Forde, who said that even with the IR1s being raised, the notes came back.

A. They did.

263 Q. And so that's why there's no follow-through of escalation. They always appeared. Her evidence was that they always appeared? 14:22

A. That's right.

264 Q. Would that have been your understanding that when notes were sought, they were returned? 14:22

A. It is, yes. And just to say with regards to notes, like, you know, if, for example, this has come to me and Helen Forde would have escalated it to me -- now, I do know that there would have been an awful lot of

requests for notes that I never would have been aware of because it would have been -- potentially, health records would have contacted his secretary, Noleen, and she would have contacted him. So there was a big loop in there that I wasn't -- or a big gap in there that I wasn't aware of.

265 Q. As we have started the charts issue, I'll just continue on, if that's okay?

A. That's fine.

14:23

266 Q. -- while we're in the groove of that. If we go to AOB-00458 and this is from Debbie Burns to you in relation to Mr. O'Brien taking charts home. Just move down -- Helen Forde to Anita Carroll:

14:23

"Anita, just to let you know that another IR1 has been put in today for two charts that Mr. O'Brien has at home and that are needed for Monday."

Anita sends it on to Debbie Burns, just FYI, and then Debbie Burns sent it to you on 10th May 2013, saying:

14:24

"Can you speak to me?"

Now, I know it's a while ago, but Mrs. Burns knew about the charts issue at least from that date. Was it something that you talked to Mrs. Burns about?

14:24

A. I genuinely can't recall. But if Mrs. Burns asked me to come and speak to her, I would have went. I would have probably went down and knocked the door. And it's

because there's more -- there's another, as it says there down at the bottom, 2 IR1s have been raised.

267 Q. Yeah.

A. So, obviously, because, obviously, Mrs. Burns -- and I know she said in her evidence was very focused on governance and on the facts of IR1s, so that's probably why she asked, but I genuinely don't recall the outcome of that conversation. It would probably have been something along the lines "Can you go and speak to Mr. O'Brien?" because I did speak to Mr. O'Brien about the notes and being at home. And, I suppose, just to say, again, you know, that's two. I never would have anticipated that there was as many, whenever it did come to the head in 2017 that there was as many. It always seemed to be dribs or drabs of one or two notes. 14:25

268 Q. And because of the way the charts were recorded or not recorded --

A. Yes.

269 Q. -- there was no one who had a global view of the numbers at that point? 14:25

A. No.

270 Q. No one was keeping an eye on that?

A. No, because it's back to what Mrs. Forde would have said, look, you know, you would have went in and looked -- and it's a wee bit like what was Angela's, the previous e-mail, she had said that they're still tracked to Thorndale Unit. So, they're in Thorndale Unit, according to the system, but when they go down to look, they're not there. So obviously they could have

been in Mr. O'Brien's office or in his secretary's office. But the thing about it is they usually would have checked them places before they actually escalated.

271 Q. We heard some evidence around iFIT being fitted -- 14:26

A. Yes.

272 Q. I'm not sure whether you know anything about that, whether the system is in place. I think the business case was passed or accepted. Perhaps Mrs. O'Kane is the person to ask about that? 14:26

A. I think so. I'm not aware whether it is or not because I don't need notes anymore in my current role.

273 Q. Just a couple more e-mails around this time just to give the Panel a flavour of those involved in the knowledge about the charts and the notes. If we go to 14:26 TRU-276837, this should be an e-mail of 8th October 2013 -- Heather Trouton e-mails you, saying:

"I need to talk to Aidan re this."

14:27

It's probably the page before. [Short pause]. Thank you. There doesn't seem to be a chart reference, but I'll come back to that. I'll clarify that.

If we go to TRU-277892, we'll have more luck with this 14:27 one. Back down again, please. [Short pause]. This is about missing notes. We just need to go down, sorry. So, there's a request for a chart -- the patient's name doesn't need to be noted. The chart is with

Mr. O'Brien. Noleen has e-mailed them twice, no response, and that's from Barbara Mills to Pamela Lawson. If we go up, we'll see that Pamela Lawson then sends it through to you and Elizabeth Trouton on 14th October 2014: 14:28

"Elizabeth, would you please explain to Mr. Glackin that these notes will not be present for the appointment tomorrow as Mr. O'Brien has them." 14:28

And just on down then, we have Helen Forde sending it to Anita Carroll, saying -- on 14th October 2014, saying:

"See below, still a problem." 14:29

And then Heather Trouton to you on 1th October:

"Martina, are you aware this is still a problem? Has it improved at all?" 14:29

And you say, you reply on 26th October 2014 to Mrs. Trouton to say:

"Heather, it had improved but I feel it may be slipping again and I will talk to Aidan again." 14:29

Now, those selection of e-mails would suggest that, at least from this remove, I don't know what happened, but

there's a suggestion in the e-mails that there's a potential patient impact --

A. It has, yes.

274 Q. -- on the chart, but Mr. Glackin's, presumably, is Outpatients? 14:30

A. It was, yes.

275 Q. Do you recall if that chart was found, or did that come to fruition that the chart wasn't available for the patient?

A. I genuinely don't remember this actual case, because, as you said, there's been a lot of e-mails about it. And what I feel when I have said it had improved is that I probably wasn't getting as many escalations or IR1s because I didn't -- its silence meant that there was nothing -- there was no issues, if that makes sense, rather than, you know, somebody coming to me. So I don't know in the background -- again, back to what I had just said previously, was it a case that the secretary had sorted it out before it got any further with Mr. O'Brien but this was one that obviously has an impact, which is why it's got to me. I'm assuming it wasn't sorted and it may have been that Mr. Glackin came to speak to me about that because he did speak to me a few times about issues like that. So, potentially, that could have been one of the occasions. I can't genuinely remember. 14:30 14:30 14:30 14:31

276 Q. And would Mr. Glackin have gone to his medical manager about that, as opposed to going to you?

A. Probably not, no.

277 Q. Do you think there might have been any merit in him going so, given that it has a potential care impact?

A. Mr. Glackin would probably have used Patient Centre to look up the last clinic letters. So, I'm not sure if it had an impact -- I don't know. I'd only be surmising. I don't know. But I don't think, no, Mr. Glackin wouldn't have went to his medical manager about it. Now, Mr. Young would have been Clinical Lead, so I don't know whether he had spoken to him or not. 14:31 14:32

278 Q. Do you know if the consultants were aware of this problem?

A. It was never spoken to me that there was a big problem. But I think they were aware of it. I think it's sort of, the inference is there that there was a problem, but maybe nobody ever just really hit it on the head and said, "Look, you know, we're missing charts" at any of the clinics, and this is potentially why the dictation came to fruition -- the lack of dictation was because there was no Patient Centre letter and then no notes. 14:32 14:32

279 Q. Just in relation to clinician, it's clear Mr. Glackin knows about it -- there might be a suggestion that others were aware of the problem -- clearly patient implicated in this. And I asked you would there be merit, but looking at it from this remove, do you think it should have been something that Mr. O'Brien's peers either dealt with directly with him or brought to the attention of his medical managers? 14:32

A. I do, yes, but I can understand why they didn't in the sense of, it's a close-knit team, they would have trained under Mr. O'Brien and it may have been just difficult to sort of report something like that. I believe they should have, but I can understand why they potentially didn't.

280 Q. Well, we can ask them --

A. Yes.

281 Q. They can explain that. There is another e-mail on 7th November, just a couple of weeks after this, at AOB-00791, 7th November 2014. You'll see, just go down to the bottom -- that e-mail below. This is from Pamela Lawson to Mr. O'Brien, copying in Helen Forde, Marie Loughran and you: 14:33 14:33 14:34

"Dear Mr. O'Brien,
Can I ask you please to bring in the following charts asap. One is required for an admission to 2 North and the other one is required for Mr. O'Brien's clinic." 14:34

Presumably on the Monday, the 10th -- this must be the Friday. And you then reply -- or forward that to Heather Trouton on the same date. And you say:

"Heather, can we have a chat about this, as it is becoming a problem again?" 14:34

Now, in relation to Heather Trouton or Debbie Burns or anyone else that you have brought to their attention,

this issue, did you receive any help or any guidance or any intervention to try and resolve it?

A. We would have talked about and I would have spoken to Mr. O'Brien with regards to it. And I do know Heather tried to address it through Mr. O'Brien and Mr. Young. But it -- 14:35

282 Q. And how did she try to do that?

A. There is an e-mail in the system with regards both triage and charts. I think it's in or around 2013, November 2013, where she's asked for them, as his clinical managers really, to address it, which didn't happen. And I don't know and again it'll be up to Mr. Young and Mr. Brown to say did they ever speak, but, as far as I'm aware, I don't think they did. 14:35

283 Q. And you say that was around November 2013? 14:35

A. Yes.

284 Q. So, that was a year and a half after the February 2012 e-mail that you were involved in?

A. Yes.

285 Q. So, would you agree it's been going on, even at that stage, for a protracted period of time? 14:35

A. It has, yes.

286 Q. Did anyone think of doing an audit on the potential clinical risk to patients or impact on patient care that this by this stage chronic problem was having? 14:36

A. No, we didn't. We didn't, no.

287 Q. Do you think that that might have been an opportunity, then to get to grips with this at that point, given that it festered on for quite a long period?

A. Absolutely. You know, I've done a lot of reflections with regards to what has went on from 2009 till 2020 and there were opportunities to do audits; look at impact on patient safety; look to see, you know, what was the inconvenience of not having a chart. I think a lot of the consultants -- like, the one for admission, that concerned me and that was why I would have escalated that to Heather. Because you have a lot of stuff on Patient Centre but you need the notes for somebody that's coming in because you don't know what allergies they have, you don't know what their past medical history is that potentially will put them on a different pathway. So that's -- I know, reading that, that that has rang alarm bells with me. I'm not saying and I'm not playing down for one minute an outpatient attendance, but you are able to get on to Patient Centre and now, which has been replaced with NIECR, and see past clinic letters which will sort of give you a bit of history. 14:36 14:37 14:37

But, yes, Laura, really we did need to -- we should have done that. We should have done that, yes. 14:37

288 Q. And, again, you will have heard other's evidence -- 2016 seemed to be a certain crystallisation of many issues --

A. Yeah.

289 Q. -- that might have allowed for a more thorough analysis of the scope and depth of the problems?

A. Exactly, yes.

290 Q. Now, I wonder if we could go to AOB-01225 -- sorry, go to AOB-01228. I'll try and give you the right page from the start. Go down to -- the e-mails work backwards so we'll... [Short pause]. So this is from Pamela Lawson, 17th October 2016, to Helen Forde and you're copied in: 14:38

"Hi Helen,
I just learnt this morning that Mr. O'Brien is going from mid November, possibly until January 2016." 14:38

That was a period of absence for Mr. O'Brien?

