Urology Services Inquiry

Oral Hearing

Day 42 – Tuesday, 16th 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

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THE INQUIRY RESUMED AT 10:00 A.M. ON TUESDAY, 16TH MAY 2023, AS FOLLOWS:

CHAIR: Good morning, everyone. Mr. Wolfe.

MR. WOLFE KC: Good morning members of the Panel. Your witness this morning is Vicki Graham. As you will observe from the timetable going forward, she's the first of a number of witnesses from whom you will hear who had a role in the cancer services side of the Trust's output. You will also observe, having heard evidence in respect of the serious adverse incidents that were reviewed in 2020 and into 2021, that there is a particular interest in the performance of the urology multidisciplinary team, and these witnesses are germane particularly to the performance of that part of the Trust's output. 10:02 10:02 10:03

I understand that Ms. Graham wishes to take the oath.

VICKI GRAHAM, HAVING BEEN SWORN, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS: 10:03

1 Q. MR. WOLFE KC: Ms. Graham, you have kindly in advance of today provided the Inquiry with a witness statement, as well as more recently an addendum statement tidying up a few corrections. If we can have those up on the screen, please, starting with your witness statement, WIT-60853. You'll recognise that as the first page of your statement? 10:03

A. Mhm-mhm, yes.

2 Q. We've added the note in respect of your addendum which we will come to in a moment. If we just go through to the last page of this statement at WIT-60917. You'll recognise your electronic signature there? 10:04

A. Yes, that's correct.

3 Q. Dated 20th October 2022?

A. Mhm-mhm.

4 Q. Subject to the corrections set out on the addendum, would you like to adopt that statement as part of your 10:04 evidence to the Inquiry?

A. Yes, please.

5 Q. Thank you. Then your addendum which is dated 4th May of this year, WIT-94667. That's the first page. If we go to the last page then at 7094670, you can see that 10:05 is your signature again?

A. Yes.

6 Q. Electronically?

A. Yes.

7 Q. Again, do you wish to adopt that addendum as part of 10:05 your evidence?

A. Yes, please.

8 Q. Now, you're currently employed by the Southern Trust as a performance manager Band 7; is that correct?

A. Yes, that's correct. 10:05

9 Q. And you're on secondment in that role from 1st May 2023?

A. Yes.

10 Q. I think that's set out in paragraph 7 of this

statement. We needn't turn it up. But we're not here this morning to talk about that role, we're here to talk about your earlier roles. Let me just outline them. You were appointed as a Cancer Tracker MDT Coordinator, which was a Band 4 post, and you took that post up on 18th February 2009; is that correct?

A. That's correct.

11 Q. And you stayed in that post until 5th October?

A. Yes.

12 Q. 2014? 10:06

A. Yeah, that's correct.

13 Q. We needn't turn it up but in order to save some time, you've set out your main duties for that post at WIT-60859 but can I reduce it to this: You were employed in that role to track the progress of suspected cancer patients? 10:06

A. Yes.

14 Q. That is a large part of your role?

A. Mhm-mhm.

15 Q. And you also had to coordinate the weekly multidisciplinary team meeting? 10:07

A. Yep, that's correct.

16 Q. That says in very short form what were undoubtedly a large number of duties. We'll look at those twin sides of your role presently. In that role, you reported to the Cancer Services Coordinator. Is that right? 10:07

A. Yes that's correct.

17 Q. Who was that?

A. That was Angela Muldrew at that time.

18 Q. I think the Inquiry has heard that name. She has recently taken up a role on the governance side of the multidisciplinary team; isn't that right?
A. Yes, that's correct.
19 Q. Briefly again by way of overview, after 2014 you moved into the Cancer Services Coordinator role; isn't that right? 10:07
A. Yes, that's correct.
20 Q. You took up that post on 6th October 2014?
A. Yes, that's correct. 10:08
21 Q. And you stayed in it until August 2020?
A. Yes.
22 Q. In that role, the trackers were now reporting to you; is that right?
A. Yes, that's correct. 10:08
23 Q. Whereas you previously reported to Mrs. Muldrew in your role as a tracker, your equivalent and all other trackers were reporting to you?
A. That's correct.
24 Q. In a nutshell, that role was to support the Head of Service within Cancer Services, and the OSL, that's the operational lead? 10:08
A. Yes.
25 Q. And you had responsibilities in performance management and commissioning functioning? 10:08
A. Mhm-mhm.
26 Q. You had management of the budget agreement?
A. Mhm-mhm.
27 Q. And you had management of the administrative staff?

A. Yes.

28 Q. Including the trackers?

A. Yes.

29 Q. Again just for the Inquiry's note, the main duties are set out at WIT-60860 at paragraph 4.2. In that role, the coordinator's role, you reported to Sharon Glenny; isn't that right? 10:09

A. That's correct.

30 Q. She was the operational support lead, and above her was Fiona Reddick -- 10:09

A. Yes.

31 Q. -- who was the Head of Service?

A. Yes.

32 Q. We'll hear from both of those witnesses, Mrs. Glenny this week and Mrs. Reddick in due course. 10:09

Now, as is hopefully self-evident, these roles were located within Cancer Services?

A. Mhm-mhm.

33 Q. But as we will shortly discover, your role, at least as a tracker, was in support of Urology Services? 10:10

A. Yes. For a period of time, yes.

34 Q. And you left Cancer Services in August 2020?

A. Yes.

35 Q. Now, I want to start with a little bit of detail by looking at the Cancer Tracker role. This is an opportunity for the Inquiry to understand, in the short time we have this morning, the nature of that role and why it was important, and the kind of difficulties or 10:10

pressures you suffered and your staff suffered in that role and why that was the case. Then, we'll move on to look at aspects of the MDT Coordinator role.

A. Yeah.

36 Q. Now, if we could have up on the screen please WIT-60926. This is an extract from a document which commences at WIT-60920. It's a cancer performance briefing paper from I think 2015, produced by the Trust. Indeed, let's just go back to the start of that paper at 60920. There we go, that's the start of the paper. That's a paper you sent in with your statement. We can see, if we just scroll down, please, that it says: 10:11 10:11

"Coordination and centralisation of patient pathways and processes is essential to achieve ministerial targets. Central to the success of managing the patients along the pathways and achieving the cancer access targets is the tracking administrative function". 10:12 10:12

So, that gives a flavour of what the job is about. Then, if we go forward to where I was at 60926 of that sequence, just a few pages on, it says: 10:12

"The tracker has a pivotal role in ensuring that patients on the 31 and 62-day cancer pathways are fast-tracked through all of the above milestones, escalated and discussed at MDMs".

Therein is a list of the core responsibilities. I have said a lot already; time to hear your voice. Could you give us a synopsis of the tracker's role? Where does your intervention as a tracker start and what are the various tasks that are undertaken through to the patient's first definitive treatment?

A. As the tracker, we had responsibilities for patients, all suspect cancer patients, should they be referred in from their GP, which is a 62-day patient, or else a 31-day patient which can come in any other way, from the hospital, any other consultant, incidental findings or that. So, as I say, we had overall responsibility for that patient from the date of referral until their first definitive treatment, and that would have been their first outpatient appointment. We would have been trying to get that within our own time scales within the pathway, the first outpatient appointment, the diagnostics, and then their treatment if they were confirmed cancer, and trying to get that done within the target.

37 Q. What is the significance of the 31 and 62-day targets?

A. The 62-day target is from the date of referral from the GP. They have 62 days to complete, get their first outpatient appointment, get all their diagnostics done, go through MDM, come up with a treatment plan, meet with the patient, agree with that treatment plan, and then they have to have their first treatment by day 62 from that referral.

The 31-day is another incidental, another consultant referral. You can come in any other route for the 31-day patient. While they may be on the system, the CaPPS system, their date decision to treat does not start until the consultant sits down with the patient and agrees a treatment plan for them. Then they have 31 days to get their treatment. It is the role of the tracker to ensure to the best of their ability that that is done within the timeframe. 10:15

38 Q. Yes. It seems from reading your statement that that is the objective --

A. Yes.

39 Q. -- that you're really asked or expected to deliver?

A. Yes, for each patient. 10:15

40 Q. And it wasn't always possible?

A. No.

41 Q. But that seems to be the golden rule, if you like?

A. Yes.

42 Q. You would almost feel as if you to some extent failed in your task, if you didn't -- 10:15

A. If you didn't get them within target, yes.

43 Q. Of course I didn't mean that you would be to blame.

A. No.

44 Q. But that was how it was? 10:16

A. Yes, that's correct.

45 Q. And if a patient -- if you weren't able to, with your colleagues on the clinical side, deliver on the target, that necessitated a report, didn't it?

A. That's correct. That was a breach to the Trust for that patient.

46 Q. Could I ask you this: These targets as they are described in your statement and through the documents that you've supplied, was that the only emphasis in your role? Was there any greater sense of delivering on a Trust vision for these patients? 10:16

A. Well, you were there -- you were there to do it for the patient as well. Yes, obviously the performance was very important but behind each hospital number was a patient, and the trackers were very mindful of that, that you were trying to get them the best service through the treatment or their pathway as quickly as you could. Should that have been linking in with multiple teams to get appointments brought forward, linking in with the consultants, you were there to do the best that you could to hopefully get that patient through their pathway as promptly as possible, and that would probably be the overall aim. 10:17 10:17

47 Q. In terms of the quality of the patient's experience, was that anything to do with you? Was that something that you would look out for? 10:17

A. The trackers would never have had any direct contact with the patients, we were always working in the background. 10:17

48 Q. Yes. You say in your witness statement that you followed the cancer access waiting times guidelines?

A. That's correct.

49 Q. This provided information on each tumour site's pathway

and targets, and it also provided the breakdown as to what could be counted as first definitive treatment?

A. Yes. It gives scenarios of when you could apply the treatments for each cancer site.

50 Q. Yes. So, as appears obvious from what you've said in your statement, this was in a sense a very rules-based exercise; things had to be done depending on the tumour within particular periods of time? 10:18

A. Yes, that's correct.

51 Q. And the trackers -- 10:18

A. Adhered to them. Yes, we followed them.

52 Q. -- adhered to those as best we could.

A. We had our timelines and we had to follow them.

53 Q. Yes. We can just briefly look at some of these documents that you have referred to. WIT-60970. This is the cancer waiting times guidance, and that was the handbook that you worked to; is that right? 10:19

A. Yes, that's correct.

54 Q. And if we could go to WIT-60992 within this document, these are the urological cancers. And if one was to look through that in detail - we'll not do it this morning, it is really unnecessary for our purposes today - it sets out the expectations in terms of different urology cancers and what is expected in terms of the timeline? 10:19 10:20

A. Yes.

55 Q. Against that timeline, was the risk that there may not be compliance, that it may not be possible to put a patient into a clinic or into --

A. Yep.

56 Q. -- diagnostics within the time expected by the guideline?

A. Yes. That would have been a daily challenge for the trackers. 10:20

57 Q. Yes. And you had an escalation policy?

A. We had an escalation policy that we followed to try and get the patients brought in sooner for an appointment, or a diagnostic or surgery.

58 Q. Again, to briefly acknowledge that policy WIT-60941. 10:20 That is the 2000 and --

A. 2019.

59 Q. -- version, but there were previous iterations of that policy?

A. Yes. There was one previous. 10:21

60 Q. Can you help us with this in a nutshell. What was escalation? When did it arise as an issue for you and your trackers?

A. I suppose whenever I first started tracking, there was more capacity within the Trust. So whenever I first 10:21 started tracking, it was the role of the tracker obviously to get the patients through their pathways as promptly as possible. Therefore, I would have tried, and other trackers would have tried, to link in if the first out-patient appointment wasn't by day 14, or by 10:21 day 10 even, we would have linked in with the red flag appointment team to try and get that appointment brought forward. If that wasn't possible, then we would have followed the escalation policy or likewise

the diagnostics. So we would have tried to resolve things ourselves with the local teams to try and get the patients brought forward. Then, we referred to the escalation policy which was escalating on up for to see if maybe people at a higher level were able to put on additional or extra theatre sessions or do whatever they could do to get the patient brought forward. 10:22

61 Q. Yes. If we scroll down briefly through the document, the general principles of escalation are set out. Maybe they are an exercise in common sense. 10:22

"The earlier the better. It is easier to stand people down once the problem is resolved than to catch up on lost time. Try everything you know to resolve the problem". 10:22

A. Yes.

62 Q. What's a practical example of that?

A. Linking in with the red flag team to see if they had any other appointments that they could maybe bring their patients forward to, any cancellations. Linked in with them or maybe linked in with radiology to see if there was any other way to get the patient on another list, maybe saving two days on their pathway. Or even linking in with a consultant for a clinic appointment or surgery, or the secretary. So you tried to resolve everything locally yourself. If not, then you would have escalated on up. 10:22 10:23

63 Q. And we can read the rest of that. Then it sets out triggers for escalation. Can you explain what a

trigger for escalation is?

A. So, say you were unable to get the first outpatient appointment in by day - we always aimed for day 10, but 14 was the target - so if they couldn't get it in by then and red flag appointments had no more capacity -- no more lists to book the patient into, they would have escalated that on to me and we would have forwarded that on to the Operational Support Lead and the heads of surgeries to see if there was any maybe additional clinics that could be put on. 10:23

64 Q. As a tracker, if you were at risk or your patient was at risk of breach, you would escalate it to the --

A. The next one up.

65 Q. -- coordinator?

A. Yep. 10:24

66 Q. When you were coordinator --

A. I would have escalated it on up.

67 Q. -- trackers were referring to you?

A. That's correct.

68 Q. I think we can see what is perhaps a typical example of an approach if we turn up WIT-61107. It's Christmas Eve; red flag appointment are writing to you in respect of urology escalations. I would ask you not to name the patients obviously, we'll just let the names sit. But she, that is the red flag appointments person, is telling you that these patients are going to breach their first appointment deadline. If we scroll, we can see that you then take that up with Mrs. Corrigan, the Head of Urology Service. She then writes but she has

obviously spoken to Mr. Michael Young, one of the urologists, and he is going to see the patient next Wednesday, it seems, or the patient. Then, you are satisfied with that?

A. Yeah. At each point in escalations or any point in the pathway, the tracker would be updating their CaPPS System so we had a very clear picture of what was done for each patient at what point in time. 10:25

69 Q. Presumably, as I think we know, escalations weren't always apparently straightforward as that? 10:26

A. No. 2015/16, I would say, for maybe 17/18 on, capacity became a problem and it wasn't always possible to get things brought forward.

70 Q. We are just going to come to those kind of issues in a moment. Tell us about first definitive treatment. It appears from your statement that you were only required to track until first definitive treatment; is that correct? 10:26

A. Yes. We were only commissioned to track to first definitive, yes. 10:26

71 Q. The work starts when the referral comes in?

A. Mhm-mhm.

72 Q. And you track the patient all the way along the pathway until first definitive treatment?

A. Correct. 10:26

73 Q. And we can see in the Northern Ireland cancer access standards, if we pull up WIT-60998, this is another document that you work to; is that right?

A. That's correct.

74 Q. It's obviously from January 2008 but it remains --
A. It is still remains the same, yes.
75 Q. -- the same. We just scroll down into the introduction. It talks, at least in terms of the 62-day patients, that. 10:27

"75% of patients urgently referred with a suspected cancer should begin their first definitive treatment within a maximum of 62 days". 10:27

That was for 2007, 2008. In 2008/2009, 95% of patients urgently referred as a suspected cancer should begin their first definitive treatment within a maximum of 62 days. And it was the 95% target --
A. Which we were working towards. 10:28
76 Q. -- which you were working to during your time working there?
A. Mhm-mhm.
77 Q. And different tumour sites had different definitions of what was a first definitive treatment; is that right? 10:28
A. Yes. That would be correct, yes.
78 Q. Just by way of example, and it's an issue with some of the patients from whom the Inquiry has heard. Let me ask you about prostate cancer and draw your attention to a number of entries. If we go to WIT-61008. The 10:29 Inquiry will have an opportunity to read this document in full but it's working through various types of treatment and tumour sites. This table deals with the situation where the first definitive treatment --

"The first definitive treatment is normally the first intervention which is intended to remove or shrink the tumour".

10:29

If you scroll down a little bit for me, please, you can see on the left-hand column drug treatment, chemotherapy, biological therapy or hormone therapy. Then it says, third box within that section

10:30

"Hormone treatments should count as first definitive treatment in two circumstances. 2. Where the treatment plan specifies that a second treatment modality should only be given after a planned interval. This may, for example, be the case in patients with locally advanced breast or prostate cancer where hormone therapy is given for a planned period with the aim of shrinking the tumour before the patient receives surgery or radiotherapy".

10:30 10:30

Is that a standard or definition that you work to?

A. Yes. Hormone therapy was a treatment.

79 Q. Yes. We'll come on to look at it in the context of the SAI review in a bit more detail later. When you saw that the patient had reached the point of first definitive treatment, was that the end of your role?

10:31

A. That was when our role, yes. That's when we would have ceased tracking.

80 Q. Yes. You wouldn't have tracked to see the outcome of

that treatment?

A. Post first definitive, no, we wouldn't have been tracking that patient.

81 Q. So, if the patient came back into multidisciplinary team and required further treatment? 10:32

A. We would have facilitated that MDM discussion but it would have been up to the referring clinician to advise us to put that patient on because we wouldn't known about them. We wouldn't have been tracking them in the CaPPS System. 10:32

82 Q. Just to further extend this, if the patient needed further treatment, I don't know, say radiotherapy or whatever it might be, and required a date for that or an appointment, that wasn't --

A. Within our remit, no. 10:32

83 Q. -- that wasn't the interest of the tracker at that point?

A. No.

84 Q. Because that had gone beyond first definitive treatment? 10:32

A. Yes, that's correct.

85 Q. Thank you. I want to ask you about the pressures or demands on the service. You've indicated already that it became increasingly difficult as time went by. If we go to the briefing paper that I've already opened. 10:33 This is the document which we looked at at WIT-60920 a short time ago. If we go to the second page of that, 60922. It is the case that across all tumour sites that the demand for tracking services --

A. Yes, increased.

86 Q. -- indeed the demand for cancer services more broadly increased exponentially over the years?

A. That's correct, yes. It did.

87 Q. This document takes us from, as it can be seen, 2008 and 2009 through to 15/16. 15/16 you are in the coordinator's role for two years? 10:34

A. Yep.

88 Q. We can see, if we look to the right-hand side of the table, this of course is 62-day suspect referrals only, and the number of referrals has jumped from 2008/09 from 3,092, and in '14/'15, it sat at 12,102. If we scroll on down, please. 31-day suspect referrals on WIT-60923. A smaller group but again an exponential increase over that period of time? 10:34 10:35

A. That's correct.

89 Q. Moving from 2,497 in '09 and 2010 through to almost 6,000 cases in 2014/'15. Is it fair to say that the numbers continued to increase thereafter?

A. Yes, that would be correct. It did. 10:35

90 Q. We can see that, I think, in something you said in an email in 2019. If we go to WIT-61137. You're saying to your manager that you're very worried about some sites, especially lower --

A. Lower GI. 10:36

91 Q. Gastrointestinal. As "it has not over 1,000", I think it should say "has now hit 1,000 plus patients"?

A. Mhm-mhm.

92 Q. Is that per month?

A. That was just what they would have been tracking, actively tracking at that point in time.

93 Q. "You never remembered it as big as this and skin is now up at 443 and urology also in the 400s".

10:36

Is that creating a pressure for your staff?

A. Yes, because for each patient, you're having to go in and check first, you know, the red appointment team will have updated the first appointment, but it was the responsibility of the tracker also to keep a check on 10:36 appointments. You were checking the appointments for every one of those 400 patients; the diagnostics for every one of those 400 patients; you were checking NACR for every one of those outcomes, you were seeing if results have come back, listening out for MDM. So you 10:37 know the pressure was huge for each tracker, for each one of those patients. Even if you're given five minutes per patient to track a week, that was just for your tracking function let alone you had to also do the MDM function as well. 10:37

94 Q. Of course we can't forget that the importance of tracking --

A. Yeah.

95 Q. -- is to ensure that the patient --

A. Is listed, yes. 10:37

96 Q. -- is seen as quickly as possible, having regard to their condition?

A. And that was a concern because just with the increase in the workloads, that every patient wasn't able to be

tracked in a timely manner, you know as they would have liked. And therefore them patients didn't get listed maybe for MDM discussion because they weren't picked up in the tracking.

97 Q. We can see, I think in 2019, that you're expressing concern about staffing pressures. If we go to WIT - it's just two pages on - 61139. You're writing that the tracking team remain under a lot of pressure; ongoing sick leave, annual leave in the team; this has resulted in a lot of cross cover, the focus solely being on the MDM prep and then attending the MDM. You set out a rough guide of where you're at and no sit - no tumour site, is that - is really fully up-to-date. 10:37 10:38

A. Mhm-mhm.

98 Q. Was it a case of - and just to be clear about this - that although the demand on your resources was increasing with referrals, as we've seen across the board really, the employment of staff hadn't increased to deal with that? 10:38

A. That would be correct. 10:39

99 Q. Was there one tracker per tumour site or how did it work?

A. There would mostly have been one tracker per tumour site and then maybe would have had help from a few other trackers, depending on what tumour sites that they were actually covering. So if your tracking was up to date, you would have maybe offered to help out with the other trackers to try and get their tracking up-to-date. 10:39

100 Q. We can see in 2016, if we go to WIT 61098 - scroll down, please - that you're explaining almost two years into the job the particular pressures that --

A. I was facing.

101 Q. -- you were facing. You had been asked to take on different roles to cover absences? 10:40

A. Yep.

102 Q. You say, if I can just look at the first line, you'd attended a meeting with Ms Muldrew and Glenny, and you're telling them by way of this email that you had tried to explain to them that you'd been feeling under extreme pressure due to the last few weeks and found yourself getting a bit teary to the point, 10:40

"Where I feel I can no longer continue to do all that I have been doing. I know that the last few weeks have been very difficult and trying for everyone, and I am grateful for all the help and support, but I always say to the trackers to let me know if they feel things are getting too much". 10:40 10:41

Was that a particular pinch-point in time where things were particularly bad, or was it --

A. It could have been a regular occurrence, just depending on your staffing levels and how many trackers maybe were off sick. Because I had the tracker experience, I would have been also covering maybe one or two sites, training new trackers coming in but also doing the Cancer Services Coordinator role to the best that I 10:41

could at that time.

103 Q. What does this say about the capacity of the Trust over a period of years to effectively manage the requirements or the needs of red flag referrals?

A. I mean, I did get great support from my two line managers, that wasn't the issue, but it is just there was limitations on recruitment and who we could actually get in to cover the post. Even if you did get a new member of staff, because I think in one of my emails we had two new members of staff in, but it is the training, the time it takes to train the staff. I would have been doing the training as well, so therefore that was near extra pressure. 10:41 10:42

104 Q. Just let me be precise about what we are talking about here. Was there either a difficulty in doing the tracking effectively, or was it both a difficulty in doing the tracking, in other words keeping up -- 10:42

A. Yes.

105 Q. -- as well as a pressure on the urology service in being able to offer your tracking team - or the patient, probably better put, it's the patient - the necessary services, whether they are diagnostic or review? 10:43

A. Yes. It probably would have been both areas that would have been under pressure. 10:43

106 Q. And was it only a factor in urology or was across the board?

A. No, it was across all the board. All tumour sites would have been experiencing difficulties.

107 Q. Was this, to the best of your understanding, due to sheer weight of numbers, that is, the demand for the service?

A. Yes. The demand was going up so therefore the workload was increasing alongside that, and then staffing issues as well. 10:43

108 Q. Yes, but the capacity to deal with those numbers wasn't there.

A. Yes, had reduced, yes, or maybe just hadn't increased the same way as referrals had. 10:43

109 Q. You've explained in your statement, and this is paragraphs - I needn't bring them up on the screen - 17.1 to 17.4 of your statement at WIT-60880, that tracking not being up to date meant it was not always possible to track all the patients on a weekly basis, 10:44 and if patients couldn't be fully tracked, then they were at risk of missing the listing for MDM?

