Urology Services Inquiry

Oral Hearing

Day 10 – Wednesday, 16th November 2022

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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Gwen Malone Stenography Services

THE INQUIRY RESUMED ON WEDNESDAY, 16TH DAY OF NOVEMBER, 2022 AS FOLLOWS:

CHAIR: Good afternoon, everyone.

MR. WOLFE KC: Good afternoon. Your witness today, Chair, and into tomorrow, is Mr. Mark Haynes, Consultant Urological Surgeon. I think he is going to take the affirmation. 14:05

MR MARK HAYNES, HAVING AFFIRMED, WAS EXAMINED BY MR. WOLFE KC AS FOLLOWS: 14:05

1 Q. There should be some water for you there, Mr. Haynes. I am going to start this afternoon by welcoming you to the Inquiry. Thank you for coming along to give your evidence. The Chairman, Ms. Smith, is sitting in the middle, and you can see the names of her Panel members. 14:05

You have, in advance of today, prepared a Section 21 response, which I will, in shorter terms, call a witness statement, and you will know what I mean by that. Can that be brought up on the screen for Mr. Haynes? It's at WIT-53861. You will no doubt recognise that, Mr. Haynes. If we could shuffle along to the back of it, at the last page. WIT-53959, and that is your signature? 14:06 14:06

A. Yes.

2 Q. Before I ask you whether you wish to adopt your statement, I understand that you have one or two

observations to make in relation to it?

A. Yeah. Sorry, in going through it again, I picked up a couple of corrections, so at 5.1.B, which covers my appointment as AMD, it should read "until August 2021" not 2017.

3 Q. Let me slow you up. It's 5.1.B, the typo, it should read 1st October '17 to August?

A. '21.

4 Q. '21. Delete '17 and insert August '21. Okay.

A. The second one is at 62.7. This paragraph -- 14:07

5 Q. Just wait until we get there. So it's WIT-53937?

A. This paragraph refers to late 2016 and then into early 2017, and when I read that I realised the line relatively soon after later starting at AMD is incorrect. It should read instead "in late 2016" as at 14:08 that 5.1.B I only started as AMD in 2017.

6 Q. Okay. Are those the only corrections you wish to make?

A. Those are the only corrections that I have noted that I wish to make. Additionally, I would just like to take the opportunity to, in person, apologise for being 14:09 late with my statement, despite the extensions I was given.

CHAIR: Thank you very much, Mr. Haynes.

MR. WOLFE KC: In light of all of that, Mr. Haynes, do you wish to adopt your statement as part of your 14:09 evidence to the Inquiry?

A. Yes, I do.

7 Q. Another housekeeping matter. You should have in front of you a cipher list. That's a list of patient names,

giving them a number instead of a name when you wish to refer to them. In short terms, when you wish to refer to a patient, use the patient number, even if it takes you a bit of time to try and find it. I realise the list isn't in alphabetical order. At various points, 14:10
I will bring documents on to the screen. In fact, there's one in front of us containing a patient's name which has not yet been redacted. Clearly, no-one in this chamber should use the patient's name; always use the patient number. We are, all of us, subject to the 14:10
Restriction Order handed down by the Inquiry.

You are here with us, Mr. Haynes, through to tomorrow. In essence, the Inquiry wishes to obtain, through your evidence, a better sense of the Clinical and 14:10
Administrative issues and incidents of concern relating to Mr. O'Brien and the way he practised, which led, eventually, to the events of 2020; the Early Alert and the announcement of this Inquiry. You were in post for six years by 2020, and by that time, I will be 14:11
suggesting to you, that you had an opportunity, both as a colleague and as a manager, to witness what the Trust has referred to as concerns at close quarters. Hopefully you will be in a position to assist the Inquiry, along with your other colleagues, in terms of 14:11
how the Trust addressed those concerns, and whether they were adequately addressed, from your perspective; and if not adequately addressed, what could and should have been done differently, and what may have impeded

the implementation of an adequate response.

This is undoubtedly going to be the initial phase of your evidence. I have spoken to you, for the record, on Monday of this week, and there's many issues that we won't be covering this afternoon, including, for example, the Governance structures, MDM, that's the multidisciplinary way of working. Some issues will be touched upon but briefly, and will need to be revisited in due course. 14:12

Let me start by asking you some questions about your career to date.

You took up post at Craigavon in the Southern Trust in 2014; isn't that right? 14:12

A. Yes. I started work in Craigavon on 14th May 2014. Prior to that, I was a Consultant in Sheffield Teaching Hospitals and I'd started there, having finished my training on the South Yorkshire training rotation. 14:13 I started as a Consultant in Sheffield on 1st April 2010.

8 Q. When you moved to Craigavon, it was into the position of Consultant Urological Surgeon; isn't that correct?

A. Yes, yeah. 14:13

9 Q. You have told us in, your witness statement, that within that role, you had no management responsibilities at all?

A. Not when I initially took up post.

10 Q. In the role of Surgeon, you were responsible on the Medical side of management to the Associate Medical Director, who, at that time, was Mr. Mackle, and then Dr. McAllister; isn't that right?

A. Yes. 14:14

11 Q. On a day-to-day basis, there was a contact with Mr. Young in particular, Mr. Michael Young, who was the Clinical Lead within Urology?

A. Yes.

12 Q. Then on the operational side, you were accountable to the Director of Acute, who at various points was Mrs. Burns and Mrs. Gishkori? 14:14

A. Yes.

13 Q. I suppose, on a more local level within the Service itself, you had frequent contact with Mrs. Corrigan? 14:14

A. Yes.

14 Q. Who is the Head of Service. At that time in 2014 you joined a Consultant team that comprised Mr. Young, Mr. O'Brien, Mr. Suresh, Mr. Glackin; isn't that right?

A. Yes, that's correct. 14:15

15 Q. Then later that year you were joined by Mr. John O'Donoghue?

A. Yes.

16 Q. As time moved on, you entered into the managerial sphere within Acute and then, more specifically, within 14:15 that part of Acute that covered Urology. Let me just briefly step through that, and then we will focus on aspects of it. As I understand it, from 1st June 2016 through to 30th September '17, you were Clinical

Director within Surgery and Elective Care?

A. Yes.

17 Q. But you were on the side of the fence dealing with Trauma, Orthopaedics and General Surgery but not dealing with Urology? 14:16

A. Yes, that's correct.

18 Q. Whereas you continued to practice as a Urologist, that managerial role was on the other part of Acute dealing with those?

A. The other part of Surgery and Elective Care. 14:16

19 Q. Yes. I think it was Mr. Weir who was Clinical Director covering Urology at that time?

A. Yes.

20 Q. Again, just stepping through your career during those years. In April 2017, you took up a post in the 14:16 Belfast Trust dealing with nephron sparing surgeries; is that right?

A. Started providing part of my week within Belfast Trust, it wasn't a separate post but part of my working week was providing nephron sparing surgery in Belfast Trust. 14:17

21 Q. Was that every week?

A. That was every week. There was a Thursday and a Friday when I would have done activity at various points during the period of time since then. It was initially intended as a temporary one year arrangement to cover 14:17 a sabbatical period, but at various points it's been every Friday and alternate Thursdays, and evolved now to a position where it's all day Thursdays and all day Fridays.

22 Q. Just moving along that timeline. As you have told us already today, 1st October 2017 you took up the managerial position of Associate Medical Director within Surgery and Elective Care and that did cover Urology? 14:18

A. Yes.

23 Q. Just before taking up that role, in September 2017 you became Chair of NICaN in that particular area of NICaN covering Urology; is that right?

A. Yes. I became Chair of the NICaN Urology Clinical Reference Group. I chaired my first meeting in September 2017. 14:18

24 Q. What kind of time commitment did that take from you?

A. Within my job plan, for instance, now it occupies a two hour period of each week. The reality is, from week-to-week, it can occupy anything from considerably more to just about that, two hours or sometimes less. 14:19

25 Q. You still hold that post?

A. Still hold that post, yes.

26 Q. I see from your witness statement that in August 2021, you took up the position of Divisional Medical Director within Surgery and Elective Care. Is that in essence, or was that in essence, the same position with a different name as Associate Medical Director, or was there a tweak to it? 14:19 14:19

A. It was in essence fulfilling the same role, but the job descriptions were, if you like, redeveloped or made more specific.

27 Q. Yes.

A. I think on appointment as AMD it's for an initial period of three years and so, as a general rule, a re-advertisement and re-interview for those posts.

28 Q. I'm struggling a little to hear you, Mr. Haynes. Is everything okay on the stenography? Yes. 14:20

Then in December 2021, you took up a role described as Divisional Medical Director Urology Improvement on Secondment. Could you help us with that? Do you still retain Divisional Medical Director role in addition to 14:20 this other role?

A. I was seconded across to specific responsibilities within relation to Urology and Urology Improvement at that point, with Ted McNaboe who was a Clinical Director has been seconded to be the Divisional Medical 14:21 Director for Surgery and Elective Care.

