Urology Services Inquiry

Oral Hearing

Day 43 – Wednesday, 17th May 2023

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

Dr Sonia Swart (Panel Member)

Mr Damian Hanbury (Assessor)

Held at: **Bradford Court, Belfast**

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

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

CHAIR: Morning, everyone.

MS. McMAHON: The witness this morning is Leanne McCourt, who is a Urology Clinical Nurse Specialist. Ms. McCourt will take the oath. 10:07

LEANNE McCOURT, HAVING BEEN SWORN, WAS EXAMINED BY MS. McMAHON AS FOLLOWS: 10:07

1 Q. MS. McMAHON: Ms. McCourt, thank you for coming to give evidence to the Inquiry. You have already provided some written evidence to the Inquiry, and if we just confirm that. Your Section 21 response starts at 10:07 WIT-85913. We will see that's notice no. 73 of 2021. If we go to page WIT-85969, we will see your signature there. Do you recognise that as your signature?

A. That's my signature, yes.

2 Q. It's dated 10th November 2022. Do you wish to adopt 10:08 that as your evidence?

A. Yes.

3 Q. You have also provided us with a questionnaire, and that's exhibited with your statement. For the Panel's note, that is at WIT-86017, WIT-86043. 10:08

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

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

A. That's right.

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

A. That's correct.

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

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

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

A. 2017.

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

A. Yes.

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

A. That's correct.

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

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

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

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

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

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

A. No. 10:10

12 Q. Between that period of time?

A. Yes.

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

A. Yes.

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

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

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

A. That's right.

16 Q. -- to become clinical sister?

A. That's right.

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

charge nurse?

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

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

A. That's correct.

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

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

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

A. It was the start of April '17.

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes. Yes.

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

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

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

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

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

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

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

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

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

record of consultation, a copy went into the notes, and then there was a form that went in where you ticked what information you had given, whether it was paper-based and whatnot, and that went in the patient notes. 10:15

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

A. It would have been, yes. 10:15

31 Q. Now, you will have heard the evidence. I don't want to repeat the evidence yesterday but I do want to give you an opportunity to comment. You have heard the allegations about Mr. O'Brien not valuing or using clinical nurse specialists. In your subsequent role 10:16 after 2019, I think you were subsequently appointed --

A. Yes.

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

A. No, that was not my experience because I was key worker 10:16 for some of his patients.

33 Q. Now, you were eventually appointed in March 2019 as a clinical nurse specialist, having worked two years in the unit. Even at that time, you say in your statement that you still had managerial responsibilities so that, 10:16 in fact, fed into the limited time that you had for your clinical nurse specialist role?

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

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

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

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

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

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

The key points from that census in 2014 were that the

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

A. Yes.

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

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

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

A. Yes.

39 Q. The result of that then is also longer waiting?
A. If the CNS can undertake nurse-led activity at a level where she is competent with - it's usually the more straightforward cases - that can free the consultants up to deal with the more complex cases that require consultant input, and take some of the burden off the consultants. 10:20
40 Q. You will give an example we will go to later on where you undertook triage --
A. Yes. 10:20
41 Q. -- during Covid. We will come to that as an example of shedding the load slightly to allow people to be seen.

You have mentioned about a concern that red flag referrals are prioritised and there is a danger that because of that, routine referrals are getting longer and longer with a concern that people are becoming more unwell, having originally been maybe allocated as routine? 10:21
A. Yeah. 10:21
42 Q. What's the situation with that now? Do you have any knowledge about how those people are moving along?
A. I think there's still an issue.
43 Q. Still a backlog?
A. Yes. 10:21
44 Q. But it's your evidence to the Inquiry that if there was that capacity in the CNS, that there would be greater movement along the journey for those patients?
A. Yes. It could only be a positive thing.

