Urology Services Inquiry

Oral Hearing

Day 57 – Thursday, 29th June 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, 29TH JUNE 2023 AS FOLLOWS:

CHAIR: Morning, everyone.

MS. McMAHON BL: Good morning. Good morning, Mrs. Corrigan. 10:05

MRS. MARTINA CORRIGAN CONTINUED TO BY QUESTIONED BY MS. McMAHON, AS FOLLOWS:

10:05

1 Q. MS. McMAHON BL: We left off yesterday on the triage issue and I just want to clarify a few points in your evidence and we can move on to some other issues we need to discuss. 10:05

The Panel have already been taken to an e-mail by Mr. Wolfe, with Mrs. Burns, from Anita Carroll setting out the process to be adopted in relation to default --

A. Yes.

2 Q. -- triage. For the Panel's note, that is at WIT-98404, with the process in a diagram form at WIT-98405. You weren't in that e-mail, but it was sent out to all senior individuals -- 10:05

A. It was, yes.

3 Q. -- about the process that was to be adopted. Now, we spoke yesterday about the meeting in February and your subsequent e-mail of March 2014? 10:06

A. Yes.

4 Q. -- which set out that Mr. O'Brien was only to do

referred name triage?

A. That's right, mm-hmm.

5 Q. And I just want to feed what you said back to make sure I've understood it before moving on to the default issue. So, at that point, Mr. Young was to take up Mr. O'Brien's triage duties. 10:06

A. It was to be the team, but Mr. Young chose to take it up. It was his choice, rather than discuss it with the team, that he would do it himself.

6 Q. And was it relayed to Mr. Young from you or Mrs. Burns that it was expected to be the team? 10:06

A. It was relayed in the e-mail that Mrs. Burns sent the day after the meeting that it was to be the team. I spoke with Mr. Young after -- I think he asked me to come and see him or I said I was going to come and see him and I recall speaking to him about it and what he said was, yes, he would speak to the team, but Mr. Young was -- he said "That's going to add a burden to the team", but, he said, "Look, just for now, get all the referrals sent to me instead and then we'll see how it goes." 10:07 10:07

7 Q. I think your evidence yesterday was that he didn't inform his other colleagues about that --

A. As far as I'm aware, I don't think his other colleagues knew. 10:07

8 Q. And, subsequently then, Mr. Young stopped doing the triage?

A. He did, yes, and after our conversation yesterday evening, I went back and checked, so it was mid

September. What happened was, at the beginning of August, we had the meeting with the Board that had senior people involved in it. It was agreed that we would move to Urologist of the Week and what the agreement was was for -- that would happen from 1st September, but it would only be mornings for that month and then, from the beginning of October, they would move to a full week Urologist of the Week. So, instead of it being a full day, it was a morning and I think it was just because there was activity booked during September. So, the afternoon activity was to go ahead, but the mornings was to be dedicated for triage. 10:07 10:08

Mr. Young then, without discussion, had returned the referrals belonging to Mr. O'Brien to the Booking Centre to say he was no longer doing it because his reasoning was they had moved to Urologist of the Week, which was agreed, and everybody had dedicated time, including Mr. O'Brien, to do the triage. 10:08

9 Q. So, there was a shift in the landscape insofar as there was an opportunity and a time given -- 10:08

A. Yes.

10 Q. -- for triage?

A. Yes.

11 Q. Mr. Young's expectation then was that things would revert as expected and each consultant who was a Urologist of the Week would undertake their triage duties while they were on call for that? 10:08

A. That's right, yes. And that's what was presented to

the Board and that's what was agreed by the team, including Mr. O'Brien, because there was discussions coming up to the meeting with the HSCP and that was all agreed, that they would have time to do the triage on their Urologist of the Week.

12 Q. At that point in September/October, the backlog in triage that became apparent -- we saw the e-mail yesterday referencing November 2014, some of the backlog until that point. Was Mr. Young up to date with the triage that originally should have been allocated to Mr. O'Brien, or when he stopped doing that in September was there already a backlog?

A. He was up to date with the letters for the general urology, if you like, but with regards to Mr. O'Brien's named referrals, there was a backlog in that. So, Mr. O'Brien's responsibility was the named referrals and there was a backlog.

13 Q. So, even with the ones that were allocated to Mr. O'Brien being specifically referred to him, the backlog existed at that point?

A. It did, yes.

14 Q. And then that became exacerbated when he took on the Urologist of the Week duty and there became more of an issue with triage?

A. It did, yes. If I can just say too, always, and we may come to this, Mr. O'Brien always triaged, albeit it was late. The issue obviously that came to light in 2017 was that he hadn't triaged. But, up until that, you know, any of the chasing that would have been done was

for the late triage and he would have always -- sorry, for triage that was late, and he would have always done that. But that was the actual then ultimate problem, was he actually didn't triage.

15 Q. I know you listened into Mrs. Burns' evidence in relation to the default position. Her understanding seemed to have been that although the default was in place to allow people to go on to the list according to the GP's prioritisation, that there was -- it was anticipated that they would ultimately be triaged by a consultant and, if they needed recategorised, then that would take effect on the list, dependent on what the consultant's view was about the clinical priority. Was that your understanding or was it your understanding that the GP's default was where someone sat on the list? 10:10 10:11 10:11

A. I think, because I do recall the meeting where this was discussed -- it's obviously part of the IEAP, which was the reason why it was brought up that the -- what happened sort of before that, and I hope I'm right with this, but what happened before that is when a GP sent in a referral, they weren't added to the waiting list until they were triaged. So, what happened was I'd got a letter -- somebody's referred me in and one of the consultants has triaged me, so I go on the list according to my priority. Somebody comes in, a letter comes in under Mr. O'Brien and it doesn't go on to a waiting list because it hasn't been triaged. So then they come to pick patients for the clinic. So because 10:11 10:12

I'm on the waiting list, I'm picked, but the patient that hasn't been triaged hasn't. So I think it was more a move to make sure that everybody was on a waiting list and to make sure they're on the waiting list that the GP priority was what was agreed, which is what is in the IEAP anyway. 10:12

16 Q. Just to go back to the essence of the question, really, which was: Was it your understanding that the GP categorisation would be the priority the patient was set at or was it -- 10:12

A. Yes.

17 Q. Sorry --

A. Yes.

18 Q. Yes. And so it wasn't anticipated that that would subsequently be triaged again by you at that point? 10:12

A. No, sorry, when the letter came in, if it said it was urgent or new -- or, sorry, urgent or routine, it would go on the waiting list with that priority. For all -- and Mrs. Burns was right yesterday, that was for -- it doesn't matter whether it was Ophthalmology or ENT or General Surgery or Urology, it went on on that priority. But once the consultant would have triaged, they either upgraded it or downgraded it and then that priority would have been changed then on the waiting list. 10:13

19 Q. So, your understanding was the same as Mrs. Burns'?

A. It was, yes.

20 Q. And for the Panel's note, Mrs. Corrigan refers to this in her Section 21 at WIT-26271 at paragraph 55.5. And

what that paragraph does is suggests that Mrs. Burns and you were involved in that collectively around an understanding of the triage position?

A. Yes.

21 Q. You don't disagree with Mrs. Burns' evidence at all? 10:14

A. The one thing I do disagree with, I think it's the timeline. I think everybody is getting a wee bit confused about the timeline when all the decisions were made. Because what happened was this all came to a head in November 2013 -- I think, yesterday, you 10:14 brought me to an e-mail of February 2013 where Mrs. Trouton was trying to address it. It came to a head again in November '13 and she actually asked for Mr. Young and Mr. Brown to help out with the issue. Mr. Young, at that stage, had sort of given an 10:14 indication that he would help out with triage -- that was in November -- now, remember this is before we met with Mr. O'Brien -- but then he came back at the beginning of December to say that, no, that wasn't what he was suggesting. So there was a number of meetings 10:15 in December time and it came to a head that the letters still weren't being triaged.

So, in or around January, I do recall the meeting -- it was with Heather, Mrs. Trouton; Mrs. Anita Carroll; 10:15 Mrs. Robinson, and myself, and they were basically asking what we were going to do about the whole thing about Mr. O'Brien's triage. Now, Mrs. Burns was not present at that meeting at that time and Anita had

suggested the GP prioritisation, that we would move to that.

What happened then was I sent down to, as we used to call it, the corner office, down to Mrs. Burns and asked her to come up and join the meeting. It was a heated discussion, it was a heated debate, and that's where the escalation policy came out of -- but really was to do with Mr. O'Brien at that stage, but then it ultimately moved that there was an Ophthalmology problem and it was then for all specialties. So, I suppose, that's where the difference is. It ultimately started out with Mr. O'Brien, but this was pre -- before Mrs. Burns and I met with him, because it wasn't being resolved. And in between times, Mrs. Carroll and Mrs. Trouton were doing the escalation, which is the e-mail that you spoke about there, the flow chart. 10:15 10:16 10:16

22 Q. It was brought in before Mrs. Burns was aware, the default, is that what you're saying?

A. No, I think what I'm saying is it was discussed before Mrs. Burns and I met with Mr. O'Brien, and I think that's where the confusion is because she was saying that everything happened in or around the same time. But there had been discussions right through sort of December/January, with regards to what resolution we would come up with to try and make sure that these patients were put on a waiting list of some description -- or, sorry, for their priority. 10:16 10:17

23 Q. And I think Mr. Wolfe took the Panel and Mrs. Burns to

the note of your interview with Dr. Johnston?

A. Mm-hmm.

Q. And where you said that the process was developed by you, Anita Carroll and Katherine Robinson, with no one else in the room, and that this would enable you not to have to monitor triage because it was being done. Is that an accurate reflection, given that you've said that there was still an expectation that, even though the default process was in place, that triage would ultimately be done and a recategorisation applied, as necessary? 10:17

A. It's not a reflection. I went back to look about those notes. Those notes are still in draft form. The interview happened in February 2017 with Mr. Johnston or Dr. Johnston, and I wasn't shared the notes until the following January. It's totally inaccurate. The part where it says there was only two of us in the room, that's actually referring to the meeting that Mrs. Burns and I had with Mr. O'Brien, because Dr. Johnston asked us was there anybody else in the room whenever -- because I had said, I think, that there was no notes of the meeting and he said "Was there nobody else there?" And I had said, "No, there was just the two us." But when you read the notes, it looks like it was just the two of us, just us in the room with regards to Anita, Katherine -- and Debbie, Mrs. Burns was definitely not in the room when we discussed it, but I went and got her and brought her back into the room. It was in our office on admin 10:18 10:18 10:18

floor.

So, the notes don't reflect what happened at all, because the notes actually say I have told Mr. O'Brien to triage, which doesn't match up with anything, you know, any of the evidence or anything that I've ever said or understood.

25 Q. And when did you get those notes?

A. January 2018.

26 Q. And did you correct them or send back in and say "These are not accurate --

A. I couldn't find where I had corrected them or sent them back, but -- because I've only started to look for them yesterday after Mrs. Burns' evidence. But I definitely would have corrected them things if I had of had them. And I've never seen a final draft either.

27 Q. You understand that one of the focuses for the Panel is the governance system and processes that allow decision-making, I suppose, to be tracked back to origin. This seems to have been a fairly relatively important discussion that was going to slightly change the route by which triage was going to be approached, and certainly there's some contested evidence now around what was expected to be done. Do you feel that decisions like that should be minuted and documented and circulated to the individuals, both who are in charge and whom it's going to affect?

A. Absolutely, because I know from the meeting with Mrs. Burns, I did put it in writing with regards to the

plan with Mr. O'Brien not triaging. But I have looked back and I have never actually shared information with regards to the GP, the default of the GP prioritisation, which is now, you know, a regret. But then again, I don't think it was, you know, for me to do it because it wasn't my decision. It was a decision made by two assistant directors in discussion with a director, so I absolutely agree, we should have had minutes from that meeting, albeit even if it was an e-mail note. 10:20 10:21

28 Q. You say it was Anita Carroll, Heather Trouton and Debbie Burns --

A. -- who ultimately made the decision, yes.

29 Q. Around the default?

A. Yes. I suppose it's -- one of the things is everybody sort of feels that there was no escalation after that. But, on checking, there was escalation of it definitely up until November '14 -- or November '15, but after that it just seems to stop, we don't get the same escalation. And, I suppose, the only reason I ended up knowing about the actual escalation, because, you're right, I wasn't copied into it, was I was getting e-mails from Mrs. Carroll asking me to chase Mr. O'Brien for un-triaged letters and I did go back to Mrs. Robinson and I said to her "Why am I getting e-mails direct from Mrs. Carroll?" and she said "It's to do with the new escalation" and it was actually Katherine that shared that with me because, up until that, I hadn't been copied in. I just think maybe it 10:21 10:21 10:21

was an omission.