A. That's correct, and that was a concern for all trackers, you know. That didn't sit easy with them, that they weren't able to get all their patients 10:44 tracked on a weekly basis.

110 Q. And that delayed their pathway?

A. And that delayed their pathway. Not for -- they had things in place to try and mitigate that happening. We would have used alert systems on the CaPPS System. If 10:44 you knew a patient was going for, say, a biopsy or CT scan, that we would have worked from the notification so you were going straight into those patients that were having something done to try to get them listed

for the MDM discussion as promptly as you could. But again, as the number of them increased, therefore it was harder to keep on top of them as well. But we were using everything that was within the CaPPS System, the functionality, to allow us to, you know, track the most pressing patients.

111 Q. We can see in terms of the performance of the Trust how it was reported to the external verification report in 2017. If we just pull up the front page of that to orientate our self TRU-103831. So, this was an external verification report through NICaN in October 2017. The rag rating for the urology MDT was red, that is 65% compliance, against the external verifications objectives. We can see just in terms of the 62-day cancer waiting times, if we go to the next page at TRU-103832 -- we talked earlier about the 95% target. It says in the last paragraph on the screen there: 10:45 10:45 10:46

"Trust performance on the 62-day cancer waiting times targets was below the 95% required. The table in the annual report contained formatting errors but verification showed that 81% of patients were treated within the target". 10:47

That doesn't come as a surprise to you, does it? 10:47

A. No, it doesn't. I would say maybe even after that it possibly dipped even further.

112 Q. Yes. I think if we look at Sharon Glenny's statement at WIT-81745. This is the statement of Sharon Glenny,

your line manager in the coordinator role?

A. Yes.

113 Q. We can see that you're absolutely right, that cancer performance measured against the 95% target has dipped in urology from, if we look at the left-hand table from 10:48
81, nearly 82% in 2016/'17, down to 2020/'21 32%. Now, obviously that may have been a Covid-affected year but even if we take the last full non-Covid year, 2018/'19, it was as low as 54.5% compliance. Again, I know you left -- 10:48

A. Yes.

114 Q. -- the service in 2020 to go to a new job. Again, do those figures reflect the pressures felt on the tracking side?

A. Yes. 10:49

115 Q. Which are again reflective of what's going on in the service itself?

A. Yes, in the service itself. It would have done.

116 Q. If we go just on down the page, I think. Scroll down. So, Mrs. Glenny refers to the use of escalations, and 10:49
these were sent to the Operational Head of Service, who would have been Mrs. Corrigan?

A. Yep.

117 Q. She says that there have been capacity and demand difficulties across the whole cancer pathway throughout 10:49
her tenure, including delays with first appointment, with diagnostics and flexible cystoscopy, and delays ultimately with surgery.

Just scrolling down. Maybe back up, sorry. I think she makes the point ultimately that there was minimal action that could be taken due to ongoing capacity and demand difficulties. Again, does that reflect your experience; there was efforts by your staff? 10:50

A. Oh, there was. Everybody was working very hard to do the best that they could for each patient but there was limitations on what they could actually get done due to capacity.

118 Q. Could I ask you about some specific issues in terms of your experience of working with Mr. O'Brien. Is it fair to say that when you were working as a tracker up until 2014 that you had experience of shortcomings on his part in terms of the delivery of triage, that is red flagged referrals, the delivery of his triage back into the system? 10:50 10:51

A. Yes, that would be correct. Not on every occasion but I would have been aware there would have been delays happening with triage.

119 Q. As a Cancer Tracker, what were your options in terms of dealing with that? 10:51

A. As a Cancer Tracker, I would have been linking with the red flag appointment team to try and, you know, see if they could get the referrals back from triage. Then that would have went through the escalation policy to try and get appointments booked. 10:52

120 Q. We can see perhaps a number of examples of that, if we go to TRU-274365. If we go to the bottom of the page, please. So, Caroline Davies is red flag --

A. Appointment team, yes, that's correct.

121 Q. She is writing to you to say:

"I've just been through my urology referrals and I had thought I had got all my referrals back on Friday but the 12 referrals below are still outstanding". 10:53

So, this is 15th December. If we just scroll down, just stop there, we can see these referrals are coming in and going out -- 10:53

A. Yes, that's correct.

122 Q. -- on these dates?

A. Yes.

123 Q. So it's 15th December and the referrals have gone on the 8th or 9th December. If we scroll back up the page, please, you then respond to that by saying to the Head of Service you refer to the patients below, and you're saying: 10:53

"They will not be seen by day 14 due to referrals going missing the week that Mr. O'Brien was triaging. I will ask Caroline to request these from the GP surgery. Should these be booked directly into next available or should these be sent to triage"? 10:53

10:54

Can you remember what was happening there?

A. I think because at that time they weren't electronic referrals, they were all paper referrals that would have been faxed in, so it was probably to try and get

the ones that were outstanding, because they would have kept a detailed spreadsheet of what referrals came in and what referrals went for triage and then cross-referencing when it came back from triage. So the ones that are outstanding, you have been able to identify which ones they were, contact the GP surgery and re-request maybe another referral in just to try and speed things up for that patient.

124 Q. What is the significance of day 14?

A. Day 14 was our target. We always aimed to get their first appointment by day 10, and if it went outside that, day 14 was the maximum that we liked to get patients booked into for the first outpatient appointment. And we had the 72 hours for triage, that was our turnaround target. So if it didn't return back within three days, that prompted an alert also.

125 Q. It was the expectation that a red flag referral should come back, was it at the latest 72 hours --

A. At latest, yeah.

126 Q. -- because I've seen elsewhere that ideally it should come back --

A. At latest 72 hours. Ideally we would like it done sort of on the day or the next day. It was simply just to give you more time throughout the pathway. Then you'd have been coming up to the Christmas holidays there as well. It was to try and get the patients in and get them seen and investigations requested before the holiday period.

127 Q. Then if we look at the next month. If we go to

TRU-274384. Just go to the bottom of the page, please. Caroline Davies again, red flag service?

A. Yes, that's correct.

128 Q. It's 19th January and she is saying:

"Just to let you know I am still missing these referrals now on day 10, 11".

I think this is a different set of referrals from December? 10:55 10:56

A. Yes, that would be.

129 Q. If we scroll down, we can see it is 19th January. If we go to the first or any of the patients, the referral is going across on the 8th or 9th January. That gets you to day 10 or 11, as she says? 10:56

A. Yep.

130 Q. If we scroll back up to what she says. You're saying,

"Mr. O'Brien was on triage so I think he must still have them", et cetera. Then you have to take this up. 10:56 Scrolling up the page.

"Martina, please see below urology referrals that are outstanding. Do you think it is safe to assume that Mr. O'Brien has referrals and that we leave these until 10:56 he gives the referrals back".

Then if we just scroll up the page, Mrs. Corrigan is saying she has emailed Mr. O'Brien and assumes that he

will sort it out?

A. Mhm-mhm.

131 Q. Was that -- I'm not for one minute suggesting it was every month --

A. Yes. It would have happened -- 10:57

132 Q. -- but was that a typical experience?

A. It could have, yes. And then in the background whenever I refer to a sector, sometimes Mr. O'Brien then would have done requested investigations so they were in the system before he would have seen the 10:57 patients as well, so we would have been checking other systems even though the referrals were outstanding just to see what action he was taking on them.

133 Q. If we go to TRU-257252. This is May 2015, you're in the cancer coordinator's role? 10:58

A. Yes.

134 Q. Wendy Clayton was your line manager?

A. At that time. At that point in time, yes.

135 Q. She is writing to say that "Martina", that is Martina Corrigan: 10:58

"Has just advised that it is Mr. O'Brien's turn to triage the red flag urology referrals next week. If there is any delay with triage, can you highlight to Martina within 48 hours and she will raise directly 10:58 with Mr. O'Brien".

Can I suggest that that email implies that it was well-recognised --

A. Yes.

136 Q. -- by management, including your management within Cancer Services, that Mr. O'Brien's triage or his failure to triage was to be watched?

A. Yes, that would be correct. As I say, I was only in my role as service administrator post for six months at that time, so I was still getting familiar with the sort of delays that you'd have been expecting. I think they were just trying to be proactive, that we were aware and I could alert my team then if he is triaging and then not -- Mr. O'Brien is not -- if they are not returned within 48 hours then, to alert Wendy. 10:59 10:59

137 Q. Did you ever obtain an explanation or seek an explanation as to why these periodic and repeated delays with return of triage were occurring? 10:59

A. I don't think ever I got an explanation but I always know either Martina or Wendy, they would have been linking in directly with Mr. O'Brien to try and get the referrals and we had to wait for them to return, or re-request other referrals then to try and get them triaged. But that wouldn't have been that often, to be honest. 11:00

138 Q. Because you were sitting in the Cancer Service and not in Urology Service, was there a sense that you were powerless to do anything more than simply escalate -- 11:00

A. That's all. We had to follow the escalation policy. Once you had done that, it was just a matter of keeping an eye and waiting for them to return.

139 Q. What was the impact of delays in returning triage for

you and your staff, first of all?

A. It was a lot of chasing up for the red flag appointment team because they were constantly checking what was coming back in, updating their spreadsheet. If they're still outstanding and they still maybe would have escalating again that these are still outstanding. The trackers then would have been updating the CaPPS System, linking in with the red flag appointment team. It probably would have caused a lot of emails back and forwards trying to track the progress for each patients. And still being mindful that their clock was ticking and you were trying to get the patients in to be seen. 11:00 11:00

140 Q. So, against the background where there are all sorts of pressures, as you have described -- 11:01

A. Yep.

141 Q. -- this was an added difficulty that you could have done without?

A. An additional pressure, yes.

142 Q. Was there a concern that delay risked harm to patients? 11:01

A. I don't think at that point, no, there wouldn't have been. It would more just to get the referral back just to get the patient seen in clinic. As I say, at time investigations could have been questioned by the time the referral had been returned. 11:01

143 Q. The issue, it appears, doesn't ever quite resolve, or at least it continues over a period of time. If we go to, for example, 2018, TRU-279374. The Inquiry has heard some evidence already about the delays

attributable to Mr. O'Brien triage in the autumn of 2018. You're writing to the entirety of the urology consultant?

A. Yes. I just then -- a collective group. Mhm-mhm.

144 Q. October 18. You're counting back from 12th October to 4th October 36 outstanding referrals? 11:02

A. Yes.

145 Q. Are you aware of any attempts on the part of your management team to try and grapple with the need for a solution to this? 11:02

A. I do think there was ongoing discussions about it. I maybe wasn't always part of them but I do think they were trying to get things sped along, you know, so that the referrals would come back. But again, I couldn't honestly comment on that. I don't recall. 11:03

146 Q. Was delay in returning referrals triaged, was it a problem in other services, other cancer site services?

A. You would have got some delays across -- it just wasn't always specific to urology. There could have been late upgrades or other issues with triage. Again, once you emailed out, they would have maybe been returned pretty promptly. In fairness, every time I would have emailed out the consultants or that, referrals did tend to drip back into the system again to get booked. 11:03

147 Q. Yes. Is it fair to say that Mr. O'Brien was a particularly well-known repeat offender when it came to triage, or were there other repeat offenders that -- 11:03

A. I would say Mr. O'Brien probably more so, yes.

148 Q. Were you aware within the Cancer Service that non-red

flag referrals, that is urgent and routines, were for a period of time up until early 2017 not being triaged at all by Mr. O'Brien?

A. I wouldn't. To be honest, I was focused on the red flag referrals. I wouldn't have been aware of that, or that I can remember. 11:04

149 Q. Yes. That wouldn't have been an area of business relevant to your work?

A. No, no. We had enough ongoing within the red flags.

150 Q. Yes. Could I ask you explain this document for me please, AOB-05917. If we scroll down, please. Angela Montgomery, again your line manager for a time when you were a tracker? 11:05

A. Yes.

151 Q. She is writing in respect of a particular patient who attended Mr. O'Brien's clinic on 18th November 2011. She is reporting that you have been unable to get an outcome from this appointment as you cannot locate the chart. 11:05

11:06

"Can you please see if you could get us an outcome"?

What exactly was the concern there?

A. It was to try and see what the management plan would be for that patient or what, you know -- I needed an outcome for that clinic, that specific patient. 11:06

152 Q. Does that mean a letter or --

A. Yes, like a letter.

153 Q. -- a dictation, a dictated letter?

A. Yes, from that clinic appointment for tracking purposes. In 2011 we maybe have been going up and looking through charts to see if there was any handwritten notes at that point in time.

154 Q. Does that suggest you went looking -- 11:07

A. Yes, I would say at that point --

155 Q. -- looking for the chart?

A. -- we did. We would have went round and actually checked the charts.

156 Q. But the chart wasn't to be found? 11:07

A. No, couldn't find the chart. Then I needed the outcome so I'd escalated it.

157 Q. Yes. Was that similarly a repeat issue as regards Mr. O'Brien's practice?

A. It would have been, yes. I do recall then whenever I 11:07 would have been the tracker then with Mr. O'Brien in urology, he would have gave me a list of the outcomes of the Day 4 clinics. He would have emailed them directly to me so I was aware for each patient then what was happening with them. That kept me informed, I 11:07 suppose, for each patient then.

158 Q. If we could look at AOB-90395. It's not coming up. 70395. You're writing to Mr. O'Brien now in 2014 again. Patient reviewed at an outlying clinic SWAH on 23rd December 2013. It's now 7th March 2014 and you 11:09 have had no joy in getting an outcome.

"Could you provide me with a management plan or advice if she can be removed from CaPPS?"

Again, is that but another example of the problem we've just looked at?

A. Yes. Probably at that point I would have been going to Mr. O'Brien at times to try and get outcomes from the patients, whether via email or if he was in clinic, going round at the end of the clinic to see if I could get an outcome for a patient. 11:09

159 Q. You've suggested that at some stage his behaviour around this changed? 11:09

A. Yes, I would say it did. I suppose the more we worked in the MDM together, Mr. O'Brien, after his Friday clinic, which would have been the Day 4 clinics, we would have seen the patients and met with them in their plan; he would have emailed me through the detailed list of the plan for each patient. So, to me that did improve things. 11:10

160 Q. But as regards these outlying clinics, did that remain a problem for a longer period of time?

A. Maybe more so, yes, for the outlying clinics. 11:10

161 Q. It has been reported to the Inquiry that the issue of Mr. O'Brien failing to dictate outcomes following clinics was not particularly well known and didn't emerge as an issue really until late 2015 and then was taken up with Mr. O'Brien in March 2016. We've seen from the two emails that I have brought up, 2011 and again 2014, that so far as you are aware within the cancer side of the service, you are not getting outcomes back; on occasion you can't locate the chart? 11:10

A. Yes.

162 Q. And the explanation for that might be that Mr. O'Brien had the chart at home?

A. Mhm-mhm.

163 Q. And hadn't dictated? 11:11

A. Yes.

164 Q. You are aware of that?

A. To a point because --

165 Q. Are your managers aware of that?

A. I would say they would have been aware of it but we would -- as a tracker, you would have tried to get an outcome any way you could have done, should it have been checking the chart if it was there, linking in with the consultant directly. As I say, Mr. O'Brien did improve and was advising me. Therefore, I probably was getting the outcomes on my patients so I wasn't necessarily seeing the bigger picture. Because if the patients were going through MDM, I was getting the outcome then as well at that point. 11:11 11:11

166 Q. If you intend taking a break, Chair, it might just be convenient now? 11:12

CHAIR: We'll come back at 11.30, everybody.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

11:12

CHAIR: Okay, everyone. Mr. Wolfe.

167 Q. MR. WOLFE KC: Okay. Mrs Graham, can we now move on to the MDT part of your work. If we start perhaps with WIT-60899. From paragraph 24.12, just scrolling down,

you provide, I suppose, a blow-by-blow account of all of the many responsibilities that came with that part of your role?

A. Yeah.

168 Q. Can you just take a minute or two to summarise what the MDT coordinator role demanded of you. 11:31

A. On a weekly basis, we would have compiled the list of patients that were being discussed at the meeting. That would have come from a tracking point of view or the consultants would have advised us what patients to actually discuss, so that would -- 11:31

169 Q. If I could slow you right down. I know the stenographer spoke to us at the break. We've plenty of time.

A. That would have been compiling the list of all the patients that needed discussed for that week, whether it be with pathology, radiology, whatever it was they were looking to discuss. Then I would have been going to all the different systems, NACR et cetera, and updating that information onto the CaPPS System. Then attending the meeting, taking the outcomes of the meeting, and doing the after-work as well from the meeting, the MDM outcomes. 11:31 11:32

170 Q. Helpfully there was a standard operating procedure which -- did you draft it? 11:32

A. I did draft it.

171 Q. Yes. We'll just let the Inquiry see it. They can read it in their own time. It's WIT-61148. It runs to several pages. Just scroll down it. Actually, there

is a typo at the top --

A. Yes, in the breast --

172 Q. -- it jumps out at you, but this is the one for the urology MDT?

A. Yes. 11:32

173 Q. Scrolling down. It talks about the methods by which a patient could be added to the MDM list. Keep going through it slowly. A patient could go onto the list through you; isn't that right?

A. That's correct. From tracking, yes. 11:33

174 Q. And scrolling on down. Keep going. Then there's an administrative process that you briefly outline before the MDM, and you set out some of the tasks associated with that. Scrolling on down. Then, administrative processes after the MDM? 11:33

A. Mhm-mhm.

175 Q. I think that's essentially it. We know that the operational policy for urology cancer services -- if we can bring that up on the screen, please. It's TRU-99632. This is a detailed policy setting out all 11:33 of the nuts and bolts associated with the work of the MDT. It has specific reference to the tracker or the coordinator. If we could bring that up on the screen and if we go through to TRU-99653. It says:

11:34

"It's the responsibility of the MDT coordinator to ensure that patients have been given appointments for investigations at appropriate times, and to schedule those patients for MDM discussion as previously

agreed".

So, that's your initial role or primary role. Then if we go two pages down to 655 in this series, again this sets out your role on the administrative or clerical side. On down the next page, please. It talks -- I can't find it but within that policy, which was updated in 2020, you can see that at TRU-98103 it again speaks to the role of the coordinator. 11:35

In terms of the role that you performed, what were the particular challenges faced by you in dealing with the MDT aspect of your work?

A. I would say whenever I started working as the tracker and going to urology MDM, getting the clinical information was quite problematic. We're admin, we are not clinical, and you were trying to take information from maybe clinic outcomes or radiology or the referral letter and compile that in so it was ready for discussion. I can honestly say Mr. O'Brien changed that and he set up like a pro forma standard of what the patient presented with, their investigations to date. So, as a tracker that helped me enormously, that to me all the relevant information was there for the patient to be discussed. It gave the whole patient's history as to just one wee area that they were looking. So, therefore it gave you the whole patient's history. To me, there was a whole lot more information available for each MDM discussion. I do appreciate that would 11:36 11:36 11:36

probably have taken Mr. O'Brien a lot of time. As a tracker, I felt it was reassuring to know there was a lot more information there and it was coming from a clinician as opposed to somebody in an admin setting putting information in. He would also probably have checked that information before the MDM as well.

176 Q. You had worked under a number of chairs at the start. Mr Akhtar; is that right?

A. Yes, that's correct, and I covered MDMs as well. While all the information was there, it was up to the admin member of staff to collate that information. 11:37

177 Q. I think in terms of what you thought of Mr. O'Brien's input to that MDM, if we could look at WIT-60889. If we scroll down to page 40.2, please. I can't find it. It was your impression that Mr. O'Brien, when you worked with him as Chair of Urology MDM, that he was committed and dedicated to the role? 11:39

A. Oh very much so.

178 Q. Yes, it's 40.2, thank you. You explain in that section of your statement why you thought that was the case. 11:39

A. Yes.

179 Q. And he assisted you in better administering the work of the MDM?

A. Yes, I would agree with that.

180 Q. And brought information about individual patients into the process in a clearer and better organised way than was the -- 11:39

A. And also to preview the day before for each patient that was discussed, I had to print off an MDM update

report, so therefore Mr. O'Brien had all the information for each patient which he would have reviewed, you know, the day before or after his theatre session, I believe, in preparation for the Thursday meeting.

181 Q. Yes. In terms of the approach adopted at the MDM, was it Mr. O'Brien's habit to have prepared each case and to present each case? Was that your experience?

A. Yes. O'Brien would have presented each case but there would have been general discussions from other consultants. It wasn't as if it was a foregone that this is the plan and that's it. It would have been openly discussed amongst the other urologists, radiologists and pathologists. At times the discussions would have been quite lengthy, but I suppose the benefit for me with the urology tracker, at the end of each discussion Mr. O'Brien was always very clear to me and always gave the management plan word for word what was going to happen for that patient. 11:40

182 Q. You have described some lengthy discussions. Does that suggest that there was sometimes deliberation and debate amongst those round the table -- 11:40

A. I believe so, yes.

183 Q. -- about the appropriate plan?

A. Yes, there would have been discussions, but they all came up collectively in my opinion with a management plan for that patient. 11:41

184 Q. Could I ask you to comment on this. If we bring up WIT-84374. This is a record of a discussion between

Mr. Carroll; you'd have worked with Mr. Carroll?

A. Yes, that's correct.

185 Q. Who, when he spoke to the serious adverse incident reviewers in 2021, he was at that time Assistant Director for SEC, surgical and elective care. If we go to the bottom of the page, he is being asked to comment on his impression of what it was like to work with Mr. O'Brien, and his experience of him and perhaps as shared by others. In the last paragraph he said: 11:41 11:42

"He advised that the patients under the care of Mr. O'Brien were often elderly and held him in high esteem. The big doctor. He went on to say that staff appeared to be habitualised by Mr. O'Brien's behaviour, that they avoided challenge at the multidisciplinary team meeting". 11:42

Do you understand what is meant by that?

A. I can but I never witnessed that, to be honest. There was definitely ongoing discussions with other consultants, and that was my take on it. 11:43

186 Q. Do you ever remember examples of Mr. O'Brien being challenged?

A. No. I wouldn't say challenged, maybe discussions or debate, but that would have happened in every MDM, that they were coming up with an agreed treatment plan for each patient, which to me is the purpose of an MDM, that it is not one decision, you know, that it comes together collectively. That's not how I perceived it 11:43

at the MDT.

