



Urology Services Inquiry

Oral Hearing

Day 14 – Thursday, 1st December 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.

Gwen Malone Stenography Services

1 THE INQUIRY RESUMED ON THURSDAY, 1ST DAY OF
2 DECEMBER, 2022 AS FOLLOWS:

3
4 CHAIR: Morning, everyone. Good morning, Ms. Gillan,
5 I understand that you have joined the DOH-team.
6 welcome. Mr. Wolfe.

7 MR. WOLFE KC: Good morning, Inquiry, good morning,
8 Mr. Haynes, and thank you very much indeed for coming
9 back, hopefully to finish the first phase of your
10 evidence today.

11
12 MR. MARK HAYNES, PREVIOUSLY SWORN, CONTINUED TO BE
13 EXAMINED BY MR. WOLFE KC AS FOLLOWS:

14
15 Q. Just to recap, you will recall that on our first two
16 days we were working across a timeline, exploring your
17 involvement in the issues concerning Mr. O'Brien and
18 the wider governance issues within the Trust,
19 commencing from your time in the Trust in 2014,
20 becoming Associate Medical Director in October 2017,
21 and we had reached that point in the timeline in
22 October 2018, when you had, I think, discovered that
23 there was a monitoring arrangement in place pursuant to
24 the commencement of the MHPS investigation the year
25 before, so I want to take up at that point again.

26
27 could I have up on the screen, please, TRU-279139. In
28 fact, take me down a page to 40.

1 You can see, Mr. Haynes, that this is a dictation
2 report that has been circulated. Scroll up to 39,
3 please. This is Wendy Clayton reporting to Ronan
4 Carroll and Martina Corrigan in respect of a Return to
5 work action plan which had been issued in February 2017
6 in respect of Mr. O'Brien. She is saying:

7
8 "See below dictation report. There are approximately
9 82 charts in the office on Level 2, do you need me to
10 try and find out how long they have been there?"

11
12 Just scroll down, please, so I can see the whole table.
13 Thank you. That is the dictation report for that
14 month. We can see alongside Mr. O'Brien's name that
15 there are 17 discharges awaiting dictation and clinic
16 letters to be dictated, 91.

17
18 Let's take it on up into 39. Okay. Ronan Carroll
19 copies you and Mr. Young into this. He advises that:

20
21 "Aidan needs to be spoken with and asked to address
22 dictation as soon as possible and return notes" --
23 which were in his office -- "possible notes are for
24 dictation and he is in the Craigavon Area Hospital
25 tomorrow."

26
27 You respond to that e-mail, just scrolling up. What
28 you say to Ronan is:

1 "Neither I or Michael have been involved in any of the
2 conversations surrounding this issue since the start
3 due to the potential conflict working relationship
4 issues it would create. It would not be appropriate
5 for us to become involved now. Colin"

6
7 That's Colin Weir, who was the Clinical Director; isn't
8 that right?

9
10 "... along with the Medical Director have held all
11 previous meetings. I would suggest that it should be
12 approached through the same personnel as previously.
13 I need to ensure had an any meeting is appropriately
14 documented and it would be worth liaising with Human
15 Resources to ensure things are done correctly."

16
17 That is you, Mr. Haynes. You are the Associate Medical
18 Director. Typically can I suggest that these things of
19 issues about under-performance by Clinicians within
20 your team, if I can put it in those terms, would, quite
21 properly, come to you as Associate Medical Director,
22 but you are saying here that "there are reasons why the
23 issues shouldn't come to me"?

24 A. What I'm saying there is that there was a process that
25 had superseded, if you like, the normal process, and
26 that that same process should be followed rather than,
27 if you like -- so you already had a process that was
28 being followed that involved a Clinical Director and
29 a Medical Director, and they had held meetings with

1 Mr. O'Brien previously about this issue and following
2 that through, so rather than address it at a point
3 along it, bring in new people to have potentially the
4 same conversations and potentially risk starting again,
5 if you like, a clean slate, that everything should
6 follow through the same personnel and process as
7 before.

8 1 Q. Yes. Just moving up the page, I think Mr. Young adds
9 a comment. Mr. Young was Clinical Lead within Urology.
10 Again, typically, if things aren't going well with
11 a colleague, Mr. Young, but for this process, would
12 have been the kind of person who the system might look
13 to, to speak to the clinician guilty of the
14 shortcoming?

15 A. Yeah.

16 2 Q. He said: "Martina has been keeping an eye on this but
17 with her being off it does not appear to have been
18 tracked. In fairness it was a close system on who knew
19 to do."

20
21 Can you help us with that little phrase? Is that that
22 it was the issue, or the management of the issue was
23 kept to the small group you referred to?

24 A. I presume that's what Mr. Young is referring to.

25 3 Q. He agrees with your comments. Can I take you to, just
26 in this sequence or this period of time, again. Those
27 e-mails were 18th October. You started the day -- if
28 we can go to 279130. We have looked at that e-mail
29 just a short time ago. Ronan Carroll asking for action

1 in respect of this dictation issue. Then up the page
2 what you say here is:

3
4 "The NCAS report" -- that's the MHPS report -- "into
5 his practice has been received by the Trust and
6 presented to him", and you have been notified of that
7 by the Case Manager Ahmed Khan, but you haven't been
8 told the full detail of the report. Mr. O'Brien is now
9 to respond.

10
11 "In his meeting when he was presented with the report
12 he cited multiple examples that he claims is evidence
13 of inappropriate and clinically unsafe practice by
14 a number of his colleagues".

15
16 You haven't been told who.

17
18 "He has also made it clear he will be fighting every
19 allegation."

20
21 You say, as much as you say about the monitoring plan
22 in the other e-mail which was sent, I think, a few
23 minutes before this one in the early -- well, for some
24 people the early hours of the morning, not for you,
25 I suspect:

26
27 "Michael and I cannot it be involved in tackling the
28 behaviour and we need to be 100% that everything is
29 done to the book with HR input."

1
2 A couple of questions arising out of that. First of
3 all, you are hearing Mr. O'Brien has concerns about
4 inappropriate and clinically unsafe practices in
5 respect of a number of colleagues. Was that ever
6 vouched or further explained for you?

7 A. So, I have referenced it there. There's reference to
8 it in some of the responses Mr. O'Brien had given,
9 I think, to the Julian Johnson set of SAIs, and there's
10 reference to it in another document that Mr. O'Brien
11 tabled at a meeting, at a departmental meeting. But on
12 none of them occasions did he cite who that was
13 referencing. I think what I'm saying there is,
14 essentially, outlining, as I've said, this was being
15 tackled down one process. In with this he is now
16 essentially throwing accusations which potentially are
17 going to be at myself and Michael, who have been asked
18 then to come in late into the process which then placed
19 us in a very difficult position where we don't know
20 what these allegations are and we've not been party to
21 the management of him to this point.

22 4 Q. Just sticking with allegations of this kind. If
23 a Clinician is seriously concerned about unsafe
24 practice on the part of a colleague, that should be
25 followed through with an Incident Report, perhaps, or
26 perhaps a complaint to the Medical Director. Were any
27 of those things done, to the best of your knowledge?

28 A. To the best of my knowledge, none of them typical
29 routes, as you say, we have outlined multiple ways in

1 which concerns can be raised. It becomes, as with
2 anything, as AMD if I am one of them potential routes
3 that a concern can be raised by and potentially the
4 allegation is about me, then it needs to go down than
5 alternative route and, to the best of my knowledge,
6 that wasn't formally done other than these very vague
7 accusations of inappropriately and clinically unsafe
8 practice.

9 5 Q. To your point that you cannot be involved, and Michael
10 Young can't be involved, is it fair to say, and we will
11 explore this as we go on, that what you are saying here
12 is that you can't be the person going to Mr. O'Brien
13 and addressing these issues, but, nevertheless, you
14 retained, as we shall see, a background role. You were
15 certainly a recipient of information with regard to
16 derogations from the action plan, and you were to make
17 suggestions in respect of that. Is that fair?

18 A. Yes. As I say, essentially one thing to maintain that
19 consistency that it's being tackled by a team, a group
20 of individuals from the start, and that should be
21 consistent through. As we go through, as you know,
22 I've fed in and you referenced there I've maintained
23 concerns in terms of how data has been collected about,
24 in terms of the monitoring. But it just felt difficult
25 to -- progressively more difficult to me where, now, at
26 this point now I have been told, as well as having
27 concerns myself, as well as having raised some of the
28 concerns that fed into what was part of that monitoring
29 plan, and part of the MHPS report, I have now got

1 allegations being thrown against me placing me in
2 a difficult position in the middle here, potentially
3 against me. I haven't been told clearly.

4 6 Q. Could we just go down a few pages to 279134.
5 Mr. Carroll is saying:

6
7 "I would like this dealt with today or at least a plan
8 in place."

9
10 Again, you set your position out earlier. Can you
11 recall whether that call to arms, or call to sort this
12 out with a plan, how that was addressed?

13 A. I can't recall off the top of my head. Just scrolling
14 down, was that the one before from Wendy to --

15 7 Q. Yes.

16 A. -- to all? So I am unsure. Looking at that now, I may
17 have interpreted that e-mail from Ronan as a reply to
18 Wendy.

19 8 Q. Yes.

20 A. As in, can you go and speak to Colin?

21 9 Q. This is going to be an e-mail-heavy morning, at lest
22 the first part of it, so I apologise in advance. If we
23 could go to TRU-258911. Again, 18th October, and
24 Mr. Carroll is explaining that the -- we started this
25 morning by looking at the backlog. Mrs. Corrigan had
26 been off for some time and the backlog, which was
27 documented in Mrs. Clayton's starter e-mail, accrued
28 during her absence. Mr. Carroll is replying to some,
29 I suppose, criticism from Mr. Gibson. Mr. Gibson was

1 stationed in the Medical Director's office, and
2 Mr. Carroll is explaining:

3
4 "Wi th Martina having been off since June, the
5 overseeing function has not taken place and in the
6 day-to-day activities was overlooked. We need to
7 understand why this dictation has not gone out. This
8 could explain the volume of notes or there may be some
9 other reason"

10
11 I think that should say "has not gone out".

12
13 This is your reply:

14
15 "According to Simon there were monitoring and
16 supervision arrangements put in place and which we
17 confirm to a range of interested parties."

18
19 You are making it clear:

20
21 "I wasn't one of these interested parties, neither from
22 Colin's e-mail was he or Michael, from his."

23
24 "If the Clinical Lead in the Service, the Clinical
25 Director" and yourself, "the Associate Medical
26 Director, weren't, I'm not sure who was".

27
28 "I can only assume given the Trust's previous failings
29 in tackling behaviours in this case the arrangements

1 were robust, and regularly monitored at multiple levels
2 and clear back stops for sickness, et cetera, so it
3 wasn't reliant upon only Martina."

4
5 Does that e-mail suggest an element of surprise that,
6 although you were Associate Medical Director, nobody
7 had troubled you with information that there was a plan
8 in place, even if you weren't to be an active
9 participant in enforcing the plan?

10 A. I think possibly surprise, possibly frustration.
11 I think the table -- sorry, just taking back to Wendy's
12 e-mail. That was a table cut from a monthly report
13 relating to September, and I think one of the notable
14 things there is that the clinics not dictated went back
15 to June. So there were multiple reports before that
16 September one which, presumably, and I think from
17 memory, didn't highlight the clinics in June hadn't
18 been dictated. I have mentioned previously about my
19 concerns that the data wasn't robust in how it was
20 collected. I think there was probably an unwritten
21 sense of frustration from myself that, actually, I felt
22 that the data wasn't robust and actually, it's been
23 evidenced here. We have had okay June, July, August
24 backlog reports, and then in September there's 92
25 dictations dating back to June, so something has
26 happened in how that data has been collected at that
27 point. As I say, I suspect there is a sense of
28 frustration that everything that was then coming back
29 to myself where perhaps, if it had come to me at an

1 earlier point I might have suggested or raised concerns
2 as to how the data was being collected and suggested
3 methods for it to be a little bit more robust, and
4 again, an additional sense of frustration that we kind
5 of -- everything has hinged on one person, and one
6 person goes and what happened?

7 10 Q. Yes. I think you are answering the question I'm about
8 to ask. The system in place, dependent upon one person
9 to monitor and to escalate, which falls apart in her
10 absence, can't have been a robust or an effective
11 system?

12 A. Or as I think is stated, wasn't done in her absence.
13 I think it's important, Martina -- in terms of this
14 monitoring, that Backlog Report data wasn't generated
15 by Martina, that was generated by others. If we
16 haven't got a clear understanding of how that data is
17 being generated, a clear understanding of why it's
18 being generated by the individuals collecting that
19 data, then you get poor quality data, and that's
20 illustrated. The data collection was not robust, and
21 the process for that data collection, if you like, to
22 be assimilated and put together, was reliant on one
23 individual.

24 11 Q. Yes. I think it's important to keep in mind the dates
25 here and what's happening around this time. MHPS has
26 just reported. Dr. Khan has issued determinations
27 which, to some extent, were blocked by the issuance of
28 a grievance. Dr. Khan is both Case Manager and Acting
29 Medical Director with Mrs. O'Kane to take up the reins

1 or Dr. O'Kane at the start of the new year. Lots of
2 things happening. Just on this evidence that this
3 monitoring plan has run into difficulties, anything
4 done by you or anybody else to try and fix it?

5 A. Again, the monitoring plan was put in place by
6 individuals, and the management of that monitoring was
7 by individuals that wasn't myself. I think I have
8 suggested I have got concerns there. Did I actively
9 take it off someone else and change it? No, I didn't.

10 12 Q. Mm-hmm. Because we will see, in the course of the
11 morning, that those concerns are maintained throughout
12 the next year, leading to a meeting in early January
13 2020, when, as we see, the concerns are put out on the
14 table and an arrangement is suggested to try to address
15 it at that point.

16
17 Just let's scroll up, please. No, I think I haven't
18 got the page.

19
20 There was a suggestion by Mr. Weir that he would meet
21 with Mr. O'Brien but he wished to be fully briefed and
22 advised in respect of what sanction, if any, might be
23 applied or discussed. Do you know whether that meeting
24 happened?

25 A. I don't know. I know Colin did meet with Aidan on
26 occasions, but I don't know whether specifically at
27 that point.

28 13 Q. Yes. As you say, we do know that he met on occasions
29 with Mr. O'Brien. Could I ask you to look at the

1 following set of e-mails: TRU-251540, starting at the
2 bottom of the page, please. Again, we are recalling
3 that MHPS has just reported, Mr. O'Brien is appraised
4 of the outcome, and what comes next in terms of
5 a conduct hearing. Mr. Carroll is writing to Esther
6 Gishkori, who is the Director of Acute, Colin Weir and
7 Michael Young. Ronan has been speaking to Mr. Young,
8 who has advised him that morning that he received phone
9 calls from Mrs. O'Brien on the Saturday evening, and
10 Michael O'Brien, who I understand is the son of
11 Mr. O'Brien, on the Monday evening, and both of those
12 phone calls centre on Mr. O'Brien's investigation.

13
14 "Give me a ring if you require anything further."

15
16 It's just signed off.

17
18 Mr. Weir then records that he met with Mr. O'Brien in
19 Mr. Weir's office. Mr. O'Brien requested the meeting,
20 and the conversation centred around the investigation.
21 I am conscious a moment or two ago I asked you whether
22 Mr. Weir had met with him to discuss the shortfall on
23 dictation, but that isn't this meeting. Mr. O'Brien
24 requests this meeting. Mr. O'Brien has recorded the
25 meeting, which is of some benefit to the Inquiry,
26 I suppose, although I understand that you and others
27 are somewhat upset by the fact that recordings of
28 conversations have taken place.

29 A. I think what you have got here is, Mr. O'Brien

1 initiated a meeting with an agenda, and a tape-recorder
2 effectively in his pocket. It also documented below
3 that, you've got family members putting pressure on
4 individuals within the service. I think there was
5 a lot -- why hadn't someone asked, do you mind if
6 I record this conversation? that would be reasonable,
7 I wouldn't have an issue with it. The fact that you've
8 had meetings where the agenda has perhaps been led by
9 someone who knows they are recording it, with their own
10 agenda and own intended outcome, it's a bit underhand.
11 It's a bit frustrating.

12 14 Q. The surreptitious nature of the recording that you
13 allude to, just to be clear, there are at least two
14 other meetings involving you which were recorded, your
15 consent wasn't sought?

16 A. Two meetings and a phone call, and never at any point
17 were we made aware that a recording was being taken.

18 15 Q. Yes. Mr. Weir seems upset about the nature of
19 Mr. O'Brien's approach in this meeting. He feels that
20 he should not have made this approach, that "his
21 questioning and responses could undermine the
22 investigation and action plan."

23
24 I assume that's a reference to the MHPS investigation
25 and subsequent plans that were never brought into
26 fruition for an action plan.

27
28 "He put me in a difficult and awkward position and
29 having met Mr. Young and knowing his experiences, he

1 says, I cannot meet or discuss anything with
2 Mr. O'Brien, anything other than day-to-day activities
3 in his work as a Urologist."

4
5 He asks: "Can we be protected from this as I suspect
6 evidence is being gathered from us and I will make the
7 Medical Director aware."

8
9 Is it fair to say there was a degree of concern and
10 suspicion between colleagues at that time?

11 A. I mentioned, I think on day 1 I was here, a fear this
12 awareness of the connections around Mr. O'Brien.
13 I mentioned an awareness that a previous AMD had been
14 accused of bullying when he tried to address things.
15 So, there was an awareness of, if you like, those
16 around Mr. O'Brien. We've got an investigation, if you
17 like, taking place, and we've now got family members
18 making contact with individuals within the team. We've
19 got a concern from Mr. Weir that a meeting is being
20 sought in his understanding to discuss one thing but
21 the conversation heading down an agenda, that's
22 recorded. I think it just illustrates an approach of
23 Mr. O'Brien that really backs that -- why there was
24 that underlying awareness and fear of, actually if
25 I try and tackle anything with him, what am I going to
26 be hit with? We have got allegations of unsafe
27 practice, without names, against the individuals in the
28 Department potentially, again throwing another barrier
29 to people addressing his practice.

- 1 16 Q. From his perspective, is it reasonable to suggest that
2 he felt let down and suspicious of colleagues?
- 3 A. I think if we were to look on the whole, I would say
4 there is plenty of reason for Mr. O'Brien to feel let
5 down, but let down that actually we'd failed to address
6 things at a much earlier stage and things had got to
7 this point. You know, as we said in the retained swab
8 SAI, while it wasn't a recommendation of the SAI it was
9 the issue recognised of not acting on Radiology
10 results. Had that been addressed for Mr. O'Brien at
11 that time, it would have prevented him having the same
12 issue happen at a later date. How much he's fed into
13 that inability to address it, that's another subject
14 but there's lots of reason to feel that he's been let
15 down, but ultimately the reason the investigation was
16 happening at that time was down to the way he had
17 behaved and his action and his clinical -- his
18 practice.
- 19 17 Q. When you say he has lots of reasons to feel let down,
20 and then you go on to explain it by reference to the
21 swab issue, in part. Is that you suggesting that he's
22 entitled to feel let down because he wasn't more firmly
23 managed or more firmly directed?
- 24 A. I feel we've let him down by not having more firmly
25 managed it at earlier stages and us getting to the
26 point where we are now. Whether he felt let down for
27 that same reason, I suspect not.
- 28 18 Q. Yes. Just putting up the page again. I think you come
29 in on this issue. Yes. You are writing to Dr. Khan

1 and Simon Gibson, Acting Medical Director and his
2 manager, and you are saying to them:

3
4 "Are you aware of this? Surely this behaviour, phone
5 calls from wife and his son/legal adviser to Mr. Young
6 below with Mr. Weir shouldn't happen. How can we, his
7 colleagues, be protected?"

8
9 Did you get any satisfactory or any response to that?

10 A. I can't recall. I think there was --

11 19 Q. Just scroll down. I don't think I have seen a response
12 to it. Yes. No. So the question is, I interrupted
13 you there.

14 A. I can't remember whether it was specifically related to
15 there, but I think at some point Mr. O'Brien got
16 a letter saying that he wasn't to make contact with
17 individuals in that way.

18 20 Q. So far as you are aware, did that kind of behaviour
19 desist?