30 Q. What you've described seems to be quite a piecemeal way of communicating that everyone knows a bit of the picture, but nobody seems to have an overall view, would that be fair? 10:22

A. That's very fair, yes.

31 Q. Having heard Mrs. Burns and the other evidence so far, is there anything else you want to say about the triage or the default triage process, or do you think you've covered your understanding of it? 10:22

A. I think I've covered my understanding of it, unless there's any other questions for me.

32 Q. I just want to ask you a couple of questions about the non-dictation issue. Generally, you have covered that in your statement at WIT-26264 and, if we could go to 10:22 WIT-26265 at paragraph 54.14, I just want to read this paragraph out -- just go back. So you say -- the paragraphs:

"Not dictating on patients after clinics or day 10:23 procedures"

-- you say:

"This first came to my attention in 2014 when the 10:23 consultants, Mr. Haynes, Mr. Glackin and Mr. O'Donoghue, were doing some extra sessions to help reduce the review backlogs. Whilst doing this exercise they raised informally that there appeared to be a

number of patients who didn't have a clinic letter on the Patient's Centre system, which meant they needed to see the patient face-to-face to make a decision on their follow-up care. Whilst I was informed about this and discussed it with Mrs. Trouton and Mr. Mackle during 2015, it was very difficult to quantify how many patients didn't have a clinic letter, as there was no electronic system to capture this information and, therefore, there was nothing further formally done on this issue until Mrs. Trouton and Mr. Mackle included this in their letter of March 2016. 10:23 10:24

It became apparent that despite it being raised with Mr. O'Brien formally in March 2016, this didn't improve and, in January 2017, before his return to work, Mr. O'Brien revealed to me that there were 668 patients who had not had a dictation dating back to 2014, which is in line of when this was brought to my attention." 10:24

Now, I just want to ask you about that. You have mentioned in this the number of patients who didn't have a clinic letter on the Patient Centre system. Now, is that the way in which the clinic letter had been done, is marked on the system, or if you could just explain what it was that they noticed? 10:24 10:24

A. Okay, well pre NIECR, the letters that were typed were uploaded onto a system called "Patient Centre" and whenever the consultants would have been looking to see if the patients needed a review or follow-up, they

would have went in and read the last clinic letters. So, it would have been clinic letters, but also would have discharges was added to that system. What I mean by that was they, basically -- I had given them a list of patients in the review backlog, and basically then what they would have done was went in and looked at the last letter. But what they were coming back to me to say was that there were no previous letters, so they couldn't make a decision without actually having to see the patient, which was then impacting -- because obviously they're able to do that online exercise whenever sort of it nearly suited them, you know, sort of because they were doing it as additional if -- to help us out. So they could have done it in an evening or a Saturday because they didn't need to see the patient, whereas, what they were finding was, because they didn't have it, they were coming back to say "We need to see the patient." 10:25 10:25 10:26 10:26

33 Q. So they had to go into the system in order to realise the letter wasn't there?

A. Yes.

34 Q. The system didn't preemptively indicate the absence of letters?

A. No, no. Nor does the new system. The NIECR wouldn't tell you that either.

35 Q. We mentioned yesterday about the bi-weekly reports on outpatient activity. Was that a report that could have possibly captured the absence of dictated letters or was it not built into that system?

A. No, it wasn't built into that system.

36 Q. You said now this system's changed, the NIECR?

A. Yes.

37 Q. What is the position now in relation to referral -- by the time you'd left in relation to referrals? Was there a way of capturing that information that you can inform us about or -- 10:26

A. No, there wasn't, because it came back to the spot check exercise that I had to do -- basically, I had to run the clinic information, find out what all the patient details were, and then I had to go in and physically look to see were the letters on. So, there's no way of capturing that. It's back to the G2 system will tell how many letters has been dictated, but it doesn't actually tell you how many letters on each patient or how many patients don't actually have a letter. So, it is a poor system at the moment. 10:27 10:27

And I know there's a lot sort of riding on this Encompass coming in, but I think what it will be, whenever you dictate a letter, it will be automatically put onto the system and it will flag up whether you -- whether the patient doesn't have a letter. And it's -- well, I know they're starting to trial it in July, next month, in the South Eastern Trust. 10:27 10:27

38 Q. So, it's in a trial period at the moment?

A. It is, yes.

39 Q. But that could potentially, if it was adopted by the Trust, remedy that issue?

A. Yeah, it will be adopted by the Trust. It's a regional project that they've been working on for a number of years, and I think that's possibly why there's been no investment in the likes of the Patient Administrative System because this is coming. It's going to be paperless -- for all disciplines -- social worker, AHPEs... I don't know enough detail about it, but I do know there's a lot depending on it.

40 Q. I can ask Mrs. O'Kane about that when she comes back. She can give us the most up-to-date information? 10:28

A. Yes.

41 Q. Just the other thing I wanted to ask you about in that paragraph was that -- you stated at the bottom of that paragraph, if I can go back to it: 10:28

"It became apparent that despite it being raised with Mr. O'Brien formally in March 2016, this didn't improve and, in January 2017, before his return to work, Mr. O'Brien revealed to me that there were 668 patients who had not had a dictation dating back to 2014." 10:28

Now, just what were the circumstances under which Mr. O'Brien told you about that and gave you that figure? Because I think you had a meeting with him on 9th January, which Mr. O'Brien recorded? 10:29

A. That's right, yes.

42 Q. -- or was recorded?

A. Yes, that's right.

43 Q. You weren't aware that it was being recorded?

A. No.

44 Q. The Panel's note of the transcript is at AOB-56018 to AOB-56032. There doesn't appear to be a mention of numbers or an indication of that sort of figure. But just to give that context, do you recall? 10:29

A. What I recall is Mr. O'Brien gave me outcome sheets of all the patients that had -- obviously, there was the issue from his secretary advising that there were 60 plus clinics not dictated on. Mr. O'Brien gave me all the outcome sheets and it totalled up to 668. But, to 10:30 be fair, and an amendment to that would be that whenever he discussed it with me, albeit there was 60 plus clinics, some of them did have a dictation. But we still had to go through all 668 patients to double-check that they did definitely have a dictation 10:30 and an outcome.

45 Q. So, the majority of those had already had letters dictated?

A. I can't recall the figure. But whenever I went back to go into it, the 668 matched up with the 60 plus clinics 10:30 that we were told there was no dictation on. But then what Mr. O'Brien had said was, when he was discussing with me, he had outcome sheets and he said, no, we'd have a line through a patient's name to say "I have sorted that patient out because they've been brought 10:31 back for a procedure." But they still all had to be checked. So I suppose I'm splitting hairs here, but there were 668 patients that we had to check was there a dictation on. I can't recall how many of them

didn't.

46 Q. So, just to break that down slightly, the number that you've put in that paragraph was a number you subsequently gathered information about. It wasn't a number given to you by Mr. O'Brien? 10:31

A. No. No.

47 Q. And Mr. O'Brien would say that out of those 668, all but 189 patients had had correspondence dictated. Does that ring any bells with you?

A. The number doesn't, no. And, I suppose, the only thing I will say is I know in Mr. O'Brien's evidence he did mention our meeting and the 668 patients, from what I can recall, so that number is still -- 10:31

48 Q. I don't think the 668 -- it's the what was done at that point -- 10:32

A. Yes. Yes.

49 Q. Again, it's just obviously Mr. O'Brien has a different narrative around what was actually dictated?

A. Yes, and I appreciate that.

50 Q. I just wanted to see if that rang any bells with you? 10:32

A. No, it doesn't. There was a lot of numbers and figures around that time with regards to -- we had the un-triaged letters and we had the undictated and then we had the private patients. So we were running at a fast pace, so... 10:32

51 Q. Now, I just want to move on to the key worker issue for oncology. You had said in your Section 21 - we don't need to go to it - the first one at WIT-26267 that you had only been made aware of the allegation that

Mr. O'Brien didn't allow access to key workers for oncology patients in November 2020. I think you've heard the evidence of the nurses on this issue?

A. I have, yes.

52 Q. And they dispute that they were not permitted or denied access to -- 10:33

A. That's correct.

53 Q. -- Mr. O'Brien's clinics. And you were interviewed by Dr. Hughes for the SAIs and, in the course of that interview, you had indicated to Dr. Hughes that you'd worked in the Southern Trust for 11 years and, during that time, Mr. O'Brien never recognised the role of the Clinical Nurse Specialist and, for the Panel note, that interview is at WIT-84355 and 84356, and that was an interview with Mr. Hughes and Patricia Kingsnorth on 18th January 2021. Now, given the variance in that evidence, November 2020 and then leading on, the Inquiry sent you a subsequent Section 21 to ask for clarity and what I want to do know is just highlight to the Panel your explanation for some of the issues. Just, also, by way of context, the notes that were kept in relation to some of the SAI interviews and meetings, I don't think there was any expectation from anyone that they would be verbatim, but they were deemed to reflect accurately the contribution from those who were interviewed, and that's been questioned by some of those who gave information to Dr. Hughes and Patricia Kingsnorth and some of the other note-takers, whether those notes accurately reflect their contribution. 10:33 10:33 10:34 10:34

Now, it's a matter for the Panel what turns on this at all -- it's about process -- but I just want to put on record your version of what happened for you. So, we asked you questions around your interview with Dr. Hughes and I want to read from WIT-94940, paragraph 1.2, and I'm going to read from 1.2 to 1.5, first of all: 10:35

"It was my impression that Mr. O'Brien didn't recognise the potential value of having a nurse with him at clinics generally. I do not recall all the factors which led me to forming this impression of Mr. O'Brien, but I believe it was influenced by things like the following: 10:35

When the two Clinical Nurse Specialists attended meetings and made suggestions about the services - examples could have been changing appointment slots for the clinics so that there were not too many people in the room; equipment suggestions; suggestions regarding training for the other nurses in the unit and so on - Mr. O'Brien, whilst he would have listened, never got involved in these conversations or showed any interest in taking forward their suggestions and I, therefore, personally felt that he didn't value the role that they held. 10:35 10:36

This was not an impression formed, I believe, as a result of a single meeting, but one that developed over

time between approximately 2009 and 2015."

Under heading 1 that Mr. O'Brien never involved them in his Oncology Clinics, you say at 1.3:

10:36

"The CNS team expanded in about 2014 with two temporary Band 6s being appointed, Janice Holloway and Dolores Campbell - see my previous Section 21 Statement No. 24/2022 at WIT-26197 to 26198. Kate and Jenny had plans and suggestions for these two new appointments, 10:36 including having additional staff to support all clinics. It was during conversations with both CNS, Kate and Jenny, that they would have mentioned that this was for all of the consultants, although not as much for Mr. O'Brien as he rarely had a nurse in 10:37 attendance at his clinics.

1.4. I should emphasise in this regard that I do not ever recall during any of my conversations with nurses in the unit on this broad issue any specific mention of 10:37 Oncology Clinics or their the cancer key worker role when they were mentioning Mr. O'Brien's non-use of nurses. It was usually couched in much more general terms. I also note in this regard that the handwritten note of the 18th January 2021 meeting records me saying 10:37 on the first page, 11th line of text down from the top of the page, that Mr. O'Brien never involved them in clinics, with no specific reference to oncology.

In this regard, the handwritten note better reflects what I believe I said at the 18th January 2021 meeting, during which I would have referenced my knowledge regarding Mr. O'Brien's approach generally, rather than in respect to any specific cancer or key worker role. 10:38

The handwritten 18th January 2021 meeting notes were provided to me by the Trust on or about 11th May 2023, having recently been located, and I confirm that they are now attached to this witness statement." 10:38

So just stopping there for a second, you point out that the handwritten note didn't have the word "oncology" but the typed did, that's your point on that. 10:38

Paragraph 1.5:

"Of course I now reflect and accept that had I thought about the matter in more detail, I would likely have realised that this approach by Mr. O'Brien might have 10:38 included the nurse's cancer key worker roles. However, I believe I was, perhaps, less conscious or less sighted as to this aspect of their work for a number of reasons, including, I believe, that I did not attend MDT meetings and because of cancer, as opposed to acute 10:38 services role, in respect to these."

