Urology Services Inquiry

Oral Hearing

Day 41 – Thursday, 27th April 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

Gwen Malone Stenography Services

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THE INQUIRY RESUMED ON THURSDAY, 27TH DAY OF APRIL, 2023 AS FOLLOWS:

CHAIR: Good morning, everyone. Ms. McMahon.

MS. McMAHON: Good morning. Your witness today is Katherine Robinson and she is going to take the oath. 10:02

KATHERINE ROBINSON, HAVING BEEN SWORN, WAS EXAMINED BY MS. McMAHON AS FOLLOWS:

10:02

1 Q. MS. McMAHON: Ms. Robinson, I should start off by apologising to you. I know you were listed earlier in the week to give evidence but, due to unforeseen circumstances, we moved you to today, so thank you for your patience with the Inquiry. 10:02

You are called here today because you've had two roles of potential relevance, Medical Records Manager and also the Head of Acute Referral and Booking Centre and secretarial admin, the current role that you are in. 10:02 To assist the Inquiry, you have given us some written evidence. Your witness statement, if we could bring that up, is found at WIT-60361. That's your witness statement to the Inquiry number 79 of 2022. If we go to the end of that at 60395, we will see your signature 10:03 at the end. That's dated 18th October 2022. Do you wish to adopt that statement as your evidence to the Inquiry?

A. That's fine.

2 Q. You have also given an addendum statement, which is found at WIT-91999. This statement was made on 23rd April, and that's your signature at the bottom. Do you wish to adopt that statement as well?

A. Yes. 10:04

3 Q. That statement really is just to correct references to Mr. Haynes' title. You referred to his title as Clinical Director but he was actually at that time the Associate Medical Director. Thank you. For the Panel's note, Mrs. Robinson has also given evidence 10:04 previously to MHPS on the issues germane to this Inquiry, and that statement can be found at TRU-00816 to 00818.

The purpose of your evidence today will be to look at 10:04 the systems of governance that you were involved in, in both your roles really, while in the Southern Trust, and to look at the issue - in particular three issues - referrals and booking, triage and dictation, and then we will look at DARO as well. Those are the areas that 10:05 you had some oversight for in your role?

A. Yes.

4 Q. We will go on to look at some of the things that weren't working, how you found out about them and who you then spoke to and what happened. We will look at 10:05 what others say about the systems that were brought in to try and deal with some of the problems. Then, because of your experience, I will ask you if there's any learning that you can share with the Inquiry, given

their remit to make recommendations.

So, you were the Medical Records Manager with the Trust from 2000 to 2013?

A. Yes. 10:05

5 Q. I will just quote from your witness statement where you say at that point your main role was to ensure the issue, storage and retrieval of patient charts in line with legal requirements for the storage of charts? You were also responsible for the Appointments Office 10:06 where you ensured all clinics were booked, suspended, cancelled as appropriate, and the general management of that office.

Helen Forde, who I think you know, gave evidence to the 10:06 Inquiry on Tuesday at length about the issue around charts. I don't really want to cover that with you in any great detail but I do want to ask, given you were in that role immediately prior to Mrs. Forde taking over -- did you have the opportunity to listen to 10:06 Mrs. Forde's evidence?

A. I did, yeah.

6 Q. Was there anything that she said that you disagreed with or generally were you on the same lines?

A. Very much so. 10:06

7 Q. Did the issues that Mrs. Forde described around charts generally, not speaking about Mr. O'Brien at the moment, but generally the issue around tracking and being coded out, trying to find charts, some being

offsite, were they all familiar themes for you when you were in that role?

A. Absolutely. Yeah.

8 Q. Now, the fact that Mrs. Forde was then discussing them when she was in the role, would it be fair to say that there was never a comprehensive solution found that would have dealt with the problems of charts not being where they should have been? 10:07

A. Yes and no. On the whole, it might have been very hassle-y looking for charts that weren't where they were supposed to be, but, if you think about it, if we were producing 95% of charts for clinics, yes, it might have been a lot of hassle but we were actually pretty much fulfilling the job, if you like. 10:07

9 Q. The issues around Mr. O'Brien about taking charts, charts being at home or offsite, were those issues that were familiar to you as well during your tenure in that post? 10:07

A. Yes. It may not have been as big an issue but it would have been -- yeah, finding charts that were tracked to O'Brien was always difficult. His office was always full of charts, they were all over the floor or whatever. If you had gone to the office and he was there, he would have been extremely helpful in helping you to locate a chart. It's pretty much the same thing as Helen was saying. 10:07 10:08

10 Q. Was that viewed by you and others at the time as more an administrative issue rather than a patient risk issue?

A. Very much an administrative risk issue, we would have thought.

11 Q. So if you wanted to get the chart, you went to find it and you were able to retrieve it for whatever it was needed for, but it just was a laborious task? 10:08

A. Yes, because there was so many of them always there.

12 Q. I just want to ask you briefly about coding of charts. We heard that secretaries have codes that they use when they take a chart, and the consultant also has a code. Under what circumstances would a secretary need to 10:08 access a chart if a consultant hadn't asked for it, for example? Why would the secretaries need their own code?

A. Well, actually the charts should be more tracked to the secretary than they should the consultant. If you 10:09 think about it, after a clinic takes place, the charts should actually go to the secretary's office for typing, follow-up, et cetera. The consultant really shouldn't need them, if they have been dictated on, that is. But a lot of the time a lot of the charts 10:09 went to the secretary's office even for dictation and the consultant would have rocked in there then to do their bit. Are you with me?

13 Q. Yes. Yes, I am with you. So, the dual purpose of the code was really to try and identify not only the person 10:09 that the file was with but give you a hint as to why they might have the file. For example, if Mr. O'Brien or another consultant had coded a file out, it may be because he has taken it to another clinic?

A. Yes, or it could have been a complaint or it could have been a medico-legal thing. There could have been any number of reasons why a consultant would want a chart. But just say a chart was not tracked to a secretary, right, just say somebody forgot and it wasn't tracked to a secretary, the Medical Records people searching for that chart would know, ahh, but it was at X, Y and Z clinic so it's got to be with that secretary or that typist, so that's where we will start to search. So, the whole coding issue all meant something, if you know what I mean. The Medical Records people was all very clear if you like. 10:10 10:10

14 Q. When you work in that system, you get hints of where the chart might be?

A. Well, you can track back. If I couldn't find it in O'Brien's office but he had been in respiratory clinic six weeks before, do you know what, I bet you they've asked for that and let's go there and see if it was there. There was a wee bit of detective work, if you like. 10:10 10:10

15 Q. Yes. Would it ever be the case that secretaries would remove files for private work?

A. Well, yes, and they are allowed to do that but they have to do it in their own time.

16 Q. Does that mean they have to ask for it in their own time as well as work on their own time, or can they -- 10:11

A. Yes. They should be doing it all in their own time.

17 Q. Now, we don't need to go to it but you had sent an email to various staff, and the Panel will find that at

WIT-60590, and it was on that issue of secretaries doing private work during working hours and to remind people that that wasn't permitted. What was the ex tent of that problem? Was that a significant issue or was it something that rumbled on and you had to, every now and again, remind people of their roles?

A. I think it was an issue that came up every now and again, and perhaps - I can't remember now obviously - but perhaps Medical Records Manager may have said to me, look, some of your secretaries are getting these charts and we know they are for private patients. This is not necessarily O'Brien, I am talking about other people as well. It wasn't a huge, huge issue but every now and again people needed reminded, you know, you're not supposed to be in here, rocking up doing private work, do it in your own time; we've enough to be doing. Do you know what I mean?

18 Q. Would it only be made known to you if somebody came along and said, look, I know X is doing that, or was there another way in which you might know private work is being done on NHS time?

A. No. The main way is actually by people telling us or Medical Records informing us, or whatever. That was really the main way. We didn't have -- like, there is a report that can be run for private patients but it wasn't something we would have had time to do; let's see who is doing private work and let's catch them out. It wouldn't have been on your radar.

19 Q. We will talk later about capacity, it wouldn't have

been something perhaps you would have had time to do?
A. No.
20 Q. Now, the Regional Booking Office was established in 2009?
A. Mm-hmm. 10:12
21 Q. This set up a centralised booking office for the entire Trust at that time. As far as your role was concerned, did that help to try and make things run more smoothly?
A. Well, obviously I'm going to say yes it would, because I was the manager. Really, the whole aim of 10:13
centralisation, I think it came really from the - I'm going to say Department of Health, could have been the Board, somebody, right - there should have been centralisation for all Trusts. There was a real aim behind that to equalise waiting times so that somebody 10:13
in Daisy Hill who was waiting, say, 50 weeks for a surgical appointment and somebody in Craigavon was waiting 60, it was to try and equalise the times so that when you put it all under one waiting list, it didn't matter where geographically you lived, you were 10:13
given pretty much around the same time. That was really the real reason for it. Obviously it did work because while it was very difficult to set up and ensure people were going to the correct site, and we did try to ensure that patients who lived in the Newry 10:14
area, as far as possible went to Newry to save them travelling. But they were really looking at the waiting times. It did work. We were trying our best for patients.

22 Q. Was it trying to give everybody the same opportunity?
A. Yes. I may not have said it very well but yeah.
23 Q. Absolutely, it's very clear what you said. To give everybody an opportunity to get access to healthcare at the same time, or wait the same time at least? 10:14
A. Yeah.
24 Q. You have mentioned in your statement - again, just for Panel note and for others, WIT-60366 - that around this time from 2009 to 2013, there was a huge emphasis to reduce waiting times and meet specific government 10:14 targets. I think you have said it slacked off after 2013, that that incentive went away. During that period of time from '09 to '13, what was your experience of people working together to try and achieve outcomes to reduce waiting times? 10:15
A. It was actually a very stressful time to be working in the Trust because the Trust was so focused on targets. Having said that, there was a very much a team effort by everybody, right, we are not going to be the only Trust in Northern Ireland that's not going to meet 10:15 this, we'd better meet it. There was kind of nearly an unwritten thing that we were going to be the best Trust in Northern Ireland, which I believe we were. There was very much a team effort to try and achieve these targets. And that's consultants, everybody pulled 10:15 together to get that done, but it was very difficult.
25 Q. There was a bit of Trust competition almost for people to meet the targets that were set?
A. Well, I felt that. Now it could be just me, but I was

going to make sure there was no way my side was going to be letting anything down, if you know what I mean.

26 Q. The issues that become apparent later on around triage and dictation, were those issues in that window of time, '09 to '13? 10:16

A. There were issues but the triage issue has been going for many years and I have been in the Trust a long time. Probably too long, but anyway. Triage has been an issue particularly with Mr. O'Brien for a long time. However, between 2009 and 2013 Dr. Rankin had a meeting 10:16 every Tuesday morning. Dr. Rankin was very strict and basically you had to come with all your facts. If you came and said I am waiting on ten people - and you had to declare everything, like, she would have went nuts if you hadn't - say you said I'm waiting on ten people 10:16 or patients being triaged, she would have turned around and said "Martina, Martina get that sorted by lunchtime". Martina would have went off and done that.

O'Brien was very obliging then because everybody was 10:16 very much trying to meet these targets. So it wasn't -- while there was issues, it wasn't a really, really bad problem at that time.

27 Q. And there seemed to be a more effective way of dealing with it that Mr. O'Brien and others were responsive to? 10:17

A. Well, I felt they were responsive, but then we were in target times so everybody was very much focused we have got to meet these targets. The fact that you had to go to a Tuesday morning meeting and declare anything, I

mean everybody would have been quite nervous going to this meeting. It was definitely no prisoners, like. So, you had to get your house in order.

28 Q. Was there any incentive around that, about meeting targets, for staff or for departments? 10:17

A. I suppose the incentive was it was a certain amount of job satisfaction, you know; we have got our waiting list down from -- it went from four years at one time, to 26 weeks and down to nine weeks. There was a certain amount of pride, we have done great for our 10:17 community, if you like; we have met this target, this is actually good work.

29 Q. Was there any additional money?

A. Yeah, there would have been loads of additional money and loads of additional clinics. Not really for us, 10:18 mind you, but for consultants and whatever, you know.

30 Q. Would consultants have been given money directly through their salary structure for meeting targets?

A. I presume so, yeah. There would have been a lot of money. I mean, every session, extra session they did - 10:18 which they did a lot and that's across the board - they would have all got payment for that, yeah.

31 Q. Was that incentive ended around 2013?

A. I honestly don't know but the focus came off targets a bit around that time. 10:18

32 Q. Does that coincide with your recollection of when things might have started to slip?

A. Yes.

33 Q. Now, the Integrated Elective Access Policy, which we

know is IEAP and the Panel have heard about, and we don't need to go into in any detail for the purposes of your evidence, that was introduced in 2008. That required patient referrals to be registered within 24 hours, to be triaged by a clinician, entered onto a waiting list, and subsequently patients were written to asking them to make contact to book an appointment. That system was, I think, referred to as the partial booking system? 10:19

A. Yes. 10:19

34 Q. It seems from your evidence and others that that system was clearly an attempt to reduce Do Not Attends; the people who don't turn up at clinics, which seems to be a perennial problem. The partial booking system is almost an incentive to be involved in their own booking so they are more invested in turning up. What was your experience of the effectiveness of that? 10:19

A. It was very labour intensive and still is, but I still think it's a good system because patients do have a choice then of when they are going to be seen. I think the DNA rate has come down a bit. Now, I mean, I don't know my facts here at this minute, I am not as focused on it, but the DNA rate definitely, definitely came down at different points It's maybe risen again because we are doing so many clinics at short notice now, but that's a whole other story. I do think it was effective. 10:19 10:20

35 Q. Just moving on to your current role. Just before we do, you had said in passing that the issue around

Mr. O'Brien and triage was known for many, many years. What sort of timeframe are you talking about?