A. Yes. Yes.

291 Q.

"I would like to get any charts back into records from his home. Martina is on leave until 31st October. Is there anything we could do in the meantime? I think if he started to bring a few in each day we could cope with it better." 14:38

14:39

A. Yes.

292 Q. And then Pamela sent it on to Amy Nelson with Helen Forde in your absence. And then on 10th November 2016, you're back in at this stage?

A. Mm-hmm, yes. 14:39

293 Q. Pamela Lawson to you, copying in Simon Gibson:

"Martina,
Is there any way we can get these charts? I'm looking

one at the moment for..."

-- and then the reference, and that's from Pamela. Then on up, please. You then send on 14th November to Mr. O'Brien further e-mails, Aidan -- presumably, the expectation is he would have been alert to what had gone on before and see that people are chasing charts? 14:39

A. Yes.

294 Q. Mr. O'Brien writes to you then on 14th November 2016 and states: 14:40

"Martina..."

-- he indicates why he's not available at the moment. He expects to be home over the weekend. He expects to be able to dictate correspondence concerning patients and have the charts delivered to Noleen, his secretary's office, for typing: 14:40

"I would greatly appreciate if I could be afforded this opportunity to have all the charts returned in this manner." 14:40

So, there's a request there from Mr. O'Brien to be facilitated to access the charts? 14:40

A. That's correct, yes.

295 Q. On down. On down. So, you send a reply on 14th November 2016 to Mr. O'Brien, saying:

"Aidan,
I am more than happy with this plan. Please let me know if there's anything I can do to assist."

And you say:

"By any chance, could redacted name be left in as I have had Governance looking for this chart as well."

And then you sign off. So there's clearly there a facilitation -- a request and a facilitation on your part that Mr. O'Brien could keep the records at his home in order to allow him to dictate from correspondence while he is on enforced leave for personal reasons.

Now, in relation to that, there's been a lot of evidence and teasing out whether there's a Trust policy, what the rules of engagement are around charts. Did you see that as a deviation from the normal practice, or did you see that as a pragmatic solution given the circumstances? I mean, what's your rationale for what seems to be on the face of it permission to keep charts at home, even for a short time?

A. Yes, I suppose it's back to there was a knowledge that Mr. O'Brien had charts at home, going back to one of your original e-mails. I have to say I, until the charts arrived in from home, I was assuming this was one or two clinics. Mr. O'Brien would see eight

patients at a clinic. So, I was thinking you were talking, maybe, 20 or maximum 30. Still not ideal, but Mr. O'Brien was very, and I think I might have said this before, he had his way of doing things and there was no way I would have turned him from doing his plan. In hindsight, reflection, I should never have condoned him working from home, but at that stage we didn't know the volume of undictated clinics that he had at home, which was only escalated by his secretary, I think, at the start of November -- or, sorry, December 2016. And, first of all, that was a shock to see that there was 60 plus clinics not dictated and then when you work out the volume of charts from that. 14:42 14:42

So, when I was agreeing to this plan and agreeing to him working whilst recovering, it was on the premises of my view that it was only -- and I don't mean 30 charts is a handful of charts, but it wasn't the 306 or 307 that came in eventually in January 2017. 14:43

296 Q. So, it was a pragmatic approach but in ignorance of the scale of the problem? 14:43

A. It was, it was, yes, it was. And I think, just to add, that if I had have went back to Mr. O'Brien and said, "No, I'm not happy with his plan", I think he still would have done it anyway because that was my experience over the years. 14:43

297 Q. Now, Mr. O'Brien, when you mentioned the issues that he has raised, there's a sense that -- and I think it's not even a sense, it's expressly stated that he liked

to do things his own way?

A. That's correct.

298 Q. -- most particularly in relation to triage, or advanced triage as it has been called. He's also raised issues about there not being enough time dealing with patients on the ward and for clinical concerns and it was one of the reasons why you moved the Urologist of the Week model, I think, to try and increase capacity for clinical care -- 14:44

A. That's correct, yes. 14:44

299 Q. -- but also to share the load and the demands over the week of a busy urological ward?

A. That's correct, yes.

300 Q. And that was something that was agreed by the whole team, including Mr. O'Brien? 14:44

A. It was, yes.

301 Q. And you described that as a concern that was listened to and a solution was put in place and it seemed to satisfy Mr. O'Brien at that time?

A. It did, yes. That was Mr. O'Brien's concern was not having enough time, as you've just said there, with regards to inpatient care, emergency care. 14:45

302 Q. Now, in relation to the triage, the time for clinics, which we'll look at as well, and the impact on the work falling behind from administrative duties -- 14:45

A. Yes.

303 Q. When you would challenge Mr. O'Brien around these matters, what was the way in which he responded to you questioning him or cajoling him or attempting to gain

compliance on his part?

A. Well, Mr. O'Brien always was very pleasant and always apologetic. He would have explained the reasons why he hadn't achieved what we were expecting from him, for example, the triage. Like even the notes at home, he would have said, "I'm really sorry", you know, and been apologetic. It did change sort of after 2017 when he returned from work. When he'd been asked a question, it wasn't as pleasant, I suppose, or -- he wasn't rude, but it would have been a different tone. And I think I talked about that my previous time when I was here. 14:46

304 Q. And there was issues at the beginning, you say, of 2009, there certainly seemed to be a tension that you described in your statement around you being a non-medic and being another manager? 14:46

A. Being another manager, yes. I suppose, my initial introduction was on one of the Monday night meetings and Mr. O'Brien was a bit taken aback and he said "Well, what will you be managing?" and I was taken aback because I'm so used to -- I had been working at that stage 22 years in the Health Service and always had a good rapport. But, to be fair, we got off on that footing, but we did have a good working relationship and I think others used that working relationship by asking me to speak to him initially, in the first instance, before trying to address it themselves, which was more of the time than not. 14:47 14:47

305 Q. And you seemed to spend a fair bit of time giving attention to Mr. O'Brien to try and chase things up?

A. Yes.
306 Q. That was your overall goal?
A. I did, yes.
307 Q. I think you talked about coming in very early in the morning when you had to look for the charts -- 14:47
A. Yes.
308 Q. And you did that, you said on the last occasion, so that he wouldn't be there?
A. That's correct, yes.
309 Q. Because of your discomfort around that? 14:47
A. That's right, yes.
310 Q. There was also a time mentioned by the previous Head of Service, Louise Devlin, explained to you that she had to go to his office as well and he had seemed angry at her? 14:47
A. He did. He was. Yes, Louise had advised me of that not long after I had started, of that occasion.
311 Q. And was that a charts issue as well?
A. No, it was triage. It was letters in his drawer and he was on annual leave and they needed the letters to 14:48
appoint the patients. And she was tasked by her manager to go and get the letters so, when Mr. O'Brien came back from leave, he was very angry with her because he hadn't had an opportunity --
312 Q. Do you know when that was? 14:48
A. Well, it would have been between 2007 and 2009 because it -- actually, it was probably in or around 2008, if I think about it, because it was when we were moving -- we all moved to the Patient Target Lists, so everything

had to be on Patient Administrative System.

313 Q. And Mr. O'Brien was resistant to the new categorisation of the red flag?

A. He was.

314 Q. He made that known to you and he would continue in his own way? 14:48

A. That's correct.

315 Q. The system was wrong and his way was correct?

A. That's right, yes. He would have said to me, I remember one of occasions he said he didn't care if it was a pink flag or a blue flag, he would be appointing the patient according to what he felt was the priority. Now, to be fair, once he moved to becoming the Chair of NICaN, his outlook changed and he did concentrate on the red flags. But that was the new categorisation and he didn't agree with it. 14:49 14:49

316 Q. The Inquiry has heard about Mr. O'Brien's excellence in aspects of his clinical care and you say in your statement as well -- we don't need to go to it but for the Inquiry's note it's WIT-26223: 14:49

"Behind all of this, I knew that he believed that this was what was right for his patients."

A. That's correct, yes. And any patients that were under Mr. O'Brien's care were more than complimentary to his care. And, you know, it goes to show when we're talking about governance, you know, one of the sort of things that comes up is, maybe, complaints. The only 14:49

complaints really we ever really seen was the fact that -- it was never about care, it was the fact that they couldn't get seen. So, if, for example, they were waiting for an appointment for a review or waiting for an appointment to come back for a day case or something, then that's what the complaints were about, as opposed to actual clinical care.

317 Q. I want to move on to your statement, in particular, and take you to some aspects and just query the basis for some of the things you say in relation to Mr. O'Brien, but I wonder if that's a convenient time... 14:50

CHAIR: Five past three. We'll take a short break. Thank you.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 14:51

CHAIR: Thank you, everyone.

318 Q. MS. McMAHON BL: Mrs. Corrigan, I just want to take you to your statement and highlight some issues you've raised in relation to Mr. O'Brien and just ask you some questions about those. If we go to WIT-26222 at paragraph 30.3(b) -- I'll just read out paragraph (b): 15:07

"My experience was that I could go to any member of the team if they needed assistance. Examples included in times of bed pressures, I would speak with most of the consultants who were on call and they would do an additional ward round, or go and request further tests to assist with the patient flow, or they would attend 15:07

the Emergency Department to assess urology patients to see if they could be turned around without needing to be admitted. I can confirm that this was the case for all consultants, with the exception of Mr. O'Brien, who, whilst he was pleasant and polite the majority of times, would not have agreed to do an additional ward round, as his view would have been that if they were still in the ward, they needed to remain there. My personal opinion was this was frustrating as the bigger picture that all of the others understood was that if someone could go home from the ward, then this freed up a bed for a patient who was awaiting admission from the Emergency Department. So when he would have been the consultant on-call, I would not have approached him for assistance." 15:08

I think the thrust of that paragraph is that while other consultants engaged with you to try to free beds, Mr. O'Brien took the view that if the patient hadn't been discharged, they weren't going to be discharged -- if they were in a bed, they needed the bed? 15:09

A. That's correct, yes. And, like, I understood where he was coming from, but some patients would be late discharges in the evening where we were just literally waiting on bloods or maybe to pass urine after a catheter had been removed. But he wouldn't agree to that. He'd say they needed to stay till the next day. 15:09

319 Q. Do you have any timeframes or specific incidents or dates or a record, in fact, of when any of these

requests or refusals from Mr. O'Brien would have occurred?

A. I don't have actual dates, but I do know that there was constant bed pressures and it would have been, you know, a constant -- particularly, if there was urology patients in the Emergency Department that needed a bed and were blocking and, you know, just speaking to the registrars, they would have said to me, you know, "Mrs. So-and-so/Mr. So-and-so, if we got their bloods back and they're clear, they can go home", whereas Mr. O'Brien wouldn't agree to them going home. So it was quite a probably regular occurrence and it just got to the stage, if I'm being honest, that I didn't ask, whenever he was on. 15:09 15:10

320 Q. Did you ever raise those issues with either the clinical manager or operational manager? 15:10

A. Well, the operational managers would have been aware of it because they potentially would have been the person that was asking me to go and speak to the consultant on call to try and free up space in the Emergency Department and they would have known my view would have been, well, there's actually no point in speaking to Mr. O'Brien because he'll not do a second ward round. 15:10

To be fair, once we moved to Urologist of the Week, there would have been two ward rounds done, but it may have been potentially just will you take a wee -- you know, if they weren't in theatres or they weren't seeing patients that had clinic, can you take a wee 15:10

run-around -- sometimes they just sent their reg or their staff grade up to do that. So, no, I don't have specific times.

