



Urology Services Inquiry

Oral Hearing

Day 43 – Wednesday, 17th May 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

I N D E X

P A G E

Ms. Leanne McCourt

Examined by Ms. McMahon

3

Questioned by the Inquiry Panel

51

1 THE INQUIRY RESUMED ON WEDNESDAY, 17TH DAY OF MAY, 2023
2 AS FOLLOWS:

3
4 CHAIR: Morning, everyone.

5 MS. McMAHON: The witness this morning is
6 Leanne McCourt, who is a Urology Clinical Nurse
7 Specialist. Ms. McCourt will take the oath.

10:07

8
9 LEANNE McCOURT, HAVING BEEN SWORN, WAS EXAMINED BY
10 MS. McMAHON AS FOLLOWS:

10:07

11
12 1 Q. MS. McMAHON: Ms. McCourt, thank you for coming to give
13 evidence to the Inquiry. You have already provided
14 some written evidence to the Inquiry, and if we just
15 confirm that. Your Section 21 response starts at
16 WIT-85913. We will see that's notice no. 73 of 2021.
17 If we go to page WIT-85969, we will see your signature
18 there. Do you recognise that as your signature?

10:07

19 A. That's my signature, yes.

20 2 Q. It's dated 10th November 2022. Do you wish to adopt
21 that as your evidence?

10:08

22 A. Yes.

23 3 Q. You have also provided us with a questionnaire, and
24 that's exhibited with your statement. For the Panel's
25 note, that is at WIT-86017, WIT-86043.

10:08

26
27 I just want to start with the background to your role
28 in urology and your career path so far that led you to
29 the Urology Services in Craigavon. You began your

1 career in urology when you qualified as a staff nurse
2 in September 2006?

3 A. That's right.

4 4 Q. You took up post as a Band 5 staff nurse in 2 South
5 Urology until 2010? 10:08

6 A. That's correct.

7 5 Q. And then you say in your statement that you transferred
8 to the Mandeville Unit in 2010; was that still a
9 urology post?

10 A. No. That was outpatient systemic cancer treatments, so 10:09
11 chemotherapy.

12 6 Q. And you were there until 2016; is that correct?

13 A. 2017.

14 7 Q. 2017. You applied for the Band 6 Urology CNS post at
15 that time? 10:09

16 A. Yes.

17 8 Q. And two posts were advertised within the Thorndale
18 Unit?

19 A. That's correct.

20 9 Q. Just to deal with that appointment at this point, you 10:09
21 were applying for a Clinical Nurse Specialist post in
22 Urology, but it seems from your statement that you were
23 told at interview that it was now a clinical sister's
24 post you were being interviewed for. Was that the
25 first time that you had been made aware that the post 10:09
26 had changed designation?

27 A. Yes. It was literally when I was sat down for the
28 interview, yeah.

29 10 Q. Did you ask at that point why the designation of the

1 post had changed or was it subsequent to that that you
2 spoke to Martina Corrigan?

3 A. I think I may have asked at the end of the interview
4 when they ask have you any further questions, but I
5 don't think I received, you know, proper clarification 10:10
6 so then I sought a meeting with Martina Corrigan, the
7 Head of Service.

8 11 Q. Is that after you had been offered the post and
9 accepted it?

10 A. No. 10:10

11 12 Q. Between that period of time?

12 A. Yes.

13 13 Q. You say in your statement that when you spoke to
14 Mrs. Corrigan, she said that an element had been left
15 out of the job description criteria and this meant that 10:10
16 the role had to be changed?

17 A. Yes.

18 14 Q. Did you ask her what element or criteria was left out
19 or did she offer that information?

20 A. I think I did at the time but I don't recall what it 10:10
21 was.

22 15 Q. She also said at that time that there would be a CNS
23 post coming up and that you would be in a good position
24 to apply for it, because you were successful in the
25 subsequent post -- 10:10

26 A. That's right.

27 16 Q. -- to become clinical sister?

28 A. That's right.

29 17 Q. Is that the same time that Jason Young was appointed as

1 charge nurse?

2 A. Yes. Jason and I started within two or three weeks of
3 each other, yes.

4 18 Q. So that was as a result of two CNS posts advertised,
5 and they became clinical sister and charge nurse posts? 10:11

6 A. That's correct.

7 19 Q. One of the key differences, I think you have stated in
8 your statement, was the difference in managerial role
9 for clinical sister. You'd been attracted to, I think,
10 the more clinical application side of the Clinical 10:11
11 Nurse Specialist?

12 A. Yes. It was essentially an entirely different role as
13 is highlighted in the job descriptions that were
14 attached. It's different priorities, different
15 responsibilities. 10:11

16 20 Q. What was your appointment as clinical sister; do you
17 remember the date?

18 A. It was the start of April '17.

19 21 Q. Were you working alongside other CNSes at that time?

20 A. Yes. I would have worked alongside Kate and Jenny in 10:12
21 the unit.

22 22 Q. Now, even though you weren't a CNS at that point at
23 2017, did you undertake any key worker role?

24 A. I would have on occasion, yes, if there was no CNS
25 available. 10:12

26 23 Q. How would that come about? would somebody appoint you
27 as a key worker or would that be something that you
28 would be expected to step into?

29 A. So, I would actually have been responsible for the rota

1 and the roster, so I would have known what clinics were
2 on certain days. So, I would have made myself
3 available to whatever consultant that was. I would
4 have said in the morning of the clinic "I'm available
5 if you need key worker this morning", or I would have 10:12
6 said who would have been available.

7 24 Q. So, I think you were here for Mrs. O'Neill's evidence
8 yesterday when she described - I won't say ad hoc but
9 it does seem there's a system applied - of the key
10 worker being available should the consultant require 10:12
11 it?

12 A. Yes.

13 25 Q. You have said in your statement as well that you do
14 consider key workers were available because of the fact
15 that you were responsible for the rotas? 10:13

16 A. Yes. Yes.

17 26 Q. Was it your experience that if a key worker was
18 required by any consultant, that they would indicate
19 that to you, or was it a proactive role from the
20 nursing staff? 10:13

21 A. No. At that stage it wouldn't have been proactive on
22 the nursing staff, apart from whoever had the key
23 worker role that morning, knowing they had that
24 responsibility. It would have been the consultant
25 coming to us saying "I have a patient I need you to 10:13
26 see". From that aspect, it wasn't the nurse going to
27 the doctor and saying I have... We made ourselves
28 available and the consultant would have availed of us.

29 27 Q. Now, one of the issues that has arisen and the Inquiry

1 is interested in is the alleged failure of Mr. O'Brien
2 to access key workers. Did you have any experience of
3 that? Do you have any knowledge of that before you
4 informed about the SAIs?

5 A. No, and indeed I would have been key worker for some of 10:14
6 Aidan's patients.

7 28 Q. In your recollection now, your experience, was there
8 any difference in the way any of the consultants
9 applied the use of the key worker, or indeed the
10 Clinical Nurse Specialist? 10:14

11 A. At that time, as I said, it wasn't proactive on the
12 nurses point, it would have been the consultant coming
13 to you and telling you. They pretty much would have
14 worked in the same way; they would have come to you.
15 Some of them would have brought you in for the 10:14
16 consultation if that was able to happen, some would
17 have approached you afterwards. As Kate alluded to
18 yesterday, Mr. Haynes, if you were busy, he would have
19 left the notes for you outside the room you were in and
20 you would have known when you came out that that 10:15
21 patient was to be seen.

22 29 Q. So, if you were actually used as a key worker,
23 Mrs. O'Neill described an A4 sheet that was completed;
24 was that a system you were familiar with?

25 A. Yes. So, there was the permanent record of 10:15
26 consultation in that, and there also was a second sheet
27 that you could have ticked what information you'd
28 given, and your name was on both sheets and they were
29 copied. So, the patient got a copy of the permanent

1 record of consultation, a copy went into the notes, and
2 then there was a form that went in where you ticked
3 what information you had given, whether it was
4 paper-based and whatnot, and that went in the patient
5 notes.

10:15

6 30 Q. Within that system, was it possible for a consultant to
7 give someone information and not apply themselves to
8 the nurses' system; in other words, not fill in the
9 sheet?

10 A. It would have been, yes.

10:15

11 31 Q. Now, you will have heard the evidence. I don't want to
12 repeat the evidence yesterday but I do want to give you
13 an opportunity to comment. You have heard the
14 allegations about Mr. O'Brien not valuing or using
15 clinical nurse specialists. In your subsequent role
16 after 2019, I think you were subsequently appointed --

10:16

17 A. Yes.

18 32 Q. -- was it your experience that Mr. O'Brien didn't use
19 clinical nurse specialists in his practice?

20 A. No, that was not my experience because I was key worker
21 for some of his patients.

10:16

22 33 Q. Now, you were eventually appointed in March 2019 as
23 a clinical nurse specialist, having worked two years in
24 the unit. Even at that time, you say in your statement
25 that you still had managerial responsibilities so that,
26 in fact, fed into the limited time that you had for
27 your clinical nurse specialist role?

10:16

28 A. Yeah. It was frustrating, so it was.

29 34 Q. Was Mr. Young appointed at the same time in 2019?

1 A. No. Jason actually left the Southern Trust at that
2 stage and he took up another post in a different Trust.
3 So, Jason had left and then I was successful in the CNS
4 post but still with the managerial duties that I had
5 had previously.

10:17

6 35 Q. Now, looking back in the timeframe the Inquiry is
7 looking at and the arguable opportunity then to appoint
8 a CNS around 2016/2017, in hindsight is it your view
9 that that was a missed opportunity to fill those posts?