45 Q. Now, I think your post was funded from Macmillan initially?
A. That's correct.
46 Q. I just want to just ask a little bit about that. The funding application, you have exhibited in your witness statement. I don't need to go to it but it can be found at WIT-86489. That was an application completed in the name of Esther Gishkori at the time. Do you remember Ms. Gishkori being one of the directors? 10:21
A. I know of her. I never had any direct -- 10:22
47 Q. You know her name?
A. Yes.
48 Q. I just want to highlight some of the points for the Panel's note that the application made. This was around 2014. So, Ms. Gishkori indicates in the 10:22
application that there was a commitment to a five-year incremental prioritised cancer CNS workforce, and this had been approved through the Health and Social Care Board at the time and PHA senior management team, with the department support. So, at that time there was 10:22
a conglomerate of interested parties who were trying to move this issue forward?
A. Yeah. Yeah.
49 Q. It was described as CNS coverage and attempts to put staff in place, commissioning priority, commencing in 10:23
2016/'17, which is just around the time you were being interviewed --
A. Yeah.
50 Q. -- for the ultimate clinical sister's post. This had

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

A. Yes.

51 Q. Were you appointed as a Band 7?

A. Yes.

52 Q. The form acknowledges: 10:23

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

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

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

A. I would have deputised for Kate, yes.

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

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

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

A. Absolutely. Yes. 10:24

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

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

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

A. Absolutely. Absolutely. 10:25

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

A. Yeah. 10:25

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

A. Yeah, absolutely. 10:25

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

greater then the need to meet the need of the patient from the clinical aspects of the CNS and key worker?

A. Yes.

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

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

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

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

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

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

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

issues regarding Mr. O'Brien?

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

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

A. Absolutely not.

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

A. Yes. Yeah.

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

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

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

A. Yes. Yes.

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

A. Yes.
69 Q. So, it's not a full picture in that regard?
A. No.
70 Q. If we just move down very slightly so we can see the names. You will see during that period, on one occasion, you were used by Mr. O'Brien, and others bearing figures from 6, 13, 16 and 35? 10:29
A. Yes.
71 Q. So during that period, a total of 75 but just once by Mr. O'Brien? 10:29
A. Yes.
72 Q. And again --
A. Sorry --
73 Q. Sorry, go ahead?
A. Sorry. I also, when I've had time to think and think where I was in my career during this timeframe, I would have also undertaken my non-medical prescribing. If I recall correctly, the day that Aidan would have had one of his clinics would have been one of the days I was requested to be at Queen's, so that would have been one of my study days down at Queen's. That could also have impacted on those figures. 10:29 10:29
74 Q. That has to be factored in as well?
A. Yeah. Yeah.
75 Q. Then for the period from 27th February 2019 until March 2020, again you have named the consultants on one side and a number of patients on the other. In that one we see Mr. O'Brien has used you as a key worker on 14 occasions; other consultants have used you on 4 10:29

occasions, 3 occasions, 5, and the highest number, Mr. Haynes, 121.

Would that reflect that Mr. Haynes uses the key worker almost with every patient? 10:30

A. Yes. So, Mr. Haynes comes from a background where he has worked on the mainland. As my previous inclusions of the Macmillan reports, CNS is much more of a feature of the patient pathway on the mainland. I think he had been very familiar with that role and that could 10:30 perhaps account.

76 Q. Again, it's just your input as well. The figures could be --

A. Working patterns and things like that had to be accounted for, yes. 10:30

77 Q. I think the final... This period is from April 2020 until March 2021. Again, several of the consultants, including Mr. O'Brien, have used you as a key worker. Once again, Mr. Haynes hitting high numbers of 55?

A. Yes, and Mr. O'Brien would have retired in summer that 10:31 have --

78 Q. June 2020?

A. Yes.

79 Q. So it's a partial picture?

A. Yes. And Covid as well. 10:31

80 Q. And Covid.

A. Yeah.

81 Q. Well, that in fact is April to June 2020 for Mr. O'Brien's purposes then, if he left then.

A. Yes.
82 Q. Did anyone ever come to you when you were in charge of the rota and indicate there were any problems with working with Mr. O'Brien in this role?
A. No. 10:31
83 Q. Now, the Inquiry -- and you would have heard in evidence yesterday about the SAIs, the outcome. Are you in the same position as Mrs. O'Neill, where you found out about this when you got the report in full in March 2021? 10:32
A. Yes. Yeah.
84 Q. So when you went to the meeting in February 2021 with Dr. Hughes, the Zoom meeting with the staff, this was the first time it had been articulated to you, was it?
A. I wasn't present for the first meeting, was it the 18th? I was present at the one on 22nd. 10:32
85 Q. Yes.
A. Yes, I was at that.
86 Q. The 18th is the MDT meeting --
A. Yes. 10:32
87 Q. -- that Mrs. O'Neill was at?
A. Yes.
88 Q. You were then present at the one for all the nursing staff, all relevant nursing staff?
A. Yes. 10:32
89 Q. That was the first time that the contours of the complaints had been set out for you?
A. Yes. Yeah.
90 Q. What was your immediate reaction when you heard some of

the issues coming up?