You were then asked at (b) to:

"Identify to whom you are referring at the meeting when you say that some of the Clinic Nurse Specialists would have asked to be at clinics but Mr. O'Brien never included them, dealing how, when and in what circumstances you came to be told or made aware of this information?"

And you answer at 1.6:

"The nurses that I am referring to are Kate O'Neill, Jenny McMahon and, laterally, Leanne McCourt and Jason Young. I can confirm that I have no evidence of dates and times, but I believe this would have been mentioned to me occasionally during casual conversations about various aspects about the running of the unit if I had, for example, just called in to see how things were with them and the staff."

So I think the thrust of what you're saying at that point is no one ever made a complaint or an allegation specifically; it was something that you picked up from comments that were made, would that be fair?

A. That's fair, yes.

54 Q. The extract then we gave you from the meeting with Dr. Hughes was, as follows, at paragraph 2:

"Dr. Hughes asked if anyone expressed concerns about excluding nurses from the clinics. Martina advised that two of the Clinical Nurse Specialists did report

that they did regularly challenge Mr. O'Brien and asked him if he needed them to be in clinic to assist with the follow-up of the patients, but it got to the stage where staff were getting worn down by no action and they gave up asking, as they knew that he wouldn't change." 10:40

And we've asked you to name the two nurses and you say at paragraph 2.1:

"The two nurses were Kate O'Neill and Leanne McCourt." 10:40

And at paragraph 2.2, you say:

"I should clarify in this regard that I do not recall the nurses saying they regularly challenged Mr. O'Brien. I note in this regard that this word does not appear in the relevant part of the handwritten notes - first page, 9th and 10th lines of text up from the bottom of the page." 10:40

So, again, that's a difference between the typed version -- the word "regularly" appears to be added in the typed version, it's not in the handwritten.

Then you're asked at (b): 10:41

"Please provide the details of how and when they reported the details you provide in this paragraph. If

not to you, to whom did they report and how and when did you find this information out?

I can confirm that this was never formally reported to me. It was occasionally but not regularly mentioned to me conversationally and in passing and in the general terms referenced to my answer at paragraph 1 above. As Dr. Hughes has recorded as observing in the notes, we all became habitualised to Mr. O'Brien's practice and while still periodically discussed the issues with each other, I can confirm that to my knowledge there was nothing formally raised in writing about the matter. I am, therefore, unable to provide dates or further details of these conversations. 10:41 10:41

(d) What, if anything, did you or anyone else do on receipt of this information?" 10:42

And you say at 2.4: 10:42

"I believe that I mentioned this matter during general conversations with Heather Trouton, Ronan Carroll and Mr. Mackle, as well as the Clinical Directors, Mr. Colin Weir and/or Mr. Ted McNaboe, but did not do anything else with this information." 10:42

If I can just ask you there did anyone that you mentioned it to do anything about that information that you know of?

A. Sorry?

55 Q. Did anyone that you mentioned this matter to that you've listed in that paragraph do anything, that you know of?

A. No, not that I'm aware of. 10:42

56 Q. If I could go to two pages on, paragraph 4 -- for the Panel's note, it's at WIT-94944. And we've given you an extract at paragraph 4 where Dr. Hughes reiterated -- this is a note from the meeting: 10:42

"At no stage were specialist nurses allowed to share patient contact with Mr. O'Brien? Martina confirmed that, yes, this was correct. She also confirmed that all of the other consultants see the benefits of using a CNS and that they include him in all of their clinics." 10:43

We then ask you a series of questions around that and you start by saying at 4.1: 10:43

"I can confirm that I was aware from general discussions with the CNS, Kate and Leanne, that they would have occasionally mentioned in passing that most of the consultants used a nurse at their clinics and this could have been any of the other Band 5s in the unit, Kate McCreesh, Dolores Campbell or Janice Holloway, if Kate and Leanne were not available, but that this was not the case for Mr. O'Brien's clinics. To be clear, I did not base this statement upon a 10:43

review or audit of files of patients of Mr. O'Brien.

4.2. I should clarify in this regard that I believe that when Dr. Hughes asked 'At no stage were specialist nurses allowed to share patient care with Mr. O'Brien?' and I replied, 'Yes' - second and third full paragraphs on WIT-84356 - my response was in relation to what had come to light during the previous months from approximately Autumn 2020 when issues relating to MDT recommendations not being actioned were coming to light. I believe that this is supported by the handwritten note of the meeting, which on its second page in the 6th line of text down from top of the page, includes a reference to MDT recommendations not being followed through (agreed MDT not followed through), followed shortly thereafter, 8th and 9th lines down, by Dr. Hughes' question: At no stage were specialist nurses allowed to share care with them? I interpret the reference to 'them' at the end of this question to be a reference to the relevant MDT patients whose recommendations had not been actioned or followed through. In the typed version of the note, 'them' appears erroneously to have been replaced by 'Mr. O'Brien'. My answer was, I believe, in respect of the relevant MDT patients." 10:44 10:44 10:44 10:44 10:45

Now, I think what you mean by that, if I could summarise it, and if you agree, is that when you were asked that question, you thought it was confined to the

nine SAIs or the outcome that had been --

A. Yes.

57 Q. -- the analysis that was being undertaken by Dr. Hughes at that point?

A. That's my recollection, yes. 10:45

58 Q. Paragraph 6 at WIT-94948:

"Did you tell Mr. Hughes at your meeting with him and Patricia Kingsnorth on 18th January 2021 that you did not know anything about the CNS key worker issue and 10:45 were only made aware of it as a result of the SAI investigations in November 2020? If not, why not?"

And you say:

10:46

"I do not recall being asked a specific question to this effect. Rather, I was asked did I know if Mr. O'Brien included nurses in his clinics and my answers were related to what I knew generally as referenced at Question 1 above. Looking back now, I 10:46 regret that the notes of the meeting and quite possibly what I stated verbally at all were not as clear in this regard as they could have been."

Then at paragraph 7.1 -- or 7, you're asked: 10:46

"If you did tell Dr. Hughes, why do you think it is not included in the meeting notes? "

You say:

"I refer to my previous answer. I also expect, in fairness to all concerned, that the notes were intended as minutes of the meeting and not as verbatim transcript." 10:46

And then, lastly, at paragraph 8, you're asked:

"Do you consider the notes of that meeting with Dr. Hughes and Patricia Kingsnorth to be an accurate account of that meeting?" 10:46

And you say:

"I refer to my previous answers where I have clarified my understanding or recollection of what was said at the meeting (see, in particular, paragraphs 1.4, 2.2 and 4.2 above). I also refer to my response to Question 7." 10:47

At paragraph 8.2, you say:

"Beyond the issues mentioned in the preceding paragraph, I have so far also identified the following issues with the notes: 10:47

8.2.1 The third full paragraph of the second page of the typed meeting notes WIT-84356 records that I

confirm that all of the other consultants see the benefit of using a CNS and that they include them in all of their clinics. I believe that I would have made the first statement regarding all the other consultants seeing the value or benefit of CNS. I believe I may also have indicated that I understood that the other consultants made wide use of them. However, I do not believe I would have said they used them in all of their clinics, as I believe I would have been aware that this was not always possible due to resourcing issues. In this regard, I see that the relevant portion of the handwritten note, 11th line of text, second page, records 'MC all consultants had benefit of CNS.' It does not record me saying anything about their use of them in all clinics. 10:47 10:48 10:48

8.2.2 The fifth full paragraph on the second page of the typed meeting notes with 84356 records 'Martina advised that during MDT on occasions there were issues raised about Mr. O'Brien and at times these were escalated to the AD or AMD.' I think that the reference to MDT here may be mistaken as I would not have attended it. I note in this regard that the relevant exchange between myself and Dr. Hughes appears to have been captured between the 12th and 17th Hynes of text on the second page of the notes. It is clear from the 15th line that I was referring to our team meeting and not to MDT." 10:48 10:48

That's just -- I want to make sure that I have brought to the Panel's attention to anything else relevant in this before we move on.

At paragraph 5.2.1 at WIT-94947, you have sought to amend the notes when you're asked about the accuracy of them, given what you've said in your statement and then the copy of the notes from Dr. Hughes. 10:49

"I believe upon reflection and upon considering both the typed and handwritten notes of 18th January that both paragraphs are inaccurate and require revision, as follows ..." 10:49

-- so I'm going to read it out. You will see what's been underlined, which is what you've added in -- 10:49

A. Yeah.

59 Q.

"I became specifically and acutely aware that Mr. O'Brien did not permit the Clinical Nurse Specialist to provide support as key worker to his oncology patients. I only became specifically and acutely aware of this from approximately Autumn 2020 from the investigations into the most recent SAI patients. I believe that this cancer key worker issue was never raised with me as a specific concern and as only oncology multidisciplinary meetings are part of the Head of Oncology Services remit, I was never involved in these. However, as mentioned in my 10:50 10:50

response to Section 21 Notice No. 7 of 2023 at Question 1 thereof, the broad issue of Mr. O'Brien's non-use of nurses and Clinical Nurse Specialists was mentioned to me a number of times by nurses in the years prior to 2020 and I ought, upon reflection, to have appreciated the potential cancer key worker issue as a result."

So that's the clarity provided by that Section 21. Then if we could go -- you put in another addendum witness statement which starts at WIT-98544. I just want to tie the points all up together so the Panel has a picture. 10:50 10:51

A. That's fine, yes.

60 Q. This is dated 23rd June 2023. And you, in reference to that notice, you make some corrections at WIT-98546. And the background to this is that -- did you listen to Patricia Kingsnorth's evidence? 10:51

A. I did, yes.

61 Q. And the evidence indicated that she had both provided and spoke about e-mails between you and her and the note of that meeting, actually, had been sent to you. You had seemed to correct the typed version to reflect your involvement in the meeting, and now it's been brought to your attention you wanted to set the record straight for your evidence to the Inquiry and because we've read out what was apparently wrong with the typed notes, I just want to read out your explanation -- 10:51 10:52

A. That's fine, yes.

62 Q. -- as to why you said that.

A. Yes, please.

63 Q. So I just want to read -- the heading of this section is "Section 21 Notice No. 7 of 2023 dated 5th May 2023."

10:52

Paragraph 2:

"I can confirm that I have now seen the e-mail exchange and attachments exhibited to Patricia Kingsnorth's addendum witness statement of 2nd June 2023, WIT-96809, WIT-96827. In light of this, I would offer the following additional evidence:

10:52

I had not recalled this e-mail exchange when preparing at relatively short notice my statement of 12th May 2023 in response to Section 21 Notice No. 7 of 2023. I have no reason to doubt that this exchange occurred and I accept that I must have added to the draft typed minute of 18th January 2021 meeting prepared by Mrs. Kingsnorth and sent to me on 24th January. I believe that I made the additions to the typed minute without access to Mrs. Kingsnorth's handwritten meeting notes, which I only saw for the first time after 5th May 2023 when preparing my 12th May 2023 statement and without any notes of my own from 18th January 2021 meeting. I believe that all of these events, i.e. the 18th January 2021 meeting and the 24th to 25th January 2021 e-mail exchange, occurred at a time when I was particularly busy with my day-to-day work, it being the

10:53

10:53

10:53

middle of the winter of 2021/2022, Covid-19 lockdown, and I having been asked to cover the patient flow team in order to release the nurses to work on the wards. This regularly involved 13-hour shifts, with the result that meetings such as that of 18th January 2021 and attention to e-mails such as that of 24th January 2021 occurred during breaks. 10:54

Where there is any conflict or discrepancy between Patricia's handwritten note of 18th January 2021 meeting and the final typed note of the meeting of 25th January 2021, I would place more reliance on the handwritten note." 10:54

A. Yeah. 10:54

64 Q. Anything else you want to say about that or does that cover everything?

A. No, that covers everything.

65 Q. Thank you. While we have this witness statement in front of us, the issue also came up with Fiona Reddick around the recruitment of a cancer nurse specialist, in particular, rather than CNS and the protracted period of time that had been taken to recruit. Now, Ms. Reddick gives some evidence around the securement of funds from Macmillan about the posts. You have also indicated prior the paper I think you sent to Mrs. Burns advocating for nurses to fill those specialist posts. So, there is a little bit of conflict about the history of it but I think that the 10:54 10:55

point for the Panel, perhaps, is that the need was recognised in 2009 and 2010 for five --

A. That's correct, yes.

66 Q. -- CNS, at least. There was an expectation under the Cancer Regional Guidelines for nurses specific to oncology, but that those figures weren't met until 2020? 10:55

A. That's correct, yes.

67 Q. And what you've helpfully done, and this is information that Mrs. Reddick won't have seen because it's just been provided by you last week, is set out a timeline for the Panel as an exhibit to the statement, the timeline and supporting documents for recruitment of Urology Clinical Nurse Specialists. The timeline starts at WIT-98549 and it goes through to WIT-98552. 10:55 10:56

Now, that's your version of events and it hasn't been put to anyone else, but the timeline sets out the attempts that were made and the difference in, perhaps, approach from the Cancer Services and from Urology Service in trying to secure nurses? 10:56

A. It does, yes, it does. And I have tried to include all of the supporting documentation to show e-mails and papers and the Macmillan applications to show the timeline.