10 A. Yeah, and it's frustrating because, as you have heard
11 yesterday, we had an innovative team, we had lots of
12 ideas we wanted to take forward, and we unfortunately
13 weren't able to do that in the timeframes that we would
14 have liked.

10:17

15 36 Q. Just in relation to the post, I just want to give the
16 Inquiry a flavour of some of the background to the
17 funding. You have provided some information in your
18 statement and I just want to highlight some of the key
19 aspects of that. You have referred to what you
20 consider to be chronic and longstanding underfunding in
21 relation to the Clinical Nurse Specialist workforce,
22 and you have referenced the Macmillan specialist adult
23 cancer nurses in Northern Ireland, a census of the
24 specialist adult cancer workforce in the UK, which was
25 published in 2014. We don't need to go for it but, for
26 note, it is WIT-85941. You refer to that at paragraph
27 25.1 I.

10:17

10:18

10:18

28
29 The key points from that census in 2014 were that the

1 CNS workforce in Northern Ireland had not kept pace
2 with the increasing number of people diagnosed with
3 cancer each year, and there were also concerns raised
4 in that report about the ageing CNS workforce in
5 Northern Ireland. There was also mention of a regional 10:19
6 disadvantage where you reference that there was an
7 impact from the report, and patient inequality and
8 patients being disadvantaged when compared regionally.
9 would that be something that you would have been
10 familiar with or familiar with now? 10:19

11 A. Yes.

12 37 Q. Also, at national level the data in the report
13 acknowledges that Northern Ireland has a shortage of
14 CNS posts compared to the rest of the UK, and in 2014
15 the gap was widening. Do you have any information or 10:19
16 insight into what the situation is now as regards
17 parity or regional disparity?

18 A. I think it has improved but there's still a lot of work
19 to do, and the ageing workforce issue hasn't gone away.
20 I think we need to focus more on succession planning as 10:19
21 well, getting the younger CNSes into the posts and
22 planning for succession, that they can step in then and
23 continue the role forward.

24 38 Q. From practical application now to the actual delivery
25 of the service, you have mentioned that the knock-on 10:20
26 effect of poor CNS provision, one of the knock-on
27 effects, is the inability of consultants to be freed up
28 to deal with more complex cases?

29 A. Yes.

1 39 Q. The result of that then is also longer waiting?
2 A. If the CNS can undertake nurse-led activity at a level
3 where she is competent with - it's usually the more
4 straightforward cases - that can free the consultants
5 up to deal with the more complex cases that require 10:20
6 consultant input, and take some of the burden off the
7 consultants.

8 40 Q. You will give an example we will go to later on where
9 you undertook triage --

10 A. Yes. 10:20

11 41 Q. -- during Covid. We will come to that as an example of
12 shedding the load slightly to allow people to be seen.
13

14 You have mentioned about a concern that red flag
15 referrals are prioritised and there is a danger that 10:21
16 because of that, routine referrals are getting longer
17 and longer with a concern that people are becoming more
18 unwell, having originally been maybe allocated as
19 routine?

20 A. Yeah. 10:21

21 42 Q. What's the situation with that now? Do you have any
22 knowledge about how those people are moving along?

23 A. I think there's still an issue.

24 43 Q. Still a backlog?

25 A. Yes. 10:21

26 44 Q. But it's your evidence to the Inquiry that if there was
27 that capacity in the CNS, that there would be greater
28 movement along the journey for those patients?

29 A. Yes. It could only be a positive thing.

1 45 Q. Now, I think your post was funded from Macmillan
2 initially?
3 A. That's correct.

4 46 Q. I just want to just ask a little bit about that. The
5 funding application, you have exhibited in your witness 10:21
6 statement. I don't need to go to it but it can be
7 found at WIT-86489. That was an application completed
8 in the name of Esther Gishkori at the time. Do you
9 remember Ms. Gishkori being one of the directors?
10 A. I know of her. I never had any direct -- 10:22

11 47 Q. You know her name?
12 A. Yes.

13 48 Q. I just want to highlight some of the points for the
14 Panel's note that the application made. This was
15 around 2014. So, Ms. Gishkori indicates in the 10:22
16 application that there was a commitment to a five-year
17 incremental prioritised cancer CNS workforce, and this
18 had been approved through the Health and Social Care
19 Board at the time and PHA senior management team, with
20 the department support. So, at that time there was 10:22
21 a conglomerate of interested parties who were trying to
22 move this issue forward?
23 A. Yeah. Yeah.

24 49 Q. It was described as CNS coverage and attempts to put
25 staff in place, commissioning priority, commencing in 10:23
26 2016/'17, which is just around the time you were being
27 interviewed --
28 A. Yeah.

29 50 Q. -- for the ultimate clinical sister's post. This had

1 been outlined in the commissioning plan so there was
2 a commitment there obviously to match that post. The
3 Macmillan application indicates there's a Urology CNS
4 Band 7 included within the plan for 2018/2019. Now,
5 the end of that timeframe would be when you were
6 appointed? 10:23

7 A. Yes.

8 51 Q. Were you appointed as a Band 7?

9 A. Yes.

10 52 Q. The form acknowledges: 10:23

11
12 "There is an overwhelming deficit in the number of
13 CNSes within the Southern Trust".

14
15 Just two other points for the Panel's note from that 10:23
16 form, just by way of background, is the fact that in
17 2015, the Northern Ireland Cancer Patient Experience
18 survey reported 72% of patients having access to a CNS,
19 which was much lower than England which sat at 89% at
20 that time in 2014, and Wales at 88%. The lack of 10:24
21 access and single-handed CNS provision were found as
22 immediate risks or serious concerns in 17 out of the 30
23 MDTs peer reviewed to date within that research.

24
25 Were you part of MDMs in your role prior to being 10:24
26 appointed Clinical Nurse Specialist?

27 A. I would have deputised for Kate, yes.

28 53 Q. So, if Mrs. O'Neill couldn't be there, you were the
29 other person who attended?

1 A. And on occasion we have both gone as well.

2 54 Q. The description of how Mrs. O'Neill was treated as one
3 of the team, her opinion was valued, is that something
4 that you recognise in your experience?

5 A. Absolutely. Yes. 10:24

6 55 Q. You felt that you could speak about things and bring up
7 issues, and you would be treated as an equal member of
8 the team?

9 A. Absolutely. Indeed, now with my own nurse-led
10 services, I would actually be bringing patients to MDM 10:25
11 for discussion, and I feel very empowered to be able to
12 do that.

13 56 Q. And you feel supported by the medical staff and other
14 staff?

15 A. Absolutely. Absolutely. 10:25

16 57 Q. I just want to highlight some of Mrs. O'Neill's
17 evidence to give you the opportunity to say whether you
18 disagree or agree. If there's any difference of
19 opinion, you can let me know.

20 A. Yeah. 10:25

21 58 Q. Now, we have heard the evidence about the inadequacy of
22 staffing, both nursing, admin, and consultants, and the
23 resources issue. That's something you would agree with
24 had an impact on service?

25 A. Yeah, absolutely. 10:25

26 59 Q. Also, the increase in the innovation and nurse-led
27 clinics increased the demand for key worker and CNS
28 generally. The Panel has heard that the more
29 innovative and service-driven the nurses became, the

1 greater than the need to meet the need of the patient
2 from the clinical aspects of the CNS and key worker?

3 A. Yes.

4 60 Q. Do you have any experience or knowledge of Mr. O'Brien
5 not recognising or preventing the involvement of 10:26
6 clinical nurse specialists or key workers?

7 A. No. I always felt supported by Aidan, from first
8 meeting him as a junior staff nurse. When you are just
9 new into your post, you remember the people that sort
10 of took you under their wing, took the time to explain 10:26
11 things. Aidan would have been very much of those
12 people.

13 61 Q. You have heard, I think, a quotation yesterday from
14 Martina Corrigan where she said staff felt worn down by
15 no action to address Mr. O'Brien's issues. Is that 10:26
16 something that you recognise?

17 A. No, not worn down in that aspect. Maybe worn down in
18 the volume of patients and things like that but not
19 specifically to Aidan, no.

20 62 Q. Did you ever have any experience of challenging - which 10:26
21 is the word that was used by Mrs. Corrigan - did you
22 have any experience of challenging Mr. O'Brien
23 regarding being available at clinics, or having to make
24 your presence felt to try and be part of it?

25 A. I didn't feel it was an issue so I wouldn't have 10:27
26 challenged on that, because I didn't feel it was an
27 issue. I felt --

28 63 Q. Just to confirm then, did you ever speak to
29 Martina Corrigan, or Ronan Carroll indeed, about any

1 issues regarding Mr. O'Brien?

2 A. Not that I recall, and I would have spoken to Martina
3 about day-to-day issues. To the best of my knowledge,
4 I have never spoken to Ronan Carroll. Apart from maybe
5 attending the same meeting he was at, I have never 10:27
6 spoken to Mr. Carroll one-to-one.

7 64 Q. Did you ever express being frightened of Mr. O'Brien?

8 A. Absolutely not.

9 65 Q. Did you feel you could approach him or indeed confront
10 him if the need arose? 10:27

11 A. Yes. Yeah.

12 66 Q. Now, you have included a table in your statement of
13 your key worker activity, and I just want to take the
14 panel briefly to that. It's at WIT-85958. Now, just
15 by way of background, this particular data is your own 10:28
16 individual data that you kept yourself, or is this
17 a formal record within the unit?