187 Q. Maybe it wasn't the culture of this MDT but was there ever any conversations which might be regarded as critical of steps taken by any of the consultants round the table? 11:43

A. Not that I was aware of, no.

188 Q. That wasn't...

A. No, and that certainly not the impression that I got from Mr. O'Brien. Like, I worked with Mr. O'Brien for a good number of years at the MDM, and he was always very respectful and I enjoyed my time working with him. And he was very dedicated to the patients, I felt, and was always very approachable. 11:43

189 Q. The Serious Adverse Incident Review from 2020 highlighted what I think was long known in the Trust, that the urology MDM was not regularly quorate. That is, in specific terms, it was regularly the case that medical and clinical oncology didn't attend, and radiology were often not in attendance. Did you appreciate that as sitting as the coordinator to -- 11:44

A. Yes, that would have been known and that would have been escalated. I believe the Head of Cancer Services was also linking into that and had escalated it on further. 11:44

190 Q. Yes. Were you able to sense the impact of that on the work of the MDT from meeting to meeting? 11:45

A. I know there wouldn't have always been an oncology input but to me it never stopped a decision being made. Whether or not the oncology decision was made at a

later point if they had been referred to oncology, but at the MDM I don't recall any patients not being discussed because of them not being there.

191 Q. If radiology weren't there, was there a workaround to -- if radiology input was needed, that a case would be put off until he could attend? 11:45

A. It would maybe be deferred to the next week if a report wasn't available, yes, that's correct. That would have been escalated or put on that they weren't able to be discussed. 11:46

192 Q. You've referred to cancer services being aware of this and it appears that they certainly were?

A. Yes.

193 Q. Are you aware of what steps were taken to try to address these problems? 11:46

A. I know there was ongoing discussions but I wouldn't been in attendance at them so I wasn't fully aware. I do believe there was a shortage maybe of oncologists regionally and they tried to get us to link in virtually to the meeting to try and, I suppose, resolve that issue. But as to the actual discussions that took place or meetings, I wasn't at them. 11:46

194 Q. The Serious Adverse Incident Review, and I think you have had an opportunity to look at the overarching report that was part of your pack? 11:47

A. Yes.

195 Q. It pointed to a problem, as they described it, that Mr. O'Brien wasn't allocating or appointing or directing a specialist nurse to patients after MDM.

Now, I want to ask you about that area. There was a core nurse member of the MDM; isn't that right?

A. That's correct. There always would have been a specialist nurse in attendance to the MDM.

196 Q. And it was usually one of two. There was -- 11:47

A. Yes.

197 Q. Can you remember their names?

A. Kate O'Neill or Jenny McMahon.

198 Q. Did you know them or work with them quite closely?

A. Oh, yes. Quite closely, yes. 11:47

199 Q. Within an MDM setting, what is the role of the core nurse member? Have they much of a contribution to make to the issues that are being addressed around the table?

A. I think if maybe they have met with the patients before they had come to the MDM discussion, they were there to get the outcome and the patient and an update. I suppose it was my understanding then that they would be meeting with the patients after the MDM. 11:48

200 Q. That was your understanding? 11:48

A. My understanding, but again I wasn't aware that maybe that didn't always happen because wouldn't have been documented at that point in time.

201 Q. Say that again.

A. It wasn't documented on CaPPS that they were going to be reviewed by the nurse specialist. 11:48

202 Q. What understanding did you have in terms of whether there was a requirement to allocate a specialist nurse as a key worker at the MDM?

A. I wasn't aware of that.
203 Q. Is that something that was ever done, to the best of your knowledge, at the MDM?
A. As in a specific nurse was allocated to each patient?
204 Q. Yes. 11:49
A. No, that wouldn't have been done. But the nurse specialist definitely did seem to be aware of the patients that were being discussed.
205 Q. In what sense? How was that obvious?
A. Because they would have maybe emailed me through the 11:49 list of patients that maybe had had prostate biopsies and they had been at the clinic for that.
206 Q. So, they would have had in some cases a working experience of that particular patient --
A. That was my understanding. 11:49
207 Q. -- as part of the care pathway?
A. Yes, yes.
208 Q. But that doesn't necessarily mean, does it --
A. No, it doesn't.
209 Q. -- that the same nurse would be partnering that patient 11:49 through the rest of their care?
A. No. That's correct.
210 Q. Had you any sense of how that was to be achieved or at least offered to the patient as a service if there was a need for further treatment after the MDM? 11:49
A. I suppose I just assumed that it would be done at the next outpatient, you know, review appointment.
211 Q. Did you have any awareness of any problems around that, that in some cases it wasn't happening?

A. No.
212 Q. For whatever reason?
A. Not that I can recall, no.
213 Q. That wasn't drawn to your attention?
A. No. And I suppose from a tracking perspective, that wasn't really what I would have been focusing on. It was really more the patient as opposed to what was going on outside of that. 11:50
214 Q. I suppose that wasn't something that was tracked or --
A. No. 11:50
215 Q. -- recorded or necessarily audited?
A. I do think there was the function maybe in CaPPS, that there was a nurse specialist there, but that wouldn't have been something that we would have been recording at that point in time. 11:50
216 Q. So, if there was a problem --
A. Yes.
217 Q. -- and the Inquiry will be looking at this, but if there was a problem in linking the patient with a specialist nurse after the MDM, that should have been capable, and it would be to this day capable, of being tracked or monitored in some way? 11:51
A. If it was identified, yes, or a nurse specialist was named, probably. But I'm not sure that would have set outside the role of the tracker to do that. 11:51
218 Q. I'm not suggesting for one minute that it was your role. In fact, it appears very clear that it wasn't. Would it have been a resource intensive or difficult thing to achieve to record whether a nurse is now with

that patient going forward, and that would simply have been a matter of asking a question?

A. I think that would have been doable, yes. That would be possible, yes, I would imagine.

219 Q. I want to ask you about the issue of -- because we're getting close in the process, after the MDM. I appreciate that a patient can come to the MDM on several occasions before a treatment decision is arrived at or, better put, a treatment recommendation. Maybe I'll start by asking you, what would be your role after the MDM when a decision has been reached in respect of a patient's treatment? 11:52

A. As I say, Mr. O'Brien would have dictated to me word for word what the treatment plan would have been for that patient. 11:52

220 Q. Just to be clear, he is doing that across all of the patients?

A. Yes, across all the patients that were listed for discussion on that day. He would have given me a detailed patient X and given me the plan. I would have taken down the notes at that point in time, handwritten notes. Then after the meeting I would have come down typed them onto the CaPPS system on a Thursday evening. Whenever I had the outcome plan for each patient, I would have phoned Mr. O'Brien and he would have come down after I printed out, and went through each outcome for each patient. That would have taken a considerable length of time for him to do. 11:53 11:53

221 Q. Because there can be 40 patients?

A. 40 patients, yes. I can honestly say that Mr. O'Brien sat down and read through each patient word for word.

222 Q. So what's generated as a result of that process in specific terms?

A. I would have generated the outcome, the treatment plan from CaPPS, and then would have printed out the GP letter which would have give a detailed overview of that patient and the management plan. Then, if it was for an oncology referral, that oncology referral also would have been printed out and Mr. O'Brien also would have also signed that at that point in time, as well along with the GP letter, if that was the outcome. 11:53 11:54

223 Q. Okay. Let me put to you just a specific example, one that the inquiry is familiar with. Could I ask you before I put it on the screen, you'll see a name but the patient should be referred to as Patient 1. I'm not sure if you have a cipher list beside you, do you? 11:54

A. No.

224 Q. Okay. We'll call this patient Patient 1 and the Inquiry will understand who that is. If we could have on the screen, please, PAT-001482. Is this what you mean by possibly the form of it? Maybe the stationary has changed over the years but is this what you mean by an MDT or MDM outcome? 11:54

A. It would have been, but in my experience when it was Mr. O'Brien, there would have been a lot more detail on it. 11:55

225 Q. So now the chairman is Mr. O'Donoghue. I emphasise that this wasn't your case, this was a case from, as we

can see on the document, Patient 1 came to MDM on a couple of occasions but this was the discussion, 31st October 2019. Some other tracker or coordinator, probably Mrs McVey; was that who replaced you?

A. Yes, that's correct.

226 Q. It says that "Patient 1 has intermediate risk prostate cancer, to start ADT and refer for ERBT".

In addition to that record that you would have typed up on Mr. O'Brien's time at greater length, there would have been a letter to the GP?

A. Correct, yes.

227 Q. In terms of what it says there in relation to the timing of any referral - ERBT, as you know, is radical radiotherapy - in terms of the timing of the correspondence to oncology in Belfast, at what point would that be triggered generally?

A. For me, looking at this here, it doesn't -- from a tracking perspective, it would be to start ADT, which is the hormones.

228 Q. Yes.

A. And once the tracker had seen that the hormones had been commenced, the referral, we wouldn't be aware, it doesn't specify a time frame when the oncology referral needed to be sent. The tracking, the oncology referrals maybe wouldn't have been done straightaway; they could have been on hormones for a period of time. So I wouldn't have done that at that point in time because they had their definitive treatment.

CHAIR: As you have probably heard from me speaking earlier, I am somewhat under the weather today. If you will just excuse me for five minutes.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS: 11:57

CHAIR: Thank you, everyone. For everyone's reassurance, I have been Covid tested and it is definitely not Covid.

229 Q. MR. WOLFE KC: So we're just looking, by way of example, at Patient 1, how it's described there. In terms of definitive treatment then, and we have understood from your evidence earlier that there's, if you like, "rule book" specifying how you as a tracker and an MDT coordinator are to understand with particular tumour sites what is to be regarded as definitive, first definitive treatment. We've seen reference to hormones in the book earlier. Would you understand this as being a case where hormones, the ADT, is the first definitive treatment? 12:03

A. Correct. That would be my understanding.

230 Q. The implications for that in terms of you as a tracker are what? What do you do to assure yourself that the definitive treatment is instigated?

A. You would then be checking PASS to make sure the patient had been reviewed by the consultant, and that they had either been commenced on hormones at that point in time going by the clinical outcome letter on that day, or we would have been checking the system to 12:04

see that the hormones had been prescribed to that patient. We always tracked it right until we knew that the hormones had been administered to the patient and then we would have closed CaPPS as treatment complete.

231 Q. I should have asked you earlier, CaPPS is Cancer Patient Pathway System? 12:04

A. Yes. That's the system the trackers would use.

232 Q. It is a timeline of various events?

A. Yes.

233 Q. And it stops -- 12:05

A. Yes. We have our wait screen, which is the front screen, and therefore you are able to pick what first definitive treatment would have been for each patient, the date decision to treat had to be put in, and the date the hormones were commenced. 12:05

234 Q. I don't wish to extrapolate too much from this example, I am just using it as a vehicle to illustrate what, for example, a typical outcome from MDM might look like. I want then to move, say, a bit more deeply into what is and is not the tracking role or the tracking facility 12:05 in such a... You've said and explained very well what you would look for to see, that hormones have commenced, and once your satisfied as to that, the patient's pathway is no longer tracked; is that fair?

A. That's correct. 12:06

235 Q. What would be the situation or what would be the response by the tracker if there was a deviation from what has been handed down or recommended by the MDM?

A. I can't ever recall that happening, to be honest. The

treatment plan that was normally agreed was one that I would have seen happening at the clinic with that patient. So, I would imagine if there was something -- I honestly can't answer because I never come across that. 12:06

236 Q. Yes.

A. I would imagine if there was some sort of deviation, they would have checked with the consultant and it would have been through MDT again.

237 Q. The tracker has an autonomy and responsibility to make a decision as to whether tracking should now stop? 12:07

A. But if you ever were in doubt, you would have checked with the consultant.

238 Q. So, in a case where there is uncertainty as to whether first definitive treatment has commenced, for whatever reason, that would necessarily involve a further conversation, in your view? 12:07

A. Yes. But to my knowledge I don't ever remember it happening.

239 Q. Can you help us - I think you may have implicitly answered this question earlier - but if the MDM decision or recommendation isn't implemented but some other course is taken, what is the role of the tracker if that other course amounts to some other form of treatment that satisfies the requirement of first definitive treatment? 12:07 12:08

A. I would have probably have closed it down as that being the first definitive, because, you know, the consultant with met with the patient and to me whether it was the

patient's choice for maybe opt for something different. Again because it never happened, I can't answer it, but I would imagine if it was listed as one of the first definitive treatment and that's what happened, you would take that as the first definitive treatment. 12:08

240 Q. Could I ask you, clearly Dr. Hughes and Mr. Gilbert were the authors of the serious adverse incident reviews involving nine cases. They made some general remarks across the number of cases, all of the cases being different but they saw some common themes 12:09 emerging. I want to put to you some of what Dr. Hughes has said, both in his Section 21 statement to the inquiry as well as in the SAI review itself.

If I can have up on the screen, please, WIT-84168. He 12:09 says in the first bullet point that we can see there:

"The MDM made appropriate recommendations for eight out of the nine patients".

12:10

So what we would have seen on an MDM outcome sheet, they are saying was appropriate in eight out of the nine cases. But there was no mechanism, they say:

"To check that actions were implemented, whether this 12:10 was further investigations, staging treatment or appropriate onward referral".

Your evidence would seem to disagree with that in the

sense that you would wait to see that there was a definitive treatment in play or in place before closing the tracking on the case?

A. That's correct, yes. We would always wait. Just because something was said at the MDM, we always waited until they were seen and the patient, I suppose, consented to whatever treatment and then we would have closed that. But that also says this included further investigations. If they had had their first definitive, we wouldn't have been tracking for further investigation stage or treatment or onward referrals because we wouldn't have been aware of them. 12:11 12:11

241 Q. To take an example, if the first part of the treatment is hormones and if that satisfied the requirement of first definitive treatment, then you can and do look for that; you must look for that? 12:12

A. Yes. You must look for that, yes.

242 Q. However, and this is where he is probably right, if the second part of the treatment is then for referral after the hormones to the oncology centre in Belfast, the Cancer Centre in Belfast, that is not something that you would track? 12:12

A. No, because that was beyond what we class as first definitive, yes.

243 Q. You probably were aware that that isn't something that was tracked within Cancer Services? 12:12

A. Yes, we didn't, because that onward referral, we wouldn't have been aware of the timeframe that hormones would have been commenced. They could have been on

hormones three months, six months. Therefore, we wouldn't have been known when the referral was to be sent to oncology.

244 Q. He explains - if we go onto the next page, please. Just the third bullet point on the page - that there was what he calls a lack of resource within the Trust to adequately track cancer patients through their journey. He specifically says: 12:13

"The Urology MDM was under-resourced for appropriate patient pathway tracking. The Review Team found that patient tracking related only to diagnosis and first treatment, that is 31 and 62-day targets. It did not function as a whole system and whole pathway tracking process. This resulted in preventable delays and deficits in care". 12:13

Again, whether you were under-resourced --

A. Yes.

245 Q. -- you weren't resourced? 12:14

A. We weren't resourced, and we were commissioned just to track to the first definitive. That was a regional, all the Trusts were doing that. Outside of that, we weren't doing the whole patient pathway.

246 Q. Would there have been discussion at your level or to your knowledge above your managerial level within Cancer Services as to, if you like, the shortcoming in such a limited tracking arrangement? 12:14

A. I wouldn't have been part of them discussions at my

level, no.

247 Q. And you didn't hear any such discussions?

A. No. It would have been maybe more to get more resources in to get for trackers, more trackers, but again it would have been to the first definitive treatment. 12:14

248 Q. There is a reflection within the SAI review - I can't bring up the reference just now but the Inquiry Panel will know what I am talking about - which suggests that the experience of the reviewer, Dr. Hughes, was that elsewhere tracking was to continue beyond the first definitive treatment, that this was not wholly unknown in these islands. Do you speak to or did you speak to other trackers in other places? Were you aware of what was going on in other Trusts? 12:15 12:15

A. We would have listed patients for discussion that were perhaps closed, but it would have been the clinician would have told us to put them on for discussion again. Maybe they had a staging CT scan or presented with something that they needed relisted. So we weren't actively tracking that patient but you certainly would have listed them for MDM discussion again. If that warrant, like, you know you would have followed that management plan, you know, acted on that, but we wouldn't have actually being tracked on it. 12:15 12:16

249 Q. So you weren't, as you've described several times now, auditing or tracking?

A. No. If the consultant certainly asked us to list a patient for discussion, we would have done that.

250 Q. Yes, yes. What I was really asking you was were you aware of experiences elsewhere, in other Trusts for example, in Northern Ireland, about how far they tracked the care pathway?

A. No. It was my understanding that it was still like what we were doing, because it was a regional approach. 12:16

251 Q. If I could go down to the next page please, WIT-04170. On the second bullet point there, he refers under this heading of "Lack of Coherent Escalation and Governance Structures" to: 12:17

"The governance of professionals within the MDT running through their own directorates, but there was no functioning process within cancer services to at least be aware of concerns even if the responsibility for action lay elsewhere within the Trust". There was a disconnect between the urology MDT and cancer services management. The MDT highlighted in action by cancer services on oncology and radiology attendance at MDM but did not escalate other issues". 12:17

Is that something that sits well with you, that opinion? Was there a disconnect between the service within which you sat and urology, for example?

A. From my point of view, I don't think -- we escalated if there was a problem with radiology and oncology, and the Head of Cancer Services was trying her best to solve that issue. Anything outside of that, I wasn't aware of. 12:18

252 Q. So, for example, you referred to, by this stage who was it Mrs?
A. Reddick.
253 Q. Reddick?
A. Yes. 12:18
254 Q. To try to resolve issues?
A. Mhm-mhm.
255 Q. This was when you were --
A. The tracker and the Cancer Services Coordinator, yes.
256 Q. Can you think of an example of the kind of things that 12:18
Cancer Services with would try to resolve for MDT?
A. I'd say it was maybe like to get oncology input and then the radiology input as well. That would have been the two things that I can remember that was raised in my time. 12:19
257 Q. Could I just bring you then to the overarching SAI report. If we go to the section on governance and leadership, WIT-84302. It says in the third bullet point, it largely repeats the sentiment we've already seen, that: 12:19

"There was no system to track if recommendations were appropriately completed".

Can you see the sense, from a tracking perspective and 12:20
from a patient's safety perspective, of having a tool, whether it is a live tracking device or whether it's some form of audit to be in place, to bring the monitoring of the treatment further along the line?

A. I can definitely see the benefits of it. If it was properly resourced and the functionally within CaPPS expanded to allow you to track a patient through -- say, they had a bladder cancer through maybe multiple occurrences or stuff like that, there definitely would be a benefit for the patient. 12:20

258 Q. In light of what we heard from you in evidence earlier this morning, would I be correct to form the impression that given the resources that you had at that time within tracking, it wouldn't have been feasible to do much more given the resources you had? 12:21

A. I would agree, that's totally right. The tracker were under immense pressure with increased workload. They were struggling to track what they were commissioned to track, you know, 31-day and 62-day to first definitive, let alone a whole patient's pathway for years. 12:21

259 Q. If we go into the recommendations from this review. WIT-84306. Just scroll down to recommendation 5, please. The recommendation in association with the need to ensure that MDM meetings are resourced to provide appropriate tacking of patients and to confirm agreed recommendations is that appropriate resourcing would be put in place for the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit, and pathway assurance. And this should be supported by safety mechanisms from the laboratory services and clinical nurse specialists as key workers. A report should be generated weekly and made available to the MDT. The role should reflect the enhanced need 12:22 12:22

for ongoing audit and assurance. It is essential that current limited clinical resource is focused on patient care.

So, can you see any difficulties in practice in terms of how such a tracking arrangement, if it was resourced, any difficulties in terms of how it would work? 12:22

A. I suppose the difficulty -- you would need very clear guidelines as to what point you actually stopped tracking that patient. Do you track them forever? And what resources would you need to do that for each patient that is coming in? I know there is the audit going on now in the background, but I do see the challenges for tracking whole patient pathways from come in for years. I don't know what sort of resources you would need for that. 12:23 12:23

260 Q. Recommendation 6 then is that,

"In the context of the need to ensure an appropriate governance structure to support cancer care, this will be achieved by developing a proactive governance structure based on quality assurance audits of care pathways and patient experience for all". 12:23

It is your understanding that audits are now being pursued under Mrs. Muldrew? 12:24

A. Yes, that's correct.

261 Q. We'll no doubt hear from her in due course.

Could I ask you about a particular issue about the direct referral of patients to oncology service. I want to look at this in the context of a patient called 102 to see if you can help us with this. If we look first of all at WIT-54874. This was an incident report raised in November 2014 shortly after you had stopped being a Cancer Tracker; isn't that right? 12:24

A. That's correct.

262 Q. You moved to your promoted role on 6th October. So, that's the incident date. If we just scroll down the page, we'll see a description of the incident. The patient was discussed 12:25

"At urology MDM on 20th November 2014. The recorded outcome was for Patient 102 to have a restaging MRI scan. It showed confined prostate cancer and he is for direct referral to Dr. H for radical radiotherapy. For outpatient review with Mr. O'Brien". 12:25

Then it says: 12:26

"Was reviewed by Mr. O'Brien in outpatients on 28th November 2014. No correspondence created from this appointment. A referral letter from the general practitioner was received 16th October 2015" - that's almost a year later - "stating that Patient 102 had not received any appointments from oncology". 12:26

I am picking up on the use of the term "direct referral" within that. I want to ask you, within your statement, you deal at paragraph 24.16 with the concept of inter-Trust transfers?

A. Yes. 12:27

263 Q. Maybe if we just bring that up on the screen, WIT-60901. You explain that:

"If a patient did not have, their first treatment in the Southern Trust they would have been referred to another Trust for treatment. This transfer of care between Trusts is called an inter-Trust transfer. If it had been decided at an MDM that a patient was transferred to Belfast and this was their first definitive treatment, [you] would have generated an ongoing referral letter via the CaPPS system for that patient. I then would have got the oncology letter signed by the chair, and after it had been checked to ensure the management plan was correct, the oncology letters had the same governance process which was followed by the GP letters. The ongoing letter was emailed directly to the relevant tracker in the Belfast Trust. My failsafe for this process was to highlight what patients required ITT to another Trust by a highlighter pen and wrote that on the patient preview list", et cetera. 12:27 12:27 12:28 12:28

Can you help us with this concept of direct referral? Is that what you're in essence describing there?

A. Yes, because they hadn't received their first definitive treatment. An inter-Trust transfer is where they go to another Trust then to receive treatment.

264 Q. And conscious again that Patient 102 was unlikely to have been your case because you had moved role. 12:28

The incident report which I showed you there, the essence of it was that it appeared that a direct referral had been generated in your place in the Southern Trust but hadn't been received or dealt with 12:29 in Belfast, and it took a GP to write in a year later and raise the alarm. Can you help us to understand what might have gone wrong there?

A. I suppose because -- I don't know the case exactly but I suppose one thing that could have went wrong is they 12:29 had hormones commenced, their first definitive, then oncology referral was generated from the Southern Trust. Therefore, because they have been closed in CaPPS, they wouldn't have been tracking that to see that they had got the referral. It's the only 12:30 explanation that I can give.

265 Q. But again, not knowing the case --

A. Yes.

266 Q. -- and I know we're in a sense speculating, but in terms of any case going that route, you've outlined the 12:30 kind of correspondence that must be generated --

A. Yep.

267 Q. -- at your end, at the Southern end?

A. Yep.

268 Q. If that is not responded to for whatever reason, Belfast Trust have a computer problem or somebody is not doing their job properly or whatever it might be, what is the alarm bell in that situation; what is the safety net? 12:30

A. In my time I don't believe there was a safety net there, but looking back now, there needs to be one, you know, to follow up those patients that aren't being actively tracked. But once we have done our -- to me it is with the consultant, the patient is the 12:31 consultant's responsibility. Because oncology referrals would also have been generated, it just wouldn't have been say a CaPPS oncology referral, most consultants would have followed that up with an actual written letter to oncology that maybe contained more 12:31 information on that referral than the CaPPS referral.