68 Q. I don't want to go through the timeline in any detail -- the Panel have it for their consideration and, if anything arises from it that they feel need clarified, we can approach the relevant individuals. 10:57

One thing that does seem to come out, and it also was apparent from Fiona Reddick's evidence, was that the oncology nurse provision sat under Urology and not under Cancer Services?

A. That's correct, yes. 10:57

69 Q. Now, there is some evidence in that table about what could be viewed as potential conflict of opinion or difference of opinion about job descriptions and the Panel will have heard evidence around Jenny McCourt and the appointments and whether she should -- 10:57

A. That's right.

70 Q. -- have been appointed as a CNS and the job was changed and it seems from some of this narrative that Mrs. Reddick did get involved in trying to assist in the job description and, because of a lack of 10:57 consensus, there was a -- not a downgrading, I don't mean to put it like that, but there was a re-configuration of the posts that Jenny McCourt and Jason Young eventually took up?

A. Yes, that's correct. And, I suppose, the thing about 10:58 it was, it was -- and I think it is a big learning for us in the Trust is the Oncology and the Urology sat under two separate ADs and it's showing with regard to the conflict on this. But the job description had been actually drawn up with myself and the Head of Service 10:58 that had responsibility for nursing, along with the lead nurse for Urology. And we had advertised it and it was really at the last minute. What happened was the lead nurse, Mrs. Sharp, had asked Mrs. Reddick for

some sample questions. So she asked for the job description, which was -- the interviews were 17th January, I think, and she asked for the job description a few days before and whenever she read the job description, there wasn't a specialist course or working towards a specialist course in the desire or in the essential criteria. So, herself -- I wasn't involved in the discussions, it was two nursing colleagues had the discussion and it was decided to -- and it's not downgraded, but it was decided to pull the specialist part of it. But can I say that when the two people were appointed, they did continue to support the specialist nurse. They really did, albeit the title of the job changed. They did work with -- Jason would have worked with Jenny on the benign and Leanne with Kate on the cancer. 10:59 10:59 10:59

71 Q. So I think Mrs. Reddick had indicated that there sometimes could be a tension between the expectation from the Cancer Services and what services they wanted to ensure were provided and perhaps some other services, such as Urology, where the Clinical Nurse Specialist, as you say, can be allocated to benign -- it's not just specifically oncology? 10:59

A. That's correct, yes.

72 Q. And sometimes that tension -- and that's, perhaps, an example of that where two competing demands or expectations result in everyone getting a little bit of something, but nobody really getting what they need? 11:00

A. Exactly, that's exactly it, yes. And I think that's

probably where the key worker issue comes in because that's very much led by Oncology and can -- you know, the Clinical and Cancer Services -- and albeit I had responsibility operationally wise, which really was the running of the unit and making sure they had the right equipment and they had their decontamination in place and they had consent etc., and they had the right resources to support the CNSs.

73 Q. I think we've covered all of that in the key worker issue. There's nothing else that you want to say on that? 11:01

A. No.

74 Q. I can move on --

A. Yes.

75 Q. -- then to the issue about not following up on results? 11:01

A. Okay, yes.

76 Q. We don't need to go to it but your statement at WIT-26268 states that you only learned of this in June 2020 during admin -- I think it was a lookback?

A. It was, yes. It came out as a result of the -- for the emergencies and the elective patients at theatres. 11:01

77 Q. There are some e-mails from 2011, I think, where the issue is actually raised with you, but I'll maybe go to the first one, TRU-259873. I appreciate these are a long time ago in 2011 -- 11:02

A. Yes.

78 Q. But I just want to --

A. No, that's fine.

79 Q. The Panel will be interested to see the knowledge at

that time. [Short pause]. So I think the Panel have seen this particular e-mail -- it's from Mr. O'Brien -- and then, if we go back up, that was sent to you about the -- do you need reminding of that --

A. No, I do know that e-mail. 11:02

80 Q. "When were we supposed to read them..." --

A. Yes, yes.

81 Q. And you'll see that that was sent to you, but also Eamon Mackle is in that as well and Heather Trouton. Eamon Mackle writes to Gillian Rankin copying you in 11:02 where he specifically said:

"Gillian,
I have been forwarded this e-mail by Martina and I think it raises a governance issue as to what happened 11:02 to the results of tests performed on Aidan's patients. It appears that at present he does not review the results until the patient appears back in OPD."

Just go back up -- it's 26th August. So that is an 11:03 e-mail trail from 2011. Your knowledge said 2020. Does that indicate that this issue either fell off your radar or you didn't hear anything more about it or can you give us some background as to what might have happened around this time? 11:03

A. I know now why this has happened and it's as a result of the Inquiry, it's as a result of the retained swab SAI. And I think that is probably one of the feelings I feel, on reflection, is, you know, this happened, but

I've never heard tell of the retained swab until 2022/2023. I think, with regards to this, it was more to do with the fact of Mr. O'Brien was bringing the patients back to review them with results. He was still reviewing the results, as opposed to not looking at them. He was still looking at them and saying "I want to see the patient back." 11:04

What happened in 2020 was that it would have appeared that he hadn't done anything at all with the result, and, I suppose, that's why I had said that in my Section 21. It was more to do with -- this was -- he wasn't saying he wasn't reviewing them, but he was saying he wouldn't do anything with them until the patient was back in front of them, whereas the other consultants, even back in 2011, their view would be if a result was normal, they'd just write to the patient, whereas Mr. O'Brien wanted to bring the patient back and tell them there was a normal review. And if you have a review backlog, there would have been easier ways to address it. 11:04 11:04

So, I suppose, the difference with that one and with the result in the admin exercise that I did in 2020 was I never thought he wasn't reviewing them, whereas it felt that he didn't review the results electronically. 11:05

82 Q. But you can see by this e-mail --

A. Absolutely.

83 Q. -- that it seems to have been the same issue?

A. It seems to be. And, again, just because of the Inquiry, there was other issues with not reviewing results, but I was never aware of that.

84 Q. Would that have fallen under your remit to deal with something like this, or would you have expected that to be something the medics dealt with? 11:05

A. I would have expected the medics to deal with it.

85 Q. There is another e-mail, just for the Panel's -- I'll take you to it but just for note in sequencing, it's at TRU-276807. It's an e-mail of 25th July, Heather Trouton -- 25th July to Trudy Reid, Louise Devlin and to you. It copies in Mr. Mackle, Robin Brown and Samantha Sloan: 11:05

"Subject: Results. 11:06

Dear all,

I know I have addressed this verbally with you a few months ago but, just to be sure, can you please check with your consultants that investigations which are requested, that the results are reviewed as soon as a result is available and that one does not wait until the review appointment to look at them." 11:06

And that's from Heather Trouton. And if we go up to TRU-276805, just above that, we can see that you send this, you forward this to the consultants. The other way. There's an e-mail -- just go down, please. There's an e-mail there and I might need to come back 11:06

with the further reference, but there is a reference of you, Martina -- there it is -- to -- and you'll see some names blanked out, but Mr. Akhtar, Mr. Young, Mr. O'Brien, on 27th July 2011 and you say:

"Dear all,
Please see below for your information and action."

So, the e-mail below is an indication from Mrs. Trouton as to what the expectation was? 11:07

A. Yes. What Mrs. Trouton has done is sent the e-mail to her Heads of Service to ask us to remind the consultants that they needed to review the results.

86 Q. And you actually asked Mr. Mackle to help you with the reply to that e-mail to Mr. O'Brien? 11:07

A. Yes, I did. I did, yes.

87 Q. And, for the Panel's note, that is at AOB-00280. Just a different reference.

88 Q. In relation to the Bicalutamide issue, that wasn't something that you knew about until October 2020 and 11:08 that was as a matter of issues arising. How did you come to know about that?

A. My recollection of that is that it was on Mr. Haynes' review of one of Mr. O'Brien's patient that that issue arose and there was discussions around it. But up 11:08 until that I have never, albeit I would be quite au fait with a lot of sort of conditions and medications for urology, I'd have never actually heard of that one. And Mr. Haynes then did explain all of the side effects

etc. etc, you know, to me. It just a part of that. And then there was a number of other patients that was on it that was raised whenever the oncology patients were sent out for a management plan to Mr. Keane in the independent sector.

89 Q. There has been some evidence given around the difficulty people might have with forming a proper view of what was going on by the fact that information wasn't shared, and that's obviously a clinical, a specific clinical issue. Do you think there's merit in people at senior management knowing all of the issues that are being looked at or analysed or potentially causing difficulty so that people know the extent of problems and can take more informed decisions? 11:09

A. I do, definitely. I think one of the -- on reflection, one of the biggest problems with all of this, it's a bit like what Kate said earlier -- some people know some things that others don't. And it should nearly have went into -- because when we sat down as an oversight committee and all the different issues then were laid out in a row, it was a big issue, whereas, you know, I'm not underplaying any of them but, you know, triage was looked at on its own, charts at home was looked at on its owns, the Bicalutamide was looked at on its own, whereas I think, you know, there should have been somebody -- viewed probably somebody clinical because they actually know the descriptions and the seriousness of the likes of some of these issues. 11:09 11:09 11:10

And then the other thing is we have our SAIs, which were bringing out all of issues over the years, but they weren't joined up either. And so I think our Senior Management Team was blind because they were only hearing bits, rather than the whole picture. 11:10

And, as you said there, I would never have heard of Bicalutamide until this happened. So, that probably came from MDT. So we needed somebody clinical to be bringing that back to us. 11:10

90 Q. There was also an issue about the waiting lists, patients being added to that, or not, in the case of Mr. O'Brien. Were you involved in that at all in collating information around that?

A. The only -- no. Mr. Haynes had sent the e-mail about the ten waiting list forms and my involvement then was I was asked would I do the admin exercise because they were concerned that there may have been other patients not added to the waiting list. Now, I have heard Mr. Haynes' evidence and it was to do, perhaps, with the filtering. But, ultimately, there was a filter on in the spreadsheet that he used. But, ultimately I suppose, Mr. O'Brien would have been known -- for example, the day that he met me on 9th January, he handed me four letters that was on no system anywhere. So my only involvement in that was then follow-through with regards to the admin exercise. 11:11 11:11

91 Q. I just want to ask you, just slightly out of sync, but just to get your explanation on it so that we know what

it means just in relation to Patient 102 -- and I know you have a cypher list in front of you. And if we go to TRU-277904. Now, you weren't involved in the SAIs. Were you involved in any screening or anything to do with that? 11:12

A. No, the screening was the Assistant Director with the Associate Medical Director and/or the Clinical Director, and somebody from Governance.

92 Q. And we'll see -- just go on, please -- we'll see an e-mail from Heather Trouton 22nd October 2015 to you and Eamon Mackle and it's in relation to a Datix incident report, number W45991, where she's asking does this need screened. And then if we go to -- sorry, we just see your answer at the bottom after that is -- on 21st October 2015, you reply, saying: 11:12 11:13

"I will check tomorrow. I don't think so but I will let you know."