321 Q. And what about your -- when you say people knew about it, the operational managers or the clinical managers knew about this, did they do anything about it? 15:11

A. No.

322 Q. Or did you request that they did or --

A. I suppose --

323 Q. -- did they indicate that they were going to speak to Mr. O'Brien? 15:11

A. I suppose I never asked them to ask -- or, sorry, never asked them to address it. It would have been just a comment to them, "You know, Mr. O'Brien has said..." -- whilst again what I have said, he always was pleasant, I would have got what you could perceive nearly a lecture on why the patient couldn't be moved out of the ward. 15:11

Now, there was many a time the consultants went up and there was nobody could be, but at least, you know, we were trying to address the situation. And I would have said that, "But there's no point, because Mr. O'Brien is on." So, I didn't ask, but that assumption was there, or that thought was there. 15:11 15:12

324 Q. And if we just look at paragraph (c), you say:

"At any time I could approach any of the team, apart from Mr. O'Brien, to discuss any issues in relation to

performance and they would have helped me out, if they could. For example, adding an extra patient to a clinic, taking a look at notes to see if a patient needed to be seen urgently, if, for example, there had been an informal query from a patient or via an MLA/MP etc."

Again, any dates or records or any particular recollection when you weren't able to approach Mr. O'Brien? 15:12

A. No, I have none neither and what I would say, it was more to do, just to clarify that, it was more to do with the other consultants would have turned it around very quickly. But, you know, I'm just thinking even of the likes of an MLA enquiry, it would have taken a long time to get a response back and we had seven days. So, what I would have done from Mr. O'Brien, I'm saying what I would have done is possibly taken it to one of the other consultants to ask them instead. 15:13

325 Q. Did you actually ever go to Mr. O'Brien and he refused to help? 15:13

A. No.

326 Q. And if we go to WIT-26260 at paragraph 52.4, and you say:

"I would have had ad hoc face-to-face meetings with Mr. O'Brien as and when required - for example, to discuss patient flow issues, triage issues, needing a response to complaints etc. These were not normally 15:13

planned and were in the nature of the operational management of the service."

Now, this potentially could be interpreted as slightly conflictual with the last paragraph -- 15:14

A. Yeah.

327 Q. Would you accept that or would you like to explain the way in which you found him arguably unapproachable, but are able to detail when you did actually speak to him about issues that impacted on patient care? 15:14

A. Yes, what I said was I would have initially spoken to him about the patient flow issues but stopped going to him with regards to the fact that I wasn't getting anywhere with him. And the needing response to complaints would have been a specific complaint that 15:14 went on for weeks and weeks and weeks. So, what I really meant by the previous one was your quick turnaround, that we had 20 days for complaint -- and, again, back to what I had been originally saying, that it was never to do with his clinical care; it was the 15:14 fact of getting access into his care. But I would have needed him to respond to that specific part of it, so it was the delay in it. And when he didn't respond to an e-mail, I just would have went and found him.

15:15

The triage issues are, again, back to -- I would have escalated to my managers, Mrs. Trouton or Mr. Mackle, and they would have said "Go and have a wee word to see will he do it for you" and I would have just got up off

the chair and away I went to the various places that he potentially could have been, Thorndale/theatre/ward. So, that's what I meant by the ad hoc face-to-face.

328 Q. If we go to WIT-26224, paragraph 30.12:

15:15

"Mr. O'Brien would often mention his legal connections through his brother and his son both being barristers and, in my opinion, made some of the medical and professional managers nervous and I would suggest was a reason for not challenging some of his practices." 15:16

First of all, you say in your opinion it made some people nervous. Did anyone ever tell you they had a particular nervousness about it?

A. No, but it was mentioned, it was mentioned in passing by -- 15:16

329 Q. By who?

A. -- I'm just thinking -- Mr. Mackle, maybe, could have said it to me. I'm trying to think -- Ms. Trouton maybe said it to me. The view was a lot of people knew 15:16 the connections. Mr. O'Brien -- and he never, he would never have said, you know, "I'm going to seek legal advice" or anything like that, he never did say that, but he would have regularly mentioned in conversations when we'd been talking things that he would have talked 15:16 through with regards to, say, issues with equality, for example, and he would have said about, you know, his brother being a barrister -- but not in a threatening way, but just, like, in a drop into a conversation way.

330 Q. You never saw him or heard him say it in a way with which you believed to be the intention to influence or intimidate anyone?

A. No. No.

331 Q. Did you feel nervous or intimidated by that? 15:17

A. No, not personally. But I suppose it was always in the back of my mind, but never held intimidated.

332 Q. So there was no hard and fast evidence --

A. No.

333 Q. It was a perception -- 15:17

A. Yeah.

334 Q. Is that as high as you would put it?

A. Yeah, perception.

335 Q. If we go to WIT-262233, paragraph 38.1(d) -- just there, thank you -- you say: 15:18

"Mr. O'Donoghue came to see me to discuss Mr. O'Brien's attitude towards him at meetings and said that he felt Mr. O'Brien undermined him, which made working with him very difficult. I asked him if he needed me to do 15:18 anything about this, but he said at that time he just needed to vent and that he would deal with this himself. However, I did advise him to speak with one of his other consultant colleagues about the issue." 15:18

Do you have any recollection when that conversation with Mr. O'Donoghue took place?

A. It was after a multidisciplinary meeting that I had Zoomed into it at the last -- so I'm assuming it was

probably sort of in and around 2019 where I actually couldn't believe the way Mr. O'Brien had spoken to Mr. O'Donoghue at the meeting. And I think Mr. O'Donoghue knew that I had heard it and came up to speak to me. I was quite shocked, but he just said to me, as I said there, that that was a regular occurrence and that he was used to it and he just needed to vent to me. I did advise him to speak to some of his consultant colleagues, and I did -- I do know I did speak to Mr. Haynes about it. 15:19

336 Q. Is there a note of that or any record of that conversation or anything to do with this?

A. No, it was one of those I was coming back up to the office and Mr. O'Donoghue had followed me up. So I don't make a note of it, no. But I do clearly remember the conversation. 15:19

337 Q. And so Mr. Haynes knew about it, but you didn't escalate it to your operational manager or anything like that?

A. No. I think it was because Mr. O'Donoghue had sort of said to me not to, that he wanted to deal with it himself. 15:19

338 Q. So did you say you told Mark Haynes or Mr. O'Donoghue did?

A. No, I mentioned it to Mr. Haynes. 15:19

339 Q. Do you know if Mr. Haynes did anything after that?

A. I don't, no.

340 Q. If you go to WIT-26266, 54.15? This is about not conforming to booking of patients, doing his own thing:

"Mr. O'Brien was asked on numerous occasions not to do his own scheduling of patients with the other lists. However, he continued to do this. This included him ringing each patient and detailing what they needed to do or not to. Whilst this was practice was good for the individual patient, no other consultant did this. And whilst he was doing this, he was not triaging, dictating, or looking at results and was therefore doing a task that was not necessary. 15:20

I know that, over the years, clinical managers, especially those doing his job plan/appraisal asked him to stop this practice and explained to him the reasons why he should stop. This issue arose in this context because I understand that Mr. O'Brien always requested more admin time and it was felt that if he ceased the individual scheduling of patients, then he would have that additional time. 15:20

This was always Mr. O'Brien's practice, which led to him not having time to do other admin, but also meant that, as he scheduled his own patients, he was not conforming to chronological management and, therefore, whilst he insisted it was in the patients' interest that he did the scheduling, other patients were disadvantaged." 15:21

Now, this was something that Mr. O'Brien actually did

in his own time?

A. Yes.

341 Q. And Mr. O'Brien would say that or may say that that was a direct out-working of the fact that he didn't have enough time to do it during the hours allocated to him, and was that something that he brought to your attention, that he didn't have enough hours to complete his tasks, admin tasks? 15:21

A. He didn't specifically say it to me directly, but it was mentioned in some of our departmental meetings, particularly in relation to the triage, and the other consultants would have said, you know, he would have said about spending a Sunday afternoon contacting patients, whereas they would have said "but there's no need to do that" and he would have said it was good to phone the patient. And they would have said "But you hand that over to your -- you sit with your secretary and, you know, you schedule together, rather than ringing the patient and sending them out a letter." But he continued to do it. And take the point that that was on a Sunday afternoon, but, you know, he was still behind in his dictation, in his results, in his triage -- so, if he wanted to work on a Sunday afternoon, would he not have been better to do that? 15:22 15:22 15:22

15:23

Now, Mr. O'Brien, at the outset, when I arrived in 2009, would have had the most PAs of the other consultants and he still was behind in all of these tasks as well. So, it was looking at his practice to

try and -- I don't know whether you're coming to, but, like, even his letters, when he did dictate, were pages and pages long as opposed to what a GP would want would be a few lines, giving a summary of what care needed to happen after that. 15:23

342 Q. Now, you have mentioned about the chronological management. Would you accept that a clinician may have multiple reasons for moving people around the list, depending on update on their clinical presentation or any other matter that would warrant that -- that's the 15:24 clinician's gift to do that, would you accept that?

A. I accept that, yes. Yes. I think one of the issues for us, too, was that Mr. O'Brien would have worked from his own lists as opposed to the PTL, Patient Targeted Lists, so his wasn't in the same order as what 15:24 we had. And I totally accept that there was some patients needed to be seen sooner than -- it's a bit like the example I gave earlier, you could look at a patient waiting on TURP, but the patient with the catheter is more urgent than the patient waiting for -- 15:24 I don't mean an ordinary TURP, but a TURP. So, Mr. O'Brien would have had that information, as did the other consultants.

343 Q. And the issue of whether Mr. O'Brien had arranged for the admission of patients who attended privately ahead 15:24 of patients who had remained on the waiting list for longer periods of time, again would it be your view or would you understand that there is a clinical perspective applied to the assessment of patient

priority that is perhaps out with the expertise that you would have?

