Urology Services Inquiry

Oral Hearing

Day 49 – Tuesday, 6th 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 AT 10:00 A.M. ON TUESDAY, 6TH JUNE 2023 AS FOLLOWS:

CHAIR: Good morning, everyone.

09:50

NOLEEN ELLIOTT, HAVING PREVIOUSLY BEEN SWORN, CONTINUED TO BE EXAMINED BY MR. WOLFE KC AS FOLLOWS:

MR. WOLFE KC: Good morning, Mrs. Elliott. I want to start this morning by looking at the area of DARO and how results were managed within Mr. O'Brien's office. If we can start by looking at your explanation of how DARO should work. DARO is Discharge Awaiting Results for Outpatients; is that what the acronym means? 10:00

A. I think actually "order" is the last. 10:00

1 Q. Okay. So Discharge Awaiting Results Order?

A. Yes.

2 Q. I am obliged, thank you for that. If we look at your witness statement at WIT-76334. Just above the page at 12.1, you are explaining how the process works. 10:01

"If a patient is awaiting results prior to a decision regarding follow-up treatment being made, they must be recorded as a discharge".

10:01

That is the code, D-I-S --

A. Yes.

3 Q. -- that would be included. "And not added to the Outpatients waiting list for review".

That was instruction that you were given by the service administrator; is that right?

A. That's correct.

4 Q. You say in answer to the question "Have you experience of these systems being bypassed, whether by yourself or others", your direct answer to that is: 10:01

"I am aware that the SOP for DARO was not fully implemented while working for Mr. O'Brien. That was at the request of Mr. O'Brien. Mr. O'Brien would have stated on his letters that he was booking an investigation (e.g. scan, blood results, etc), and review in a specific time, i.e. 3 months, 6 months, etc. In such cases, Mr. O'Brien did not want me to DARO these patients and requested that they be put on the Outpatient waiting list to be seen in the specified time. He was adamant that the patient was not to be discharged and should be on a waiting list for review as requested". 10:01 10:02 10:02

You are saying there in clear terms that there was a DARO system, your line management expected you to implement it but Mr. O'Brien was telling you to bypass that and to ignore that? 10:02

A. That's correct.

5 Q. What was his rationale for that, to the best of your understanding? Did he explain that to you?

A. Yes. Well, it was the word "discharge", the fact that

the patient was discharged and not on any waiting list. He would have said that that was lost then to follow-up, as well as he would have said that he wanted to review the patient irrespective of what the test indicated. So, the fact that they were taken off any review waiting list, he didn't accept that.

6 Q. So his approach was what, then, in the alternative?

A. The patient was, for instance to take an example, if the patient was sent for a CT scan, the CT scan to be to be done in three months and he would have asked me to put the patient on the Outpatient review waiting list for review, say, in four or five months, whatever. It would have been a short time after the scan would have been due to be reported on.

7 Q. Okay. Why did he favour that approach?

A. He favoured that approach because the patient was on a waiting list, what he had requested. Irrespective of the scan result, he still wanted to see the patient.

8 Q. Even if that was unnecessary from a clinical perspective?

A. Whenever the scan -- yes, he would have always wanted to review his patients.

9 Q. Regardless of outcome?

A. I cannot ever remember anybody being discharged from a result if they were already on a review waiting list.

10 Q. Did the system work effectively, in your view?

A. It had its pitfalls because obviously of the long waiting lists for review appointments.

11 Q. We will maybe see some of that in a moment. In terms

of management's awareness of his disregard for the DARO system, you have said in your witness statement, if you just go to 12.3 -- yes, in front of us. This is your explanation:

"The DARO reports would have been sent out by the service administrator to the secretaries on an ad hoc basis for the secretary to validate and return. I would have had approximately 60 patients on DARO report (mainly from specialist registrar and staff grade doctors and some from Mr. O'Brien). Other secretaries would have had considerably more patients on their DARO report. Therefore, I believe that management would have been aware that the SOP for DARO was not fully implemented by Mr. O'Brien due to the vastly reduced numbers on Mr. O'Brien's DARO report".

You are suggesting that if the service administrator compared one clinician with another, they would have seen that Mr. O'Brien's DARO returns were significantly less. Is that what you are saying?

A. That's correct. The DARO report that was sent to the secretaries was sent in its totality, so it was all the consultants' DAROs was on the one report, so it was very easy to cross-reference to see that one clinician's DARO was sitting with 300 on it and Mr. O'Brien's was sitting with 60. There was another consultant that was similar to Mr. O'Brien.

12 Q. Let's just maybe look at that. If we go to a DARO

report, WIT-77755. This is Ms. Cunningham writing to all the secretaries; is that right?

A. That's correct, yes.

13 Q. 11th May 2016. She is saying:

10:07

"Please see the attached DARO report updated today and filter as appropriate. It is essential that this report is actioned upon receipt and validation confirmed by return email to me by the end of the month. If patients are no longer appropriate for DARO, they must be reinstated or removed from DARO as per the DARO SOP".

10:07

What is the work exactly you are being asked to do here by validating?

10:07

A. So, on the DARO report, all the patients are identified individually.

14 Q. Would it help if we scroll down so you can illustrate it?

A. Yes.

10:08

15 Q. I think. Yes.

A. So you can see there --

16 Q. The first two entries are Mr. O'Brien; isn't that right?

A. Yes, yes. You can see there the patients are actually identified with their hospital number. Then over on the last line, it tells you what we were expecting back. In that case it was a PSA that was expected back in May '15. So, what we would have done as

10:08

secretaries, we would have checked up if that PSA -- now, I am not sure what date that DARO was but if it was after, if the DARO was after May '15, then you obviously checked. Sometimes that was the reason we put the date in there, because obviously some of the tests are required in the future. So if that DARO report was done and produced in May and it was a CT that was expected in September, you knew that you didn't need to look that up because it was in the future. 10:08 10:09

You would have went through and checked the results. If the results was actioned and a letter done, then you would have removed them off the DARO as per the results letter. If there was no results letter done, then you left that for the clinician. So you would have printed off the result and left it for the clinician to advise on the outcome. 10:09

17 Q. If a patient has been put up on DARO, you are awaiting the results of the CT scan and if that CT scan comes in and the clinician actions the CT scan, how would you know about that? 10:09

A. Well, when the CT scan comes in, we always check what the status is with the patient. So, you would have looked up PSA and seen this patients is on DARO. So I would have handwritten on the bottom, "Patient on DARO, please advise". Once the clinician then done the results letter, that results letter determined what action was taken or what the outcome of that was, 10:10

whether it was a discharge, a review, or a... I am trying to think what else there would have been. You wouldn't really have anybody put on a waiting list following that. It would have been review or discharge probably. 10:10

18 Q. You would use the DARO system in that case to keep track of what has been done in the case?

A. That's correct. If you need the cooperation of the clinician.

19 Q. Yes. So if the patient isn't on DARO -- 10:11

A. Hm-mhm.

20 Q. -- and the CT scan results come in, and if the action required as a result of the CT scan results hasn't been followed up by the clinician, how would you know?

A. Well, in Mr. O'Brien's case if the patient wasn't on DARO, there were obviously on a review waiting list. If the scan came back and there was something untoward or something serious on the scan, Mr. O'Brien would have asked me to arrange an appointment earlier than the expected appointment. So he very regularly would have asked me to put people as an extra patient on to my PR slots on the review clinics. 10:11

21 Q. That system relies on the clinician advising you whereas the DARO, if you go to the trouble of inputting on DARO, there is a tracked record of a patient; is that right? 10:12

A. There is but you still need the cooperation of the clinician. I think this is something that has come up on other people's evidence, that the clinician didn't

need to be involved. You have to have the involvement of the clinician.

22 Q. But if you have the patient on the DARO system, at least that has the merit of the safety net of letting people know that something has to happen to that patient? 10:12

A. Yes, because they will come up the next month on the DARO.

23 Q. Of course.

A. And the next month if they are not actioned. 10:12

24 Q. And questions can be asked?

A. Yes.

25 Q. Whereas on the approach that Mr. O'Brien seems to have preferred, that patient could be lost unless he remembered about it. Is that fair? 10:13

A. Yes. That is very much up to the clinician to action, yes.

26 Q. You were explaining to me how the service could have used this system to deduce that Mr. O'Brien wasn't playing ball with it? 10:13

A. Yes.

27 Q. I fear that I might be jumping ahead into a second report, just to help you with Mr. O'Brien's total. Forgive me that; there is no trick in it, it is just my referencing. If we go to WIT-77866. Just scroll up a page. Stop there, please. Mr. Haynes has got 194 cases? 10:13

A. That's correct.

28 Q. I think, off the top of my head, Mr. Glackin might have

had more than that?

A. 300 odd.

29 Q. If you just scroll on up. I don't think we need do it but if we scroll down slowly down to the end of Mr. Haynes' list, we can see -- and remember this is a report for 2019; isn't that right? 10:14

A. Hm-mhm.

30 Q. No, it may be 2016. I will come go back. Mr. O'Brien's, scroll down, comes to a total of 73 cases? 10:14

A. Yes. If you bear in mind there, if you notice on the descriptor at the end, a lot of those were other clinicians doing backlog clinics for Mr. O'Brien. You can see that the very last entry was Personal Information redacted by that was actually Mr. Suresh. A lot of those 73 weren't even Aidan's. It was nothing to do with Aidan, if you know what I mean. 10:15

31 Q. Just help me with that. What entry are you pointing to?

A. Do you see the last entry for Aidan? 10:15

32 Q. Yes?

A. That is PSA March '18/QSS kidney.

33 Q. So the right hand column?

A. Actually the very last Personal Information redacted by

34 Q. That is Mr. Suresh? 10:15

A. He did that clinic and put that man or that patient on DARO. There are seven entries within that number of 73 like that.