20 A. As far as I'm aware, I was never contacted in that way.
21 As far as I'm aware, it did desist. We know that the
22 recording of conversations didn't.

23 21 Q. If I could turn to TRU-251546. The Revalidation Team
24 is writing to you, Mr. Haynes. Presumably that's
25 a task you have to go through in your role as Associate
26 Medical Director. It's with regard to the revalidation
27 of Mr. O'Brien, and you are asked to complete and
28 return an attached form. Just scroll down until we see
29 the form, please. You are asked to certify whether

1 there are any concerns or information about Mr. O'Brien
2 that may impact on the Responsible Officer's
3 revalidation decision. If we can go to TRU-251542,
4 please. Your response is to write to the Medical
5 Director's Office. Maria O'Kane is in post as Medical
6 Director at or about this time, so she's copied into
7 this. You are saying:

8
9 "As you are aware, I have limited involvement in the
10 ongoing investigations. Would you have any
11 recommendation for me as to how to respond?"

12
13 It's fair to say that you didn't feel competent to
14 complete that form because, as you've explained, you
15 have been largely kept out of the monitoring process?

16 A. More that form is a means for us to provide, if you
17 like, reassurance to the Responsible Officer that there
18 aren't any investigations that we are aware of into the
19 individual who we are signing it about. I was aware
20 that there was an investigation into Mr. O'Brien and,
21 therefore, could not sign a form saying, 'I am not
22 aware of any investigation into Mr. O'Brien'.

23 22 Q. I think that process stretches for a number of months
24 and we will come back to it later. We explored, on the
25 last occasion, your concerns about the robustness of
26 the data and, I suppose, how comprehensive it was in
27 terms of the use of backlog reports. I think you first
28 raised that issue in 2018. We looked at it on the last
29 occasion. The issue comes up again. If we go to

1 WIT-55742 at the bottom of that page, please. On 4th
2 December you are part of a list of people receiving the
3 backlog reports and the Administrator says:

4
5 "No major outstanding backlog. Results to be dictated
6 are from the middle to the end of November. And the
7 audio typist is currently on results to be typed area
8 of backlog."

9
10 I'm not sure what that means. The point is this, you
11 respond -- just scrolling up, please. This is,
12 I think, a repetition of the point you'd made less than
13 12 months earlier. You are interrogating, I suppose,
14 the data that's been sent to you. You apologise if the
15 question sounds awkward but you say:

16
17 "Could you describe the method by which the information
18 is collated? I can see how you obtain the waiting to
19 be typed information but, for instance, how is the
20 information on results to be dictated collected? Is
21 this based on e-sign-off data or some other method?
22 I am concerned that the data presented doesn't fit with
23 my impression of practices. I regularly see patients
24 coming to Outpatients with scan results that have been
25 performed, often months earlier, requested by someone
26 else but no results letter or action ever done and no
27 sign-off either on ECR or on the paper copy.
28 Similarly, how is the clinics awaiting dictation data
29 obtained?"

1
2 You have copied this to Martina Corrigan:

3
4 "As I have spoken to her about this so she will be able
5 to help if my question isn't clear."
6

7 Again, help us with this. I know that, and we will
8 come to it in a moment, you go on to refer to
9 a specific example of a problem, the case of Patient
10 92, that fitted within the mould of this concern. Just
11 unpack that e-mail for us, if you could.

12 A. I think there's another e-mail as well along the same
13 lines --

14 23 Q. If it helps we can --

15 A. I was just going to, just say, so we have created
16 a Backlog Report that we are using to provide, if you
17 like, our system with assurance that when patients have
18 got, for the results to be dictated, results have come
19 back, something has been done with them, but I'm not
20 clear how that's being generated. I'm not clear how
21 I could parachute someone in to collect that data and
22 provide an instruction as to how they provide that
23 data. Therefore, I'm not entirely certain that that
24 data is robust. I have cited examples there of we are
25 saying everything is up to date, but we see people come
26 to clinic, and it hasn't been signed on ECR, it hasn't
27 got a signature on the paper report, so it doesn't look
28 like this data is correct. But without understanding
29 how the data is being collected, it comes back to my

1 concern of what we are using to monitor our services
2 isn't robust. I was going to said, I have said in
3 another e-mail, you could actually say it's accurate
4 because if someone never does a letter on a result, and
5 it waits until they are seen in clinic, then they
6 haven't got any results awaiting dictation because they
7 never do a letter. There is no-one awaiting a
8 dictation because that's their practice, they don't do
9 it. It's very different from my practice, as I have
10 outlined before, where I do do them letters. Again
11 I think I have said in another e-mail, I know how the
12 data is generated for myself by my secretary, but
13 I don't know whether that's the case across the board.

14 24 Q. You allude to a particular problem of a colleague, and
15 I assume that that's Mr. O'Brien?

16 A. I don't think I have actually said a colleague. I have
17 referenced a colleague, as in it's a colleague.

18 25 Q. Mm-hmm.

19 A. So one of my colleagues. I haven't specified who.
20 I don't know when I have written that whether I have
21 had in my mind a specific colleague.

22 26 Q. Okay, that's fair. Can we scroll up, please. You get
23 a response from Mrs. McCaul. She says:

24
25 "If you could, I would be grateful of an example of
26 a patient who has come to your clinic but no result
27 letter or action ever done".

28
29 That would be great so that they can see what's going

1 on. You refer to the case of Patient 92. We have
2 heard specifically on the last occasion your evidence
3 in respect of that, but essentially a CT scan had been
4 ordered, performed and reported upon promptly. This
5 was a patient of Mr. O'Brien, for whatever reason, he
6 didn't action the results. Fast forward several
7 months, and her general practitioner, I think, is
8 red-flagging her into the system and she has renal
9 cancer, I think. Fortuitously, it's dealt with.

10
11 That was clearly an example of a patient you had in
12 mind. Let's just scroll up, please. You say:

13
14 "I should add that although this case is an individual
15 who may have had concerns raised about previously, he
16 is not alone."

17
18 This is a wider issue of not addressing CT outcomes?

19 A. This is my concern, as we've talked, AMD for Surgery
20 and Elective Care looking across an entire surgical
21 service that actually that may not be the only case of
22 Consultants who are not acting on results. If we have
23 got a monitoring process in place that's providing us
24 with system-wide assurance, it shouldn't be focused on
25 an individual, it should be focused on everyone within
26 the system, to provide that system-wide assurance. If
27 you want to get that system-wide assurance, you have to
28 know how you are collecting the data.

29 27 Q. You give a specific answer back in respect of that

1 particular patient. It raises issues about, I suppose,
2 the upset being felt by Mr. O'Brien's secretary in this
3 context. You elaborate upon your concern:

4
5 "My concern that there are individuals who think that
6 the reported results for dictation data is robust, it
7 isn't. The number is generated at best for some as
8 a guess. Because this regular report is taken by
9 senior personnel in the Trust as robust, it is seen as
10 a monitoring tool within the Governance processes that
11 results are being actioned and communicated to patients
12 in a timely manner, with no risk of un-actioned
13 significant results. I fear your team are at risk if
14 we have a situation where a patient comes to harm
15 because a result isn't actioned and subsequent
16 investigation reveals a large number of un-actioned
17 results, your team would be open for criticism for
18 reporting inaccurate information."

19
20 You are putting the problem at their door. They have
21 got to worry about the fact that they are not doing
22 their job as well as it could be done. Equally, what
23 lies behind that is a significant Patient Safety issue?

24 A. Yeah. I don't think I'm putting it at their door.
25 I am trying to highlight why my concern is of relevance
26 to the individuals who are collecting this data.
27 Again, if we haven't provided guidance as to how the
28 data is to be collected and what the data is being
29 collected for, then the individuals collecting the data

1 aren't necessarily at fault in the way that they do it.
2 If we provided very clear guidance as to how that data
3 is collected, what it's for and what that Patient
4 Safety relevance is, and it's not collected
5 appropriately or accurately, then it's down to the
6 individual. But when we don't provide that guidance,
7 then the lack of guidance creates the issue.

8 28 Q. Just to be clear, this is the kind of data that is
9 being relied upon, at least under the category of
10 dictation, for the monitoring of Mr. O'Brien?

11 A. This is part of the data that's included within the
12 Backlog Report. I mentioned earlier today the clinics
13 awaiting dictation. How can we go in September and
14 have clinics awaiting dictation from June, but they
15 weren't reported on in a July or an August report?

16 29 Q. So the risk here is of under-reporting?

17 A. Under-reporting.

18 30 Q. I think that's the end of the sequence. Just scroll up
19 that I can check. We will come back to that one.
20 That was December. Was that issue of data reliability,
21 and potential under-reporting, resolved?

22 A. I know I had conversations. I think I met with
23 Catherine and the team to talk through or, if you like,
24 flesh out why and what my concerns were. During
25 Mr. O'Brien's time, I don't think we got to what
26 I would be confident on as a 100% robust method of
27 collating that data. Within Urology, for our Radiology
28 results I am now satisfied we have a 100% reliable
29 process for that.

- 1 31 Q. But that wasn't achieved during Mr. O'Brien's time?
- 2 A. That wasn't achieved, no.
- 3 32 Q. Before I move to March, further thoughts as something
- 4 of an aside. In terms of the dictation of letters,
- 5 a letter is dictated, or should be dictated following
- 6 Outpatients or perhaps any other major milestone in the
- 7 patient's care pathway, for the purposes of the General
- 8 Practitioner it's directed to the General Practitioner?
- 9 A. Generally you would write to the referrer and you would
- 10 copy in individuals involved in the patient's care.
- 11 Generally the GP would always get a copy. If they are
- 12 not the primary addressee, they'd got a copy of the
- 13 letter. For instance, a patient under the care of
- 14 Urology, the Oncology team, as well, they get a letter
- 15 that's addressed to the Oncologist but copied to the
- 16 GP.
- 17 33 Q. Just in terms of the patient, is the patient the
- 18 recipient of a letter of the nature I have described,
- 19 or not?
- 20 A. It's good practice that they should be. They are not
- 21 always. Certainly before I came to Craigavon, in
- 22 Sheffield it was standard practice that all patients
- 23 were copied into GP letters. It's not a standard
- 24 practice, although I do copy many of my patients into
- 25 my letters but that's not standard practice across all
- 26 Consultants in Northern Ireland.
- 27 34 Q. In terms of your standard practice, is there a criteria
- 28 that determines whether you will write to the patient
- 29 as well as the GP, or is it hit-and-miss? Is it, for

1 example, a major result goes to the patient or not?
2 what influences?

3 A. All results I write directly to the patient and copy to
4 the GP in my practice. From clinic consultation, then
5 I generally copy in a large proportion but not
6 necessarily all. I couldn't give you a clear, this is
7 why I don't copy patient X in, but I copy in a large
8 proportion.

9 35 Q. This is an area the Inquiry's interested in and they
10 may have some questions for you beyond what I have.
11 Just in the Northern Ireland context, it's not, to the
12 best of your understanding, standard across your
13 colleagues to copy patients in?

14 A. Not in the same way as it was just across the board
15 when I worked in Sheffield, that every patient got
16 copied into GP correspondence.

17 36 Q. Do you know whether that's because of a different
18 culture, is it because of a different rule or
19 guideline, or is it something you just don't know?

20 A. I don't know. I suspect it's culture rather than
21 a guidance, but that would be a suspicion.

22 37 Q. Thank you. Could I go to WIT-55773, please. The
23 bottom of the page, please. A Higher Clerical Officer
24 in the Red Flag Appointments office writes on 29th
25 March saying:

26
27 "There are 24 referrals from 22nd March needing triage
28 for Urology on the ECR, can you escalate please?"
29

1 Ms. Graham then escalates that to the team of
2 urologists, repeating largely the same message. Then
3 you come in and say to the Medical Director:
4

5 "This relates to one of the Aidan O'Brien issues. He
6 has been On-Call since 22nd March and should have been
7 doing the triage."
8

9 Just up the page. No, I think that's the end of it.
10

11 You, by this stage, are aware of the monitoring plan
12 from the tail-end of the previous year, and you
13 recognise that this is a deviation which needs some
14 form of explanation or action. So, while you are not
15 involved directly in the monitoring, the information
16 properly comes to your attention as Associate Medical
17 Director?

18 A. The information came to my attention as a member of the
19 team of urologists.

20 38 Q. Yes.

21 A. Rather than escalated to me as Associate Medical
22 Director. That's why all the consultants are copied
23 in.

24 39 Q. Yes. You, amongst that list of colleagues then, pops
25 on your AMD hat because nobody else is going to refer
26 it to Dr. O'Kane?

27 A. Yeah.

28 40 Q. It's in that mode that you forward to her. Dr. O'Kane
29 becomes involved in these concerns about deviation,

1 a couple of days later. If we can start at WIT-55769,
2 please, at the top of that page. We have that one.
3 Keep going, yes, thank you.
4

5 She is asking you has this happened in this way before,
6 and you respond by setting out the wider context. Is
7 it fair to say that Dr. O'Kane, new to the Trust and
8 new to the job of Medical Director, needed certain help
9 along the way from the likes of you to appraise her of
10 the issues in the background?

11 A. I think that would be the role of any of us in position
12 when a new Medical Director takes up post.

13 41 Q. Because her question to you seems to belie, I suppose,
14 a lack of knowledge, in the sense that we have had, by
15 this stage, a well-documented, through the MHPS
16 process, explanation of the triage shortcomings going
17 back over a significant period of time. She's asking
18 what appears to be, on the face of it, a rather naive
19 question -- I hope that's not unfair to her -- that it
20 certainly seems to suggest that she is not yet up to
21 speed on the triage issue which has clearly been
22 a historic issue?

23 A. I'd be making assumptions on -- it could be as you say,
24 or it could be has this happened in this way before
25 since the monitoring started?

26 42 Q. Yes. You certainly take it back to June 2015, set out
27 the full context, and you go on to say that:

28
29 "Red flag referrals must be completed daily."

1
2 You go on: "I think this is reflecting aspects of the
3 monitoring plan that all referrals received by
4 Mr. O'Brien will be monitored by the CBC in line with
5 the above time scales and a report will be shared with
6 the Assistant Director of Acute Services", et cetera.

7
8 You refer to the escalation e-mails issued by
9 Mrs. Graham and you say that you "would assume that
10 this is being shared with the Director of Acute
11 Services and escalated to the MHPS Case Manager."

12
13 It's not clear to you that that has been done, and you
14 say:

15
16 "Anecdotally, certainly the e-triage is not completed
17 by 4pm on the Friday of his on call week. Indeed,
18 looking now there are 79 referrals on e-triage received
19 between 21st March and 27th March that have yet to be
20 triaged, including 16 red flags."

21
22 I think this e-mail is the 31st March, so there's time
23 yet. You say:

24
25 "I am now aware of the reporting and escalation that
26 may have occurred to this following the return to
27 work."

28
29 Moving up the page again, please. At that stage,

1 Mr. Haynes, can you recall any further interaction with
2 the Medical Director's office with a view to trying to
3 resolve this, or do you know whether Dr. Khan, as Case
4 Manager, became involved?

5 A. I can't recall off the top of my head. One of the
6 things that I am aware of now, and I may have become
7 aware of, is we asked, I think on day 2 I was here,
8 about the monitoring plan and whether I felt the
9 expectation with regards to triage was okay, and I said
10 that you needed some, if you like, some slack. You
11 needed some recognition if you had a busy On-Call week
12 24 hours might not be achievable. I believe
13 a derogation was agreed that actually he did need some
14 slack, so it may have been this hadn't been escalated
15 because it hadn't quite reached the derogated
16 thresholds. The other thing on this is, as I said,
17 this came through our Red Flag office and escalated
18 through Vicki Graham. It wasn't escalated through the
19 monitoring processes that this hadn't been done. This
20 had come through a separate route to my attention
21 rather than through a monitoring process to Dr. Khan.

22 43 Q. Yes. It's clear that, although you appropriately allow
23 the soft landing for the busy week, you do appear to
24 have concerns that triage isn't being done in
25 accordance with the requirements of the plan.

26
27 If we move to May of that year. If we go to WIT-55765.
28 If we can just go to the bottom, please. Actually,
29 bring it to the top so Mr. Haynes, can see the context

1 for this.

2
3 There's been a meeting on 24th April 2019. You are not
4 in attendance at that. It appears that those persons
5 have been, and there's action notes following the
6 meeting. It's unclear, to me at least, what the nature
7 of that meeting was. Could it have been in relation to
8 the validation issue?

9 A. I don't know, not being at that meeting or party to the
10 e-mail trails around that meeting.

11 44 Q. Yes. If we just scroll down and see some of the issues
12 that were being discussed. It's perhaps issues arising
13 out of the MHPS. Then the last bullet point is
14 something I wish to ask you about.

15
16 "One of the headline issues from the meeting is the
17 need to seek assurance from Acute. Question is there
18 an agreed job plan and Simon" --

19
20 That's Simon --

21 A. Gibson.

22 45 Q. Gibson, of course. "... is to check with you on behalf
23 of Dr. O' Kane is the 2017 action plan being followed
24 and all monitoring arrangements in place. Siobhán
25 Hynds reported that Martina Corrigan is ensuring
26 monitoring arrangements are still in place, with no
27 exception reports flagged to the Case Manager. It was
28 agreed that the Case Manager should periodically seek
29 this assurance."

1
2 It seems to be reported here that no exception reports
3 are flagged to the Case Managers, that's certainly how
4 you interpret it. If we scroll up the page, please.
5 Dr. O'Kane writes to a list of people, including
6 yourself, and says that:

7
8 "Ahmed or Mark as his AMD should seek regular assurance
9 rather than me and then inform the MDO. AOB-is still
10 undertaking assessments of private clinic at home as
11 per the request, sign-off of transfers from private to
12 public practice. She" -- that is Dr. O'Kane -- "has
13 brought this to the attention of Urology and they have
14 asked for a rationale as to why the GMC has suggested
15 his practice is stopped before this is progressed."

16
17 On the first issue, you intervene, Mr. Haynes. If we
18 just scroll up. You explain as regards the job plan:

19
20 "Mr. O'Brien does not have a signed-off job plan.
21 Discussion has occurred and the job plan has been
22 awaiting doctor agreement since November 2018. I am
23 second sign-off and so would not be requested to sign
24 it off until he and his Clinical Director have signed
25 it."

26
27 what was holding up that?

28 A. I can't recall the exact issues but I know the CDs,
29 I think it was still Colin Weir --

1 46 Q. Yes.

2 A. -- had met and attempted to come to an agreement on
3 the job plan, but that had got held up. I don't know
4 whether that was got to a point and then didn't happen,
5 or got to a disagreement. I can't remember.

6 47 Q. The action plan is then discussed in your e-mail. You
7 say that you are not currently in a position to provide
8 the reassurances requested. You weren't party to the
9 action plan and have only recently been made aware of
10 its contents, that is within the last six months.

11

12 "Having been made aware of its contents I am aware of
13 instances where the actions regarding concern 1" --
14 that is triage -- "have not been met.", and you refer
15 to attached e-mails.

16

17 "Specifically, triage of all referrals must be
18 completed by 4 o'clock on the Friday". Et cetera.

19

20 "Given that I am aware of aspects of the action plan
21 not being met, I am concerned the statement that there
22 had been no exception reports flagged to the Case
23 Manager" -- that was the minute contained in the
24 earlier e-mail from Dr. O'Kane --

25 "... the implication being that either there has been
26 an agreed deviation from the action plan and monitoring
27 is now occurring against different standards, or that
28 the monitoring and/or escalation process has not
29 functioned as it should. As I was not party to any of

1 the previous discussions, if I become part of this
2 I need an initial briefing with all and also some
3 run-through of monitoring to date. Through this
4 briefing I need to understand the process as it is at
5 the present and how despite evidence, there appeared to
6 have been exceptions and the reporting process appears
7 to have failed to flag these to the Case Manager."
8

9 It appears to be right to say that the Case Manager has
10 not been brought into these matters as he should or has
11 been anticipated by the monitoring plan?

12 A. That's my interpretation of it. As you say, them
13 action notes from that meeting, they have said there's
14 been no exceptions and yet I, as I have stated there,
15 am aware of exceptions, and so it appears that
16 monitoring process hasn't flagged these.

17 48 Q. Put it this way: If there has been escalation to the
18 Case Manager, you would be expected to be told about
19 it?