A. Oh, absolutely, yes, yes. And, you know, at the time when myself and Sharon Glenny, the OSL, would have been working with the consultants to meet the longer -- try and address the longer waiters -- we would have sat with the consultants and they would have explained to us why the patient midway down was more urgent than the patient that was waiting longer. So, it would have been out of our expertise and we would definitely wouldn't have went off and done scheduling without the consultant's input. 15:25 15:25

344 Q. If we go to WIT-26268, paragraph 54.1.11 and not following up on results.

15:26

"In June 2020, when the directors, Mrs. McClements and Dr. O'Kane, asked me to do an admin look at Mr. O'Brien's patients who had gone to theatre both as an emergency and electively, I discovered that some of these patients had had investigations and it appeared that they had not had their results reviewed by Mr. O'Brien." 15:26

Now, I just want to ask you about that. Was that you looking at the patient notes yourself to see whether the results had been looked at, or was it a matter of a trigger in the system indicating that to you? How did you form the impression that the results hadn't been reviewed? 15:26

A. Well, I remember this particular patient in that I was doing the admin review, which is basically seeing when they were operated on and had they to come back in, and it was to do with the stents. But also part of it was I was doing it electronically without notes in front of me. But what I had noticed was that the patient had had an MRI in December '19 and this was June '20 and it didn't appear to be actioned on. Now, it was just me as a layperson and I actually escalated it to Mr. Haynes. We did pull the notes and, at that occasion, it didn't appear that the family had -- sorry, that the patient had been spoken to with the results -- 15:27 15:27

345 Q. And how would you have known it hadn't been actioned by looking at that electronically? What would be the teller? 15:27

A. Well, the trigger was, what I did was, first of all, looked at the date of the result and then seen if there had been any follow-up with the patient. Again, as a layperson, my view was there was no indication -- there was no appointments. This was somebody who was actually in a review backlog, so there was no appointments from May 2019, I think it was. So, they had had no follow-up at all on the scan. So, to me, that raised a sort of a concern because, if it had have been actioned on, the patient would have probably had had an appointment or further scans or tests. So there had been nothing happened it since the result in December 2019, which is why -- 15:27 15:28

346 Q. So it was the absence of a follow-up?
A. It was absence of the follow-up -- and then, obviously, being not a clinical person, I did seek clinical input.
347 Q. Now, you mentioned about Bicalutamide being an unlicensed drug. It is licensed, I think that's uncontentious, but your information in relation to Bicalutamide was that derived from one of the clinicians? 15:28
A. It was, yes. I would not have had any -- I actually had never heard of the drug until this. 15:28
348 Q. If we go to WIT-26289, paragraph 60.5(b), there's one line in this. [Short pause]. Now, in that paragraph you refer to -- I think I'm just going to have to read the paragraph because the line that I want to go to is at the very last one -- 15:29
A. Okay.
349 Q. And it doesn't mean anything without everything before it so...

"Digital dictation. This was the second area of weakness. Whilst this showed electronically how many letters there were, it didn't show if there was a letter for each patient. So, for example, if there were eight patients who attended clinic, then I would have received a report from the service administrator 15:29 15:30 to say that there were eight letters on the G2 system and, as part of my monitoring, I would have had to spot check these clinics to ensure all eight patients each had a letter. I did this spot check every three

months, as I was assured that all patients were having a letter dictated on their attendance.

However, in September 2019, I discovered during my spot check that whilst there were eight patients and eight letters on the G2 system, one patient had three letters - one letter to their GP, one letter to the patient with instructions, and one letter to the clinical nurse specialist to review for lower urinary tract symptoms. One patient had two letters - one letter to the GP and then a specific one to patient with instructions. Three patients had one letter each. And unfortunately three patients didn't have any letter dictated. I duly highlighted this to Mr. Carroll. My observation on that is that I suspect Mr. O'Brien realised this feature of his system, realised that this check was not done for every clinic and slipped back into his old ways. 15:30 15:30 15:31

I had organised a meeting about this on 8th November 2019 with Mr. McNaboe and Mr. O'Brien. Mr. O'Brien sent me a letter dated 7th November 2019 in which he stated: 'It is evident that the issues that you wish to discuss cannot be considered deviations from a Return to Work Plan which expired in September 2018.' This, in my opinion, amounted to evidence that he had decided that when he thought he was no longer being monitored, he could start to do his own thing again." 15:31 15:31

This is obviously -- you heard the dispute around the duration of the Return to Work Plan --

A. Yes.

350 Q. But you seem to be suggesting in that paragraph that Mr. O'Brien was perhaps deliberately circumventing the expectations that he would dictate clinics appropriately after the patient -- he had decided what to do next. Would that be fair to say, that you felt that this was a deliberate effort by Mr. O'Brien or is that a harsh reading of that paragraph? 15:32

A. Well, I suppose, it's just strange that it sort of happened, you know, whenever I was doing my spot checks previous to this that there were eight letters for eight patients or, you know, sometimes there were ten letters or twelve letters for eight patients. So, that seemed to be going okay. And then I didn't know, and I know we've talked about this before, that the work plan was supposed to stop in September 2018 when I was still monitoring it, and then just looking back on my spot check in September 2019, I just -- it just seemed too coincidental that if Mr. O'Brien felt that he wasn't being monitored anymore, that suddenly we had a deviation that I found through just doing a spot check. So it's my personal opinion. It's not based on --

351 Q. Did you speak to Mrs. Elliott, Mr. O'Brien's secretary, about this or anybody else? 15:33

A. No, just Mr. Carroll.

352 Q. And did he take any steps at that point that you can recall?

A. No, this was actually fed back into, which we know now was the September -- or was to be fed into the September 2019, and one of the actions that came out of the deviations because there was the issue with not triaging as well and, you know, we had the circumstances around that for personal reasons, but Mr. McNaboe then were tasked to go and speak to him about this. So, obviously Ronan had fed it into -- and I think I did share it with Dr. Khan and Siobhan Hynes. I think I did, I'd need to double check that. 15:33 15:34

353 Q. Was this an example of it passing over from the operational side to Mr. Carroll?

A. Yes.

354 Q. Through to the medical side?

A. Yes. 15:34

355 Q. Was it your understanding that it was addressed or because it became part of a wider issue that it was subsumed into that?

A. I don't know if Mr. O'Brien was ever spoken to about that because obviously the meeting of 7th November didn't happen, and I think there was a misunderstanding with regards to that meeting. But it didn't happen. So, I don't know, I don't know if it was ever addressed with Mr. O'Brien. But it was, to me, it was a deviation from the Return to Work Plan, because he was -- part of the Return to Work Plan was that he had to dictate on every patient. 15:34 15:34

356 Q. WIT-26294, paragraph 63.1, the question you're asked is:

"Did you raise any concerns about the conduct/ performance of Mr. O'Brien? If yes, outline the nature of concerns you raised and why it was raised."

15:35

And you say at 63.1:

"During my tenure working with Mr. O'Brien, the main concerns that I escalated were in respect to his non-triage, patient notes at home and his lack of 15:35 engagement with respect to performance, both elective and emergency, for example, not doing a ward round to help with patient flow. I would also raise concerns regarding Mr. O'Brien bringing patients in from home on the week that he was Consultant Urologist of the Week, 15:35 thereby adding more pressure to an already pressured system."

I would just ask about that last sentence, the bringing patients in from home, just what you mean by that? 15:36

A. Antidotal, it was on a week that Mr. O'Brien was on call, that -- it's not even -- it would have been fact, I shouldn't have said that, it would have been fact that I would have been contacted by Patient Flow to say Mr. O'Brien has brought in two patients that he wants 15:36 to operate on as part of his Urologist of the Week and when he was Urologist of the Week, we were -- there was, I will be honest, there was a dread because it meant that there was an awful lot of urology patients

in the hospital, and we were already pressurised with trying to find beds for, you know, elective, trying to find beds for medicine, and Patient Flow would have said to me, "Oh, no, it's not Mr. O'Brien on again - that means that we're going to get into difficulty because he'll be bringing patients in from home." It was one of the times that Mr. O'Brien did challenge me about not being a clinical person because we were in a particularly difficult period of the winter. 15:37

Mr. O'Brien was on call and he wanted to bring two people in to the ward. I went and spoke to Mr. Young and got him to look at the information with regards the patients and he said to me, "No, don't bring them in today, bring them in tomorrow morning instead", which I did, and Mr. O'Brien came up to myself and the Patient Flow Manager, Patricia Laheran, and he was very angry with both of us for stopping the patients from coming in. But it wasn't done on our say-so, it was actually asking advice. And it happened every time Mr. O'Brien was on call. And then, strangely, whenever the next few weeks were on, we wouldn't have had as much pressure on the system. 15:37 15:37 15:38

357 Q. You said it happened every time when Mr. O'Brien was on call?

A. Yeah, the majority -- not every time, the majority of times. 15:38

358 Q. What about timeframes? Can you remember what sort of times we're talking about?

A. It would have been probably every sort of six weeks,

but it would have been more pressure for us during the winter period when we were struggling. And one of the conversations I would have had with Mr. Young is "We really need to speak to him because, as a result of having too many patients in, what suffered was elective." So, we would have had to cancel elective because we were bringing in the emergency patients.

359 Q. And what was your understanding of -- I mean, you say "brought patients in from home" -- what is your understanding of -- are these patients from the waiting list or private patients? What was your understanding? 15:38 15:39

A. Well, my understanding was they were from the waiting list. And I know this will be controversial because Mr. O'Brien had said it before, but there was a view that Mr. O'Brien would have brought elective patients in and operated on them in the emergency list. The meeting that was recorded on 7th July, was it, Mr. O'Brien did bring that up because they had went in the weekend before because -- to look at the emergency list, but it would have come back from theatres, from the theatre management, that on a week that Mr. O'Brien was on call, that there would have been patients who -- and definitely needed an operation, I'm not saying they didn't, but they may be people who had stents in or, you know, a catheter in, or, you know, needed to be operated on would have been brought in as an emergency and operated on, on the emergency list, but they were originally on an elective list. 15:39 15:39 15:39

360 Q. So, are you suggesting that they didn't fit the

definition of an emergency?

A. Yes, and that's coming from the theatre management, as opposed to something -- you know, I would have depended on them to advise us of that.

361 Q. Is this an example -- you said earlier Mr. O'Brien kept his own list? 15:40

A. Yes.

362 Q. Would this be an example of the out-working of that list?

A. Yes, it could have been, yes. 15:40

363 Q. But you don't know, do you?

A. No, I don't. No, I don't. You know, in hindsight and on reflection, there probably should have been audits done or look at, you know, the patients that were in and the reasons they were in and did they definitely need to be on theatre lists. And I know that particular weekend that Mr. O'Brien had raised the issue at that meeting, they had done a lookback on it and I genuinely can't remember the outcome from it because theatres would have done that, looked back on it, rather than me, if you know what I mean. 15:40 15:41

364 Q. You mentioned Mr. Young, who was Mr. O'Brien's Clinical Lead -- you had gone to him and he had deferred the admission until the next morning?

A. He had, yes. 15:41

365 Q. Did he indicate his surprise or did you get the sense that this was something that he knew was taking place?

A. I think Mr. Young knew it was taking place.

366 Q. Do you think other consultants knew it was taking

place?