35 Q. What you are saying in terms of the Trust's knowledge

of Mr. O'Brien's departure from DARO is if anybody looking at that was asking himself the question which consultants are using DARO and which aren't, they could do a simple subtraction sum with an awareness of Mr. O'Brien's large practice and work out that 73 is indeed a very small number?

A. Yes.

36 Q. Thank you. Could I ask you about your compilation of the Backlog Reports as they referred to DARO. If we go to WIT-77948. This is a report from 8th June 2015. You are telling the reader that DARO has been validated in respect of the cases on this document? 10:16

A. That's correct.

37 Q. We know that Mr. O'Brien was largely - I think you allowed for some exceptions - largely not using DARO? 10:17

A. That's correct.

38 Q. What do you mean when you say DARO has been validated for these cases if Mr. O'Brien was largely not using DARO?

A. Because as I described in my statement, the registrars and the specialist doctor or the staff grade doctors that were doing clinics under Mr. O'Brien's name were DARO-ing. So there still was -- there was always entries for Mr. O'Brien on the DARO report. It was those entries that I was validating. 10:17

39 Q. So, cases that are carried out by or looked at by his registrars or, on occasions, by locums, perhaps by tenured consultants such as Mr. Suresh as a favour or to help out or whatever it was --

A. It would have been mainly extra clinics put on.

40 Q. So they would still fall under Mr. O'Brien's name as such, and those were your responsibility to validate in accordance with DARO?

A. Yes, that's correct. 10:18

41 Q. Do you think it was entirely clear to management that Mr O'Brien wasn't using DARO, that he was bypassing it, because clearly you are saying on this, results are being validated according to DARO, the report, the central report, albeit with a smaller number, is 10:18 showing DARO validations; you have DARO cases under Mr. O'Brien's name. Should you not have been raising with management more explicitly that DARO was being bypassed?

A. When we talk about validating DARO, for every entry 10:19 that was on the DARO, I had to put an explanation in another column for our service administrator. There was a very detailed report went back for the validation of DARO. The service administrator, it would have been very obvious to me that there was a disparity or a 10:19 difference in the numbers. Should I have highlighted? I thought, well, it is blatantly obvious there, and it wasn't that there was anything new. There again, I took over working for Mr. O'Brien when he has already been a clinician for years so there was nothing new in 10:20 not using DARO.

42 Q. Certainly by 2019, management are writing to you and others to underline their view that DARO should be used. Let's just look at how that played out. If we

go to WIT-22786 and just look at the email at the bottom of the page. It is 30th January. You are one of the recipients, we can see in the last penultimate line of the address column with the email. Collette McCaul, she was the service administrator; is that right?

A. That's correct.

43 Q. She is clarifying the process in relation to DARO.

"If a consultant states in the letter I am requesting CT, bloods etc and will review with the result, these patients all need to be DARO-ed first pending the result ... and not put on the waiting list for an appointment at this stage. There is no way of ensuring that the result is seen by the consultant if we do not DARO. This is our fail safe to patients are not missed. Not always does a hard copy of the result reach us from Radiology etc so we cannot rely on a paper copy of the result to come to us.

"Only once the consultant has seen the result should the patient be then put on the waiting list for an appointment if required, and at this stage the consultant can decide if they are red flag appointment, urgent or routine, and they can be put on the waiting lists accordingly.

"Can we make sure that we are all following this process going forward".

Your response to this seemingly was to pass this email to Mr. O'Brien; is that right?

A. That's correct, yes.

44 Q. You didn't reply to it directly yourself?

A. No, because to me it was out of my control to reply, you know. I needed the cooperation of the clinician if I was to comply with that. 10:22

45 Q. Yes. But you didn't tell your management I am between a rock and a hard place here, which instructions do I follow? 10:22

A. As far as I know, at that stage they already knew. They already knew that I was between a rock and a hard place.

46 Q. Certainly the email from Mr. O'Brien - just let's scroll up, please - might suggest that. Thank you. 10:23 Just down a little bit. Mr. O'Brien responds to Ms. McCaul. What Mr. O'Brien writes is:

"I have been greatly concerned, indeed alarmed, to learn of this directive which has been shared with me 10:23 out of similar concern".

That is you sharing the email with Mr. O'Brien?

A. (Witness nodded).

47 Q. You suggested you had a similar concern to him. What 10:23 was that concern that you had?

A. I think it was the fact that I needed the cooperation of the clinician. It is not something I could have done without his approval because at the end of the

day, his DARO would have been sitting with 300 odd, and if he wasn't going to action it, where did that leave me?

48 Q. Okay. You had no particular concern about the DARO system itself, your concern was how am I going to operate it if Mr. O'Brien doesn't cooperate with me? 10:24

A. Yes. Well, there is pitfalls with the DARO as well, and historically people have been sitting on DAROs for years before clinicians sign them off.

49 Q. So again that -- 10:24

A. That has been happened in surgery, yes.

50 Q. That is not a pitfall of DARO, is it?

A. It is a pitfall of the system of the way it's managed, I suppose.

51 Q. It is a pitfall of the clinician not actioning? 10:25

A. But that did happen.

52 Q. Yes, yes. Nobody is suggesting that DARO can compel a clinician to take the action. DARO is a safety net which allows the system to have visibility on the patient so that the patient doesn't get lost? 10:25

A. They are not lost but they are not sitting on a review waiting list. So, they are sitting in a no man's land.

53 Q. Until the clinician takes action?

A. Exactly. If the clinician doesn't take action, the patient doesn't be treated. 10:25

54 Q. The alternative is as Mr. O'Brien practised, which is to take it out of the DARO system and manage it according to his approach, which was, as you conceded I think earlier, which was at risk of the patient being

lost?

A. It is not at risk of a patient being lost, it is at risk of the patient being seen in a timely fashion due to the long waiting lists. If the waiting lists weren't so long, everything would have worked fine. It was just the fact that he had such long waiting lists.

55 Q. The purpose Mr. O'Brien writes of the reason for the decision to review a patient is indeed to review the patient. 10:26

"The patient may indeed have had an investigation request to be carried out in the interim and to be available at the time of review of the patient. The investigation may be of varied significance because of the review of the patient but it is still a clinician's decision to review the patient". 10:26

He is making the case, as I think you outlined earlier, that these matters should stay with him; he should have control of the leavers in terms of when and for what reason the patient should be seen? 10:27

A. That's correct, yes.

56 Q. He sets out further concerns.

Mr. Haynes is brought into this debate. If we scroll up. He explains that the process is now a urology process but a Trust-wide process. It is intended in light of the reality that patients in many specialties do not get a review at the time intended and many cases 10:27

take place years after the intent to ensure that scans are reviewed and in particular unanticipated findings actioned. Without this process, there is a risk that patients may await review without a result being looked at. There have been cases (not urology) of patients' imaging not being actioned and resultant delay in management of significant pathologies. As stated, this is a Trust-wide governance process that is intended to ensure there are no unactioned significant findings. There is no risk in the process described". 10:28

Did Mr. O'Brien speak to you after he had raised his objection with Ms. McCaul?

A. He did, yes.

57 Q. Did he change his approach? 10:29

A. No, he didn't.

58 Q. Did he show you Mr. Haynes' explanation?

A. I can't remember seeing this until I got it in my pack.

59 Q. All right. So, was there any debate between you and Mr. O'Brien about the difficulty you faced? You had instructions from your service administrator to follow a particular process, and Mr. O'Brien, notwithstanding his knowledge of what the Trust was saying back to him through his Associate Medical Director, Mr. Haynes, was that explained to you at all? 10:29 10:30

A. No. Although I had a meeting with Katherine Robinson and we had a workaround of how I would be kept sort of assured that I knew where things were. So the system we set up was that whenever a result came in --

whenever a patient attended a clinic and there was a scan ordered, I always kept the chart in my office awaiting results. So those were kept on a shelf in my office. Once the result came in, that chart then was moved to another shelf which was tracked as "result with AOB to see". So, that was my reassurance that Mr. O'Brien had got that scan result or that blood result. Then, periodically I would have went through those charts to see if there was any action taken. So, that was my safeguard around the DARO. 10:30 10:31

60 Q. You would have, as the ultimate check, inquired into whether action had been taken by Mr. O'Brien or by the testers, by the radiology or pathology?

A. Well, once the scan result came in, it was obviously -- it was always left on Mr. O'Brien's desk, and the chart then was tracked to "result for AOB to see", so I knew that he had that result. That was my reassurance that that result is definitely in. The results awaiting -- or the shelf with awaiting results, periodically when I would have got time, I would have went through those, checking up if the scans had came through, if there was something outstanding for a long time, bearing in mind there was quite a long waiting list for some of these scans. 10:31 10:32

61 Q. If the result has come in and you have marked it as essentially transferred over to Mr. O'Brien, would you have taken any steps after that? 10:32

A. No.

62 Q. So, you wouldn't be in a position to know whether

action had been taken by Mr. O'Brien in light of the results?