A. Well, I would say as far back actually as the '90s there was always an issue with Mr. O'Brien's triage. I can remember the Appointments Office, the girls in it, when they were sending referrals to O'Brien, they recorded them in a book, you know the patient's name and hospital number, that's away to O'Brien, because you never knew when you got it back or where it went to; it always seemed to get lost. There was always a wee joke about it, you know, when it goes to O'Brien you might never see it again. It has been an issue for a very long time. 10:20 10:21

36 Q. When you talk about a book, is this like a book that is kept in the office? Anything that was sent at that time was recorded so there was a record that it had been sent? 10:21

A. Yeah, but it was only for Mr. O'Brien.

37 Q. So that was a very early informal system that was introduced by staff? 10:21

A. Yeah.

38 Q. In your current role, as I said, you are the head of Acute Referral and Booking Centre and Secretarial Admin, and you have held that post since 2013. Would you give us just a brief synopsis of what your role covers and who you are in charge of? 10:21

A. Okay. I look after almost 200 staff, and then there are various managers who actually deal with the day-to-day stuff. So, that's the booking centre,

secretaries, audio typists, other admin staff, cardiac investigation staff, whatever. You look after them, so that means kind of you are ensuring the processes are correct, everybody is doing their job basically. Probably not saying it very well.

39 Q. Obviously governance, as we call it, everybody doing their job properly --

A. Yeah.

40 Q. -- is central to your role?

A. Yes. 10:22

41 Q. And it sounds like given the remit that you have, you are really responsible for the oil in the system to keep everything going. Would that be fair?

A. Yeah.

42 Q. Now, your line manager was and is Anita Carroll? 10:22

A. Yes.

43 Q. You have given us some examples in your statement of different ways in which you interact, both with Mrs. Carroll and with others, in order to try and get information that you can make decisions around. I just want to just speak to some of those. 10:22

One of the things, and you will have heard Helen Forde speak to this as well, is the personal development plan, the one-to-one every few weeks. Is it every few weeks with Mrs. Carroll? 10:23

A. Yes, yes.

44 Q. And also ad hoc conversations/meetings as and when required?

A. Yes.

45 Q. Do you find your line manager very accessible to you if you have any issues?

A. Absolutely. We are lucky in that we have a very supportive line manager. We don't always agree and we argue and we debate whatever but yes, very supportive. 10:23

46 Q. So there's always an opportunity for you to bring things up?

A. Yes.

47 Q. Do you find that that works both ways. If you need to be told anything - and we will look at an example you have given later around biopsies, I think that's a current issue - generally is communication that might impact on any of your operating systems normally very good? 10:23

A. No. Communication is extremely poor but not from my line manager. The fact is communication is very poor, I think, from all the Heads of Service in Acute, which I would have a lot of dealings with. My work very much involves a lot of them. If you think of Martina Corrigan is the Head of Service for Urology, ENT, she wouldn't have been -- she would have been actually okay in keeping you informed. But say there are other people in charge of surgery, maternity, medicine, whatever, they don't always keep you informed in a timely way. Sometimes they do, sometimes they forgot, sometimes it's the OSL people forget actually we need to be told certain things. But that doesn't necessarily go to Anita for Anita to tell me, that 10:24 10:24

actually should be from them to tell me directly.

48 Q. Is that is that sometimes because people don't know they need to tell you, or can that be personality driven - some people are poor communicators?

A. I think it's a mixture of everything. And people are extremely busy and they just don't think, but then we would be kind of saying to them, look, you didn't tell us about this, you really need to. 10:24

49 Q. You have hinted at some of the different personalities and management styles in your statement. I just want to look at that in a wee bit more detail. Obviously the Panel are interested in any recommendations they can make around improving governance and communications. So, looking at how people do it and how it impacted on you sometimes is a way in which the Panel can see live examples and perhaps if there's some learning from that. 10:25 10:25

One of the things you mentioned was Dr. Rankin's Tuesday morning meetings. I think you have indicated that everything had to be shipshape in her approach to governance. Would you say that she had quite a high level approach to governance, that she was quite concerned with what was going on, wanted to know what was happening and wanted to find solutions? 10:25 10:25

A. She wanted to know everything that was going on but I think it was more performance driven than governance. But that's just my perception.

50 Q. Now, you also in your statement - and again just for

reference, at WIT-60380 paragraph 20.3 - you mentioned around Debbie Burns. She took over from Gillian Rankin in the Director's post. You have said she was not as rigid regarding targets and her meetings were not as formal as Dr. Rankin's. Now, does that mean that there was more of a lax approach to the data, or what way did that operate for you -- 10:26

A. No, I didn't mean not more lax at all. She was just probably as focused on it. But Dr. Rankin's meetings were stressful meetings, I suppose. Maybe I haven't put it across very well but you would have very much -- it was on a Tuesday morning, you would have been preparing for that over the weekend, you wouldn't have been going in without anything right. Debbie's, you've got a wee bit more. You knew, yeah, she mightn't look some things but it wouldn't have been quite as stressful. 10:26 10:27

51 Q. In relation to Dr. Rankin, were you able to approach her about problems or was it just at those meetings you had to address them? 10:27

A. Oh no, you wouldn't have been approaching Dr. Rankin. You would have approached her at those meetings.

52 Q. You would have been expected to go through Mrs. Carroll if you had problems? She would have brought them to Dr. Rankin; would that have been the hierarchy? 10:27

A. Yes, yes.

53 Q. What about Debbie Burns; was she accessible at that level or again was there an expectation you went to your own line manager first?

A. There was probably an expectation that you went to your own line manager but I wouldn't have had a problem going to Debbie. If I met her on the corridor and had an issue, I would have said it to her. I wouldn't have had a problem. 10:27

54 Q. Just those two examples, did that make your job slightly easier that you could have stopped Mrs. Burns and said this issue, that issue? Or did it not matter, the different management styles?

A. I think it's a mixture of both. In hindsight when I look back, the days of Dr. Rankin's meetings were extremely stressful and I'm sure everyone will tell you that, but we were all on our toes so nothing was missed, so there is that plus side to it. Then when you look on the other hand, is that a good environment for people to be working in? Not really. So, it's a mixture of both really. 10:28 10:28

55 Q. You have also mentioned Mrs. Gishkori?

A. Mm-hmm.

56 Q. She then took over from Debbie Burns. So, you have seen everyone -- 10:28

A. Yeah.

57 Q. -- in post. So your evidence is useful to see what learning you think there might be at that level, at Director level. Just again for note, the Panel will find the reference to Ms. Gishkori at TRU-00817 at paragraph 14. 10:28

You have said there was no forum with Mrs. Gishkori in

post for learning from things. Is that a structure forum that you are speaking about, or there was a general sense that there wasn't feedback that you could take lessons forward in improving your systems?

A. I think it was more there wasn't a structured forum. 10:29

58 Q. In relation to Ms. Gishkori, what was the situation like? Was she able to be approached directly if there were concerns that you felt, for example, that Mrs. Carroll wasn't able to deal with or didn't deal with; did you feel that was an open door for you there? 10:29

A. No, and that's not because I felt afraid, I just would have known you go through your hierarchy with certain people more.

59 Q. You had no difficulty with that. As you said, Mrs. Carroll responded when you brought things to her? 10:29

A. Yeah. Yeah.

60 Q. Now, I just want to move on to some of the systems that you had in place or were in place in your work in order to alert you to problems or not.

A. Okay. 10:30

61 Q. Obviously we are here, so there were lacunas in the system that meant that things slipped through. Just in relation to the information that was coming to you so that you could see what was going on with all of the different areas of responsibility you had. You 10:30 gathered data from a broad range of sources; there was lots of information coming through you from different managers that you were responsible for. You met those managers more or less in a mirror way that you met your

own manager. They had PDPs, they had one-to-one meetings with you, e-mail, phone correspondence, and presumably people could contact you directly if there was a matter of concern. You had, I think you call it, an open door policy? 10:30

A. Yes.

62 Q. Would you consider that you had a good working relationship with your managers?

A. Very much so. Very much an open door policy. I tell my people all the time, I don't care how bad it is, 10:31 I might go crackers when you tell me something has gone wrong but I want to know and we will work on this together, whatever. Do you know what I mean? Thankfully, we do have that. So no matter how bad it is, I hear about it. 10:31

63 Q. You have someone called a service administrator for every specialty area, and that includes Urology within surgery?

A. Mm-hmm.

64 Q. And you have a booking manager for the Booking Centre? 10:31

A. Mm-hmm.

65 Q. One of the things I want to ask you about so that we will understand a bit more clearly is the Backlog Reports that you received. Now, could you just tell you what a Backlog Report is and what its function is? 10:31

A. Okay. When I inherited the secretaries in 2013, the Backlog Reports were already set up. The main aim for the Backlog Reports were to give us an idea of where we were with backlog and typing and filing and

administrative things. Now, as the years have gone on, we have refined these a wee bit better. They weren't always perfect. Really, the main aim also was when we got that information, then we were able to say actually those respiratory secretaries need help, they are six weeks behind in their typing whereas cardiology are totally up to date, maybe we need to rejig work, maybe we need to move an audio typist more into respiratory. It was that kind of thing. Move things across sites and all that. That was the main aim of it. 10:32

66 Q. Which origins lay in workload allocation for secretarial and admin staff?

A. Yes.

67 Q. And did it then evolve into becoming something else?

A. Well, I think as time has gone on, there are some consultants who think this is some sort of governance tool, which to a certain extent maybe it is but its primary aim was for admin people. It's not really up to us to check that every doctor is doing their work right, as I see it. But certainly if we come across something, it's up to us to escalate it. Are you with me? 10:33

68 Q. For example, let's bring up one of the reports and then we will see what you mean. TRU-164942. This is a report of 18th September 2014. This is from Noleen Elliott from Urology. Is this a typical form you would have received in; is this a pro forma? 10:33

A. Yes. Although we have got slightly better at it. There's maybe more columns added now.

69 Q. Could you just take us through the columns and what they mean. Discharge is awaiting dictation?
A. Okay. That's telling us that there are patients who are discharged from the ward who need letters dictated on them. 10:34
70 Q. There are 31 outstanding. Then the next chart -- sorry, the next column?
A. That's the number of charts awaiting typing and the oldest clinic date. Well, there's usually something in there, but that's nil. Then results awaiting 10:34
dictation, that means there's 12 patients that he needs to dictate on. DARO validated -- it's not mentioned.
71 Q. Should that be filled in?
A. It should, yeah. But this secretary isn't the only one. A lot of the time that wouldn't be filled in 10:34
because DARO takes a long time to do. So, there are periods where a secretary would not fill it in from one month -- you know, leave a month out or something like that. Or could have been on leave.
72 Q. Just didn't have time to do it? 10:34
A. Didn't have time to do it or whatever. It is only after three or months have gone, you'd be going hold on a minute, this hasn't been validated, what's going on.
73 Q. Just going back to DARO, you would generally expect there to be something there? 10:35
A. Yes.
74 Q. Just going back to the clinics awaiting typing, is this the issue around non-dictation; is this where you would expect to see a number?

A. Yeah, but awaiting typing and awaiting dictation is two different things. Awaiting typing is where the secretary has to do her bit. Awaiting dictation is where the consultant has to do their bit. We didn't have that column in there. But I would have expected then, just like any other relevant information, a comment in there to say I am waiting on any clinics to be dictated. It was really just to give us a feel what's going on, is all the work flowing in your area. 10:35

75 Q. Is any secretary able to manage the capacity? 10:35

A. Yes.

76 Q. Are you saying that the information that you needed about charts that needed dictated couldn't be reflected on this?

A. Well, I disagree because while the column wasn't there, and it's maybe not clear, I still think if you can put in about your backlog filing, why can't you put in if there's dictation not done. 10:36

77 Q. Would you have expected that information to come to you? 10:36

A. I would have, yeah. Even if it wasn't entirely accurate, it's just to give us a feel. It doesn't matter if it's 30 clinics or 40, it's just to give us a feel of what's not done.

78 Q. The purpose of these reports are for governance around your duty of care, if I can put it like that, around your staff? 10:36

A. Yes.

79 Q. To make sure people are managing their workloads?

A. Yes.
80 Q. And also that they are doing their work?
A. Yes.
81 Q. But it wasn't, if I can use the term, to keep on eye on what consultants were doing; that wasn't the purpose of this? 10:36
A. Absolutely not. But if a consultant is really not doing something and there was a really big issue, then I do feel it's the duty of his secretary to tell us; otherwise how else would we know? 10:36
82 Q. Would secretaries know that they had to tell you that?
A. I would have thought yes and I still believe yes. Actually then after a lot of this came out, I was made to have a meeting with all secretaries to explicitly explain what their duty was around filling in reports, 10:37 telling us X, Y and Z, whatever. It couldn't have been any clearer.
83 Q. Is there any other way in which the non-dictation of clinics would have been made known to anyone else apart from this? I mean, if this had have been filled in in 10:37 a way that perhaps reflected the reality in September 2014, and said - I will just pick a number, 13 - I am still waiting on 13 clinics being dictated, you would have known then that there was a backlog then and you maybe then would have worked with your secretary to try 10:37 and address that. But was there any other way of any medical side becoming aware that there was a patient risk potentially because clinics weren't being dictated?

A. Not that I'm aware of.

84 Q. If we just go to the next page, there's another example in October 2014. We will see again the nil in that, and 14. No mention then again of awaiting dictation, the title? 10:38

A. Mm-hmm.

85 Q. Just another couple of from 2016. TRU-165082. This is a bit of a different layout. Is this what you would call a Backlog Report or has this a different name?

A. The same thing. 10:38

86 Q. The same thing, okay. So you can see Urology. The initials along the top, presumably, are the consultant surgeons'?

A. Yes.

87 Q. Is the information that informs this chart gleaned from 10:38 the previous forms that we have just looked at? Does someone take those for each secretary and put them on to this?

A. Yes.

88 Q. Is this like an overview? 10:39

A. Yes.

89 Q. If we look at the discharges to be typed, these are the headings: Clinic typing, discharges to be dictated, results to be typed, results to be dictated. The information which you said was absent, even though you 10:39 might have expected it be included on the previous forms, is there room for that on this when you can't record what you are not given? But is there anything on this form, if you looked at that, that might alert

you to the fact that there are outstanding dictation?