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

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

A. Yeah, yeah. 10:33

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

A. Yes. 10:33

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

A. Yes. Yes.

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

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

I think that you had said before you had seen this, you put in your statement at Section 21 about this incident. What you have said is to be found at WIT-85958. I will just read from that for you. So, from the top of the page: 10:34

"In my experience, certain consultants would have sought more key worker input than others would. I do not know why some individual consultants adopted this approach more than others. I do recall Mr. O'Brien 10:34 stating in general conversation to me 'key worker, what is this key worker role'? I do not recall the specific date or who else was in the vicinity at the time of this conversation. When he arrived to do his clinic, I had said to him that I was available as key worker for 10:34 his clinic. In my opinion, his response was verbalised in the context of a condescending tone. I was taken aback and do not accurately recall my response. Consultants were aware of the importance of the key worker role as per Kate O'Neill's email from 10:35 June 2017".

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

A. Yes. 10:35

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

specialist.

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

A. No. I have been misquoted. I've been -- I have been misrepresented.

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

A. So, I would have said very similar to what I said in my Section 21. Aidan would have been very particular in his use of language and words, and I think it was just the "key worker" word that he didn't like. It's not -- I don't for one minute think he didn't understand what a key worker was, or indeed what a CNS was and what my role was, he absolutely did. I believe he did value that role. It's just he could have been very specific about his use of words and language and phrases. 10:35 10:36 10:36

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

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

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

A. Not the role per se.

99 Q. Just the name? 10:36

A. Just the phrase, yeah. Yeah.

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

sent to all consultants. The subject is "Issue raised at the Thorndale unit meeting today". I will just read it for the note:

"For all consultant colleagues, following discussion at the above meeting today can we ask that all patients who require the input of a key worker would be offered the opportunity" - you could challenge this because there are lots of letters missing - "the opportunity to meet with the appropriate member of staff on the day. Patients have informed us of the benefit of meeting with staff members and it makes it much easier for them to make contact via telephone should/when any queries arise". 10:37 10:37

Then there's other information about clinical care. This was sent out from Kate O'Neill so that everybody was on board, if I can put it like that?

A. Yes. And I have to say, whatever way that has formatted. Kate can actually spell. 10:37

101 Q. Yes, I think it was the formatting but I want to make sure I put the right vowels in the right place.

A. Yes.

102 Q. Then just in finalising the point about the SAIs, like Mrs. O'Neill you weren't interviewed by Dr. Hughes before that Zoom meeting? 10:38

A. No.

103 Q. You had no input into that process?

A. No.

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

A. Yeah. 10:38

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

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

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

A. Myself and Kate, yes.

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

A. No.

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

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

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

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

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

A. Yes. 10:41

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

A. Yes.

112 Q. -- and also greater resources for CNS?
A. Yes.
113 Q. Now, we did mention earlier one of the other nurse-led activities was the triage during Covid. I wonder if you could explain that in relation to how that operated at that time? 10:41
A. I think this was the summer of 2020. So, the rest of our team were redeployed at that stage, so there were just the three CNS nurse team that left in Thorndale, so again we have no real managerial duties at that time. Mr. Glackin had approached us and just asked us to assist with that process. So, Kate and I would have triaged the red flag prostate patients that were coming into the system, ordering their scans up, and having -- if they needed a second PSA, if they needed a urine sample sent. So, organising that in the background, organising an ultrasound or an MRI to have as much information as possible for when the patient would have had their consultation. Some of those consultations at that stage would still have been virtual, over the telephone between the consultant and the patient. So, having all that to hand for the consultant to make -- 10:41 10:42 10:42
114 Q. At the first appointment?
A. -- to make it as meaningful as possible.
115 Q. So, ordering the tests before the consultant gets to see the patient? 10:42
A. Yes.
116 Q. Would that have some resonance with the way in which Mr. O'Brien preferred to approach triage, which was, if

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

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

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

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

A. Yeah. Yeah.

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

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

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

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

A. Yes. Mr. Glackin.

120 Q. Mr. Glackin oversaw that?

A. Yes.

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

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

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

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

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

A. That worked, yes.

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

A. Yes. Yeah. 10:45

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

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

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

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

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

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

A. Yeah, on occasion. 10:46

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

A. Yes, yes.

129 Q. You have said in your statement that radiology was the one that seemed to have a greater impact by their absence than any of the others?