29 Q. The Urology Improvement role then, is it fair to say that that role has been created to deal with the issues that have arisen out of 2020 and the kinds of issues being looked at within this Inquiry? 14:21

A. Yes.

30 Q. We will maybe have an opportunity to deal in more detail with that in due course. Rewinding slightly to your appointment on 1st October 2017 as Associate Medical Director. That post had lain vacant for 14:22 roughly a year. Dr. McAllister gave up the role or stood down from the role in late 2016, is that right, that the post was vacant?

A. Yes. The post was vacant and as was communicated to me

and the Clinical Director at the time, we were to essentially act within our roles and escalate to the Director for Acute Services or Medical Director at the time for the professional issues.

31 Q. To what extent during that period of vacancy were you acting up in the role or carrying out, even informally, some of the aspects of the Associate Medical Director role? 14:23

A. Ultimately without an Associate Medical Director, the two of us, the two Clinical Directors inevitably would have had to take on some of the roles and functions of the Associate Medical Director, as would the Medical Director have, if you like, acted down and taken on some of them roles. 14:23

32 Q. In terms of the role itself, could we have the job description on the screen for us, please? It's WIT-53997. Before we look at the job description itself, Mr. Haynes, how do you see that role looking back on it now, leaving aside the job description? I suppose, in a nutshell, what did the role involve? 14:23 14:24

A. A whole host of things. I mean, from a professional management perspective, there was the oversight of Job Planning and that side of the professional, if you like, contractual parts. There were Governance aspects to the job. There were also, inevitably, operational day-to-day aspects in terms of running Services, particularly as -- this started in October 2017, but if we move into 2018 and 2019, operationally we had challenges within Surgery and Elective Care relating to 14:24

bed pressures, relating to delivery of theatre time. Then obviously moving into 2020, Covid created an operational issue. There were, if you like, strategic and professional aspects, but there was very much an operational aspect to it as well.

33 Q. In terms of some of the professional aspects, could I scroll down, please, to WIT-53997? Just let me have the top of the page. Sorry, yes, we are on that page. Then down to the second paragraph, please. The job summary, if I could step to the second paragraph says: 14:26

"Specifically the AMD will be responsible and accountable for the medical staff within the Speciality and their role in the provision of services. As a Senior Medical Leader within the Trust the AMD will work closely with the Director, Assistant Directors of Acute Services to provide medical management within the Directorate and contribute to the overall provision, direction and performance of the organisation."

If I skip on to the next sentence:

"The AMD will also be responsible for the safety and capability of the medical workforce within the Speciality, providing the Director of Acute Services with defined information for assurance purposes to the Medical Director."

In terms of the professional aspect of the job, how

were you able or how did you try to pursue the idea that you would be responsible for the safety and capability of the medical workforce?

A. Within each Service, within Surgery and Elective Care, each team would have had Patient Safety Meetings or previously called Morbidity and Mortality Meetings which would occur monthly and would be regular discussions within that team of patients where they suffered morbidity, so perhaps a complication of an operation or an unexpected re-admission after an operation, and would also discuss deaths within the Service while inpatients. That meeting would discuss, and from each Speciality, escalate any concerns or raise any concerns through that which would have come through. In terms of my role within that was ensuring that they happened, that the Clinicians were available to attend them, and that there was a Patient Safety Lead for each of the Specialities within Surgery and Elective Care. 14:27 14:27 14:28 14:28

Aside from them, there's the SAI process or the instant reporting process, which ultimately can lead to SAIs. There was a screening element or a responsibility with the AMD to go through instant report forms as part of a team, assessing them for those which required a further look into as an SEA or SAI, or those that perhaps didn't meet that threshold or criteria. Once the SAIs and SAIs had reported, they came through the Acute Clinical Governance meeting and as an AMD, along 14:28

with other AMDs, I would have sat on that, which is where the reports were presented and signed off. Then, following them reports, recommendations, some would have responsibilities within me or the teams working as part of the Clinical Teams within Surgery and Elective Care. 14:29

There was the complaints processes as well. We'd have an awareness of complaints within Specialties and within the Services. They would be reviewed through the Assistant Director. We had meetings where the complaints within the Specialties would be -- you'd have some oversight of what complaints were about, so if there was any themes from them -- I've lost train of thought now, sorry. 14:29 14:30

34 Q. You are describing the various issues that could come before either of those two forums, either Patient Safety or the Governance Committee?

A. Yes. Then there was also some oversight of litigation. We were made aware of any litigation, potential litigation, and also made aware of any outcomes of litigation again to be able to look for themes. 14:30

35 Q. Is there potential within that kind of system where perhaps you are getting individualised reports of patient endangerment, or a complaint, or a risk; is there a potential within that system to draw separate straws in the wind together and to identify perhaps in an individual practitioner a cause for concern? 14:31

A. Unfortunately, my experience is that the potential of

that lies within the individuals who are perhaps receiving all of that. I think it's pertinent too, as you said, the AMD role; if you have a period of time without one, and as I have said in my statement, "and no handover", so I'm perhaps unaware of things that have come before me, so I'm starting with a fresh page, and so if it's reliant on me to draw strands together or a pattern together, it will take a period of time for me to develop that pattern recognition. 14:31

36 Q. Does the Head of Service on the Operational side, did Mrs. Corrigan attend either of those kinds of meetings, or were these Clinical meetings? 14:32

A. So, the Patient Safety meetings, Mrs. Corrigan would have attended but covered both ENT and Urology, so would not have attended all of one Speciality, so would have attended one sometimes, and one another time. I mentioned that the Assistant Director would have had meetings, and I mentioned complaints. There would be a regular meeting of him with the team where she would have been part of that meeting. 14:32

37 Q. Just scroll down to WIT-5399, just two pages down, under the heading "Clinical Governance responsibilities". This draws out some of the systems and processes I think you were referring to, Mr. Haynes. It says in the second paragraph: 14:33

"You will be directly responsible to the Director of Acute Services for Patient Safety. This includes ensuring processes are in place to identify, review and

take remedial action when Patient Safety issues arise."

If we can focus for a moment on the kinds of issues relating to Mr. O'Brien that we were coming across your desk or if not coming across your desk, were known to the Service from October 2017, did any of those -- and pick any item at all, whether it's a Triage issue or a dictation issue or a failure to action on investigations -- would those kinds of issues have come across any of the forum that you have just described? 14:33 14:34

A. Specifically in relation to Mr. O'Brien, the SAIs reports when finalised did come through Acute Clinical Governance, but that was a considerable time later than that point. The concerns that had been raised and were part of the MHPS process were already being managed through the Oversight Group who were involved with that process. I was outside of that. That process was happening, I was aware it was happening but I was not part of that process. There was an assumption or -- from me that that was being managed through that process rather than through my responsibilities. 14:34 14:35

38 Q. Yes. You have made the point in your witness statement, I think at WIT-53902 -- we don't need to bring this up on the screen -- at para 33.5, that in this role you weren't a line manager as such? 14:35

A. No.

39 Q. You have gone on to explain that -- maybe we should bring this piece up on to the screen. It's WIT-53902. Focus in on 33.5. Yes. You say on the third line

down:

"When I commenced this role there rapidly became a live issue in relation to Mr. O'Brien and due to the proximity of my direct day-to-day working relationship with him and my role in relation to the identification of concerns, the Medical Director (who was then Dr. Richard Wright) did not directly involve me in this process with the Clinical Director and Medical Director continuing this." 14:36

You go on to say that you have, however, been involved in other staff management issues.

I just want to unpack that a little, because it perhaps informed how you approached the Mr. O'Brien issues as they continued. Dr. Wright was in post as Medical Director when the MHPS process commenced in early '17. You took up the AMD post, if I can call it that, at the end of that year, in October 2017. By that stage the MHPS investigation was essentially six months old and indeed you'd contributed to it, which we will look at in a moment. Just so we are clear here, there was an action plan which was the subject of monitoring from Mr. O'Brien's return to work at the start of that year, and that was held by Mrs. Corrigan, and if she had a concern, she was supposed to escalate to Dr. Khan; is that your understanding now?

A. That's my understanding now, yeah.

40 Q. You are coming into post in October 2017 with the responsibilities, as we have just observed, of ensuring that your medical workforce was fit for purpose, were safe practitioners. Are you saying that, in terms of Mr. O'Brien's performance, and the concerns that related to him, you were essentially out of bounds if you were to come into that area? Was it made clear to you that that's nothing to do with you? 14:38

A. Not so much made clear that that's nothing to do with you, but there was a process and a system and individuals who were managing Patient Safety issues in relation to him specifically. Therefore, my role as not part of that, stemming from the decision that I wasn't part of it because of my place in raising the concerns and being part of the team, being a colleague as well, was that I was not part of that management of either the monitoring or any escalation from there. The monitoring of the Patient Safety concerns for Mr. O'Brien, to my understanding, were outside of my remit. 14:39 14:39

41 Q. We will come on to look at it, it may well be tomorrow. Certainly by 2018 and into '19, you are taking an involvement and you do have a voice in conversations to do with apparent deviations from the monitoring plan; is that fair? 14:40

A. Yes. I guess as I grew in my role as AMD and became aware of the monitoring process and the systems that were being used to guide that monitoring process, I became concerned that some of the assurance we were

taking was perhaps not based on robust data.