A. No.

90 Q. Is that because the right question wasn't asked or because you put the onus on the secretarial staff to keep you up-to-date with those sort of issues? 10:40

A. Well, I think it's up to the secretary to tell us. Otherwise, how would we know?

91 Q. So when we look at those figures along this, and I think this one is May 2016, I think, this particular... April and May 2016. We will see with 10:40 Mr. O'Brien is 0015 discharges to be dictated; results to be typed 0; results to be dictated, 11.

Now, given that there were backlogs existing at that time, would it be your view that those figures, as the 10:40 system collated them, nothing to do with Mr. O'Brien putting information or anything like that, just from a system issue, would those figures not properly reflect what was probably happening on the ground?

A. No, they weren't. 10:41

92 Q. Do you recall when the backlog reports were introduced?

A. They were introduced before I took over secretaries. I mean, I took over in 2013 so it would be sometime before that.

93 Q. The type that we saw with Noleen Elliott's name on it 10:41 just a moment ago, how often would they be sent in or requested? Was that a monthly thing or a weekly thing?

A. I am pretty sure it was a monthly thing; maybe twice monthly at one point. They sent that information in

individually into their service administrator. Their service administrator then collated that for the specialties she was responsible for; in this case surgical urology, ENT et cetera.

94 Q. So there was a set system of when they were expected to be sent? 10:41

A. Yeah.

95 Q. Now, just in relation to the situation at the moment around Backlog Reports, is the system the same?

A. Slightly changed in that the Backlog Report has probably slightly more detail asked for in it. As I say, we had that meeting with everybody telling them they must fill this in blah-blah. The secretaries now fill it in a folder, a shared drive or whatever, they go in and input it themselves as opposed to the service administrator collating it. 10:42 10:42

96 Q. Has the system around dictation changed in such a way that the issues have arisen, and we will go to, can't arise again in the Backlog Report? Will you get to see the accurate information? 10:42

A. We should because there is a specific column that says "Clinics not dictated".

97 Q. Again, that is I suppose reliant on human input --

A. It is but then because all this happened, and we were tearing our hair out at the time, going how on earth did we miss this; is there anything we could have seen that would have made this more visible; what has gone wrong here blah-blah, actually it took quite a while but there's a new report developed now on G2/Patient 10:43

Centre which actually will tell us if there's been a clinic took place and there's no dictation been done.

98 Q. We will just move on to dictation, just to give a bit of a background to the issues that arose. You say in your statement that it was only in December 2016 - we have looked at some of the charts, the Backlog Reports from '14 and '16 - but it was around December 2016 that you became aware -- 10:43

A. Mm-hmm.

99 Q. -- that there were problems. That resulted in you having a meeting with Andrea Cunningham, who is Service Administrator -- 10:43

A. Yes.

100 Q. -- and Mrs. Elliott. Now, you say at the time that there were significant quantities of clinics that Mr. O'Brien hadn't dictated. How exactly did that come to your attention? 10:43

A. I think Andrea was pushing Noleen for information for the Backlog Report or whatever, and then Noleen declared, well, actually, there's loads of clinics not dictated. Andrea then alerted me and I said hold on, what are we talking about here? Then I went to meet her then at that point. 10:44

101 Q. And it's your evidence to the Panel that Mrs. Elliott knew she should have been reporting these undictated clinics? 10:44

A. Well, I feel she should.

102 Q. Would there have been any grounds for confusion around that duty?

A. Well, I suppose there's always grounds for confusion. I'm not sure.

103 Q. Well, did she ever come to you or Mrs. Cunningham and say I'm not sure of my role around this, or I'm not sure how to fill this in, should I have been putting this information in? Did those conversations, to your knowledge, ever take place? 10:44

A. No.

104 Q. Were you involved in any training for Mrs. Elliott for her role? 10:45

A. No. Her training took place before we took over because she started, I think in -- in the medical secretary role around 2012. I am not sure of the exact date but sometime around that. So, that initial training wasn't taking by my team. 10:45

105 Q. Would that have been by Mrs. Forde then?

A. Oh, no, Helen was medical records so she had nothing to do with that, right? Sorry --

106 Q. Go ahead.

A. That was another manager in another team in Acute. 10:45

107 Q. And who was that?

A. I think it was Jane Scott at that time.

108 Q. Now, we will look at what Mrs. Elliott says later on but just while we are on this point, some of the comments from her own statement. Just for the Panel's note, Noleen Elliott's statement is at WIT-76334 to WIT-76361. Mrs. Elliott said that she adhered to the Trust policies and procedures in fulfilling her role; she was never offered any support for quality 10:46

improvement initiatives during her tenure.

Is that fair comment?

A. I would say so, yes.

109 Q. That she worked extra hours, mostly unpaid, to complete a heavy workload. Management made it clear that overtime would only be paid for extra contractual work. Is that something you are familiar with? 10:46

A. Well, you generally only got overtime if there was additional clinics and there was actual specific funding for that. But I don't recall her ever coming and saying, look, I can't keep up, I have X, Y and Z to do, can I please have some overtime. I don't recall that. 10:46

110 Q. She says she was conscientious about her work? 10:47

A. Yeah, she would have been.

111 Q. She said management didn't feel there was an issue because she was up-to-date with typing?

A. Well, we don't know if there's an issue with somebody if they are really struggling unless they tell us. I mean, we have 200 people and they are spread about everywhere, they are not sitting in one wee office. You know, you kind of do rely on people come and say to you, look, I have a problem here. 10:47

112 Q. She also said: 10:47

"Service administrators", which in this capacity would be Ms. Cunningham, I presume, she is speaking about, "do not fully understand the pressures secretaries are

under in fulfilling their roles and the case is that if work is kept up to date by whatever means, then it would be assumed the secretary would not require any help".

10:47

Now, that speaks to the culture, really. Is that something you recognise?

A. To a certain extent she has a point, but to say that service administrators don't really understand, I don't -- I totally refute that. Sorry, could you repeat the question? Sorry. 10:48

113 Q. In relation to the culture that she describes, that basically if they are doing their job, nobody really asks if they have got any problems, does the need to get the work done overtake any concern about the welfare of the secretaries or other staff? 10:48

A. Well, maybe it's a fair point. Maybe we don't ask people often enough how they are getting on whatever, but do you know what, we really don't have the time. If anybody came at any time to say to us, look, I am struggling here, I think I need a bit of help, we would absolutely 100 percent look into it. I don't want anyone to be unhappy at work or feel completely stressed out, they are not paid for it. I mean, I would take that actually very bad and so would my service administrators. 10:48 10:48

114 Q. She also says, just in relation to her understanding of the dictation issue, during 2016 she was concerned that Mr. O'Brien had a backlog in dictation but she was

reassured by him that all urgent dictation was being undertaken. That suggests - well, we will talk about it shortly - but it's about the secretarial, Consultant, line manager dynamics. Sometimes there appears to be a tension between the secretarial role and who she should be listening to, if I can put it like that, or who she should take direction from? 10:49

A. Yes. It's actually a very difficult group of staff to manage because obviously the vast majority of secretaries want to keep in with their consultant, if you like, and their consultants would be very supportive of their secretary, et cetera, et cetera. They do have a close working relationship. 10:49

Then we are this crowd that comes along, actually, you are actually supposed to be listening to us. A lot of the time nobody is interested in us, do you understand me? The consultant is the big guy here, we are not. 10:50

115 Q. We will look at some examples and the difficulties that that may cause later. Any solutions you may have, I am sure the Panel would be delighted to hear them. 10:50

Mrs. Elliott also says that in early 2017, she was aware that patients' charts and outcome sheets were removed from Mr. O'Brien's office. I think that was by -- 10:50

A. Martina.

116 Q. -- Martina Corrigan. Yes, thank you. She told you that the outcomes remained outstanding, and she was

told that it was being taken care of, but she was never given any update and she believes she should have been. Just have you any response to that?

A. I probably don't know myself what was happening. All -- anything going on to do with Mr. O'Brien, or any consultant actually, was all kept very hush-hush. Everything was very confidential, you were only told what you needed to know. So I probably didn't know. 10:50

117 Q. In relation to that, you may have heard Mrs. Forde saying on Tuesday about the silo of line management, operational and clinical; very rarely they seemed to communicate across the barricades, as it were. Was that your experience, that there was a silo in the way things were managed or communicated up and down admin lines or clinical lines? 10:51

A. Very much so, yeah.

118 Q. Do you think that contributed to issues either not being identified, not being addressed and/or getting worse?

A. Yes. 10:51

119 Q. Mrs. Elliott also said that:

"Line managers should engage with staff on a more regular basis so that any issues regarding workload can be highlighted and addressed."

10:52

Can I just ask you how often would Mrs. Elliott have met with Mrs. Cunningham, or any of the secretaries? How much access did they have to their line managers?

A. Well, they all would have an open door policy and

certainly you could ring them at any time. But she has probably has a point in there were not enough formal meetings. So, whatever -- I totally accept that. It's actually very hard to actually get a group of people together. Number one, the biggest problem in our Trust at that time would have been accommodation; where would you house these people? Now we do have online, so it will probably get easier going forward.

120 Q. Like Zoom?

A. Yeah, yeah, but it took us quite a while to get that. 90 percent of the Trust had it and then finally my team got it, if you like. So I take her point, I do think that's something actually we could improve on, is meeting with secretaries. 10:52

121 Q. One of the things about online meetings, I suppose, is the disconnect or the distance with people. Sometimes when people meet up -- and one of the things Mrs. Elliott does say in her evidence is the relationship with other secretaries could have been better, difficulty in fitting in and getting support from her colleagues". Does that sound familiar? 10:53

A. I think that was before my time.

122 Q. During your time were you ever made aware of any of those issues, or did Mrs. Cunningham ever come and say there's a disconnect with the secretarial staff and it's impacting on work? 10:53

A. Not that I can recall, no.

123 Q. If we go back to the dictation issue, December 2016. You said in your MHPS statement - and again for the

note for the Panel, it's at TRU-00817, paragraph 11 - in reference to Mrs. Elliott:

"She raised this", the dictation issue, "as we started to get more robust with the reports and she felt she needed to declare it. The SWAH clinics from 2015/'16 were not done."

When you talk about being more robust with the reports, were you turning the screw slightly in some way that resulted in Mrs. Elliott having to reveal the nature of the dictation? 10:54

A. Yeah. As far as I can recall, we were, yes.

124 Q. That was a new system introduced or was it just people getting back to people and chasing up information? 10:54

A. Just getting back and chasing up information.

125 Q. In a way, Mrs. Elliott revealing that information is a governance success story?

A. Yes, which is why we reacted immediately.

126 Q. When you say immediately, you met her almost immediately; you had a meeting on 15th December? 10:54

A. Yes. I knew that was very serious.

127 Q. In 2016. Again, when you say serious and risk, and we will talk a little about risk later on, serious both for getting the work done, but was it in your head or anybody else's head that this is a patient risk? 10:55

A. It definitely would have been in my head at that point this is a patient risk here, I need to raise this.

128 Q. Did you speak to Mrs. Carroll about this time?

A. Yes.

129 Q. I don't think there's any dispute about that and nobody says you didn't, so there's evidence to that. You do say that you reported this to Mrs. Carroll and to Martina Corrigan? 10:55

A. Yeah.

130 Q. You say in your statement - again for the Panel's note at WIT-60383, paragraph 24.3 - "and then", referring to Mrs. Corrigan, "she then dealt with the Consultant". 10:56

Is that an example of something moving across the lines to go to the medical side to be addressed? You had brought to it as high as you could go for someone who would have some sense of responsibility with the medics? 10:56

A. Yeah. The service which Martina was the head of, that's their issue if it's anything to do with the consultant, whatever. The secretary is our issue, because they were our management team. My boss couldn't have done anything about that. That was over to Martina and, I can't remember, Heather Trouton or whoever was there at that time. 10:56

131 Q. Now, Mr. O'Brien has put evidence before the Inquiry - and we will speak to it again when he is called - around his view of the dictation issue, and also DARO and triage, and why he considers his clinical practice was best suited or not for the systems that he advocates for. He also takes issue with capacity issues and ability to do that. Now, they are matters 10:57

for the Panel to consider in the round how they view that. For your purposes of your evidence, I am going to stick to what you know and not ask you to comment on what Mr. O'Brien thinks might have been a better system from a clinician's point of view. 10:57

A. Yeah.

132 Q. It's really about how the information gets to you. Now, when we talked about risk just a moment ago, you have said in your statement - and, again, just for the note for the Panel at WIT-60390 - "I did not indicate risk around the DARO issue on the register. I probably should have". 10:57

Did you put dictation down as a risk on the register, this issue? Did it find its way onto any of the registers? 10:58

A. Well, I don't know if it found its way on to any register but dictation is not my issue, as far as I am concerned. If the consultant doesn't do the dictation, that sits with the service, that's his issue. The DARO is a bit more our issue because the secretary wasn't doing what was required. 10:58

133 Q. Well, when you talk about the Risk Register and wasn't your issue, the risk that, I suppose, did manifest was - please correct me if I am wrong - the correct question or the correct interrogation of what secretaries was doing needed to be adjusted in order for you to get the information you needed. Is it your view that once that was identified, you remedied it as 10:58

much as you could --
A. Yes.
134 Q. -- to make sure you got the proper information?
A. Yes.
135 Q. And the actual dictation issue was a clinical matter for others? 10:59
A. Yeah. Yes.
136 Q. Did you ever put these issues, triage and non-dictation, on the Risk Register? Was the Risk Register something you were familiar with or used? 10:59
A. Yeah, I was familiar with it. I have to say it never entered my head. I suppose in the last couple of years we have become more clued into it. I mean, we have backlogs of typing on it and things like that, and we have stat -- because we have difficulty recruiting audio typists, it's on it and stuff. I suppose just at that time, it never occurred to me. 10:59
137 Q. Now, there was an issue raised by other witnesses, and I am sure the Panel will revisit it, about the number of dictations. Some patients may require multiple letters so some of the data may not have been as robust as it appeared? 10:59
A. Mm-hmm.
138 Q. Is that something you are familiar with, that showing one patient dictation may actually mean there are four letters needing dictation for that patient so those figures may not be reflective of the true position? 11:00
A. I am aware of it but I don't think that's a major, major issue. I think at the end of the day, if

a consultant isn't dictating 20 clinics, we need to know about the 20 clinics. It doesn't really matter if it's actually means an extra ten patients because there's two letters to thing. It matters but it's not that big of an issue. The main issue is for us to know it. 11:00