269 Q. Moving from that one to just briefly an area that you deal with in your statement. I'll give the Inquiry the references, WIT-60905 at paragraph 25.2. You've explained to us there that if a member of staff raised 12:31 a concern with you when you were the Band 5 Cancer Services Coordinator, for example about delay, you would commence an investigation?

A. Yes.

270 Q. You'd get a chronology together because you had access 12:32 via CaPPS and other systems to the whole timeline?

A. Yes, that's correct.

271 Q. And you would try to establish what went on?

A. Yes.

272 Q. Within your statement you cite several examples, two of which related to Mr. O'Brien's work. If we could briefly open that. I don't want to delve into the fine detail of this with you. But if we go to WIT-61045 and we can see, scrolling down the page, that you and Mrs. Clayton are speaking about this case, and it generated a Datix. There is another case that you referred to, if we go on down several pages, WIT-61049. This one is described as "possible Datix". This, in fact, I can tell by the name and the details, relates to what the Inquiry knows to be Patient 2, who was one of the patients who was the subject of the SAI in 2020. He was one of the nine patients and is referred to within that SAI report as Patient E. 12:33 12:33

The question I wish to pose to you around how complaints were addressed or how concerns were addressed, you were able to formulate Datix or incident reports? 12:34

A. Yes. 12:34

273 Q. That was something within your job description and you were familiar with what was to be done?

A. For a Datix, yes, what information was needed, yes.

274 Q. The trigger for a Datix was if you were concerned that risk had been caused to a patient, would that be a trigger? 12:34

A. Yes.

275 Q. If that was the case, you might have raised the Datix or you would refer it to a line manager who might take

some appropriate action?

A. That's correct.

276 Q. You say, and this is the issue I want to address with you. If we go to WIT-60909, you say that:

12:35

"If I or others, while working as a Cancer Tracker MDT coordinator Band 4 or as Cancer Services Coordinator Band 5, raised any concerns that were identified as a serious adverse incident, I do not recall being advised of the outcome of any investigation if it was logged onto the Datix".

12:35

This, you say, was due to being a Band 4 or Band 5, and it was your understanding that you did not need to know.

12:36

So that I can fully understand, hopefully I've got this right, you might have raised a Datix incident report, we've seen one example already and I think you cite other examples?

12:36

A. Yes.

277 Q. You've raised them because of a concern that clinicians providing a service to patients which impacts on your service were maybe - this was the reason for the investigation - were maybe not doing their job properly; there had been some issue or concern, perhaps a delay, leading to an impact or potential impact for the patient. Is it not important that you should know how such reports have been dealt with so that you can

12:36

learn --

A. Yes, I would agree.

278 Q. -- for the future?

A. Yes, I would agree with that. I think it is very important for that information to be passed down so I was aware and I could also make my team aware, because if you don't know what's happened or what's went wrong, how do you fix it? 12:37

279 Q. You obviously came out of Cancer Services I think in August 2020? 12:37

A. Yes, that's correct.

280 Q. You're writing this statement in 2022, I think. Had the position around this, this shortcoming as you describe it in not telling you the outcome of Datixes, had that been mended at that point? 12:37

A. Not to my knowledge. Not to my knowledge, no.

281 Q. Do you know if it is still the case, as you describe here?

A. I don't know. I'm not sure.

282 Q. Finally, could I just ask you about a reflection you've shared with the Inquiry within your statement. It's at WIT-60909. At the bottom of the page you're asked: 12:38

"Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?" 12:38

You say, "No, I did not have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as

necessary while I worked in Cancer Services. I was not aware of any ongoing issues or concerns within urology services. I was aware that referral numbers were on the increase for urology and for all of the tumour sites. I was also aware that there were problems with tracking, and that it was not always possible to be kept up-to-date due to the increase in referrals across the sites, et cetera. These issues were discussed at the local cancer performance and regional cancer operational meetings". 12:39

Can it really be the case that you didn't have any concerns about these issues as posed in the question? I mean, take, for example, the failure, as you see it, to even tell you the outcomes of concerns that you raised; take, for example, shortcomings in triage; take, for example, the fact that tracking patients stops abruptly at the first definitive treatment; did you, when you reflect upon it? 12:40

A. I suppose, when I reflect on it now, the concerns -- there was no alarm bells ringing with me within urology when I was working as urology tracker, to be honest. Even as a service administrator, yes, there was problems with delay and triage and capacity but that was across multiple tumour sites, and them issues were always raised at meetings or through escalations or weekly reports or cancer performance meetings or the regional cancer operational meeting. So, from my point of view there wasn't much more that I could do to alert 12:40

that.

I suppose, on reflection with the tracking of patients, yes, it would be great to be able to track further but that was something regionally that we weren't doing, so it was something that we never considered.

283 Q. Okay. I am going to leave it there with you. Thanks for your answering my questions. I'm sure the Chair might want to think about whether they have any questions for you. 12:41

CHAIR: Thank you very much for your evidence, Ms. Graham. I am going to ask Mr. Hanbury, first of all. I think he will have some questions for you.

THE WITNESS WAS QUESTIONED BY THE PANEL AS FOLLOWS: 12:41

MR. HANBURY: Just a couple of organisational things. You have been complimentary with Mr. O'Brien for his preparations for the MDT. What about his colleagues, because they alternated week on week? 12:41

A. They did. He would have primarily been the chair when I was there, and then maybe towards the end or annual leave or if he was in another meeting, there would have been cover, I would have prepped the meeting the same for them. But once I left, I'm not sure, once the 12:41 chair had changed, what their prep was like, to be honest.

284 Q. But in your time --

A. In my time, I must say Mr. O'Brien was very detailed,

very structured and dedicated for the patients that were being discussed.

285 Q. The other urologists, did they not do it the same way?

A. They probably worked maybe slightly different, but they still would have been very focused on the patients that were being discussed. 12:42

286 Q. Speaking about results slipping through and sort of safety nets, was there a mechanism in your time if unexpected CT results, radiology results or pathology results unexpectedly came up with a cancer diagnosis, would come back to the tracker or MDM coordinator? Did that happen? 12:42

A. That would have happened. We would have had an alert from radiology that if there was, say, like an incidental finding, that they would have emailed that result or the patients' detail through to the generic cancer tracker email address that so we could put it on the CaPPS system then to track from that point moving forward. 12:42

287 Q. Right. Do you think that was robust, that mechanism? 12:43

A. It worked. And then consultants would also have notified us of incidental finds as well. As regards it being audited or not, no, it probably could have been tighter. That was our failsafe at the time, that if there were any worrying results came through, the Cancer Tracker was the first point of call to get them onto the CaPPS system so that they were being actively tracked at that point in time. 12:43

288 Q. In your time that did seem to work well?

A. Yes, that seemed to work well.

289 Q. We have spoken about oncology but there are quite a lot of urological conditions that need a specialist surgical opinion in contrast to oncology. For example, small kidney lumps, and things like penile cancer as well. In your time again, when that needed to happen, did that generate an ITT or inter-Trust transfer directly from the MDT, the MDM? 12:43

A. It wouldn't happen directly. I would have printed off like a surgical referral or whatever if I was instructed to do so, yes. And I suppose the query is if there was another first definitive, that could have been maybe we were going over and above what the role of the tracker was, I would have printed off a referral at that point in time for the patient. 12:44 12:44

290 Q. Okay. And then to go on from Mr. Wolfe's question, would you be informed then of whether an appointment was issued?

A. No, you wouldn't have been.

291 Q. From the receiving sector?

A. If you weren't tracking yes, no.

292 Q. So you wouldn't know that?

A. No.

293 Q. Thank you. We've spoken about the lack of quorum from an oncology point of view. If an oncologist was there, for example, and the patient already knew they had, say, prostate cancer.

A. Yes.

294 Q. And the oncologist said "That's fine, we need to see

them", what would happen then? Would your role be to arrange an appointment for the oncologist to move the patient?

A. I would have generated an oncology referral and then emailed it to the relevant oncology tracker down in Belfast.

295 Q. So that was quite a smooth process?

A. Yes.

296 Q. When the oncologist was there?

A. Yes, it would have been.

297 Q. So when the oncologist wasn't there?

A. Maybe more so because you weren't sure what they were accepting.

298 Q. So it was more dependent I guess on --

A. Yes, on the Consultant.

299 Q. A urologist making that?

A. Yes, making the referral, yes.

300 Q. Okay, thank you. We've seen one or two examples of patients with new diagnoses coming back, maybe not quite as soon as they should, say at a month rather than I guess a week or two weeks. Was that your role or you would try to badger for an early appointment?

A. Oh yes, we would have done.

301 Q. How did that work?

A. Say you would have linked in with each department or at times we would have went to the consultant directly to see if they had any --

302 Q. Later slots?

A. Later slots or whatever, yeah. And in fairness they

did try to accommodate you the best they could to get the patient completed on target. The tracker would have brought that up at the start of each meeting, where they were exactly on their pathway and where the focus, you know, the patients that need to be seen first.

MR. HANBURY: Okay, thank you. Yes, that's all I've got, thank you very much.

MS. GRAHAM: Thank you.

303 Q. DR. SWART: It must have been quite depressing to look at this deterioration in the percentage of patients getting to sixty two days, I think from my experience working with tracking teams, that's quite hard for the team. What was the morale like in the tracking team? Did you have a lot of turnover of staff?

A. The turnover of staff actually wasn't, you know, the same staff's still there actually now, they've just grown. And I would say all the trackers took great pride. They're thinking behind each number there is a patient there, and they were doing their best to get them through their pathway as quickly as they could, and it did impact on them whenever say perhaps their tracking wasn't up to date or the performance went down because it's nothing personal to them. But if it's your site it's hard not to take it.

304 Q. It's hard isn't it?

A. Yeah.

305 Q. Did you provide any information for the Trust about the actual numbers of days, were you given the task for

example - I'm just using an example that I'm familiar with - of letting someone know "I have a list of every patient who'd waited say over 104 days"?

A. Yes, I would have done it as a cancer service coordinator every week. I had done a primary PTL list of all the patients that were over a day 85, across all the specialties I would have provided with an update management, where they were in their pathway and that was circulated out to all the heads of services and the EDs so they knew week on week how many patients were waiting every day.

306 Q. What did they do with that information?

A. At times we didn't get any feedback because --

307 Q. So you don't know if harm reviews were done or anything like that?

A. No, because it had become a point in time there was just no capacity to move them patients off.

308 Q. So it would be for them to act?

A. Yes.

309 Q. I just wondered if you'd got feedback.

A. Yes, no on a weekly basis we would have -- I would have provided that information.

310 Q. And again, cancer tracking, a really important part of most speciality teams. Did you have the chance to sit down with say the urology team and talk about the different kinds of hormones because one of the issues in this inquiry, I'm sure you've picked up is that all hormones are not exactly equal. Were you aware of that?

A. No, and I think that's a very valid point actually on reflection now, I think maybe a wee bit more learning and education for the trackers so that they're more aware of what is deemed, and the different types of hormones, and also for the consultants maybe to have a better understanding of the role of the tracker and who are we best off tracking. I do think that that would be a big help moving forward.

311 Q. I've tried to look at the cancer rules a few times, they are quite complicated aren't they?

A. Yeah.

312 Q. The cancer tracking bible rules, yeah.

A. The tracking, I suppose guidance is very different to the clinical guidelines, and I do think that would make a big difference moving forward.

313 Q. And in that same vein, cancer is evolving all the time, the standards are increasing. Did the cancer team as a whole, in the Trust I mean, did you have annual days where you got together to share learning and look at where cancer is going and look at quality issues because underneath all of this there's a lot of quality stuff going on. Did you have chance to do that?

A. We had maybe a few, you know, where all the cancer trackers would have met at different hospitals for maybe shared learning or for say maybe a lung consultant would come up, you know, a respiratory physician would have come on and give maybe a wee bit of education around that, but it wouldn't happen routinely just because of the increased workloads and

the MDMs.

314 Q. But you didn't have a pattern of those meetings for the Trust?

A. No, no, on the Trust, no.

DR. SWART: That's all from me, thank you.

315 Q. MR. HANBURY: We're aware of a few cases where there seemed to be some delay between the first MD and when say the abnormal results came back, cancer. And then staging investigations would happen, and then the patient would be rediscussed. I was trying to work out sort of why that would happen, but if the patient for example had been started on hormones that patient might have come off your pathway, is that correct?

A. That quite possibly is the case on that, or else maybe we weren't aware of the patient, it was an incidental finding and we hadn't been notified of that patient. 12:50

316 Q. They have already been through MDM once --

A. Oh right, they've been through. Yes.

317 Q. And this is the second interval between one and two?

A. Then they would probably have been started on hormones and then we wouldn't have tracking. 12:50

318 Q. If the patient hadn't started hormones, then you would have been on that patient to try to --

A. Yes. To expedite things further, yes.

MR. HANBURY: Lovely. Thank you very much. 12:50

CHAIR: You will be very pleased to know I have no questions. I am not sure my voice would hold up to questioning anyone today. So thank you very much, Mrs. Graham. Thank you.

It is now just after 12.50. Start again at two o'clock, I think the witness is due.

MR. WOLFE KC: Yes. Thank you very much.

CHAIR: And Ms. McMahon is taking the witness through, actually. Thank you very much 12:51

THE INQUIRY ADJOURNED FOR LUNCH AND RESUMED AS FOLLOWS:

MS. MCMAHON: Chair, members of the Panel, the witness this afternoon is Kate O'Neill, who is the clinical nurse specialist within Urology. She is going to take the oath. 14:01

KATE O'NEILL, HAVING BEEN SWORN, WAS EXAMINED BY MS. McMAHON AS FOLLOWS: 14:01

MS. MCMAHON: Hello, Mrs. O'Neill. Thank you for coming in today to give evidence to the Inquiry. Now you've already provided some written evidence to the Inquiry in the form of your statements. I just want to ask you to look at those to identify them as your statements, and your signature. We'll call the first one up. It's at WIT-80896. That's a statement you made on 20th September 2022? 14:01 14:02

A. That's correct.

319 Q. And the signature can be found at WIT-80980.

A. That's correct.

320 Q. And is that your signature?

A. It is, yes.
321 Q. And you wish to adopt that as your evidence?
A. Yes. Please.
322 Q. And you then give us a more recent statement dated 12th May. That can be found at WIT-94681. That's dated -- I think it's incorrectly dated as 27th September, the date of that is actually 12th May. Hopefully that will be confirmed when we look at your signature. WIT-94683. 14:02
A. That's correct. 14:03
323 Q. It's actually dated 5th May. Let's get the mistake out of the way early perhaps and that will be the last one. Do you wish to adopt that as your evidence as well?
A. I do. Thank you.
324 Q. You've given very detailed evidence to the Inquiry, and the Panel have your written evidence to read and all of the parties as well have that. The purpose of calling you for evidence today is so that we can focus in on a few aspects of your evidence so that we can explore those issues a little bit more. 14:03 14:03
A. Yes.
325 Q. And to give you the opportunity to explain some of your evidence, and also what others have said --
A. Okay. Thank you.
326 Q. -- about the role of the clinical nurse specialist and the key worker. 14:03
A. Yes.
327 Q. Just to give you a plan of what I hope to cover this afternoon, it will a trot-through, some of these, but

we'll look at the background to Urology Services very briefly because the Panel have heard quite a bit on that. Then we will just look at your employment history and the evolution of your role and responsibilities. Then we'll look at Urology itself and some of the staffing issues that you had. Then your nurse-led activities because I know you've detailed quite a significant number of clinical areas that you yourself cover now within Urology as well? 14:04

A. That's correct. 14:04

328 Q. Then we'll focus on the CNS and the key worker role?

A. Okay.

329 Q. And the MDMs, MDTs, and what Mr. O'Brien said and what others have said about the clinical nurse specialist role and the key worker. Of course, we will touch upon the SIA process and Dr. Hughes' process, because I know you spoke to him. 14:04

A. Yes.

330 Q. You've helpfully put some learning in your Section 21 and I just want to pick out a couple of points around that. 14:04

A. That's fine.

331 Q. This first part will probably be me speaking at you and you confirming some details, but it is really just to set the scene for the context of your evidence. 14:04

The key focus on the questions, just to give you a sense of why I am asking certain things, is we need to look at governance aspects of CNS does and how the

existing processes, or the processes that did exist, and the procedures and how everyone worked together either enhanced or prevented good governance. That's really the focus for this afternoon.

14:05

You have been there from the beginning in urology. There have been quite a number of reports that you have survived, if I can put it what way. If I run through a couple of them to show the evolution of Urology Services. The first one was really the opening of the modular Thorndale Unit in 2007.

14:05

A. Yes.

332 Q. Then there was a regional review of adult urology services in 2009. Then the Team South Implementation Plan of 2010 which the Panel have heard quite a bit about?

14:05

A. Yes.

333 Q. Ultimately then there was the national peer review in 2015. Along the way, there have been external and internal patient satisfaction surveys?

A. That's correct.

14:06

334 Q. Just as a global point, if you would agree with me perhaps, that all of those reports, recommendations, learnings, have helped inform the way in which Urology Services and the clinical nurse specialist role has moved along over time?

14:06

A. I agree.

335 Q. Now, you yourself started as a staff nurse in 1992; is that right?

A. 1990, I believe.

336 Q. 1990. And then you became a ward manager in 2000?
A. Correct.
337 Q. To 2005. Then you were a G and H grade, and then a Band 7 Urology CNS from July 2005 to June 2019?
A. Correct. 14:06
338 Q. Then a band 8, 8A Urology CNS from June 2019 to present?
A. Correct.
339 Q. I've read in your statement there was a bit of a delay in upgrading you, if I can put it like that? 14:07
A. There was indeed.
340 Q. In order to find the funds for the recognition of the work that you are doing. But you are currently an 8A?
A. Yes.
341 Q. Is that the same grade as your colleague, Jenny McMahon? 14:07
A. It is.
342 Q. Are all CNS grade 8A?
A. Not currently, no.
343 Q. Are they grade 7, some of them still? 14:07
A. Grade 7s.
344 Q. Would you and Ms. McMahon be the senior members of the CNS team?
A. Senior in terms of years and experience and also in terms of the different things that we would lead. 14:07
345 Q. You have said a sentence in your statement and I just want to ask you a little bit about that, just so the Panel get a flavour of your workload. You've said the job description, which you have attached - we don't

need to go to that - that it did not accurately reflect the role undertaken on a daily basis. Now, that could be perhaps said of a lot of jobs but in your case, what aspects in particular are you referring to?

A. So that was really from the appointment to CNS level from 2005 forward. As we developed and designed the new unit that became Thorndale, there was no ward manager in place for the unit. So, as the CNS Jenny and I had to share ward management responsibilities for the small team that we had. So, that covered everything from sick leave to annual leave, to revalidation, to training needs, to equipment management, to just the day-to-day running of the clinics. 14:08 14:08

346 Q. The absence of a ward manager I think straddled from 2005 right up to 2021? 14:08

A. To April 2021, yeah.

347 Q. All of those other additional duties fell upon you and Mrs. McMahon?

A. They did. We shared those, and I'm not aware of any other CNS within our own Trust, or indeed meeting them at regional or national conferences, that were sharing a similar workload. They didn't appear to have ward management requirements of them. 14:09

348 Q. I wonder if I can just ask you if your microphone could be moved slightly closer, just so that you're picked up okay. Thank you. 14:09

You've reflected that in your statement. I'll just

read - we don't need to go to this document - I'll just read from it. For others it is at WIT-80907 at paragraph 7.3 and you are referring to this period between 2005 and 2021.

14:09

"During this time I assisted my colleague Jenny McMahon CNS with the provision of benign nurse-led activity in a variety of areas throughout the hospital that could provide us with suitable accommodation. From 2007 onwards in the absence of a ward manager, given my background in ward management, I undertook many of the roles that is required of a ward manager and was part of the core compliment of nursing staff for all clinical activity. The concern that Jenny McMahon and I had in relation to the lack of a ward manager and how it may impact on our development as CNSs was escalated to the lead nurse Maureen O'Donnell and Martina Corrigan, Head of Service".

14:09

14:10

14:10

A. That's correct.

349 Q. So, there has been an historical difficulty with staffing?

14:10

A. Historical difficulty with staffing in a very small team. So if one went off sick in a team of nine or 10, that had a significant impact.

350 Q. You've also highlighted in your statement at paragraph 7.8 that there was an additional need for specifically clinical nurse specialists?

14:10

A. Yes. That need was identified in the regional review of Urology Services in 2009, where they identified the

requirement for an additional two CNSs on the Craigavon Area Hospital site.

351 Q. One of the impacts of that, you've said, is the inability to progress the development of the additional nurse-led services, such as the prostate cancer follow-up? 14:11

A. Yes. In terms of the speedy of initiating them and progressing them, that would have been one of the impacts. The other significant one was the support for oncology clinics. 14:11

352 Q. So, up until what year was it just you and Mrs. McMahon?

A. Up to -- for an additional CNS, 2019.

353 Q. 2019?

A. 10 years after the requirement for two was acknowledged. 14:11

354 Q. We'll talk a little bit later on about key workers but a key worker doesn't have to be a CNS?

A. Absolutely not, and we would have delegated that workload. If I was on leave or doing a parallel clinic, I'd have delegated that workload to the staff nurse. One in particular in the earlier days, but then they increase two Band 5s temporarily up to Band 6 in 2015 into '16 to assist with key worker role. However, they weren't backfilled completely, so that meant they had their daily activity to complete as well as any additional that we could ask. 14:12 14:12

355 Q. So, tasks were added on rather than delegated specifically?

A. Yes, they were upgraded. We did get a Band 5, an additional Band 5 part-time hours at that time. But because of the turmoil that was going on in the inpatient ward in relation to high turnover of ward managers, we were asked if we could take over the management of the Stone Treatment Centre as well. So, now we had Thorndale to manage and now Stone Treatment Centre in its entirety in terms of staffing and equipment, and all of the running of that.

14:12

356 Q. Now, you'll know one of the issues that the Panel want to consider is the issue of key worker or clinical nurse specialist provision for patients who are either being newly diagnosed or going through a patient pathway in relation to cancer services?

14:13

A. Yes.

14:13

357 Q. Just in general terms, or you can be specific if you have examples, what was the impact on your ability to provide key workers or clinical nurse specialists for those clinics, given the state of staffing issues?