A. Well, if he had have highlighted on the result back to me to book this patient for the next available clinic, then yes, that would have been tied up with the chart and sorted. But anything that I didn't get back still remained on that shelf with the descriptor "result for Mr. O'Brien to see". 10:32

63 Q. Anything that didn't get back from results remained on the shelf? 10:33

A. Yes, yes, that's correct.

64 Q. Katherine Robinson, in her account to the Inquiry -- if we could just go to the WIT-60388. She says at 28.4:

"The issues with use of DARO were frustrating and worrying. The secretary spoken to on at least two occasions to say that she should be following the instructions from her line manager and not the consultant regarding administrative processes. Although I have a log of these interactions, I do acknowledge that it is difficult for in the management of consultant secretaries is not easy due to the relationship of being managed by a different group of people. On this basis the issue was escalated to Mr. Haynes, the clinical director and this was reinforced. The secretary then did comply". 10:33 10:34 10:34

Let's just look at that, first of all. Were you spoken to on two occasions or at least two occasion to the

best of your recollection?

A. Yes. That would have been one of those meetings that I would have spoken with Katherine Robinson and the workaround was organised. To say that "the secretary did comply", it was not with the DARO, it was the workaround.

65 Q. Right. So, you're confident DARO wasn't used by Mr. O'Brien, the workaround was you to keep visibility on the movement of the charts -- 10:34

A. Yes. 10:35

66 Q. -- as results came in or if they didn't come in?

A. That's correct.

67 Q. Could I bring you to a document that we looked at yesterday, WIT-22816. This is the note of the meeting where, as we explained yesterday, as we looked at 10:35 yesterday, you were asked whether you had changed some entries on Mr. O'Brien's behalf. You tried your best to explain your understanding of that. You were asked about the DARO function, and you explained that you didn't use - that is Mr O'Brien and yourself - didn't 10:35 use all administrative processes, in particular the DARO function. You go on to say that:

"AOB hated using this function so Noleen had only approx 50 on her DARO list because she only used it 10:36 when registrars sent patients for results. For AOB's patients she used the outpatient waiting list as per AOB. This method was felt by them to be their safety net".

An example is recorded there.

If we go scroll on down to results, and this explains your workaround; is that right? 10:36

A. That's correct.

68 Q. "On receipt of paper form of results, these would be passed to AOB and the chart would be tracked to CAOBS".

Is that his office? 10:36

A. That is the secretary's office.

69 Q. Your office.

"With "result for AOB to see". This was proof that AOB had been passed the actual result. These charts 10:37 remained in the secretary's office until the result was returned for Noleen for further action. Routine results never made their way back to Noleen, only urgent ones. Periodically Noleen went through the charts in the waiting results section of her office to 10:37 chase up anything outstanding. It was explained to Noleen that this was not foolproof and this is why DARO was introduced some years ago".

Do you understand the view that this approach was not 10:37 foolproof?

A. Yes.

70 Q. That DARO was the better approach from the administrative perspective?

A. From the administrative perspective, yes.

71 Q. You are aware, I think, that the serious adverse incident reviews that took place in 2020 and into 2021 identified two cases where results hadn't been actioned. Let me just briefly bring you to the conclusions reached in those reviews. If we turn to WIT-84298, we are referring here to service user C. Just scroll down a little, please. It says: 10:38

"Service user C had a delayed diagnosis of metastatic prostate cancer following successful treatment of renal cancer. This was due to non-action on a follow-up CT scan report". 10:39

Then just below that, Patient I had a delayed diagnosis of prostate cancer due to a non-action on a histopathology result at TURP. Service User C on the site that is in front of you, we refer to that patient as Patient 5, and Service User I is Patient 8. 10:39

A. Okay.

72 Q. Can I just ask you about the processes that you and Mr. O'Brien managed by looking perhaps briefly at the circumstances of Patient 5. Mr. O'Brien, in his response to the Inquiry in respect of Patient 5, sets out an account of his interaction with you on these issues. If we go to AOB-82738. If we just go to the top of the page, please. The situation is that Mr. O'Brien has arranged for a CT scan for this gentleman. That CT scan was performed on 17th 10:40

December - top of the page - 2019. It was reported on 11th January 2020. He explains, going to the second paragraph, that you would have retained this patient's chart in your office to awaiting the report of the CT scan; is that right? 10:41

A. Yeah. That would have been in the awaiting results shelf.

73 Q. So that chart would have been sitting on the shelf and you would be waiting on the result coming from radiology; is that right? 10:42

A. Yes, that's correct.

74 Q. But the results in terms of the system, Mrs. Elliott, do they come to you by email?

A. No, by post.

75 Q. By post. 10:42

A. It was only the Radiology Department would have e-mailed anything that was really like red flags, sort of needed urgent attention, those were e-mailed. But all the other results came through via post.

76 Q. This is a patient who had a history of renal cancer and the scan is pointing up a concern that he may have metastatic disease of the prostate, and suggesting, as Mr. O'Brien observes here, the need for further evaluation and the need for perhaps bone scan. So, that is something for him to consider. 10:42 10:43

Just in terms of process then, the paper copy arrives with you of the results. You record the receipt of those results, do you?

A. Yes. They would have been date-stamped. They wouldn't have been recorded on any database or anything, they were just date-stamped.

77 Q. On a hard copy you put a stamp?

A. Yes. 10:43

78 Q. With a date on it, okay. Then do you move the chart into Mr. O'Brien's office or how does it work?

A. No, it would have been moved then to the "results with Mr. O'Brien to see" shelf.

79 Q. Within your office? 10:43

A. Within my office.

80 Q. If these results are written up or recorded on 11th January, do they reach you fairly promptly after that --

A. Yes. 10:44

81 Q. -- in the normal way?

A. Normally they would have been the same week. Within a week at least.

82 Q. If you put them on the results received shelf or "for Mr. O'Brien to see" shelf, how does he get to know then 10:44 that you are holding a set of results that he has to see?

A. The result was left on his desk. So the result went, the paper copy of the result --

83 Q. Oh I see. 10:44

A. -- went to his office.

84 Q. So you continue to hold the chart?

A. Yes.

85 Q. He gets the result?

A. Yes. Now bearing in mind this was whenever Aidan didn't want any charts in his office because he was being monitored for the number of charts in his office.

86 Q. Well, if he needed to check back on the chart to see a fine detail or whatever to remind himself of something, was the chart was close at hand, you were holding it? 10:45

A. It wasn't really relevant in 2018 because NIECR was operational by then so all information would have been there.

87 Q. So, I think the paper copy of the result is now with Mr. O'Brien within presumably the day you receive it? 10:45

A. Yes, the same day, unless I was on leave or the post was held, you know, not opened.

88 Q. But it would be date-stamped, so that would be the day it would go? 10:45

A. To his office, yes.

89 Q. Yes. Then it is on his side of the court to action?

A. Yes.

90 Q. Now, if he anticipated reviewing that patient in January, what would you expect the next step to be from him to you? 10:46

A. He would have either e-mailed and asked me to put the man on the next available clinic, or it would have been hand written on the result, 'please book this man to my Friday oncology clinic' or whatever. So there was either an email back to me or the result came back to me with a hand written note on it. 10:46

91 Q. Just returning to what Mr. O'Brien says about this.

"My secretary had retained Patient C", or service user C - we call him Patient 5 - "hospital chart in her office to await the report of the CT scan so this chart would be available for his intended review in January. She transferred the chart with the report of the CT scan to my office on some unspecified date following receipt of the report".

Can I just ask you about unspecified date. Do you know what that means? 10:47

A. I don't know what that means, no.

92 Q. If we obtained the report, would we see a date on it? It should be date-stamped?

A. The report should be date stamped, yes. But tracking, I am not sure about the tracking of the chart, to be quite honest. To me, the chart being tracked is irrelevant. If the report went into Mr. O'Brien's office, it is irrelevant whether there was a chart attached or not. 10:47

93 Q. Yes. Where he says "as she did not track the transfer of the chart from her office to mine, it has not been possible to determine when it occurred", what you are saying is your approach is not to transfer the chart, it is to transfer the report? 10:47

A. Yes. 10:48

94 Q. The report will have a date stamp on it?

A. That's correct.

95 Q. And that will be the date that you would place it in his office, place it on his desk.

He says:

"It is probable that it was during February 2020 due, once again, to my not being able to review SUC during January 2020 due to the inadequacy of outpatient review capacity. In fact he still remained on the list for review at my oncology review clinic in June". And I think that should say 20 20 and not 2019?

Help me with this, if you can. If the result goes on to his desk, date-stamped, you would expect some action to flow from it in a case such as this where there is a need for follow-up investigations for the patient? 10:48

A. Well, this is an example of a patient that wasn't on DARO. So he was already - if you are saying that is June 2020, he was already on for review in June 2020. If that particular result warranted that patient to be brought, his plan to be brought forward, then Aidan would have let me know to bring that patient forward or to book him to the next available clinic, which was obviously an oncology review because he was on the oncology review waiting list. 10:49

96 Q. As regards this particular case, you didn't receive any follow-up instructions from Mr. O'Brien?

A. No, mustn't have whenever -- well, I am not aware of any follow-up, no. 10:50

97 Q. Help me with the rationale that is set out here, if you can. Mr. O'Brien is saying it is probable that the chart came to his office during February due to him not

being able to review the patient during January 2020. Do you understand what that means?

A. No, no, sorry. I have no recollection of that happening.

98 Q. If the results are available within days of them being reported on 11th January, was it Mr. O'Brien's habit, to the best of your understanding, to review results quickly, or did he tend to wait until he had a review clinic arranged or review appointment arranged for the patient? 10:50 10:51

A. No. It's general practice that a clinician looks at their results on a daily basis, you know. It was very hard for me to monitor that because Mr. O'Brien would have taken the results with him in his briefcase. The results were never left in his office so it was very hard to monitor. 10:51

99 Q. On a case such as this, results have come in, he wants to review him in January. How would that review be set up? Who would make the arrangements for that?