And if we go to WIT-54879 -- 11:13

A. I'm just thinking is there a part of that missing because I thought that was to do with Mr. Mackle had come back to me and said "Is this a notes issue?" because I wouldn't --

93 Q. I thought that was a different chain, but do you want to go back to that? 11:13

A. No, because I thought that was -- because I would never have said "I don't think it needs screened." And I think Heather sent that e-mail and she asked "Does this

need screened?". I think Mr. Mackle came back to me and said "Is that a notes issue?" and I said "I don't think so but I'll check tomorrow", as opposed to it being --

94 Q. -- an answer to Heather? 11:14

A. An answer to Heather. Sorry, yeah.

95 Q. Well, I suppose the question is really on this --

A. Yes, sorry, yeah.

96 Q. It was just -- no, that's fine.

A. No, it's sounds as if I was saying I didn't think it was to be screened, but that would definitely have not been my call! 11:14

97 Q. I've read out the reply to the wrong e-mail! Well, thanks for pointing that out. But if we look at this particular thing, the issue just -- it's just really for process, understanding process? 11:14

A. Absolutely, yes.

98 Q. And you'll see the second box down, 11/12/2015, and the sender is David Cardwell. Who is David Cardwell?

A. David is one of the Band 7s that works in Governance and would have a responsibility for Datixes. 11:14

99 Q. And the connection with the previous e-mails is simply that this is the same complaint issue?

A. Yes, yeah.

100 Q. So the body of the message says -- this is a feedback message from David Cardwell. Incident form reference is W45991, and the feedback is : 11:14

"Hi Martina,

Helen Forde has asked me to send this to you with the following message, W45991. I think it should go to Martina Corrigan as it said there was no correspondence for the appointment. So it wasn't that the secretary didn't type it. I think it was that it wasn't dictated, so that would need to go to Head of Service for Urology to discuss with consultant."

And then it says:

11:15

"Regards, David Cardwell."

So, you will know from listening to the evidence that the Panel are interested to understand the way the systems work when they are triggered. 11:15

A. Yes.

101 Q. This is a Datix IR1 was filled in. And it has gone through the system to David Cardwell. It seems to have had an initial filtering so that a view is taken on what the issue is, the factual accuracy of it, it seems? 11:15

A. Yes, mm-hmm.

102 Q. -- and also what should be the next steps. So, this is the potential of seeing something closed, ultimately --

A. Yes. 11:16

103 Q. -- after arising from an IR1. So, Helen Forde has indicated what she thinks should happen next?

A. Yes.

104 Q. And it's for you to do that?

A. That's correct, yes.

105 Q. So can you pick up the story from there? What happens then? Or do you recall this at all?

A. I recall it now that I see it again, but I do know I never discussed it with Mr. O'Brien and the reason I didn't discuss it with Mr. O'Brien was this was in or around the time of the issue that they were starting to have conversations with Dr. Wright and I had said to Heather -- to Mr. Mackle and Mrs. Trouton that was there a discussion needed to be had, and they said they were going to speak with Dr. Wright first. That's my recollection of it. But I definitely, in my all conversations with Mr. O'Brien, I never actually discussed with him dictation or non-dictation up until this point. 11:16 11:16 11:17

106 Q. Now, the dictation issue had arisen in 2014, raised by Mr. Haynes and Glackin and O'Donoghue.

A. Yes.

107 Q. So this was a year later. The dictation issue would have been -- would you have known about it at that point, 2015, that it had been an issue since the previous year? 11:17

A. Yes, I did, because it was me who had been raising it with Mrs. Trouton and Mr. Mackle. What this is probably -- what I assume what has happened here is this has brought it all to a head because we now have had an IR1 in, as opposed to actually the consultants verbally saying it to me about it. We didn't have any sort of concrete evidence, if you like, but this, 11:17

because it was raised through this system, then it was being actioned on.

108 Q. So, this -- so, if I'm right in what you're saying, it is issues had been raised in 2014, but this was the first time the Governance systems had been triggered through Datix IR1 on the dictation issue? 11:18

A. Yes.

109 Q. And the result of that was that you were to speak to Mr. O'Brien, but you didn't?

A. No, I didn't, no. 11:18

110 Q. And does that potential remedy that's suggested in that, does that result in IR1 or that Datix being closed?

A. I think it would have been, yes. I think that's the problem. Like, there was no conversation with me that 11:18 I can recall from Mrs. Forde. It's just, it obviously had came under there and I think it was Mrs. Burns described that when you send one, it triggers off e-mails. So, because of it being -- it looked as if it was health records or a secretary issue. She has said 11:18 it hasn't, so it's been passed back to David to pass on to me, and it's her suggestion that I needed to go to speak with a consultant. And then once David had passed it to me, he's assumed to close it, which it wasn't closed, I just see here, to 22/03/16. But... 11:19 Yeah, sorry, I was just reading the top paragraph there. So, they've just assumed it was closed off but nobody would have followed up to say to me "What was the result of your conversation?". So, it was closed

off nearly too early.

111 Q. So would Mr. Cardwell's role in this be really as a conduit between the --

A. Yes.

112 Q. -- individuals who could provide him the information. He populates, but he's not a decision-maker, is he? 11:19

A. No, no, he's not a decision-maker, no. And I just think, you know, it's a bit of learning and I don't know if it happens now because obviously there's been other Heads of Services and Governance, so, whether -- but one of the learning would be is really it should have been left for me to respond back to say, you know, "I'll not be doing that", or, you know, "I've spoken to..." -- 11:19

113 Q. Spoken to, yeah. 11:20

A. Or, you know, to feed that back, rather than just close it off.

114 Q. So the close of the loop is the feedback of what should be done, rather than what's done?

A. It is. Because the other thing with Datixes is, as somebody who would have had Datix in my system, you always keep them under review until you have them sorted, but this one's been closed so that's gone, if you like. It's in the closed, as opposed to in the review section. 11:20 11:20

115 Q. I just want to finish up one more section before we take a short break, if that's okay with you and the Panel?

A. Yes.

116 Q. It's just your view on Mr. O'Brien's return to work in 2017?
A. Okay, yes.
117 Q. We don't need to go to it, but for the Panel's note it's at WIT-26315. Now, you say that you don't think Mr. O'Brien should have been allowed back to work so soon and you refer to that as being a mistake. One of the reasons why is you say that there were issues that weren't considered and you didn't think his Return to Work Plan was a proper plan to manage him. 11:20 11:21
118 Q. Now, one of the examples you give is that the monitoring arrangements that were put in place for his return focused on the gaps in his outpatient dictation and outcomes, but they completely ignored his administrative responsibilities towards patients who came in as emergencies or as a day case. Now, that knowledge of what you say is a lacuna in the area that Mr. O'Brien was to be monitored in, was that something that came to you later on, or were you aware at the time that there was a gap in relation to those particular patients? 11:21 11:21
A. It came to me later on, because obviously when I did the admin exercise, I discovered that these were two areas. But at the time of -- it's a bit like, and I know we'll probably go to it, the admin review, it should have been wider. It was too confined. The view was -- in my view at the time, I remember saying if there's one area he's not performing in admin wise, I wonder are there other areas? But he came back just 11:22

with them four areas, as opposed to wider, and I think there should have been a step back and think exactly that -- you know, I wasn't the only one. I wasn't involved in the Return to Work, apart from it was presented to me to do the monitoring on. So I'd no feedback in it.

So, that was the reason it came later and in my sort of view was that I was -- sort of what my thoughts were, which I didn't openly discuss, was, was correct. 11:22

119 Q. So, in June 2020, when you were involved in the investigations, you realised that there was two -- the two cohorts of patients who had been left out of the potential oversight were the emergencies and the day case? 11:23

A. That's right, yes. Because whenever I did the -- it was particularly the elective exercise, I had found a proportion of patients had no dictation done on them. So, the patient had come in, had gone home and the GP didn't know, for example, that they had had their procedure or they had to go on a particular medication or they had to return for further follow-up. 11:23

120 Q. And when you look at the potential for that -- well, not the potential, the actual missing of those cohorts and the potential for that to have been captured by the Return to Work Plan, who do you say should have noticed that or should have realised that those outliers were potentially vulnerable? 11:23

A. I think that's possible, and I don't remember if I said

this the last time, I think that's possibly one of the downfalls of an oversight, a senior oversight, I think that they would have needed to bring in people operationally that knows how the systems all work and asked their advice or opinion on it. I think back to it and I understand 100% the anxiety that Mr. O'Brien would have went through being excluded, but there should have been a step back, instead of rushing. I think that's a big fault and I think it's nearly a problem in Acute -- you're always rushing, you're always running, rather than taking a step back and actually saying, you know, "I wonder should we speak to Martina? Would she know better?", or, you know, even the likes of Mrs. Carroll, Anita, because she's admin, you know, overview of all the functional services and secretaries and potentially could have fed in of where there was areas that was gaps in. 11:24 11:24 11:24

121 Q. So it might have benefitted from more collective --

A. Absolutely, yes.

122 Q. -- view on the appropriateness of the Return to Work Plan to see all the potential weakness areas and make sure that there was sufficient monitoring of that? 11:25

A. That's right, yes.

MS. McMAHON BL: Chair, I wonder if that was a convenient time? 11:25

CHAIR: Is ten minutes enough, Mrs. Corrigan?

THE WITNESS: Yes.

CHAIR: We're just going to take a short ten-minute break.

THE WITNESS: That's fine.

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

123 Q. MS. McMAHON BL: Mrs. Corrigan, we just have a couple more topics to cover, you'll be glad to hear, perhaps. The first one of those, I just want to ask you about Mr. O'Brien's retirement -- 11:37

A. Okay.

124 Q. -- the issues around that. Did you have any involvement in the decision-making around that at all? 11:38

A. I didn't, no. Mr. O'Brien contacted in -- I remember the call was on a Saturday afternoon and we talked at great length of the reasons why he felt the need to retire, and he did actually ask me could he return to work and I had said I had no issue with him returning to work, but it was not within my gift to do that. And he -- it was actually me that Mr. O'Brien sent his retirement letter to and I forwarded it on to the relevant personnel. But, after that, I had no more involvement. 11:38 11:38

125 Q. You weren't consulted about his part-time employment or you didn't have discussions with anyone?

A. No, I didn't, no.

126 Q. I just want to ask you a couple of things people mention in their statements -- 11:38

A. Mmm.

127 Q. -- just to get your view on it. I think the first one is probably uncontroversial, given what we've talked

about. Fiona Reddick has said that she advised you that it was a key performance indicator to have cancer nurse specialists and that she had raised that with you at cancer performance meetings. Is that something you would disagree with it? 11:39

A. I wasn't disagree with it, but it wasn't specifically to me. It was to all the other Heads of Service because the performance meeting was a collective meeting. So it would have been more generally about key workers. 11:39

128 Q. And I don't know whether you heard the evidence of Melanie McClements?

A. I did, yes.

129 Q. She indicated that -- did you get a chance to --

A. I did, yes, I listened to it. 11:39

130 Q. I think just the point is that she indicated that you had said to her that the 2019 breach was the first breach of the plan?

A. I definitely wouldn't have said that because I was aware that there had been previous breaches. I'm 11:39 actually not sure, it might have been just that it was the first breach from when she came into post, I don't know, but I definitely would have not have said that. I was aware that there were more.

131 Q. Just for the Panel's note, Ms. McClements' evidence on 11:40 that is TRA-06645, line 18, to TRA-06646, line 6. And also at TRA-06714, line 29, to TRA-06715, line 8. So you think there's been, perhaps, a misunderstanding?