20 A. I don't think within that monitoring process I would
21 necessarily have expected to be explicitly told because
22 I wasn't -- we have said I wasn't within that
23 monitoring process. What I would have expected, given
24 that I was aware that there were escalations of triage
25 not having taken place, I would have expected that that
26 would have been escalated to the Case Manager, and
27 I was surprised to see the suggestion in the action
28 notes that no exception reports have been flagged to
29 the Case Manager. As I have said, the implication

1 being that there was an agreed deviation from the plan
2 that I wasn't aware of that amended action plan
3 expectation, or that the process and escalation has
4 failed.

5 49 Q. Certainly nobody has written back to this e-mail to
6 say, you're quite wrong in your inference, we're all
7 over this, The Case Manager has been actively concerned
8 about this and is getting ready to meet with
9 Mr. O'Brien. None of that kind of thing happens?

10 A. If there's no reply, then no.

11 50 Q. I think that's the end of the sequence. Come
12 September, Mrs. Corrigan e-mails Dr. Khan to highlight
13 further deviation relating to concern 1 in the action
14 plan and concern 3, that's the use of dictation. If we
15 just have the e-mails up, please. If we go to
16 WIT-55761, and go to the bottom of the page, please.
17 Martina Corrigan is writing to Dr. Khan in his role as
18 Case Manager, 16th September 2019, and she says:

19
20 "I am escalating this to you".

21 She is attaching e-mails showing where she has asked
22 Mr. O'Brien to address the issues. So the two in red
23 obviously are the difficulties, concern 1 not adhered
24 to, "please see escalated e-mails as of today Monday
25 26th September Mr. O'Brien has 26 paper referrals
26 outstanding and on e-triage, 19 routine and 8 urgent
27 referrals. And on dictation, concern 3: Mr. O'Brien
28 continues to use digital dictation on his clinics, but
29 I have done a spot-check today" and she has identified

1 the following. I won't read those results out, but you
2 can see from clinics from July into August and
3 September, there are dictation issues. Of course,
4 those dictation issues are subject to the frailty of
5 the reporting system that you have highlighted earlier,
6 which risks under-reporting. Just scrolling up,
7 please, to see how this issue develops. Dr. Khan
8 thanks Martina and asks Siobhán Hynds and Simon Gibson
9 to meet with him urgently.

10
11 Over the page. Dr. Khan is alerting the Medical
12 Director that this is an issue, saying Mr. O'Brien has
13 failed to adhere to two elements of the agreed action
14 plan and explains that he has requested an urgent
15 meeting with two of the managers.

16
17 Dr. Khan explains that he has discussed the case.
18 Ms. Hynds has requested further information from
19 Martina, and they wait for this. He understands that
20 the Trust grievance process is on hold, and that is the
21 reason why the MHPS conduct hearing can't proceed.

22
23 Scrolling on up, please. Within this e-mail,
24 Mr. Haynes, you have obviously been appraised of this
25 issue. Dr. Khan has communicated with you and you have
26 confirmed, I think, that there's a number of
27 non-adherence to the agreed action plan. Dr. O'Kane is
28 asking for a teleconference on this issue.

1 Just focusing on this e-mail here. Mr. Haynes, you
2 write in at this point to alert Dr. O'Kane of another
3 issue that has come to your attention concerning
4 Patient 112. His name appears on the e-mail. That
5 e-mail raises a concern that the MDM decision or
6 recommendation was for Mr. O'Brien to see this patient
7 and conduct a biopsy, and there was no evidence on the
8 system that that had been done. Mr. O'Brien hadn't
9 dictated on that issue, so colleagues were none the
10 wiser as to what was happening in that case, and it was
11 causing a concern. Ultimately that case was considered
12 by Mr. Gilbert, who we heard from yesterday, who was
13 asked to give an opinion as to whether it ultimately
14 amounted to a Serious Adverse Incident for review, and
15 he decided that it didn't meet the threshold for SAI
16 but, at that time, concern, as indicated in your
17 e-mail, had arisen because nobody knew what was going
18 on. Is that fair?

19 A. Yes. It's in the context of the monitoring. There was
20 an MDT outcome, a clinic appointment had happened and
21 no letter had been generated from that appointment.
22 The appointment was on 16th June and we were in October
23 here -- sorry, 16th August and we were in October. As
24 it transpired, things had happened, but there was just,
25 as per the action plan of a dictation being generated
26 from the outpatient consultation, that hadn't happened
27 and, as a result, we weren't aware what was happening
28 and the cancer tracker wasn't aware what was happening
29 for this patient.

1 51 Q. Just scroll up the page, please. I think that's the
2 end of that sequence. Can you remember becoming
3 involved in a meeting then to address that deviation?
4 A. The planned teleconference in October 2019.
5 52 Q. Yes. September.
6 A. My recollection is, I couldn't phone into that.
7 I wasn't at that.
8 53 Q. Come the end of the month, WIT-5753, you are alerting
9 Dr. O'Kane to a further Incident Report that's about to
10 be generated. That's a different case, is it, to the
11 one I have just alluded to? That one was arising out
12 of consideration of a case at the Belfast MDM?
13 A. Yeah. My memory is that was a patient with testicular
14 cancer, who had had his surgical treatment and needed
15 referral to the Oncology team. That's my memory.
16 54 Q. It's clear, is it, Mr. Haynes, that there's various
17 concerns being generated around Mr. O'Brien's practice
18 at this time. It's all clearly visible to senior
19 management, including the Medical Director, but pausing
20 for a moment. Was anything concrete being done to
21 address any of these matters directly with Mr. O'Brien?
22 A. In terms of, I think it was Patient 112, the e-mail
23 before, as I had said in there, I had contacted
24 Mr. O'Brien myself to find out what was happening with
25 that patient. In terms of addressing the non -- each
26 of these is about not conforming to the action plan.
27 Here, the bits in red are Outpatients in August 2019
28 and the letter is dictated a month later. Whether any
29 of them were directly taken up with Mr. O'Brien,

1 I don't know. My assumption was that that went through
2 the Case Manager as that was the process for managing
3 against the action plan.

4 55 Q. We know from your evidence, and an e-mail a short time
5 ago, that you said, 'if I'm to become involved at this
6 stage, I will require a full briefing and brought up to
7 speed on what has happened in respect of the plan
8 historically'. Did anyone take you up on that
9 proposal?

10 A. Not that I recollect.

11 56 Q. In terms of the intervention of the Medical Director,
12 while she's clearly apprised of these issues, are you
13 aware of anything being done to challenge Mr. O'Brien
14 at this stage in respect of what are being reported and
15 escalated as shortcomings?

16 A. Not that I'm aware of.

17 57 Q. You did a piece of work in respect --

18 CHAIR: Mr. wolfe I am just wondering is this an
19 appropriate time to take a break?

20 MR. WOLFE KC: Yes, by all means, it is. I didn't
21 realise the time.

22 CHAIR: Yes. We can come back in 15 minutes, please.
23 Ten to.

24
25 THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

26
27 CHAIR: Mr. wolfe.

28 MR. WOLFE KC: Thank you. Could we have up on the
29 screen, please, WIT-55763. Yes, thank you.

1 Mr. Haynes, in this context of further concerns having
2 been raised by Ms. Corrigan and escalated to
3 Dr. O'Kane, she having arranged for a meeting, I think
4 to take place a couple of days later. It appears
5 you've gone and done some work in relation to issue of
6 dictation in particular. Can you help us just in terms
7 of why you saw fit to do that?

8 A. I think it was, as I've said before, I was concerned
9 that the data that was informing the process wasn't
10 necessarily robust so what I have gone and done is,
11 what I have considered a more robust review, I think of
12 two clinics. Yes, two Outpatients clinics.

13 58 Q. If you scroll down -- sorry to cut across you -- we can
14 see the results.

15 A. Those were a considerable period before the point at
16 which I reviewed them consultations.

17 59 Q. I think if you look at the document in toto, I think
18 what it establishes is that, over that period of the
19 two clinics, only five out of 20 letters have been
20 dictated. Given the dates of those clinics, would you
21 have expected to see dictation in respect of all of the
22 patients concerned?

23 A. You would have expected to have seen a letter for each
24 patient and, as I have highlighted, where the letters
25 are available, the dictation has been done a period
26 after the clinic, so we can see one there on the screen
27 where the clinic attendance took place on 20th August
28 and the letter was dictated on 19th September.

29 60 Q. Yes. We will come on later to look at the fine print

1 of the action plan in respect of that, but that's
2 outside of the time limit, even though it's ultimately
3 done.

4
5 If we could go to TRU-279848, and just at the bottom of
6 the page, please. I think arrangements are being put
7 in place for a meeting. Back to the issue of Patient
8 112, and you are saying that an IR1 is going in that
9 day. Dr. O'Kane is writing to the group, which
10 includes the Case Manager, Dr. Khan, and yourself,
11 amongst others. She's asking for a meeting to be
12 arranged. You have less flexibility, it seems, and she
13 sets out an agenda. Let's just look at the agenda
14 briefly. She is asking for an outline of the
15 escalation plan in relation to managing this and other
16 potential exceptions within the Service following on
17 from the MHPS. She wants an update on the recommended
18 review of administrative processes which were described
19 in the MHPS redacted report and referred to recently in
20 GMC correspondence. That's taking us back to
21 Dr. Khan's determination where he said that there had
22 been failures at all levels of management in terms of
23 the administrative systems, and he wanted an
24 independent review of that. Twelve months later, that
25 hasn't got off the ground and, in fact, wasn't to get
26 off the ground until the summer of 2020. She wants an
27 update on the progress of SAI reports which have
28 arrived within the Trust recently, and she wants an
29 outline of management of any potential risks to Patient

1 Safety.

2
3 I think you are right, I think you've said you weren't
4 able to attend that meeting, ultimately?

5 A. The telephone one, no, I didn't.

6 61 Q. Unfortunately, we've looked, and we will follow this up
7 with the Trust, there doesn't seem to be a record, that
8 we can find, relating to the outcome of that meeting by
9 way of a minute or otherwise. Given that you were to
10 be an attendee, did you receive any feedback, to the
11 best of your recollection, in terms of what had been
12 decided?

13 A. Not to the best of my recollection. I've also had
14 a look in the e-mail archive to see if I could find
15 anything and I couldn't find anything related to that.

16 62 Q. Yes. It does appear to be, I suppose, the moment where
17 many of the key overseers of these issues are sitting
18 down, whether remotely or otherwise, to have an
19 important discussion of where we go from here in
20 respect of Mr. O'Brien's reported shortcomings, and
21 indeed other issues. Thinking about that, nothing at
22 all that you can remember coming your way in terms of
23 how this is to be handled?

24 A. Not that I can remember specifically. As I have said,
25 I have looked to see if I can find anything in the
26 archive and haven't been able to, to date.

27 63 Q. We understand that. Indeed, you comment upon it, in
28 your statement, that Mr. McNaboe he was, by this stage,
29 the Clinical Director?

1 A. Yeah.

2 64 Q. He had taken over from Mr. Weir, and you understand
3 that he was to meet with Mr. O'Brien. I will just help
4 orientate you on this. You say in your statement at
5 paragraph 62.9, if we go to WIT-53937, just at the
6 bottom of the page, please. This paragraph reflects or
7 at least charts the progress over the period that
8 I have spent most of this morning already dealing with,
9 but you deal with it concisely in this paragraph and
10 I will just read it out:

11

12 "Soon after commencing as Medical Director, in early
13 2019 Maria O' Kane spoke to me regarding Mr. O'Brien and
14 the MHPS investigation and concerns being escalated to
15 the GMC. However, I do not know/recall whether this
16 conversation took place before or after the concerns
17 were escalated to the GMC. I became concerned" -- as
18 we have seen this morning -- "that the secretarial
19 'backlog report' was being used as part of the
20 monitoring of Mr. O'Brien and I remained concerned that
21 Mr. O'Brien was not always dictating on outpatient
22 attendances at the time of the clinic. I was also
23 concerned that there was a high likelihood that he was
24 not acting on all results requested in his name and
25 this was not being adequately monitored in the backlog
26 report."

27

28 That was exemplified by Patient 92, for example. Then
29 you go on to say:

1
2 "I raised concerns regarding the robustness of the data
3 contained therein - namely, the 'results awaiting
4 dictation' and 'clinics waiting dictation' " --
5 we have seen that -- "and raised these on a number of
6 occasions ;"-- we have seen that. "indeed, some of
7 these concerns predated the use of this report as part
8 of the MHPS monitoring process. I am aware that, as
9 a result, Mr. McNaboe, Clinical Director, did meet with
10 Mr. O'Brien with regard to lack of compliance with the
11 requirement to dictate after every clinic attendance.
12 I do not recall being involved in the out-workings of
13 this meeting."

14
15 Mr. McNaboe, you suggest, has met with Mr. O'Brien.
16 I just want to show you Mr. O'Brien's perspective on
17 that. Could we go to WIT-82593, please. Mr. O'Brien
18 recites the terms of the action plan. I am catching
19 the last paragraph there, and I will read that:

20
21 "It is my view, in order to ensure that the Trust
22 continues to have an assurance about Mr. O'Brien's
23 administrative processes and management of his
24 workload, an action plan should be put in place with
25 the input" -- sorry, that's the outcome of the MHPS.

26
27 Mr. O'Brien comments that the Return to work Plan from
28 2017 came to an end at the conclusion of the
29 investigation process. The plan was to be in place

1 from the commencement of MHPS until the end of the MHPS
2 process, and then, as we know, Dr. Khan provided, in
3 his determination, for a new action plan, monitoring
4 and an agreed job plan. That recommendation didn't
5 take place. Is Mr. O'Brien, technically at least,
6 right to say that, as far as he was concerned, there
7 was no action plan in place at this time? Or to put it
8 another way: there was an action plan in place so far
9 as the Trust was concerned, but he suggests that there
10 ought not to have been?

11 A. My thoughts would be it would be open to
12 interpretation. The MHPS report had come out and he'd
13 raised a grievance about it, so whether that grievance
14 meant that that report was finalised and accepted and,
15 therefore, the previous action plan come to date
16 I guess would be something that different parties may
17 have different opinions on. Whether or not there's an
18 action plan in place, the expectations of the plan are
19 reasonable expectations of any individual. To suggest
20 that, because an MHPS action -- a new action plan
21 hasn't been put in place, therefore I don't need to do
22 any dictations on any patient and I don't need to
23 action any results, just strikes me as a strange
24 position to take.

25 65 Q. He may not be going as far as that. He seems to limit
26 his remarks to the absence of an action plan. He says
27 here at 571, just working through some of the his
28 perspective -- it's coincident in time with the
29 processes we have been looking at this morning, so he

1 says that the recommendation made by the Case Manager
2 for a further action plan to be agreed with the input
3 of NCAS. He was not approached by the Trust to agree
4 any such plan. So far as you are aware, that is
5 correct, is it?

6 A. Mm-hmm.

7 66 Q. He comments about the Return to Work Plan requiring
8 triaging. He says he did try to triage all red flag
9 referrals on a daily basis, but it wasn't always
10 possible. He says in endeavouring to comply, he took
11 off each Friday following Urologist of the week as an
12 annual leave day in order to complete as much as
13 possible within the week. However, doing so was at the
14 cost of losing an Oncology Review clinic as well as
15 a clinic for patients attending urodynamic studies and
16 flexible cystoscopies.

17
18 was the Trust aware that he was working in that way, or
19 were you aware?

20 A. I didn't know he was taking each Friday off as annual
21 leave, specifically to do that. As we have discussed
22 before, he chose to do triage in the way that he did
23 which was more time consuming and could have triaged in
24 a quicker way, albeit maybe not the way he wanted to,
25 but he could have triaged in a quicker way and not come
26 up against as big a workload issue as highlighted.

27 67 Q. would you accept that his way of triaging was,
28 nevertheless, a more thorough way of getting to grips
29 with the patient needs in terms of investigations and

1 next steps?

2 A. I've said within my statement that I am a believer in
3 advanced triage. I would do it in a different way to
4 Mr. O'Brien. He took it to a virtual consultation,
5 which is not triage. Contact, phoning patients, as
6 I think he said somewhere, phoning 60-odd patients in
7 a week is doing virtual -- is doing a telephone clinic
8 for them 60 patients. That's taking it from being
9 triaged to essentially consulting a patient at the
10 point of referral. So triage is getting patients on to
11 the right pathway, be that a red flag pathway, and to
12 me, advanced triage is where investigation is required,
13 arranging that investigation to expedite the pathway
14 for the patient when they come into contact with the
15 Service.

16 68 Q. Just scrolling down, please. He talks about the
17 dictation issue. He accepts that that continued to
18 remain a problem, says that was because of the limited
19 time actually available to remain on location at
20 outreach clinics. He says that the Return to Work Plan
21 required his "... secretary would actually choose who
22 would be admitted for surgery, and, as she was unable
23 to do this, I continued to select patients for
24 admission while my secretary continued to conduct all
25 the administrative tasks which arose as a consequence".

26

27 Do you follow what that means?

28 A. Yeah. When I plan my operating list, I do it in
29 conjunction with my secretary. What my secretary does

1 is brings to my attention those patients who are at the
2 top of the waiting list, largely at present it's red
3 flag, so suspected cancer or cancer procedures only,
4 and then I advise what would fill the waiting list from
5 that group of patients who are at the top.

6 69 Q. Is he suggesting here that his secretary acts in
7 a different manner?

8 A. No, I think he's suggesting that he has a process.
9 I presume that his secretary tells him who the patients
10 are at the top of the waiting list and he says what can
11 be fitted on to that theatre list, what would be
12 appropriate to do.

13 70 Q. He goes on to say:

14
15 "The one aspect of the Return to Work Plan which could
16 have been done differently was in relation to triage".
17 He makes the point that this was a missed opportunity
18 to deal with triage in a different way. I know you
19 sympathise with the view that triage could be done in
20 a different way by putting a greater onus on the
21 primary care sector to get it right, I suppose, from
22 the outset. I think you are sympathetic to that point
23 broadly?

24 A. I think there's lots of ways triage can be approached
25 differently, and that starts at the point of the
26 initial referral. It does so also then extend to if
27 you have the initial referral that's right most of the
28 time, then some of that pre-attendance investigation
29 can be arranged appropriately without involving

1 a Consultant.

2 71 Q. He goes on then at paragraph 577 to say that no issue
3 was raised by the Trust with him in relation to any
4 potential breach of the plan until November 2019, when
5 he received e-mails from Ms. Corrigan, Head of Service,
6 and he sets out the e-mail. Although we have, over the
7 course of the past couple of hours, observed that
8 multiple people within the management system are aware
9 of many occasions when there have been departures from
10 what was expected, he's only getting called up for
11 this, if this is correct, by the end of 2019. Have you
12 any reason to doubt the correctness of that? There's
13 no other intervention with Mr. O'Brien prior to that,
14 after MHPS had reported that you are aware of?

15 A. Not that I am aware of.

16 72 Q. Ms. Corrigan is setting out for Mr. O'Brien the
17 deviations, and concern 1 and concern 3, triage and
18 dictation respectively. She is asking for a meeting
19 between herself, Mr. McNaboe and Mr. O'Brien.
20 Mr. O'Brien e-mails back on 5th November asking for the
21 nature of the deviation, although it's set out there.
22 He indicates his willingness to attend, despite the
23 stress of having to do so in the midst of a cancer
24 review clinic, but indicating in his response whatever
25 the issues they wished to discuss, there could have
26 been no deviation from the Return to Work Plan, given
27 that it had expired one year previously. He's bringing
28 to Mrs. Corrigan's attention his view that, whatever
29 may have been the expectations of him, it wasn't the

1 subject of an action plan. We have spoken about that.
2 He says that he duly attended Mr. McNaboe's office at
3 the allotted time on 8th November but found it locked.
4 He didn't receive a follow-up invitation to meet with
5 them in order to discuss issues which, from their
6 perspective, appeared to have arisen. Just to finalise
7 this section. He accepts that during the autumn of
8 2019 he may have been somewhat slower in administration
9 than otherwise had been the case, due to personal
10 circumstances. He points to his own personal
11 difficulties within the family.