A. I do, yes.

367 Q. Do you think the medical management knew it was taking place?

A. Yes, because when the issue was raised, the one that sort of had come to the forefront, Mr. Weir was involved in that well. So, yes. 15:41

368 Q. As far as you can remember or during your time, did anyone take any steps to stop that practice from happening? 15:42

A. No. Not that I'm aware of.

369 Q. If we go to WIT-26302, paragraph 68.2 when you're speaking about learning:

"In my opinion, there has also been the following learning from a governance perspective..." 15:42

I just want to make sure I've got the... Move it on, please. No, I can't seem to find that. There's a reference in your statement to Mr. O'Brien not being available for morning ward rounds. 15:43

A. It is in that one.

370 Q. Is it? Did I go past it?

A. If you go back --

371 Q. If you go back up? 15:43

A. Yeah.

372 Q. Oh, I see, it's the second line from the bottom:

"I think there were a lot of missed opportunities to

become aware of issues such as medication practice, Bicalutamide, not having a key worker present with him during oncology consultations, not acting on results and not being available for the morning ward rounds."

15:43

How did you come to have that information about him not being available for ward rounds?

A. That would have come via the registrars and via the nursing staff. And it was no secret Mr. O'Brien was definitely a night person and an afternoon/night person, opposite to myself really. But you would have found Mr. O'Brien on the ward at eleven o'clock at night, but the ward round, they all wanted to try and get the ward round started in or around half eight. The regs, as part of their timetable, would have had to be on the ward round. So they would have made a start to get round because they would have had patients to take to theatre, for example, or they needed to go to clinic or just even the likes of getting scans done, bloods done, MRIs or bloods done etc., then they liked to get it done and they would have said that they would have had the ward round really over by the time Mr. O'Brien arrived.

15:43 15:44 15:44 15:44

373 Q. Was that a longstanding issue or was it something that people just mentioned happened now and again?

A. No, it was longstanding.

374 Q. And, again, was that something that went over a protracted period of time so far as you're aware?

A. As far as I'm aware, yes.

375 Q. So you're hearing from others that this was --
A. Yes, yes, I never would have witnessed myself. And, to be fair, once we moved to Urologist of the Week, there was an evening ward round and Mr. O'Brien would have always been on the evening ward round. 15:45
376 Q. Do you know if anyone spoke to Mr. O'Brien about that --
A. No --
377 Q. -- give any explanations about why he mightn't have been there or any specific examples of why he said he 15:45 wasn't able to attend?
A. No, no, I'm not aware. And, I will be honest, I never challenged him on it either because I didn't see it myself. I was never on a ward round, for example. I potentially would have been on the ward when the ward 15:45 round was happening, but not necessarily being in the position to challenge.
378 Q. If we go to WIT-26314, paragraph 70.5:

"Mr. O'Brien always dictated his own workload right 15:45 from the time of the Regional Review when he would not agree with the numbers of patients being booked to his clinic. The then Director of Acute Services, Dr. Rankin, overturned this and asked that we book the agreed number of 14 patients to his clinics, 8 new and 15:46 6 review, which we did, and we ended up having to reduce this to 8 patients as Mr. O'Brien wasn't finishing his clinics until 8:00 p.m. at night, which was unfair on patients waiting and on the staff, as

this was every Tuesday evening."

Just, again, is that information that's been relayed to you by others?

A. Yes, it was. The staff actually came to speak to me because obviously they were at the front face of it, having to deal with both the patients and they were having to stay on. 15:46

379 Q. And do you recall who would have told you about this, or informed you that this was an issue? 15:46

A. I think it was -- I think it would have been either/or or both of the CNSs, Kate O'Neill and Gemma McMahon, and I can't remember whether both of them came to see me or one other. But I do recall the conversation because I then had to reduce the clinic. 15:47

380 Q. And was there anything -- was there anything done about that, about the late clinics or the fact that staff actually came to you with that issue. Were you able to do anything about it?

A. No, I suppose the only way I addressed it was to reduce the clinic. I think part of the whole conversations with regards during Regional Review was there was an agreement that they were going on guidelines of ten 10 for a review and 20 minutes for a new and Mr. O'Brien felt that you needed at least 30 minutes for a review patient and that was why his clinics over ran. 15:47 15:47

381 Q. If we go to WIT-26147 and paragraph 1.5(a) --

A. -- which again I will say it was good for the patient because they were getting a lot of time, but it wasn't

good for the next patient coming behind.

382 Q. And you've referenced that in the paragraph, the reduction in turnover compared to others?

A. Yes, yes, yeah.

383 Q. Paragraph 1.5: 15:48

"Issues raised about Mr. O'Brien during this period were..."

-- sorry, if we just go up and see the period, I think 15:48 it was 2009 to 2013 -- yeah, it is.

"...were (a) administering of regular IV antibiotics and fluids..."

15:48

-- more detail later on --

"...and then a question was raised on the number of benign cystectomies that had been carried out by Mr. O'Brien." 15:48

Now, when you mention the IV antibiotics and fluids, paragraph 1.5, you refer to Mr. O'Brien, but there was someone else involved?

A. There was, yes. Mr. Young was involved as well, yes. 15:49

384 Q. So it wasn't an issue confined to Mr. O'Brien?

A. No, it wasn't.

385 Q. In relation to 1.5(b) when you refer to the number of benign cystectomies that had been carried out by

Mr. O'Brien, the question that was raised was about the number of simple cystectomies that had been performed for benign pathology in the Southern Trust compared to other Trusts, would you accept that that was the query that was identified? 15:49

A. Yes.

386 Q. And there was a subsequent audit undertaken?

A. It was, yes. My only input in it, and that is totally my fault saying "benign cystectomies", but -- I accept that. The only input I had was to get the charts from 15:49 -- for the external consultant, Mr. Drake, that came in to do it and I sat with him and Mr. Mackle while he was going through it. And the only reason I was there was if they needed to ask any questions with regards to a patient letter or something like that. I just 15:50 facilitated it, as opposed to had any input into it.

387 Q. I suppose, the point really there is it wasn't carried out by Mr. O'Brien --

A. No.

388 Q. It was a broader sweep? 15:50

A. Yes.

389 Q. And also Mr. Young was involved in those --

A. He was, yes.

390 Q. -- operations as well?

A. There was one patient of his, yeah. 15:50

391 Q. I just want to ask you some questions about the support that was offered to Mr. O'Brien at different times. We don't need to go to it but, for the Panel's note, you say in your statement at WIT-26258, you personally

always offered support to those who had their clinical ability issues raised, and you name some other medics that you'd provided support to. Do you feel that you did provide Mr. O'Brien with sufficient support, given the duration of the problems and, indeed, your knowledge of the depth and breadth of them over the years? Do you think he was supported sufficiently by you or, indeed, the Trust?

A. Well, I suppose I always would have offered to help Mr. O'Brien out and if it was, you know, to support him by, you know, even helping him with his triage in the sense of, you know, facilitating pulling notes or trying to help him through -- I always offered him "If I can do anything for you...", but he never took up that offer. And, like, even with regards to the triage, I would have said to him, you know, "Do you want me to get some of the other team to help out?" and Mr. O'Brien would have always come back and said, "No, I appreciate I'm behind..." -- he was always apologetic. He was, you know, in the beginning, always apologetic and saying that, no, he would address it. He didn't look for help. I know when myself and Mrs. Burns met with him, she offered him support at that stage and even was somebody from an additional admin point of view that would help him out with regards to whatever admin duties that, as an admin person, we could help.

Did we offer him enough assistance? We offered it. He

didn't take it. Probably should have offered it more often. So, I think it went both ways. He was offered it informally and formally on that occasion, but he never took up the offer.

392 Q. And we've touched on one of those -- perhaps, an example of support -- just earlier today when you facilitated the notes at home? 15:52

A. Yes.

393 Q. -- to allow Mr. O'Brien to access that for completion of his -- 15:53

A. Yeah.

394 Q. -- marking up his papers?

A. Yes.

395 Q. And, also, we'll look at the triage issue, which arguably there are two examples of work-arounds -- 15:53

A. Yes.

396 Q. -- in order to try and get things back on track?

A. Yeah. Yes. And I'm just even thinking back to when we started first, you know, the likes of the review backlog, we arranged for Kate O'Neill and Gemma McMahon 15:53 to try and help to reduce the review backlog. As clinical people, they would have gone in and looked at the last patient letter and contacted the patients. And we were able to reduce that substantially at that time. And, you know, we didn't mention it over the 15:53 years, but it would be something else to do. But it's just a whole capacity issue because even if the consultants had agreed to it, we didn't have the clinical people to do it. You know, you can always do

an admin validation by making sure the patient hasn't been seen since they were added to the waiting list or have a look at -- for example, some patients deceased or moved away out of -- across to the main land or whatever. But the problem with it is once you contact the patient and ask them do they still want to remain on the waiting list, their expectation is arisen that they need to be seen again. So, we would have talked about things to try and help with that burden that was sitting, you know, with all the patients on a waiting list. 15:54

397 Q. Now, you'll have heard evidence around the potential lens people look through that the issues that arose were administrative issues and that, perhaps, clouded some judgement around the potential patient risk that might arise from that. Now, we also heard on the last occasion when you gave evidence that you had specifically mentioned potential for clinical risk in the March 2016 letter in your draft? 15:54

A. Yes. 15:55

398 Q. The ultimate draft that Mr. O'Brien got, that part was out?

A. Yes.

399 Q. But at least from that time, you had on paper an identification that clinical risk was in your mind, would that that be fair? 15:55

A. That would be fair, yes.

400 Q. Given that, and your knowledge of that and your awareness of that and your operational head on, if I

can put it like that, was there ever a sense that you needed to speak to your medical counterparts and say, "This isn't just our problem operationally, it isn't a notes and records or a record-keeping problem, this actually has the potential for significant impact." 15:55
Did anyone cross the potential divide and say, "We need your help sorting this out"?

A. From my perspective, I would have escalated and I would have had quite a number of conversations with regards to them issues with Mr. Mackle mostly so, and Mr. Young 15:56
would have helped me out with sort of clinical issues that I would have felt that I wasn't able to address. To cross that, I didn't -- I don't believe I ever said -- it was quoted to me so many times by managers -- this is always an admin issue -- clinically, 15:56
Mr. O'Brien is brilliant and we have no issues with it. Like, for example, Mr. O'Brien was his Clinical Director and one of his quotes is "If I had to come in, I would have had no issues coming in under Mr. O'Brien." So I think that clouded, wrongly, my 15:56
judgement -- I have reflected on this -- in that I felt there may be an issue because nobody else did and that's my fault, I should have escalated it further. But it's one of those things that when I was escalating it or and thinking it and saying it in a letter and 15:56
then it was removed, that it was me was thinking it was, where it really wasn't, if that makes sense? I'm probably not saying that very well.

401 Q. I think Vivienne Toal said something similar. She said

"His excellence as a surgeon blinded us to the issues" -- I paraphrase her, but would that be a view you share?