A. Yes, and that's because we only had one radiologist. I am not taking anything away from him, he is expert at his job, but he is one person and he can't be there at every meeting because of other commitments. 10:47

130 Q. The position, you say, has improved and there are now two radiologists?

A. We now have two. 10:47

131 Q. Do you still attend these meetings?

A. Yes.

132 Q. And what's quoracy like now, in your experience?

A. It is much improved. We have a medical oncologist and a clinical oncologist most weeks as well. 10:47

133 Q. Now, in relation to raising concerns or identifying anything that you were concerned about, you have said in your statement you were never discouraged from raising concerns and did feel you would be treated with respect and your opinion valued "should I ever need to do this". 10:47

Was it the case that you and all of the other clinical nurse specialists, and indeed other nursing staff, were quite a close-knit unit? 10:47

A. Yes. It was a small team, yes, so we were aware. If something had happened, the team would have been aware of it, yeah.

134 Q. Would you have frequently spoken informally about

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

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

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

A. Yes, yes.

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

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

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

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

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

a potential data breach?

A. Yes.

139 Q. And what did he do about that?

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

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

A. Sorry. 10:50

141 Q. -- so we will make sure that that is dealt with. That's obviously not to be reported anywhere.

When you speak about actually raising it, the point in your statement is that you fed the concern up the chain, if I can put it like that? 10:50

A. Yes.

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

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

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

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

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

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

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

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

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

A. It was more reactional, I think, yeah. 10:52

146 Q. Now, you have given two examples in relation to Mr. O'Brien in your statement. We don't need to go to this but for your note it's at WIT-85917. You have described him in two different ways in this paragraph, and I just want to ask you about it. 10:53

Actually if we just can bring it up, just for the witness's recollection. 85917, please. At paragraph 1.18 and the third line down -- well, I will start at the beginning of that. 10:53

"I would also like to note that I have listed occasions within this document where I found Mr. O'Brien to be condescending in tone but this was not always the case. If I needed advice from him, he was professional and 10:53 forthcoming. When I was a junior staff nurse, he would have taken time to explain things and helped me to learn. He was very dedicated to care of his patients and I would describe him as kind and caring to his patients in clinic. I recall one such time when I was 10:53 present when a life-changing diagnosis was given to a young man. Mr. O'Brien offered to drive him to the oncology appointment he had arranged for him later that day, as he was concerned the young man was distressed

and shaken".

So, you specifically have that recollection?

A. Yes.

147 Q. Would you like to take a break? 10:54

A. Yes, please.

148 Q. That would be okay. Thank you.

CHAIR: We will take ten minutes.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS: 10:54

CHAIR: Are you ready to continue?

THE WITNESS: Yes.

149 Q. MS. McMAHON: Thank you, Ms. McCourt. 11:12

Just before the break, we had been looking at an extract from your witness statement at WIT-85917 and I had read paragraph 1.18. I just want to read 1.19, where you say: 11:12

"This process is difficult and discordant for me as there was a consultant I knew to be kind and caring, albeit arrogant and condescending at times, and then there was a consultant mentioned within the root cause analysis report, and the findings that have now led to a public inquiry". 11:12

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

Mr. O'Brien; would that be fair?

A. Yes. Yes.

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

A. That's correct.

151 Q. You said that incident made you feel very uncomfortable by the way that he spoke to the other consultant.

11:13

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

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

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

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

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

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

consultant.

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

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

Then you give us two examples of this?

A. Yes. That's correct, yes.

154 Q. Where you say:

"The queries noted below are in relation to scan appointments or oncology referral appointments of two patients". 11:15

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

A. Potentially they could have, because the MDM outcome

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

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

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

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

A. Yes, yes.

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

A. Yes.

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

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

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

A. Not to my knowledge.

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

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

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

A. Yes.

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

respect of this patient?

A. Yeah.

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

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

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

A. In terms of?

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

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

166 Q. So it's anticipated that the patient will be a proactive part of their journey and if they don't have a letter in six weeks, then they can get in touch?