A. So, Mr. O'Brien had full control of his oncology review, so the majority of those patients would have been patients for review following the MDM, and then there would be the additional slots where he would have reviewed this type of patient. There was always a review backlog there, and this is obviously what he is speaking about when he says that he hadn't the capacity. 10:52 10:52

100 Q. The result has come in; he wants to review him, it suggests here. He has, if you like, the role or the

authority to make an appointment for this patient but he has to have the capacity, he has to have the space to do so?

A. That's correct.

101 Q. Are you interpreting that as saying he simply didn't have the space to fit this patient in? 10:53

A. No. This was an ongoing problem with the oncology clinic. Mr. O'Brien would have endeavoured to have the full day. His oncology clinic was always on a Friday, and he very, very regularly would have had an all-day oncology clinic to try and clear up this backlog. This was all extra work that he would have done over and above. 10:53

102 Q. Do you have visibility on the needs of the patient in a situation like this? This patient had suspicion of metastatic prostate cancer, he needed a bone scan; that didn't come to light and wasn't actioned until July or August 2020. This was obviously a period of some destabilisation within the Trust with COVID, Mr. O'Brien retired and the circumstances around that. But in general, if we can look at it perhaps, where a review isn't possible because of the capacity reasons that Mr. O'Brien is suggesting there, and you agree with that, what happens in the meantime for a patient where the scan results are saying further action is required, this patient may have cancer? 10:53 10:54 10:54

A. Well, to me that is very much up to the clinician to make the arrangements around that. That is not something a secretary would have within her remit. We

certainly did not have the time to chase up every single result and see that it was actioned.

103 Q. If that patient had been on DARO, the service would have had visibility of the fact that results had come in from radiology; isn't that right? 10:55

A. That's right, yes.

104 Q. And would have had visibility that those results hadn't been actioned because the case still remained on DARO?

A. Yes. So our service administrator -- the narrative, should that person have been on DARO, how I would have 10:56 validated that DARO would have been "result with Mr. O'Brien to see and action". Now, that happened on a regular basis but our service administrator never came back to say why has this not been actioned, so I'm not sure whether it would have went anywhere. All right, 10:56 it would have been noted on the DARO but whether those sorts of things were ever actioned, I am not concerned -- I am not convinced that they were.

105 Q. Before leaving this, can I ask you two more questions in relation to this area? When results come in, is it 10:57 any part of your function to plan something, to make a quick assessment from a non-clinical perspective of how urgent a case might be?

A. Well, unless it really jumped out at you, we would have generally just read the conclusion. We certainly 10:57 hadn't time to sit and read all the results. It was very, I have to say ad hoc as to what time we had to read. We are not clinicians, so not all things I suppose that were red flag or of concern were

highlighted by the secretary.

106 Q. In terms of the cancer tracker, would you have any engagement with the cancer tracker when results came in, particularly where results suggested an unexpected course or a serious course for a patient? 10:58

A. This is just if they were a newly diagnosed cancer.

107 Q. Or in Patient C's case, where there had been a history of cancer and this was a situation where there was a suspicion of metastatic disease from the primary.

A. I am not convinced, I am not sure if this patient was on a tracking system within the MDT. I can't really comment on that because I am not sure. 10:58

108 Q. Yes, but what I'm saying is regardless of whether the patient is on a tracking system, if you as the secretary see something untoward in the result, do you have any role - I am thinking here from the perspective of an additional safety net - to get the thing moving with the cancer tracker? 10:59

A. No, no. No role, if that's what you are saying.

109 Q. You had no role in that respect? 10:59

A. No. I never referred anything to the cancer tracker for MDT discussion.

110 Q. Can I leave that area and ask you about your role in respect of private patients. Mr. O'Brien had a private practice; is that right? 10:59

A. Yes, a private outpatient practice.

111 Q. And he saw patients in his own home?

A. That's correct.

112 Q. You have said in your witness statement at WIT-76345

that you had no input into his private practice; is that right?

A. No. Apart from when patients would have rang me asking for a private appointment, I would have diverted them then to his private practice number. That was sometimes by email.

113 Q. We can see some examples of that, perhaps just briefly look at these, TRU-294353. Just to the bottom of the page, please. You're writing to Mr. O'Brien:

11:00

"The above patient was ringing regarding his review appointment. He attended your SWAH clinic on 13th of October '14 and was told that you review him in early 2015. There is no outcome logged on PAS. I have attached his PSA results for your information, can you please advise".

11:00

11:01

This is a case where the patient has been seen in October, it is now May and there has been outcome from Mr. O'Brien, there has been no dictation?

11:01

A. That's correct.

114 Q. And you can't see anything about that episode on PAS. Scrolling up the page, then. Have you assumedly fielded a call from the patient because you are now writing to Personal Information, that is Mrs. O'Brien?

11:01

A. That's correct.

115 Q. And the above patient has requested a private appointment, he has attended Mr. O'Brien's clinic on the 13th, I think that should say October, 2014.

Was Mrs. O'Brien Mr. O'Brien's secretary as such for private purposes?

A. That's correct, yes.

116 Q. We had a brief look at that yesterday, and you suggested in your statement to Dr. Chada that there was a typo in respect of -- 11:02

A. The chart requested.

117 Q. The chart requested.

A. You see Mrs. O'Brien, or the O'Briens, if I use that terms, they never requested the charts from me, it was from Leanne Hanvey. This is why I think that was a typo because I wouldn't have known who requested that, you would have just assumed that it was Mr. O'Brien. 11:02

118 Q. Although you know perfectly well that Mrs. O'Brien is the liaison person quite often in respect of private patients; that is why you are writing to her? 11:02

A. Yes, yes, as for the appointments system, yes.

119 Q. That was a not infrequent transaction between you and her? 11:03

A. Especially towards the beginning of my tenure with Mr. O'Brien. It sort of slacked off as time went on. There was less and less requests for these sort of appointments.

120 Q. And Mr. O'Brien had a private patient typist who did all of the typing in respect of his private work; isn't that right? 11:03

A. That's correct.

121 Q. And that was Mrs. Hanvey?

A. Miss Hanvey.

122 Q. Miss Hanvey, I beg your pardon. She worked within the Trust as a secretary in her own right?

A. In urology, yes.

123 Q. Obviously the private patient work was additional to her day job; is that right? 11:03

A. That's correct.

124 Q. Could I ask you about TRU-296740. This is 24th September 2018, and the query is in relation to private patient typing. You have said, "I have attached letter which were on G2"; that is the digital dictation system? 11:04

A. That's correct.

125 Q. "I note that you actually saw this patient privately and wonder if these should be on your private patient letterhead paper instead. There were no recent episodes on PAS for me to link this to. Can you please advise". 11:04

Just if we scroll I think up, please. It is down, I beg your pardon. So, this is the letter that you have typed; this is a letter to the general practitioner on behalf of this patient. If we scroll just down a little, maybe. Mr. O'Brien has evidently seen this patient privately in September 2016. If we scroll down to the end of the letter, please. More recently, because this letter is 2018 - just scroll up to the end so we can see when it has been typed - so you are typing this following dictation on 22nd December 2018. 11:04 11:05

Mr. O'Brien, having seen the patient more recently, there is a letter to the patient on the next page which suggests he had spoken to the patient by telephone --

A. Yes.

126 Q. -- in September 2018. This has been typed up, this is the result of that private consultation being typed up by you. So, you appear to be concerned that you are typing up the outcome of a private patient encounter; is that right? 11:06

A. Yes. At that time, yes. It was clarified by Mr. O'Brien. 11:06

127 Q. What was your concern and tell you us how it was clarified?

A. All right. So this gentleman had no open outpatient episodes so therefore he wasn't on a waiting list. Whenever we type letters, we have to link it with an outpatient episode. Now, this man was actually on a waiting list and had been on a waiting list for many years for a TURP. That doesn't come up. Whenever you ask the PAS system for the outpatient episode, you don't see the waiting list episode. This is why I thought this man hasn't been seen for years so why am I typing a letter? But it turned out because he was on the waiting list for so long, Mr. O'Brien needed to reassess his symptoms, hence why he wanted to repeat the flexi and the urodynamics. So, Mr. O'Brien clarified that the telephone call was actually a virtual NHS appointment and that was how then I came to type that letter. The reason he had seen Mr. O'Brien 11:06 11:07 11:07

privately in the interim was because he was a neighbour of Mr. O'Brien's, or he lived very close to Mr. O'Brien, so it was out of just courtesy that he had saw him in his own home when he was experiencing difficulties during his long wait on the waiting list. 11:08

128 Q. So, your concern that you were typing up a private patient episode was resolved by Mr. O'Brien telling you that what, in fact, had transpired was a NHS remote telephone conversation?

A. Yes. 11:08

129 Q. Was that recorded as such?

A. As far as I am aware, yes. I would have had to have opened up and attached that then to an open episode, outpatient episode.

130 Q. This patient has obviously been seen for flexible cystoscopy and urodynamic studies within three weeks of him being seen by Mr. O'Brien remotely by telephone in September. You have explained that there were no PAS, no PAS episodes to link this case to when you were typing this letter; was that unusual? 11:08 11:09

A. As I say, I didn't appreciate that he was on the waiting list for surgery. When someone is put on the waiting list for surgery, they don't generally have an outpatient episode open as well; it is either one or the other. They are either coming in for surgery or they are coming in for review. It was because Mr. O'Brien wanted to reassess this man's symptoms because he was on the waiting list for so long that that episode, outpatient episode, had been to be 11:09

reopened to enable him to do this.