A. So, my working week would have involved Monday morning, new clinic. Productivity was the show in town in terms of meeting cancer targets. Monday afternoon, I was available for the uro-oncology clinic that Mr. Glackin would have ran. Tuesday morning, I would have been involved in prostate biopsies, nurse-led prostate biopsies. Tuesday afternoon was another new clinic. Again, these new clinics averaged 20 patients per session. Wednesday morning was another new clinic, again performing biopsies and helping with all the

14:13

14:13

diagnostics. Wednesday afternoon I was available for Mr O'Donoghue's clinic. Thursday morning could have been a variety of things; it could have been a locum consultant doing uro-oncology review and I would have helped out at that or sometimes there would have been meetings around lunchtime on a Thursday. Thursday afternoon was MDT. I worked occasionally in the early part on a Friday morning a half day, but from about 2015 on it was a four-day week." 14:14

358 Q. So from 2015 you didn't work on Friday at all? 14:14

A. Very rarely.

359 Q. Is that the days Mr. O'Brien had his clinic?

A. He would have had his uro-oncology clinic on a Friday morning.

360 Q. Would there have been another member of staff in your place on a Friday morning? 14:14

A. There would have been but continuing with parallel work, so accessible.

361 Q. So, in lay person speak, parallel work, the nurse has her own clinic doing something else but is available if needed? 14:15

A. Yes absolutely. That was known and understood, as it would have been on a Tuesday morning for example, when I was performing prostate biopsy clinic. Mr. Haynes tended to have his uro-oncology review clinic on a Tuesday morning, but the understanding was that we were accessible. He would have asked patients when he had finished his encounter with them at that time, he would have asked them would they remaining to meet their key 14:15

worker, and he would have brought the notes down and set them outside the clinic room where I was performing biopsies. So, in between patients I would have taken on key worker activity and then returned to my own role again. 14:15

If I was on leave, a staff nurse would have done that in my absence. They too would have been assisting maybe with urodynamics or flexible cystoscopies, so they were accessible. 14:16

362 Q. If we just try and capture the picture up until 2020 in the clinic, uro-oncology clinic, whatever consultant was having that clinic, whatever day of the week it is - I see they have all got different days - and working on the availability of a nurse at that time? 14:16

A. Okay.

363 Q. Now by 2020, 2019 there were four CNS?

A. By 2019 we had --

364 Q. Patricia Thompson?

A. No, that was later. Leanne McCourt was appointed in 2019 through support from Macmillan, and then 2020 there was additional appointments with Patricia Thompson and Jason Young. 14:16

365 Q. You and Mrs McMahon was appointed on 4th July 2005?

A. Correct. 14:16

366 Q. Leanne McCourt was appointed on 1st March 2019?

A. That's my understanding.

367 Q. Jason Young was appointed on 31st August 2020?

A. Yes.

368 Q. Then Mrs. Thompson was appointed on 3rd August 2020?
A. 2020, yes.
369 Q. So, by 2019 there were three of you and then, by the end of 2020, there were five?
A. There were five. If we bear in mind the training needs that people have coming into a new post, as well as Jenny and myself continuing to advance our practice. Jenny and Leanne undertook nurse prescribing in late, I think September/October 2019; they commenced that course. That took a lot of their time. I think it was like 50% of their working week was committed to the university for that year. So, whilst on one hand we got somebody, it dipped on the other side so the net gain was limited. 14:17 14:17
370 Q. Just while you've mentioned the nurse-led activities, you have that in your statement. You have set that out - we don't need to go to this, WIT-80930 for note - and that is something that seems to be very innovative in Urology Services. There seems to be a very significant amount of nurse-led activities and concentration on new skills? 14:17 14:18
A. There is, and that is something we have promoted from Urology started. We started what I would have called ground zero when it first began. It was a speciality we knew nothing about it, but we energised ourselves to learn and progress, and that's how we got to where we are. In 2015 they started the one-stop clinics and that was a new concept as well, where, in an attempt to shorten the patient's diagnostic pathway, they arrived 14:18

for one appointment, they were assessed by the doctor, had their diagnostics, including ultrasound scanning, flexible cystoscopy or prostate biopsy as well as flow rates and post void residuals and all that kind of thing all completed in the one setting. So, by the end 14:19
of their appointment on that day, which may have taken a couple of hours, they left with a very clear plan. They were either commenced on medication for one reason or another; they were added to a theatre waiting list; they were put forward for a more diagnostic test such 14:19
as an MRI scan, but many of the clinics picked up new cancers and required key worker input on the day, and that was always facilitated. The ultrasound team would have informed us that they picked up for example, an eight centimetre renal tumour, and we would have 14:19
reported that back to the doctor and said the next patient due back in to for review for closure of their assessment today, we have identified a tumour. We would have had the site-specific information for that, the surgery information for it. In the interim before 14:20
they would be called back in to the doctor and one of us, we would have negotiated with the red flag team that we worked very closely with - it was a benefit that they were next door to us - but they were accommodating in processing people rapidly if they 14:20
required time-specific surgery. They would have seen them on the day to progress their pathway.

That was something that was very advanced regionally.

It was recognised within the Trust in terms of their award for frontline team of the year and overall winner, but it also attracted visits from the teams from the other Trusts within the region and from the Health and Social Care Board. 14:20

371 Q. Is that still the position at the moment?

A. It is not where we want it to be, now, it obviously stopped with Covid. The reset button hasn't come back to where we want it to be, but it is definitely something that we would endeavour to have. It's there 14:21 in a condensed form at the minute, but we certainly would want to expand it because at that time, doing four clinics per week, we were processing up on 80 or 100 new patients per week and we are not at that at the moment. 14:21

372 Q. When it was that input and output at the time, is it the case that the advancements in technology and your ability to provide what sounds like a very significant wraparound service resulted in perhaps more work on the other side, where you need more key workers? 14:21

A. Well, it did. In addition to that, the fact that the nurses were performing the diagnostics primarily, it allowed additional patients to be seen at the clinic. The first few months we amended and adjusted time slots to make it as productive as possible in terms of 14:21 meeting cancer targets.

373 Q. You said you would have liaised and indicated to the consultant that the next patient coming in following those tests is maybe going to get news they aren't

expecting?

A. Yes.

374 Q. And would there be automatically be a key worker go in, or would the consultant be asked or would they request it? What way did that work? 14:22

A. No, we generally gathered up the information that was required for the patient and we would have went in shared that information with the consultant, and collectively we'd brought the patient or relative to give over that news and determine the pathway forward. 14:22

375 Q. Was that for all consultants?

A. That was for all consultants.

376 Q. For all urologists?

A. Yes.

377 Q. Did you get any pushback in relation to that from any consultant where they didn't want to use the key worker in that role? 14:22

A. No, not at all. I think there was fantastic teamwork going on at that time in terms of achieving the productivity, everybody engaged, everybody helped out, everyone done their best in terms of the numbers that we seen on a daily basis, I think it was fantastic. 14:22

378 Q. Mr. O'Brien in his statement has made some comments about the clinical nurse specialist, and I would like to read those out. If we can go to those at WIT-82488. Just as a general point, was it your experience with Mr. O'Brien that he was supportive of the clinical nurse specialist work? 14:23

A. Absolutely. I have found O'Brien to be supportive from

Urology started. I was very new at that time into nursing and this was a brand new speciality, and he would have encouraged us to undertake training of any nature. Indeed, when I trained there was no degrees at that time, so, like a lot of others along with me, we would have, through self-directed learning at universities or whatever, completed our nursing degrees in early 2000 and then progressed to take a post-graduate diploma in specialist practice. So, I definitely would have found him very supportive in that nature. 14:23 14:23

379 Q. Before I read the paragraphs, were you involved in the organisation CURE?

A. Yes, for a period of time. When it was first set up, I was a junior staff nurse at that time so I would have been involved in, like, ticket sales or helping out at functions that they would have had. Then for about a 10-year period from 2000 to 2010 approximately, I would have assisted with secretarial duties and the coordination of fundraising, usually gala balls and that type of thing. 14:23 14:24

380 Q. Did they organise or invite people to seek funding for courses that you might have benefitted from?

A. That would have been encouraged. It was about research and education. It was for nurses as well as doctors. We would have activity encouraged junior staff and anyone in the team to avail of that. Modules at that time were probably £200 or £300 each, but if you were young, married, small children, everybody has their own 14:24

challenges, this was an additional way to coax people to undertake it.

381 Q. Did you ever apply for funding for any course that you did?

A. Yes, for some of those modules and part of the post-graduate diploma in specialist practice, and for any of us attending conferences in the UK. 14:24

382 Q. Did you think CURE was a useful contribution to the urology development?

A. Absolutely, and it certainly supported some of the middle grade doctors in terms of their research work as well. So yes, absolutely. 14:25

383 Q. If we just look at Mr. O'Brien's statement at paragraph 248. I just want to read these couple of paragraphs out. 14:25

"Following my appointment in 1992, I was fortunate in having the hospital fund the purchase of equipment to undertake urodynamic studies and which was located in a room off Ward 2 South. A number of Staff Nurses keen to develop specialist skills became trained and accredited, experienced and skilled in the total holistic assessment and management of lower urinary tract dysfunction in both male and female adults. One of these nurses, Ms. Jenny McMahon, was appointed a clinical nurse specialist when the Thorndale Unit was opened in 2007. She has been an outstandingly competent CNS. She is one of the most experienced urodynamicists in Northern Ireland. She has augmented 14:25 14:25

her competence by performing flexible cystoscopies and is an accredited prescriber. She conducts her own lower urinary tract symptom review clinics. I have always been supported by her. She has been a pleasure to work with.

"The Department had the additional benefit of having a urology cancer CNS since 2007 with the appointment of Mrs. Kate O'Neill to that post, though she was a loss to inpatient management as she had been the ward manager until then. Kate was joined by a second urology cancer CNS, Ms. Leanne McCourt in or around 2016, '17. Both were based in the Thorndale Unit. Kate O'Neill has contributed significantly to the development of urological cancer services since her appointment in 2007. Since the establishment of the Urology MDT in 2010, she has attended most MDMs as the MDT core nurse member. If unable to do so, she ensured that she was deputised. She was the author of the section regarding urology cancer CNS involvement in Cancer Services in the Clinical Management Guidelines, which I commissioned in preparation for national peer review in 2015. She became competent in performing, transrectal ultrasound-guided prosthetic biopsies contributing significantly to diagnostic capacity. She ensure that all patients were reviewed by consultants following MDM discussion and, as the MDT core nurse member, she was responsible for ensuring that all newly diagnosed cancer patients had access to a urology

cancer CNS for holistic needs assessment, support and sign posting, et cetera. She was assisted by Leanne McCourt. It is regrettable that there was no urology cancer CNS available to patients when attending for review at clinics at SWAH. Nevertheless, I found both Kate and Leanne to be supportive of me in my practice".

A couple of things I want to ask you about this. It is clear that Mr. O'Brien holds you, Mrs. McMahon and Ms. McCourt in very high esteem? 14:28

A. That would be impression that we would have at work, yes.

384 Q. Would you reciprocate that with him?

A. Absolutely. We had an excellent working relationship.

385 Q. I just want to pass on for the moment the issue around the allocation of newly-diagnosed patients being the role of the MDT core nurse manager. Just while this has come up at this point, he mentions that there was no CNS available to patients at the outlying clinic at SWAH? 14:28

A. Yes.

386 Q. Can you explain why that was and what impact that had?

A. It was definitely resource-based and there was -- as we said earlier, the emphasis on productivity in terms of meeting cancer targets. The agreement with the Head of Service was that the CNS would not go out to any satellite clinics. The CNS focus was to be on the Craigavon site to assist with diagnostic services and provide key worker activity there. How that was 14:29

managed by consultants may have differed. For example, Mr. Glackin would have had a clinic in South Tyrone Hospital Dungannon, but he would have appointed uro-oncology patients to be seen in Craigavon instead of South Tyrone as he knew there was access to CNS there.

387 Q. Was that something Mr. Glackin did as part of his own practice --

A. I believe so.

388 Q. -- or was there an expectation that that would happen with others? What was your view? 14:30

A. I don't recall it ever being formally discussed but I was conscious that Mr. Glackin had made a decision that patients who required CNS activity would be seen on the Craigavon site, unless there was some very particular reason, transport or otherwise, that they couldn't attend there. 14:30

389 Q. If they couldn't, were those patients given leaflets and information about following up?

A. I can recall being contacted by Mr. Glackin in relation to a patient who had difficulty with transport, and he contacted me at the end of his clinic to ask if particular information could be forwarded to the patient. That was posted out with my contact number. 14:30

390 Q. So, the information wasn't available at the actual clinic in SWAH, it was followed through by Craigavon follow-up? 14:30

A. Yes.

391 Q. And is that still the position today?

A. Well, those outreach clinics --

392 Q. Those are gone?

A. Those are gone now. The one at South Tyrone doesn't have oncology patients at it.

393 Q. It is all in Craigavon? 14:31

A. Yes.

394 Q. Just on that point, the leaflets and documentation that might be helpful to people and their pathway, that's available in the room, so the consultants --

A. They are in all of the consultation rooms. The 14:31 information leaflets were started in 2007. Once we set up the unit, the information leaflets were available from that time forward. We've just added to them as information changed.

395 Q. Before we just move on to look in greater detail at the 14:31 CNS role, the key worker issue, Jenny McMahon, in her Section 21 reply, speaks about the difficulty with the shortage of consultants and the reliance on locum consultants?

A. Yes. 14:31

396 Q. I just wonder if I could read out a couple of extracts from her statement --

A. Yes, sure.

397 Q. -- and you can see whether you agree with her or not. For note, this is WIT-81213. She talks about the 14:31 overreliance on locum consultants.

"The result of this in my opinion has contributed to a delay in seeing new patients who had been categorised

as routine, and a backlog in review patients being seen routinely. I also believe that having consulted urologists, post vacancies can cause additional pressure on existing team members and he impact upon commitments for on call, performing triage in a timely manner, a necessity to attend most if not all MDT meetings in order to achieve quoracy".

Is that her experience of that reflecting yours?

A. It is not up on the screen for me but it does, it absolutely does. 14:32

398 Q. I can put it up if you want. Sorry, I thought you said put it up. If you want me to do that?

A. No, that's fine. I would absolutely agree with that.

399 Q. Does that sound familiar, her concerns around that? 14:32

A. Absolutely. Because on a working day, we were involved with every activity from in in the morning to setting up the rooms; everything to make it as functional as possible. The high turnover of locum consultants, just it required from us like introductions frequently, new consultant, new routine, this is where things are, this is the people you need to contact for whatever reason. So, it was like a repetitive introduction over and over again for new people. 14:33

400 Q. I think the Panel have heard information around the difficulty in securing consultant urologists. I think it is not just confined to this area? 14:33

A. Absolutely not. No, no, it seems to be a regional issue.

401 Q. Has Mr. O'Brien's post been filled?

A. No. We've still vacancies there.

402 Q. Ronan Carroll, just for the Panel's note, states at WIT-13106 states that "Mr. O'Brien's post remains vacant despite being advertised on three occasions". 14:33

I just want to move on and ask you questions specific to key worker aspects. The terminology in the documents can be a bit confusing, the cancer nurse specialist, clinical nurse specialist, key worker; they 14:34 seem to be used interchangeably. For the purposes of our discussion, the key worker will be someone who is specifically allocated to someone in oncology. Ms. McMahon describes this conflation of terms at WIT-81230, and we will call this up so you can look at 14:34 it this time.

11.2, I'll read it out for you.

"I understand the terms urology nurse specialist, 14:34 specialist nurse, and clinical nurse specialist to be generic titles that can be applied to any clinical setting. In contrast, the terms cancer nurse specialist, uro-oncology nurse specialist and Macmillan cancer clinical nurse specialist are often 14:35 used interchangeably and refer to job titles where the main focus of the role is in cancer care".

Then she says:

"The term key worker is used to describe a function within the role of a CNS who is a core member of the cancer multidisciplinary team".

A. That's correct. 14:35

403 Q. So, the term "key worker" is a specific role and that's why it is given that name?

A. Yes.

404 Q. It says what it does. It is a key worker --

A. Exactly. 14:35

405 Q. -- for the person who is newly diagnosed or receiving treatment.

Now, we've seen comments from Mr. O'Brien in the earlier extract, and I know it is something that you 14:35 are aware of, that the expectation in the Trust documents, and specifically the NDT operational policy from the Trust, is that there is a requirement that the core MDT nurse and the clinician appoint a key worker?

A. Yes. 14:36

406 Q. Now, the MDT core nurse member, does that refer specifically to the person who attends the MDT when that patient is discussed?

A. No. The core nurse member is the nurse who is identified as the lead CNS for MDT. So, they would 14:36 have specific roles in that, with that title.

407 Q. And is that a title that you have?

A. Yes.

408 Q. And what does that involve?

A. For me, that is a high level of knowledge, skills and experience in relation to the speciality. It means involvement in service development. It involves understanding the training needs of the staff within the unit. It involves making sure the appropriate information is available for patients. It involves advocacy for the patient at the MDT setting, speaking on their behalf. And as they have mentioned and you've referred to several times, the appointment of key worker and holistic needs assessment. 14:36 14:37

409 Q. How does that work in practice? In that role, how do you normally allocate the key worker to a patient?

A. So, if it is appropriate to say now the operational policies, I understand, were written at a time when there was an expectation that new appointments were imminent. They had been outstanding for a significant number of years at this stage. So, the biggest challenges to me were still resourced-based in terms of identifying a key worker. It could not be done at the MDT setting because we didn't know when each clinic review was occurring, so in the same way as a holistic needs assessment wasn't being done formally, it was being done informally at that time due to resources. 14:37 14:37

So, what we managed as a team on daily basis then, was when the clinic was appointed - as I said, Mr. Glackin's was on a Monday afternoon - well, then I was able to be at that clinic or I delegated someone to be at it. It only became more complicated when there were 14:38

parallel clinics going on, and it required the consultant to come out and get us when they were seeing patients, yeah.

410 Q. So, two things from that. The first is that the allocation of the key worker usually happened on the day of the clinic depending on -- 14:38

A. On the day of the clinic, yes, or a day or two in advance. We would have looked at the schedule, seen who all was available, what clinics were taking place and then allocating somebody to it. It is a very different framework that we're in now. 14:38

411 Q. That was always the case because you couldn't anticipate staff who would be on?

A. Exactly.

412 Q. So you waited until closer to the time and said, for example, Leanne McCourt will be on - I'm just anybody's name? 14:39

A. Yes, sure.

413 Q. She will be on Monday afternoon, Mr. Glackin, she will be the key worker for his patients? 14:39

A. Yes, indeed.

414 Q. All of them for that afternoon, if they hadn't been allocated someone?

A. Exactly.

415 Q. Perhaps someone coming for the first time would end up appointed to Ms. McCourt? 14:39

A. Yes.

416 Q. Was it ever in your experience the practice that at the MDT, the clinical lead and you identified the key

worker at that point?

A. No, never at any stage. In the operational policy of 2015 and updated again in '16, it actually determines the inadequacy of CNS services to provide this, of people to provide this service, and that the lead clinics, at that time Mr. O'Brien, and I should continue to engage with the Southern Trust to advocate the appointments that were outstanding. 14:39

417 Q. So, the recognition was that it was a capacity issue that didn't allow this to happen? 14:40

A. Absolutely, yes.

418 Q. For the Panel's note, the urology cancer MDT operational policy is at WIT-84545.

You will have seen that Mr. O'Brien makes reference to the responsibility -- one of the aspects of the SAIs that we will ultimately come to was the failure of certain patients to have key workers. None of the patients had been allocated a key worker or access to the CNS? 14:40 14:40

A. Yes.

419 Q. Now, you'll see that the quote from Mr. O'Brien was that there was joint responsibility. I think I can take from your evidence that the policy that the Trust operated, we can see on the screen in front of us, was never going to, in fact, be able to be applied -- 14:41

A. Absolutely.

420 Q. -- the way it was anticipated?

A. It was a standard that was set that we couldn't

undertake or complete.

421 Q. And even when it was updated at this point, no one was adhering to that because it wasn't possible?

A. No. And in the evidence that Mr. O'Brien provided, I think he made reference to the fact that it was a joint responsibility -- 14:41

422 Q. Yes.

A. -- from the point of 2017 onwards, when, in fact, the same joint responsibility was written in earlier policies. 14:41

423 Q. Preceded that, from that 2017 document. At times, given that the chairship of the MDT rotated and at times Mr. O'Brien would have been chair --

A. Absolutely.

424 Q. -- and lead clinician, there might have been times when it dovetailed into yours and his responsibility? 14:41

A. Absolutely.

425 Q. But your evidence to the Panel is that was never the way it was operated because in reality --

A. No, no, because we couldn't determine who was available until closer to the time. 14:42

426 Q. Were you consulted on this policy by the Trust in advance of it being drafted?

A. I would have had engagement with the head of cancer services, Fiona Reddick, in the lead-up to peer review in the preparation of the document, yeah. 14:42

427 Q. Did you ever say to anyone, well, we are already in breach of this because that's not possible?

A. With frequency, and in meeting with Fiona Reddick. I

think there is reference to it in notebook evidence that we provided recently, just key points that we had concerns about in terms of achieving them, key worker being one of them, and holistic needs assessment. At that stage we were even asking can you forward the documentation that other teams or other specialties would be using for holistic needs assessment that we could have a look at. And that was 2015.

428 Q. You have provided a couple of examples of the way in which different consultants approached access to the nurse? 14:43

A. Yes.

429 Q. We'll find that at WIT-80968. Now, the starting point for this is that you never experienced Mr. O'Brien preventing the assistance of CNS or a key worker? 14:43

A. That was our understanding. That was my understanding, that was my experience, yes.

430 Q. Did you ever speak to Martina Corrigan to the effect that Mr. O'Brien doesn't allow us access, or it's difficult, or he is obstructive in any way? 14:43

A. No. The issues I would have raised with Martina Corrigan or any of team on a regular basis would have been more about overrun of clinics or productivity within clinics. I certainly wasn't aware that anyone was being prevented from having access to a key worker in any role, no. 14:44

431 Q. Or not using CNS when available?

A. Yes.

432 Q. Did any of your staff ever come to you and say I've

noticed a pattern, or anything like that?

A. No, there was no pattern identified. I guess the reassurance I have in relation to that is that I still have key working contact with patients that were seen as early as MDT starting in 2010/2011, and these were Mr. O'Brien's patients, and I have key worker contact for patients as late as 2019. 14:44

433 Q. I just want to read this paragraph.

"I never felt that Mr. O'Brien prevented/obstructed CNS involvement in his clinic, nor did my colleague Jenny McMahon or Staff Nurse Dolores Campbell, who would both have deputised for me on occasions, ever raise this as an issue. My job plan meant that I was generally available for uro-oncology clinics with Mr. Glackin, Mr. O'Donoghue and Mr. Haynes but to a lesser extent Mr. O'Brien and Mr. Young. This meant that I would see much fewer patients with Mr. O'Brien and Mr Young". 14:44 14:45

Can I just stop there and ask, was there any nurse in particular who would have been allocated the Friday shift who might have worked with Mr. O'Brien more? 14:45

A. In the early days probably Staff Nurse Dolores Campbell, who then acted up into Band 6 for a period of time, and in later times Leanne McCourt. 14:45

434 Q. And I think Nurse McMahon moved to benign services in 2014?

A. Yes.

435 Q. So that is why she wasn't involved in MDT and she

doesn't have the oncology context that you can bring to this?

A. That's right. Mr. Young, his new patient clinic took place on a Thursday afternoon when I was at MDT, and his uro-oncology review was generally on a Friday afternoon when I wasn't there, but the same nurses would have been accessible for him and, you know, were used morning and afternoon on a Friday. That is what I was told. 14:45

436 Q. In relation to the key worker, if there were people come back for review appointments or first time appointments with Mr. O'Brien on a Friday, the nurse who would have been allocated a key worker on the basis of the system you have explained would have been Dolores Campbell and Leanne McCourt? 14:46

A. Yes, and could well have been doing parallel activity at that time.

437 Q. Then continuing on with this sentence:

"I do recall Mr. O'Brien introducing me to patients to either plan prostate biopsy for them, engage or signpost to other services such as palliative care team or for the provision of information". 14:46

A. Yes.

438 Q. 14:46

"On those occasions I felt that I was able to offer information support and a contact number. On occasions would I have received phone calls from patients seeking clarity regarding their consultation with any of the

consultants. Had I not been present during the consultation the patient was referring to, I would have viewed the dictated letter from NIECR for clarity in relation to their questions, or sought clarity from their consultant. For many years, I have worked a four-day week".