42 Q. To summarise, and so we are clear, in your role as AMD, you were not part of the monitoring arrangements pursuant to the action plan, but there came a point in time when you became involved or were asked to become involved, and you provided commentary and input in terms of the robustness of the evidence that was being gathered? 14:41

A. Yes.

43 Q. In terms then of the role of AMD, you were conducting that role in addition to a busy urological practice which had you both in Craigavon, and no doubt the satellite hospitals of the Southern Trust, and in Belfast once a week, you were Chair of NICaN and you had this AMD role. Thinking about it with some hindsight perhaps, was that a role that you were capable of performing effectively, given your other commitments? 14:41 14:42

A. I think, as I have included in my statement, I never felt I was in a position to give the time required to be Associate Medical Director, and part of that was driven by the waiting list, the length of time our patients are waiting for urological treatment, so I was always reluctant to pull back from any clinical work because of the direct impact that I could see on patients on a day-to-day basis. The inevitability of that was that I was not giving the time that would have been, I think, required to be AMD. 14:42 14:42

44 Q. You say in your statement that until relatively

recently, November 2021, you did not include the full three PA requirement, which was in your job plan, to this role. Is another way of saying that is that you weren't able to fully commit all of the hours available to you on the job plan to that role? 14:43

A. No. My job plan was full, and rather than take something out to replace it with AMD time, I left the AMD time as less than the 12 hours. I didn't have my job plan being for hours that I didn't exist in the day, if you like. 14:44

45 Q. You did the hours required for the AMD role, but they just didn't feature?

A. I did what I was able to and what I needed to, often working in my own time, and indeed I often displaced some of my own clinical work into my own time in order to enable me to deliver activity as AMD. 14:44

46 Q. Is it fair to say that as you performed what appears to have been an important managerial role, given the issues that this Inquiry has to consider, at an important time for Urology, that you were always in danger of making compromises of that role because of your Clinical commitments and responsibilities? 14:44

A. I think that's fair to say, and I've reflected in my statement that there would have been meetings that I was not able to get to because they clashed with my clinical work, which continued. 14:45

47 Q. At one point, it was October 2018, you indicated to the then Director of Acute, Ms. Gishkori, that you were minded to resign your position as Associate Medical

Director, citing workload pressures and performing far in excess of what could be considered realistic or sustainable. Do you recall that?

A. Yes, I do.

48 Q. The reference, I don't need to bring it up, but just for the record, is TRU-163344. Just before I ask you the question. Ms. Gishkori has commented on your contribution as Associate Medical Director. If I could have up on the screen, please, WIT-23380, and focus on para 47 if you would for me, please. I'm sorry I don't have the question that prompts that answer, but I think we probably get a sense of what the question was. It was probably something to do with how she encountered staff in the team, and she says: 14:46 14:46 14:47

"Mark Haynes was the AMD for Urology. We were supposed to meet monthly, however he rarely attended scheduled meetings and he rarely attempted to make any informal contact with me. He was unable to provide time." 14:47

Is that fair comment?

A. As I say, I have reflected and commented that I would often not be able to attend meetings. The Acute Clinical Governance meeting, which was one of the meetings I have mentioned earlier in relation to SAIs, takes place on a Friday morning at the same time as I have an operating list in Belfast Trust which makes it very difficult for me, certainly made it very difficult for me to attend pre-Covid when video 14:47

meetings weren't so common. Post Covid, it's still a challenge for me to attend but with Zoom meetings and the like I'm able to attend. It facilitates attendance.

The second part of the sentence I don't recognise at all. I regularly went up to Ms. Gishkori's office without an appointment, just on spec to find out if she was there to keep her up-to-date on issues from my perspective. The e-mail in which she referred to as, indeed I forget the line in it from her but comments implores on me or asks me not to make a decision until she has spoken to me and stresses how much she values my input and opinions, which doesn't seem to tally with me rarely attempting to make informal contact. 14:48

49 Q. To assist you, we can bring that e-mail up. It's TRU-163344. I think it's part of that series of e-mails. Just scroll through that. Is that a single page? If we maybe go up 43 -- yes, it's the middle e-mail. Yes, is that the comment you are alluding to? 14:49

A. That's the comment.

50 Q. You have written to her earlier that afternoon indicating your proposal to resign your post. She is asking you to defer your decision because in part she would miss you and always values your view and opinions". 14:50

You obviously didn't ultimately follow through with your proposal to resign. Did she talk you out of it or

did you just think better of it?

A. In all honesty, I can't completely remember. I would have had a conversation with Esther Gishkori. I would have had a conversation with many individuals at that time. My memory is that I was talked out, on an assurance that all recognised that I wasn't able to give the time that I needed to, but they understood why, as I think I have said in my e-mail below, I am a Urologist first.

14:50

51 Q. Yes. You have talked about your inability to go to the Friday Acute Governance Meeting, is it fair to describe that as kind of one of the core pillars of the Governance Framework at which an Associate Medical Director would rather be expected to attend if he can?

14:51

A. Yes. It would be myself or my Deputy, which would be one of the Clinical Directors and the issue with clash with Clinical activity was not just myself but also affected the Clinical Directors who worked with me, and we did make a request or an attempt to get the timing of that meeting either changed, or at least rotated through the week so different Clinicians, Clinical Directors and Associate Medical Directors would be impacted by the clash with Clinical activity on different months. Unfortunately, that was unsuccessful.

14:51

14:52

52 Q. Yes. In terms of the other, if you like, formal pieces of the Governance Framework, the other meetings that make up the discussion fora for addressing Patient Safety issues primarily, were there any other such

meetings that you were regularly unable to attend because of your Clinical commitments?

A. I have mentioned the Patient Safety meetings in my statement and I have commented that there have been occasions and there are occasions where there is 14:52
a clash where the Patient Safety meeting in Belfast Trust is at a different session to the Patient Safety meeting in Craigavon or in Southern Trust, and therefore I could be conducting Belfast activity at the time of the Southern Trust Patient Safety meeting and 14:53
therefore not able to attend. There is also reality that the activity that I do in Belfast is primarily cancer activity, and a decision had been made to continue particularly cancer operating if it clashed with Patient Safety meetings. For instance, the Friday 14:53
morning when I am doing cancer surgery I still have an operating list to attend and carry out.

53 Q. Your inability to attend those meetings, I suppose, gives rise to the question: how suitable a role was this for a busy Clinician? 14:53

A. I think that's a very good question and I think others have reflected on having that same clash of Clinical activity with their Clinical Management activity.

54 Q. You are holding a thought there. Do you want to finish? 14:54

A. I think there is always -- in order to provide leadership as a Clinician, the Clinician needs to, in some way have, if you like, that respect of the team. You need a Clinician who is a Clinician in a Clinical

Management position. Ultimately, on this subject, I think we would need to be stronger in our expectation of Clinicians that actually in order to take this on you need to withdraw from being the full-time Clinician that you are.

55 Q. That's perhaps a helpful general reflection. Could I -- could I ask the question maybe more provocatively. In terms of what we are facing up to within this Inquiry, which is an exploration in part of whether the Governance System within the Trust was fit for purpose. Was your absence from the wheel of some of these key meetings, and perhaps other Governance-related activity, does that offer some kind of explanation, at least in part, for any ineffectiveness of the Governance Framework? 14:55

A. Specifically in relation to Mr. O'Brien?

56 Q. Yes.

A. I don't believe so, because I was alive to and aware of the issues in relation to the concerns. My absence, say, from the Acute Clinical Governance didn't mean that I was not aware of the SAI reports and their recommendations. I was very aware, because, as you know, I was on that SAI team.