18 A. No. I came from a research background where I kept
19 data on everything, so I just continued that into the
20 post I was in. It's just something I have always done. 10:28

21 67 Q. So, these are the amount of times you were used by
22 named consultants as the key worker?

23 A. Yes. Yes.

24 68 Q. I just want to run through them and then we will just
25 look at some of the detail. The first one is in the 10:28
26 period from July 2017 to 26th February 2019. This was
27 a period when you were working as a clinical sister, so
28 you were only used as a key worker if there was no
29 other key worker available?

1 A. Yes.

2 69 Q. So, it's not a full picture in that regard?

3 A. No.

4 70 Q. If we just move down very slightly so we can see the
5 names. You will see during that period, on one 10:29
6 occasion, you were used by Mr. O'Brien, and others
7 bearing figures from 6, 13, 16 and 35?

8 A. Yes.

9 71 Q. So during that period, a total of 75 but just once by
10 Mr. O'Brien? 10:29

11 A. Yes.

12 72 Q. And again --

13 A. Sorry --

14 73 Q. Sorry, go ahead?

15 A. Sorry. I also, when I've had time to think and think 10:29
16 where I was in my career during this timeframe, I would
17 have also undertaken my non-medical prescribing. If
18 I recall correctly, the day that Aidan would have had
19 one of his clinics would have been one of the days I
20 was requested to be at Queen's, so that would have been 10:29
21 one of my study days down at Queen's. That could also
22 have impacted on those figures.

23 74 Q. That has to be factored in as well?

24 A. Yeah. Yeah.

25 75 Q. Then for the period from 27th February 2019 until 10:29
26 March 2020, again you have named the consultants on one
27 side and a number of patients on the other. In that
28 one we see Mr. O'Brien has used you as a key worker on
29 14 occasions; other consultants have used you on 4

1 occasions, 3 occasions, 5, and the highest number,
2 Mr. Haynes, 121.
3
4 would that reflect that Mr. Haynes uses the key worker
5 almost with every patient? 10:30
6 A. Yes. So, Mr. Haynes comes from a background where he
7 has worked on the mainland. As my previous inclusions
8 of the Macmillan reports, CNS is much more of a feature
9 of the patient pathway on the mainland. I think he had
10 been very familiar with that role and that could 10:30
11 perhaps account.
12 76 Q. Again, it's just your input as well. The figures could
13 be --
14 A. Working patterns and things like that had to be
15 accounted for, yes. 10:30
16 77 Q. I think the final... This period is from April 2020
17 until March 2021. Again, several of the consultants,
18 including Mr. O'Brien, have used you as a key worker.
19 Once again, Mr. Haynes hitting high numbers of 55?
20 A. Yes, and Mr. O'Brien would have retired in summer that 10:31
21 have --
22 78 Q. June 2020?
23 A. Yes.
24 79 Q. So it's a partial picture?
25 A. Yes. And Covid as well. 10:31
26 80 Q. And Covid.
27 A. Yeah.
28 81 Q. Well, that in fact is April to June 2020 for
29 Mr. O'Brien's purposes then, if he left then.

1 A. Yes.

2 82 Q. Did anyone ever come to you when you were in charge of
3 the rota and indicate there were any problems with
4 working with Mr. O'Brien in this role?

5 A. No. 10:31

6 83 Q. Now, the Inquiry -- and you would have heard in
7 evidence yesterday about the SAIs, the outcome. Are
8 you in the same position as Mrs. O'Neill, where you
9 found out about this when you got the report in full in
10 March 2021? 10:32

11 A. Yes. Yeah.

12 84 Q. So when you went to the meeting in February 2021 with
13 Dr. Hughes, the Zoom meeting with the staff, this was
14 the first time it had been articulated to you, was it?

15 A. I wasn't present for the first meeting, was it the 10:32
16 18th? I was present at the one on 22nd.

17 85 Q. Yes.

18 A. Yes, I was at that.

19 86 Q. The 18th is the MDT meeting --

20 A. Yes. 10:32

21 87 Q. -- that Mrs. O'Neill was at?

22 A. Yes.

23 88 Q. You were then present at the one for all the nursing
24 staff, all relevant nursing staff?

25 A. Yes. 10:32

26 89 Q. That was the first time that the contours of the
27 complaints had been set out for you?

28 A. Yes. Yeah.

29 90 Q. What was your immediate reaction when you heard some of

1 the issues coming up?

2 A. I felt for the patients and their families, that was my
3 first thing. Then you start to question your role or
4 how you could have impacted on that. I was just
5 shocked that it was every patient did not have a key 10:32
6 worker. That was the first time that sort of I became
7 aware that that was an issue.

8 91 Q. And was there a feeling of how could we have missed
9 that, or was it...

10 A. Yeah, yeah. 10:33

11 92 Q. Now, there is a note that the Panel looked at yesterday
12 of an extract from you. I think that you saw the note
13 of this meeting as a result of the Inquiry disclosure,
14 I don't think you have seen it before then?

15 A. Yes. 10:33

16 93 Q. I think you completed your Section 21 before you had
17 seen that because you have provided an account of your
18 version in your Section 21?

19 A. Yes. Yes.

20 94 Q. We don't need to go to the meeting but, for the Panel's 10:33
21 note, that SAI meeting with Dr. Hughes and the nurses
22 is WIT-84357 to 84359. The quote that is attributed to
23 you is:

24

25 "Leanne McCourt doesn't feel he valued the nurse 10:33
26 specialists. She recalled him asking her in the
27 kitchen what the role of a nurse specialist was. He
28 didn't understand the role of a nurse specialist".
29

1 I think that you had said before you had seen this, you
2 put in your statement at section 21 about this
3 incident. What you have said is to be found at
4 WIT-85958. I will just read from that for you. So,
5 from the top of the page:

10:34

6
7 "In my experience, certain consultants would have
8 sought more key worker input than others would. I do
9 not know why some individual consultants adopted this
10 approach more than others. I do recall Mr. O'Brien
11 stating in general conversation to me 'key worker, what
12 is this key worker role'? I do not recall the specific
13 date or who else was in the vicinity at the time of
14 this conversation. When he arrived to do his clinic, I
15 had said to him that I was available as key worker for
16 his clinic. In my opinion, his response was verbalised
17 in the context of a condescending tone. I was taken
18 aback and do not accurately recall my response.
19 Consultants were aware of the importance of the key
20 worker role as per Kate O'Neill's email from
21 June 2017".

10:34

10:34

10:35

22
23 So, there's a slight deviation in the explanation of
24 the note.

25 A. Yes.

10:35

26 95 Q. The note of the SAI indicates that the problem was with
27 the clinical nurse specialist, that Mr. O'Brien had
28 expressed concern about that, and the note reflects
29 that he didn't understand the role of a nurse

1 specialist.

2

3 Just in relation to that SAI meeting note, does that
4 properly in your view capture what you meant?

5 A. No. I have been misquoted. I've been -- I have been 10:35
6 misrepresented.

7 96 Q. Well, what did you say and what message were you trying
8 to impart to Dr. Hughes?

9 A. So, I would have said very similar to what I said in my
10 Section 21. Aidan would have been very particular in 10:36
11 his use of language and words, and I think it was just
12 the "key worker" word that he didn't like. It's not --
13 I don't for one minute think he didn't understand what
14 a key worker was, or indeed what a CNS was and what my
15 role was, he absolutely did. I believe he did value 10:36
16 that role. It's just he could have been very specific
17 about his use of words and language and phrases.

18 97 Q. So his query, in your evidence, was more towards the
19 descriptor rather than function or value?

20 A. The term. Yes, the actual term. 10:36

21 98 Q. You have said it was condescending; did you feel that
22 meant to you in any way he was devaluing or showing any
23 disrespect towards the role?

24 A. Not the role per se.

25 99 Q. Just the name? 10:36

26 A. Just the phrase, yeah. Yeah.

27 100 Q. If we just go to the email you have referred to in that
28 part of your Section 21 at WIT-86613. This was an
29 email from Mrs. O'Neill dated 16th June 2017, which was

1 sent to all consultants. The subject is "Issue raised
2 at the Thorndale unit meeting today". I will just read
3 it for the note:
4
5 "For all consultant colleagues, following discussion at 10:37
6 the above meeting today can we ask that all patients
7 who require the input of a key worker would be offered
8 the opportunity" - you could challenge this because
9 there are lots of letters missing - "the opportunity to
10 meet with the appropriate member of staff on the day. 10:37
11 Patients have informed us of the benefit of meeting
12 with staff members and it makes it much easier for them
13 to make contact via telephone should/when any queries
14 arise".
15
16 Then there's other information about clinical care.
17 This was sent out from Kate O'Neill so that everybody
18 was on board, if I can put it like that?
19 A. Yes. And I have to say, whatever way that has
20 formatted. Kate can actually spell. 10:37
21 101 Q. Yes, I think it was the formatting but I want to make
22 sure I put the right vowels in the right place.
23 A. Yes.
24 102 Q. Then just in finalising the point about the SAIs, like
25 Mrs. O'Neill you weren't interviewed by Dr. Hughes 10:38
26 before that Zoom meeting?
27 A. No.
28 103 Q. You had no input into that process?
29 A. No.

1 104 Q. I just want to ask you briefly about the nurse-led
2 activities that you have spoken about that you have
3 said contributed and improved patient care. One of the
4 examples you give is prostate biopsy service. We don't
5 need to go to this but, for the Panel's note, it is at 10:38
6 WIT-85928. Until recently, the waiting times for these
7 biopsies were ten to twelve weeks, resulting in
8 patients having to be sent to the independent sector to
9 try and move them along?