139 Q. From your perspective, where you are coming from, you just need to know it so you can get it done?

A. Yeah.

140 Q. But could you see that from a clinical aspect, multiple letters, especially depending on what they are about and the need to have those dictated, could have more significance? 11:00

A. Yes.

141 Q. And so the need to have the figures right becomes increasingly significant in that scenario? 11:00

A. Yes, but it hasn't been a major issue in our Trust as far as I'm aware. I know it's been an issue here but it hasn't been a major -- it's not something that has been brought up a lot with other consultants. 11:01

142 Q. Is that because the dictation issue is more robustly managed, so perhaps less of an issue?

A. Probably.

143 Q. Just for the Panel's note, with reference to the robustness of data, an example that have is an email from Mark Haynes dated 15th December 2018, which can be found at TRU-279349, where he claims the reported results for dictation data is not robust and is at best for some a guess. 11:01

We have touched on it briefly, I just want to go back to it slightly because it is the case that a lot of governance systems are only as good as the people who use them or the information that you are provided. You reflect that in your statement. We don't need to go to it but for the Panel's note, it's WIT-60273 at paragraph 12.2. I will just read out your words back to you so you recognise them. 11:02

"We had no way of getting this information except for the secretary advising. From this incident, Mr. O'Brien's practice with regard to dictation was monitored by the Head of Service, Martina Corrigan". This is the important line, I suppose, for our purposes: "This incident demonstrates that the secretary had been bypassing systems". 11:02

That vulnerability of bypassing systems, do you feel content now that that's closed off, the possibility of that reoccurring? 11:02

A. Yes.

144 Q. Now, you had sent an email - and I have the text of it here so I am going to read it out to you - dated 16th December 2016, to remind people of their responsibilities. This was when you had obviously just had the meeting the day before -- 11:03

A. Yeah.

145 Q. -- with Mrs. Elliott, and you had sent out this "to

all" email?
A. Yes.
146 Q. Where you have said:

"All secretaries to be mindful to escalate any issues with clinics on their Backlog Reports. This is particularly important if a consultant does not dictate on a regular timely basis so that we are aware that there may be patients who will be referred on to another consultant or indeed added to the inpatient waiting lists". 11:03 11:03

That's at WIT-60429, for note. What that suggests is not only were you trying to get the system right but you had an acute awareness of the potential outfall of it not being done? 11:04
A. Yeah.
147 Q. Your answer may be you had no other way to do it, but do you think it was fair to put that obligation on secretaries to keep an eye on things so that you were informed of potential vulnerabilities in the system? 11:04
A. I think it's fair in how else were we to know? I don't get how else we were to know.
148 Q. Just in relation to that dynamic then with consultants and secretary and the issue of deference and maybe, as you say, they build up to friendships and want to -- they need, by the nature of their relationship, to have a good working relationship? 11:04
A. Mm-hmm.

149 Q. And then, you know, you are coming along or your colleagues are coming along and saying what is the true picture? You are saying it from the lens of are you doing your work, is there something else I can help you with, are you managing your capacity? But the interpretation of that, should the secretary then try to answer that, is that she has to interrogate the consultant's admin work. You can see how that can be viewed, by the secretary at least -- 11:05

A. Yeah, but we are not asking for exact details here. We are just asking for give us an overview of what's happening, just let us know what's happening. So if your consultant is not dictating and he has loads of clinics, it doesn't matter if it's 20 or 30, just let us know and we can deal with it. I mean, we are not pinning them down to say oh it's 20 or 21. Are you with me? 11:05 11:05

150 Q. At your MHPS statement, just in relation to dictation, you had said, "We currently don't have a sophisticated enough report to say clinics are not dictated on". Obviously that was 2017. The reference for that is TRU-00817 at paragraph 12. 11:06

From what you said this morning, has the situation moved on from that? 11:06

A. Yeah. There's a report now developed. It took quite a while to get and I believe a cost was associated with it. But it's now developed and sorted.

151 Q. One of the emails that you have just given to the

Inquiry is an email from you to Mark Haynes. If we could go to this email, TRU-279349. Now, this is a series of emails. 14th December, that's the e-mail I referred to earlier about the results for dictation, the data is robust. I think we are in the general area but I will read out the extract from the email. 11:07

"The secretary has a huge issue with her their management", and you are speaking about, this is a reference to Noleen Elliott, "i.e. and Colette and I, asking her questions et cetera and is extremely upset and feels we are harassing her. The secretary does not want to be involved but I suspect like all of us there is no choice". 11:08

That does obviously clearly illustrate tension in you trying to get information and Mrs. Elliott's view of maybe she obviously considered that there was some sort of onerous burden on her to provide you with that information. You have explained that you think it was information that should be freely available and freely given anyway. From a governance perspective and a management perspective, if staff are feeling under this pressure, whether perceived or real, does that cause you to back off, or to simply try to find other ways to get the information you need? 11:08 11:08

A. Well, it wouldn't sit well with me, anything like that. I don't want anybody to be upset in their work. I mean, that is just -- life is too short, don't like

that at all. That's why I would have said there I am trying to get Trudy. Trudy Reid was a governance person at that time. I think from memory, I was asked to give information or find what happened to certain results for an SAI. So, we had to go up and actually find, well, did the result come in to you, where did you pass it, is it there in your office, or what? I mean, there's only is a certain amount you can do from afar, sometimes you have to just go to the office. 11:09

That definitely wouldn't have sat well with me and that's why I was trying to get Trudy. Like, what am I going to do here, I don't anybody to be annoyed. We didn't know what was going on. Clearly there was -- I am old enough to know there's something going on AOB and there was an SAI or whatever, but I didn't actually know. 11:09

152 Q. There was information then at the time that you weren't privy to?

A. Absolutely not, no. 11:09

153 Q. It was clear that you had knowledge then of how Mrs. Elliott was feeling around that?

A. Yes.

154 Q. And she was obviously very stressed?

A. Yeah. 11:10

155 Q. Just in relation to the current position about dictation, you have said in your statement - again for note, WIT-60386, paragraph 26.2 - you have said:

"We are still waiting on a report that will show which patients have no letter dictated on them. IT is working on this."

A. Yeah, that's the report about dictations now sorted. Done and dusted, yes. 11:10

156 Q. Okay. It's the same one you were speaking to?

A. Yeah.

157 Q. So, you are content that the current systems of governance around dictation are fit for purpose?

A. Yeah. 11:10

158 Q. I want to move on to triage.

A. Is there any chance I could have a break?

CHAIR: I was just about to say actually, Ms McMahon. I think it might be an appropriate time if we are about to move on until a different subject. We will break until twenty-five past eleven. 11:11

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

159 Q. MS. McMAHON: Just before the break we were just about to move on to the issue of triage. The Panel will have heard evidence about this issue and from others and will again, so just from your perspective. I just want to look at some of the background to the problem and workarounds that were brought in. 11:26 11:26

Now, you have mentioned earlier that the problems around triage, you said, went back to te 1990s and the old appointments office, as you call it?

A. Yeah.
160 Q. Was there ever a time in your recollection that triage around Mr. O'Brien was under control?
A. During Dr. Rankin's tenure, I think, was pretty much under control for Mr. O'Brien then. 11:27
161 Q. We are back to the period of 2009 to 2013?
A. Yeah.
162 Q. Now, the IEAP target for triage is 72 hours. I think that's acknowledged as being very difficult to meet?
A. Yes. 11:27
163 Q. So, the Trust agreed that a week or so was acceptable?
A. Yes.
164 Q. For the Panel's reference, that is at the witness's statement, WIT-60372, paragraph 12.1. Even that slight deviation from what was anticipated under the protocol, 11:27 was that introduced for everyone, that a week or so for triage was probably a bit more realistic?
A. Yes.
165 Q. That didn't specifically arise as a result of issue around Mr. O'Brien, or did it? 11:27
A. No. Everyone would have struggled, or pretty much everyone would have struggled with meeting 72 hours, to be honest.
166 Q. That slight workaround of a week or so, did that mean the triage came in and there were less concerns around 11:28 it with that bit of flexibility?
A. Yes. A lot of the triage was done on a Consultant of the Week model so therefore it made sense to have the rota -- you know, if you were on Consultant of the Week

and it was your turn to do triage, it made sense for us to give you a week.

167 Q. Now, Mr. O'Brien has written evidence and will give, I'm sure, further evidence on his view of the capacity to do triage around Consultant of the Week. I know that that's not anything you would know about so I am not going to go down that road with you. Just operationally and systems-wise the way that triage worked, that's one workaround generally for everyone that the Trust implemented that you say made operational sense? 11:28

A. Yeah.

168 Q. In 2014, there was a further workaround brought in to the booking centre?

A. Yes. 11:29

169 Q. To use the default system of the GP categorisation?

A. Yes.

170 Q. In your recollection, who decided that?

A. Well, Martina Corrigan told us we could do that because at that time the waiting list -- patients on the waiting list were being booked, and those belonged to Mr. O'Brien who were not on a waiting list and were being bypassed. So we were very annoyed as a booking centre, because Mr. O'Brien hasn't triaged these, these patients are being disadvantaged and we are going on down to the next person on the list. Martina then agreed, right, go by the GP priority. It meant we were able to get those long-waiters, et cetera, booked. 11:29 11:29

171 Q. Was it your understanding Mrs. Corrigan brought that in

off her own bat, as it were, or did that come from someone else?

A. I don't know. It was brought in to allow us to enable us to book. It wasn't just suddenly decided I am going to bring this in for the fun of it, if you know what I mean. 11:30

172 Q. Just trying to get to the source of the decision really. There was some suggestion it was Mrs. Burns. Did you hear that at all, that it had come from the Director? 11:30

A. I can't recall that.

173 Q. At this point when that workaround was brought in, an informal process, was this still an era in which your Department was keeping the book of triage that was sent up to Mr. O'Brien that maybe hadn't made found its way back? 11:30

A. There was probably too much of it to be kept in a book. We were probably scanning it, photocopying it, doing all sorts of things with it. Mr. O'Brien's triage actually created a lot of work for us. It just became probably acceptable for Mr. O'Brien's triage, you photocopy anything before you send it up or whatever. 11:31

174 Q. So, you were saying you were photocopying and scanning. Was that so that you would have a copy?

A. Yes, because we knew it mightn't come back down. 11:31

175 Q. The fact that you retained these documents meant that you had a physical record of people who were actually being bypassed on the waiting list?

A. Yes.

176 Q. Because of a failure to triage?
A. Yes.
177 Q. You have referred to this informal process at your statement, and we don't need to go to it. Just for note, WIT-60373, paragraph 12.2. You refer to this as a workaround but it was also a bypass of the system. Do you think that meant that the root cause of the problem wasn't being addressed? 11:31
A. Yeah.
178 Q. From your perspective and the perspective of your staff, did you think this workaround was a way of facilitating perhaps bad practice on the part of Mr. O'Brien? 11:32
A. Yes, probably was but it was probably also due to, look, everyone was worn out with Mr. O'Brien on the triage issues and nothing seemed to change. So it was anything that was -- any decisions that were made would have been done with the patient in mind, if you know what I mean. It wouldn't have been let's try and hide something here or let's try and not escalate this any further or whatever. It would have been very much, look, for the interest of the patient we are going to have to do something. That would be my understanding. 11:32
179 Q. It was a pragmatic approach to a problem but didn't seem to be improving? 11:33
A. Yes.
180 Q. There was a more formalised procedure introduced, if I can use that term, where triage was let into the Thorndale Unit daily?

A. Yes.
181 Q. Can you explain how that came about and what it meant?
A. The Thorndale Unit was moved to where the Thorndale Unit is now. It used to be slightly outside the hospital building, now it's inside. I think it was they just came up with this, look, let's leave our triage around here every day and we will get it done on a daily basis. I am not sure if it was to do with Mr. O'Brien, I can't remember. But it was no big deal to us. As much as yes, we didn't do it for any other specialty, it was no big deal because actually some of our staff liked every now and again to get out for a little walk, if you know what I mean. 11:33 11:33
182 Q. What had existed before, was it an electronic sending of the triage needing done? Why was this different? What was different about actually physically bringing it to Thorndale? 11:34
A. Well, I think it was then visible to the rest of the consultants in Thorndale what triage was there. I'm not sure. 11:34
183 Q. So, it was perhaps seen as a physical reminder this needs done?
A. Yes.
184 Q. And did that work?
A. On and off. 11:34
185 Q. Now, when we consider the issue of risk or harm, you have said in your statement that:

"I would have considered Patient Safety in that there

was a potential for delays with patients' treatment plans around triage". That's at your statement, for note WIT-60389, paragraph 30.1.

You clearly could see, standing back even from the clinical perspective of that system, that triage played an important role in making sure people got medical treatment on time? 11:34

A. Yeah.

186 Q. Would it have been your view that the system of triage that didn't operate to properly assess people actually increased the potential for risk and patient harm? 11:35

A. Yes.

187 Q. In 2015, and you have referred to this in your statement - again for note, WIT-60376 at paragraph 13.6 - you have referenced a report by what was the old Health and Social Care Board. 11:35

A. Mm-hmm.

188 Q. Where they say that the referral booking centre process is robust, but they actually reference Mr. O'Brien and they recommended that the GP prioritisation be used. 11:35

Did you see that as an endorsement of the default system that was put in place, that you were using the GP prioritisation rather than waiting on the consultant to triage? 11:36

A. Yes and no. I think what was meant by that was, look, if you are in dire straits, use the GP default. I don't think it was meant to be, look, you have

a problem with this particular consultant, use this all the time. I don't think it was meant for that.