57 Q. Yes. Of course an inability to make formal meetings is perhaps just one part of the job. How did you go about conducting the role even informally? Did you make a point of ensuring your antenna was alive in receiving necessary information from colleagues? 14:56

A. In terms of informally, I have mentioned that I would

regularly come up to the Director for Acute Services' office informally to touch base there. I'd regularly go to the Assistant Director's Office and the Heads of Service Office and touch base with them. I'd informally regularly make contact with the Clinical Directors, both by telephone, in person, by e-mail. As surgeons, the Clinical Directors are also surgeons, we would often see each other in theatres when our sessions were at the same time and we would be able to catch up and touch base at that time as well. The informal network was much easier to maintain than the formal network, which had rigid dates and times sat to. 14:57 14:57

58 Q. I am conscious that you have said you weren't a line manager for any of your Urological colleagues. At any point, knowing what you knew about the reported shortcomings in Mr. O'Brien's practice, did you ever face-to-face him on any of those issues in your role as AMD? 14:58

A. I didn't. When these issues were raised with him, they were raised by his direct line manager which would have been his Clinical Director. 14:58

59 Q. Just for the record, that was Mr. Weir moving on to Mr. McNaboe?

A. Yes, but I didn't directly raise them with him.

60 Q. Was that because you didn't see it as your responsibility or was it some kind of reticence or perhaps professional embarrassment to do so? 14:58

A. I was a working colleague of Mr. O'Brien and I was aware of how he worked, as you know, from the concerns

I've raised. I was also aware that he was a challenge to challenge, and I knew that from discussions that we would have had as a group. I also had an awareness of his personal connections, if you like, with members of his family within the legal profession, his personal connections with the Chair of the Board, and the rumour mill had told me that a previous AMD had been accused of bullying when trying to tackle Mr. O'Brien. I guess the answer to why didn't I personally tackle him when I knew the Clinical Director was, is because I had to work within a team with him, I didn't want to -- essentially, it was a fear thing. I didn't want to find myself in a difficult small team working relationship as a result of the other bits that I was, if you like, aware of. I think, as I just said, grapevine, it's that sort of rumour mill, grapevine fear rather than anything documented, but that would have played a significant part in it. 14:59 14:59 15:00

61 Q. Just two points there before I move on. It was a small urological team of Consultants, I think six at that point. Is it not inevitable, as Associate Medical Director, that you are going to be dealing with a professional colleague and you will need to be dealing with a professional colleague on difficult issues, and the job simply can't function unless the post holder is prepared to rise above that and grasp the nettle, difficult though that might be in human terms? 15:00 15:01

A. I think so, but, as I said, when I came into post in

2014, and then as I came through and recognised issues, these weren't new issues; these were issues that had been attempted to be tackled with him before and had become part of almost -- I hesitate to say, it's almost accepted practice, he practised in this way and everyone else practised in another way. You know, we have talked about the notes at home. I'm not aware of anyone else who would be taking notes at home and storing them at home regularly, but that was accepted practice and almost everyone knew. Of course I should have tackled him personally, but I was coming in, if you like, late to this, with a many year history of other people attempting to tackle it to no success, and it becoming part of normal working arrangements for him. 15:01 15:02 15:02

62 Q. You do accept it essentially fell within your job description, notwithstanding this history, to have a fresh go at trying to tackle the issues?

A. Yes, and where other issues have arisen with other individuals, not necessarily within Urology, I have taken an active role in that, so it's specifically with Mr. O'Brien I didn't. 15:02

63 Q. The second issue you raised just a short time ago, which I intended to deal with later but I will deal with it now. You've suggested through the rumour mill I think was how you described it, a certain chill factor in terms of being able to deal with him, associated with what was known to be his family connections to the legal profession and his social 15:03

contact, or whatever it might be, with what now is the former Chair of the Board, Mrs. Brownlee. Was this tearoom gossip, or at what level was this being communicated to you and affecting your actions?

A. It was an awareness. It wasn't something that I recall being formally communicated to me, but it was an awareness that I had and others would have had. 15:03

64 Q. Are you able to say how it came to your notice or attention?

A. I genuinely don't know how. I just know I was aware of. 15:04

65 Q. In terms of the support that you receive from the organisation, whether from the operational side or otherwise, to fulfil this challenging role, was it there? Was the support there to enable you to do as good a job as you can or, looking back, can you pinpoint anything that might have been done differently to assist you in your responsibilities? 15:04

A. Within my statement I have commented, the Clinical Managers do not, as a standard, have any administrative support to assist us in terms of as we are undertaking our role, and so, as daft as it sounds but in addition to trying to do the bits that I've got to do, I'm also managing my own diary and managing my own follow-up of things I need to chase and follow-up which, as you've outlined, when you are trying to do a job that needs 12 hours in a considerably shorter period of time, inevitably, if someone is not reminding me to follow up on something, things will slip off the radar. So 15:05 15:05

I think that administrative support for Clinical Managers, which wasn't present, I think is required.

66 Q. You mention I think several times in your witness statement that one of the things that I suppose to some extent hamstrung you in the role was the absence of a handover. Just unpack that a little. Does your complaint in that respect suggest that you got your Letter of Appointment and the next day you were AMD and were just expected to know the role? 15:06

A. Yes. As I said, I've mentioned induction or handover, I think I have mentioned both, so, yes, so essentially you became AMD and you were in the role. 15:06

67 Q. No training, no orientation, no induction, no informal chat about current and developing issues?

A. You would have had an informal chat, or I would have had an informal chat with the Medical Director when I was considering applying for the post of AMD then, but I wouldn't have had an induction and handover from the previous AMD. Obviously it was difficult at that time because there hadn't been a previous AMD for 12 months either. 15:07 15:07

68 Q. Knowing what you were to discover in relation to the series of Mr. O'Brien issues as they became reported, was there anything that was terribly new to you that might have -- or put it another way. Was there anything terribly surprising to you that could have been alleviated or assisted with the handover? 15:07

A. I think a handover or an induction in terms of how you fit within the -- as you have described the Governance

processes, would have meant that you are able to pick it up much quicker rather than spend the first couple of months learning that, to then become more effective. It would increase your effectiveness from the off, rather than learning to become more effective. 15:08

69 Q. It is fair to say that upon taking up the role, you had a previous awareness of many things that were of concern in relation to Mr. O'Brien?

A. Yes.

70 Q. You were aware of Triage issues, you were aware of dictation issues, notes at home. One thing you say you weren't aware of was the action plan and the monitoring arrangements. I think we will come to this later. You weren't aware of that until late '18 into '19, something like that? 15:09

A. Yeah.

71 Q. Is that fair?

A. Yeah.

72 Q. Having looked at your career and your steps into management within the Trust, let me go back to that first year when you took up post in the Trust. So 2014, you were given the task, or maybe you assumed the task, of writing a paper for presentation to the Commissioners, Mr. Sullivan, in respect of the Adequacy of Resourcing to the Southern Team in order to meet the Demand in the context of the Implementation Plan for Urology Services for Team South which had been published four years earlier in 2010. You recall that? 15:09 15:10

A. Yeah.

73 Q. Before delving into this, if I was to draft a headline to capture this evidence that you've set out in your statement, from the commencement of your post and currently today, Urology Services in Northern Ireland and specifically in the Southern Trust, are wholly inadequate. There was -- if I didn't put the word resources in there, the resources to meet the demand had been wholly inadequate?

A. Yes, the capacity to meet demand is inadequate and the result is growing waiting lists for all aspects of our Service. 15:11

74 Q. If we look at the presentation that you made to HSCB back, I think it was September 2014. If you pull up for me, James, WIT-54072. If you focus on the summary at the bottom, please. 15:12

Within the paper that you provided, Mr. Haynes, you say on behalf of the Trust:

"We have reviewed the Urology Services within the Southern Trust and examined every aspect from the perspective of aiming to provide a sustainable Service. We believe the plan as described will enable us to provide this while maximising the efficiency of utilisation of Consultant time. In order to do this there is a need for expansion of the Clinical Nurse Specialist within the team. This explanation will require training and funding, and without this the Service cannot be provided in a sustainable manner. 15:12 15:12

However, even with this expansion and maximisal efficiency of Consultant time, there is no currently sufficient Consultant time available to provide capacity for projected demand. Without providing this capacity we will also not be able to deliver any backlog reduction."

As I understand it, the proposal that the team was putting forward was for a seven Consultant team. There were two options, one embraced a seven Consultant team using 11.4 PAs per week. It is the case that that wasn't provided; isn't that right? 15:13

A. Yeah, that's right. At the time, I think there were five posts. I can't be 100%, but I think there was five posts funded recurrently and one post was funded by the Trust at Risk, which was subsequently funded recurrently. The projection was, as you say, in order to meet projected demand I think it was 80 PAs a week of Consultant time were needed, which could be delivered as eight consultants delivering 10 PAs or seven consultants delivering 11.4 PAs each. 15:14

75 Q. Just to correct myself slightly, that was not funded until 2020?

A. The seventh post the funding came in in 2020, yeah.

76 Q. Yes. Presumably by the time it was funded, demand and the waiting list had continued to expand so that the seven that you were pitching for in 2014 -- if you forgive that word -- may not have been adequate by 2020 when it was delivered? 15:14

A. Probably would not be adequate by then. I think in terms of looking at what is funded and what we are able to provide, it's a very fine balance. We may be funded, say, at 2019, we were funded for six consultants, but because of challenges in nursing staff recruitment we weren't able to provide within Southern Trust the Theatres that were needed to meet the requirements for them six consultants. Even if nine consultants had been funded, the Trust would still have not been able to provide the facility because of shortages elsewhere. I guess if I was the Commissioner it would be a very difficult thing to justify providing funding for a Consultant post if you are not able to provide the facility to deliver it. That's before you then look at whether the post can be appointed to and, again, as I've highlighted in my statement, we currently have two vacancies within Southern Trust Urology that we have not been able to successfully recruit to. 15:15 15:15 15:16

77 Q. What kinds of risks does the mismatch create within a Service? 15:16

A. It creates risks across every aspect of the Service. We've touched on earlier the impact on an individual in the Service taking up a Clinical Management role and the ability of them to provide the time for that Clinical Management role, because there's always a pull from a delivering care perspective to deliver care. The Service is always busy and patients are waiting longer than we, as individual Clinicians, would like to 15:16

for many aspects of that Service, and so each individual working in that Service is inevitably asked and feels somewhat of a personal pressure to take on additional work, and so each member of the team would take on additional work. The impact of the waiting 15:17
times on patients is very real and so if we're not able to meet the number of new patient referrals coming in each month, essentially the process of Triage is, while it's prioritising the patients who get seen first against the patients who get seen later, it's almost 15:18
effectively pushing back or rationing the patients we are seeing later, because if you can only deliver a certain volume of care each month and that volume is being taken up delivering care to those who have got the more urgent categories of conditions, so say 15:18
suspected cancer referrals or they are clinically urgent, patients who have routine referrals sit and wait, and wait, and actually essentially get seen when they became urgent so they get re-referred as Urgent.