10 A. Yeah. 10:38

11 105 Q. Since the introduction of the nurse-led TP service, the
12 waiting times have now reduced to two to three weeks.
13 Is that still the case?

14 A. In or around. It has fallen back a wee bit with me
15 being involved with this process but we have plans to 10:39
16 get it back on track when I am back next week, yes.

17 106 Q. So, that's the success of a nurse-led intervention?

18 A. Myself and Kate, yes.

19 107 Q. Have you ever felt any resistance from any of the
20 consultants about any of the nurse-led clinical aspects 10:39
21 of your job?

22 A. No.

23 108 Q. I think you said in your statement that you felt well
24 supported by Mr. Glackin and Mr. Haynes?

25 A. Yes. They mentored Kate and I through the learning of 10:39
26 this procedure, yes.

27 109 Q. You have also said that the CNSes are now allocated to
28 the consultants' result clinic. When did that process
29 start?

1 A. That would have started when we came back from our
2 period of redeployment in probably March '21. At the
3 same time, the managerial duties were taken over by the
4 manager of Outpatients. Basically, my managerial
5 duties were taken over by Outpatients, and the manager 10:40
6 of Outpatients was responsible for managing the other
7 staff. That freed up the nurses to be able to be more
8 proactive within that role. What happens now is night
9 and day as compared to what would have happened at the
10 beginning of my tenure. So, we get the schedules 10:40
11 through, we know when the clinics are happening.
12 Usually because I can do the e-roster from my previous
13 role, I have kept that on for just the CNS team. So,
14 once we know what clinics are running, I can allocate
15 a CNS to that clinic. What the CNS does in the morning 10:40
16 or the afternoon of that clinic, she has the clinic
17 list in front of her; she will screen through using
18 ECR; she will know exactly how many patients require
19 the key worker input; she will have all her information
20 sitting, and indeed she will be proactively in the 10:41
21 consultation with the patient, the consultant, and
22 family.

23 110 Q. That's expected that the nurse is in that consultation
24 for the results?

25 A. Yes. 10:41

26 111 Q. Is that a result of two things, the reduction in the
27 admin duty appointment of someone to take over those
28 duties --

29 A. Yes.

1 112 Q. -- and also greater resources for CNS?
2 A. Yes.

3 113 Q. Now, we did mention earlier one of the other nurse-led
4 activities was the triage during Covid. I wonder if
5 you could explain that in relation to how that operated 10:41
6 at that time?

7 A. I think this was the summer of 2020. So, the rest of
8 our team were redeployed at that stage, so there were
9 just the three CNS nurse team that left in Thorndale,
10 so again we have no real managerial duties at that 10:41
11 time. Mr. Glackin had approached us and just asked us
12 to assist with that process. So, Kate and I would have
13 triaged the red flag prostate patients that were coming
14 into the system, ordering their scans up, and having --
15 if they needed a second PSA, if they needed a urine 10:42
16 sample sent. So, organising that in the background,
17 organising an ultrasound or an MRI to have as much
18 information as possible for when the patient would have
19 had their consultation. Some of those consultations at
20 that stage would still have been virtual, over the 10:42
21 telephone between the consultant and the patient. So,
22 having all that to hand for the consultant to make --

23 114 Q. At the first appointment?
24 A. -- to make it as meaningful as possible.

25 115 Q. So, ordering the tests before the consultant gets to 10:42
26 see the patient?

27 A. Yes.

28 116 Q. Would that have some resonance with the way in which
29 Mr. O'Brien preferred to approach triage, which was, if

1 I could say, front-loaded with some relevant tests in
2 advance of first appointment?

3 A. Yes, it is a form of advanced triage but when it's done
4 succinctly and properly, as you get more experienced at
5 it, it can be very efficient because you don't need to 10:43
6 have a consultation with the patient per se to order
7 those scans.

8

9 Now, prior to an MRI, you will have needed to have
10 spoken to the patient because there's an MRI safety 10:43
11 questionnaire needs to be completed. Apart from that,
12 once you get into the routine of doing it, you can do
13 it quite efficiently. It has dividends then at the
14 other end when they have their meeting with the
15 consultant if all the results are available. 10:43

16 117 Q. So, the patient is a little bit further along the care
17 pathway?

18 A. Yeah. Yeah.

19 118 Q. Whose innovation was this? Where did this idea come
20 from? 10:43

21 A. We have very briefly talked about this prior to Covid,
22 and indeed Mr. Haynes would be very keen for nurse-led
23 triage. But with everything that was going on, it
24 never came to fruition. I think it was just Covid were
25 strange times. It was trying to innovate practice to 10:44
26 make each encounter with the patient as beneficial and
27 meaningful as possible. Then obviously when our staff
28 came back to us, the managerial stuff took over again
29 so we didn't continue that role. But that is

1 definitely something that I want to pursue in the
2 future. I think there's a big impact that the CNS can
3 have within that red flag role.

4 119 Q. Was there any oversight from any of the consultants
5 into the process of triage that you and Mrs. O'Neill 10:44
6 were undertaking?

7 A. Yes. Mr. Glackin.

8 120 Q. Mr. Glackin oversaw that?

9 A. Yes.

10 121 Q. Is that like a safety net to make sure everyone was 10:44
11 assessing that as far as --

12 A. Yes. We kept a spreadsheet of where each patient was,
13 what the results were, and Tony was always on
14 understand if we had questions or queries, guidance. I
15 felt very supported. 10:44

16 122 Q. What impact did that have then on the service
17 provision? Were people then able to move through the
18 system more quickly?

19 A. Yes, yes, because decisions could be made at the time
20 of the consultation then because all the information 10:45
21 was to hand.

22 123 Q. That's an example of something during Covid --

23 A. That worked, yes.

24 124 Q. -- that was beneficial but has now perhaps fallen away?

25 A. Yes. Yeah. 10:45

26 125 Q. You do mention as well in your statement about the MDMS
27 and the quoracy issue. We have heard something about
28 that yesterday and have and will do from other
29 witnesses. Your experience that was if there wasn't

1 quoracy, then at times patients discussed at regional
2 meetings. Can you just explain that, how that came
3 about?

4 A. If there wasn't a radiologist on hand and a decision
5 was pressing or was time-sensitive and needed to be 10:45
6 made, that patient could have been added on to the
7 regional meeting. It's not that they -- if we'd had
8 a radiologist, that wouldn't have needed to have
9 happened, but that's on occasion what did happen in
10 order for the patient to proceed down their pathway. 10:45

11 126 Q. You have said that can lead to a delay in
12 decision-making. Was that because of the infrequency
13 of the regional meeting or because of some other
14 reason?

15 A. Because the regional meeting is for specific cases that 10:46
16 need to be discussed there. Had we had quoracy within
17 our MDM, some of those cases that were discussed there
18 perhaps wouldn't need to have happened there, so it's
19 maybe putting stress on another MDM when it was really
20 our responsibility to have a quorate MDM to have them 10:46
21 discussed there.

22 127 Q. In practical terms, if a radiologist was absent locally
23 and there was one available regionally, they could use
24 their expertise?

25 A. Yeah, on occasion. 10:46

26 128 Q. On occasion. And they would be informed of the
27 patient's presentation by the consultant in charge of
28 them?

29 A. Yes, yes.

1 129 Q. You have said in your statement that radiology was the
2 one that seemed to have a greater impact by their
3 absence than any of the others?
4 A. Yes, and that's because we only had one radiologist. I
5 am not taking anything away from him, he is expert at 10:47
6 his job, but he is one person and he can't be there at
7 every meeting because of other commitments.
8 130 Q. The position, you say, has improved and there are now
9 two radiologists?
10 A. We now have two. 10:47
11 131 Q. Do you still attend these meetings?
12 A. Yes.
13 132 Q. And what's quoracy like now, in your experience?
14 A. It is much improved. We have a medical oncologist and
15 a clinical oncologist most weeks as well. 10:47
16 133 Q. Now, in relation to raising concerns or identifying
17 anything that you were concerned about, you have said
18 in your statement you were never discouraged from
19 raising concerns and did feel you would be treated with
20 respect and your opinion valued "should I ever need to 10:47
21 do this".
22
23 Was it the case that you and all of the other clinical
24 nurse specialists, and indeed other nursing staff, were
25 quite a close-knit unit? 10:47
26 A. Yes. It was a small team, yes, so we were aware. If
27 something had happened, the team would have been aware
28 of it, yeah.
29 134 Q. Would you have frequently spoken informally about

1 issues arising in order to ensure the clinic, for
2 example, ran smoothly?

3 A. It would have more practical things like that, like
4 clinics overrunning or having to stay late. Things
5 like that, more practical things. 10:48

6 135 Q. Mrs. O'Neill described yesterday a nurse always opened
7 and always closed the unit. Is that still the case?

8 A. Yes, yes.

9 136 Q. You have mentioned an incident that you did raise in
10 relation to a doctor. We don't need to go into 10:48
11 specific details but just in general terms, you
12 considered that a doctor was behaving in a way that was
13 a potential data breach and you brought this to the
14 attention -- well, actually you tell me who you brought
15 it to the attention of? 10:48

16 A. I spoke to -- Jenny McMahon was on that day so I spoke
17 with Jenny. She was of the same opinion, as was I, it
18 was a potential data breach, it needed raised further.
19 So, I contacted the lead nurse and I also -- I think,
20 Mr. Glackin - who isn't the consultant in question, by 10:49
21 the way - was in the clinic that day so I also got his
22 opinion on it as well. Then the lead nurse came down,
23 chatted to me, and that was escalated then to
24 Mr. Carroll and Mr. Haynes.