A. Perhaps, yes.

132 Q. Her evidence was that had she known there'd been prior breaches, then her response would have been different?

A. And, I suppose, just to say on that, I actually probably never had any conversations with Mrs. McClements over the pre-2020, as such, about Mr. O'Brien because I would have felt that wasn't my position to do that -- it would have been Mr. Carroll -- because he had his one-to-ones with Mrs. McClements. So I would have assumed that it was him would have discussed, you know, return to work and breaches and things like that. And I don't actually recall actually talking about the July '19, personally, but obviously I'm not arguing it didn't happen but I don't recall it. 11:41

133 Q. So, would it be fair to reflect your evidence as saying that Mrs. McClements should have been told about the issues around Mr. O'Brien, just not by you? 11:41

A. Absolutely, yes.

134 Q. Siobhán Hynes, also -- we don't need to go to this, but at her witness statement at WIT-42079 to 42080 at 23.1 and 23.2 said that she wasn't aware of any deviations and that you had told her there was just one in 2018? 11:42

A. Yes.

135 Q. Again, what do you say in relation to that?

A. On reflection of that, I -- look, Mrs. Hynes would have been copied into the deviations pre that and my only thought of why I said that was it was when she asked me about the breach, they were trying to prepare the final MHPS and I was aware that she was aware of the ones before and I just said that there had been nothing in 11:42

2018. That's the only reason why, because, again, Mrs. Hynes was very much involved in all the breaches.

136 Q. And there were breaches in 2018, including when you were --

A. Oh, there were, yes, yes. 11:43

137 Q. -- and when you came back?

A. And when I came back, yes.

138 Q. So there were quite a few?

A. Yes. What date was that?

139 Q. She just refers to 2018. 11:43

A. Oh, right, okay.

140 Q. I can take you to them, but we took a note of them the last time.

A. Yes -- no, no, of all the breaches, no, no, I remember them, but I was just wondering what she asked me. 11:43 Because I think she asked me had there been anything from February '18 -- I can't remember, sorry.

141 Q. I suppose, just to reflect that there were more -- her evidence is that she didn't know?

A. And I -- pardon? 11:43

142 Q. Her evidence was you had said there was just one in 2018?

A. Right, okay.

143 Q. And that isn't right?

A. No, it isn't right, no, no. And I don't know why she 11:43 wouldn't have been aware of the other ones. The only thing was, when I was off, there would possibly have been no escalation when they did find all the breaches, so unless it's something to do with that.

144 Q. There were two then when you were off, two during that period?
A. Yes.
145 Q. And then the others were before or after?
A. After, in 2019 then. It was September 2019. 11:44
146 Q. And 2018 --
A. And '18, yes.
147 Q. Now, Helen Forde says in her statement -- again, we don't need to go to it -- at WIT-61202 at paragraph 41.1 that she believes that you should have 11:44 raised the issues in a formal way. Now, the formal way would appear to be through the Datix. That was one of the formal ways it was available. And the Panel have evidence that some of the issues were raised that way.
A. Yes. 11:44
148 Q. What other formal way may you have raised the issues that you gained knowledge about from 2009 through?
A. I'm not sure was Mrs. Forde talking about just the charts or was she talking about everything in general -- 11:44
149 Q. I think her knowledge was based mostly on the charts?
A. Yes, and I suppose they were raising the Datixes and it was on quite a number of people's radars, apart from myself. So, I would have had conversations -- like, obviously we've seen the e-mails from Mrs. Burns and 11:45 Mrs. Trouton with regards to trying to address it. So I'm not sure how else I would have raised it formally, because I did speak to my line managers about it, and the clinical teams.

150 Q. Not just the charts issues, but all of the issues that you became aware of --

A. Yeah.

151 Q. Do you feel that you did everything that you could to draw them both to the attention -- well, number 1, to deal with them at your level, if possible, and also, as much as you could, to draw them to the attention of people who may be able to do something about them? 11:45

A. I do, and it was just something, though, that struck home yesterday with Mrs. Burns was why we never raised any Datix about the triage. I genuinely don't know why we didn't. I think it was because it was always addressed at the time and sorted out and then it slipped back over the years. So, that is a regret that we didn't, and I really don't know why. I think it's because, exactly what you've said there, I think I escalated it as much as I could and I expected once it was escalated, that they would help me resolve it. 11:45 11:46

I think I was in a position with Mr. O'Brien that, and I think I said this the last time, that people used the good working relationship that I had with him for me to try and address it informally, which I always did, and then when it got to a stage where I couldn't, I would have escalated it, which left me in a position -- obviously, I had to work with him as well and take him along with us with regards to the work. 11:46 11:46

152 Q. Now, Ester Gishkori in her evidence -- I'll just give you the reference, TRA-06786 and TRA-06913, line 4 to

TRA-06914, line 6, she said that she had a sense that Mr. O'Brien was more or less complying during her tenure -- now, her tenure was August 2015 to April 2020. Would that reflect that you hadn't spoken to Mrs. Gishkori about the issues that arose during those years? 11:47

A. I didn't because Mrs. Gishkori's style of management was that she wanted everything to come through the Assistant Directors and I don't believe I ever had a conversation with her in respect to Mr. O'Brien and, like, I wasn't involved or knew any of the oversight -- and when they were happening, meetings in September, and Mrs. Gishkori never approached me with regards to any aspect of that. And listening to her evidence, it was really Mr. Carroll, Mr. Weir and Dr. McAllister that she dealt with, but she never, never approached me. And I didn't approach her because of her very clear line of communication would be through the Assistant Director. 11:47 11:48

153 Q. She also said that she first heard about the issues in March 2016 and the quote from her transcript at TRA-06791 at line 12 to 20 and at TRA-06792, line 27 was: 11:48

"So, they were all having meetings outside of my knowledge completely." 11:48

Was there either a deliberate or an inadvertent decision taken to exclude Mrs. Gishkori from meetings

where the issues were discussed?

A. Not that I'm aware of. And I suppose them meetings, as I said yesterday, it was with Dr. Wright and Mr. Mackle and Mrs. Trouton. I wasn't actually at them meetings either. And, I suppose, unless she's talking about the March 2016 meeting, as you know, I was asked to step in at the last minute because Mrs. Trouton wasn't available. So, I don't know if that was discussed with Mrs. Gishkori or not. But it wouldn't have been appropriated for her to be, I don't think, you know, it was Mr. Mackle and then I was accompanying Mr. Mackle because of previous issues with Mr. Mackle being on a one-to-one with Mr. O'Brien. 11:49

154 Q. So, again, she should have known about the issues, just not from you? 11:49

A. Not from me.

155 Q. Now, what was referred to in evidence with Mrs. Gishkori, the softer landing approach that was adopted in September 2017 when Mrs. Gishkori and Colin Weir and Mr. McAllister tried another tack to get Mr. O'Brien to comply with some of the expectations, were you aware of that approach that was being taken at that time? 11:50

A. Not aware of anything.

156 Q. Did you subsequently become aware of it because of the Inquiry or did you know about it before then? 11:50

A. No, only subsequently because of the Inquiry.

157 Q. Given that you had been an original drafter, although not the decision-maker around the letter in March that

Mr. O'Brien was to receive, when you found about that approach that was undertaken in September 2016, what was your view of that?

A. I didn't agree with it. I think that -- and I think it's possibly because it was new personnel were dealing with it, but the issues had been going on for so long that I really do think at that stage, when nothing had happened after the March '16 letter, that it should have been faced head on, as opposed to the softer landing. 11:50 11:51

158 Q. Now, Mr. Glackin in his statement considers that it would have been better if the Performance Management Plan and the timelines had been shared with the consultant team. It sort of touches slightly on what you had said before about getting the right people on board about what was expected or planned. Do you agree with that? 11:51

A. I do agree with it, yes.

159 Q. I want to move on just to the admin review. And I know you heard Mrs. McClements' evidence on that and we established a timeline in considerable detail through her evidence. There's no need to repeat that. She accepts that the GMC query for an update about the admin review -- independent admin review, as envisaged, following the MHPS recommendation, that focus on that was triggered by the GMC request in August 2019. The first mention of you in the timeline was 31st July 2020 when Stephen Wallace shares the Terms of Reference with you and others? 11:51 11:51

A. Yes.
160 Q. And for the Panel's note, that's TRU-292694. We had looked at what your role was or had you been given a role or was there an expectation on you that, in some way, you would undertake this review. What's your version of that? 11:52
A. Well, the original discussions on Terms of Reference were I was to have no original role in it. And then the independent aspect of it with Dr. Donnelly and Dr. McCullough was that I was the person that they would come to to seek out information from. So I was their point of contact, which was agreed by the Oversight Committee. And they obviously shared their first draft with me and I shared it on with the Oversight Committee. 11:52 11:53
161 Q. And did you have any contributions to those drafts?
A. No, I had none at all.
162 Q. Are they the drafts recently that have been provided recently to the Inquiry?
A. No, that was the number 1 draft -- I had no involvement with that at all. 11:53
163 Q. I think there were 14 versions?
A. There are 14 versions, yes.
164 Q. Are they all from the two doctors tasked with it?
A. No, not at all. Version 1 was from them and, from then on, the Oversight Committee asked that we revisit, because it wasn't covering it. I will say from the outset that I was -- I never seen the determination of the 2018 and all that was ever shared with me was two 11:53

recommendations, the one to develop an action plan and then the one for the admin review. We can go through all of them. I was involved with them in the sense of Mrs. McClements then asked Mrs. Carroll to become involved in it after Dr. McCullough and Dr. Donnelly. 11:54
And she invited Katherine Robinson from her admin background and myself to work with her on it, which we did. We drew up a number of drafts. They were shared. There were comments made from some of the Oversight Group, particularly Dr. Gormley. And then it was -- I 11:54
think it was Stephen Wallace would have sourced Denise Lynd from the Belfast Trust as the independent person.

Looking at it now and on reflection, first of all I should never have been involved and, secondly, the 11:54
remit of it was Urology from the Terms of Reference -- that should never have been. When I had the report, the full report shared with me as a result of the Inquiry and read it, I knew that the exercise that was carried out was not the right exercise at all. Really 11:55
and truly an independent person should have been somebody totally from outside the Trust -- for example, the Leadership Centre. So, yes, my hands are all over it, but I was doing it for -- I think I was directed wrongly in the sense of, again, it's back to -- first 11:55
of all, I don't say no, a big fault of mine; but, secondly, the fact of my admin background, along with Mrs. Carroll and Mrs. Robinson, that it ended up on my table.

165 Q. So, to summarise your view on that, it was neither independent --

A. No.

166 Q. -- nor robust, nor reflective of the MHPS recommendation? 11:55

A. Absolutely not. Because somewhere along the line the translation got lost and it ended up being just the four points of the Return to Work Plan and, you know, the admin review and part of why we're here today is looking at the wider system, you know, the governance 11:56 systems -- you know, how do we get an SAI to where we get an SAI? All of that should have been looked at and it wasn't.

167 Q. Now, those 14 versions of the admin review processes were served to the Inquiry just last week? 11:56

A. I know, yes.

168 Q. For the Panel's note -- you may not have got to them yet -- they are TRU-166332 to TRU-166788. We don't have to go through the 14 versions, you'll be glad to hear but -- 11:56

A. We'd be here till this time next week!

169 Q. You need to bring a sleeping bag! But, yeah, the point you have made is a general point in relation to all of them in the versions?

A. Yes. 11:56

170 Q. And the Panel has already heard evidence in relation to that.

Now, you talk about what went wrong in your opinion

and, again, for the Panel's note, it's WIT-26299 to WIT-26301, and I'm just going to read out a summary of what you've said in those pages.

You acknowledge some of your own failings. You say that Mr. O'Brien's personality was strong and challenging and he wore people down. The issue over lack of respect for non-clinical managers -- and we've touched on that in relation to Mr. O'Brien. He was a mentor to people -- and then there was a potential reluctance to engage -- 11:57 11:57

A. Yes.

171 Q. It was a close-knit team in Urology. Nothing had been done for years about him so people stopped raising the issues and became complacent. You query in your statement the outside interest of Mrs. Brownlee, who was the Chair? 11:58

A. Yes.

172 Q. And, in that regard, the suggestion is that he was -- they were friendly? 11:58

A. Yes.

173 Q. And what did you feel then that that engendered in others or made people think?

A. I just think there was a perception there that, you know, there was an inference. Like, it would have been things that Mr. O'Brien would say "I was speaking to Roberta and, you know, was telling her about the fact that we couldn't get an -- we didn't have enough theatre time and she said she was going to look into 11:58

it." Like, that's not the sort of -- you know, I always felt there would be an influence then -- did she come and ask the likes of the Director to look at the theatre time and do something about it.