I think we have established that?

A. Yes.

439 Q. Okay, I think that's the relevant part of that extract. There are different ways in which the consultants access different services. You have mentioned one incidence of resistance to nurse-led activity in your statement? 14:47

A. Yes. 14:47

440 Q. When you talk about prostate biopsy in relation to Mr. Young?

A. Yes.

441 Q. Was that just a little bit of resistance to nurses taking on that role or was it something else? 14:47

A. Well, possibly. I guess if the majority of your work had been in Northern Ireland only, you weren't used with the CNS wraparound service that would have been more visible in sites throughout England. So, my feeling for it at that time was it just took Mr. Young that wee bit longer to engage with it. My way of assisting that process was to ensure that I audited the services that I was providing and presented those audits at either departmental meetings or patient 14:48

safety meetings to ensure that my clinical work was robust and safe. It was a gradual process but we got there in the end, and referrals into the nurse-led service began.

442 Q. The resistance, is it dissipated entirely? 14:48

A. Oh, it's gone and it didn't delay anybody in any way because we didn't have a waiting list as such for prostate biopsy. They were done within a week or two unless there was some other medical reason that they couldn't be done in that time. I also had a consultant 14:48 radiologist doing a list, so for a period of time I would have put Mr. Young's patient on to his list and that meant there was no delay in the pathway for them.

443 Q. You've mentioned briefly Fiona Reddick as Head of Cancer Services? 14:49

A. Yes.

444 Q. Do you have much of a link or contact with her?

A. Very little. It would really only perhaps have been at the AGM of MDT.

445 Q. She says in her statement that she highlighted to 14:49 Martina Corrigan that urology patients should have a key worker urology cancer nurse specialist as part of a key performance indicator. Is that something that you are familiar with, or is that --

A. That would have been something I was familiar with but 14:49 again, it was always back down to the resources that hadn't been put in place.

446 Q. For the note, that statement from Fiona Reddick is WIT-91020. We don't need to go to it. Paragraph 36.1.

I may know the answer to this given what you've said but I'll ask it any way. Was there ever a uniform approach to the key worker role? By that I mean with the limited resources that you had to provide that role, was it ever the case that you triaged, for example, the clinics as nurses and said, well, these three people are in for first review and it's not going to be good news; this person is going to have their treatment changed and they'll need somebody in in case they have any questions? Was that possible or was capacity so pushed that particular approach wasn't -- 14:50 14:50

A. I think we wouldn't have had the resources to have had that depth of oversight in terms of who was attending the clinic. We do now. That's the difference that additional resources in the last few years have brought about. 14:50

447 Q. Given that Cancer Services did have some overarching responsibility but Urology Cancer Services sat slightly outside that remit and sat independently, was there ever any communication or conversation between the various CNSs as regards best practice? 14:51

A. In terms of key -- what do you mean? Within our own team?

448 Q. Or with other teams as well; how they approached it? 14:51

A. There was no forums for engagement with other CNSs. There has recently been established within the Trust a CNS forum and it's been going possibly for about 18 months, a year or 18 months now, but not at that time.

But in terms of what is required for key workers and engagement with the consultants for that, I would have emailed them - and I have provided that in my evidence - in 2015, to determine the information that we wanted to bring to that encounter and the records that we wanted to make in terms of what information was provided, contact number was given, permanent record of management. I sent that email again in 2017 as there was new members in the consultant team at that stage.

449 Q. So, there wasn't any expectation that the key worker would be in with the consultant seeing every patient? 14:52

A. Absolutely not. It wasn't possible. Where it was possible, it was done. Where it wasn't and we were in parallel clinics, the nurse on duty on that day would have told the consultant on his arrival for the clinic there is no one available for your clinic today, however, today it's Dolores that will be assisting you with key worker activity if and when required, or whoever. We would give them the name. 14:52

450 Q. Do you think you would have been aware had there been a particular consultant who was not using the key worker? 14:52

A. I'm pretty sure I'd have been aware of that. We worked so closely, it was such a small team, a small unit. The team were open with Jenny and I about raising any concerns they had, whether it was in relation to equipment, or middle grade doctors or whatever their concern was, they would have came to us with them readily. 14:53

451 Q. I want to bring up the pro forma I think you mentioned.

WIT-81164. I think this is the one in use from the summer of '21?

A. This is post-Covid. Isn't everything now? But this was used post-Covid. This will allow improved auditing of key worker activity. One of the main positives from this pro forma, if you scroll down a bit, is it takes the information whether the patient wants to have a holistic needs assessment completed. When this is forwarded or submitted to the Cancer Support Service, they initiate that engagement with the patient and set up the holistic needs appointment. So, we cover two areas really with that pro forma; we cover what is done on the day and then we set up the holistic needs appointment. 14:53 14:53

452 Q. Is this completed at post MDT or at first clinic? 14:54

A. At first clinic.

453 Q. Is the key worker named on this?

A. The key worker is named on it, yes. I think up near the top. It's on the electronic version. Maybe that was an earlier one but on the electronic version that we use, yes, you type in your name. 14:54

454 Q. So does this system operate in a way where you have to fill it in, it won't let you --

A. It is minimum data set. If it is not completed, it won't go. 14:54

455 Q. You can't not allocate a key worker?

A. Absolutely not. It is recorded there and that will be audited, yes.

456 Q. And the information now goes monthly through for audit

rather than before; I think the position was it was yearly?

A. Indeed. Alongside this, the audit team that is new in Cancer Services I believe, there is one person there, so they send us, for example at the beginning of June, they will send us all of the new cancers in May. It is on a shared drive so any of the CNSs can go into that shared drive and complete who the key worker is for that patient. If there was any omission in it, we would look into why that was the case. 14:55

457 Q. Now, you are a frequent attender at the MDMs and MDTs?

A. Yes.

458 Q. They were initialled in April 2010 and Mr. Akhtar was sole chair until March 2012 and then Mr. O'Brien was sole chair from 2014? 14:55

A. Yes.

459 Q. And then it is a rotational chair based on the urologist of the week rota?

A. Yes.

460 Q. So that was introduced in October 2014. Now, the National Cancer Peer Review measures has certain requirements for quoracy at MDM, and one of them is a clinical nurse specialist key worker and also two urologists, a radiologist, a pathologist, a Cancer Tracker and an oncologist? 14:55 14:56

A. That's correct.

461 Q. Just from the outset, what was your experience of attendance at the MDM at quoracy?

A. In terms of nursing presence at it, it would be highly

unusual for a nurse to not be at that clinic or that MDT. I was certainly at it on every occasion that I was working and MDT was happening. In my absence, someone else would be assigned to go on my behalf. Unless for sickness or something like that, the attendance rate for the CNS team or nursing team was very high. From the outset, there was severe challenges in relation to radiology and oncology input in relation to attendance, yeah. 14:56

462 Q. Your role at the MDM, what was that? 14:57

A. My role at the MDM was being the patient advocate; bringing information to the team that may not have been known or shared with them. That might have been in terms of patient's fitness for particular treatments, or their inability to engage with the treatment plan at that particular time. I have given evidence in relation to examples of that. 14:57

463 Q. What was the culture towards the nurse at the MDM? Did you have any difficulties with interaction or sharing ideas or communicating with anyone? 14:57

A. No, I wouldn't have had any difficulties. I would profess not to be a great public speaker, so in the early days I might have been somewhat timid in it or whatever, but for now, and for many years, I have brought the patients' information to it. I have questioned decisions around patients. All of that is very interactive, and I have found it to be supportive. 14:57

464 Q. The culture there is that you feel an equal part of the team?

A. Absolutely.

465 Q. I just want to look at the overarching summary of the SAIs, and that can be found at DOH-00126.
I think it's at the bottom of the page. You're familiar with this summary document that was shared with you? 14:58

A. Yes.

466 Q. By Dr. Hughes?

A. That's correct.

467 Q. In March 2021? 14:59

A. Yes.

468 Q. I just want to read out the extract from the bottom.

"The Review Team regard the absence of specialist nurse from care to be a clinical risk which was not fully understood by senior service managers and the professional leads. The Review Team have heard differing reports around the escalation of this issue but are clear that patients suffered significant deficit because of non-inclusion of nurses in their care"? 14:59 14:59

Next page:

"Statements to Urology Cancer Peer Review in 2017 indicated that all patients had access to a key worker, Urology cancer nurse specialist. This was not the case and was known to be so." 14:59

Just so the Panel is clear in your evidence, you don't agree with that?

A. So, my understanding of that is that on the Craigavon Area Hospital site all patients had access to a key worker but not for the satellite clinics. And that was an issue that was known to senior members of the team. 15:00

469 Q. So, the setup itself didn't facilitate access to a key worker but you're understanding is that the access to the key worker within the clinics within Craigavon -

A. Yes. 15:00

470 Q. - operated properly in your understanding?

A. In my understanding if we weren't present we were definitely accessible. And in terms of reassurance, if it's appropriate in relation to that, a member of the nursing team opened, literally opened Thorndale unit in the morning and a member of the nursing team closed it in the evening. They didn't leave until the last patient left because the emergency trolley needed locked away et cetera, et cetera. So there was access to a trained member of staff at all times. 15:00 15:01

471 Q. Now, the Inquiry have heard from some patients, the patients experience -

A. Yes.

472 Q. - of individuals and just give you two examples of that? 15:01

A. Okay.

473 Q. I don't need to go to these, just in summary form can be found for parties at TRA 00243:

"The daughter of Patient 1 confirms he had never been assigned a clinical nurse specialist".

And the daughter of Patient 5 describes a difference that a CNS made at TRA 01917. And says: 15:01

"I wasn't aware of the existence of clinical nurse specialists or their role or function and how important it was until it was mentioned at the SAI meeting". 15:01

And then I read up on the role and function and recognised that, you know, I think, you know, people say "why did you not complain?" If you don't know what the baseline expectations are in terms of what you're entitled to, then you don't complain. If we had known 15:02 that, if that hadn't been done, we would have followed that up but that was not indicated to us at any juncture.

Now there are two experiences of patients. Separate 15:02 from that, did you ever receive a call or complaint or any information that a patient hadn't received either a followup link with the CNS or a key worker allocation?

A. Not in relation to a followup or there was no escalation from consultants or otherwise in relation to 15:02 key worker followup for any patients. It was distressing for us to hear this information brought to our attention in 2021. It was a shock to hear it and I think some of the kind of sentences that were recorded

on that day of things that the nursing team said were said out of that environment of "how did this happen? How did this take place?" I read the testimony from the family of Patient 5 and I think there's nothing that demonstrates the need for a key worker as clearly as they can, when they had it with the first diagnosis, no key worker and I think I met that gentleman and his daughters in the summer of 2020 with Mr. Haynes when the second diagnosis occurred and would have had engagement from that point forward. 15:03

474 Q. So you didn't know any of those patients initially?

A. No.

475 Q. - until the SAI process?

A. Yes.

476 Q. And you agree that there should have been a key worker allocated? 15:03

A. Absolutely and I struggled with trying to determine why that wouldn't be the case. I did note, on looking back at the evidence, that some of the patients were admitted through the Emergency Department and that progressed, you know their diagnosis. We did not have the resource to check who was on the in-patient ward at any given time. If patients were admitted through ED and were diagnosed with a cancer of whatever nature in relation to Urology, we depended on the consultant or registrar to let the CNS team know that, so that we could go up and meet them with their family and bring information to them. And we have done that on occasions, we would hope with additional resources and 15:04 15:04

the way we are planning things now that we can do, you know, there is more improvements to be made in relation to that.

477 Q. The way in which different consultants operate then involved the nurses being flexible, I suppose, around when they were available and how they became involved in the part of the pathway? 15:04

A. Yes, yes.

478 Q. You've said in your statement about the different ways that the consultants interacted with the patient to give them information about the CNS or the key worker service? 15:04

A. Yes.

479 Q. And that can be found at WIT-80962. And I'll just pick out a couple of examples. You said Mr. Glackin may have given out the pack with the contact number himself. Mr. Haynes generally requested that the patient wait until you were available. Mr. O'Brien may only have invited you into the room if the patient required nursing intervention. For example, addressing change or referral on to another service such as the community continence team or the palliative team. 15:05 15:05

A. Yes.

480 Q. So it seems they all had individual approaches to how they managed their own practice? 15:05

A. They all had variations in it, that's correct.

481 Q. You mentioned when you were made aware of the SAIs you were, I think, you were surprised?

A. Absolutely, I think I was astounded is the word I used.

482 Q. Astounded?
A. Yeah.
483 Q. And when you got that report, I know you had a meeting with Dr. Hughes in February '21, we'll come on to that, when you saw the report in March 2021 - 15:06
A. Yes.
484 Q. - was that the first time that you saw it altogether?
A. Absolutely. When we met Dr. Hughes at the end of February my astonishment came from the background that this process had been going on for three or four months 15:06 in terms of investigating the SAIs. And on reflection I would think that after one, if not two, but definitely if three people were identified as having no key worker, perhaps there was an opportunity there to engage with the CNS team or say to the CNS team, "this 15:06 is becoming a feature here, is this widespread? Is this something you know about? Can you do anything about this?"

So, I was a bit taken aback that we didn't hear 15:06 anything of that until the outcome of the SAIs were ready to be signed off as such.
485 Q. Just so the Panel is clear about the chronology, you first saw the report and we'll go to the meeting of that, that you had, you first saw the report in March 15:07 2021?
A. Yes.
486 Q. Prior to that you had been at the MDT meeting -
A. Yes.

487 Q. - when Dr. Hughes spoke about the findings. And just for the Panel's note that was the 18th of February 2021?

A. Yes, on the 18th of February he spoke to the members of the MDT. 15:07

488 Q. Let me just get that up so it will help your memory.

A. Yes.

489 Q. WIT-84347?

A. Thank you.

490 Q. Because I just want to ask you something about the notes, did you see the notes of this at any point? 15:07

A. There was no minutes circulated from this. A member of our nursing team asked for these in October or November of last year and that was the first time that we actually seen them. 15:08

491 Q. So, there is -- you'll see the attendance list?

A. Yes.

492 Q. You're on that and Mrs. McMahon is on that, Martina Corrigan?

A. Yep. 15:08

493 Q. Move further down, thank you. You'll see that he sets out the background -

A. Yes.

494 Q. - to his SAIs. And then at the start of the second paragraph he says: 15:08

"Dr. Hughes explained that the cancer nurse specialist was excluded from these patients care. Nine patients didn't have the supporting link leading to a greater

risk of fail-safe measures to ensure pathway is adhered to. Dr. Hughes said he was not sure why this happened and he doesn't know if all at MDM were aware. He has been told Mr. O'Brien didn't refer patients to cancer nurse specialists". 15:08

Is that the first time you had heard that allegation?

A. Absolutely.

495 Q. At the time you heard that, did you think -

A. That's not a familiar thing to us, no. 15:09

496 Q. And then the paragraph that we can see on the screen beginning:

"Dr. Hughes confirmed" -- just before that:

15:09

"Mr. Glackin advised he was chair of Urology MDM, he took over from Mr. O'Brien. He confirmed nurses were excluded from Mr. O'Brien's practice".

A. Yes.

497 Q. Was that -- was that the first time you had heard that 15:09 from Mr. Glackin?

A. Yes.

498 Q. And was that your experience?

A. That wasn't my experience.

499 Q. Then: 15:09

"Dr. Hughes confirmed he has been speaking to nurses and will be putting recommendations into the report to reflect this"?

A. And we were asking "what nurses?"

500 Q. Yes, I just want to ask you that because I have looked for documentation of any meeting with nurses -

A. Yes.

501 Q. - to this point and I just wondered if you could point us in the direction of any - 15:09

A. I don't know who the nurses were. I know the clinical nurse specialist Patricia Thompson had just joined our team from South Eastern Trust and she was assisting with the SAI inquiry. So there may have been queries through Patricia but certainly not, he didn't speak to us and when I said I was astounded that they hadn't met with us, I can recall Martina Corrigan saying "oh there is a meeting arranged or to be arranged" and when I look back now we got an invitation to that meeting close to 6 o'clock the evening after this meeting took place. 15:10 15:10

502 Q. So this was a meeting on the 18th of February 2021?

A. Yes.

503 Q. 6 o'clock in the evening after this meeting you were informed that he, Dr. Hughes, was to meet with the nurses - 15:10

A. The following Monday -

504 Q. The following Monday -

A. - I think it was. 15:10

505 Q. - I think it was the 21st?

A. I think that's right.

506 Q. Just on the point you've mentioned there, you're clear that he didn't speak to anyone?

A. No.

507 Q. From your team any way?

A. No, as I say Patricia was part of our team, she had only just newly joined us, she was asked to be involved as in the SAI investigation as she was seen as someone with no history in the Trust and you know, hadn't worked with any of the consultants, so she could look at this with a very open mind. 15:11

508 Q. Just to perhaps reinforce your belief that that's who Dr. Hughes was speaking about, he provided feed-back to your feed-back on the findings. I know the CNS put in a response to the SAI recommendations and we will go to it in moment - 15:11

A. Okay.

509 Q. - but just to close off this particular point about what he could possibly be referring to when he makes this statement in front of you? 15:11

A. Right, okay.

510 Q. And Mrs. McMahon at TRU 163161, now what has happened here the nurses have replied and we will look at your reply shortly? 15:12

A. Okay.

511 Q. Dr. Hughes has then marked your reply with what he thinks is the answer -

A. Right, okay. 15:12

512 Q. - to some of the concerns, you won't have seen this?

A. Right.

513 Q. I won't put words in Dr. Hughes mouth but there is a possibility that he is talking about Patricia Thompson?

A. All right, okay.

514 Q. So you will this is reply from the nurses. You've commented specifically on the SAI terms of reference makes reference to interviews with staff and you've said: 15:12

"Just to clarify that the CNS team have not been interviewed at any stage throughout the process".

A. Okay.

515 Q. "We were, however, introduced to the Review Team via zoom meeting on the 22nd of February". And that was four days after - 15:12

A. Yes.

516 Q. - I think it was the Thursday and you were all spoken to on the Monday? 15:13

A. Yes, that's correct.

517 Q. And then you've mentioned about proof-reading and the red text here is Dr. Hughes reply?

A. Okay.

518 Q. "Specialist nurses were specifically represented on the SAI Review Team with ongoing feed-back throughout the process around details and specifics". 15:13

A. Okay.

519 Q. Now I think the only nurse on that team was Patricia Thompson? 15:13

A. Correct.

520 Q. Did Patricia Thompson ever come to you and say "this is the context or the facts of these SAIs, could I have some more information as to why there might be no key

worker or why there is an allegation of CNS involvement?" Did she ever speak to you about these issues?

A. I think I can recall her asking, did we all have a key worker activity for Mr. O'Brien and we all did. You know, so whether that was feeding into it or not. 15:13

521 Q. So it was as general as that?

A. Yes, I can't remember any very specific questions in it.

522 Q. So, for example, there was no situation where she sat with you and said "Patient X, could you just take me through, they were there on Friday morning, who was on duty? Were you fully staffed? Could there be a capacity issue?" There was no exploration as to any layers beneath the suggestion that there was either no use of CNS or no key worker allocated? 15:14 15:14

A. I can't recall anything of that detail.

523 Q. I just notice the use of plural "nurses", I know you can't speak on behalf of all of the nurses, specialist nurses - 15:14

A. All right.

524 Q. But you think you would have known if any of your team would have been approached to comment?

A. I believe I would have, yeah.

525 Q. We don't need to go to this but in his evidence, members of the Panel, Dr. Hughes states that TRA-01984: 15:14

"I should say that we had a clinical nurse specialist on the Review Team with us as we were going along who

was new to the service and would have imparted into the information."

I wonder if we can just go back to the note from the -- go to the meeting with Martina Corrigan, I just notice the time and I wonder if I am just going to move on if you would like me to continue on? 15:15

CHAIR: Maybe we should take a short break and come back at 3.30.

15:15

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

526 Q. MS. MCMAHON: Just before the break we were looking at some of the interviews with Dr. Hughes and I want to look at the one that he had with Martina Corrigan, it is found at WIT-84355. And just the second paragraph, I am just going to read that out. The date of this is 18th January 2021, this is the month before the MDT one we just looked at. 15:30

A. Okay. 15:31

527 Q. "Martina advised that she worked in SHS CT for 11 years and confirmed that during that time Mr. O'Brien never recognised the role of the clinical nurse specialists. She confirmed that he never involved them in his Oncology clinics. She is aware that some of the clinical nurse specialists would have asked to be at the clinics but Mr. O'Brien never included them. Martina advised that two of the clinical nurse specialists did report that they did regularly 15:31

challenge Mr. O'Brien and asked them if he needed them to be in the clinic to assist with the followup of patients. But it got to the stage that staff were getting worn down by no action and they gave up asking as they knew that he wouldn't change." 15:32

Do you recognise any of those complaints as coming from you in that paragraph?

A. That would not be the experience that I had. I gave evidence in relation to engagement with Mr. O'Brien Uro 15:32 Oncology patients from 2010 onward from MDT started. And in those first three years when we were in the original Thorndale unit, I had the ability to be present throughout the consultations with Mr. O'Brien, Mr. Akhtar and Mr. Young at that time. And if I wasn't 15:32 available then someone else was assigned to that clinic although they would have been doing parallel work, so they would have been accessible.

When we returned in to the main footprint of the 15:32 hospital in the current Thorndale unit, the team expanded significantly in terms of consultant urologists, albeit that some of them were rotational and locums. But the team became so big that I couldn't be present at all encounters and therefore it was a 15:33 present or accessible for some of us at that stage.

528 Q. But there was always someone there?

A. Yes, always someone there, yeah.

529 Q. Now, we've asked Mrs. Corrigan about those comments in

a most recent Section 21 and the relevant parts of her reply are at WIT-94939. I just want to take you through some of these extracts -

A. Yes.

530 Q. - and will give you the opportunity to comment as I will do with Mrs. Corrigan - 15:33

A. Okay.

531 Q. - when she comes to give evidence?

A. Yes, okay.

532 Q. Paragraph 1.1, so you'll see we've asked her to look at that interview and taken extracts from it, including the extract I have read out to you. 15:33

A. Okay.

533 Q. And asked her to explain the origin of her belief or her source of information that she based that on. 15:34

A. Yes.

534 Q. If we go down to 1.1. And she said:

"When I began my tenure as Head of Service in September 2009, there were two clinical nurse specialists in post, Kate O'Neill and Jenny McMahon. I would regularly have been in the Thorndale unit as often as once or twice a week in the early years of my tenure, 2009 to 2015 and at least once per month from 2016 to 2019. The reduction in frequency was due to my workloads, when would I have called down to speak with either the CNS, the consultants or other staff. It was my impression that Mr. O'Brien didn't recognise the potential value of having a nurse with him at 15:34 15:34

clinics generally. I do not recall all the factors which led me to forming this impression of Mr. O'Brien but I believed it was influenced by things like the following. When the two clinical nurse specialists attended meetings and made suggestions about the services, examples could have been changing appointment slots for the clinics, so that there were not too many people in the waiting room, equipment suggestions, suggestions regarding training for the other nurses in the unit and so on. Mr. O'Brien, whilst he would have listened, never got involved in these conversations or showed any interest in taking forward their suggestions and I therefore personally felt that he didn't value the role that they held. This was not an impression formed I believe as a result of a single meeting but one that developed over time between approximately 2009 and 2015." 15:35 15:35 15:35

Now, Mrs. Corrigan will be asked about her impression -

A. Yes. 15:35

535 Q. - when she gives evidence but do you have any comment to make on that paragraph?

A. My impression would be that Mr. O'Brien engaged with the two CNS's as it were at that time on a regular basis. Involved us in many of his activities, supported us in learning, in achieving additional skills. Jenny and I, bearing in mind the ward management part of our role that we had to do, you know things were coming up very frequently. We did not 15:35

attend operational meetings at that stage, that only came later in the last few years. So when we got any opportunity to go to a meeting and raise an issue that we had, we generally were well rehearsed before we went. We usually went with the problem and a choice of two or three solutions and it was, "what do you think best will work?" So as opposed to going and asking for, you know, what they could bring to the table to us we provided solutions a lot of the time. 15:36

So maybe from that respect, maybe there was an interpretation Mr. O'Brien didn't engage so much but on a daily working basis that was not my experience.