25 137 Q. Was your first port of call to speak to Mr. Glackin 10:49
26 before escalating it to the nursing route or the --

27 A. I think it's just because Tony was on hand doing
28 a clinic that day.

29 138 Q. Was he of the same view as you were, that there was

1 a potential data breach?

2 A. Yes.

3 139 Q. And what did he do about that?

4 A. well, he advised me to speak to [REDACTED] and tell
5 him to remove the data from his telephone. I took 10:49
6 a minute and thought about that, and thought that's not
7 the way I am going to proceed, I am going to contact
8 the lead nurse and get things done officially. I
9 didn't think it was my place to address that particular
10 aspect of the issue. 10:50

11 140 Q. Now, you have mentioned a name there. We will just
12 ensure that that is removed from the transcript. We
13 are just talking in abstracts around governance, so
14 I know it's a slip --

15 A. Sorry. 10:50

16 141 Q. -- so we will make sure that that is dealt with.
17 That's obviously not to be reported anywhere.
18
19 when you speak about actually raising it, the point in
20 your statement is that you fed the concern up the 10:50
21 chain, if I can put it like that?

22 A. Yes.

23 142 Q. Did anyone ever come back to you and say what happened
24 about that, or explained anything about it?

25 A. I don't know the end outcome. I know the consultant in 10:50
26 question was spoken to but I don't know what the
27 outcome was or what way it was left.

28 143 Q. Do you feel that when you do raise concerns around that
29 or any aspect, do you feel it should be the case that

1 it's fed back down, if I can put it that way; that you
2 are told, even in broad terms, of any learning from
3 that?

4 A. Yes. I think it's part of the process; the process is
5 cyclical. If it doesn't come back round and you don't 10:51
6 know what happened, it's sort of -- it defeats the
7 purpose, I think, because learning -- it's all about
8 learning and being transparent and knowing what
9 happened.

10 144 Q. Just on that point, there has been talk about the SAIs 10:51
11 obviously yesterday. Was there any formal learning
12 identified for the CNSes as a result of those, for
13 example, nine SAIs?

14 A. I think, as I said, comparing the CNS role in terms of
15 key worker then to now, absolutely. It's a more robust 10:51
16 system, it's a more proactive system. There is now
17 a person within Cancer Services that is in charge of
18 audit, and they would send us a retrospective list at
19 the end of every month of all the new diagnoses from
20 that month. We appoint a CNS each month to cross-check 10:52
21 that with the key worker activity so we can identify if
22 indeed any patient doesn't have a key worker and
23 rectify that.

24 145 Q. The Inquiry has heard of improvements in the service.
25 Just going back slightly on my question, when there was 10:52
26 a collection of potential learning points from the nine
27 SAIs, was it ever a case of sitting down and saying
28 let's unpick this, let's see exactly what the
29 vulnerabilities were in our system that perhaps allowed

1 this to happen and let's make sure that we plug all of
2 those, that we do this in a formal way? Or it was
3 a reaction to outcomes, there was no key worker so we
4 must have a key worker? Was it more ad hoc like that?

5 A. It was more reactional, I think, yeah.

10:52

6 146 Q. Now, you have given two examples in relation to
7 Mr. O'Brien in your statement. We don't need to go to
8 this but for your note it's at WIT-85917. You have
9 described him in two different ways in this paragraph,
10 and I just want to ask you about it.

10:53

11
12 Actually if we just can bring it up, just for the
13 witness's recollection. 85917, please. At paragraph
14 1.18 and the third line down -- well, I will start at
15 the beginning of that.

10:53

16
17 "I would also like to note that I have listed occasions
18 within this document where I found Mr. O'Brien to be
19 condescending in tone but this was not always the case.
20 If I needed advice from him, he was professional and
21 forthcoming. When I was a junior staff nurse, he would
22 have taken time to explain things and helped me to
23 learn. He was very dedicated to care of his patients
24 and I would describe him as kind and caring to his
25 patients in clinic. I recall one such time when I was
26 present when a life-changing diagnosis was given to
27 a young man. Mr. O'Brien offered to drive him to the
28 oncology appointment he had arranged for him later that
29 day, as he was concerned the young man was distressed

10:53

10:53

1 and shaken".

2

3 So, you specifically have that recollection?

4 A. Yes.

5 147 Q. would you like to take a break?

10:54

6 A. Yes, please.

7 148 Q. That would be okay. Thank you.

8 CHAIR: we will take ten minutes.

9

10 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

10:54

11

12 CHAIR: Are you ready to continue?

13 THE WITNESS: Yes.

14 149 Q. MS. McMAHON: Thank you, Ms. McCourt.

15

11:12

16 Just before the break, we had been looking at an
17 extract from your witness statement at WIT-85917 and I
18 had read paragraph 1.18. I just want to read 1.19,
19 where you say:

20

11:12

21 "This process is difficult and discordant for me as
22 there was a consultant I knew to be kind and caring,
23 albeit arrogant and condescending at times, and then
24 there was a consultant mentioned within the root cause
25 analysis report, and the findings that have now led to
26 a public inquiry".

11:12

27

28 In that paragraph you seem to be articulating some
29 sense of conflict between your two experiences of

1 Mr. O'Brien; would that be fair?

2 A. Yes. Yes.

3 150 Q. And you do mention in your witness statement as well of
4 an incident at an MDT when you felt that Mr. O'Brien
5 had spoken in an unprofessional manner to another 11:13
6 consultant?

7 A. That's correct.

8 151 Q. You said that incident made you feel very uncomfortable
9 by the way that he spoke to the other consultant.
10 11:13

11 "It reminded me of the way a parent may chastise
12 a naughty child, and lasted several minutes. In my
13 opinion it was a very disrespectful way for Mr. O'Brien
14 to address the other consultant, especially in front of
15 colleagues. I do recall asking the other consultant 11:13
16 after the meeting if he was okay, and he told me he
17 was. I am not sure if this was ever formally
18 escalated".

19

20 Was this something that happened in front of other 11:13
21 members of the MDT?

22 A. Yes. It happened within -- yeah, at the MDM meeting,
23 yes.

24 152 Q. Was that your only experience of something like that
25 happening? 11:14

26 A. Yes, yeah. It was a one-off.

27 153 Q. And the context to that was that Mr. O'Brien had joined
28 the meeting, one of his patients had already been
29 discussed, and then this issue arose with another

1 consultant.

2

3 Now, you had concerns in relation to two of
4 Mr. O'Brien's patients from late 2019 to mid 2020. We
5 can go to the part of your statement, WIT-85923. At 11:14
6 7.10, you say:

7

8 "I had concerns regarding the timeframe of
9 Mr. O'Brien's clinical letters being available on ECR
10 as it made the key worker role more difficult. I also 11:14
11 had concerns about delayed referral for additional
12 treatment. If I had not been physically in the room
13 with the patient for the appointment, I would not have
14 been party to what had been discussed if the patient
15 had then contacted me with a query". 11:15

16

17 Then you give us two examples of this?

18 A. Yes. That's correct, yes.

19 154 Q. Where you say:

20

21 "The queries noted below are in relation to scan
22 appointments or oncology referral appointments of two
23 patients".

24

25 I will just summarise the details of those. Just 11:15
26 before I do, were you concerned at any point that
27 referral delays or delays in any treatment presented
28 a risk to patient safety?

29 A. Potentially they could have, because the MDM outcome

1 was specific, to be referred. It wasn't to be referred
2 in a month's time or six months' time, it was for
3 referral. I know from working with other consultants,
4 that when they saw the patient at the follow-up
5 appointment, that referral was normally made there and 11:15
6 then at the dictation after each patient.

7 155 Q. When you say that it made the key worker role more
8 difficult, is that the example you finish that
9 paragraph with, by not knowing what a patient might --
10 if they phone up, you won't actually know what the 11:16
11 treatment plan was?

12 A. No, you would always -- well, you would have known from
13 MDM what the treatment plan was. Sometimes if you
14 weren't in the actual clinic appointment, it was hard
15 to get the context of how the patient had taken the 11:16
16 news. You get a feel for what they understood or what
17 they didn't understand, so it's always better to have
18 been there. Then if the letter also isn't on ECR, that
19 just compounds that difficulty.

20 156 Q. The patient you referred to as a Patient [REDACTED], which is 11:16
21 at paragraphs 7.12 to 7.18 of that page, they had seen
22 Mr. O'Brien on 20th February 2020. Do you recall this?

23 A. Yes, yes.

24 157 Q. Then you noted that there was no letter of referral to
25 Oncology on the NIECR on 3rd March, and you referred it 11:16
26 to Mr. O'Brien's secretary, Noleen Elliott?

27 A. Yes.

28 158 Q. What caused you to look on the system for that
29 referral?

1 A. Because normally what happens is when a consultant
2 dictates a letter of referral, that letter makes its
3 way onto the ECR system and you can see that that
4 referral has been made. As the clinic letter and the
5 referral letter weren't on there, I thought it was just 11:17
6 a matter of it had been dictated but hadn't been typed
7 yet. Sometimes what the secretaries can do, if there's
8 a delay in typing, they can expedite that and make sure
9 that that's done. So, that's why I had contacted
10 Noleen. 11:17

11 159 Q. And did you ever get any reply from her?