A. Yes, yes. And I think it was everybody else sort of, you know, in and around and sort of up/out would have said that, that there was no issues clinically and it was all admin. 15:57

402 Q. I know you mention Mr. Mackle -- obviously, there's an issue, Mr. Mackle took a step back so the potential for him to remedy anything maybe was curtailed somewhat, but did you ever speak at length to Colin Weir or Charlie McAllister about this and try and get their fresh eyes on it when they took up post in 2016? 15:57

A. I did speak to them, but it was more in the context of the letter, of the March 2016 letter, and I do know I had conversations and raised all of them issues, definitely with Dr. McAllister, and I'm assuming so with -- but I can't actually remember -- with Mr. Weir. But we did have conversations about it on the issues around Mr. O'Brien. And I will be honest, I don't think it was a big surprise to them. I think they knew it as well, but it's just it sort of had come to a head. 15:58 15:58

403 Q. And the gear change was that it was put in writing?

A. Yes. 15:58

404 Q. For the first time really in that letter in March?

A. That's right.

405 Q. And, the last time, we went through the timeline after that?

A. Yes.

406 Q. But just for the Panel's note, Mrs. Heather Trouton references support that you would have given to Mr. O'Brien at TRA-02379. In her evidence, she said:

15:58

"I have no doubt that Mrs. Corrigan would have been, because she met Mr. O'Brien on numerous occasions and you can ask her herself, but I have no doubt that Mrs. Corrigan would have followed up and sought to support, as she always did, Mr. O'Brien with his admin practices, meeting or no meeting."

15:59

Now, in your second Section 21 you've accepted that you didn't approach Mr. O'Brien after that meeting in March?

15:59

A. No.

407 Q. -- the 20th March 2016, after he'd received a letter. Do you think that was a potentially high water mark to seek to intervene, given that matters had taken on a different -- well, at least were on a different footing now that the issues had been expressly set out -- that that would have been an opportunity, perhaps, to move in and put some framework or support in place formally?

15:59

A. Absolutely. I do regret that that didn't happen. And I do recall very vividly saying in a comment, 'Look, if there's anything you need me to do please just give me a shout.' That's sort of my terminology. And I didn't follow up on that. I think just things took... with the change of the personnel -- sorry, with the

15:59

change of personnel it was just a bit...

408 Q. It seems this that there wasn't any follow up?

A. No, there wasn't. No, there absolutely wasn't. Not on my behalf.

409 Q. With perhaps the reverse burden being put on Mr. O'Brien to come back with a plan? 16:00

A. Yes.

410 Q. And perhaps more appropriately, he might have been proactively engaged with one?

A. Yes. I totally accept that. 16:00

411 Q. Also around that time, Mr. O'Brien clearly under pressure of sorts, reflected in the concerns that you brought to him, he was also the lead clinician of NICaN, the clinical reference group in urology and he didn't get any allocated time for that as part of his duties, isn't that right? 16:00

A. That's correct, yes. As far as I'm aware, I didn't have anything to do with his job plan but I don't think he did.

412 Q. And he was also a the lead clinician of the Trust Urology Cancer MDT and again that was anticipated that would be subsumed into his existing work role? 16:01

A. As far as I'm aware, yes.

413 Q. Again, you may know about this one, the Chair of the Urology MDM each week is not something that's allocated specific time? 16:01

A. It wasn't. I think it is now as part of the recommendations from of the SAIs, nine SAIs.

414 Q. Apart from the Chair of the Urology, which rotates, as

far as I understand --

A. That's correct, yes.

415 Q. -- the other two positions, were they rotational or were they roles that Mr. O'Brien undertook himself?

A. Mr. O'Brien undertook them himself, I think after, it was in 2012/13 Mr. O'Brien took on the Chair and that was when Mrs. Burns spoke to him and said to him, you know, 'Is there anything we can do to help?' It wasn't rotational and I think he was actively involved in them roles. 16:01 16:02

416 Q. You've mentioned yourself but there's reference as well with Heather Trouton about Mr. O'Brien doing work when he's off, his admin stuff when he's off and we can see --

A. That's right, yes. 16:02

417 Q. -- one of the examples earlier today and you've said that he worked after hours, after conventional hours. Do you think that those factors and the fact that he had to do that were red flags, if I can use that term in a different way, as to the potential pressure he was under to get things done? 16:02

A. I suppose the thing for me is, this happened just when he took on these roles, it was pre-2000-and, I can't remember whether it was '12 or '13 he took on the NICaN role. This was a longstanding issue of him not doing his admin and the view, whenever I would have spoken to the others, was that he -- yes, he's got these extra but he also has smaller clinics and he also has been advised not to do longer letters and not to schedule 16:03

patients on his own. So, he's doing the same perhaps slightly less workload than the rest of them and they are all able to continue on with their admin, nobody else was behind it.

16:03

So, yes, I understand where that point is coming from, but when you look at his peers, they were all able to manage and even when they were doing the week of the Chair of the MDT, they would have still been able to keep on top of their admin. 16:03

418 Q. You recall that in March 2016, just before the letter was given in the meeting, that a plan was put in place to support one of the other consultants with open surgery, Mr. O'Brien was involved in that support?

A. That's correct, yes. It actually happened in December 2016 and I know Mr. Mackle was involved in it, as along with all the other consultants. 16:04

419 Q. My question was going to be just --

A. Sorry.

420 Q. -- did you think that given that -- I don't mean to cut across you but just in case I forget. Do you think that was a productive thing to do that he would in some respects gain more responsibility by supporting another given that by December he was certainly nine months after getting the letter and things hadn't improved, as we've seen through various e-mails, do you think his engagement to provide support to another consultant was perhaps ill-timed? 16:04 16:04

A. My recollection of that is that it was voluntary. The

team met. It was on the nights that the consultant was actually on call, emergency wise because during the day one of them would have joined him in theatre. My recollection of that is they were to be renumerated for it and it was voluntary, nobody was asked to do it and 16:05
Mr. O'Brien, along with the team, agreed to do it. So, it wasn't that he was doing that support on his own, it was that they all volunteered to do it and they were renumerated. I know there was a bit of difficulty because it wasn't backwards and forwards about the 16:05
remuneration being paid but it was. So, I understand. The question is do we feel, but that was up to Mr. O'Brien to say, look, I have to step back from doing this and leave it to his other colleagues to do that support. 16:05

421 Q. And did you have any knowledge around that time if Mr. O'Brien was undertaking private work at the same time?

A. I didn't have any knowledge of that, no. I'm assuming that he still continued to do, but I don't know. I 16:06
don't know.

422 Q. I think you'd mentioned earlier that there was a planned meeting with the consultants on 24th September 2018 that was cancelled --

A. Yes. 16:06

423 Q. -- and then there was a subsequent meeting for 30th November 2018. I think there were issues being raised and there was going to be a collective meeting, and it had been hoped that that would be a meeting to meet

with just senior management personnel. It was planned for Monday the 3rd. And you -- I think it was you informed everyone that it was cancelled then?

A. I think the meeting maybe went ahead, the start of it but nobody else could go only me. I think. I can't remember. There's just something about that in my head. 16:06

424 Q. Let me just check with the reference to make sure. AOB-04250. I don't want to misrepresent it.

A. Because is there a transcript of that meeting? That's why I'm sort of thinking it went ahead but didn't... 16:07

425 Q. It was an away day that was organised?

A. Yeah.

426 Q. Maybe you're just getting the dates mixed up. This is Friday, 30th November 2018: 16:07

"Dear all, apologies, as I meant to sent this e-mail earlier."

We can see the two recipients are the consultant group. 16:07

"It has been agreed that the away day on Monday is cancelled but that the consultants and I would get together at 10:00 a.m. for a couple of hours to discuss some of the issues that have been raised on the 24th September meeting ." 16:07

Which had taken place?

A. Yes.

427 Q. Do you remember if there were attendees at that couple of hours meeting at the ten o'clock that you've suggested there. Is that the one you think no one turned up?

A. No, I think the 3rd December meeting happened with the consultants and myself. There were a number of issues discussed, which I can't remember, I would need to remind myself of it. Which I can do later on. But we did -- what that actual away day was, was there was going to be -- Ronan was going to be at it and I'm not sure, 2018, would have been, would it have been Esther, Esther was to come to it. But because it was in the midst of a bunch of pressures I think the agreement was for me to go ahead with them but they wouldn't be able to attend - as in the other senior managers. 16:07 16:08 16:08

428 Q. And at those sort of meetings or away days was this an opportunity for everyone to speak frankly?

A. Absolutely, yes. Unfortunately, the one on 24th September was all planned and I know it did go ahead, albeit that was -- I had been off after my shoulder surgery and I had been hoping to be back by that stage. As you know, I didn't get back and that was through occupational health and I wasn't allowed to drive until, 5th November. But they did go ahead on that day because I have seen notes of it but they had never been shared with me until quite recently. So, this is was a follow up and one that I would be at from the conversations that they had on 24th September. And there is a transcript from that recording. 16:09 16:09

429 Q. I want to move on to triage, just ask you some issues about that. It was first raised with you in April 2010 - just for the Panel's note, this is dealt with in your statement, WIT-26262. So, you became aware of it in April 2010 by Booking Centre staff. I can take it in short form but I will take you to some e-mails. There are quite a few e-mails about triage? 16:10

A. Yes.

430 Q. Would you accept that?

A. I accept that, yes. 16:10

431 Q. From 2010 involving you, in 2011 involving you. I think you say it was an ongoing issue that went back to 2008/2009 when the protocol was introduced?

A. That's right, yes.

432 Q. And it came to a head then in 2016 when concerns were raided and there were 782 letters in the drawer in Mr. O'Brien's filing cabinet not triaged? 16:10

A. Yes.

433 Q. Before we get to 2016... [Short pause] Just to give us a starting point I'll just go to one of the e-mails in 2011. 6th April 2011, TRU-281925. 16:10

This is from you to Eamon Mackle, Gillian Rankin, Heather Trouton is copied in. Title is "Urology triage" and, as I say, 6th April 2011: 16:11

"Dear all,

Further to your request for information we're meeting with Mr. O'Brien tomorrow (please see attached). I

have also e-mailed Wendy to see if it is possible to get information on theatre start and finish times as requested."

I can't remember the attachment, where they're at. 16:11
Okay, that's it. Just go back up so we can see it. TRU-281926, for the benefit -- "Urology Triage" this is:

"Update Monday 4th April 2011. 16:12

There were a total of 129 letters for triage from Mr. O'Brien's office - longest date was 1st February 2011 and these were a mixture of GP and other consultant referral letters. 16:12

On Friday, 1st April - Mr. Young triaged 14 letters to allow for patients to be sent for ICATS clinics week beginning 4th April.

16:12

On Friday, 1st April - Mr. Akhtar triaged 53 letters which included three red flags sent up from Mandeville. From these three, two were downgraded.