15:18

On a surgical perspective, the impact of waiting lengths of time within Urology is, if you look at the Cancer work, if we are not able to operate rapidly for cancers, there is always going to be a concern that their disease progresses and requires more involved 15:19
treatment, but that same issue is very real for patients with benign neurological conditions, so patients with kidney stones, particularly patients who are requiring more than one treatment for a kidney

stone, so patients may have a first operation where they have a stent put in and then a planned second operation to treat the stone and remove the stent, but if them stents stay in for a period of time they themselves can grow stones on and become more complicated to treat and require more operating time. You can almost create this vicious cycle within surgical treatments of longer waits necessitating longer treatments meaning you need more time to treat the people that you are treating, meaning that you are even further away from meeting the population demand. 15:19 15:19

I think there's also an impact, if you like, on the sensitivity of individuals working within the system to identify where things are going wrong, and that comes across all things. Where we have got long waiting times, inevitably we get a large number of complaints and most of them relate to the length of time that someone is waiting. If that is the major factor in the complaint you might miss something else within there, so it reduces the sensitivity from that perspective. It also reduces the ability of you, as an individual, to have an awareness of what's happening and what your colleagues are doing, because you are so busy trying to keep up with what you are trying to do that you haven't got an oversight of other people's work. You haven't got an in-depth knowledge of what how a colleague's managing patients, so we are less sensitive as a system to identify an issue. 15:20 15:20 15:20

78 Q. Yes. The question started in relation to risks. You have helpfully taken us through patient, Clinician. Just on that managerial role, surely in the case of Mr. O'Brien, those concerns were so well known and so frequently reported through the various systems that I am going to look at in a moment, that the stress created by the demand capacity mismatch can't afford an explanation for why those concerns weren't better grappled with. Is that fair? 15:21

A. Sorry, I didn't quite follow. Sorry. 15:22

79 Q. It's set out in your statement, I think, at paragraph 74.1, where you say:

"The capacity demand mismatch meant colleagues were less likely to identify concerns." 15:22

I wonder, in the case of Mr. O'Brien, the concerns in association with him were very obvious through the various reporting systems that I'm going to examine with you. The demand capacity mismatch doesn't provide much of an explanation for failing to grapple with those issues in a more timely and appropriate fashion. 15:22

A. As individuals identifying more of the same concerns, it would have impact on us because we would not necessarily have been seeing the patients, because within the Service specifically at that time, and generally in many Services, individual Consultants will manage their own patients and so the opportunity, when you are busy, particularly when you are busy just about 15:23

managing to do what you are doing for the patients under your care, to look at someone else's patients just doesn't present itself very often. The time that you're able to perhaps take a step back when you see someone do a more in-depth assessment of everything over a prolonged period of time and identify the concerns that had been identified with Mr. O'Brien, perhaps you might not do it because you have got other things to do. I'd agree the problems were known, but within the Urologists for raising, if you like, more concerns, the busyness of the individuals meant that, I guess, the problems were known, I'm busy enough on my own and I haven't spotted, I'm not going out of my way to look for more problems at this moment because I'm trying to keep up with what I'm doing. If that follows? 15:23 15:24 15:24

80 Q. Yes. We will visit this in a little bit depth later, but we do know that from June 2020, it did prove possible to carry out, in a matter of a few days, a comprehensive desktop review of some issues of concern that hadn't materialised at the time of the MHPS review were, in a sense, different but similar. The essential point I'm putting to you is that while the Inquiry may well understand the pressure created by the absence of resources to deal with demand, it, in a sense, may desensitise both management and individual Clinicians, the issues were there to be discovered and could have been discovered with relative ease? 15:25 15:25

A. Yes. As I have reflected in my statement, I personally

regret not recognising that a deeper look into Mr. O'Brien's practice was required at the time of the MHPS investigation being instigated. What was looked into were the issues that had been identified, but we didn't proactively look for other things.

81 Q. In terms of the difficulties posed for your patients by the absence of adequate resources, you, both in your AMD role and in your Chairmanship of NICaN, wrote regularly to management, and indeed Commissioner, to express concerns about the kinds of choices Clinicians were going to have to make, or were increasingly having to make, between two patients with both challenging and traumatic conditions, but one having to be preferred over the other. Is that something that caused you a particular difficulty, those kind of choices?

A. It concerned me that we were in a position that we were having to make those choices. As I have outlined in correspondence, it places us in a vulnerable position, we are having to make prioritisation decisions which we do on the basis of the information available and we do to the best of our ability, but inevitably there is a risk of a patient, an individual patient coming to harm as a result of that prioritisation decision.

82 Q. At one point on 11th October 2019 you wrote to colleagues. The reference is WIT-55757. You wrote to colleagues to say, in essence, if you believe that the treatment of your patient is unreasonably delayed, you should raise a Datix, perhaps to keep themselves right within the system and as some kind of communication or

signal, perhaps to the Commissioners that all was not well?

A. Yeah, I think the incident reporting system is, if you like, the intelligence-gatherer for the system. I think I've said in my statement that it had almost become normalised for patients to wait a long time for patient. If, if you like, the wider system is normalised such that we kind of know it, we could almost -- I felt we were in a vulnerable position to not be flagging that patients are coming to harm because they are waiting longer than they should, and so I encouraged to flag that patients are coming to harm because of the waiting times. 15:28 15:29

83 Q. Within this context, Mr. O'Brien in his statement, if we could pull up WIT-82957. I have a rogue reference, I think. I will read it out, I have a note of it. In essence, Mr. O'Brien says in his statement that the issues which arose in his practice were inextricably linked to the inadequate system within which he was working. We will no doubt ask him about that in the fullness of time, but one supposes that he is reflecting the fact that, given the pressures and impossible choices placed upon clinicians working within the system, with all its inadequacies that you have described, the issues that arose in his practice, such as Triaging, dictation, actioning investigations -- to quote some examples -- the ability to do that work as the system might expect or as the employer might expect, was difficult, and perhaps he 15:29 15:30 15:30

might say impossible, given all of the other demands that he had to meet. Does that resonate with you?

A. The description of being busy resonates with me, but the lack of response of taking responsibility for bits which you can take responsibility for and action, doesn't. If we take actioning results, there are systems that you can engage with to ensure that patients are advised of their results. Electronic sign-off is something that I'm sure will be touched upon at some point. Essentially, through the electronic care record, Northern Ireland electronic care record, when a result becomes available there is a tab on there where you can immediately have a list of the patients who have had a scan under your care so you can view the results and you can action them. Indeed, by engaging with that system, as is described in a relatively recent GIRFT document about Outpatient Transformation, you can have some impact on the demand for the system. Personally, I can make a decision to see everyone back with the results of a scan, or I can advise by letter the patients with a normal scan and only see the patients who have an abnormal scan, and that has an impact on the demand placed on the system. There are individual practices and modes of practising that you can do to impact on the wider Service.

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In terms of the deficiencies or concerns about Mr. O'Brien, dictating a letter at the end of a clinic to me was always a practice that I've done since I was

a core trainee in my first clinics where I did outpatients clinics. Not doing it is something that would never cross my mind. Doing that immediately, requesting any scans that are required immediately at the time of that consultation, adding patients to the 15:33
waiting lists, in terms of completing the paperwork required for that, they are things that you have to take responsibility and, as a Clinician, you shoulder responsibility for.

15:34

Additionally, if you are not able to do it, there is a responsibility on us to raise with our employer that we are not able to do it. If I'm not doing my Triage, I need to tell my employer that I'm not doing my Triage. It's incompatible to me with being a doctor to 15:34
not be able to do something and not actually hold my hand up and say I can't do it.