12 A. Not to my knowledge.

13 160 Q. You then raised it with Mr. Haynes on 11th March, so
14 just over a week later. What was his action after
15 that? 11:17

16 A. Well, in terms of patient ■■■, I noticed very quickly
17 after it he received an appointment. I'm not sure
18 whether that was due in any part to prompting from
19 Mr. Haynes. Again, unfortunately, it wasn't fed back
20 to me what exactly had or had not been discussed or 11:18
21 done. I just know that that was -- he ended up with an
22 appointment then soon after.

23 161 Q. The chronology is that six days after you spoke to
24 Mr. Haynes on 17th March, Mr. O'Brien dictated a letter
25 of referral for that patient to Oncology? 11:18

26 A. Yes.

27 162 Q. He eventually received the appointment on 10th April
28 2020 and was subject to the lookback review; found that
29 no issues of clinical concern had been identified in

1 respect of this patient?

2 A. Yeah.

3 163 Q. Apart from you looking in the system for the referral
4 letter, was there any other way the system could have
5 alerted you or anyone else to the fact that a referral 11:18
6 hadn't been done?

7 A. No, because, as I now know, there was no whole of
8 pathway tracking, so there were no flags to alert us to
9 that other than the patient having contact details and
10 being empowered to know what to expect. And, when the 11:18
11 expectation didn't occur, they knew they had somebody
12 to contact for concerns or queries.

13 164 Q. How is that different now, if it is different now?

14 A. In terms of?

15 165 Q. Of being alert to the fact something may not be done 11:19
16 that is anticipated that is done?

17 A. I still have no -- you know, I have no way of tracking
18 what has or hasn't happened. Unfortunately, I wouldn't
19 have the capacity to do that. So within my role as
20 a key worker, I can now more definitively say that 11:19
21 patients, when they are diagnosed, do have a key
22 worker. When I meet with that patient, I do instill
23 into them, you know, they are the most important person
24 in their journey. I tell them when to expect within
25 the timelines appointments or scans, and I say if that 11:19
26 doesn't happen within that timeframe, don't be sitting
27 at home worrying, please pick up the phone and call me
28 and then I can look into what has or hasn't happened,
29 and hopefully it's just a matter of reassuring them.

1 166 Q. So it's anticipated that the patient will be a
2 proactive part of their journey and if they don't have
3 a letter in six weeks, then they can get in touch?
4 A. Yes. Yes.
5 167 Q. What about patients who perhaps lack capacity in some 11:20
6 regards and maybe aren't au fait with just keeping an
7 eye on things, is there any provision made for those
8 type of patients?
9 A. Usually patients like that will have a family member
10 with them, so I would engage at the time with the 11:20
11 family member. Or if they have come on their own,
12 being a nurse you sort of get a feel for if a patient
13 maybe isn't taking everything on board so I would
14 always ask, you know, who is at home with you, things
15 like that. If they are happy, I would normally say 11:20
16 well, you know, if your son or daughter has any
17 queries, would you mind if they phoned in, could I talk
18 to them, you know, update them on that perspective,
19 that there always is somebody other than the patient in
20 that position. 11:20
21 168 Q. The system as it exists now in referral of patients,
22 for example to Oncology, how confident can the Panel be
23 that those referrals are being carried out and that
24 there couldn't possibly be the situation that arose for
25 this patient arising currently? 11:21
26 A. I can only speak for my role within this in that, now,
27 patients who have a new diagnosis do have the key
28 worker and are empowered to know what's happening.
29 I think there have been discussions around the whole of

1 pathway tracking that was alluded to in the testimonies
2 yesterday but, to the best of my knowledge, that isn't
3 currently in position at present.

4 169 Q. And do you think that would be a good idea?

5 A. Absolutely.

11:21

6 170 Q. The other concern about a patient who raised this, just
7 further down on that page - it's at WIT-85924, I think
8 it's the next page - Patient [REDACTED] also is the ciphered
9 Patient 101 for the purposes of the Inquiry. This was
10 a patient who was seen by Mr. O'Brien on 13th December 11:22
11 2019, and he telephoned the unit on 16th December 2019
12 inquiring about a CT scan. The clinic letter from
13 13th December had not been typed and you couldn't see
14 if the scan had been ordered. You e-mailed, I think on
15 this occasion, Mr. O'Brien directly and he replied 11:22
16 saying that he had now requested the CT. The outcome
17 from the MDM on that patient on 28th November 2019
18 indicated an early referral to Oncology should be
19 considered, and you e-mailed the Oncology secretary and
20 no referral had been received. Was that the same time 11:22
21 as you contacted Mr. O'Brien?

22 A. No, I think it was -- it was after. I think it was the
23 time when I had received the information from the
24 previous patient and then it sort of jogged my memory.
25 Covid was also starting to happen, there was a lot 11:23
26 going on. But I think the inquiry of the previous
27 patient prompted me to look back and see what had
28 happened with this particular gentleman, and I noticed.

29 171 Q. Was this a particular gentleman that had a couple of

1 referrals outstanding?

2 A. Yeah. So the CT thing was addressed. Then I looked
3 back to see just what was happening with him, where he
4 was in his pathway, and I noticed there was still
5 nothing appearing in terms of an Oncology referral or 11:23
6 appointment.

7 172 Q. The patient phoned again on 16th April 2020 inquiring
8 about radiotherapy appointment?

9 A. Yes.

10 173 Q. And you could not see a referral letter for 11:23
11 radiotherapy on the NIECR system?

12 A. Yes.

13 174 Q. The patient ultimately had an appointment with Oncology
14 on 7th August 2020. This was another patient subject
15 to the lookback exercise. That did not identify any 11:23
16 issues of clinical concern in relation to this patient.
17 But were those two examples examples in which you
18 engaged with Mr. O'Brien and/or his secretary?

19 A. Yes.

20 175 Q. Did you raise those concerns with anyone else at that 11:24
21 time?

22 A. Just Mr. Haynes, who had a dual role. He was one of
23 our Consultant Urologists and he was also the Medical
24 Director at that time.

25 176 Q. Did you have any knowledge of any previous concerns 11:24
26 around Mr. O'Brien in referral and reviews --

27 A. No.

28 177 Q. Nothing?

29 A. No.

1 178 Q. So as far as you were concerned --

2 A. These were isolated, yeah.

3 179 Q. Isolated.

4

5 You reflect on those cases in your witness statement at 11:24

6 7.28. You say:

7

8 "I am satisfied they received their definitive

9 treatment. However, I do feel that the two patients

10 involved could have endured more anxiety than they 11:24

11 ought to have due to the prolonged referral time. From

12 my perspective, I feel I could have been better

13 informed regarding what had or had not been done about

14 my concerns".

15 11:24

16 In this regard, those were concerns that hadn't

17 actually been raised with anyone beyond Mr. Haynes?

18 A. Correct.

19 180 Q. You didn't raise them with Martina Corrigan --

20 A. No. 11:25

21 181 Q. -- or with anyone within your own line management in

22 nursing?

23 A. Yes. And with hindsight, I think if I had to do that

24 again, that's what would have happened.

25 182 Q. You speak about learning and improvement in your 11:25

26 statement. We don't need to go to it but it's at

27 WIT-85932. You have given some bullet points of the

28 way in which communication and action planning could be

29 improved. Some of these focused particularly on

1 practical application of your skills to the system, if
2 I can put it like that. You have said that one of the
3 ways in which the system could be improved is to enable
4 clinical nurse specialists to have access to a managed
5 DARO list. Could you just explain that a little bit? 11:25

6 A. So, this is a list that secretaries hold for the
7 consultants. I think the actual terminology is
8 Discharging Awaiting Review or Outcome. These are
9 patients waiting scans or a blood result to come back.
10 I'm thinking more of this in terms of my nurse-led work 11:26
11 as a safety net for that. At present, I don't have any
12 way of monitoring, apart from me keeping it all on
13 a spreadsheet and revisiting it every week. If I have
14 ordered a scan for a patient, currently the radiology
15 scans don't come back to the nurse that ordered them, 11:26
16 they will come back to the consultant. They don't
17 populate in my ECR automatically for sign-off.

18
19 I now have it set up that my PSA bloods come back to
20 me, so I don't have to go, and not waste time but use 11:26
21 time to find them. They are populated on a list,
22 a sign-off list that I can just go to, but the same
23 doesn't happen for the scans. It's just another layer
24 of safety that could be there and prompting me that to
25 look for that. 11:26

26 183 Q. So you might order the scan as such but the result goes
27 back to the clinician?

28 A. Yes.

29 184 Q. Would it be something that might assist if the result

1 were to go back to both you and the clinician?

2 A. Yeah.

3 185 Q. You have said again another improvement could be that
4 all scan and blood results should automatically
5 populate onto the ECR work list of the person who 11:27
6 ordered them. I think it's the same point?

7 A. Yes. Yes.

8 186 Q. There's also room for improvement in the admin support
9 of the CNS services, given the demands?

10 A. And there has been improvements in that most recently, 11:27
11 yes.

12 187 Q. And I think we have touched upon the increased tracking
13 post-MDM decision?

14 A. Yes.

15 188 Q. Not just up to the point of MDM? 11:27

16 A. Yes.

17 189 Q. That's something the Panel have heard evidence of, and
18 we will hear some more.
19

20 Just in relation to the concerns overall, you say that 11:27
21 you feel
22

23 "I should have been made aware of the aforementioned
24 governance concerns within Urology. "
25 11:27

26 Now, there's tension there between keeping someone's
27 confidence when they are going through a process, or
28 even their practice is being looked at, even
29 informally, and keeping people up to date. Do you

1 accept that, that there is a requirement?

2 A. Absolutely, and then there's a balance to be struck.

3 190 Q. But if you had have known about issues sooner, what
4 difference do you think it might have made?