12
13 First of all, on that, I think you highlighted earlier,
14 and we have seen working through this, that the
15 administrative difficulties to which he alludes
16 predated the autumn and were obvious to those looking
17 at it from late the previous year, when Mrs. Corrigan
18 had been absent during that year. You pointed,
19 I think, to clinics in June that hadn't been dictated
20 by the autumn. Leaving the accuracy of that to one
21 side, Mr. McNaboe tells us, in his Section 21
22 response -- I will not open it. The reference, members
23 of the Panel, is WIT-15750, at paragraph 55.4. He
24 says:

25
26 "I did talk to Mr. O'Brien about this" -- this being
27 the deviation -- "very informally in the hospital
28 corridor and he assured me that he would catch up very
29 soon. I never had to speak to him again about this

1 i ssue. "

2
3 Plainly, Mr. Haynes, by the end of that year, as we
4 have seen through these e-mails, that there has been,
5 I hesitate to use the word "constant", but a regular
6 flurry of activity around deviations, but the activity,
7 it seems, doesn't appear to reach the point where
8 Mr. O'Brien is being formally challenged to address the
9 concerns that were there. Is that a fair synopsis?

10 A. I think from what you have run through there, a meeting
11 was intended to happen that didn't happen, and
12 Mr. McNaboe has outlined that he did raise that, but in
13 a less formal way.

14 73 Q. I mean, this was a year where MHPS had reported. The
15 actions around that were stymied by the grievance,
16 a referral had been made to the GMC. They are matters
17 dealing with the past shortcomings, but the
18 shortcomings, as we have observed, were continuing and
19 present, and yet the Trust's reaction to it seems to
20 have been no more than a passing informal meeting in
21 a hospital corridor and an assurance that, I will catch
22 up. Do you think that was adequate or sufficient?

23 A. No. I thought at the time that the formal meeting was
24 what was being arranged. I didn't fully appreciate,
25 when I was advised that it had been raised with him,
26 that it had been done in an informal manner.

27 74 Q. We haven't seen the minutes or a record of the meeting
28 that had been set up. I hope it's safe to infer that
29 the response of that meeting was to delegate

1 Mr. McNaboe to go and speak to Mr. O'Brien. It doesn't
2 appear, from what you have said in your Section 21
3 response, that you don't recall taking any active
4 involvement in that process? In other words, you
5 didn't speak to Mr. McNaboe afterwards to ascertain
6 what had resulted?

7 A. I was assured that it had been raised with him.

8 75 Q. In terms of the assurance, and I think it's fair to
9 allow you the fact that you only received an assurance,
10 but did you or anybody else inquire into the value of
11 that assurance or how that assurance from Mr. O'Brien
12 was tested? Because if you think about the context
13 here, the Trust has had a period of years, thinking
14 back to the early part of your evidence, of
15 shortcomings in practice. That's validated through the
16 MHPS process. Then, on the face of it, there has been
17 some improvement around the private patient issue,
18 around the issue of retention of patient notes, but two
19 of the cardinal issues of concern, dictation and
20 triage, are still predominantly causing difficulties
21 for the Trust, and yet there doesn't appear to have
22 been any firm grappling with it?

23 A. Yeah. I do know, I was aware that he had raised, as
24 I say, that actually the action plan shouldn't even be
25 in place still, so as I say, effectively I shouldn't be
26 being monitored. Again, I'd say raising issues with
27 the process rather than an issue or a recognition that,
28 whether the process that was being used to monitor him
29 was right or wrong, the expectations were reasonable

1 and he wasn't meeting them. Knowing how he had, as
2 I have said, as we have covered earlier in terms of how
3 he'd responded with the previous contacts through his
4 family members, with individuals in the investigation,
5 the approach to the MHPS investigation of raising
6 a grievance and stymying that, this was potentially
7 another, if you like, all thrown in to create problems
8 with the process rather than addressing the problem.

9 76 Q. The Medical Director's office is the area, the core
10 area of responsibility for professional practice, isn't
11 it, and the information is flowing into that office.
12 Just so we are clear, you did not attend any meeting
13 with the Medical Director and colleagues that sat down
14 to try to get some kind of control on what was
15 happening here? That kind of meeting didn't occur?

16 A. The meeting we have referenced here was, I think it was
17 at a 24-hour notice on a day when I was operating and,
18 therefore, I wasn't able to phone into that.

19 77 Q. Sorry, I'm not pointing the finger at your
20 non-attendance at that meeting. What I'm, rather,
21 asking is, one might imagine that, on the background of
22 MHPS, determinations arising out of MHPS not taken
23 forward, followed up with continuing shortcomings,
24 perhaps there ought to have been some form of meeting
25 convention, bringing all these issues on to the table
26 attempting to dissect it and saying, does he need help?
27 Are patients at risk? Are there any other areas of his
28 practice that we really should be looking at? That
29 doesn't appear to have happened?

1 A. Yeah. That doesn't appear to have happened and, as
2 I've reflected previously, that sort of wider step back
3 of what do we know, what might we not know, what more
4 do we need to do to gain assurance about the why the
5 practice wasn't done?

6 78 Q. If we go to WIT-55825, please. This is the backlog
7 report for October being circulated on 4th November.
8 One can see, again, what appears to be significant
9 dictation issues. You are telling Dr. Khan this is
10 relevant for oversight for October. Dr. O'Kane is
11 asking for a view from Dr. Khan and Mrs. Hynds, and
12 she's asking Ronan Carroll to describe the system
13 managed process in place to capture the relevant
14 information agreed with Case Managers. Siobhán Hynds
15 puts it quite bluntly:

16
17 "Mr. O'Brien is clearly deviating from the action plan
18 that was put in place as a safeguard to avoid this and
19 he is also an outlier in terms of his other Urology
20 colleagues."

21
22 She asks: "Has there been any discussion with
23 Mr. O'Brien about this?"

24
25 We know, from what Mr. O'Brien and Mr. McNaboe said,
26 there was supposed to be a meeting. Mr. McNaboe claims
27 there was an informal in the corridor. Dr. O'Kane asks
28 Mr. Gibson to coordinate a meeting, which is to be
29 minuted, and she is asking for a description of the

1 detail of the management plan around this, the
2 expectation regarding compliance and the escalation.

3 She says:

4
5 "It would be important before all of you meet with
6 Mr. O'Brien that you have this process well-described
7 and documented. Process mapping, this might be the
8 most useful approach."

9
10 She touches on the triage issue:

11
12 "While I appreciate there's a divergence in views about
13 the process we have in place to manage referrals, he is
14 being asked to comply with this as it is until it is
15 collectively agreed that the system should be changed."

16
17 Dr. O'Kane, at the end of a year in her post, doesn't,
18 on the face of it, appear to understand the process for
19 monitoring and the shortcomings of it, and the dynamics
20 of it and the action points arising out of it. Her
21 response, notwithstanding the evidence of deviation
22 from it, is to sit down and have a process meeting
23 before we can meet with Mr. O'Brien. Is that your
24 understanding of what was happening here?

25 A. Yeah. My understanding is that we have a clear
26 understanding ourselves of what we are monitoring and
27 how we are monitoring it before we sit down with
28 Mr. O'Brien to run through what we are monitoring and
29 how we are monitoring it.

1 79 Q. We have the action plan, which I think is tolerably
2 clear in what it expects. How did you respond to this?
3 was this a frustration that this was the route that was
4 being taken rather than going to the problem itself?

5 A. I can't recall how I responded to that. I know we did
6 meet that group.

7 80 Q. Yes. The meeting took place on 24th January. It's
8 important to say, isn't it, given what we know now,
9 that where you have a clinician who is viewed by the
10 Trust as a potential risk to patients, or at least his
11 practice or the shortcomings in his practice causes
12 risks or may cause risks for patients, with every
13 passing day, not to be too melodramatic, there are
14 risks for patients not being addressed. Is it fair to
15 look at matters in that way?

16 A. Yes.

17 81 Q. Because the SAIs that emerge from June 2020 and into
18 the autumn, they all relate to patients in the main who
19 are being treated at this time. They are in the system
20 at this time. The shortcomings revealed through the
21 SAI process could have been nipped in the bud,
22 corrected, if the information coming into the Medical
23 Director's office about shortcomings in other areas of
24 practice had been weighed, appreciated and the subject
25 of a more comprehensive examination. Is that, again,
26 a fair analysis?

27 A. I think that's a fair analysis. I think it's also fair
28 to say that, for other clinicians, if they had the same
29 concerns raised informally directly with them, would

1 put their house in order.

2 82 Q. Yes.

3 A. That didn't happen either. If it was raised with me,

4 if I wasn't dictating my clinic letters, I wasn't up to

5 date with my results, I'd take action.

6 83 Q. Yes. Yes, you would --

7 A. I wouldn't expect a system to make sure that I take

8 action; I'd expect I would take action.

9 84 Q. Yes. No doubt that's right. The system has to have an

10 intelligence and a sensitivity to the person or persons

11 they are dealing with, not to personalise it to

12 Mr. O'Brien. If you have a clinician who,

13 historically, hasn't given any trouble, any difficulty,

14 then your assurance might be taken as read, but if the

15 history is of a personality, and you have reflected it

16 in your statement, who does things unconventionally,

17 who doesn't listen to what you regarded as good advice

18 around DARO, for example, around new policies coming in

19 in respect of different types of procedure, it takes

20 a different approach, doesn't it?

21 A. It has to, yeah.

22 85 Q. The meeting that took place on 24th January is at

23 WIT-55822. This is Mr. Gibson reporting back to

24 Dr. O'Kane in respect of that meeting. Just scroll

25 down, please. Three issues are considered.

26 Consideration is given to the backlog report. I think

27 your views are indirectly reflected in that, about

28 uncertainty around the reliability of that report.

29 Ultimately it was felt, just reading from the bottom

1 three lines of the second paragraph, "that there may
2 have been inaccuracies in the data provided by staff,
3 data was never independently verified and there was no
4 electronic method of collecting this data. It was
5 never raised in the Patient Safety meetings in Urology
6 and was not regularly discussed at the Urology
7 Specialty meeting."
8

9 Although you had, no doubt, conscientiously raised this
10 issue on at least two occasions, and you may say more,
11 in 2017 and again in 2018, and it was part of
12 conversations in that year, it wasn't an issue that was
13 being addressed? I don't say it was your
14 responsibility to address it, but it wasn't being
15 addressed by, assumedly, the Medical Director's office
16 or whoever else?

17 A. It hadn't been addressed. I think that paragraph there
18 describes, it was the initial intent of the backlog
19 report wasn't strictly as it was then being utilised as
20 it was there to quantify workload across secretarial
21 and audio typist teams to keep on top of any backlogs.

22 86 Q. But yet, it was being used as a baseline for assessing
23 compliance with the monitoring plan. At the same time,
24 though, your concern about it was that it was
25 unreliable in the sense of potentially under-reporting
26 incidents or under-reporting failed dictation, and
27 other issues around that. The information that it did
28 give up in respect of Mr. O'Brien's practice, and he's
29 admitted some difficulties around dictation during that

1 year, but that was bad enough, wasn't it? The short
2 falls in dictation, even without factoring in the
3 under-reporting, was bad enough to justify
4 intervention?

5 A. Even though there were shortfalls in terms of
6 under-reporting, and there were shortfalls in terms of
7 the reliability of the data, the backlog report had
8 identified issues in relation to Mr. O'Brien's practice
9 and compliance with the action plan.

10 87 Q. The next issue is headed "expectation regarding
11 compliance". It said:

12
13 "None of those present at the meeting were aware of any
14 written standards in relation to what was considered
15 reasonable for dictation of results or letters after
16 clinics. The Trust has never stated a standard, and
17 those present were not aware of any standards set
18 externally by Royal Colleges or other organisations.
19 Therefore on the occasions when this data was
20 considered there was no agreed standard to use as
21 a gauge against reported performance."

22
23 Just so I am clear about this, this meeting is talking
24 about the response of the Trust as an organisation, or
25 put it another way, the failure of the response of the
26 Trust as an organisation to Mr. O'Brien's shortcomings,
27 and this is being put forward as an explanation for why
28 the issue hasn't been grappled with?

29 A. I think it's being put forward as an issue that we need

1 to address in terms of, if we are going to monitor any
2 individual's performance, we need to be clear what that
3 standard you are monitoring against is.

4 88 Q. Sorry to cut across you. The standard was made
5 abundantly clear in the action plan?

6 A. That's where my next sentence was coming to.

7 89 Q. We share the same view. I don't see any dissent from
8 the sentiment expressed there. It's almost as if we
9 can't challenge Mr. O'Brien because we are not sure of
10 the standard we have set for him, whereas, in fact,
11 that standard was -- let's open it up, TRU-00732.

12 A. I think it's a reflection of how we expected
13 Mr. O'Brien to approach being challenged on not meeting
14 the standard, and that would be challenging whether the
15 standard existed. He'd already challenged whether he
16 should be monitored against the action plan, and,
17 therefore, if there was no other standard against which
18 to be holding him to, that we anticipated that that
19 would be an approach he would take to being challenged
20 on it.

21 90 Q. Scroll down to concern 3, please. This is, as you
22 recall, the action plan that was developed, I think in
23 February 2017, on the eve of the MHPS investigation
24 getting off the ground. It records the statistics on
25 absence of dictation for a period of 18 months
26 stretching into 2016. What it tells Mr. O'Brien he
27 must work to is that all clinics must be dictated at
28 the end of each clinic/theatre session using digital
29 dictation. It explains this has been set up in his

1 office with his laptop, and training being provided or
2 organised.

3
4 "This dictation must be done at the end of every clinic
5 and a report via digital dictation will be provided on
6 a weekly basis to the Assistant Director of Acute
7 Services, Anaesthetics and Surgery to ensure all
8 outcomes are dictated. An outcome plan/record of each
9 clinic attendance must be recorded for each individual
10 patient."

11
12 As I think you have agreed with me, the standard was
13 clear. Are you saying that the, I suppose, perhaps
14 a fear reflected in the meeting was if we challenge him
15 in respect of this standard he will point to the
16 absence of a Trust standard beyond this action plan?

17 A. Yeah. The absence of a standard beyond the action
18 plan, and he's already challenged that the action plan
19 shouldn't be the thing that he's held to.

20 91 Q. Does that betray a lack of appetite to confront?

21 A. I don't think it betrays a lack of appetite to
22 confront. I think it betrays a recognition that when
23 we confront, what we are going to be faced with is
24 this, and it's just going to be sent back to us on,
25 well there isn't a standard so what are you holding me
26 to?

27 92 Q. Is the Trust, as the employer, not entitled to set the
28 standard?

29 A. I would agree, yeah.

1 93 Q. Presumably this standard reflects the working norm of
2 most consultants?

3 A. Yeah. Most consultants wouldn't need to be told
4 a standard exists.

5 94 Q. Going back to the final point at the meeting of 24th
6 January. WIT-55822 again. Just down to the third and
7 final point "escalation". It says:

8
9 "As there was some cynicism in relation to this, the
10 validity of the data combined with the lack of standard
11 to assess compliance, there was no agreed process for
12 escalating any concerns regarding non-compliance in
13 relation to the monthly backlog report. It should be
14 noted that those present agreed that the weaknesses
15 identified in the current process described above may
16 cause challenges when taking forward this issue with
17 Mr. O'Brien."

18
19 Looking back at this, Mr. Haynes, is this of the
20 quality of Alice in Wonderland stuff? A clear action
21 plan had been set for an employee. He was deviating
22 from the standards, and yet the Trust, as represented
23 by the people at this meeting, are running scared of
24 their own action plan. Meanwhile, the Trust must have
25 realised that the shortcomings are putting patients at
26 risk?

27 A. As I said, I think that paragraph outlines the concerns
28 about the backlog report as well as there not being
29 a recognised guidance in terms of how the data was

1 created. There wasn't an escalation process alongside
2 that backlog report for Mr. O'Brien or any other
3 individual. There was a recognition that the action
4 plan existed, absolutely, but Mr. O'Brien challenged
5 whether that action plan remained valid. Without
6 clarity on that challenge of his, there wasn't
7 anything, any additional standard to fall back on as
8 a standard to monitor against. It was the action plan
9 which did exist, was clear, but the individual being
10 managed was also clear that, in his mind, that action
11 plan had ceased to be valid.

12 95 Q. But if you think back to 2016 and 2017, there were no
13 standards written down then. There was just
14 a realisation, to take, for example, dictation,
15 Mr. O'Brien wasn't doing the dictation. There was 600
16 examples of that over an 18-month period. We don't
17 need to reach to some rule book to see if there's
18 a written-down standard. It's clear that he is not
19 doing it, let's exclude him from practice, and move
20 into an MHPS process. We have that MHPS process.
21 I don't say nothing changes, there's some improvements
22 around some of the aspects, but the outcome of this, it
23 appears, is that we can do nothing. That simply
24 doesn't make sense, does it?

25 A. I think what it's saying is not that we can do nothing,
26 but we need to be clear what our process and
27 expectations are when we raise this with him.

28 96 Q. Yes. He retires six months later. Was there any
29 intervention between January and July, or was there any

1 other work done around these issues in that space of
2 six months to enable you to grapple with the
3 shortcomings?

4 A. I can't recall, unfortunately, that period of time.
5 All of our time got taken significantly with the impact
6 of the coronavirus pandemic, and I have no doubt that
7 shifted time and focus away, as we moved into March and
8 had to shift services.

9 97 Q. The conclusions sets out a number of things to be taken
10 forward. It says:

11
12 "If these are taken forward this would allow an
13 opportunity to identify if there are any concerns
14 starting to emerge so that appropriate supports to be
15 offered to Mr. O'Brien to ensure concerns do not
16 continue."

17
18 You are unable to help us in terms of what became of
19 what appear to be concluding recommendations?

20 A. No.

21 98 Q. Mr. O'Brien, in the early months of that year 2020, was
22 considering retirement and you became aware of that.
23 I want to ask you some questions out of the following
24 e-mail correspondence. If we go to TRU-258959.
25 Perhaps the next page, I think.

26
27 On 15th April, Mrs. Corrigan is reporting to you and
28 others, Mr. Young and Mr. Carroll, that Mr. O'Brien's
29 application for pension benefits is all in hand and he

1 will be processed on as a leaver on the system from the
2 30th June. You will just need to let me know if it has
3 been agreed for him to return to work following
4 retirement and, if so, on what date as we will need to
5 reinstate him to the payroll"?

6
7 Can you help us with this? As I understand it,
8 notwithstanding a retirement and the receipt of pension
9 benefits, there was an arrangement by which retired
10 doctors might be able to return to the workplace as
11 a locum or as an employee?

12 A. On occasion consultants may retire and then return on
13 a part-time basis as an employee, to provide some
14 service.

15 99 Q. Yes. That was clearly something that was being
16 discussed. If we can just scroll up the page, please,
17 thank you. Mr. Carroll directs a question to Martina
18 Corrigan with you copied in:

19
20 "We are taking Aidan back? Yes?"

21
22 You respond at the top of the page there:

23
24 "Needs more discussion that can be had at present. In
25 short, yes, but with strings attached and these strings
26 need to be clear and accepted before he is offered
27 anything."

28
29 what does that last line tell us about your thinking or

1 the discussions that perhaps were being engaged in
2 behind this e-mail?

3 A. I'm not sure if much discussion was happening at that
4 moment, as the first line says. Again, recognising the
5 time, it was in April 2020, but what my second line
6 says really reflects what you've said there about the
7 January 2020 meeting, that if he was to come back, then
8 there needed to be a very clear expectation of what and
9 how he performed and how he was monitored, and that had
10 to be agreed in advance before he was offered anything.

11 100 Q. Does the fact that it was even being contemplated that
12 he could return, albeit with strings attached, suggest
13 that it was your view, and perhaps the wider Trust's
14 view, that things were not so bad about his practice
15 and his performance that his return could not be
16 contemplated?

17 A. I think, as in many specialties, it reflects that, with
18 the loss of a Consultant and as it remains to date, no
19 replacement having been appointed, that we would lose
20 capacity to deliver for patient need and move us
21 further away from patient demand with our capacity.
22 The thought process was, can he be managed? Can his
23 delivery of care be managed in a way that maintains
24 safety, given what we know, but enables some service to
25 still be delivered?

26 101 Q. You were open to him returning at that point, albeit
27 you had to work out what strings could be attached to
28 it?