131 Q. How does Mr. O'Brien arrange a remote telephone engagement with a patient on the NHS when his previous interaction with him in 2016 had been private? How does that come about? 11:10

A. That would have been done -- we would have done that retrospectively. So, the clinicians would have rang patients. There was never -- I know there are some consultants where they set up virtual clinics. So, the secretary sets the clinic up and then the patients know 11:10 they are going to be rang on such and such a day at such and such a time. But that didn't happen in urology. The clinicians would have rang the patients and then we would have set up the episode after, retrospectively. 11:11

132 Q. So, this is an Outpatients remote conversation?

A. Yes.

133 Q. Mr. O'Brien presses on with that and then he tells you about it and you record it retrospectively; is that right? 11:11

A. Yes, that's right. This was a new concept that sort of came in and then was increased, the usage was increased during COVID. Virtual clinics were only really starting to come in in the latter stages just before COVID hit. 11:11

134 Q. Are you saying that this patient had been on the waiting list for cystoscopy since when?

A. I can't remember because there was actually another -- there is another email from my service administrator

saying that this man was never put on the waiting list, and it is the same man because it went that far back. Whenever you have someone on the waiting list quite a while, there are -- whenever you go into PAS, you can only see about six episodes. Sometimes you have to scroll down maybe three or four pages before you get the actually waiting list episode.

135 Q. Were you able to find him on the waiting list?

A. Oh yes, he was on the waiting list, yes, but it was, I don't know -- this was '18. I have a funny feeling it would have been 2014. I am not 100% sure but I think it was 2014. 11:12

136 Q. Yes.

A. I don't know, did Mr. O'Brien refer to it at the beginning of the letter? 11:12

137 Q. Let me scroll up.

A. Maybe it was '16. I think he referred to this man is on the waiting list. Maybe not.

138 Q. By the end of '15, or by April '15, he reported significant improvement and then in '16 he reported recurrence of former symptoms. Scroll down. Then he prescribed medication. Scrolling down. 11:13

A. If you notice there on the bottom of that first page, he had said there - scroll up, please - "he would be better served". Yes, so last paragraph there, "I advised that he would be better served by his prostate resected". So, it could have been September '16 there, according to that. 11:13

139 Q. Your concerns that this was a private patient episode

were resolved for you when you spoke to Mr. O'Brien.

If we could look at your witness statement, please, at WIT-76342. Here you explain at 24(i) that you were responsible for putting patients on the waiting list for surgery, and preadmitting patients when requested by Mr. O'Brien? 11:14

Did you follow that approach for patients who had seen Mr. O'Brien privately and were coming into in the NHS system? Was it your responsibility to list them for surgery and pre-admit? 11:15

A. No, because I wouldn't have seen those private letters so I didn't get a chance to do the outcomes of those private letters. 11:15

140 Q. Right.

A. That wasn't within my job, you know. I didn't see those.

141 Q. Help me with this. If we go to your amended statement at WIT-96807 and if we scroll down, please, you're explaining it at answer 2. Just scroll down a little bit further. Your first answer in your original statement is set out first. 11:15

A. Hm-mhm.

142 Q. You said: 11:16

"Initially I have stated however the patients Mr. O'Brien had seen privately were not on the Trust PAS waiting list. I was able to check the chart

tracker on PAS to see when the patient's chart was tracked to Mr. O'Brien's filing cabinet by Leanne Hanvey, who did all Mr. O'Brien's private patient typing and this is the date that I used to put the patient originally as seen as a private patient by Mr. O'Brien on the NHS wait waiting list". 11:17

You say you want to change that. You have added: "However if the patient(s) Mr. O'Brien had seen privately were not on the PAS waiting list, I was able to check on the chart tracker on PAS to see when the patient's chart was tracked to Mr. O'Brien PP filing cabinet by Leanne Hanvey. This was the date I used to put the patient originally seen as a private patient on to the NHS waiting list". 11:17

Can you help us to understand the distinction that you are drawing here?

A. Well, that very case that we were speaking about last was one case where that patient was on the waiting list, so this was me just the correcting that not all private list patients were not on the waiting list. It was only when they were not on the waiting list that I used this method of putting them on the waiting list. 11:18

143 Q. Okay. I think that maybe we were confused. I was asking whether you had a role in putting patients moving from the private into the NHS onto the waiting list and preadmitting them. Is that what you are describing here? 11:18

A. Yes, sorry.
144 Q. That when a patient had been indicated for a procedure, your role kicked in at that point?
A. Sorry, could you please repeat that? Sorry.
145 Q. When a patient originally seen by Mr. O'Brien as private -- 11:19
A. Yes.
146 Q. -- was moving into the NHS for a procedure --
A. Hm-mhm.
147 Q. -- you had a role at that point? 11:19
A. No.
148 Q. No. What are you describing here?
A. It was whenever I was preadmitting, so when Aidan gave me the theatre list for his next theatre session and the patient wasn't on the waiting list, this was 11:19 whenever I checked the tracking of that chart and determined that it was a private patient. Then, I needed a date to add that patient to the waiting list. Because I had no way of knowing when the patient was seen, I - and I know it now to be wrong - I used the 11:19 tracking date that that chart was tracked to Mr. O'Brien's PP cabinet as the date of the patient going on the waiting list. I now know that to be incorrect.
149 Q. Why is that incorrect? Let me put a scenario to you. 11:20 Mr. O'Brien sees a private patient on a Saturday and he decides that the patient should come in for a procedure, and he takes a view on the priority of that patient.

A. Hm-mhm.
150 Q. He will then contact you; is that right?
A. No, he never -- no. As I say, I did nothing. I had nothing to do with his private practice.
151 Q. Okay. The private patient is moving to the NHS, he is an NHS patient, he needs a procedure. 11:20
A. Hm-mhm.
152 Q. You have to pre-admit that patient for that procedure; no?
A. Only when he is being preadmitted, which isn't at the time of the consultation. You never would have a patient coming to see him on a Saturday and put on the following Wednesday. So there was always a time lapse. 11:21
153 Q. The patient is coming in for the procedure within the next month or so? 11:21
A. It is not. It would never be months.
154 Q. Would it not?
A. Well, not to my knowledge, no.
155 Q. Well, take that as the scenario. How do you arrive at a waiting list date for that patient? 11:21
A. Right, I'll give you the scenario. So, Mr. O'Brien's --
156 Q. Just in terms of what you are describing here, you have the chart coming back into the private patient cabinet; isn't that right? 11:22
A. Yes, by Leanne Hanvey. I had nothing to do with the tracking of that chart. So, I needed a date to put that patient on the waiting list. I hadn't time to run around the hospital looking for Mr. O'Brien to find out

a date. As I say, I incorrectly used the date the chart was tracked into the filing cabinet as the date of admission. I just needed a date so that I could pre-admit the patient.

157 Q. Okay. If that was a mistake on your part to use the date when the patient's chart arrives in the private patient filing cabinet, if that was a mistake, what should the date have been? 11:22

A. The date the patient was attended for consultation.

158 Q. What consultation? 11:23

A. Private consultation.

159 Q. That should --

A. Of which I didn't know.

160 Q. If the patient had seen Mr. O'Brien four weeks earlier, six weeks earlier, and a decision had been made that that patient should go for a procedure, that is the date you should have used? 11:23

A. That's correct. The date as in with the NHS as well. It is the date that the decision was made for the procedure is the date they go on the waiting list. 11:23

161 Q. What you were finding with many patients who had their origin in his private practice was that there was no record on PAS, on the PAS waiting list?

A. Some people would have maybe went to him privately because they weren't being seen, they are on the long waiters outpatient waiting list. So there could have been some people with episodes opened, new appointments waiting that had went to see him privately. But I would assume Leanne Hanvey should have closed those 11:24

down. As I say, that was out of my control because I didn't take anything to do with his private work. It was when they transferred into the NHS that I became involved.

162 Q. You have said that your approach is wrong, or was wrong? 11:24

A. Well, I know now it to be. When I say wrong, it is inaccurate, is probably a better word.

163 Q. When did you come to that view?

A. Well, whenever all this came up in the Inquiry, I thought I need to put my hands up here and say what I had done. 11:25

164 Q. Who told you you had taken the wrong approach?

A. Well, I knew myself that it wasn't an accurate date.

165 Q. In terms of your training in respect of the handling of private patients or advice given to you by the Trust in respect of private patients, can I draw your attention to this brief guide for administrative staff? It is TRU-165872. This was sent to administrative staff and shared with secretaries in 2014. It is a very brief one-page document. Just scroll down. What you need to do, it says you need to "Ensure the status of private patient is recorded on the PAS system". 11:25 11:26

First of all, do you remember getting this guide? 11:26

A. I don't, no.

166 Q. Were Mr. O'Brien's private patients recorded on the PAS system as private patients?

A. On the waiting list? If they were on the waiting list,

or?

167 Q. Well, I can only use the language in front of me.

A. I don't understand it. "Please ensure the status of private patient is recorded"; I don't know what that is referring to. 11:27

168 Q. Is the patient on the PAS system; if he or she is private, that should be labelled as such?

A. You see, once the private patient came in under the NHS, they were an NHS patient, they were no longer a private patient. So I don't understand that because they were no longer a private patient and they were treated equally to other patients. 11:27

169 Q. So, there is no method on the PAS system to record alongside the patient's name that they are a private patient? 11:28

A. Well, if they were attending a private consultation they wouldn't be on the PAS system.

170 Q. But if they are coming into the hospital, for example, from the Republic of Ireland, they are a private patient? 11:28

A. I'm not aware of that.

171 Q. No.

"For booked patients with a Republic of Ireland address, ensure the patient is recorded as private on PAS", to take that example. 11:28

A. I don't remember ever anybody from the Republic of Ireland being on my books.

172 Q. So you know, I suppose the broad question is this: Are

you saying that you are not aware of any method to use the PAS system to label the patient as a private patient?