536 Q. We just move up again, ask you about the statement that Mr. O'Brien never involved them in his Oncology clinics? 15:37

A. Yes.

537 Q. She says:

"The CNS team expanded in about 2014 with two temporary Band 6's being appointed, Janice Holloway and Dolores Campbell. Kate and Jenny had plans and suggestions for these two new appointments including having additional staff to support all clinics. It was during conversations with both CNS, Kate and Jenny, that they would have mentioned that this was for all the consultants although not as much for Mr. O'Brien as he rarely had a nurse in attendance at his clinics". 15:37 15:37

A. Again that's not familiar to me and my experience

Janice and Dolores stepped up, I think it was January 2015 to the end of 2016 that they were in position. And as I said earlier today, they still had to continue with the normal day-to-day running functioning of clinics as they weren't fully backfilled. So they definitely assisted us. It didn't have the impact that we thought it would have had because they weren't backfilled so much. 15:37

In relation to the conversations, that's not familiar to me, the regular and repetitive conversations that we would have had would have been in relation to overrun of the clinics and productivity and that kind of thing. And where she may have said somewhere I think you said we were worn down, we might have been worn down about those sort of factors but not in relation to this, this was not something that was in our vision, no. 15:38 15:38

538 Q. And just move up to paragraph 1.4:

"I should emphasise in this regard that I do not ever recall during any of my conversations with nurses in the unit on this broad issue, any specific mention of Oncology clinics or their cancer key worker role when they were mentioning Mr. O'Brien's none use of nurses. It was usually couched in much more general terms". 15:38 15:38

And then she goes on to refer to handwritten notes, which I will just read out, we have the handwritten notes of the minutes.

A. Okay.

539 Q. "I also note in this regard that the handwritten note of the 18th January 2021 meeting records me saying that Mr. O'Brien never involved them in clinics with no specific reference to Oncology. In this regard the handwritten note better reflects what I believe I said at the 18th January 2021 meeting, during which I would have referenced my knowledge regarding Mr. O'Brien's approach generally rather than in respect of any specific cancer or key worker role". 15:39

Then she states when the handwritten notes were provided to her on the 11th of May, just this year when the Inquiry received them. And she says at paragraph 1.5 by way of explanation: 15:39

"Of course I now reflect and accept that had I thought about the matter in more detail I would likely have realised that this approach by Mr. O'Brien might have included the nurse's cancer key worker roles. However, I believe I was perhaps less conscious or less cited as to this aspect of their work for a number of reasons including, I believe, because I did not attend MDT meetings and because of cancer as opposed to acute services role in respect of these". 15:40 15:40

So what Mrs. Corrigan seems to be saying there, if she -- her belief that Mr. O'Brien didn't involve nurses in his clinics, she should have realised it would have

included those cancer key worker roles.

A. Yes.

540 Q. If she had realised that but your evidence to the inquiry is there was no issue around that as far as you knew? 15:40

A. As far as I knew and it was never escalated to me from any of the team that he was excluding them from their role as key worker. It should be noted that the Uro Oncology Review Clinic that was held on a Friday morning by Mr. O'Brien didn't necessarily or was rarely 15:41 filled with Uro Oncology patients, there might have been Uro Oncology MDT patient first, it might have been followed by a complex patient that he was dealing with that you know he wants to organise surgery for. Then he would have seen a Uro-dynamic patient that had just 15:41 finished their procedure with Jenny, then flipped back to an MDT patient. So, that was the reason that parallel activity continued alongside it and he could come to us as needed and would have knocked on the door, put his head in and said "Kate, I am going to see 15:41 this gentleman now and do you want to join me?" And I would I have done that.

All consultants work at different rates and in different patterns. For Uro Oncology review, in my 15:41 experience the norm for any of the consultants may have been between 15 to 20 minutes or thereabouts for a review. It was common knowledge that Mr. O'Brien's appointments were much longer than that. His

appointments or his clinic were adjusted to accommodate that through the Head of Service. So his clinics were reduced from 12 to 10 and further to eight. And in latter years the eight, it would have took a considerable amount of the day to complete the eight, it wouldn't have been completed in a morning.

541 Q. If we look at paragraph 1.6 the question that has been asked of Ms. Corrigan: 15:42

"Please identify to whom you are referring when you say some of the clinical nurse specialists would have asked to be at clinics but Mr. O'Brien never included them. Detailing, how, when and in what circumstances you came to be told or made aware of this information?" 15:42

And she says:

"The nurses I am referring to are Kate O'Neill, Jenny McMahon and laterally Leanne McCourt and Jason Young. I can confirm that I have no evidence of dates and times but I believe this would have been mentioned to me occasionally during casual conversations about various aspects of the running of the unit if I had, for example, just called in to see how things were with them and the staff". 15:42 15:43

Do you recall telling Mrs. Corrigan that would you have asked to be at clinics but Mr. O'Brien never included

you?

A. No and nor do I recall any of the other members of the team bringing that to my attention either. If Martina came down into Thorndale on a Friday morning, for example, the patient that Mr. O'Brien could have been seeing have been non-Uro Oncology at that particular time and whether that was an interpretation that we weren't involved or not, I am not sure but it wasn't something that was obvious to us.

542 Q. So we put another extract to Mrs. Corrigan: 15:43

"Dr. Hughes asked if anyone expressed concerns about excluding nurses from the clinics and Martina advised that two of the clinical nurse specialists did report that they regularly challenge Mr. O'Brien and asked him if he needed them to be in the clinic to assist with the followup of the patients. But it got to the stage were staff were getting worn down by no action and they gave up asking as they knew that he wouldn't change". 15:44

And we have asked her to name the two nurses to whom she refers. And she says:

"The two nurses were Kate O'Neill and Leanne McCourt". 15:44

Before we move on to her further explanation, is that information --

A. That's not familiar to me. The things that we would been escalating to Martina on a regular basis, as I

said earlier, would have been the overrun of clinics and productivity, that kind of thing, but not that we are here and ready to provide key worker support. And at no time was I asked not to come into a room. No.

543 Q. She points out the word "regularly" in the typed note is not in the handwritten note. She says: 15:44

"I should clarify in this regard that I do not recall the nurses saying that they regularly challenged Mr. O'Brien. I note in this regard that this word does not appear in the relevant part of the handwritten meeting note". 15:45

So the handwritten note doesn't include the word "regularly" and the typed up note does. This is not verbatim account of the meeting, obviously the notes, but she corrects that. 15:45

She was asked:

"Please explain the details of how and when they reported the details you provide in this paragraph. If not to you to whom did they report and how and when did you find this information out". She says: "I can confirm this was never formally reported to me. It was occasionally but not regularly mentioned to me conversationally and in passing and in the general terms referenced in my answer to question 1. As Dr. Hughes is recorded as observing in the notes, we 15:45

all became habitualised to Mr. O'Brien's practice, and whilst we all periodically discussed the issue with each other, I can confirm that to my knowledge there was nothing formally raised in writing about the matter. I am therefore unable to provide dates or further details of these conversations". 15:46

We move on to 3.1. This is the extract we gave her.

"Dr. Hughes advised that the clinical nurse specialists are so important on the patient's journey. Martina agreed and said that this support for the CNS was vital both for oncology and for benign conditions and advised that Mr. O'Brien did include the CNS in urodynamics as it was the specialist nurse who performed the test. However, he didn't include the CNS when he was consulting with the patient after the test". 15:46

She has been asked about the source of that statement. She says at paragraph 3.1: 15:47

"I believe the source of this information was from conversations that I would have had with Jenny McMahon who did the urodynamics tests between 2014 and 2019". 15:47

We have asked Ms. McMahon to reply to that. Do you have any familiarity with that issue?

A. Well, I don't do the benign work but it would be familiar to me insofar as would I have helped out with

urodynamics if there was times at short notice somebody became sick or that type of thing. Rather than cancel a list, I would have helped out if I could. So, my limited understanding of it is that Jenny and an assistant would have performed the urodynamic studies, interpreted the results and kind of done a hand-over or presentation to the consultant in terms of the findings of that, and the consultant spoke with them afterwards.

544 Q. If we go to paragraph 4. Then Dr. Hughes has reiterated: 15:47 15:48

"At no stage were specialist nurses allowed to share patient contact with Mr. O'Brien? Martina confirmed that yes, this was correct. She also confirmed that all of the other consultants see the benefits of using a CNS and that they include them in all of their clinics". 15:48

Again, she is asked for the source of this. She states at 4.1. 15:48

"I can confirm that I was aware from general conversations with CNS Kate and Leanne that they would have occasionally mentioned in passing that most of the consultants used a nurse at their clinics and this could have been any of the other Band 5s in the unit, Kate McCreesh, Dolores Campbell or Janice Holloway, if Kate and Leanne were not available, but that this was not the case for Mr. O'Brien's clinics. To be clear, I 15:48

did not base this statement upon a review or audit of the files of patients of Mr. O'Brien".

I think that you have already provided evidence that that -- 15:49

A. Yes. I think if this would have been brought to my attention, this would have been so standout that I would have been having a meeting with the team, saying "what's going on", "give me examples of this", and "how can we address this". So, it's not something that was 15:49 familiar to me.

545 Q. Just down to 4.3. Then she says about four lines down:

"I believe that I believe this statement on a number of grounds first from speaking occasionally with the other 15:49 consultants, Mr. Haynes, Mr. Glackin and Mr. O'Donoghue, who would each have endorsed the value of having a CNS or nurse with them at clinic. Second, from the fact that nurses were not making comments to me in respect of the other consultants as they had in 15:49 respect of Mr. O'Brien about non-use of nurses and clinical nurse specialists".

And you have no knowledge of that again --

A. No, no. 15:49

546 Q. -- just to confirm. Lastly 5.2. Then we ask Mrs. Corrigan:

"Given your statements above to Dr. Hughes which you

made in January 2021, please explain the following paragraph from your Section 21 notice dated 29th April 2022 where you state that you did not become aware of the issues around key workers until November 2020 and only as a result of the SAI investigation". 15:50

She has considered the apparent conflict in that aspect of her evidence, and she says:

"I believe upon reflection and upon considering both the typed and handwritten notes of 18th January 2021, that both paragraphs are inaccurate and require revision as follows." She states: "I became", and she has added "specifically and acutely aware that Mr. O'Brien did not permit the clinical nurse specialist to provide support as key worker to his oncology patients. I only became", and she has added, "specifically and acutely aware of this from approximately autumn 2020 from the investigations into the most recent SAI patients". 15:50 15:51 15:51

Then she has added:

"I believe that this cancer key worker issue was never raised with me as a specific concern, and as the oncology multidisciplinary meetings are part of the head of Oncology Services remit, I was never involved in these". 15:51

Then she has added this sentence:

"However, as mentioned in my response to Section 21 notice 7 of 2023 at question 1, the broad issue of Mr. O'Brien's non-use of nurses and clinical nurse specialists was mentioned to me a number of times by nurses in the years prior to 2020 and I ought, upon reflection, to have appreciated the potential cancer key worker issue as a result". 15:51 15:52

A. Yes. So in relation to that, between 2010, when MDTs started, right through to the appointments were finally in place in 2020, '19 or '20, the need for additional CNSs to perform the role of key worker and holistic needs were discussed at meetings with the Head of Service and the lead nurse on a repetitive and exhaustive manner. It was on the agenda every opportunity we got to talk to them, in the same way as it was when we had opportunities in planning for peer review with the lead nurse for Cancer Services. We couldn't achieve those standards set out in the operational policy without additional resources. 15:52 15:53

547 Q. Could I just ask you at this juncture if Mrs. Corrigan or anyone else wanted to check if someone had a key worker, is that marked in a specific -- prior to the pro forma that we looked at earlier? 15:53

A. Yes, yes.

548 Q. How would I find out if they had a key worker or not?

A. Probably only from -- well, from about 2015 onward from

peer review, at that stage we would have completed an A4 page stating the information that we provided to the patient, the key worker name, and that they were provided with a contact number. We would have put that inside the patient's notes, so it would have required going to the patient's notes to see it. There was no audit process in place to allow you to do that more formally. 15:53

After peer review and with engagement with Mary Haughey, who was like service improvement for Cancer Services, we started to meet up. She was a new appointment and we started to meet up from 2016 onward in terms of how to improve things in the condensed resources that we had. One of those items was the permanent record of management. So we audited that. It was another A4 page that we audited in the autumn into winter of 2016. The findings that of were presented to the MDT team in March of 2017, and agreement from that point forward that this should be completed at every key worker encounter. Again, it would have meant looking at the patients note so it was gong to be a time resource. 15:53 15:54 15:54

549 Q. So, was it a printed off pro forma sheet --

A. Yes.

550 Q. -- saying you'd ticked the box?

A. Yes.

551 Q. Signed by the key worker?

A. Mhm-mhm.

552 Q. So it would be in the medical notes, not the nursing notes?
A. The patient got a copy.
553 Q. Was there any record in the nursing notes of a key worker being allocated? 15:55
A. No. If we were meeting a consultant with the patient, the consultant done all the scribing as such in the medical notes. There was no nursing notes at that encounter.
554 Q. If the key worker had been allocated but not used by the consultant and the consultant had hand-over leaflets, they could tick this form as well, could they? 15:55
A. They could. I wasn't in the room so I can't ensure that they did. I gave examples in my evidence that Mr. Glackin, for example, if he seen us busy with biopsies or whatever, he would have came to you at the end of clinic I seen this gentlemen, I provided the information but I couldn't determine whether he filled out that page. 15:55
555 Q. So, would someone then have gone and done that after that or it wouldn't possibly have been done?
A. Possibly not.
556 Q. But the patient had received the information?
A. The patient had received the information, yes. 15:55
557 Q. I just want to go to the meeting that Dr. Hughes had with Ronan Carroll at WIT-84342. This is on the same day as the meeting with Martina Corrigan.
A. Yes.

558 Q. I'll just read from that second paragraph.

"DH, Dr. Hughes, "described the issues regarding the lack of specialist nurses for AOB's patients and the impact that this had on the patients and family when trying to access services. He advised that AOB's use of ADT was highlighted by the oncologist in Belfast Trust who wrote to AOB to highlight issues, but this wasn't escalated further". 15:56

DH in the form of a question asked, "How did AOB practise this way?" And Ronan Carroll said, 15:56

"Believed everyone had excuses for AOB. The consensus was that he was a very strong personality who could be spiteful and even vindictive. Many of the CNS were afraid of him but Ronan Carroll was unaware that the CNS were excluded from seeing AOB's patients". 15:57

We asked Mr Carroll again about the source of this information. If we go to WIT-94962, the most recent response from Mr Carroll to that statement. You will see that there is a statement put to him and he is asked the following questions, where the source of the information is. He says - and he is referring with the meeting with Dr. Hughes - 15:57 15:57

"I believe in the meeting I was attempting to describe to Dr. Hughes my experience of Mr. O'Brien and how

difficult it had been over many years to deal with him as a difficult colleague in a robust and consistent manner. While I am unable to provide specific evidence to substantiate the comment that many of the CNS were afraid of him, it was my opinion and view that staff may have become influenced by his unique style which could be overbearing and somewhat intimidatory". 15:58

Were you afraid of Mr. O'Brien?

A. No. I read this from the information that was provided to me. I did provide information in my own evidence that visibility, accessibility and engagement with the nursing management structure above lead nurse was limited. My engagement with Mr. Carroll was extremely limited. I can tell you the dates -- not the dates but the two occurrences that I had any engagement with him. One was when he walked down into the unit, came into the office, there was only Jenny and myself there, it was during the time that we were looking at the re-banding. He didn't take a seat, he stood in the office, at the office door and asked us to clarify one or two issues in relation to that re-banding, thanked us for the information and left. 15:58 15:59 15:59

The next time that he came to the unit that I was aware of was when Covid was hitting, to tell the team what the plans would be. Therefore, I believe that he had no understanding of our working relationship with Mr. O'Brien because he never asked for it and he never 15:59

witnessed it. So, I think that assumption was made.

559 Q. Let's go down to paragraph 1.5. I'll give you a full opportunity to comment.

"In addition at the time of the meeting with Dr. Hughes I would have been aware of the 4 action plan issues identified at the end of 2016 and the start of 2017. I was engaged in the monitoring of this action plan and had been interviewed by Dr. Chada in 2017 and was aware of the more recent issues identified by Mr. Haynes in June 2020 which precipitated the Trust undertaking a lookback exercise. My awareness of the CNS not undertaking the key worker role was as a result of the SAI review chaired by Dr. Hughes. There had to be a reason why the senior CNSs, Ms. McMahon and Ms. O'Neill had not advised their lead nurse to whom they reported that they were not permitted to undertake their key worker role for patients tracked and discussed at the Urology MDT, which I suggested may have been fear on their part. I believe in the meeting I was attempting to describe to Dr. Hughes my experience of Mr. O'Brien and how difficult it had been over many years to deal with him in a robust and consistent manner. I considered that the staff appeared to have come to passively accept AOB's behaviour". 16:00 16:00 16:00 16:01

What Mr. Carroll is stating there is in seeking to understand why you didn't report the issue, he

considers that it might have been based on fear. Your evidence would seem to be that you didn't report the issue because there wasn't an issue?

A. To me, there was no fear. In relation to Mr. Carroll says he was aware of the four action plan issues et cetera et cetera, we never had any awareness of investigations going on in relation to Mr. O'Brien, not when there was a team of two and not when there was a team of five. None of the investigative processes that were happening in the background were brought to our attention at any time, either by management or by Mr. O'Brien himself, so we had no awareness of what was going on in the background. We worked as a team collectively. Mr. Carroll's interactions with Mr. O'Brien were at a management level that we would not have been privy to, so perhaps theirs was confrontational but ours certainly wasn't. 16:01 16:02 16:02

560 Q. Just go to paragraph 1.7 finally on that. He is been asked to name those who fall into the category of being afraid and how he knows that information. He says: 16:02

"While none of the CNS named in response to the question 1A above directly informed me that they were afraid of Mr. O'Brien to cause me to take further actions when Mr. O'Brien was employed as a consultant urologist, my comments relayed to Dr. Hughes were based on my general perception of Mr. O'Brien's manner. He was imperious and had a propensity to instill anxiety and/or fear within the urology team. Supporting this 16:02

perception, Mr. Haynes, a fellow consultant urologist giving evidence to the Urology Services Inquiry referred to Mr. O'Brien as "a challenge to challenge" and this is a view I also share".

Is the description in that paragraph a view you share of Mr. O'Brien?

A. No, and again I look at that as two people who were working in management role with him. So, perhaps those encounters were more difficult than what we witnessed on a daily basis. 16:03

561 Q. I just want to briefly go to the meeting notes of the meeting with the CNSs and Dr. Hughes. I am not sure we have the correct page number but we'll find it from WIT-84355. If we move on down through the pages in chronological order. It is WIT-84357 and this is the meeting on 22nd February 2021, and this was a meeting that preceded the MDT meeting. Dr. Hughes; Patricia Kingsnorth is present; Roisin Farrell; Patricia Thompson, who was on the SAI review time; Martina Corrigan; Kate O'Neill; Leanne McCourt; Jenny McMahon and Jason Young, I presume that is? 16:03 16:04

A. Yes.

562 Q. You recall this meeting with Dr. Hughes?

A. I do, yes. 16:05

563 Q.

"Patricia Kingsnorth thanked all for attending. She explained she tried to arrange the meeting in January

but it had to be cancelled due to Covid. She advised the meeting that the CNS care was not brought into question".

I think that is a theme throughout, that there is no issue with any of the CNS at all? 16:05

A. I think my interpretation is if you are not engaged with the patient or introduced to them, we didn't get the opportunity to offer the care that we could have. That's the most regrettable thing of this. 16:05

564 Q. We see Dr. Hughes is giving information about some of the families. Dr. Hughes advised that another family had a [redacted]. They talk about some of the patients, talk about the issues. He says just near the bottom of the screen, "all should have input from nurse specialists. 16:06

At this point you hadn't any knowledge of any detail of the SAIs?

A. That's correct. 16:06

565 Q. Then after setting out the background, he asks you to speak. You set out the background to the staff allocation. Then you set out the staffing issues again. Was this the first time you had been asked about capacity in relation to availability of any staff? 16:06

A. Yes.

566 Q. The bottom line there:

"Dr. Hughes advised that these were first review patients. He advised they weren't given phone numbers. He needs to know if Mr. O'Brien had an issue working with nurse specialists or was it a deficit".

16:07

Then we have a comment from Leanne McCourt, and we can ask her about that tomorrow. Jenny McMahon has also made comments and she has a further Section 21 to explain those. You've said in the latter part of that paragraph of the page:

16:07

"Kate O'Neill advised the period during 2019 Mr. O'Brien only seen reviews. She asked Martina Corrigan if this was decided". "Do you recall what that was about?

16:07

A. I think I was asking was that agreement. I can recall Mr. O'Brien saying words to the effect as he was moving towards retirement, he felt obliged to review patients who had been on a substantial lengthy waiting list for inpatient procedures, I guess to see if they were well enough to proceed, if they still wanted the surgery, if they had it done elsewhere; all of those features. During that period, he would not have undertaken new patient clinics. So, the amount of key worker involvement that we would have had with his patients had dipped in that period. I think that is what I was highlighting at that stage, was that something had been agreed with management or otherwise.

16:07

16:08

567 Q. So, you had actually said at this meeting:

"Kate O'Neill advised if there was no nurse available, other staff was available to assist".

A. Absolutely.

568 Q. Was that in the context of you being told there was nobody allocated? 16:08

A. Yes, and trying to determine how that could have came about.

569 Q.

"Dr. Hughes advised there are nine patients in the review and they were not referred to nurse specialists and three have died. He advised families were not aware of nurse specialists. He feels nurse specialists should have been embedded". 16:08

Then you have said:

"Kate O'Neill advised at MDT that nurse specialists should have been advised if available. She advised there was an audit done from March 2019 to March 2020. 88% was given nurse specialist contacts". 16:09

That was across all consultants?

A. That was across all consultants, and that's why I have attempted to determine where the patients came from and that's where I picked up some came in through the Emergency Department. 16:09

570 Q. Then Dr. Hughes asked Kate if she would send the information to him. Did you send that on?

A. I believe I did, yeah.

571 Q. "He advised he wants to be able to say resources were available but patients were not referred. He feels this is a patient's choice whether or not to avail of the support of nurse specialists". 16:09

You've said your input on this.