29 A. I had a clear view that there needed to be strings,

1 that there needed to be a very clear way of managing
2 his performance and what them expectations were, and he
3 needed to agree them before any offer was forthcoming.
4 I had personal reservations that, given what I knew
5 from before, that them strings would never be agreed.
6 I was also aware of the issue we have in terms of
7 meeting patient demand, and so felt I had to explore
8 whether there was a means of solving the shortfalls
9 that we knew at the time, but still enabled some
10 service to be delivered to patients.

11 102 Q. what kind of strings did you have in mind?

12 A. The strings I would have expected would have been along
13 the lines of a robust monitoring plan, as we've
14 discussed, that he agreed in advance as to how and what
15 them expectations would be.

16 103 Q. There then followed a conversation on 8th June, less
17 than two months after this e-mail. AOB-56497. This is
18 a telephone conversation between you and Mr. O'Brien,
19 with Mr. Ronan Carroll present. It's being recorded by
20 Mr. O'Brien without your permission and consent?

21 A. Yeah.

22 104 Q. And transcribed for us on behalf of Mr. O'Brien's legal
23 team. I needn't take you through it all but if we
24 scroll down a little bit, please. Essentially you are
25 telling him that, I have taken the issue of essentially
26 his ability to return to work forward with a number of
27 conversations within the Trust, with HR and at Medical
28 Director level. Unfortunately, the practice of the
29 Trust would be that they don't re-engage people while

1 there's an ongoing HR process.

2
3 In the interests of time, I don't need to take you to
4 it all, but you go on to allude to the MHPS process
5 having been rendered incomplete by the grievance to the
6 Trust. You also refer to the GMC process. Those
7 features of Mr. O'Brien's employment were known in
8 April, less than eight weeks earlier, when you and
9 presumably others were open to his return, albeit with
10 strings attached. What had changed in the interim?

11 A. I think in my April e-mail I've have said "needs more
12 discussion". I don't think that was sent after
13 a discussion with a wider group. That was initial
14 thoughts of myself. What changed between April and
15 June was multiple conversations, as I have transcribed
16 there from the telephone conversation. What I haven't
17 alluded to there in the telephone call, and I guess
18 that was more on a protecting my colleagues, but I'd
19 also had conversations with my Consultant colleagues
20 within the team as to whether, given what we knew about
21 Mr. O'Brien's practice, re-engaging him would be
22 appropriate, and we all had concerns about that. I'd
23 had conversations with the Medical Director, albeit
24 telephone conversations, around them same concerns, and
25 ultimately came to a view myself that it would be wrong
26 to re-engage him, given everything we had around
27 Mr. O'Brien. Part of the conversations with our HR
28 team would have been along the lines of, are we able to
29 turn down this offer? Is that acceptable?

- 1 105 Q. who ultimately is the decision maker in that context;
2 is it the Trust management Medical Director level or is
3 it you as Associate Medical Director?
- 4 A. I think ultimately my view would be taken as the guide
5 for whoever made that decision, and ultimately that was
6 a decision that I was happy was the right decision, was
7 not to re-engage him, given what we knew.
- 8 106 Q. You, having reached that view on the basis of
9 conversations with others, do you have to communicate
10 that to others for approval? Presumably the HR
11 function has some input on it because it's an
12 application, presumably from Mr. O'Brien offering his
13 services to the organisation?
- 14 A. Yeah. I've liaised with HR to check that it's okay for
15 us to decline that.
- 16 107 Q. Yes. I think you were asked to write to Mr. O'Brien or
17 put the decision in writing. If we could have up on
18 the screen, please, TRU-163341. This has recently been
19 received from the Trust. I can't put a context around
20 it, but I can surmise that the day after your
21 discussion with Mr. O'Brien, you go to Zoe Parks to
22 seek advice on how to put the position in writing to
23 him. And Zoe Parks, is she in the HR function?
- 24 A. Yes.
- 25 108 Q. what we haven't been able to ascertain is, is the
26 process from April to the decision communicated to
27 Mr. O'Brien in June. Presumably, there would have been
28 e-mail communication between you and HR and you and
29 Medical Director's office leading to the decision that

1 he can't be accepted back?

2 A. I think it's more likely that it was telephone
3 conversations.

4 109 Q. You don't think any advice was given to you in writing?

5 A. Not that I can recall. As I have said, some of them
6 I had conversations with my colleagues in the team as
7 well.

8 110 Q. who would you have been dealing with, just to be clear,
9 having these discussions with?

10 A. I would have had conversations with Dr. O'Kane.
11 I would have had conversations with Zoe, as in an
12 e-mail there.

13 MR. WOLFE KC: Okay. I think I can bring that issue to
14 an end

15 CHAIR: If we come back then for ten past two, please.

16

17 THE INQUIRY ADJOURNED FOR LUNCH

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1 THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

2
3 CHAIR: Good afternoon, everyone.

4 MR. WOLFE KC: Good afternoon, Mr. Haynes. Is it fair
5 to say then that, in your discussions with Mr. O'Brien,
6 explaining to him that the Trust had a practice of not
7 re-engaging people who were the subject of ongoing HR
8 processes, that was really a convenient phrase to
9 explain your decision that he couldn't come back
10 because he wasn't trusted to deliver clinical service
11 in accordance with what was expected of him?

12 A. Yeah, I think that summarises. The ongoing processes
13 were part of it, but what was behind the processes was
14 his established behaviour and concerns, and we actually
15 didn't feel we could mitigate them in order to
16 re-engage him.

17 111 Q. The suggestion that the Trust had a practice, was
18 a somewhat manufactured phrase to explain what was
19 really a decision on your part? There was no such
20 practice. The Trust didn't have a policy or practice?

21 A. I don't think the Trust had been in that position
22 before and so, essentially, was having to have create
23 a view unique to Mr. O'Brien, and that was, given
24 everything that was going on around Mr. O'Brien, that
25 it wouldn't be appropriate to re-engage him.

26 112 Q. Your conversation with Mr. O'Brien on 8th June came one
27 day after you received an e-mail from him concerning
28 ten patients who were to be added to a list for surgery
29 in Daisy Hill Hospital as part of an initiative during

1 Covid to clear some of the backlog; isn't that right?

2 A. We were still in the early stages of the pandemic.

3 There was no backlog-clearing at this time. The only
4 elective surgery that was happening within the Trust
5 was happening in Daisy Hill Hospital. In addition to
6 that, there were, by that time, independent sector
7 contracts across the region which were assigned to
8 patients from Trusts, but each Trust, and within the
9 Southern Trust I had established it, had a process of,
10 whereby we had to work across specialties to assign
11 a very limited available Theatre capacity to patients
12 according to need. There was a variety of things that
13 were guiding how that was done. There were documents
14 that were regularly updated by the Federation of
15 Surgical speciality Associations regarding what type of
16 procedures should be done, and within the Trust we had
17 a process whereby I, essentially as the AMD for Surgery
18 and Elective Care, acted, if you like, as the
19 gatekeeper for access to the Trust's in-house,
20 inpatient capacity. Each speciality had a nominated
21 representative who would let me know the patients who
22 required or met the criteria for needing surgery at
23 that time, and then we would look to assign the
24 available capacity amongst the specialties according to
25 them patients as highlighted.

26 113 Q. Yes.

27 A. So his e-mail came in that context.

28 114 Q. Let's just open the e-mail to see where we are.

29 TRU-252800. Pick it up so I can see the bottom e-mail

1 in full. Thank you. This is Mr. O'Brien writing to --
2 who are those women? Are they in the booking office?
3 A. I can't recall.
4 115 Q. He is saying he has:
5
6 "Added a list of ten patients to the existing list of
7 patients for urgent admission submitted to Tony Glackin
8 on Thursday, 4th June. Mark Haynes has already
9 arranged to have the first of those patients" --
10 I don't need to mention her name -- "admitted to
11 Kingsbridge and I have scanned and attached completed
12 green forms for the remaining nine patients."
13
14 Just scroll down, the green forms are attached.
15 A series of green forms for each of the ten patients.
16
17 What are the green forms and their significance,
18 Mr. Haynes?
19 A. The green form is, if you like, is the administrative
20 paperwork that would accompany the decision to add
21 someone to a waiting list. If I have done an
22 outpatient consultation and I have agreed with the
23 patient that they are to be added to a waiting list,
24 that form would be filled in at that point, dated at
25 that point, and then that form would go with the notes
26 to my secretary, who would add the patient
27 administratively to the waiting list with the detail
28 provided on that waiting list form.
29 116 Q. Are you saying on the day I -- or you, more

1 particularly, puts a patient on the waiting list, say
2 1st November, the green form should be completed on
3 that date?

4 A. That would be the practice that you would expect.

5 117 Q. What does the green form initiate? Any procedure or
6 check?

7 A. The green form in itself provides that. If you like,
8 it's the entry point to the waiting list. It's the
9 information that's used to add patients to the waiting
10 list. In any patient interaction there's a number of
11 things that would need to be done at the end of that.
12 We have talked about dictation of correspondence to
13 GPs. If you add someone to a waiting list, then the
14 waiting list form would need to be completed. If
15 someone needs a CT scan requesting, the CT request
16 needs to be done. Then there's the outcome of the
17 clinic, so you would have an outcome sheet which
18 records what the follow-up or plan for the patients
19 that you have seen. Similarly for an inpatient. An
20 emergency admission who needs adding to a waiting list,
21 then that green form is the means by which it's raised
22 to the secretary and added on to the waiting list. It
23 also contains some information around the management of
24 patients who are on blood-thinning medication
25 pre-operatively.

26 118 Q. Presumably that's significant as part of a pre-theatre
27 assessment?

28 A. Yes, it feeds into how any blood thinning medication
29 will be managed as part of a pre-op assessment.

1 119 Q. I think we can see that from each of these forms, we
2 can see that they are all dated. That's signed and
3 dated, Mr. O'Brien, 7th June, that's one patient. We
4 are familiar with the next patient, who is Patient 1.
5 We can see, again, 7th June. I think it's probably
6 accepted that they are all 7th June. You tell us in
7 your witness statement -- I don't need to turn up the
8 statement, it's WIT-53938, paragraph 62.11. You tell
9 us, Mr. Haynes, that you were concerned about two
10 patients who were contained on the list. Can we scroll
11 back up, please, to the list itself? The patients that
12 you are interested in telling us about are, in the
13 middle of that list, Patient 105 and Patient 104. You
14 can see on the cipher list beside you which is 104 and
15 105. What was your concern when you looked at this
16 list?

17 A. What was unusual was that, as I said, at this time
18 I would receive e-mails from the nominated
19 representatives in general for each speciality of
20 patients who needed access to Theatres. What was
21 unusual here was, I, rather than the details just
22 contained within there or on a single Excel file of the
23 patients who needed surgery and the details of how much
24 time they needed, was I'd received the green forms.
25 When I looked at them green forms there are two dates
26 on the green forms. There's the date at the bottom
27 which is the day that it's been completed, but in the
28 top right-hand corner is the date that the patient is
29 to be added to the waiting list, and that would

1 correspond to the date of the interaction when they
2 should have been added to the waiting list. Again, in
3 the context of concerns regarding Mr. O'Brien and the
4 administrative workload associated with consultations
5 with patients, that flagged a little bit of an alarm
6 with me, actually here have we got patients who aren't
7 being added to the waiting list when they have had
8 their consultations?

9
10 At the time I had access to a copy of the download of
11 the waiting list as of a date in May, as I think I have
12 referenced within the e-mail. Within the e-mail I have
13 suggested that I have attached it but I don't appear to
14 have actually attached it, so I have missed it off the
15 attachments. What I've done is, I have looked at these
16 patients where I have got a date when they should have
17 been added to a waiting list, and I have looked at that
18 waiting list download for May and identified that them
19 two patients aren't on that file that I have got. So,
20 it raised a concern to me that could we have some
21 patients who should be on a waiting list that we don't
22 know about, although Mr. O'Brien knows about? Could
23 there be a group of patients that are in danger of
24 being lost?

25 120 Q. Yes. I think the e-mail in which you refer to the
26 waiting list that you were scrutinising, I think that's
27 referenced in your e-mail to Dr. O'Kane. If I could
28 pull up TRU-252799. You say:
29

1 "Attached to the green forms, as mentioned and
2 highlighted, are cases in particular that should have
3 been added to the waiting list at the date indicated.
4 Also attached in addition to the waiting list forms is
5 a full Urology waiting list as of 11th May 2020. As
6 far as I can tell, the patients highlighted should have
7 been added to the waiting list on the dates shown but
8 they are not on the waiting list and I believe had been
9 added to the waiting list more recently on the back of
10 the e-mail below."

11
12 Dealing with Patient 104, does the date highlighted,
13 Mr. Haynes, indicate the day that that patient had been
14 seen in clinic by Mr. O'Brien and should have been
15 added to the waiting list?

16 A. The date highlighted corresponds to the date on the top
17 right-hand corner of the green form for that patient.

18 121 Q. Okay.

19 A. Which corresponds to a consultation or patient episode.

20 122 Q. Yes. Above that is Patient 105, and his engagement
21 with Mr. O'Brien was in September of the previous year.
22 You've indicated that you were working off a waiting
23 list for 11th May, but you haven't attached it here.
24 Have you been able to locate that waiting list?

25 A. I haven't been able to locate that. The waiting list
26 itself exists on the patient administration system.
27 The Excel file that I would see is a report obtained
28 off there. It would have been obtained at the time.
29 I haven't been able to locate one for that date, for

1 11th May.

2 123 Q. The Trust has been able to recently supply us with two
3 waiting lists, one for 6th May, which is the week
4 before the one you were scrutinising, and one for 22nd
5 May. Just put them up -- maybe we won't put them up on
6 the screen, I don't think it's necessary. It's full of
7 patient names, just to avoid that. What I can say to
8 you is that both of those documents, one dated, as
9 I say, 6th May and the other dated 22nd May, so they
10 straddle the waiting list that you say you were looking
11 at. We can locate on that waiting list the name of
12 Patient 105, but we can't locate on it the name of
13 Patient 104. These waiting lists -- and maybe you
14 could help us with the whole concept of waiting lists.
15 These waiting lists are described as Urology PTL
16 inpatients and day cases without filter. Can you help
17 us with that and compare it with what you think you
18 were looking at?

19 A. I had a look at them two waiting lists and when they
20 were forwarded to me as we'd found them, I think it's
21 6th May one, in the format that it was downloaded,
22 there was a filter applied to one of the fields, so
23 when searched for these two patients with that filter
24 applied, neither patient came up. When I unchecked
25 that filter, one patient came up. So, really looking
26 at that, and I am trying to work out why the 11th May
27 one I've clearly looked at a document and not
28 identified two, but we have got two documents that
29 straddle that date and one of these two patients is on

1 that document and the other isn't. It's possible that
2 that 11th May document also had that same filter
3 applied and I hadn't recognised it and taken it off,
4 and so didn't identify the patient when I searched for
5 them. That's why it's comments on the filter, filter
6 off.

7 124 Q. Yes. You will have considered Mr. O'Brien's response
8 to your analysis. What he says, and I don't need to
9 bring it up on the screen, but the reference for your
10 note is WIT-82405, paragraphs 18 and 19. He said that
11 the claims that the two patients weren't on the waiting
12 list is misplaced and untrue, and he says any competent
13 and impartial consideration of the medical records and
14 correspondence held by the Trust would have indicated
15 that these patients were on the inpatient waiting lists
16 on PAS in the ordinary way.

17
18 Do you now accept that or do you have reservations
19 about it?

20 A. I accept that there's correspondence, as Mr. O'Brien,
21 has provided, that shows that things had been done.
22 What I would say is, I've -- what I have done at that
23 time, and the reason I had a concern, was that the
24 green form had a date in the top right-hand corner of
25 when someone should be added to the waiting list and
26 a date at the bottom dated 7th June, where that green
27 form should have been filled in at the time. In the
28 context of the concerns about Mr. O'Brien, me having
29 a concern that there is an aspect of work that hasn't

1 been considered previously and needing further
2 assessment, was appropriate, and looking into it
3 further was appropriate. It is possible that they were
4 on a waiting list on PAS, and the document I had to
5 look at of 11th May did not contain the full waiting
6 list. That wasn't, if you like, a wilful oversight on
7 my part. I was looking at what I felt was and what
8 I believed to be the waiting list. My concern was
9 founded on the green forms and, if you like, backed up
10 by that review. The subsequent piece of work did
11 identify additional concerns, as we know, with regards
12 the outcome or administrative workload regarding
13 patients under the care of Mr. O'Brien. Then
14 subsequently them concerns, if you like, were added to
15 or were overtaken by concerns regarding additional
16 patients towards the end of June 2020, early July 2020.

17 125 Q. Yes. I just want to bottom out the waiting list issue
18 so that we all understand it from your perspective, in
19 case it needs to be dealt with again. You accept the
20 possibility, and perhaps the probability, until we get
21 our hands on 11th May waiting list, if we can get that,
22 that you were possibly looking at a filtered waiting
23 list, and, therefore, didn't see the two patients on
24 that filtered waiting list?

25 A. On the files you have got, the 6th May and is it 22nd
26 May?

27 126 Q. Yes.

28 A. One of them patients is on them two files.

29 127 Q. Yes.

- 1 A. In the format that that 6th May file was e-mailed when
2 we found it, there was a filter applied which had taken
3 one -- a patient who was on that wasn't visible and
4 didn't appear in a search.
- 5 128 Q. Yes.
- 6 A. That's a possibility that that was also the case on the
7 11th May. It doesn't explain why the second patient
8 wasn't on either of them documents.
- 9 129 Q. Yes.
- 10 CHAIR: I am not very clear on this and I am sure it's
11 my fault and not yours. What is the purpose of the
12 filter?
- 13 A. The waiting list is vast and within the waiting list
14 there are a variety of different categories for
15 admission and things. Why a filter was applied,
16 I don't know, but in the format that -- generally, if
17 we want to search a waiting list manually, hundreds of
18 patients to go down, so you don't search it by manually
19 going through, you will generally go to one of the
20 fields, bring up the filter, and either do a word
21 search or exclude things you don't want to look at.
22 In the Excel file, say you want to filter out on the
23 procedure type or procedure code, you can filter it by
24 that so you bring up that filter, you can select all or
25 you can un-select ones you don't want to select.
- 26 130 Q. MR. WOLFE KC: If you wanted to only look at patients
27 for stent replacement, for example, maybe that's a poor
28 example. Give us an example?
- 29 A. Say, for example, you wanted to look at numbers of men

1 awaiting bladder outflow surgery you could go to the M
2 code, and I think it's M65 point something.

3 Mr. Hanbury might -- You can filter for the M65, select
4 only the M65 code and that will bring up every patient
5 awaiting bladder outflow surgery, so it will bring that
6 waiting list down to just that. Similarly, you could
7 look for the patients that are on the urgent waiting
8 list by changing the filter to just urgent or just
9 routine.

10 CHAIR: Again, just so that I am clear, though, who
11 applies the filter? The person who is searching the
12 document, presumably?

13 A. I don't generate that list. That list is provided to
14 me and that may have been on part of a shared drive
15 that I had access to. At some point, someone's done
16 a search or a query of, I think it's a boxy query it's
17 called, but essentially told the database which
18 patients they wanted to be downloaded from the waiting
19 list into an Excel file, and that's generated an Excel
20 file. If you then do some work and you apply a filter
21 and don't remember to turn it off and save it
22 somewhere, then that would be applied. There's a large
23 number of columns across the top and if you don't spot
24 that there's a filter on, then you may miss it. It can
25 be obvious if it's excluded large numbers because your
26 numbered column on your left might go to 227, 306, in
27 terms of the numbers with big gaps in between, but if
28 it's a smaller number excluded it might not be obvious
29 to you.

1 CHAIR: Okay, thank you.

2 MR. WOLFE KC: I hope people understand why I am not
3 bringing this up, it's just full of names. I will
4 certainly bring it up if anybody wants it up on the
5 screen. The references, I don't think I gave them
6 earlier, for the pages that I'm looking at, and you
7 will be conscious that the waiting list, as Mr. Haynes
8 has described, is quite a thick document, but the
9 waiting list for 6th May 2020, it's the Urology PTL
10 inpatients and day cases waiting lists, without filter
11 is TRU-163379. Thereon, about two-thirds of the way
12 down the page, you will see the name of Patient 105,
13 and the same descriptor of the waiting list but for the
14 later date of 22nd May 2020 is at TRU-163385. Again,
15 it's the same patient who features, Patient 105, but
16 Patient 104 is not to be found on that waiting list.
17 The missing piece in the jigsaw is the waiting list you
18 actually scrutinised on the day, which you believe was
19 dated 11th May or generated 11th May. I suppose, if
20 you weren't conscious that it was filtered, or may have
21 been filtered, you can't help us with what the filter
22 was?