A. Yes. Yes.

167 Q. What about patients who perhaps lack capacity in some regards and maybe aren't au fait with just keeping on eye on things, is there any provision made for those type of patients? 11:20

A. Usually patients like that will have a family member with them, so I would engage at the time with the family member. Or if they have come on their own, being a nurse you sort of get a feel for if a patient maybe isn't taking everything on board so I would always ask, you know, who is at home with you, things like that. If they are happy, I would normally say well, you know, if your son or daughter has any queries, would you mind if they phoned in, could I talk to them, you know, update them on that perspective, that there always is somebody other than the patient in that position. 11:20 11:20

168 Q. The system as it exists now in referral of patients, for example to Oncology, how confident can the Panel be that those referrals are being carried out and that there couldn't possibly be the situation that arose for this patient arising currently? 11:21

A. I can only speak for my role within this in that, now, patients who have a new diagnosis do have the key worker and are empowered to know what's happening. I think there have been discussions around the whole of

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

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

A. Absolutely. 11:21

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

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

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

referrals outstanding?

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

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

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

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

A. No.

177 Q. Nothing?

A. No.

178 Q. So as far as you were concerned --
A. These were isolated, yeah.
179 Q. Isolated.

You reflect on those cases in your witness statement at 7.28. You say: 11:24

"I am satisfied they received their definitive treatment. However, I do feel that the two patients involved could have endured more anxiety than they ought to have due to the prolonged referral time. From my perspective, I feel I could have been better informed regarding what had or had not been done about my concerns". 11:24

In this regard, those were concerns that hadn't actually been raised with anyone beyond Mr. Haynes?
A. Correct.
180 Q. You didn't raise them with Martina Corrigan --
A. No. 11:25
181 Q. -- or with anyone within your own line management in nursing?
A. Yes. And with hindsight, I think if I had to do that again, that's what would have happened.
182 Q. You speak about learning and improvement in your statement. We don't need to go to it but it's at WIT-85932. You have given some bullet points of the way in which communication and action planning could be improved. Some of these focused particularly on 11:25

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

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

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

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

A. Yes.

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

were to go back to both you and the clinician?
A. Yeah.
185 Q. You have said again another improvement could be that all scan and blood results should automatically populate onto the ECR work list of the person who ordered them. I think it's the same point? 11:27
A. Yes. Yes.
186 Q. There's also room for improvement in the admin support of the CNS services, given the demands?
A. And there has been improvements in that most recently, yes. 11:27
187 Q. And I think we have touched upon the increased tracking post-MDM decision?
A. Yes.
188 Q. Not just up to the point of MDM? 11:27
A. Yes.
189 Q. That's something the Panel have heard evidence of, and we will hear some more.

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

"I should have been made aware of the aforementioned governance concerns within Urology."

11:27

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

accept that, that there is a requirement?

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

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

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

191 Q. And handled differently how? 11:28

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

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

A. Yes.

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

A. Yes.

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

been modified in light of the recommendations?

A. Not officially. I haven't been asked officially what happens now, what difference has this made. No.

200 Q. I know you said earlier your background was in research and data, I think. Is there any way that you or anyone else keeps on eye on whether recommendations have been implemented that are relevant to CNS? 11:31

A. So anything -- when the Task and Finish group meetings were more regular, outcomes that would have specifically concerned the CNS group, I would have been involved in moving those forward. But there are a lot of much more higher level outcomes that I wouldn't have input into or be involved in. There's a lot happening that would be above my level that I wouldn't be aware where that has progressed to. 11:31 11:32

201 Q. I have brought you to various parts of your statement. Is there anything at this point that you would like to highlight or say or anything you think should be highlighted that I haven't asked you about?

A. No, I think we have -- this has been a balanced view of what the situation is. 11:32

202 Q. I have no further questions.

CHAIR: There will be some questions for you. Obviously I am going to ask Mr. Hanbury first if he has some questions. 11:32

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

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

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

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

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

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

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

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

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

A. About the non-involvement?

207 Q. Especially one that seemed to have delay referral to Oncology?
A. Yes.
208 Q. That did surprise you?
A. Yeah, yes. 11:34
209 Q. Thank you. I am impressed you do a range of CTs as well as bloods?
A. It's MRIs.
210 Q. MRIs. Did you have to go through a special sort of process to enable that? 11:34
A. Yes. I think there was a scheme of works that I had to sign up to.
211 Q. So, do all the CNSes do that now?
A. Yes. Yes.
212 Q. The Inquiry is aware of some patients whose MDM outcomes weren't followed through. You said later on that wasn't the role of the CNS to necessarily police that, for want of a better description? 11:34
A. Yes.
213 Q. But then actually that's what you did do -- 11:35
A. Yes.
214 Q. -- with those two patients. Do you think actually that is part of your role, or would you push back?
A. I certainly wouldn't have the resources to proactively follow up every patient that I'm a key worker for. 11:35
I think as part of my role, as discussed earlier, I would empower the patient to know when to expect things and what to do if that doesn't happen. But I don't think I would have facility or resource to