"Kate O'Neill gave an example of contact from a patient. She was never questioned when she added to MDM". 16:09

Further down: "Kate O'Neill asked if the SAI is to be closed at the end of the week will be inclusive of Mr. O'Brien's response". 16:10

Why did you feel the need to ask about Mr. O'Brien's response at that point?

A. I suppose we were still in a state of shock and annoyance as to where the SAIs had came to. I was conscious, as I'd said the previous week, that we hadn't been involved up to that point, and I was just asking the question has Mr. O'Brien been involved and had an opportunity to engage or provide a response, as I felt we hadn't been previously. So, it was nothing more than that. 16:10 16:10

572 Q. Now, you haven't seen this minute or this not verbatim note of the meeting until the Inquiry?

A. Not until the autumn or winter of last year. I suppose

I didn't really know the processes of SAIs, you know, where they brought it to and who all was involved. It was a query, it was a question.

573 Q. You've said again:

"Kate O'Neill advised it would be nice to work in an environment doing one job at a time. Reflected workload". 16:11

I think you have given us details of that? 16:11

A. Indeed.

574 Q.

"Kate O'Neill advised is to do what needs done on the day. If theatres need covered, their day would change". 16:11

What is that a reference to?

A. That's just a reference to clinical activity. So, you would get the schedule for the week, you would appoint the staff to the clinical activity that was planned and then out of the blue somewhere a theatre space would become available, a session for a Thursday morning or whatever, and somebody would drop their clinic to go to theatre because that was seen as the priority. 16:11

575 Q. So, at the end Dr. Hughes advised:

"There is no criticism of nurse specialist. The issues are with the person not referring patients which is best practice. He advised this review has highlighted the importance of nurse specialists. These issues are 16:11

not of nurse specialists doing".

You asked if this was be reflected in the report and both he and Patricia Kingsnorth said yes.

A. Yes. 16:12

576 Q. That was the end of the meeting. The other people quoted in the meeting will be asked their reflections on that.

A. Sure.

577 Q. In order to finish that little bit of evidence, you then and your team replied to the SAI recommendations that were ultimately made -- 16:12

A. Yes.

578 Q. -- in a draft report. The Panel will find that at TRU-163161 to 163166. You will recall that I showed a document earlier and I just want to go back to it briefly at TRU-163161. This is the Dr. Hughes comments back to -- 16:12

A. Yes.

579 Q. -- the CNS reply. You will see that you've said that none of the CNS team were interviewed at any stage throughout the process. You set out the guidelines for all patients being assigned a key worker? 16:13

A. Yes.

580 Q. You will see on one of the findings in relation to feedback from Dr. Hughes, he has taken on board one of the findings of the guidelines that were set out, so he is going to reflect that? 16:13

A. Okay.

581 Q. So, there was a bit of toing and froing, I think, about the word "failsafe"?

A. Yes.

582 Q. I want to give you the opportunity on that. Dr. Hughes was questioned about it, and Dr. Gilbert. I think, just so we understand what you are saying if the Panel have any recommendations in that regard. Just so I can remind you, Dr. Hughes had appeared to indicate in his evidence that the failsafe issue was the nurse in some way being involved in the tracking of tests and reviews and such like. But Dr. Gilbert had a slightly different angle in his evidence. We don't need to go over this but, for the Panel's note, it is TRA-01168, lines 23 and 24, where he says: 16:14 16:14

"The purpose of the cancer nurse isn't the failsafe or a safety net, it is continuity".

Would you agree with that?

A. I would agree it is continuity, yes. 16:14

583 Q. There was a bit of pushback on this. Was there a concern that maybe there would be a responsibility placed on the nurse that simply wasn't possible?

A. It wasn't a concern. If we had resources to do it, it wouldn't have been a concern. However, there could not have been, and there was not in the operational policy, any indication that the nurse specialist or key worker would be responsible for the follow-on of ensuring that onward referrals took place, that results were signed 16:15

off or that type of thing. I think I have provided the evidence in relation to the final year that I worked on my own as a urology nurse specialist, 2016, in terms of the numbers that came through the service at that time. I only asked for this in the last six months to try to clarify for myself where we were at that time. If I can recall them correctly, in 2016 there were 444 new urological diagnoses and one CNS. The comparison I asked for was with the breast team, and there was 274 diagnoses and 2.8 CNS. So, we were struggling. That was a difficult year. 16:15 16:16

584 Q. Just before I go on to learnings, just to finish off, the Panel has heard some evidence that the separate or not necessarily distinct but sometimes perhaps unhelpful lines of management with operational clinical can perhaps be a block to good governance. It seems in your statement that you found the separation of roles was positive for you, and I'll just read from your statement? 16:16

A. Yes. 16:16

585 Q. WIT-80906. And your line manager had both operational and clinical responsibility, which allowed you then to access the best of both worlds?

A. Yes. That was it. All three parties, the CNSs, the lead nurse and the Head of Service could all bring different skills to those conversations. I found that beneficial. 16:17

586 Q. The Panel will find that at paragraph 5.4. You said:

"From 2009 to present the line manager for operational and clinical activity became separate entities with formal separation between the Head of Service and the lead nurse. I did not consider that this separation of oversight caused any difficulties to my practice or for patient care and risk management. I considered the various skill sets that each individual brought to these encounters to be beneficial and indeed enhanced discussions. All three participants, the Head of Service, lead nurse and CNSs, would have worked together to address issues of patient care and risk management". 16:17 16:17

A. Yes.

587 Q. Just in relation to improvements, I think you've peppered your evidence with examples of that. Would one of the biggest improvements have been increased capacity since the incidents -- 16:18

A. Increased resources?

588 Q. Yes. Sorry, increased resources.

A. Without a doubt, and there is more to be done in relation to that and there is more appointments pending. It has transformed my working life. For sure. Now after MDT, we look at the rota. You are assigned to the uro-oncology clinic on the morning of the clinic. We start at 8:00 a.m., so between 8:00 and 9:00 you prep that clinic, you know what's coming; in fact you usually have all your documents ready, all the packs are required. The recording of the CNS pro forma will allow us to audit that service. Again, the input 16:18 16:18

from the audit team in cancer services on that monthly database will allow us to check things.

In addition to that, I no longer have to organise the entirety of the prostate biopsy clinic. We have support to do that from two consultants' secretaries, and that has improved things significantly for me.

589 Q. In relation to other issues around the specific key worker allocation, you feel the issues that arose, for example those nine SAIs, is the potential still there for those issues to arise again? 16:19

A. I think we have eliminated that significantly. There is still improvements that I feel could be done and we'll work towards those. One of those would be more engagement with the ward-based patients, whether it could be considered or not going forward if we had sufficient resources to actually have a CNS on the ward round. You know, that provides a format for engagement with the ward staff and patients. 16:19

590 Q. You were involved in the lookback exercise that was carried out in reviewing? 16:20

A. Just which part of it now?

591 Q. At WIT-80977, you are referring to the lookback exercise in relation to the role of the Cancer Tracker and the benefits of tracking patients past their first appointment. Is that improved, in your experience? I know the Panel heard the Cancer Tracker evidence this morning, but from your experience is that system in any way better for you? 16:20

A. I think there is still improvements to be made on it. I'm not sure if they are still funded to only go to that point of first definitive treatment. But there certainly is more engagement in relation to the audit processes. 16:20

592 Q. Now, you've said, looking back in your statement, that you didn't think governance arrangements were fit for purpose, and the findings indicate a disconnect between Urology MDT and Cancer Services management. Is that something that you still feel -- 16:21

A. I felt from the outset when the Mandeville Unit opened, you know, where people went for cancer treatment at the hospital, there was no footprint at all for Urology within that setting. I found that strange. To me, it removed the opportunity of meeting people on the 16:21 corridor or seeing the door open in an office where you could put your head in and say 'any progress with, you know for example, the advertisement for the CNSs, or any new equipment requirements. We didn't have that. They were in their corridor and we were in ours and the two 16:21 never passed, except there you would have seen these people at the AGM or MDT. There wasn't engagement all the time.

We would have worked closely with the cancer trackers and 16:22 red flag team. They would have been in and out of the unit so we would have significant engagement with them.

593 Q. Is that the situation now; is it still that disconnect?

A. There is more to do. I thought about these just

recently. We are as a team improving and striving to continue to improve. I have no doubt the cancer team is doing that and others, but we just haven't had the opportunity yet to come together and say what all has been achieved thus far, and collectively how much further can we go. 16:22

594 Q. I have just taken some highlights from your evidence because it is very detailed. Is there anything else you would like to add at this point or anything you would like to say? 16:22

A. The things that I would add is, strangely enough despite all of the resource issues, I have enjoyed working with Urology. I have felt surrounded by people who are engaged to do the best for the patients. Despite retiring, I came back for two days for more punishment. We get up every morning to come in and do our best. It's highly regrettable that the SAIs exposed an area where we weren't allowed or included in patients' care. That was very regrettable and I apologise to those people and their families for that. 16:23

595 Q. Thank you. I have no further questions but the Panel may have questions for you.

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS: 16:23

CHAIR: Thank you, Ms. McMahon. I am going to hand you first of all to Mr. Hanbury who I think has some questions.

596 Q. MR. HANBURY: Thank you for your impressive evidence. I have a few clinical questions, which you will find very easy hopefully. On the subject of MDM quorum first of all, obviously starting with urologists, what was your impression of how many were normally there, because you were the best attender by far? 16:24

A. For urologists themselves?

597 Q. Yes.

A. The MDT wouldn't have continued unless there was a minimum of two. 16:24

598 Q. Who were they, normally?

A. From a selection but there was more often more than two. So, Mr. O'Brien, Mr. Haynes, Mr. Glackin, Mr. Suresh, and all of the locums as they came and went. 16:24

599 Q. Mr. Young, you sort of took me by surprise when you said he had a clinic then?

A. Yes. Mr. Young stepped back from MDT and was, in latter years, less involved with cancer work, so more to do with stones and that kind of thing. 16:24

600 Q. And Mr O'Donoghue similarly?

A. Mr O'Donoghue would have been at MDT.

601 Q. He would have been there?

A. Yes.

602 Q. Then going on then to the sort of quorate, we have had heard a lot about oncology and how sort of disappointing that was. It must have been. But what about radiology particularly; do you want to say anything more about that? 16:24

A. No. Radiology was similar to oncology. In the early years, there was just one radiologist assigned to MDT, so if he was on leave then that required patients to be rolled over, as they termed it. To the following week.

16:25

Now, there was instances where a patient's -- it was time critical that they were moved forward, and we would have engaged with the Belfast regional team to seek their assistance in those situations, and they were very receptive to that.

16:25

603 Q. That was when you logged in on the sort of specialist part of the...

A. Yes.

604 Q. Was there ever a time when you felt there was just not enough people there, sort of you considered really you couldn't carry on?

16:25

A. I was very conscious of the frustrations of it all down through the years. I think it reached a peak at one stage, and I can't recall what year, it may have been after Mr. Glackin started to chair it, where there was a consideration should we actually cease and desist, you know, until somebody somewhere grasps this and helps us with it.

16:26

605 Q. Do you think in retrospect maybe you set the bar not quite right; maybe that word might have provoked a response?

16:26

A. If we had ceased and desisted? Maybe it was eight years later than we thought about it, you know.

606 Q. Just going on to sort of more your role at MDMs.

Obviously one is provided with a list of patients and how they come through and what have you. Presumably you keep a record of who you see as a CNS team?

A. Yes.

607 Q. There is theoretically a chance to compare one list with the other and spot the gap, as it were? 16:26

A. Absolutely.

608 Q. Did you do that?

A. However, if you were assigned as I was, I was always -- if I was there, not on leave, I was available for 16:27 Mr. Glackin's clinic, I was available for Mr. O'Donoghue's, so theirs was always going to be higher. Mr. Haynes, he would have brought the notes down and the patients would have waited et cetera. So, it dwindled down. When Mr. O'Brien ceased doing new 16:27 clinics, that reduced the amount of key worker activity because the same amount of patients weren't coming through for key worker for him, and I wasn't always there on a Friday. So I expected to have less for him but no one raised a concern that they weren't being 16:27 seen at all. As I said, I have acted at key worker points, critical points for patients throughout their journey; patients that belong to Mr. O'Brien.

609 Q. I absolutely agree. It is just a question to identify your 12% or so because we are talking about hopefully 16:27 small numbers there?

A. Absolutely. Was it audited in that manner, no.

610 Q. In retrospect that might be a thing to do for the future maybe?

A. The data that we are collecting now will allow you to do it. We know it is there.

611 Q. Exactly. Thank you for your evidence on that. On a similar sort of line, you mention this, it is understandable you can't produce skills in outreach clinics as well? 16:28

A. That's correct.

612 Q. Was there a move to say get Mr. O'Brien's, or whoever's patients they were from the regional clinics back for their first diagnostic appointment to Craigavon. Was that considered? 16:28

A. Well, I said earlier that I can't recall it being discussed in any formal setting, but my awareness is that Mr. Glackin for example, made a decision to return his patients, uro-oncology patients to Craigavon except if they couldn't attend for transport reasons or whatever. It is very different when you're looking at Enniskillen, it's a long way from Craigavon and patients would have readily expressed their concerns for transport issues and getting two or three buses to attend an appointment, so they might not have been as keen to return back to our setting. 16:28 16:29

613 Q. I accept that, but you could flag up, because you have access to the addresses --

A. Yes. 16:29

614 Q. And you could make a special effort to contact them?

A. And, you know, with the resource we absolutely could. Throughout the period of time that Mr. Young and Mr. O'Brien were attending Enniskillen clinic, Mr.

Young's practice generally would have been to emailed me and said I've met this gentlemen, he requires prostate biopsies, would you be able to organise this, this is his background, and he would have sent that to you. 16:29

Mr. O'Brien practised differently. He would have phoned you from the clinic if you could take the call. He would have had the phone on loud speaker, he would have introduced you virtually to the patient and the 16:29 patient and I would have set up the appointment for prostate biopsy. But that never happened for anyone that required oncology or key worker input.

615 Q. Thank you. Just a couple of questions on outpatients. Mr. O'Brien says that you kindly shared your experience 16:30 seeing some of his follow-up clinic patients in prostate cancer?

A. Yes.

616 Q. Did you ever see any patients on a sort of non-standard dose of anything as part of your review? 16:30

A. Not that I picked up that time. There was very little review clinics being done then because of the resource issue. It was miniscule of what was happening in terms of numbers. Again, I had no administrative support to help out with that. So the numbers were very, very 16:30 small and the majority of them were like watchful waiting, that type of patient; unfit to undergo treatment.

617 Q. So nothing untoward ever came across your desk?

A. No.

618 Q. Just last question. There was some discussion about letters being copied to patients. What's your view of that, because I was interested to see that you frequently copied your letters to patients -- 16:31

A. Yes.

619 Q. But that wasn't commonly done?

A. Yes. It wasn't a practice that everyone done, in the same way when you were sitting in with various consultants at uro-oncology clinics, people work 16:31 differently. Some people wrote down the majority of the consultation; others would have dictated that immediately after the consultation. So, people practised differently, but you had to be in the room to know what the practice was. 16:31

620 Q. I guess that's my point. Do you think it is important that patients do get a copy of their letter, is a more direct way of --

A. They are one of the main members of the team that's making the decision, they have to be engaged in it. 16:31 Any virtual clinics that I am doing, they will get a copy of that letter.

621 Q. Thank you. Thank you very much.

622 Q. DR. SWART: Looking at what you have been doing, you seem to have had a very broad, very multitasking role 16:32 with some pretty impressive things done in an innovative way.

A. I agree.

623 Q. It is unusual to have a specialist nurse doing so many

different things at once. Where did you get your inspiration and guidance and challenge from, from a more senior level. Who was there saying have you thought of this, have you thought of that?

A. Many people. I hope I don't get too emotional saying this. The most significant was the first ward manager, the late Eileen O'Hagan. Very inspirational in her work. We were also supported as well by a member of staff who -- I just forget his title, it has gone from me in this instance. He engaged with urological education in what was then the University of Ulster, now Ulster University. We had a lot of contacts there. 16:32 16:32

At the beginning of Urology, we were a young team, we were all learning together. It was nearly coerced amongst each other - "if I go for this, if I try a few modules, will you do it too", so we helped each other along with it. We enjoyed our work. The fact the reason we enjoyed it is because we were surrounded by people who encouraged us. 16:33 16:33

624 Q. What about did you have a senior cancer nurse in the Trust. I can't see that there was one. I see you have a lead nurse. Did you have someone who was really championing the role of cancer nurse specialist, beating at the door? 16:33

A. No, not for us. In fact, Jenny and I were doing that on our own behalf --

625 Q. Yes, I can see that?

A. -- because a lot of the lead nurses that were appointed

at the level above us had no urological experience at all. And a bit like introducing the new locums, we felt it was quite repetitive with the appointments of lead nurses down through the year; hello, this is who I am, this is what I do, this is our desire to move forward, this is what we want to expand; how can you help us with that.

626 Q. So, I can see a lot of self-direction --

A. Absolutely.

627 Q. -- in the evidence, but was there any Northern Ireland wide forum where you had a chance to learn from others, present your work, but also receive a bit of challenge because we all learn from what, don't we? 16:34

A. We would have met as a CNS forum for a period of time, some number of years ago, maybe twice a year. At that time it would have been supported potentially by a drug rep. They would have organised it in some central place, had a light evening tea. It was usually in the evening time in our own time. Had a light evening tea; they done a presentation on whatever their aspect of care or treatment was, and then they left the room to us for an hour, an hour and a half and we would have shared our experiences at that time. So, yes. 16:34

628 Q. But was there an annual ability to do that? Cancer Services Craigavon -- 16:34

A. No.

629 Q. -- presenting to the region about our challenges with maintaining peer review standards or whatever?

A. No, not with CNSs. The only opportunity that I got to

do that was with the patient and client experience group.

630 Q. I wanted to ask you about telephone calls from patients?

A. Yes. 16:35

631 Q. Following on from Mr. Hanbury's question. It has been clear to us that many patients didn't receive copies of clinic letters from consultants and so on. Most people now would do that because it's easier for the patient really. How much time did you spend answering phone 16:35 calls from patients with queries about what was happening to them?

A. So they would have been periodic and they would have been shared by any of the team; whoever received the phone call attended to it. It wouldn't have been very 16:35 frequent at all.

632 Q. It wasn't substantial amount of time every day?

A. Absolutely not. It escalated massively during Covid but that was by other factors outside our remit - access to GP and that type of thing. It excelled 16:35 during that time. But not a very frequent thing.

633 Q. What would happen? Did you have a set of process for it, did you try and deal with it; what did you do?

A. So, for example - and I have provided this in my evidence - I had a phone call late 2019 from a key 16:36 worker patient who was concerned that he hadn't received an appointment in Belfast for consideration for radiotherapy. I emailed the consultant's secretary stating the patient was seen on this date, I think it

was two weeks previous, it is now this date; has this information been dictated and forwarded on? She came back to me it hadn't been because the patient was going to have urodynamics done the following week and they were combining the two together.

634 Q. So if the patient rang, you would try and sort it out?

A. Absolutely, and that was with the engagement with any of the consultants where it was necessary.

635 Q. What about if the secretaries got phone calls; did they ever ring you saying patients are ringing us and we don't know what's happening? 16:36

A. They would have rang us for interpretation of things maybe, or if, for example, MDT had occurred, we had seen the patient but the dictation wasn't typed up. At that time they might have rang us, can you recall what happened in this instance. Very often they would have put the patient call through to us after consulting with us first, or we would have phoned the patient back. 16:37

636 Q. Just going back to the nine patient SAI. When you were astounded by that result, did you accept the result? Did you go back and check if they had been allocated a key worker and it was a mistake? 16:37

A. Yes. I accepted the findings because they were the lived experience of the patients and their relatives so I didn't contest that. 16:37

637 Q. You didn't say it wasn't right?

A. Exactly. I did go back and look. I did have encounters with three out of the nine but after the

SAIs at a later point in their care pathway.

638 Q. It wasn't a mistake, is what I am trying to say?

A. No, not at all.

639 Q. Thank you. That is all from me.

640 Q. CHAIR: Just very briefly. You talk about yourself and Jenny having being your own advocates in terms of cancer specialist nurse work. Did you ever team meetings with the other? I know there were the two of you for long enough. You were on your own, first of all, then the two of you for long enough. As a group, as a small group of people, did you ever have team meetings and discuss issues and, you know, ever then have any idea of how things were going with the rest of your team? 16:38 16:38

A. Do you mean with the consultant team? 16:38

641 Q. Nurses; I am talking about the nursing body. I am talking about the Urology CNS team and Leanne McCourt and Jason Young?

A. Yes, as they all joined, absolutely, because we wanted to determine people's interest because I think if people are doing something they enjoy, they are with you longer. So, we wanted to determine what their interests were and then set out a pathway of learning for them, and education and support. 16:38

642 Q. How often would you have had those meetings? 16:39

A. We would have had them like informally, chats all of the time. Formally, probably on a quarterly basis or thereabouts.

643 Q. At those quarterly formal meetings, was there a proper

agenda for things to be discussed? Were they minuted? How were they conducted?

A. How were they conducted? Items for the agenda would have been brought by any of us. Our concerns were nearly always similar or shared anyhow. It was always how would we improve things based on those. 16:39

644 Q. Are those the times -- when you say that you would have known if any of the team had any issues with any of the consultants or if they had any issues about being excluded, for example, from, as we have heard from Mr. O'Brien's -- 16:39

A. I feel that I would have known before a meeting. If any of the staff had a concern, they would have readily have come in with it. Readily have come in.

645 Q. It was that type of working environment? 16:40

A. Yes. It was a small tight environment. With ease they would have came to Jenny or I with issues like that.

646 Q. You didn't work on a Friday, certainly from 2015, so you wouldn't have been involved in any of Mr. O'Brien's Friday clinics after that date? 16:40

A. Yes, that's correct.

647 Q. The description you've given us is of how busy you all were. If it was Mr. O'Brien - and I am speculating because Mr. O'Brien can speak for himself - but if he felt that you were all very busy doing other things and wouldn't have been right to involve you, do you think that might have been a reason for him not calling on people? 16:40

A. I guess that is something that Mr. O'Brien has to

answer. But he knew the team so well that they all reported engagement with him. Mr. O'Brien's patient experience would have said to us, you know, he was very engaging, he gave them great time, he was thorough in his consultation with them and they appreciated that. For us, maybe the downside of that was the length of time that some of those consultations took.

648 Q. Given what you have said about Mr. O'Brien, and obviously he held you in high regard, can you understand why key workers weren't appointed in these cases that we are looking at? 16:41

A. I can't determine that because when I forwarded the information, in 2016 I think, the emails that I gave in, about what we wanted to do in terms of key worker, the only consultant to respond was Mr. O'Brien to that email. He responded saying thank you Kate; words to the effect of this will assist us in making progress with key workership, I think he called it on that day. 16:41

649 Q. So you have no reason?

A. No reason or explanation as to why it occurred. I deeply regret that it did. 16:42

650 Q. Okay, thank you very much.

A. You're welcome.

CHAIR: It's now longer than I thought, 4.45. Tomorrow morning then at 10 o'clock. 16:42

THE INQUIRY ADJOURNED to 10.00 A.M. ON WEDNESDAY, 17TH MAY 2023