174 Q. So, it wasn't anything said by Mr. O'Brien, but what he did say indicated that he had a direct line of communication? 11:58

A. Yes, yes.

175 Q. Mrs. Brownlee, in her reply, to some of the evidence is somewhat critical of you in saying well, if you believed that she was behaving improperly you should have taken action, effectively, and what do you say in relation to that? 11:59

A. I suppose it's one of these things that I never had -- it was my perception. And, secondly, not an excuse but sort of everybody sort of -- not everybody but there was quite a number of people knew of that relationship. So, I didn't think it was my place to raise it formally. 11:59

176 Q. And for the Panel's note, Mrs. Brownlee's comments in that regard are at WIT-90894 to WIT-90896 and that particular reference is at paragraph 48. 11:59

The other thing you say about what went wrong was that issues would resolve for a short period of time but would re-emerge. If things had been escalated earlier that it might have prevented patients coming to harm? 12:00

A. Yes.

177 Q. You also say there was a failure to address the fact

that Mr. O'Brien was set in his ways and continued to deviate from processes and systems. People had busy operational roles and you they also mentioned the lack of minutes about doing things in person?

A. Yes, and that's back to the comment about the meeting that we had, for example, on the default. But there would be an awful lot of ad hoc just on the foot in the corridor, you know, in the ward conversations and by the time you got back to your desk you would never have -- I didn't, as in me, I wouldn't have written them down. So, I don't have dates and times for everything. 12:00 12:00

178 Q. And you say you shouldn't have to babysit Mr. O'Brien or cajole him?

A. Yes. 12:01

179 Q. You are also critical of the MHPS process and that he shouldn't have been allowed back so soon until the investigation was completed and there was no proper plan in place. And then under key learning, again for the Panel's note, WIT-26302, you say you agree with Dr. Hughes's SAI learning. From a governance learning you mention the following: 12:01

"Failure to formally raise concerns."

12:01

Is that including you and others?

A. It is including me and others, yes.

180 Q. "Better inclusion of non-clinical managers with clinical managers."

You say that's been improved and we can ask Mrs. O'Kane about that?

A. Yes.

181 Q. "The SAI learning should not be done in isolation. There should be no delays. Resources for governance departments." 12:01

What do you mean by that?

A. Again, it's an -- and I was interested, Mrs. Burns's view on this in comparison to Dr. Boyce's. So, for example, we would have received a complaint in and it would have went to the Complaints Department and then it came to the Head of Service to deal with it. Now, you might have lots of people to try and coordinate. It came back to me then to script it up and then take send it on. That took a lot of time and when you think of the operational roles that we would have had, it meant that timescales slipped or you were sitting -- I would have been, everyone knows a morning person, so maybe at five o'clock in the morning when I couldn't have spoken to somebody. So, what we were always asking for was support from governance to each of the divisions, and I know Mrs. McClements has said she thought it was in place. It's still in the process because they're having difficulty recruiting to it in the sense of people applying for the jobs. But they would have done the leg work for the Heads of Service and had all the information. Even followed up on the 12:01 12:02 12:02 12:02

likes of the Datixes. So, to close them off as opposed to just having -- David's brilliant but David's looking after all of us, you know, so he's lots of Datixes that are coming in and that he's having to try and make sure everybody -- whereas, if we had our dedicated divisional governance people, which they now have moved towards as a result of the SAIs, I think that would have been very helpful.

182 Q. You also mention that there needs to be a clear management structure as there's no line of accountability for clinicians? 12:03

A. Yes.

183 Q. Would it be more that there is a line of accountability but that it wasn't actioned properly?

A. There was -- yeah, that's a fair point and I suppose listening to Mrs. Burns yesterday too, it was interested to hear that at that stage they were only all new and they weren't used to the challenge part of it. But I suppose it's something to ask the clinicians but I don't ever think they considered the clinical end as their managers. It was more to do with, you know -- like they nearly seen me not as their manager as such but as part of the team. I was the go-to person as opposed to, you know -- now, their job plans and their appraisals, etc., etc., I couldn't have become involved in and they would have pulled other people. I just think there's that disconnect for the clinicians, albeit the people who are in post, they don't seem to go to them. 12:03 12:04 12:04

184 Q. Now, you said you thought you did everything you could at the time to try and move things along as the issues came to your knowledge. Others have accepted that they made mistakes in evidence to the Inquiry. Do you feel that you made any mistakes? 12:04

A. Oh, absolutely. On reflection, there's a lot of things that if I had have stepped back, took the time to step back and look at, you know, for example, one of the things, and I know we're talking about governance that always sort of was like a bugbear for a couple of the 12:05 Heads of Service was the SAIs were done in isolation, which is fine. The recommendations came up and the next thing you got a list of 'These are the recommendations that you need to implement.' We never got a copy of the SAI. It's a wee bit like back to the 12:05 MHPS. If you're given recommendations in isolation, but the biggest problem thing for me is, and it's come from this Inquiry, when I actually sit down look and all the SAIs and read them, the recommendations could be actually mapped across. And if we'd have done that 12:05 at the beginning.

I don't think there was enough emphasis. I didn't purchase forward on some of the things, you know, like the results. In my head that was sorted at the time. 12:05 Could there have been more -- could there have been sort of, if I'd taken the time, more indicators that there was issues going wrong. And mitigating circumstances, I know, was the day and we talked about

yesterday, the day-to-day operational role, but there was times that I potentially should have done things that I didn't do them, I just sort of thought, well it's Mr. O'Brien and he will do it and just let it go, whereas I should have been, every single time, escalating it to everybody. I suppose to a certain extent sometimes I think I protected him by, you know, going to him and saying, 'Look, Aidan, will you please do this?' He'd do it but I never said to anybody that he hadn't done it and then he did do it. If that makes sense? 12:06 12:06

185 Q. We've covered a lot of the issues both the last couple of days and on the last occasion, but is there anything else you'd like to say while you're here, anything you feel we should have covered, we didn't cover that you need to inform the Inquiry about while you're before them? 12:06

A. Not really, except that, I suppose, as you had introduced I'm probably the one constant from 2009. Should I have joined up the dots, you know, before the Inquiry got -- yes, on reflection, I should have. But I do think there was more people involved than me and I'm just sorry it came to this. And I am sad for Mr. O'Brien that his career ended the way it did. So... 12:07 12:07

MS. McMAHON BL: Well, I have no further questions. The Panel may wish to ask you some questions. But thank you for your evidence.

THE WITNESS: Thank you.

CHAIR: Mr. Hanbury.

MRS. CORRIGAN WAS QUESTIONED BY THE PANEL, AS FOLLOWS:

186 Q. MR. HANBURY: Thanks very much for your evidence. You will be pleased to know you have answered a lot of my questions already. I have a few clinical and easy things to go through. 12:07

Just on the waiting list management, we've heard from Noleen Elliott about the method Mr. O'Brien and she had of, and you alluded to the somewhat haphazard way where we've certainly had one SAI of a delayed stent change, do you think -- was that anticipatable in terms of how -- can you see that sort of thing slipping through the net with that mechanism? 12:07 12:08

A. With regards to stent change, I know there's a lot of work that's been done because basically you are putting a foreign body into somebody that will need removed. And then that really what was going on with Mr. O'Brien, was he was writing it in his diary and taking it away. So -- and then not dictating. So, people didn't know about it. Whereas now there is, like, sort of it's not theatre management, it's a system that you record the date on and then the date that they're due to have their stent removed and then that's shared, the secretaries all have that. So, they should be able to then make sure that the patient is added to the waiting list when they should be. 12:08 12:08

187 Q. And that's true throughout the other urologists too?
A. Oh, absolutely. And to be fair to Mr. Young, he's been looking for this for years because of this very reason. So, I'm aware now -- and I suppose that's one thing I will say when I said about the babysitting of Mr. O'Brien, one of my sort of bugbears is that my job should really be to improve. I never had time to improve. So, I suppose now that I've stepped out and somebody else is in and they don't have this added, they're putting in improvements that I would have liked to put in. 12:09
188 Q. Okay. Just on that theme. There seemed to be a relatively short time between decision to operate and actually getting someone in. Again, was that something particular to Mr. O'Brien or is that true of other urologists too? We've heard one or two problems about pre-assessment? 12:09
A. Oh, yes, pre-assessment. No, it was mostly Mr. O'Brien that they would have raised the issues with. Now, red flags, obviously, is different, but as soon as the patient had been seen they would have been sent to pre-assessment. But, no, Mr. O'Brien, because of the delay in him doing his paperwork it didn't get to pre-assessment in time. Whereas the other guys they literally will complete the paperwork in the clinic and send the people round to pre-op, so at least they have their initial consultation done at that stage. 12:10 12:10
189 Q. I see. Thank you.

Also on the theatre side, you mentioned something in your evidence about late starts/early finishes, was that in the Department, were you looking at productivity and what was comments about that?

A. We were looking at productivity because there was various issues as to why there was perhaps late starts and we needed to actually go into detail on it. We did a lot of work on it. And it might have been something as simple as there was no porter to take a patient from the ward for theatres. It wouldn't have necessarily been the consultant's fault. It was all sort of the mitigating circumstances around it. 12:10 12:10

So, we did a lot of work on that to try and improve that start and finish times, the productivity. 12:11

190 Q. And was there any particular difference between consultants or did you not look at it from that point of view?

A. We did, yes. We drilled down to consultants and if there was consultants and not necessarily Mr. O'Brien that maybe were turning up late at theatre, we would have changed the way -- so, they would have done a pre-assessment on the ward, a pre-op rather, on the ward with the patient, just went and spoke to them, along with the anaesthetist. If they were doing that late then they were getting to theatre late. So, you know, I would have spoken to any consultant that that was relevant to. 12:11 12:11

191 Q. Moving to outpatients, just a couple of things.

Obviously, this has evolved over the years and one stops, these were all new parents?

A. They were, yes. There nine --

192 Q. Roughly --

A. Nine new patients, yes. 12:11

193 Q. Thank you.

A. And basically the patient would be -- the reason was only nine - and that was for all consultants - was that they were getting all their tests done and the patient knew that they'd be there for the three hours, or 12:12 whatever.

194 Q. Okay. And then for the follow up, the consultants would run separate follow-up clinics?

A. They did, yes.

195 Q. And how many, generally, would be seen then? 12:12

A. Well, it depended on the consultant. Mr. O'Brien would have been eight. You probably will find Mr. Haynes would have been 16 and the rest of the team would have been in or around 14.

196 Q. Also on this, you mentioned in your statement that the 12:12 outreach clinics are somewhat less efficient and i noticed that there were sometimes a late start a SWAH?

A. Yes.

197 Q. What was your view about outreach clinics in general. Do you think they were a good use of time? 12:12

A. The clinics in Enniskillen, no, and I suppose what happened was, the plan originally was that they would go and do day cases in the morning and a clinic in the afternoon. But that never transpired because it was

very difficult because we're two different Trusts. But, obviously travel was built in to the job plan. So, the clinics didn't start till 10:00 and really finished at 4:00. To have a consultant out of the system for that length of time to only see that handful of patients was not productive. And just to add, this is a comment, I know from the CNS, Kate O'Neill, she'd said about the outreach clinics. The agreement was there was no be red flags in Enniskillen, same as South Tyrone, but Mr. O'Brien would have identified patients. 12:13

Again, his heart was in the right place. He didn't want people to travel he. Didn't want the elderly population to travel. I'm from Fermanagh, I'm used to travelling. So, I used to have this debate with him that, you know, my elderly relatives are able to travel. But just to say that that was the reason and why we wouldn't have sent any CNSs out was because the plan was not to have red flags there. 12:13

198 Q. There are new developments in lots of surgeries and we have a problem with hyponatraemia in urology? 12:13

A. Yes.

199 Q. And that was obviously topical in Northern Ireland for other reasons.

A. Yes. 12:14

200 Q. You mentioned some of the urologists were sort of keen to go to saline TURP?

A. Yes. There was quite a lot of debate. There was quite a lot of meetings about that. I know Mr. O'Brien was

very set that he was to go and remain doing what he had to do and there was peer pressure on him to move because of the hyponatraemia. It was actually because of a gynae case in Belfast. So --

201 Q. But the other urologists were more accepting of the new technology? 12:14

A. Absolutely. And we trialed quite a bit of equipment and all and we did it during the time when Mr. O'Brien would have been if theatres as well.