189 Q. But what's clear from that reference in that report is that the Board knew about the issue?

A. Yes. 11:36

190 Q. In 2015?

A. Yes.

191 Q. Did they ever, or anyone from the Board ever come back and ask is there a patient risk involved; is there a risk assessment being done; is this impacting on the 11:36 services that they have commissioned? Any information like that ever sought from you to be fed back to the Health and Social Care Board?

A. I can't recall.

192 Q. In 2017, e-triage was introduced. First of all, did it 11:37 help? If it did, how did it help?

A. Well, it was great from the booking centre's point of view because we no longer had to keep photocopying or scanning referrals because they were electronic. Therefore everybody could see, especially the rest of 11:37 the whole of the consultants could see if Mr. O'Brien hadn't triaged on his week or whatever. It was all very visible. So yeah, it is good.

193 Q. Was it good just as indicating the extent of the problem rather than fixing it? 11:37

A. Yes.

194 Q. Is that the same situation at the moment with e-triage?

A. Yes.

195 Q. So, if triage wasn't being completed again, what we are

considering here could be replicated?

A. Well no, because I don't think that problem would arise again, if that's what you are getting at, because there's too many eyes on it for starters.

196 Q. So, the governance systems or the robustness of the existing systems has been dialled up to keep an eye on the issue? 11:38

A. Oh, yes.

197 Q. Does that suggest if it was dialled down or eyes were taken off that the e-triage system does not permit for the identification of these problems? It doesn't allow you to see what's not being done? 11:38

A. Sorry, you couldn't repeat the question?

198 Q. If everyone's focus turned away from looking at the triage issue, the e-triage doesn't solve all the problems; the system can't be left to work itself and self-identify that there are triage not being done. It still requires a lot of supervision? 11:38

A. Yes, but not as much. I mean, any other -- if a consultant in a specialty wasn't doing something, well, his colleague would soon be saying hey, you need to be doing X, Y and Z, whereas previously they wouldn't have known. 11:39

199 Q. We are back to the human element of governance --

A. Yeah. 11:39

200 Q. -- and how effective it needs to be in order for people to engage with it?

A. Yes.

201 Q. The Panel has and will hear evidence of workarounds

with Mr. O'Brien's colleagues around triage and the effectiveness of that.

A. Yeah.

202 Q. Did you ever go over to areas of working consultants? Were you ever, for example, in Mr. O'Brien's office looking for anything or trying to find charts in the early days, or triage letters with your different hat on in later years? 11:39

A. A long time ago, yes. I would have been, yeah.

203 Q. Noleen Elliott describes his office as pristine. Would that have been your experience? 11:39

A. Yes. Mr. O'Brien was very tidy. If you see his handwriting, it's absolutely perfect, he is a beautiful hand-writer. But it would have been full of charts and they would have been on the floor, but they would have been pretty much systematic. 11:40

204 Q. So it was busy but organised?

A. Yes.

205 Q. One of the advantages of e-triage, you have said in your witness statement, is that you no longer had to scan referrals to the consultants except for the Emergency Department, and referrals from one consultant to the other. Is that still the system -- 11:40

A. Yes.

206 Q. -- from 2017? Now, you have said in your statement and you have said in evidence, and also you have reflected this in your statement, 1990s, you knew what was going on about triage, and you say everyone knew, I think you said? 11:40

A. Mm-hmm.
207 Q. Is that right?
A. Well, I believe everyone knew because Mr. O'Brien had a reputation of being an absolute gentleman, very nice man, very courteous whatever, but a bit of a disaster when it came to admin work. That would have been kind of known. 11:41
208 Q. You have said that it was only in 2000 that you were made of the issues as part of your management role?
A. Yes. 11:41
209 Q. Was that like a formal hand-over or did somebody raise it formally as an issue? Why is the year 2000 recorded in your statement as when you became aware of issues?
A. Because I went to the post as Medical Records Manager. It obviously was raised, I don't believe formally, but it was obviously raised then as people couldn't find charts or whatever. It became more -- you became more aware, if you like, because you were -- 11:41
210 Q. Had more responsibility?
A. Yes. 11:42
211 Q. You would have had more eyes over all of the issues?
A. Yes.
212 Q. Now, you did mention in your MHPS statement - for the Panel's note, again that is TRU-00816 to 00818 - that one of the other consultants, Mr. Young, would have been a bit delayed but if chased he would have done it. 11:42

"Mr. O'Brien wasn't the only one who didn't return his triage but he was constantly the worst".

Is that still your view?

A. Yes.

213 Q. Did that persist?

A. Yes. 11:42

214 Q. One of the things you have identified in your statement is the amount of manpower it took to try and manage this issue?

A. Yes.

215 Q. You say to chase him and his secretary, and there's a lot of frustration among your staff about this. Just explain that a bit more. 11:42

A. Well, if you were on that team that dealt with Urology as one of your specialties in the RBC, the Booking Centre, and you were giving out you were missing a triage report on a weekly basis whatever, you would know that Mr. O'Brien's was always going to be the one that you hadn't got letters back, and you were always chasing, so you were always photocopying, you were always e-mailing whatever. Whereas other consultants wouldn't have been as bad. 11:43 11:43

216 Q. Would you have had any awareness around when other consultants were Urologist of the Week, whether they completing their triage? Had you any knowledge around that, if they had problems or they were able to do it? 11:43

A. Yes. I would have had knowledge of all consultants completing or not completing. You certainly would have had the odd one who would have had the odd letter maybe not triaged for a length of time or whatever, but

eventually you would have got it.

217 Q. Would they have had generally the same sort of workload around triage each week as Urologist of the Week?

A. I imagine certain specialties would have, like ENT and Dermatology, for example, which are big specialties. 11:44

218 Q. Urologists, for example; would all of the urologists who are Urologist of the Week on a rolling basis, would generally the triage burden for that week, if I can call it that, be roughly the same for each week?

A. Pretty much, yeah. 11:44

219 Q. And the other consultants were more or less, I think you have said, completing triage?

A. Yes.

220 Q. You have mentioned e-triage. Is that a system that's responsive to change? Can that be altered or tweaked 11:44 as needed to make sure that it's dealing with all the issues as they arise?

A. I'm not sure.

221 Q. But would you be happy that the governance arrangements around triage are fit for purpose at the moment in the 11:45 Trust?

A. Yes.

222 Q. The one caveat would be human reporting of issues?

A. Yeah.

223 Q. It still relies on that? 11:45

A. Yeah.

224 Q. You mentioned about consultants indicating to their colleagues "that needs done", or secretaries telling the SAs or you that things aren't done. Is there

anything you can suggest that might improve people's capacity to honestly reflect the reality on the ground so that the system improves? I suppose I am asking to you fix human beings in a way, but is there anything from your perspective as a manager - because you have quite a significant team of 200 people - is there anything you have introduced that you think, yeah, that works, people communicate better when I do A, B, C? 11:45

A. I hope I am thinking of this right but... I have lost my train of thought, sorry. 11:46

225 Q. I will come back to the question if I remember it, we will get there. We will park that, we will move on to DARO. Is that okay?

A. Yes.

226 Q. It's clear from the evidence in your statement, and from Mrs. Elliott's evidence and from Mr. O'Brien's, that he takes issue with DARO. He relies on reasons that relate to the way in which he wishes to carry out his clinical duties as to why DARO isn't effective for him and he doesn't want to engage in it, and I will come to a point where he indicates that Mrs. Elliott doesn't engage with it. I think that's a neutral way to put it but I will come on to that. What I want to get from your evidence is the way in which non-compliance with DARO -- first of all, what it is and then non-compliance with it, why it's important, why that became an issue. 11:46 11:46 11:47

You explain in your witness statement - and we don't

need to go to this. For note only, it's WIT-60373, paragraph 12.3 - that DARO was brought in, I think following an admin review by Gillian Rankin?

A. Yes.

227 Q. You explain it as the following: 11:47

"It is the accepted method of recording of patients on the patient administration system of those patients awaiting tests. DARO is a discharge code on pass which tells us the patient is discharged while waiting 11:47 tests".

So, it's a specific code that indicates that, for example, if I were to go to an Outpatients clinic and tests were ordered, maybe for six months or nine 11:48 months, I am sort of partially discharged but I am waiting tests to be done, so that you know there's something to be done for that patient before or until they are fully discharged from the Trust?

A. Yes. 11:48

228 Q. It's like a hybrid code that indicates that something else is awaited?

A. Yes.

229 Q. Do you remember Gillian Rankin doing an admin review and then bringing this in 2010? 11:48

A. Yes. I specifically remember it because it was an entire massive, massive process mapping exercise involving loads of people. It was actually a very good thing because at that time - I can't remember when we

came together as a Trust but anyway - Daisy Hill, or the Hill as we refer to them as, we were all coming together and everybody was given what they do and what we do and whatever, so they had already something similar already in. This was actually -- we were taken out of that, actually that's a very good thing because they were actually chasing up their results better than we do in Craigavon. Then we implemented it in Craigavon under Gillian Rankin's instruction and it was a good thing. It was in order to ensure that tests were followed up. 11:49 11:49

230 Q. What existed before that that this was meant to sort out, as it were? What was the system before if I went to a clinic and the consultant ordered a test? How was that reflected in your systems before 2010, or was it not? 11:49

A. I actually can't remember, sorry.

231 Q. But would it be fair to say in general terms that the system prior to 2010 didn't allow you to identify patients who were still awaiting some sort of healthcare test? 11:49

A. Yes.

232 Q. And this new system did?

A. Yes.

233 Q. Which then allowed your staff to follow that up? 11:49

A. Yes.

234 Q. Until its logical conclusion, the test was done and the result was in, the result was seen and the further stage was taken, if necessary?

A. Yes. And also, so if a paper result comes from the labs whatever, right, and say it doesn't actually appear on the secretary's desk for whatever reason, it meant the secretary then can always chase that up because she's got her DARO report in front of her and say, there's Katherine Robinson, her results should have been back by now, I wonder what's happened to it.

235 Q. Would the code have also indicated the timeframe, for CT scan three months, so I would know if I was operating DARO I must check that up in three months? 11:50

A. It should. If the secretary puts it on correctly and puts that in the comment field and knows that the CT waiting time is roughly three months, she should really put awaiting CT three months, so that you know when you are actioning your DARO report, right, it's May now, I need to look at that in July, whatever. 11:50

236 Q. So it's a way of flagging up an outstanding issue?

A. Yeah. It's supposed to be a good thing. It actually gave more work for secretaries.

237 Q. Because they had to know what was planned and also write it up -- 11:51

A. And chase up.

238 Q. -- and chase it up. The burden was on them to make sure. Did they change the coding of the system when things were done at any stage? 11:51

A. Yes. Once your result came back, you were taken out of DARO then. Whatever was supposed to happen to you, so if you were supposed to be added to the review waiting list or added to an inpatient waiting list, that all

took place at that point.

239 Q. Like the Backlog Reports, was this a system that was introduced for the purposes of the secretaries being able to keep an eye on what was happening and for you to see what was outstanding? 11:51

A. Yes. That's my understanding.

240 Q. It wasn't a system that was introduced to monitor clinicians?

A. No.

241 Q. Would it have been something the clinicians inputted into? 11:51

A. No. They probably didn't even know, the vast majority of them, that it existed. But, actually, weren't we doing them a favour by doing it, if you looked at it that way, you know. 11:52

242 Q. Well, in Mr. O'Brien's view, as reflected in your statement - we don't need to go to it, it's at WIT-60374, paragraph 12.3 - he disagreed with this on the basis that if he wanted a patient reviewed and to have tests at the same time, he wanted the patient to be placed on a review waiting list and not in DARO. 11:52

Is it right to take from that that if you are allocated to DARO a code, if I'm awaiting a test, then I am then not on a list for review clinic until that test has been done and seen? 11:52

A. Yes.

243 Q. Is that the outworking of DARO?

A. Yes.

244 Q. Mr. O'Brien is of the view that being placed on a review waiting list shouldn't be paused awaiting tests. Was that the issue?

A. Yes. I think he had an issue with the fact that the review waiting lists were so far behind and capacity was a huge issue. I think that was his big issue. 11:53

245 Q. If I understand it correctly, Mr. O'Brien's view is, well, if you put them on the review waiting list at the same time, by the time the tests are done, it will probably come around to the review time anyway because of the waiting lists? 11:53

A. Yes.

246 Q. You considered that to be risky. I just want to go through the reasons you give for that so we understand the way your system works. This is a quote from your statement at paragraph 12.3. 11:53

"This view was risky as far as we were concerned. Patients could not be recoded with two episodes at the same time impasse at that time due to the quality issues and guidance". 11:54

So it was risky because you could only either be on DARO or on the review waiting list?

A. At that time. 11:54

247 Q. At that time. That has subsequently changed?

A. Yes.

248 Q. We will look at that shortly. You think that new system allows for dual coding?

A. Dual coding with new codes. Also, we have noticed that a lot more specialties' consultants want a patient on both. That's all to do with waiting times.