23 A. No.

24 131 Q. Against what you have observed, let me take you to the
25 records that Mr. O'Brien has supplied. I suppose there
26 doesn't appear to be an argument from you, Mr. Haynes,
27 that you now accept that Patient 105, if he's on the
28 waiting list that straddles the date you are looking
29 at, he must have been on the waiting list for 11th May?

- 1 A. Assuming the parameters for the waiting list file
2 download were the same as those on 6th May and 21st
3 May, because it's a download from the waiting list and
4 the parameters are set by the person who pulls that
5 off, it does the search of the database to make that
6 Excel file. Assuming that the parameters were the same
7 then --
- 8 132 Q. You mean the search parameters?
- 9 A. Yes. The Excel file is not the waiting list.
- 10 133 Q. No?
- 11 A. The waiting list exists on a different system. To
12 interrogate that system and create an Excel file, then
13 search parameters are put in to draw, to pull down
14 a download.
- 15 134 Q. My interest is in the waiting list, not the Excel file.
- 16 A. I looked at an Excel file.
- 17 135 Q. Yes. What the issue is between you, who raised it, and
18 Mr. O'Brien, who challenges it, you make the case in
19 your correspondence to Dr. O'Kane, and subsequently to
20 Mr. O'Brien, was, so far as I can see, both these
21 patients are not on the waiting list, not on the Excel
22 -- you don't refer to Excel file, you call it the
23 waiting list. You presumably now accept that one of
24 those patients, if he was on it in week 1 and on it in
25 week 3, he must have been on it in week 2, in terms of
26 the waiting list --
- 27 A. Yeah.
- 28 136 Q. -- when you were scrutinising the issue?
- 29 A. Yes, but I don't know whether he was on the file

1 I scrutinised.

2 137 Q. No, and I accept that point. But you make the broader
3 point about the waiting list?

4 A. Yeah.

5 138 Q. The second of the patients, Patient 104, if we bring up
6 AOB-37036. I think we can see the waiting list entry.
7 Yes. This document received from Mr. O'Brien's
8 representatives, it's referred to as the CURWL. That's
9 a form of waiting list or a waiting list used by
10 Mr. O'Brien?

11 A. That's a waiting list code on PAS.

12 139 Q. On PAS?

13 A. Yes.

14 140 Q. The name of the patient has been blanked out. It's
15 Patient 104, who was seen by Mr. O'Brien in February,
16 and he insists that this document establishes that that
17 patient was also on the waiting list, or is also on the
18 waiting list, but that name doesn't appear on either of
19 the waiting lists that I've shown you this afternoon.
20 Can you help us with this document and compare it to
21 the waiting list documents that I've shown, although
22 I haven't put them up on the screen but you are
23 familiar with them. Is there different waiting list
24 sets or how do we explain the different formats?

25 A. As I say, the waiting list itself exists on the patient
26 administration system. The files I've looked at are
27 downloads off that into Excel. I don't know what
28 document format that is, that may be a print-off of the
29 patient administration system, it may be off an Excel

1 file. The document I've referred to was an Excel file,
2 which is a drawdown off the waiting list on the patient
3 administration system.

4 141 Q. I have already made the point earlier, I don't wish to
5 put this document up on the screen, but that is
6 something you are familiar with, if you can see it
7 across the room. Is that the Excel or is that the
8 waiting list?

9 A. That's the 6th or the 22nd?

10 142 Q. That is the 6th and the 22nd?

11 A. That's the Excel file.

12 143 Q. That's the Excel file. What's your position on this
13 issue ultimately, Mr. Haynes? You appear to accept
14 that at least one of the patients was on the waiting
15 list, albeit you didn't see him on the Excel file?

16 A. I think my position on this is: the e-mail triggered
17 concerns with me because I had green forms, which were
18 not typical with the communication for me, for the
19 urgent bookable list that was being done at the time.
20 On them green forms, them forms that should be filled
21 in at the time of the patient interaction the date at
22 the bottom was 7th June and the date at the top was
23 different. I have conducted a review of a file that
24 I had at that time, which I believed to be the waiting
25 list and couldn't identify two patients who I felt
26 should have been on that file. It's possible that that
27 file was not complete and did not contain the whole
28 waiting list, but I did not know that at that time.
29 But I would say, given that the concerns that we had

1 regarding Mr. O'Brien, my approach to be concerned by
2 having these waiting list forms with different date at
3 the right-hand corner to the bottom, and not
4 identifying them patients on the file that I had and
5 believed to have, and compile the waiting list and
6 managing that by escalating that I had a concern that
7 there was administrative work relating to patient
8 consultations not taking place and looking into it
9 further, was appropriate. Whether that initial concern
10 was right in that the file that I reviewed, did it not
11 include everyone that it should have? I think I was
12 right, given the history of Mr. O'Brien, to have
13 a concern and to look further into it.

14 144 Q. It's fair to say that although you emphasise this
15 afternoon the concern around the green forms, the
16 prominent concern, as you wrote correspondence both to
17 Dr. O'Kane and Mr. O'Brien at that time, was your claim
18 that these patients aren't to be found on the waiting
19 lists. I suppose maybe just comment on that, please,
20 first?

21 A. Because the green form is the mechanism by which the
22 patients are added to the waiting list, so my belief
23 was that this form hadn't been filled in at the time
24 and, therefore, these patients hadn't been added to the
25 waiting list and that belief was, if you like, backed
26 by I hadn't been able to identify them on that file
27 that I had on 11th May.

28 145 Q. Yes. But you accept that it's entirely possible for
29 patients to be on the waiting list, and it's a separate

1 issue whether the green form has been completed?

2 A. Yes, because the waiting list is a -- the green form is
3 not the waiting list itself. The information on the
4 green form is added to the waiting list on the patient
5 administration system.

6 146 Q. Should I take your evidence to suggest that if it was
7 only the green form that was causing a concern, because
8 they are all dated on the same day, you would have
9 actioned that for further investigation?

10 A. What I have done with them green forms and within the
11 table that I've highlighted in that e-mail, is I have
12 looked at all ten to check if they are on that Excel
13 file from 11th May, and I have only flagged a concern
14 with the two that weren't on that Excel file. It was
15 the green form and the discrepant dates from the top to
16 the bottom that raised a concern, and then that concern
17 was further reinforced by me not identifying them
18 patients on that Excel file, and I translated that into
19 them not being on the waiting list.

20 147 Q. Given, I suppose, the fundamentality of this issue as
21 a starting point for what was to unravel; further
22 investigations internally, leading to certain
23 conclusions and then the Early Alert, and ultimately
24 public inquiry. Given that this is, in a sense,
25 a starting point, should you have been more careful in
26 respect of your interrogation of the waiting list
27 before making the assertions that you did?

28 A. I would contend that this was part of a continued
29 finding of, as we have been through already in terms of

1 concerns about not acting on results, not dictating
2 from clinics, this was me flagging another concern
3 along the same vein. I would contend that, for me, the
4 nature of concerns changed in late June 2020 / early
5 July 2020, when I saw Patient 1 in Daisy Hill and
6 raised concerns there. The nature of the concerns
7 changed, and I'd contend that it's them concerns that
8 actually triggered really where the major change of, if
9 you like, the nature of the concerns regarding
10 Mr. O'Brien. This was a continuation of concerns that
11 he wasn't on top of his administrative work.

12 148 Q. As I say, you raised this issue with Dr. O'Kane on 11th
13 June by e-mail. As I have indicated, the issue which
14 was at the heart of this came to your attention on 7th
15 June when the e-mail came in. You spoke to Mr. O'Brien
16 the next day, 8th June, to tell him what was bad news
17 for him, that he couldn't come back to the Trust
18 following retirement. You didn't speak to him during
19 that meeting about the concern that had arisen the day
20 before, about the waiting list issue, these two
21 patients. Why not?

22 A. I'd raised my concern, as you say, on 11th June. Going
23 back to the urgent bookable list process, at the end of
24 each week there was a deadline for all specialties to
25 let me know the patients that were to be looked at for
26 that, so I tended not to interrogate the e-mails I got
27 until I had everything in and then could look at what
28 Theatre lists we had available and what the demand was
29 across all specialties. I didn't interrogate that

1 e-mail until 11th June, and when I interrogated that
2 e-mail I had concerns. At that time I would have
3 looked at the needs for the breast surgical team, the
4 colorectal team, the gynaecology team, the ENT team and
5 the urology team, and then put them together in terms
6 of the time need and what we had available and the
7 urgency, and looked to meet as many patients as we
8 could, demand, and looked to see where patients could
9 be managed, including what was available to us in the
10 independent sector.

11 149 Q. When you wrote to Mrs. O'Kane on 11th June, that was to
12 trigger a process which, administratively, was led by
13 Mrs. Corrigan. She carried out some initial work at
14 looking back at certain cases, and we will look at that
15 in a moment. Did you know at this time, that is around
16 11th June, that Mr. O'Brien was not prepared to take
17 the decision to refuse his return to work. He wasn't
18 prepared to take that lying down. He was going to
19 fight that?

20 A. I don't recall being aware of that. The decision to
21 look into things further was really, as in the concern
22 in my e-mail, if there are patients who haven't been
23 added to the waiting list, and specifically with the
24 group of patients that both were, which was patients
25 who had had ureteric stents inserted as first step in
26 their management of stones, then we needed to identify
27 if there were any others because they needed to have
28 their needs addressed, so that was the reason for that
29 work. Initially one of the groups Martina Corrigan

1 looked at was emergency admissions who had had
2 procedures and stent inserted, so we wanted to make
3 sure that there were no patients sat with a stent in
4 but actually not on a waiting list and not having their
5 needs addressed.

6 150 Q. Were you ever advised that by 23rd June Mr. O'Brien's
7 legal representatives were threatening injunctive
8 proceedings to challenge the Trust's treatment of him?

9 A. I would have been made aware that there was contact
10 from Mr. O'Brien's legal representatives, but I don't
11 know when I would have been aware of that.

12 151 Q. Yes. We have had the previous year, 2019, and I think
13 we reached a point this morning where you agreed with
14 me that there had been, to put it bluntly or maybe
15 generally, little activity to challenge Mr. O'Brien or
16 to investigate whether there were any other concerns.
17 Help me with this. Is it merely a coincidence in time
18 that this deep dive into his practice, which
19 Mrs. Corrigan led on and you assisted with, occurred at
20 or about the time when he was threatening to go to
21 court to challenge the treatment of him by the Trust?

22 A. Yeah, it's a coincidence in time. My concern was that
23 there was patients -- that the risk of there being
24 patients who needed surgical procedures, who were not
25 on the waiting list, and patients who have stents in
26 with stone disease are at significant risk of coming to
27 harm if they get lost. My concern was that, and would
28 have been triggered had I come across it at any other
29 point. This concern, while we had concerns previously,

1 as we've highlighted of the letters not happening, of
2 the scan results not being actioned, this was something
3 that hadn't been identified on the previous look intos
4 and so this was a new concern with a very clear and, if
5 you like, immediate patient risk of patients who have
6 got stents in who possibly were not on a waiting list.

7 152 Q. There were all sorts of triggers the previous year of
8 a different kind. You say this is a concern of
9 a different order. Ultimately, they all fall into
10 Patient Safety issues; dictation, triage, not actioning
11 results. Are you really saying that the threatened
12 legal action was wholly unrelated to the investigation
13 that you pursued in respect of his practice, or was
14 there at least a suggestion that it would suit the
15 Trust's purposes, the Trust's defence of any legal
16 proceedings if we were to have in place some further
17 evidence to show that he wasn't a safe practitioner?

18 A. That wasn't suggested to me. I think what instigated
19 in June of 2020 was, to my mind, and as I have
20 reflected in my statement, what we should have done at
21 a much earlier point. We should have had a wider look
22 into his practice.

23 153 Q. I don't wish to ask you about the content of any
24 conversation, but did you ever meet the Trust's legal
25 advisers at this time?

26 A. We did meet the Trust's legal advisers. I can't
27 remember when. I can't remember whether it was at this
28 time or at a later date.

29 154 Q. The work that was instigated arising out of all of

1 this, it was taken forward by Martina Corrigan
2 initially. If we look briefly at that. TRU-160971.
3 Just step through this relatively quickly. Thank you.
4 She takes on a piece of work which looks at elective
5 admissions in the first instance, and she identifies
6 that in the period between 1st January '19 and May '20
7 there were 147 emergency cases in the care of
8 Mr. O'Brien. Is that the way to interpret that?

9 A. She has looked at emergencies there, not elective.

10 155 Q. Yes. There were no concerns flagged with 101 patients,
11 but there were some concerns flagged, and she sets out
12 further particulars of those.

13
14 Mr. Carroll then, scrolling up the page, please, to
15 page 70 in the sequence, Mr. Carroll asked her to, in
16 order to have a complete picture, it would be his view
17 that the elective patients also need looked at. Then
18 going down to 993 -- it's just as easy to scroll down
19 to page 993 in the sequence -- the full reference is
20 TRU-160993. She attaches a spreadsheet for elective
21 patients now and she provides a summary, some
22 observations and she says:

23
24 "I have filtered 18 patients and sent them to Mark for
25 a clinical opinion as I have a few concerns with
26 respect to these."

27 You then look at those patients, isn't that right?

28 A. Mm-hmm, yes.

29 156 Q. Then if we go to TRU-258962, a couple of pages back.

1 Can you talk us through that, from memory?

2 A. So, what I have done there is them patients that
3 Martina Corrigan has highlighted, I have had a look at
4 them and I've summarised an opinion in terms of my view
5 of what I have identified within them, and then further
6 down, I think, I have for each patient, I have added
7 a commentary for each patient. Within there, I think
8 -- within my opinions, number 1 really summarises what
9 we've covered before, which is a planned outpatient
10 review being the fail-safe for patient results being
11 resulted and actioned rather than the result being
12 reviewed and actioned before an appointment. Again,
13 following on from that, the same sort of statement.
14 "No process for review of results and communicating
15 findings to patients and GP." A concern that the DARO
16 process is not adopted. No discharge summaries
17 dictated. A number of concerns that we'd have had
18 through previously. Some concern that the outcome of
19 a consultation has not been actioned, which I think is
20 along the same lines as the concern I had when I saw
21 the green forms; that outcomes of a consultation
22 haven't been actioned.

23 157 Q. Then concern arising out of MDM reviews?

24 A. Yeah.

25 158 Q. This, of course, could have been any practitioner. It
26 just happened to be Mr. O'Brien. What all of this
27 points up is a governance framework which isn't
28 capturing any of these issues. This was hidden to you
29 up to this point and hidden to other managers in the

1 system?

2 A. This was a wider look into Mr. O'Brien's practice that,
3 as I have reflected, we should have done at an earlier
4 point, at the onset of the MHPS investigation.

5 159 Q. I suppose the point I'm making to you is that a more
6 sensitive or a more responsive governance framework,
7 had it been in place, it should have been picking up on
8 things like this?

9 A. You would have hoped so.

10 160 Q. Subsequently then, on 11th July, you write to
11 Mr. O'Brien. If we bring that up, please. 02534.
12 You remember this letter, Mr. Haynes. Essentially, it
13 summarises the concerns identified by the Trust,
14 through you and Mrs. Corrigan, indicates that an MHPS
15 process would be initiated, and asks for his initial
16 observations while imposing restrictions in that he
17 should no longer undertake clinical work and he should
18 not access or process patient information. Did you
19 ever receive a response to the issues? We can scroll
20 down and see how the issues are set out. At the bottom
21 of the page there, you enclose a summary of the
22 concerns. The concerns identified will be managed in
23 line with MHPS. You are at the initial Inquiry stage
24 and you invite him to make any initial representations
25 as I have said: "And once we have concluded our
26 initial inquiries a determination will be made about
27 next steps in the process."

28

29 scrolling down, please. You categorise, just down at

1 the bottom -- sorry, that's the restrictions you were
2 imposing. You ask him to notify the Trust if he's in
3 possession of any files. In fact, he is in possession
4 of two files at home, and they are subsequently
5 collected. These are the concerns. Concern 1,
6 patients identified with unnecessary delays regarding
7 referrals for treatment. Then you set out what you
8 found on a lookback of emergency and elective. You
9 summarise that there. Then you have, by this stage,
10 identified a number of potential SAIs which were
11 ultimately to find their way into Dr. Hughes' and
12 Mr. Gilbert's zone as part of their review.

13
14 The next step in the chronology was the Early Alert to
15 the Department on the 31st of that month, 31st July.
16 Did you have any part in composing that?

17 A. In terms of the chronology, between that review by
18 Martina Corrigan, there is my escalation of concern
19 regarding Patient 1 and I think it was -- I can't
20 remember who the next patient down within there was.
21 The IR1 certainly was completed on Patient 1 there at
22 around that time. As I have said, we have Martina
23 Corrigan's review findings, which again had concerns.
24 Then I also had significant concerns about the patients
25 who had found their way into that, who then found their
26 way into that SAI process with Dr. Hughes and
27 Mr. Gilbert. To me, they, if you like, raised the bar
28 of the concerns, because things moved away now from
29 just, if you like, it's not just, but from being not

1 doing what was required at the time of the consultation
2 to practice of managing patients not being in line with
3 MDT and resulting in patient harm, as far as I could
4 see. My understanding is the escalation as an Early
5 Alert was on the back of them two concerns. In terms
6 of the wording of the Early Alert, I don't recall
7 wording the Early Alert. I may have been in meetings
8 discussing it. I may have been circulated at some
9 point, but I don't recall feeding into the wording.

10 161 Q. Just to recap. We started with your evidence with your
11 key reflection, as I called it. I think you've agreed
12 with me that there was a missed opportunity here to
13 conduct a comprehensive review of practice, and that
14 opportunity existed in 2017 or, at latest, after the
15 MHPS review reported. If that had been done, you said
16 it is likely that the clinical practice which was
17 identified in 2020 and which led to the lookback
18 exercise, would have been identified earlier. I assume
19 you stand by that reflection. It's quite clear, isn't
20 it, that the review which Mrs. Corrigan dealt with
21 administratively, and which you substantively
22 contributed to with analysis across 18 patients, that
23 was presumably not a straightforward exercise, but was
24 done relatively quickly, without expenditure of great
25 resources, and didn't require any particular legal
26 consent or permission to get it done; this could have
27 been done at any time?

28 A. That's, as I have reflected, the concern that I had
29 then that triggered that, we should have done the same

1 at a much earlier stage.

2 162 Q. You, in your statement, have offered some, I suppose,
3 further reflections about why this opportunity was
4 missed. If I could take you briefly to your statement
5 again at 74.1, WIT-53953. And you cite, I suppose,
6 three primary factors:

7
8 "Having had the opportunity to reflect, do you have any
9 explanation as to what went wrong with the Urology
10 Services and why?"

11
12 You say the three factors are: "Insufficient capacity
13 to meet demand; failure of the Trust processes to link
14 concerns over time and address concerns when first
15 identified; and the behaviour of Mr. O'Brien."

16
17 The first of those issues, you say that the demand
18 capacity mismatch had the effect that colleagues were
19 perhaps less attuned to all that was going on and were
20 more likely to miss or fail to observe what might, in
21 calmer times, have been more obvious. How do you
22 explain that, or can you give us an example to
23 illustrate what you mean?

24 A. It's on multiple levels. If we look at our complaints
25 process as a potential source of identifying concerns,
26 if, because we can't meet the demand for a service you
27 will get lots and lots of complaints about primarily
28 waiting time, then within them complaints there may be
29 patients whose waiting time is contributed to by some

1 of the failings that we have identified with regards
2 Mr. O'Brien's practice, but they have been masked that
3 patients are all waiting five years for an Outpatient's
4 appointment, a routine Outpatient's appointment, and
5 five years on a waiting list for surgery, and so you
6 might not recognise that there's an issue aside from
7 the long waiting lists.