A. Not at that time, no. The only time I would have said somebody was transferred over to the private sector was whenever there would have been an episode opened and they would have been seen privately, then you would have said attended AOB privately and closed down that episode. 11:29

173 Q. If we look at WIT-96807 and if we scroll down to paragraph 3, please. In terms of your role in dealing with private patients coming into the NHS, you have explained how you came by using the chart hitting the cabinet as the date for waiting list purposes, and you have said, I think, that that was wrong? 11:29 11:30

A. Hm-mhm.

174 Q. You have said at paragraph 3; "then there was the introduction of the transfer status form" and you are not sure of the date?

A. Well, this was post inquiry -- or and post MHPS process. 11:30

175 Q. Could I just draw your attention to the following documents briefly. If we go to TRU-267692. This is a copy of a transfer status form, the transfer of private patients to NHS status. It is contained at Appendix 4 of a guide relating to paying patients, which was introduced in 2016. The Inquiry has material which shows that the private patient transfer form in one shape or another was in operation from at least as far 11:31

back as 2009/2010, and the form has changed in its appearance over the years but has been included in a number of guides for practitioners in 2011, 2014, and this one is from 2016. Is it fair to say that you only began to see the use of these forms in the period after the MHPS investigation? 11:32

A. Yes, that's correct.

176 Q. Did you see them coming through your office?

A. Yes. Mr. O'Brien would have left them for me, and I would have put the patient on the waiting list and then they had to go down to the cashier's office. That is where they went after I had done my bit. 11:32

177 Q. So, describe the circumstances in which they would have been used, as you understand it.

A. Just as it says, the transfer from a private patient into the NHS. So this was now the last -- the date of the last private consultation there, that obviously would have been the date that the patient was put on the waiting list. It would have been the NHS waiting list so they would have been... I don't believe we were ever said that you had to highlight them as a private patient because they were not a private patient. Once they hit the NHS waiting list, they were treated -- they were an NHS patient irrespective of what happened prior to that. 11:32 11:33

178 Q. Prior to you starting to see these forms after the MHPS investigation, prior to that what was the method used by Mr. O'Brien to move the patient from private into NHS?

A. Nothing that I was aware of. When the patient was being pre-admitted that I used the method that I have described before.

179 Q. How would the system have known that the patient was transferring his or her status? 11:34

A. It didn't know until they were admitted.

180 Q. Did you understand that the regulation of this area required the Medical Director's office to give approval to the transfer?

A. No. No. 11:34

181 Q. That wasn't something you were aware of?

A. No, and I actually worked with two other secretaries in the office that had the same; their consultant done private work. None of them -- they actually started using these forms after Mr. O'Brien was using them. To 11:35 my knowledge, no secretary was aware that this is what was required.

182 Q. Just looking at one of the principles set out in the form, or in the guidance, if you go to TRU-267673, it says that... just go over the page, sorry. Where a 11:35 change of status is required, the form we have just looked at must be completed and this has to go to the medical director for approval.

Just go back to the previous page. There it is. 11:36 4.4.1.

"A patient seen privately in consulting rooms who then becomes an NHS patient joins the waiting list at the

same point as if his/her consultation had taken place as an NHS patient".

I am thinking back to the period before you became aware of the transfer of status form. In your role, were you able to ensure that when a private patient comes in to the NHS, that he or she joined the waiting list at the same point as if her consultation had taken place in the NHS? 11:36

A. Yes. I would have been aware that there was no preferential treatment for private patients. That is why I say that the date I used for putting that patient on the waiting list was inaccurate, and that was a fault of mine. 11:37

183 Q. The date you used, the more recent date, if you like, you are concerned that that would give the impression that a private patient had been advantaged -- 11:37

A. Yes.

184 Q. -- in some way?

A. Yes. 11:37

185 Q. Do you have a means of ascertaining or satisfying yourself that private patients hadn't been advantaged?

A. Sorry?

186 Q. Are you able to ascertain from your position that private patients weren't advantaged? 11:38

A. I don't know whether they were or not because I have never seen dates to check that out. I don't know when patients were seen. Because I wasn't involved in Mr. O'Brien's private practice, I cannot comment on

that.

187 Q. The position would perhaps be susceptible to inquiry if the date had appeared on the PAS system, in other words if the waiting list system had been used. But you were finding in many of these transfer cases that you couldn't find patients on the waiting list? 11:39

A. That's correct.

188 Q. Just briefly then to conclude, Mrs. Elliott. Some of your reflections contained in your witness statement refer to the extremely long waiting lists. I think you say that your main concern in urology was these extremely long lists, there was not enough capacity to deal with the workload and therefore patients suffered. You talked about how you had been, I suppose, taught coming up in the Trust, particularly in your governance roles, that we should be aiming for a gold standard, as you describe it, but that wasn't deliverable as time went on. Is there anything more you want to say about that? 11:39 11:40

A. I think there seems to be a bit of a disconnect in what governance inspired to do and what is actually happening. It is just not achievable to have that gold standard. 11:40

189 Q. One of your reflections as well is that management needs to engage more with the workload. Was that a disconnect as well? 11:40

A. Very much so, yes.

190 Q. What could they have done about it, do you think? What should they have done about it?

A. Well, I think they just started to strip away any support we had.

191 Q. This is on the administrative side?

A. Yes. So we started off with four, I think four audiotypists; we ended up with one, and we were just expected to work harder and harder. 11:41

192 Q. You have reflected in your statement at WIT-76358 that the move to the Breast Service, I suppose, has led to an improvement in your working environment and you find it to be a more effective service. What are the differences that you are observing from a position as a medical secretary in that service by contrast with the Urology Service? 11:41

A. It is basically the difference in day and night.

193 Q. Could you give us one example of how things work better and are better for patients because you're able to do your job as a secretary in a better way to work? 11:42

A. Because you had more time to do it, more time to check on things. We attend the MDT meetings so you are very much aware of the cases that are discussed at MDT and you follow it up. It is just a pleasure to work in compared to urology. 11:42

194 Q. Okay. I have no further questions for you. The Chair will speak to you.

CHAIR: We will have some questions. I am going to give you the option, if you'd like us to take a short break and come back in about 15 minutes. 11:42

A. Okay.

CHAIR: Okay. I don't know how long we will be but I

just thought you had a long enough morning and we will take a short break. 12:00.

THE INQUIRY BRIEFLY ADJOURNED AND RESUMED AS FOLLOWS:

12:00

THE WITNESS WAS QUESTIONED BY THE PANEL AS FOLLOWS:

CHAIR: I am going to hand you over, first of all, to Mr. Hanbury, who has some questions for you.

195 Q. MR. HANBURY: Thank you very much. Just a personal view that I have could not have survived 30 years in the world of urology without a good secretary, so I am sort of coming from that. I have some sort of clinical operational questions for you. First of all, in the office, it is obviously a shared office, we have visited it. You shared it with Mr Young's secretary as well; who was the other secretary? 12:00 12:01

A. Mr O'Donoghue's secretary. Towards the end there was a lot of change. Mr O'Donoghue's secretary, and then Mr Tyson's secretary who replaced Mr. Suresh. So, there was -- at the end there was four secretaries in the one office. 12:01

196 Q. I mean, you mentioned the atmosphere. You could discuss operational issues with the other secretaries for advice and what would you do with this and what would you do with that. Did those sort of conversations happen? 12:01

A. Yes. The previous referral I made to the atmosphere was another office. It wasn't that office.

197 Q. Right.
A. I moved offices whenever I went to work for Mr. O'Brien.
198 Q. That was the one you ended up with, that was a sort of helpful and supportive atmosphere? 12:02
A. Very much so.
199 Q. Was it? Okay, thank you. You mentioned working four days a week but presumably the audiotypist didn't really pick up much of the Monday queries. Did you have to pick up five days' worth of work in four days? 12:02
A. Yes. Well, apart from the short period of time in 2018 when the audiotypist was upgraded to a secretarial post for about six months before she then got a secretarial post in another speciality. But she was very good and would have done a lot more administrative work on the 12:02 Mondays. But that, as I say, was for a short period of time. Then the audiotypist that replaced her when she left would have just took messages. So, I would have got a raft of messages when I came in on Tuesday morning for me to contact patients. 12:03
200 Q. So she had taken messages but not actually done anything about it?
A. No.
201 Q. What about when you were on annual leave, for example?
A. Annual leave the other secretaries would have covered. 12:03 We all had to cover each other.
202 Q. All right. Thank you. You said interestingly yesterday how could a secretary encourage the clinician? I think you can do that quite well but it

needs face-to-face. There seemed to be a big culture of e-mailing rather than discussion face-to-face; is that a fair observation? You said you saw Mr. O'Brien sort of twice a week but he was in, say, four days a week, and your offices were very close? 12:03

A. That's correct but he very seldom was in his office. Well, obviously he had the clinic activity and those clinics were all held in the Thorndale Unit. He had his all day theatre list. He usually would have came up maybe midday on his theatre day; just pop in more or less. A lot of these, the popping into like the office, was like a courtesy pop in. As regards one-to-one and face-to-face consultations, there were very limited. 12:04

203 Q. If I could just draw you on that. The popping in, that is a good opportunity for you. Would he say how's things, is there any worries, any nasty results type of thing? 12:04

A. Yes. For instance on the undictated clinics, periodically I would have said 'any chance of you sorting those clinics out'. That would have been my chance then, you know, to have, I suppose what you would say encouraged. 12:04

204 Q. But then also if you had had a worrying result, for example, that you had picked up or jumped out as you say, would you say actually do you mind having a look at those two, for example. Is that something you did regularly? 12:04

A. Yes. Sometimes if there was something that jumped out,

I would have actually went down to the clinic, to the urology clinic down in Thorndale if I thought there was something that really needed his immediate attention. That was done on a regular basis, especially on a Friday because I knew I was going to be off on the Monday. He always had his oncology clinic on a Friday so I quite often attended that clinic with urgent issues. 12:05

205 Q. Okay. All right, I will come back to that one. Just a few questions on the surgical admissions. You said most of the information came in via email. Was there an actual form or a card that the clinicians would write out and submit to you in paper form, or was it all done electronically? What was it? 12:05

A. Right. So, if a patient -- the Trust policy is that if a patient is added to a waiting list, there is a green form filled out. That is for the purpose of the pre-assessment unit, so that they could then pre-assess the patient and all the information would be on that form regarding if they were on a blood thinner or if they were diabetic and so forth. 12:05 12:06

Mr. O'Brien didn't normally use those green forms, or he very rarely used the green forms.