5 A. For a start, you would have had more of an awareness. 11:28
6 Referring back to the two cases that we discussed,
7 I think I would have handled those very differently had
8 I had an awareness that there were issues in and around
9 those processes.

10 191 Q. And handled differently how? 11:28

11 A. I would have went to my lead nurse and my Head of
12 Service also.

13 192 Q. So, you would have escalated the issue?

14 A. Yes.

15 193 Q. Now, I asked you before the break about learning, and 11:28
16 I think it was my word to say there was ad hoc learning
17 from the SAIs. I just want to indicate from your
18 witness statement that you are a member of the Task and
19 Finish group. You refer to this at WIT-85936 at
20 paragraph 20.5. This was a group established in 2021 11:29
21 to action the outcomes of the Urology SAI
22 recommendations by the Trust?

23 A. Yes.

24 194 Q. Is this a way in which learning comes back out through
25 the formal system to the CNS, or does the learning sit 11:29
26 within the group?

27 A. So, in a way it's turning the learning into an action
28 that results hopefully in an improvement. Myself and
29 Kate - I think it's myself and - no, myself and

1 Patricia - are within that Task and Finish group. But
2 as for updating the CNSes per se, no, that isn't part
3 of the remit of that group.

4 195 Q. So when it's tasked to action the outcomes of the
5 recommendations, how do they do that? 11:30

6 A. So, I have been involved with the service user group.
7 There's going to be a survey as to what information and
8 role they expect within their journey, and we are
9 looking at the information that's given. Out of also
10 this Task and Finish group, I think that is where the 11:30
11 additional audit resource has come from in terms of us
12 now having a list each month of the new diagnoses and
13 being able to cross-reference those. So there has been
14 good that has come out of it, but there's more to be
15 done. 11:30

16 196 Q. You were nominated to be a representative from the
17 Urology CNS team on that group?

18 A. Yes.

19 197 Q. So, there was obviously an anticipation that that would
20 be a valuable contribution to the group? 11:30

21 A. Yes.

22 198 Q. Is there any expectation or is it a requirement that
23 you feed learning from that group back through to the
24 CNSes?

25 A. I suppose I would do that informally but I certainly 11:31
26 haven't done it formally as such, but we would talk
27 about things.

28 199 Q. Is there anyone on that group or any oversight of that
29 group that asks have the learning about the CNS systems

1 been modified in light of the recommendations?

2 A. Not officially. I haven't been asked officially what

3 happens now, what difference has this made. No.

4 200 Q. I know you said earlier your background was in research

5 and data, I think. Is there any way that you or anyone 11:31

6 else keeps on eye on whether recommendations have been

7 implemented that are relevant to CNS?

8 A. So anything -- when the Task and Finish group meetings

9 were more regular, outcomes that would have

10 specifically concerned the CNS group, I would have been 11:31

11 involved in moving those forward. But there are a lot

12 of much more higher level outcomes that I wouldn't have

13 input into or be involved in. There's a lot happening

14 that would be above my level that I wouldn't be aware

15 where that has progressed to. 11:32

16 201 Q. I have brought you to various parts of your statement.

17 Is there anything at this point that you would like to

18 highlight or say or anything you think should be

19 highlighted that I haven't asked you about?

20 A. No, I think we have -- this has been a balanced view of 11:32

21 what the situation is.

22 202 Q. I have no further questions.

23 CHAIR: There will be some questions for you.

24 Obviously I am going to ask Mr. Hanbury first if he has

25 some questions. 11:32

26

27

28

29

1 THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS
2 FOLLOWS:

3
4 MR. HANBURY: I have a few clinical things that
5 hopefully won't be too taxing. No particular order. 11:32

6 203 Q. We have seen that letters weren't automatically copied
7 to patients from the doctors, but we get the
8 impressions that the nurses usually did do that; is
9 that your experience?

10 A. Yeah. I know within my nurse-led clinics, I would 11:33
11 always copy the letter to the patient. A number of the
12 consultants do this also.

13 204 Q. Is that happening more now, do you think? Not
14 universally, possibly.

15 A. I think it's the same as what it had been, yeah. 11:33

16 205 Q. Okay. Thank you. The two patients you mentioned where
17 you had to chase things, looking back on your
18 spreadsheet, were they patients that CNSes had known
19 about?

20 A. The first gentleman I absolutely was introduced to. 11:33
21 The second man, I personally wasn't but he did have
22 contact details. I'm not sure who had given him those
23 or how he had those. I was certainly not his named key
24 worker from his clinical appointment, but then
25 I undertook that to make sure things were in place for 11:34
26 him.

27 206 Q. I suppose second question about that: were you
28 surprised when the lookback review said that they did?

29 A. About the non-involvement?

1 207 Q. Especially one that seemed to have delay referral to
2 Oncology?

3 A. Yes.

4 208 Q. That did surprise you?

5 A. Yeah, yes. 11:34

6 209 Q. Thank you. I am impressed you do a range of CTs as
7 well as bloods?

8 A. It's MRIs.

9 210 Q. MRIs. Did you have to go through a special sort of
10 process to enable that? 11:34

11 A. Yes. I think there was a scheme of works that I had to
12 sign up to.

13 211 Q. So, do all the CNSes do that now?

14 A. Yes. Yes.

15 212 Q. The Inquiry is aware of some patients whose MDM 11:34
16 outcomes weren't followed through. You said later on
17 that wasn't the role of the CNS to necessarily police
18 that, for want of a better description?

19 A. Yes.

20 213 Q. But then actually that's what you did do -- 11:35

21 A. Yes.

22 214 Q. -- with those two patients. Do you think actually that
23 is part of your role, or would you push back?

24 A. I certainly wouldn't have the resources to proactively
25 follow up every patient that I'm a key worker for. 11:35
26 I think as part of my role, as discussed earlier,
27 I would empower the patient to know when to expect
28 things and what to do if that doesn't happen. But I
29 don't think I would have facility or resource to

1 essentially track every scan or appointment for every
2 patient that I'm a key worker for, it wouldn't be
3 possible.

4 215 Q. Okay. Thank you. You mentioned, and it may be a Covid
5 thing, but with the MDM Chair zooming in for a meeting, 11:35
6 that was quite unusual, was it? Was that just over
7 Covid or did that happen at other times too?

8 A. No, that was at Covid.

9 216 Q. Would that factor into --

10 A. The only meeting that we would have linked into 11:36
11 remotely would have been when we joined the regional
12 meeting in Belfast; we would have always linked
13 remotely into that. Usually the main body of our MDM
14 would have physically been in the room. We are getting
15 back to that, so we are. 11:36

16 217 Q. Thank you. Just on the whole pathway tracking -
17 I understand what you have said - are you aware of that
18 happening anywhere else in the region?

19 A. Not that I'm aware of.

20 218 Q. So that's not happened in other Trusts. Okay, thank 11:36
21 you.

22

23 I think you did some prostate cancer follow-ups;
24 clinics?

25 A. Yes. 11:36

26 219 Q. Did any patients you see, did you see any sort of
27 non-standard use of the drug Bicalutamide --

28 A. No.

29 220 Q. -- in any of the patients that you came across?

1 A. Most of my patients are new into this service so I pick
2 them up after they are diagnosed, so the majority of
3 mine would be new diagnosis.

4 221 Q. Thank you. Did you attend regional and national
5 meetings to get -- 11:37

6 A. So I would be a member, you know, of NICaN, on their
7 clinical reference board. Then we would keep ourselves
8 appraised. We would attend conferences on the mainland
9 and things like that.

10 222 Q. Was that BAUN or one of the -- 11:37

11 A. BAUN. Also now we have, within the Southern Trust,
12 a CNS forum group, which is very useful for even
13 sharing ideas because you can be sure if you are facing
14 an issue, someone will have faced it before you and
15 know how to fix it, even in terms of practical things 11:37
16 like set something up clinics. It's good to share
17 learning and information.

18 223 Q. And that's enabled, in terms of study leave and funding
19 is available for that, so you are not discouraged from
20 doing that? 11:38

21 A. No. Absolutely.

22 224 Q. Just who does the bladder cancer chemotherapy; is that
23 your role?

24 A. No. It would be one of my colleagues, one of our Band
25 6 CNS, or she is actually termed a clinical sister. 11:38
26 She would do the bladder installations.

27 225 Q. Were there any difficulties with bladder chemotherapy
28 scheduling, follow-ups, cystoscopies, anything like
29 that?

1 A. I think there have been issues regarding the follow-up
2 cystoscopies but in terms of the treatments, no, that's
3 all running to schedule.

4 226 Q. I guess just the follow-up, did that depend who the
5 patients belonged to, or is that just a generic waiting 11:38
6 list problem?

7 A. For the cystoscopies, it was just the volume of
8 patients.

9 227 Q. Just volume, okay.

10 A. Yeah. Yeah. 11:38

11 228 Q. Just one last question about MDM radiology, which you
12 have mentioned. If you had a patient who couldn't be
13 discussed locally and then needed to be done
14 regionally, presumably that radiologist had not seen
15 the case before? 11:39

16 A. Yes. Yes.

17 229 Q. Because obviously they spend a lot of time preparing --

18 A. Yes.

19 230 Q. -- and that, so you necessarily get such
20 a well-considered decision in that? 11:39

21 A. Yes, that's correct.

22 231 Q. That's all the questions.

23 DR. SWART: Just a very simple question really, the key
24 worker role, was that regarded as absolutely essential
25 as opposed to optional by the whole department going 11:39
26 back to, say, 2017?