In Mr. O'Brien's time of 2018 when this was mentioned, his review waiting list would have been so long, the patient's tests would have been back. If you waiting on the review waiting lists, you would be waiting a long time. Are you with me? 11:54

249 Q. Would it not be more beneficial to be on both, as it were, getting your test and be on the review waiting list for Mr. O'Brien? 11:55

A. Yes, it would.

250 Q. Because the lists were so long, for whatever reason, was what he was suggesting a sensible approach for his particular clinical practice? 11:55

A. Yes, but at that time that wasn't our process or wasn't available with the codes, et cetera.

251 Q. It wasn't your process but also it wasn't able to be done on the system as you operated it -- as it could be operated? 11:55

A. Yes. Yes.

252 Q. Now is it the case that I can be on the DARO for awaiting tests and also on the review clinic at the same time? 11:55

A. Yes.

253 Q. If I am on the review clinic list, am I still on the waiting list as such?

A. Yes.

254 Q. So, it doesn't make any difference to the numbers?
A. No.
255 Q. Just waiting.

You have said the implications of not doing it the way that it was anticipated you would all do it, and most people complied, is that right, with DARO? 11:55
A. Absolutely everybody complied.
256 Q. Everybody complied. You said, first of all, at paragraph 12.3: 11:56

"We needed the patient to be in DARO so that when the DARO report was run, we could chase results if a patient should not have had a test in a certain timescale". 11:56

We have just explained that. The secretaries would know by a code that something needed followed up. The way Mr. O'Brien was, whether it was clinically appropriate or not or pragmatic for his practice, by not using DARO, that information wasn't available; you didn't know people were awaiting tests if DARO wasn't used? 11:56
A. Yes.
257 Q. You have also said one of the other implications of not engaging with DARO was: 11:56

"Review lists always ran behind so there was every chance a patient could get lost to follow-up without

having tests carried out in a reasonable timeframe".

And that's the same point?

A. Yeah.

258 Q. You have said as well at paragraph 26.4 of your statement at WIT-60386: 11:57

"I was concerned with regard to this nonadherence to the guidance. I was always afraid that patients would be on the review waiting list for a long time but by the time they got called for an appointment, it would be too late if their test result had been missed and had indicated something untoward". 11:57

Again, like a previous email, your statement in your Section 21 would seem to suggest that you were aware that there was a patient risk? 11:57

A. Yes.

259 Q. Patient harm potential?

A. Yes. 11:57

260 Q. Was that something that others were aware of, that this could result in patient harm?

A. I don't know.

261 Q. Did you ever discuss that with anyone, the DARO issue and non-compliance with it? 11:57

A. Well, when the issue arose, when I was made aware that Mr. O'Brien didn't want to use it, or whatever, I made -- I think I wrote to Mark Haynes because he was AMD at the time or something like that, because I was a wee

bit concerned. It was just, look, are we doing the right thing here, are we not? What's going on, whatever?

262 Q. We will come on to the email. It was 2019.

A. '19, right, okay. 11:58

263 Q. We will come on to that in a second. From your perspective, your lens was entirely systems functioning?

A. Yes.

264 Q. And things continuing to operate smoothly? 11:58

A. Yes.

265 Q. You have said in your statement at paragraph 26.3 that Mr. O'Brien instructed his secretary not to use DARO. Was that something that was reported to you or did Noleen Elliott tell you that directly? 11:58

A. Noleen Elliott told Colette McCaul, who was her line manager at the time, and Colette McCaul then told me.

266 Q. Was there an expectation that Noleen Elliott - we discussed this slightly earlier - would follow the guidance that DARO was the system in place? Or was 11:59 there an expectation that she would use systems to better reflect the clinic practice of her consultant?

A. Well, it's a very tricky one but I believe the secretary should be listening to us because we are the admin people and you should be following your 11:59 instruction from us. However, I understand it's very difficult because she worked very closely with the consultant; you see them as 100 times more important than we will ever be. But you have to follow process

and you report to us.

267 Q. But did Noleen Elliott have any appreciation, as reflected in your statement, that to not do that, not to follow DARO, may result in tests being not followed up, results not being followed up or patients coming to harm? Do you ever get the sense that she was aware that that was a potential? 12:00

A. She may not have thought of it that way.

268 Q. Did you know her to have any workaround? If she wasn't going to use DARO under the direction of Mr. Mr. O'Brien, did she develop any other system for keeping an eye out for tests that needed done or results that needed followed up? 12:00

A. Not that I am aware of.

269 Q. So, as far as you are aware, by not using DARO, there was no system in place between her and Mr. O'Brien and the patients that were seen by him for monitoring follow-up with tests or results? 12:00

A. As far as I'm aware.

270 Q. Now, she did then start to use the code? 12:00

A. Yes.

271 Q. How did that come about, that she was able to comply with it? Was that a conversation with you?

A. I'm pretty sure I had a conversation with her and told her that she had to take her instructions from us, which is not an easy conversation to have but it's the way it is. 12:01

272 Q. I think you have said in your statement at WIT-60388 that you spoke to her on at least two occasions?

A. Yes. I definitely remember, but I have no evidence, I definitely remember 'you need to listen to us when we tell you'.

273 Q. Was the second occasion because she didn't listen after the first one? 12:01

A. Possibly. I can't totally remember.

274 Q. Now, you have said in your statement that this issue around DARO has now been resolved - and we talked about the codes earlier - regionally throughout all Trusts?

A. Yes. 12:01

275 Q. With the use of another code, DTR?

A. Mm-hmm.

276 Q. That stands for Diagnostic Tests Received?

A. Requested.

277 Q. Requested. That takes away my next question because 12:02 it's my mistake in typing that up.

A. Okay.

278 Q. So a diagnostic test is requested, which prompts then to follow up whether it's been done. Is there another code when it's been done and the result need to be 12:02 viewed?

A. DTC, Diagnostic Test Completed.

279 Q. Given that system, the same question I have asked for the other systems: Do you think now that the DARO system is fit for purpose from a governance 12:02 perspective?

A. Yes.

280 Q. And the problems that arose and that we have just discussed are unlikely to arise again?

A. No, they could arise again. Well, yes and no. DARO will work if the secretaries do their bit, whatever. However, we need more checks in our system. We don't have enough checks by our service administrators or Band 4 people or whatever to check that everything is tickety-boo. Until we get that, our system is not 100 percent safe, no, and I couldn't say that. I have asked for another couple of staff to do checks on DARO. For all secretaries or whatever, they can do their own wee bit but if we oversee that as well, by spot-checking or whatever. I am very hopeful that we're at that, funding has been agreed and we are going to get that. 12:03 12:03

281 Q. So that's a capacity issue. Then if you got extra staff, when you talk about checks, what would those checks involve? 12:03

A. For example, in 2013 when I first took over the secretaries, I realised, you know, how do we -- my thinking was how do we actually know we are doing a good job? How do we actually know something is all right? Well, we don't because we are not doing any auditing. So I got a member of staff -- well, the service administrator started it and then finally I asked Anita and she got me funding and we recruited a member of staff. That person then does spot checks on secretarial stuff. For example, I will just pick Noleen Elliott because her name has been mentioned. We would spot-check her work periodically, and by that we would go into clinics she has typed to ensure that 12:03 12:04

after she typed those that she added those patients correctly to the waiting list, the Inpatient waiting list, the Outpatient waiting list or whatever. The only problem with it was we didn't have enough staff to do it, and that person then kept being using for everyday crises and floating here, there and everywhere. 12:04

The thinking was there let's audit this, let's try and get this right, whatever. Until we put better checks, better audits in our system at the root cause, not at a senior level, this will not ever change. That's my belief. Sorry, I probably digressed. 12:04

282 Q. No, it's very helpful for the Panel to hear that because you are the one operating and in charge of the system so what you have to say is obviously very important. 12:05

Does the system still show if something has been missed completely? 12:05

A. No, only if we audit it.

283 Q. The benefit of audit would be you could do periodic checks, basically stress test the system, to see whether it's been effective?

A. Yes. 12:05

284 Q. But also if there were areas of vulnerability, for example a secretary was finding it difficult or had capacity issues, or there was some tension around the use of systems, those staff could focus in on that

area --

A. Yes.

285 Q. -- and provide support until it was fixed?

A. Absolutely.

286 Q. I know you have mentioned that there's now an electronic system of results that can be accessed, but not all secretaries have access to that. 12:05

A. Yes.

287 Q. What's the thinking behind that, that it's not available for all secretaries to go in to see if results are in so they can update the system? 12:06

A. I think it's because the e-sign-off, which will come in, I'm sure, at some point in the future, that the consultants go in and sign their results electronically. There's a lot of reluctance on consultants to do this. However, the system is not 100 percent robust enough either. 12:06

So Mr. Haynes and Mr. Glackin within Urology, very much quite progressive thinking, they are big into this, and they have their two secretaries who got access to go in and check that they have all sorted out electronically whatever. But the rest of the secretaries aren't allowed it yet because the system is not 100 percent robust. 12:06 12:06

288 Q. So, they are stress-testing the system --

A. They were lucky they have access.

289 Q. From that perspective that makes their job easier then to be aware when results are in and what needs to

happen next, and update the system to reflect that?

A. Yes.

290 Q. So arguably - I don't know if it's the case - their reports on their systems could be more updated than anyone else because they have access to the E results? 12:07

A. Yes.

291 Q. Do you think this is a good thing from a governance perspective, that it will potentially roll out if it's effective?

A. Yes. 12:07

292 Q. You said about consultants not being happy about it; I'm not sure which part they are not happy about, maybe you could explain that?

A. I just think there's a reluctance for consultants to go in and electronically sign off, maybe because -- I 12:07 don't know, I am assuming, maybe because they are held to account more if electronically signed off, where you could always technically say you have never seen a result if you were a consultant. We have got smarter and regularly now we are scanning results to 12:08 consultants. You can't say you never received it through the post, we have it scanned to you. That's because we had to physically move -- all our secretaries were physically moved off the main hospital site during Covid and were out in buildings and 12:08 everywhere and anywhere but we're not on the main site, so actually there had to be some sort of a solution from our point of view put in. It's a good thing because you can't say you have never seen it.

293 Q. The inadvertent outworking of Covid has resulted in perhaps improved governance because results are getting their way to the person they need to, whether they are ready for them or not?

A. Yes. It's improved governance in that sense but I mean there's lots of disadvantages; a consultant not being beside their secretary, in my opinion. But that's life. 12:08

294 Q. You think maybe a bit of pushback because once you have seen it and signed it, you are expected to act on it? 12:09

A. Yes, but that's only my perception.

295 Q. Well, it's a perception from your position and your experience.

We will go on to look at the email from Colette McCaul -- from Mr. O'Brien actually. I want to identify this as an example of potential crossover of conflicting views and communication styles, and where the interaction between operational and medic may meet. I want to just get your view on that. Obviously the Panel will be looking at potential learning around communication systems for staff, and what might be improved. This is an example on the papers of the way in which a problem arose and found its way to a consultant, Mr. O'Brien, and then how that was managed. 12:09 12:09

If we can go to, I think the first page is at 60430. I think that might be your reply but we will work

backwards. That's your last reply, 60388. This is a selection of emails that start with Colette McCaul e-mailing on 30th January 2019 - I've definitely that one wrong - where she sends an email to all secretarial staff. I am determined to get this email up, if you just bear with me. 12:10

60432, a one-off. This is the first email from Colette McCaul. Colette McCaul, is she manager to the secretaries? 12:11

A. Service administrator.

296 Q. All of those names in the "to" list, are they all secretarial staff?

A. Yes.

297 Q. She sends this out and said: 12:11

"Hi all, I just need to clarify this process. If a consultant states in a letter I am requesting CT bloods etc, etc, and will review with the result, these patients all need to be DARO first pending the result, not put on waiting lists for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO. This is our failsafe so patients are not missed. Not always does a hard copy reach us from Radiology etc, so we cannot rely on a paper copy of the result to come to us. Only once the consultant has seen the result should the patient be then put on the waiting list for an appointment if required, and at this stage the 12:11 12:11

consultant can decide if they are red flag appointment, urgent or routine, and they can be put on the waiting list accordingly. Can we make sure we are all following this process going forward".

If we just move up. We can see there just before we move up, Noleen Elliott. This was sent on 30th January and, on 1st February, Noleen Elliott forwards it to Mr. O'Brien. Then Mr. O'Brien replies; quite a lengthy reply. Just down slightly. 12:12

He replies on 6th February. He replies to Ms. McCaul directly. Would that be unusual for a consultant to contact the service administrator like that?

A. Not unusual. It wouldn't be very regular but not unusual, no. 12:12

298 Q. Did Mr. O'Brien know that you were in charge of the Referral and Booking Centre and issues around DARO? Would he have known you were the head of that service?

A. Well, he probably should have but I mean a lot of them, I mean, we have no significance, believe me, you know. 12:13

299 Q. Well, I won't get into that but you certainly have here. Just I am asking that because you are not copied in. He has copied in all of the other consultant surgeons in Urology. He also copies in Martina Corrigan. I just want to read out the e-mail. He said: 12:13

"Dear Ms. McCaul, I have been greatly concerned, indeed

alarmed, to read this directive which has been shared with me out of similar concern".

Now, the email that I just read from Colette McCaul, was that a reminder email about the use of DARO or was this a new directive that you must use it properly? 12:13

A. Reminder.

300 Q. She was reminding people how it was used and to use it properly, for all the reasons we discussed?

A. Yes. There must have been something happened, yes. 12:14

301 Q. Then he goes on to speak about his view of why his clinical practice isn't best served by using it the way it's suggested. He says:

"The purpose of and the reason for the decision to review the patient is indeed to review the patient. The patient may indeed have indeed have had an investigation requested to be carried out in the interim and to be available at the time of review of the patient. The investigation may be of varied significance to the review of the patient but it is still the clinician's decision to review the patient. 12:14 12:14

One would almost think from the content of the process that you have sought to clarify that normality of the investigation would negate the need to review the patient or the clinician's desire or need to do so. One could also conclude that if no investigation is requested, then perhaps only those patients are to be 12:14

placed on a waiting list for review as requested, or are those patients not to be reviewed at all?"

I don't think there's any suggestion of that, that there's not to be review. 12:15

Secondly, he goes on:

"If all patients who have had an investigation requested are not to be placed on a waiting list for review as requested until the requesting clinician has viewed the results and reports of all of these investigations, when do you anticipate that they will have the time to do so?" 12:15

Just stopping there. Just so I understand the system, when they are supposed to be put on the review is when the tests are back; is that what happens with the DARO? You get the test, the results, and then they go on to the review, those tests and result, to be fed back to the patient? 12:15

A. If you need a review. Some of them won't even need a review.

302 Q. Some of them could discharge ultimately if the test is of no significance? 12:15

A. Yes. Or if a test result comes back and there is something really standing out bad, I mean that patient could be reviewed the next week.