Nine were upgraded to red flag and these have been left 16:12
with Mandeville for appointments at Mr. Akhtar's additional clinics next week. Longest wait in this list is 3rd February."

Then we go down:

"There are 62 letters still to be triaged by Mr. O'Brien - 30 dated February, 32 dated March. And the above figures refer internal referrals, consultant to consultant."

So, does that indicate that there are other outliers un-triaged as well as Mr. O'Brien or is this all Mr. O'Brien? 16:13

A. No, I think this was all Mr. O'Brien's and this was an attempt to get patients ready for -- to be ready for the clinics. I think. Sorry. Can, I just see the original? No, the original just was given. I actually can't remember this. 16:13

434 Q. No?

A. No.

435 Q. Something else? So, this seems to be a report -- I presume it emanates from you but it's populated by information from someone else? 16:14

A. It it is, yes. It's populated from the Referral & Booking Centre. I obviously was trying to get -- it was in the good old days when we were able to get patients onto lists or onto clinics nearly when they were coming in through to the door. So, obviously to get the clinics filled I have had to ask for the referral letters to be triaged to allow to get them sent for clinic. 16:14

436 Q. So you divided them up almost?

A. Yes.

437 Q. Or they have been divided up by the other consultants?

A. Yes.

438 Q. This is 2011?

A. Yes. 16:14

439 Q. So there seems to be a mystery on his clinical lead then?

A. Yes.

440 Q. And an awareness around the issue. 16:14

I want to ask you just about another e-mail, AOB-00279, this is an e-mail from 19th August 2011. Before I do that, I just want to give the Panel references for meetings that I referred to earlier. The 24th September 2018 meeting is at AOB-56387 and the November 16:15 meeting I referred to, Mr. Glackin's meeting of that is at AOB-56426 and the cover e-mail is the preceding page at 56425. Sorry, I'll just go back to the e-mail, 19th August. This is 19th August 2011 from you to Mr. Young, Mr. O'Brien, Mr. Akhtar, copying in several 16:16 people there, including Mr. O'Brien's secretary at the time. And you say:

"Dear all,

I have just received the bi-weekly report on outpatient 16:16 activity and note that there are a total of 43 referral letters outstanding for triage. These are waiting between six and ten weeks. As per the Integrated Elective Access Protocol they should be turned around

within 72 hours, which I recognise is not always possible, and we are normally allowed one week turnaround time.

I would be grateful if you could please check your triage folders and any outstanding letters be triaged as a matter of urgency, as Dr. Rankin will be looking at an update from me at our Tuesday a.m. performance meeting." 16:16

16:16

Now, there seems to be a suggestion at the bottom that outstanding triage, outstanding letters may be something that's applicable across the board with consultants?

A. Yeah, reading that I would see that and it may have been back to the fact that we're looking for them, within 72 hours and we rely on a one-week turnaround time and it looks like Mr. Young and Mr. Akhtar are included in this, as well as Mr. O'Brien. This would have been the meeting that I mentioned earlier on with Katherine Robinson on a Friday morning and Katherine would have given me that information that these were outstanding and I know they would have been mentioned so I wanted to give it to them all to get. 16:17 16:17

16:17

So, there would have been delay, in fairness, at that stage, with, particularly Mr. O'Brien and Mr. Young, not so much Mr. Akhtar.

441 Q. There's mention there of the bi-weekly report on

outpatient activity. Now, is that something that was existing then and no longer exists or -- I'll ask the question properly perhaps. What was it about the report that alerted you to the referral letters being outstanding? 16:18

A. One of the meetings that Dr. Rankin introduced was a Tuesday morning meeting and I know there's been a bit of between Katherine and Dr. Rankin and then I'll say it again; you knew your stuff going into that meeting, absolutely knew your stuff. That's why I knew every 16:18 patient nearly on my Patient Target List but part of that was Dr. Rankin had asked for a Friday morning meeting with Katherine Robinson to happen every two weeks and we would have met with Katherine and she would have provided us with the letters received, the 16:18 outstanding triage and literally what the waiting times were for the patients to be seen. And we had to bring that information on a Tuesday morning.

It was stood down. It did still continue on in 16:19 Mrs. Burns's times but it was stood down, I think in Ms. Gishkori's time and Mrs. Robinson and myself would have always said they were the days when we really knew what we were -- sort of where we were with regards to the likes of our performance. So, it was probably, it 16:19 was a very good meeting.

442 Q. And why was it stood down?

A. I just think -- the performance meetings, so, Dr. Rankin went out on a Tuesday morning, Debbie always

had her, I don't think it was a Tuesday morning but she would have always had a performance meeting as well. So them meetings, we would have needed them meetings to happen to feed into the directors' meetings and I think then Ms. Gishkori didn't have performance meetings, so, I just think they went by the wayside. 16:19

443 Q. Was it replaced with anything else --

A. No.

444 Q. -- that allowed oversight?

A. No. 16:20

445 Q. So, that layer of governance just disappeared?

A. Yes, and I just, you know, as I said there, there were really good meetings, you knew your stuff, albeit that -- we had a lot of work to put in to prepare for it but at the same time we had that really indepth oversight. Now, because my background is admin and because I would have brought the performance issues to both my ENT and my Urology departmental meetings on a monthly basis, I would have still run the figures. I probably am in a more unique position probably to my detriment now because of everything that was given to me to do - but I was able to run the business objects reports, I am able to run them, to see what were -- how many patients was on the waiting list, how many referrals had been received in to try and look at referral trends, and basically what the waiting times were. 16:20 16:20

446 Q. And would that have informed you about outstanding triage based on referral letters?

A. Yes, it would have, because at that particular time there was -- if a letter wasn't triaged they weren't added to the waiting list until they were triaged. And I know there's the whole thing about the default, but when you run the list, you could actually see that there was a blank and you knew the letters weren't triaged.

But, with regards to escalation, in fairness to the Referral & Booking Centre, they always escalated, even after the meetings and all stopped, Katherine was very good and her team still continued to escalate to us that there were -- they were chasing letters. There was X, Y and Z, so, that's why we were knowing about the triage. 16:21

447 Q. I think she gave evidence about keeping a red book and the number of letters that went and she copied some of the letters?

A. Yes.

448 Q. They were informal methods of trying to keep an eye on things? 16:21

A. Yes, yes. That was pre-NICER when they would have come through the gateway on to that, so they would have copied the letters that went.

449 Q. If we go to AOB-00348 there's an e-mail of 28th February 2012 and this is from Mr. O'Brien to you where he's setting out: 16:22

"Martina,

Regarding the demand capacity analysis for outpatient, am I correct in understanding that there is 71 new patients to be seen as outpatients during March and that there is a capacity to provide 79 patients with appointments and that therefore will be no problem? 16:22

Secondly, I do hope that I should be up to date with triaging."

Again the last sentence there at the bottom. Sorry, I should read the third paragraph, my apologies. 16:23

"Thirdly, I have been concerned to find patients appointed to my clinic at Craigavon in these past two weeks and who were triaged by me and Michael Young through he Haematuria Clinic in November 2011 and have not been given an appointment at that clinic, but instead diverted to my consultant-led clinic three months later. 16:23

I've since been advised that only those patients triaged through the Haematuria Clinic and designated red flag are actually being appointed to the Haematuria Clinic. Both Michael Young and I are of the view that all patients triaged through the Haematuria Clinic were treated effectively as red flags and treated equitably. Instead, these patients have not been given an appointment for three months. They have had longer to wait than those with a least important condition who 16:23

have had appointments within two months.

I would be grateful if you would look into this for me. There is something fundamentally wrong here."

16:24

Then he says:

"Lastly, I will meet with you in coming days to arrange review of the oncology backlog beginning in April 2012."

16:24

I suppose Mr. O'Brien has topped and tailed the middle paragraph with triage and the backlog issue --

A. Mm-hmm.

450 Q. -- without going into too much detail. But the middle bit is his concern around allocation. I mean does this fall squarely within your remit to address this or is this a clinical decision issue?

16:24

A. I vaguely remember this, because obviously it's going back to 2012. But I think it was an issue that Mr. Young and Mr. O'Brien would have triaged patients through Haematuria Clinic and it was a Booking Centre issue. So, I probably -- I'm sure I did send that on to Katherine and we've had a conversation with regards to it. I don't -- I genuinely don't remember the result of it, but I'm sure we resolved it.

16:24

16:25

451 Q. Another example of you engaging with Heather Trouton on the triage issue --

A. Mm-hmm.

452 Q. -- in 2013, TRU-272708, e-mail dated 20th February 2013, escalating an issue to Mrs. Trouton. Scroll down please. So, this is from you at the bottom, 19th February 2013, to Mr. O'Brien and his secretary at the time, Monica McCrory, copying in Fiona Reddick, Ronan Carroll and Heather Trouton:

"Urology Referrals

Dear Aidan, 16:25
Please see below list of outstanding letters that are with you for triage. Can you please let me know when these will be returned to Mandeville so that they can appoint these patients if necessary."

16:26

A. Yes.

453 Q. Monica replies to you and says:

"Thanks Martina. Aidan is on leave this week. I will show it to him on his return." 16:26

You copy, then you send to Heather Trouton:

"Heather, see below. This is very worrying in that Aidan is in Enniskillen on Monday and therefore will not be back until Tuesday, which is another eight days." 16:26

And then Heather replies on 20th February 2013 to you

to say:

"Can Monica take them and give them to another consultant?

I agree, they should not have been left and will address on Mr. O'Brien's return. But in the meantime we can't leave until he comes back from leave."

Do you remember this particular e-mail chain or what was the backstory for this or what happened? 16:26

A. Well, the Urology referrals they're talking about here is red flag because they've come from Mandeville and that's obviously why Fiona and Ronan's copied into it. As you said, there's lots of e-mails about triaging and I don't really remember this but I would have spoken to Monica to ask her to leave them in -- 2013 I'm trying to think. There would have been Mr. Connolly and Mr. Pahuja and Mr. Glackin and Mr. Young, so, I would have asked if some of them could have done it, because there's no way I would have left the red flags for that length of time without them being triaged. 16:27 16:27

Now, I don't recall, because that's February '13, whether Heather addressed it on Mr. O'Brien's return. But I do know that later on in 2013, I think it was November, there was quite a bit backwards and forwards about it because I potentially may have escalated it again it at that stage. 16:27

454 Q. Was there ever any copying of the medical management into any of these e-mails so that they'd be aware of that?

A. No. And that's -- I think it's back to the structure, you know, yes, we had Mr. Mackle but it just seems to be two strands. 16:28

455 Q. If you go to AOB-00646. This is an e-mail of 6th March 2014 - a year later. You will have heard Mrs. Burns's evidence this morning?