202 Q. Again, on the subject of sort of new things, were you involved in the sort of out-of-region referrals for cases? I'm thinking -- 12:14

A. I was, just before I left my post, yes. We would have had the prostatectomies. Now, it wasn't us, it would have been the Southern Trust patients would have been sent to Cambridge. 12:15

203 Q. Right.

A. And we also had --

204 Q. That was for?

A. For prostatectomy. 12:15

205 Q. Radical prostatectomy?

A. Sorry, radical prostatectomy, yes.

206 Q. I suppose I was thinking more for benign work, the laser type of prostatectomy. That was seen not to be available, but it might now. But was there a time when it was referred out? 12:15

A. Yes. It would have been referred out, yes, but it wouldn't have been that many and it would have been more regional discussion. So, the region, what they

would have done is they would have sourced somebody who would have been able to do it. The amount of cases then that would have come back through me then to identify the cases which I would have done with the consultants. We would have done a lot of benign work down in Dublin. 12:15

207 Q. Okay. One other thing on the cancer side, penile cancer, there was something about referrals to English units, particularly Manchester. Was that something that was happening? Did that come on your radar? 12:16

A. It was happening but there were so few of them and that was partially the reason. But they do have a consultant now who specialises that in Knocknagoney. So any Northern Ireland referrals will be there -- were sent to there. I think that was an issue with one of the SAIs. 12:16

208 Q. Prior to that, if a clinician wanted to refer --

A. Yes.

209 Q. -- then there is no problem?

A. Absolutely none. It was called an extra contractual referral. So, basically the consultants would have, and I would have been involved in the paperwork with it, so the consultants would have sourced where the case could be done. So, they would have come back, we would have filled in the details, then we just got approval and the approval was just more or less that the patient's expenses and all would be paid for their travelling. So, yes, there was no hurdles at all with that. 12:16

210 Q. Two more very short points. Job planning, I know you weren't involved much in there but when Mr. O'Brien took on it's NICaN role and the Chair of the MDT, those are quite time-consuming roles. Did he give up anything else? 12:17

A. No, he didn't.

211 Q. And how was that fitted?

A. He was asked to give you up, you know, he was -- like I was at conversations where he was advised to give up stuff but he never did. 12:17

212 Q. So, if he wanted to have given it up, that would have been no problem from your point of view?

A. Yes.

213 Q. Thank you. Just the very last thing. You mentioned late starts to ward rounds. That was prior to Urologist of the Week? 12:17

A. It was, yes.

214 Q. When Urologist of the Week started, was there a problem there from any of the urologists?

A. None of the urologists, no. Except Mr. O'Brien didn't usually turn up at half eight for the ward round, everybody else would have been there, probably even from earlier. So, not that I'm aware of, I'm saying that, but that was never brought to my attention. 12:17

12:18

The sources used to be, like I have always had good working relationships with the regs and the sisters and the nurses on the ward. And it would have been coming them.

215 Q. Right. So, you wouldn't be able to say when he turned up?
A. No.
MR. HANBURY: Thank you very much.
CHAIR: Dr. Swart? 12:18
216 Q. DR. SWART: I just want to ask you a little bit about the meetings you had with the Consultant Urologists talking about triage, if there were any such meetings, particularly did you have any chance to sit down with them and discuss things like the risk to patients of 12:18 not triaging or abusing the default system, or any of that sort of thing? Was there any general discussion with a certain body?
A. Not for the new patients. The triage was more discussions on the long waiting times that ultimately 12:18 happened. But we would have had quite a lot of discussions about the review backing and the risks on that. But not for triage, no.
217 Q. Not for triage?
A. Not for triage, not for new patients. 12:19
218 Q. Why? I mean there is clearly a risk if you've got this very long process?
A. Yes, I agree. And I would have brought performance figures to -- we tried to do once a month we would have had a performance meeting. 12:19
219 Q. So they knew there were delays?
A. Yes, they knew there were delays. What I would have done was the red flags, how many red flags were received, what the waiting times is. Same for the

routine and urgent.

220 Q. Mm-hmm.

A. But no, no discussion on the risk on that. And a step back, we should have but we didn't.

221 Q. And the risk for the review patients, what were the kind of discussions you had on that? Were there any ideas forthcoming about how to assess all these people waiting? What was the conversation like? 12:19

A. The conversation was, I suppose, and I think maybe I alluded to it, is how will we get all of these massive amount of patients seen? One of the suggestions would have been back to the review of results, that if it's a normal result just write the letter and we can actually get quiet a number of people off the waiting list. But that was custom and practice for a lot of the consultants anyway. 12:19 12:20

There was a stage, we would have always done admin revalidation because obviously, as I said yesterday, people coming off for various reasons. 12:20

There was a directive from the Department of Health where they had asked that there all the patients be contacted and asked did they want to remain on the waiting list? We had to put a stop to that in Urology. I do know it continued in other specialties and it was as a result of an e-mail from Mr. O'Brien. But to be fair, Mr. Haynes was the same view. So, really what had happened was a patient of Mr. O'Brien's had been 12:20

contacted. He said, 'No, everything's okay just take me off.' Mr. O'Brien was going to schedule him when he rang him up. He said, 'But sure I'm not on a waiting list anymore.' So we had to stop that process.

12:21

Then I kept saying, 'But we need something else.' But the problem is we just didn't have the capacity to see the patients.

222 Q. So at that time, you know, what was the culture of medical management in Urology? We heard quite a lot about the Trust and some of the problems, but how did it feel to you? Did you feel that the clinical lead was taking charge of this and saying, 'Actually, we do have to do something, we need help.' Or was there a sort of helplessness? What did it feel like to you? 12:21

A. I think there was a sense of helplessness. I think there was -- like the likes of Mr. Young would have escalated issues, you know, like for example particularly theatre, the theatre is the thing everybody wants, a surgeon wants to be doing. But, they do like to be in theatre and they would have maybe escalated that to -- but it was mainly more so to the Directors of Acute as opposed to the Medical Directors. So, I do think that disconnect was very obvious.

12:21

12:22

To be fair to Dr. Wright and Dr. O'Kane, when they both came along I wouldn't have known their predecessors at all. When they came along I brought them to the teams they asked to be brought to and they listened to what

their issues were. Not necessarily able to do anything about it but they did listen to them.

If they did have issues, no, they didn't put it any further than me. 12:22

223 Q. Did you get the feeling that any of them felt, say if your Clinical Lead and the Clinical Director that they felt that were in charge, that they were managing the doctors? Or did you feel that the managing of the doctors went over to the operational side? What did it 12:22 feel like?

A. It felt to me, personally, that it was the operational side. I felt that it was a lot on me, if you like. I would have managed them, you know, with regards to clinics and scheduling and things like that. 12:22

Now, Mr. Young, in fairness, and it's just again -- sorry I'm going back to a comment that was made by Kate O'Neill when she said they didn't know until literally that week with regards to what was happening, 12:23 Mr. Young, as Clinical Lead sat the team down on it used to be the first Thursday of the month but I got him to push it back because of the timescales and he scheduled everybody. So, everybody knew for five weeks what they were doing, they knew their clinics, they 12:23 knew their theatre sessions, etc., etc. Yes, you had the odd time when somebody got sick and things like that. But he took that lead as Clinical Lead.

224 Q. That's a sort of almost an operational role?

A. Operational issue, yes. But with regards to clinical stuff and escalating, now to be fair to the saline and to the hyponatraemia, Mr. Young took very much a lead on that. That's because it was a directive that had come down that we had no choice on. Other stuff, no. 12:23

225 Q. Now that you look back on that, I think you reflected that this is a bit of a problem. How much has that changed as a result of some of the things that have happened or has any of it changed or what's happened since, do you think? From your perspective? 12:24

A. From my perspective, obviously, I haven't been in an operational role for now nearly two years, yeah, it is two years.

226 Q. Sometimes you can look at it --

A. Look at it from outside. I see that there's more, say, for example, job planning would have been a big issue, people's job plans and appraisals weren't being done in time. So, they've now put that layer in and that's a strong layer of working through. 12:24

I think the fact that they've released Mr. Haynes to do some improvement, definitely there's a -- looking in there's definitely a sea change and Mr. McNaboe would have been filling - he would have been ENT O- he would have been filling that part of Mr. Haynes's role. He still copies me into everything so I do know there's a lot of things going on 12:24

227 Q. Just one small thing. The notes at home actually turned out to be quite a big issue, quite an important

issue?

A. Yes.

228 Q. Not only because of the issue itself but because of what it signified?

A. Yes. 12:25

229 Q. However in simple terms it's an information governance breach?

A. It is, yes.

230 Q. Quite a serious one and it kept happening. What was your mechanism for raising information governance 12:25 breaches specifically? Was it just through IR1s? Were you asked by the Trust to make a note of all of your information governance issues? What support was there for all of this because it's quite a big area in health now. So, why did that the filter up anywhere as 12:25 actually this is a problem?

A. I don't know why it didn't filter up that it was a problem and guilty, didn't think of it as an information breach although --

231 Q. But were you asked specifically -- 12:25

A. No.

232 Q. -- for each department to sort of consider these things?

A. Not initially, but recently, yes, we were all -- we all have to complete a questionnaire on all information 12:26 breaches. And I do know, for example, one of my wards, Elective Admission Ward, we had a data breach and I did all the right things with regards to that.

233 Q. It comes down to say. 'Tell us what's happened'?

A. Yes. And we knew then. It was because there's more awareness now than there would have been. So it was a hand-over sheet being left in a bag. So, you know.

234 Q. That's a common one?

A. Yeah. 12:26

DR. SWART: Sadly. Thank you very much.

THE WITNESS: Thank you.

235 Q. CHAIR: Mrs. Corrigan, just a couple of things that I want to get clear in my head about some of the evidence you gave us. Yesterday you talked about patients 12:26 coming in the night before and that this was causing difficulties when Mr. O'Brien was Urologist of the Week. If I've got this right, and correct me if I've got it wrong, is what you're saying that while he was Urologist of the Week he was adding patients on to the 12:27 list from his own list that he kept?

A. Yes, that was what happened. So, you have somebody who is on his elective list, potentially has contacted him at home to say they're having difficulty, because that was a regular occurrence, and then he's told them to 12:27 come in on the week that he's Urologist of the Week because he can't fit them into his elective week.

236 Q. And as the Urologist of the Week he should really only have been dealing with the emergencies?

A. Yes. 12:27

237 Q. I just wanted to be clear that I got that right in my head.

A. Yes.

238 Q. The other thing, one of the things we know that

Mr. O'Brien recorded meetings after the MHPS process started and slightly before it in fact, but I just wondered, there is one meeting that he doesn't have recorded and I'm not sure that you were there or not, and it was a meeting where -- I think it might have been around September '18 when the urologists all got together? 12:27

A. Yes.

239 Q. And I think you weren't there?

A. I wasn't. 12:28

240 Q. We have a transcript of what happened up until the coffee break. But the issue that was going to be discussed after the coffee break was triage?

A. Yes.

241 Q. And were you at that meeting, first of all? 12:28

A. No, I wasn't. I was still off on [redacted]

242 Q. You can't help us really --

A. No.

243 Q. -- about what was discussed among the consultants? 12:28

A. I can't.

244 Q. We can ask them in due course.

A. The one meeting that I was at was the 3rd December meeting and the one thing I thought was very strange was that at the end it just stopped when Martina Corrigan left the meeting. The team stayed beyond but the recording stopped and I know there would have been conversations. Like, meetings never ended when I left sort of thing. I just thought that was a 12:28

strange one at the time when I read it.
CHAIR: Thank you very much. Thank you for coming along for the second time. Hopefully we'll not have to have you back. Just in case I won't make any definite promises but thank you. 12:29
MS. McMAHON BL: I would draw your attention to one final reference from Mr. Lunny. We don't need to go to it but it's just for the transcript and your note, WIT-42163, and that's an e-mail exchange between you and Mrs. Hynes where you're updating her on the 12:29 breaches. So, there's a bit of detail in that e-mail which shows that you set out what the position was at that point. I just want to make sure that's on record and the Panel can look at it if they wish.
THE WITNESS: Okay. 12:29
CHAIR: Thank you, ladies and gentlemen. We've finished early at the end of term and I'm sure, like the rest of us, you're all looking forward to the summer break. We won't be back again for hearings until 12th September but you'll be well aware that 12:29 there will still be work going on in the background in the meantime.

I hope you all get a well earned break over of the summer holiday and see you all again in September. 12:29 Thank you.

THE INQUIRY WAS THEN ADJOURNED UNTIL TUESDAY, 12TH SEPTEMBER 2023