84 Q. I will put the perspective you have just reflected up on the screen, if I can get my references correct this time. WIT-53874, please. At the bottom of the page, 15:34
11.1, if I can highlight what you are saying there. It's in answer to a question of whether you had knowledge of the IAP process. In terms what you are saying is you realise that it was your responsibility to return triage promptly with recognition that Red 15:35
flag referral triage should assume a higher priority. You go on to suggest that normal and routine triage might be dealt with a bit more time flexibility. You go on to say you have always recognised

a responsibility to act on results and correspondence in a timely manner, and a requirement to ensure that you work within available processes to ensure correspondence and results do not get overlooked, and you go on to say, over the page, that a cardinal principle perhaps is, if you are unable to meet an aspect of your workload, it's your responsibility to escalate this within line management structure. 15:36

A couple of points arising out of that. Even if I take it from your last answer that Mr. O'Brien can't be forgiven or excused for not doing Triage of routine and urgents, for not dictating in all cases as timely as he should have, not actioning results until a clinic date, is it, nevertheless, understandable that Clinicians working in this context have to think with a degree of ingenuity and with a degree of flexibility to achieve the throughput necessary to hit the waiting lists in any meaningful way? 15:36 15:37

A. Absolutely, and within the vision presentation that was agreed through the team, and I talked to the presentation, Triage is covered within there. Part of the discussion of Triage within there is about, if you like, maximising the efficiency of the patient contact. If a patient is referred for, for instance, blood in their urine where they will always get a scan of their kidneys and a telescope examination of their bladder, why not arrange their scan before they attend for the telescope examination so they have a single patient 15:37 15:37

contact where all results are available and decisions can be made? That was one of the things we covered in there. Indeed, we would have gone on to conduct that Triage, and the way I conducted that Triage was I would have, for that example of a patient with blood in their urine, I had a group of standard letters that I generated, so it didn't take me long to generate a letter to the patient saying you are going to have a scan. My Triage was electronic, or it is electronic now. I would have already been in the Electronic Care Record, I would have put on the request for the scan and I'd have done the Triage. It would have taken a few minutes longer than just doing the Triage, but it wouldn't have taken the time of a 20-minute consultation. It would have made the single contact much quicker. Indeed, in a system where you have long waits potentially, the very fact that you've organised a scan beforehand, if it shows an abnormality, can enable you to pick out those patients who absolutely do need quicker treatment because you have found an issue. For instance, in that patient with blood in the urine example, if they had a scan that showed a kidney cancer, you could bring them quicker forwards because you knew you have a kidney cancer that you need to treat. If the scan showed an abnormality in the bladder that looked like a bladder cancer, you could almost move them directly to an inpatient list with a brief consultation to advise them of what was needed. It made, if you like, the challenge of meeting demand

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necessitated approaches that maximised the efficient use of our time, and certainly that's the way I approached work.

85 Q. In terms of Patient Safety then, what you are proposing maintains a safe approach? 15:40

A. Yes.

86 Q. In terms of the second element of what I have just read out, which is if you can't deal with the demands of the job, then it's your obligation to raise that with management, with the employer. It would appear, and 15:40 we'll develop this later perhaps, that Mr. O'Brien's, let's call it inability, or to be neutral, to deal with Triage in the way that he was expected to deal with it, was known to the employer for some time. How that was articulated in terms of his ability, or willingness, is 15:41 perhaps a debate for another day, but in terms of your experience of working with him and knowing how management within the Trust operated, was it a case often of, we know his concerns but we are not prepared to listen or not prepared to assist? 15:41

A. I think all members of the Urology team would have expressed at various points that there was essentially too much work to do, and Triage was part of that. As you say, there were points in time where it had been identified previously where he'd not been doing Triage, 15:42 and that had been found rather than raised as I'm not doing this, is my understanding. I don't think it was so much a, we know he's an issue that he can't do it, it's every one of us has an issue that we have got

a lot of work. I think what was challenging was my colleagues knew, for instance, how I did Triage, which was trying to be as efficient as possible. Mr. O'Brien had taken a view that he would phone all of these patients, which inevitably meant that the patients, when they got phoned, got a very good service because they got essentially a consultation, but it also inevitably took even more time than was required, and so he'd made a choice to do it in a way that took longer than was necessary, and he wasn't willing to change the way that he did it to take less time and, therefore, enable him to keep on top of it. 15:43 15:43

87 Q. His consideration was that it was necessary to do it in this way because of the demands posed by the waiting lists, if I don't Triage in a deeper, more meaningful way with this patient, he will be flung on to the, as you said, routine waiting list and unlikely to be seen for an age? 15:43

A. I mean, ultimately, Triage, as I've reflected earlier, in a system which is not able to meet demand means that those with routine conditions on the information available to you at Triage, wait many years to be seen. That is inevitable. But to take that mismatch in capacity and demand and turn it into a full telephone consultation for every referral during a week to mitigate that risk overloads an individual and creates an impossible to deliver workload. At no point had anyone suggested that that was the way it should be done. 15:44 15:44

88 Q. Let me move on, Mr. Haynes, to what I take from your statement to be a fairly fundamental or key reflection. You have set it out at paragraph 77.1 of your statement, which is at WIT-53957. You say, when reflecting on what has happened within the Urology Service, looking back from perhaps a position this year, or certainly after 2020, you say:

"I regret not recognising in late 2017/early 2018 that, in addition to the factors investigated in the MHPS, there was a likelihood of additional issues that had not been identified but which required investigation. The fact that some aspects of good clinical practice were absent in Mr. O'Brien's working patterns I feel, in retrospect, ought to have raised the concern that other deficiencies of good practice may also have been present. If this had been recognised, and a comprehensive review of practice been carried out at the time, I feel it is likely that the clinical practice which was identified in 2020 (and which led to the Lookback exercise) would have been identified earlier."

You will understand perhaps when I describe that as a key reflection, could I just ask you about that before looking further at what was known about Mr. O'Brien? Essentially, you appear to be saying that as a result of the MHPS process and the other processes that give you as a manager and other managers within

the system the information or the intelligence to know that there were things going wrong there, that should have raised a suspicion that there may be other things going wrong and we are not seeing the whole picture?

A. Yes, that's what I feel. 15:47

89 Q. We'll look, in the course of the rest of this afternoon and maybe into tomorrow at that, but just to probe it a little at this stage. It wouldn't have been too difficult to conduct a comprehensive review? A review itself would not have been a difficult exercise? 15:48

A. A review itself would not have been a difficult exercise. There are different strands, though, to it. As we will touch on in the 2020 and onwards, in terms of identifying issues like the scan result that hasn't had any action, that's a relatively straightforward 15:48 check in terms of looking to see has the scan been reported, is there any evidence of the patient being made aware? In terms of looking to see have the outcomes from a Clinic been provided, have they been carried out, is a letter dictated, they are relatively 15:48 straight forward. In terms of the Clinical decision-making without a, if you like, an index concern to guide you into which aspect of workload to look at first, it would potentially be a bit of a longer process, because you're needing to review the 15:49 Clinical management of a much broader section of patients in order to identify concerns. As we will no doubt come to when the first, to my mind, real shift in concerns in relation to Mr. O'Brien came from

administrative processes, if you like, which of course have patients at the end of them and Patient Safety at the end of them, but actually the way the advice he was giving, the treatments he was offering, there was a shift in the summer of 2020 with the initial identification of two patients who I had concerns about their prostate cancer management. At that point, because you have, if you like, a target group, it's much quicker to do a targeted review of that group to see if there are any more concerns. At that point in '17/'18, without knowledge at that time of a target group of patients where we might be highly likely to find an issue, we would have had to review an entire practice at a sample. It's something that could have been done but it wouldn't have, perhaps, have been -- I think you mentioned part that have June 2020 review took two days. The actual review of the Clinical decisions would have taken longer than that two days.

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90 Q. Yes. We will go on to examine the kind of factors that might have impeded or prevented a timely and more thorough review in light of this key reflection. What we can see from the papers, Mr. Haynes, is that you raised many concerns about Mr. O'Brien using both the formal mechanism such as a Datix leading to SAI and informal communications as well, whether it was an e-mail to the Head of Service or, as she reports, conversations about things that arose in your practice looking across it, at what Mr. O'Brien is doing. In terms of your approach to this, do you approach these

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matters having regard to your obligations under the GMC's Good Medical Practice Guide? For example, you are required as a practitioner to take prompt action if you think that Patient Safety, Dignity or Comfort is being compromised. Is that what, in a sense, drives this, not necessarily the written word but that kind of principle as a practitioner? 15:52

A. Yes. Each time I've raised a concern, it's about fundamentally Patient Safety. It's a concern that there is a patient risk associated with the concern. 15:52

91 Q. In your time practising in the Southern Trust, you've referred, and I read it out a short time ago, about the need for practitioners to work within the established processes, to do the things that they are asked to do in a timely fashion or to report if they are unable to. 15:53 In your experience, was Mr. O'Brien an outrider in that respect or did you, within the Urology Service, find that even periodically, other colleagues behaved in a manner which might be regarded as irresponsible as regards Patient Safety. 15:53