303 Q. Or the next day if the --

A. If the consultant has looked at it.

304 Q. Yes. So, the system is not designed to avoid moving people over to be reviewed?

A. No.

305 Q. "Have you quantified the time required and ensure that measures have been taken to have it provided?" 12:16

I am not sure what that part is about. Is that must be speaking of his own time to engage with DARO? Did you ever get any feedback about what this meant? 12:16

A. No.

306 Q. "Thirdly, you relate that it is by ensuring the results are seen by the consultant that patients will not be missed. I would counter this by ensuring that the patient is provided with a review appointment at the time requested by the clinician that the patient will not be missed". 12:16

He goes on to give an example which we don't need to go into. But Mr. O'Brien's clearly coming from a position of the system that I want used works for my purposes?

A. Yes.

307 Q. Then at the second-last paragraph: 12:17

"Lastly, I find it remarkable that your process be clarified with secretarial staff without consultation with or agreement with consultants who by definition

should be consulted. I would consider you consider withdrawing your directive as it has profound implications for the management of patients and certainly until it has been discussed with clinicians. I would also be grateful if you would advise by earliest return who authorised this process". 12:17

When did DARO come in, do you remember?

A. 2010, roughly.

308 Q. And this email was sent in 2019. So, a fair interpretation of this is that Colette McCaul sent out a reminder to f people of how to use DARO. Do you know if consultants were involved in the instigation of DARO in 2010? 12:17

A. No, and I doubt if they were, to be honest. 12:17

309 Q. Because, as you have said earlier in your evidence, it's not a system that they use?

A. No. And it was to support them, it wasn't to annoy them.

310 Q. But it wasn't also a system about which they were monitored? 12:18

A. Yes.

311 Q. In reply to this, Mr. Haynes replies and he copies everyone. Again, you are actually in this reply?

A. Mm-hmm. 12:18

312 Q. He identifies, and he says the following:

"Morning. The process below is not a Urology process but a Trust-wide process. It is intended in light of

the reality that patients in many specialties do not get a review Outpatients at the time intended and can in many cases take place years after the intent. To ensure that scans are reviewed and in particular unanticipated findings actioned. Without this process there is a risk that patients may await review without a result being looked at. There have been cases, not Urology, of patients' imaging not being actioned and resultant delay in management of significant pathologist. As stated, this is a Trust-wide governance process that is intended to ensure that there are no un-actioned significant findings, there is no risk in the process described. If the patient described has their scan in May, the report will be available to you and could be signed off and the patient planned for review in June. There is no delay to the patient's care. The DARO list is reviewed regularly by the secretarial team and will pick up if the scan has been done but you haven't received the report, if the scan hasn't been done etc". 12:18 12:19 12:19 12:19

He is identifying there is it is for their benefit, or it should work for their benefit?

A. Yes.

313 Q. "It may be ideal that such a person described should be best placed on both the DARO list and the Outpatient waiting list" - I presume that stands for this - "but PAS does not allow for this". 12:19

So Mr. Haynes accepts what's now in place, the dual coding system, would perhaps have been more effective but it wasn't available at that time?

A. Yes. 12:20

314 Q. "I have no issue as a clinician or as AMD" - Associate Medical Director - "with the process described as it does not risk a patient not being seen and access a safety net for test results being seen". 12:20

I think you then have the last word, if I can put it like that. You reply on the same day. Can I just ask you what you thought when you have received that email, that it had gone from Colette McCaul, who was one of 12:20 your staff; she got a direct reply from Mr. O'Brien; then the Associate Medical Director also came on board but copied you in? When you saw that train, were you surprised by that, by the tone of it, by the content of it? Was this all news to you, that there was some 12:20 resistance

A. It was news to me that there was some resistance, yeah. I suppose my initial thing would have been why is the secretary bothering the consultant with this, because I think that's where it originally started. But I 12:21 mean, I don't remember any big --

315 Q. Are you referring it to Mrs. Elliott sending it on to Mr. O'Brien?

A. Yes. Why are you doing this?

316 Q. He has intimated at the start of his email, if you remember, if I can put it like this, that she was concerned as well and that's why she sent it to him, and he shares that concern. Did she ever express those concerns to you around the use of DARO? 12:21

A. No.

317 Q. Did she ever express them to Ms. McCaul?

A. Not that I know of.

318 Q. So you reply. You copy everyone in as well, and you don't copy in Anita Carroll. 12:21

A. I think that was a mistake because I think if you see the last email, I have said "I meant to copy you in". It's just been a mistake.

319 Q. You meant to let your line manager know?

A. Yes. 12:22

320 Q.

"Folks, can I just back this up to say Dr. Rankin introduced this process Trust-wide many years ago due as a result of safety issues with patients. It actually increases secretarial workload due to extra 12:22 checks but this is in the best interests of patients. I am aware, Mr. O'Brien, that your secretary in particular does not use DARO in all cases and will put patients directly on the review waiting list as per your instruction. I have expressed my concern with her 12:22 not implementing the DARO process fully. Colette McCaul is the line manager to Urology, ENT, ophthalmology and oral surgery. It is her responsibility to follow directives and remind staff of

processes that are in place. Colette was merely doing her job".

So you were significantly riled to let people know what Colette had done in the first place was appropriate? 12:22

A. I don't know if I was riled. I was very much supporting my service administrator.

321 Q. That was my word, not yours. It's certainly a robust reply in support of your service administrator?

A. Yes. 12:23

322 Q. I know you have copied in the email above and you have sent that on to Mrs. Carroll. Did you speak to her about this?

A. I can't remember. I'm sure I did.

323 Q. Is this an example of a consultant taking a view on a system that's in place for governance purposes for you to keep an eye on what's happening and for secretaries to provide information, and you trying to get things done where there's a clear tension if they don't want to do it and raise quite lengthy objections to it? 12:23 12:23

A. Yeah, but Mr. O'Brien wouldn't have been the only one would do this. You know, there would be other consultants. Not that often but occasionally you would get another consultant having a hissy fit about something, you know. 12:23

324 Q. Would they e-mail directly to yourself or one of your staff?

A. A mixture of things, a mixture of things. Or they

could email even Anita, or whatever. Do you know what I mean?

325 Q. There was nothing unusual in this except you had to back your member of staff up, as it were?

A. Is there any chance I could have a bathroom break? 12:24

CHAIR: Yes, of course. We will sit again at twenty to one.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 12:40

326 Q. MS. McMAHON: You had mentioned earlier that the escalation process that was in place, your managers escalated to you on various topics we have discussed. There doesn't seem to have been a breakdown in communication from your line management or below you -- 12:40

A. No.

327 Q. -- once you are getting the information you needed to get you identified this was a problem. Did you have much top to do with Heather Trouton in her role?

A. No. The only person I would have dealt with really 12:40 would have been Martina Corrigan. You don't go over somebody's head, if you know what I mean. It isn't the way it is. You wouldn't be rocking up to a Director or whatever. It isn't the way you do that.

328 Q. I am going to read out some extracts from 12:41 Mrs. Trouton's statement where she supports the view that things were escalated, and identify some issues, just so the Panel have it for their note. I am going to read the extracts. I might ask you whether you

agree or disagree but you can rest for a second while I go through this. It's for the Panel's note and your comment, if you feel you need to give one.

A. Okay.

329 Q. We don't need to bring any of these up. Just for the Panel's note, WIT-12004, paragraph 57. Heather Trouton confirms that there was an escalation process in place. She says this: 12:41

"Intermittently the Booking Centre team had great difficulty in securing timely return of triage letters from Mr. O'Brien. An escalation process was put in place if initial action through normal administrative processes had not proven effective. The issue was escalated both through the admin management lines and directly to the Head of Urology and ENT. The Head of Urology and ENT would have contacted Mr. O'Brien directly and requested urgent return of triage. This was usually effective, but on occasion it was escalated to me and the Director of Acute Services for action. On intervention at senior level, Mr. O'Brien would then have completed and returned his triage". 12:41 12:42 12:42

Is that your experience?

A. Yes. 12:42

330 Q. She then says at paragraph 198 of her statement:

"Despite intervention with Mr. O'Brien at many levels in the organisation and despite reducing his workload

regarding referral triage, the Trust was not successful in changing the administrative practices of Mr. O'Brien".

Is that also something you would agree with? 12:42

A. Yes.

331 Q. Do you think more could have been done?

A. Definitely.

332 Q. What do you think might have helped?

A. Well, I think he should have been held more to account for not doing it, or disciplined or whatever. I don't know what they doing in the medical world. But if an admin person hadn't done something, we just wouldn't have got away with it. It was always a frustration. 12:43

333 Q. You have already explained the issue of resources had on your ability to do spot-checks and things like that? 12:43

A. Yes.

334 Q. She also states, Mrs. Trouton states at paragraph 460:

"Considered the escalation process for non -- triage to be robust. Knowing what I know now regarding the number of untriaged referrals located in Mr. O'Brien's office, this system was not sufficiently robust". 12:43

Does that reflect your belief? 12:43

A. Well, we certainly weren't perfect but it was no shock to me with that amount of referrals outstanding, because it was clear to be seen on a PTL.

335 Q. She is perhaps speaking about when she found out the

quantity?

A. Possibly, yeah.

336 Q. She also says at paragraph 430:

"Weekly performance meetings were held with Gillian Rankin and Debbie Burns where" - you - "presented triage data and any action that was required. That" - you - "also held weekly meetings to discuss all issues pertaining to clinic booking, triage, and attendance". 12:44

She just simply confirms that she was aware you were doing this at the time. So, she is reflecting your good governance -- 12:44

A. Yeah.

337 Q. -- and following your duties. She does go on to say in that paragraph that she has only, in the context of this Inquiry, become aware that the booking centre allocated a code to patient waiting list to denote those letters not triaged by Mr. O'Brien. She says if she had been told, she could have requested that reports were run to ascertain the number of patients were triage had not been returned and then required return from Mr. O'Brien. 12:44 12:45

She is saying it wasn't until the Inquiry that she found out that this code and the patient waiting list denoted that letters hadn't been triaged. Would that be something that she would normally be informed about, that you'd operationally made that decision? 12:45

A. No, definitely not, that's way too intricate a detail. But had anyone wanted to know the position of triage at any time, all that had to be done was a PTL run from Business Objects. The fact there was a code there was really to help us, as in the Booking Centre, and the records Department to, if we put a code in MTNL - missing triage no letter - to show that down the line, say that patient was being appointed and they come to look for the referral letter, it won't be in the usual place because that one wasn't triaged, it will be in this other filing cabinet. 12:45 12:46

338 Q. So the code was a workaround?

A. It was a workaround but it was for the benefit of really an admin benefit. Heather wouldn't really have needed to know about it. If she had asked for a PTL, it would have been on it. It was clear to be seen. 12:46

339 Q. You did run reports to see the numbers at the time?

A. Yes, I would have, yes.

340 Q. They just didn't reach her; is that it?

A. Probably. 12:46

341 Q. Would you say from your understanding they wouldn't have had to?

A. No.

342 Q. She also says that she: 12:46

"Identifies the issues being lack of capacity and the frustration with staff towards Mr. O'Brien's practices, and also says that he was genuinely struggling to adapt to new system".

Now, we have talked about the DARO from 2010 and the e-triage 2017, and the problems persisted before then. Did you get a sense that Mr. O'Brien was struggling to adapt to new systems of work? 12:47

A. No.

343 Q. Because, as you have explained, the DARO system was a secretarial function and the triage was done by the other consultants. Did you feel there was any systems disconnect for him that perhaps might have been a training need? Anything like that ever discussed? 12:47

A. No.

344 Q. Do you think there was too much tolerance or deference shown to Mr. O'Brien's work practices?

A. Way too much tolerance. 12:47

345 Q. Now, you have said a couple of times already, I think, that you did feel supported by Martina Corrigan?

A. Yes.

346 Q. And you felt supported, and I think it's apparent in that email, by Mark Haynes about the DARO issue? 12:48

A. Yes.

347 Q. You also felt supported when you raise the issue of the non-dictation in December 2016, to try and get that sorted?

A. Yes. 12:48

348 Q. We will come back again to the point you have made a few times about resources. You deal with this at paragraph 17.1 of your witness statement. For the Panel's note, that's at WIT-60378. I will just

summarise the points you have made and if you need to comment on them, you can do.

You said the capacity in Urology was always an issue. Just for the purposes of the tape, if you agree? 12:48

A. Oh, yes, yes.

349 Q. The secretarial support that was allocated was insufficient?

A. Yes, but not the worst.

350 Q. And you identify the biggest challenge was the inadequate number of the service administrators? 12:48

A. Yes.

351 Q. Who could otherwise have audited secretarial work, which would greatly enhance governance?

A. Yes. 12:49

352 Q. I think you have explained to the Panel earlier today that there is some action around that that there may be posts put in place that might allow your governance systems to be better monitored?

A. Yeah. 12:49

353 Q. You have said in your statement that in 2018 you brought this to Anita Carroll, the issue about capacity, and you got a Band 4 at the time?

A. Yes.

354 Q. But that wasn't enough? 12:49

A. No, but that wouldn't have been all her fault. Probably part that have was my fault. You were going easy at the time, give us one Band 4.

355 Q. Ask for less and maybe you will get more?

A. And then you will work on it, if you know what I mean.

356 Q. Just in relation to learning. Again for the Panel's note, that's dealt with at your witness statement WIT-60390, and over the page 60391. You have sentences of self-reflection, I think, in your statement where you have said you need to be more proactive and less reactive; you need more staff to audit so errors can be picked up. 12:50

One of the things you have said and I wonder if you could just explain why you think this might be helpful, that there's "no governance forum where admin managers can engage with clinicians about administrative issues, and this should be encouraged". 12:50

A. Yes. 12:50

357 Q. I know there was a meeting with the consultants at one point when they called to discuss the systems, but that wouldn't be something that the admin would be able to call a meeting with the consultants to attend?