27 A. I definitely think at that stage it maybe was thought
28 of more as an enhancement, whereas now I definitely
29 think it is considered an essential part of the patient

1 journey.

2 232 Q. So when did that change, do you think?

3 A. When we got freed up from our managerial duties,
4 I think we became more proactive and then I think the
5 consultants realised the role that we actually -- they 11:40
6 had an understanding of it but I don't think they
7 realised the full remit or importance of it until it
8 was actually proactively in action.

9 233 Q. How often did you sit down as a group of CNSes and
10 other nurses in the department with the consultants and 11:40
11 perhaps a manager and discuss your plans for the
12 department over the coming year and five years and
13 those sorts of things? How often did that happen, and
14 was that that formal or informal?

15 A. In more recent times that has become more of a thing 11:40
16 that happens, but prior to that it would have been
17 maybe they would have -- issues like that discussed at
18 the end maybe of an audit or a morbidity and mortality
19 meeting, something like that. But it definitely is
20 more embedded now in the actual running of the unit. 11:40

21 234 Q. So did you have strategic planning meeting to say where
22 we are going, what we are doing and all of that?

23 A. Yes. Yes.

24 235 Q. You have also been on this Task and Finish group. What
25 have you personally learned from being on that? 11:41

26 A. There's a lot of wheels in motion.

27 236 Q. Yeah.

28 A. And sometimes the people on the ground don't get fed
29 back to us as to where we are with things and what is

1 happening.

2 237 Q. Because you mentioned a few things. Were the changes
3 made quite quickly to start with? What was the pace?
4 What was the feeling of that meeting; was there a sense
5 of urgency? Or... 11:41

6 A. I feel people wanted stuff to happen more quickly but
7 perhaps the resources weren't there to enable that.
8 But there definitely was willing, whether there were
9 resources as timely as there should have been.

10 238 Q. Whose job did you see it to unblock those resources; 11:41
11 where did you see that?

12 A. I saw that happening at a higher level than me.

13 239 Q. Did they explain to you how that actually all worked --

14 A. No.

15 240 Q. -- or was that a mystery? 11:42

16 A. Mystery. It was not explained.

17 241 Q. Do you think that's right, do you think it should be
18 a mystery?

19 A. I think the more understanding of a process you can
20 be -- the more understanding of a process you have, the 11:42
21 more you can feed into it and make suggestions. Yes,
22 I think that could be important, yeah.

23 242 Q. Did you and are you taking all of that learning back to
24 these consultant meetings and trying to tell people
25 what's happening? Because the nine SAI Task and Finish 11:42
26 group, I mean it's a big deal, isn't it, and it
27 ultimately was a big part of matters of this public
28 inquiry. Did you see it as your role to come back and
29 tell everyone what was going on and were people

1 interested, or did it fizzle a bit? I just get a sense
2 from you that it's fizzled slightly.

3 A. Yes, I think that would be a fair comment to make.
4 I know I would have mentioned it within our small team
5 in passing but certainly not formally. But some of the 11:42
6 consultants are on that Task and Finish group as well.

7 243 Q. Yeah. Okay. But not in the whole department?

8 A. No.

9 244 Q. Okay. Just talking a bit about the wider UK strategies
10 and going to meetings, that obviously is useful. Is 11:43
11 there anybody in the Trust who takes that role of
12 really guiding the whole development of cancer nursing
13 from a specialist viewpoint as opposed to a managerial
14 viewpoint?

15 A. Not that I am aware of. 11:43

16 245 Q. Is that present in other Trusts?

17 A. I have only worked in the Craigavon Trust so it's not
18 something I have looked for or asked about. It sounds
19 like it could make a difference in terms of guiding
20 people in their careers and succession planning and 11:43
21 things like that.

22 246 Q. Okay. That's all from me. Thank you.

23 A. Thank you.

24 MR. HANBURY: (Off microphone) ... you've got clinical
25 and medical oncology. Is that very recent? When did 11:43
26 that start, roughly?

27 A. It's probably about within the last year-and-a-half or
28 so.

29 247 Q. First one and then the other, or both at the same time?

1 A. I think they both -- it happened at once, if I'm
2 recalling right.

3 248 Q. Every two months or so?

4 A. Yes.

5 249 Q. Okay. Thank you. 11:44

6 CHAIR: Ms. McCourt, I want you to take a look at
7 a couple of things that have been opened to you
8 today --

9 A. Yes.

10 250 Q. -- and I am going to ask you to reflect on that. If 11:44
11 could you look first of all at WIT-84359, please. This
12 is the minute of the meeting that the nurses had with
13 Mr. Hughes and Mrs. Kingsnorth on 22nd February '21 and
14 that was the first time you had met Mr. Hughes?

15 A. Yes. 11:44

16 251 Q. Did you know Mrs. Kingsnorth before that?

17 A. No.

18 252 Q. You didn't. You are recorded at the top of that page
19 as having said that you don't feel - and you are
20 referring to Mr. O'Brien here - that he valued the 11:45
21 nurse specialists; you recalled him asking you in
22 a kitchen what the role of nurse specialist was and he
23 didn't understand the role of a nurse specialist. You
24 then, in your statement to us -- you didn't have sight
25 of that but in your statement to us, and we can call 11:45
26 that up also, it's at WIT-85985. Sorry, it's not the
27 correct reference. It's Section 21. Maybe Ms. McMahon
28 can help me out with that. That's the reference that
29 she has given to me earlier. It's paragraph 958, yes.

1 85958. It's paragraph 50 at the top of that page.
2 Yes. You were writing this response to the Inquiry
3 without having sight of, what, the minutes --
4 A. Yes.
5 253 Q. -- which you have only recently seen? 11:46
6 A. Yes.
7 254 Q. what you tell us, if you can just scroll down slightly,
8 please. Just start there.
9
10 "I do recall Mr. O'Brien stating in general 11:46
11 conversation to me 'key worker, what is this key worker
12 role'? I do not recall the specific date or who was in
13 the vicinity at the time of this conversation".
14
15 Can I just check, is that the same conversation that is 11:46
16 referenced by this minute?
17 A. Yes.
18 255 Q. So, it may well have taken place in the kitchen?
19 A. Yes, it did. I can recall the logistics.
20 256 Q. So what you recall when you are writing your statement 11:46
21 to us is the use of the word 'key worker', and nurse
22 specialist is what is recorded in the minute?
23 A. Yes.
24 257 Q. Do you accept, first of all, that you did tell the 11:46
25 meeting on 22nd February that he didn't value nurse
26 specialists?
27 A. No, I didn't say that.
28 258 Q. Okay. Do you recall saying anything of that nature to
29 Mr. Hughes?

1 A. No. I would have said...

2 259 Q. You would have said this?

3 A. Yes.

4 260 Q. So, what is recorded here is accurate?

5 A. Is the accurate encounter. 11:47

6 261 Q. what is in your statement is accurate. what you tell
7 the Inquiry is:

8

9 "I do recall Mr. O'Brien stating in general
10 conversation to me, 'key worker, what is this key 11:47
11 worker role? I don't recall the specific date or who
12 else was in the vicinity at the time of this
13 conversation".

14

15 Can I just check, you now know that it was in the 11:47
16 kitchen?

17 A. Yes, yes.

18 262 Q. Do you recall now whether anyone else was --

19 A. I don't know. The kitchen door would have been open so
20 I don't know. It's only a small -- 11:47

21 263 Q. Yes. Okay.

22 A. Yeah.

23 264 Q. "In my opinion, this took place when he arrived to do
24 his clinics", so whenever you were saying to him I am
25 available to be key worker? 11:47

26 A. Yes. Yes.

27 265 Q. "I had said to him that I was available as key worker.
28 In my opinion, his response was verbalised in the
29 context of a condescending tone and I was taken aback

1 and do not accurately recall my response".
2
3 what you have told us today, Ms. McCourt, is that it
4 was really him being particular about the use of
5 language? 11:48
6 A. Yes.
7 266 Q. why, then, were you taken aback?
8 A. Because I would have used that phrase to him before.
9 It would have been my habit to have said, 'Aidan, I
10 will be the key worker for your clinic'. That wouldn't 11:48
11 have been the first time I would have used that phrase
12 with him. So --
13 267 Q. why, then, were you taken aback at this condescending
14 tone?
15 A. Because he had never said anything like that before. 11:48
16 He had never verbalised anything like that before to me
17 about that term.
18 268 Q. So you are quite clear in your evidence to the Inquiry
19 that you did not tell Mr. Hughes that you felt that
20 Mr. O'Brien didn't value nurse specialists? 11:48
21 A. Absolutely I wouldn't have said that because it's not
22 what I believe.
23 269 Q. Okay. You are quite clear that this condescending tone
24 that took you aback was only because it was the first
25 time he had said something like that to you? 11:49
26 A. Yes, because I would have used that key worker phrase
27 to him prior.
28 270 Q. I see, okay. So, being taken aback...
29 A. why would he have chosen that day to comment on it when

1 I have used that phrase before? I just didn't
2 understand why on that day.

3 271 Q. Did you challenge him about it?

4 A. I don't think I did, to be honest, no.

5 272 Q. Thank you. I have no further questions.

11:49

6 MS. McMAHON: Thank you, Ms. McCourt.

7 THE WITNESS: Thank you.

8 CHAIR: That's our evidence today, Ms. McMahon, and we
9 will start again at 10:00 tomorrow.

10

11:49

11 THE INQUIRY WAS THEN ADJOURNED TO THURSDAY, 18TH MAY
12 2023 AT 10:00 A.M.

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