8
9 From the individuals working within the system, what
10 they are constantly doing is having to prioritise and
11 re-prioritise and re-prioritise need of patients they
12 are seeing who are all waiting too long for treatment.
13 Again, within that busy system, you wouldn't
14 necessarily get the opportunity to, if you like,
15 critically appraise another individual's management of
16 patients because you are all busy just trying to keep
17 on top of that that's coming, if you like, directly to
18 your desk. I have highlighted and we have discussed
19 how my working practice, my working week is, and that's
20 just keeping on top of what's my practice. Spending
21 time within that to actually have an eye on someone
22 else's practice, you just don't get that opportunity as
23 much.

24 163 Q. Can I maybe just debate that with you? I entirely take
25 the point that all of the clinicians in urology are
26 running to stand still and, respectfully, doing your
27 best every day to keep patients well. When you have
28 that strain in the system and strain on practitioners,
29 you, more than ever, perhaps, need strong management,

1 supported by strong governance systems and sensitive
2 governance systems, to pick up on the errors or the
3 shortcomings in practice. I think as you reflected the
4 last day, and maybe hinted at a moment or two ago, you
5 weren't particularly well equipped, given your clinical
6 responsibilities, to act as effectively as you would
7 have liked as Associate Medical Director, given the job
8 description you have, and it seems that although you
9 and others are feeding information into the Medical
10 Director's office, for whatever reason there wasn't
11 a responsiveness there, perhaps. Obviously, it's
12 a matter for the Inquiry to assess that, but based on
13 what we looked at this morning, we saw that not until
14 the end of 2019 was a casual challenge presented to
15 Mr. O'Brien through Mr. McNaboe meeting him in
16 a corridor. Isn't that the point? You may well be
17 working in difficult circumstances, but you need to be
18 supported by management and good governance?

19 A. Yeah. Okay, yes. The point I'm making is in terms of
20 us, as individuals within the team, having, if you
21 like, a critical oversight of each other's practice.
22 When you are that busy you don't get that opportunity
23 for critical oversight of each other.

24 164 Q. We heard yesterday, and we saw yesterday, if I could
25 just bring up a document, WIT-84353. This is a record
26 of your discussion with Dr. Hughes as part of his SAI
27 Review. By that stage, of course, you were Associate
28 Medical Director. This is a meeting taking place at
29 the start of 2021. You identify yourself as the person

1 who raised the concerns. You say, about halfway down
2 the page there:

3
4 "Mr. Haynes advised that there were a number of
5 concerns about how Mr. O'Brien practised", but you were
6 not "acutely aware about his lack of conformities to
7 standard treatments."

8
9 Just at the very bottom of the page, you say:

10
11 "The MDT did disagree with Mr. O'Brien's
12 decision-making regarding ADT. He recalled
13 a disagreement with Mr. O'Brien in relation to his use
14 of ADT for a patient and he said that Mr. O'Brien
15 became entrenched in his decision-making and he never
16 accepted their challenges."

17
18 Breaking that down -- and we see various other pieces
19 of evidence given to Dr. Hughes -- there was
20 a knowledge or an awareness within the MDT that
21 Mr. O'Brien treated with Bicalutamide 50 milligrams
22 instead of LHRH on occasions. We see that through
23 a number of patients who were the subject of SAI.
24 I think I'm right in saying that you observed that
25 through the Bicalutamide audit that you conducted on
26 behalf of the Trust. With that long preface, although
27 you were working in these difficult circumstances,
28 colleagues such as yourself, and you had a managerial
29 hat to wear as well, were aware of shortcomings in his

1 prescribing practice, but, according to Mr. Glackin,
2 while it was raised at the MDT, it was neither minuted
3 nor escalated. Do you agree with that? There was
4 a challenge to him. You say he didn't listen, he
5 became entrenched, but it wasn't taken anywhere else?

6 A. My recollection of the event I was referring to there,
7 was not so much about the type of ADT or the dose of
8 ADT, it was more about the initiation of androgen
9 deprivation therapy in a patient who was not suitable
10 for curative treatment due to comorbidities or age, and
11 the discussion was regarding watchful waiting or
12 deferred androgen deprivation therapy rather than
13 starting androgen deprivation therapy immediately.
14 That was the discussion, rather than a, what type of
15 androgen deprivation therapy started here.

16
17 In terms of the awareness, as I know now, the NICA
18 Urology Group had generated guidelines for androgen
19 deprivation therapy while Mr. O'Brien was Chair of that
20 group and, if you like, the reason or the trigger for
21 that was concerns within the MDT structures regarding
22 Mr. O'Brien's use of Bicalutamide, and specifically at
23 a low dose. I think with regards the Bicalutamide
24 piece, the prescription of Bicalutamide 50 milligrams
25 for me became not so much the problem but the hallmark
26 of the patients who hadn't been offered treatment that
27 they should have been offered for their prostate
28 cancer. For example, Patient 1, who my recollection is
29 the MDT outcome was to commence hormones and be

1 referred for radiotherapy, he wasn't referred for
2 radiotherapy but I could identify him because he had
3 been started on Bicalutamide. That was, if you like,
4 the hallmark of the patients who hadn't been managed
5 according to the MDT guidance.

6 165 Q. Yes. What I'm suggesting to you is that the
7 Bicalutamide as, if you like, the hallmark, if that had
8 been poked at a little better, a little further, it
9 would have revealed as, for example in Patient 1's case
10 and there are perhaps several others, in fact others
11 emerged from the SCRR process, going back many years,
12 a decade, in fact --

13 A. Yes.

14 166 Q. -- and that would have revealed -- and the logic of
15 this, no doubt Mr. O'Brien will explain, there were
16 cases where patients seemed to be solely treated on 50
17 milligrams and no referral to radiotherapy for curative
18 treatment. Again, going back to the point where we
19 started on this, the demand capacity mismatch places
20 everybody under stress, generating complaints about
21 waiting lists, and you become desensitised, no doubt,
22 to other things that would ordinarily spell difficulty
23 or trouble for you, and you would maybe react. But you
24 weren't wholly without information here, not just you
25 but your colleagues, to better react to shortcomings in
26 practice?

27 A. I think that, as you say, can be extended over many
28 years, and the Bicalutamide issue was recognised by
29 others across many years, but not escalated in the way

1 that it could have or should have been.

2 167 Q. I think that's the second point that you use to
3 explain, I suppose, the contribution or contributory
4 factors to this lack of reaction. You say at 74.3 of
5 your statement that there was a failure of the system
6 to meet old concerns with new ones, and an absence of
7 handover, as you pointed out before, didn't assist. Is
8 there anything more you want to add to that?

9 A. Sorry, I am just coming back to the busyness. As
10 I say, there may have been as urologists, an awareness.
11 As I outlined, I recall a disagreement over a whether
12 a patient should be started on hormones when really
13 I felt they should be managed by watchful waiting, but
14 we wouldn't have had an oversight of a large number of
15 patients being managed as Outpatients primarily, who
16 are never coming into the Inpatient environment for
17 their prostate cancer. They would have come to clinic.
18 They would have been started on whatever treatment they
19 were started on. They would continue on follow-up as
20 Outpatients for many, many years, without any Inpatient
21 attendance and ever coming under the eyes of the rest
22 of the team. There may have been, at various stages,
23 the occasional patient who did come in as an Inpatient,
24 but in a busy working environment where you are seeing
25 the occasional patient, you may not link one thing to
26 another. I've again reflected in my statement about
27 another patient, Patient 4, where, when I reviewed his
28 care later in 2020, I recognised that when he'd been in
29 during an Inpatient stay in late 2019, what I'd thought

1 initially was simply an oversight and changed his
2 hormone treatment, was not an oversight, it was
3 actually a pattern of practice. It was only on having
4 a much broader oversight of Mr. O'Brien's practice that
5 I recognised that, whereas at the time that I saw that
6 patient, he was one patient, an isolated event that
7 I haven't perhaps linked across time, and it might be
8 another year before I came across another such patient.

9 168 Q. Just continuing with this debate a little longer.
10 Patient 1 comes into your MDM in late October 2019.
11 You have set out the recommendation earlier. I don't
12 need to bring up the MDM record. As part of the
13 history set out there, Mr. O'Brien started that patient
14 on 150mgs of Bicalutamide, not the generally-accepted
15 approach, given local guidelines for hormone treatment.
16 The note also records that the plan was, because of
17 lack of tolerance of the drug, to start him on 50
18 milligrams, actually a day or two after the MDM. You
19 saw a patient of Mr. O'Brien that we talked at some
20 length about yesterday, Patient 6. Sorry to throw this
21 at you without records. The fine detail of it doesn't
22 matter, but, again, that was a patient you saw, was
23 described as an MDM, but you sat alone in it because of
24 attendance issues. Mr. O'Brien had had that patient on
25 50 milligrams of Bicalutamide, as he describes it in
26 his witness statement, to relieve that patient's
27 concern about the disease progression. Certainly
28 Dr. Hughes and Mr. Gilbert, when we asked them about
29 these cases yesterday, say, they are all examples of an

1 unconventional approach to prostate cancer management.
2 Are you really saying that these clues weren't out
3 there, or they were out there but the dots weren't
4 joined up for you?

5 A. I think we are looking, with the benefit of hindsight,
6 at some isolated dots. As you say, Patient 1 was
7 started on Bicalutamide 150 and perhaps the dose
8 reduced, but the expectation from MDT was that he was
9 going to be referred for Radiotherapy but that didn't
10 happen. The issue in terms of him not receiving
11 potentially curative treatment was the non-referral for
12 radiotherapy. Many patients will receive Bicalutamide
13 150 as their adjuvant hormone treatment prior to and
14 after radiotherapy, so Bicalutamide 150 in that setting
15 is a recognised treatment. At the point of the MDT,
16 the patient's been started on some hormones. I can't
17 recall whether the dose reduction was done before MDT
18 or after MDT.

19 169 Q. It just stopped because of reaction issues before MDT,
20 with a view to starting it. The MDT was 31st October,
21 he was to restart after a break on 1st or 2nd November?

22 A. But there was still an expectation that he was to be
23 referred for Radiotherapy, so the expectation would be
24 that actually ideally and best outcomes for a high risk
25 cancer as he had, would be for a period of adjuvant
26 hormone treatment along with Radiotherapy. Some
27 patients who can't tolerate adjuvant hormones may just
28 have Radiotherapy alone, but they still have the
29 Radiotherapy. He didn't get the referral for

1 Radiotherapy, but we wouldn't have been aware of that
2 at the MDT. We would have been aware he had
3 a tolerance issue with the commencement of hormone
4 treatment and therefore him discontinuing it and a plan
5 for how to reintroduce it would be perhaps reasonable.
6 The Patient 6 I don't entirely recall. But again
7 patients who are going to be started on hormone
8 treatment for prostate cancer, a dose of Bicalutamide
9 50 milligrams would be used as a standard cover for
10 testosterone flare associated with LHRH analogue
11 injections, so a patient having been started on that
12 medication and then having a diagnosis confirmed with
13 a view to them starting on treatment, that wouldn't
14 necessarily flag an alarm. It's when that's continued
15 beyond that without the additional referral that was
16 recommended that it becomes an issue, and that
17 information isn't necessarily available at the MDT at
18 the time that that patient is discussed.

19 170 Q. It's not an issue I intend to pursue terribly long with
20 you today, but were you conscious that within your MDT
21 there was an absence of tracking along the length of
22 the patient's pathway? Was that a different system
23 than you were used to in Sheffield, for example?

24 A. Tracking is different here and, unfortunately, is
25 funded up to the point of the commencement of their
26 first treatment. In men who are receiving hormones and
27 radiotherapy, the first treatment is the initiation of
28 their hormones, so they are only tracked to the point
29 of initiation of hormones. They are not tracked beyond

1 that is my understanding. So, potentially that is
2 a factor in this , that we weren't tracking subsequent
3 treatment. It's a factor within many aspects where we
4 are not tracking subsequent treatments after.

5 171 Q. The third issue that you raised as an explanation, or
6 a partial explanation, for what had gone wrong was the
7 behaviour of Mr. O'Brien. I think you have explained
8 that previously and it came up again this morning in
9 terms of what was perceived to be pressures being
10 applied to Mr. Young and Mr. Weir by Mr. O'Brien and
11 his family members. Is there anything else you want to
12 say by way of elaboration on that?

13 A. No. I think, as I say, we have covered it before.
14 I mean, again, even after the June phone call and being
15 told we wouldn't have him back, and I think our contact
16 was then was contact through the legal team. So
17 everything that came escalated in the same, you know,
18 again just demonstrating that the approach was, if you
19 like, heavy-handed. It was very much straight in.

20 172 Q. Certainly those explanations are there to be
21 considered, and no doubt the Inquiry will consider
22 them. They do, would you agree with me, sit against
23 a backdrop of management that was complacent, perhaps,
24 disinterested, perhaps, or afraid, perhaps, to make the
25 appropriate challenge to Mr. O'Brien when a lot of
26 information, and we've had the debate about what was
27 known and what wasn't known, but there was a lot of
28 information known, and that must also provide
29 a significant part of the explanation. would you

1 agree?

2 A. Yeah. You highlighted there the potential, the fear
3 bit and the practice over many years, and that has to
4 be a factor, and that relates to the third point I've
5 raised there in terms of the behaviour, the historic
6 behaviour of Mr. O'Brien.

7 173 Q. You have been involved in what might be described as
8 a clean-up operation following the exposure of these
9 shortcomings, and, in particular, the impact on
10 patients. You have been responsible for overseeing
11 a Bicalutamide audit. You have participated in the
12 Lookback Review and the work associated with that then
13 in terms of going back to patients whose care or
14 treatment is found to have been suboptimal and seeing
15 whether different treatment needs to be given; you have
16 done all of that. That has had a particular impact on
17 your practice, has it?

18 A. Essentially, my Southern Trust Outpatient practice now
19 consists almost entirely of Lookback Review patients
20 and my post-MDT work. I don't see any new patients
21 currently.

22 174 Q. That must have a deleterious effect on what would
23 otherwise be your patients, the waiting lists and
24 emergency work, and it must put a stress on the rest of
25 the team?

26 A. For the new patient workload it puts a strain on the
27 rest of the team. From patients under my care awaiting
28 review appointments, I've, through my practice in
29 Southern Trust, maintained a very short review backlog

1 through working practice that we touched on before,
2 including virtual reviews and the like, as I think
3 I mentioned the GIRFT review regarding Outpatient
4 practice. I have long practiced that in terms of,
5 rather than seeing patients where their care can be
6 managed and follow-up can be managed remotely,
7 I conduct remote monitoring. But as a result of the
8 workload coming through the Lookback Review, my own
9 review backlog has lengthened out because I haven't got
10 the capacity to see patients from the Lookback Review
11 and patients needing review within my care although
12 I am retaining the post-MDT, the cancer patient
13 reviews.

14 175 Q. Just a word on, I suppose, what is the state of the
15 nation, which is Southern Trust, in terms of the
16 various initiatives that have had to take place. Is
17 lookback going to be expanded in terms of its temporal
18 reach?

19 A. The first phase of the lookback is, I think, almost
20 finished. Conversations have been occurring with the
21 Trust and the Department regarding the second phase of
22 the lookback, and I would be pretty confident that is
23 going to be proceeding. The bit that is just, if you
24 like, being clarified, is the prioritisation within
25 that.

26 176 Q. That's in light of the RQIA's recommendation that it
27 should go back further, perhaps to 2015, and the Royal
28 College has found, upon a sampling exercise, that there
29 are cases in 2015 that raise some concerns?

1 A. Yeah. You mentioned the SCRR process, and within there
2 we have identified patients whose care dates back
3 before then as well.

4 177 Q. With the SCRR process as it stands, I think we have had
5 some new reports in recently, but is there any pressure
6 being applied or impetus evident in terms of completing
7 that exercise? The last we heard it was 53 cases that
8 had been screened into that process, and certainly the
9 last I looked we had in the low 20s of reports back to
10 yourselves and then into the Inquiry. What is holding
11 up progress?

12 A. The SCRRs are being done externally by clinicians,
13 largely from elsewhere, so outside of Northern Ireland.
14 My understanding is that, yes, they are being chased up
15 and pressure applied but there are a number still
16 outstanding.

17 178 Q. In terms of the governance systems and frameworks, you
18 will be conscious that Dr. Hughes' SAI initiative
19 produced recommendations and action plans, and no doubt
20 they are being fed through the system and no doubt
21 resources are an issue in respect of some of them, and
22 we will hear from Dr. O'Kane next week, perhaps, in
23 relation to those.

24
25 Has there been any noticeable change on your ground, if
26 you like, on your Urology patch, which would assure the
27 public that the kind of issues that have given rise to
28 this Inquiry are not likely to be repeated because
29 change has been made?

- 1 A. I've mentioned during my evidence that we have
2 a process in place so that I can assure that I am
3 assured and can assure anyone that we have our
4 Radiology results being looked at, being actioned by
5 the team, and that that process is a weekly process
6 that is keeping the entire Urology team within Southern
7 Trust up-to-date with -- I mentioned the aim, our
8 target is for all results to be actioned within two
9 weeks of the result being made available.
- 10 179 Q. Just to cut across you. Sorry. Would that cover
11 the -- it is helpful to put these into scenarios.
12 Would that cover the kind of scenario the Inquiry is
13 familiar with with Patient 92, just to take that
14 example?
- 15 A. Yes.
- 16 180 Q. Or the retained swab example? I can never remember
17 that patient's identity.
- 18 A. Yes, so that would cover patients like Patient 92.
19 Patients like Patient 5 as well. That covers that. In
20 terms of the MDT outcomes, resource has been put into
21 the MDT in terms of assurance checks, and assurance
22 audits have been done following the Urology MDT that
23 the actions or recommendations of the MDT have been
24 carried out by the clinicians seeing them patients.
25 That was summarised at the MDT's annual meeting earlier
26 this year, I think it was -- I can't remember the date
27 of it, it was a couple of months ago, but essentially
28 it was that the individuals working are carrying out
29 the recommendations as per the MDT outcome.

- 1 181 Q. If the recommendation to you yesterday was to start the
2 patient on ADT, and refer for curative Oncology,
3 curative radiotherapy I should say, and you failed to
4 do so, how would the Clinical Lead or the MDT
5 coordinator become aware of your failure?
- 6 A. There would be tracking for that outcome to ensure that
7 that's happened. When that patient has come to clinic
8 that outcome would be checked and that would be fed
9 back, either escalated to me or through the MDT.
- 10 182 Q. What about the situation where you have taken the
11 recommendation back to your Outpatients clinic, the
12 patient has come in to see you, circumstances have
13 changed and you can't implement the MDT recommendation,
14 or you have thought of something else and you decide
15 that's no longer appropriate. That was, in terms, part
16 of some of the cases or a case before Dr. Hughes and
17 Mr. Gilbert. Would that kind of scenario be covered by
18 any change, or does that remain a matter of trusting
19 the professional without any basis for assurance?
- 20 A. That patient should be brought back to MDT for
21 confirmation of that change of plan through the MDT.
22 I certainly know of examples myself where I've viewed
23 the outcome, seen the patient and their staging, and
24 taken them back to the MDT because I felt the MDT
25 outcome, having reviewed things, required a different
26 outcome, and so the patient was rediscussed.
- 27 183 Q. Was that always your practice or has that been the
28 practice since?
- 29 A. That has been -- certainly would be my -- I hope

1 intended practice. There are many situations. I think
2 that's one situation where I have reviewed the staging
3 and felt that the appropriate management differs from
4 the MDT discussion, and so I have taken that back to
5 MDT. That's different to a patient being recommended
6 that they should have treatment A, and a patient saying
7 I hear you, I understand, but I'm not listening to you,
8 I am going to not have treatment. That, historically,
9 I would have documented in a letter the patient's
10 decision-making but I wouldn't necessarily have taken
11 that back to MDT. Now I would look to bring that back
12 to MDT.

13 184 Q. In terms of disease progression, was it always the
14 rule, if you like, and maybe an unwritten rule, but was
15 it always the expectation that, with disease
16 progression, it should come back to the MDT for further
17 discussion?

18 A. Yes. My understanding and reading of MDT guidance is
19 that, on disease progression, yes, patients should come
20 back to MDT. That hasn't always happened, but that is
21 something that we bring back to MDT now.

22 185 Q. Again, is that something that can be monitored or
23 observed, from a governance perspective, to ensure that
24 it's done?