A. I never had cause to have the same concerns as I had with regards Mr. O'Brien for any of my colleagues. Within the evidence is an example of an exchange which is around the DARO process which is one of the safety nets for patients who have had scans done and are waiting results. If I have seen a patient who is having a CT scan, I might want to see them in clinic in X months' time, but if I have requested a scan to be performed in, say, December, administratively that is 15:54

added on to the DARO list, and that's a list that the secretarial team would check on a monthly basis to see if that result has come back, and if it's had any action done on the back of that. A reminder of that process was circulated to the secretarial team, which was forwarded on to Mr. O'Brien by his secretary, and he replied to many, including me, essentially stating that he wouldn't be engaging in that process. That was the only reply in that manner that was received from anyone. I addressed it directly to him in a reply and also escalated, because at that time the MHPS process would have been ongoing and so Dr. Wright was engaged in that, so I forwarded it to Dr. Wright as well. It was an example of, you mentioned I said we have got to engage with the processes that are available to us, AND it's an example where he wasn't engaging with that process. 15:54 15:55 15:55

92 Q. That issue which I was going to go on to look at specifically, that e-mail exchange between the pair of you, that is relevant in the context of those SAI cases, of which there are several, where results are not being actioned and there's a development, usually an adverse development, for the patient, and the matter becomes more complex as a result clinically? 15:55

A. Yes. I described it there as a safety net. It is a safety net. It shouldn't be the primary process that's relied on to get the results back. In my practice I'd have two steps before then. I have described the electronic sign-off system that I use, 15:56

and my, if you like, next step in the safety net is the hard copy paper report that would go to my secretary, and she would check whether that's been signed off by me electronically and actioned. Then the third step is the DARO, so if the first two fail then the DARO list is there as a back-up. 15:56

93 Q. Leaving that specific to one side for the moment, you come into Southern Trust in 2014 and you report in your statement that your experience of Mr. O'Brien is that he has a non-standard way of working. You illustrate that in a number of ways by, for example, indicating that it was your experience that he didn't use administrative services in the way that other clinicians would. He didn't use the dictation facilities. He took notes home so that they weren't available to you when you were seeing a patient, those kinds of things, and this was known to other practitioners? 15:57 15:57

A. As became apparent to me after I started work and working within the Department, it was the way he worked. Progressively as I recognised that that was the way he worked, I would have raised when -- so during them times when we moved up to six when Mr. O'Donoghue started, we would have tried to work as a team and as individuals and as new starters, myself and Mr. O'Donoghue, seeing some patients who Mr. O'Brien had seen previously, and both of us raised a concern, along with Mr. Glackin and Mr. Young when they were doing it that you didn't have any 15:57 15:58

documentation about the decision-making that had gone on before. There wasn't a letter available, and so it made reviewing these patients very difficult. You mentioned that I have raised concerns using the incident reporting system, and indeed that very concern I raised really in respect of two patients, 102 and 103, that there were no letters, and in 103 no letters and hadn't been added to the waiting list although that was the patient's understanding from a consultation previously. 15:58 15:59

94 Q. Yes. Just looking at that issue, I want to just signpost this. I want to look, tortious though it might be, at a range of issues that you became aware of and perhaps reported into the system, just so that the Inquiry has your perspective on the shortcomings in Clinical practice that you were experiencing, but also in respect of some of these examples we will take a deeper dive and expose your reflections on the adequacy of the system for dealing with some of those matters. That's the twin purpose of looking at some of those matters. You have mentioned Patient 103, who you address in your witness statement. If we could have up on the screen WIT-54882. This issue first arose in April 2016. This is Patient 103. You say you saw this lady this morning on your ward round. You had no dealings with her prior to that. You hadn't received a referral there are no letters on the ECR and her notes detailing previous consultations were not available to you on the ward. You have gone on to 15:59 15:59 16:00

discuss a plan with her, et cetera.

This is you raising it with the Head of Service, Mrs. Corrigan. Was that a patient of Mr. O'Brien's?

A. Yes.

95 Q. Why were you dealing with it?

A. I was the urologist of the week on that day.

96 Q. Why did you not raise a Datix in relation to that matter?

A. I genuinely don't know. As I say -- 16:01

97 Q. Should you have?

A. I absolutely should have and indeed other Datixs that I raised were about the identical issue. I mentioned Patient 102, that was a similar no letters and no notes issue, I believe. 16:02

98 Q. Yes. Just scrolling up the page, you are telling Tracey Boyce about this issue. She was the Director of Pharmacy, I think, at the time, but may have had a Governance role as well. The timing of this, this is when the Trust is about to develop Terms of Reference 16:02 for the MHPS. Are you contributing here a concern or a piece of evidence relevant to what the MHPS might look at?

A. Yeah. I was providing detail of one of my concerns and an example to feed into that, development of the MHPS 16:03 Terms of Reference, I think.

99 Q. Do you know what the specific upshot of raising this with Mrs. Corrigan was back in April of the previous year?

A. No. I know what happened with the patient.
100 Q. Yes, but in terms of the problem?
A. No.
101 Q. The problem for you was, you didn't have notes at the time that the patient was in the bed, or in the chair at your clinic, and you couldn't find anything in terms of dictation of an outcome from her previous clinic with Mr. O'Brien; is that the problem? 16:03
A. Yeah, and this particular patient, as evidenced in my e-mail, I was able to review the results and I was able to come to a view as to how she needed to be managed, but the opportunity that had been missed was, had she been referred to me as she believed she had been or added to the waiting list for her kidney to be removed, as was the decision that had been made, had that happened she may have avoided that emergency admission. It took her to be admitted as an emergency for me to become even aware of, if you like, her existence and to be able to make a plan for managing her. 16:04 16:04
102 Q. In terms of the incidents that you were reporting into the system, the first use of a Datix that I have come across concerns Patient 102. If we could bring the Datix up, it's WIT-54874. You can see your name as the reporter and what you have said here is the "patient had been discussed at urological MDM on 20th November 2014." So that's a year-and-a-half earlier. Sorry, a year earlier, I beg your pardon. 16:04 16:05

"The recorded outcome ... was restaging MRI scan as

shown. Organ confined prostate cancer and he is for direct referral to Dr. H for radial radiotherapy and for outpatient review with Mr. O'Brien".

You have recorded: 16:06

"Was reviewed by Mr. O'Brien in outpatients on 28th November 2014. No correspondence created from this appointment. Referral letter from the GP received 16th October 2015 stated that the patient had not received 16:06 any appointments from oncology. He has now been referred to oncology."

Just to unpack that a little. This was a case MDM had made a recommendation, Mr. O'Brien had sat down with 16:06 the patient at review. What was discussed at that, we can't say from this but there was no referral to oncology, which was the expectation of MDM, and a year later, the GP is writing on the patient's behalf saying where is the oncological referral? 16:07

A. Yes. Within there I have talked about the outcome for direct referral. What that refers to is a process where, at MDT, a referral to the oncology team would be generated. Okay. If you like, the first part of the referral for that patient was generated at the 16:07 multidisciplinary team meeting. Certainly for myself, for those patients where I'm seeing them like we're seeing there, I would also then generate a letter referring the patient to the oncologist as well. For

whatever reason, the direct referral here either wasn't received or wasn't actioned, and so no oncology appointment was received. In there being no letter generated from the outpatient consultation, either telling the GP or the oncologist that they have seen that the patient has been seen as against again a backstop, a second attempt, the patient didn't get any oncology appointment, and then I received a GP referral on 16th October 2015, and from that, I generated a referral as stated in the second part, by e-mail and letter. 16:08 16:08

103 Q. So, two issues. First of all, at the MDM, it's the responsibility of the coordinator, in conjunction with the Chairman, to ensure an Oncology referral?

A. The direct referral would have been generated, yes. 16:09

104 Q. Yes. That will go to presumably Belfast?

A. Yes.

105 Q. The treating clinician, in this case Mr. O'Brien, speaks to the patient and good practice or required practice to generate a specific dictation after that, either to Oncology or the GP or both? 16:09

A. At the very least, good practice would be to generate a letter, I would say generate a letter to the GP, to the referring team, to the team you are referring to, but also generally -- or I would endeavour to copy patients in where appropriate, where they like, so that would be good practice. My personal view is that it's actually required practice. Part of contemporaneous documentation of any consultation is the letter 16:09

I generate at the end.
106 Q. If we scroll down on this one, I want to ask you a wider question about the process of incident reporting. You have said in your witness statement, Mr. Haynes -- just for the note, it's WIT-53932, at paragraph 61.3, you have said in your statement that, to this day, you remain unaware of how this concern that you had raised was dealt with. Is that a weakness of the reporting system that you are suggesting, that, if you like, the reporter, in this case you, doesn't get to hear the outcome, or is it unique to this individual case or is it more general than that? 16:10 16:11
A. I think it's more general that there isn't feedback provided to the reporter. My own personal reflection on that would be that, in not knowing how it's been dealt with, I don't know whether I need to be alert to more. I don't know whether there's a process to be monitoring for me not to be alert to more. It can also act as a deterrent for people to raise concerns if they are raising an incident report and then never hearing anything back. They don't know whether that five to ten minutes they have spent in filling in the long electronic form has actually generated any action at the end. 16:11 16:11
107 Q. If we look at the format, if we go down to 54879. If we could pick up on the, using the left-hand margin, 11th December 2015 entry. There is a series of entries, just for the Panel's ear, which reports on various transactions that take place in association 16:12

with this report. Mr. Cardwell is communicating with the Head of Service, Mrs. Corrigan, and he is describing this as a 'feedback message'. He has been asked to send this to Mrs. Corrigan and it says, in essence, that this is a matter that should go to the Head of Service to discuss with the Consultant. That would have placed an obligation on Mrs. Corrigan to speak to Mr. O'Brien. The Trust has told us that she has no recollection of doing so. Two points: You didn't hear about it, you didn't hear the outcome. It doesn't appear to have been screened for SAI purposes, and Mrs. Corrigan can't recall and has no record of addressing it with Mr. O'Brien. 16:13 16:13