206 Q. What would happen with the green form if it was filled in, would that come to you or a central wait list? 12:06

A. It came to the secretary and then the secretary would have sent it down to the pre-assessment unit.

207 Q. Then would the patient be pre-assessed there and then

or with respect to the upcoming operation?

A. Well, it depended if they were red flag, they would be pre-assessed as soon as possible. If they were on a routine waiting list, there was no urgency. But there would have been a case where people were pre-assessed even though we knew they would not be coming in for that surgery for years. So, that gave that patient sort of a false hope that they were going to be operated on fairly soon. So that was like a fault in the system that caused a lot of extra phone calls to the secretary. 12:07

208 Q. Okay. But then say the green form had not been filled, then the pre-assessment people wouldn't know that various things needed done?

A. No, they would have known because they obviously were able -- once someone was put on the waiting list, it obviously fired up on their system. 12:07

209 Q. Right. Okay, I see.

A. The purpose of the green form was regarding any extra information as in the blood thinning products, diabetes, and those sort of bits of information that were relevant for the pre-assessment department. 12:07

210 Q. All right. So, for example, if someone needed a urine test before a ureteroscopy or a stent change, that would be on that green form? 12:08

A. No. Mr. O'Brien would have organised that on the pre-assessment note that he gave me. So, he would have sent me the email with the people that were to be pre-admitted, and on that he would have had

instructions for the ward staff. Say, for instance, a patient, as you say, was coming in for the afternoon session, he would have either brought them in the day before if they needed tests done the day before, or he would have brought them in early morning and asked the ward staff to do those tests prior to him going down to theatre.

211 Q. Right. That brings me on to my next question. He would e-mail you with a list of case for his operation list, for example the main session, what would roughly the interval have been between then and the theatre list? Would it be the following week or month? 12:08

A. No. It was normally was -- he would have done it at the weekends. Say I got it on the Tuesday, it would have been for the following Wednesday, so the Wednesday week. 12:09

212 Q. So roughly 10 days?

A. Roughly 10 days.

213 Q. All right, which is fine for simple tests. Say if a patient needed something more sophisticated, like to see a consultant anaesthetist or if it was high risk, for example, how was that dealt with? 12:09

A. Aidan would have sorted that out himself with the anaesthetist, or he would have liaised then with pre-assessment. 12:09

214 Q. Was that enough time to get that?

A. Yes. He would have been very proactive in preparing patients for his theatre, and that wasn't always involving me.

215 Q. I accept that. We have heard from one of the anaesthetist in this Inquiry that they needed a reasonable amount to time to plug patients into clinics. Perhaps 10 days is pushing that a bit, or you couldn't comment on that particular aspect? 12:10

A. No.

216 Q. But roughly 10 days or so?

A. Roughly.

217 Q. Thank you. Another thing is that you organised the admissions for the local anaesthetic procedures like 12:10 flexible cystoscopy, urodynamics.

A. That's correct.

218 Q. Was that because the Thorndale Unit didn't have administration or support?

A. No, those flexis, those would have been the check 12:10 flexis. They were done in our Day Procedure Unit which is a separate building from the Thorndale.

219 Q. My question is more general in that were there other people helping with this administrative load or --

A. It was always the secretaries. 12:10

220 Q. -- were you responsible for every single procedure?

A. Yes.

221 Q. So, there was really no further administrative assistance in --

A. No. 12:11

222 Q. -- day surgery, Thorndale, and you have already said about main unit. Thank you.

A. No. The secretary done all the pre-admitting.

223 Q. Also, I was surprised. Radiology, say it had a

nephrostomy change or something like that, usually they have their own admin systems; why did you have to do that?

A. It was always the case, I have never known to be any different. They would have let us know when to bring the patient in and we done the arrangements or set up the arrangements with the patient. 12:11

224 Q. That is enough on that. Filing. On your evidence, you said sometimes there was Lever Arch files full of six or 10 files full of results of filing. What were they, were they like routine bloods or X-rays or is that a mixture of everything? 12:11

A. That was filing that I inherited when I took up post. It was a mixture of oncology letters. I would have taken the oncology letters out and tried to address them because at that particular time, the oncology letters weren't on the NIECR system. We tried to work through it. There was people brought in to try and address back-filing, but to limited effect. 12:12

225 Q. Okay. Thank you. The results, you have already explained a lot about that. Going back to an abnormal CT scan, for example, and Patient 5, where a decision has been made and you have the charts, Mr. O'Brien has the abnormal result, and then he would write on it or e-mail you. What were the sort of options he could have given you? For example, an urgent appointment on Friday afternoon oncology? 12:12

A. Yes. It mainly was to make an appointment. He would have specified when.

226 Q. With a time scale, for example?
A. Yes.
227 Q. Then you would have gone ahead and made that appointment; is that correct?
A. I made the appointments for all the oncology reviews. That was done by the secretary, not the booking office. 12:13
228 Q. Thank you. But obviously you were directed to do that in whatever time scale?
A. Yes.
229 Q. Was there another option for you to flag that up to re-discuss on MDM? 12:13
A. No, we never heard.
230 Q. So what was the mechanism?
A. It was --
231 Q. If he had had an abnormal report that he wanted to discuss at MDM, how would that happen? 12:13
A. Mr. O'Brien himself, the clinician, would contact the cancer tracker to be added to the MDM.
232 Q. Right. That would be done by e-mail, would it?
A. I am not too sure because we weren't -- the secretaries weren't involved in referrals to MDM. I am not sure how he did that or how any consultant did that. 12:14
233 Q. All right. Just on that same theme then, for example an abnormal pathology report in one of the other patients, it really doesn't matter which one. That piece of paper, if he had wrote on the report 'to discuss it at MDM', that wouldn't come through you, that would have to be done by Mr. O'Brien or the clinician? 12:14

A. Yes.
234 Q. Okay. Thank you. You mentioned the triage letters from Urologist of the Week. Often that was up to an extra 60 letters is what you wrote?
A. That was where you would say Aidan did advanced triage, where he would have requested scans and then the letter was generated to be sent to the patient to keep them informed of what their next appointment would be, i.e. the scan. 12:15
235 Q. So that was informing the patient what was happening. Did the other urologists do that as well? 12:15
A. As far as I am aware, yes.
236 Q. They wrote to patients. Thank you.
A. In some cases, if it was routine or an urgent, if it wasn't red flag in other words, he could have started them on a treatment plan knowing that they wouldn't be seen for years potentially. So, he could have started them on like an antibiotic or a low dose antibiotic for those non-red flag patients. 12:15
237 Q. Okay. Thank you. You mentioned about the stents. Again, this is related to admissions and sort of distressed patients phoning in, a couple we have heard from you. Were you aware of the sort of difference of the types of stents or the reason that people have stents? Either routine change, or a stone potentially blocking the kidney which needs a ureteroscopy and a laser. They are two quite different scenarios. 12:15 12:16
A. It was never explained to us, we were like self-taught. You got to know as time went on. Those sort of things

were never explained to secretaries.

238 Q. Okay. I suppose the next question is the patients who had the regular stent changes, like one of the SAI cases, they are done roughly every six months. How would that appear to Mr. O'Brien as someone who needed their stent changed at a particular month, say six months after it had been put in? 12:16

A. So, the descriptor on the waiting list episode would have been change of stent and then the date, like October '15 or whenever it was due. So that would have appeared then on the waiting list list, you know, of patients. 12:17

239 Q. Is that on a paper list or is that electronic? How would have Mr. O'Brien have seen that?

A. The waiting lists were produced by management every month, or bimonthly maybe, but Mr. O'Brien would have kept his own waiting list. I produced the waiting list from the patient centre or the PAS system. 12:17

240 Q. And that is hard copy or electronic?

A. I would have printed that off for him. He would have requested it periodically. 12:17

241 Q. So, he was aware of who was overrunning and who was...

A. Yes.

242 Q. Okay. Thank you. That is all I have. Thank you.

DR. SWART: I wanted to ask you a few things really about working in the office and getting all these phone calls from patients. It is very, very obvious that with these long waiting lists, people who are going to be ringing and I think you said you had a lot of phone 12:17

calls. Did you have a set way for the telephone to be answered if people weren't in the office? Was that set up in a way that there was always someone to take a phone call from a patient, or did you have an answer phone, or how did you do that? 12:18

A. There would have been an answer phone but when I was off on a Monday, the calls were always transferred. They would only have been put on answer phone for meal breaks.