A. We can call all we want but nobody would turn up, so... 12:50

358 Q. So what you are advocating for in that sentence is the possibility of everybody getting together to iron out issues or to identify how systems might be better improved?

A. I think admin on the whole has no centralised forum to air concerns, thrash out different things or whatever, that there are medics also at. I remember back, and I am talking early '90s, there used to be an old, what was called then the Medical Records Committee. It 12:51

didn't deal with medical records as physical charts, it dealt with the wide-ranging issue of admin. We hadn't had that so I believe that is very much needed.

There's probably a perception in the Trust that the Heads of Service for each area deal with all of those sorts of things, but I think their roles are too wide. I think admin needs a section on its own for governance, and for the right people to be added and for us all to thrash things out. That's my opinion. 12:51

359 Q. I suppose that's more focused when you look at the number of people that are under your remit. You have 200 people who do such vital work at that level of the Trust. Then that sort of forum, you think, might prevent either issues arising, or short-circuit what needs to be done to fix things? 12:52

A. Yes.

360 Q. Do you think there's a good enough understanding among clinicians about how your systems operate?

A. I think each clinician will have a very good understanding of how each of their secretaries work. How other things operate, no, I wouldn't be so sure. 12:52

361 Q. Would they be aware that the secretaries really answer to you rather than them?

A. I am not so sure about that. 12:52

362 Q. Helen Forde, when she gave evidence, I had asked her whether she was involved in training doctors around charts and tracking and the issues around that. Do you have any involvement in dealing with medics or training

with them?

A. No, but when Helen drew up that document, she did speak to me. A couple of things then that I had wanted to say were on that document, if you like. So I didn't do the work, she done the work, but it was a joint kind of thing, if you know what I mean. We would have worked quite closely together. 12:53

363 Q. Your input - and I know Helen has retired - but the input of people from Medical Records into training for the doctors as they join the Trust, you think if that was formalised as a mandatory session that that would help inform people's use of systems? 12:53

A. It would, but let's tackle our current people, never mind new people coming in. I would be thinking along those lines. 12:53

364 Q. So bring them in for refreshers?

A. Yeah.

365 Q. You have also said that "the processes need to be seen as systematic ways to prevent harm". I had touched upon it earlier that it could be seen maybe by the consultants that the systems were a way of monitoring what they did, but you are saying that they actually are trying to provide a fail-safe so that issues of harm don't arise? 12:53

A. Absolutely. 12:54

366 Q. So it's a perception issue as well, it's a bit of a change of mindset; would that be right?

A. Yeah. Very possibly.

367 Q. You have also suggested that more monitoring needs to

take place regarding pathways. What did you mean by that?

A. Can I have the sense?

368 Q. I will give you the page. Do you have your statement there? It is WIT-60393. I will bring it up on the screen as well and then I can identify the paragraph. It may be my own mistake, it might be over the page. 40.1. Thank you, Mr. Lunny. 12:54

A. I think, sorry, what I was already saying, there needs to be more monitoring, there needs to be more check. 12:55

369 Q. You say:

"From an admin point of view, monitoring needs to take place regarding pathway of patients. This would help show at an early stage if there was a problem with, for example, non-dictation of clinic letters. When a consultant does not follow processes, then Datixes should be generated as well as the usual reports to line manager services et cetera. I believe we escalated appropriately but things didn't always get dealt with and we had no power to actually change anything". 12:55 12:55

The paragraph explains itself really when I read it out. Just on that, did you ever fill out any Datix or IR1s at any stage? 12:55

A. No, no. In hindsight I should have but I didn't. I didn't find the Datix system was very effective, I think it's more effective now. I think out of this

Inquiry there's a lot more Datixes going through and everybody is maybe a wee bit hyper.

370 Q. Do you think there's a potential overuse of Datix for issues arising that might undervalue that system?

A. There is the potential but hopefully it doesn't come to that because it causes nothing than more work. 12:56

371 Q. It wasn't your custom and practice to fill in Datixes at the time?

A. No.

372 Q. But you're saying now that -- 12:56

A. But that's my fault, I should have.

373 Q. But now people are doing that?

A. Yes.

374 Q. Are they coming to you, some of these Datixes?

A. Yes. 12:56

375 Q. When they come to you, are they problems that you would anticipate that Datix was envisaged to highlight, or are they problems you think is that a Datix? Are more minor things coming up?

A. There's a mixture of everything but, I mean, you have no problem if a Datix comes with you, right, we need to look into this, we need to sort this. But I do have an issue when I get the same thing five times in a row and you know we are already dealing with it. Now, I don't need it five times in a row, it's only giving me work. 12:56 12:57

376 Q. Do you think that's a way in which people are recording that they have reported it?

A. I think very much so. I think that's coming out of the Inquiry because everybody is trying to cover their

backs. And we will all be the same; I'll be no different.

377 Q. Now, you have also said in your statement that more auditing is a must, and there's a lot of focus in the Trust on targets, performance and bed management, and that those issues - I presume you are speaking historically - those issues distract you from governance? 12:57

A. Yes.

378 Q. And therefore governance was not always the primary focus? 12:57

A. Yes.

379 Q. Is that still your view of the way things are run at the moment?

A. Yes, but I think there's a real willingness to change. And I think that's come out because of the Inquiry. 12:57

380 Q. Just finally, you have said that the referral and Booking Centre processes you consider to be efficient, but the manager could do with more support?

A. Yes. 12:58

381 Q. Is that you?

A. No.

382 Q. As well as you?

A. No. Actually the manager, Christine, could do with actually support. 12:58

383 Q. You have said that governance processes need to be strengthened around secretarial end; you don't have the manpower to do the auditing. We have covered that point.

A. Yes.

384 Q. I think we have covered everything we need to cover for your evidence. I have tried to ask you as we go through is there anything you can suggest or recommend or give us the benefit of your considerable expertise. 12:58 If there's anything now that you feel I haven't brought you to or you want to say, or any learning or any other area you want to suggest, this is your opportunity to do that. It may be that you wait until the Panel have some questions for you. 12:59

A. I will wait until the Panel.

MS. McMAHON: I am finished, thank you.

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS: 12:59

CHAIR: Thank you, Mrs. Robinson. I am going to ask first of all if Mr. Hanbury has any questions.

385 Q. MR. HANBURY: Thank you very much for your evidence; everything has been very interesting. 12:59

You mentioned DARO, which is something that doesn't happen in England, as far as I am aware. It does depend on the consultants looking at results and acting on them. The Inquiry has heard that Mr. O'Brien was 12:59 reluctant to do that even going back a long way. In the early days of it, do you think that explained why patients waited so long for a review, or was there another reason?

A. No, I don't think it's anything to do with the waiting time for reviews. I think the waiting times for reviews is due to capacity, and also maybe the things that could have been analysed, are we reviewing patients too often. You know the way some consultants would review everybody, some won't, you know. So I think there was a bit of maybe analysis needed on that. I don't think it's anything to do with DARO.

386 Q. Do you think the acronym is slightly unfortunate with the D being "discharge" with the assumption you would discharge? 13:00

A. Yes, yes, but really you are just putting them in a holding bay.

387 Q. Okay. Were you surprised to get that email from Mr. O'Brien, that he seemingly didn't know about it for nine years? 13:00

A. Well, I suppose I was surprised at the time. I mean it was a long time in operation and then all of a sudden this rocks up. I can't remember how I felt at the time, you know. 13:00

388 Q. Okay. With respect to the development from DARO to the results awaiting dictation, a chart that the secretaries would fill in, you showed a table between various urologists, and there was hardly any results awaiting dictation from Noleen Elliott particularly. 13:01 Were you surprised with that, having visited Mr. O'Brien's office and seeing the number of charts there?

A. I'm not sure at that time that I actually would have

paid an awful lot of attention to it.

389 Q. Yes.

A. We would have probably looking like if there had been something like results awaiting typing and there was six months sitting there, then that would have rung -- 13:01
that would have struck a bell with me. Or there was something not dictated, that would have struck a bell because we need action on that. But the numbers wouldn't have actually probably at that time really...

390 Q. That sort of falsely reassured you in a way, did it? 13:01
The fact that it was always zero, or it was in that table?

A. Yeah, probably.

391 Q. Thank you. Your audits and spot checks was interesting. I mean, looking back, because you had 13:01
electronic systems in those days, could you have had the ability to go back to clinics and been able to match the patients in the clinics with whether there were dictations yes or no. I suppose it didn't cross your mind that that wasn't being done? 13:02

A. It wasn't really done. It did probably cross our minds but we didn't have the resources to be concentrating on that. There wasn't a report. Had there been a report, yes, we could have run that a long, long time ago. But we wouldn't have the resources to be doing all that 13:02
spot-checking. We were trying to do our best.

392 Q. Thank you very much.

CHAIR: Dr. Swart?

DR. SWART: Thank you for your very clear statements

today.

Two things, really, jumped out at me. One was your statement that "consultants are a hundred times more important than we will ever be". The other one was "we had no significance". Now, I think that's quite worrying, especially from someone who clearly has passion for their job. What do you think the root cause of this is, and do you have any suggestions as to what should be done about it? Because all the evidence, Patient Safety evidence, internationally shows that having strict hierarchies where people feel unimportant isn't good for safety. Can you just give me your thoughts on the basis of how that felt and what you think should be done. 13:02 13:03 13:03

A. Our structures relating to admin are weak and they don't really have a position in the Trust, in my opinion. Now, this is my opinion.

393 Q. That's what I am asking. Yes, that's fine.

A. I think until admin be given their place, their rightful place, it will not change. 13:03

394 Q. What does that feel like as a member of staff? What impact have you seen on that feeling?

A. Well, I actually think it's got worse over the years. I actually think admin did feature quite a bit years ago, it's actually gone downhill. But it's very disappointing. Some days I wake up and I think, well, I am coming to the end of my career so whatever they like. 13:04

395 Q. Does it cause problems with recruitment and retention of staff, does it cause increased sickness rates, mental health issues? Have you seen any of that or are people just grinning and bearing it?

A. I think there's a lot of grinning and bearing it. 13:04

396 Q. In terms of the silos, what is it about the management structure, not just for admin - but you have been there a long time, you will have some observations - what is it about the structures that encourages silo hierarchical working versus what might be more 13:04 interactive consultative working? Is there anything in the structure that you feel particularly encourages that?

A. I can't think. Sorry.

397 Q. That's all right. It's fine. You mentioned changing 13:05 working patterns in Covid. I think most people learned quite a lot during Covid. Was there anything that came out during Covid that you think the Trust could really learn from for the future, that needs to be considered? In terms of the way you worked, or the interactions you 13:05 had, or the way the staff felt? Anything at all.

A. Well, I definitely think we became more efficient in some ways. I do think while Zoom is not brilliant all the time, I mean there's nothing like a face-to-face meeting, you know, but it is helpful in others less 13:05 travelling and whatever. I do think we all got on board with that and embraced it, so I do think that was a good thing. Obviously it changed how we see patients in that there's a lot of virtual clinics take place and

whatever. All of that has been very good. It was forced upon it but it's good.

398 Q. Have you been able to share that learning and have you voice listened to in terms of that?

A. I think there was a survey done and we were asked something what did we think. Yeah, I completed something. 13:06

399 Q. Yes. The other thing I wrote down was bypassing systems. Now, why does this happen, do you think? What is the root cause of that? Is it frustration, is it people have fear of speaking up and tackling it? 13:06

A. I think it's purely out of frustration and trying to get the job done.

400 Q. Do you think that has improved at all recently? Has there been any positive impact of this dreadful pressure you must feel as a result of the Inquiry? Have you seen anything that -- 13:06

A. I think there's definitely a willingness to change things and there's more of a willingness to probably listen a bit more to people like me. I hope that's carried through when the Inquiry finishes and it doesn't all fall. I mean, my experience of our Trust is very much - and I know I am not going to be popular saying this - but if there is a problem, sure we'll recruit somebody at a very high level. That's not what solves the problem. Quite often it's down at the foot soldiers. 13:07 13:07

401 Q. If you had to put in DARO again today, what would you do differently about implementation of the process?

A. Probably what's in at the minute, where you can put the patient onto the review waiting list and --

402 Q. In terms of consultation, would you do anything differently?

A. Well, probably a letter or email needs to go out to all the medics. But remember I didn't implement it, I follow the implementation. 13:07

403 Q. If the Trust was to do it?

A. Maybe it does no harm. Having said that, when you send medics anything, and you will know this, everybody has a different opinion. You can't have 50 different ways of doing things. I mean, we have to have sometimes you have to grin and bear it and go with it. 13:08

404 Q. Do you think they should be brought into the tent more? You want to be brought into their tent? Do you have any views on how you engage differently with doctors? 13:08

A. Yes, that would be a good thing. Definitely.

DR. SWART: Thank you.

405 Q. CHAIR: Just to follow up on that last question. We have heard about particularly Mr. O'Brien's reluctance to change his working practices. Would you be of the view that unless people know the reason why they are being asked to change, you are not really going to tackle that reluctance? 13:08

A. That's a fair point.

406 Q. So, it again comes back to the communication issue, and if people don't know why they are being asked to do something, they are not really going to understand that it's a good thing. As you say, this was something that

was - the DARO system, for example - helpful to consultants but unless that's explained to them, they might not actually see it as something beneficial?

A. Fair point, yeah.

CHAIR: Thank you very much. Thank you, Mrs. Robinson. You will be glad to know we no longer need to hear from you and you are free to go. 13:09

I think, Ms. McMahon, that concludes our evidence we will be able to deal with this week. Isn't that right? 13:09

MS. McMAHON: Yes.

CHAIR: I think we have now two weeks until 16th May when we see you all again. Thank you very much.

THE INQUIRY ADJOURNED TO TUESDAY, 16TH MAY 2023, AT 10:00 A.M. 13:09