A. Yes. 16:28

456 Q. So, this is an e-mail from you to Katherine Robinson, copying Anita Carroll, Heather Trouton and Deborah Burns in and the subject is "Mr. O'Brien's triage". 6th March 2014. 16:28

"Katherine,
Debbie and I met with Mr. O'Brien and he has agreed that apart from his own named referrals, that on the weeks that he is on call he will be no longer triaging general urology letters. Mr. Young has asked that 16:29 during the week of Mr. O'Brien's on call and the general urology letters that Mr. O'Brien would have triaged please be left with him for triaging.

I note that the next weekday that Mr. O'Brien is on 16:29 call for March is actually 31st March so this will not happen until then. Any issues, can you please highlight to me in the first instance? "

I want to ask about this. There has been discussions what was the expectation was. In short form it seems that Mrs. Burns was of the view that this engagement with her was removing triage from Mr. O'Brien in its entirety.

A. Apart from the named --

457 Q. Apart from the named referrals?

A. Yes.

458 Q. But there was no expectation that he would do any other?

A. No, there wasn't, at that stage. And I think the problem is, I did speak to Mr. Young and Debbie's, Mrs. Burns's view from whenever she sent the e-mail was that it would be a team as opposed to just one individual helping out. Mr. Young took it on himself and didn't, as far as I'm aware, ever discuss it with the team, which would have been, at that stage, maybe Mr. Suresh and Mr. Glackin and himself, I'm trying to think, I have to think about it.

459 Q. Sorry, did you say he did discuss it or he didn't?

A. He didn't.

460 Q. He didn't?

A. No, I don't think so. Mr. Young had helped Mr. O'Brien out on other occasions with doing triage for him whenever -- like and I know it's been mentioned maybe in Mr. Mackle's evidence, it would have been sort of in or around 2010 time or even pre that. But what I was going to say was Mr. Young took it on himself and then Mr. Young returned it to the Referral & Booking Centre

or advised the Referral & Booking Centre that he wasn't doing it any longer and I have a notion that was in or around September/October 2014, but we moved to Urologist of the Week during that time. So, the expectation was that Mr. O'Brien would be part of that because the Urologist of the Week, what was agreed, was that they would have dedicated time to do triage on that week. So, there would have been never any - and I know Mrs. Burns was involved in all the conversations and I just think there's a gap of the fact that we didn't tell her but I genuinely didn't think she needed to be told because there was that understanding that once they moved to Urologist of the Week it was all of the teams would be doing their triage. 16:31 16:31

461 Q. You've given a lot of information there. 16:31

A. Sorry.

462 Q. I'm just going to have to make sure I understand it --

A. Okay.

463 Q. -- if you don't mind. Was the implication that this March 2014 was a stopgap? 16:31

A. Yes.

464 Q. Attending Urologist of the Week coming in in December 2014 when there would be a greater capacity to all consultants to equally take on triage when Urologist of the Week? 16:32

A. No, not a stopgap. At that stage, in March 2014, we hadn't even mooted the idea of Urologist of the Week. When I say there Mr. O'Brien was on call not until 31st March, they wouldn't have done a week on call, they

would have done maybe a day and a night on call. So, when they were doing that that's when they would have got their letters for triage.

In March 2014, both Debbie and my understanding of the meeting was that Mr. O'Brien was to stop triaging, except for named referrals, what superceded that was, then as a result of this meeting Mr. -- 16:32

465 Q. Before we go on that. Just at this point Mr. O'Brien's only do them referrals? 16:32

A. Yes.

466 Q. What's the expectation on the rest of the consultants?

A. The expectation from Debbie and myself from the meeting was that I was to discuss it with Mr. Young for the team to help out. So, say, for example, Mr. O'Brien was on 31st March, then maybe Mr. Glackin would have triaged that day. If he was on, say, 5th April, then Mr. Young would have triaged if he was on. So on and so forth, that they would have nearly done like a timetable. 16:33

467 Q. But Mr. Young undertook that without speaking to the other consultants?

A. Exactly, exactly. I didn't think he didn't want to burden them.

468 Q. Did he then not only undertake to sort it out but undertake to do it himself? 16:33

A. To do it himself, yes.

469 Q. So, he then took over Mr. O'Brien's triage, unless it was a named referral?

A. Unless it was a named referral, yes.

470 Q. And because you had no idea at that point that Urologist of the Week was coming down the tracks in December, was it anticipated that that was temporary, or was that going to continue until triage was caught up with, or what was the plan? 16:33

A. The plan was, it was to continue until the foreseeable future. It wasn't to go back to Mr. O'Brien at that stage, or at all, except for the named referrals.

471 Q. Did other consultants take on any of that from Mr. Young at any point, do you know? 16:34

A. No, because I actually don't believe and they can be asked but I don't believe they realised that Mr. Young had taken that on. I don't believe they had. I think he had done that rather than discuss it with a sort of do -- a bit like where it talked about the previous consultant had had the issues, it was a team meeting and a team decision and a voluntary. Really and truly what should have happened, what we expected to happen was Mr. Young would have discussed it and then would have said no, I'm not agreeable to that, or yes, I'll help you out. But that conversation never happened. 16:34 16:34

472 Q. And did the other consultants know that Mr. Young was doing this for Mr. O'Brien?

A. I'm not aware that they know. No, I don't think they did. 16:34

473 Q. Now, Heather Trouton in her Section 21 - just for the Panel's note, at WIT-12005 at paragraph 60 - calls this an unfair system for the rest of the consultant team.

She's cc'd into this e-mail. She would have been aware that this was what was being proposed and what you've described it's not a stopgap, it's a way forward?

A. It was a way forward, yes. That was Mr. Young stopped it himself without consultation or without saying, you know, it was Katherine escalated it, Katherine Robinson escalated it to me that the letters -- one of her staff had said that Mr. Young had returned all the letters and he was no longer triaging Mr. O'Brien's, but without any discussion?. 16:35

474 Q. So, if there was a backlog referred to at all in relation to Mr. O'Brien after 6th March 2014, it could only be a backlog of named referrals?

A. Absolutely, yes. And to be fair to Mr. O'Brien and Mr. Young they did have a lot of named referrals because obviously Mr. O'Brien was there since 1992 and Mr. Young since 1998, GPs had got to know them, so, you would have found that an awful lot of referrals came in addressed to both of them, whereas the other consultants, it would have been more general. So, named referrals would have been quite a lot. 16:35 16:36

475 Q. So, this is a separate issue from the default?

A. It is, yes.

476 Q. It's a completely separate issue?

A. Totally. 16:36

477 Q. This happened before the default system was brought in?

A. After.

478 Q. This happened in the March, that was brought in in the February?

A. Yes.

479 Q. Let me just stop you there I want to just make one pointed before we go on to that. Your evidence on the last occasion, TRA-02991. I just want to make sure that the figures we're talking about are named referrals? 16:36

A. Okay, yes.

480 Q. This was your evidence on 23rd February at line 13 and I asked the question:

16:37

"Okay. So, the first part of this, I just wanted to..."

This is about the letter, the draft of the letter --

A. Mm-hmm. 16:37

481 Q. -- we spoke about earlier where the March meeting with Mr. O'Brien 2016.

"Okay. So the first part of this, I just wanted to read some of this out, as I say, because it has just been received by the Panel. "

A. That's right, yes

482 Q. We had received it late with service of the drafts of your letter. The first paragraph in that you speak to 16:37 un-triaged patient referral letters and you have said:

"There are currently 253 un-triaged letters outstanding from the period of time when you were on call. These

are dating back to November 2014."

Now, what does that refer to if Mr. O'Brien was told to stop triaging in March 2014?

A. So, in March 2014 until I think it was either September/October '14, Mr. O'Brien would have been triaging named referrals only. Mr. Young, when he -- at this stage we are into the Urologist of the Week from, I think it is definitely November '14, and these 253 letters would have been -- all letters would have been both named and general referrals that would have been received in whilst Mr. O'Brien was on call. 16:37 16:38

483 Q. So, it may be my fault --

A. No, no.

484 Q. -- I just need to follow the logic. Are these letters being attributed to Mr. O'Brien as being un-triaged, even though the expectation was that he wouldn't be triaging? 16:38

A. Yes. I suppose, what -- I'm not making myself very clear, okay? So, what I was saying was, from March -- the expectation in March with the meeting with Debbie and I was that Mr. O'Brien wasn't going to triage anymore. When Mr. Young decided to stop it, the letters started to go back to Mr. O'Brien again. I wasn't aware that he had stopped it. But in between times, Urologist of the Week had started and in all the discussions in August with the Department of Health and with our Senior Management Team, as in the Director, Debbie, I think Paula Clarke was involved in 16:38 16:39

discussions, Heather, we knew that when the consultant was moving to Consultant of the Week, that included Mr. O'Brien.

485 Q. That was in December?

A. No, I thought it was earlier. I thought it was October time, 2014. 16:39

486 Q. Yeah, well it was later in the year?

A. Yeah, it was. I think from my memory, I don't know why 13th October, but that's probably just maybe me getting mixed up in dates. But even if he haven't been Urologist of the Week, because Mr. Young had stopped doing it, they had started going back to him. 16:39

487 Q. I just want to break that down again. You didn't know that Mr. Young had stopped triaging Mr. O'Brien's referrals? 16:40

A. I didn't know from Mr. Young that he had stopped doing it. It was Katherine escalated it to me: 'Did you know Mr. O'Brien is getting back all his referrals again because Mr. Young has ceased taking them?'

488 Q. And when was that? 16:40

A. I really would have to check. In my head it's September/October time, 2014.

489 Q. So, you knew before this. So, is this -- I just want to make sure that the numbers reflect the reality for what was being alleged in this at this point. These are obviously figures that we've been referring to quite a bit? 16:40

A. Yes.

490 Q. I just want to -- so, this is basically these haven't

been done, they should have fallen to you, had you been doing triage, and there are 253 of them?

A. Yes, and that would have been a mixture of, as I said, named referrals and not -- if you look, this is November 2014, but this figure actually relates, albeit it might have only been a handful of letters in November 2014, but you also would have had Mr. O'Brien on call in December and in January, and in -- 16:40

491 Q. Well that postdated?

A. Yes. 16:41

492 Q. Because you talked about that. That's March 2016?

A. March 2016.

MS. McMAHON BL: So, you're talking about that time. I do have more e-mails and questions about e-mail but I just I wonder if you want to... it's been a long day. 16:41

CHAIR: It's been a long day. I think we'll break now, ladies and gentlemen, and start at 10 o'clock tomorrow. Ms. McMahon, just in ease of everyone, do you think you will conclude with this witness?

MS. McMAHON BL: Yes, I think by lunchtime. 16:41

CHAIR: By lunchtime?

MS. McMAHON BL: Yes, I will. I will have a look at my notes tonight and we'll get through it.

CHAIR: Okay. That's good to know. Thank you.

16:42

THE INQUIRY THEN ADJOURNED UNTIL THURSDAY, 29TH JUNE 2023 AT 10:00 A.M.