First of all, applying your knowledge of the SAI criteria, a failure -- whoever's fault it was and regardless of whether harm was caused -- a failure to refer a patient for radiotherapy, in contravention of the MDM decision, is clear SAI territory, isn't it? 16:13

A. There's potential for harm or evidence of harm, and there isn't evidence of harm, but within the SAI criteria is that potential for harm, and so applying that to here, absolutely, it would meet that criteria. Again, on reflection, I think we have been too reluctant to apply that potential for harm to the screening of potential incidents than we should have been. We should have been more alert to potential and less focused on evidence of harm as the trigger for screening into an SEA or SAI. 16:14 16:15

108 Q. Could I address the same issue with you through an examination of Patient 93? Just familiarise yourself with that person. You have dealt with this in your witness statement at paragraph 61.6. This was a case that was referred into Mr. O'Brien, because he was Urologist of the week, as a routine referral, when, in fact, there was evidence of raised PSA and you believed that it ought to have been red-flagged. We can see that through your e-mail on the issue at TRU-278871. You are e-mailing Martina Corrigan, 31st August 2016, and you say: 16:15 16:16

"The story here is raised PSA referred by the GP on 4th May", obviously just over four months earlier. "GP referral as routine. Has not returned from Triage so it was put on the waiting list as routine. If it had been triaged would have been red flag upgrade". And you set out the PSA and the PSA on repeat. 16:17

"The patient saw Mr. Weir for leg pain and the CT showed metastatic disease from the prostate primary. Referred to us" -- by which you mean Urology -- "as a result of triage delay in treatment 3.5 months, although it wouldn't have changed the outcome." 16:17

So, again, that is a case where you rather ought to have completed within IR1, a Datix?

A. Yes.

109 Q. Just help me on this, because we picked up on two

examples where you haven't. Why would that be? Why would you decline to use an available system resource designed for this kind of thing?

A. I can't say why I didn't specifically use it for this patient. I think the process of incident reporting is not the most user-friendly, and I haven't checked but I presume the reason I got the escalation within the e-mail, is, I was Urologist of the week again so I was on call. We know that one of the factors that influences or I've seen papers about incident reporting, one of the factors that affects the likelihood of a report being completed is how busy individuals are as well, as well as the aspects of feedback from the instant reports that have been provided and other features. I would have been busy at the time. I would have been trying to, if you like, juggle the competing demands and what I have done is, I have identified a concern. I have raised it. I have not raised it through the process I should have, but I guess I have asked the question whether it should be raised as an SAI. Within the system, instant reporting is only one mechanism by which patients can be flagged as concerns or find their way in, so complaints may be a route by which patients find their way into an instant reporting and subsequent investigation. Litigation might be a way we find out about things. Concerns raised to individuals, and I have given, within my statement, examples where concerns about different things, about other individuals were raised

16:18 16:19 16:19 16:19 16:20

directly with me and not through a reporting system. Yes, it should have had an IR1 or an incident report form completed, and indeed, other deficiencies of the same thing did have indent reports filled in, but the fact that it happened was raised, and we just didn't triangulate that across into the same system as would be used to investigate other things.

110 Q. Yes. In your view again, the application of the SAI criteria in the case of a four month delay arising out of a failure of Triage, is again clear territory for an SAI? 16:20 16:21

A. It's that potential of harm.

111 Q. Yes. If we just focus for a moment on how it appears to have been responded to. You get your e-mail off to the Head of Service. Then if we could pull up TRU-274751. Scroll down please? Scroll down further. Is that as far as it goes? 16:21

Taking it from there, Mr. Carroll, who is Assistant Director of Acute, I think, at that time, so he is a senior manager on the operational side. He receives this on the same day you've sent it. It's been forwarded, I think, from Martina Corrigan. He is now sending it on to Charlie, that's Charles McAllister. He is the Associate Medical Director at that time, and he invites him to read the series of e-mails and picking up on your point, I think, that the patient hadn't come to any harm by the delay, Mr. Carroll says: 16:22 16:22

"Suffice to say that although the outcome for the patient would not have been any different this, as you know, is not the issue that needs to be dealt with", a point you have just agreed with me on.

16:23

Scrolling up, please, James. We get Mr. McAllister's thoughts on it. His thoughts are that this should go to Mr. Young first and then Mr. Weir second. Then up the page again, and further on up until we reach Mr. Young. Mr. Young responds by saying, here are his points, the GP should have referred it as a red flag in the first place.

16:23

"If the Booking Centre has not received a triage back then I agree that they follow the GP advice."

16:24

Do you understand what he is saying there? He is basically saying we have a Default Triage System in place if the GP gets it wrong and if Mr. O'Brien isn't triaging just stick it back into the routine list. Would you agree with me that's essentially a failure to triage?

16:24

A. That's exactly what this is. It's a failure to triage. As he touches on later on, I think on point 5, because of waiting times the impact of that failure to Triage where that initial referral category, so Urgency category is not appropriate for the condition, is that the patient would have waited -- not being seen for a year he said at the time so I assume that was an

16:24

approximation of the routine waiting list at that time.

112 Q. If he had not come back into the system incidentally and saw, I'm not sure if it's the same Mr. Weir but a Mr. Weir in respect of a leg complaint, and if he had not been scanned, he would have languished on the routine waiting list, all other things being equal and not being seen and not treated for his cancer before he died? 16:25

A. Not being seen and treated for his cancer until he either attended as an emergency or got seen on that routine waiting list, or it's possible that his disease may have progressed in the interim while he waited. 16:25

113 Q. The default Triage system, was that something you were aware of being operated in this way before you became Associate Medical Director? 16:26

A. Evidently I was aware that patients were being put on to a waiting list on the category of the GPs, as I have commented on at the start of this e-mail. Whether I was aware of there being a process specifically aimed at how to tackle when Triage isn't referred, which is that you just add them to the waiting list of the category that they were referred on, I wasn't formally aware of that until a later point, but I was aware, because I was seeing patients in clinic, and as I have commented within that e-mail, that the patient was on a routine waiting list because the category that they were referred on. I think in my incident report on patient 10, I have commented on them being, it would appear not triaged and seen on a routine -- I can't 16:26 16:26

remember whether it was routine or urgent but on that basis, so I was aware that patients were being added to the waiting list.

114 Q. Yes. Looking back at this, I know we can say that, come 2017, the implementation of the monitoring plan to keep active check on what was being done by Mr. O'Brien on the Triage front, we can say that, with some exceptions, that was being well-watched. Before that, the introduction of this Default Triage System, to give it its fancy name, was, in essence, the system bending to Mr. O'Brien's will rather than the system addressing the problem? 16:27 16:27

A. I think it wasn't addressing the problem; it was ensuring that if that piece of paper, the referral, never made it back and the patient wasn't on a waiting list then patient would truly never get seen, so the intention of the default system was to avoid the patient who'd been referred, disappearing and being lost completely. What it translated to happening was that the non-return of triage didn't get tackled because patients were already on a waiting list, and so it became a, if you like, a soft -- a soft get-out of addressing the problem without addressing it at all. 16:28 16:28

115 Q. Yes. I know that you weren't in a management position within Urology at the time so you will forgive the relative unfairness of the question, but when Mr. Young says that, at point 7, "the patient was in fact seen within a few months", I mean that was rather as a result of accident rather than design? 16:29

A. Yeah, that was.

116 Q. The approach to this in terms of how your e-mail setting this up for an SAI eventually falls flat in the sense that this is where it stops, so far as we are aware? 16:29

A. Yeah. As I said, the potential for harm doesn't appear to have been followed through with escalating it through the screening process and so it's come on, was there actual harm? Because, through good fortune, he'd seen another Clinician, Mr. Weir, and that consultation 16:30 had triggered a scan which had shown a significant finding, which triggered Mr. Weir to make contact more urgently and the patient to be seen more urgently, was essentially that, if you like, that series of fortunate events were used as an assessment of, well, because we 16:30 got lucky, it doesn't need looking at.

117 Q. Essentially, what we end up with is an under-reporting of serious adverse incidents?

A. Yes.

CHAIR: It might be an appropriate time to rise for the 16:30 day.

MR. WOLFE KC: Yes.

CHAIR: So 10:00 tomorrow.

MR. WOLFE KC: Thank you.

CHAIR: Thank you very much, Mr. Haynes. 16:31

THE INQUIRY WAS THEN ADJOURNED TO THURSDAY, 17TH NOVEMBER 2022 AT 10.00AM