25 A. I think that's more difficult to monitor or observe
26 because without having all of the patients follow-up
27 being looked at on every occasion that they are seen,
28 you wouldn't necessarily identify the patients who have
29 progressed and, indeed, many of the patients we would

1 expect to progress and therefore progression is not an
2 unexpected event, so you would perhaps have already
3 have a plan for how progression is going to be managed,
4 if that makes sense?

5 186 Q. Yes. Can you help us with the whole area of the Cancer
6 Nurse Specialist. It was a critical issue explored by
7 Dr. Hughes as part of his review. His conclusion was
8 that Mr. O'Brien, in respect of the nine patients he
9 was considering, had not made arrangements for the
10 nurse to become involved. Some of the evidence that he
11 received suggested that Mr. O'Brien excluded the nurse.
12 That's by way of context. The MDM operational policy
13 for the Trust, which was published, I think in 2016,
14 puts an onus, at least on the written page of that
15 document, puts an onus on the Clinical Lead and the
16 core nurse member to ensure that a key worker uses the
17 language of key worker is allocated. I understand in
18 practice the key worker tends to be the CNS. Can you
19 help me with that. Is that the way allocation was done
20 in practice or, in the alternative, was the operational
21 policy in a sense put to one side and it was really
22 a matter for you, the treating Clinician, to put the
23 contact information for the nurse into the hands of the
24 patient, or indeed to make the introduction at the time
25 of the clinic?

26 A. If we go before, before Covid I guess is a good
27 timescale -- time frame, then patients would have come
28 to a review clinic and, within that review clinic,
29 there would have been patients who were on for

1 a general review and some patients who were on for
2 post-MDT review. Practice for me would have been to
3 highlight them patients as needing the key worker input
4 and introduce them after the consultation and they
5 would have gone and had a consultation with the key
6 worker at that point. That's reliant on manpower. So
7 sickness and things like that would have always
8 potentially have an issue if someone wasn't available,
9 and they would have been provided with the details for
10 the contact with the key worker. Now we have got
11 a bigger Nurse Specialist team than we perhaps had
12 before, and the CNS team are aware of when them clinics
13 are that patients are coming back post-MDT, they are
14 aware of who them patients are, and they are available
15 for them clinics. For myself, my clinic is in Armagh,
16 so it's off site, and so I have the CNS in clinic with
17 me throughout the clinic, so they are available for the
18 entire every patient during that clinic.

19 187 Q. Just to be clear, although the operational policy which
20 I assume you are familiar with, but take it from me the
21 wording is "key worker allocated by" -- or "the
22 responsibility for ensuring allocation is with the
23 Clinical Lead and the core nursing member". Is that
24 never how it worked?

25 A. The reality is, I'm not sure how the Clinical Lead can
26 assign who the key worker is when they don't know who
27 is going to be there in clinic on the day that the
28 patient attends.

29 188 Q. Yes. Very well. Thank you, Mr. Haynes, for your

1 evidence. I'm sure the Panel have some questions for
2 you.

3
4 MR. HAYNES WAS QUESTIONED BY THE INQUIRY PANEL
5 AS FOLLOWS:
6

7 CHAIR: Thank you. I am conscious that we haven't
8 taken a break this afternoon, but we will try to be as
9 brief as possible, Mr. Haynes, just to get it
10 concluded, if you don't mind sitting on for another
11 while. Dr. Swart?

12 DR. SWART: Thank you very much for your detailed
13 answers, I have just got some general questions really.
14 The first one is about safety culture. Mr. wolfe has
15 already alluded to the fact that the key interests of
16 the public will be are Urology Services at Southern
17 Healthcare Trust safe? That will also be the key
18 interests of the Trust Board. I know it's quite
19 difficult to have exactly the right sort of measures of
20 Patient Safety and embed them, but I think none of us
21 would want a situation where we wait for harm and then
22 resulting in investigations, so the idea would always
23 be to have early warnings of safety issues. You have
24 referred to that in a number of places in your
25 evidence, but also in your S21. You referred to the
26 importance of accurate data, intelligent information,
27 both in terms of the administrative issues and the
28 results and letters, and so on, but also in terms of
29 outcomes, clinical outcomes in Urology. I would agree

1 with that. My question to you is: what efforts have
2 you made to take that further? Have you been able to
3 have any discussions with the Medical Director or other
4 senior people in the Trust to put such things in place
5 so you don't have to have such laborious processes?

6 A. With regards the outcomes data, I think we are in
7 a very difficult position. We do not have the reliable
8 hospital episode outcomes data available for us to even
9 partake in the same outcomes monitoring arrangements
10 that would be within Services in England and Wales. We
11 don't have -- we discussed prostate cancer. If we
12 looked at prostate cancer, we just don't have the
13 capability to provide the data that would be provided
14 to the National Prostate Cancer Audit, for instance.
15 We are not going to fix that data availability rapidly,
16 and so, if you like, the alternative approach is to
17 approach with standardised audits of conditions and
18 practices, and that's where we've been establishing
19 within the Urology team, is an audit programme actually
20 looking at them outcomes and using the standardised
21 tools available. Again, if we look at prostate cancer
22 or bladder cancer within the NICE guidance there are
23 audit tools that can be used in that, and so they have
24 been brought in to be part of a standard audit
25 programme to look at that.

26 189 Q. I would imagine this is a trust-wide issue in terms of
27 indicators so my question was really have you had
28 support from senior people in understanding the
29 importance of all of this and the fact that it would

1 actually help you in your day-to-day practice?

2 A. I think there's an understanding that it would help but
3 understanding and being able to -- understanding it
4 would help and being able to actually provide it is
5 a different thing. We are limited by the tools we have
6 available for data and outcomes capture.

7 190 Q. Just moving on the same safety theme, I think we all
8 recognise increasingly that ensuring Patient Safety is
9 a team sport, to use that phrase. You need everybody
10 in the MDT and everybody in the Urology Department to
11 participate in it. It must have had a huge, this whole
12 Inquiry and all of the harm that's been identified,
13 must have had a big impact on the Urology team. Do you
14 feel like a team and how much support has been put in
15 to help you work together most effectively to get over
16 some of the issues that have been raised?

17 A. I think we feel like a team but we feel like a team who
18 haven't got any substitutes and half the people have
19 been sent off. We are short. We haven't got enough of
20 us. We are and we do function as a team, and that's
21 not just the clinicians, that's across the Medical and
22 Nursing team. We function well as a team, we
23 communicate well as a team, but we struggle to meet the
24 mountain of work ahead of us, and that's the biggest
25 challenge to us all.

26 191 Q. Was any support to put in to help the team in what must
27 be extraordinarily difficult?

28 A. We have been offered support by the Trust through this
29 but I don't think any amount of support is going to

1 takeaway from, you know, say, the anxiety of me over
2 the weeks leading up to my first two days and starting,
3 I think it was Thursday night my sleep started to be
4 disturbed. On this occasion, no amount of support is
5 going to impact on that. I have also highlighted that
6 I don't sleep that late in the morning anyway. So no
7 amount of support is going to change that and until, if
8 you like, the spotlight has moved on there is going to
9 be continue to be anxiety within the whole time working
10 within Urology, and I would say not just in Southern
11 Trust. Northern Ireland is small and across Urology we
12 are a small team who all know each other, and so what
13 effects us in Southern Trust has an impact on everybody
14 else as well.

15 192 Q. Okay. Thank you.

16 CHAIR: Mr. Hanbury?

17 MR. HANBURY: Thanks very much for your interesting
18 evidence. Just a few operational things about being
19 a urologist. I would like to start off being the
20 urologist of the week, and this is something that most
21 departments now do in England, as well as I am sure
22 Northern Ireland. A lot of the evidence is how busy it
23 is. Why did you decide to do the On-Call every night
24 as well as the weekend rather than just 9:00 to 5:00?
25 Also my second question is, I think you see the
26 elective cases as well as all the emergencies, so
27 that's quite a big workload. That was a team decision,
28 was it? How did you come to that?

29 A. Yes, that was a team decision. As a small team, we

1 offer for services across the Trust, so for elective
2 patients we are not all on site in Craigavon where our
3 inpatient elective surgery is carried out, and so
4 without having the back stop of the Urologist of the
5 week seeing all patients, then there's the potential
6 that the Consultant who has operated on them is doing
7 a session in south Tyrone or sitting here today who
8 were operated on on Tuesday wouldn't be seen. So the
9 patients I operated on on Tuesday are seen by the
10 Urologist of the week today. It doesn't stop us as the
11 operating surgeon seeing the patient. It just ensures
12 that every patient is seen for the elective care. In
13 terms of the night stats, that's a subject for debate,
14 where some people are very comfortable with doing
15 a full week of On-Call. I am less comfortable. That
16 might relate to my own personal circumstances and the
17 fact that if I am busy at night, I can't drive so
18 I don't drive home, I stay in the hospital, so I would,
19 if I had a personal option, I would not do seven days
20 in a row and would do intermittent days. I think
21 there's the flip side of it in that, if you do On-Call
22 night -- I am not sure what you have picked up from our
23 practice, we don't have a Urology middle grade from 11
24 at night, so if you are called in on an On-Call night
25 and actually it's an elective day the next day and you
26 have got an operating list that's difficult as well.
27 There are pros and cons of both seven days in a row or
28 doing it once in seven.

29 193 Q. Thanks. A couple of operational things about MDMS. We

1 have heard a lot about it. It must be very frustrating
2 for you as a team when you don't have Radiology and
3 Oncology in your local. I just wondered what efforts
4 you go to to get Radiologists or Oncologists remotely
5 with video conferencing; is that easy or a struggle?

6 A. As you all know, the, sort of, remote working has
7 exploded since 2020. If there's any bonus of the
8 pandemic it has been that. If we look at Radiology and
9 Oncology, the issue wasn't so much whether they could
10 be there, it was that there wasn't someone to do it.
11 Someone couldn't be in two places at the same time.
12 While you could have had an Oncologist link in, and we
13 did indeed have Oncologists link in remotely, if there
14 was a shortage of Oncologists then they couldn't link
15 in because there wasn't one available to link in, and
16 all of the Urology MDTs happen at the same time so
17 there's an Oncology cover needed across each MDT.

18 194 Q. Okay. That brings us to second thing about specialist
19 part of the MDT. Did you have an allocated section of
20 time every week or how did that work? We have heard
21 a lot about prostate and not much about kidney, for
22 example. How did your small renal mass MDT work and
23 who did you link in with?

24 A. In terms of the general MDT -- I will separate off the
25 small renal mass MDT, because that was established as
26 a separate entity, as it were. The general MDT, each
27 local MDT will link into the specialist MDT for their
28 patients. It's not so much at a set time, but there's
29 regular communication during the MDT between the

1 coordinator in each Trust and the specialist MDT
2 coordinator so Belfast know when Southern Trust are
3 ready for them, and equally southern know when Belfast
4 are ready, so link in and the patients are discussed at
5 the point of link in. The small renal mass meeting was
6 established really on the back of me coming in to
7 Belfast Trust, working with Mr. Hagan the time at the
8 time in terms of delivering the small renal cancer
9 treatment, and really recognising that the management
10 of the small renal mass was changing. There is more
11 ablative treatments, suitability for various treatments
12 was different, and so in order to discuss suitability
13 for things like cryo-ablation, microwave ablation, IRE
14 ablation, you needed a radiologist who did them, and so
15 them patients actually went through the MDT normally
16 and came to the small renal mass meeting where we
17 discussed what options were available for the patients.
18 Were they suitable for ablation because the Radiologist
19 who did the ablation now didn't attend the MDT.

20 195 Q. That happens now --

21 A. The specialist MDT is split into disease types with
22 small renal cancers being the first disease type
23 discussed.

24 196 Q. Just one more on scheduling and pre-op assessment. You
25 have eloquently illustrated the, sort of, complexities
26 of waiting lists and things like that. I was
27 interested that you seemed to do a lot with your
28 secretary. Do you not have a waiting list office to
29 prioritise so that stent change patients don't get

1 forgotten about, et cetera? That's one question?

2 A. That was the practice I would have been used to in
3 Sheffield where we have a scheduling team that did it.
4 In Southern Trust the secretarial team act in that
5 scheduling role in liaison with the Consultant, and so
6 the practice was somewhat different to what I had
7 experienced in Sheffield where we added to a pooled
8 waiting list, and the scheduling team scheduled
9 patients with some discussion with the consultants but
10 to the consultants' theatre list, according to each of
11 our sub-specialist expertise.

12 197 Q. That's a slight change of culture to Northern Ireland.
13 Okay.

14 A. Pre-Covid it was very much you managed your own waiting
15 list. I would say now there is a lot more pooling and
16 working across a single waiting list for the teams
17 post-Covid. It's different to Belfast where we do have
18 a scheduler in Belfast.

19 198 Q. Okay. Lastly, the Inquiry came to our attention for
20 two cases, all surgical outcomes, not under your
21 service. One theme we identified was somewhat
22 preceptive admission arrangements, lack of pre-op
23 assessment, or might have been available but the time
24 wasn't allowed for it. Is that what happens in your
25 service, can you reassure us?

26 A. It's across different categories and accepting that we
27 prioritise or effectively ration types of surgery at
28 the moment, red flag patients would be added to the
29 waiting list and would get pre-operative assessment

1 done, because their pre-operative assessment will be
2 done within time. The practice now, that green form is
3 not a piece of paper any more. It's an electronic form
4 that, on submission, goes directly to the pre-operative
5 assessment team, so the red flag patients are sent
6 their appointment for pre-operative assessment because
7 the pre-operative assessment team have received that
8 form. For the urgent patients, essentially where them
9 patients are coming or likely to be called for, then
10 pre-operative assessment is arranged in advance of
11 that. The challenge is knowing, if you like, how many
12 patients to have ready, because pre-operative
13 assessment needs to be done within three months,
14 I think is the guide for surgery. You can't get them
15 all preoperatively assessed too early, you don't want
16 to have every patient added to the waiting list
17 preoperatively assessed at the time of adding to the
18 waiting list, because lots of it will become out of
19 date and you will use a huge resource doing something
20 that then needs to be repeated.

21 199 Q. Specifically with complex major, with some cardiac
22 comorbidities you would be able to schedule that?

23 A. Yes, indeed. If you had a patient who you knew had
24 some comorbidities that was going to factor into that
25 consent process, I would write to my colleague,
26 Consultant anaesthetist who do the pre-operative
27 assessment clinic and ask them to see them to have
28 a discussion about the perioperative risks. Often
29 I would see them back in clinic to have that discussion

1 again before we looked at scheduled surgery.

2 MR. HANBURY: Thank you very much.

3 CHAIR: Thank you. Mine is slightly more specific. We
4 have heard this morning about the fact that Mr. O'Brien
5 recorded a number of meetings that he had with a number
6 of people without their knowledge. Unfortunately
7 I don't have the reference, but there was a meeting of
8 the Urology team, I think it was in 2018, if I have got
9 that right. I can certainly find the references,
10 I have left them in my office. Part of that meeting
11 was recorded by Mr. O'Brien up until the coffee break,
12 and after the coffee break the discussion was to be
13 about triage. First of all, do you remember that
14 meeting of the team around that time where a number of
15 issues were discussed generally. I think Mr. Glackin
16 was to provide document for you all to agree about the
17 issues that needed to be looked at or actioned by
18 management?

19 A. Yes. I think that's the September, from memory,
20 meeting. I think it took place in the Stone Treatment
21 Centre, is my recollection. Again, my recollection is
22 Mr. Glackin did take handwritten notes and did provide
23 a typed summary of that meeting.

24 200 Q. Yes. We have the benefit in the Inquiry of the
25 transcript of, as I say, the first part of that meeting
26 but certainly not the second part, so we are reliant on
27 that note that was provided by Mr. Glackin. I wondered
28 what your recollection was of the discussion within the
29 team about the whole issue of triage and whether any

1 consensus was reached within the team? If you could
2 maybe enlighten us a little bit about that?

3 A. I don't have a specific recollection and I can't
4 remember what Mr. Glackin's note says right at this
5 moment, but I think the whole team, I think it's
6 consistent throughout. From when I started in 2014,
7 the whole team were engaged in the establishment or the
8 generation of the vision presentation to the
9 Commissioner at that time, I think later in 2014, and
10 I think that was a paper and a presentation, and within
11 there triage is discussed and a proposal for triage
12 discussed there. There would have been many points
13 during that meeting where triage, and different
14 approaches to triage were discussed. It will have come
15 across really just discussing every aspect that impacts
16 on it. There's the workload element associated with
17 doing advanced triage, as I have mentioned, I mentioned
18 how I do it, but there's also the workload element of
19 what comes back from that. If you do advanced triage
20 then you have got a certain volume of scan requests you
21 are generating, and that's got to be factored in.
22 There will have been discussion around how realistic
23 taking on all of that workload is within a service
24 where we are struggling. Ultimately, I don't think we
25 came to a very clear, 'this is exactly what everyone
26 will do', and we continued doing triage in the way that
27 each of us felt most appropriate from that point.

28 201 Q. I appreciate that it is difficult, it's very hard to
29 remember every single meeting you have ever been at

1 with your colleagues. From what you have been telling
2 me it's likely, is it not, that in that meeting
3 everybody would have said what way they triaged, and
4 presumably Mr. O'Brien would have told his colleagues
5 at that meeting, 'I'm only triaging the red flag
6 cases'?

7 A. I don't have any recollection of him ever stating that
8 at any point.

9 202 Q. Would it be fair for me to assume that, in some ways,
10 it's less important to triage the red flag referrals
11 that come in, and more important to triage the routine
12 and the urgent to make sure that they aren't red flag?

13 A. I think that's a very reasonable suggestion. The
14 urgent and routine, when you have waiting times as long
15 as they are, if they should have been upgraded and
16 aren't triaged, then they are at a greater risk than
17 the red flag referral that's going to be seen on a red
18 flag basis anyway, and therefore be seen more urgently.

19 203 Q. The other thing that I do remember is that the minute
20 that was provided by Mr. Glackin, there was a section
21 on triage where it says that the Consultant body wanted
22 the Trust to set out what was expected in detail about
23 triage, what was expected of the Consultants by way of
24 triage when they were Urologist of the week. Did you
25 ever get anything back from management to say, 'this is
26 what we expect you to do'?

27 A. Not that I recall. I think in that same meeting in the
28 recorded bit, I did highlight that it's actually our
29 responsibility. We are the Trust and it's for us to

1 tell the Trust what we think is appropriate and the
2 Trust to say whether they agree. I think I'd have
3 a view that actually that's our responsibility to agree
4 what we feel is required and to inform the Trust
5 because we are the Trust.

6 204 Q. Can one assume then if the minute says that the Trust
7 should says out what it expects us to do that there
8 wasn't agreement among you?

9 A. I would assume that. It may be in amongst, and in
10 terms of a triage outcome, there is what type of
11 triage? So is it a basic are they on a routine, urgent
12 or red flag, or is there a more advanced form of triage
13 happening, and what is the expectation in relation to
14 that. The second part of that is timescales in
15 relation to that. I guess the timescale aspect is
16 something that we might have a view, but that would be
17 fed or guided more from outside of the team. I think
18 the reality of the team as it is now, I don't think we
19 need to be told what them time scales are; we do it.

20 CHAIR: Mr. Haynes, thank you very much. Just for what
21 it's worth, the Inquiry is very, very much aware about
22 the anxiety of coming to speak to us, and we hope we
23 haven't made it too painful for you. Thank you.

24 I think then next Tuesday is our next sitting day.

25 MR. WOLFE KC: Next Tuesday at 10:00, yes. Could
26 I just deal briefly with a very short housekeeping
27 matter that arises out of my opening on day 7. The
28 transcript for that day at 10:21, on day 7, recorded
29 our observations that as regards Patient 16, there was

1 some uncertainty about the level of SAI associated with
2 that patient. You will recall there's Level 1, 2 and
3 3. It had been reported to us at that time that this
4 was an SEA or Level 1. In fact, it's now been
5 confirmed, as we suspected, that it is a Level 3, so
6 that's Patient 16. It may have started off as a Level
7 1 or an SAE, but it was upgraded to a Level 3.

8 CHAIR: Thank you, Mr. Wolfe. 10:00 on 6th December.

9
10 THE INQUIRY WAS THEN ADJOURNED TO TUESDAY, 6TH DECEMBER
11 2022 AT 10AM