243 Q. Were all those calls picked up then at the end of each period? 12:18

A. Yes. As soon as you would have returned to the office, you would have checked your answer phone.

244 Q. How did you feel about people ringing up and saying, 'I feel terrible, I am on this waiting list and nothing is happening'? How did you did you feel about that? Can you just go through how you dealt with it in terms of a pattern so that you could cope it? 12:18

A. The usual thing was, first of all, to check that they were on the waiting list, and then it was to advise them of the length of the waiting list and that we were trying our best to get them seen as soon as possible. If they were to say to me that their symptoms had deteriorated, then that is when I would have involved Mr. O'Brien and e-mailed. 12:19

245 Q. When you told them, what was the reaction usually like? If you said, you know, you are on a waiting list, this is the length of it, did they get cross with you or would they get upset, or what happened? 12:19

A. Yes, you had various different emotions coming from the patients.

246 Q. Were you given any guidance as to how to deal with all of this?

A. Not really, no. 12:19

247 Q. I know you said that you e-mailed Mr. O'Brien a few times. We know from reading patient complaints generally that this is a problem, quite a big problem, within the Trust and probably in another hospitals. Quite a lot of the patients feel that they are being 12:20 fobbed off generally. I am not talking now specifically about this situation.

What is your view, having done this for quite some time and had these people ringing up, what is your view on 12:20 how that should be dealt with?

A. I don't know how to deal with people when they are on such long waiting lists.

248 Q. How do you think people could possibly assess how much their symptoms have deteriorated, for example? Was 12:20 there any way other than sending an email to Mr. O'Brien for you? What options do you think you had?

A. The options was for them to -- we were told to send them back to the GP. 12:20

249 Q. Did you do that quite often?

A. Oh yes. We would always have said if you have symptoms that you need addressed, go first to your GP but I will let Mr. O'Brien know. So, there was always that

narrative, that you advised them to first of all seek help from their GP.

250 Q. In effect, did you have some patients who rang up repeatedly?

A. Oh yes. 12:21

251 Q. When they are on their third or fourth time ringing up, what kinds of things did they say to you?

A. Well, a lot of it was frustration. It was frustration too on my part because there was nothing we could do. I think they accepted that, that it was out of our 12:21 hands.

252 Q. Was there ever a time, for example, when you could liaise with some of the nurses or someone else to talk to them, because a lot of them would have had quite clinical complaints, I would think, and they would need 12:21 someone to talk to. Were there any discussions about how that might be managed within urology, as far as you were aware?

A. We were never actually advised that we had the nurses there for a backup. That was never something that I 12:21 was aware of, and I don't believe any of the other secretaries ever transferred to the clinical nurse specialist.

253 Q. What do you think; do you think that would have been helpful? 12:22

A. Well, I know now that that is expected and, yes, it would be very helpful. But at that particular time, those clinical nurse specialists were up to their eyes with work so they didn't need patient calls as well.

You know, they were under-resourced as well.

254 Q. The other time you spoke to patients was when they were going to come in for their operations, and you said you would be sometimes advising them on some of their treatments like blood thinners. Did that generate any conversations with them where you were supposed to be giving them advice, because you are not trained in blood thinners. Can you describe how that was for you and whether you had any difficulties with that? 12:22

A. No, I had no difficulties because Mr. O'Brien made the first phone call. He arranged the people, the patients to come in. He would have only asked me to remind the patient to come off the blood thinner on a specific day. 12:22

255 Q. They didn't ask you any questions about that? 12:23

A. No, because he had already that all explained in his first telephone call.

256 Q. Now that you are with the breast team and it feels like night and day, as you described it, what do you think is responsible for the different culture in that department? I know you feel you have more support; is there anything else that you have noticed that is different about the way that department works? 12:23

A. It works the same way but it is under less pressure.

257 Q. Specifically, though, you told us that in the breast team you went to the multidisciplinary team meetings. Did you feel there was less of a hierarchy in the breast team in terms of everybody recognising the importance of everybody in the team? 12:23

A. Yes, there is certainly more use with the clinical nurse specialist; they play a big part in the breast team. As I say, I attended the MDM and it means that you are very aware of outcomes.

258 Q. What is the situation when the patient is ringing up there? 12:24

A. Less patients ringing because they are seen within two weeks. The turnover is extremely fast.

259 Q. Even so, you said a few things that indicate that the relationship with management, as you call it, wasn't fantastic. Who do you regard as management? Who is management? Do you mean the service administrators and people down that end? Do you mean the senior management of the hospital? 12:24

A. Well, the service administrators and then up to Katherine Robinson. Yes, that is who I see as my management. 12:24

260 Q. And that is where you feel that it wasn't very helpful. Do you think the Trust as a whole creates an atmosphere where all the staff feel valued? 12:24

A. Not particularly, no.

261 Q. Why do you feel that? What do you think the source of that is? I am sure they wouldn't set out to be like that.

A. I don't know how to describe or why it has went that way. I think everybody is just running about chasing their tail and nobody has time for anybody. 12:25

262 Q. Yes, okay. Thank you very much. That is all from me.

CHAIR: I have only a couple of questions for you.

Just in terms of the clinical nurse specialists, we have heard that certainly in the nine SAIs, there were no key worker or clinical nurse specialist assigned to those patients. Can you assist us at all. We know that Mr. O'Brien did have some patients who had a key worker assigned. Can you assist us with how that happened; how a key worker was assigned in some cases and not others? 12:25

A. No. I wasn't aware that key workers needed to be assigned to cancer patients. This was all new to me. I never heard the word "key worker" ever used when working in urology. 12:26

263 Q. What about clinical nurse specialist or any other terminology, but somebody that that patient could ring up other than you to get help if they felt they needed it? 12:26

A. I wasn't aware of that. I knew the clinical nurse specialists were there and they did their role in biopsies and urodynamics, helping with urodynamics, but it was like as if that was their role. We were not aware that they needed to be involved. 12:26

264 Q. When you say "we", we know that other clinicians did use the clinical nurse specialist in that way as a key worker, so clearly presumably his secretary might have been aware? 12:26

A. I am not aware that the secretaries I shared the office with were aware.

265 Q. It wasn't something that was discussed?

A. I've never heard the word "key worker" ever used.

266 Q. Just in terms of the DARO system, you said that Mr. O'Brien always wanted to have a review of his patients and that is why he didn't use the DARO. Essentially what you are telling us is if a result came back and the result was all clear, there was really no need for that patient to be on a waiting list; isn't that correct?

A. That's correct, yes.

267 Q. So that patient being on the waiting list was then holding up someone else on the waiting list, in effect? 12:27

A. But Aidan would have made the -- he would have put them on for a review irrespective of the result.

268 Q. Do you see my point? If he is having a review slot for someone who really doesn't need it, and a quick phone call to say your tests are all back and they are clear, you are good to go, someone else could have had that slot on the waiting list? 12:27

A. That's right but to me that is not a secretary's call.

269 Q. No, no, I am not suggesting it is. What I am saying to you is that the DARO system was set up to ensure that those people who actually needed a review appointment were getting it. Would you accept that? 12:28

A. Well, Aidan would have used the DARO for those people that he knew was going to be discharged, albeit one or two patients; like, it wasn't vast amounts. But no, if a clinician says he wants to review, the secretary has to adhere to that. I can't comment on whether one patient deserves a review and another doesn't. It is not something I can comment on. 12:28

270 Q. Just in expanding on that a little bit, am I right in understanding that you did not feel that it was ever your role to challenge Mr. O'Brien?
A. No, I never would have challenged him.
271 Q. And whatever he told you to do, you did? 12:29
A. Yes.
272 Q. Thank you very much, Mrs. Elliott.
MR. HANBURY: I've just one more on the theme of the results. We have heard in the Inquiry where things didn't go so well, but were there times that, say, 12:29 negative results, as the Chair just said, were dictated on and you did letters so that patients were then advised? So, when you said Mr. O'Brien did use DARO sometimes --
A. Oh yes, yes. Those patients would have been -- 12:29
273 Q. -- and the CT came back and it was fine, for example, what would happen? Was there a letter?
A. Yes, he would have discharged the patient. Now, that was very rare.
274 Q. Okay, but would he dictate a letter to the patient -- 12:29
A. He would.
275 Q. -- to say it is fine?
A. He would. But that was very rare, I am saying one or two patients maybe a month. It was very rare.
276 Q. Thank you. If, for example, on the DARO system, say 12:30 for a prostate cancer follow-up, and the clinician says I want to see you in six months' time and we will have a PAS test beforehand, under the DARO rules would you then have to see the PAS result and then decide?

A. Yes.
277 Q. But then if there is a huge backlog, that patient might wait for six months to come back?
A. Yes, that's correct.
278 Q. So it didn't -- 12:30
A. It didn't speed up the review appointment.
279 Q. So you ended up -- I mean, was the whole idea of follow-up by letter, is that what the... reading between the lines.
A. Sorry? 12:30
280 Q. Maybe it is an unfair question. If a patient waited a huge length of time even having had the results, there is still a problem, isn't there?
A. If it was a very high PAS, Aidan would have addressed that. If they had have been on the review waiting list 12:31 to be seen in six months and the PAS came back high, he would have asked me to escalate that appointment and he would generally have said put him on my SWAH clinic for such and such a date. So, he did expedite a lot of appointments because of high or untoward results. 12:31
281 Q. As you say, the onus is then on the clinician to make that call?
A. Yes, yes.
282 Q. Thank you.
CHAIR: Thank you very much. Thank you, Mrs. Elliott. 12:31 I am sure you will be very relieved to know that we have finished asking you questions. It is not quite lunchtime but near enough. Thank you.

Tomorrow morning, Mrs. McMahon is back, is that correct? Ten o'clock tomorrow.

THE INQUIRY ADJOURNED TO 10.00 A.M. ON WEDNESDAY, 7TH JUNE 2023 12:32