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

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

A. No, that was at Covid.

216 Q. Would that factor into --

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

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

A. Not that I'm aware of.

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

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

A. Yes. 11:36

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

A. No.

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

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

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

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

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

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

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

A. No. Absolutely.

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

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

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

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

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

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

227 Q. Just volume, okay.

A. Yeah. Yeah. 11:38

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

A. Yes. Yes.

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

A. Yes.

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

A. Yes, that's correct.

231 Q. That's all the questions.

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

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

journey.

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

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

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

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

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

A. Yes. Yes.

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

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

236 Q. Yeah.

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

happening.

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

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

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

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

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

A. No.

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

A. Mystery. It was not explained.

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

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

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

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

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

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

A. No.

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

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

245 Q. Is that present in other Trusts?

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

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

A. Thank you.

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

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

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

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

248 Q. Every two months or so?

A. Yes.

249 Q. Okay. Thank you. 11:44

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

A. Yes.

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

A. Yes.

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

A. No.

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

85958. It's paragraph 50 at the top of that page.
Yes. You were writing this response to the Inquiry
without having sight of, what, the minutes --

A. Yes.

253 Q. -- which you have only recently seen? 11:46

A. Yes.

254 Q. What you tell us, if you can just scroll down slightly, please. Just start there.

"I do recall Mr. O'Brien stating in general 11:46
conversation to me 'key worker, what is this key worker role'? I do not recall the specific date or who was in the vicinity at the time of this conversation".

Can I just check, is that the same conversation that is 11:46
referenced by this minute?

A. Yes.

255 Q. So, it may well have taken place in the kitchen?

A. Yes, it did. I can recall the logistics.

256 Q. So what you recall when you are writing your statement 11:46
to us is the use of the word 'key worker', and nurse specialist is what is recorded in the minute?

A. Yes.

257 Q. Do you accept, first of all, that you did tell the
meeting on 22nd February that he didn't value nurse 11:46
specialists?

A. No, I didn't say that.

258 Q. Okay. Do you recall saying anything of that nature to Mr. Hughes?

A. No. I would have said...
259 Q. You would have said this?
A. Yes.
260 Q. So, what is recorded here is accurate?
A. Is the accurate encounter. 11:47
261 Q. What is in your statement is accurate. What you tell the Inquiry is:

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

Can I just check, you now know that it was in the 11:47 kitchen?
A. Yes, yes.
262 Q. Do you recall now whether anyone else was --
A. I don't know. The kitchen door would have been open so I don't know. It's only a small -- 11:47
263 Q. Yes. Okay.
A. Yeah.
264 Q. "In my opinion, this took place when he arrived to do his clinics", so whenever you were saying to him I am available to be key worker? 11:47
A. Yes. Yes.
265 Q. "I had said to him that I was available as key worker. In my opinion, his response was verbalised in the context of a condescending tone and I was taken aback

and do not accurately recall my response".

What you have told us today, Ms. McCourt, is that it was really him being particular about the use of language? 11:48

A. Yes.

266 Q. Why, then, were you taken aback?

A. Because I would have used that phrase to him before. It would have been my habit to have said, 'Aidan, I will be the key worker for your clinic'. That wouldn't 11:48 have been the first time I would have used that phrase with him. So --

267 Q. Why, then, were you taken aback at this condescending tone?

A. Because he had never said anything like that before. 11:48 He had never verbalised anything like that before to me about that term.

268 Q. So you are quite clear in your evidence to the Inquiry that you did not tell Mr. Hughes that you felt that Mr. O'Brien didn't value nurse specialists? 11:48

A. Absolutely I wouldn't have said that because it's not what I believe.

269 Q. Okay. You are quite clear that this condescending tone that took you aback was only because it was the first time he had said something like that to you? 11:49

A. Yes, because I would have used that key worker phrase to him prior.

270 Q. I see, okay. So, being taken aback...

A. Why would he have chosen that day to comment on it when

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

271 Q. Did you challenge him about it?

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

272 Q. Thank you. I have no further questions. 11:49

MS. McMAHON: Thank you, Ms. McCourt.

THE WITNESS: Thank you.

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

11:49

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